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GOING BEYOND GENDER-SPECIFIC TREATMENTS IN WIFE BATTERING: PRO-FEMINIST COUPLE AND FAMILY THERAPY

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ABSTRACT. *There has been lingering debate as to whether couple and family treatments should be employed in situations of conjugal violence. The purpose of this paper is to highlight the theoretical and clinical issues at the center of this controversy, and to offer an argument for the sequential use of relationship therapies as a "second phase" to follow gender-specific individual and group treatments of perpetrators of violence and their partners. Basic elements of pro-feminist couple and family treatment are described. Key intake questions, as a prelude to marital and family treatment, are suggested to assess the appropiateness of relationship therapies and to protect victim safety.* © *1998 Elsevier Science Ltd*

TWENTY YEARS ago, little attention was given to wife battering in community mental health services. Domestic violence was seen to rarely occur in what was believed to be highly unusual family circumstances. Most human service professionals were blind to its high prevalence, to its occurrence in homes across income levels and cultural groupings, and to its serious social and psychological consequences. We did not know how to ask the right questions to detect domestic violence, let alone understand how to deter or treat it.

Over the past several decades there has been a marked expansion of understanding and some convergence of clinical and scientific opinion regarding domestic violence. The knowledge generated has been rich in content, yet still remains somewhat fragmented. There have been persistent differences of view regarding the management and treatment of domestic violence, particularly across professional disciplines and service sectors. In these early years of research and theory building, several ideological clusters have emerged with differing views as to the causes and cures of domestic violence (Gelles & Loseke, 1993).

The feminist perspective has been the most persuasive. The feminist movement was instrumental in raising public and professional awareness of the seriousness and frequency of wife abuse. The substantial contribution of this movement has been both practical and

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political. In a practical sense, feminists led the way in building supportive networks for battered women, which included shelters, resource centers, and advocacy groups. They identified wife battering as a political issue in that it is rooted in a societal belief system that promotes patriarchy and endorses the dominance of men over women. Domestic violence was recognized as a means to enforce the control and suppression of women. The first priority of the feminist movement has been the liberation and protection of women. The interventions that directly emerged from their efforts had this focus, and sought to provide places of refuge for women suffering abuse. Further, they mobilized social and psychological resources to facilitate the liberation and healing of women. Their strong advocacy position, taken in defense of women and in the promotion of women's concerns, has importantly challenged traditional mental health services. Perpetrators of family violence are now more clearly seen as committing criminal acts and are not assumed to be mentally disturbed. Families are now more pragmatically recognized as being "hazardous workplace sites" for many women rather than providing "havens of safety and intimacy".

A sociological perspective has also contributed importantly to the ongoing debate as to the cause and course of domestic violence. Central to this perspective is the contention that social structures (such as sex, age, income, ethnicity, etc.) affect individual behavior and family life. Attributes of the family as a social group are studied; a social group that is recognized as a "violence-prone institution". The importance of feminist theory, with its gendered view of social relations is respected within this perspective, but is criticized as being too narrow and restricted in focus in the use of patriarchy as the "single prevailing variable" to explain wife abuse (Gelles, 1993). Based on their findings in large-scale community surveys, family sociologists have come to a contentious conclusion: that women initiate relationship violence at rates similar to men. This is explained by sociological concepts of "resource acquisition" and "power dominance", as aspects of exchange-social control theory in which violence is seen as a "conflict tactic" used by both men and women in response to what are conflicts of interest in a relationship (Gelles, 1983; Straus, Gelles, & Steinmetz, 1980). This finding has been qualified by the recognition that men are the predominant perpetrators of severe assaults causing injury (Gelles & Straus, 1989; Straus & Gelles, 1988) and that women most often use violence in their own defense (Straus, 1980; Straus & Gelles, 1988). An overarching sociological model depicts violence in families as being promoted and perpetuated by societal norms and standards. This perspective calls for social and political action to prevent family violence through eliminating violent societal norms and violence-provoking community circumstances. Social values need to be challenged, which legitimize and glorify the use of physical force, and perpetuate sexist beliefs. Community circumstances that fuel rage and violence, such as poverty, racial oppression, and unemployment, are seen as requiring direct remediation. As do the feminists, the sociological theorists identify domestic violence as a societal issue that is as much a political as it is a behavioral concern.

A basic distinction in cases of domestic violence has been recently suggested (Johnson, 1995), which differentiates "patriarchal terrorism" and "common couple violence". This dichotomous classification does explain the marked differences of the views that have persisted between feminist and sociological researchers. Feminist researchers have largely drawn their study subjects from shelters, hospitals, and the police. They see situations that are marked by powerful male dominance and more severe levels of abuse. Further, these tend to be situations that are pervaded by frequent bouts of attack and terror. Sociological researchers have preferred to use randomly selected households in cross-sectional community surveys. This approach has generated couple situations in which there appears to be equivalent frequencies of male and female violence, in which violence does not seem to steadily escalate, and in which there is a predominance of mild and moderate levels of physical abuse.

The question of whether "minor assaults" will escalate over time is an important research and clinical question. Mental health practitioners should be extremely cautious in making any case management assumptions that are based on the belief that mild expressions of physical abuse will not escalate over time. Gelles (1993) has suggested a similar dichotomous categorization of basic types of couple violence. He draws on the findings of community surveys, which reveal that "minor" forms of spousal violence are by far the most prevalent (158 households per 1,000) compared to severe spousal violence (30 households per 1,000). Minor abuse in this context involves perpetrators who push, grab, shove, slap, or throw objects. He argues that minor violence, if left untreated, can escalate into severe or life-threatening abuse. He suggests that a key distinction needs to be made by therapists. This involves the determination of whether violence is mutual or reciprocal, as opposed to violence being initiated by the male for purposes of control and power. The past disputes between feminist and sociological researchers over which view of couple violence was most accurate, may have been based on alternative sampling frames and methods. Both views may be correct, and not contradictory, as they may be focusing on different "clusters" of violent couples. In turn, these two types of domestic abuse may require different treatment approaches.

The psychological perspective in wife abuse (O'Leary, 1993) has been criticized for its tendency to blame women for their own victimization, and shift responsibility for violent acts away from the perpetrator of the abuse. This perspective has pursued the linkage between psychopathology and violence. Perpetrators are seen as having a range of psychological dysfunctions from personality disorders to psychosis (depending on the severity and circumstances of their abusive outbursts). Early psychological theories used the concept of masochism to explain why victims were attracted to, and remained with, men who assaulted them. This narrow psychodynamic perspective has been seen to shift blame, away from the men who perpetrate the violence, to the women victims as they are given responsibility for their own suffering. Contemporary psychological theories recognize that psychological explanations are important in understanding and treating domestic violence, but are misguided when they are used to condone or excuse what is fundamentally a criminal act (Bograd, 1992; Dutton, 1995; Edleson & Tolman, 1992). Further, more sophisticated understandings are developing regarding the behavioral roots of male violence and differing psychological categories (e.g., sociopathic, borderline personality, etc.) of men who physically abuse their partners (Dutton, 1995; Gondolf, 1988; Saunders, 1995; Shields, McCall, & Hanneke, 1988). However, no consistent psychological profile or typology of batterers has been identified. Dutton (1988) suggests that this may be due to sampling differences across studies, and to widely heterogeneous batterer characteristics.

Women who suffer severe abuse have four times the rate of depression, psychosomatic complaints, and suicide attempts than do women who are not victims of violence (Stets & Straus, 1990). However, there does not seem to be a psychological profile that would predict a woman's likelihood of being in a battering situation (Harway, 1993). Being violent is clearly the perpetrator's "psychological problem" not the victim's. Hotaling and Sugarman (1986) in their review of studies of battered women, concluded that no predisposing psychological traits were evident apart from experience of violence in their family of origin. Staying in a violent relationship also seems to be more profoundly determined by relationship and economic factors than psychological attributes of the battered woman (Dobash & Dobash, 1979; Sullivan, 1991). In a longitudinal study, Phillips (1993) found that staying in a relationship with a batterer had nothing to do with personality attributes (self-esteem, depression, traditionalism), but was predicted by relationship variables (marital satisfaction, dependent children, and help-seeking behaviors). There has been important psychological study that has contributed to the understanding of relationship dynamics from the victim's

perspective. For example, Walker's (1979, 1984) hypothesis that links "learned helplessness" within a "battered woman syndrome" and Herman's (1992) conceptualization of "complex post-traumatic stress disorder" has advanced the understanding of the psychological implications of continued and severe abuse, and how this abuse can alter women's psychological capacities in violent relationships.

Early marriage and family therapy approaches have been in concert with prevailing psychological theories when responding to wife battering. The use of couple therapy in situations of domestic violence has been highly controversial (Bograd, 1992; Goldner, 1992; Hansen, 1993; Lipchik, 1991). Feminist therapists challenged the use of traditional marital counseling in situations of wife battering for a number of substantial reasons. First, it was evident that many women were put at risk if they discussed sensitive couple information in conjoint sessions. This was seen to invite retaliation or attack afterwards from their partners. For a woman in a relationship that was regulated by fear, it would be naive to think that she could talk openly and safely about relationship concerns in the presence of the batterer (Bograd, 1984; Edleson & Tolman, 1992; Goldner, 1992; Willbach, 1989). There was heightened risk in couples therapy that a batterer would become violent, since stressful relationship issues are actively identified and pursued while participating in dyadic therapy (Star, Clark, Goetz, & Malia, 1979). Further, for men who entered therapy in order to placate, monitor, or control their battered partner, conjoint sessions added to the abuse rather than stopped it (Bograd, 1984). Both victims and batterers often deny or minimize the relationship violence (Geffner & Pagelow, 1990). Such denial can be further complicated by any minimization of violence by the therapist, particularly those who use empathy and support in seeking to heal the "inner wounds" of the batterer (Herman, 1988). Further, If a therapist does not immediately halt dyadic sessions, at the first evidence of violence, and focus subsequent therapeutic effort on identifying and terminating the violence, it transmits an indirect signal of collusion in the denial of the impact of the assault.

When initiating couple therapy, battering can be defined as a relationship problem (in which the woman shared some responsibility) rather than a criminal act (in which the perpetrator held sole responsibility for his use of violence). This remains more of a clinical issue for relationship therapies that are based on systemic treatment concepts. Hansen (1993) summarizes the key conceptual issues as victim blaming, attribution of co-responsibility of victims for violence that is perpetrated against them, and the therapist stance of clinical neutrality that denies gender power differences, and the use of intimidation and force for relationship control. Systems theory, when unreservedly applied in the treatment of family violence, inherently implicates the battered woman as playing a part in maintaining the violence she suffers, and thereby diffuses responsibility for male violence (Bograd, 1984, 1992; Goldner, Penn, Sheinberg, & Walker, 1990; Lamb, 1991). Behavioral symptoms (such as violence) are often seen in a systemic analysis as "symptoms of a relationship issue", rather than being an immediate problem to be solved in their own right (Bograd, 1984). In mainstream couple and family therapies, the clinician seeks to maintain a stance of "neutrality", and eschews permanent alliances with either partner to avoid becoming "emotionally entangled in the couple's problem" (Nichols & Schwartz, 1995). This position of therapeutic neutrality facilitates mediation efforts and promotes the healing of relationship wounds. However the neutral stance of the therapist, by diffusing the central clinical importance of the abuse (i.e., violence is a symptom of a more clinically important relationship issue) or by continuing therapy when abuse occurs while therapy is being conducted, could be easily misconstrued by perpetrators and victims as a condoning of the violent acts, and an indirect blaming of victims for having a participant's role in their own abuse (Bograd, 1992; Willbach, 1989). Adherence by clinicians to therapeutic neutrality in situations of wife battering ignores the fact that this "symptom" is a dangerous one that can be lethal if left

unchallenged, and further that it is a "symptom" that is under the choice and control of the perpetrator alone.

Traditional marital therapy seeks to enhance couple emotional relations, communication skills, and cooperative problem solving and to thereby strengthen the foundations of a relationship. This is contraindicated in violent relationships in which the woman wishes to escape the relationship. That is, when the woman wants to terminate the relationship in safety and in peace. In these situations, it is advisable to retain the batterer in gender-specific treatment (e.g., mens' groups, individual therapy) and ensure that the woman can disengage from him in safety, while he is receiving emotional support and counseling. In some cases in which there is not a history of severe abuse, couple mediation rather than relationship therapy may facilitate separation. Traditional couple and family therapy has not been adequately sensitive to the impact of gender on family relations, and has inadvertently imposed a patriarchal view of family functions as a therapeutic standard or model of normal family functioning (Goldner, 1985a, 1985b; Hare-Mustin, 1986; Meyers Avis, 1985). The importance of power and control in family relations, particularly as this relates to the dominance of men over women, has not being adequately appreciated or handled by traditional couple and family therapists. The feminist critique of couple and family therapy in situations of woman battering, has offered important momentum to adapt and enhance systemic treatment of violence. The critique does not support the contention that couple and family therapy should be abolished in all situations of couple violence (Cook & Frantz-Cook, 1984). Feminist informed (or "pro-feminist") marriage and family therapy has emerged to guide relationship focused treatment of domestic violence while ensuring the safety of victimized women and children. This pro-feminist approach is conceptually and clinically consistent with existing feminist-based interventions for battering men (Adams, 1989). It involves use of systemic interventions with couples that include, as a primary element, heightened sensitivity to the gender context of relationships (Goldner et al., 1990). Within this treatment approach, safety of victims is paramount (Hansen & Goldenberg, 1993). No conjoint therapy is initiated until violence has been terminated and the couple is ready, without fear of violence, to proceed to improve their relationship style and interpersonal behaviors. This avoids the clinical dilemma of "therapeutic abuse neutrality" as physical violence is understood to have stopped, and termination of battering is not a goal of therapy. "Multi-directed partiality" (Boszormenyi-Nagy & Krasner, 1980) becomes the more relevant therapeutic issue, in which marital partners are shown they can trust the therapist to fairly hear and emotionally support each of them, as they bring their relationship issues to the surface.

There are substantial and compelling reasons for providing couple treatment in situations of wife abuse. In many situations of woman battering, the women want to stop the violence but do not want to end their marriage. Many do return to their partners (an estimated 50%), even if they have been in shelters and have received individual and group counseling (Simpson Feazell et al., 1984; Sullivan, 1991; Woods Cox & Stoltenberg, 1991). It has been suggested that a doctrinaire feminist orientation in services for battered women may shame those who are urged to leave their relationship, but who do not wish to (Goldner, 1992). Further, many women are at risk when they seek to end a relationship in which battering has occurred. It is important to protect them, by proving supports to their husbands, so that the couple may eventually separate in safety. It is not acceptable to provide services just to women victims, as those in severe abuse situations may still be at risk to be killed (or in some rare cases, to kill the men that terrorize them as the only means of escape). Clinicians who have had contact with both partners in situations of domestic violence learn women are not always nonviolent. Most violent women act out of self-defense and do not attack to control and dominate. However, there are "violent couples" that do need conjoint therapy to terminate the mutual use of violence as a means of resolving couple conflict.

The possibility of couple treatment can bring perpetrators that are resistant to treatment into services. Perpetrators often do not see themselves as having a "psychological problem" and often do not welcome counseling. However, fear of loss of their relationship is a strong motivation for many of these men, and can often be used as an incentive to maintain the batterer in treatment, if it is understood that couple treatment may be initiated when he is ready for it (Geffner & Pagelow, 1990; Hansen & Goldenberg, 1993).

Clinicians, who have assisted in the termination of physically abusive behavior, know that psychological abuse frequently remains in intimate relationships that were physically violent (Herman, 1992). When men who batter stop their physical assaults, they often continue to use indirect methods of control and domination (Aldarondo, 1996). Treatment of these men is like "peeling the layers off an onion". There are layers of abusive behaviors, both physical and psychological, that need to be addressed in couples with a history of domestic violence. Psychological abuse leaves no immediate physical signs and is not seen by the courts as criminal behavior, but it can be directly addressed in conjoint therapy. If a mandate or a rationale for psychotherapy is established while physical abuse is being addressed (and while it is still within the domain of the criminal justice system), it will increase the chances for eventual relationship therapy for those couples in which women chose to remain after the physical abuse has been stopped.

Wife abuse is often an indicator that other family members are also vulnerable to abuse. Some 55 to 60% of wife abuse situations may involve couples with dependent children at home (Straus et al., 1980; Ursel, 1991). Nearly all of these children will witness the violence and it is estimated that 30–60% will also be abused (Hughes, 1982; Straus et al., 1980). These children have been described as the "forgotten victims" of violent marriages (Elbow, 1982). A relationship exists between wife abuse and child psychological and behavioral distress (Berman, 1993; Jaffe et al., 1986; Rosenberg & Rossman, 1990; Wolfe, Jaffe, Wilson, & Zak, 1985). Children who witness domestic abuse, particularly boys, are more likely to become perpetrators of domestic abuse as adults (Jaffe, Wilson, & Wolfe, 1987; Kalmuss, 1984; Straus et al., 1980). There is evidence that girls who come from violent homes see physical abuse as an unavoidable and inescapable aspect of family life (Hotaling & Sugarman, 1986). This argues for the eventual inclusion of couple therapy, particularly for intact families with children, as a precursor to family therapy. Family therapy that would address children's beliefs and behaviors that are rooted in their experience of violence in the family.

FACTORS TO BE EXAMINED BEFORE ENTERING COUPLE THERAPY

It has been important to clarify wife battering as both a criminal and clinical problem (Bograd, 1992). In pro-feminist couple counseling, the perpetrator is fundamentally recognized as having committed a criminal act through his use of physical force. He is responsible for his choice to use violence and his battering behavior cannot be condoned under any circumstances. Clinicians engaging in the treatment of family violence need to establish when their duty is to be an agent of "social control" (enforcing the law that prohibits violence) and when they are being agents of therapy (seeking to heal individuals and relationships). It is possible to assume both roles simultaneously in the treatment of domestic violence (Bograd, 1992; Goldner, 1992; Goldner et al., 1990). It has been important to clarify that in all attempts to provide treatment in situations of domestic violence, safety must be paramount (Taylor, 1984). No couples therapy should be initiated unless the safety of victims can be assured (Bograd, 1984; Cook & Frantz-Cook, 1984; Edleson & Tolman, 1992; Hansen & Goldenberg, 1993; Willbach, 1989). The most conservative forms of gender-specific treatment (e.g., separate group treatment for men and women) must be employed "until there is ample evidence that the woman is safe from physical harm" (Bograd, 1992, p. 250).

Conjoint couple therapy is contraindicated if there has been recent violence, or if there is reason to believe violence may occur during the therapy.

Sequencing (rather than type) of treatment is a primary concern that is guided by safety considerations. Use of individual, group, and couples or family therapy are considered through two phases of clinical intervention. First phase services begin by holding perpetrators responsible for their violent acts and by encouraging victims to take responsibility for their own safety. The first phase involves gender-specific (i.e., separate for men and women) group and individual therapies. First phase treatment for *perpetrators* should address individual belief systems (challenging patriarchal and oppressive views) and assist with individual behavioral control (identifying and regulating angry affect). The services should assist *victims* to protect themselves and their children, strengthen self-esteem and facilitate choice in relationships (i.e., help women find their "bottom line"). One of the important aspects of this first phase of treatment is to assess the level of dangerousness in the couple situation. Until there is reason to believe that the violence has been stopped and that fear no longer pervades the relationship, first phase treatment should continue. It seems that some batterers are not good candidates for first phase treatment, and will not likely ever qualify for couple or family therapy. These are the men who have antisocial or sociopathic personalities (Dutton, 1995; Gondolf, 1988, 1993). In these cases, it seems that the most appropriate counseling will assist women to appreciate the danger they face, and facilitate their employment of strategies of enhanced self-protection and family safety.

Couple and family therapy should be initiated as second phase treatment when the battering has stopped, when the woman believes she is safe, and when both partners express a commitment to their relationship. It should facilitate communication skills, positive conflict resolution, and collaborative problem solving. It should reinforce gender equality and ethical interpersonal relations. When appropriate, it should strengthen affective ties and build on the positive aspects of the relationship. It should explore the maladaptive reasons that hold the couple together and, when appropriate, help couples separate in cooperation and safety.

Use of a co-therapist team (female-male) is recommended in the treatment of heterosexual couples. This is an effective approach to information gathering in the initial assessment phases of couple treatment in which separate interviews are required with both partners (Cook & Frantz-Cook, 1984). Further, it can facilitate the direct observation of gender bias in personal interactions as clients communicate with male and female co-therapists. Presence of both female and male therapists can be an important element in building trust and rapport when both partners believe their voice will be heard and understood (Harris, 1986). It has been suggested that it prevents clients from "feeling ganged up on" by providing a treatment team with both sexes represented (Geffner, Mantooth, Franks, & Rao, 1989). Further, clients can receive clinical support and encouragement from "same-sex" therapists in the safe expression of their feelings and reactions (e.g., through therapists acting as "alter egos" or speaking about shared learning of "gendered patterns" of behavior). Also, it seems that clients are more open to confrontation of their beliefs and behaviors from same sex therapists (Harris, 1986). The clinical team can actively and purposively model gender sensitive behavior, mutual respect, and collaborative decision making during sessions. If during the course of the dyadic therapy, it is necessary to shift to individual therapy (e.g., there is a slip in the control of violent behavior, or there is confusion in one partner as to whether the couple should remain together or separate, etc.), then there can be a smooth transition to individual counseling with termination of conjoint efforts.

Examples of dyadic marital treatment, for couples experiencing mild to moderate levels of domestic violence, emerged in the literature in the mid 1980s (e.g., Cook & Frantz-Cook, 1984; Gelles & Maynard, 1987; Geffner et al., 1989; Harris, 1986; Lane & Russell, 1989; Madonna, 1986; Magill & Werk, 1985; Neidig, Friedman, & Collins, 1985; Rosenbaum &

O'Leary, 1986; Steinfeld, 1989; Taylor, 1984; Weidman, 1986). More recently, a number of prototype "pro-feminist" models for couple treatment of wife abuse have appeared (e.g., Edleson & Tolman, 1992; Goldner, 1992; Goldner et al., 1990; Hansen & Goldenberg, 1993; Karpel, 1994; Lipchik, 1991; White, 1989). Although treatment outcome information on pro-feminist couple therapy is sparse, the preliminary findings (Harris, 1986, Lipchik, 1991; Sirles, Lipchik, & Kowalski, 1993) are encouraging and suggest an approximate success rate of 65 to 80%. Unfortunately, these studies are plagued with the same methodological limitations as are most treatment outcome studies in family violence (Rosenfeld, 1992).

PRO-FEMINIST COUPLE AND FAMILY THERAPY IN DOMESTIC VIOLENCE: KEY INTAKE ASSESSMENT THEMES

Pro-feminist approaches to couple and family therapy employ similar clinical criteria that need to be considered before conjoint dyadic therapy is initiated. Key assessment questions include:

Is the Victim Safe from Physical Violence During Therapy?

Couple and family therapy should not be used to stop ongoing violence. It should be initiated only after the violence is under control and safety is reasonably assured (Cook & Frantz-Cook, 1984; Hansen & Goldenberg, 1993; Karpel, 1994). For most couples this will mean that the perpetrator has "graduated" from a group treatment program; he understands he is responsible for his own use of violence; and he has demonstrated that he is capable of self-control. During separate interviews with perpetrator and victim, therapists should determine if he is denying the seriousness and externalizing blame for his abusive behavior, and is still volatile in his use of physical force. It is also important to review and reinforce a family safety plan, which at the least ensures escape to safety for those victimized, and which at best, also involves a commitment by the couple that criminal charges will be laid if any abuse re-occurs. Because of the "cycle of violence" (Walker, 1979), that is characteristic of many couples in which abuse occurs, it is important that there be a sufficient time interval since the last abusive episode occurred before initiating relationship therapy. Gondolf (1993) suggests a waiting period of 6 months of nonviolence, but this time interval to establish safety will vary greatly across couple situations and will depend on the circumstances of the prior assault. A key question in this regard is whether the perpetrator is coming to couple therapy to change his behavior, or if his interest in therapy is simply an act of temporary contrition to hold his partner in the relationship.

What was the Past Severity of the Abuse?

Most couple treatment programs that have been described in the recent family violence literature suggest that relationship therapy is appropriate for situations involving mild to moderate abuse. Harris (1986) warns that "it is best to assume that all batterers are potentially dangerous" and lists factors that indicate a greater likelihood of continued couple violence. Certainly men who inflict serious injury, use sexual assault along with physical assault, display frequent and explosive jealousy, or show excessive general cruelty (e.g., killing of pets) are not good candidates for most types of psychotherapy (Dutton, 1995; Gondolf, 1993). Great caution must be exercised prior to involving such dangerous men in any type of conjoint therapy. Most often they will require long-term individual and group treatment before there is a possibility that they will be ready for second phase treatment. The couple and family issue that will most often prevail, with brutal and explosive perpetrators, is how to provide the psychological supports these men require, to enable their partners to leave

them in safety when the women wish to do so. Some men will continue to abuse, even with legal and clinical interventions, and Rosenfeld (1992) argues that incarceration may be needed in these cases for incapacitation, rather than deterrence or rehabilitation.

There are two basic, and closely interwoven, transactional elements that will come into play in comprehensively assessing "severity" of an abusive relationship: fear in victims and perpetrator motivation for abuse.

Does Fear Pervade the Relationship and Constrain the Victim's Freedom of Choice?

It is not reasonable to proceed beyond gender-specific treatments when fear still pervades a relationship. Couple therapy depends on the ability of partners to discuss their relationship issues and concerns in a free and honest exchange. In situations of patriarchal terrorism, patterns of male dominance will block any meaningful and positive relationship improvements. The most common reason that battered women identify for staying with their abusers is fear. They often fear for their own safety, for the safety of their children, and in some cases, for the safety of the perpetrator (Pagelow, 1981). These fears should not be ignored or taken lightly, and need to be directly addressed prior to the initiation of any relationship therapy. DeMaris and Swinford (1996) identified factors influencing fearfulness in women and, in particular, noted the danger of intervening with relationship therapy in situations in which a woman had been subjected to severe abuse, such as the use of coercive sex as an element of the physical assaults and intimidation.

Couples have been referred to us for conjoint treatment in which the man and the women are both "very scary" people. These couples often have experienced serious family violence in their childhood, and are often members of existing extended family and friendship networks in which violence is commonplace. Family life for these couples is framed by a "culture of violence". Men and women in these couples are like powerful nation-states that hold each other at bay through a threat of the use of dreadful weaponry. Both partners, in their own way, show a potential for lethal behavior. Yet they can be highly committed to each other as a couple, and both can have strong emotionally attachments to their children. They seek treatment because the women want to remove the threat of violence from their family life, and when the men are ready to acknowledge the social and emotional costs of violence (including their own past experience with police, courts, and jail). Fear in these couples appears to be *balanced*, and it is not clear that there is oppression by one partner who holds strong supremacy over the other. At the other end of the continuum, we have also treated couples in which one past incident of indirect violence (e.g., punching a hole in the wall during an argument) had created a situation of fear and intimidation. If such an atmosphere of fear can be detected during intake counseling sessions with a woman, we will not proceed with conjoint counseling until the fear is addressed in first phase treatment. Couple circumstances vary widely in terms of the duration and extent of physical abuse. The case examples briefly described here demonstrate that knowledge of severity of abuse alone, is not enough to guide treatment decisions. No matter what the severity of the abuse, presence of fear of continued abuse in a victim is a key element in her readiness to participate in conjoint couple therapy. The more that fear dominates the relationship, the less appropriate the use of conjoint methods.

What is the Perpetrator's Motivation for Being Abusive?

Johnson's (1995) differentiation between patriarchal terrorism and reciprocal ("common") couple violence is clinically useful. I prefer to use "reciprocal couple violence" rather than "common couple violence," as the term "common" may be easily misconstrued to mean normal or regular behavioral acts. Such differentiation highlights the importance of fear as a

relationship dynamic and draws attention to the motivation of the perpetrator as a key treatment issue. If a woman is trapped in an oppressive relationship in which she is controlled and dominated by her partner through his exercise of abuse and intimidation, couple therapy can be fundamentally dangerous. Couple and family work should never be initiated in circumstances of patriarchal terrorism.

Impulse control treatment (e.g., time-out, self-talk, etc.) for oppressive and controlling perpetrators does not in itself adequately prepare men for conjoint therapy with their abused partners. It is best when their abusive patriarchal beliefs have been challenged and they are aware of the impact of these beliefs on their relationship with women. Anger management is not enough, as it is the emotions and beliefs behind the anger that need to be addressed (Gondolf & Russell, 1986). Russell (1995) sees this as going beyond the prevailing male deficit model (e.g., impulse and anger control) to a belief systems model (addressing abusive beliefs based on the "centrality, superiority and deservedness" of the male self). Psycho-educational interventions, which enlighten perpetrators in regard to their abusive patriarchal beliefs, set the stage for the honest acceptance by each perpetrator of his of personal responsibility to stop using violent tactics of control. These are vital first steps in the ultimate termination of "victim blaming behavior," which runs rampant in perpetrators of wife abuse. Jennings (1990) suggests that a "relapse prevention approach" should be followed, which recognizes that even when physically abusive behavior is terminated, batterers are still vulnerable to relapse. Those who have not integrated an appreciation of cooperative problem solving and gender respect in their conjugal relations, will likely continue to use psychologically abusive tactics, and will be vulnerable for a relapse to the use of physical abuse. In this sense, it is helpful to use an "addiction metaphor" and consider these men "in recovery," rather than being "cured," when they stop their physical assaults on their partners. In the assessment of a couple's readiness for conjoint relationship therapy, the acknowledgement that battering is never justified in the resolution of marital conflict, and the acceptance of personal responsibility for any acts of violence by the batterer, is an important signal that it is safe to proceed to conjoint therapy.

It is possible to stop physical violence but only contain, or put "attitudinal limits" on patriarchal beliefs. For example, there are cases in which patriarchal beliefs represent fundamental aspects of culture or religion. Cervantes and Cervantes (1990) consider multicultural implications of wife battering and identify three cultural attitudes that support violence against women: sex role stereotyping, promotion of adversarial sexual beliefs, and acceptance of interpersonal violence in conflict resolution. There are wide variations across cultures on these themes. Several special examples of these have emerged in our clinical practice. Some couples, particularly those from isolated or socially impoverished family backgrounds, do not understand the limits of a husband's rights and privileges under the law. These husbands have difficulty accepting the idea that it is wrong to dominate and control a wife, but do learn quickly that it is against the law. This situation can exist with couples who have recently emigrated from cultures that are dramatically different from our own, and that are highly patriarchal. Another variation of this same theme involves couples with fundamentalist religious beliefs that include a strong adherence to patriarchy. Frequently these cases involve "patriarchal bullies" rather than "patriarchal terrorists", who use mild to moderate abuse in basic ignorance of the law. Many of these men are shocked and humiliated by the court process. Usually the court appearance is a sufficient deterrence in itself to curb further physical abuse in cases such as these. Conjoint treatment for such couples involves "culturally sensitive family therapy" that centres on gender respect in the negotiation of family roles and tasks (Trute & McCannell Saulnier, 1985). It is possible for these couples to create fair and egalitarian patterns of family decision making, that are still congruent with their cultural and religious beliefs. White's (1989) model, with its constructivist perspective,

is directly applicable, as it is an approach to relationship change that includes a heightened focus on patriarchy, and weakens beliefs in the legitimacy of the use of violent acts in couple relations. Madane's (1995) approach, which includes use of extended family networks and recognition of spiritual destruction in wife abuse, is informative to multicultural practice. An essential aspect of conjoint couple therapy for domestic violence should be to challenge the use of patriarchal rationalizations that justify the use of abusive behavior and diminish perpetrator responsibility for abusive behavior. Further, positive methods of couple problem resolution should be facilitated, that include gender respect and exclude individual exploitation.

Is the Couple an Intimate Relationship or Just Two People Living Together?

Before providing couple therapy that might consolidate or provide "emotional glue" to a relationship, it is important to assess whether positive emotional bonding has ever existed in the relationship. Has the couple moved from being two "I's" to a "WE"? Do both partners want to remain together and to improve the emotional elements of their relationship? Lipchik (1991) highlights the importance of knowing "that the partners are more than objects of self-gratification for each other . . .. There must be signs of bonding and personal caring from each . . .." (p. 61). We have completed intake assessments of couples in which physical violence has stopped, but in which there is an absence of emotional support and a predominance of gender exploitation (e.g., cases in which the woman is a "meal-ticket" for her unemployed or underemployed male partner and no more to him). We will only proceed with couple or family therapy in such cases if both partners acknowledge the reality of the situation, and convince us that they both are motivated to change.

Presence of children in the household is a factor in the exploration of this attachment issue. Each parent may have substantial emotional ties with their children, while remaining emotionally detached from each other. We provide family therapy to impoverished families residing in the core-city area of the city in which our clinic is located. Some of the couples in this "urban culture" are called "barbecue relationships" by local service providers. They have short periods of "running very hot" and long periods of "running very cold." During the "cold" relationship periods men are peripheral to family life and have little contact with the women and with their children. However, during the "hot" times they spend a great deal of time with their families, and these can be times of both intimacy and abuse. Although the men in these families are often absent, they do show strong emotional ties to their children and do want to be "good fathers" to their children. We do see "barbecue couples," when battering is gone from the relationship, and there is ample evidence that the home is safe. However, the primary focus of the therapy is on parenting; enhancing couple relations comes second as a treatment goal. These clinical priorities are congruent with the cultural context of the families, and do serve a preventative purpose in disrupting the intergenerational patterns of domestic violence.

Is There Evidence of Psychosis or Major Personality Disorders? Is There Addiction to Alcohol or Drugs in One or Both Partners?

These are two basic screening questions in the assessment of client suitability for couple and family therapy. Individuals who show symptoms of psychosis or marked personality disturbances require treatment that is specifically for those conditions and are not suitable candidates for couple treatment of domestic violence (Hansen & Goldenberg, 1993). Perpetrator studies suggest that batterers as a group may show more psychopathology, particularly features of personality disorder (Dutton, 1995; Gondolf, 1985, 1993; Hamberger & Hastings, 1986; O'Leary, 1993). Gondolf (1985) estimates that a small proportion of batterers (as any

as 15%) have significant psychopathology and do require long-term, intensive psychotherapy. Perpetrators with antisocial/sociopathic (Gondolf, 1985, 1993) or psychopathic/borderline personalities (Dutton, 1995) are not a good bet for treatment success in individual therapy, and are rarely ready for couple or family focused relationship therapies.

Studies have suggested that between 36% and 52% of wife batterers abuse alcohol (Byles, 1978; Fagan, Stewart, & Hansen, 1983). Alcohol intoxication has been identified as a frequent trigger for physical abuse (Gelles, 1972). Alcohol abuse should not be seen as a cause or an excuse for battering, but as a facilitating condition that heightens risk for family violence. Just as battering must be stopped before relationship therapies are initiated, so must active alcohol abuse be stopped, as a precursor to couple and family treatment of domestic violence (Cooley & Severson, 1993; Hansen & Goldenberg, 1993).

SECOND PHASE TREATMENT OF DOMESTIC VIOLENCE: CONCLUDING COMMENTS

A key requirement of relationship therapies in domestic violence is that they ensure that women do not feel under pressure to include their partners in counseling, and that women's safety remains a central service objective. It is important to acknowledge that no one ideological, social, or therapeutic approach will meet the needs of all abused women and all woman abusers (Goldner, 1992). There have been significant advances made in the treatment of domestic violence over the past decade. These advances have clarified the distinctions between wife abuse as a criminal act and as a therapeutic concern. To adequately recognize and deal with wife abuse as the serious and widespread problem it is in our communities, we will need to move from a doctrinaire "advocacy for victims position" and expand it to include the recognition that the treatment of wife battering goes beyond provision of gender-specific treatments. We will need to acknowledge that we are attempting to manage complex relationships that are personally intense and behaviorally volatile. We need to go beyond individual treatment and intervene at the level of the relationship, after personal safety is secured. To bring long lasting, violence-free living to families, it means more than just focusing on one member of the family. It means creating situations of therapeutic safety so that those who wish to can maintain their intimate relationships without fear; and that those who choose to, can nonviolently discontinue their marital relationship.

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