Current Research, Assessment and Treatment of Domestic Violence Victims and Offenders

Presented by

Robert A. Geffner, PhD, ABPP
Current Research, Assessment, and Treatment of Domestic Violence Victims and Offenders

Robert Geffner, Ph.D., ABN, ABPP
Licensed Psychologist; Licensed Marriage & Family Therapist
Diplomate in Clinical Neuropsychology
Board Certified in Couple & Family Psychology
Founding President, Family Violence & Sexual Assault Institute
Founding President, Institute on Violence, Abuse and Trauma
Distinguished Research Professor of Psychology,
Alliant International University, San Diego
Past President, American Academy of Couple & Family Psych.
Co-Chair, National Partnership to End Interpersonal Violence
email: bgeffner@pacbell.net
www.ivatcenters.org

Presentation Outline:
- Current Research on Relationship Aggression, Typologies, Males & Females
- Attachment and Adverse Childhood Experiences
- Biopsychosocial/Bioecological Issues & Models
- Risk and Other Assessment
- Readiness to Change – Transtheoretical Model
- Treatment Controversies and Techniques for Reducing Spouse/Partner Abuse
- An Abuse-Specific Individual and Couples Counseling Program
- What is Successful Treatment?

Definitions

Distinction between Abuse and Aggression:
- Abuse = a pattern of behavior where one partner gets his/her needs met at the expense of the other through the use of power and control; usually has elements of intimidation, and often produces trauma.
- Aggression = usually physical but can be verbal or sexual, where one person commits an assaultive behavior on the other person.
- Thus, can have abuse without physical aggression, or aggression without abuse. Mutual Abuse would be where both partners are fighting with each other for power and control (not common – 10-15% of cases).

DIFFERENT TYPES OF MALE BATTERERS

Assaultive Type Characteristics
Family Only
- High dependency on partner
- Low levels of impulsivity
- Poor communication skills
- Family of origin violence
DIFFERENT TYPES OF MALE BATTERERS

Dysphoric/Borderline
- Parental rejection
- Child abuse (family of origin violence)
- High dependency on partner
- Poor communication
- Poor social skills
- Hostile to women
- Low remorse

Low Level Antisocial
- Antisocial behaviors but not at antisocial level of personality disorder; substance abuse often present

Generally Violent/Antisocial
- Family-of-origin violence
- Juvenile delinquency
- Deficits in communication, social skills
- Violence viewed as appropriate response to provocation

Adapted from Holtzworth-Munroe and colleagues, 2001-2002

Johnson’s Typology of IPV
(Johnson, 2008)
NOT VALIDATED AND DOES NOT MATCH ACCEPTED RESEARCH

<table>
<thead>
<tr>
<th>Motives of DV</th>
<th>Intimate Terrorism (IT) (Feminist Perspective)</th>
<th>Situational Couple Violence (SCV) (Family Violence Perspective)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintaining general control over one’s partner</td>
<td>Family conflict that is instigated by stress</td>
<td>Family conflict rooted in coercive control or situational stress</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Distinguishing Features</th>
<th>Violence rooted in coercive control</th>
<th>Violence rooted in conflict or situational stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple violent and non-violent control tactics</td>
<td>Specific conflicts or situations in which one or both partners act out violently</td>
<td></td>
</tr>
</tbody>
</table>

QUESTIONS TO CONSIDER WHEN LOOKING AT FEMALE PERPETRATORS

The context of the abuse: “The actions of a person of one sex cannot be considered the equivalent of the other sex engaging in the behavior” (A slap is not the same when given by a woman as when given by a man).
- Males consistently under-report acts of abuse against them.
- Wives are more seriously injured than husbands, and wives also less frequently use severe violence (Browning & Dutton, 1986, Brush 1990). Men usually initiate the violence and are more likely to engage in multiple acts of assault (Saunders, 1990).
- What is the history of abuse in this relationship? Is the woman an abused victim who is finally striking back or is she the primary aggressor?
**Female DV Offenders**

From Lisa Conradi & Robert Geffner 2004; 2011

- History of victimization
- Identification with masculine gender traits
- Problems related to substance abuse
- Emotional abuse by partner
- Perception of self as dominant in relationship
- History of violent behavior
- Perception of personal characteristics as aggressive.

**The Three Minor Themes Included:**

- A woman's change in her self-identity
- Violence as a motivation to get her partner's attention
- Emotional detachment.

---

**Attachment Types**

Secure
- Fearful/Anxious-Avoidant/, Detached
- Anger, Rage, Depression

Dismissing/Anxious-Ambivalent, Preoccupied
- Disorganized, Poor Social Skills, Power and Control

Rejection and Need for Control leads to BPO or Antisocial

Bowlby, Ainsworth, Bartholomew

---

**ALCOHOL/DRUG USE ABUSE & TRAUMA AND DOMESTIC VIOLENCE**

Treatment for alcohol or drug problems must occur prior to or currently with the treatment for IPV. There is no evidence that alcohol treatment by itself will be effective in changing abusive behaviors - however alcohol and drug problems most likely seriously interfere with the process of change and must be addressed.

Treatment for trauma is similar. It must be a focus of an intervention program and/or individual therapy.

---

[Diagram of parts of the cerebral cortex]
Brain activity of children exposed to IPV on fMRI Scans same as soldiers exposed to violent combat – increase in Amygdala and Anterior Insula when viewing pictures of angry faces.


Executive Function Issues/Deficits for Offenders and Victims of Family Violence: A Biopsychosocial Approach

- General organization and planning
- Ability to solve problems
- Regulation of activity/Impulsivity
- Learned aggression, power and control
- Low threshold for frustration/stress
- Closed head injuries or other neuropsychological impairments

Common Principles Linking Trauma and Brain Impairment to Family Violence

- Affect and impulse dysregulation – Aggression
- High levels of anxiety
- Rapid shifts in psychological state
- Disturbances in sense of self: low self-esteem, body image distortion, identity diffusion/fragmentation, attachment issues, lack of self-awareness
- Self-destructive behaviors
- Attention, concentration, and memory problems
In Summary …..

- Abused victims and offenders need to be carefully diagnosed to R/O disorders such as PTSD.
- Abuse and maltreatment, even without PTSD, may be associated with chemical and structural brain changes.
- While these changes are still under investigation, they appear to have real-life consequences for affect regulation, etc.
- Assessment can assist with diagnosis, prognosis, and intervention recommendations.


ISSUES/QUESTIONS

1. Who is the primary/dominant aggressor in the relationship?
2. Past victimization/trauma/abuse?
3. Depression history?
4. Relationship history?
5. Emotional expressiveness?
6. Issues of child abuse and parenting?
7. Conflict management styles?
8. Neuropsychological impairment?
9. Substance abuse/dependence history?
10. Attachment issues?
11. Motivation to change/accept responsibility?

RISK FACTORS FOR RELATIONSHIP AGGRESSION

- attitudes about power, control, & gender roles
- paranoia
- impulsivity
- excessive alcohol/drug use
- stress
- low self-esteem
- poor social skills
- anger
- shame
- depression
- lack of empathy
- lack assertiveness
- attachment disorders
- trauma history
- psychopathy
- neuropsychological Impairment
- jealousy
- poor conflict resolution skills
- dominance needs
- communication deficits
- prior abuse history
- personality disorder(s)
- lack readiness to change
Assessment of IPV

Complete assessment includes:

- Thorough assessment of violence, abuse, power and control issues
- Assessment of emotional and psychological functioning
- Assessment of chemical usage
- Assessment of motivation to change

Assessment Strategies

• Examine circumstances relevant to the violence/abuse (use of alcohol/drugs, child rearing, traumas, impulsivity, mood regulation, etc.)
• Types of threats
• Personality characteristics
• Analysis of the frequency and severity
• Coping strategies
• What happens after violent episode is over?
• Psychological and physical impact of violence/abuse on each family member
• Readiness to change

Geffner, Conradi, Geis, & Aranda, 2007

Assessment

• Basis of Treatment Planning
• Identify Exposure Timeline
• Symptom Clusters - ongoing evaluation
• Risk and Protective Factors
• Inclusion of Each Family Member??

SPOUSE ABUSE IDENTIFICATION QUESTIONNAIRE

(Robert Geffner, Ph.D., ABPN & Mildred Pagelow, Ph.D.)

Were either you or your spouse physically abused in childhood? If so, in what way?

Was there a history of violence in either of your families?

If so, was the violence directed at the children, or was it directed at one parent by the other?

Does either your spouse or his/her parents abuse alcohol? Do you? Do your parents?

Has your spouse ever threatened to harm you?

Are your spouse's problems usually blamed on you or others?
SPOUSE ABUSE IDENTIFICATION QUESTIONNAIRE

____ Have you been attacked or blamed when your spouse got angry?
____ Are you afraid of your spouse's temper?
____ When drinking, does your spouse get rough or violent?
____ Has your spouse ever hurt you? When? What happened?
____ Has your spouse ever deliberately hurt or killed a pet?
____ Does your spouse have a Dr. Jekyll and Mr. Hyde personality?
____ Are your children afraid when your spouse is angry?
____ Have you felt free to invite family or friends to visit you?

SPOUSE ABUSE IDENTIFICATION QUESTIONNAIRE

____ Is your spouse an extremely jealous person?
____ Has your spouse ever forced you to have sex even though you did not want to?
____ Have you ever called, or thought of calling, the police because an argument was getting out of control?
____ Have your neighbors or friends ever called the police because of your situation?
____ If the police were called, was your spouse arrested or given a citation?
____ Does your spouse ever threaten to take the children where you could not find them? Did this ever occur?
____ Do you feel safer when I talk with you alone?

Risk/Lethality Assessment

Predictive Factors:
- History of Violence, frequency, threats, criminal history, jealousy, isolation, stalking, sexual assault, use of weapons, abuse of animals
- Child abuse
- Mental illness
- Substance abuse
- Neuropsychological impairment
- Additional stressors

Dangerousness and Risk Assessment

S Substance Abuse
N Narcissism
A Attitudes About Violence
P Paranoia
P Psychopathy
I Impulsivity
N Neuropsychological Factors
G General Resources Lacking

Influence of Dissociation, Trauma and/or Maltreatment History
Dalenberg, 1999; adapted by Geffner, 2000
DANGER ASSESSMENT - 2

When you were beaten/abused by your spouse/partner, how bad was the incident according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones
4. Threat to use weapon; head injury; internal injury; permanent injury
5. Use of weapon; wounds from weapon

(If any of the descriptions for the higher number apply, use the higher number.)

Mark Yes or No for each of the following ("S/he" refers to your spouse, partner, ex-spouse, ex-partner, or whoever physically hurt you).

1. Has the physical violence increased in severity or frequency over the past year?
2. Does s/he own a gun?
3. Have you left your partner after living together during the past year?
   3a. (If you have never lived with your partner, check)
4. Is your partner unemployed?
5. Has s/he ever used a weapon against you or threatened you with a lethal weapon? (If yes, was the weapon a gun? __)
6. Does s/he threaten to kill you?
7. Has s/he avoided being arrested for domestic violence?
8. Do you have a child that is not your partner's?
9. Has s/he ever forced you to have sex when you did not wish to do so?

Danger Assessment 2 (cont'd)

10. Does s/he ever try to choke you?
11. Does s/he use illegal drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs or mixtures.
12. Is s/he an alcoholic or problem drinker?
13. Does s/he control most or all of your daily activities? For instance, does s/he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car? (If s/he tries, but you do not let him/her, check __)
14. Is s/he violently and constantly jealous of you? (For instance, does s/he say "If I can't have you, no one can?

Danger Assessment 2 (cont'd)

15. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him or you are a male, check here: __)
16. Have you ever threatened or tried to commit suicide?
17. Has s/he ever threatened or tried to commit suicide?
18. Does s/he threaten to harm your children?
19. Do you believe s/he is capable of killing you?
20. Does s/he follow or spy on you, leave threatening notes or messages on answering machine, destroy your property, or call you when you don't want him/her to?

_____ Total "Yes" Answers
Fear Index (by F. Dunford)

Considering your present feelings how much do you agree with the following statements:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am afraid of my (Spouse/Partner).</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>2. I am scared that my (Spouse/Partner) will physically hurt me.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>3. At times I fear for my life.</td>
<td>1 2 3 4</td>
</tr>
</tbody>
</table>

Brief Client Screening Battery

Robert Geffner, Ph.D., ABN, ABPP

Trauma Symptom Inventory (TSI-2)
- Briere, 2009 (120 items, 4-point Likert scale)
  - 15 minutes (PAR)
  - or
The Detailed Assessment of Posttraumatic Stress (DAPS)
  - Briere, 2001 (105 items, 4 point Likert scale)
  - 25 minutes (PAR)

Interpersonal Behavior Survey (IBS)
- Mauger & Adkinson, 1980 (272 items, true/false)
  - 40 minutes average (WPS)

Personality Assessment Inventory (PAI)
- Morey, 2007 (344 items, 4-point Likert scale - 45 minutes (PAR)

Conflict Tactics Scales – 2 (CTS 2)
- Straus, Hamby, et al, 2003 (78 items, Nominal)
  - 15 minutes (WPS)

Tier 2 Measures if Needed:

Minnesota Multiphasic Personality Inventory – 2 - Butcher & Megargee, 1989 (567 items, true/false)
- 1 ¼ hours (Pearson)

Parenting Stress Index (PSI) Short Form 4th ed - Abidin, 2011 (36 items, 5-point Likert scale) - 10 minutes (PAR)

Suicide Probability Scale (SPS) - Cull & Gill, 1988 (36 items, 4-point Likert scale) - 10 minutes (WPS)

Dissociative Experiences Scale - Revised (DES-R)
- Carlson & Dalenberg, 1998 (41 items, 6-point frequency scale) - 15 minutes

Marital Satisfaction Inventory - Revised (MSI-R)
- Snyder, 1997 (150 items, true-false inventory) - 30 minutes or less (WPS)

Test Publishers

PAR -Psychological Assessment Resources, Inc. - P. O. Box 998, Odessa, FL 33556
800 331-8378  www.parinc.com

WPS -Western Psychological Services - 12031 Wilshire Blvd., Los Angeles, CA 90025 800 648-8857 www.wpspublish.com

MHS -Multi-Health Systems - P. O. Box 950, North Tonawanda, NY 14120
800 456-3003 www.mhs.com
EVALUATING THE ATTACHMENT BOND –
Compassionate Model, Stosny

How much do you love this person?
Is the bond between you a strong one?
Or is it maintained by habit, convenience, or coercion?
Is the damage done to the relationship repairable?
Do you want to repair it?
How can it be repaired?
How will you know that it is repaired?
How will you relate differently when it is repaired?
How can you move forward and grow from the hurt of the past?

Attachment Issues in Treatment

On a scale from 1 - 10,

How safe and secure do I feel?
How safe and secure does my partner feel?
How safe and secure do our children feel?
How strong is my level of compassion for my partner?
How strong is my partner’s level of compassion for me?

Adapted from Stosny, 2006

WEEKLY BEHAVIOR INVENTORY
Robert Geffner, Ph.D., & Carol Mantooth, M.S.

<table>
<thead>
<tr>
<th>Happened to Me</th>
<th>Happened to Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slapping</td>
<td>Slapping</td>
</tr>
<tr>
<td>Kicking</td>
<td>Hair Pulling</td>
</tr>
<tr>
<td>Punching</td>
<td>Kicking</td>
</tr>
<tr>
<td>Hair Pulling</td>
<td>Punching</td>
</tr>
<tr>
<td>Throwing Things</td>
<td>Throwing Child</td>
</tr>
<tr>
<td>Throwing Mate or Shoving</td>
<td>Hitting w/Physical Object</td>
</tr>
<tr>
<td>Hitting w/Physical Object</td>
<td>Scarring Child</td>
</tr>
<tr>
<td>Choking</td>
<td>Use of Weapon</td>
</tr>
<tr>
<td>Threat of or Use of Weapon</td>
<td>Threat of Use of Weapon</td>
</tr>
<tr>
<td>Burning</td>
<td>Burning</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>Sexual Abuse</td>
</tr>
<tr>
<td>Destruction of Property</td>
<td>Verbal Abuse</td>
</tr>
<tr>
<td>Verbal Abuse</td>
<td>Emotional Abuse</td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>Act Assertively</td>
</tr>
<tr>
<td>Act Assertively</td>
<td>Communicate Effectively</td>
</tr>
<tr>
<td>Communicate Effectively</td>
<td>Use Time Out</td>
</tr>
<tr>
<td>Use Time Out</td>
<td>Control Anger Behavior</td>
</tr>
<tr>
<td>Control Anger Behavior</td>
<td>Spent Quality Time</td>
</tr>
<tr>
<td>I Did Homework</td>
<td>I Don't Feel Safe to</td>
</tr>
<tr>
<td>I Did to Partner</td>
<td>I Did to Children</td>
</tr>
<tr>
<td>I Did Homework</td>
<td>I Don't Feel Safe to</td>
</tr>
<tr>
<td>I Did Homework</td>
<td>I Don't Feel Safe to</td>
</tr>
<tr>
<td>I Did to Partner</td>
<td>I Did to Children</td>
</tr>
</tbody>
</table>

R. Geffner, Ph.D. – Chicago, IL - 5/2016 - Do Not Reproduce Without Written Permission
Processes of Change

HOW people change
Affective, Cognitive, and Behavioral strategies and techniques used to change attitudes, beliefs, & behaviors
Facilitate transitions between stages
Used as basis of intervention design

Adapted from Deborah Levesque, 2002; 2007 by Geffner

Stages of Change (Transtheoretical Model)

Precontemplation
Contemplation
Preparation
Action
Maintenance
Termination


Precontemplation Stage

No intention to change in next 6 months
Cons > pros
Defensive
Resistant
Demoralized
Change experienced as coerced
About 40% of population at risk

From Deborah Levesque, 2003; 2007

In the first stage, precontemplation, individuals with violent behaviors have no intention of changing and are likely in strong denial. Contemplators accept or realize that they have a problem with violence/abuse and begin to think seriously about changing it, but they have not made a commitment to take action in the near future. Individuals who are in the preparation stage are planning to take action within a short time period. They think more about the future than about the past, and more about the benefits of being non-violent than about the losses. Action is when the client is overtly expressing a genuine belief that violence/abuse is unacceptable and is actively utilizing the therapeutic interventions to change him/herself and the relationship. Maintenance, often far more difficult to achieve than action, can last a lifetime. Maintenance is a long, ongoing process. Three common internal challenges to maintenance are overconfidence, daily temptation, and self-blame for lapses.
Contemplation Stage

Intend to change next 6 months
Pros = cons
Ambivalent
Lack commitment
Lack confidence
‘Chronic’ contemplation
About 40% of population at risk

Preparation Stage

Intend to change in next 30 days
Pros > cons
Have a plan
Have taken small steps
Decisive/committed
More confident
Ideal program participants
20% of population at risk

Action Stage

Overt change
Greatest risk of relapse
Inappropriate goals
Inadequate preparation
Not enough time
Give up too easily

Maintenance Stage

Relapse prevention
Dynamic, not static
Self-efficacy
Consolidate gains
Improve coping skills
Life-long struggle
Termination

- Minimal temptation to relapse
- High self efficacy
- Achievable for 20% of smokers and alcoholics
- Many offenders may face a lifetime of Maintenance

Decisional Balance

- Pros of Change
  - perceived positive consequences
  - facilitators
- Cons of Change
  - perceived negative consequences
  - barriers

Redefine Success

- Successful change takes time
- Don’t expect immediate action
- Intermediate markers of success
  - Progress through stages of change
  - Increased Pros of change
  - Decreased Cons of change

Recidivism by disposition

- Treatment non-completers 67.6%
- Incarceration 56.7%
- Counseling unspecified 47.4%
- Probation only 36.1%
- Certified BIP 35.1%
- Arrest only 33.2%

Summarized by Rosenbaum, 2004
THE STIGMA OF LABELING

- For most perpetrators, the label of “Batterer” or “Stalker” is difficult to handle.
- For the most part, they don’t see themselves as these labels and there is a lot of resistance - which can create treatment obstacles if not dealt with relatively early in treatment.
- Many of them have a difficult time with seeing themselves as stalkers because their intent was loving, protective, meant in a positive manner - they often have a difficult time understanding that their victim felt fear.

TREATMENT MODALITY:

INDIVIDUAL vs GROUP
GENDER SPECIFIC vs COUPLES
CONJOINT vs PARALLEL
FIXED vs OPEN
ENDED/ONGOING

Phase-Oriented Treatment

- Safety and Stabilization.
- Symptom Reduction
  - Regulating emotion
  - Processing trauma
  - Attachment issues
  - Substance abuse/dependence
- Developmental skills.

Treatment Goals

Regulating emotion:
- Help the client learn healthy ways to regulate emotions
- Help the client reduce and eliminate self-destructive behaviors.
- Promote acceptance of painful feelings.
- Promote the direct expression of feelings in healthy attachments and relationships.

Building positive relationships

Correcting cognitive distortions:

Desensitizing and processing traumatic experiences.

Building social and life skills

Adapted from the ISSTD Guidelines for treatment (2000).
Goals of Brain Based Interventions

- Body regulation
- Emotional balance
- Response flexibility
- Empathy
- Insight
- Modulating fear and anger
- Intuition
- Cognitive restructuring

Five Essential Ingredients for Healing

- Attachment and Connection: To build and rebuild relationships where they felt mutual curiosity, compassion, empathy, connecting to a deep set of values that provide a meaningful vision.
- Safety and Empowerment: Safe context/boundaries/structure within and between themselves and their relationships
- Value: Collaboration/strength based guidance/vulnerability and resilience
- Skills: Psycho educational experiences/cognitive behavioral/neuro-mind-body/communication/mindfulness/self-regulation within and between
- Hope: Creation of workable realities
  Adapted from Mary Jo Barrett, 2014

COUPLES TREATMENT

Arguments against doing couples treatment:

Using a systemic framework involves placing blame and responsibility for the problem on all members of the relationship instead of placing responsibility for the violence on the violent partner.

Safety issues for the victim. It is often felt that the victim (usually female) may not be able to speak freely without fear of repercussions. In addition, the victim may be lulled into a feeling of safety and speak out in the therapeutic setting and then pay dearly for it later.

The violence may be escalated instead of stopped.

The truth may not be told by either party.

The victim is not the one with the problem; the abuser is the one with the problem.

This can be seen as further victimizing the victim.

Arguments for doing couples treatment:

Most couples stay together. They are going to need help to make it work, while still holding the abuser responsible for the violence.

It is difficult on a relationship when one person is changing and learning new healthier behaviors and the other person is still stuck doing the old unhealthy behaviors. In couple's treatment, both members of the couple are learning the new skills and can work on them together.

The therapeutic setting allows therapists a more accurate view of what happens in the relationship and adjustments/feedback can be done immediately.

The therapeutic setting may empower the victim to feel that there are ways of making the abuse stop, and that the abuser will be held accountable for abusive behavior.

The therapists can also model appropriate nonviolent behaviors and communication that can serve to reinforce these behaviors in the relationship. The victim and abuser can both learn that abuse is not acceptable behavior.
SOME PRECONDITIONS FOR CONJOINT COUPLES THERAPY

The victim and perpetrator desire this type of treatment.
The victim has a safety plan and understands the potential dangers.
An adult must accept responsibility if child abuse has occurred.
No custody issues if divorcing.
Lethality evaluation suggests low probability of danger.
The perpetrator does not harbor obsessional ideas toward the victim.
Therapists are trained in both family therapy and domestic violence.
Not currently abusing drugs or alcohol.
If there has been substance abuse, then treatment for this is required.
Neither partner exhibits psychotic behavior.

INTERVENTIONS

STRESS MANAGEMENT
ANGER/AFFECT REGULATION
IMPULSE CONTROL
PSYCHOEDUCATION
TRAUMA TREATMENT
SUBSTANCE ABUSE TREATMENT
COMMUNICATION & SOCIAL SKILLS
EMPATHY TRAINING
POSITIVE ROLE MODELS
RELAPSE PREVENTION
PARENTING

Shame-Based System
• Attacks and condemns you as a person (which leads to negative painful feelings about the self)
• Presumes that you are bad/worthless/inequitable/defective/unlovable
• Presumes that you are not responsible for your feelings and actions through the use of psychological defenses such as blaming, denial, minimizing, and justifying
• Based on a system of perfectionism that breeds isolation, despair, fear, discouragement, and, ultimately, more shame

Empowerment-Based System
• Evaluates and assesses your behavior (which may, at times, lead to negative painful feelings about your actions)
• Presumes that you are human, that you have “flaws” and problems, and that you will make mistakes at times
• Presumes that you are responsible for your thoughts, feelings, and actions (and your inaction!)  
• Based on a system of accountability that leads to personal growth and a respect for your own and others’ rights

Stosny’s Compassionate Approach to Treating Attachment Abuse

Compassion and Self-Building
Understanding Repeat Offenders & Barriers to Change: Implications for Batterer Intervention Programs

Jesse L. MacLaurin and Robert Geffner, 2007
Institute on Violence, Abuse & Trauma, AIU

Repeat Offenders

• Approximately 1/3 of batterers continue to engage in intimate partner violence
• Data show 10% of these men engage in the most severe violence (Dunford, 2000; Gondolf, 2002)
• Results seem to suggest:
  • Arrest on its own is not working
  • Treatment on its own as now practiced is not working
  • Need for alternatives and options

#1 Childhood Victimization

• Severe, Frequent, & Cumulative
• Physical & Emotional Abuse and/or Neglect
• Harsh Physical Discipline
• Exposure to Domestic Violence

From Jesse MacLaurin, 2007

#2 Early Attachment Trauma

• Chronic Loss or Separation
• Abandonment
• Deprivation and/or Rejection
#3 Maladaptive Socialization

• Dysfunctional Home
• Deviant Peer Association
• Antisocial Norms

#4 Mental Health Problems

• Chronic or Acute
• Coping Competency Deficits
• Problematic Personality: Traits/Characteristics/Disorder
• Clinical Disorder/Diagnosis

#5 Substance-Related Problems

• Early Onset/Chronic Use
• Family/Peer/Partner Use
• DV & Substance Use

#6 Intimacy & Attachment Problems

• Early/Ongoing/Pervasive
• Aggressive Problem Solving
• Imbalance of Power
• Detached/Hostile Emotional Climate
#7 Motivation Limitations

- Lack of Internal Motivation
- Lack of Prosocial Goal Orientation
- External Locus of Control
- Negative Attitude & Attributions
- Low Self-Efficacy
- Poor Self-Regulation

#8 Readiness Limitations

- Early, Unchanged or Regressed Stage of Change:
  - **Precontemplation**: Defensive/Resistant
  - **Contemplation**: No Motivation
  - **Preparation**: Ambivalent
- Lack of Authentic Change Engagement: “Just going through the motions”

#9 Treatment Need Deficits

- Lack of Comprehensive Care
- Lack of Collaborative Care
- Lack of Continuity of Care

#10 Treatment Responsivity Deficits

- Failure to Relate
- Failure to Respond
- Failure to Resonate
Clinical Implications

- Integrated Treatment Approach
- Coordinated Service Delivery
- Trauma & Attachment Informed Treatment
- Comprehensive /Collaborative/ Continuous Care
- Readiness Assessment & Treatment Matching
- Risk-Need-Responsivity Assessment & Matching
- Incorporation of Motivational Interviewing

Clinical Implications (Cont’d)

- Enhancing Interviews and Follow Ups
- Empathy Training Emphasis
- Avoid Confrontational Approach – Need to Connect More and Exhibit Caring
- Give Homework Assignments and Exercises
- Family Therapy If Have Children
- Conjoint Therapy if in a Relationship
- Supplemental Interventions
- Time-Oriented Treatment Not Working – Need Behavior & Attitude-Based System

Good Therapeutic Techniques

1. Focus on Change, Not Blame
2. Establish Rapport; Use Humor When Appropriate
3. Set Up Model of Equality, Good Communication
4. At First, Don’t Get into Details; Leads to Defensiveness
5. When in Denial, Ask About His/Her Story
6. Validate Feelings (e.g., How Uncomfortable Feels)
7. Help Feel in Control; Give Choices
8. Reframing – Move to Feelings or Solution Focus
9. Use Role Play, Demonstration, Homework

OBSTACLES IN IPV TREATMENT

The potential or possible clash between the legal system and the treatment system
The resistance to take responsibility for one’s actions
Past history of abuser
Mental disorders
Financial and time concerns
From a systems perspective, dealing with only one part of a system, with often little or no attention given to the other part(s) of that system
Clinical Recommendations

System Blaming
• Empathize with the client’s experience to build the therapeutic alliance
• Let the client know that this program will be helpful, even if s/he was “unjustly” arrested

Social Justification
• Collaboratively evaluate the client’s beliefs about what is normal behavior in his culture and what it means to be a woman
• Assess with the client whether she may need to change people, places, or things that support or encourage his violent behavior

Adapted by R. Geffner from Levesque, 2006

Clinical Recommendations (Cont’d)

• Stress that while the client cannot control or change his/her partner's behavior, s/he has choices about how will respond to it
• Assist the client in deciding whether to continue the relationship, and whether s/he will be able to make healthy changes if s/he decides to continue it
• Problems with alliance
• Examine your own attitudes about DV offenders and DV treatment
• Address potential problems with alliance and your responsibilities to the client openly and proactively

Sequence of Questions – Eve Lipchik, MSW
1. Define problems and goals from clients’ point of view
2. Ask for exceptions to problem:
   • When don’t you or didn’t you have this problem?...even a little bit?
   • What is different at that time?
   • What will have to be different for more of that to happen?
   • How do you usually solve problems like this?
   • What percentage of the time is this situation problematic as compared to not?
   • To what degree would it have to change for you to feel things are tolerable?
   • What would a small change towards that goal be?
   • How would that make a difference for you? for others?
   • What would you notice about yourself...others...what would they notice about you?

IF THERE ARE NO EXCEPTIONS:
Ask: If a miracle happened tonight and you woke up tomorrow morning and your problem is solved, how would things be different? Describe from your point of view and that of others.

In response to clients’ answer:
• Does some of that happen already at times? a little?
• What would have to happen for more of that to happen?
Motivational Interviewing

Motivational Interviewing: “is client-centered, directive, method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.” (Miller & Rollnick, 2002)

Step 1: Building a Bond
Step 2: Gathering Information & Providing Feedback
Step 3: Summarizing & Reconnecting

Specific Techniques and Programs

Modules and Order of Treatment for Couples vs Abuser vs Victim Only
20-52 Week Sessions
Examples of Techniques
ENDING SPOUSE/PARTNER ABUSE: A PSYCHOEDUCATIONAL APPROACH FOR INDIVIDUALS AND COUPLES
Robert Geffner, Ph.D.
Family Violence & Sexual Assault Institute, San Diego, CA
With
Carol Mantooth, M.S.
Andrews Center, Tyler, TX
Springer, 2000

TREATMENT OUTLINE

Foundations and Brief Interventions
1. Ground Rules and Assumptions; House of Abuse
2. Safety and Control Plans
3. Basic Anger Management
4. Effective Stress Control
5. Desensitization Techniques for Reducing Anxiety & Anger
6. Social Roots of Aggression and Alcoholism Issues

Communicating and Expressing Feelings
7. Communication: "Fair Fighting, Dirty Fighting"
8. Communication: Rules and Barriers
9. Communication: Expression and Listening
10. Communication: Handling Criticism
11. Identification of Feelings
12. Emotional Awareness and Expressing Feelings

Self-Management and Assertiveness
13. Dynamics of Self-Esteem
14. Improving Self-Esteem
15. Self-Talk and Irrational Beliefs
16. Changing Distorted Self-Talk
17. Stress Inoculation for Anger Control
18. Dynamics of Assertiveness

Intimacy Issues and Relapse Prevention
20. Problem-Solving, Decision-Making, and Negotiation
21. Most Violent and/or Most Frightening Incident
22. Most Violent/Frightening Incident Continued
23. Intimacy and Love
24. Empathy Training and Role Reversals
25. Relapse Prevention Plans
26. Future Plans
   Monthly Group Follow-Up Sessions
THE WEAVER PROGRAM
Koonin, Cabarcas, & Geffner

- Addresses female specific concerns-PMS, economic depression, conflict of roles, demands of life, family issues
- Addresses issues of parenting-very often there is child abuse going on in addition to the domestic violence
- Addresses victimization issues - from past abuse
- Addresses societal influences
- Addresses cultural influences
- Addresses alcohol/drug issues
- Deals with self-esteem and how violence/abuse is impacted by the lack of self-esteem

TREATMENT OF WOMEN ARRESTED FOR DOMESTIC VIOLENCE:
FVSAI 2002
MICHELE KOONIN, LCSW, ARACELI CABARCAS, PsyD & ROBERT GEFFNER, Ph.D.

Part 1: Foundations
2. Cultural Influences
3. Girlfriends And Jealousy
4-5. Anger and Depression
6. Alcohol and Drugs: It's Impact On Us

Part 2: Self-Management
7. Responsibility: Acceptance Of Our Own Actions
8. Time-Outs: Behavior Management
9. Stress Management
10. Bottom Lines and Boundaries
11-12. Self-Esteem and Self-Care
13. Self-Talk, Beliefs, and Our Identity
14. Changing Self-Talk and Beliefs

Part 3: Family Of Origin
15. Family Of Origin: Looking At Where We Came From
16. Who I Am, Who I Want To Be
17. Victimization

Part 4: Communication
18. Feelings
21. Becoming Assertive
22. Dealing With Conflict and Learning How To Solve Problems Effectively
Part 5: Family Issues
23. Family Album

Part 6: Intimacy Issues
25. Intimacy: What Does It Mean?
26. Understanding Love
27. Understanding and Meeting Your Own Needs
28. About Sex

Part 7: Relapse Prevention
29. Letting Go
30. Roles and Expectations
31. Self-Esteem: Feeling Good About Ourselves
32. The Final Touches
33. Role Reversal and Empathy
34. Relapse Prevention: Putting It on Paper

Safety Planning based on degree of danger

Goals of the Safety Plan
- Decrease possibility of fatality
- Empower client: decrease sense of isolation, enhance support system,
- State of mind (depression, trauma response)
- Safety planning with victim who is staying in the relationship
- Safety strategy when leaving an abusive relationship
- Safety planning with children: escape, don’t get in the middle, neighbors, make a call

Emotional/Psychological Maltreatment in Spouse Abuse

A pattern of acts or omissions, such as violent acts that may not cause observable injury, that adversely affects the psychological well-being of the victim. Arguments alone are not sufficient to substantiate emotional maltreatment.

Psychological violence is a pattern of behavior involving one or more of the following behaviors: explicit or implicit threats of violence, extremely controlling types of behavior, extreme jealousy, mental degradation (name calling, etc.), and isolating behavior.

Property violence by one spouse may constitute emotional abuse if intended as a means to intimidate the other spouse. Property violence includes, but is not limited to: damaging or destroying the other spouse’s property, hitting/kicking a door or wall, throwing food, breaking dishes, and intentionally or recklessly damaging automobiles. Threatening injury to or injuring children, threatening or actually kidnapping the children, and threatening or actually injuring pets, are all included in this category.
**EMOTIONAL/PSYCHOLOGICAL ABUSE**

Psychological/emotional abuse always accompanies and, in many cases, precedes physical battering or marital rape. Like hitting, targeted and repeated emotional abuses can have severe effects on the victim's sense of self and reality.

- Jokes about habits/faults
- Withholding approval as punishment
- Yelling
- Repeated insults/targeted insults
- Repeated humiliation (public)
- Repeated humiliation (private)
- Labeling as "crazy," "bitch," "whore," "animal," etc.
- Threatens violence/retaliation
- Puts down abilities as parent, worker, and lover
- Demands all of the attention (resents children)
- Tells about affairs
- Threatens with abusing children or getting custody
- Offers to stay because he/she "needs" them and can't make it without them

*From Geffner & Mantooth, 2000*

---

**SEXUAL ABUSE AND VIOLENCE**

This is the most difficult aspect of family abuse to identify and discuss, whether in a group or individually. Sexual abuse in the home is, however, more common than many would like to believe.

**Sexual Abuse/Assault in Marriage:**

- Jokes about women said in their presence
- Sexual "put-down" jokes
- Women/men as a sex object (leering)
- Minimizing feelings and needs regarding sex
- Criticizing sexual "performance"
- Sexual labels; "whore," or may call "frigid"

---

**Anger: A Misunderstood Emotion**

**What is Anger**

**Anger Triggers Stress**

**Three Components of Anger**

**Anger in Relationships**

- Power and Control
- Unproductive Self-Talk

**Anger at Work**

- Unwanted touch
- Uncomfortable touch (or forced to touch/watch others)
- Withholding sex and affection
- Always wanting sex
- Demanding sex with threats (e.g., withholding child support; custody battle; disclosure)
- Forced to strip - humiliation (maybe in front of kids)
- Promiscuity with others
- Forcing sex with him or others
- Forcing uncomfortable sex (e.g., after surgery, etc.)
- Forcing sex after beatings
- Forcing sex with animals
- Sex for the purpose of hurting (use of objects/ weapons)
- Sexual torture

*From Geffner & Mantooth, 2000*
Anger Styles

- Internalized Anger
- Dealing Effectively with Anger
  - Stress Management
  - Communication
  - Handling Criticism
  - Changing Self-Talk
  - Coping for Stressor Situations
  - Acting Assertively

Relaxation Exercise – Stress Management – Session #4

8. Personal Relaxation Program
   Usually, such a program would include three components: Progressive Muscle Relaxation, Breathing Exercises, and/or Mental Imagery. An example of such a program is:

   Sit in a chair and relax your body (your arms and jaw should be "loose").

   Close your eyes and erase all thoughts from your mind.

   Create in your imagination a vivid, soothing mental scene...a peaceful sky, a green valley, ocean waves, and so forth.

   Focus on breathing slowly and deeply...let your breath out slowly through your nose.

   For additional relaxation, repeat a phrase or sound that you find soothing (such as the word "flower" or the number "one").

   Repeat this exercise at least three times each day, whether or not you are tense, for about 30 to 50 seconds.

   After two weeks, your body will be conditioned to relax whenever you do this exercise, and you will feel yourself calming down.

Me Now

- My boundaries:
- My fears:
- My supports:
- My hopes and dreams:
- My hopes and dreams:
- My goals:
- My accomplishments:
- My strengths:
- My weaknesses:
- My regrets:
- My "Wish I would have's":
- Things I want to change:
- Things I think I can't change
- Things I need to do and learn:
The me I want to be

Fill in this puzzle with the you that you would like to be. After the puzzles are filled in, ask yourself the following questions:

1. How close are the two Me’s?
2. What are the biggest areas of difference?
3. What do I want to let go of? Where did I learn these things? How can I let go of them?
4. What is it that I want to change about myself the most? What are the obstacles to doing that?
5. What do I still do in spite of knowing that it is wrong for me? What keeps me stuck in still doing it?
6. How do I help myself become who I want to be?
7. How do I keep myself from becoming who I want to be?

SAFETY ISSUES AND RECIVIDISM DURING TREATMENT

- Progress in treatment is often slow and sometimes regresses.
- Times of difficulty or crisis are times when there may be regression. We all have a tendency to go to “what we know” in times of difficulty.
- The treatment process (hopefully) will provide an atmosphere where the client can be open about times of difficulty and of stress.
Times of crisis may include: divorce proceedings, child visitation, financial crises, another lover in the picture, and loss of hope that the relationship is going to survive.

Victims may often become angry and make demands on the perpetrator that may not be able to be met. This may precipitate a regression.

Clients need to be aware of the possibility of these times of crisis and know that they can ask for support from a variety of sources when/if that happens.

If clients/victims ask for help, support them, safety plan with them, and give them positive feedback for the newer and more productive ways that they handle issues.

Now look at the Female Caring Wheel on the next slide. Using the Caring Wheel, and the Aggression Wheel from Session One (the previous slide), and answer the following questions:

1. What changes have I made in relationships?
2. What have been the outcomes of those changes, both positive and negative?
3. What changes do I need to still work on in the future?
What is Successful Completion of Treatment for DV Offenders?

1. Client is taking real and practice Time-Outs on a weekly basis.
2. Client completes anger journal on a weekly basis.
3. Client demonstrates ability to identify physical and behavioral signs of abuse and anger.
4. Client demonstrates positive communication of anger as well as other feelings.
5. Client demonstrates positive social problem-solving skills.
6. Client has completed all additional homework assignments.

7. Client can recognize negative self-talk and transform it to positive self-talk.
8. Client is able to teach other clients behavioral skills and education concepts.
9. Client is able to recognize minimization, denial and blaming in self and others.
10. Client has not perpetrated violence or abuse for at least six months.
11. Client can recognize and address volatile situations with self and others.
12. Client has attended the minimum number of group sessions.
13. Client has paid all outstanding balances.
14. Client has actively participated in group sessions.
15. Client acknowledges complete responsibility for his/her violence or abuse.
16. Client evidences control over psychoactive substances, if applicable.
17. Client can recognize power and control behaviors and does not utilize them.
18. Client utilizes appropriate behaviors to solve conflicts.
19. Client has demonstrated a change in attitudes, beliefs, and behaviors.

Adapted from Daniel Sonkin, 2002, by Robert Geffner, 2002

PROGRESS EVALUATION FORM

Please rate the client named above on each of the listed criteria, based upon progress to date, and specify individual or group sessions. Use the 0 to 5 rating scale below, based on your impressions and observations. Obtain ratings from the client’s partner, if possible, on a separate form.

5=occurs very often; 4=often; 3=occurs sometimes; 2=not often; 1=occurs rarely; 0=unknown; na=not applicable

____ Attendance: arrives at group session on time; attends regularly; contacts program in advance about absence; has legitimate excuse for absences.
____ Nonviolence/Nonabusiveness: has not recently physically abused partner, children, or others; no apparent emotional or verbal abuse, threats, intimidation, or manipulation.
____ Sobriety: attends meeting sober; no apparent abuse of alcohol during week; complying to ordered or referred alcohol treatment.
Acceptance of responsibility: admits that violence and/or abuse occurred; not minimizing, blaming, or excusing problems; accepts responsibility for abuse, and contribution to problems.

Using techniques/skill development: takes steps to avoid abusiveness; takes time-outs, watches self-talk, practices conflict resolution skills, etc.

Homework: does homework assignments regularly, thoughtfully, and completely; follows recommendations for outside activities.

Help-seeking: seeks information about alternatives; discusses options with others in the group; calls other participants for help; open to referrals and future support.

Actively engaged/participates: attentive body language and positive non-verbal response; maintains eye contact; speaks with feeling; follows topic of discussion in comments; lets others speak; asks questions of others without interrogating; acknowledges others' contributions; participates constructively.

Self-disclosure: reveal s struggles, feelings, fears, and self-doubts; not withholding or evading issues; not sarcastic or defensive.

Respect: respectful of partner and other gender in general; uses non-sexist language and no pejorative slang; demonstrates non-controlling attitudes.

Empathy: understands the fears and trauma the abuse causes; realizes the negative impact of using power, controlling behaviors, and intimidation in relationships.

Insight: shows insight concerning abusiveness, its effects on partner(s) and children, and its dangerousness; understands the changes that are needed to ensure non-abusiveness.


EVALUATION OF INTERVENTION PROGRAMS

Credentials of Therapists/Facilitators/Consultants
List of Goals and Objectives
Indication of How Goals Are Met
How Techniques Fit Into Theoretical or Clinical Framework
Specify Reasons for Particular Methods and Procedures
Structured or Written Outline of Program
(Is Program Structured, Unstructured, or Both?)
Length and Frequency of Sessions; Duration of Program
Multidisciplinary, Multimodal, Comprehensive Intervention

Safeguards to Reduce Risk of Re-Victimization
Assess Behavioral and Attitudinal Change
Monitor Effectiveness and Provide Evidence of Progress
Techniques to Prevent Relapse
Long-Term Follow-ups
Feedback From Victims/Significant Others
Substantial Cooperation and Networking with Agencies, Etc.
Different Options Available Depending Upon Situation

R. Geffner, 1991; Revised 8/96