

The Role of Couples and Family Counseling in Batterer Intervention

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Final Draft, January 6, 2009

Introduction

Despite a vigorous collective effort on the part of victim advocates, mental health professionals, policy makers and others, domestic violence, also known as *intimate partner violence* (IPV), in acknowledgement of physical abuse by dating, cohabitating and same-sex partners, continues to be a major social problem, with a widespread and significant impact on victims and families, both physically and emotionally. A 2003 report by the Center For Disease Control estimated that the direct annual health care costs associated with domestic violence to exceeded \$4.1 billion (Center for Disease Control, 2003). According to at least one nationwide source of domestic violence statistics, the National Crime Surveys by the Department of Justice, rates of domestic violence dropped from 5.8 incidents per thousand in 1993 to 3.0 per thousand in 2001; however, the fact that this decline in domestic violence assaults has been comparable to a general decline in violent crimes across the country calls into question the extent to which policy efforts aimed at reducing domestic violence per se are solely responsible.

Estimated prevalence rates vary depending on survey methodology, with crime surveys yielding the lowest rates and so-called “conflict studies” yielding the highest. The National Crime Victimization Survey (NCVS) reports that less than 1% of males and about 5% of females are physically assaulted or raped by an intimate partner each year in the United States (Rennison, 2003). However, the vast majority of IPV surveys, which frame IPV in terms of interpersonal conflict, have found much higher prevalence rates, and no significant gender differences. For instance, based on information provided by nearly 3,000 women from the 1985 National Family Violence Survey, Straus (1993) found annual perpetration rates of 12.4 per 100 couples by women and 12.2 per hundred couples by men. The comprehensive meta-analytic review by Archer (2000), which examined 82 studies (including the National Violence Against Women Survey) with a combined data sample of 64,487 respondents, also found comparable perpetration rates across gender.

While prevalence rates of domestic violence may be comparable in the general population, greater numbers of male perpetrators come to the attention of law enforcement. This is due partly to the higher rates of injuries suffered by female victims, but also reflects a disinclination among male victims to contact the police. According to the National Family Violence Surveys, the most empirically sound general population surveys of domestic violence conducted in the United States, female victims call the police approximately 10 times more often than male victims (Stets & Straus, 1992). Not surprisingly, the great majority of individuals arrested for a domestic violence offense in California are men, representing about 81% of the 50,479 perpetrators arrested in 2002 on a PC273.5 charge of spousal abuse (Criminal Justice Statistics Center), and men account for fully 90% of individuals mandated to a batterer intervention program nationwide (Price & Rosenbaum, 2007).

California currently is among 29 states to have adopted preferred arrest or mandatory

arrest policies as part of its law enforcement response to domestic violence (Hirschel, Buzawa, Pattavina, Faggiani & Reuland, 2007). In California, PC 13701(b) encourages “the arrest of domestic violence offenders if there is probable cause that an offense has been committed.” After being charged, offenders who are found guilty or (more likely) plea bargain their case are directed to enter a batterer treatment program (BIP), consisting of a minimum of 52 weekly group sessions, in lieu of, or in addition to, a jail sentence. Except for some limited exceptions, this is currently the only legally sanctioned treatment option in California, per PC 1203.097, for individuals convicted of PC243(e) and PC273.5 (partner assault), and of PC 273.6 (violation of a protective order.) The same program is mandatory for all offenders, regardless of whether they had been convicted of a misdemeanor or felony; and although individual counseling is allowed in some cases, couples and family counseling is expressly prohibited, regardless of any mediating variables, such as severity of the behavior, level of pathology, motivation, the extent to which the violence was mutual, or the willingness of the partner to participate.

Unfortunately, same-sex groups have been found to be not much more effective in reducing violence than arrest and supervised monitoring by the courts, probation or parole (Saunders & Hamill, 2003; Babcock, Canady, Graham & Schart, 2007). In California, only half of offenders legally mandated into a BIP complete the program as indicated by law (California State Auditor, 2006). This report offers suggestions for lawmakers on ways to improve California’s response to domestic violence.

One Size Does Not Fit All

There is evidence that BIP’s are more effective when they are tailored to the needs of the client population (Babcock, Canada, Graham & Schart, 2007). Most acts of domestic violence involve pushing, grabbing, slapping and other types of less severe assaults leading to no or negligible physical injury to the victim. Even among cases that have come to the attention of law enforcement there is a wide variety of offender types, who defy easy categorization (Maiuro et al., 2001). A comprehensive review of the literature on batterer treatment (Holtzworth-Munroe and Stuart, 1994) found that the majority of male batterers do not fit the stereotypical profile of a dangerous batterer, or “intimate terrorist” (see table 1). At least half of offenders fall into the “family-only” category, and the rest are equally divided between “dysphoric/borderline” and “generally violent/antisocial.” The primary distinction between the family-only types and the others is that offenders in the first group are less physically and emotionally abusive, and act out generally within the context of an argument rather than exclusively to control and dominate and/or due to serious psychopathology. Additional research finds that female perpetrators can be similarly categorized (Babcock, Miller & Siard, 2003). It should be pointed out that these categories do overlap. Some “family only” offenders, for instance, *are* hostile to women; and some borderline or antisocial types may maintain control over their partners strictly with emotionally abusive and non-physically controlling behaviors once they have established domination with severe violence early in the relationship. As a rule, however, family-only types are the best candidates for couples counseling, although dysphoric/ borderline individuals may also benefit once they have first gained sufficient control over their violent impulses through group (and perhaps individual) treatment, and if the victim’s safety can be assured.

Table 1. Holtzworth-Munroe Typology
Descriptive Dimensions and Variables According to Subtype:

<u>Dimension</u>	Family-only	Dysphoric/ Borderline	Generally vio- lent/Antisocial
Severity of marital violence	low	moderate-high	moderate-high
Psychological/sexual abuse	low	moderate-high	moderate-high
Extrafamilial violence	low	low-moderate	high
Criminal behavior	low	low-moderate	high
Personality disorder	none or passive-dependent	borderline or schizoid	antisocial/ psychopath
Alcohol/drug abuse	low-moderate	moderate	high
Depression	low-moderate	high	low
Anger	moderate	high	moderate
<u>Variable</u>			
Genetic influences	low	moderate	high
Parental violence as a child	low-moderate	moderate	moderate-high
Child abuse/rejection	low-moderate	moderate-high	high
Deviant peer group	low	low-moderate	high
Attachment	secure/ preoccupied	preoccupied**	dismissing
Dependency	moderate	high	low
Empathy	moderate	low-moderate	low
Impulsivity	low-moderate	moderate	high
Marital social skills	low-moderate	low	low
Nonmarital social skills	moderate-high	moderate	low
Hostile attitudes toward women	low	moderate-high	high
Attitudes supporting violence	low	moderate	high

In addition to the different types of offenders, there are also differing types of victims and, indeed, varying types of domestic violence relationships. Female victims often do not fit the profile of a classic “battered woman” - and not just in the general population but also among samples of women in shelters and partners of men court mandated to batterer intervention. Erin Pizzey, the founder of the first battered women’s shelter in the Western world, estimated that of the women she provided refuge to, half had a history of violence, either towards their children, their partner, or both (Pizzey, 1982); and a recent survey of women in shelters found that nearly three quarters had perpetrated serious physical assaults against their male partners (McDonald, Jouriles, Tart & Minze, in press). Although this latter did not determine the context of the women’s violence, other surveys of battered women have found that while their use of violence is often in self-defense, most of the time it is not (e.g., Saunders, 1984). In a major survey conducted near Boston, Massachusetts, half of the women who had their male partners arrested indicated that they were not afraid or minimally afraid of their partner, and half were certain or fairly certain that the abuse would not be repeated (Apsler, Cummins & Carl, 2002). In fact, domestic violence does not always increase over time, but often desists (Morse, 1995; O’Leary et al., 1989). The classic, 3-phase battering dynamic as described by Lenore Walker (1983) actually describes a specific and limited type of domestic violence, that of a dominant male with dysphoric/borderline personality and a passive female victim. Far more common is the mutually-escalating, conflict-based abuse found in laboratory observations (for a review, see Dutton, 2006).

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Couples and Family Counseling

Research

Over 50% of domestic violence is mutual, involving mutual combat between the parties involved. Women initiate physical aggression as often, or more often than men, rarely in self-defense, and motivated for similar reasons as men - typically for the purposes of expressing frustration, to communicate or to control, or out of a desire to retaliate (for a review, see Hamel, 2007a). Research also makes it very clear that female victims, due to their smaller size, are more often physically injured, and there is evidence that the impact of IPV is also greater on women's emotional health and causes greater fear (Anderson, 2002; Mirrlees Black, 1999; Straus & Gelles, 1990; Williams & Frieze, 2005). However, men suffer a substantial minority of physical injuries, between 25% - 43% (Archer, 2000; Laroche, in preparation; Mirrlees Black, 1999; Straus, 2004; Tjaden & Thoennes, 2000) and are just as impacted as women by psychological abuse and controlling behaviors (Pimlott Kubiak & Cortina, 2003; Vivian & Langhinrichsen-Rohling, 1995).

Therefore, labeling individuals involved in domestic violence rigidly as either "victims" or "perpetrators" may make legal sense, but does not always make sense in terms of increasing the success of interventions and ultimately reducing domestic violence in our communities. Among offenders mandated to BIP's, levels of physical and emotional abuse by the partner are often significant, and this is the case both with female offenders (Swann & Snow, 2002) and male offenders (Gondolf, 1996; Stacey, Hazlewood & Shupe, 1994). In a large survey of law enforcement in Arizona, a majority of officers who had responded to domestic violence calls indicated that "too many DV calls are for only verbal family arguments," and more officers agreed than disagreed with the statement, "DV victims are often as responsible for the incident as the person arrested" (Toon & Hart, 2005). When a man is arrested, he may be the primary aggressor in that particular incident, but his female partner is often the more abusive partner, both physically and emotionally, in the relationship as a whole (Capaldi, Shortt, Kim, Wilson, Crosby & Tucci, in press).

When the violence is mutual, the legal victim is not held legally responsible for his/her actions. It is not uncommon for probationers in batterer treatment to complain of a partner who continues to abuse them, thereby increasing the possibility of recidivism. Probationers will sometimes stand in front of the front door, refusing to let the client take a time out, and may threaten to have them arrested. Even when the partners do not engage in such overtly sabotaging behaviors, treatment success is compromised when only one person is being helped.

Conjoint counseling with violent couples has been shown to be as effective and safe as group interventions, and sometimes more so (Greene & Bongo, 2002), according to a number of well-designed studies, using experimental designs that included random assignment to treatment

condition. Couples counseling of using a multi-family format has been shown to be effective among voluntary civilian couples (O’Leary, Heyman & Neidig, 1999), military couples (Dunford, 2000), couples in which the perpetrator also was treated for chemical dependency (Fals-Stewart, Kashdan, O’Farrell & Birchler, 2002), and among couples who have been court-referred (Brannen & Rubin, 1996; Stith, Rosen, McCollum & Thomsen, 2004)). The multi-family couples group has been found to be effective for a variety of ethnic groups, including African-Americans (Stith, Rosen & McCollum, 2004) and Latinos (Brannen & Rubin, 1996) (see table 2, next page). An important consideration is that these studies all focused on cases that were carefully screened for less severe and chronic abuse.

Couples counseling programs for domestic violence have arisen out of practical necessity. At one pioneering organization, for instance, conjoint sessions were instituted after it became evident to the staff that many of the women refused to leave their partners and instead sought assistance in working on their relationship (Geffner, Mantooth, Franks & Rao, 1989). The facilitators who ran the men’s treatment groups reported frustration in working only with perpetrators, who routinely reported ongoing conflicts at home despite their best efforts to change. The female partners did not always do their part to reduce the cycle of violence and abuse. Time outs, for example, were often misinterpreted as acts of abandonment and sometimes resulted in an escalation of conflict with serious consequences. Such problems can be more readily overcome when couples are introduced to the same educational materials. Learning and working together throughout the course of treatment reduces much of the mistrust present when individuals go to separate counseling. Furthermore, there is evidence that the couples format is more palatable for the average couple, who have a greater concern with their overall relationship rather than the violence itself (Heyman and Schlee, 2003).

Additionally, the conjoint format provides a real-life forum in which grievances can be discussed and negotiated, and is the most direct approach in teaching the necessary pro-social relationship skills with which to reduce conflict and eliminate violence. Before such skills can be taught, the clinician must attend to the dysfunctional dynamics inherent in the relationship. Even in those relationships dominated by a male primary aggressor, violent relationships are typically characterized by reciprocal negative interactions. In the couples format, these interactions can be directly observed, and the immediacy of the experience allows learned skills to be more readily incorporated into each partner’s behavioral repertoire and enhances the possibility that psychological defenses such as projection, displacement and denial, can be successfully overcome. Role-play, useful in same-sex groups, may be more effective in couples work as a means to practice new behavior and develop empathy for one’s partner. In sum, couples therapy helps an individual in a way that no other format can to understand the consequences of their behavior on the cycle of violence in the relationship.

Sessions involving the children have additional advantages over individual or group sessions. Research indicates that there is a high rate of co-occurrence between intimate partner abuse and child abuse (Slep & O’Leary, 2005); and that much of the violence among family members is reciprocal (Davies & Sturge-Apple, 2007). Seeing multiple family members increases the odds that abuse by *either* parent, or other family members, will be discovered. Children, particularly teens, are less concerned about making a good impression and may be more honest. Ideally, the clinician should therefore interview and work with as many family members, and in whatever combination, that will yield the maximum information about the family system without compromising anyone’s safety or unnecessarily alienating key family members.

Table 2. Psychoeducational Multi-Family Couples Counseling vs. Batterer Intervention Groups

Several studies have demonstrated the effectiveness of couples groups in reducing physical spouse abuse. The following are the only 3 known studies using random assignment to treatment conditions to have compared this type of intervention with same-sex batterer intervention groups. Drawing from a variety of populations, each of the studies outlined below involved male perpetrators and their female partners. Outcome results refer to perpetrator behaviors only. (“BG” = batterer group; “CG” = couples group).

Study Authors	Location	Sample characteristics, no. couples and length of treatment	Intervention Outcomes
Brannen & Rubin (1996)	San Antonio, TX	- 42 court-referred, primarily Latino - 12 sessions, 1 ½ hours each	- Absence of substance abuse problem: No significant difference between groups on measures of physical abuse or marital satisfaction. - When perpetrator was also treated for substance abuse: Significantly greater effectiveness of CG. - 6-mo. follow-up, 92% of CG and 93% of BG men violence-free - 4 BG and 2 CG women reported assault by partner during course of treatment
O’Leary, et al. (1999)	Long Island, NY	- 75 voluntary clients, primarily Caucasian - 14 sessions, 2 hours each	- No significant differences between groups in reducing physical or emotional abuse. - 1-year follow-up: 66% had no engaged in severe violence - Men in CG reported greater marital satisfaction.
Dunford (2000)	San Diego, CA	- 861 enlisted men on navy base, ordered to treatment. Mixed ethnic sample. - 26 weekly + 6 monthly sessions	No difference between groups: 83% of the men had not re-assaulted at 1-year follow-up.

The goal of family interventions is to change the entire family unit, so that further abuse and violence will not continue, and children will not transfer dysfunction from their family into their adult relationships. Change requires families to overcome denial and acknowledge the full extent of the abuse, learn alternative communication and conflict-resolution skills, and to restructure and maintain healthy boundaries. Family therapy that includes the entire unit can effectively expose and break up/eliminate: 1) unhealthy alliances/coalitions; 2) secret keeping; 3) denial; 4) minimization, as well as, provide accurate status reports, provide added safety by opening the family system to added scrutiny, and strengthen and support a healthy hierarchy.

A more practical alternative is to have the various family members seen separately, or in various combinations. Family therapy is a viable, safe and effective modality of treatment for domestic violence (Hamel, 2008; Hamel & Nicholls, 2007; Potter-Efron, 2005).

Couples and family counseling are permitted in several states. Table 3 provides a summary of information from a recent internet search of batterer intervention standards nationwide, with a sample of 41 states, regarding minimum length of participation in a batterer intervention group, whether couples counseling is permitted and if so under what conditions. Findings include:

- Couples counseling is allowed as part of a comprehensive court-mandated batterer intervention program in 15 states (36.6%).
- Couples counseling is allowed as an adjunct, or implied as adjunct, to BIP in 11 states (26.8%).
- Couples counseling is allowed only after completion of group session in 15 states (36.6%)
- The average minimum number of group sessions mandated is 28.1 weeks.
- Only 3 states, in addition to California, require 48 weeks or more of BIP group prior to commencement of couples treatment.
- Very few states require a full 52 week program and specifically prohibit couples counseling during that time.

Table 3. Information on Batterer Intervention Standards in U.S.
Obtained July, 2007, from www.biscmi.org/other_resources/state_standards.html

State	Group Min. Wks	Couples Tx during group?	Notes
Alabama	16	No	No referrals allowed to couples tx during 16 BIP weeks
Alaska			(no information available)
Arizona			(no information available)
Arkansas		(Yes)	(no standards)
California	52	Yes/No	Cannot substitute for group or force victim participation
Colorado	24	Yes	Not as initial or primary mode of tx. and only if indicated
Connecticut		(Yes)	(no standards)
Delaware	15	Yes	Not as initial or primary mode of tx., and only if indicated
Florida	24	No	OK after 24-week group
Georgia	26	Yes	Only if indicated
Hawaii		(Yes)	(no standards)
Idaho	52	No	OK after 52-week group, and only if indicated
Illinois	24	No	OK after 24-week group, and only if indicated
Indiana	26	No	OK after 26-week group
Iowa			(no information available)
Kansas	20	Yes	Only as an adjunct to group, and only if indicated
Kentucky	20	Yes	Couples tx not mentioned; implied as adjunct
Louisiana			(no information available)
Maine	48	Yes	Cannot substitute for group
Maryland		Yes	Modality and length of treatment not specified
Massachusetts	40	Yes	Only as adjunct to group, after abuse has ceased 9 mos.
Michigan	26	Yes/No	Not as means of addressing battering behavior
Minnesota	24	No	OK after 24-week group
Mississippi		(Yes)	(no standards)

Missouri	26	No	OK after 26-week group
Montana			(no information available)
Nebraska	24	Yes/No	Cannot be part of BIP or force victim participation
Nevada	26	No	OK after 26-week group and if indicated
New Hampshire	36	Yes/No	Couples tx not mentioned; implied as adjunct
New Jersey		(Yes)	(no standards)
New Mexico	52	No	OK after 52-week group
New York		(Yes)	(no standards)
North Carolina			(no information available)
North Dakota	(no min.)	No	OK after completing group
Ohio	15	Yes	Not as component of BIP or provided by BIP agency
Oklahoma			(no information available)
Oregon	48	No	No referrals allowed to couples tx during 48 BIP weeks
Pennsylvania			(no information available)
Rhode Island	20	Yes/No	Perpetrator and Victim can't be seen together by BIP
South Carolina	26	No	OK after completing group
South Dakota			(no standards)
Tennessee	24	Yes/No	Not as component of BIP
Texas	18	Yes	Cannot be part of BIP or force victim participation
Utah	12	Yes	Only if indicated
Vermont	26	No	OK after 9 mos. Following completion of 26-week group
Virginia			(no information available)
Washington	26	No	OK after 26-week group
Washington, DC			(no information available)
Wisconsin	No min.	No	OK after completing group
West Virginia	No. min.	Yes	Not as initial or primary mode of tx. and only if indicated
Wyoming			(no standards)

The Role of Couples Counseling in an Overall Treatment Strategy

Safety, as Virginia Goldner (1998) points out, is not necessarily enhanced by remanding perpetrators to same-sex group:

Since many couples do not physically separate even though that may be the safest choice to make, it strains common sense to argue that separating them in treatment necessarily promotes safety. After their respective sessions, the two end up at home together anyway, often not any more enlightened about the specifics of their escalating process, and its dangerous moments...*It is one thing, for example, to tell a violent man that he must leave the situation before he "gets too angry." It's another to be in the room with the couple and ask the man whether he is aware that he has begun to interrupt his partner. Once his attention has been captured, his wife can then be asked whether she is beginning to feel the first signs of tension and fear. Having seized the moment, it now becomes possible to say to the man, "This is the moment you should say to yourself, 'It's time to go (p. 266).*

To ensure victim safety, couples and family counseling should proceed according to certain minimum guidelines, as formulated by Rosenbaum and O'Leary (1986). Although focused on interventions in cases involving male offenders, the following guidelines would be equally applicable with female batterers.

1. The wife is aware of resources and shelter services if needed in the future.
2. The couple wishes to remain together.
3. Both spouses are willing to participate.
4. Remediation is reasonable.
5. The violence can be controlled.

Treatment involving multiple family members should only take place when the following conditions exist (Geffner, Barrett & Rossman, 1995):

- Victim and perpetrator want this type of treatment
- The victims are aware of potential dangers and have safety plan
- An adult must accept responsibility in cases of child abuse
- There are no outstanding custody issues
- Danger assessment reveals low probability of danger
- Perpetrators have no obsessional thoughts about victims
- Therapists trained in both IPV and family therapy
- None of the clients abusing alcohol or drugs and treatment mandated in cases of substance abuse
- Neither of the partners exhibit psychotic behavior

Precedent for allowing couples and family counseling comes not only from other states with respect to batterer intervention, but additionally in California with respect to treatment of child abusers. Currently, California law mandates under PC 273.1 that anyone convicted of child abuse complete a 52 week treatment program. According to PC 273.1, only licensed mental health professionals or other counselors directly supervised by a licensed mental health professional can provide this service, and must also demonstrate “substantial expertise in the treatment of victims of child abuse...” The law also states that “the program may include, on the recommendation of the treatment counselor, family counseling. However, no child victim shall be compelled or required to participate in the program, including family counseling, and no program may condition a defendant’s enrollment on participation by the child victim.” Given that children are at an obvious power disadvantage compared to their parents, the safeguards built into PC 273.1 regarding therapist competence and victim choice are clearly warranted. The appropriateness of couples counseling in cases of adult partner violence should therefore not be open to question if similar safeguards are instituted in PC 1203.097 and PC 1203.098, especially considering the lesser power discrepancy between adults in comparison to parent and child.

Safety can be more carefully monitored in programs that are limited to couples and families who have experienced relatively minor incidents of violence, leading to minimal injuries. One New York study (O’Leary, et al., 1999) reported that “wives in the conjoint treatment were not fearful of participating with their husbands; were not fearful during the sessions; did not blame themselves for the violence; and were not put at an increased risk for violence during the program” (p. 498.) At the Family Preservation Project in East Texas (Geffner et al., 1999), there were not reported incidents of battering as a result of treatment, over the seven years prior to the publication of their outcome studies, and in none of the programs cited in table 2 was victim safety compromised as a result of treatment.

The following tables, from Hamel (2005), presents the criteria and guidelines for choosing

an appropriate treatment modality that takes into account victim safety, as well as a suggested three-phase approach intended to enhance treatment outcome.

Table 4: Treatment options according to type of violence

Perpetrator Characteristics and Nature of Violence	Recommended Modalities
<p style="text-align: center;"><u>Quadrant 1: Unilateral Severe Battering</u></p> <p>Serious and very serious violence with extreme use of control. Highly asymmetrical power structure. Severe, multiple injuries. Perpetrator often a criminal. Little or no remorse. High level of psychopathology.</p>	<p>Mandatory same-sex batterer group for perpetrator. Also, intensive individual psychotherapy with a clinician specializing in both domestic violence and in treating personality disorders.</p> <p>Supportive counseling for victim. Priority on helping him/her leave. Conjoint therapy contraindicated.</p>
<p style="text-align: center;"><u>Quadrant 2: Mutual Severe Battering</u></p> <p>Characteristics are as above, except that violence is mutual and power structure more symmetrical.</p>	<p>Separate same-sex batterer groups for each partner.</p> <p>Intensive individual psychotherapy.</p> <p>Couples counseling after each party has acquired anger management/ conflict resolution skills.</p>
<p style="text-align: center;"><u>Quadrant 3: Unilateral Common Battering/ High Conflict</u></p> <p>Range of violence, from minor to severe. Mild to moderate injuries. Low to moderate use of control. Moderate to high asymmetry in power structure. Remorse. Less severe psychopathology.</p>	<p>Batterer <i>or</i> anger management group for perpetrator, depending on severity of violence, extent of power/control.</p> <p>Supportive therapy for victim.</p> <p>Structured couples program, or traditional couples counseling <i>after</i> cessation of violence and perpetrator shows sufficient treatment progress.</p>
<p style="text-align: center;"><u>Quadrant 4: Mutual Common Battering/High Conflict</u></p> <p>Characteristics are as above, except for greater symmetry in power structure.</p>	<p>More severe cases: Separate same-sex batterer groups, or structured, multi-family couples group</p> <p>Less severe cases: Separate anger management groups, or traditional couples work w/clinician experienced in partner violence dynamics.</p>

Table 5: A three-phase approach to treatment

I	II	III
<p><u>Overall approach</u> Psycho-educational</p> <p><u>Goals</u> Eliminate physical aggression. Avoid secondary problems. Minimum ventilation of affect. Built confidence and trust. Focus on content. Learn how anger works, conflict escalation dynamics, role of stress, impact of control and “dirty fighting” tactics, and equalitarian decision-making. Acquire basic anger management, communication and conflict containment skills.</p> <p><u>Type of change sought</u> First-order, behavioral, immediate</p>	<p><u>Overall approach</u> Psycho-educational/cognitive</p> <p><u>Goals</u> Begin to reduce verbal/psychological aggression. Continue avoiding secondary problems, but begin addressing lesser primary problems. More ventilation of affect. Continue trust and confidence building. Continued focus on content; limited discussion of process. Identify and challenge “self-talk.” Expand communication skills and learn conflict resolution and problem solving techniques. Assertiveness training.</p> <p><u>Type of change sought</u> First-order, behavioral, some internal</p>	<p><u>Overall approach</u> Cognitive/insight-oriented</p> <p><u>Goals</u> Eliminate verbal/psychological aggression. Begin addressing core issues. Full expression of affect encouraged. Greater attention to process. Identify belief systems underlying distorted self-talk. Begin addressing and working through childhood-of-origin issues.</p> <p><u>Type of change sought</u> Second order, systems level, internal</p>

Recommendations

1. Couples or family counseling should be allowed as part of the mandated requirement that a defendant’s requirement to attend a 52-week batterer intervention program.
2. This counseling should not be conducted in lieu of a same-sex batterer group for the first 26 weeks, and a defendant cannot begin couples or family counseling until he or she has completed a minimum of 26 weeks in a same-sex batterer intervention group.
3. Couples or family counseling cannot commence until:
 - a. The victim has indicated in an intake session separate from the defendant that he/she voluntarily agrees to such counseling.
 - b. Probation has determined, after consultation with the batterer program, that the victim’s safety will not be additionally put at risk as a result of such counseling.
4. The couples or family counselor must be a licensed mental health professional and a certified Batterer Intervention Provider.
5. The choice of a couples counselor must be approved by the victim, and must be someone other than the defendant’s group facilitator.
6. The couples/family counselor or the victim may terminate the counseling at any time if the victim’s safety appears to be in jeopardy, and/or the defendant is not progressing as a result of the counseling.

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