Attachment Issues in Family Violence:

Implications for Therapy

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Why do we commit violence against the people we love?

This is one of those profound questions that challenge the way we see ourselves, and others. Our response to this problem reveals as much about us as it does the perpetrators and victims. Do we minimize the violence, believing that parents (especially Mothers) always know and do what's best for their children? Do we justify frequent use of corporal punishment as a necessary response to "bad" kids? Are we so overwhelmed by the tragedy of family violence that we avoid the topic? Do we get so angry at the perpetrators of this violence that we just want to punish them? Are we so anxious about safety that we just want the victim to leave the perpetrator, and get angry at them when they don't? Do we project our own dark side onto these perpetrators, or our own fears onto the victims? The issue may be so complex that we seek out simplistic answers and solutions?

Everyone in the family system is profoundly impacted by family violence, whether they are the target of this violence or "just" a witness:

- Early childhood abuse and neglect has a measurable impact on the neurophysiology of the infant, especially the orbitofrontal frontal region. This is the region of the brain that is "experience dependent," where we form our attachment relationships. Early childhood abuse or neglect by the primary parent

can cause permanent damage to this region of the brain, leading to *"a lifelong limited ability, especially under stress, to regulate the intensity, frequency, and duration of primitive negative states such as rage, terror, and shame."*[1]

- Researchers have found numerous mental health problems correlated to family violence: e.g., increased depression, substance abuse, personality disorders, antisocial behaviors, and increased aggression ad violence.
- The family, especially the quality of our bond with our parents, is the basis for our developing sense of self; the template for our relationships with others; and forming our core beliefs about the kind of world we live in.
- Family violence can affect the way family members treat each other. Abused children can abuse siblings or other children. A parent who is abused by their spouse can then abuse their children, or abuse both their spouse and children. An adult who is being abused by their spouse may not protect their children from abuse.
- Family violence can be "learned" and transmitted to the next generation, if the abused grows up to abuse their family, or marry an abuser.
- Family violence also changes our society. Cultures that endorse abusive child-rearing tactics or discipline are more likely to be violent, totalitarian, and warlike (see Alice Miller[2] and Lloyd DeMause[3]).

Let me illustrate these issues with a case from my clinical practice:

"Josh" is a 15 year-old boy who was hospitalized in a Psychiatric unit after his Mother reported serious discipline problems. She described her son as being out-of-

control and angry, hitting her and his younger brother. How did the hospital evaluate this case? They based their decision to hospitalize solely on the Mother's word. However, no one explored the family dynamics that might have precipitated this boy's anger ad violence.

At the time I had been treating the boys' Father and Step-Mother for his sexual compulsivity (multiple affairs) and her PTSD from severe physical abuse by her Step-Father. She did a good job of parenting her step-sons, but she became increasingly alarmed at evidence that they were being verbally abused by their mother. She described an incident where they were helping her carry groceries from the car into the house. When one of the boys dropped a bag of groceries they looked at her in "terror" that she was going to punish them. She didn't, but she began to talk to her husband about her concerns, trying to get him to protect his sons. Shortly after this they began divorce proceedings.

Not long after the mother then moved with her sons to another state. The stepmother stayed in contact with the boys, and asked me for help when she discovered that Josh had been committed to a psychiatric unit for violence against his Mother. I was able to talk to Josh's case manager, and informed him about this mother's long history of verbal abuse as part of developing a treatment plan. The case manager (and his clinic medical director) refused to consider this information, or perform a more complete evaluation for treatment.

I never met Josh's mother, but she and the step-mother shared the experience of being married to a man having multiple affairs during their marriage. Perhaps some of the mother's rage may have been projected from her ex-husband onto her sons. This mother

was probably also abused as a child by her father and/or mother. Yet the stepmother had the same problems of an unfaithful husband, parenting two teenage boys, and severe physical abuse from her stepfather. Both women experienced difficult relationships which affected their own attachment patterns as adults. One woman healed enough to nurture and protect her stepsons. The other acted out her rage, damaging her son's attachment to her, and passing this on to the next generation.

We cannot offer effective treatment without a thorough evaluation. Family violence is hidden by shame, fear, projection, and rigid boundaries. So when we suspect abuse we have to explore the family's conflict dynamics. Even when we ask we rarely get the complete picture. We then have to begin therapy based on limited or incomplete information. Early stage therapy requires combining assessment and treatment, if we want to be effective. Consider the difference in the above case if a complete, unbiased assessment had been done and family therapy provided, in addition to individual therapy for Josh. This case manager's refusal to consider contradictory information is a symptom of a much deeper problem in the family violence field.

Our splintered response to family violence

Unfortunately our response to family violence has split into three arenas based on separate social advocacy movements: child physical abuse ad neglect, sexual abuse, and domestic violence. These different movements have created three separate arenas each with its own theories, trained professionals, laws, research, and government agencies.

- Child physical abuse and neglect**:**

The child protection movement began in the U.S. after a famous court case ruled that the laws protecting animals from cruelty could also be applied to children:

> *"In 1873, nine-year old Mary Ellen McCormack was an orphan living in New York City with Francis and Mary Connolly. Mrs. Connolly physically abused Mary Ellen almost daily, often using a raw-hide whip. Mary Ellen had few clothes, no bed, and was not allowed to leave the house. After learning of Mary Ellen's plight, Etta Wheeler, a Methodist social worker, went to the Connolly's apartment to see the conditions under which the child lived. Ms. Wheeler saw an undernourished and uncared for child whose body bore the marks of repeated beatings. For the next three months, Etta Wheeler tried in vain to get someone to intervene on behalf of this beaten child. The police said they could do nothing, charitable institutions said much the same. The law seemed to provide no means for any public agency or private society to protect Mary Ellen. Unable to help this little girl through orthodox channels, Ms. Wheeler finally asked the Society for the Prevention of Cruelty to Animals (the "Society") to protect Mary Ellen as an abused member of the animal kingdom. Henry Bergh, the president of the Society, agreed to act. On April 9, 1874, as the result of efforts initiated by Etta Wheeler and Henry Bergh, a bruised and battered Mary Ellen McCormack was brought into a New York courtroom to tell her story to Judge Abraham Lawrence. Her face bore a fresh gash which would leave a life-long scar. Jacob Riis, then a newspaper reporter, wrote that when Mary Ellen was brought before the Court "...the first chapter of children's rights was being written."*[4]

Although child protection efforts continued for the next few decades, public attention to the problems of child abuse diminished over time. The social activists shifted their attention to other causes like mandatory education and child labor, and our national attention to child abuse disappeared. This issue of child abuse re-emerged in 1962 when Dr. Kempe and his colleagues published their famous article on the "Battered Child Syndrome".[5] This is how these physicians described our professional denial of child abuse forty years ago:

> *"Physicians have great difficulty both in believing that parents could have attacked their children and in undertaking the essential questioning of parents…. Many physicians attempt to obliterate such suspicions from their minds, even in the face of obvious circumstantial evidence."*[6]

- Child sexual abuse

Our awareness of, and response to, child sexual abuse followed a different course. Sexual abuse is more hidden and shameful than other forms of child abuse. Our first modern awareness of this issue came from Sigmund Freud's "Seduction Theory" presented to a Vienna Medical Society in 1896. In this address Freud suggested that Hysteria was caused by suppressed memories of real childhood sexual abuse. He was able to treat 18 cases of hysteria by uncovering this prior sexual trauma. Unfortunately, only 18 months later he replaced the Seduction Theory with his "Oedipal Theory" which postulated that allegations of child sexual abuse were only childhood fantasies ("wish fulfillment") toward the opposite sex parent.[7] Jeffrey Masson suggested that Freud abandoned his Seduction Theory because the patriarchal medical community was threatened by questions about men's sexual abuse of children. I would argue that the issue

is much broader, and functions, on an unconscious level. The culture wasn't ready to accept, and still resists, both male and female offending, and the sex abuse of both girls and boys[8].

If it wasn't for the Women's Movement child sexual abuse may have remained a shameful secret. In the 1970s the feminist Rape Crisis Movement[9] linked child sexual abuse (of girls) with the rape of women. Unfortunately this theoretical construct reinforced gender sexual stereotypes; attributing sexual abuse of children to patriarchy; thus increasing our denial of female sex offending; and minimizing the sexual victimization of boys.

- The Domestic Violence Movement:

The first DV shelters were created in London by Erin Pizzey beginning in the early 1970s. She also wrote the first book on Domestic Violence.[10] Her shelters used approaches that would now be considered leading edge: the women themselves, not professional staff, ran their shelters; she advocated that shelters also be established for men; she insisted that child abuse and domestic violence were linked; and she regularly spoke out about women's violence (e.g., Pizzey observed that *"62 of the first 100 women who came into her shelters were as violent as, or more violent than, their husbands or boyfriends"*).

Unfortunately, the DV movement was quickly co-opted by feminists in the mid-70s and 80s. The focus was changed from a gender-inclusive, family treatment model to one that is gender-specific and based solely on feminist theories about male violence against women. This response to family violence also shifted to punishing and re-

educating the (male) perpetrators, and protecting and advocating for the (female) victim to leave her relationship.

Even though many researchers found clear evidence of the complexity and mutuality of domestic violence (e.g., Murray Straus, 1993)[11], the feminist model continues to dominate our understanding of, and response to, domestic violence. Fortunately this gender-exclusive focus is finally beginning to change.

<u>A Family-Systems Approach</u>

We will never have a chance to end this tragic cycle of family violence without reintegrating our response to it. The child abuse movement gives us a different approach. Over 100 years ago the child abuse and neglect field evolved from the New York "Society" emphasis on arrest and punishment to the Massachusetts model of family support services and treatment. We need to do the same with all forms of family violence, whether it's violence between adults, and all forms of child abuse, including sexual abuse. Over the past three decades an increasing body of research has shown that our current models for both DV[12] and sex abuse treatment are seriously flawed, and treatment based on these models aren't effective. Attachment theory is increasingly gaining influence in both DV[13] and sex abuse treatment[14]. And there is a growing body of research in the neurobiology of attachment[15]. Why not apply this research and clinical experience to modify our assessment of, and response to, family violence?

<u>How does Attachment Theory help us to treat Family Violence?</u>

In the late 1950s and 1960s Harry Harlow performed a number of famous experiments on attachment using rhesus monkeys. Lauren Slater[16] described Harlow's

experiments with the "Iron Maiden", a terry-cloth-wrapped, wire mannuequin. Despite a cold, unemotional, at many times even abusive response, the baby monkeys clung to their surrogate mothers:

> *“No matter what the torture, Harlow observed that the babies would not let go. They would not be deterred; they would not be thwarted. My God, love is strong. You are mauled and you come crawling back. You are frozen, and yet still you seek heat from the wrong source. There is no partial reinforcement to explain this behavior; there is only the dark side of touch, the reality of primate relationships, which is that they can kill us while they hold us—that’s sad. But again, I find some beauty. The beauty is this: We are creatures of great faith. We will build bridges, against all odds we will build them—from here to there. From me to you. Come closer.” (pg. 142)*

We can't choose whether or not to attach. We are social beings. Humans, indeed most mammals, require an attachment to a primary caregiver. This caregiver can be loving and nurturing or abusive, but attach we must. Our job as clinicians is to help people improve the quality of these connections.

> *"Attachment is an enduring emotional bond that involves a tendency to seek and maintain proximity to a specific person, particularly when under stress. It is a mutual regulatory system that provides safety, protection, and a sense of security for the infant. Attachment is 'an intense and enduring bond biologically rooted in the function of protection from danger'."*[17]

For adults attachment exists both in the past, and in the present. Our childhood experience of attachment with our parent(s) has been described as four "styles"

(internalized models) of attachment: secure, anxious/avoidant, anxious/ambivalent, or disorganized/disoriented. The adult counterparts of these are: secure, dismissive, pre-occupied, and fearful.

These attachment styles affect our sense of self, and how we see the world and relate to others. These internalized models are particularly powerful at moments of danger or significant change, and in personal relationships especially in our most intense relationships with a spouse (or lover), and those with our child. In the emotional crucible of new family relationships we inevitably recreate our family of origin attachment issues. This is both a danger, and an opportunity.

We consciously, and unconsciously, choose and relate to a spouse based on these internalized attachment models. So when conflict arises we will inevitably view it through the lens of attachment: Will he listen to me? Will she accept me? Can I trust him? Why is she always critical of me? Why does he always hurt me? Will he/she be like my father/mother? Will I become my father/mother?

For children this process is on-going. Even though the fundamentals of attachment are laid down by age two, this experience is constantly being modified, or reinforced, as children face the experience of growing up. Any intervention in family violence has the potential to modify these trauma bonds. And prevention or early intervention within the family unit is enormously more influential than years of individual therapy later in life.

Early in my career I worked at Luther Child Center, a treatment center for child sexual abuse. Our consulting psychiatrist (Allen Leiter, MD) described these children as "living in a minefield." We couldn't rescue them, undo the abuse, and

many times we couldn't significantly change their families. Allen would remind us that: "They know this minefield better than us. Sometimes all we can hope to do is to walk them through the woods next to the minefield."

We can't stop these tragedies from being re-created. It is the nature of intimate relationships to bring out the best (and worst) in us. All we can do is recognize these patterns; reduce our intense emotional reactivity; take responsibility for our part in these patterns; and work to create a different response to our conflict and distress. *We can't change the past but we can certainly change our response to the past, in the present.*

What about the children?

One of the two primary flaws of the DV movement is the assumption that "domestic" violence and child abuse are somehow separate phenomena. The reality is quite different. Marital violence is directly correlated to other forms of family violence (Straus & Gelles, 1990): "The more violent husbands are toward their wife, the more violent the wife is toward her children."[18] His research showed that the highest rates of child abuse were correlated with the most severe DV, but even "minor" domestic violence (i.e., pushing & shoving, or slaps) resulted in twice the frequency of severe assaults on a child by the mother. This DV was also correlated with higher rates of sibling abuse. Another researcher (Ross, 1996) found that:

> *"Marital violence is a statistically significant predictor of physical child abuse. The greater the amount of violence against a spouse, the greater the probability of physical child abuse by the physically aggressive spouse."*[19]

Another study (Appel & Holden, 1998) found a "40% co-occurrence rate"[20] between DV and child abuse. A longitudinal study of 2544 "at-risk" new mothers (McGuigan & Pratt, 2001) found that DV during first 6 months of a child's life tripled the likelihood of child physical abuse during first 5 years of life, and more than doubled the likelihood of emotional abuse and neglect.[21]

This research has forced DV advocates to acknowledge child abuse, but only in terms of children *witnessing* the DV between their parents. While witnessing violence can certainly be traumatic this maintains the false distinction that adult, heterosexual DV (i.e., the man battering the woman) must be the primary focus of our attention. There are two problems with this position. First, there are over 130 studies of DV[22] that show that women perpetrate as much violence as men. So wouldn't these children be just as traumatized witnessing their mother's violence against their father? Second, the bigger issue is that DV is directly correlated with child abuse. These children are far more likely to be abused, not just witnesses to violence. These children become participants in this tragedy. And they are far more likely to grow up and be abusive with their family, or marry an abuser. This is the context of violence that we must address.

This is why I would argue that any reports of DV must involve an assessment for the full spectrum of family violence, including child abuse.

Balancing Safety and Family Therapy

The primary argument against family and couple's therapy is that we are putting the victims at risk of further abuse, either by allowing the perpetrator to rationalize his or her violence or further escalating the violence after the session is over. If there is on-going, serious violence the first priority is always to set up safeguards to create an

environment of safety (see Potter-Efron, 2005, Cha. 5). But blaming each other, and increasing conflict, are risks in all couple's and family therapy. Any competent therapist has to learn to deal with these issues.

I want to comment here on the balance between safety and attachment. The only sure safety is to never get close to another human being. While there are a few people who choose this route, the vast majority of us need and seek out relationships. This is especially true for children. When we rigidly follow a victim's advocacy approach the best answer to family violence is to leave, divorce, and cut-off from the perpetrator. This rarely works. Either family members don't want to leave, or leaving creates further trauma. If the violence is on-going, and the perpetrator won't stop, we'll still carry the wounds of this abuse to our graves even if we leave. No matter how far away we move we'll carry these wounds with us. The best option is to change this pattern of violence within our family, or take the longer road of healing our damage on our own.

This dichotomy between safety and connection to a loved one who is also our abuser is most pronounced in the fields of DV and sex abuse:

Clinical Example: Lynn and Shawn are a professional couple with two young sons. She had quit her management job to raise her sons full-time, and he was a mid-level manager in a high-stress, but well-paid job. They were referred to me following her psychiatric hospitalization for major depression and a suicide attempt. Shawn had a "Dismissive" Attachment style, focusing on taking care of his wife's depression and suicide attempts while ignoring his own needs and isolating from friends. He was a "workaholic" and caretaker of others, while ignoring his own distress and needs. Lynn had a "Preoccupied" attachment style, focusing on raising her sons and trying to get her husband to focus on

her. These conflicting attachment styles, combined with very high levels of external stress, led to chronic marital problems. They finally had an argument which escalated to mutual violence after both of them had been drinking. She struck him and then he “put his hands around her neck” to stop her, she began hitting him more, then he left the house to walk their dog. After he left she got increasingly angry at him for putting his hand around her neck. When he returned Lynn asked him to leave the house. Shawn refused. Lynn then called the police (later admitting this was out of anger and “wanting help”). When the police arrived both of them were arrested and put in jail for 72 hours. Fortunately the neighbors watched their young sons.

This is a classic case of mutual violence that escalated out-of-control. Neither of them used violence regularly, or to control each other. Lynn and Shawn were both decent people caught up in relationship patterns that amplified their distress. They recognized that their conflicts had an impact on their sons. Unfortunately they had stopped conjoint therapy nine months before. All Lynn wanted was “help”, but the police were mandated to arrest both of them. If they had been charged, he could have lost his job, and their sons could have ended up in foster care. In our desire to “protect” this family our response could have made their problems much worse.

The advantages of family therapy

I’m still troubled by a case that I mishandled from early in my career.

Clinical Example: I was contacted by a mother to treat her ten year-old son ("Jack") for anger and acting-out. In the first session I met with Jack, his mother, her lesbian partner, and his father (his parents were divorced). His mother had a “Disorganized” attachment

style and was almost totally dissociated from her son. Jack's father loved his son but was passive-avoidant (“Dismissing”). Neither parent strongly engaged with their son to set limits or provide love. The only adult in Jack’s life who seemed concerned was his mother's partner. In this first session she described Jack as "evil". I became concerned over the impact of this "psychological abuse" on Jack and had him leave the room while I talked with the adults. My supervisor later advised me to work only with Jack and his biological parents in the future.

Later I recognized that I had made a serious clinical error with this family. In a case consultation at a training clinic I was asked the key question: "Why did I have Jack leave the room"? The clinic director reminded me that Jack lived with this abuse every day. He needed help from me to change this family dynamic. By having Jack leave the room I was saying that I (an adult) couldn't deal with the abuse either. I later discovered that his mother's partner was the only adult who seemed to be concerned about Jack, and willing to take action. Her reaction to Jack's violence came out of her own childhood abuse from her brothers. My anxiety got in the way of demonstrating to Jack a healthy response to abuse. It also removed the one adult who both loved Jack and took action on his behalf. Family therapy with this woman would have also offered her a chance to heal from her own childhood abuse.

Family violence is complex and systemic. Treatment for each family member must be based on the particular type of DV: consisting of the classic man battering his wife, the wife battering her husband, mutual severe battering, or "common couple's violence." Within each of these subcategories treatment will vary depending on each

case. Some cases of "common couple's violence" may be intractable, while cases of severe battering by one spouse may be very treatable.

The children may be totally sheltered from this violence; witnesses to the violence; or the targets of violence. Child abuse can exist without DV; a child can be battered/abused by one or both parents; there can be mutual abuse between an adolescent and parent; or abuse between siblings. This child abuse can be caused primarily by external stressors (e.g., addiction, financial distress, or simply being overwhelmed); the parent may simply lack discipline skills; the parent could be depressed, personality-disordered or psychotic.

In short, family treatment is complex. Assessment and treatment are intertwined. We can't treat what we don't see, or deny, because our theories don't allow it. And we have to reassess as we're treating, to make sure that what we are doing is effective. Work with these families can be a very humbling experience.

The "stance" of the therapist

Family therapy is not simply a matter of technique. It's more a function of the therapists "stance." This is based on our sense of ourselves as therapists, and the attitude we have toward the people we work with. Noel Larson[23] describes treatment with perpetrators and victims as "counter-intuitive." She suggests "going for the heart" (vs. confrontation) with perpetrators, and "standing back" with victims (i.e., reinforcing their strength by not rescuing or caretaking).

Clinical example: A couple in their mid-40s came to see me to help them change a chronic pattern of emotional abuse. She was pregnant with their first child, although she had two teenaged children from her first marriage. She complained of several years of

increasingly angry interactions with her husband. The more she complained of his "abuse" the more he argued and withdrew. I suggested that she stop using the term "abuse" and instead talk about how his behavior "hurt" her. This shifted the focus from her description of his intent ("to abuse") to her personal experience (certain words and behaviors "hurt" her). He loved his wife, and agreed that his image of a "good husband" didn't include deliberately "hurting" his wife. He was able to begin listening to her experience, instead of trying to argue that he wasn't trying to "abuse" or control her. Once this destructive cycle stopped we could change the focus to their underlying fears and concerns about the pregnancy. He was worried about her health, and she was afraid that he would be emotionally (and physically) absent after the baby was born.

- If we expect family members to respect each other, and not resort to violence, we have to model this by being respectful with our clients. In order to do therapy we need our clients to be honest with us, but they won't be open and honest unless we create a climate of therapeutic safety. This also requires that we separate therapy from control functions. If possible have a case worker or probation officer enforce rules. If court-ordered into therapy we need to discuss this dilemma with our clients. In my experience intense confrontation and "breaking down denial" is more likely to lead to compliance, rather than real change.
- Look for family strengths and exceptions to patterns. No family is only violent or dysfunctional. Look for, and reinforce, any exceptions (e.g., "How were

you able to stop from losing control of your anger Tuesday night?"). These contain the clues to solutions. Build on these strengths:

Clinical Example: "Steve" is a 15 year-old who had serious problems with anger, fighting, and alcoholism. He had been suspended from school and kicked out of his aftercare addiction program after getting into fights. He was argumentative with his parents and other authority figures. Prior therapy had not been effective. By the time he came to see me Steve recognized that he was alcoholic and could never drink again. He acknowledged that his anger was hurting himself and the people he loved, but he still saw fighting as necessary in some circumstances. His underlying issue was an “Ambivalent” attachment style: hypersensitive to criticism and shame, but responding with violence or alcohol when hurt. In his early childhood he witnessed his mother hitting his father, and his father’s drinking.

My treatment began with individual and family sessions (usually with his Mother or girlfriend). This has evolved now to family sessions with Steve and his father. His father is also a recovered alcoholic, but he never had problems with anger. Increasing the connection with his father gives Steve a chance to see himself in the "mirror" of his father's eyes, and to internalize male values of sobriety and peaceful responses to fear and conflict.

Recently Steve got into another fight at school, challenging a boy who had made fun of another kid. The school suspended him, transferring him to an alternative program to protect other kids (and themselves). Both parents were hurt and disappointed, given his recent progress. Steve finally began to look at his own

“punk” behaviors, recognizing that this pattern of violence (going back to early elementary school) was destructive to his loved ones and himself.

- All of us need hope. If we take a stance of "respectful inquiry," trying to understand why and how our clients behave in violent patterns, they are more likely to open up instead of being guarded and defensive. Even if they can't answer our questions, this shifts the focus from shame and blame to an exploration of self, and seeking solutions.
- We have to contain our own anxiety and anger if we want to help the family face their violence and pain. My anxiety got in the way of helping Jack, thereby missing an opportunity for real change. Many therapists worry so much about the potential of future abuse, or being sued, that they take the easy route of treating the perpetrators and victims separately, without ever addressing family issues directly. Individual family members, especially the perpetrator(s) and spouse, will need their own therapy, I'm suggesting that we also address the violence from the family's perspective. From that position we can make real change for everyone, while individual family members do their own therapy.
- Family therapy provides for the possibility of "corrective emotional experiences":

Clinical Example: I had been working with a young couple (Bob and Lila) for several years to help them differentiate from Bob's narcissistic family-of-origin. When Lila disclosed Bob's problem of marijuana abuse to his parents, during a

recent Mother's Day visit, her mother-in-law physically attacked her. Needless to say this escalated the family triangulation, blaming the "argument" on Lila. Lila was afraid that Bob wouldn't protect her, or their daughter, because of her own family-of-origin abuse experiences. As I was helping them reduce her triangulation with his family, and her anxiety about his loyalty to his family over her, I used their parenting experiences with their two-year-old daughter to teach them differentiation. I challenged him to become a more active disciplinarian with his daughter to learn to face his daughter's (& his own) anger, while experiencing that she would still love him. And I suggested that Lila learn from her daughter that it's OK to state your needs, even if others might get angry at you. Her daughter would regularly say "Self" whenever she wanted to get out of her car seat, or do anything else. I suggested that Lila practice saying "self" to Bob when expressing her needs.

- If family therapy isn't working, consider widening the system: e.g., include grandparents, aunts and uncles, friends, minister or church members in the sessions. A widened system is more stable and can provide respite care at times of high stress, and support the family in changing violent patterns. A wider system can better "contain" the intensity of family conflict and violence, offering support as well as boundaries to the family.
- Healing rituals: Given the emotional intensity and attachment of families healing rituals around violence can be very powerful. Cloe Madanes' describes a healing ritual with a family where the older brother committed incest with

his sister.[24] The key to this ritual was that everyone in the family (beginning with the parents) gets on their knees, apologizing to the girl for not protecting her. Then her offender has to do the same. The family, especially the parents, are taking the lead in making reparations to the victim and holding the perpetrator responsible, in a non-judgmental way.

I regularly discuss making "Amends" with couples and families where someone has harmed a loved one. The four components of this are: acknowledging the truth that someone has been harmed; taking full responsibility for the abuse; demonstrating empathy by describing how their behavior has harmed the family member (with affect); and last, reparation for the harm in a way that specifically addresses how the victim has been harmed (e.g., if there has been verbal abuse in front of family members, then the abuser has to acknowledge and be respectful their spouse in front of these same family members).

- The healing power of attachment:

Clinical Example: I was working with a 15 year-old boy ("Ted") who had been placed in a therapeutic foster home. The presenting problems were violence toward an older sister, "Disorganized" attachment, and serious hearing/speech disability. He grew up in a violent family: witnessing his father's severe abuse of his mother. The foster parents were excellent and participated in all of our family sessions. Ted was making good progress: connecting with his foster parents and other kids, and getting passing grades at school. The last phase of his treatment consisted of reconciliation with his father, who had recently gotten out of prison. His father was now sober and

took responsibility for his past violence. His simple, direct statements about his past violence also reinforced the foster father's role model of controlling anger and nonviolence. His father had also grown up in a family with severe violence, and had a “Disorganized” attachment style.

Ted began visiting with his father, as they moved toward living together. During these sessions with his father and foster parents Ted became increasingly verbal; sharing with his father his experiences in his foster home and with us the visits with his father. He was planning to move out of his foster home, after graduation, and live with his father. At our last session Ted gave his father a hand-made birthday card and gift, openly expressing his love for his father.

Treating "Perpetrators" and "Victims"

The victim/perpetrator dyad is overstated. Perpetrators commit abuse for many reasons: there may be external stressors such as financial problems, unemployment, extended family pressures, community violence, and racism. Personal addictions, insecurity, fear of abandonment or jealousy. Pregnancy and the birth of a new child raises multiple issues for new couples. Or there can be escalating conflict prior to, and just after, separation. One of the primary reasons for violence is multi-generational abuse:

Clinical Example: "Dominic" was sent to me for treatment after abusing his son. He was resistant to treatment, minimizing his abuse as merely "kicking him during their horseplay." He also didn’t recognize the impact on his children of witnessing him abuse their mother. I was able to break through his denial by asking Dominic to remember this incident of “horseplay” and imagine "looking into your son's eyes." He could finally

admit seeing fear in his son's eyes. "Is this how you want your son to see you?" He could finally admit that his kicking had terrified his son. Over the following sessions we continued to break through his emotional barriers: alternating between empathy for his son, and his own traumas of combat in Vietnam and severe abuse at the hands of his mother. His developing empathy for his son also brought up the memory of an incident in which his son nearly drowned.

This man couldn't see the impact of his own behavior on his son, because his own trauma had been buried. He felt that he couldn't possibly be abusive because he loved his son, and was so much less violent than his mother had been with him.

"Victims" are not just beaten down, terrified and helpless. Many victims can become perpetrators themselves, switching back and forth in these roles: there can be mutual battering, hitting back in moments of rage and revenge, or acting out their anger on someone else (a child or pet).

"Victims" can also be resilient and have great courage. Any time I begin therapy with a "victim" of abuse I want to know how they got to where they are now. How did they survive? What kept them from going crazy, or perpetrating against others? If they also perpetrated, what kept them from being as abusive? The tragedy of the victim advocacy approach is that these strengths may be overlooked out of the desire to protect and save the victims from further abuse. But the victim's own goals are rarely considered. The abused woman or child is assumed to be unable to make good decisions for themselves. Linda Mills'[25] excellent *Insult to Injury* argues that professionals and victim's advocates who follow these conventional approaches paradoxically undercut the control

and personal power these women need to recover and protect themselves from future violence.

In short, whether working with victims or perpetrators we need to seek out the best in them. Reinforce that. That's the basis of real change

Why do people drop out of treatment? Unfortunately we tend to blame our clients for their intransigence, denial, or lack of responsibility when they don't follow our recommendations, or drop out of treatment. Many of these individuals are very difficult to treat. They can have personality disorders, addictions, and even an "addiction" to these unhealthy relationships. But the problem can also be in our therapy. Don't blame the client if therapy doesn't work. Perhaps our treatment model is flawed, or ineffective for this client. Maybe we've missed something in the assessment. Maybe we haven't engaged them, or are moving too quick toward our goals instead of their goals.

Calming our own anxiety

Working with family violence can be very difficult. As I've mentioned above we have to learn to sooth our own anxiety and anger. Our own experiences of family violence can lead to counter-transference. We have to accept the limits of what we can accomplish, and not try to rescue or fix these families. Sometimes, the best we can do is sit in the middle of the chaos of these families remaining calm and setting boundaries. We have to deal with our own gender stereotypes: so that we can help men face their own vulnerability and wounds, and women face their own dark side. We have to be willing to let go of our theories and assumptions. This kind of therapy requires that we do our own therapy and healing.

Yet work with family violence can be very powerful and healing, as we help these individuals break these cycles of violence.

Clinical Example: A nine-year old boy was referred to me for trauma treatment. He had been severely abused by his father's girlfriend over several years, and had just been returned to his mother's custody. He could have had a “Disorganized” attachment style with this severe abuse, but was amazingly resilient. The fact that the abuser wasn’t his parent reduced the damage.

At our second session he came in crying. His mother was very angry because he forgot about our session and got his good clothes dirty while playing with friends. When he began crying she hollered, "Stop crying or I'll give you something to cry about." This only made things worse for both of them. This mother was afraid that I would consider her a bad parent. She originally lost her son because of her immaturity and drug use. Her own mother considered her unfit, turning this boy over to his father. Now that she finally had her son back she was afraid of failing again. I simply commented that boys and girls were different at this age, normalizing his actions. This was a big relief for both of them: he wasn't bad, and she wasn’t a bad mother.

My treatment continued for about six months. In his individual sessions we dealt with terrifying memories of abuse by his father's girlfriend. In the family sessions, we explored the normal day-to-day connections and problems with his mother and younger sister. He took pride in being a good big brother, and got a lot of positive love and attention from his mother. Both mother and son were developing “Secure” attachments in this relationship. In our last session his mother was coaching him about his basketball play: reminding him to pass to his teammates. Therapy was finished

[1] [Karr-Morse, 1997 #347]
[2] [Miller, 1983 #200] or [Miller, 1990 #202]
[3] [DeMause, 1982 #181]
[4] From a report "Secrets That Can Kill: Child Abuse Investigations in New York State" by the Temporary Commission of Investigation of the State of New York
[5] [Kempe, 1962 #328]
[6] [Kempe, 1962 #328], cited in [Firstman, 1997 #290], pg. 413
[7] [Masson, 1984 #114]
[8] Six of Freud's eighteen cases were males, and the case examples cite sex offending by both women & men
[9] [Mitchell, ? #373]
[10] [Pizzey, 1974 #354]
[11] Straus, M. (1993b). Physical Assaults by Wives: A major social problem. Current Controversies on Family Violence. R. Gelles and D. Loseke. Newbury Park, CA, Sage Publications**:** 67-87 (Cha. 4).
[12] [Dutton, 2005 #457] and [Graham-Kevan, 2005 #445]
[13] [Dutton, 2003 #451] , [Hamel, 2005 #458] & [Potter-Efron, 2005 #459]
[14] [Madanes, 1990 #300] & [Maddock, 1995 #460]
[15] [Siegel, 1999 #462]
[16] [Slater, 2004 #465]
[17] [Potter-Efron, 2005 #459]
[18] [Straus, 1990 #279], pg. 421
[19] [Ross, 1996 #78]
[20] [Appel, 1998 #421]
[21] [McGuigan, 2001 #420]
[22] See Fiebert, M.S., 1997 http://www.csulb.edu/~mfiebert/assault.htm
[23] [Maddock, 1995 #460]
[24] [Madanes, 1990 #300]
[25] [Mills, 2003 #431]