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A study of therapeutic formats for the treatment of spouse abuse

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Abstract

These words which are spoken in a traditional Anglican-Episcopalian betrothal/nuptial marriage-ceremony hint of tenderness and caring, promising each other a life of togetherness and harmony. For various reasons the positive emotions behind these words are frequently obscured by even stronger needs or emotions including anger, power and aggression. The union of the two persons involved then becomes a disharmonious lifestyle, void of many of the promises spoken during a marriage ceremony.

A STUDY OF THERAPEUTIC FORMATS FOR THE TREATMENT OF SPOUSE ABUSE

A Research Paper

Presented to

the Department of Educational

Administration and

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CHAPTER 1

Introduction

> "Will you love her, comfort her,
> honor and keep her in sickness
> and in health . . . to have and
> to hold from this day forward . . .
> to love and to cherish, till death
> us do part . . . in constant faith
> and abiding love . . . "

These words which are spoken in a traditional Anglican-Episcopalian betrothal/nuptial marriage-ceremony hint of tenderness and caring, promising each other a life of togetherness and harmony. For various reasons the positive emotions behind these words are frequently obscured by even stronger needs or emotions including anger, power and aggression. The union of the two persons involved then becomes a disharmonious lifestyle, void of many of the promises spoken during a marriage ceremony.

The home can no longer be viewed as a comfortable, safe haven or refuge from crime and violence. Spouse abuse, the act of physical or emotional aggression toward one's spouse, has been a significant problem in the United States for many years. It continues to become a more publicized form of covert violence each year, drawing more attention as it is removed from the "family closet" and made obvious to the rest of society.

In his book published in 1976, Del Martin stated that, "Our patriarchal system allows a man the right of ownership to some degree over the property and people that comprise his household" (p. 27). This patriarchal thinking is still obvious, seven years later, to some degree, in the inequality of the sexes in that women are still often seen as subservient.

Current estimates are that over one million women annually in the United States are victims of physical abuse by their husbands. This estimate does not include those women who are verbally or emotionally abused by their husbands.

Sociologist Howard Erlanger (1979), who is affiliated with the University of Wisconsin, found that 25 percent of his sample of American adults actually approved of husband-wife battles. What was even more surprising was that the greater the educational level, the greater was the acceptance of marital violence.

Annual statistics from Integrated Crisis Services in Waterloo, Iowa, which operates a shelter for battered women along with a crisis hotline, show that there were 256 new cases of spouse abuse brought to their attention in 1981. Sixty-seven of these women sought shelter, along with 69 of their children. Within a year there was a 24 percent increase in new cases. The 1982 statistics state that 318 new cases were seen in the office or heard from through the hotline, including 79 women who were sheltered along with their 123 children.

Efforts have been and are being made; however, there are still obstacles which need to be overcome to improve the situation and lessen the incidence of spouse abuse. Although spouse abuse is not legally condoned in the United States, it is accepted by many individuals, and is still widely ignored as a social problem. It is seen by some people as being only a problem for the two individuals physically involved with one another rather than as being a societal problem.

A more complete picture of current therapeutic formats is needed to help victims, abusers and helping professionals, and society as a whole become aware of what is currently available for them. Counselors and therapists need to understand that each case of spouse abuse should be treated on an individual basis. There are no step-by-step procedures, nor any cut-and-dried systems for determining who the client should be in spouse abuse cases and what format is most appropriate and successful for that individual. Should the client be the abused wife, and/or the abusive husband, and if both should be seen, should they be seen together or separately?

Statement of the Problem

This study is an attempt to determine (a) which therapeutic formats are currently being utilized by mental health professionals when working with cases of spouse abuse, and (b) the perceived advantages of using each of these specific formats.

Both of these questions will be examined from several perspectives for this study. Data obtained for this research comes from two sources; (1) a review of current literature written by both clinicians and researchers, and (2) a questionnaire compiled by the author.

The survey was given to mental health professionals in June, 1983, in a predominately metropolitan county in Iowa. The survey instrument used was a 37-item questionnaire which included both short-answer and multiple-choice questions. Specific items within the survey instrument were designed to address the purpose of this study, while other questions were included by the researcher to obtain additional information which might be beneficial in the future when working with cases of spouse abuse.

Importance of the Study

Incidents of spouse abuse are increasing annually. Counselors may see more of this problem in the future than what they have seen in the past. Information gained from this research will give counselors a better perspective as to what is available and what alternatives they may have when working with abused and/or abusive clients.

Assumptions

The basic assumptions relevant to this study are:

1. The survey instrument used by the researcher is valid.

2. The respondents who returned the survey instrument are representative of the total population.

3. The respondents answered the questions as truthfully as possible.

Limitations

The following limitations apply to this study:

1. Although more cases of abuse are now being seen by mental health professionals in which the husband is the victim and the wife the abuser, this research will only involve the more common abuse cases in which the husband is the abuser and the wife is the abused.

2. Courtship violence, also viewed as an increasing problem, will not be discussed in this paper.

3. The survey instrument used by the researcher was not pilot-tested.

4. The limited size of the sample may not be sufficient to allow for formulation of generalizations regarding therapeutic formats to be used in spouse abuse cases.

5. Personal feelings and attitudes of the respondents to the questionnaire and subject may have influenced their answers.

6. The survey instrument was used only in one specific locality and does not represent a cross-section nationally.

Definition of Terms

Spouse abuse - Acts of aggression toward one's spouse, including physical, verbal and emotional abuse.

Individual counseling - The client is seen individually, without the spouse; the spouse is not in treatment.

Marital counseling - The husband and wife are seen together or individually by the same therapist.

Family counseling - The therapist works with all members of the family together, including the couple's children.

Group counseling - Family members involved are placed in groups with persons from other families, facilitated by a therapist.

Counselor/therapist - A professional person who provides a setting for counseling with individuals that is confidential, secure and non-threatening.

The terms counselor/therapist will be used interchangeably in this paper.

The terms counseling/therapy will be used interchangeably in this paper.

CHAPTER 2

Review of Related Literature

This study concerns various therapeutic formats which are currently being utilized for treatment of cases of spouse abuse. In order to accurately review these formats, it is important to look at varying perspectives of both researchers and clinicians regarding what constitutes appropriate formats for these cases. This chapter will review the literature regarding (a) the formats of therapy in spouse abuse cases, and (b) who is involved as the client(s) in therapy.

Historical Perspectives

Family violence, particularly violence involving the marital dyad, has not been the subject of a large amount of research in the past. According to Gelles (1983), spouse abuse has suffered in the past from what he calls "selective inattention," especially previous to 1970. Child abuse, not spouse abuse, has been more prominent both in research and in the media.

There are several reasons for the lack of literature in past years regarding spouse abuse cases. In a book written by Roy (1982), Founder and President of the Board of the first specialized social service agency for battered women in New York State, Abused Women's Aid in Crisis, some of the lack of literature could be attributed to the idea that for

a great many years, abusers were informally classified as being psychopathic and untreatable. They were relegated to the law enforcement sphere and placed in correctional institutions.

A different idea was presented by Dobash and Dobash (1979) when they stated that the prevailing psychoanalytic idea was that wife battering was partially a result of inadequate mothering. This idea, according to Dobash and Dobash (1979), implies that "women, (first as mothers, then as wives), were the primary source of violence, including that which was directed at them. Although such ideas have been severely criticized and challenged, the theory has a great deal of appeal in a patriarchal society; it was very popular especially with the media, and underlies much of the training in the helping professions" (p. 199).

Some of the problems in the past with cases of spouse abuse involved the feelings of the abused women themselves and their lack of information. Of the women surveyed by Dobash and Dobash (1979) regarding wife battering, the majority said they had rarely or never sought assistance from mental health professionals because they did not have accurate knowledge as to the services which were available to them. Therefore, social services and other helping professions were not seen as a source of possible help for them.

The women interviewed by Walker (1979) who were needing help, felt that "therapists refuse, directly or indirectly

(usually by omission) to deal specifically with acute battering incidents. Instead, the therapists concentrate on the psychological consequences such incidents produce" (p. 227).

Walker (1979) believes that many mental health professionals, including psychotherapists, psychologists, social workers and psychiatric nurses are very inadequate when working with the battered woman. She states that psychotherapists have been trained to believe that victims often provoke their assault.

Nichols (1976) has ideas similar to those of Walker. She states that even though physical abuse has been a common complaint, some caseworkers rarely pick abusiveness as the focus of intervention and tend to ignore the symptom of abuse. Either through failure to recognize it as a problem, or an unwillingness to work with such a problem, continues Nichols, the abusive situation is frequently dismissed by the caseworker.

Another significant problem, states Dobash and Dobash (1979), is the idea that many counselors have that the family as a unit is more important than is the individual woman. The idea of keeping the family together regardless of the wife battering "reflects a deeply held set of beliefs that the family should be kept together for the sake of the children. Yet, if a child's mother is being assaulted, how beneficial can the family setting be? Nevertheless, helping professionals continue to argue that an intact family is healthier than a

broken one regardless of the quality of the relationships within it" (p. 204).

Dobash and Dobash continue to state that there is some disparity perceived in this situation. If a child was thought to be in danger of receiving the same treatment or even less severe treatment, the family would be broken up promptly. Helping professionals would see the continuance of such a family setting as being extremely harmful to the child. Warner (1981) continues with these same ideas and believes that keeping the family together may even place women in a more abusive and demeaning relationship than what they are already involved in, and perhaps even leading to a deadly relationship. Lack of support for battered women is also stated by Walker-Hooper (1981). "They are not supported in their efforts to stop the violence or to leave the relationship. Most psychotherapy emphasizes keeping the family intact. They are branded as 'sick,' 'crazy,' or 'hysterical'" (p. 192).

Since the mid 1970's, according to Roy (1982), there has been an increased interest in the problem of aggressive behavior, including spouse abuse, because violence is now defined as a clinical condition, and is therefore a legitimate area of study. Because of this increased interest by mental health professionals in family violence, an increasing amount of literature has been published in recent years pertaining to therapeutic formats which were claimed to be effective in

the treatment of spouse abuse. These formats are varied and will be discussed later in this chapter.

Types of Therapy

Several therapeutic formats are presently being used by clinicians for treatment of spouse abuse. Randy Schilling (Hendricks, 1982), a graduate student affiliated with Kent State University in Kent, Ohio, wrote in his graduate thesis on abused women that there are many commonalities involved in how a counselor should approach a case of wife abuse as compared to other problems. He cites individual, peer and group counseling as methods that are possible to use with abusive couples as well as in therapy which does not deal with abusive situations.

Other researchers and clinicians believe there is a strong need to use a multi-faceted approach by incorporating other community resources in addition to therapy. For example, Del Martin (1976) recommends shelters for battered women as the most effective way of ending a violent relationship temporarily. Other possibilities would include inpatient psychiatric care for the abusive husband, and the use of peer support groups for both the abused women and the abusive husbands. Richard Bedrosian (in Hansen, 1982) believes that a combination of the different types of available therapy are necessary, and that by combining interventions that include both intra- and inter-personal levels of communication,

long-term changes can be produced.

It is very probable that, given the same clients with the same situations, two therapists would select entirely different formats for treatment. The preferred therapeutic format of one counselor may include the use of only one of the formats which will be discussed later in this chapter, while the format preferred by another counselor may be a different format or a combination of formats.

Each of the types of therapy currently used will be discussed individually in the following sections. These formats include (a) individual therapy for the abused wife, (b) individual therapy for the abusive husband, (c) group therapy for the abused wife, (d) group therapy for the abusive husband, (e) conjoint therapy in which the couple is seen together, and (f) family therapy in which the entire family, including the children, is seen.

Individual therapy. Individual therapy in abusive situations is one consideration for therapists. This could involve individual therapy for the abused wife only, individual therapy for the abusive husband only, or concurrent individual therapy in which each spouse is seen separately, either by the same therapist or by two different therapists. This section will be divided into discussions of (1) individual therapy for the abused woman, and (2) individual therapy for the abusive husband.

Individual therapy for the abused wife. There has been more research reported on individual therapy for abused women than on any other therapeutic format to be used for spouse abuse cases. Dobash and Dobash (1979) believe that the reasons for this may include the facts that (1) it is generally the woman who seeks help, (2) the woman may be the only member of the family to seek help, and (3) it has been thought in the past to be the woman's problem.

Walker (1979) states that individual psychotherapy is generally long-term in nature. Walker continues by stating that individual psychotherapy can be quite therapeutic as an intervention technique for battered women.

The first goal of this type of therapy is the stopping of the battering, with economic and psychological interdependence being a more long-term goal, according to Walker (1979). Several other researchers (Watts, 1981; Dobash and Dobash, 1979; Walker, 1979) list other goals as including the building of healthier relationships, assuming appropriate responsibility for each individual involved, exchanging aggression for assertiveness, developing a healthy way of expressing needs, and deepening the awareness of each individual's own emotional life.

Important aspects to consider when working with an abused wife include (a) the readiness of the abused wife when entering treatment, (b) the extent of her helplessness, (c) her feelings of guilt and self-blame, and (d) frustrations which the counselor may encounter when trying to work

with the abused wife. Each of these factors will be discussed in this section.

In the beginning of treatment with a battered woman, Hendricks-Matthews (1982) state that an appraisal of a woman's psychological and emotional readiness for the therapy needs to be made as early as possible. She also states that the counselor needs to be aware of the client's readiness and willingness to make use of any other suggested resources she may have for the client. If the psychological readiness of the victim is not examined in the beginning of treatment, or is viewed as unimportant, the chances of success for the therapeutic sessions are drastically decreased.

The counselor may also find himself or herself using inappropriately timed interventions. If the interventions are not presented to the client at appropriate times, the client may discard those attempts by the therapist. The client will not or can not use the interventions when they are presented to her.

The client's interpretations and/or perceptions of therapy may also hamper any possible success. If the client can make accurate perceptions or interpretations of what the therapist is attempting to accomplish, then she will also be able to more accurately interpret her partner's behavior. She may also be more ready and willing to extricate herself from the battering relationship, according to Hendricks-Matthews (1982).

The readiness of the client to therapy may also be influenced by the therapist's initial treatment of her, and actions toward her. Walker (1979) suggests that oftentimes therapists add to the woman's loss of self-esteem by not discussing the battering incidents, but instead by "concentrating on the woman's provocative nature when such incidents are revealed in therapy sessions. It is no wonder, then, that most of the battered women interviewed [by Walker] felt psychotherapeutic intervention was not useful for them" (p. 227).

After the client's amount of readiness and willingness is determined by the therapist, the next step may be to determine the amount of helplessness the client feels regarding her situation. According to Hendricks-Matthews (1982), if a caseworker believes that the wife encourages, provokes or enjoys the abusive treatment she is receiving from her husband, these beliefs by the therapist will only help support her helpless state, a state which often has roots in the woman's early childhood. Hendricks-Matthews continues by stating that "Issues that should be integral components of an appraisal of the psychological and emotional status of every battered client include the extent of her learned helplessness, her system of causal attribution, and her locus of control" (p. 132).

Hendricks-Matthews believes that the degree to which this learned helplessness is a factor in the woman's life is also important. Does the client appear and/or feel helpless

just in the abusive situation or in all areas of her life? Weitzman and Dreen (1982) support the importance which Hendricks-Matthews attaches to this statement regarding the woman's early life experiences. They state that "many battered women tend to withdraw under stress, a response which reflects an apparent difficulty with self-assertion and an internalized helplessness rooted in early life experiences, which increases dependence on already dependent-phobic partners" (p. 260).

The counselor also needs to help the woman establish, or re-establish, trust in her own basic responses. Sense of trust, according to Hendricks-Matthews (1982), can be a large step in the alleviation of helplessness.

This feeling of helplessness may also be inadvertently reinforced by the counselor. When therapists reinforce the traditional value systems about families and the roles of women, according to Walker-Hooper (1981), they produce feelings of failure in their clients. If a therapist attempts to "rescue" a battered woman, he or she may add to the woman's feelings of helplessness and dependency. This rescuing would not promote growth of critical self-control for the client who already feels quite powerless.

Feelings of guilt also need to be considered when working with battered women, according to Walker (1979). A battered woman often blames herself for the acts of abusiveness by her husband. The counselor needs to help her express

these guilt feelings by having her recount the details of battering incidents in which she could not stop the battering.

Counselor frustrations may be a problem when working with battered women. A battered woman's willingness to change and her level of motivation play a crucial role in the therapeutic process. Hendricks-Matthews (1982) state that often a woman's system of helplessness prevents her from being able to build on her own success experiences. This may be frustrating for a counselor who has worked to enhance a client's feelings of success and self-esteem.

Mental health professionals also report becoming extremely frustrated with battered women when the women don't follow through with what the helper has found for them in way of assistance from community resources. Hendricks-Matthews (1982) state that "the helpers try to bring whatever legal and social assistance is possible under a limited system. This often occurs at considerable effort to the helper. Just when some assistance is found (restraining order, a police call, hospitalization, foster home, psychological help, etc.) the battered woman often turns it down" (p. 131).

Gelles states that the continuance of battered women in therapy and in the use of resources is frustrating to him also. "Even when women do seek agency assistance on one occasion, it does not imply that they will continue to seek such help. This kind of situation often results in strong feelings of anger, cynicism, helplessness, and frustration

for the counselor working with abused women" (p. 131).

Regardless of what interventions might be used or arranged for the battered woman, oftentimes she ends up going back to her abusive husband and remaining in the abusive relationship. This can add to a counselor's frustrations who has spent several hours with a client. As Hendricks-Matthews states, even if such a reunion occurs, the woman still deserves the counselor's support. "The counselor must continue to support her, to work with her on changing the maladaptive attributions that she may be making, and to stress to her that under no circumstances does she (or anyone) deserve to be abused" (p. 137).

Individual therapy for the abusive husband. Therapy for abusive husbands is a much newer idea than therapy for abused wives, having been introduced just in recent years. In previous years, it has been seen as being a very difficult task to try to get an abusive husband into any type of therapy session. As Del Martin (1978) states, "the only way to get him (the abusive man) into therapy or counseling would be for a judge to order it as a condition of release (from jail or prison)" (p. 267).

Roy (1982) believes that this is no longer necessarily true and states that "of the known cases, there are a growing number of abusive partners who are clearly interested in stopping their violence, and an equally interested professional community intent on assisting them in realizing this goal" (p. 145).

Watts and Courtois (1981) state that batterers very seldom seek professional help because they frequently do not see their behavior as inappropriate. It is possible, however, that clients may be in therapy for other reasons than violence. It then becomes extremely important that the counselor learns to recognize violence in his client and confront the issue directly.

Moore (1979) believes that now, if we are living in what is still considered a male-oriented culture, and if men do retain the power and decision-making roles, it becomes imperative that they are included in the solutions, which means providing services to batterers as well as to those who are battered.

Barbara Hart (1979), a Legal Services Attorney and Legislative Chairperson for the Pennsylvania Coalition Against Domestic Violence, agrees with Moore and read the following statement to the United States Congress during the Harrisburg Hearing: "Unless the counselor keys into the batterer's problem with violence instead of the nature of the marital relationship, there will be no change" (in Under the rule of thumb: Battered women and the administration of justice, p. 65).

Whether that individual abuser comes voluntarily or is mandated to attend may also make some difference. Self-referred batterers may make faster progress because of their motivation and willingness to change their behaviors. According to Hart (1979), "therapy or counseling is rarely productive unless the individual voluntarily commits himself

to attempting to change his behavior . . . " (p. 65).

Counselors will have to consider how a batterer feels about his behavior to determine in which directions to proceed with treatment. As Cantoni(1981) states, "a client new to treatment often considers his actual or potential violence either as 1) normal - the community or other family member who objects is 'off-base' or 'out to get me,' 2) caused by my intrinsic 'badness' or the 'badness' of a family member, or 3) 'going crazy.' None of these assumptions provides a basis for treatment" (p. 10).

Bedrosian (1982) says that most abusing spouses, when they enter treatment, are aware of what provokes them and the emotions they feel preceding their violent behavior. Although this is recognized by most abusers, few of the abusers recognize the relationship between their thoughts and their actions. Moreover, according to Bedrosian, few spouses are aware of the powerful influence exerted by their interpretations and attitudes upon the marital relationship. Abusers need to learn how their actions and emotions are interrelated.

Cantoni (1981) has ideas similar to Bedrosian's and states that violence-prone clients have such serious deficiencies in their life experiences that they need cognitive education and advice regarding effective marital interaction.

The goals of therapy with abusive husbands are similar to the goals of therapy with abused wives. The most important goal is that of stopping the violence. Watts (1981)

states that other goals include learning alternatives to the abuse, assuming responsibility for themselves, reexamining the male sex-role stereotype, learning how to be assertive instead of aggressive, and building healthy interpersonal relationships.

Although working with battering men can be just as frustrating as working with battered women, according to Cantoni (1981), "it must be realized that persons who have serious problems with self-control are afraid of themselves. They may try to act cool, tough, macho, but in a quiet moment, with a concerned counselor, they will admit their great fear of themselves" (p. 7).

Group therapy. Group therapy has been introduced as an effective type of intervention for cases of spouse abuse in the past few years, first with abused women, then later with abusive men. This section will include discussions of both types of groups.

It may sometimes be difficult for a person who is in an abusive situation, either the abused or the abuser, to be able to form a therapeutic link with one mental health professional. According to Cantoni (1981), the client may be unable to form this link because "he or she finds the intensity of the relationship too threatening. Such a client may be able to get help in a group setting where the relationship with the counselor is diluted" (p. 9).

According to Warner (1979), peer support groups offer an environment to the participants which is cooperative and nurturing, an environment "where the participants are encouraged to share their accounts and their feelings without fear of reprisal" (p. 204). Warner continues by saying that the group experience encourages the participants to be open, verbally expressive, honest, and self-determining. The group experience provides a safe arena for discussion, new information, stress reduction techniques, and problem-solving ideas (p. 204).

Group therapy for the abused wife. The peer support groups for women have been utilized longer than those groups formed for abusive men. Many battered women have isolated themselves from others because of their strong feelings of embarassment, guilt, and fear. Isolation, says Warner (1979), also results from the husband's feelings of jealousy toward his wife, physical attacks on the woman, and possible imprisonment of the wife by the husband. Warner states that the group experience offers a woman a safe place to talk to others who are in similar situations, decreases the sense of isolation the woman may have, and offers ideas and reassurances for women who have had to cope with an abusive situation. The release of anger is also often seen in the women's groups.

According to Walker (1979), group therapy for women may have some advantages over individual therapy, in that the

women are in a situation in which they may form some friendships and find women they can confide in. A group composed of all battered women can then be an extremely valuable therapeutic experience.

Group therapy for the abusive husband. Until recently, groups for abusive men were nonexistent. Abusive men were not inclined to ask for help, nor to have a group of other men listen to their problems. The therapeutic techniques used in such groups are still in the experimental stages, and no long-term studies have been undertaken to determine the permanent effectiveness of such groups.

When working with groups of abusive husbands, exciting results may be obtained, according to Walker (1979). "One of the most significant changes is that the men who attend group therapy sessions are less likely to become depressed, suicidal, or psychotic during treatment" (p. 242).

A good example of this newest trend in the treatment of abusive husbands, the use of a peer support group, can be seen in a group called "Emerge," based in Boston. Deborah Watts (1981) says that "Emerge" is "concerned with reexamining the male sex-role stereotype, attacking sexist social relationships, and stopping the violent behavior against women. Men learn alternatives to abuse, gain support from other men, deepen their awareness of their own emotional lives, and recognize the oppressiveness of their violent behavior" (P&G Journal, p. 248).

Adams and McCormick (1982) say that "Emerge" fosters the development of self-help skills for men and uses appropriate modeling and norm setting by group members and counselors. Adams and McCormick continue to state that "in individual therapy, the only source of information for the client is the therapist. The individual therapist's ability to serve as a role model is impaired by the client's conception of him as different (e.g., "He doesn't beat his wife," "He's more educated,"). In a group, however, an abusive man is more likely to find role models he can use" (p. 181).

Group counseling for men seems to be an effective therapeutic tool. Socialization skills are taught to the men in the hope that their violent behavior will cease. As Adams and McCormick (1982) state, "the group offers a new social environment in which men are encouraged to reject the restrictive norms of compulsive masculinity and have permission to explore new ways of being men" (p. 196).

Conjoint therapy. Conjoint therapy involves counseling sessions which include both the abused wife and the abusive husband. Husband and wife generally attend the therapy sessions together.

According to Weitzman (1982), in the beginning phases of treatment the counselor needs to make a thorough assessment regarding the couple's level of psychosocial functioning. The couple, continues Weitzman, should have enough self-control to preclude further violent episodes if they are to be treated

together in conjoint therapy (p. 265).

Assessment should also be made to determine the couple's readiness for treatment. Bedrosian (1982) states that the two persons involved will most likely arrive at the therapist's office in differing states of readiness for treatment. "Very seldom will a therapist see spouses who show the same or similar levels of motivation for treatment, commitment to marriage, willingness to introspect, and so forth. Different types of motivational configurations may appear at the initial interview" (p. 119).

Another problem that may appear in the beginning stages of treatment, states Cantoni (1981), is that both spouses are usually convinced that anyone else who might happen to see their real selves, including the therapist, will hate them and have destructive feelings or actions directed at them. Such spouses may be terribly threatened by a therapeutic relationship for this reason (p. 9).

The therapist also needs to be able to assume control of the batterer's and the battered woman's behavior in the beginning phase of treatment, states Walker (1979). Walker believes that each spouse should make a contract with the therapist that states he or she will not engage in any violent behavior without first attempting to reach his or her therapist (p. 247). Weitzman and Dreen (1982) take this contract one step further and say that the therapist should not only obtain a written behavioral contract, but also a

verbal commitment from the couple to stop any violence (p. 264).

Bedrosian (1982) agrees with Walker regarding assuming control early in therapy, and states that the therapist needs to be quite directive in order to lessen the conflict by suggesting steps that can be taken by the couple to accomplish this lessening of violent conflict. If the level of overt conflict is high, the therapist needs to structure the treatment hour carefully (p. 123).

Cantoni (1981) also lists some issues that need to be dealt with early in the therapeutic relationship. These issues include feelings of isolation the couple may have, trust, dependence, control, seduction and ambivalence (p. 9).

It will also be helpful for the counselor to assess the couple's natural communication style for diagnostic purposes. Once this is accomplished, states Bedrosian (1982), the therapist "should begin to block destructive processes such as blaming, coercion, obsessive review of prior misdeeds, 'mind-reading,' and so on" (p. 124).

Advantages of conjoint therapy include the fact that both spouses are seen simultaneously and everything discussed is heard by all three participants--the counselor, the abused wife, and the abusive husband. This decreases, but does not eliminate, the possibility of one spouse feeling that the other may be in collusion with the therapist.

An advantage for the therapist is that he or she can see the communication styles of the couple, including both

verbal and non-verbal communication on a variety of subjects.

The goals of conjoint therapy in cases of spouse abuse are different than goals which may be found in traditional marriage counseling. Whereas one of the goals of traditional marriage counseling is to keep the couple together, states Warner (1981), the primary goal of counseling in cases of spouse abuse is to extinguish the battering (p. 206). To accomplish this goal, continues Warner (1981), attention needs to be "directed at individual growth, development, and personal needs, or the relationship is likely to lead to battering again" (p. 265).

Individual growth, according to Warner, would include self-esteem and self-acceptance. He believes that unless these issues are dealt with in conjoint therapy, each spouse will find it very difficult in future attempts to develop and maintain a violence-free relationship.

Walker (1979) states that one of the goals of conjoint therapy is for each spouse to learn how to ask for what he or she wants from the other spouse without incorporating false assumptions. They are also taught to recognize their own behavior patterns and how they keep the battering cycle alive. This recognition by each spouse will allow them to become aware of danger points in their relationship (p. 247).

According to Walker (1979), couples do benefit from conjoint therapy, although it is not without its problems. The couple, according to Walker (1979), "attends regularly

and their life improves. The women do not work as rapidly toward independence as they do in individual or group therapy, but they do lose the pervasive terror that immobilizes them, and they learn to express anger more constructively" (p. 248).

Family therapy. Family therapy involves the abused wife, the abusive husband and the couple's children. Any other significant family members may also be involved in therapy if the therapist believes that they may play a part in the dysfunctional process.

The use of the family for treatment for cases of spouse abuse is a new idea, having been introduced only in recent years. The reasons behind this introduction of family therapy for such cases, according to Cantoni (1981), include the counselor's assumptions that "1) all the family members learned how to relate to others, and 2) the violent behavior is one aspect of a total interactional pattern" (p. 10).

Bedrosian (1982) agrees with Cantoni's ideas and states that it's almost impossible to treat a couple involved in spouse abuse without looking at the family members surrounding them and modifying this context, even if this modification occurs indirectly (p. 125). Bedrosian also believes it's impossible to discuss the symptoms of spouse abuse without also considering any other dysfunctional family systems that might possibly be accompanying it.

The couple's children also need to be assessed for their own development and dysfunctional patterns. If, in the

beginning phase of treatment, the counselor believes the couple has had difficulty in establishing a leadership role for their children, the counselor may also need to request or utilize group work or individual counseling for the children involved.

A goal of family therapy for treatment of cases of spouse abuse, states Elbow (1982), is not to keep the family intact, unless that is the mutual goal of the couple, but to help the family develop skills that will promote healthy family functioning, regardless of marital status.

Cantoni (1981) says that clients gain some understanding of the dynamic interactions between themselves and family members during therapy, so that they recognize those aspects of their family system that are needing some change.

Other goals, according to Elbow (1982), include avoidance of mind-reading among family members, and how to express feelings to one another.

Cantoni (1981) states that it may be beneficial for families caught up in an abusive cycle to learn how to be creative. This creativity would include teaching the family how to play with one another in a positive, healthy manner.

Summary

This chapter included a review of literature regarding types of therapy to be used for treatment of cases of spouse abuse in which the wife is being abused by her husband.

Various viewpoints by researchers and clinicians were presented. Each therapeutic format was discussed in terms of the beginning phase of treatment and what the counselor may encounter, the goals of each format, and some of the frustrations the counselor may feel when using that particular format.

CHAPTER 3

Design of the Study

The purpose of this study is to review therapeutic formats which are presently being used by counselors and therapists when dealing with cases of spouse abuse and to study the perceived advantages of using each of these formats. This chapter will describe the survey instrument used by the researcher to obtain information pertaining to therapeutic formats currently being utilized. It will also describe the source of the sample, the survey instrument, and methods of gathering data.

Source of Sample

The source for this sample consisted of mental health professionals practicing in a predominately metropolitan county in Iowa, including psychiatrists, psychologists, social workers, counselors and therapists. All mental health professionals listed in the 1982 edition of the local telephone directory under the headings 1) Physicians and Surgeons - m.d. - Psychiatry, 2) Psychologists, and 3) Marriage and Family Counselors were contacted by mail in May 1983. Telephone calls were made by the researcher to agencies or clinics listed in the directory in order to obtain lists of individual names of mental health professionals employed by the respective agencies if the individual names were not listed in the yellow

pages. A total of 66 names of mental health professionals was obtained. Identical survey instruments, accompanied by a cover letter, were mailed to all 66 persons identified.

Description of the Instrument

The instrument used was a 37-item questionnaire designed by the researcher. This method was chosen because no appropriate instrument was found in a search of the literature. This study, strictly speaking, is a pilot project since there is no reliability/validity data on this particular instrument. The content of the instrument included, but was not limited to, data pertaining to (a) demographics of the respondents, (b) description of the client population, (c) perceived determinants of successful treatment, and (d) utilization of other community resources by mental health professionals. Twenty-five multiple-choice and twelve short-answer items were included in the total of 37 items in the instrument.

Methods of Gathering Data

The survey instrument (see Appendix B), along with a cover letter (see Appendix A) and a return envelope were mailed to each mental health professional in the sample 66 professionals on May 24, 1983. The cover letter explained the scope and content of the survey and of the study. A total of 28 responses was obtained from the first mailing.

A follow-up letter (see Appendix C) and duplicate instrument were mailed on June 8, 1983, to those professionals

who had not as yet responded to the first mailing. Ten instruments were returned after this follow-up letter. As a result, a total of 38 out of 66 professionals surveyed responded, for a return rate of 58 percent.

Analysis of the Data

An analysis of the data collected by the survey instrument was conducted. Because the items called for individual, spontaneous responses, the data was hand-tabulated by the researcher. Responses to each multiple-choice question were charted by frequency of response as well as by percentage. A discussion of the findings will be presented in Chapter 4.

CHAPTER 4

Results and Discussion

Results

The purpose of this study is to review the therapeutic formats which are presently being used by counselors and therapists for treatment of cases of spouse abuse. Information will be presented in this chapter pertaining to the findings of the research. Data were supplied through the use of a survey instrument which was mailed to mental health professionals in a predominantly metropolitan county in Iowa in 1983. Demographic information will be presented first to show the general makeup of the respondents. Secondly, information pertaining to therapeutic formats used by the mental health professionals who responded will be presented.

The research instrument was designed by the researcher. Included in the instrument were 25 multiple-choice questions and 12 short-answer questions for a total of 37 items.

A total of 42 copies of the survey instrument were returned by a total survey population of 66 mental health professionals for a return rate of 67 percent. Four of the copies of the survey instrument were returned unanswered by mental health professionals who stated that their work does not include spouse abuse cases. All respondents were employed as mental health professionals in the county when the survey instruments were answered. The 38 useable survey instruments which were returned produced a rate of 58 percent.

The following demographic information summarizes the 38 survey instruments completed and returned to the researcher.

There was a total of 40 males and 26 females included in the survey population. Of this total, 69 percent of the females and 48 percent of the males surveyed returned their completed survey instruments to the researcher. Among respondents, 20 were male (51 percent) and 18 were female (49 percent).

The age ranges of the respondents were included in the demographic information. These responses to item number 2 will be indicated in Table 1.

Table 1

Ages of Respondents

Age	Number of Respondents	Percentage of Respondents
20-30	3	8
30-40	9	24
40-50	8	22
50-60	11	27
over 60	4	11
not answered	3	8

N=38

The largest percentage of the respondents were between the ages of 50 and 60. A total of 15 respondents (38 percent) were over the age of 50.

Occupations of the respondents were included in the demographic information portion of the survey instrument. Four possible occupations were listed in item number 3. Also included was an "other" category for the benefit of any respondent who had an occupation which was not included in the four occupations specifically listed. Table 2 includes the responses to item number 3.

Table 2

Occupations of Respondents

Occupation	Number of Respondents	Percentage of Respondents
Psychiatrist	4	11
Psychologist	7	18
Counselor/Therapist in Agency	16	42
Counselor/Therapist in Private Practice	10	26
Other	1	3

N=38

The majority of respondents listed their occupation as counselor or therapist in an agency setting, with the next largest percentage listing as counselor or therapist in

private practice. The combination of these two categories totaled 26 (68 percent) respondents. The one respondent who answered under "other" listed her occupation as a coordinator for a family violence intervention program and director of a shelter for battered women.

The demographic information also asked for a listing of any advanced degrees that had been earned by the respondents. This was a short-answer response to item number 4, and results are listed in Table 3.

Table 3

Advanced Degrees Earned by Respondents

Degree	Number of Respondents	Percentage of Respondents
M.A.	8	21
M.S.W.	18	48
M.S.S.	1	3
PhD.	4	10
D.Min.	1	3
M.D.	4	10
No Advanced Degrees	2	5

N=38

Nine respondents (23 percent) had degrees beyond the Masters level. Five percent of the respondents stated they had earned no advanced degrees. It is not known by the

researcher if these persons who listed no advanced degrees had any undergraduate college degrees.

Item number 5 on the survey instrument asked, "How long have you been working in this profession?" The range of the 38 responses was from six months to 35 years with a median length of 14.9 years. Twenty-five percent of the respondents had worked in their respective professions for 25 years or longer. This item did not take into consideration the fact that some professionals in their current professions could also have worked for a significant amount of time in another profession which was similar to and/or trained them for their current profession. The length of time in a similar profession, added to the length of time in their current profession, might increase the median number of years shown in item number 5.

Items numbered 6 and 7 involved the amount of education the respondents had received regarding treatment of spouse abuse cases. Nine of the respondents (24 percent) received formal training that included information regarding spouse abuse. Eight of these nine respondents (21 percent of the total respondents) who had received formal training, have also attended a workshop or seminar on the topic of spouse abuse. Twenty-nine respondents (76 percent) did not receive formal training that included a study of spouse abuse cases. Fourteen of these 29 respondents (37 percent) had, however, subsequently attended a workshop or seminar dealing with

spouse abuse. Fifteen (39 percent) of the helping professionals responding to this instrument had neither received formal training on the subject of spouse abuse nor had they attended any seminars or workshops.

Item number 8 asked the respondents to define spouse abuse in a short-answer form. Sixteen respondents (42 percent) defined it basically as "physical and/or emotional abuse." Fourteen respondents (37 percent) had more in-depth answers which have been listed in Appendix D. Eight respondents (21 percent) left this item unanswered.

Item number 9 asked, "How many cases of abused wives and/or abusive husbands have you worked with in the past two years?" Of the 24 respondents (63 percent) who answered this item in numerical terms, the total of cases seen was 550, for an average number of cases being 23 per respondent. Twelve respondents (32 percent) answered this item by stating "indeterminate," "no exact count," or "numerous." The remaining two respondents (five percent) stated "none."

In item number 10 the respondents were asked to compare the number of spouse abuse cases they have seen in the past two years with the number of spouse abuse cases they had seen prior to the past two-year period. Fourteen respondents (37 percent) stated there was an increase in the number of cases they had seen. Two respondents (five percent) said they had seen a decrease in cases over the number seen in previous years. Twenty-two respondents (58 percent) said

the number of cases they had seen in the past two years had remained about the same as in previous years.

Item number 17 involved the attitudes of helping professionals who had been in their profession longer than five years. The question read, "If you have been in this profession longer than five years, have your attitudes concerning abused wives/abusive husbands changed?" Of the 27 respondents to this item, 15 (56 percent) answered "yes," and 12 respondents (44 percent) answered "no." The "yes" responses to item number 17 reflected a mixture of positive and negative attitudinal changes. The answers of those respondents who completed this item with a short answer when asked to describe their attitudinal changes will be found in Appendix D.

Table 4 shows the range of responses given to item number 21, which was directed at finding out who contacts the therapist when a person is needing professional help.

Table 4

Persons Contacting Therapists
As Reported by Therapists

Contact Person	Percentage Range of Answers	Median Percentage
Abused Wife	30-100	70
Abusive Husband	2-35	14
Referral Agency	5-100	37
Other	see the following statement	

N=38

Respondents who answered "other" regarding the person who contacted them, listed the courts, other family members not involved in the abuse, and friends as possible contact sources.

Item number 22 was included to determine who is(are) involved as client(s) in treatment for cases of spouse abuse. Four possibilities were listed, along with a possible response of a "Combination of the Above," as seen in Table 5.

Table 5

Client Population Involved
In Treatment of Spouse Abuse

Client	Range of Percentages	Median Percentage
Abused Wife Only	6-100	53
Abusive Husband Only	0-34	8
Couple, Separately	1-100	40
Couple, Jointly	5-100	43
Combination of the Above	17-100	64

N=38

Who the therapist would like to see in therapy for treatment of spouse abuse cases, if he or she had control over who their clientele would be, was investigated in item number 23. Four respondents (10 percent) answered that they would like to work from an interpersonal approach, involving one person as a client. Eleven respondents (30 percent) would work from

an interpersonal approach involving the marital dyad. A systems approach involving the abused wife, the abusive husband, and other family members would be preferred by 22 of the respondents (57 percent). One respondent (three percent) stated that he or she would not work with spouse abuse cases at all.

Physical separation of the abused wife and the abusive husband was the subject in item number 26. When asked if the treatment would be more successful if the couple lived apart during treatment, 13 (34 percent) of the respondents felt it would be more successful, 16 respondents (42 percent) believed it would not be more successful, and nine respondents (24 percent) said the success would vary with each situation. Answers of those respondents who included a short answer with item number 26 will be found in Appendix D.

Items numbered 30, 33, 34, and 35 involved the use of other community resources for the treatment of spouse abuse cases. These included use of the legal system, medication and/or hospitalization, shelters for battered women, self-help/support groups, and referrals to other helping professionals or agencies.

The response to the filing of criminal charges against an abusive husband was included in item number 30. Twenty-five respondents (66 percent) felt that filing criminal charges would affect the success of treatment in such cases, and six respondents (16 percent) said it would not affect the

success of treatment. Another seven respondents (18 percent) were unsure whether filing criminal charges would have an effect on the success of treatment. How the filing of criminal charges affects the success of treatment, whether in a positive or negative manner, was responded to by the use of short answers. These answers will be found in Appendix D.

The use of medication as part of a treatment program was discussed in item number 33. When asked if the respondent uses medication as part of their treatment program for cases of spouse abuse, 18 respondents (48 percent) answered "yes." The respondents who answered "yes" used medication in approximately one-third of their cases of spouse abuse.

Hospitalization would be used at some time, in some situations, by 100 percent of the counselors or therapists who responded to item number 34. Table 6 indicates reasons which were listed by respondents as to why they would hospitalize a client.

Table 6

Reasons for Hospitalization

Reason	Number of Respondents	Percentage of Respondents
Client is suicidal	8	21
Client is homicidal	2	8
Client is emotionally disturbed, psychotic	17	45
Client is severely depressed	9	24
Client is alcohol/ drug abuser	11	29
Client appears to be schizophrenic	1	3

N=38

The use of shelters for battered women was the subject in item number 35. Thirty-one respondents (81 percent) said they have referred an abused wife to a shelter. Six respondents (16 percent) said they have never referred an abused wife to a shelter. One respondent (three percent) stated he or she was not aware of a shelter for battered women in this community. Two respondents stated they would not use a shelter for their clients who were abused wives because "abuse is an interaction process between a couple and separating them is only a temporary solution and does not solve the problem," and "because they (the client) usually doesn't

feel threatened by the time they come to me for help." Twelve helping professionals who had referred clients to shelters listed reasons which will be found in Appendix D.

Whether a counselor has referred a client to another professional or agency was the subject in item number 36. Twenty-nine respondents (76 percent) said they had referred clients elsewhere, and nine respondents (24 percent) said they had not referred clients to another helping professional or agency. Reasons for referrals, as listed by 13 respondents, will be found in Appendix D.

The use of self-help/support groups was the subject in item number 37. Thirty-six respondents (95 percent) said they would recommend such groups to their clients as part of a treatment program. Only two respondents (five percent) said they would not utilize such a resource. One reason stated by one respondent who does not recommend such groups was "the couple has to deal with the problems . . . self-help groups oftentimes support the abused wife and see the husband as the culprit and she as the unfortunate victim."

Discussion

Items numbered 6 and 7 pertained to the respondents' amount of training, both formal and informal training, regarding spouse abuse. Data received from these items indicate that there is a large percentage of respondents (76 percent) working with cases of spouse abuse who have not

received any formal training on the subject. Some respondents (39 percent) have also not attended any seminars or workshops on spouse abuse. The knowledge these individuals have regarding spouse abuse could have derived from independent readings, actual experiences with abusive couples, or information given to them informally by other helping professionals. It is evident to the researcher that, because of the frequency with which spouse abuse cases are seen by mental health professionals, more pertinent information needs to be made available to counselors, and counselors need to avail themselves of such information regarding treatment of spouse abuse.

Disagreement among the respondents was evident in many of the items in the survey instrument. These items included, but were not limited to, items pertaining to living arrangements of the couple during treatment, the filing of criminal charges, and the use of medication for clients.

In item number 26, 13 respondents (34 percent) felt the couple should live apart from one another for treatment to be successful, and 16 respondents (42 percent) said that physical separation would not allow for more successful treatment. Nine respondents stated that the success of treatment would vary with each couple. There was no general consensus reached on this issue by the respondents.

Regarding the filing of criminal charges against an abusive husband, in item number 30, 25 respondents (66 percent) said the filing of charges would affect the success

of treatment, but how it would affect treatment was listed by some in a positive manner, by others in a negative manner.

Respondents were also divided on the use of medication for clients in treatment, as indicated in item number 33. Eighteen respondents (48 percent) said they felt medication was useful in approximately one-third of their cases. The remaining 20 respondents (52 percent) stated medication was generally not necessary. For many therapists, the use of medication would require the involvement of another helping professional, since most therapists are not licensed physicians. The fact that many therapists work (or prefer to work) independently from licensed physicians may have influenced the percentages derived in item number 33.

Some of the items in this survey instrument were agreed upon by the majority of respondents. These included items pertaining to the use of hospitalization, the use of referrals to other agencies or professionals, the use of self-help groups, the use of shelters, and the approach favored by therapists when treating spouse abuse.

The majority of the respondents (95 percent) would consider using self-help or support groups for their clients. Many stated that these groups would be used in conjunction with their own therapeutic format, not as a substitute for more personal counseling.

Referrals to other agencies also was answered positively by the majority of respondents (76 percent). Thirteen

respondents (34 percent), regarding item number 36, stated they would refer, for financial reasons that is, if the client could not afford their fees.

The use of shelters was agreed upon by the majority of the respondents (81 percent). Although some respondents saw the use of shelters as being detrimental by supporting only the abused wife, most respondents saw shelters as a valuable resource.

Although most therapists now see only the abused wife in the majority of cases, this individual approach was not the preferred method. The therapeutic format which the majority of respondents (57 percent) agreed upon was the systemic approach in which the abused wife, abusive husband and other important family members would all be seen in therapy together.

CHAPTER 5

Summary, Conclusions and Recommendations

Summary

The purpose of this study has been to review therapeutic formats which are currently being used by counselors and therapists for treating cases of spouse abuse.

Information was derived from two sources. First, a review of literature was conducted. Secondly, a survey instrument, developed by the researcher, was utilized.

The review of literature included information pertaining to current therapeutic formats that could be used by counselors and therapists, advantages of each of these formats, dynamics in the beginning phases of treatment, and goals of each type of therapy. These were discussed in Chapter 2.

Information regarding therapeutic formats that are actually being used by counselors and therapists at the present time was obtained through the survey instrument. The instrument was mailed to mental health professionals who were employed in a predominately metropolitan county of Iowa. Copies of the instrument were mailed to 66 professionals. Thirty-eight useable surveys were completed and returned for a return rate of 58 percent. Four additional surveys were returned which had not been completed. Reasons stated for not completing the surveys included the fact that those counselors specialized in other areas of therapy and did not work with abusive families. The data returned were compiled

and tabulated by the researcher.

The findings show that mental health professionals who treat cases of spouse abuse do not always proceed with therapy in the same manner as their peers. The majority of therapists, however, if they had control over who their clientele would be, would choose a systems approach of dealing with treatment for cases of spouse abuse.

Other than the use of hospitalization or the use of self-help groups for clients, the respondents were also divided on the use of other community resources for their clients.

Conclusions

Based on the results of this study, the following conclusions can be made.

1. There is not much consensus by mental health professionals on the best therapeutic formats to be used with cases of spouse abuse.

2. Spouse abuse is a significant problem in the United States and is not decreasing. The number of cases seen by therapists is generally increasing or remaining stable. A decreasing amount of spouse abuse is seen by an insignificant number of therapists.

3. Most counselors and therapists would prefer incorporating a systems approach in their work with couples involved in spouse abuse.

4. Other community resources are generally seen as viable alternatives or additions to therapy by mental health professionals.

Recommendations

The following recommendations are a result of this study. The researcher believes these recommendations are important for further study and/or action.

1. Formal training for counselors and therapists should incorporate a study of abusive patterns between spouses, and possible therapeutic formats which may be available to the mental health professionals.

2. Counselors should be encouraged to attend seminars or workshops on spouse abuse to stay up-to-date on formats and services available.

3. The therapeutic format used by a counselor in a case of spouse abuse should be determined on an individual basis, depending on several differing circumstances, including what the goals are of the abusing couple.

4. Community agencies play a key role in treatment of couples involved in spouse abuse, and should be fully utilized by counselors.

5. This study should be considered a pilot study and, with minor revisions, should be replicated.

References

Adams, David C., & McCormick, Andrew J. (1982). Men unlearning violence: A group approach based on the collective model. The abusive partner: An analysis of domestic battering, ed. by Maria Roy. New York: Van Nostrand Reinhold Company, Inc., 170-197.

Bedrosian, Richard C. (1982). Using cognitive and systems intervention in the treatment of marital violence. Clinical approaches to family violence. Rockville, MD: Aspen Systems Corporation, 117-138.

Berghorn, Gwen, & Siracusa, Anthony (1982). Beyond isolated treatment: A case for community involvement in family violence interventions. Clinical approaches to family violence. Rockville, MD: Aspen Systems Corporation, 139-157.

Bern, Elliot H. (1982). From violent incident to spouse abuse syndrome. Social Casework, 63(8), 465-471.

Cantoni, Lucile (1981). Clinical issues in domestic violence. Social Casework, 62(1), 3-12.

Dobash, R. Emerson, & Dobash, Russell (1979). Violence against wives: A case against the patriarchy. New York: The Free Press, A Division of Macmillan Publishing Company, Inc.

Elbow, Margaret (1983). Children of violent marriages: The forgotten victims. Social Casework, 63(5), 259-265.

Garnet, Shelley E. (1982). How to set up a counseling program for self-reffered batterers: The AWAIC Model. The abusive partner: An analysis of domestic battering, ed. by Maria Roy. New York: Van Nostrand Reinhold Company, Inc., 267-276.

Geller, Janet (1982). Conjoint therapy: Staff training and treatment of the abuser and the abused. The abusive partner: An analysis of domestic battering, ed. by Maria Roy. New York: Van Nostrand Reinhold Company, Inc., 198-215.

Gelles, Richard J. (1983). Violence in the family: A review of research in the seventies. Family studies review yearbook, 1. Beverly Hills: Sage Publications, 238-250.

Hendricks-Matthews, Marybeth (1982). The battered woman: Is she ready for help? Social Casework, 63(3), 131-137.

Kremen, Eleanor (1976). The "discovery" of battered wives: Considerations for the development of a social service network. Paper presented to the American Sociological Association Convention, New York City.

Martin, Del (1976). Battered wives. New York: Pocket Books.

Martin, Del (1978). Battered women: Society's problem, in The victimization of women, 3, Jane Chapman and Margret Gates (eds.). Beverly Hills, CA: Sage Publications.

Moore, Donna M., & Pepitone-Rockwell, Fran (1979). Experiences with and views about battering: A research note. Battered women, ed. by Donna M. Moore. Beverly Hills, CA: Sage Publications, 119-143.

Nichols, Beverly B. (1976). The abused wife problem. Social Casework, 57(1), 27-32.

1981 Annual report of statistics from integrated crisis services. Waterloo, IA.

1982 Annual report of statistics from integrated crisis services. Waterloo, IA.

Roy, Maria (1982). The unmaking of the abusive partner. The abusive partner: An analysis of domestic battering, ed. by Maria Roy. New York: Van Nostrand Reinhold Company, Inc., 145-169.

Under the rule of thumb: Battered women and the administration of justice (1982). A report of the United States Commission on Civil Rights.

Walker, Lenore E. (1979). The battered woman. New York: Harper & Row Publishers.

Walker-Hooper, Ashley (1981). Domestic violence: Responding to victims' needs. Conflict intervention in social and domestic violence, ed. by Carmen Germaine Warner. Bowie, MD: Robert J. Brady Co., 185-215.

Warner, Carmen Germaine (1981). Dynamics of an interview. Conflict intervention in social and domestic violence, ed. by Carmen Germaine Warner. Bowie, MD: Robert J. Brady Co., 161-176.

Warner, Carmen Germaine (1981). Techniques in conflict intervention. Conflict intervention in social and domestic violence, ed. by Carmen Germaine Warner. Bowie, MD: Robert J. Brady Co., 147-160.

Watts, Deborah L., & Courtois, Christine A. (1981). Trends in the treatment of men who commit violence against women. Personnel and Guidance Journal, 60(4), 245-249.

Weitzman, Jack, & Dreen, Karen (1982). Wife beating: A view of the marital dyad. Social Casework, 63(1), 3-12.

Appendix A

May 24, 1983

Dear

I am in the process of writing my research paper to complete the requirements for the Masters Degree in Agency Counseling at the University of Northern Iowa. My research paper concerns clinical treatment methods used in cases of spouse abuse and my subject is limited to include only cases in which the wife is the abused and the husband is the abuser.

As part of my research, I am conducting a survey to determine the methods used by selected psychiatrists, psychologists, therapists and other helping professionals in Black Hawk County. Results of this study will be useful to professionals in determining current trends in this area and the success rate of various methods.

A high response rate is essential to the success of this study. Your participation can make the difference. Your identity will remain anonymous through the use of a coding system of the questionnaires. All questionnaires will be destroyed after the statistics have been compiled.

Please fill out the accompanying questionnaire and return it in the enclosed envelope by June 7th. Your participation in this study will be greatly appreciated. Results of the survey will be made available upon request. Thank you!

Sincerely,

Susan Hoppenworth
Graduate Student
University of Northern Iowa

Enclosures

Mailing address:

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Appendix B

ABUSED WIVES/ABUSIVE HUSBANDS:
CLINICAL TREATMENT METHODS

Directions: Please respond to the following questions and statements regarding clinical treatment methods and other significant data involving cases of spouse abuse in which the husband is the abuser and the wife is the abused. Responses to the first seven questions or statements pertain to yourself as a helping professional.

1. Sex(circle one): a. male
   b. female

2. Age(circle one): a. 20-30
   b. 30-40
   c. 40-50
   d. 50-60
   e. over 60

3. Occupation(circle one):
   a. psychiatrist
   b. psychologist
   c. counselor/therapist in an agency
   d. counselor/therapist in private practice
   e. other, please indicate_____
   _____

4. Advanced degrees:_____

5. How long have you been working in this profession?

6. Was working with abused wives/abusive husbands part of your formal training?(circle one)
   a. yes
   b. no

7. Have you ever attended a seminar or workshop dealing with abused wives/abusive husbands other than your formal training? (circle one)
   a. yes
   b. no

8. How do you define spouse abuse?

9. How many cases of abused wives and/or abusive husbands have you worked with in the past two years?

10. How does this number compare with the number of cases seen in previous years?(circle one answer only)
    a. increase
    b. decrease
    c. about the same

11. If there has been an increase in cases you have seen in the past two years, to what do you attribute this?

12. Of the abused wives and/or abusive husbands you have worked with in the past two years, how many have been married for: (fill in all blanks)
    a. less than one year _____
    b. 1-5 years _____
    c. 5-10 years _____
    d. over 10 years _____

13. On the average, how long has the abuse been going on before the persons seek treatment?

14. To your knowledge, what percentage of your clients in abusive situations have had parents who were also in situations involving spouse abuse?
    a. husbands _____%
    b. wives _____%

15. To your knowledge, in what percentage of cases were the husbands or wives victims of child abuse by their parents? (fill in blanks)
    a. husbands _____%
    b. wives _____%

16. Please rank the following factors in order of how frequently they are seen as precipitators in abused wife/abusive husband cases, with 1 being the most frequently seen, 9 being the least frequently seen: (fill in all blanks)
    a. ____substance abuse by husband
    b. ____substance abuse by wife
    c. ____unemployment of husband
    d. ____jealousy of husband
    e. ____pornography
    f. ____pregnancy
    g. ____sexual problems
    h. ____disputes over children
    i. ____other, please indicate_____

17. If you have been in this profession longer than five years, have your attitudes concerning abused wives/abusive husbands changed? (circle one)
    a. yes
    b. no
    If so, how?

18. Please list any specific techniques you use for cases of abused wives/abusive husbands that seem to be effective.

19. If you have been in this profession longer than five years, have your techniques changed in working with abusive couples?(circle one)
    a. yes
    b. no
    If so, how?

20. Are there techniques you have tried that were not effective? (circle one)
    a. yes
    b. no
    If so, what were they?

21. Regarding the initial contact requesting treatment, in what percentage of cases is this contact made by: (fill in all blanks)
    a. the abused wife _____%
    b. the abusive husband _____%
    c. referral by an agency _____%
    d. other, please explain, _____ _____%

22. Of the abusive cases you have seen in the last two years, in how many have you seen; (fill in all blanks)
    a. the abused wife only _____
    b. the abusive husband only _____
    c. husband and wife, separately _____
    d. husband and wife, jointly _____
    e. a combination of the above, please explain_____

23. If you had control over who you see in an abusive situation, would you work from: (circle one)

    a. an intrapersonal approach
    b. an interpersonal approach involving the marital dyad
    c. a systems approach involving the abused wife, abusive husband and other family members

24. What is generally the frequency of treatment? (circle one)

    a. twice weekly
    b. weekly
    c. twice a month
    d. monthly
    e. other, please explain_____

    _____

25. What is the average length of treatment?(fill in one blank)

    a. _____weeks
    b. _____months
    c. _____years

26. Do you feel treatment is more successful if the husband and wife live apart from one another during treatment?(circle one)

    a. yes
    b. no

    If so, why?

27. What are your criteria for determining success with clients?

28. In what percentage of cases do you feel you are successful?

    _____%

29. To what do you attribute your success?

30. Do you feel that filing criminal charges against an abusive husband will affect the success of treatment in any way? (circle one)

    a. yes
    b. no

    If so, how?

31. Do you feel abuse is generally a primary or secondary problem? (circle one)

    a. primary
    b. secondary

32. What do you find most difficult in treating abusive couples?

33. In what percentage of cases do you use medication as part of your treatment program?

    _____%

34. Are there ever cases in which you feel hospitalization for the abuser is needed as part of a treatment program?

    a. yes
    b. no

    If so, when?

35. Have you ever referred an abused wife to a shelter for battered women? (circle one)

a. yes
b. no

Why or why not?

36. Have you ever referred an abused wife or abusive husband to another professional or agency? (circle one)

a. yes
b. no

If so, why did you decide not to proceed with treatment?

37. Do you recommend support groups/self help groups to any of your clients who are in abusive situations as part of a treatment program? (circle one)

a. yes
b. no

If not, why not?

Additional comments:

Thank you for taking time to fill out this questionnaire. If you would like a copy of the results, please write your name and mailing address below.

NAME

ADDRESS

Mail survey to:

Susan Hoppenworth
3130 Hammond Ave.
Waterloo, Iowa 50702

Appendix C

June 8, 1983

Dear Mental Health Professional:

On May 24, I mailed to you a copy of the research survey that I am using in order to complete my masters degree at the University of Northern Iowa. I am anxiously awaiting the results of this survey.

It is very important that I receive your survey, because a high response rate is essential to the success of this study. If you have lost or misplaced your form, please use the duplicate survey enclosed and mail it back to me by June 15th.

I appreciate the many demands placed upon you. Thank you for your time and cooperation.

Sincerely,

Susan Hoppenworth
Graduate Student
University of Northern Iowa

Enclosure

Mailing address:

Susan Hoppenworth
3130 Hammond Ave.
Waterloo, Iowa 50702

Appendix D

Appendix D includes short-answer responses which were requested by the researcher for six items included in the survey instrument and utilized in this study. The respondents' answers to items numbered 8, 17, 26, 30, 35, and 36 are included in this appendix.

8. How do you define spouse abuse?

"When a husband uses physical or mental methods that are attacking and cruel and abusive to express his feelings, needs or domination."

"Verbal or physical destruction of another person in such a way that their self-esteem/self-concept is diminished to the point that the person begins to doubt their own sense of worth as a human being."

"Verbal or physical force which is beyond the spouse's ability to equal for defensive/offensive purposes."

"Any physical or verbal approach which makes the partner significantly uncomfortable on a recurring basis."

"Imposition of emotional or physical pain, or imposition of one spouse's will upon another, under threat."

"When one spouse exerts excessive dominance over the partner, resulting in physical and/or emotional damage."

"An act (or failure to act) which reduces human worth and dignity, usually resulting in physical, emotional, social and/or spiritual pain and suffering."

"The physical or emotional abuse of an immature and/or emotionally disturbed person upon an inadequate spouse."

"The irrational control of one to another using either physical or emotional violation of the other in order to instill sets of feelings, (i.e., fear) which then can be used to insure dominance."

"(1) Physical beating, and (2) extremely demanding, restricting, smothering, or guilt-inspired behavior."

"Physical-emotional abuse of one partner by the other that interferes with daily/long-term functioning of the abused individual--results in abused spouse exhibiting personality traits not healthy--i.e., alcoholism, passivity, "martyr," etc."

"Maltreatment, either physical or verbal. May be physical, mental, emotional or psychological abuse."

"Two individuals who are malfunctioning and maladjusted who are not coping with stress from whatever source and taking it out on each other."

"Doing injury to another through physical, verbal or emotional assault."

"Primarily in terms of pattern of repeated physical abuse actions, with or without verbal degradation."

"Pattern of relationship in which one spouse takes advantage of strength (physical, intellectual or emotional) over other spouse in dealing with issues of power and control."

"Physical and/or physiological domination of one partner towards the other."

17. If you have been in this profession longer than five years, have your attitudes concerning abused wives/abusive husbands changed? If so, how?

"Just more aware of the problem."

"I realize that the desire to be understood and loved is very basic. If one doesn't receive it as a child, one can't give it as an adult. One must experience understanding to give it to others."

"I have gone to a more systemic, circular view; am more sympathetic to men."

"It is gradually more evident that abuse and tolerance of abuse are the 'tip of the iceberg' symptoms of major personality disorders."

"I see it now more as a systems problem."

"I have learned to look beyond the black eye or bloody nose for the subtle factors which provoke."

"Feeling that no one should ever begin to put up with abuse. Also, that either abuse or accepting abuse was learned as a child."

"Increased awareness of how much the victim contributes to the abuse."

"Initially it was difficult for me to grasp what part the victim played in these cases, as well as to understand why anyone would either perpetrate it or allow it."

"I see the problem of abuse as an interactional problem, that both are involved in the abuse, and that both have to see their part and do something about it."

"I am becoming less tolerant of repeated abusive situations in which neither party is working to change."

"I now see it as a joint problem between the marriage partners."

"I'm becoming more aware of the problem, but less tolerant."

"I recognize it as a cyclical problem highly related to the individual's self-esteem."

26. Do you feel treatment is more successful if the husband and wife live apart from one another during treatment? If so, why?

"It seems to emphasize the need for change, that the situation will not be allowed to continue."

"It helps each to decrease tension level initially."

"It allows them to deal differently with conflict."

"It helps them develop a different perspective."

"Because it is too easy for the husband to fall back into the same assault patterns with the wife right there. Also, I've found the men 'force' the women to stop treatment if they're living together."

"It gives them a 'new ground' for interaction--women can gain confidence when they are away from constant abuse."

30. Do you feel that filing criminal charges against an abusive husband will affect the success of treatment in any way? If so, how? The following short-answer responses were preceeded by a "yes" answer.

"It's a confrontation leading to reality orientation."

"Only in the sense that the wife is saying to the husband that she will no longer tolerate his abuse."

"It demonstrates the wife's unwillingness to accept violence upon her as a way of dealing with issues."

"It may alienate the spouse, but then this may be the only way."

"They may understand the spouse has reached the limit and will not continue to tolerate poor treatment."

"It allows for responsibility of action(s) to be felt; indicates willingness to alter the dysfunction."

"It is like retaliating punitively and doing such, though warranted, increases distance and isolation. If you want to be punitive, that is one thing. If you want to reconcile, that is another thing."

"It may make him face squarely the reality of what he is doing."

"An injunction against the abusive spouse with the threat of going to jail may help him to control his temper."

"It lets the abuser know that the abusive behavior will not be tolerated. This may not mean 'success' in terms of keeping the marriage together."

"This is a good use of reality in some instances of repeated or extreme abuse--also a test of the abused person's claim that they don't want the abuse to continue. But this must be used cautiously--not as retaliation."

"In some families we consider that part of the treatment plan; in others we think it will do more damage."

"It will definitely stop the abuse."

"It may convince the husband that the matter is serious."

35. Have you ever referred an abused wife to a shelter for battered women? Why or why not? The following short-answer responses were preceeded by a "yes" answer.

"I felt the client needed to be away from the physical and emotional trauma involved in the situation."

"Because the wife temporarily leaving may be needed to protect her and the children and produce more of a crisis to get movement in the family to make positive change."

"For her protection and to help demonstrate her participation in the system."

"Because oftentimes the abused women I see fear for their lives and need to be in a safe place where the abusive male can't find her."

"For protection and a change from a destructive environment."

"It provides 'time out' for the wife, and is a safe place."

"As a means to protect as well as to allow a cooling-off period."

"For refuge, opportunity to keep spouse and children together."

"A short interim separation may be called for to indicate seriousness of the situation."

"When there is a possibility that she will be killed, severely hurt or indicates in a serious way that she can no longer cope."

"For safety, and to de-escalate feelings and impress the abuser with the need for change."

"Where real present danger exists, based on available information."

36. Have you ever referred an abused wife or abusive husband to another professional or agency? If so, why did you decide not to proceed with treatment? The following short-answer responses were preceded by a "yes" answer.

"I have referred if (1) they are resistant to treatment, (2) wanting self-justification only, (3) money problems, and (4) wanting or needing social services or only immediate exit from the problem or only immediate symptom relief."

"When I was unable to establish a therapeutic relationship."

"I referred only for financial considerations; the client could not afford my fees."

"I have referred usually when there are also individual problems that need more than what we can provide in family therapy for one hour a week."

"Our program is not long-term. One of our goals is to plug family members into community resources."

"I have difficulty with transference and countertransference issues."

"Because the problems of that person were too extensive for me."

"Usually because of the person's inability to afford (financially) on-going treatment."

"Unwillingness of spouse to attend and felt would go with spouse's resistance by referral individual for male clients requesting male therapist."

"When I did not like them or they did not like me--you have to like people you work with."

"I referred a client to a substance abuse treatment program. This did not end treatment, but was only used as an adjunct or temporary step."

"Some were already in treatment elsewhere."

"I have referred to alcohol abuse treatment centers."