Gender-Inclusive Family Interventions in Domestic Violence : An Overview

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Current policy towards domestic violence, including criminal justice and mental health responses that favor psychoeducational same-sex group treatment for perpetrators (usually for men) and victim services for victims (almost always women), has proven to be short-sighted and limited in its effectiveness (Babcock, Green & Robie, 2004; Mills, 2003). In this chapter, a critical review will be undertaken of family interventions in domestic violence, from the advocacy model to past and recent alternative treatment approaches that take into consideration the systemic, interactive and complex nature of family violence. Afterwards, procedures for assessment and treatment will be outlined, based upon a new, research-based *gender-inclusive* systems model.

The Evolution of Family Interventions

Ascendancy of the Patriarchal Paradigm

With the advent of the shelter movement in the 1970's a rapidly growing number of studies on domestic violence began to appear in books and academic journals. Almost immediately, this research fell into one of two distinct schools of thought. The "gender" or "patriarchal" view, largely based on studies of battered women (e.g., Del Martin, 1976; Dobash & Dobash, 1979; Walker, 1979), equated domestic violence with "wife abuse," and located its etiology in male dominance and patriarchal social structures. In contrast, the work of Straus, Gelles and Steinmetz (1980) amassed data from large representative sample surveys (National Family Violence Surveys, or NFVS), its questions on partner abuse framed within the context of escalated conflict. More importantly, partner abuse was regarded as only part of the broader problem of family violence, in which fathers or mothers might be perpetrators of partner as well as child abuse.

This promising family violence research was soon upstaged by the patriarchal view, which began to shape the core arrest and intervention policies adopted during the past quarter century. Ironically, the NFVS data was widely cited by battered women's advocates, who could cite its high prevalence rates for male-perpetrated violence, while conveniently ignoring the comparable data on women. The far lesser overall prevalence rates of crime studies, such as the NCVS, were also ignored, but not so the large gender differences. Thus, proponents of the patriarchal paradigm could pick and choose statistics in such a way that, although misleading, would be sure to advance their cause.

Early Systems Theorists

In the early 80's, before that paradigm established its stranglehold on research, before its principles became codified into law and the psychoeducational same-sex group model became the state-mandated treatment for all domestic violence perpetration, a small number of pioneers

published writings espousing a radically different approach, based on conflict and general systems theory. The work of Giles-Sims (1983) clearly fell in the gender/patriarchal camp, in its exclusive focus on male-perpetrated battering and the assumption that the causes of abuse could be found in male dominance. However, Giles-Sims theorized that such abuse cannot be fully understood according to traditional cause-and-effect explanations; rather, wife-battering is a relational and societal problem best explained according to systems principles:

> We know that those people who were abused as children have higher rates of abusing their own children or their spouses than those people who were not abused as children (Straus, et al., 1980). A cause-effect interpretation suggests that being abused as a child causes one to abuse one's own child or one's spouse. However, not all people who were abused as children abuse their children or beat their spouses. Some that were not abused as children do abuse their children and/or their spouses. Abuse or nonabuse, therefore, is not completely determined by the earlier behavior. A theoretical gap exists to explain these cases (pp. 18-19).

This gap may be bridged by conceptualizing relationships as a *system*, one that may be either open or closed; and by considering the role of *feedback*, a general systems theory term referring to the response of one human being to another's behavior. Negative feedback reduces, and positive feedback increases, the probability that a behavior will be repeated. Systems seek homeostatis, or balance, in achieving their goals. In abusive relationships the goals of the more powerful person tend to prevail, and violence may be used to maintain that homeostasis. Systems are said to be closed when the individuals engage in highly repetitive patterns of interaction, and new behavior tends to be met with negative feedback (e.g., the woman wants to work outside the home but her husband discourages or physically assaults her). Giles-Sims elucidates in his six-stage model of wife-battering the reasons why abused women stay and the forces preventing them from leaving. If "the system is relatively open to input from the outside social system," he writes, "then the impact of social norms that discourage severe abuse may be felt sooner, and change may occur in that pattern" (p. 11). Crises develop when the victim attempts to leave the system altogether; or during conflict, when one person's response intensifies the other's previous response in positive feedback loops, and the conflict escalates to a dangerous new level.

Lane and Russell (1989) proposed a far more radical theoretical model, allowing for the much greater involvement of women in the initiation and maintenance of violence in relationships. They were among the first to suggest that there are different types of abuse, a notion central to the later work of Michael Johnson (Johnson & Leone, 2005), and they explained both within a systemic framework. The fixation on delineating victims and perpetrators, they argued, fails to fully capture the nuances and dynamics of couples in relation to one another. In a *complementary* relationship, the violence is unilateral, and the dynamic is one akin to a predator and their prey; in a *symmetrical* one, both parties are abusive and struggle to control the relationship. Women, in other words, are not always victims.

Fran Deschner (1984) was among the first to incorporate systemic principles into clinical application. In her book, *The Hitting Habit* (1984), she outlines a sensible course of treatment consisting of separate same-sex groups for each partner followed by a multi-couples group format in which everyone is taught pro-social relationship skills. Other important innovators were Neidig and Friedman, whose book, *Spouse abuse: A treatment program for couples* (1984)

remains to this day one of the clearest, thorough, and practical manuals on abuse prevention and treatment to be found anywhere. While not dismissing the role of patriarchal factors (nor individual psychopathology), the authors emphasized the mutual, escalating nature of violence and the responsibility that *both* partners have for getting it under control:

> The unilateral view of spouse abuse, with its emphasis on societal factors as causing males to be abusive, may reduce the husband and wife's sense of guilt and responsibility while increasing their feelings of helplessness. Additionally, treatment that takes the unilateral view of violence encounters the following problems that can be avoided if the interpersonal perspective is maintained. First, there is the implication that there are fixed "victim" and "perpetrator" roles. Victims may assume that they can legitimately seek retribution or punishment, which can in turn lead to additional violent attempts to settle the score. Second, if the violence sequence is punctuated too narrowly, if either party only views the incident from his own perspective, and if interactional variables are not attended to, the violence may appear as if it erupted spontaneously and is beyond the influence of both parties. This perception is a therapeutic dead end. Third, when positive relationship factors and the contribution of both spouses to the conflict escalation process are ignored, women tend to be viewed as helpless, childlike victims, thus perpetuating conditions that may contribute to additional violence (pp. 3 - 4).

Their treatment program eschews simplistic solutions along gender lines, such as the "re-education" of male perpetrators according to feminist sociopolitical theory (e.g., Pence & Paymar, 1993). Within the format of a ten-week multi-couples format, both partners are encouraged to take personal responsibility for the violence, reduce their need to control their partner, and to seek and employ broader and healthier support systems. They are also taught a variety of anger management, stress reduction, communication and conflict resolution skills.

Chloe Madanes (1990) works with the entire family, employing the theoretical principles and interventions of strategic therapy to better understand the contradictory impulses driving family conflict. "How," she asks, citing the connection between violence and love in family relationships, "does a therapist steer people toward love and away from violence when there is so often such a fine line between the two?" (p. 6). The key, she suggests, is in understanding the core motives that drive family members, which she frames as the four dimensions of family interaction. The first involves the struggle over power, and the abuse that ensues when an individual attempts to control his/her own life and the lives of others. In the second, an individual's need to be loved may lead, for example, a child to hit his/her sibling as a means to get parental attention. The third dimension involves a parent's wish to love and protect his/her children, which may include spanking the children "for their own good," sometimes leading to escalated stress, conflict and abuse. The therapist's task is to help family members understand, curb and re-direct these impulses, and to encourage their natural tendencies to repent and forgive, the predominant motives in the fourth and final dimension.

Objections to Systems Theories

Battered women's advocates and feminist academics wedded to the patriarchal view of domestic violence were quick to critique systems formulations, and the intervention strategies derived from them. Essentially, their objections centered around the issue of *responsibility*: If

patriarchal structures cause and perpetuate domestic violence, then men are always responsible for the abuse in any given relationship. We now know that patriarchal structures account for only a partial explanation, and that institutionalized power does not necessarily translate to personal power. Perhaps due to collective guilt over the historical maltreatment of women, objections such as the following from Bograd (1984) were readily accepted at the time:

> Systems language can…focus attention away from important dimensions of battering. For example, to state that a woman remains in a violent relationship because abusive transactions satisfy needs at the systems level neglects that "needs of the system" may be less critical in maintaining battering than the husband's control of physical and material resources, which restricts the wife's freedom to leave or to modify the relationship… While not dismissing the possibility that battering is sometimes mediated by dysfunctional family processes or structures, feminists posit that battering is due more to the power inequality that is the context of almost all marriages…By neglecting social factors, family therapists reduce the causes of wife battering to intrafamilial factors. But violence and power are not simply functions of individuals and marital systems. Though the individual family may be the stage of violence behavior, it may not be its source (pp. 562-563).

Until relatively recently, when governing bodies for the various mental health disciplines began to mandate domestic violence education program for their members, therapists as a whole were unfamiliar with the dynamics of domestic violence, and rarely asked their clients about its occurence (e.g., Aldorondo & Straus, 1994). But the problem was far more egregious than one of simple ignorance. Hansen and Harway (1995) suggest that therapists are encouraged to focus on pathological factors, which can be diagnosed and therefore billed, as opposed to situational factors or criminal behavior such as wife-beating, which cannot. Furthermore, the theories and clinical methods of most therapists, according to critics, actively supported the maintenance of social and familial structures harmful to women. Hansen (1995) charged that psychodynamic theories, anchored in early childhood mother-child relationships, put the blame on mothers for any subsequent developmental disturbance – and this included the now discredited notion of a "schizophregenetic mother" responsible for causing an essentially hereditary mental illness.

Critics were especially suspicious of family therapy. Minuchin's structural model, they charged, propped up patriarchal structures, and Bowen's goal of differentiation was at its core male-oriented:

> Bowen's (1978) theory recognized the ideal individual as detached and objective and the more pathological individual as emotionally reactive to the affect of others. Mothers were consistently identified as having the primary emotional relationships with the child and thus having the primary responsibility for the success of the differentiation process. In addition, the opportunities for separation and identity development outside the primary relationship were clearly greater for male children. Though these opportunities were never specified as "male opportunities," women who sought them were suggested to have other problems, such as role confusion Hansen, 1995, pp 71-72).

In retrospect one can appreciate how the needs of women may have been minimized in such an environment, given the cultural context of those times (prior to the increasing access by

women to meaningful work opportunities and the greater involvement of fathers in parenting), and refinements in the theory and practice of family therapy. But to its critics, conjoint therapy, regardless of how it is conducted, is contraindicated because it gives the impression by virtue of both parties being in the room together, that both are to blame. Furthermore, the very language of systems parlance - neutral terms such as "feedback loops" and "homeostasis" - seemed cold and amoral and failed to capture the real pain suffered by victims. And because wives tend to be more emotionally forthcoming, the therapeutic focus turns to their issues rather than to those of the battering husband (Bograd, 1984).

The Advocacy Approach to Intervention

As a result of these objections, interest in systemic approaches quickly subsided. Intervention in spouse abuse was limited to shelter-based peer support groups for female victims, and the treatment of male batterers in same-sex psychoeducational programs. As the effects of domestic violence on children became more widely known (Wolak & Finkelhor, 1998), the prevailing model expanded to include therapy for the non-offending parent and her children. One such program, (Van Horn, Best & Lieberman, 1998), centered in a San Francisco hospital, consisted of weekly mother-child sessions for a period of one year. Mothers were helped to heal from their abuse as they acquired more appropriate parenting skills, and learned to better manage both their children's aggression and their own anger towards them. The recent book by Dalpiaz (2004), herself a battering victim, eloquently explores the dysfunctional aftermath of abuse, including the complex and often contradictory feelings that persist long after the batterer has physically left.

Also deemed acceptable by women's advocates have been supportive/educational children's groups. The program described by Jaffe et al. (1990) taught children between the ages of 8 and 13 about the nature of family violence, as well as how to label and express feelings such as anger, improve their social skills with peers and adults, and ways to stay safe in an abusive environment. Similar programs have been developed by Johnston and Roseby (1997), as well as Perilla (2000), whose agency worked primarily with Latino families, treating offenders, adult victims, and children in separate but concurrent groups. (Elsewhere in this volume, Loosely et al. describe their own program, but within a gender-inclusive framework.)

Hybrid Approaches

Common to all advocacy approaches has been the segregation of perpetrators and victims, and a disdain for systemic theories, with the notable exception of Rivett and Rees' (2004) interesting attempt to explain Duluth-style men's treatment groups as a sort of family system. But while the advocacy approach continued to dominate, a small handful of feminist researchers and clinicians re-visited the possibilities of conjoint and family therapy. Eschewing an "either/or" mindset, a group of family therapists at the Ackerman Institute for the Family founded the Gender and Violence Project, and adopted a "both/and" view of violence. Their treatment model for battering included what others have called a *reconstructive approach* (Geffner, Barrett & Rossman, 1995), in which abuse is explained by individual, or linear, factors, as well as family, or circular, factors. Reconstructive therapy encourages, within appropriate safety guidelines, conjoint and family work, but is firmly grounded in feminist advocacy

ideology with a therapist-advocate rather than neutral observer. Greenspun (2000) summarized the new systems/feminist hybrid as follows:

1. We believe that violence is multiply determined. It is the outgrowth of both male abuse of power over women *and* the result of escalations within the dyad based on relational dynamics. In addition, individual factors, such as internalizations of early relationships, neurobiological predisposition and trauma history, further contribute to the use of violence and can become points of intervention.
2. We view violence by men against their intimate partners as both an instrumental *and* an expressive act, rather than one or the other. Men wield violence and threats in order to intimidate and control women, but they may also experience the moment of violence as a loss of control.
3. Social control, resocialization to egalitarian viewpoints, and psychological exploration can all serve as useful interventions in order to stop male violence. A comprehensive therapy must be able to utilize all these approaches when necessary in order to address the variety of factors that lead to violence.
4. Couple (conjoint) therapy can be employed as a treatment approach, but *only* when a clear moral framework is utilized that holds the man fully accountable for his use of violence. In this sense, the therapist cannot maintain the usual neutrality most often associated with couples therapy. Understanding the psychological and relational underpinnings should be used to deter the violence, but never to excuse it. *If the man will not take responsibility for his aggression, conjoint treatment should not be undertaken* (p. 158).

Once it was re-affirmed that only the man is responsible for the violence, the Ackerman school was free to expand treatment possibilities, secure in its feminist credentials. Its most notable exponent, Virginia Goldner (1998), emphasized the practical advantages of conjoint therapy as something good for women because it helped reduce violence against them:

> Although we always insist on the punctuation that a man's violence is not *caused* by the relationships he forms, it is, nonetheless, woven into the confusing melodrama of the couple's involvement. As a result, the obsessive power of the relationship must be addressed if second-order change around the man's violence is to occur. This cannot be done by seeing each partner separately since it is only by observing the particular, idiosyncratic "pull" of the relationship in *statu nascendi* that its power to possess comes into focus. As systems therapists have often demonstrated, a picture is worth a thousand words, especially since the partners themselves typically cannot see the context that is shaping their behavior.
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> Such couples bond to one another with a monumental intensity that makes separation both unlikely and very dangerous. Given the level of risk, it is mere common sense to argue that developing a therapeutic alliance with *both* partners is vitally important…It strains common sense to argue that separating them in treatment necessarily promotes safety. After their respective sessions, the two end up at home together anyway, often not any more enlightened about the specifics of their escalation process, and it dangerous moments (pp. 265-266).

Notwithstanding its narrow focus on male-battering, the Ackerman school and its offshoots represented a radical departure from mainstream intervention. By examining childhood abuse, dependency needs and fear of intimacy, Goldner and her colleagues clearly "raised the bar" for the next generation of domestic violence clinicians, emboldening others to work systemically with violent couples (e.g., Singer, 1997). Successful programs would also be developed employing a multi-couple format, but these have generally been limited to providing support and teaching anger management and conflict resolution skills (e.g., Geffner & Mantooth, 2000; O'Leary, Heyman & Neidig, 1999), rather than exploring underlying issues or providing a corrective emotional experience. That is not to suggest that the latter format is any less effective; in fact, Sandra Stith and her colleagues at Virginia Tech University (2004) reported superior treatment outcomes, in terms of lower male offender recidivism, for the multi-couples modality compared to standard couples counseling. In fact, both formats are valuable, depending on the needs of the couple.

In New Zealand, Downey (1997) and her staff at the Berry Street MATTERS center have incorporated the core principles of the Ackerman school into their program for teens and their families. Thus adolescent violence can be explained by socioeconomic factors, drug and alcohol abuse, early parent-child relationships and the witnessing and experiencing of abuse and neglect - *and* by patriarchal structures and family dynamics. Spousal abuse by women is not under consideration; any modeling of abuse, and its subsequent intergenerational transfer, can be found exclusively in the father's violence towards the mother. Remarkably, despite its feminist ideological constraints, the MATTERS program broke therapeutic ground in acknowledging the *reciproca*l nature of family violence, a theme which will be picked up in a later section of this chapter. After reflecting on the existing family violence literature, she suggests some far-reaching implications for treatment:

> There are reports that adolescent violence may be retaliation for being struck or that the adolescent's violence may lead the parent to strike back, which cloud the issue of responsibility for the violence. Other authors surmise that the violent behaviour of adolescents could increase stress and conflict in families rather than that the stress and conflict cause the violence….(p. 75)

> Adolescents do not fit the typical conception of a perpetrator (who is physically and socially more resourced) and parents do not fit the idea of the physically and socially vulnerable victim. To deal with violence in the therapy room there has to be a complex understanding of it, such that we can affirm that violence is wrong and assign responsibility to the person who is acting violently, while at the same time employing our usual skills to assist people to have the relationships they desire. This is particularly true with adolescents, where we can see the hurt child so clearly when the adolescent is at the turning point from victim to perpetrator. There has to be the most comprehensive theory possible without compromising the moral position that people must take responsibility for their actions (p. 77).

Drawn from both the advocacy and reconstructive approaches and Robert Geffner's work with male offenders and their spouses at the East Texas Crisis Center in the 1980's (Geffner, Mantooth, Franks & Rao, 1989), the multi-systems perspective , or MSP proposed a three-stage course of treatment designed to promote safety while facilitating change (Geffner, Barrett &

Rossman, 1995): creating a context for change, challenging patterns and expanding realities, and consolidation. Their list of preconditions, drawn from multiple clinical research sources, are a well thought-out and useful guide for any clinician contemplating family work (see table 1).

Research at the Crossroads

Less overtly ideological than the Ackerman model, and having broadened the scope of treatment from the couple to the entire family, the work of Geffner et al. brought us to the verge of a truly modern, empirically-grounded, *gender-inclusive* approach. But this was a decade ago, and since then progress in the development of family therapy for domestic violence has come to a standstill. With the exception of Rybski's (1998) structured group program for adolescents and their parents, based on the work of Neidig and Friedman, Caffaro & Caffaro's (1998) volume on sibling abuse, the narrative therapy approach for couples developed by Ziegler and Hiller (2002), this author's *Gender-Inclusive Treatment of Intimate Partner Abuse* (Hamel, 2005), and Potter-Efron's outstanding *Handbook of Anger Management* (2005), one is pressed to find anywhere in the family violence literature treatment approaches that are both systemic *and* take seriously violence perpetrated by women. Today, there seems to be implicit agreement among researchers and clinicians that it is permissible to explore options of couples and family intervention, and even acknowledge that women can be physically abusive, so *long as it is understood that men are always the dominant aggressors and that the safety of women is always the primary consideration.*

These assumptions exist frankly because of the considerable influence by battered women's advocates on public policy, which has created a climate of fear within the research community to remain "politically correct," but they have also been buttressed by the work of Michael Johnson (Johnson & Leone, 2005). It was Johnson who formulated the now-popular distinction between *intimate terrorism*, a pattern of severe physical abuse combined with highly controlling behavior presumed to be male-perpetrated, and *common couple violence*, involving less serious abuse arising from escalated mutual conflict, perpetrated equally by men and women. Although his studies are deeply flawed, based on selected samples, and although recent research with more representative community samples has found comparable numbers of "intimate terrorists" between the genders (Graham-Kevan & Archer, in press), Johnson's typology has emerged as the only widely -acceptable alternative to the patriarchal paradigm (e.g., Greene & Bogo, 2002; Philpot, Brooks, Lusterman & Nutt, 1997).

The Gender-Inclusive Approach

The accumulated body of data from family violence research conducted over the past three decades, including batterer treatment outcome studies, the literature on prevalence and context in intimate partner abuse and its effects on children, as well as research on child abuse and neglect, is summarized in table 2. For a more thorough overview, the interested reader is referred to the introduction to this volume, the recent book by Hamel (2005), or the groundbreaking paper by Dutton and Nicholls (2005). The systemic, gender-inclusive approach to domestic violence is based upon this research. It is empirically-driven, rather than ideologically-driven, drawing heavily upon previous models but represents a significant departure in other respects.

Family Violence Assessments: Who Comes In?

There are numerous reasons why partner and child abuse are under-detected (Aldorondo & Straus, 1994). Client-based reasons include the belief that violence is excusable, the desire to make a good impression, fear of further victimization and dependency needs. Among the therapist-based reasons are using inappropriate terminology (e.g., using vague terms such as "battering" rather than asking specific questions about discrete acts of violence), and failure to ask, or even see, both partners. When therapists do ask about violence, it is usually about violence directed against the mother or the children; adult male victims are an afterthought, at best. Seeing multiple family members increases the odds that abuse by *either* parent, or other family members, will be discovered. Children, particularly teens, are less concerned about making a good impression and may be more honest. An operating principle is *for the clinician to interview as many family members, and in whatever combination, that will yield the maximum information about the family system without compromising anyone's safety or unnecessarily alienating key family members*.

Who is seen during the assessment process depends on a number of factors: 1) nature of the presenting problem, 2) legal constraints, and 3) client resistance. The clinician must ascertain who *should* be seen, and who *can* be seen. Unless the clinician is working specifically with a violent population (e.g., he/she is a Batterer Intervention Provider), the presenting problem may not be partner or child abuse. Adults seek help for depression, but are not immediately forthcoming about their victimization at the hands of their partner, which may have caused the depression. Parents who bring their son in for hitting his younger brother may have previously been abusive, to the children or each other. The adolescent girl brought in for drug use and curfew violations may be trying to escape a dysfunctional family system, in which emotional and physical abuse is perpetrated and reciprocated among all the family members.

The clinician must therefore be on the lookout for any signs of abuse. Among the risk factors for intimate partner abuse are: high conflict and relationship dissatisfaction; whether one partner is afraid of the other; aggressive personality or evidence of certain psychopathology such as Bipolar Disorder, ADHD, and personality disorder, particularly the "cluster B" group in the DSM-IV; violence in family or origin or violence in previous adult relationships; low SES, any alcohol or drug abuse - and corporal punishment. Risk factors for child abuse are similar (Merrill, Crouch, Thomsen & Guimond, 2004), and checklists are available (Milner and Chilamkurti, 1991.) Whenever, in fact, evidence is found for *any* type of abuse, the clinician should investigate the possibility that other types of abuse also exist. A more thorough discussion of risk factors, for both perpetrators and victims, including how to conduct a lethality assessment, can be found in the chapter by Nicholls et al., in this volume.

When clients are court-referred after a conviction for spousal abuse, there may be legal prohibitions against seeing perpetrator and victim together in the same session. The clinician may attempt to see the victim separately, if he/she is willing to oblige, or conduct an interview on the telephone. Collateral sources may be helpful. These would include contact with other mental health professionals previously or currently involved with the client and/or victim, and a review of documents from agency sources such as Probation or Child Protective Services. In cases involving voluntary clients, the clinician may have legal access to key family members who are nonetheless resistant to treatment. Strategies for engaging clients in treatment and building a therapeutic alliance can be found in Hamel (2005). One option is to conduct interviews separately with whomever is willing to participate, and to collect the information

piecemeal. This author has had success in securing the participation of key but resistant family members by soliciting their "expertise" as crucial to the success of therapy.

Exploring the Family System

During the assessment process, the clinician will need to explore the important areas of family functioning that can directly or indirectly lead to conflict, abuse and violence. They are:

1. EACH INDIVIDUAL'S ABILITY TO COPE WITH ANGER, STRESS AND CONLFICT
   Who has poor impulse control and tends to react to the slightest provocation by yelling, throwing things, or worse? In periods of high stress, are there certain family members around whom everyone must "walk on eggshells" lest they suddenly act out? Is there one "primary aggressor" whose internally-driven aggressive impulses generate the bulk of family conflict and dysfunction?

2. FAMILY BELIEFS ABOUT ANGER AND VIOLENCE
   Is corporal punishment the preferred means of discipline? Are outbursts of verbal or physical abuse overtly disapproved, but tacitly allowed when someone has been "pushed over the limit." Are certain transgressions, such as flirting, "fair game" for violence? Is violence by the father minimized because of society's glorification of male violence, or mother's violence ignored because it is less physically damaging?

3. FAMILY STRUCTURE
   Differentiation and organization – Are each family member's roles clearly defined, and appropriate for their abilities and developmental level? In unhealthy families, roles are unfulfilled (e.g., the mother who neglects her children due to chronic substance abuse), and definitions are blurred or reversed – e.g., the child who takes care of a battered mother, the chronically unemployed father who likes to "hang out" with his son to play video games.
   Boundaries and Hierarchies – Emerging research (e.g., Davies & Sturge-Apple, this volume) finds associations between family conflict and boundary problems. The clinician needs to ask: Is there a clear boundary between the parental system and the child sub-system so that parental authority is maintained, yet permeable enough to allow for necessary information and communication from the children? Is there overinvolvement (enmeshment) or underinvolvement (disengagement) between individuals in the two subsystems? Is there an inappropriate alliance between a parent and child, causing the triangulation of another? In healthy families, the parental subsystem is not only separate from, but also above the child subsystem in the vertical hierarchical organization of its members.
   Accessibility to Outside Influence - Are the boundaries with the outside world also appropriately permeable, allowing for the privacy and integrity of the family while allowing input necessary for growth and change? Or does a family code of secrecy prevent victims from accessing help against abuse?

Adaptability – How capable is the family system of adapting to stress and changes in circumstances? Can it maintain an optimum equilibrium of functioning, allowing for stability but flexible enough to grow and to increase its available set of responses?

4. RELATIONSHIP DYNAMICS
These include attachment styles (secure, anxious, avoidant, disorganized), communication and emotion expression, and how conflicts are handled. Is a particular relationship characterized by a control-compliance or control-control dynamic? When one person attacks, does the other counter-attack, defend, or else withdraw altogether? To what extend does fear of abuse (physical or emotional) shape any individual's behavior?

5. THE FUNCTION OF EACH PERSON'S BEHAVIOR IN THE FAMILY CONTEXT
What are the likely repercussions within the family system for a given behavior? Consciously or unconsciously, human beings tend to do things for which there is some "payoff." An adolescent, for instance, may become violent towards his/her parents as a way to prevent them from divorcing. A victim may consciously initiate a fight in order to "get it over with" before an important event (e.g., Christmas).

A number of questionnaires are available to the clinician conducting an assessment. To secure information about intimate partner abuse, recommended instruments are: the Conflict Tactics Scale (verbal and physical abuse prevalence rates), CTS-2 (verbal, physical, sexual and psychological abuse, and extent of injury), Controlling and Abusive Tactics Questionnaire (abuse and control), and the Anger Styles Questionnaire developed by Potter-Efron 2005). The standard instrument for measuring child abuse is the CTS-PC. A complete, step-by-step family violence assessment protocol can be found in Hamel (2005), including questions to ask children and reproductions of the above instruments (or information on how to order them.) Children and adolescents may be quite forthcoming about their parent's violence, but not their own. At the Matters Program in New Zealand (Sheehan, 1997), the staff employ several sets of questions to obtain information while engaging the cooperation of adolescent perpetrator clients. A partial list, some of them applicable when working with other types of family violence, can be found in table 3.

Primary Aggressor Assessment, Responsibility and Empowerment

In justifying a couples approach to domestic violence, Goldner (1998) cited the "obsessive power of the relationship," and the "confusing melodrama of the couple's involvement" (p. 265), but also made it clear that a man's violence is not *caused* by his relationship problems. In the gender-inclusive perspective, violence by the man *or* the woman, or by any of the children, may in fact be at least partially caused by stress and relationship issues; and physical aggression may be a response to verbal or emotional abuse, or to controlling behavior. However, it is equally true that violence is itself a cause of stress and relationship problems - in the same manner that personal problems (e.g., anxiety, depression, unsatisfactory peer relations) may lead to excessive drinking, and excessive drinking in turn brings it own share of dysfunction (e.g., more depression, job problems).

One must attend to both the abuse and the factors that contribute to, and are caused by, the abuse. However, it is important to point out that although family abuse is often reciprocal and mutual, and systemic factors serve to perpetuate abusive systems, violence is also caused and maintained by factors inherent in the *individual*, among them distorted and anti-social attitudes, a need to dominate, and poor impulse control (Dutton, 1998). Perpetration of abuse is should thus be considered a separate problem (Geller, 1998). In deciding who should be treated specifically for the abuse (e.g., through referral to an anger management or batterer program), one may begin with the work of Appel and Holden (1998), who propose five possible models of co-occurring spousal and child abuse. Their scheme, with some modification to bring it line with gender-inclusive research, is as follows:

- Single perpetrator – One parent abuses the other parent and the children.
- Sequential perpetrator – One parent abuses the other parent, who in turn abuses the children.
- Dual perpetrator – One parent abuses the other parent, and both parents abuse the children.
- Marital violence – The parents mutually abuse one another, and the children.
- Family dysfunction – Both parents abuse one another and the children, and the children abuse one or both of the parents and/or each other.

Although the last model is the most inclusive, it is often one of the other models that best explains the abuse in a particular family. To account for all possible combinations of family violence, this scheme may be expanded to include, for example, child abuse without partner abuse and partner abuse without child abuse, as well as child-perpetrated violence when there is no child abuse. Appel and Holden (1998) also point out that families are fluid, not static entities, and may pass through several models.

In identifying the pathways for abuse, one important consideration is determining the *primary aggressor*. This is not always the biggest person, or the one who yells the loudest. The primary aggressor is *the one who tends to initiate the abuse and whose behavior has the greatest impact on the family system.* As the family dysfunction model suggests, this could certainly be a child, but a child would rarely be considered the *dominant aggressor*, a legal term referring to who has the greater power and is the greater threat in an intimate partner relationship. Dad may be the primary (and dominant) aggressor if, for instance, he initiates the verbal and physical aggression towards his partner, controls the household money, and has an authoritarian parenting style. Mom may retaliate at times by hitting back, or yell at the children, and she may in fact require some help with her own issues and be a key to the family's overall treatment success, but unless dad's anger and violence is specifically addressed as a separate problem, the outcome is likely to be poor. In another family, if dad has thrown things, but this was in response to a constant barrage of verbal and emotional abuse from a partner who insists on making all of the family decisions, then mom would be regarded as the primary and dominant aggressor. Of course, there are times when neither party can be considered dominant, because both engage in various types of abusive and controlling behaviors – e.g., dad slams doors, has grabbed mom by the arm, controls the finances and uses the "silent treatment;" and mom initiates the verbal abuse, constantly checks on his whereabouts, and has allied herself with the children.

Research indicates that distinctions between "perpetrator" and "victim" are grossly overemphasized. In the gender-inclusive perspective, everyone is responsible for their behavior.

Some individuals obviously need to be protected and given appropriate resources. Individuals who stay out of fear or due to pressing financial reasons may need special assistance in leaving their relationship (e.g., with restraining orders, refuge in a shelter). But they are nonetheless responsible for their own well-being, and to the extent that a victim remains in a relationship for personal and less pressing reasons, it would seem prudent – indeed, required – to help them evaluate their choices (Mills, 2003; Peled, Eisikovits, Enosh & Winstok, 2000) We ought to be careful not to pathologize victims (Hansen, 1995), but asking a client to address the personality characteristics that make them prone to finding abusive partners is to empower them, not blame them. Do we ignore a victim's dependency issues because it is not "politically correct?" We cannot discount the strong likelihood that an untreated victim will at some point retaliate the abuse, either against their partner or the children; or leave the abuser only to later involve themselves in another abusive relationship, subjecting the children to further dysfunction. Children don't care "who started it," or how long the parent has been a victim.

We need to distinguish between true victims who unnecessarily blame themselves out of fear of the abuser, dependency needs or denial of the abuse, from situations in which a "victim" feels appropriately guilty for engaging in abuse of their own. Taking responsibility means accepting the consequences of one's actions, regardless of victim or perpetrator status: a person whose nagging results 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 behavior, nor that the partner's behavior should be minimized. Clearly, that victim can claim the "moral high ground." But the task of a clinician is to facilitate change, not make moral judgments. By failing to understand that systems theory is first and foremost *a means of understanding* and not a specific set of treatment recommendations, and by confusing "cause" and "blame," (Felson, 2002), victim advocates have severely restricted our common efforts to combat family violence.

Treatment Options

Once the clinician has a working understanding of the family's abuse dynamics he or she can proceed to formulate a treatment plan. Treatment may be carried out in any number of modalities, sequentially or concurrently, in whatever combinations are most promising for success. On a spectrum from most inclusive to least, those modalities are:

- Therapy with the entire family.
- Therapy with several family members – e.g., parents and one child, one parent and the children.
- Couples counseling – includes the dyad by itself, or part of a multi-couples group or anger management parenting group
- Other dyads – e.g., parent and child, two siblings
- Counseling with several family members, but individually
- Separate anger management/batterer group participation for the primary aggressor(s)
- Therapy group for the child

Safety and the Course of Treatment

It should be emphasized that "most inclusive" is not always what is best. Seeing the entire family is usually a good idea, for example, when there is a high degree of reciprocal abuse,

or when the clinician needs the assistance of additional family members to confront resistance and denial. In other cases, the dysfunction is more or less contained among a segment of the family (e.g., two siblings, the parents, one parent and a child), and it would be more expeditious to narrow the treatment focus, at least initially. Of course, family therapy may be contraindicated when one or more of the preconditions outlined in table 1 have not been met. One of the most important concerns is safety. Participants cannot be expected to honestly engage in the process when they feel threatened by an untreated parent (or child or sibling). Battered women have often reported violence directed against them following a family session (Adams, 1988; Pagelow, 1981); but this is not a gender-specific phenomenon, and it matters little if that threat is physical (dad has chocked mom, requiring her hospitalization; mom has punched her daughter in the face) or emotional (mom calls her son a "little shit;" dad routinely threatens to abandon the family.)

Vetere and Cooper (2001) caution clinicians to be aware of non-verbal signs of intimidation: "If the perpetrator stops physically violent behaviour but continues to intimidate - through attitude, facial expression, physical posture and use of language – then only partial change has been achieved" (p.391). In such cases, the clinician has the choice of separating the couple or, if appropriate confronting the behavior directly, thus allowing for the possibility of insight and the corrective emotional experience for both partners that might alter a long-standing relationship dynamic.

As Goldner (1998) has articulated, safety is hardly promoted when the clinician refuses conjoint counseling against the victim's wishes, considering that the couple will simply continue the violence outside the office, where it cannot easily be monitored. And Potter-Efron (2005) suggests that conjoint therapy may be required for even the most violent couples, as a "last resort" when everything else has been tried (e.g., several round of batterer group, separate victim services). The clinician can foster a feeling of safety in victimized family members by clearly articulating his/her position that violence is unacceptable, by offering a safety plan, and by encouraging them to call the police should they be re-assaulted. Safety will also be promoted if the course of treatment follows the author's three-phase approach (see table 4), which emphasizes skill building and the re-establishment of trust and confidence among the family members in the first phase, and greater exploration of underlying issues and dynamics in the following phases.

Case Examples

CASE #1: DUAL PERPETRATOR MODEL

> Joe and Evelyn Mitchell, brought their 12-year son, Drake, to a private practice marriage and family therapist, seeking help for his school problems. A middle-aged insurance salesman, Joe tried to project an outward demeanor of strength and confidence, but was overshadowed by his extremely high-strung, domineering wife, a real estate broker who did most of the talking during the first session. It was also apparent that Joe had been suffering from depression. While answering the therapists questions about his poor school attendance and failing grades, Drake revealed that he sometimes "lost it" with friends whom she perceived as disloyal. The therapist asked Drake if there was anyone else in his life who sometimes "lost it," and he disclosed, hesitantly, that mother "screams at dad and sometimes hits him with things." It was revealed that Evelyn also

yelled at Drake, and had in fact had physically abused him for years, with hair brushes and other household objects. The week before, when he lied to her about his school attendance, she had slapped him hard enough to cause a bloody nose. And Joe had on occasion pushed and grabbed Drake, typically when under pressure from mom, once bruising his arm when he refused to clean up his room.

After the first session, the therapist asked to meet with the couple without their son. Results of the Conflict Tactics Scale and Controlling and Abusive Tactics Questionnaire confirmed that Evelyn was the dominant aggressor in the family, scoring high on the CAT dimensions of diminishment of self esteem (berating Joe for not bringing in enough income, ridiculing his sexual performance), as well as isolation and jealousy (she constantly questioned his whereabouts, accused him of having affairs.) Although severely abused, on one occasion he incurred a deep gash in his head from a fireplace poker, Joe refrained from hitting back, too scared that if he were to do so, she would leave him. Raised to not "air your dirty laundry," he never thought of calling the police, nor sought any type of assistance from extended family or from professionals, bearing the twin burdens of family violence and his own depression in secret. His role, he told the therapist, was to be "the strong one." Meanwhile, because of the long-standing alliance between father and son, Evelyn felt painfully alienated; and when they would dismiss her as "crazy," and threatened to move out together, the old shame and hurt of having lived with an abusive schizophrenic mother, and having been abandoned at age seven by her father, resurfaced again. This rejection made her more angry, and justified her criticisms of Joe, causing him to withdraw, which in turn led Evelyn to lash out in desperate bids for attention.

Because of the seriousness of Evelyn's violence and poor impulse control, the therapist referred her to a one year domestic violence/anger management group. The local battered woman's shelter did not offer support groups for men, but a concerned worker offered to see Joe on an individual basis, providing him support and helping him understand the issue around his victimization. Claiming that the counseling was "repetitive," he terminated after six weeks. (Later, he admitted to having felt uncomfortable in the role of "victim.") But the family came in together for another three months, during which time Evelyn ceased her physical assaults and most of her verbal abuse, and the parents were able to work on a parenting plan to deal with Drake's school problems. In doing so, the family hierarchy was restructured to bolster the parental subsystem. Evelyn as asked to come in for a few sessions separately with Drake, and over time (but not without some setbacks), mother was able to build a loving and healthy relationship with her son.

Encouraged with this success, the couple agreed to come in for conjoint sessions and work on their own relationship. Over the next fourteen months, the focus was first on Evelyn, and consolidating the progress she made on managing her anger; then it shifted to Joe, who found the newfound reconciliation between mother and son somewhat threatening. Joe's own dependency needs emerged, as well as his fears of intimacy. By helping Joe learn to better assert himself and set limits on his wife's aggression, while encouraging him to accept appropriate bids for love and attention, he gradually overcame his depression and became the genuinely strong and compassionate man he'd always wanted to be.

CASE #2: FAMILY DYSFUNCTION

Matt, a 29-year old construction worker, was referred to a batterer intervention program (BIP) at the insistence of his wife, Jackie, a stay-at-home-mom, for having shoved her. During the intake process, Matt complained to the BIP counselor that he has already done a batterer program, and that for the past two years it had been his wife who "caused all the problems." It began, he said, with sabotaging behaviors (e.g., standing in front of the door when he attempted to take a time out), and later turned into verbal put-downs, throwing things and, finally, hitting. The BIP counselor at first assumed that Matt was in denial, like a lot of the men he worked with; until a phone consultation with Jackie revealed a more complex picture.

Meanwhile, Jackie had expressed dissatisfaction with her shelter support group, where her own problems with anger, against Matt as well as the children, seemed to be minimized. On the CTS and CTS-PC, it was revealed that Matt had punched Jackie five years before, an incident for which he was arrested, and had frequently used a belt to discipline their 13-year-old son, Andy. In the past, both parents had frequently yelled, and sometimes Jackie initiated. But the CAT also indicated that Matt often used non-verbal intimidation around Jackie – for example, cornering her in the kitchen and literally getting into her face – and he controlled the family finances, withholding his wife's "allowance" when she gave him "a hard time." As a result of his involvement with the batterer group, Matt eventually let go of his need for control and never hit Jackie again. Wanting more information, the therapist invited the entire family to come to the next session, and the full picture of the family's violence and dysfunction began to emerge, one that over the years had clearly shifted from a single perpetrator to a family dysfunction model.

The pushing incident, it turned out, occurred when Matt restrained Jackie from hitting their eleven-year old daughter, Viola, after Viola had slapped her mother and called her a "bitch." While attempting to separate wife and daughter, Matt blamed Jackie for letting the conflict escalate, and that's when Jackie began to slap and kick her husband. When Matt pushed her away, she fell against a bookcase. Probing for antecedents, the therapist learned that earlier that day Viola had been yelling at Andy for using her Walkman without permission. Because of his age, it was Andy whom the parents typically punished whenever the siblings didn't get along, but on this occasion the parents had decided to side with Andy after finding out that Viola had retaliated by ripping up one of his crucial homework assignments. Viola indeed had been the favored child, and for years Andy had deeply resented her. Fearing his father's wrath, he would rarely confront her directly. Instead, he would engage in passive-aggressive behavior, such as burying her dolls in the backyard. But now, having just experienced a sudden growth spurt, emboldened by his father's nonviolence and having internalized dad's previously abusive coping style, Andy began to strike out physically against his sister and his mother.

Viola had previously acted as the family peacemaker when dad had been violent. She had joined mom in some counseling sessions at the shelter, and had even become a confidante. But when mom restricted her involvement with a new, more delinquent peer group in middle school, Viola turned on her. Recognizing the dangerous, escalating nature of these shifting dynamics, the therapist requested that everyone come in together

for therapy. Partly during these sessions, and in the course of a separate 26-week family violence parent program for Matt and Jackie, the therapist educated them about family abuse dynamics, the intergenerational cycle of violence, and pro-social ways with which to handle conflict. Adjunct sessions with Andy and Viola were helpful in shoring up the sibling subsystem, and to reduce the enmeshment between mother and daughter. Later, conjoint sessions with the parents addressed some of the issues in their relationship, including Jackie's lingering difficulties in trusting Matt not to be violent, as well as Matt's plummeting self-esteem following an extended lay-off from his job. The therapist helped the couple adjust to the stress of changing gender roles when Jackie found work as a legal secretary (something that Matt initially protested). Within six months, Matt had found another job, and in the meantime, had spent valuable and needed time mending his relationships with his children.

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Table 1. Preconditions for Conducting Family Therapy

- 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

Table 2. Gender-Inclusive Research Findings

- Both men and women can be victims and/or perpetrators.
- Victim/perpetrator distinctions are overstated, and much partner violence is mutual. Even when the violence is unilateral, overall *abuse* is often bilateral.
- Both genders are physically and emotionally impacted by abuse. Women suffer the greater share of physical injuries, and express overall higher levels of fear.
- Men engage in higher levels of sexual coercion and can more readily intimidate physically, but women and men overall engage in comparable levels of controlling and abusive behaviors.
- The causes of partner abuse are varied, but similar across gender, and patriarchal explanations are insufficient.
- Men and women have similar motives in perpetrating violence. "Gendered" violence may be male or female perpetrated.
- There is no automatic power imbalance favoring the man that would preclude couples or family counseling; the dominant aggressor may be male or female.
- Regardless of perpetrator gender, child witnesses to partner abuse are adversely affected, and are at risk for experiencing and perpetrating partner abuse as adults.
- There is a high correlation between perpetration of partner abuse and child abuse, for both men and women.
- Family violence is a complex phenomenon, mediated by stress, with reciprocal interactions between the individual members
- The victim of one person's abuse maybe a perpetrator towards another in the same family, and victims who leave may become perpetrators in subsequent relationships.

Table 3. Engagement and the Joining Process (Sheehan, 1997, pp. 85-86)

A. Questions that help lessen a child's anxiety about entering treatment:

"Do you feel like you're in the hot seat?"
"What do you think your parents want to say to me?"
"Do you think I'll hear your side of the story, or only your parents' side?"

B. Questions that elict a child's "honorourable self," capable of empathy:

"What was it like when you hit your mum? How did you feel afterwards?"
"When you're feeling angry, do you ever notice any other feelings there as well?"
"How would you know if anyone in the family was feeling scared of you?"

C. Questions that help bring forth the child's "agentive self," capable of taking ction to end the violence:

"At what point did you choose to hit your dad? Looking back, could you have chosen to act differently?
"Can you think of a time when you wanted to hit your mum, but chose not to? What did you do instead? Was it a better idea, or not?

D. Questions that elicit the parents' and siblings' experiences of living with a violent child:

"What was it like for you when your daughter was being violent?"
"What will it do to your relationship if nothing changes?"
"Does your sister's violence stop you from being her friend?"

E. Questions that encourage change by helping family members notice improvement:

"Who will notice first if Jason is making an effort to control his violence?"
"Do you think your mum and dad see you differently when you are controlling your anger?"
"Now that Kylie is making an effort, are other people in the family acting differently too?"

Table 4. Phases of Treatment

I	II	III
Overall approach Psycho-educational Goals Eliminate physical aggression. Avoid secondary problems. Minimum ventilation of affect. Built confidence and trust. Focus on content. Learn how anger works, conflict escalation dynamics, role of stress, impact of control and "dirty fighting" tactics, and equalitarian decision-making. Acquire basic anger management, communication and conflict containment skills. Type of change sought First-order, behavioral, immediate	Overall approach Psycho-educational/cognitive Goals Begin to reduce verbal/psychological aggression. Continue avoiding secondary problems, but begin addressing lesser primary problems. More ventilation of affect. Continue trust and confidence building. Continued focus on content; limited discussion of process. Identify and challenge "self-talk." Expand communication skills and learn conflict resolution and problem solving techniques. Assertiveness training. Type of change sought First-order, behavioral, some internal	Overall approach Cognitive/insight-oriented Goals Eliminate verbal/psychological aggression. Begin addressing core issues. Full expression of affect encouraged. Greater attention to process. Identify belief systems underlying distorted self-talk. Begin addressing and working through childhood-of-origin issues. Type of change sought Second order, systems level, internal