Issues in Domestic Violence: Working With Perpetrators of Domestic Violence

Introduction

Case Vignettes

Marlena, a clinical social worker employed in a community mental health center, is assigned to work with Jack, a client new to the center. In reviewing the intake paperwork, Marlena notices that Jack boastfully described his tactics to “keep my family in line,” including physically disciplining his wife and children. Jack has been mandated by the court to receive “anger management” therapy. Marlena is concerned, about the lack of insight on Jack’s part, and does not feel she has the slightest idea of how to work with Jack.

Dr. Timon, a psychologist, is meeting with Candace, who is seeking treatment for her increasing alcohol use. While Candace presents as quiet and subdued, the picture she paints of herself while drinking is quite different. Her relationship with long-term boyfriend Kenny is in jeopardy. Candace describes a recent fight with Kenny, who tried to stop her from leaving the house when she was drunk. Frantic to purchase more alcohol, Candace became physically assaultive, blackening Kenny’s eye and biting him. When inquiring as to whether this is the first time Candace has assaulted Kenny, Dr. Timon is surprised to learn that it has happened multiple times in the past. Kenny has never reported this abuse.

Carl and his partner Bob are seeking couples counseling with Beth, a licensed counselor. Beth finds both Carl and Bob quite affable and amusing. She is unprepared when they begin to describe the crux of the relationship dysfunction: numerous fights that include physically, sexually and emotionally abusive behaviors. Both minimize the seriousness of these fights, seeing them as “normal” in gay relationships.

While the cases described above are both quite different, they illustrate some of the issues involved in the perpetration of domestic violence. Domestic violence includes physical, psychological, sexual, economic, and emotional abuse. Perpetrators of domestic violence can appear quite different, such braggart Jack and mousy Candace, but they often share some common characteristics. An understanding of these commonalities helps to inform intervention strategies.

While many clinicians are prepared to work with victims of intimate partner violence (an estimated 5.3 million cases of intimate partner violence are reported each year) clinicians seem to have less of a comfort level in working with perpetrators (CDC, 2003). Clinicians may experience strong countertransference, they may not have had prior training in working with perpetrators, or they may be more focused on a primary mental health concern such as substance abuse or
anxiety. Stereotypes, such as the idea that all abusers are men, or that domestic violence cannot occur between gay couples, are also prevalent.

This course will provide an overview of working with perpetrators of domestic violence. It will include research on characteristics of perpetrators, theories about why violence occurs, and a review of intervention strategies. The term “batterer” will not be used as this reflects the stereotype that domestic violence is limited to physical violence only.

Upon completion of this course participants will:

Objectives

1. Describe characteristics of male and female perpetrators of domestic violence, including gender aspects, personality aspects and subtypes of offenders

2. Briefly describe causal theories of perpetration, including Family Systems Theory, Feminist Theory, Attachment Theory and Cognitive Behavioral Theories

3. Discuss issues in the assessment of domestic violence perpetrators, including risk assessment and motivation to change

4. Discuss various approaches to working with domestic violence perpetrators, including group programs and therapeutic intervention

Characteristics of Perpetrators

While the literature on domestic violence, as well as the insight-oriented bent of most mental health professionals, demand an understanding of the characteristics of domestic violence perpetrators, this is often a challenge. This is helpful, however, in identifying potential targets of treatment interventions. An understanding of the etiology of domestic violence perpetration is also critical to inform prevention efforts.

Gender Aspects of Perpetration

Perpetrators of domestic violence may be of either gender. While men are thought to perpetrate domestic violence significantly more often than women, these statistics are currently coming under scrutiny. Rennison and Welchans (2000) found women to be victimized at about five times the rate of men. Similarly, females accounted for 84.3% of spouse abuse victims and 85.9% of victims of violence between boy/girlfriends in a longitudinal study by Durose et al. (2005). Intimate partner violence perpetrated by males was shown to be more
injurious for women and result in more severe short and long-term sequalae (Tjaden & Thoennes, 2000).

More recent studies suggest that women commit as much or more domestic violence as men (Melton & Belknap, 2003). Among teens, research shows that females perpetrate more acts of violence in intimate relationships than males (Arriaga & Foshee, 2004; Hickman, Jaycox, & Aronoff, 2004; Munoz-Rivas, Grana, O'Leary, & Gonzalez, 2007). In addition, data also suggest that females who perpetrate intimate partner violence may experience more violent or frequent victimization (Kernsmith, 2005; Luthra & Gidycz, 2006), thus safety may be a primary focus of treatment. Perpetration by females is also a factor in lesbian relationships. Lie and Gentlewarrier (1991) surveyed 1,099 lesbians, finding that 52% had been a victim of violence by their female partners.

Recent authors have found that women who perpetrate domestic violence share many characteristics in common with male abusers and perpetrators of general violence (Dutton, Nichols, & Spidel, 2005).

**Risk Factors for Domestic Violence**

Several risk factors for domestic violence have been identified. These include witnessing domestic violence or physical, sexual or emotional victimization in childhood (Lyndon, White & Kadlec, 2007; Torres & Hann, 2003). Rosenbaum & Leising (2003) postulate that due to this shared history of witnessing/victimization, many domestic violence perpetrators have a history of untreated posttraumatic stress disorder. Such exposure to childhood adversities increases risk of perpetration in adulthood. Thus perpetration may be a learned behavior. There is also the theory of “stress sensitization,” whereby adverse childhood events physiologically and psychologically sensitize individuals to hyper-reactivity to later stressors (Roberts et al., 2011).

There is also a trend in research and intervention studies to look at patterns of attachment in domestic violence perpetrators. Perpetrators also appear to share disrupted attachment patterns. Dutton (1988/1994), in some of the first studies of attachment style, found that the vast majority of perpetrators were assessed as having insecure attachment. Approximately 40% had dismissing attachment (as compared with 25% in the non-clinical population), 30% preoccupied attachment (as compared with 10% in the non-clinical population), and 30% disorganized attachment (as compared with 5% in the non-clinical population). Sonkin

Gilchrist et al. (2003) defined subtypes of perpetrators. They identified several such subtypes. These included borderline/emotionally dependent offenders, who had high levels of jealousy and stormy, intense relationships, high levels of interpersonal dependency, high levels of anger and low self-esteem; and antisocial/narcissistic offenders who had hostile attitudes, low empathy and had the highest rate of alcohol dependence.
Gilchrist et al. (2003) found alcohol use to be a feature in a majority of offences (62%) and almost half the sample (48%) were alcohol dependent. Similar statistics are proposed by Caetano et al (2001) and Martin & Ripley (2010). The latter also note that alcohol and other drug abuse is not necessarily limited to the offenders. Women who abuse substances are more likely to be victims of domestic violence. In cases where alcohol is part of the clinical picture, conjoint treatment for both substance abuse and intimate partner violence increases the success of such treatment.

Some additional characteristics of domestic violence perpetrators include low self-esteem, jealousy of and dependence on partners, and poor communication skills (Lyndon et al. 2007) personal and marital distress (Hanson, 1997), positive attitudes about violence against women, and problems with impulse control (Edwards et al., 2003; Lyndon et al. 2007). In the Edwards study, impulsiveness and impulsive aggression were also correlated with measures of Borderline Personality Disorder and Antisocial Personality Disorder.

Causal Theories and Perpetration

Case Vignette

Vincent, a 34-year-old male is seeking counseling at his wife’s request. She has expressed fears of his anger. The couple is looking to start a family in the near future. Vincent is quick to state that he has never hurt his wife, unlike what he had witnessed in his own childhood. Vincent describes witnessing his father physically abuse his mother. He was also a victim of physical abuse and neglect from a mother who was clearly overwhelmed. When asked to describe what happens when he and his wife fight, Vincent describes often feeling angry at her when she spends too much time with her own family or “chooses” them over him. Instead of lashing out, he turns inward, and can spend days in silence when he is upset. On more than one occasion, his wife has told him that she feels he is emotionally manipulating her with his silences.

How would you conceptualize this case? This would depend on your framework for understanding why intimate partner abuse occurs. This section shall recap some of these theories from the perspective of perpetration. These theories also lay the foundation for understanding perpetrator intervention programs.

Family Systems Theory

Bowen’s family systems theory has two core processes: differentiation and chronic anxiety. Differentiation is “the degree to which one is able to balance the emotional and intellectual functioning in relationships.” Chronic anxiety is seen as a result of “fear of what might be.” People who have a low degree of
differentiation experience a high level of chronic anxiety. As tensions within a family become heightened, perpetrators may use violence as a way to reduce the resulting anxiety.

**Feminist Theory**

Feminist approaches, which are often psychoeducational, look at the link between domestic violence and power and control dynamics in relationships. These theories see perpetration of domestic violence as a misuse of power by men against women as a way to exert power and control. One commonly used paradigm is The Power and Control Wheel (Domestic Intervention Programs, Duluth, Minnesota).

While the Wheel depicts dynamics that are destructive, it also points to the need for more constructive behaviors. These include use of negotiation and fairness and seeking mutual resolutions to conflict; non-threatening behaviors, economic partnership; shared responsibility for family work and decisions; Trust and support of one another’s goals, activities and opinions; responsible parenting; and honesty and accountability, which includes communicating openly and truthfully and admitting when one is wrong.

**Attachment Theory**

Attachment theory looks at relationship violence as an exaggerated response of a disorganized attachment system. The overwhelming statistics quoted in the previous section support the position that a majority of perpetrators have a history of traumatic childhoods with witnessing domestic violence or being victims of child abuse as the prevalent experiences. They also see anger as an emotion born of fear of loss (Sonkin & Dutton, 2003). Due to the insecure attachment patterns of perpetrators, Sonkin (2000) suggests that incorporating attachment theory into understanding the psychology of perpetrators may ultimately help mental health professionals to devise interventions that will facilitate the process of “earned security.”

**Cognitive Behavioral Theories**

Cognitive behavioral theories are based on the idea that violence is a learned behavior and can be unlearned (Adams, 1988). Cognitive behavioral theories form the basis of “batter intervention programs,” which stress communication, social skills training, assertiveness and anger management techniques (Babcock et al., 2004). As will be discussed later, batterer intervention programs have been successful with only a portion of those they serve.
Assessment of Perpetrators

Case Vignette

Rick is a clinical social worker, meeting for the first time with Greg. As Rick gathers information from Greg, he begins to feel that Greg is “not being straight” with him about the extent of the violence occurring at home. Rick assumes a confrontational stance, which Greg matches. Half way through the session, Greg stalks out, muttering to himself, “I knew it.”

As with other clients, assessment of perpetrators occurs within a therapeutic climate. Thus, the usual therapeutic activities need to occur, such as establishing the climate for the initial meeting and providing informed consent about therapy. Particularly important here is a discussion of confidentiality issues. Clinicians need to be aware of their state laws related to domestic violence. McClennen (2010) suggests that this information be related to perpetrators in an informational way, which will help clients to acknowledge the negative impact of their behaviors.

Additionally a culturally-sensitive approach is necessary. Cross et al. (1989) defines cultural sensitivity as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals, that enable them to work effectively in cross-cultural situations.”

Although the behaviors that perpetrators engage in are likely to be difficult for many clinicians, research shows that it is important to assume a non-judgmental stance, which will result in a more positive working relationship.

Assessing Lethality

An important aspect of assessment is looking at lethality — the perpetrator’s level of dangerousness to their partners and families. Assessment of lethality is generally determined in part by professional judgment, but can be supported through the use of risk assessment instruments.

According to Humphreys (2007) some factors that increase risk include:

- active substance abuse
- extreme jealousy
- a history of violent attacks
- mental health diagnoses
- presence of children in the house
- threats of suicide if partner leaves
- threats of homicide

McClennen (2010) suggests the following assessment tools:
o The Danger Assessment Scale (DAS; Campbell, 1995) is a 15-item scale that assesses risk factors of intimate partner homicide

o The Conflicts Tactics Scale (CTS; Straus & Gelles, 1992) is used to determine the severity of physical violence among partners

o The Spousal Assault Risk Assessment Guide (SARA; Knopp et al., 1995) is a 20-item assessment that supports professional judgment of risk

o Buss and Perry Aggression Questionnaire (Buss & Perry, 1992) is a 25-item scale that measures physical and verbal aggression, anger and hostility

Motivation to Change

Another aspect of assessment involves determining how motivated perpetrators are to change. According to Dutton (1998), perpetrators can change abusive behaviors if they are motivated to do so. Many perpetrators, however, enter the mental health system under duress, or by court mandate.

There are a number of models for assessing degree of motivation to change, These include that of Bancroft and Silverman (2004), which is specific to perpetrators, and the Transtheoretical Model (Prochaska, DiClemente & Norcross, 1992), which has been applied to a variety of behavior change needs.

Bancroft and Silverman, (2004) have proposed the following guidelines when assessing the degree of change in abusers:

Has he/she made full disclosure of his history of physical and psychological abuse?
Has he/she recognized that abusive behavior is unacceptable?
Has he/she recognized that abusive behavior is a choice?
Does he/she show empathy for the effects of his actions on his partner and children?
Can he/she identify his pattern of controlling behaviors and entitled attitudes?
Has he/she replaced abusive with respectful behaviors and attitudes?
Is he/she willing to make amends in a meaningful way?
Does he/she accept consequences for his/her actions?

The Transtheoretical Model (Prochaska, DiClemente & Norcross, 1992) looks at five stages of change for perpetrators. In the precontemplation stage, perpetrators do not see their behaviors are problematic and may engage in victim-blaming. In the contemplation stage, perpetrators may first consider the pros and cons of changing. In the preparation stage perpetrators first make a
commitment to change, leading to the action stage. In the action stage they may engage fully in treatment, such as practicing specific anger-management techniques. During the maintenance stage, the focus is on maintaining these new behaviors, sometimes in the face of triggers to relapse.

This model uses specific interviewing techniques, called motivational interviewing to assess the person’s level of change and help them move forward to a new level.

**Treatment/Intervention Approaches**

There are a number of models available for working with perpetrators of domestic abuse. Research has shown that no one model is superior to another model, and Dutton (2006) advocates against a “one size fits all” approach, stating that it is important to triage the perpetrator into the appropriate program. Dutton states that those perpetrators assessed to have a high degree of lethality are better served by the criminal justice system than a mental health intervention. In addition, there is the issue of client drop out.

How successful is group treatment? Most of the efficacy studies have involved groups for male perpetrators. Researchers have found that approximately two thirds of men who complete group intervention programs for domestic violence remain nonviolent in their intimate relationships. However some 20% of men continue to be abusive. These men tend to drop out of treatment and they tend to have substance abuse problems. Thus, one in five men who attend intervention programs will continue to abuse, even if they attend treatment (Meichenbaum, 2004).

Some of the major programs typically include: (a) feminist models of power and control and consciousness raising; (b) anger management, including time-out strategies, recognition of anger triggers, etc.; (c) analysis of the personal, familial, and social costs of family violence; (d) alcohol and substance abuse content; (e) communication skills; (f) cognitive restructuring and identifying thinking errors; (g) empathy development; (h) assertiveness training; (i) parenting training; and (j) relaxation and stress management (O'Leary, 2001; Rosenbaum & Leisring, 2001).

**Group Approaches**

Many of the current treatment approaches are gender-specific. According to Aldarondo & Mederos (2002), the most appropriate treatment modality for abusive men is men’s only. This promotes men’s accountability for changing violent behaviors, develop nonviolent resolution skills, receive specialized services such as treatment for substance abuse or PTSD and help them establish nonviolent relationships. Non-gender specific models have been
developed and are indicated below. The recommended duration of intervention ranges from 12 to 52 weeks. (Meichenbaum, 2004).

Hamberger & Hastings (1993) looked at who is most likely to complete treatment programs. They found that men who complete group treatment programs tend to be more educated, are more likely to be employed, married rather than cohabitating, and are less likely to have a criminal record. Completers also tend to have a higher stake in social conformity and are “socially bonded.”

*Duluth Model (1984)*

This is one of the most prominent programs for perpetrators and is based on a feminist approach that uses an educational and counseling approach. The Duluth Model (1984) views domestic violence as a result of both patriarchal ideology and implicit and explicit societal sanctioning of men’s use of power and control over women. A *Power and Control Wheel* is used to illustrate the pattern of abuse that includes intimidation, male privilege, isolation, emotional and economic abuse. It is shown below:

![Power and Control Wheel](image)
An *Equality Wheel* that fosters a more equal relationship is used to foster more adaptive interactions and to affect the perpetrators’s attitudes and values. It is shown below:

![Equality Wheel](image)

The Duluth curriculum includes the use of check-ins, action plans, set goals, videos, role-plays and group exercises.

*Cognitive-Behavioral Group Treatment*

Cognitive-Behavioral group treatment adopts a social-learning information-processing perspective that violence occurs because it is functional for the user and because the perpetrator has cognitive and behavioral distortions and deficits. Cognitive-Behavioral group treatment employs a variety of skills training programs that focus on communication, assertiveness, anger-management techniques (e.g., timeouts, relaxation techniques, cognitive restructuring, self-instructional training and relapse prevention) (Meichenbaum, 2004; Sonkin et al. 1985).

*Domestic Abuse Education Program (DAEP)*

This program combines aspects of the Duluth program with a cognitive-behavioral approach. The program seeks to help perpetrators understand the
ways that they use control dynamics, examine the negative effects of their actions and take responsibility for their actions.

Solution-Focused Treatment

These programs, which include both males and females, allow participants to explore their histories, develop solutions and manage anger. Perpetrators are taught to focus on meaningful goals, such as controlling anger, managing anxiety, listening to their partners, communicating without violence, etc. Participants are then shown ways to reach these goals.

Other Models of Intervention

Various other models of intervention that combine features of both feminist psychoeducational and cognitive-behavioral skills-oriented approaches have been developed such as MANALIVE (Sinclair, 1989; 2002), Compassion workshops (Stosny, 1995; 2002), Skills-based workshops (Wexler, 2000; Wexler & Willard, 2002 – Hispanic version), Couples behavior therapy that focuses on alcoholism (Dunford, 2000; Farrell & Fals-Stewart, 2000) and Supportive therapy (Taft et al., 2001).

Culturally-Sensitive Treatment

Another important aspect of treatment is to ensure that it is culturally-sensitive. This may require that clinicians tailor interventions in such a way that it is appropriate for diverse clients. While a full discussion is not possible here, specific recommendations can be found in See et al., (2000) (adapting perpetrator’s programs for African American males) and Ferrer (2002) (meeting the needs of Hispanic males).

Therapeutic Approaches

Cognitive Behavioral Individual Treatment

Individual Cognitive-Behavioral treatment is similar to the group therapy approach. Cognitive behavioral theories are based on the idea that violence is a learned behavior and can be unlearned (Adams, 1988). The cognitive behavioral approach relies on therapeutic techniques, which are used with perpetrators to improve affect regulation, such as Time-Outs (walking away as anger builds), journaling when experiencing anger, and cognitive-restructuring (using positive self-talk to reduce states of anger).

One important aspect in cognitive behavioral treatment is looking at the issue of attribution bias. Meichenbaum (2004) has found that perpetrators tend to have an explosive temperament and evidence highly reactive anger with an accompanying hostile "attribution bias." They tend to blame victims for the abuse
or to believe that victims provoke them "on purpose." Perpetrators rarely consider alternative explanations and view the use of aggression as a form of justified retaliation and the use of violence as acceptable. These aspects of attribution bias are important treatment targets.

**Attachment Therapy**

With the comprehensive work by Dutton (1998, 2006) and Sonkin and Dutton (2003) attachment-based approaches are becoming increasingly popular. The primary work of attachment treatment is to create a secure base, which is often challenging with clients who have developed insecure attachment styles: avoidant, preoccupied and disorganized/fearful. Clinicians who follow this approach use “secure base priming” in order to support the perpetrator in appraising threatening situations in a less reactive way that will not activate insecure attachment patterns. Clinicians who adapt this approach also explore childhood experiences with attachment figures, focus on non-verbal cues and their own emotional reactions to clients to understand client’s emotions, and utilize mindfulness techniques with clients who exhibit a particularly negativistic outlook.

**Mind-Body Interventions** (Tollefson, 2009)

Mind-body treatment approaches typically focus on the ways in which emotional, mental, social, spiritual, and behavioral factors can directly affect physical and mental health. Mind-body treatments usually include intervention strategies that are thought to promote health, such as relaxation, visual imagery, meditation, yoga, and biofeedback. A Mind-Body Approach to perpetrator treatment seems well suited to partner abusers given that "most (abusers) suffer from some form of extreme tension held in the body" (Dutton & Sonkin, 2003, p. 4), and that "improving emotional regulation is critical to domestic violence treatment" (Rosenberg, 2003, p. 315).

Somatic awareness and mindfulness are two key themes of this approach. Somatic awareness is defined as the ability to perceive, interpret, and act on the basis of one’s own internal bodily sensations. Mindfulness is described as paying attention in a particular way-on purpose, in the present moment, and non-judgmentally. Mind-body approaches see the key factor in understanding the root cause of domestic violence lies in understanding the mind-body state of the perpetrator before his aggressive outburst (i.e., thoughts are racing, body is numb and full of tension). Frequently this state explodes into a violent outburst that to some degree is caused by a lack of awareness and an inability to modulate psychological and physical arousal. A key technique of this approach is known as mind-body bridging.

**Couples Counseling**
While some therapists choose to conduct couples counseling, most experts urge caution when choosing this medium. There is concern that the victim's disclosures in the presence of the abusive partner may lead to later retribution or imply that she is at least partially to blame for the victimization. (Aldarondo & Mederos, 2002). For this reason, individual or group therapy is considered the treatment of choice.

Summary

This training module introduced a number of factors important in the understanding of domestic violence perpetration. Clinicians embarking on treating this group are encouraged to be knowledgeable about the challenges involved in working with this group and to be proficient in assessing risk. It is also important to be culturally sensitive and to be familiar with domestic violence laws. A number of approaches may be helpful in intervening with domestic violence including psychoeducation and cognitive behavioral treatment as well as therapeutic approaches based on attachment theory and mind-body psychology.
References


