CHAPTER 7

COUPLE THERAPY IN CONJUGAL VIOLENCE

ASSESSING SAFETY AND READINESS FOR CONJOINT TREATMENT

Barry Trute & Marie Connolly

Over the past several decades there has been a marked expansion in knowledge, with some convergence of clinical and scientific opinion, on the treatment of domestic violence. However, some controversy still surrounds the debate on the use of couple therapy in the context of partner violence. The debate, which is often reflected in polarised views, traverses the ethical issues, dangers, and perceived effectiveness of conjoint work in this very complex area of practice (Bograd & Mederos 1999). Moving beyond gender-specific responses to conjugal violence and intervening at the relationship level is becoming more widely recognised as being appropriate in some cases, and skilled work with these couples is developing. The question is no longer: should we do couple counselling in situations of conjugal violence? The question now is: when and how do we do therapy in these situations? Explorations of dyadic marital treatment for domestic violence first appeared in the literature in the mid-1980s (e.g. Cook and Frantz-Cook 1984; Geffner et al 1989; Gelles & Maynard 1987; Harris 1986; Lane & Russell 1989; Magill & Werk 1985; Neidig, Friedman & Collins 1985; Rosenbaum and O'Leary 1986; Steinfeld 1989; Taylor 1984; Weidman 1986) and set the stage for prototype models which emerged over the next decade for couple treatment of wife abuse (e.g. Goldner et al 1990; Hansen and Goldenberg 1993; Jory & Anderson 2000; Karpel 1994; Lipchick & Kubicki 1996; Shamai 1996).

Theoretical explanations of domestic violence have also been subjected to critical scrutiny. Inevitably, the way in which conjugal violence is theoretically conceptualised and explained will influence the way in which it is responded to in treatment settings. The feminist perspective brought

public attention to conjugal violence as a priority societal concern, and has remained the most persuasive voice in its treatment. The substantial contribution of the feminist movement has been both practical and political. In a practical sense, feminists led the way in building supportive networks for battered women and this included the early development of shelters, resource centres and advocacy groups. They identified wife abuse as a political issue in that it is rooted in societal beliefs which promote patriarchy and endorse the dominance of men over women. Domestic violence was seen as a means to enforce the control and suppression of women. The first priority of the feminist movement has been the liberation and protection of women. The early interventions that directly emerged from their efforts had this focus, and sought to provide places of refuge for women suffering abuse. Their strong advocacy position, taken in defence of women and in the promotion of women's concerns, initially challenged the use of couple and family therapies in situations of conjugal violence.

A sociological perspective has also contributed importantly to ongoing knowledge about the cause and course of domestic violence. Central to this perspective is the contention that social structures (e.g. ethnicity, income, etc) affect individual behaviour and family life and are salient to the understanding of conjugal violence. From this perspective feminist theory with its gendered view of social relations is vulnerable to the criticism that it is too narrow and restricted in focus when patriarchy is used as the single prevailing variable to explain wife abuse (Gelles 1993; Watson 2001). Based on findings from large-scale community surveys, family sociologists have come to a contentious conclusion: that women initiate relationship violence at similar rates to men. This finding has been qualified by the recognition that men are the predominant perpetrators of severe assaults causing injury (Gelles & Straus 1989; Straus and Gelles 1988), that women most often use violence in their own defence (Straus 1980; Straus & Gelles 1988), and that women are less likely to be motivated to terrorise their partner (Kaufman Kantor & Jasinski 1998). An overarching sociological model depicts violence in families as being promoted and perpetuated by societal norms and standards. Community circumstances that fuel rage and violence such as poverty, racial oppression and unemployment are seen as being highly important in the comprehension of family violence.

Based on findings from community surveys of spousal violence, Gelles (1993) suggested a dichotomous categorisation of couple violence. Cross-sectional community survey findings indicate that 'minor' forms of spousal

violence are by far the most prevalent (at approximately five times the rate of severe spousal violence). Gelles asserted that a key distinction needs to be made as to whether violence is mutual or reciprocal, as opposed to violence being initiated by the male for purposes of control and power. Gelle's assertion was supported by Johnson's research (1995) and Archer's (2000) corroborating meta-analysis. Johnson distinguished between 'patriarchal terrorism' and 'common couple violence' as two major categories or clusters of couple violence. Johnson's analysis helped explain the marked differences of view that had persisted between feminist and sociological researchers. Feminist researchers had largely drawn their study subjects from shelters, hospitals and the police, and focused on situations marked by powerful male dominance and more severe levels of abuse. Sociological researchers had tended to use randomly selected households in cross-sectional community surveys.

Their approach has generated couple situations in which there appeared to be equivalent frequencies of male and female violence, in which violence does not seem to steadily escalate, and in which there is a predominance of mild and moderate levels of physical abuse. The past disputes between feminist and sociological researchers seem to have been based on alternative sampling frames and methods. Both views may be correct, and not contradictory, as they may be focusing on different clusters or types of violent couples. This is important because these two types of domestic abuse may require markedly different treatment approaches. Batterers or 'patriarchal terrorists' will rarely be appropriate for couple or family therapy, and if they are, it will be following long-term, gender-specific, individual or group therapy. Most existing programmes of conjoint therapy for conjugal violence treat reciprocal couple violence that has occurred at mild to moderate levels of physical assault (e.g. pushing, restraining, slapping, etc.). We prefer to use 'reciprocal couple violence' rather than Johnson's terminology 'common couple violence', as the term 'common' may be easily misconstrued to mean normal or regular behavioural acts.

The use of relationship therapies in situations of domestic violence remains highly controversial (Bograd and Mederos 1999; Hansen 1993). For some substantial reasons, feminist therapists were the first to challenge the use of traditional marital counselling in situations of wife battering. First, it was evident that many women were put at risk if they discussed sensitive couple information in conjoint sessions. This was seen to invite

retaliation or attack afterwards from their partners. For a woman in a relationship regulated by fear, it would be naive to think that she could talk openly and safely about relationship concerns in the presence of the batterer (Bograd 1984; Edleson and Tolman 1992; Goldner 1992; Willbach 1989). There was heightened risk in couple therapy that a batterer would become violent, since stressful relationship issues are actively identified and pursued while participating in dyadic therapy (Star et al 1979). Further, for men who entered therapy to placate, monitor or control their battered partner, conjoint sessions could exacerbate the abuse rather than stop it (Bograd 1984).

Both victims and batterers often deny or minimise the relationship violence (Geffner & Pagelow 1990). This denial can be further complicated by any minimisation of violence by the therapist, particularly those who use empathy and support in seeking to heal the 'inner wounds' of the batterer (Herman 1988). Further, if a therapist does not immediately halt dyadic sessions at the first evidence of violence, and focus subsequent therapeutic effort on identifying and terminating the violence, it transmits an indirect signal of therapist collusion in the denial of the impact of the assault. In traditional couple therapy, the physical abuse was often defined as a relationship problem (in which the woman shared some responsibility) rather than a criminal act (in which the perpetrator held sole responsibility for his use of violence).

Hansen (1993) summarises the dangers when couple therapy based on systems theory is employed in situations of conjugal violence, as involving victim blaming (in the attribution of co-responsibility of victims for violence that is perpetrated against them), and the therapist stance of clinical neutrality (which denies gender power differences based on the use of intimidation and force for relationship control). Systems theory, when unreservedly applied in the treatment of family violence, inherently implicates the battered woman as playing a part in maintaining the violence she suffers, and thereby diffuses responsibility for male violence (Bograd 1984,1992; Goldner et al 1990; Lamb 1991). Behavioural symptoms (such as violence) are often seen in a systemic analysis as 'symptoms of a relationship issue', rather than being an immediate problem to be solved in their own right (Bograd 1984). In traditional systemic therapies, the clinician seeks to maintain a stance of 'neutrality', and eschews permanent alliances with either partner to avoid becoming 'emotionally entangled in the couple's problem' (Nichols and Schwartz 1995). The neutral stance of

the therapist risks diffusing the focus on the central clinical importance of abuse by giving the impression that violence is only a symptom of a more important relationship issue. Similarly, continuing therapy when abuse occurs while therapy is being conducted, could be easily misconstrued by perpetrators and victims as a condoning of the violent acts, and an indirect blaming of victims for having a participant's role in their own abuse (Bograd 1992; Willbach 1989). The adherence by clinicians to therapeutic neutrality in situations of wife battering ignores the fact that this 'symptom' is a dangerous one that can be lethal if left unchallenged, and further that it is a 'symptom' that is under the choice and control of the perpetrator alone.

Traditional marital therapy seeks to enhance couple emotional relations, communication skills and co-operative problem solving and to thereby strengthen the foundations of a relationship. This is contra-indicated in violent relationships from which the woman wishes to escape. That is, when the woman wants to terminate the relationship in safety and in peace. In these situations, it is advisable to retain the batterer in gender-specific treatment (e.g. men's groups, individual therapy) and ensure that the woman can disengage from him in safety while he is receiving emotional support and counselling. In some cases when there is not a history of severe abuse, couple mediation rather than relationship therapy may facilitate separation. Traditional couple and family therapy was not adequately sensitive to the impact of gender on family relations, and inadvertently imposed a patriarchal view of family structure and function as a therapeutic standard or model of normal family functioning (Hare-Mustin 1986; Goldner 1985a, 1985b; Meyers Avis 1985). Although contemporary couple and family therapies are more highly sensitive to gender issues in relationship dynamics, there remains much work to be done to expand understanding and competence in the treatment of domestic violence in terms of other salient contextual social issues such as race, class and sexual orientation (Bograd 1999).

Although serious concerns were raised in the past to challenge the use of traditional couples therapy in situations of conjugal violence, substantial and compelling reasons were also raised in favour of providing couple treatment in these situations. In many abusive relationships (including severe battering), the women will want to stop the violence but not at the cost of their intimate relationship or marriage. Many do return to their partners (an estimated 50%), even if they have been in shelters and have received individual and group counselling (Simpson, Feazell et al 1984;

Sullivan 1991; Woods, Cox & Stoltenberg 1991). It has been suggested that a doctrinaire feminist orientation in services for battered women may shame those who are urged to leave their relationship but who do not wish to (Goldner 1992). Further, many women are at risk when they seek to end a relationship in which battering has occurred. It is important to protect them, by providing supports to their husbands, so that the couple may eventually separate in safety. It is not acceptable to provide counselling and support services just to women victims, as those in severe abuse situations may still be at risk of being killed (or in some rare cases, to kill the men who terrorise them as their only perceived means of escape). Clinicians who have had contact with both partners in situations of domestic violence learn that women are not always non-violent. Most violent women act out of self-defence and do not attack to control and dominate. However, there are 'violent couples' that do need conjoint therapy to terminate the mutual use of violence as a means of resolving couple conflict.

The possibility of couple treatment can bring perpetrators who are resistant to treatment into services. Perpetrators often do not see themselves as having a 'psychological problem' and often do not welcome counselling. However, fear of loss of their relationship is a strong motivator for many of these men, and can often be used as an incentive to maintain the batterer in group treatment, if it is understood that couple treatment may be initiated when he is ready for it (Geffner & Pagelow 1990; Hansen and Goldenberg 1993).

Clinicians who have assisted in the termination of physically abusive behaviour know that psychological abuse frequently remains in violent intimate relationships (Herman 1992). When men who batter stop their physical assaults they often continue to use indirect methods of control and domination (Aldarondo 1996). Treatment of these men is like 'peeling the layers off an onion'. There are layers of abusive behaviours, both physical and psychological, that need to be addressed in couples with a history of domestic violence. Psychological abuse leaves no immediate physical signs and is not seen by the courts as criminal behaviour, but it can be directly addressed in conjoint therapy. If a mandate or a rationale for psychotherapy is established, while physical abuse is being addressed in the domain of the criminal justice system, it will increase the chances for eventual relationship therapy for those couples in which women chose to remain after the physical abuse has been stopped.

Wife abuse is often an indicator that other family members are also vulnerable to abuse. Some 55-60% of wife abuse situations may involve

couples with dependent children at home (Straus et al 1980; Ursel 1991). Nearly all of these children will witness the violence and it is estimated that 30-60% will also be abused (Hughes 1982; Straus et al 1980). These children have been described as the 'forgotten victims' of violent marriages (Elbow 1982). A relationship exists between wife abuse and child psychological or behavioural distress (Berman 1993; Jaffe, Wilson & Wolfe 1987; Rosenberg & Rossman 1990; Wolfe et al 1985). Children who witness domestic abuse, particularly boys, are more likely to become perpetrators of domestic abuse as adults (Jaffe et al 1987; Kalmuss 1984; Straus, Gelles & Steinmetz 1980). There is evidence that girls who come from violent homes see physical abuse as an unavoidable and inescapable aspect of family life (Hotaling & Sugarman 1986). This argues for the use of couple therapy, particularly involving parents in intact families with children, as a precursor to family therapy. The subsequent family therapy, which follows from conjoint work with parents, would optimally address children's beliefs and behaviours that are rooted in their experience of violence in the family.

This chapter offers a review of key assessment issues that have emerged as fundamental to the determination of whether conjoint therapies should be initiated with couples who have suffered a history of mild to moderate conjugal violence. These screening factors are recognised in the literature as being salient for those couples that are assessed as representing 'mutual, reciprocal or common' circumstances of conjugal violence. They seek to avoid those cases that are not appropriate for couple counselling such as those that meet criteria for 'patriarchal terrorism', which includes a marked imbalance of physical power and individual free will such that one partner dominates and regulates the couple relationship.

Key intake assessment themes that must be examined before entering into couple therapy

Safety, be it physical or psychological, is at risk in relationship therapies. It is unlikely that total safety will ever be fully guaranteed when employing any approach to couple treatment in situations involving a history of physical abuse. However, couple therapy in these situations can be a calculated risk, and one that with careful screening can reasonably assure safety. That is, the risk can be minimised and safety maximised through an informed and knowledgeable risk assessment (Bograd & Maderos 1999). Such screening is vital in the determination of which couples should proceed to relationship therapies. It should provide evidence which assures

therapist confidence that there will be minimal danger of a relapse into violence during the course of conjoint treatment. It is not uncommon for couple and family therapists to be uncertain about whether physical abuse is an issue in some of the cases they are treating. It is important to find a way to explore this issue directly without putting victims at risk of further abuse. Basic screening questions have been suggested for such initial explorations (e.g. Kaufman Kantor & Jasinski 1998). When it is known that a couple has a history of physical abuse, several preliminary assessment questions must be considered as a precursor to the initiation of conjoint couple therapy:

What was the past severity of the abuse?

Most contemporary couple treatment programmes see relationship therapy as being appropriate only for situations involving mild to moderate abuse. Certainly men who inflict serious injury, use sexual assault along with physical assault, display frequent and explosive jealousy, or show excessive general cruelty (e.g. killing of pets) are not good candidates for most types of psychotherapy (Dutton 1995; Gondolf 1993). Great caution must be exercised prior to involving men who inflict serious injury in any type of conjoint therapy. Men who appear to have anti-social, dysphoric-borderline, or sociopathic personalities (Dutton 1995; Gondolf 1988 1993; Holtzworth-Munroe & Stuart 1994; Jacobson & Gottman 1998) are not suitable candidates for relationship therapies. Most often men who do not display such personality disorders, but who have employed serious abuse as a relationship control tactic, will require long-term individual and group treatment, before there is any possibility that they will ever be ready for relationship therapies. In these situations involving dangerous perpetrators of violence, it seems the most appropriate services are not couple or family therapies but those that offer victims immediate assistance to appreciate the danger they face, and facilitate their employment of strategies of enhanced self-protection and family safety.

Will the victim (s) be safe from physical violence during therapy?

It has been important to clarify that in all attempts to provide treatment in situations of domestic violence, safety concerns must always be paramount (Taylor 1984). No couple therapy should be initiated unless safety from physical assault can be reasonably assured (Bograd 1984; Cook & Frantz-Cook 1984; Edleson & Tolman 1992; Hansen & Goldenberg 1993; Willbach 1989). The most conservative forms of gender specific treatment (e.g. separate group treatment for men and women) should be

employed until there is ample evidence that the relationship is safe from the use of physical force by one partner against the other. Conjoint couple therapy is contraindicated if there has been recent violence, or if there is reason to believe violence may occur during the therapy. Couple and family therapy should normally not be used to stop ongoing violence. It should be initiated only after the violence is under control and safety is reasonably assured (Cook & Frantz-Cook 1984; Hansen and Goldenberg 1993; Karpel 1994).

In couples showing reciprocal violence this will mean that each partner takes responsible for their own use of violence; and each demonstrates sufficient self-control to self-restrain from the use of physical force. During separate interviews with each partner, therapists should determine if there is denial of the seriousness of the violence with a remaining relationship volatility that could lead to the use of physical force. Well entrenched denial and minimisation of the seriousness of physical violence does not bode well for the usefulness of relationship therapies. A key question in this regard is whether the partners can commit to couple therapy to change their behaviour, or if interest in therapy is an act of temporary contrition to hold the relationship together.

Does fear pervade the relationship and constrain the victim's freedom of choice?

It is not reasonable to proceed beyond gender-specific treatments when fear and intimidation still pervades a relationship. Couple therapy depends on the ability of partners to discuss their relationship issues and concerns in a free and honest exchange. In situations of patriarchal terrorism, patterns of male dominance will block any meaningful and positive relationship improvements. The most commonly identified reason that battered women identify for staying with their abusers is fear. They often fear for their own safety, for the safety of their children, and in some cases, for the safety of the perpetrator (Pagelow 1981). These fears should not be ignored or taken lightly, and need to be directly addressed prior to the initiation of any relationship therapy. DeMaris and Swinford (1996) identified factors influencing fearfulness in women and, in particular, noted the danger of intervening with relationship therapy in situations in which a woman had been subjected to severe abuse such as the use of coercive sex as an element of the physical assaults and intimidation.

Couples have been referred to us for conjoint treatment in which both partners are frighteningly difficult people. In our experience, these

couples characteristically have experienced serious family violence in their childhood, and are often members of extended family and friendship networks in which violence is commonplace. Family life for these couples is often framed by a 'culture of violence'. The men and women in these couples are like powerful nation-states that hold each other at bay through a threat of the use of dreadful weaponry. Both partners, in their own way, show a potential for lethal behaviour. Yet they can be highly committed to each other as a couple, and both can have strong emotionally attachments to their children. They seek treatment because the women want to remove the threat of violence from their family life, and when the men are ready to acknowledge the social and emotional costs of violence (including their own past experience with police, courts and jail). Fear in these couples appears to be balanced, and there is not oppression and control by one partner who holds strong supremacy over the other. At the other end of the continuum, we have also treated couples in which one past incident of indirect violence (e.g. punching a hole in the wall during an argument) had created a situation of fear and intimidation. Fear can be considered along a continuum from mild to severe, in the same manner as is level of physical assault. If fear of her partner is detected during intake counselling sessions with a woman that seems to inhibit her involvement in therapy, we will not proceed with conjoint counselling until the fear is addressed in individual sessions with her. It is not uncommon to find lingering elements of fear in abuse victims. If these are detected in the course of conjoint therapy, they should be addressed as a key element of the therapy. Any residual fears that constrain an open and frank exchange between partners should not be disregarded or left to dissipate as a secondary benefit of the therapy.

Couple circumstances vary widely in terms of the duration and extent of physical abuse. The case examples briefly described here demonstrate that knowledge of severity of abuse alone is not enough to guide treatment decisions. No matter what the severity of the abuse, the presence of fear of continued abuse in a victim is a key element in her readiness to participate in conjoint couple therapy. The more that fear dominates the relationship, the less appropriate the use of conjoint methods.

What is the perpetrator's motivation for being abusive?

Johnson's (1995) differentiation between patriarchal terrorism and reciprocal ('common') couple violence is clinically important. This differentiation highlights the importance of fear as a relationship dynamic,

and draws attention to the motivation of the perpetrator as a key treatment issue. If a woman is trapped in an oppressive relationship, in which she is controlled and dominated by her partner through his exercise of abuse and intimidation, couple therapy can be fundamentally dangerous.

Impulse control treatment (e.g. time out, self-talk, etc) for oppressive and controlling perpetrators, does not in itself adequately prepare men for conjoint therapy with their abused partners. It is best when their abusive patriarchal beliefs have been challenged and they are aware of the impact of these beliefs on their relationship with women. Anger management is not enough, as it is the emotions and beliefs behind the anger that need to be addressed (Gondolf and Russell 1986). Russell (1995) sees this as going beyond the prevailing male deficit model (e.g. impulse and anger control) to a belief systems model (addressing abusive beliefs based on the 'centrality, superiority and deservedness' of the male self). Psycho-educational interventions, that enlighten perpetrators in regard to their abusive patriarchal beliefs, set the stage for the honest acceptance by each perpetrator of his of personal responsibility to stop using violent tactics of control. These are vital first steps in the ultimate termination of 'victim blaming behaviour', which runs rampant in perpetrators of wife abuse. Jennings (1990) suggests that a 'relapse prevention approach' should be followed, in which it is recognised that even when physically abusive behaviour is terminated, there is still a vulnerability for relapse. Those who have not integrated an appreciation of co-operative problem solving and gender respect in their conjugal relations will likely continue to use psychologically abusive tactics, and will be vulnerable for a relapse to the use of physical abuse. In this sense it is helpful to use an 'addiction metaphor' and consider physically violent people 'in recovery', rather than being 'cured', when they stop their physical assaults on their partners. It is possible to stop physical violence but only contain, or put 'attitudinal limits', on patriarchal beliefs. These are cases in which patriarchal beliefs are fundamental aspects of culture or religion. Cervantes and Cervantes (1990) consider multicultural implications of wife battering and identify three cultural attitudes that support violence against women: sex role stereotyping, promotion of adversarial sexual beliefs and acceptance of interpersonal violence in conflict resolution. There are wide variations across cultures on these themes. Several special examples of these have emerged in our clinical practice. Some couples, particularly those from isolated or socially impoverished family backgrounds, do not understand

the limits of a husband's rights and privileges under the law. These husbands have difficulty accepting the idea that it is wrong to dominate and control a wife, but do learn quickly that it is against the law. A similar situation can exist with couples who have recently immigrated from cultures that are dramatically different, and that are strongly patriarchal. Another variation of this same theme involves couples with fundamentalist religious beliefs that include a strong adherence to patriarchy. Frequently these cases involve 'patriarchal bullies' rather than 'patriarchal terrorists' who use mild to moderate abuse in basic ignorance of the law. Many of these men are shocked and humiliated by the court process when they are charged with assault. Usually one court appearance is a sufficient deterrence in itself to curb further physical abuse in cases such as these. Conjoint treatment for such couples involves culturally sensitive family therapy that centres on gender respect in the negotiation of family roles and tasks without the use of physical force (Almeida and Durkin 1999; Trute and McCannell Saulnier 1985). It is possible for these couples to create fair and egalitarian patterns of family decision making, that are still congruent with their cultural and religious beliefs. White's model (1989), with its constructivist perspective, is directly applicable as it is an approach to relationship change which includes a heightened focus on patriarchy, and weakens beliefs in the legitimacy of the use of violent acts in couple relations. Madane's approach (1995), which includes the use of extended family networks and the recognition of spiritual destruction in wife abuse, is informative to multicultural practice. An essential aspect of conjoint couple therapy for domestic violence should be to challenge the use of patriarchal rationalisations that justify the use of abusive behaviour and diminish perpetrator responsibility for abusive behaviour. Further, positive methods of couple problem resolution should be facilitated, that include gender respect and exclude individual exploitation, and that whenever possible, remain congruent with cultural and religious beliefs.

Is the couple an intimate relationship or just two people living together?

Before providing couple therapy that might consolidate or provide emotional 'glue' to a relationship, it is important to assess whether positive emotional bonding has ever existed in the relationship. Has the couple moved from being two 'I's' to a 'WE'? Do both partners want to remain together and to improve the emotional elements of their relationship? Lipchik (1991) highlights the importance of knowing 'that the partners

are more than objects of self-gratification for each other.... There must be signs of bonding and personal caring from each....' (p61). We have completed intake assessments of couples in which physical violence has stopped, but in which there is an absence of emotional support and a predominance of gender exploitation. For example, cases in which the woman is a 'meal-ticket' for her unemployed or under-employed male partner and no more to him. We will only proceed with couple or family therapy in such cases if both partners acknowledge the unfairness of the situation, and convince us that they both are motivated to change.

The presence of children in the household is a factor in the exploration of this attachment issue. Each parent may have substantial emotional ties with their children, while remaining emotionally detached from each other. We provide family therapy to impoverished families, from a range of different cultural groups. Some of the couples have relationships that run hot and cold. In 'cold' relationship periods the men are peripheral to family life and have little contact with the women and with their children. However, in the 'hot' times they spend a great deal of time with their families, and these can be times of both intimacy and abuse. Although the men in these families are often absent, they do show strong emotional ties to their children and express the wish to be 'good fathers' to their children. We do see these 'hot and cold' couples when physical assault is gone from the relationship, and there is ample evidence that the home is safe. However, the primary focus of the therapy is on parenting; enhancing couple relations comes second as a treatment goal. These clinical priorities are congruent with the cultural context of the families, and do serve a preventative purpose in disrupting the inter-generational patterns of domestic violence.

Is there evidence of psychosis or major personality disorders? Is there addiction to alcohol or drugs in one or both partners?

These are two fundamental screening questions in the assessment of client suitability for couple and family therapy. Gondolf (1985) estimates that a small proportion of perpetrators of conjugal violence (under 15%) have significant psychopathology and do require long-term, intensive psychotherapy. Perpetrators with 'anti-social/sociopathic' (Gondolf 1985 1993) or 'psychopathic/borderline' personalities (Dutton 1995) are not likely to respond successfully to individual treatment, nor are they suitable candidates for couple or family focused relationship therapies (Hansen and Goldenberg 1993).

Studies have suggested that between 36% and 52% of wife abusers abuse alcohol (Byles 1978; Fagan et al 1983), but that the relationship between substance abuse and violence is not clear (Holtzworth-Monroe et al 1997). Alcohol intoxication has been identified as a frequent trigger for physical abuse (Gelles 1972). Substance abuse should not be seen as a cause or an excuse for battering, but as a facilitating condition that heightens risk for family violence.

Abuse of alcohol and other substances are not uncommon in victims of domestic violence. Although questions remain whether alcohol abuse is a direct consequence of abuse, or if it is related to having an abusive partner who is an active user, there is clear evidence that substantially larger proportions of women who are victims of physical abuse use alcohol to cope with their victimisation (Giles-Sims 1998).

Each unique couple situation must be reviewed in terms of the place and involvement of substance abuse in relationship dynamics, and in the couple's history of alcohol and substance abuse, particularly as this relates to episodes of conjugal violence (Bograd & Mederos 1999). Just as the use of physical abuse must be stopped before relationship therapies are initiated, so must active alcohol abuse be stopped, as a precursor to couple and family treatment of domestic violence (Cooley and Severson 1993; Hansen & Goldenberg 1993).

Reflexive/reflective work with couples

At any particular point in time, developments across the range of practice environments are influenced by new research and practice initiatives in the literature. In recent years, the concept of reflexivity and reflexive practice has generated significant interest as the complexity of the client and worker-in-situation has been confronted and explored (Sheppard 1998; Pease & Fook 1999; Connolly 2002). When working in the violence area it is important to examine and understand not only what the client brings, but also what the couple counsellor brings into the clinical encounter. Reflexivity is centrally concerned with the effect of the self on the work. In practice, reflexivity can be seen as the process by which the interventionist's socialised thinking, both personal and professional, influences the action — which then influences the situation and how it is subsequently interpreted and responded to. Reflexivity becomes a process that provides an opportunity to understand the way in which the couple counsellor's personal views and interpretation intersects with practice-in-situation (Connolly 2001). Because work in the violence area

is infused with strong emotions, values, and beliefs around the nature, causes, and responses to violence, the extent to which reflexivity influences professional judgement and conduct is important. For example, how a clinician perceives couple violence, victims and perpetrators, will inevitably impact on how they respond in the treatment setting. This is also likely to affect practice outcomes (Connolly 2002). If a clinician works in an agency that has a particular mandate or practice philosophy, (or in Bourdieu's term 'institutional attachment' (Wacquant 1998:226), this circumstance may wittingly or unwittingly influence the clinician's response to the client. Or perhaps the clinician embraces an ideological position that encourages a certain solution notwithstanding the particular client's circumstances. The need for vigilance about the influence of the personal self of the therapist (Kerr & Bowen 1988), and the 'censorship exercised by disciplinary and institutional attachments' (Wacquant 1998:226) is of central importance when working with violent dynamics. So too the need to recognise, work with, and critique reflexivity in both the personal and professional self (Connolly 2002). In the context of socialised thinking, working with couples in violence work is rather like navigating perilous waters. Developing ways in which we can critically reflect on the worker and client-in-situation is important to the achievement of more reflective practice outcomes.

Treatment of conjugal violence: concluding comments

The feminist critique of couple and family therapy in situations of woman physical abuse, has offered important momentum to adapt and enhance couple and family treatments in situations of domestic violence. However, the critique does not support the contention that couple and family therapy should be abolished in all situations of couple violence (Bograd & Mederos 1999; Cook & Frantz-Cook 1984). Feminist informed marriage and family therapy has emerged to guide relationship focused treatment of domestic violence while ensuring the safety of victimised women and children. It involves the use of systemic interventions with couples which include, as a primary element, heightened sensitivity to the gender context of relationships (Goldner et al 1990). In this treatment approach, safety of victims is paramount (Hansen & Goldenberg 1993). No conjoint therapy is initiated until violence has been sufficiently restrained and the couple is ready, without fear of violence, to proceed to improve their relationship style and inter-personal behaviours. This avoids the clinical dilemma of 'therapeutic abuse neutrality' as physical violence is understood

to have stopped. However, the couple therapist never abandons a firm stance against physical abuse and is vigilant about its occurrence in the relationship during therapy. If violence erupts in the relationship during couple treatment, conjoint therapy must be immediately discontinued, and both partners must be seen individually to assess why safety was lost. If the violence is assessed as a minor slip, if the relapse is seen as temporary, and if couple safety is once again reasonably assured, then the couple therapy may be resumed. In the early phases of couple treatment it is advisable to review individual, couple, and family safety at the start of each conjoint session to reinforce its importance to the relationship therapy. The couple therapist can maintain a strong personal position against the use of violence in relationships, without abandoning their commitment to the wellbeing of both partners. 'Multidirected partiality' (Boszormenyi-Nagy & Krasner 1980) becomes the more relevant therapeutic stance, in which marital partners are shown they can trust the couple therapist to fairly hear and emotionally support each of them as they bring their relationship issues to the therapy, while remaining ethically congruent against the use of physical force in inter-personal relations. Couple therapists must be equally joined and accepting of both partners, even when one is identified as the 'victim' and the other as 'the perpetrator' (Lipchik & Kubicki 1996).

Couple and family therapy should serve to facilitate communication skills, positive conflict resolution and collaborative problem solving. Further, couple therapy following a history of conjugal violence should overtly reinforce the importance of gender equality and ethical fairness in the distribution of instrumental and emotional work in close, intimate relations. Most importantly the couple therapy should strengthen affective ties and build on the positive aspects of the relationship, which serve as the emotional glue that holds couples together and dissipates the anger and distrust which are the products of physical abuse.

A key requirement of relationship therapies in domestic violence is that they ensure that women do not feel under pressure to include their partners in counselling, and that women's safety remains a central service objective. Individual therapy may be preferable to couple counselling if there is profound confusion in one partner as to whether the couple should remain together or separate.

There have been significant advances made in the treatment of domestic violence over the past decade. These advances have clarified the distinctions between wife abuse as a criminal act and as a therapeutic concern. To adequately recognise and deal with wife abuse as a serious

and widespread problem in our communities, we will need to move from a doctrinaire victim advocacy position to services that go beyond the provision of gender-specific treatments. Violent relationships are often situationally complex, emotionally intense and behaviourally volatile. To bring long lasting, violence-free living to families means more than just focusing on one member of the family. It means creating situations of therapeutic safety so that those who wish to can maintain their intimate relationships without fear; and that those who choose to, can non-violently discontinue their marital relationship. The challenge is to develop appropriate and effective treatment processes when couples with a history of conjugal violence are ready to engage in conjoint therapies. No one therapeutic perspective will meet the needs of all abused women, and all woman abusers (Goldner 1992), nor will any fixed sequence of individual, group, couple and family treatments necessarily respond to the broad-ranging needs of couples and families. Scientific scrutiny, rather than ideological argument must guide the refinement of these methods. Ideological censorship of differing practice ideas and innovations can only serve to limit rather than to advance the positive wellbeing of victims and their family members.