Intimate VIOLENCE

Contemporary Treatment Innovations

Donald Dutton, PhD
Daniel J. Sonkin, PhD
EDITORS

Intimate Violence: Contemporary Treatment Innovations

Intimate Violence: Contemporary Treatment Innovations has been co-published simultaneously as *Journal of Aggression, Maltreatment & Trauma*, Volume 7, Numbers 1/2 (#13/14) 2003.

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Intimate Violence: Contemporary Treatment Innovations, edited by Donald Dutton, PhD, and Daniel J. Sonkin, PhD (Vol. 7, No. 1/2 [#13/14], 2003). *"EXCELLENT. . . . Represents 'outside the box' thinking. I HIGHLY RECOMMEND THIS BOOK for everyone working in the field of domestic violence who wants to stay fresh. Readers will be stimulated and in most cases very valuably informed." (David B. Wexter, PhD, Executive Director, Relationship Training Institute, San Diego, CA)*

Trauma and Juvenile Delinquency: Theory, Research, and Interventions, edited by Ricky Greenwald, PsyD (Vol. 6, No. 1 [11], 2002). *"Timely, concise, compassionate, and stimulating. . . . An impressive array of authors deals with various aspects of the problem in depth. This book will be of considerable interest to clinicians, teachers, and researchers in the mental health field, as well as administrators and juvenile justice personnel handling juvenile delinquents. I highly commend Dr. Greenwald on a job well done." (Hans Steiner, MD, Professor of Psychiatry and Behavioral Sciences, Stanford University School of Medicine)*

Domestic Violence Offenders: Current Interventions, Research, and Implications for Policies and Standards, edited by Robert Geffner, PhD, and Alan Rosenbaum, PhD (Vol. 5, No. 2 [#10], 2001).

The Shaken Baby Syndrome: A Multidisciplinary Approach, edited by Stephen Lazoritz, MD, and Vincent J. Palusci, MD (Vol. 5, No. 1 [#9], 2001). *The first book to cover the full spectrum of Shaken Baby Syndrome (SBS). Offers expert information and advice on every aspect of prevention, diagnosis, treatment, and follow-up.*

Trauma and Cognitive Science: A Meeting of Minds, Science, and Human Experience, edited by Jennifer J. Freyd, PhD, and Anne P. DePrince, MS (Vol. 4, No. 2 [#8] 2001). *"A fine collection of scholarly works that address key questions about memory for childhood and adult traumas from a variety of disciplines and empirical approaches. A must-read volume for anyone wishing to understand traumatic memory." (Kathryn Quina, PhD, Professor of Psychology & Women's Studies, University of Rhode Island)*

Program Evaluation and Family Violence Research, edited by Sally K. Ward, PhD, and David Finkelhor, PhD (Vol. 4, No. 1 [#7], 2000). *"Offers wise advice to evaluators and others interested in understanding the impact of their work. I learned a lot from reading this book." (Jeffrey L. Edleson, PhD, Professor, University of Minnesota, St. Paul)*

Sexual Abuse Litigation: A Practical Resource for Attorneys, Clinicians, and Advocates, edited by Rebecca Rix, MALS (Vol. 3, No. 2 [#6], 2000). *"An interesting and well developed treatment of the complex subject of child sexual abuse trauma. The merger of the legal, psychological, scientific and historical expertise of the authors provides a unique, in-depth analysis of delayed discovery in CSA litigation. This book, including the extremely useful appendices, is a must for the attorney or expert witness who is involved in the representation of survivors of sexual abuse." (Leonard Karp, JD, and Cheryl L. Karp, PhD, co-authors, Domestic Torts: Family Violence, Conflict and Sexual Abuse)*

Children Exposed to Domestic Violence: Current Issues in Research, Intervention, Prevention, and Policy Development, edited by Robert A. Geffner, PhD, Peter G. Jaffe, PhD, and Marlies Sudermann, PhD (Vol. 3, No. 1 [#5], 2000). *"A welcome addition to the resource library of every professional whose career encompasses issues of children's mental health, well-being, and best interest . . . I strongly recommend this helpful and stimulating text." (The Honorable Justice Grant A. Campbell, Justice of the Ontario Superior Court of Justice, Family Court, London, Canada)*

Maltreatment in Early Childhood: Tools for Research-Based Intervention, edited by Kathleen Coulborn Faller, PhD (Vol. 2, No. 2 [#4], 1999). *"This important book takes an international and cross-cultural look at child abuse and maltreatment. Discussing the history of abuse in the United States, exploring psychological trauma, and containing interviews with sexual abuse victims, Maltreatment in Early Childhood provides counselors and mental health practitioners with research that may help prevent child abuse or reveal the mistreatment some children endure."*

Multiple Victimization of Children: Conceptual, Developmental, Research, and Treatment Issues, edited by B. B. Robbie Rossman, PhD, and Mindy S. Rosenberg, PhD (Vol. 2, No. 1 [#3], 1998). "*This book takes on a large challenge and meets it with stunning success. It fills a glaring gap in the literature . . . " (Edward P. Mulvey, PhD, Associate Professor of Child Psychiatry, Western Psychiatric Institute and Clinic, University of Pittsburgh School of Medicine)*

Violence Issues for Health Care Educators and Providers, edited by L. Kevin Hamberger, PhD, Sandra K. Burge, PhD, Antonnette V. Graham, PhD, and Anthony J. Costa, MD (Vol. 1, No. 2 [#2], 1997). *"A superb book that contains invaluable hands-on advice for medical educators and health care professionals alike . . ." (Richard L. Holloways, PhD, Professor and Vice Chair, Department of Family and Community Medicine, and Associate Dean for Student Affairs, Medical College of Wisconsin)*

Violence and Sexual Abuse at Home: Current Issues in Spousal Battering and Child Maltreatment, edited by Robert Geffner, PhD, Susan B. Sorenson, PhD, and Paula K. Lundberg-Love, PhD (Vol. 1, No. 1 [#1], 1997). *"The Editors have distilled the important questions at the cutting edge of the field of violence studies, and have brought rigor, balance and moral fortitude to the search for answers." (Virginia Goldner, PhD, Co-Director, Gender and Violence Project, Senior Faculty, Ackerman Institute for Family Therapy)*

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Routledge
Taylor & Francis Group
NEW YORK AND LONDON

First Published by

The Haworth Maltreatment & Trauma Press, 10 Alice Street, Binghamton, NY 13904-1580 USA

The Haworth Maltreatment & Trauma Press is an imprint of The Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904-1580 USA.

Transferred to digital printing in 2011 by Routledge
711 Third Avenue, New York, NY 10017
2 Park Square, Milton Park, Abingdon, Oxon, OX14 4RN

Intimate Violence: Contemporary Treatment Innovations has been co-published simultaneously as *Journal of Aggression, Maltreatment & Trauma*, Volume 7, Numbers 1/2 (#13/14) 2003.

Cover design by Lora Wiggins

Library of Congress Cataloging-in-Publication Data

Intimate violence: contemporary treatment innovations /Donald Dutton, Daniel J. Sonkin, editors.
p. cm.
"Intimate Violence: Contemporary Treatment Innovations has been co-published simultaneously as Journal of Aggression, Maltreatment & Trauma, Volume 7, Numbers 1/2 (#13/14) 2003."
ISBN 0-7890-2018-1 (hard cover : alk. paper)–ISBN 0-7890-2019-X (soft cover.: alk. paper)
1. Family violence–Treatment. 2. Victims of family violence–Rehabilitation. I. Dutton, Donald G., 1943- II. Sonkin, Daniel Jay. III. Journal of aggression, maltreatment & trauma.
RC569.5.F3I58 2003
616.85′822–dc21 2003005333

Dedicated to the professionals engaged in the daunting and sometimes rewarding task of working with abuse perpetrators.

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ABOUT THE EDITORS

Donald Dutton, PhD, received his PhD in Psychology from the University of Toronto in 1970. In 1974, while on faculty at the University of British Columbia, he began to investigate the criminal justice response to wife assault, preparing a government report that outlined the need for a more aggressive response, and subsequently training police in "domestic disturbance" intervention techniques. After receiving training as a group therapist at Cold Mountain Institute, he co-founded the Assaultive Husbands Project in 1979, a court mandated treatment program for men convicted of wife assault. During the fifteen years he spent providing therapy for these men, he drew on his background in both social and clinical psychology to develop a psychological model for perpetrators of intimate abuse. This model views intimate abusiveness as emanating from a trauma triad and comprised of witnessing abuse, being shamed and experiencing insecure attachment. He has published over 100 papers and three books, including *Domestic Assault of Women* (1995), *The Batterer: A Psychological Profile* (1995) and *The Abusive Personality* (1998). *The Batterer* has been translated into French, Spanish, Dutch and Polish and Dutton has provided numerous workshops to professionals based on this work, including talks at the Sorbonne in Paris, Washington, D.C. and New York City. Dutton frequently serves as an expert witness in civil trials involving domestic abuse and in criminal trials involving family violence, including his work for the prosecution in the O.J. Simpson trial (1995). The latter led to an interest in spousal homicide and to "abandonment killing." He is currently Professor of Psychology at the University of British Columbia, Vancouver, BC, Canada.

Daniel J. Sonkin, PhD, is a Licensed Marriage and Family Therapist in an independent practice in Sausalito, California. His work focuses on the treatment of individuals and couples facing a variety of psychological problems including domestic violence and child abuse. In addition to his clinical experience, he has testified as an expert witness in criminal cases where domestic violence is an issue. He has also evaluated de-

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Richard E. Heyman, PhD, is Research Associate Professor in the Department of Psychology at the State University of New York at Stony Brook. Dr. Heyman's research on assessing and treating families and on the risk factors and causes of family maltreatment is internationally known. He is the author of over 50 publications in scientific journals and scientific books. His research has been funded by the National Institute of Mental Health, the Centers for Disease Control, the U.S. Army and the U.S. Air Force. Dr. Heyman is a licensed clinical psychologist and maintains a private practice in Stony Brook, NY.

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Alan Rosenbaum, PhD, is Professor in the Department of Psychology at Northern Illinois University and the Center for the Study of Family Violence and Sexual Assault. He founded the Marital Research and Treatment Program at the University of Massachusetts Medical School and served as its director for sixteen years. This program included the Men's Educational Workshop, one of the largest university based batterers' treatment programs in the U.S., as well as anger management programs for men, women, and adolescents. Research interests include outcome evaluation of batterers' treatment, the etiology of intimate partner aggression, female aggression, and the contributions of biological factors to domestic violence.

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Karin Schlee, PhD, was trained in the research and treatment of domestic violence and intimate partner violence at the State University of New York at Stony Brook. She received experience working with various traumatized populations working at the National Crime Victims Research and Treatment Center, the Medical University of South Carolina, and the Ralph H. Johnson Veterans Administration Medical Center in Charleston. She is now a licensed psychologist in New York who shares a private practice and serves as a consultant psychologist.

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Robert Wallace, MA, MSW, CSW, and **Anna Nosko, MSW,** both social workers, co-led abuser groups at The Family Service Association of Toronto for over ten years. Their treatment model, which borrowed from Social Group Work Theory, Affect Theory and Attachment Theory, provided the basis for several articles and conference presentations throughout North America. They also participated in research evaluating the efficacy of this approach. Most recently, they have continued to work together in training and consulting with clinicians involved in the delivery of group services to those experiencing HIV and depression.

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Preface

It is with pleasure that we publish this innovative volume, edited by Donald Dutton and Daniel J. Sonkin. For too long, there has been an emphasis on treating domestic violence offenders with a unilateral psychoeducational approach. Even though many researchers and practitioners have been stating for a decade that we need alternative approaches for treatment that are based upon the specific characteristics of the offenders, policies and standards in many states of the United States, in the provinces of Canada, and in other countries have not followed this. In addition, many of those working with victims or offenders have not wanted to consider that alternative treatment modalities might be more effective with certain clients, or to acknowledge that special populations might also need different approaches. This volume not only addresses these issues, it presents innovative approaches by those who have worked in the field of family violence for many years.

This volume provides current information on various techniques for working with both males and females who commit intimate partner abuse. Recent research and approaches have begun to focus on a few key issues as important for long-term success in the treatment of offenders. Two major ones are shame and attachment. It is important to be open to approaches in which these key issues are explored in treatment since they had not been emphasized in many more traditional approaches. It is time that we focus more on alternative approaches that may be effective with certain populations, that we not assume that all offenders are the same, that we move away from a "one size fits all" mentality, and that we begin to emphasize the importance of treatment

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[Haworth co-indexing entry note]: "Preface." Geffner, Robert. Co-published simultaneously in *Journal of Agression Maltreatment & Trauma* (The Haworth Maltreatment & Trauma Press, an imprint of The Haworth Press, Inc.) Vol. 7, No. 1/2 (#13/14), 2003, pp. xxvii-xxviii; and: *Intimate Violence: Multidimensional Psychotherapeutic Perspectives in Treatment* (ed: Donald Dutton, and Daniel J. Sonkin) The Haworth Maltreatment & Trauma Press, an imprint of The Haworth Press, Inc., 2003, pp. xxiii-xxiv. Single or multiple copies of this article are available for a fee from The Haworth Document Delivery Service [1-800-HAWORTH, 9:00 a.m. - 5:00 p.m. (EST). E-mail address: docdelivery@haworthpress.com].

http://www.haworthpress.com/store/product.asp?sku=J146

being based upon an assessment and tailored to the individual needs so that long term changes in attitudes, beliefs, and behaviors can be achieved. Outcome research to verify the effectiveness of the various approaches is needed as well. This volume is an important step in the right direction to meet these needs, and it adds to the prior volumes published in this series to help all of us think and operate "out of the box" when we work with offenders and/or their partners to eliminate such family violence. I am proud that we are able to offer this volume in the effort to move the field forward.

Robert Geffner, PhD
Senior Editor
Journal of Aggression, Maltreatment & Trauma

Acknowledgments

We would like to thank Dr. Robert Geffner for his dedication to the field of domestic violence and child abuse. His vigorous energy for quality publications has helped to create a highly respected series of journals and books that have been a valuable asset to researchers and clinicians alike. We would especially like to thank Ms. Jennifer Zellner, our editor at the Family Violence and Sexual Assualt Institute Journals Department. Through her expertise on the written language, and sensitivity to the sometimes tempermental writer's nature, she has helped to bring this project from rough manuscript to coherent book so that each author can be proud to have been a contributor. Lastly, we would acknowledge all the authors for their innovative contributions to the field of domestic violence. It takes a lot of courage to stand apart from the crowd, especially when the subject matter itself is likely to generate intense controversy. We thank you for your creativity and willingness to express your ideas no matter how much they diverge from the party line. Because you thought outside the box, we are hoping that it will inspire our readers to do the same.

Introduction: Perspectives on the Treatment of Intimate Violence

Donald Dutton
Daniel J. Sonkin

SUMMARY. The authors describe the rationale for a publication that explores new and innovative approaches to treating domestic violence perpetrators. A brief history is also presented on perpetrator treatment, the feminist perspectives on treatment and how recent research findings suggest that perpetrators of domestic violence need more than education and attitude adjustment.

KEYWORDS. Domestic violence, perpetrators, treatment

Treatment for men who assault their wives began in the late 1970s, pioneered by Anne Ganley at the Veteran's Administration Center in Tacoma, Washington. Dr. Ganley developed a cognitive-behavioral

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[Haworth co-indexing entry note]: "Introduction: Perspectives on the Treatment of Intimate Violence." Dutton, Donald, and Daniel J. Sonkin. Co-published simultaneously in *Journal of Aggression, Maltreatment & Trauma* (The Haworth Maltreatment & Trauma Press, an imprint of The Haworth Press, Inc.) Vol. 7, No. 1/2 (#13/14), 2003, pp. 1-6; and: *Intimate Violence: Contemporary Treatment Innovations* (ed: Donald Dutton, and Daniel J. Sonkin) The Haworth Maltreatment & Trauma Press, an imprint of The Haworth Press, Inc., 2003, pp. 1-6. Single or multiple copies of this article are available for a fee from The Haworth Document Delivery Service [1-800-HAWORTH, 9:00 a.m. - 5:00 p.m. (EST). E-mail address: docdelivery@haworthpress.com].

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10.1300J146v07n01_01

modification model, based on principles derived from social learning theory, to enable men to modify and regulate their anger and abusive behavior. Her model was especially applicable to court-mandated treatment as it strongly affirmed a sense of personal responsibility for one's actions and taught men applications through which anger could be modified. Nevertheless, the model came under intense criticism, especially from feminist-activists who claimed it did not produce results and that abuse was not related to anger or psychological phenomena but was an outgrowth of patriarchal social systems and the suppression of women. Many treatment groups came under attack for everything from diverting funds to shelters to promising false hope to battered women. In some areas, therapists treating batterers were told they must be accountable to shelter activists who in most cases knew nothing of therapeutic practice or the psychology of perpetrator populations. Indeed, if patriarchal social systems cause wife assault, most men should be assaultive and there would be no therapeutic objective in treating individuals (see also Dutton, 1994).

Two results of this political assault on treatment were the development of feminist models of treatment and intense scrutiny of the outcome success of treatment groups. Of the feminist models, the most widely known was the "Duluth Model." Developed in Minnesota, this model utilized community resources and "attitude readjustment" for clients toward a more feminist view of their relationship. There are several problems with the Duluth approach. It assumes that attitudes control abusive behavior when research data suggest that both attitudes and behavior are symptoms of deeper personality factors (Dutton 1995a, 1995b, 1998a) and have a bidirectional form of influence. Also, attitude "readjustment" may generate reactance in men who do not share feminist values, and may inadvertently create shame reactions in clients that recapitulate their early victimization experience. My [D.D.] own research on the developmental precursors of abusiveness found that exposure to shaming experiences was a major contributor to adult tendencies to externalize blame, reject feedback and experience chronic levels of high anger (Dutton, 1995b; Dutton, Starzomski, & van Ginkel, 1995). In this volume, Robert Wallace and Anna Nosko write eloquently of "vicarious detoxification" of shame in group therapy with batterers. A therapeutic implication of the salience of shame (shame-proneness) in batterers is to structure therapy so as not to recreate early shaming experiences. One example is to have clients write their own "violence policy" in response to the statement "I feel it is acceptable to be violent when . . . ." Most clients will answer "in defense

of my self and my family." Other answers can become material for group discussion. The point is that all ensuing therapeutic interventions can be presented as helping the client to remain consistent with their own policy, not an externally imposed policy that can generate shame and resentment.

The failure of the Duluth model to deal with deeper psychological issues lends superficiality to the method that produces, according to one report, a 40% recidivism rate (Shepard, 1992). This rate approaches the 50% recidivism rate we obtained for treatment dropouts in a long-term follow up study (Dutton, Bodnarchuk, Kropp, Hart, & Ogloff, 1997b). By comparison, the eleven-year recidivism rate for "anger management" treatment completers was 23%.

Treatment groups for batterers have been scrutinized more closely than any other treatment form. Meta analyses (Smith & Glass, 1977) yield effect sizes that tell us the mean difference between treated and untreated clients of subsequent manifestation of problem behaviors. The most successful treatment is that given to motivated neurotics with a specific problem that they want to change. The least effective is that given to criminal justice populations, especially sex offenders. Batterer treatment falls somewhere in the middle.

An unstated motive for the attack on treatment efficacy by feminists is the desire to see "within the system" approaches to domestic violence fail, necessitating the argument for radical social change. Shelter house activists who see the same women return even after their husbands receive treatment generalize that observation to the incorrect conclusion that the treatment failure must occur for all men. In fact, the worst candidates for treatment are psychopaths, but the failure of treatment for them should not be generalized to all clients (Dutton, Bodnarchuk, Kropp, Hart, & Ogloff, 1997a). Radical social change is beyond the control of national governments, let alone activist groups. What can we do to diminish family violence in the current context that is within our control?

It is, of course, possible to criticize some elements of current group practice: In many jurisdictions, the practice has not developed beyond the original anger management or attitude readjustment models. The Duluth model is particularly widespread and even legislated in some states, including California. Yet our knowledge of the psychology of batterers has developed extensively in the past decade. My [D.D.] own work on cyclical batterers has implicated shaming, insecure attachment and witnessing of parental violence as interactive contributors to an abusive personality that sees, feels and acts differently than most men

during intimate conflict. It stands to reason that acknowledgment of attachment, shaming and trauma precursors to battering should become an integral part of treatment.

In this volume, we contributed a chapter on the treatment of attachment insecurity which, in our opinion, will only grow in therapeutic importance as its adult ramifications become more fully realized. Robert Wallace and Anna Nosko contribute a chapter on shaming. The interested reader is referred to excellent source material on the former topic by Robert Karen (1994) and the latter topic by Helen Block Lewis (1971). The adult personality resulting from childhood exposure to shaming, violence and insecure attachment is a form of borderline personality organization (Dutton, 1994, 1995a, 1995b, 1998c). Working with borderlines, even the less extreme form, is notoriously difficult for a therapist. In this collection, Jennifer Waltz describes the application of a treatment model for borderlines developed by Marsha Linehan to working with batterers.

At present, there is no one "treatment of choice" in working with physically abusive clients. No research demonstrates clear and consistent superior effectiveness for one treatment strategy. In the present publication, Rosemary Cogan and John H. Porcerelli outline psychoanalytic strategies for working with people in abusive relationships, and Richard E. Heyman and Karin Schlee describe a couples treatment approach. Each represents an alternative to current practice.

We make no claim of exhausting the therapeutic possibilities for new approaches to working with intimately violent men. Most batterers suffer from some form of extreme tension held in the body. Both "body work" and Reichian breathing are useful in teaching them to control and reduce their tension through nonviolent means. We had originally attempted to obtain an article on body work for this volume but the treatment form is notoriously difficult to describe verbally. Its practice is probably better learned in a form of oral tradition or through direct experience with a qualified practitioner. We learned of its benefits from a marvelous clinician, Bob Berger, who practices in Crescent Beach, south of Vancouver. Reichian breathing, which comes from the same tradition as bodywork, again teaches alternative tension reduction techniques by combining stretching and breathing. Clients learn to vocalize on exhales, opening the throat and dissipating more stored tension. Exercises can be practiced in group, as part of an opening routine, or to demonstrate anger reduction in an individual client.

In addition to new treatment techniques, the present volume also presents articles for treating special populations. Robert Kiyoshk de-

scribes integrating native spiritual healing with conventional anger management for use in native treatment groups. Although this article is specific to working with indigenous populations in Canada, the issue of spirituality is an important element to the treatment process, and his ideas described in this article can be applied to other ethnic groups as well. Vallerie E. Coleman describes the psychoanalytic treatment of lesbian batterers. Her article thoroughly discusses the etiology of violence in lesbian relationships and how clinicians can address this problem from a psychodynamic perspective. Ophra Keynan and colleagues describe Beit Noam, an innovative residential program in Israel, and their unique approach to treating Israeli perpetrators of woman battering. Lastly, Penny A. Leisring, Lynn Dowd and Alan Rosenbaum discuss the treatment of female batterers. With the advent of mandatory arrest laws for domestic violence, more and more women are being mandated into treatment programs. These clients present a unique challenge to clinicians in that a significant percentage of them are not only perpetrators of violence, but current victims of domestic violence. They discuss how clinicians treating women must learn how to incorporate the treatment of trauma with acting-out/violence containment strategies in order to effectively treat these clients.

In the final section of the publication, we have two articles that all clinicians working with perpetrators will find extremely useful. First, Alan Rosenbaum, William J. Warnken, and Albert J. Grudzinskas, Jr. provide an excellent discussion of the legal and ethical issues confronting individuals treating the court-mandated perpetrators of domestic violence. Although theory and techniques are important, clinicians must be aware of and prepared to address the numerous legal and ethical issues they are likely to encounter in treating the court-mandated clients. Issues of confidentiality, dangerousness, child abuse and boundaries are frequently encountered with this clinical population, and addressing these issues effectively not only increases the likelihood of successful treatment outcome, but also reduces the therapist's exposure to civil and legal liability. Historically, outcome studies have focused on the reoccurrence of violence (Dutton, Bodnarchuk, Kropp & Ogloff, 1997b) rather than asking treatment participants about their experience of the intervention. In the final article, Mindy S. Rosenberg presents findings from a post treatment interview with treatment clients asking them what the experience was like, and which skills worked best for them. Clinicians can learn from their clients as well as the empirical data.

Research has also indicated that batterers have histories of being abuse victims. I [D.D.] have written about the high levels of trauma

symptoms found in batterers (Dutton, 1995a, 1995b) and have attempted to show how a trauma model better accounts for their psychological features than other models, including social learning theory (Dutton, 1998a, 1998b). In this collection, we have attempted to reconcile this work with treatment practices and to point to new opportunities for treatment. It is sometimes difficult, in working with an abusive client, to remember that the person was once an abuse victim. Nevertheless, integrating these two parts of that client's overall personality ensures a more complete therapeutic stance. We need never accept bad behaviors in order to acknowledge the human essence of the client.

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THEORETICAL APPROACHES TO THE TREATMENT OF INTIMATE VIOLENCE PERPETRATORS

Treatment of Assaultiveness

Donald Dutton

SUMMARY. Assaultiveness and abusiveness have a psychology that must be addressed in therapy; they are not merely the product of "bad attitudes" or social roles, nor can they be narrowly defined as the robotic imitation of action. Perceptions and feelings about the world of intimate relationships both sustain and are sustained by abusive actions. These provide points of intervention for cognitive behavioral therapy (CBT). Given the tendency to shame easily, abusive men must not be confronted too quickly or too strongly. On the other hand, given their well-established denial system and tendency to minimize the consequences of their abusiveness, some confrontation must occur. Hence a "Zen" line of least resistance must be found between the opposites of acceptance and con-

[Haworth co-indexing entry note]: "Treatment of Assaultiveness." Dutton, Donald. Co-published simultaneously in *Journal of Aggression, Maltreatment & Trauma* (The Haworth Maltreatment & Trauma Press, an imprint of The Haworth Press, Inc.) Vol. 7, No. 1/2 (#13/14), 2003, pp. 7-28; and: *Intimate Violence: Contemporary Treatment Innovations* (ed: Donald Dutton, and Daniel J. Sonkin) The Haworth Maltreatment & Trauma Press, an imprint of The Haworth Press, Inc., 2003, pp. 7-28. Single or multiple copies of this article are available for a fee from The Haworth Document Delivery Service [1-800-HAWORTH, 9:00 a.m. - 5:00 p.m. (EST). E-mail address: docdelivery@haworthpress.com].

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10.1300J146v07n01_02

frontation. Treatment outcome studies indicate moderate success for cognitive behavioral treatment (CBT) for batterers. Treatment is less successful with men who have personality disorders, especially psychopathy.

KEYWORDS. Treatment, batterer, shame, attachment, trauma, CBT, personality disorder, anger

As cited in an article on pharmacological treatment for assaultive males, Maiuro and Avery (1996) developed a three-stage program termed 'biopsychosocial intervention.' The biological aspect involves administering pharmacological treatment for depression, irritable temperament, hyper-reactivity, emotional lability, pathological anxiety, obsessiveness, compulsiveness, and post-concussive or other related syndromes. The biological treatment intervention was based on the assumption that pharmacological agents such as antidepressants, anxiolytics, and serotonin re-uptake moderators might aid in treating certain aspects of the abusive personality. However, as the researchers point out, this form of intervention cannot be substituted for social change or psychological (group) treatment. Instead it must be viewed as an adjunct to the broader forms of intervention: psychological and sociocultural. The following were listed as potential *psychological* treatment targets: defenses against acknowledgment of responsibility (e.g., denial, minimizing, blame projection), anger management (detection and control of anger responses), assertiveness, bargaining and communication skills, attitudes toward women, family of origin modeling influences, relationship enhancement skills, and relapse prevention skills. I agree that these appear to be reasonable targets for psychological intervention. Yet both the narrower biological and psychological interventions must be set within a social context of activism concerning general cultural acceptance of violence, violence toward women, women's safety, and male sex-role conditioning.

Dr. Anne Ganley (1981), then a psychologist at the Veterans' Administration Hospital in Tacoma, Washington, developed a treatment group approach for assaultive males in the late 1970s. Following from a social learning perspective, Dr. Ganley's treatment model was based on

the notion of abusiveness as a learned behavior. We adopted her treatment model and, in line with our own experience, revised it somewhat. This model is outlined here, including extended applications relating to borderline personality disorder, psychopathy, attachment issues, and trauma. I then examine the outcome research on treatment effectiveness. The clinical goals of treatment are relatively simple: to get the man to recognize and accept responsibility for his abusiveness, and to develop control over and reduce the frequency of such behavior. The treatment program described below is simply one means of achieving these objectives. Notice that each week has both a 'didactic' (skills acquisition) and a process (group dynamic) component (see Appendix A). The interested reader is referred to Yalom's (1975) classic text on this subject.

SIXTEEN WEEKS IN A TREATMENT GROUP

Court mandated treatment models arose in a number of locations in the early 1980s and range in length from eight to fifty-two weeks. The criminal justice system needed an effective way for judges to settle wife assault cases before them, and treatments were developed to meet that need. Many men who are sent by the courts for wife assault treatment have had no experience with psychotherapy. They imagine their worst fears and weaknesses being exposed; consequently, the experience is initially terrifying.

Bob Wallace and Anna Nosko (1993) have described the opening night ritual in such groups as a "vicarious detoxification" of shame (also see Wallace & Nosko, 2002). Men who come to group, assuming they are 'normally' socialized, experience high levels of shame as a result of their violent behavior. Hearing other men in the group discuss their own violence allows the man to 'vicariously detoxify'; that is, to face his own sense of shame. This sense of shame, were it not detoxified, would maintain the man's anger at a high level and preclude his opening to treatment. The anger is maintained to keep the shame at bay. Anger allows blame to be directed outwardly, preventing shame-induced internalized blame.

For this reason, we start very slowly in our groups, simply asking men on opening night to describe "the event that led to your being here" (e.g., the assault). Their stories provide them with a sense of mutual affliction and of shame detoxification that furthers the bonding process.

Moreover, these stories provide us with an initial assessment of the man's level of denial and willingness to accept responsibility for his violence. The only other treatment objective on opening night is to review the group rules with the clients. These rules are reproduced in Appendix B.

Apart from common sense rules such as attending consistently in a sober condition, these rules also outline the confidential nature of the group and the exceptions to this rule (such as disclosures of child abuse or of direct threats towards another person). As straightforward as these rules may be, they still trigger resentment concerning the criminal justice system's handling of the man's case. Many men feel poorly treated by the system, view their wives as also needing anger management, and see therapists as extensions of the system that unfairly depicted them as the perpetrator and their wives as the victim. These feelings frequently surface during discussion of the participation agreement. It is important to acknowledge and empathize with these feelings while still maintaining a focus on stopping abusive behavior (see Waltz, 2002). Differentiation of the feelings from the behavior and exploring how the feelings may interfere with change are important tools to be used in this regard.

At the end of group one, we ask men how they feel at this juncture. Generally, they express relief about "surviving" the first group, and about being in a group composed of men with similar problems. Their relief generally has to do with not feeling judged; this aspect proves to be particularly important given the shame feelings often experienced by abusive males, as described by Wallace and Nosko (1993). For this reason, I would not recommend confrontation on opening night.

Immediately following the beginning of group, therapists should interview female partners to assess her safety plans, her perception of personal risk, the man's current level of abuse, and any feedback he may have brought home from his first group experience. One danger sign, for example, is the use of the group to minimize one's abuse: "You think I'm bad, you should hear these other guys in my group." The therapist should also ascertain what information can safely be fed back to the man. If the woman is not comfortable with direct feedback (attributed or traceable to her), present the issue during group in general terms. Ask the men if they have any lingering reactions to what they heard the preceding week and discuss "defensive social comparison," where one uses the group to deny or to minimize one's abuse. The point should be that each man, regardless of his level of abuse, has to take responsibility for that abuse. In other words, it is irrelevant that someone else may be more violent than he.

The second meeting should begin with addressing residual feelings from week one. It is useful to get the clients to focus on and describe such feelings; this begins a weekly 'check-in' exercise that will initiate the group process for each week to come. It can also lead into a simple exercise for week two: differentiating feelings from "issues" and actions. We present this as an exercise: Men are asked, "What do you argue about? How do you feel after these arguments?" and "How do you act when you are arguing?" This exercise is again deceptively simple; it outlines some apparent distinctions between feelings and actions. At the same time, it again shows the client that other men share many of the same issues. This revelation furthers the bonding process in the group (i.e., group cohesiveness) and facilitates shame detoxification. We tend not to confront men much during these initial few weeks. We describe what confrontation is and distinguish it from attack or put down. We explain that confrontation is a device to help someone change, whereas attack is simply done to make the attacker feel powerful. We warn men that we will later use confrontation as a part of treatment. However, if a group is particularly woman-blaming it is important to initiate the confrontation process earlier, before a negative form of group cohesiveness develops that is built on shared commiseration about how difficult women can be. Reorienting the men from an other-blaming orientation to a self-control orientation typically has to be repeated during early sessions. A self-control orientation, as the guiding philosophy, emphasizes personal responsibility and control of self (along with negotiation with, rather than control over, others).

Week three also begins by checking-in on the feelings generated from the previous meeting, and then examines what is meant by "abuse." The various forms of abuse (physical, sexual, and emotional) are discussed, and the "power wheel," developed during the program in Duluth, Minnesota (Pence & Paymar, 1986), is explained. A working definition of abuse also includes the motive of harming the partner's self-esteem or restricting her autonomy. Men are informed that, for the duration of the group, they will be asked to report any abuse committed that fits the aforementioned definitions.

At this point, there is one practical issue regarding the 'check-in' exercise that deserves mention: It can run for an hour and a half in a ten-man group, reducing group time for other exercises. If this begins to happen, get the men to respond succinctly to three questions: Was there any abuse this week (if so describe), did you handle your anger well on any occasion, and do you need any group time for special problems?