Title(s):

The Treatment of Violence and Victimization in Intimate Relationships

Author(s):

VIRGINIA GOLDNER Ph.D. - Co-Director, Gender and Violence Project. Send correspondence to 102 East 22nd Street, New York NY 10010; e-mail: vgoldner@aol.com.

Title Note:

The ideas presented in this essay were developed through an intensive 12-year collaboration with my close colleague and co-investigator, Gillian Walker, ACSW, who is writing a forthcoming article on more recent aspects of the work of the Gender and Violence Project at the Ackerman Institute for the Family. In the cases presented in this essay, Virginia Goldner was the therapist and Gillian Walker was the consultant.

Abstract:

This essay presents an analysis of violence in intimate life that draws on multiple theoretical perspectives. These include but are not limited to feminist theory, object relations theory, systems theory, narrative and social constructionist theory, and neurobiology. It is argued that it is possible to be effective in ending violence and abuse through a modified couples treatment format that addresses relationship issues, individual trauma, and biological vulnerability while simultaneously taking a clear, moral position that violence, abuse, and inequality are intolerable in any form.

Violence by men toward their female partners is devastating tothe women, shameful to both members of the couple, and deeply disturbing to family and friends, and to professionals who are called upon to intervene. This is because violent men and battered women can present a paradoxical and confusing picture of their relationship. In many such couples, abuse and coercion seem to coexist with intense love and friendship in a unique and painful way. Extreme polarities like love and hate, remorse and cynicism, blame and overresponsibility, are characteristic of their interactional process, and, as a result, these men and women often send contradictory messages to outsiders about the status of their

* * *

relationship, about their goals for therapy, and about the need for social control.

Thus, it should not be surprising that professionals working with these clients tend to react to them in extremes: siding with one partner against the other, refusing ever to take sides at all, exaggerating or minimizing danger, insisting on one particular clinical paradigm and rejecting all others - in other words, polarizing everything. Clearly, these divisive practices in the treatment system mirror the polarizing processes of the families themselves, and would have to be changed before these clients could be helped to do the same (Goldner, 1992).

One essential antidote to thinking in such "either/or" terms is to think in many theoretical languages and to work in many clinical styles. In the work of the Gender and Violence Project at the Ackerman Institute for the Family, these multiple frameworks include, but are not limited to: feminist, systemic, psychoanalytic, behavioral, neurobiological, cultural, as well as those derived from narrative and social constructionism.

Multiple viewpoints and models that are thoughtfully conceived, richly described, and empirically documented are urgently needed since the field of domestic violence has been chronically burdened by ideological division. Ideas that could mutually enrich one another have instead been set up as oppositional positions, creating a polarizing context of forced choices between inadequate alternatives. This essay attempts to build bridges between competing discourses by providing a thorough delineation of the conceptual basis of our multifaceted approach and a detailed description of the clinical principles that emerge from it. We are also engaged in an empirical evaluation of our program, which will be reported when our research is concluded.

We make no claims for the universality of this particular way of working, which emerges from our personal interests and politics, and through our clinical experience with a particular population. Our clients present as heterosexual and are predominantly, though not exclusively, middle- and lower-middle-class Euro-Americans. While we have worked effectively and successfully with couples from other cultures, their numbers are small by comparison, and thus we invite colleagues working with more diverse populations to experiment with our ideas and techniques in order to determine what is applicable and useful.

WHY COUPLES THERAPY?

A discussion of our model must begin by addressing, once again, the question of the use of couples therapy when the presenting problem is violence. Why offer couples therapy at all when feminist thinkers have presented such cogent critiques of the systemic approach, and so many are explicitly opposed to conjoint treatment? (See, for example, Avis, 1992 ; Bograd, 1984 , 1992 ; Gondolf, 1995 ; Hansen, 1993 ; Jacobson, 1994 ; Kaufman, 1992 ; Margolin & Burman, 1993 ; Willbach, 1989 ; Yllo & Bograd, 1988 .) Clearly, placing a violent man and his victim in close quarters and inviting them to address contentious issues in their relationship has the potential to revictimize the woman physically and psychologically, and to provide the offender with a platform for self-justification. Indeed, it should be emphasized that we ourselves have made these points (Goldner, 1992 ; Goldner, Penn, Sheinberg, & Walker, 1990), shared these concerns, and contributed many ideas to the evolving feminist critique of standard systemic couples therapy approach to violence.

We do, however, believe that couples therapy, grounded in feminist concerns for justice and safety, should be a credible treatment option when violence is the

* * *

presenting problem. The currently dominant approach, gender-specific group treatment for offenders (Edleson & Tolman, 1992 ; Pence & Paymar, 1993), has not been shown empirically to be safer or more effective than other methods, including couples treatment that focuses on violence-reduction (Brown & O'Leary, 1995 ; Feldman & Ridley, 1995 ; Geffner, 1997). See Goldner (in press) for further discussion.

Outcome research in this area, however, is still too rudimentary to serve as a guide or a justification for any particular way of working. In our case, we have made couples therapy our focus for many other reasons. First, we come to the problem of violence from within the tradition of family therapy, and have spent 10 years using, critiquing, and transforming its methodologies and theories in order to capitalize on the strengths of the systemic approach while minimizing its dangers.

We are also responding to our client base. There are men and women who specifically want couples therapy and will not use other forms of treatment, even when the risks of couples therapy are made clear. This preference is often part of the problem. For example, couples therapy may be the only form of treatment some men will agree to, perhaps because it is the only format that, by including the woman from the start, conveys the message that she is co-responsible for the abuse. Compounding the problem is that the mere fact of seeing both partners together confers a mantle of legitimacy on the couple as a couple, which allows the partners to minimize the catastrophic implications of the violence for the future of their relationship.

But at the same time, the lived experience of many of these couples includes an extraordinarily intense, mutual reactivity. The partners are often so obsessed with one another and so absorbed by the relationship that they cannot or will not consider working separately. They want and need some relief from the daily ordeal of the emotional roller coaster of the relationship in which the man's violence is embedded.

Although we always insist on the punctuation that a man's violence is not *caused* by the relationships he forms, it is, nonetheless, woven into the confusing melodrama of the couple's involvement. As a result, the obsessive power of the relationship must be addressed if second-order change around the man's violence is to occur. This cannot be done by seeing each partner separately since it is only by observing the particular, idiosyncratic "pull" of the relationship in *statu nascendi* that its power to possess comes into focus. As systems therapists have often demonstrated, a picture is worth a thousand words, especially since the partners themselves typically cannot see the context that is shaping their behavior.

There is also the paradox of attachment to reckon with. Both partners in these relationships know that the violence is a terrible thing, and that no one should stay in a relationship if they are harming another person or being harmed by them. But for many, their intense attachment, which is universally stigmatized by the outside world, compels them to stay engaged despite the risks, the shame, and the destructiveness. Thus, while women can sometimes be persuaded to leave dangerous men, too many return - even when there is no economic necessity to do so - only to be even more badly hurt the next time. Moreover, there is overwhelming evidence to document that those women who do manage to leave are at the greatest risk of attack and murder from their now former spouse. A recent Justice Department report, for example, documents that violent victimization is *six* times greater for women who separate than for

* * *

those who do not (U.S. Department of Justice, 1994).

These data support the common clinical observation that such couples bond to one another with a monumental intensity that makes separation both unlikely and very dangerous. Given the level of risk, it is mere common sense to argue that developing a therapeutic alliance with *both* partners is vitally important. Then, if separation is indicated, the process can be mediated by trusted third parties who are not seen as belonging to one camp or the other. Moreover, 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.' "

Finally, with regard to the issue of taking responsibility, it is true that conventional systemic thinking has the potential to blame the victim. Since most conjoint approaches derive from the systems idea that all problems (and thus even violence) are mutually constructed and maintained, they tend to deny the obvious power inequality between the partners, and too easily collapse the distinction between psychological interdependence and individual responsibility. To argue that partners mutually *participate* in an interactional process does not mean they are mutually *responsible* for it, or for its catastrophic outcome (Goldner, 1985). Moreover, as we have argued many times (Goldner, 1992 ; Goldner, in press ; Goldner et al., 1990 ; Walker, in press ; Walker & Goldner, 1993), a systemic approach emphasizing context and circularity does not have to start from the morally offensive presumption of mutual responsibility. A battered woman is *not* equally responsible for her broken nose, even if she acknowledges having been angry or "provocative"; just as the victim of sexual abuse is not equally responsible for what happened in the middle of the night, even if she felt aroused.

In fact, working from an expanded matrix of assumptions that begins with safety and equity, and includes an appreciation of psychological interdependence, behavioral reactivity, biological vulnerability, individual responsibility, and cultural context, it can be argued that keeping both partners in the room intensifies the moral dimensions of treatment, making issues such as equality, respect, fairness, intimidation, and violation emotionally real. The presence of the victim speaking her experience to her abusive partner in the presence of concerned others (therapist and team) who are "bearing witness," creates a moral imperative that brings the trauma of abuse into the here-and-now, making the necessity of the man's accountability all the more real.

The point here is that there is no singular "battered woman" and "violent man" for whom there is one right and many wrong treatment approaches. Researchers, clinicians, and advocates have been hard at work for 20 years making distinctions between different kinds of abusers, victims, abusive relationships, and forms

* * *

of treatment (Feldman & Ridley, 1995 ; Holtzworth-Monroe, Beatty, & Anglin, 1996 ; Holtzworth-Monroe, Smutzler, Bates, & Sandin, 1997).

Some men are more able and willing to exercise restraint and to take responsibility for their behavior and attitudes. Some women are totally isolated and traumatized by the abuse, others still have some agency and power within the relationship and outside of it. And some relationships are only about power and control, while others somehow still manage to include feelings of love and friendship. Finally, while some couples are in a nearly constant state of conflict and explosivity, others sustain long periods of relative calm.

What the feminist perspective brings to the table is a fundamental, ethical and political framework with which to view abuse and victimization. On these larger issues, and on the question of safety, there must be no compromise or ambiguity. But having established the moral bottom line, a zero tolerance for violence and a commitment to safety, accountability, and equity above all else, there should also be room for many voices and approaches to this grave and complex problem. We all have much to learn from each other and innovation should not be treason.

Case Example

The following excerpt from a couples group session illustrates how the men and women in our project confront the moral and political issues underlying violence and victimization. Adrienne and Kent, a couple who have maintained a nonviolent relationship for 3 years, are talking with Elaine and Dennis, who are still actively struggling.

Elaine: There was no place for us to go. We tried marriage counseling, but we didn't know how to do things differently.

Tx (GW): What's the difference between marriage counseling and the couples work you've done with us?

Elaine: In marriage counseling I felt they always kept going back to "what was your piece of it," whereas in this, it's not that I'm absolved from responsibility for the relationship . . .

Adrienne: [interrupts] But you're absolved from the violence.

Elaine: Yes! . . . . My last therapist kept saying, "If you come from a place of love then he can't become violent." [sigh] So I kept trying to come from a deeper place of love, which was hard as I got more and more frightened and resentful.

Dennis: I still struggle with this, thinking, "I wasn't *that* bad," or "I was provoked." I would say, "You hit *me* ," but Elaine would insist that there's a big difference since I can annihilate her in one blow. Hearing Elaine helps me realize that I can't use her hitting me as an excuse for my violence. It's easy to say, "Yeah, I got violent," but I was provoked, which minimizes what I did. I struggle with that because I don't want to think of myself as being that horrible a person that I'd actually hit someone.

Kent: Being three years away from having hit Adrienne, I never forget why I'm here. Somewhere along the line you'll be able to deal with the fact that you were a violent person, but you weren't a horrible person. I'm okay about it now. I've told people about it. I'm all right about it as long as I control it for the rest of my life. And that I'm very proud of. It's a very powerful feeling to know that I was someone who was very abusive, and I'm so much better off having lived up to the challenge

of taking responsibility for the fact that no matter what somebody else does to me, I'm in control of myself. I cannot "be provoked" the way I gave myself excuses to be provoked. This has been the biggest accomplishment in my life.

* * *

TREATMENT FUNDAMENTALS

Clinical Multiplicity

In our project, the commitment to work from multiple perspectives was developed over 12 years of clinical practice. However, the rationale for it goes well beyond the clinical, embodying a political and theoretical commitment as well. Seeing through multiple lenses is not a compromise; it is a choice that reflects an intellectual, political, and psychological ideal: to recognize the value of competing and contradictory perspectives, and to negotiate the emotional demands of such multiple attachments without splitting ideas and people into good and bad (Goldner, 1992 ; see Sheinberg, 1992 , for a related argument).

This habit of mind creates a context in which *each perspective acts as a check on the other* - a crucial kind of reflexivity when dealing with a volatile issue like battering. This is especially important in the clinical situation where what is most necessary in creating a context for change is the clinician's ability to contain contradictory truths, rather than to choose among them. A simple example is embedded in the irony that violence is a means through which men take control by losing control. Another is the paradox of attachment: the fact that battered women love and protect the men who hurt them.

Given the moral and psychic complexity of these issues, work with clients should aim to develop the most comprehensive understanding of abuse and victimization, without compromising a clear moral vision regarding issues of accountability, *that is, without blaming the victim, shaming the victim, or allowing the perpetrator to misuse psychological insight to avoid taking responsibility for his actions.*

Sustaining moral clarity in a context of psychological ambiguity is arduous, but essential if one's clinical work is to have integrity. Over the years, we have become increasingly adept at shifting levels and frames as the situation demands so that the couple's relationship and its dilemmas are situated in multiple narratives and discourses, all of which are "in play" as the clinical situation unfolds. We do not elevate one discourse above another. Rather, like the physics metaphor of wave and particle, where first one, and then the other way of seeing dominates, our rhetorical stance in an interview is always "in motion."

The clinical conversation may, for example, cohere around a feminist narrative highlighting issues of power and control, and then reconfigure into another gestalt that brings forth issues of vulnerability and despair. Each discursive domain pulls the dialogue toward some issues and away from others, and all command a piece of the truth - which then falls away as the next truth begins to crystallize.

Positioning the Therapy

The essential challenge and enticement of our treatment approach is grounded in a series of initial conversations that position the therapy in relation to the issue of violence. These are the conversations that set up the terms of the therapy, by addressing the relationship between violence, therapy, and social control.

For example, we may start out highlighting the paradoxes of treatment by noting, "Our conversation today is a bit odd in the sense that if you, John, did to Jane on the street what you did to her in the kitchen, we certainly wouldn't be talking here. You'd be in front of a judge and Jane would be your accuser. And, by the same token, Jane, if he'd attacked you on the street instead of in the kitchen, you wouldn't have gone back to that street corner the following morning to see how he was doing."

Naming and framing these conundrums and their implications for therapy creates a context where clients share the burden

* * *

of dealing with the dilemmas of treatment with the therapist, who would typically carry it alone. Core questions such as "should I attempt couple's therapy?" or, "should I end couple's therapy?" are starting points for a dialogue rather than a private ordeal. While these decisions are the ultimate responsibility of the therapist, the decision process and its risks now become the initial crucible of treatment. This, in itself, is a powerful therapeutic intervention.

Therapy vs. Social Control

A fundamental, moral question confronting therapists who treat couples where the man has been violent, is whether to adopt a stance of therapeutic neutrality or to advocate on behalf of the victim. While many feminist therapists argue that a stance of neutrality in the face of morally repugnant acts like battering implicitly sanctions abuse, thus victimizing the victim once again, many family therapists argue that the very labels "victim" and "victimizer" distort and oversimplify the dynamics of intimate relationships, forcing the therapist into becoming an agent of social control - a stance that they believe is completely incompatible with the role of a therapist.

In this instance, the art of multiplicity rests on the belief that it is not only possible, but also necessary, to carry both positions into the treatment situation so that their truths can play in counterpoint, each an implicit commentary on the other. Raising these questions in the clinical situation without destroying or collapsing it in the process requires a framework in which the moral and psychological aspects of intimate life are held in tension. This makes it possible to address moral issues in terms that are both psychologically meaningful and morally rigorous. Issues such as mutuality vs. domination, self-assertion vs. intimidation, or the question of a victim's personal agency - given the context of her victimization - require this kind of doubled vision.

Setting a moral frame is one of the first tasks in treatment. It is for this reason that we make violence the presenting problem, even if the couple lists a variety of problems and complaints. The man's violence may or may not be explicitly named, but once it is elicited, it becomes the central focus of our treatment, especially in the early sessions.

We make the issue of violence the primary presenting problem because, from a second-order perspective, violence is *our* presenting problem, in the sense that we run the risk of therapy becoming part of the abuser's excuse system if his violence is not the initial focus of treatment. Thus, we make a core distinction between the crime of violence for which we hold the man solely responsible and the "relationship issues" that can properly be construed as mutual. Without drawing this line in the sand, it is too easy for violence to become a negotiable line-item on a marital quid pro quo, as in "If she wouldn't nag, I wouldn't hit."

Case Example

In the following case example, which focuses, only for purposes of this discussion, on our work with the man, the therapist's dilemma around questions of therapy vs. social control became the linchpin for an intervention that repositioned the treatment around the issue of violence, and "invited" the man to take responsibility for his violent actions (Jenkins, 1990).

Andrea and Jeff, a white Jewish couple in their 30s, both on mental health disability, were referred to the Ackerman Institute because Jeff had hit Andrea when they were in the lobby of the Mental Health Center where both were attending its Day Treatment program. The couple were "mental patients," each with a long psychiatric career, including many hospitalizations,

* * *

and Jeff, in addition, presented with a moderate case of tardive dyskinesia, one of the side-effects of long-term psychiatric medication.

Before we joined their relationship, there were 5 therapists involved in their lives, each with a different idea about how to handle the issue of violence. Jeff's psychiatrist wanted to rehospitalize him, or, minimally, to raise his medication. His individual therapist wanted him to remain an outpatient and to increase the frequency of his therapy sessions. Andrea's therapist felt she should move out of the tiny apartment she shared with Jeff, attributing his violence to "close quarters"; and their two group therapists took the position that Andrea was a difficult person who provoked Jeff in order to gain sympathy for herself.

The treatment team could agree on only one thing: "When in doubt, add more therapists." So Jeff and Andrea were sent to the Ackerman Institute for couples therapy, where two more therapists (VG and GW) were added to their weekly rounds. Not surprisingly, given the politics of the referral, it was virtually impossible during the initial session to assess what these two people actually thought about anything, let alone what they might want from couple's therapy, or if, indeed, they wanted couple's therapy at all.

When they returned the following week, the interesting news was that Jeff had not employed any of the strategies we had suggested during the first session, and even though the couple had fought many times, he had not become violent. We wondered aloud if Jeff's newfound restraint could be construed as a communication to the therapists about his dim view of our various proposals for change. He replied by saying that he thought our focus on violence was "too superficial" because, he went on, there were "a lot of issues that led up to the physical violence," which was "the culmination of a lot of built-up pressure and tension" caused by the couple's unresolved issues. Therefore, he argued, "those other things" should be the focus of treatment.

As a therapy consumer in a psychological society, Jeff was reiterating the popular wisdom that "superficial" symptoms have "deep" causes. This idea has found its way into most psychological discourses, including the cybernetically derived notion that symptoms are the product of dysfunctional systems. Jeff's argument fits with this discourse insofar as he implicates Andrea in his violent actions by making violence merely a superficial expression of underlying "couples issues." This bit of systemic pop psychology does more than implicate the victim, it also completely obscures the catastrophic effects of an act of violence upon her, while simultaneously separating the violent act from its true agent, the violently behaving man. Thus it is not Jeff who hits Andrea, in one case breaking two ribs; it is "built-up pressure and tension" that are the culprits.

Clearly, Jeff's definition and analysis of the situation differed considerably from our own. Moreover, despite intensive inquiry, Andrea remained willfully enigmatic, except on the subject of Jeff, where she voiced considerable skepticism about his motivation for treatment. And, given the Byzantine politics in the referring agency, it was still an open question as to who was setting the agenda for therapy. These ambiguities, and the clinical dilemma they posed, became the subject of an interventive proposal we made to Jeff at the end of the second session.

Tx (VG): We're in a bind about this therapy, and we think you are too. Like you, Andrea, we don't know if Jeff is here primarily because he's "been sent," or whether he's here because he personally wants to be here for himself. [she nods]

* * *

Page 270:

And we know from things you've said, Jeff, that this is a big issue for you in life - when you do things because you want to do them, and when you do things because the "good boy" in you feels he should. [he nods] But we all know that when you act the good boy, you can get enraged later, and that's when Andrea can get hurt. [they both nod] So we were trying to figure out how we could clarify the terms under which you would be coming here - whether it would be to please other people, or because you wanted to be here for yourself. And we realized the issue of violence could help clarify the whole question. We agreed with what you said in the session, Jeff - that no matter how many different people give you their ideas about the violence, in the end, it's up to you whether or not you hit Andrea.

Jeff: Right!

Tx: Maybe that's what you were telling everyone last week by refusing all our suggestions about how to handle your anger, and then showing us (and everybody else who has been watching the two of you) that you could get as angry as you wanted and still not hit her. [he nods] So we have a proposal. We'll schedule our next session in two weeks. If you don't hit Andrea in the next two weeks, and you two choose to come back to see us (which, at this point, is still your choice to make), we'll understand that to mean that you are telling us "I am choosing to be in couples therapy for myself because I want to be." That's the message we would hear, because if you hit Andrea, you'll *have* to be in couple's therapy, because your therapists will put tremendous pressure on you to keep coming here, and if you refused, they might take more extreme measures, like raising your medication, or eventually putting you back in the hospital, or you might even end up going to jail for assault. . . . As long as you behave violently, the choice about therapy is taken out of your hands. So if you hit her, we'll understand you to be saying that you want to be in therapy, *but you want it to be compulsory.*

[After some mutual discussion with Andrea about her sense of risk and choices, we added an additional thought.]

Tx: We're also caught in another bind about what we should focus on in these sessions. Jeff, you said today that you thought we were dealing with superficials, that you could control hitting Andrea, but that there are a lot of other issues that you really do need help about.

Jeff: Yeah, that's what I've been trying to say!

Tx: But the problem is that your therapists have sent you here because you've been violent, so that is obviously what they expect us to focus on. Again the choice is yours to make. If you hit Andrea, we'll have to talk about violence because that's why you've been sent to us. If you don't hit her, and you two decide to come back, we'll understand that to mean you're choosing to be in therapy to talk about other things that you feel are important, just as any husband might choose to do.

We didn't see or hear from the couple (or from the agency) in the 2 weeks that followed. In imagining the fate of our intervention during this period, we computed that, in the interval between our meetings, Jeff and Andrea could have had as many as ten additional therapy sessions with five other therapists in which to discuss, critique, and potentially dismantle the intervention we had so carefully crafted. Nonetheless, when they arrived for their session 2 weeks later, Jeff began as if no time had elapsed at all. "We've been having a lot of arguments," he said, "and there's been no physical violence. So we have a lot of other issues to talk about. If we could start on those, that would be helpful."

We asked Jeff how he had managed to

* * *

Page 271:

keep himself from hitting Andrea. "Did you have some fights that could have ended in violence?" we asked. "Very many, very many," he replied. "So what did you do that was different?" we asked.

Jeff: I don't know, I don't know. But I think - all this structure and all the people paying attention has made me think about it a whole lot.

Tx: You mean all the therapists paying attention?

Jeff: Yeah, and especially this place. I mean a lot of the attention is being focused on it. And I realize that I do feel better when I stop myself. Like, you know, a half hour later it's just like . . . ridiculous. I don't even feel like doing it any more. So it's just a matter of - [he concludes slowly and with emphasis] I'm glad I restrained myself, because . . . it accomplishes nothing!

The changes in Jeff's attitude and behavior can be detected in his language choices. In the previous session, Jeff spoke of violence without a personal pronoun, as in " *the* violence," which, in his lexicon, was caused by "issues," "built-up pressures," and, by implication, Andrea herself. By contrast, in this session he has begun to speak about violence in terms which foreground his personal intent and agency. Reasoning backwards from his current stance of nonviolence, Jeff now represents hitting Andrea as a choice he sometimes wants to make ("a half hour later I don't

even feel like doing it anymore"). He also thinks about his violence in instrumental terms ("it accomplishes nothing"), and frames it as an impulse he can control ("I'm glad I restrained myself").

Jeff attributes this shift in perspective and behavior to "all the structure and attention" being focused on [violence], which "has made me think about it a whole lot." As a result, what he had kept rather vague and depersonalized is now brought into focus, and its consequences articulated. This clearly has produced a sense of mastery and, as a result, Jeff begins to separate himself from his impulsivity ("I do feel better when I stop myself").

Therapy vs. Consultation

In this, one of our first cases, we constructed a therapeutic paradox that, in essence, made the terms of therapy conditional on the man's becoming nonviolent, without actually depriving the couple of treatment in the process. We were encouraged by Jeff's willingness to accept the distinction we made between his violence and all other couple issues, as well as by his capacity to change his behavior without additional forms of social control.

This successful outcome led us to incorporate the principle of this intervention into our program design. We now frame the initial stage of treatment as an "extended consultation" rather than as the beginning of therapy. The goal of the consultation, we explain, is to determine whether a conjoint approach can be a safe and effective format for ending the violence.

Since safety is our primary concern, we stress the point that couples therapy can be a risky matter once a man has acted violently. If the therapy is to be genuine, contentious issues must be addressed, but given that the man has allowed himself "to go over the line" in the past, there is a risk that he might let his anger spill over and physically abuse his partner after a conflictual session.

The risk of such "therapy-activated" violence creates a dilemma of meaning and authenticity for the clinical work. In particular, the woman is caught between a rock and a hard place. If she expresses herself fully and completely, with all the emotional intensity her concerns warrant, she could put herself at risk after the session. But if, out of fear, she minimizes issues to mollify her partner, the therapy

* * *

is inauthentic and she loses the chance to speak her mind, which is what people come to therapy to do.

Thus, in order to proceed with couples therapy, we explain that we need to begin with an extended consultation (1-3 sessions) to determine whether it is possible to create a "therapeutic safety zone" where real issues can be confronted without putting the woman in harm's way. This initial positioning of the therapy constitutes a therapeutic paradox in that we are asking couples to resolve the presenting problem of the man's violence and the woman's lack of safety before getting the therapy they need to accomplish this goal. This is, in fact, the dilemma that is generated by the dominant feminist position on couples therapy, which argues that the violence must stop before such therapy (or in some cases any therapy) can begin. For those men and women who are not able or willing to accept referrals for other kinds of treatment, such as

batterer's groups and women's support groups, a refusal to work conjointly leaves them alone with the problem until they solve the problem, a position that can make a dangerous situation worse, especially for the women and children who are the usual targets of the man's rage.

In our framework, however, this paradox turns back on itself since we take the position of *officially* withholding therapy unless the violence stops, while *de facto* providing therapeutic input to make *sure* that the violence stops. (What is an "extended consultation" anyway? One session can properly be called a "consultation"; after that, any competent clinician is doing "therapy" - by whatever name).

Making the transition from "consultation" to "therapy" conditional on nonviolence creates highly motivated clients who will do whatever it takes to create a safe space for treatment. Many are so in the thrall of this therapeutic gauntlet that they carefully count the number of sessions, asking periodically, "Since this is the - ? session, does that mean we got past the consultation and are now accepted into your therapy program?"

Clinical Assessment

The consultation process is of course, more than a rhetorical ploy. We do use these early sessions to focus intensively on the risk of violence and the question of safety, reserving the right to terminate the consult and propose other treatment alternatives if we feel the case is too dangerous for conjoint treatment. But we make the work of assessment therapeutic in itself, so that the evaluative process becomes a platform for understanding and change.

We begin the first session by setting up a structure for the initial consultation. We tell the couple we will meet first with both of them, then with each alone; then, after a break for the therapists to consult, we will meet again with both partners to "give you our best thinking about the situation, including recommendations for what kind of treatment we think would be most helpful." This structure permits us to see the couple in action, and to learn from the woman when we speak with her privately whether, out of fear, she has left out or minimized important information about the level of violence and any other forms of abuse and intimidation to which she has been subjected. The separate meetings also foster the therapeutic alliance with the man, since meeting alone with him demonstrates that our definition of treatment is not just restricted to being the woman's advocate.

During the conjoint phase of the interview we routinely ask about the level and frequency of violence, using direct questions such as: "How often do conflicts between the two of you end in some kind of violence?" and, "What's the worst incident that's ever happened?" Here we may learn

* * *

that the woman has been violent as well as the man. If this is the case, we make it clear that violence is unacceptable to us in any form, but we also point out that unless the woman has a weapon, her violence is not as dangerous or injurious simply because she is physically not as strong. This point can be underlined by asking the man if he's actually felt physically afraid of the woman during an argument (which is her experience of him). The answer is almost always "no."

We also explore the variety of meanings each partner brings to an act of violence. Is it in self-defense? Is it embedded in a strategy of intimidation? Is it an attempt to provoke a counterattack to "get the inevitable over with," or to justify subsequent violence? And so on.

We also ask about the man's previous history of violence with other women, toward children, and about violence in other contexts: "What about fights with men in your life, or with strangers?" Clearly, the more there is a pattern of violence, the more dangerous the man. This is especially true of violence outside of the domestic sphere. The man who gets into fights on the street is far more impulsive and explosive than the man who is violent only toward those who can't really fight back. And, on the matter of impulsivity, we ask about substance abuse because drinking and drug use loosen inhibitions, and ours is a therapy emphasizing restraint.

We also explore each partner's cultural context and heritage, trying to understand how domestic violence is viewed in their families and community, if and how it is connected to other kinds of oppression, and so on. Finally, we try to evaluate whether there is a neurobiological dimension to the man's violence. Here we ask about his school history, his childhood history of tantrums, rages, attentional problems, and head injuries. See Walker (in press) for an expanded discussion of these issues.

Beyond the explicit content of the interview, we also observe the way the couple seems to be experiencing the session and one another. Can they be in each other's presence and get any work done, or are they so mutually reactive that the therapist must be constantly controlling and containing the process? We are particularly concerned about the man's capacity to work in the interview, since we must be able to engage him from the outset if he is to stop behaving violently. Is he argumentative, bombastic, or hyperdefensive toward his partner? Toward the therapist?

With regard to the women, we are primarily trying to determine whether they have been so damaged by the abuse that they can no longer think for themselves and make a case for their point of view, or whether that they are so ruled by fear that they do not speak freely. Here we primarily try to assess if the woman's thinking seems clear or confused, whether her emotions are overwhelming her or are excessively muted, or whether she seems exceptionally cautious. We also observe her physical appearance for signs of abuse. Since we do see her alone, we have the chance to compare her self-presentation in both contexts, and to discuss our observations privately with her.

By the end of the first interview, we must feel that the man can tolerate our use of words like "violence," "safety," "fairness," and "fear," and that he can tolerate a redefinition of the presenting problem from something relational or partner-focused to an explicit focus on his violence, and his full responsibility for it despite any so-called "extenuating circumstances." Remarkably, most of the men we have seen in consultation have been able to make this shift. This is probably because we have become quite adept at framing the issues in ways that challenge but do

* * *

not alienate them. We make sense of their violence in ways that are psychologically meaningful, even as we hold them fully accountable for it.

We also maintain that the woman must take personal responsibility for her safety, making it her first priority. This means putting her physical safety ahead of other concerns that might

compromise that safety. For example, her love for the man might make her want to protect him by minimizing his violence, or her desire to confront issues might heat up a volatile situation, or her guilt and worry about "breaking up the family," might lead to her stay with him even if he is not committed to change.

The three-session, extended consultation takes up all these issues, providing a forum to evaluate whether, with intense therapeutic support and guidance, each partner can make the daily choices necessary to keep from hurting and being hurt no matter what issues arise and regardless of the circumstances.

Deconstructing the Violent Moment

Within the first two sessions of the consultation, we begin a detailed inquiry of a violent incident, either the most recent or the "worst." The goal is to work with strong memories and experiences. As the partners begin to describe their stories, they are inevitably pulled in by their own narrative. Eventually we enter the storytelling process by asking questions that "unpack" its structure. We are listening for themes that tie the moment of violence to emotionally charged issues of special meaning for each partner. (See Goldner et al., 1990 , for another example of this technique in a case conducted by Penn and Sheinberg.)

Although it is common for us to map both partners' intersecting stories, we close in on the man's narrative quickly to give him tools to disengage before he acts violently. By interrupting his narrative with careful inquiry around resonant phrases and metaphors, we begin to marginalize the woman on whom he is obsessively focused and whom he blames for his loss of control. We focus instead on the emotionally intense associations his storytelling brings to mind. These are often sense memories and images that emerge from his personal history, for which his partner is clearly not responsible.

These moments of inquiry often take the interview through the looking glass, into a world of intensely painful sense memories. Here we typically find ourselves back in a time when the man was a boy, subject to sadistic acts of violence, power, and control.

Case Example

Richie and Sarah, a white, lower-middle-class couple of Catholic and Jewish heritage, respectively, came to Ackerman in a last-ditch effort to salvage their 8-year relationship. They had a 6-year-old son, and were already living separately because of the constant fighting and increasing violence. Sarah quickly got to the heart of the problem, asking Richie:

Sarah: Can you say to me that you will *not do it again?*

Richie: Let me just talk for a second. [to therapist] I have said that. I say it's never going to happen again, I promise; I swear, I'll hurt myself before I'll hurt you again. But sure enough, a few weeks later or a few days later - who knows? Same thing would happen again. Totally unexpected. We didn't know the tension was rising. We didn't try to diffuse it. And before we knew it, the tension was *so* - it was so overwhelming that it just flared up again.

Tx (VG): When you say "it just flared up," let's think about what you mean. What happened inside you at that moment for you to go against your promise that you would never hurt her again?

* * *

Richie: For me, I would see - I would see a very hostile person in front of me. Very hostile. Where I had no way around it. You know, logically, intelligently. No way around it. And I would meet it head on. I have always been that way. To meet hostility with hostility.

Tx: So one of the things that you would have to do in order to concretize your promise to her. . .

Richie: I have a hard time with that. I have to admit it. My background is very difficult. Especially when it come to women. Abusive women. I have a very hard time with hostility from women.

Tx: Well, since you do have such a "hard time," in order for you to honor your promise of nonviolence, we'd need to work directly with that feeling itself. When you just said to me "I have a hard time," it's in my "background," what was in your mind? What's the image that gets on to her at a moment like that and suddenly you feel, "I'm entitled?" [pause] You superimpose something on her.

Richie: [long pause] . . . . [slowly] I sure do.

Note here how the therapist shifts the terms of the therapeutic discourse. Where Richie uses a psychological/partner-focused narrative emphasizing his difficult childhood and Andrea's hostility (which he has already transformed into "abuse"), the therapist shifts to a moral discourse that highlights his broken promises and feelings of entitlement.

Richie: [haltingly] The hostility registers in me. I see that. That's clear. . . . But it's interesting, you say I superimpose a picture on her. In thinking about it, you're right, I *do.* At that particular instance [gets choked up]. . .

Tx: [softly] Take your time.

Richie: I see a person. From my past.

Tx: Do you see the person now as you are talking?

Richie: [holding back tears] I see the face of a woman that is - bearing down on me in a very hostile manner. And it's a person from my past, a person who's abused me as a child.

Tx: Who is it?

Richie: A foster parent.

Tx: How did she bear down on you? How old were you?

Richie: Six and seven. She would accuse me of things. She would tell me I'm doing things that I'm not doing! To justify the punishments she would dish out to me.

Tx: So she really wanted to hurt you.

Richie: Yes. *This* woman, yes.

Note how Richie begins to internalize his experience of hostility. What he had initially framed as "tension" located in the environment and then as "abuse" emanating from Andrea, now becomes "hostility that registers in me. I see that." Moreover, he takes a giant first step in separating his projection of the sadistic foster mother of childhood from his current experience of the angry Sarah when he elects to clarify the therapist's phrase, "she really wanted to hurt you," by specifying, " *This* woman" [the foster mother], yes."

Tx: She was almost looking for *excuses* to hurt you.

Richie: Yes. And whether I intended to or not, I always managed to accommodate her. Very similar to this relationship.

Sarah: But she did terrible things to you! I never did those terrible things to you!

Tx: That's part of what I think Richie is sensing now.

Richie: I would try to run away, but she would be sitting in the kitchen in the middle of the night, and the kitchen window was the only way out. And besides, the window was too high up for me to jump out. There was very little I could do.

Tx: So she *really* terrorized you.

Richie: Yes.

* * *

Page 276:

Tx: [softly] And she still haunts you today.

Richie: Yes.

Tx: And that's when it gets very confusing with Sarah. . . The image starts to wobble there.

Richie: Only when there's hostility.

Sarah: But anything can set him off! The littlest question can set him off!

Tx: Well, Richie, we have this side of Sarah. The side that's very forceful - that really wants to express herself, that is not going to be silenced. And when she is that part of herself, this is the part that clicks in for you. Maybe the thing the therapy can do is that, as we bring forth Sarah's inside feelings and experiences and history, you will be able to separate her from these ghosts.

Note here how the therapist reframes Richie's pejorative characterization of Sarah as hostile, abusive, and irrational with the phrase, "the side [of Sarah] that's very forceful, that [needs] to express herself [and] is not going to be silenced." This feminist revisioning of Sarah's anger was critical since being angry had historically discredited her and had been taken as a sign of her craziness.

Moreover, by using the language of "parts" ("when she is that part of herself, this is the part that clicks in for you"), the therapist shifts the terms of the discourse from shaming identity categories like "abusive woman" and "violent man" to fluid psychic processes. The "parts" metaphor, as it is used here, derives from the object relational notion that psychic experience can be construed as an "internal world" of moving parts, each carrying an aspect of the subject's sense of self. These self-states are connected to various aspects of early attachment figures ("traumatized boy/sadistic foster mother"), and can be re-evoked by the intense experiences of romantic love and parenting.

By constructing metaphors that draw attention and interest to these internalized dramas, the therapist intentionally marginalizes the current actual partner, who has been the object of the other's obsessive preoccupation. This intense clinical focus on each individual's internal world and its unique contribution to the relational field creates a context for self-inquiry that puts the brakes on the compelling, automatic projection process that has come to possess the couple. (Looking "inward" is one way to reconfigure an overheated interaction, as is looking "upward" toward the family-of-origin, or looking "outward" at the culture.)

The careful deconstruction of each individual's personal biography is a necessary preamble for the morally crucial discussions of personal responsibility and agency that are central to our approach. Without such detailed self-inquiry, these matters lose their psychic immediacy and the clinical work can devolve into empty rhetorical gestures: "I know I must take full responsibility for hitting her," "I know I shouldn't put up with this kind of treatment," and so on.

The significance of this work for Richie became clear in the fourth session. Sarah came into the room furious, reporting that Richie had arrived 2 hours late to pick up their son for the weekend, even though she had told him repeatedly that his being on time was desperately important to her. Sarah was so incensed by Richie's lateness that she physically attacked him at the door and refused to let him pick up their son. (Richie did not strike back.)

The therapist spoke to Richie alone when Sarah felt too overwrought to stay in the session after screaming and sobbing for the first 20 minutes. Richie had been listening silently the whole time, and began to speak when Sarah left the room.

Richie: . . . there are several things that I would change if I had the ability, but I can't. So I have to live with them. Like

* * *

Page 277:

having hit Sarah. I know there's no excuse for that, but after taking all this abuse, having been hit and hurt myself, finally, [he punches one hand with the other] I just - let go. But that is not an outcome I want.

Tx: So what helped you stop yourself this weekend?

Richie: For now [sigh], there are a few things. Keeping my distance is one.

Tx: That's helping you keep your clarity?

Richie: Yes. I don't even call her since talking on the phone can start something.

Tx: Okay. Anything else?

Richie: [sighs] I try to realize that. . . I'm older now and it's not the way to handle the situation now.

Tx: . . . That's a good thought.

Richie: So - [softly] I can't let what's happened to me in the past still make my decisions for me. . . . Now I don't feel this happening right away. But once I start feeling the tension develop, I automatically - I start going through my mind - what am I supposed to do at this point to keep from hitting her or being hit. And lately, I've been keying into the thought: "Don't let that woman control you." And once I say that to myself, I walk out. I mean there's nothing else. First the tension. Then the bell goes off. Then, "Don't let that woman control you." And walk out.

Tx: And how do you feel about yourself when you do that?

Richie: Well, I guess, even though leaving is not what I want, for me, it's a *real accomplishment.*

Richie's personal transformation warrants detailed analysis. First, it should be noted that he created this innovative anger-management strategy entirely on his own. It was not an explicit therapy assignment. Richie's interest and ability to construct this detailed behavioral sequence demonstrates that a morally detailed focus on personal responsibility combined with a psychologically detailed inquiry of the rage experience can provide the impetus and insight for some men to create their own solution-focused strategies for nonviolence.

Richie's personal plan of action also demonstrates that he has retained the insight that his rage emanates from within himself and is not a diffuse force of nature. Moreover, he takes personal responsibility for the potential destructiveness of his anger by asking himself, "What do *I* do now?" Finally, he creatively uses the painful work of the initial session to create a coping strategy for taking charge of himself in this potentially explosive, re-traumatizing situation.

If we deconstruct the language Richie uses here, the phrase "Don't let that woman control you" is ambiguous. While his reference to the past ("I can't let what's happened to me in the past still make my decisions for me") points toward the ghost of his foster mother, he may still be slipping to Sarah, as the "woman who controls him." But even if there is some conflation, a remarkable shift has happened. Before treatment, the unconscious thought, "Don't let that woman control you" would trigger a violent attack on Sarah. Now the same thought is his inspiration for restraint and nonviolence, even if it means separation.

Taking Responsibility

For men like Richie and Jeff to take responsibility for their violence, they must first recognize it as an action they have personally chosen. This is extremely difficult for many men to apprehend fully since they experience their violence as a regressive experience of losing control, as in the common phrase "I lost it." Others have captured this impulsive immediacy with sensory metaphors, "I just saw red," or "this feeling of heat rushes through me." Indeed, for many, the violent act

* * *

becomes virtually a visitation from outside themselves: "It was totally unexpected, and then it just flared up again," or even, "During the years The Violence was active in the home" (Kaufman, 1992).

Representing violence with metaphors of being overtaken by a force from within, or by an alien force from without, obscures the many ways in which violence is a strategy of intimidation that these men choose because they can get away with it, and because it works. A man can enforce his will and extend his areas of privilege in a relationship by hitting his partner, or merely threatening to hit her. It is a powerful and effective method of social control.

From a both/and perspective, violence is best conceptualized as simultaneously willful and impulse-ridden, as both instrumental and dissociative. We emphasize the volitional aspects of violence because, thinking pragmatically, individuals can only decide to change behaviors they define as voluntary. Moreover, we want to highlight those aspects of violence that the "loss-of-control" narrative keeps in shadows, in particular the mental strategies men use to incite their anger and to justify internally the resulting act of violence.

This focus requires becoming hypersensitized to what could be called "linguistic evasions." These include narratives framed in the passive voice, or in the second or third person, and talk that is vague as to the specifics of the violent act and its effects on the victim. It is the moral difference between Richie's initial description, "We didn't know the tension was rising," and his later recognition, "I feel the hostility registering in me," or between the common justification, "She provoked me," and the ultimate recognition, "I was looking for excuses to let myself feel provoked so that I could feel justified in hitting her."

Treatment is most effective in helping men take responsibility for being violent when the therapist can rhetorically encompass both the intentional and impulsive dimensions of their experience. For example, in response to the phrase "I just lost it," one might ask, "What made you choose to lose it?" or "Can you remember the moment when you chose to lose it?" This rhetorical paradox conveys understanding of the dissociative aspect of a man's violent rage, while simultaneously highlighting the choice points that pave the way for the violent impulse to "overtake" him. (He goads and provokes his partner; he perseverates internally about injustices large and small; he insists on dealing with contentious issues when he is exhausted or emotionally depleted; he refuses to back down or to leave the situation, or even to let his partner leave when it is obvious that things are going from bad to worse; and so on.)

By therapeutically interpolating a moral discourse emphasizing choice and personal responsibility into a psychological discourse that emphasizes the power of disembodied, overwhelming affects, the therapist is *expanding the man's self-description without negating his experience.* This layering of meanings allows him to feel understood at the same time as he is being morally challenged. The use of such multiple frames, often in the same sentence, holds the complexity of the violent impulse in language, which makes it easier for men to take responsibility for the behavior that ensues.

Fear and Safety

Ours is a therapy that emphasizes the personal responsibility and accountability of both partners. Thus, we believe that women in these relationships must take some responsibility for protecting themselves, given the danger they are in. This is not only a safety issue, although that is paramount. It is also important because an emphasis on personal responsibility

gets women engaged in a change process that mobilizes their sense of agency. Although these women have been victims, this does not mean they must be paralyzed by the passivity of the "victim position." Thus, we ask the women in our project to make a promise to themselves and to us: as long as they stay in the relationship, personal safety must be their primary concern.

This singular focus has turned out to have galvanizing effects. First, we have found that when we ask women to "put their safety first" (ahead of their concern for the man or the relationship), it gives them a focus through which to collect their resolve and evaluate their choices. This is crucial because, by the time these women have come for help, most have "lost themselves" in their preoccupation with the man and his issues. As a result, they often feel confused about the abuse and about who is responsible for it.

Case Example

The risk of moral ambiguity is amplified by the paradox of attachment. Since most of the women we see still love the men who hurt them, they are too ready to blame themselves for the man's violence. For example, when invited to continue a discussion about being afraid of her husband, which she had begun in a restaurant, Maureen turned to Josh saying, "Do you know what it's like to be scared of just talking to someone - to be shaking inside, even though you know you're not doing anything wrong?" But after speaking this single line, Maureen stopped herself because she suddenly became confused about fairness. Turning to the therapist, she said, "I don't know what you want me to do - this sounds like blaming to me and that's not right." And later, when she began to cry as she spoke of being incessantly controlled by her husband, she quickly swallowedher tears and said, "I shouldn't cry; it upsets Josh."

A focus on the issue of safety begins to move the moral center of gravity from male entitlement to female victimization. By bringing forth the woman's experience, which has been completely eclipsed by the man's self-absorption, we create a context for the man to empathize with his partner's victimization instead of reactively denying his personal responsibility for it, blaming the woman, or trying to claim the victim position for himself.

We also find that as soon as we ask women to think about fear and safety, we open space for very powerful testimony. Often, it takes no more than saying the word, "fear," for women to begin to sob and shake. This is profound material that the therapist must bring forward and privilege by helping the man to listen without interrupting or resorting to nonverbal threats or censure. Eventually, he can be helped to develop a kind of active listening through which he "bears witness" to the woman's history of hurt and terror at his hands.

In order to set the frame for this kind of encounter, the therapist must be sensitive to the woman's realistic fear of talking openly (including talking openly about her fear). Here is the dialogue between Maureen and Josh - an upper-middle-class white couple - that ensued around these issues.

Josh: [angrily] She puts this wall up between us. And I'm sick of making excuses for her!

Tx (VG): I think one reason she puts the wall up is because she's afraid of you. She's afraid of getting hurt. . . By you.

Maureen: But I shouldn't feel afraid.

Tx: Why not?

Maureen: Because it's not rational.

Tx: It seems like a realistic attitude to me. Things that should never happen between people did happen to you with Josh. And that changes everything. Now you never know, when you're having an

* * *

Page 280:

ordinary disagreement, whether or not you'll get physically hurt again. That colors the way you talk to him. You probably keep a lot more things to yourself.

Maureen: But I don't have a choice.

Tx: What do you mean?

Maureen: I don't have a choice, because I'm in danger. [starts to sob] I'm *always in danger!*

Tx: Yes, that's the terrible thing - the terrible thing. And that's the thing you feel he doesn't understand.

Maureen: He doesn't. [crying] He doesn't. [in a tearful rush] I've never had so many secrets in my life! I'm not a secretive person. And the secrets I keep are small and insignificant. They are just meaningless. It's just that they are safer to keep.

Tx:Do you understand this, Josh?

Josh: Yeah . . . she doesn't feel that - I mean, in her normal life she doesn't feel she can be open with me because she's scared of what the repurcussions are going to be. She doesn't feel comfortable. She doesn't feel free with me.

Tx: How do you think that connects to the violence?

Josh: Well she feels like there's a threat . . . a threat in what she says and what she does. So I mean I understand; I can understand that would affect her level of intimacy with me.

Tx: So what do you think needs to happen?

Josh: She's got to feel safe. She has to feel safe. That's number one. She has to feel safe.

Tx: How do you think that could happen?

Josh: . . . Well it can't happen quickly.

Tx: That's for sure!

Josh: Well, what has to happen is . . . that a lot of time will have to go by where she sees that I can control myself so that *nothing* happens. And she'll just slowly start to get used to the idea that she can say things that are personal, and nothing will happen.

Some weeks later, Maureen tested Josh's resolve in a dramatic way. In the middle of a fight, she became hysterical and enraged. She taunted Josh sexually, trying to climb into his lap and daring him to choke her, while refusing to let him get out of the house. Josh managed to get out of the room and called the therapist in tears, saying he did not want to hurt Maureen, but that she was trapping him in the apartment. Eventually, Maureen got on the phone and Josh was able to leave the scene. An emergency session was scheduled for the next day.

Putting Safety First

Our singular emphasis on safety gives women a platform from which to talk and think. It also gives them a legitimate way to focus on their personal self-interest without feeling guilty and disloyal. While they may not feel entitled to put *themselves* first in the relationship, they can clearly see the necessity of putting their physical safety first.

Case Example

The issue of safety, and who was responsible for it, was the linchpin of our work with Paul and Karen, an upper-middle-class white couple who were referred to us when Karen's obstetrician learned that Paul had kneed her in the stomach after she spit at him during an argument. The doctor insisted that Karen not return home until the situation was under control, and finally offered to bring Karen to *her* home in order to insure the safety of mother and baby.

We met the couple a week later. Karen had spent the week at the home of her doctor, keeping in touch with Paul by phone. Karen begins by speaking of their romantic reunion in the Ackerman waiting room, adding that we are the ninth

* * *

therapist they've been to. Pretty soon it becomes clear that the couple wants us to "let them" move back in together.

However, it is obvious nothing has changed. Against her doctor's advice, Karen has already gone back to the apartment because Paul asked her to, only to find that he had destroyed many of her professional art supplies. Reporting this incident she adds, "My doctor felt that this was very abusive; she said it wasn't passive-aggressive, it was an aggressive act. She wants us to come here and talk before things escalate."

Karen's opening statement highlights the problem for the therapist. We now know what Karen's doctor thinks and wants, but does Karen have a point of view of her own? Moreover, since the couple has "been sent" to our domestic violence program by a hypervigilant professional, is responsibility for the violence being handed over to us as well?

Karen: When I met Paul in the waiting room he gave me a couple of nice kisses and he said, "Everything's going to be all right; we're going to have a wonderful life. We're going to get help,

everything will be fine." I would love to believe it and I do believe it. [starts to cry] But you're the ninth therapist we've been to.

Tx (VG): [tremulously] We're the ninth therapist you've been to?

Karen: Yes, and I would love to believe it, you know, and I do believe that we could get help and get better but [softly] I'm so frightened.

Tx: Your fear can be a very important message. What is it telling you to do?

Karen: The doctor that I'm staying with wants me to be safe. She thinks I should be out of it and yet I don't get out of it. She didn't want me to go back - but I went back because Paul wanted me to, and he had told me and told her that everything was under control. But when I got there, I saw that he had taken all the stuff from my office and crushed and torn it up and thrown it out! My doctor thought everything was calming down, but now she says that the whole thing is a progression that's beginning to build again, and we need to get help.

Tx: So Paul's behavior sent a message of danger to your doctor. What kind of a message did it send to you?

Karen: I don't know. I mean I thought that maybe we could move to our new house this weekend, but I'm really afraid. I'm afraid that I'll be so far away from everybody and I'll get hurt or. . . . I don't know. I'm afraid.

Tx: So why would you want to go when your fear tells you it's not safe?

Karen: I hate to have too many people know about it.

Tx: What do you think would be worse for you - having more people know about it or having another incident? [Karen laughs] No, I mean it seriously. It may be that the shame for you is more painful than the physical danger you might be in.

Karen: It's always been that way.

Tx: Well - I'm worried about the fact that you don't listen to your fear because if you do move to your new house, you take your doctor out of the picture - if she's going to be physically gone - and she is the person who is standing for you protecting yourself - who will take that job?

Karen: . . . Our new therapist?

Tx: Well, you see I think Paul took it in a backhanded way. In his doing something that was destructive and symbolically provocative, he alerted the doctor (and everybody else who is watching the two of you) that things were not calming down. And I'm just wondering whether you and Paul might be able to figure out a way to evaluate those risks yourselves.

Karen: [softly with emphasis] What would that be?

Tx: I don't know. But it seems important because you've been telling me you're

* * *

worried about moving to the new house this weekend - and your worries sound quite realistic. But you spoke as if you were going to go anyway. Somehow you can see that you're in an unsafe situation, but if there's not someone *else* there saying "this situation is unsafe," you get drawn into the wonderful fairy tale he tells about having a beautiful life. . . . I just wonder what it would take for you to wake yourself up from the bedtime story he tells you - for you to hear your *own* voice saying "Karen, take care of yourself. You don't want to be hurt. You want this baby to come to term. You don't want any more shame to come to this relationship."

Karen: [slowly and softly] But you see, I don't really understand what I should do. I don't understand what actions to take. I don't really understand how to protect myself.

Tx: Maybe the first thing to think through is whether in *your* view, just looking at today, you think that the emotional climate between the two of you is safe enough for you to be living with Paul at this time.

Karen: There are periods when it's safe.

Tx: I'm sure that's true. But what about right now?

Karen: See, I don't know if I can tell. I can tell when I look back, then I can see.

Tx: Okay, looking back at the recent past and looking at the immediate future - % *Karen:* I'm scared.

Tx: Okay.

Karen: I'm scared because I went to the house and he'd torn up all my stuff.

Tx: Okay. You see I think Paul was sending out a very important message. His destructive behavior was saying "Alert, alarm, not safe". . . . But no one can be responsible for your safety or the safety of the relationship but the two of you. Not therapists, not police, not friends. Only you can. . . . So I guess *in order for us to be able to make another appointment for this time next week* [note the implicit conditionality of this phrasing], we would need to know what plan the two of you can put in place, in terms of living, given the level of danger. What should happen? Who should be where in the next eight days?

Karen: Every time I think about staying with someone else, I have all these excuses about why I shouldn't bother this person or that person.

GW: Is the excuse about bothering them or is it that some piece of you wants to get back together?

Karen: I think I use it as an excuse that I'm bothering them, but I think that the thing is just that I want to get back together.

Tx: The only way you can really insure getting back together is if you put your safety first. If you put your attachment first, something explosive will happen and you'll be apart again.

Karen: I'm so unsure of my opinions - I feel like I don't trust my judgment any more.

GW: Do you trust his over yours?

Karen: [laughs] No, I certainly don't trust his!

Tx: Well, it sounds like you don't trust his over yours, but. . . .

Karen: I acquiesce.

Tx: - You yield to it and you would like to be true.

Karen: Right.

Tx: Maybe that's because - despite all the harm Paul has done, he still holds up the positive image of the relationship on behalf of both of you. *He's* the one who says, "Everything will be all right; we'll have a beautiful life." And then, when he acts destructively, both of you have to face the dark side of things. . . . And the painful thing we've been focusing on is that it *is* a dangerous relationship. But when you hear people saying "Stay away!" the pull toward each other and toward affirming

* * *

Page 283:

the bond between you almost gets more intense.

Karen: So I could try to think of affirming the bond as being strong in myself - of putting myself first.

Tx: Exactly.

[We saw the couple one week later. This is how the session began:]

Tx: So, what did you decide to do?

Karen: I stayed where I was.

Tx: How did you decide to do that?

Karen: Well, I just thought really clearly about how - how to keep myself safe - and about what I wanted. I felt insecure about going back into the relationship with Paul. Even though it was hard and I was torn. I thought it was better if I just . . . stayed separate.

Tx: And was it very hard for you to come to this?

Karen: Very difficult. I kept thinking I needed to be in the relationship to work on it - that sort of old thinking - that I'd have to have some contact or I'll lose everything. But I think that because, you know, we talked last week about how being apart could be a positive thing for us - I think that intellectually it was validated for both of us. I think it gave Paul strength the same way it gave me strength.

Here again we can find change, not just in Karen's choice "to stay separate" but also in the way she speaks about her internal process and her view of the relationship. Notice how she begins by saying "I thought really clearly about how to keep myself safe and about what I wanted." Compare this with her self-description 8 days earlier: "I don't really understand what I should do. . . . I don't understand how to protect myself. . . . I'm so unsure of my opinions. . . . I don't trust my judgment any more." And note how, in the space of one week, Karen can characterize her need "to have some contact or I'll lose everything" as "that sort of old thinking."

Speaking Memories and Bearing Witness

As men give up their violence and other coercive behaviors, they understandably expect their partners to respond with relief and appreciation. But they are often disappointed, because the women, far from expressing gratitude, often get even more angry at them. This paradox makes sense given the context of fear and intimidation in which the women have been held hostage for so long. As long as the man was violent, it was far too risky to show or even feel the full extent of their anger. It is only in the context of a long-enough interval of safety that these women can allow themselves emotionally to remember and speak about their ordeal. What emerges is often a deep anger and a great bitterness.

Case Example

Thus, it seems appropriate to end this essay bearing witness - along with Jim her partner - to Irene's description of her life under seige. It has been one year since Irene and Jim, a Jewish lower-middle-class couple, married 20 years, first began treatment with us. They are now in a couples group with other men and women who have also completed couples therapy in our program. The group, sometimes meeting on its own, sometimes therapist-led, provides social support and a context of accountability for the daily work of maintaining a nonviolent and equitable relationship.

Irene: I have to let you know what you did to me!

Jim: Tell me. Tell me now. Let it out.

Irene: [sighs]. . . . [softly] I really lost myself. I spent so much time watching you - it was such a waste of time! Every waking moment, every move, every word, every look was always calculated. Almost nothing was spontaneous. Everything you said had to be weighed, okay? "What is his reaction going to be? What is it going to

* * *

be?" I was always - [starts to cry] I never knew when the floor was going to be pulled out from under me! We talk here about growing as a person. I couldn't do that! Every ounce of strength I had was put into figuring out what was going to happen next. We never had a relationship - all we had was a twenty-one year fight that was punctuated by vacations! And then there was the honeymoon period - the making up - I never knew which - I never *had* any footing. I'd start to feel "things are getting better, he's growing up," and I would get off-guard again. And then bingo! As soon as I started to relax, I got it again. Right between the eyes! I didn't know *who* I was, or *what* I was, or where I was. I didn't know what was going on! And I'm very, very upset about the time

that was lost. I'm *very* upset about that. . . . Every single decision, every move I made was predicated on your behavior or whether or not something would set you off. I used to *read your face* when you came in through the door at night. I used to *look at your face;* I used to look at the way you held yourself, whether you were talking or weren't talking; and there were times I said to myself, "Uh oh, you better get out of here!" And I would be perfectly cheerful, "Oh, hi, honey! You're home! Did you have a nice day?" And I would just be chirping on, a bunch of bullshit, you know - Just waiting, you know, waiting, waiting, waiting, waiting, and trying to get out of the way as quickly as possible. [bitterly] And if he didn't get me that night, he'd get me the following morning. Or the day after. But once I knew that that little fuse was set, I'd get it. I'd get it. . . I didn't know if I'd get choked or I'd get smacked or I'd get my arms twisted, or I'd get the verbal shit! Every time I stood up for myself - [to the group] You say [tearfully] stand your own ground, find your own space - well, every time I stood up or I tried to hold my space, that wasn't the right thing to do either! Because that set him off even worse. . . . So *that's what it was like,* Jimmy! That's what is was like. So what I am today, I didn't become this overnight. That's the point, Jimmy. That's the point. You say I'm afraid of change. This didn't happen overnight. This took twenty-one years of hard work to get to this place! So don't go dumping this shit on me that I'm afraid to change. You paint yourself as being such a fuckin' saint here. You're such a good little boy now. Well, they should have known you before! And now that he's such a good little boy - Everybody's just like - "You're doing a great job, Jim," and you *are* doing a great job, Jimmy. You *are* doing a great job. But that don't mean what you did before doesn't count. . . . So *that's* where I am!

REFERENCES

Avis, J. M. , 1992
Where are all the family therapists? Abuse and violence within families and family therapy's response.Journal of Marital and Family Therapy 18, 223-233 pp,

Bograd, M. , 1984
Family systems approaches to wife battering: A feminist critique.American Journal of Orthopsychiatry 54, 558-568 pp,

Bograd, M. , 1992
Values in conflict: Challenges to family therapists' thinking.Journal of Marital and Family Therapy 18, 243-257 pp,

Brown, P. D. , O'Leary, K. D. , 1995
Marital treatment for wife abuse: A review and evaluation. Paper presented at 4th International Family Violence Research Conference, Durham NC.

Edleson, E. , Tolman, R. , 1992
Intervention for men who batter. Newbury Park CA: Sage Publications.

Feldman, C. M. , Ridley, C. A. , 1995
The etiology and treatment of domestic violence between adult partners.Clinical Psychology: Science and Practice 2, 317-348 pp,

* * *

Geffner, R. A. , 1997
Family violence, current issues, interventions and research (pp. 1-37). In R.A. Geffner, S.B. Sorenson, & P.K. Lundberg-Love (eds.), *Violence and sexualabuse at home.* Binghamton NY: Haworth Press.

Goldner, V. , 1985
Feminism and family therapy.Family Process 24, 31-47 pp,

Goldner, V. , 1992
Making room for both/and.The Family Therapy Networker 16(2), 55-61 pp,

Goldner, V. , in press
Morality and multiplicity: Perspectives on the treatment of violence. Journal of Marital and Family Therapy.

Goldner, V. , Penn, P. , Sheinberg, M. , Walker, G. , 1990
Love and violence: Gender paradoxes in volatile attachments.Family Process 29, 343-364 pp,

Gondolf, E. W. , 1995
Gains and process in state batterer programs and standards.Family Violence and Sexual Assault Bulletin 11, 27-28 pp,

Hansen, M. , 1993
Feminism and family therapy: A review of feminist critiques of approaches to family violence (pp. 69-82). In M. Hansen & M. Harway (eds.), *Battering and family therapy: A feminist perspective.* Newbury Park CA: Sage Publications.

Holtzworth-Munroe, A. , Beatty, S. B. , Anglin, K. , 1996
The assessment and treatment of marital violence (pp. 317-339). In N.S. Jacobson & A.S. Gurman (eds.), *Clinical handbook of couple therapy.* New York: Guilford Press.

Holtzworth-Munroe, A. , Smutzler, N. , Bates, L. , Sandin, E. , 1997
Husband violence: Basic facts and clinical implications (pp. 129-156). In W.K. Halford & H.J. Markman (eds.), *Clinical handbook of marriage and couples interventions.* New York: John Wiley & Sons.

Jacobson, N. , 1994
Rejoinder to Lipchik and Geffner. *Family Therapy News* (April): 13, 27.

Jenkins, A. , 1990
Invitations to responsibility. Adelaide, Australia: Dulwich Centre Publications.

Kaufman, G. , 1992
The mysterious disappearance of battered women in family therapist's offices: Male privilege colluding with male violence.Journal of Marital and Family Therapy 18, 233-245 pp,

Margolin, G. , Burman, B. , 1993
Wife abuse vs. marital violence.Clinical Psychology Review 13, 59-73 pp,

Pence, E. , Paymar, M. , 1993
Education groups for men who batter: The Duluth model: New York: Springer.

Sheinberg, M. , 1992
Navigating treatment impasses at the disclosure of incest: Combining ideas from feminism and social constructionism.Family Process 31, 201-216 pp,

U.S. Department of Justice 1994
Sex differences in violent victimization. Washington DC: National Criminal Justice Reference Service.

Walker, G. , in press
The initial assessment sessions with couples where battering is an issue. *Journal of Marital and Family Therapy.*

Walker, G. , Goldner, V. , 1995
The wounded prince and the women who love him (pp. 24-45). In C. Burcke & B. Speed (eds.), *Gender and power in relationships,* London: Routledge, Chapman and Hall.

Willbach, D. , 1989
Ethics and family therapy: The case management of family violence.Journal of Marital and Family Therapy 15, 43-52 pp,

Yllo, K. , Bograd, M. , 1989
Feminist perspectives on wife abuse. Beverly Hills CA: Sage Publications.
January 7, 1998January 7, 1998July 14, 1998

* * *