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Intimate Partner Violence: Making the Case for Joint Couple Treatment

Sara Antunes-Alves[1] and Jack De Stefano[1]

Abstract

Intimate partner violence (IPV) has received increasing public awareness in recent decades because of its prevalence and widespread deleterious and sometimes fatal effects. While clinicians and researchers alike are turning their attention more than ever to the treatment of the problem, there is continuing debate in the field on how to best address and manage the problem legally, socially, and therapeutically. This article adds to the debate by reviewing some of the major issues in IPV and its treatment. In spite of advances in our understanding, the use of gender exclusive batterer groups continues to be a preferred approach to dealing with the problem. We describe how and why, in many cases, conjoint couple therapy has replaced group treatment as an alternate approach and provide empirical evidence in support of this practice. We conclude with some practical guidelines for clinicians who are to engage in conjoint treatment for IPV.

Keywords

intimate partner violence, batterer groups, couple therapy, couple counseling

Intimate partner violence (IPV) is a painful reality in the relationships of men and women of all ages, cultural backgrounds, and socioeconomic classes and as such it is seen as a major social problem. The harmful effects of IPV extend to all areas of the individual's life, and there is well-established evidence that victims of IPV experience negative medical, psychological, and material outcomes (Bledsoe & Sar, 2011; Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). In the psychological domain IPV has been linked to increased risks of depression, posttraumatic stress disorder, substance abuse, and suicidality (Golding, 1999). Added to these is the growing realization that children exposed to domestic violence develop vulnerabilities to a host of psychosocial difficulties (Horner, 2005) and that parents who are the recipient of physical abuse are compromised with respect to their parental capacities (Buchbinder, 2004).

While there is widespread agreement among the public at large that ending IPV is desirable, how to best achieve this goal has become a daunting task. Certainly, since the movement to expose and end IPV began in the late 1970s (Cooper-White, 2011), considerable strides have been made, especially by the legal justice system and other governmental organizations, to address the problem. Jurisdictions in both the United States and Canada have standards that are used for the credentialing of practitioners and agencies working with victims and perpetrators of violence (Dankwort & Austin, 1999). In Canada, for example, common threads run across the provinces and territories, and we are seeing a convergence of certain accepted practices and beliefs. Yet, in spite of concerted efforts to provide services for individuals and families beset by violence, there is still widespread debate and disagreement about how IPV should be regarded and treated[1]. The debate in the field is due in part to our growing understanding of IPV as a complex, multidimensional phenomenon that will not respond to a one-size-fits-all intervention process.

In this article, we argue that a conjoint couple therapy approach to IPV is advantageous under specific circumstances. We first highlight some of the dominant ideas and practices surrounding IPV as a background against which we can begin to consider conjoint treatment as a modality with certain clients. Advocating for conjoint treatment is not a new concept and we build on the previous excellent work of others (e.g., Allen & St. George, 2001; McCollum & Stith, 2008). Our focus is two-fold: First, we present the literature about when and under which circumstances conjoint treatment is indicated. Second, we try to distill from this literature implications for general practice. IPV is often not the purview of the specialist and given the scope of the problem many practitioners, including generalists and other health care specialists, will be confronted with a client or patient for whom violence is part of a larger presentation.

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IPV and the Dominant Conceptual Framework

Our understanding of IPV has evolved since its early beginnings when groups for batterers were considered the only acceptable way to intervene in partner violence. Over the past few decades, there have been a handful of interventions, but there is little evidence that any of them are very effective in stopping the recurrence of family violence (Babcock, Green, & Robbie, 2004). In tracking the history of IPV, Greene and Bogo (2002) describe how women were historically often held equally responsible for male perpetrated abuse. They explain that with the growing acceptance of feminism and the feminist critique of gender and male power privilege, society was forced to attend to patriarchy, and domestic violence was explicitly squeezed into a framework that saw violence as the result of male privilege and abuse. This understanding of IPV followed the rationale that violence is not merely the result of a batterer's lack of impulse control or poor interpersonal skills but of a wider, societal problem (Cooper-White, 2011).

However, addressing IPV was initially dominated by an individual level approach in both the research and the clinical practice (Gelles & Maynard, 1987). For victims, this included shelters and crisis centers for women and children, whereas offenders received rehabilitation services in the form of counseling for battering spouses and self-help groups for violent men. Shelter workers and feminist advocates sought to make batterers solely accountable for their criminal behavior rather than punctuating these violent acts as a consequence of interpersonal deficits (Babcock, Canady, Graham, & Schart, 2007). These trends gave credence to the view that IPV was the batterer's (usually the man) problem, and the goal of intervention was to educate and to resocialize the perpetrators of abuse (Feder & Wilson, 2005). Thus, the perception of the public at large was that men were responsible for domestic violence and they should therefore be the target of intervention. This led to a gender-specific, individually oriented (i.e., male) focus that isolated and protected the woman while her partner was being rehabilitated.

The dominance of the partner violence discourse as being situated squarely within a gender exclusive, perpetrator frame probably accounts for the widespread use and popularity of batterer groups. However, while the use of groups was considered de rigueur for IPV treatment, the outcomes of these programs have had mixed results (Babcock et al., 2007). In fact, Babcock, Green, and Robbie (2004) conducted a meta-analysis of five randomized clinical trials investigating violent men who were part of a batterer's program and found effect sizes of .09 and .12 for recidivism. In other words, IPV treatment programs account for about a 10% decrease in the reoccurrence of violence. The authors further stated that violent partners have a 35% chance of maintaining nonviolent behaviors without treatment, while this number only increases to 40% with treatment. Systematic reviews of empirical studies report similar findings leading to doubts about the efficacy of batterer programs and thereby opening the door to alternate or parallel treatments (Feder & Wilson, 2005; Levesque, 1998).

Added to the relatively modest effect sizes for these programs is the fact that these (like other studies) are limited by conceptual and methodological problems (Allen & St. George, 2001). Conceptually, most of these forms of treatment have been based on a single understanding of the nature of relational violence, that there is a clear perpetrator and a victim. This view is now seen as unidimensional, since IPV is a complex phenomenon where multiple factors coalesce to form the phenomenon. For male perpetrators, our view has expanded to consider the individual characteristics and traits of these men (Dutton, 2007; Murphy & Eckhardt, 2005). Dutton (2007) in particular has been critical of the feminist paradigm for not considering such aspects as borderline personality organization, substance use issues, and behavioral skills deficits that are often manifest among perpetrators, as these become important considerations in studying treatment effectiveness and outcome studies.[2]

Differentiating the Types of Violence

The recognition that all batterers are not identical (and thus respond quite differently to intervention) led to the creation of theories of specific subtypes of violent men. In spite of nuances among classes of subtypes, most typologies recognize that there is a subclass of men for whom violence is part of a lifestyle and thus a preferred strategy for solving their problems. This notion is contained in Holtzworth-Munroe and Stuart's (1994) typology of male batterers as falling into one of the three types of perpetrators: the family-only type, dysphoric/borderline type, and violent/antisocial type. These classifications were based on personality and contextual evidence including frequency of violence, psychopathology, and past or current risk factors for using violence. Both the dysphoric/borderline and the violent/antisocial men generally do not respond to group treatments and many would probably meet criteria for a personality disorder (Dutton, 2007). Also, the literature on typologies recognizes the contributions of contextual factors like social and structural stressors, economic adversity, and intergenerational modeling of violence to an understanding of the violence of men (Rowe, Doss, Hsueh, Libet, & Mitchell, 2011).

As all batterers are not identical, neither is the nature of partner violence. Johnson (1995, p. 285) suggests a useful proposal where violence can be categorized as either "patriarchal terrorism or common couple violence." Patriarchal terrorism refers to coercive actions used to achieve control over one's partner and tends to escalate over time. Common couple violence, by contrast, is not characterized by control, tends to be situational, and is more likely to be mutual in the couple. The distinction between the two lies in the motivation: Common couple violence is less purposive and erupts from interpersonal conflicts and stresses, whereas patriarchal terrorism is motivated by the desire to control one's partner. Common couple violence tends to (a) be more situational, (b) be less one-sided and less frequent, (c) not elicit a pervasive fear in the partner, and (d) be the result of an escalating pattern of conflict (Stith & McCollum, 2011).

Greene and Bogo (2002) propose that both types of violence may be treated with therapy, but that most therapists will encounter individuals where common couple violence is at play. This has been said to be the most common form of relationship violence (Stith & McCollum, 2011). Research on IPV has illustrated that many couples who seek therapy tend to experience lower level, mutual aggression (Simpson, 2005), but often do not consider the physical abuse as their primary or presenting problem (Aldorondo & Straus, 1994; Ehrensaft & Vivian, 1996).

While the majority of therapists working with voluntary couples will encounter mostly common couple violence, Greene and Bogo (2002) warn that therapists must be able to identify the differences between the types of violence and adjust their interventions accordingly, or to refer clients elsewhere. This implies that practitioners entertain different, sometimes competing, perspectives as they decide on what approach or program is best for the client. Thus, even as there is disagreement in the field about how to best treat the problem of IPV, our increasing accumulation of knowledge about intervention options means that clients will be offered what they need and not what is available or politically correct.

It is hard to imagine that at one time treating IPV with conjoint couple therapy was seen as questionable (Stith, Rosen, McCollum, & Thomsen, 2004), because it did not fit with the Zeitgeist of the time. IPV has historically been considered as falling outside the scope of traditional couple therapy, largely due to the concern that therapy could increase the risk of violence or encourage victim-blaming (Rowe et al., 2011). Yet, traditional interventions that focused exclusively on the reduction or elimination of violence without addressing other important needs have had poor success rates (Brown, O'Leary, & Feldbau, 1997). Also, conjoint treatment implies that narrow, dichotomized descriptions of partner violence are ipso facto exclusionary and may not be what the couple needs or wants.

Conjoint Work With IPV: When Is It a Good Idea?

The use of conjoint couple therapy to treat cases of IPV has been debated in the professional and scientific communities. Much of the criticisms in the literature describe how conjoint treatment might put the victims at greater risk by directing blame at them (Stith et al., 2004) or by making future aggression and retaliation more likely (Simpson, 2005). Whether the danger is perceived or real, the victim of violence is obviously not free to speak in the presence of a controlling abuser. Stith and McCollum (2011) talk about how help-seeking by the perpetrator may actually have the unintended consequence of reducing or eliminating their legal or moral accountability for the violence. These concerns are not unique to conjoint treatment, but they must nonetheless be more carefully considered when deciding whether conjoint work is feasible for a particular couple.

Under specific circumstances, conjoint couple therapy may be the appropriate intervention for IPV if certain conditions are present. As a general guideline, conjoint couple therapy may be helpful with couples where there is common couple violence and where the violence is mild to moderate in nature (Bagarozzi & Giddings, 1983). There seems to be general consensus that where violence is severe and life-threatening, systems-based interventions are contraindicated and a more traditional approach of parallel treatment or intervention would be called for (Gelles & Maynard, 1987; Straus & Gelles, 1986). There is also agreement that couples who take responsibility for their aggressive behavior, are motivated to change, and do not attribute their behavior to external factors are also good candidates for conjoint work (Bograd & Mederos, 1999; Dutton, 1986; Holtzworth-Munroe, Bates, Smutzler, & Sandin, 1997).

Thus, in the actual clinical work with these couples, counselors are advised to conduct a thorough assessment of the type and severity of the violence as well as the couple's stage of change (Bograd & Mederos, 1999; Lipchik & Kubicki, 1996). This can be accomplished more efficiently with well-validated assessment instruments (Stith & McCollum, 2011), such as the Abuse Assessment Screen (McFarlane, Parker, Soeken, & Bullock, 1992), the Assessment of Immediate Safety Screening Questions (Family Violence Prevention Fund, 2002), and the Domestic Violence Initiative Screening Questions (Webster, Stratigos, & Grimes, 2001), which must include a thorough screen for substance use or mental health problems as these may compromise the safety or evolution of the case (Dutton, 2007). Such instruments help provide clinicians with additional background on the nature of violence and aid in identifying the need for additional services and outside referrals for both victims and perpetrators separately (see the Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings: Version 1, 2007 for a comprehensive list of the valid assessment tools related to IPV). In short, these guidelines imply that therapists working in this area have received training in IPV and high-conflict couples and that they network with other professionals in the field as a way to maintain competent practice and avoid burnout.

One important criterion in the success of conjoint counseling is the context in which violence occurs during the couple's interpersonal conflict. For example, Pan, Neidig, and O'Leary (1994) conducted a large-scale study on randomly selected military personnel and found that marital discord was the most accurate predictor of partner violence. Thus, clinicians are advised to focus on improving the relationship and interactions in conjoint couple therapy by facilitating problem solving around such issues of finances, career decisions, and sexual satisfaction. Similarly, Burman, Margolin, and John (1993) observed that physically aggressive couples were significantly more mutually hostile and had inflexible and rigid behavior patterns compared to nonviolent troubled couples. Violent couples have deficits in communication and problem-solving skills, particularly during conflict or when either partner becomes angry (Babcock, Green, Webb, & Yerington, 2005). This implies that the violence that we see in these couples is often a result of ineffective interpersonal problem solving and thus skills training could be a goal of conjoint treatment.

In fact, there is evidence that conjoint interventions are as effective at reducing violence as gender-specific treatments,

such as men and women's groups. O'Leary, Heyman, and Neidig (1999) conducted a study with 75 intact couples assigned to either a gender-specific or a conjoint treatment for psychological and (mild to moderate) physical aggression. They found that both treatments significantly reduced physical aggression (by 55%) in the short term and long term. While there was no significant difference found between treatment types, husbands in conjoint treatment improved significantly on marital adjustment.

The notion that conjoint therapy increases the chance of further violence for cases of mild and infrequent common couple violence seems to be challenged by Simpson's (2005) study of 134 couples that reported mutual, mild levels of violence. In that study, rates of psychological and physical aggression remained at close to zero during and after conjoint treatment.

It would appear that conjoint couple therapy addresses important issues such as relationship satisfaction and individual functioning in a way that other interventions such as batterer programs and men's groups do not. Thus, while conjoint treatment is as effective at reducing violence as traditional men's treatment programs (Brown & O'Leary, 1997; Morrel, Elliott, Murphy, & Taft, 2003), it may be better suited for tackling the interpersonal conflict and poor problem solving that are part and parcel of the problem (McCollum & Stith, 2008). This fact may actually diminish the fear that women might feel in conjoint treatment. Studies of mild to moderate IPV found that very few women were afraid in their husbands' presence during conjoint meetings (Greene & Bogo, 2002) and that these women were actually at no further risk of abuse compared to those who obtained individual therapy (Brannen & Rubin, 1996; O'Leary, Heyman, & Neidig, 1999; Stith et al., 2004).

LaTaillade, Epstein, and Werlinich (2006) argue that because relationship distress and conflict are strong predictors of IPV, not addressing these issues in the couple therapy context can actually increase the risk of violence. Conjoint modalities may bolster a sense of safety in the relationship, as they are tailored interventions that take into account the couple's unique background and behaviors in a way that a batterer group often cannot (Allen & St. George, 2001). The highly structured group approaches follow a standard protocol to all perpetrators and victims, with the aim of policing or surveillance (Aguirre, Lehmann, & Patton, 2011). Tailored treatment, unlike protocol driven interventions, has the advantage of keeping couples more engaged in their own therapy (Allen & St. George, 2001).

Group treatment of batterers typically uses a confrontational style in its attempts at fostering responsibility in batterers (Pence & Paymar, 1993). Unfortunately, this confrontational approach elicits a host of untoward reactions from clients: fervent counterarguments, silence, phony agreement, or termination of treatment; supportive strategies seem better able to motivate clients (Murphy & Baxter, 1997). For example, the brief motivational interviewing technique (Miller & Rollnick, 2002) was applied to enhance interpersonal skills using an emotion-focused approach that emphasized expressive skills, empathy, and communication (Morrel et al., 2003). With this technique, the therapist provides feedback in an empathic and nonconfrontational way, reinforcing any statements made by clients that indicate a willingness to change any risk factors for aggression. Morrel, Elliott, Murphy, and Taft (2003) found a significant overall reduction in physical aggression over time (effect size $d = .58$).

Taken together, the literature converges on the fact that conjoint treatment is better able to address underlying relationship dynamics and, especially, each partner's decision to remain in the relationship. This is an important factor that is often overlooked in other forms of therapy (Stith & McCollum, 2011). Where traditional programs typically focus primarily on reducing violence (and this is obviously an important primary goal), conjoint treatment focuses on other relational dynamics like distress and dissatisfaction, which are highly correlated with the perpetration of violence (Stith, Green, Smith, & Ward, 2008). Certainly, if the couple chooses to stay together, one-on-one treatments for the abuser may disadvantage the victims as they are excluded from the process of improving the relationship (Heyman & Neidig, 1997). Thus, a one-sided approach that isolates the partner and deprives the therapist of the opportunity to observe how this plays out in the give and take of the relationship is something that batterer intervention programs cannot provide (Rosen, Matheson, Stith, McCollum, & Locke, 2003). This is particularly salient when we consider that much of IPV is bilateral (Madsen, Stith, Thomsen, & McCollum, 2010), and thus the communicational and interpersonal display of both partners is needed for a thorough assessment.

Some Considerations and Guidelines for Practitioners

While batterer programs and groups for violent men continue to be both popular and necessary, expanding the paradigm to include other modalities and approaches is always desirable. The initial thrust of these programs was the reduction of violence and this continues to be an important goal of all treatment (Heyman & Neidig, 1997). However, we must acknowledge that our thinking about intimate relationships violence has expanded, and we can now see that all IPV is not identical (Greene & Bogo, 2002). Violence reduction, the goal of many batterer programs, can also be achieved through different avenues: By resolving the couple's interpersonal problems and helping them establish better ways to manage relational stressors, two possible outcomes that can be addressed in conjoint format. Thus, conjoint therapy can be directed both at having the perpetrator take responsibility for the aggression (i.e., the goal of most group interventions) and at assisting the partners to develop mutual problem-solving capacities (Holtzworth-Munroe et al., 1997).

In many couples, violence is not a means to control but, rather, as research shows, an ineffective strategy for trying to deal with personal and interpersonal issues (Johnson, 1995). In fact, as is often the case, individuals seek help when their available psychological resources and strategies no longer allow them to cope with the difficulties that they are encountering. Additionally, even when violence is a factor in their lives, clients rarely seek out specialized programs for IPV first. Many individuals still rely on available sources of social support (Pollack et al., 2010) and when professional help is sought, primary

care physicians and public health specialists may be the first consulted. Thus, many practitioners (without training in IPV) may find themselves hearing a client's report of violence even when the request for help is unrelated to the violence (Goldner, 1998). Being untrained or inexperienced in IPV does not protect a practitioner from a client's disclosures. In fact, when a treatment is already established and a strong alliance is in place, a client may take the risk of talking about incidences of violence when they may not have originally intended to do so. The clinician will thus find himself or herself in the position of having to make a referral or continuing with the case with appropriate supervision. Regardless of the choice that the clinician and client make, some basic, research-informed ideas about IPV and its treatment will serve clinicians with limited experience with IPV well. After all, a clinician may already have prior information (e.g., the couple's or individual's substance use or comorbid conditions) and knowing about factors that compromise treatment is essential for appropriate clinical decision making (Stith & McCollum, 2011).

Among these factors, the couple's commitment to the relationship and the desire to stay together are important motivators that are likely to predict the eventual outcome (Morrel et al., 2003). Where a therapist does feel confident to provide services, case management is essential especially as it concerns gauging, on an ongoing basis, the level of distress in a couple and the severity and imminence of aggressive acts. Additionally, service providers (even those with considerable experience) should not be working in isolation and liaison with agencies and other service providers provide an added layer of support when needed (Simpson, Gattis, Atkins, & Christensen, 2008). This implies that regardless of the clientele with which we work, up-to-date familiarity with community and other resources is essential. Obtaining supervision and working closely with other professionals who have related experience are advised, not only for professional guidance but also as a means of self-care in dealing with the oftentimes high-conflict nature of the couple in session (Stith & McCollum, 2011).

In sum, conjoint couple therapy for IPV is becoming established as a legitimate treatment for partner violence and has been shown to be effective in stopping the violence, and increasing appropriate interpersonal communication in the couple (Heyman & Neidig, 1997). The collective insights from the literature on conjoint treatment are worth summarizing as they can provide practitioners from various camps with a start point for decision making (e.g., refer or continue with supervision). Therefore, conjoint treatment should be considered when (a) there is no substance abuse or mental health issues that may compromise safety; (b) the couple experiences common couple violence of mild to moderate severity; (c) the violence is a result of poor problem solving (i.e., is situational) and is not motivated by need for control; and (d) the violent individual takes responsibility and does not blame the partner for the violence. Once these important parameters have been weighed, ongoing adjustments and case management (with realistic contingency plans) guard against eruption or escalation of violence and ensuring that therapy is a safe place for both partners.

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Notes

1. While violence in same-sex relationships is also a serious problem (see Lockhart, White, Causby, & Issac, 1994; Tjaden, Thoennes, & Allison, 1999 for a more detailed review), the current article will focus exclusively on violence in heterosexual couples where the man is the perpetrator of the violence.
2. In an effort to reconcile the two ends of the continuum, Murphy and Eckhardt (2005) propose that feminist approaches are focusing on *distal* factors, that is, cultural and social norms conducive to violence against women, whereas a more person-focused approach in assessment and treatment is concerned with *proximal* factors specific to the individual.

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