CHAPTER 2

Thinking Outside the Box: Gender and Court-Mandated Therapy

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A major setback for the chances of performing effective court-mandated therapy with domestic violence offenders was the enforcement of "psychoeducational models" by several state and county commissions. Gelles (1996) saw these as a by-product of the feminist stereotype of all males as potentially violent and conservative courts as wishing to punish transgressors. It is, in many ways, a reprise of the "whipping-post legislation" proposed in the early part of the 20th century (Pleck, 1987), only now the punishment was for being male or part of an "oppressor group" or for using "male privilege." Of course, when one reads the demographics of arrested client populations, one finds that court-mandated clients are frequently working class, unemployed, African American, or Hispanic or a member of another cultural minority (Sherman et al., 1992). That was the case, too, when the whipping-post legislation was passed in three states. It was used disproportionately against African American men (Pleck, 1987, pp. 119–120).

The punishment aspect now takes the form of shaming the clients and getting them to repent their gender privilege rather than the corporal punishment described by Pleck. It generates short-term compliance with a set of gender-political beliefs while leaving the infrastructure of abuse untouched: a homeostatic system of emotions and cognitions that derive from them (Dutton, 2003). In other works (e.g., Dutton, 1994b; Dutton & Nicholls, 2005), I have criticized the feminist approach to "intervention." I have pointed out that the "Duluth model" of psychoeducational intervention

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(Pence & Paymar, 1993) fails to establish a therapeutic bond and reshames clients who have, as part of their clinical problem, shaming (Dutton, 2003).

THE THERAPEUTIC PROBLEM WITH THE DULUTH MODEL

The Duluth Domestic Abuse Intervention Project (DAIP) designed an intervention program to be applied to men who had assaulted their female partners but who were not going to receive jail time (Pence & Paymar, 1993). The objective of the program was to ensure safety of the women victims (protection from recidivist violence) by "holding the offenders accountable" and by placing the onus of intervention on the community to ensure the women's safety. The curriculum of the Duluth model was developed by a "small group of activists in the battered women's movement" (Pence & Paymar, 1993, p. xiii) and was designed to be used by "facilitators" in court-mandated groups. It is now one of the most the commonly used court-sanctioned interventions for men convicted and having mandatory treatment conditions placed on their probation. This is true in many states and Canadian provinces. The curriculum of the model stresses that violence is used as a form of "power and control," and a "power and control wheel" has become a famous insignia of the program. In addition, power and control tactics are seen as being an exclusively male problem. As the authors put it, "They are socialized to be dominant and women to be subordinate" (p. 5). Hence, the "educational" aspect of the program deals with male privilege that exists in patriarchal structures such as North American countries. The DAIP view of female violence is that it is always self-defensive. "Women often kick, scratch and bite the men who beat them, but that does not constitute mutual battering" p. 5). Male battering stems from beliefs that are themselves the product of socialization. These include the belief that the man should be the boss in the family, that anger causes violence, that women are manipulative, that women think of men as paychecks, that if a man is hurt it is natural for him to hurt back, that smashing things is not abusive, that women's libbers hate men, that women want to be dominated by men, that men batter because they are insecure, that a man has the right to choose his partners' friends and associates, and that a man can't change if the woman won't change (pp. 7–13). According to the manual, the basis for these beliefs came from a sample of five battered women and four men who had completed the Duluth program. The authors do not comment on the obvious problems with the small sample size or lack of representativeness.

The Duluth perspective on psychological problems is outlined in their manual: "Most group members are participating not because of a personal problem or family dysfunction but rather because violence is a socialized option for men. To attach a clinical diagnosis to the batterers' use of violence provides a rationalization for behavior that may not be accurate" (Pence & Paymar, 1993, p. 23). In the rare case where "mental illness" is diagnosed, other treatment is recommended.

The Duluth model's focus on power and control has men keeping "control logs" and reviewing the socialization that leads to expectations of "male privilege." It "discusses how making women into sex objects and then defining sex objects as bad degrades women and lowers their self esteem. From there it goes on to discuss why men would want women to have low self-esteem" (Pence & Paymar, 1993, p. 41). It does not address any psychological issues or emotions that group members may have. "Negative feelings" are seen as caused by patriarchal beliefs (p. 48). Instead, it focuses on patriarchy, including drawing a pyramid on the board and asking "who is at the top?" and how did he get there? (p. 43). *The facilitator is advised to use slavery or a colonial relationship as an example to "draw a picture of the consciousness of domination"* (p. 49). The Duluth model uses role plays to show male abusiveness (p. 61) and raises men's consciousness about trivializing women's anger (p. 62). Men are encouraged to "respond in a respectful way" (p. 63) when their female partner gets angry. Since only 9.6% of U.S. marriages are male dominant (Coleman & Straus, 1985) but 100% of master–slave relationships were (by definition) master dominant, the analogy seems somewhat stretched.

The objectives of the Duluth model, respectful and nonabusive relationships, are not different from other theoretical models of intervention for abusive men (such as cognitive-behavioral therapy [CBT] or even psychodynamic treatment). However, the means to the end differ significantly from psychological models that have been proven to be more effective than the pure Duluth Model (Babcock, Green, & Robie, 2004). Many of the processes and skills that the Duluth programs utilize are, in fact, similar to psychotherapeutic models of intervention (e.g., affect regulation, assertiveness skills, negotiation skills, and so on). The primary difference seems to be the unyielding adherence to their etiology of violence: the sociodemographic "oppressor model" of male domination with instrumental violence taken as a given and the emphasis on male control of women (to the exclusion of other factors contributing to abuse). The Duluth model avoids utilizing the term *therapy* because therapy implies that there is something wrong with clients, whereas, according to the Duluth philosophy, they are normal, simply following cultural dictates. My own position, based on the research data for interpersonal partner violence (IPV), is that psychological (individual and interpersonal),

biological, and social/political causal factors are not inherently incongruent and that, if we truly want to develop effective models of intervention for domestic violence, we must consider all levels of explanation. This has been referred to as a "nested ecological model" (Dutton, 1995b).

The Duluth model psychoeducational groups were legislated as mandatory in many states, and state "domestic violence councils" were put in place to "oversee" that treatment groups adhered to the model, including making group leaders "accountable" to victim advocates (Maiuro, Hagar, Lin, & Olson, 2001; Tolman 2001). In California, the policy gave leeway to therapists to add on to the essential components of the Duluth model: that all abuse was a male-generated need for "power and control." In other locations, service providers became disenchanted with the Duluth program to the point that, when a recent treatment outcome study sought to compare Duluth with CBT models, only one "pure" Duluth model could be found. The others had reverted to using CBT techniques blended with Duluth perspectives in order to satisfy state requirements (Babcock et al., 2004). Dutton (2003) argued that Duluth models had a major flaw that was contraindicative of effective treatment in that "facilitators" were required to take a strong adversarial stance to clients, precluding the formation of a therapeutic bond with their clientele.

THE THEORETICAL PROBLEM WITH THE DULUTH MODEL

The theoretical problem with the Duluth model has been explored here and in other papers (Archer, 2000; Corvo & Johnson, 2003; Dutton, 1994b). Simply put, it is that the evidence for patriarchy as a "cause" of wife assault is scant and contradicted by several data sets, including data showing that male-dominant couples constitute only 9.6% of all couples (Coleman & Straus, 1985), women are at least as violent as men (Archer, 2000), women are more likely to use severe violence against nonviolent men than the converse (Stets & Straus, 1992b), powerlessness rather than power seems related to male violence, and there are no data supporting the idea that men in North America find violence against their wives acceptable (Dutton, 1994b). To the contrary, only 2.1% of U.S. men think it is acceptable for a man to strike a woman to "keep her in line" (Simon et al., 2001). Finally, abuse rates are higher in lesbian relationships than in heterosexual relationships (Lie, Schilit, Bush, Montague, & Reyes, 1991), suggesting that intimacy and psychological factors regulating intimacy are more important than sexism. Studies such as the Archer's (2000) meta-analytic combination of numerous studies with a combined sample size of 60,000 found women to be more violent than men, especially as the age of the sample dropped (Archer, 2000).

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Other studies ruled out the rejoinder that this was all self-defensive violence (Dutton & Nicholls, 2005; Follingstad, Wright, Lloyd, & Sebastian, 1991). In fact, less than 3% of all males (and about one-third of males in court-mandated treatment) fit the stereotype of terrorist violence put forward by the Duluth model (Dutton, 2006a, 2006b, XXXX; Dutton & Nicholls, 2005). Many males will be arrested who come from families where violence is dyadic, minor, or female perpetrated (Stets & Straus, 1992b). According to Duluth, all men must be treated as patriarchal terrorists regardless of differences in etiology.

The single most predictive factor for successful therapeutic outcome is the therapeutic relationship (e.g., Schore, 2003). However, it becomes extremely difficult to form a positive relationship when the therapist is required to disbelieve acts of violence by the partner, can lose their certification with probation if they don't confront their clients enough, or are considered enabling or manipulated when they advocate for their clients' continued treatment.

One must balance confrontation with support, belief, and caring in order to develop a solid therapeutic alliance. Building a therapeutic alliance without colluding with dangerous acting-out behaviors is one of the greatest challenges facing domestic violence perpetrator treatment providers. Because so many of these individuals experienced abuse by authority figures, the process of building a trusting relationship is particularly difficult (see also Mills, 1999).

According to Luborsky (1984), the therapeutic alliance may be defined as "that point in the therapeutic relationship when the client on one hand elevates the therapist to a position of authority, but on the other hand believes that this power and authority is shared between them, that there is a deep sense of collaboration and participation in the process. In this way a positive attachment develops between the client and the therapist" (p. 134).

Luborsky (1984) describes two types of therapeutic alliance: the type 1 therapeutic alliance, which is more evident at the beginning of therapy and where the alliance is based on the client's experiencing the therapist as supportive and helpful, and the type 2 therapeutic alliance, which is more typical of the later phases of treatment and where there is a joint struggle against what is impeding the client, a shared responsibility for working out treatment goals, and a sense of we-ness.

Luborsky (1984) makes several recommendations to therapists on how to develop this alliance:

1. Freud's suggestions, made almost 75 years ago, still hold true today. "A friendly, sympathetic attitude toward the client is beneficial for the initial development of the alliance."

2. Feeling and expressing empathy toward the client.
3. Helping clients feel invested in the tasks necessary to change (e.g., client-involved treatment planning).

These recommendations run counter to the Duluth model, which emphasizes confrontation and accountability. Given the inherent dangerousness of domestic violence situations, it is important for therapists to incorporate clear guidelines and structure in treatment to minimize acting out; however, without a positive relationship with the therapist, the client is not going to truly be invested in treatment and is likely to either fake it (comply) or drop out altogether, being labeled as "unmotivated" (not unlike the abused child who is viewed by teachers not as a victim but as a problem). Murphy and Baxter (1997) also cautioned against highly confrontational approaches, and the Michigan Governor's Task Force on adopted standards for IPV treatment specified that programs that use abusive or hostile confrontational techniques are contraindicated because such techniques may reinforce the use of abusive control at home (Tolman, 2001, p. 227).

Maiuro et al. (2001) surveyed the treatment modalities allowed in the state standards examined, finding that 90% of states dictated group therapy (mostly feminist psychoeducational approaches). Surprisingly, 55% of states allowed individual treatment, 55% allowed couples therapy, 65% specified gender-specific treatment, and 35% specified gender-specific treatment before couples therapy. No specific comparisons of individual versus group therapy existed, but Maiuro et al. listed the advantages of group treatment: group cohesiveness to maintain treatment, economy, and "shame detoxification" (Maiuro et al., 2001). Maiuro et al. caution that "although few would question the need for employing certain methods in order to protect the safety of victims, there is danger in prematurely dismissing potentially effective approaches. The risk is magnified by the fact that such generalizations may become officially codified in standards as a 'known' basis for practice" (p. 34). This premature "knowledge" of what works is a risk for treatment practice. Maiuro et al. call this "the greatest risk of stunting the development of new or alternative interventions for families afflicted with domestic violence. In this respect more work in needed to assure that the existing guidelines truly protect the well-being of victims without inadvertently impeding much needed program development" (p. 38).

Of greater concern was that of the states surveyed, only 20% required a college degree for treatment providers and required only "specialized training in domestic violence" (i.e., socialization into the prevailing paradigm). This reflects, in my view, the antiprofessional perspective of feminist activists. Maiuro et al. (2001) recognize this and suggest (a) that the lack

of required research training may contribute to a lack of familiarity with research methods (contrary to the Boulder model of training for psychologist) and (b) that care must be taken to avoid a state standards committee made up exclusively of activists and treatment providers. They recommend an ethicist to ensure against conflicts of interest, including "secondary gain in the form of training contracts for a particular intervention approach or an agenda to put those competitors out of business who do not adopt a particular philosophy or offer a specific form of program" (p. 37). One method to ensure this is to have rotating multidisciplinary board (including at least one researcher) with reappointments every 2 years. Maiuro et al. also suggest a national blue ribbon panel of experts to provide consultation to state boards. I believe that these are excellent recommendations.

ANGER AND VIOLENCE

One shibboleth of the Duluth philosophy is that anger does not cause violence (Pence & Paymar, 1993, pp. 9, 105). The Duluth perspective is rather critical of CBT, which it frequently mislabels as "anger management," although CBT has never focused primarily on anger and has, at minimum, approximately 16 treatment objectives. The Duluth model's view of abuse is that it is always an instrumental act and hence not a product of anger. Again, this view is not supported by the evidence. Maiuro, Cahn, Vitaliano, Wagner, and Zegree (1988) found that domestically violent men had significantly higher levels of both anger and hostility than controls. The authors concluded that their findings supported the "idea that anger *dyscontrol* is a key issue in the profile of domestically violent men" (Maiuro et al., 1988, p. 17) and noted that depression as well as anger were elevated in this group. Margolin, John, and Gleberman (1989) found that physically aggressive husbands reported significantly higher levels of anger than husbands in three control groups. Dutton and Browning (1988) showed videotaped husband–wife conflicts to wife assaulters and control males. The assaultive males reported significantly higher levels of anger than controls, especially in response to an "abandonment" scenario. Sonkin and Dutton's (2003) application of attachment theory to domestic violence also contradicts this notion. According to attachment theory, insecure attachment patterns are essentially maladaptive methods of regulating affect, particularly anger and other emotions stemming from loss.

Dutton and Starzomski (1994) found elevated anger scores for assaultive men as measured by the Multidimensional Anger Inventory (Siegel, 1986). They related the anger to certain personality disturbances, especially borderline personality disorder, antisocial personality

disorder, aggressive-sadistic personality disorder, and passive-aggressive personality disorder, all of which have anger as a component of the personality disorder. Dutton, Starzomski, Saunders, and Bartholomew (1994) found elevated anger in assaultive males to be related to certain attachment disorders, especially an attachment style called "fearful" attachment that they relabeled "fearful-angry" attachment. Citing Bowlby's (1969) work on attachment that viewed anger as having a first function of reuniting with an attachment object and dysfunctional anger as further distancing the object, Dutton and his colleagues explored developmental origins of elevated anger in assaultive males, viewing it as being produced by paternal rejection, exposure to abuse, and a failure of protective attachment (Dutton, 1994a, 2006a; Dutton, Saunders, Starzomski, & Bartholomew, 1994). Failure to address these underlying issues therapeutically while focusing on symptomatic beliefs and "male privilege" would be counterindicative of treatment success.

Jacobson et al. (1994) recruited physically aggressive and maritally distressed nonviolent control couples to discuss "areas of disagreement" in a laboratory setting. Both maritally violent husbands and wives displayed significantly more anger than controls (although the study focused on husbands, 50% of the wives committed severe acts of abuse as well.

Eckhardt, Barbour, and Stuart (1997) and Eckhardt, Barbour, and Davis (1998) reviewed several anger measures and asserted that both anger and hostility were elevated in maritally violent men. Eckhardt et al. (1998) used an "articulated thoughts simulated situations" technique that found that maritally violent men articulated more anger-inducing irrational thoughts and cognitive biases than nonviolent controls. In short, numerous studies from several independent sources have found anger to be prominent in physically assaultive males. Clearly, the research evidence shows that anger and arousability are components of abuse that require treatment in managing, not neglect.

SUBTYPES OF PERPETRATORS

Despite the Duluth focus on "male oppression," men who are court mandated for treatment for wife assault come from couples varying in their violence patterns (Stets & Straus, 1992a, 1992b). Stets and Straus analyzed gender, relationship status (married, cohabiting, and dating), and level of violence used (none, minor, or severe) in data reported from the U.S. 1985 National Survey (Stets & Straus, 1992b; Straus & Gelles, 1985, 1992). The most common form of couple subtype was mutual violence, followed by female more severe (to nonviolent on less violent males), followed by male more severe. However, men who are arrested

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in dyadic violence couples (the most common form) and who report their wives as being violent are disbelieved in Duluth model groups. Their experience is invalidated and treated as rationalization and victim blaming. Furthermore, Duluth models in some areas (e.g., Arizona) preclude therapists from interviewing wives to make assessments of whether violence is dyadic or unilateral; hence, the therapist cannot know if clients are excusing their behavior or making veridical reports. Although men would be responsible for their own violence in either case, differential treatment strategies might be invoked given the information on the presence or the absence of dyadic violence. When a client reports victimization by his partner and is disbelieved or invalidated by his therapist, it only supports the attitude that many victims of child abuse experience—don't bother telling because no one will believe you. In addition, even if the man is a unilateral abuser, he may vary in terms of the personality structure that supports his use of violence, beliefs surrounding violence, and emotional response to intimate relationships (Dutton, 2002a; Hamberger & Hastings, 1986; Holtzworth-Munroe & Stuart, 1994; Saunders, 1993; Tweed & Dutton, 1998).

Sonkin and Dutton (2003) described an attachment theory conceptualization of domestic violence. Studies have indicated that batterers, like the general population, consist of individuals with differing attachment categories. These different categories stem from different parenting experiences in childhood. For example, some batterers have learned to deactivate attachment-related emotions (dismissing), whereas others have learned to hyperactivate attachment distress (preoccupied). Persons suffering from unresolved trauma or loss have developed extremely maladaptive mechanisms for regulating attachment distress (disorganized or fearful), such as dissociation or extreme aggression. By treating all batterers the same, the Duluth model misses the nuances that other models, such as attachment theory, capture and that provide useful information for intervention.

Duluth model treatment does not assess for and cannot treat personality disorders, disbelieves clients who claim that their partner is violent too, and does not have the flexibility to tailor therapy to fit individual needs of clients. It shames perpetrators, emphasizing their use of "power and control" and "male privilege" when the client may feel powerless in the world.

TREATMENT OUTCOME STUDIES OF THE DULUTH MODEL

Because of the ever-present risk of confounds among quasi-experimental studies, results from randomized experiments are the "gold standard" for evaluation. In a treatment outcome study done on the Duluth model,

Shepard (1987, 1992) found a 40% recidivism rate in a 6-month follow-up of Duluth clients, higher than most control recidivism levels. Babcock et al. (2004) put recidivism rates at 35% for a 6- to 12-month follow-up according to wives and 21% for the same time period using criminal justice data (i.e., arrests).

Feder and Forde (1999) randomly assigned batterers on probation to either a feminist-psychoeducational program or no treatment in Broward County, Florida. In general, there were no statistically significant differences between the two groups on recidivism as measured by police records ($d = .04$) or by victim report ($d = -.02$). There was a small but significant effect on recidivism among the subset of men randomly assigned to group treatment who attended all 26 sessions. In this study, random assignment apparently failed, with an uneven number of men being assigned to the treatment and control condition (Feder & Forde, 1999). Moreover, this study suffered from a particularly high attrition rate of men from treatment (60%) and a low response rate from victims at follow-up (22%).

Davis, Taylor, and Maxwell (1998) compared a long (26-week) psychoeducational group to a brief (8-week) psychoeducational group and to a community service control (70 hours of clearing vacant lots, painting senior citizen centers, and so on) in Brooklyn, New York. They found a statistically significant reduction in recidivism and a small but respectable effect size of $d = .41$ based on criminal records among the long treatment group only; the 8-week group was indistinguishable from the community service control ($d = .02$). When based on victim report of recent offenses, neither the long nor the brief intervention had a statistically significant effect on reassault when compared to no treatment. Correspondingly, the effect size due to treatment based on partner report of subsequent violence was small ($d = .21$). It is important to note that, like in the Broward County experiment (Feder & Forde, 1999), random assignment may have been compromised. In the Brooklyn experiment (Davis, Taylor, & Maxwell, 2000), nearly 30% of initial assignments were subjected to "judicial overrides" (Gondolf, 2001); that is, judges reassigned defendants to different interventions.

Ford and Regoli (1993) designed a study that randomly assigned batterers into treatment as a pretrial diversion (i.e., defendants' criminal records would be cleared pending treatment completion) or treatment as a condition of probation postconviction versus alternative sentencing strategies (e.g., paying a fine or going to jail). Even though this study was designed to test different sentencing options rather than effects due to treatment, one can compare batterers sentenced to treatment versus batterers not sentenced to treatment (although the type of treatment and actual attendance rates were not specified). Again, there were no

significant differences or effect sizes comparing recidivism rates based on victim report between men sentenced to treatment versus those who were not. Neither treatment as pretrial diversion ($d = .00$) nor treatment as a condition of probation postconviction ($d = -.22$) was found to be superior to purely legal interventions.

Conducting an experiment in which judicial discretion is sacrificed and criminals are randomly assigned to treatment or no treatment can be problematic on ethical as well as practical grounds (Dutton, Bodnarchuk, Kropp, Hart, & Ogloff, 1997). Adopting an experimental design does not *guarantee* a more rigorous evaluation than quasi-experimental designs afford (Gondolf, 2001). While it is true that experimental designs permit greater confidence in conclusions regarding causal relations, it is also the case that problems with differential attrition and failure of random assignment reduce internal validity of this design. It is recommended that researchers report both recidivism rates for all batterers who were assigned to treatment as well as those who actually completed treatment (few studies have done so).

Babcock et al. (2004) conducted a meta-analytic examination of 22 studies of treatment outcome. The d' for Duluth treatment was .19. Comparisons between CBT and Duluth were not significant, but "pure" Duluth models were hard to find. As the authors stated, "Modern batterer groups tend to mix different theoretical approaches to treatment, combining feminist theory of power and control as well as specific interventions that deal with anger control, stress management and improved communication skill" (p. 1045). It is hard to imagine a therapeutic case for a positive treatment result in groups where no therapeutic bond is developed.

The d' of .34 reported by Babcock et al. (2004) is less than optimal for most therapeutic outcomes. The average effect size in psychotherapy studies is $d' = .85$, but it is substantially lower for court-mandated treatment (Davis & Taylor, 1999). By standards of court-mandated client populations, however, this is an average result.

EXPANDED TARGETS FOR PERPETRATOR TREATMENT

There are several ways to increase the treatment success of same-sex-group court-mandated therapy. All rely on established CBT techniques used for other problem areas and simply recognize the relevance of these techniques for batterer treatment. A rich psychology of intimate violence perpetrators has developed since the first wave of treatment was developed. Essentially, this research has unearthed what emotions, cognitions, and situational

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interactions intermingle to generate and support abusive behavior. They constitute the infrastructure of abuse.

Borderline Personality Organization and Assaultiveness: The Theoretical Connection

Dutton has shown empirically a strong relationship between borderline traits in male perpetrators and intimate abusiveness (Dutton, 1998, 2002a, 2002b). In a series of studies, Dutton and his colleagues (for a review, see Dutton, 1995a, 1995c, 1998, 2002b) have examined personality profiles of assaultive males. The overall strategy of this work has been based on self-report scales filled out by abusive men as part of an assessment procedure for treatment and corroborated through the female partners' reports of the men's abusiveness. Men's self-reported self disturbances (of a borderline character) were similar to those for diagnosed borderlines and were significantly related to chronic anger, jealousy, wives' reports of clients' use of violence, and experiences of adult trauma symptoms in the wife assault group.

In effect, a constellation of personality features (borderline personality organization, high anger, fearful attachment, chronic trauma symptoms, and recollections of paternal rejection) accounted for reports of abusiveness by one's intimate partner in all these groups. Each of these features of abusiveness is a potential target for treatment. With minor variations, this constellation was replicated with blue-collar controls, college students, psychiatric outpatients, and gay male couples (Dutton, 1998, 2002b).

Attachment and Abusiveness

If early experiences influenced adult abusiveness, attachment theory might provide a valuable perspective in the etiology of abusiveness. Bowlby (1969) viewed interpersonal anger as arising from frustrated attachment needs and functioning as a form of "protest behavior" directed at regaining contact with an attachment figure. He viewed dysfunctional anger as anger expressions that increased the distance from the attachment object.

In turn, chronic childhood frustration of attachment needs may lead to adult proneness to react with extreme anger ("intimacy-anger") when relevant attachment cues are present. Thus, attachment theory suggests that an assaultive male's violent outbursts may be a form of protest behavior directed at his attachment figure (in this case, a sexual partner) and precipitated by perceived threats of separation or abandonment. A "fearful" attachment pattern may be most strongly associated with

intimacy-anger. Fearful individuals desire social contact and intimacy but experience pervasive interpersonal distrust and fear of rejection. This style manifests itself in hypersensitivity to rejection (rejection-sensitivity) and active avoidance of close relationships where vulnerability to rejection exists. While the fearful share anxiety over abandonment with another insecurely attached group (called "preoccupied"), their avoidance orientation may lead to more chronic frustration of attachment needs.

Dutton and colleagues assessed attachment styles in abusive men. Fearfully attached men experience high degrees of both chronic anxiety and anger (Dutton, Saunders, et al., 1994). Fearful attachment alone accounted for significant proportions of variance in both emotional abuse criterion factors completed by female partners. Fearful attachment was also strongly correlated with borderline personality organization. Since both anxiety (+0.42) and anger (+0.48) are strongly associated with fearful attachment, one could argue that an emotional template of intimacy-anxiety/anger is the central affective feature of the fearful attachment pattern. Using a structured interview, Babcock, Jacobson, Gottman, and Yerington (2000) also found insecure attachment styles to be related to abusiveness. Mikulincer (1998) found, as had Dutton et al., that attachment style related to dysregulation of negative emotions in intimate relationships.

Early Trauma From Shaming and Exposure to Violence

In abused boys, a prominent sequela of abuse victimization is hyperaggression. Carmen, Reiker, and Mills (1984) suggested that abused boys are more likely than abused girls to identify with the original aggressor and to eventually perpetuate the abuse on their spouse and children. In their view, an effect of physical maltreatment by a parent is to exaggerate sex role characteristics, possibly as a means of attempting to strengthen the damaged self. Van der Kolk (1987) noted that traumatized children (including physical abuse) had trouble modulating aggression and included being physically abused as a child as a trauma source.

Herman and van der Kolk (1987) noted how posttraumatic stress disorder (PTSD) included poor affect tolerance, heightened aggression, irritability, chronic dysphoric mood, emptiness, and recurrent depression and was "described in patients who have been subjected to repeated trauma over a considerable period of time" (p. 114). This profile also described spouse abusers. Hence, the possibility was presented that PTSD may be another link or mediating variable between childhood abuse victimization and adult perpetration of intimate abuse.

In order to test this notion, wife assaulters were compared to two groups of diagnosed PTSD men from independent studies (Dutton, 1995d). In the wife assault sample, 45% of all men met research criteria for PTSD, and assaultive men exhibited elevated levels of chronic trauma symptoms.

The source of trauma, as revealed in this work, was physical abuse combined with shaming by the father and with a lack of secure attachment to the mother. Consequently, the latter could not provide buffering against the former (Dutton, 1998, 2002b). Tangney, Wagner, Fletcher, and Gramzow (1992) have presented a more focused analysis of the potential role of shame as a mediator between the early experiences of assaultive men and their adult experience of anger and abusiveness. They describe shame proneness as a moral affective style that has to do with "global, painful, and devastating experience in which the self, not just behavior, is painfully scrutinized and negatively evaluated" (p. 599). In this sense, shame-inducing experiences, which generate a shame-prone style, may be viewed as attacks on the global self and should produce disturbances in self-identity. Shame-prone individuals have been found to demonstrate a limited empathic ability, a high propensity for anger, and self-reports of aggression (Wallace & Nosko, 2003). Dutton, van Ginkel, and Starzomski (1995) found recollections of shame-inducing experiences by parents of assaultive men to be significantly related to the men's self-reports of both anger and physical abuse and to their wives reports of the men's use of dominance/isolation.

Dutton et al. (1995) found three recalled sources of shame in assaultive males. These were public scolding, random punishment, and generic criticism. All three were recalled as generating experiences of shame. These, in turn, were correlated with adult anger and tendencies to project blame. Not surprisingly, given these tendencies, abusive actions also correlated with recalled shame experiences. Partial correlations revealed that parental shaming still correlated significantly with measures of abusive personality after physical abuse by the parents had been partialed out. The converse, however, was not true. With parental shaming partialed out, physical abuse by parents did not correlate significantly with abusive personality measures. Hence, experience of being shamed seemed to interact with exposure to violence to produce assaultiveness. It is for this reason, above all, that shaming clients in Duluth groups on the basis of their being male is contraindicated.

Surprisingly, until now these features of an abusive personality—insecure attachment, borderline traits, and trauma reactions—have not been a focus of CBT for spouse assault. Dutton (2006a) has outlined a "blended behavioral therapy" that has a multifocus on anger, attachment, shaming, trauma, and borderline personality traits.

TREATMENT OF FEMALE BATTERERS

Given that Stets and Straus (1992b) found that three times as many women as men used severe violence against a nonviolent partner, treatment for female batterers seems a necessity. Nevertheless, the dominant view of male perpetrator/female victim pervades female perpetrator treatment as well. Hamberger and Potente (1994) described their court-mandated sample as "battered women who have gotten caught up in pattern of violence, that most often, they did not initiate and do not control" (p. 127). What is interesting is the attention paid to the context of women's violence, whereas in "psychoeducational groups" all mention of partner violence is construed as victim blaming and failing to take responsibility for one's actions. While the male perpetrator who claims partner violence is viewed as being in denial, this problem is assumed and sought after as part of an "assessment" of female perpetrators. Hamberger and Potente claim that only 3 of 67 women were primary perpetrators. A question is raised about the apparent discrepancy between Hamberger and Potente's data showing so few female instigators and the data from the Moffitt, Caspi, Rutter, and Silva (2001) study and Archer's (2000) research showing female violence to be more frequent than male and just as severe. In the Moffitt et al. (2001) study, females were even more violent than males in large community sample. Furthermore, the female violence in relationships was predictable by their antisocial behavior 3 years prior to entering the relationship. Hence, on the basis of current longitudinal studies of community groups (Ehrensaft et al., 2003; Moffitt et al., 2001), we would expect to see more females in court-mandated treatment and many of them being the instigator of aggression.

Busch and Rosenberg (2003) found that arrested female perpetrators were just as violent as males. This study uses criminal justice data to compare women and men arrested for domestic violence on their levels of violence, reported victimization, general criminality, and substance abuse. Participants were 45 women and 45 men convicted of domestic violence between 1996 and 1998. Results indicated that women were less likely than men to have a history of domestic violence offenses and nonviolent crimes. They were also more likely to report that they had been injured or victimized by their partner at the time of their arrest. However, in other ways, women and men were similar: They were equally likely to have used severe violence and inflicted severe injuries on their victims, to have previously committed violence against nonintimates, and to have been using drugs or alcohol at the time of their arrest.

Both Dowd (2001) and Renzetti (1992) call for a more thoughtful and complex analysis than the dominant feminist view, which has largely precluded treatment of aggressive women. Whether male or

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female clients are treated, a thorough assessment is necessary to evaluate seriousness and locus of instigation of any bidirectional violence. Renzetti (1992) found that substance abuse, dependency, and jealousy were clinically significant in battering lesbians. Similarly, Margolies and Leeder (1995) found dependency, jealousy, and black-and-white thinking clinically significant in lesbian batterers. These issues also all surfaced in male heterosexual perpetrators.

Leisring, Dowd, and Rosenbaum, (2003) suggest an important clinical goal for female perpetrators is to stop their violence because it is a predictor of male violence. The University of Massachusetts treatment program for women (which they implemented) had some didactic components in common with men's treatment: anger recognition and control, personal responsibility, empathy, time-outs, communication training, reframing cognitions, and substance abuse. Leisring et al. emphasize personal safety for the woman client, attention to one's own needs, increased emphasis on PTSD in creating anger control problems, increased attention to conditions that undermine mood stability, and less emphasis on power and control. The authors argue, on the basis of the National Violence Against Women Survey data (Tjaden & Thoennes, 1998), that men fear their partners less than women do, so power and control issues are not as important for women. I will not revisit the reasons why crime victim surveys misrepresent the larger population. Suffice it so say that Follingstad et al. (1991) found power and control motivated female as well as male self-reported motives for IPV.

Henning and his colleagues compared female to male domestic violence offenders. Rising numbers of women arrested for domestic violence present many theoretical and practical challenges (Henning & Feder, 2004; Henning, Jones, & Holford, 2003). At the theoretical level, there is ongoing debate about whether women are equally aggressive as men (Pagelow, 1984). At the practical level, little research is available to guide how female cases are handled in the criminal justice system. In this study, data were obtained regarding demographic characteristics, mental health functioning, and childhood familial dysfunction for a large sample of male (n = 2,254) and female (n = 281) domestic violence offenders. The women were demographically similar to the men, and few differences were noted in their childhood experiences. Women were more likely than men to have previously attempted suicide, whereas more men had more conduct problems in childhood and substance abuse in adulthood. Compared to the male offenders, women reported more symptoms of personality dysfunction and mood disorder. Ninety-five percent of the women offenders had one or more personality disorders above 75 on the Millon Clinical Multiaxial Inventory-3 compared to 70% of the male offenders. Females were six times more likely than men to have borderline scores above 75.

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These data suggest that the trauma model used for male perpetrators described here should also be useful for female perpetrators. Court-based treatment, whether of male or of female perpetrators, needs to include a focus on attachment, trauma, shame, and intimacy issues. It is indeed time to think "outside the box" created by a traditional feminist "one size fits all" paradigm of how intervention must be.

COUPLE VIOLENCE AND TREATMENT

Stets and Straus (1992b) found that couples using the sample level of violence (mild or severe) was the most common form of domestic violence. An ensuing controversy, touched off by a paper by Johnson (1995), focused on "common couple violence" versus "patriarchal terrorism," overlooking the fact that a female severe/male nonviolent pattern was three times as prevalent as "patriarchal terrorism." Suffice it so say that data do not support the feminist view that all female violence is self-defensive and not serious (Dutton & Nicholls, 2005). The implication of the feminist view was that couple violence was never applicable to domestic violence. In fact, it is not applicable to patriarchal terrorism. However, some studies have found couple violence effective with violent couples (Heyman & Schlee, 2003; O'Leary, Heyman, & Neidig, 1999). Obviously, the form of treatment is dictated by an assessment of violence levels and danger, but to rule it out a priori, as the Duluth model does, operates against treatment efficacy.

INTERACTIONAL STUDIES

Gayla Margolin and her colleagues (1984, 1989, 1993) has contributed consistently to this line of study (see also Margolin & Burman, 1993). Margolin's work started with an examination of interaction patterns in four different types of couples called physically abusive (PA), verbally abusive (VA), withdrawn but nonabusive (WI), and nondistressed and nonabusive (ND) based on responses to the Conflict Tactics Scales (CTS) and the Dyadic Adjustment Scale . At that time, self-report questionnaires were used to assess interaction style (e.g., Communication Apprehension Inventory and Spouse Specific Assertivness Scale); later these would become more sophisticated techniques for videotaping and scoring marital interaction.

By 1988, Margolin et al. (1989) had moved to assessment of "in vivo" interactions. Typically, couples would sign in for the research, would undergo an initial screening/assessment, and then were asked to

"discuss" two "problematic topics" (chosen from three offered in the screening self-reports of the couples). These discussions were videotaped for later coding. Experimenters observed the interaction through a one-way mirror (and later reviewed the videotapes).

As with her previous studies, Margolin and her colleagues examined PA couples, VA couples, WI, and ND couples. Again, these categories were based on self-report measures of CTS and the Dyadic Adjustment Scale by both members of the couple. The women in these studies did not perceive themselves as battered (even in the PA group) and, according to Margolin et al., ranged considerably in the extent to which they themselves had engaged in "physical violence" (p. 31). Margolin et al. (1989) found the chief differentiating factor between the PA group and other groups was in the behavior of the husbands; PA husbands exhibited more instances of negative voice and more overtly negative behaviors than husbands in the other groups. PA husbands also reported more sadness, fear, anger, and feeling attacked (and somewhat more physiological arousal) than the husbands in the other three groups.

Despite the controlled and semipublic nature of the discussions, PA husbands exhibited negative affect patterns that were indicative of nonconstructive approaches to conflict and that could escalate into a more extreme expression of aggression. These included irate, angry, whining, yelling, sarcastic, nagging, lecturing, accusatory, mocking, and otherwise irritating voice tones. Negative behaviors included signs of dismissal, waving arms, pointing a finger at the other, threatening or mimicking gestures, and negative physical contact. They tended not to exhibit head hanging or leaning away and maintained eye contact.

PA wives showed a greater escalation of offensive negative behaviors than did VA or WI wives during the middle portions of the discussion period and then showed a greater deescalation in the final period. The authors concluded that "paradoxically, the wives' backing down may negatively reinforce the husbands' behaviors and may inadvertently strengthen his attack" (Margolin et al., 1989, p. 31). Of course, we do not know the outcome had the women continued to escalate. To draw that conclusion, we would have to follow a group of women who never deescalated and trace what the outcome. What group were they in? It may be that, regardless of their response at this point, violence would occur. This view is more consistent with work on personality disorders in abusive men (e.g., Dutton, 1998). A borderline male batterer or an individual who has an "abusive personality" would proceed to the aggression phase of the conflict at this point on the basis of physiological arousal and misconstrual of the woman's actions.

Burman, Margolin, and John (1993) utilized sequential analysis of couple interactions from videos taken in the couples' homes. These

were believed to be "more ecologically valid." The PA group was again comprised of bidirectionally violent couples. Couples were instructed to recall a typical serious conflict and how it began, who said what to whom, how the conflict progressed, and how it ended. Couples then reenacted these conflicts. These reenactments (which averaged 10 minutes in length) were videotaped and coded. Instead of coding 15-second intervals, this time "floor switches" (a statement of one person bounded on either side by a statement of the other) were used. This created a series of "lags" from one person's action to the reaction of the other and so on. PA couples were characterized in the data by exhibiting more hostile affect and by the number of contingent behavior patterns involving anger. Nondistressed couples can "exit these negative interaction cycles quite quickly" (Burman et al., 1993, p. 37). The authors concluded that "contrary to images of women in abusive relationships as passive and reticent, the women in the types of PA relationships presented here are angry with or contemptuous of husbands and are quick to respond to their husband's anger" (p. 37).

The University of Washington (UW) group (Babcock, Waltz, Jacobson, & Gottman, 1993; Babcock et al., 2000; Cordova, Jacobson, Gottman, Rushe, & Cox, 1993; Levenson & Gottman 1983) also used sequential analysis for assessing three dimensions of marital interaction: positive–negative affect, reciprocity, and asymmetry. The UW lab focused these techniques on domestic violence, expanding techniques previously used to study marital satisfaction. Their finding was that parallel patterning of physiological responses was related to reported marital satisfaction. In the UW studies, these techniques would be used on DV couples in an "experimental apartment' created in the psychology lab. Couples would re-create their most serious conflicts in that environment, and physiological reactions would be measured.

In turning to the study of domestic violence, the UW lab recruited participants through newspaper ads. The criterion for the DV group was wives' reports of husbands' violence on the CTS. Wives reports were used because "we assumed husbands might underreport their own violence" (Babcock et al., 1993, p. 42). The focus of the study was on husband violence and categories of violent husband developed from a popular book on the research, classifying violent husbands as "pit bulls" (tenacious, emotional) or "cobras" (cool, instrumental). Couples were solicited as "couples experiencing conflict in their marriage." One has to read the method section then to discover that "*according to the wives themselves, almost half (28/57) would have qualified for the DV group if wife violence had been the criterion*" (Jacobson et al., 1994, p. 983). In other words, there were bilaterally violent couples in the mix, although the focus became entirely on the males. No measures were taken of the

wives' use of violence, and all independent variables focused on male violence as though it were being produced unilaterally in all relationships (even though it clearly was not).

Babcock et al. (1993) assessed power discrepancies between husband and wife based on economic status, decision-making power, communication patterns, and communication skills. DV couples were more likely than nonviolent controls (maritally distressed/nonviolent and happily married nonviolent) to engage in withdrawal behaviors (wife withdrawal/husband demand). Husbands who had less power were more physically abusive to their wives. The authors' viewed this as "compensatory power." Feminist views have been confusing on this topic. Yllo and Straus (1990) argued that as male power increased, violence toward women should increase. Instead, they found, on a state-by-state analysis of male power, a curvilinear relationship. The states with high-power males and the states with the lowest-power males used the most violence. The "compensation" argument was used for the low-power states. It is hard to see how the feminist hypothesis could be disconfirmed. If high-power males use more violence, it is interpreted as domination. If low-power males use more violence, it is interpreted as compensation for a wish to dominate. What data set can disconfirm? I suppose no relationship between male power and violence.

One interesting unreported piece of data from the Babcock et al. (1993) study was that male socioeconomic power was unrelated to decision-making power at home or to communication skill advantages. Power, it seems, generates from several levels, many of which are inconsistent or unrelated.

Cordova et al. (1993) used a Marital Interaction Coding Scheme (MICS) applied to videos taken of couples arguing in the UW lab. The MICS required coders to initially code interactions into three broad schemes: aversive behaviors, facilitative behaviors, and neutral behaviors. Since the study focused on changes in aversive behavior over time, sequential analyses were examined. Negative reciprocity was defined as the occurrence of aversive behavior given the prior occurrence of aversive behavior by the other partner. Various lag times for this reciprocity were measured (immediate vs. delayed). As with Margolin et al.'s (1989) sample, DV husbands exhibited a higher proportion of aversive behavior than did their nonviolent counterparts. Similarly, the authors concluded that "the behavior of DV wives in this sample does not suggest passivity, docility or surrender. Rather, the women are continuing in conflict engagement, even though they have histories of being subjected to physical abuse. . . . Although these women were being beaten, they had not been beaten into submission. They were standing up to rather than surrendering to their battering husbands" (Margolin et al.,

1989, p. 563). Of course, this explanation overlooks the fact, reported in Jacobson et al. (1994) (on the same sample), that 28 of 57 wives would themselves have qualified for the DV group given the criteria used. Why then depict them as "reactive victim/heroines"? Because that fit the paradigm of male perpetrator/female victim so prevalent in the DV literature at the time. In fact, Cordova et al.'s (1993) data table (table 2, p. 562) reveal that the DV women used more aversive acts than did the DV men (18.2 vs. 15.8) in the time assessed (that was also true for women in the other two groups). Unlike Margolin et al., Cordova et al. did not find a decrease in negative reciprocity at the end of the interaction sequence.

Cordova et al. (1993) are clearly troubled that the wives in their sample used so many aversive acts. They say that "these results appear to be surprising in the light of descriptions such as Walker's (1984) of the battered woman syndrome" (p. 564) and then try to explain away the female violence (the women felt safer in the lab, the women were trying to put an end to "protracted tension," and so on). Not once do they state the obvious: These women were almost as violent as their male partners.

Jacobson et al. (1994) studied the "affect, psychophysiology and verbal content of arguments in couples with a violence husband" (p. 982). Again, the same taped 15-minute arguments from the same couples were examined, although the sample had now increased to 60 DV couples and 32 DNV couples. Arguments were coded for (a) affect: affect-positive/neutral, aggressive, and distress (fear or sadness) and (b) content-withdrawal, criticize, defend, demand, emotional abuse, physical aggression, positive/neutral, distress, and self-defense. The chief finding was that "only husband violence produces fear in the partner." The authors state that "this gender difference underscores one of the major differences between husband and wife violence: Only husband violence produces fear in the partner" (Jacobson et al., 1994, p. 986) This finding was cited extensively as showing a differential effect for male versus female abuse. Dutton, Webb, and Ryan (1994), in studying gender differences in affective reactions to conflict, found that women used affect scales differently, reporting higher scores even in baseline controls. Jacobson et al. (1994) admitted "the men were less likely to acknowledge there was anything wrong with them" (p. 987). The data also showed that DV wives were more belligerent than their husbands and showed more contempt. The husbands showed more defensiveness than the wives. Jacobson et al. justify this interpretation by arguing that "even DV husbands admit that wife violence is largely reactive to either physical or emotional abuse on their part" (p. 986). Were the wives asked these questions as well? This is not reported. At the end of the

paper, the authors describe "the intense anger, combined with fear and sadness, may be part of the helplessness reported by battered women" (p. 987). Of course, that conclusion overlooks the fact that half the women were themselves physically abusive and that women in general exhibited more belligerence on the experimental tapes.

Gottman et al. (1995) focused on the physiological reactions observed in the conflicts: cardiac interbeat interval, pulse transmission time, finger pulse amplitude, and skin conductance level. In addition, MCMI-2 data were obtained for husbands and wives, and the laboratory interactions were coded as described previously using the SPAFF. On the basis of physiological reactivity, the men were classified as type 1 (those who lowered their heart rate during marital interaction) and type 2 (those who increased their heart rate). All data were reported through the filter of comparing these two groups of men (e.g., type 1 men had significantly higher rates of antisocial personality disorder and aggressive sadistic personality disorder than did type 2 men). Type 1 men were more angry, belligerent, and contemptuous than type 2 men. Type 1 men were more generally violent outside marriage and had greater problems with drug dependency.

Leonard and Roberts (1998) performed an unusually well controlled study of the interactive mechanisms in operation. Sixty maritally aggressive and 75 nonaggressive men received either no alcohol, a placebo, or alcohol (vodka). The couples (who had been married less than 2 years) were asked to discuss an issue that was a chronic source of conflict for them. Then their interactions between the men and their wives were videotaped and coded in a "baseline interaction" (before the alcohol administration and involving their second-most-important disagreement) and an experimental interaction (after the alcohol or placebo, most important issue of disagreement). As with the Jacobson et al. (1994) and Margolin (1984, 1989, 1993) studies, aggressive couples exhibited more negative behavior (criticism, disagreement, interruptions, disapproval, put-downs, and so on) and higher levels of negative reciprocity (these behaviors are reciprocated) in their baseline interaction than did nonaggressive couples. Alcohol increased the husbands' use of negativity. This was not a placebo effect. It was a pharmacological effect of alcohol. Since baseline negativity was higher in the abusive couples, alcohol raised negativity levels still higher. The authors conclude that "it may be that alcohol simply disrupts attempts at conflict resolution for both aggressive and non-aggressive husbands. These disruptions, in turn, may lead some husbands to behave aggressively, but may lead to different outcomes among other husbands (Leonard & Roberts, 1998, p. 613). Finally, they concluded that "alcohol is neither a necessary nor sufficient cause of violence but there is growing evidence that it may contribute to violent behavior" (p. 614). Alcohol

seems to potentiate an already dysfunctional interaction sequence that is indicative of abusive couples.

COUPLES THERAPY

Given the interactional aspect of couple violence described here, marital or couples therapy (sometimes called systems therapy) seems like a logical way to proceed. Heyman and Schlee (2003) have written a good overview of this approach in which they review the Stony Brook Treatment Project using a system called Physical Aggression Couples Treatment (PACT), which emphasizes the circular causality demonstrated in the research studies on couples described in this chapter. In this system, each partner is held responsible for his or her own behavior, but each takes a role in conflict escalation (or, conversely, its reduction). PACT is an extended version of the Domestic Conflict Containment Program (Neidig & Friedman, 1984). The rationale is as follows: Most acts of physical aggression in intimate relationships occur in the context of an argument between partners. Conflict escalates until one or both partners strike each other (called "circular causality"). Two of the working rules are that (a) this system is not used when the women is still at risk for physical violence and that (b) the purpose of the system is not to teach women to be "nonconflictual" (i.e., acquiesce to whatever the partner wants). Rather, it is to become aware of reaction to conflictual responses from one's partner, take responsibility for them, and control them. Neidig and Friedman (1984) called the perpetrator/victim distinction a "therapeutic dead end" and believed that people needed to learn to use assertive/nonviolent communication in vivo.

Family systems approaches (Giles-Sims, 1983; Neidig & Friedman, 1984) view wife assault from an interactive (microsystem) rather than an intrapsychic perspective. The rules of the family system, which define what behavior is acceptable, the power imbalances of that system, and the personal resources of individual members that provide a basis for exchange, are viewed as major contributors to family violence. Giles-Sims (1983) acknowledges that "victims may inadvertently be reinforcing the violent behavior" (p. 33), a perspective supported in the child abuse literature by the interactive studies of Patterson and his colleagues. Patterson, Cobb, and Ray (1972), for example, observed parents' reinforcement of the violence of their highly destructive boys (Patterson, 1979). These parents were not aware of reinforcements they provided, and Giles-Sims suggests that the same may be true for battered women.

Neidig and Friedman (1984) begin their description of their couples' treatment program with the statement that "abusive behavior is a

relationship issue but it is ultimately the responsibility of the male to control physical violence" (p. 4). Their view is that approaches that attribute total responsibility to either party lead to blaming, compounding the problem. It does so, according to these authors, by beginning a chain of retributional strategies by the victim and the aggressor whereby each tries to "get even" for the other's most recent transgression. A systems approach avoids blaming by getting couples to think of the causes of violence from a circular feedback perspective rather than a linear one. This leads to "constructive interventions in the escalating process" that permit each partner to accept a portion of the responsibility. Having said that, however, Neidig and Friedman assign "ultimate responsibility to the male for controlling violence" as a recognition that both parties are not equal in physical strength. The difference between "total responsibility" and "ultimate responsibility" may sound like splitting hairs. If a man is responsible for his violence, then why is he not to blame if he acts violently? One answer may be that his violence occurred in a state of high arousal when he perceived no alternatives to the actions he took and where his partner played her part as well. Therapeutically, a couple approach and an individual approach have a fundamental disagreement: The couple approach tries to reduce blame, and the individual approach tries to increase responsibility.

The decision of whether an individual or a couple approach is best may depend on the client. If a man has a history of violence in several relationships with women, he may be a conflict generator capable of creating the system pattern observed by the systems therapist in his current relationship. Certainly, the "abusive personality" profiled here requires extensive therapeutic work at an individual level before couple treatment seems viable. In addition, as some therapists have shown (Richter, 1974), single persons are capable of generating entire interaction patterns within families on the basis of their individual pathology. Richter describes how a paranoid personality who holds power in a family can generate a shared paranoia in the entire family system. I expect that men with abusive personalities are conflict generators in all intimate relationships regardless of the personality or style of their female partner. Of course, such men may also pick women with their own backgrounds of abuse victimization and personality disorders. I recommend obtaining detailed social histories of clients and their partners prior to embarking on a systems approach, especially in view of the Kalmuss and Seltzer (1986) findings reported in this chapter. If a male batterer has a history of violence with women that pre-dates his current relationship or strong indicators of an abusive personality, couples treatment may not be advisable. Where the female feels threat from the man's violence potential or where violence is still recent, couples therapy might be delayed until the man has successfully completed

an anger management program and is violence free for a lengthy period. In general, where the violence and conflict seem specific to the present relationship, couples treatment may be more useful after the man's or woman's anger treatment.

Cascardi and Vivian (1995) found that the majority of couple-clients seeking marital therapy both engaged in aggressive acts and the woman got the worst of it (Cascardi & Vivian, 1995). Vivian and Langhinrichsen-Rohling (1994) classified couples as follows: (a) mild bidirectional—about 50% report low-level aggression (pushes, slaps, and grabs) committed by both husband and wife; (b) moderate; and (c) severe wife victimization—30% to 40% report high levels of wife victimization and much lower levels of husband victimization. This leads to the question from the Stets and Straus (1992b) table. What happens to female-dominant violent couples? Obviously, they do not seek marital therapy. Interestingly, only a small percentage of women seeking marital therapy report physical violence as a problem. O'Leary, Vivian, and Malone (1992), and Ehrensaft and Vivian (1996) found 14%, despite CTS reports revealing higher levels of physical aggression in the marriages.

Heyman and Schlee (2003) assess for levels of aggression prior to their treatment program and found that very few couples reported severe levels of aggression (p. 145). When someone was injured or fearful or when the husband was in denial, the couple was screened out. They did not comment on wives in denial. Posttreatment assessment revealed significant drops in aggression and increases in rated marital adjustment by both parties. The reduction in aggression was still significantly lower than its pretreatment level 1 year after cessation of treatment. Complete cessation was found with 26% 1 year later. Reductions occurred in a substantial subgroup.

Stith, Rosen, McCollum, and Thomsen (2004) also found significant reductions in male violence recidivism 6 months after couples treatment cessation in a study of 42 couples (only 25% recidivated). This was in a couples' group therapy format. In an individual couples format, 43% recidivated. In a nontreated control, 66% recidivated. By comparison, in a treatment outcome study done on the Duluth model, Shepard (1987, 1992) found a 40% recidivism rate in a 6-month follow-up of Duluth clients, higher than most control recidivism levels. Dutton (1987) found a recidivism rate of 16% (or 84% complete cessation) based on wife's reports for a cognitive behavioral group treatment for men. This was for a court-mandated group. Stith, Rosen, and McCollum (2003) reviewed six outcome studies of couples treatment and concluded that they were at least as effective as "traditional treatment." The latter seemed to include both "psychoeducational" and cognitive-behavioral group therapy for males.

In conclusion, I present evidence here to argue that a premature foreclosure has occurred in treatment of intimate partner abuse. Because feminist activists have determined the intervention of choice in many states, Duluth models proliferate despite a poor outcome record. Other therapeutic strategies that may be more appropriate with certain couples have been banned or ruled out. I have included the case for treating female perpetrators and for couples work. I have also presented the case for an expanded focus of male perpetrator treatment to include associated features of abusiveness. I would argue that, although the evidence is still scant, these foci will be relevant in the treatment of female perpetrators as well.

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