Spouse ABUSE

Assessing & Treating Battered Women, Batterers, & Their Children

Second Edition

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Preface to the Second Edition

In the 11 years which have elapsed since the publication of the first edition of this book, there has been a virtual proliferation of books on the subject of spousal abuse. Most have focused on the expanding empirical base on this topic. Nonetheless, clinicians' knowledge about how to assess and intervene with individuals and families touched by this social problem remains scanty. Fortunately, in some jurisdictions, public recognition of the prevalence and seriousness of violence in families has led to calls for better training for mental health professionals. Several states now mandate domestic violence training in graduate programs and continuing education for licensed clinicians. We are hopeful that soon all clinicians will have the skills necessary to help affected families. In the meantime, we offer an expanded version of our earlier book. This book continues to be of immediate utility as it provides hands-on training for clinicians at a variety of levels.

Since the publication of the earlier edition, terms such as domestic violence and intimate partner violence have been more frequently used than "spousal abuse." Some have objected to the use of "spousal abuse" as implying that violence occurs only within the context of a marital relationship. However, the term "spouse" itself has been more broadly applied in the last 11 years so that it is now understood to apply not only to married couples but also to other couples in committed relationships, whether heterosexual or homosexual. At the same time, we recognize that dating couples also experience a great deal of violence and much of what we describe in this book applies equally to dating couples. Although we refer primarily to spousal abuse throughout the book, we also use other terms such as domestic violence, intimate partner violence, and other closely related terms.

This edition reports up-to-date information about the prevalence and seriousness of spousal abuse. We have expanded the information about how to conduct an assessment, revised and elaborated on how to work with batterers, and have greatly expanded the sections on assessing and treating children. We remain convinced that families exposed to violence are affected at multiple levels and therefore believe that intervention must also occur at multiple levels. We are dedicated to seeing all clinicians develop minimum levels of competency for work with families affected by violence.

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What Kinds of Families Are Violent?

HOW COMMON IS VIOLENCE IN THE FAMILY?

"The American family and the American home are perhaps as or more violent than any other single American institution or setting. . . . Americans run the greatest risks of assault, physical injury, and even murder in their own homes by members of their own families" (Straus, Gelles, & Steinmetz, 1980, p. 4). Shocking as it may be, this statement tells us something about the prevalence of familial violence in our society. And, although this quotation is more than 20 years old, it is as relevant today as when it first appeared in print. In support of this statement, Greenfeld et al. (1998) indicate that 3 out of 4 victims of intimate violence included in official government statistics were assaulted in their homes.

We present these findings here to convince our readers of the necessity of learning about how to treat spousal abuse and each person affected by it.* No longer can clinicians assume that only specialists in domestic violence must be knowledgeable about this problem. In fact, it is highly likely that all practitioners will at some point be treating either a violent individual, the target of that violence, or a child who views the violence. Every clinician, therefore, must be an expert in the assessment and treatment of spousal abuse. It is our intention, with this book, to provide the information necessary to sensitize clinicians to the issue and to outline treatment strategies and interventions.

It is difficult for clinicians with no personal experience of spousal abuse to understand its insidiousness. "Case Example 1" (pp. 8-10) presents a family in which spousal abuse follows a typical course.

*Spousal abuse is also referred to as domestic violence or intimate partner violence.

Statistics about the prevalence of spousal abuse differ for a variety of methodological reasons, such as how violence is defined or measured, who is surveyed, and the context of the study (e.g., when spousal abuse is assessed as part of a study of crime, prevalence statistics are somewhat lower because most do not think of domestic violence as a crime, even though it is). Some of the commonly reported figures are those of Gelles and Straus (1989), which indicate that 1 out of every 6 wives reports that she has been hit by her husband at some point in her marriage.* In 6 cases out of 1,000 the attack takes the form of a severe beating, and in 2 cases out of 1,000 the attack involves the use of guns or knives. More recent figures support earlier findings with 1 out of 5 women reporting being assaulted by an intimate partner (Tjaden & Thoennes, 1998).

Estimates were made that 8.7 million couples experienced at least one assault during 1985 (Straus & Gelles, 1988). The same researchers estimate that in 3.4 million households, the violence had a relatively high risk of causing injury. More recently, Tjaden and Thoennes (1998) indicated that there are 9 million incidents of spousal abuse annually. These figures must be taken with some caution because experts estimate that the actual figures are likely to be considerably higher. There is widespread agreement that reports of incidents of spousal abuse far underestimate actual figures (Kilpatrick, Edwards, & Seymour, 1992; Tjaden & Thoennes, 1998, 2000). Greenfeld et al. (1998) estimate that only about half of the women who experience violence perpetrated by an intimate report it to the police. And it is not only the couple who are impacted by spousal abuse, but also the children in the household. It is estimated that 3.3 million to 10 million children are exposed to spousal abuse (Carlson, 1984; Straus, 1991). The National Crime Victimization Survey indicates that children under 12 live in more than half of the households where women are physically abused (Greenfeld et al., 1998). Moreover, as many as 30% to 70% of batterers are reported to abuse their children as well (Hughes, 1982; Pagelow, 1989; Straus et al., 1980).

Of course, spousal abuse is not restricted to couples who are legally married. Koss (1990) indicates that the proportion of violence in dating relationships is extremely high – fully 50% of couples have experienced it. Dating violence is said to affect 10% of high school students (Silverman et al., 2001) and from 22% (Sorenson & Bowie, 1994) to 39% of college students (White & Koss, 1991). Likewise, violence is not something unique to heterosexual couples: Renzetti (1993) found that as many as

*Because 95% of batterers are men and most of the battered are women (Connors & Harway, 1995), the male pronoun will be used throughout this book to refer to batterers and the female pronoun will refer to those battered.

59% of lesbian couples have also experienced violence. In one of the few studies of gay male violence, 17% of gay men surveyed reported having been in a physically violent relationship (Gay and Lesbian Community Action Council, 1987). Looking at a variety of published studies, the National Coalition of Anti-Violence Programs (1997) concluded that as many as 25% to 33% of gay and lesbian relationships included violence. Likewise, spousal abuse is found in all groups regardless of socioeconomic status, religion, or racial/ethnic background. For example, Tjaden and Thoennes (2000) report that Hispanic and non-Hispanic women are equally likely to experience physical assault and stalking victimization. Bachman and Saltzman (1995) report similar figures of spousal abuse across a number of ethnic groups. Greenfeld et al. (1998), however, indicate that spousal abuse is higher among black women aged 16 to 24, women in the lowest income groups, and those living in urban areas.

These statistics clearly indicate that spousal abuse is a problem that affects people from a wide variety of backgrounds.

HOW SERIOUS IS SPOUSAL VIOLENCE?

Some practitioners, aware of the incidence of violence today, are not aware of the seriousness of violent episodes and thus tend to underestimate the danger their clients may experience.

Yet, the research indicates that conjugal assaults tend to have serious consequences. About half of victims of spousal abuse reported a physical injury (Greenfeld et al., 1998). About 50% of those injuries were relatively minor (bruises and similar trauma); the remainder were relatively serious, and many of those were injuries to the head or face. About 30% of female victims were killed by an intimate, a figure that remained the same as in 1976 (Greenfeld et al., 1998).

A study of 300 shelter residents indicates that these women had endured an average of 59 assaults each. Prior to intake, each woman had on the average experienced over five assaults every 4 weeks, for an annualized frequency rate of over 65 conjugal assaults per year. Over 20% stated that they were being assaulted twice or more per week. Sixty-two percent of women who had ever been pregnant during their abusive relationships had been assaulted during a pregnancy. Two-thirds of the sample had experienced at least one assault where they were extensively beaten up or worse. One in 6 had been threatened with a knife or gun by her partner, and one in 30 had actually been attacked with a knife or gun (Okun, 1986). These 300 women reported on intake 28 fractures (most com-

monly of the nose or jaw) and 22 serious injuries not involving fractures (chronic back injuries, torn ligaments, dislocations, ruptured eardrums, broken teeth, lacerations, stab wounds, bullet wounds). These injuries included only those that had been sustained at the time of intake, not previous injuries.

A frightening finding is that of this group, only 24% of women had ever received medical treatment for injuries sustained during conjugal assaults. The remainder had wanted medical treatment but were prevented by their partner from obtaining it. Sixty-nine percent of these women had experienced at least one assault that resulted in police intervention, and over 17% had received multiple visits from the police. Similarly, Greenfeld et al. (1998) report that only 1 in 10 women victimized by an intimate other had sought medical treatment. However, in 1994 (Greenfeld et al., 1998) there were more than a quarter of a million hospital visits resulting from spousal abuse, and there are annually $150 million dollars in medical expenses accrued.

In many cases, domestic violence results in murder, with lethality in cases of wife battering most likely to occur when the woman tries to leave (Browne, 1987). That women are in particular danger is substantiated by the finding that almost a third of female murder victims are killed by a husband, an ex-husband, or a nonmarital partner (Greenfeld et al., 1998).

Thus, serious injury (or death) as a result of domestic violence is highly likely. In addition to injuries or death to the recipients of domestic violence, children who witness spousal abuse experience damage both over the short and the long term; and symptoms may range from internalizing problems to externalizing problems (Barnett, Miller-Perrin, & Perrin, 1997).

CONTEXT WITHIN WHICH BATTERING OCCURS

Understanding spousal abuse requires an understanding of the cultural context within which battering occurs. “Men who assault their wives are actually living up to cultural prescriptions that are cherished in Western society – aggressiveness, male dominance, and female subordination – and they are using physical force as a means to enforce that dominance” (R. E. Dobash & R. P. Dobash, 1979, p. 24).

Sex-role stereotypes may maintain battering as the societal problem that it is today. In fact, a number of researchers, studying the causal path-

ways for a variety of types of violence, attribute violence to gender-role conflict and hyper-masculinity (Connors & Harway, 1995; Lisak & Roth, 1988; O'Neil & Egan, 1993; O'Neil & Nadeau, 1999; Pryor, 1992). Another explanation is that the traditional family is a system where the balance of power is inherently unequal, mimicking other relationships of men and women, where men have usually held the power and women have been subservient to those in power over them. One of the effects of power imbalance is that women, as the less powerful member of the family, learn to be more accommodating and also to tune in more to the needs of their spouse. This pattern of behavior is accentuated among battered women, as evidenced by the complacency that many battered women exhibit, their difficulties in leaving, and the tendency to placate the batterer so as to avoid repetition of violent episodes (Nutt, 1999). Other research substantiates that females are more emotionally expressive than males. Thus women are seen as being emotional (equated with irrationality) and men as nonexpressive (equated with rationality). At the same time, expressions of aggressiveness (which is more characteristic of males) are not typically labeled as expressions of emotion nor as irrational acts.

Expressions of aggression by a batterer toward his wife (even those stemming from a loss of control) fail to be condemned by society because they are role congruent, whereas fighting back (usually in self-defense) by the wife would be condemned because it is incongruent with the female gender-role.

WHO SEEKS TREATMENT?

We have argued that the statistics cited previously suggest that at some point in their practice all therapists will find in their waiting room either a battered woman, a batterer, the children of these couples, or someone else affected by spousal violence. Thus, it is important to know exactly how these individuals will present when they seek treatment.

Will they come for therapy to rid themselves of the violence? Some research suggests otherwise. Holtzworth-Munroe et al. (1992) describe their efforts to find a nonviolent control group for a study of spousal violence. In five different studies, they sought nonviolent maritally distressed couples from psychological and family therapy clinics and nonviolent nondistressed couples from the surrounding community. Among the maritally distressed but allegedly nonviolent couples, 55% to 56% of the men actually reported having at some time engaged in violent behav-

ior toward their wives and their therapists did not know about the violence. Among the nondistressed couples, 30% to 34% of the men (depending on the sample) were violent toward their wives.

In the same study, the percent of husbands who had been violent toward their wives in the previous year ranged from 43% to 46% (depending on the sample) among the distressed couples and 15% to 21% among the nondistressed couples. Although the majority of the violent behaviors were not classified as severe (but did include pushing, grabbing, shoving, throwing things, and slapping), husbands had generally engaged in several different violent behaviors and/or in one violent behavior more than once. Some husbands had engaged in severe violent behaviors such as choking or using a knife or gun.

The Holtzworth-Munroe et al. (1992) study suggests that a critical skill for clinicians, therefore, must be assessment for spousal abuse. In Chapter 3, we will describe how this assessment should be conducted.

One final note: Our interest in this area was motivated by some research we conducted (Hansen, Harway, & Cervantes, 1991; Harway & Hansen, 1993a, 1993b) suggesting that even experienced therapists were not knowledgeable in assessing or treating spousal violence. In both studies, therapists received a questionnaire by mail that mentioned a case vignette of an actual violent family. In the first study, therapists were members of the American Association of Marriage and Family Therapy (AAMFT) and included both master's and doctoral level clinicians representing themselves as marriage counselors, clinical social workers, psychologists, and psychiatrists. After the presentation of the vignette, they were asked to describe what was happening in the family, what interventions they would make, what outcome they would expect from their intervention, and what legal and ethical issues the case raises. When asked to describe what was going on in this case, 40% of practitioners in this sample failed to address the issue of violence (even though the violence was clear in the case). Moreover, among those identifying the conflict, the severity was minimized: Ninety-one percent of those who addressed the conflict considered it mild or moderate.

Recognition of family violence is an important first step, but no less important are the therapists' descriptions of how they would intervene. Because even those who addressed the violence underplayed its seriousness, the interventions they subsequently recommended were inappropriate. Fully 55% of respondents *would not* intervene as if the violence required any immediate action. The results were consistent across characteristics of the respondent (master's or doctoral education, psychologist

or other license, and gender). There were few differences by theoretical orientation of the respondent.

The second study also involved a mail questionnaire, this time sent to a random sample of the memberships of several practice divisions of the American Psychological Association (APA; Divisions 12 [Clinical Psychology], 29 [Psychotherapy], and 42 [Independent Practice]). A case in which rather extreme domestic violence was implicated was presented to respondents.

Results of the second study supported those of Study 1 in that some substantial proportion of our psychologist respondents did not generate appropriate interventions even when told outright that the case was one of domestic violence with a lethal outcome.

The fact that relatively consistent findings were obtained from both studies suggests that many psychotherapists (with a variety of types of training) are unable to formulate appropriate intervention plans even when explicitly told that a case is a violent one. Moreover, it also appears that therapists are unprepared to assess for dangerousness in violent families. In the second study, diagnoses given by respondents prior to knowing about the homicide were compared to assessments of dynamics made after being told that the case had resulted in a murder. Diagnoses and assessments were remarkably similar: A substantial proportion of respondents used as a diagnosis a V code for marital problems (V61.10 in *DSM-III-R* [American Psychiatric Association, 1987] which corresponds to V61.1 in *DSM-IV* [American Psychiatric Association, 1994]). After being told that a murder had occurred, most still speculated that the underlying dynamics of the case were heavily dependent on the couple's issues. Only a handful of respondents, either before learning of the homicide or after, focused on the pathology of the perpetrator! Moreover, fully one-half of our sample, asked what intervention they could have made prior to the fatal outcome, failed to consider obtaining protection for the wife or of insuring her safety.

WORKING WITH FAMILIES EXPERIENCING SPOUSAL ABUSE

The data presented in this section make it clear that working with families that experience spousal abuse is difficult work, fraught with peril both for the clients and the therapist. Because of the prevalence of spousal abuse and the danger that clients are in, mental health professionals are cautioned to be knowledgeable about this issue, competent in assess-

ment and treatment of violent families, and willing to consider the possibility of abuse even when the clients present with problems seemingly unrelated to violence. Moreover, the impact on the children must also be considered, whether or not the parents are aware of their child's exposure.

Case Example 1: Susan and George*

Susan Spence met George Gambrills at a church social. From the first, she was quite taken by him: tall, good-looking, very personable, gainfully employed as an engineer at an aircraft manufacturer, and with all the characteristics of a potential marriage partner. George perceived Susan as the woman of his dreams: intelligent, moral, financially able to contribute to a family, and very beautiful. They dated for 8 months. Their courtship was idyllic: George was very romantic; he frequently bought her roses and gifts and took her to expensive restaurants. He enjoyed being with her so much that they spent virtually all of their time together. Susan began to distance herself somewhat from her girlfriends. For one, she had little time left after work that was not spent with George. Also, George had reasons for not liking each of her friends, and she began to feel alienated from the individuals themselves. George found himself suspicious of Susan's friends. He felt she should need him and come to him instead, claiming that was what a relationship was supposed to be. By the time he proposed, George was her best and only friend. Susan immediately said yes and began preparing for the wedding. George was intricately involved in the planning. He wanted a fancy white-tie wedding. He wanted a Saturday night wedding at a big hotel in town. He wanted beef Wellington for the main course. He wanted his brother Fred to be best man and his sister Erica to be maid of honor. He said he felt uncomfortable with Susan's brother Tom and did not want him to be an attendant. He wanted his cousins Samantha and Benjamin to be attendants. Susan had dreamed of her wedding for many years. George's plans were very different from the wedding she had envisioned. Though Susan was upset, she was so in love that she acquiesced to all of his requests.

*Names and all identifying characteristics of persons in all case examples have been disguised thoroughly to protect privacy. None of these persons or cases refer to any specific client; all are composites drawn from numerous cases.

Shortly after the wedding, George seemed to change and began to be abusive. At first he simply put her down. She wasn't as perfect as he thought she was, but then she had never been married before, and with a little instruction. . . . His criticisms increased to nagging and deriding her, expressing unfounded jealousy, and spewing insults about her family and workmates. Then he began insisting she restrict her activities, forbidding her to leave the house during her time off, controlling the family finances, and eventually complaining so much about her work that she quit her job. Susan felt relief at quitting her job, as shortly thereafter she discovered she was pregnant. Relationships with her family began to deteriorate because George began to tell her things that relatives had allegedly said about her behind her back. Susan was upset when George forbade her mother staying with her when her baby, George, Jr., was born. However, she thought George would be kinder now that he had the son he had always wanted. Instead, George, Sr., found fault with everything she did for the child. In addition, he did not help with the care of the baby, but would hold him and tell him how inept his mother was. George felt Susan let herself go physically after the birth of the baby and was angry that she no longer looked like the woman he married.

The first time that George struck her, Susan was stunned. He had been yelling at her about her slovenly housekeeping and how poorly she was caring for the child when suddenly he pushed her so hard she fell over the coffee table. He also punched her so hard in the face that her ponytails came undone. The morning following the fight, George was contrite, telling her that he had so much pressure at work that he had lost his mind. He apologized and bought her an exquisite bracelet to make up for hurting her. He promised that it would never happen again.

Unfortunately, the violence continued and became more and more acute and more and more frequent, each time followed by a period of contriteness with George going out of his way to be especially loving to atone for his loss of control. Most of the time, George would slam Susan against the wall, once even going so far as to slam her so severely that her hearing was affected. At other times, George would become enraged and lock her in the apartment, leaving her isolated for days at a time. Young George, Jr., was watching his father. At the age of 2 he would become aggressive toward other children, biting them and kicking them. Throughout it all, Susan continued to love George, excusing his violence by pointing to the extreme stress of his job and indicating that the real George was the loving man who bought her gifts and acted so lovingly following a fight. She also felt her young son was only going through a "stage" and would learn to behave better.

Susan became pregnant with Caitie when George, Jr., was 4. Her husband was angry and complained that they did not have the money for another child. He did not accompany her to the hospital for the birth of their daughter. When Caitie was a baby her father refused to have anything to do with her. He began to belittle her just like he belittled Susan. When Caitie was 4 she began to complain of headaches. Her pediatrician recognized these as stress related and recommended the family seek counseling. George, Jr., continued to have difficulty in situations where he was required to accommodate other children. He was very disruptive and impulsive in preschool. Susan was addressing the concerns of George, Jr.'s preschool teacher and Caitie's pediatrician when she sought out psychotherapy.