Intimate Partner Violence: Practical Issues for Psychiatrists

August 01, 2008 | Comorbidity In Psychiatry [1], Cultural Psychiatry [2], Sexual Offenses [3], Psychiatric Emergencies [4], Trauma And Violence [5], Addiction [6], Alcohol Abuse [7] By Alison M. Heru, MD [8]

The term “domestic violence” emerged in the United States with the rise of the women’s movement in the 1970s. Before that, violence between partners was considered a private matter. A specific type of domestic violence, intimate partner violence, refers to violence between intimate partners. Public awareness campaigns help us identify one type of intimate partner violence in which one partner, typically the male partner, is the aggressor, and the other partner, typically the female, is the victim.

CHECK POINTS

- Contrary to accepted wisdom, women may be frequent aggressors.
- Intimate partner violence has been found to take 2 separate forms: severe with significant risk of injury to the victim and mild or reciprocal with low risk of injury.
- To treat a couple with intimate partner violence with couples therapy, guidelines to exclude severe violence should be followed and the couple screened for comorbid substance abuse/dependence, depressive disorders, and posttraumatic stress disorder.

In recent years, researchers have identified different types and patterns of intimate partner violence. Two discrete populations of intimate partner violence are now well recognized; one population coming to attention through the court and shelter system and the other distinct population existing in the community. The first population consists of the male batterer and female victim: the picture of domestic violence that is now well recognized as a significant social problem. The second population consists of couples in which intimate partner violence is less severe and in which violence is usually reciprocal or bidirectional, with both partners acting as perpetrators and experiencing victimization. In this type of intimate partner violence, serious injury generally does not occur, and the couple may not consider the violence to be a major relational problem.

Heyman and Slep have designated these 2 populations as partner abusive with impactful assaults and partner abusive with non-impactful assaults. Partner abusive with non-impactful assaults is recognized by other researchers as well. Johnson designated this non-impactful form of intimate partner violence as common couple violence, which is differentiated from patriarchal or intimate terrorism. Common couple violence occurs in 90% of violent couples and is found in surveys of the general population. Intimate terrorism occurs in 10% of couples who experience intimate partner violence and is found among the female victims who have sought refuge in women’s shelters and among men referred by the courts for anger management.

Reciprocity of violence, meaning that both partners act as aggressors and are victims of violence,
has been reported by respondents in community surveys. In the US National Comorbidity Survey, 6.5% of women and 5.5% of men reported reciprocal physical violence. In the 2001 National Longitudinal Study of Adolescent Health, which assessed subjects aged 18 to 28 years, violence was reported in 24% of relationships, with half of these (12%) showing reciprocal violence. In cases of non-reciprocal violence (ie, 12% of relationships), women were the perpetrators in 70% of cases. Men were more likely to inflict injury than women, and reciprocal intimate partner violence was associated with injury more often than no reciprocal intimate partner violence. The fact that women are frequent aggressors has also been identified in a meta-analysis of 82 studies. In fact, women are slightly more likely than men to report using physical aggression in intimate relationships, according to Archer. These findings are also reported in a study of couples seeking outpatient treatment, in which 61% of husbands and 64% of wives were classified as aggressive. Of concern, in a sample of 272, presumably happy couples planning on marrying, 44% of women and 31% of men reported having been physically violent toward their partners.

What is the relationship between these 2 types of intimate partner violence? Are there truly 2 distinct types, partner abusive with impactful assaults and partner abusive with non-impactful assaults, as suggested by Heyman and Slep, or is there a continuum, with milder reciprocal intimate partner violence at one end of the spectrum and severe intimate partner violence at the other end? Heyman and Slep state that partner abusive with impactful assaults is associated with aggressive males; a history of developmental risk factors, such as parental conflict; frequent chronic acts of violence; and use of power and control tactics. There is more belligerence and contempt expressed during conflict, and the female partner is fearful. Syndromes such as battered woman syndrome, a type of posttraumatic stress disorder (PTSD), are consequences of partner abusive with impactful assaults. Little is known about the characteristics of couples who experience partner abusive with non-impactful assaults because they are not generally well recognized.

Most agencies and health care providers are urged to screen and assess female patients for intimate partner violence and to refer appropriately. What changes should be made to the recommendations about screening based on these new findings? What should the general psychiatrist know about screening and about treatment referral? Should the psychiatrist look for reciprocity? If couples request couples treatment, what should the psychiatrist advise? The following discussion attempts to answer these questions.

Assessment of Intimate Partner Violence

The US Preventive Services Task Force states that screening instruments for intimate partner violence have not been evaluated against measurable violence or health outcomes and that there is no evidence that screening in a health care setting reduces harm. However, the American Academy of Pediatrics, the American College of Emergency Physicians, and the American College of Obstetricians and Gynecologists encourage screening of patients for domestic violence and appropriate referral. The American Academy of Family Physicians also advocates for their physicians “to teach parenting and conflict resolution skills to promote respectful and peaceful personal relationships.” Surprisingly, the American Psychiatric Association does not discuss routine screening in its policy statement on domestic violence. If the psychiatrist decides to screen for intimate partner violence, what would be the best way to do this and what treatments are recommended?

To detect and quantify intimate partner violence, most researchers use instruments such as the Conflict Tactics Scale or its shorter version. However, this is not practical in an office setting because it does not cover all the necessary elements for a clinical assessment. Couples, however, do report more intimate partner violence on self-report questionnaires than when asked directly, and perhaps a good clinical tool could be developed. In the interim, asking about specific behaviors, such as pushing, kicking, and slapping, will elicit a more positive response from patients than asking about violence. Asking about the potential impact of aggression, such as “Are you afraid of your partner?” yields important information that can direct treatment. It is important to ask about intimate partner violence in a sensitive way that does not shame the patient (Table 1). Neither men nor women may want to admit that they are being abused because of strong cultural bias against being seen as a victim.
### Treatment of Intimate Partner Violence

Treatment has traditionally been divided into separate treatments for victims and perpetrators. Simply assessing women for intimate partner violence and offering a referral can interrupt intimate partner violence. In a study by McFarlane and associates, 360 female victims of intimate partner violence recruited from primary care clinics were compared on 2 interventions: a wallet-sized referral card and a 20-minute nurse case management protocol. After 2 years, both treatment groups reported significantly ($P < .001$) fewer threats of abuse and assaults. Compared with baseline, both groups adopted significantly ($P < .001$) more safety behaviors. Brief telephone intervention, 6 phone calls for an overall total time of 1 hour over 8 weeks, also increased safety-promoting behaviors that were still present at 18 months. Improving social support can also help women obtain needed resources and result in improved psychological well-being and health outcomes.

In addition, specific interventions, such as a 6-week empowerment intervention, can result in higher physical functioning, less psychological abuse, less physical violence, and significantly lower depression scores. After a 10-week intervention using trained advocates, women were twice as likely to be free of violence as a control group at 2 years’ follow-up. However, after 3 years, the advocacy program’s effect on intimate partner violence did not continue, although the women had an improved quality of life and more social support. In summary, small interventions for female victims are effective.

Treatment for male batterers is generally court-ordered and delivered in sex specific (ie, all-male) groups. Sex-specific treatment follows the Duluth model, which focuses on educating the male perpetrators about different ways to express anger and reduce interpersonal, controlling behavior. According to the Duluth model, the primary cause of domestic violence is “patriarchal ideology and societal sanctioning of men’s use of power and control over women.” These programs are not considered to be therapy. Rather, group facilitators lead consciousness-raising exercises to challenge the men’s perceived right to control or dominate their partners.

A fundamental tool of the Duluth model is the Power and Control Wheel, which illustrates that violence is part of a pattern of behavior that includes intimidation, male privilege, isolation, and emotional and economic abuse, rather than isolated incidents of abuse or cyclical explosions of pent-up anger or painful feelings. The treatment goals of the Duluth model are to help men change from using the behaviors on the Power and Control Wheel, which result in authoritarian and destructive relationships, to using the behaviors on the Equality Wheel, which form the basis for egalitarian relationships. However, a meta-analysis of 22 studies of sex-specific treatment for batterers indicates that treatment effect sizes are small. Therefore, other treatments are being developed.

Several states have developed couples treatment for male batterers. In California, a comparison study of court-referred batterers found that sex-specific treatment and conjoint couples treatment were equally successful in reducing intimate partner violence. In Virginia, a model of conjoint treatment when used for couples in which the male partner has perpetrated mild to moderate violence and in which both partners want to remain together, has been shown to be successful. Six months after treatment, male violence recidivism rates were significantly lower for the multicouple...
group (25%) than for either the individual couples (43%) or the comparison group (66%).\textsuperscript{30} Women who have been arrested for perpetration of intimate partner violence may not have access to appropriate treatment.\textsuperscript{31} In summary, sex-specific treatment is not very effective in reducing the perpetration of violence, but couple or multicouple treatments show promise for mildly to moderately violent male perpetrators.

What about couples who present in an outpatient setting requesting help with intimate partner violence? Both sex-specific treatment and conjoint 14-week group treatment have been shown to be effective for outpatient couples with husband-to-wife repeated acts of physical aggression.\textsuperscript{32} In this study, both treatment groups followed a cognitive-behavioral program that focused on psychoeducation, anger-control techniques, and communication skills. Both groups reported a reduction of physical violence posttreatment and at 1-year follow-up, although only 25% of husbands remained violence-free. The only difference found between groups was that husbands in conjoint treatment had improved marital satisfaction.

Several untested treatments of intimate partner violence exist. Virginia Goldner,\textsuperscript{33} at the Ackerman Institute for Family Therapy in New York, has used attachment and feminist theory, especially the work of Jessica Benjamin, and views the work of the family therapist as inserting a moral perspective. Goldner highlights clinical multiplicity, with abuse and coercion coexisting alongside intense love and genuine friendship. Goldner believes that the mutative factor in any therapy includes “bearing witness and helping the abuser accept responsibility for his actions” and describes the role of the therapist as helping “clients develop a rich psychological understanding of the abuse” without blame or shame and without letting the perpetrators avoid responsibility for their actions.

Jory and Anderson\textsuperscript{34} practice couples therapy based on “accountability and a theory of intimate justice.” They simultaneously engage the victim of abuse and the abuser by creating 2 therapeutic environments: one affirming the victim and one challenging the abuser. Lastly, solution-focused treatment for domestic violence offenders offers a “strengths perspective, a solution-focused approach, holding a person accountable for solutions instead of focusing on problems.”\textsuperscript{35}

When should couples therapy be considered? The essential components of safe couples treatment includes adequate screening of couples at risk for severe intimate partner violence.\textsuperscript{36} The aim for the general psychiatrist is to exclude severe intimate partner violence or partner abusive with impactful assaults from couples therapy (Table 2).

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<th>Factors that preclude couples therapy</th>
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<td>Uncontrolled, continuous use of alcohol or substances</td>
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<td>Fear of serious injury from partner</td>
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<tr>
<td>Severe violence that has resulted in medical attention</td>
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<td>Conviction for a violent crime or violation of a restraining order</td>
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<td>Use of a weapon against the partner</td>
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<td>Threat to kill the partner</td>
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<td>Stalking or other partner-focused obsessional behavior</td>
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<td>Bizarre forms of violence, eg, sadistic violence</td>
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To exclude intimate partner violence, the following factors must be assessed: uncontrolled continuous use of alcohol or substances, fear of serious injury from the partner, severe violence that has resulted in the victim requiring medical attention, conviction for a violent crime or violation of a restraining order, previous use of a weapon against the partner, previous threat to kill the partner, stalking or other partner-focused obsessional behavior, and any bizarre forms of violence, such as sadistic violence. If any of these factors are present, couples treatment is not recommended. If severe intimate partner violence is present, safety planning should be discussed with the individual at risk. This should include education about how to maintain the safety of the patient and of his or her dependents and specifically how to access services in the community.
For couples with partner abusive with non-impactful assaults who wish to enter couples therapy, it is nevertheless important to ensure safety. The key components to safe conjoint treatment include the signing of a “no violence” contract, the use of a negotiated time-out tool, and strategies to manage anger. Treatment of comorbidity is important, and in addition to alcohol screening, patients and their partners should be assessed for depressive disorders and PTSD.

Significant reduction in intimate partner violence can occur when comorbid alcoholism is successfully treated. Couples can enter couples treatment when the alcohol abuse/dependence is under control. Greater treatment involvement is associated with greater reduction in violence. Couples treatment consists of a sobriety contract, behavioral assignments, and relapse prevention. The behavioral assignments are aimed at increasing positive feelings, shared activities, and constructive criticism. At the end of treatment, each couple completes a continued recovery plan that is reviewed quarterly for 2 years. The reduction in intimate partner violence is mediated by reduced problem drinking and enhanced relationship functioning.

Summary

Intimate partner violence has been found to exist in 2 separate forms, severe with significant risk to the victim and mild or reciprocal with low risk of injury. It is unknown whether these 2 types of intimate partner violence are clinically distinct or whether they represent the extremes of a spectrum. Further research is needed to clarify whether these are distinct or whether one type can evolve into the other.

Physicians should make the effort to discuss intimate partner violence with their patients, both male and female, and to distinguish the 2 types of violence. For couples with partner abusive with non-impactful assaults or reciprocal violence, couples therapy may be indicated. To treat a couple engaged in intimate partner violence with couples therapy, guidelines to exclude those who are experiencing severe violence should be followed, and the couple should be screened for comorbid substance abuse/dependence, depressive disorders, and PTSD. The patient and partner should be fully assessed and informed about the treatment options available. In the field of intimate partner violence assessment and treatment, continued research is needed to provide psychiatrists with clear directions for diagnosis and treatment.

References:

10. U.S. Preventive Services Task Force. Screening for family and intimate partner violence:


**Evidence-Based References**

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