

# **Intimate Partner Abuse: Understanding and Treating Domestic Violence**

By Ellen L. Bowen, LCSW, BCD

High profile domestic violence cases over the last several years have riveted the public's attention. What used to be considered a private matter to be dealt with in the context of the marriage or family, is now seen as a complex problem that demands an aggressive and collaborative community response. In recognition of the lethality and far-reaching damage that domestic violence causes, state laws have been changed, law enforcement agencies have sought more training for their staff, district attorney offices have adopted stricter policies about prosecution, and now licensed therapists in California are required to obtain continuing education in Domestic Violence.

While a therapist may plan to never work with abusers, it is important to recognize that domestic violence is so pervasive in our culture that the therapist who never sees it is either exceptionally rare or in denial. The American Medical Association has called domestic violence the #1 health problem of women in the U.S. It is the leading cause of injury to women between the ages of 15 and 44--more than car accidents, muggings and rapes combined. Estimates are that one in twelve couples in the U.S. experience repeat severe violence (Straus & Gelles, 1990).

## **What is Domestic Violence?**

Domestic violence is an attempt to establish power and control in an intimate relationship through the use of violence and other forms of abuse. The offender exerts control by using physical abuse, emotional abuse, sexual abuse, economic oppression, isolation, intimidation, and maltreatment of the children. Relationships involving family violence may differ in terms of the severity of the abuse, but power and control are the primary goals of all offenders.

## **Who Abuses an Intimate Partner?**

Domestic violence occurs in all cultures, races, occupations, income levels, ages, abilities, religious preferences and sexual orientations. No part or group of our society is immune. Both men and women can be violent in their relationships but may express that violence in different ways.

If someone has a need for power and control, where does that need come from? Why does power and control become such an issue in an intimate relationship that a person becomes violent? Nearly all of the research on domestic violence has studied male heterosexual abusers. The best predictor of an abuser is witnessing violence in the family of origin. Seventy-five percent of men who abuse their wives observed violence between their parents when they were children. Researcher Donald Dutton, PhD, University of British Columbia, found that additional childhood contributors to adult abusiveness are being shamed by one's father and having an insecure attachment to one's mother. (Dutton, 1995). Men who experienced punishment that was shaming and rejecting (ex. in public, random, or given as a global criticism rather than specific correction) were found to be much more likely to be abusive to their partners.

By contrast, the issue of female violence has been largely overlooked. Men experience tremendous cultural pressure to not report violence inflicted on them by women or to be dismissive of that violence. Dutton is currently researching female violence and points out that a hotline for male victims receives 250 calls per day.

Female offenders appear to fall into one of three categories: dominant aggressors similar to male offenders, women who have fought back in self defense but have been primarily victims of domestic violence, and women who are in mutually aggressive relationships.

Common to both male and female abusers is their childhood histories that lead them to: expect that they will not be cared for, that they will be taken advantage of, and that they have learned to expect that they are not worthy of being treated otherwise (Egeland and Farber, 1984).

### **Effective Treatment**

In 1997 when two colleagues and I founded NOVA Non-Violent Alternatives, the Duluth Model (from Duluth, MN) was considered to be the best approach for treating abusers. This model strives to re-educate men in their use of power, male privilege, and male entitlement in their relationships with women. It is based on a socio-cultural, feminist perspective of male patriarchy and relationship violence (Pence & Paymar, 1993). Several new research studies have found this model to be ineffective in decreasing male violence to women. (Babcock et al, 2003)

Instead, what presents the best hope for effective treatment is a model that blends Attachment Theory and Cognitive-Behavioral Therapy (remember the contributing risk factors: witnessing domestic violence during childhood, father's shaming, insecure attachment with mother). A key feature of an abuser is an inability to sooth or comfort oneself when distressed, requiring the involvement of another person to help regulate affect. In NOVA, we tell our clients that in order to make a change in themselves they will need to:

- Learn to tolerate pain in order to grow,
- Maintain a clear sense of self while close to another person,
- Learn to self-sooth one's own hurts and pains,
- Be non-reactive to a partner's anxiety.

It is essential that these therapeutic skills be mastered before any couples therapy takes place. Treating domestic violence in the context of couples therapy before adequate individual work is counter-therapeutic, irresponsible and dangerous—because of the likelihood that therapy will, in effect, re-victimize the victim.

While therapists may be tempted to treat abusers in individual therapy, I believe that the most effective change comes from a group experience with other abusers. While often initially daunting for the client, this setting provides the most powerful experience for healing shame: a supportive community where abusers are able to acknowledge and examine the painful, long-buried wounds from childhood, experience acceptance and healing and yet hold each other accountable for their behavior.

### **Some Final Thoughts...**

Clearly, not all therapists are cut out to work with abusers. We need to be honest with ourselves about what we can and cannot tolerate because the stories we must listen to, witness and hold will most certainly elicit our own intense feelings and pain. Through this process I have had to examine myself, my own fears and insecurities, my family of origin, life experiences, love relationships, reasons for doing this work, and my preconceived prejudices about working with this population. When we put our program together, I wondered if I would be angry at these men or afraid of them. I have been a clinical social worker for 31 years. I know now that I could not have done this work when I was younger; it has taken the seasoning and maturing of life experiences to help me understand.

As a therapist, I must navigate two very different roles: holding the abuser fully responsible for his/her violent behavior, and at the same time providing an empathic alliance. As David Wexler points out: "When the clinician can maintain an empathic stance, he or she can relate to the batterer not as some disturbed social freak but rather as one more wounded man who has suffered narcissistic injuries and disappointments in his love relationship and at times find this state unbearable---which leads to acting out at the perceived source of frustration. Who among us does not know this experience?"

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