Chapter 19

Treatment of Family Violence: A Systemic Perspective

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Why We Commit Violence Against the People We Love

Exploring family violence brings up 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.

Family violence has a profound impact on everyone in the family system, whether they are the target of this violence or a witness:

- Early childhood abuse and neglect has a measurable impact on the neurophysiology of the infant, especially the orbitofrontal 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" (Karr-Morse & Wiley, 1997, pg. 38).

- Researchers have found numerous mental health problems correlated with family violence, such as increased depression, substance abuse, personality disorders, antisocial behaviors, and increased aggression and violence.
- The family, especially the quality of attachment with our parents, is the basis for our developing sense of self, the template for our relationships with others, and our core beliefs about the kind of world we live in.
- Family violence can affect the way family members treat each other. Abused children could abuse siblings or other children. Parents who are abused by their spouse could then abuse their children or abuse both their spouse and their children. Adults who are 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 his or her 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 (DeMause, 1982; Miller, 1983).

Josh is a 15-year-old boy who was brought into a psychiatric unit by his mother, who reported serious discipline problems. She described her son as being out of control and angry, hitting her and his younger brother. The hospital staff chose to hospitalize Josh and based their decision solely on the mother's word. No one explored the family dynamics that might have precipitated this boy's anger and violence.

At the time, I had been treating the boys' father and stepmother for his sexual compulsivity (multiple affairs) and her posttraumatic stress disorder from severe physical abuse by her own stepfather. She did a good job of parenting her stepsons, 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 as though 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 discuss this with Josh's case manager and informed him about this mother's long history of verbal and emotional abuse. 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 stepmother 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 also abused as a child by her father and mother and had witnessed her mother regularly browbeat her father. Yet the

stepmother had the same problems of an unfaithful husband, parenting two teenage boys, and having previously experienced severe physical abuse at the hands of her stepfather. Both women experienced difficult relationships that 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 we 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 on the basis of limited or incomplete information. Early-stage therapy requires combining assessment and treatment if we want to be effective. Consider the difference in the previous 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 and neglect, child 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 United States after a famous court case ruled that the laws protecting animals from cruelty could also be applied to children:

> In 1873, 9-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 rawhide whip. Mary Ellen had few clothes and 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 3 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 lifelong 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."[1]

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, such as mandatory education and child labor, and our national attention to child abuse disappeared. This issue of child abuse reemerged in 1962 when Kempe and his colleagues published their famous article "Battered Child Syndrome"(Kempe, Silverman, Steele,

Droegemueller, & Silver, 1962). This is how these physicians described our professional denial of child abuse 40 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. (Kempe et al., 1962, cited in Firstman & Talan, 1997, p. 413

- Child Sexual Abuse

Our awareness of and response to child sexual abuse followed a different course. Our first modern awareness of this issue came from Sigmund Freud's seduction theory presented to the 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 (Masson, 1984). 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, functioning on an unconscious level. The culture wasn't ready to accept *both* male and female offending and the sex abuse of *both* girls and boys.[2]

The issue of child sexual abuse wasn't revived until the 1970s when the feminist rape crisis movement linked child sexual abuse (of girls) with the rape of women. This theoretical construct

reinforced gender sexual stereotypes, attributed sexual abuse of children to patriarchy, increased our denial of female sex offending, and minimized the sexual victimization of boys.

- The Domestic Violence Movement

The first domestic violence shelters were created in London by Erin Pizzey beginning in the early 1970s. She also wrote the first book on domestic violence (Pizzey, 1974). 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" [Pizzey, personal communication, 1995]).

Unfortunately, the domestic violence movement was quickly co-opted by feminists in the mid-1970s and 1980s. The focus was changed from a gender-inclusive, family treatment model to a gender-specific focus based solely on feminist theories about male violence against women. The response to this family violence also shifted to punishing and reeducating the (male) perpetrators and protecting and advocating for the (female) victim to leave the relationship.

Although researchers found clear evidence of the complexity and mutuality of domestic violence (e.g., Straus, 1993; see also chapters 1, 2, 3, and 6 in this volume), the feminist model continues to dominate our understanding of and response to domestic violence. Fortunately, this gender-exclusive focus is finally beginning to change.

A Family-Systems Approach

We will never have a chance to end the tragic cycle of family violence without reintegrating our responses to it. The child abuse movement gives us a different approach. More than 100 years ago, the child abuse and neglect field evolved from the New York Society's 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 or 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 domestic violence (Dutton & Nicholls, 2005; Graham-Kevan & Archer, 2005) and sex abuse treatment are seriously flawed and that treatment based on these models is not effective. Attachment theory is increasingly gaining influence in both domestic violence (Dutton & Sonkin, 2003; Hamel, 2005; Potter-Efron, 2005) and sex abuse (Madanes, 1990; Maddock & Larson, 1995) treatment, and there is a growing body of research on the neurobiology of attachment (Siegel, 1999). Why not, then, apply this research and clinical experience to modify our assessment of and response to family violence?

How Does Attachment Theory Help Us Treat Family Violence?

In the late 1950s and 1960s, Harry Harlow performed a number of famous experiments on attachment using rhesus monkeys. Lauren Slater (2004) described Harlow's experiments with the "iron maiden," a terry cloth–wrapped wire mannequin. Despite a cold, unemotional, and 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. (p. 142)

We can't choose whether 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." (Potter-Efron, 2005, p. 113)

For adults, attachment exists both in the past and in the present. Our childhood experience of attachment with our parent(s) can be categorized according to four "styles" (internalized models) of attachment: secure, anxious/avoidant, anxious/ambivalent, or disorganized/disoriented. The adult counterparts of these are secure, dismissive, preoccupied, and fearful. Adults with a dismissive attachment style protect themselves emotionally by avoiding relationship intimacy, largely because their caregivers were not responsive to their needs as they grew up. Preoccupied attachment has its roots in inconsistent parenting and is characterized by a tendency to cling to one's adult partner and to fear abandonment. Children who experienced trauma and abuse are likely to develop a fearful

attachment style as adults, characterized by a fear of both intimacy and abandonment. Securely attached adults neither fear emotional closeness nor have unreasonable fears of abandonment.

These attachment styles affect our sense of self and how we see the world and relate to others. They provide us with internalized models that 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 with our child. In the emotional crucible of new family relationships, we inevitably re-create our family-of-origin attachment issues. This is both a danger and an opportunity.

We consciously and unconsciously choose and relate to a spouse on the basis of 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 ongoing. Even though the fundamentals of attachment are laid down by age 2, this experience is constantly being modified or reinforced as children face the experience of growing up (see chapter 9 in this volume). Any intervention in family violence has the potential to modify these trauma bonds. And prevention or early intervention within the family unit is far more influential than years of individual therapy later in life.

A 9-year-old boy, Jesse, was referred to me for trauma treatment. Over a period of several years, he had watched his father and girlfriend scream at each other and had been subjected to emotional and physical abuse by the girlfriend, who routinely called him “stupid,” slapped him across the face, and once punched him hard enough to break his nose. Jesse had just been returned to his mother’s custody. He could certainly have evidenced a disorganized attachment style because

of this severe abuse, but he was amazingly resilient. The fact that the abuser wasn't his parent reduced the damage.

Our second session started 10 minutes late. Jesse came in crying. His mother was very angry because he had forgotten 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 and had turned Jesse 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 a bad boy, and she wasn't a bad mother.

My treatment continued for about 6 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, who often pestered him. His mother encouraged him to be kind to his sister. Despite his frustrations, Jesse was able to do this and to take pride in being a good big brother. His mother lavished him with praise for his positive efforts, and mother and son developed a loving and secure attachment. In our last session, mother was coaching Jesse about his basketball play, reminding him to pass to his teammates. Therapy was finished.

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 or undo the abuse, and many times we couldn't significantly change their families. Allen would remind us, "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 domestic violence movement is the assumption that "domestic" violence and child abuse are somehow separate phenomena. The reality is quite different. Child abuse and domestic violence are directly correlated. According to Straus and Smith (1990), the more violent either partner is to the other spouse, the more violent they are toward the children. Their research showed that the highest rates of child abuse were correlated with the most severe domestic violence, and that even "minor" domestic violence (i.e., pushing and shoving or slaps) resulted in twice the frequency of severe assaults on a child by the parent *being abused* (Straus & Smith, 1990, table 14.2, p. 253). Echoing these findings, another researcher wrote 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" (Ross, 1996, p. 589.

Appel and Holden (1998) found a 40% co-occurrence rate between domestic violence and child abuse. A longitudinal study of 2,544 "at-risk" new mothers (McGuigan & Pratt, 2001) found that domestic violence 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.

This research has forced domestic violence advocates to acknowledge child abuse but only in terms of children *witnessing* the domestic violence between their parents. While witnessing violence can certainly be traumatic, this maintains the false distinction that adult, heterosexual domestic violence, typically defined as the man battering the woman, must remain our primary concern. There are two problems with this position. First, it is contradicted by more than 130 studies of domestic violence that show that women perpetrate as much violence as men (Fiebert, 1997).Wouldn't these children also be traumatized witnessing their mother's violence against their father? Second, domestic violence is directly correlated with child physical abuse. These children are far more likely to be directly 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 to marry an abuser. This is the *context* of violence that we must address.

For these reasons I would argue that any reports of domestic violence 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 couples therapy is that we are putting the victims at risk of further abuse by either allowing the perpetrator to rationalize his or her violence or further escalating the violence after the session is over. If there is ongoing serious violence, the first priority is always to set up safeguards to create an environment of safety (Potter-Efron, 2005). But

partner blaming and increased conflict are risks in all couples and family therapy. Any competent therapist has to learn to deal with this.

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 ongoing and the perpetrator won't stop, we still carry the wounds of this abuse to our graves even if we find the courage to 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 else take the longer road of healing the damage on our own.

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 midlevel 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, was emotionally withholding and uncomfortable with relationship intimacy, but was dutifully obliged to take care of his wife through her depression and suicide attempts. He was a workaholic, ignoring his own distress and needs while isolating himself from friends. Lynn had a preoccupied attachment style, focusing on raising her sons and trying to get her husband to pay attention to her. These conflicting attachment styles, combined with very high levels of external stress, led to chronic marital problems. They finally had an argument that escalated to mutual violence after Lynn screamed at him that she felt ignored. Both of them had been drinking. She punched 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.

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 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 9 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 when I was contacted by a mother to treat her 10-year-old son, Jack, for anger and acting out at home and school. In the first session, I met with Jack, his mother, her lesbian partner, and his father (his parents were divorced). His mother had a fearful attachment style. Having grown up in a chaotic family with an angry, alcoholic mother and a schizophrenic father who shot himself when she was 6, she had difficulty maintaining healthy relationships as an adult and was almost totally dissociated from her son other than occasionally scream at him. Jack's father loved Jack but was passive-avoidant with a dismissing attachment style. Neither parent engaged sufficiently with their son either to set limits or to provide love. The only adult in Jack's life who seemed concerned was his mother's partner. In

this first session, as she related an incident in which Jack threw a bowl of cereal at her, she described him 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 presentation, the clinical director, Dr. Verhulst, asked me the key question: “Why did I have Jack leave the room?” He pointed out that Jack lived with this abuse every day and that he would need 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 matched with the particular type of domestic violence: the classic man battering his wife, the wife battering her husband, mutual severe battering, or what has been termed “common couple’s violence” (Johnson & Leone, 2005). Within each of these subcategories, treatment will vary, depending on each case. Some cases of common couples 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 domestic violence, a child can be battered/abused by one or both parents, and there can be mutual abuse between an adolescent and a parent 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, and 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 won'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 Therapist's Stance

Family therapy is not simply a matter of technique; it's also largely a function of the therapist's stance. This is based on our sense of ourselves as therapists and the attitude we have toward the people we work with. Noel Larson (1999) describes treatment with perpetrators and victims as counterintuitive. 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). This work sometimes requires that clients reframe the way they describe their experiences:

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 teenage children from her first marriage. She complained of several years of increasingly angry interactions with her husband, who yelled and often spoke harshly to her. 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 harm 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 caseworker 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 than to 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.

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 intensely oppositional with his parents and other authority figures. He had trashed his rooms many times, hurled lamps and other objects around the house, and once shoved a big-screen television to the floor. Prior therapy had not been effective. By the time he came to see me, Steve recognized that, despite his young age, he was already an 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. In his early childhood, he witnessed his mother hitting his father as well as his father's binge drinking, and he had developed an ambivalent attachment to his parents. Hypersensitive to criticism and shame, he responded with violence or alcohol when hurt.

My treatment began with individual and family sessions, at first with his mother and then with his father. His father is also a recovered alcoholic, but he never had problems with anger and had grown enormously as a result of his involvement in 12-step programs. Increasing the connection with his father gave 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, confronting a boy who had made fun of another kid. The school suspended him and transferred him to an alternative program where kids could be protected from other kids and themselves. Given his initial progress, both parents were hurt and disappointed. I encouraged them to express these feelings and to praise Steve for the positive intention behind his actions—his concern for an underdog. I also helped his parents set firm but fair limits on his behavior with reasonable expectations. Their patience paid off because 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 parents and himself, as he unwittingly pushed away the people whose love he valued the most. In therapy, the parents had in effect succeeded in reestablishing secure attachment bonds with their son, and he was able to acquire the emotional stability to overcome his problems.

- All of us need hope. Take a stance of "respectful inquiry" to understand why and how clients behave in violent patterns. This also helps them 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 the seeking of alternatives.
- 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 also worry so much about future abuse or being sued that they take the simplistic, traditional course of treating the perpetrators and victims separately without ever addressing family issues directly. And if we get hung up in our anger at the perpetrator for their violence or even at the victim for not leaving, we miss the underlying complexity of family systems. We have to begin by soothing ourselves so that we meet the family on their field of battle. From that position, we can make real change, even while individual family members do their own therapy.

Family therapy provides for the possibility of corrective emotional experiences:

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. This escalated the family triangulation, with his family blaming the argument on Lila. She 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 2-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 (and his own) anger while experiencing that she would still love him. And I suggested that Lila learn from her daughter that it's okay to state your needs, even if others might get angry at you. Her 2-year-old daughter would regularly say "Self" whenever she wanted to do something herself or do it her way. I jokingly suggested that Lila practice saying "Self" to Bob whenever she needed to stand up for herself.

- If family therapy isn't working, consider widening the system. For example, include grandparents, aunts and uncles, friends, a 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 (1990) describes a healing ritual with a family where the older brother committed incest with his sister. The key to this ritual was that everyone in the family (beginning with the parents) gets on their knees and apologizes to the sister for not protecting her. Then her offender has to do the same. With the parents taking the lead, the family makes reparations to the victim and holding the perpetrator responsible in a nonjudgmental 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 *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 of their spouse in front of these same family members).

Attachment bonds are strong and lasting. The next example illustrates the healing that can occur when once-abusive parents take responsibility for their behavior:

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 a serious hearing/speech disability. He grew up in a violent family, witnessing his father's severe physical and emotional abuse of his mother. The foster parents were excellent and participated in all 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, Carl, who had recently gotten out of prison. Carl was now sober and took responsibility for his past violence. His simple, direct statements about his previous behavior reinforced the foster father's efforts to model positive ways of controlling anger and nonviolence. Carl had also grown up in a family with severe violence. As an adult, he had developed a fearful attachment style, tending to become rageful both when feeling emotionally suffocated and when his wife showed any signs of anger, which he perceived as abandonment.

Ted began visiting with his father. During the 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 Carl. At our last session, Ted gave his father a handmade birthday card and gift, openly expressing his love for him.

Treating “Perpetrators” and “Victims”

The victim–perpetrator dyad is overstated. Perpetrators commit abuse for many reasons, including external stressors such as financial problems, unemployment, extended family pressures, community violence, 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 multigenerational abuse:

Dominic was sent to me for treatment after abusing his son, Jacob. 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, such as the time he grabbed her by the neck and shoved her up against the wall. I was able to break through his denial by asking Dominic to remember this incident of “horseplay” and to imagine “looking into your son’s eyes.” He could finally admit seeing fear in his those eyes. “Is this how you want Jacob to see you?” I asked him. 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 building empathy for Jacob (the breakthrough occurred while discussing an incident in which his son nearly drowned) and working through his own traumas resulting from combat in Vietnam and severe abuse at the hands of his mother.

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 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).

In addition, victims can be resilient and have great courage. Any time I begin therapy with someone who has suffered 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 did perpetrate, what kept them from being as abusive as their abuser? 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 their own goals are rarely considered. The abused woman or child is assumed to be unable to make good decisions for him- or herself. Linda Mills's excellent *Insult to Injury* (2003) 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 be ours. 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 our assessment. Perhaps we haven't engaged them or are moving too quickly toward our goals instead of their goals.

I heard a fascinating research paper (Carney, Buttell, & Muldoon, in unpublished presented at a national conference. The authors were trying to determine why so many men dropped out of batterer's treatment. They cited intake testing from a South Carolina program and did a complicated multivariate analysis comparing the men who dropped out of treatment to the men who stayed in treatment. The most interesting piece of data was what the researchers and the batterer's program ignored. Part of their testing involved administering the revised Conflict Tactics Scales (CTS2). This testing showed a great deal more physical, sexual, and psychological abuse by these men's wives and girlfriends. The one difference I could see was that the men who completed treatment were more likely to cause injury with their abuse, while the men who dropped out were more likely to have been injured. Yet this key piece of data was ignored by the researchers in their analysis and by the program in their treatment.

A young man came to see me after charges of having abused his wife. He had torn her blouse during a fight. I asked him to describe what happened. During a dispute over money, she kicked and punched him, and he was attempting to push her away. During another recent fight, she began attacking him with a knife. He stopped this attack by holding up a chair to keep her from cutting him. Both her father and her uncle had been killed with knives. I worked with him on deescalating the violence and trying to leave if their conflicts escalated. Soon after our treatment, he moved with her to another state. There she reported him for domestic violence after another fight. He was sent to batterer's treatment, and she was sent to a shelter for "victim" treatment.

Calming Our Own Anxiety

Working with family violence can be very difficult. We have to learn to soothe our own anxiety and anger. Our own experiences of family violence can lead to countertransference. 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 and maintain our calm and our 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 individuals break these cycles of violence.

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