An Exploratory Study of Psychotherapists' Biases In the Treatment of Domestic Violence

Susan E. Hanks

AN EXPLORATORY STUDY OF PSYCHOTHERAPISTS' BIASES IN THE TREATMENT OF DOMESTIC VIOLENCE

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by

Susan E. Hanks

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THE CALIFORNIA INSTITUTE FOR CLINICAL SOCIAL WORK

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in the Treatment of Domestic Violence

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ABSTRACT

AN EXPLORATORY STUDY OF PSYCHOTHERAPISTS' BIASES IN THE TREATMENT OF DOMESTIC VIOLENCE

by

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This qualitative study explored the experiences of psychotherapists in their clinical work with battered women and battering men with specific focus on the psychotherapists' attitudes, beliefs, feelings, and professional clinical and training experiences which influence their provision of psychotherapeutic services to such clients. The major questions addressed in this study were:

Question 1: Is it the case that some psychotherapists are reluctant to treat domestic violence clients and that such reluctance is not informed by clinical theory, practice theory, or family violence theory but is based upon personal biases (attitudes, beliefs, and feelings) about the phenomenon of domestic violence and about battered women and battering men?

Question 2: What attitudes, beliefs, feelings, and experiences influence psychotherapists' decisions to avoid versus treat domestic violence patients?

Semi-structured interviews were conducted with nine purposefully selected, autonomously practicing senior psychotherapists. Data from the interviews were content analyzed according to Glaser and Strauss' (1967) method of constant comparative analysis.

Results indicated that psychotherapists in this study were willing to treat domestic violence cases in principal but differed in their eagerness to do so. Their reasons for avoiding versus treating specific cases of battered women differed from their reasons for avoiding versus treating specific cases of battering men. Their views of the unique factors influencing the assessment and treatment of men who batter and of women who are battered were delineated. An optimal style of clinical practice that contributed to the psychotherapists' longevity in, rather than attrition from, the field of domestic violence was described. The findings of this study can serve as the basis for further research, guide

graduate and professional training, and inform administrative policy-making within the mental health service provider community.

This study is dedicated to my mother and father

William and Genevieve Hanks

whose love and support made my education possible.

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CHAPTER I

INTRODUCTION

> Violence has become one of the most pervasive issues of our time. Its prevalence over the centuries--on every level from the international to the domestic--has usually been addressed or rationalized piecemeal, but its twists in the 20th century have finally made it a public policy issue.
>
> Jane Gary Hopps
> Editor-in-Chief
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Over the last two decades, the social recognition of violence within the family has prompted the mental health and social service delivery systems to adapt programs, theories and intervention techniques to accommodate the needs of battered women, battering men, and children who witness domestic violence. During the same time period, this researcher has repeatedly observed--while in her roles as a clinician, educator, researcher, administrator, and organizational and social policy consultant in the field of family violence treatment and prevention--that many psychotherapists choose not to work with battered women and battering men. Many seasoned psychotherapists have informally disclosed to this researcher that they prefer not to work with clients who present with a problem of domestic violence. The administrators and staff of mental health agencies with whom this researcher has consulted have unofficially reported that their agencies have informal, unwritten policies not to accept clients who initially present with a stated problem of domestic violence. Often the individual psychotherapists and agency administrators are reluctant to acknowledge these attitudes publically for fear of being perceived as discriminatory or politically incorrect. As a result, clients seeking psychotherapy who initially present with a stated problem of domestic violence often unknowingly experience barriers to psychotherapeutic services.

It is this researcher's impression that it is a common, although undocumented, fact that many psychotherapists are reluctant to treat cases of domestic violence; yet, because of the prevalence of this problem in clinical populations, psychotherapists may be naive to think that they can avoid encountering this problem in their practice. Family violence is known to appear in many clinical populations although it frequently goes unrecognized (Harway & Hansen, 1990; Herman, 1986; Hilberman & Munson, 1978; Jacobson, Koehler & Jones-Brown, 1987; Stark, Flitcraft & Frazier, 1979).

This researcher began with the observation, which grew out of her review of the literature and her experience in the field, that psychotherapists' reluctance to treat domestic violence patients may be based on their personal attitudes, beliefs, and feelings about the phenomenon of domestic violence and about battered women and battering men, rather than being informed by clinical theory, practice theory, or family violence theory. A variety of personal attitudes, beliefs, and feelings about the nature of the clinical work with a domestic violence client have been reported to her by colleagues and offered as rationales for their reluctance in treating this population. These factors include: fears for personal physical safety; desires to avoid unpleasant, dysphoric affects aroused by the clinical material; anticipation of clinical demoralization based on beliefs that this population is unamenable to treatment; beliefs that psychotherapy is ineffective for this problem; anticipation of personal dislike for the client(s); avoidance of possible need for assessment of potential for dangerousness or endangeredness of the clients; and, avoidance of anticipated legal constraints placed on the clinical encounter by the child abuse and Tarasoff reporting laws.

Much of the literature in the field of domestic violence addresses the characteristics and treatment of battered women and men who batter, the differing views regarding the etiology of domestic violence and, as related to psychotherapists, concern that they may inadvertently psychologically harm and/or endanger the domestic violence patients they are treating (APA Task Force, 1984; Bograd, 1984; Freize, 1979; Greenberg, 1984; Harway

& Hansen, 1990; Margolin, Sibener & Gleberman, 1988; Rosenbaum & O'Leary, 1981; Saunders, 1986, 1988; Stark, Flitcraft & Frazier, 1979; Walker, 1979,1981; White, 1988). There is a paucity of literature and research focused on psychotherapists' experiences in treating battered women and battering men. Little is known about psychotherapists' views of clinical work with this population, how they mange the personal and professional stressors inherent in work with a violent or victimized patient population, or how these views and experiences might effect psychotherapists' longevity in, or attrition from, the field of domestic violence treatment.

It is this researcher's belief that it is important that skilled, seasoned psychotherapists make their clinical skills available to treat problems of domestic violence. Domestic violence, or spouse abuse, threatens the physical and psychological well-being of all family members--the battered woman, the man who batters, and their children--and the integrity of the family as unit. Children who witness their mothers being assaulted by their fathers grow up in an emotional climate of fear, intimidation, and anxiety. They are at risk for replicating violent family dynamics as adults (Carlson, 1977; Hanks, 1987, 1992; Hotaling & Sugarman, 1987; Jaffe, Wolfe & Wilson, 1990; Jaffe, Wolfe, Wilson & Sluzczarck, 1986; Jaffe, Wolfe, Wilson, & Zak. 1986; Stullman, Schoenenberger & Hanks, 1987; Wolfe, Jaffe, Wilson & Zak, 1986). As one of the psychotherapists who was interviewed in this study stated, domestic violence is "a terrible emotional crime against children. . . because children watch the two people who brought them into the world with the assumption that father and mother presumably love each other most, and see that that's what people do when they love each other most."

The attrition of experienced psychotherapists from the field of domestic violence treatment is another commonly known, although undocumented, phenomenon. It has been this researcher's observation over the years that over time many experienced, highly qualified psychotherapists withdraw from the field of domestic violence treatment, and, regrettably, their skills, knowledge, and expertise become lost to the field and unavailable

to potential patients. Hence, it is important to understand what enables those psychotherapists who have maintained clinical longevity in the field to do so. Finding ways of avoiding "burn-out" for those dedicated to helping battered women, battering men and their children has been identified as one of the major challenges in the field in the 1990's (Epstein & Silvern, 1990).

In this researcher's opinion, not all battered women and battering men are necessarily appropriate psychotherapy candidates. Psychotherapy is not necessarily the most appropriate form of intervention. However, the fact that some clients present with the particular problem of domestic violence should not automatically exclude them from access to psychotherapeutic services. Although specialized domestic violence treatment programs throughout the country are beginning to develop assessment criteria for determining who is and who is not appropriate for psychotherapy, most psychotherapeutic services for problems of domestic violence will be continued to be provided by clinicians in traditional mental health agencies and by psychotherapists in private practice who are not trained in specialized diagnostic and treatment approaches (Bowker, 1983). Hence, there is a need to understand the subtle biases existent among psychotherapists which may be encountered by clients who seek their assistance.

These phenomena have not been discussed in the literature on clinical theory, clinical practice, or family violence. No research could be located describing the attitudes, beliefs, and feelings of experienced psychotherapists which influence their provision of clinical services to domestic violence clients. This exploratory study of the attitudes, beliefs, feelings, and professional clinical and training experiences of psychotherapists addresses this lacuna in the literature. The questions that are addressed in this study are:

Question 1: Is it the case that some psychotherapists are reluctant to treat domestic violence clients and that such reluctance is not informed by clinical theory, practice theory, or family violence theory but is based upon personal biases (attitudes, beliefs, and feelings) about the phenomenon of domestic violence and about battered women and battering men?

Questions 2: What attitudes, beliefs, feelings, and experiences influence psychotherapists' decisions to avoid versus treat domestic violence patients?

Purpose of the Study

This qualitative study explored the experiences of psychotherapists in their clinical work with battered women and battering men with specific focus on the attitudes, beliefs, feelings, and professional clinical and training experiences of psychotherapists which influence their provision of psychotherapeutic services to such clients. Semi-structured interviews were conducted with a group of nine senior, autonomously practicing psychotherapists. Data from the interviews were analyzed according to Glaser and Strauss' (1967) method of constant comparative analysis. The findings of this study can serve as the basis for further research on these phenomena and inform graduate and professional training, clinical supervision, and administrative policy making within the mental health service provider community.

For the purpose of this study, domestic violence has been defined as a behavior which occurs between two adults in a mutually defined, significant, intimate "marital" relationship which may or may not be legally sanctioned. Domestic violence refers to the use of physical force, restraint, or threats of force to compel someone to do something against his/her will or to do bodily harm to self or loved ones. This definition includes but is not limited to: assault (pushing, slapping, choking, hitting, etc.); use of threat with a weapon; sexual assault; unlawful entry; destruction of property; keeping someone prisoner or kidnapping; theft of personal property; and, infliction of physical injury or murder. Psychological intimidation or control may also be maintained through such means as stalking, harassment, threats against children or others, violence against pets, or destruction of property. Domestic violence can occur together with other forms of violence within the family, such as child physical abuse or child sexual abuse. Domestic violence, therefore, is a behavior, or set of behaviors, and does not constitute a psychological

syndrome unto itself. It is multiply determined, the result of many different sets of intrapsychic, interpersonal, environmental, and socio-cultural dynamics (Family Court Services, 1991; Hanks, 1992).

Statement of the Problem

Successive events of the 1960's--inner-city rebellions, the Kennedy and King assassinations, and the Vietnam conflict--brought the phenomenon of public violence into national awareness. Building on the philosophies and strategies developed in the civil rights movement of the 1960's, the women's movement of the 1970's extended social concern about violence in the public arena to concern about violence in the private arena of the family (Breines & Gordon, 1983; Hopps, 1987; Schecter, 1982).

This concern gave rise in the 1970's to the grass roots emergence of the battered women's movement and was responsible for the identification and labeling of the phenomenon of the "battered woman"--a term first coined by feminist author Del Martin (1976). During the 1970's and throughout the 1980's, the prevalence of women in the United States who self-defined as "battered wives" literally overwhelmed the resources of the battered women's shelter network. The battered women's shelter network, which evolved outside of the umbrella of the traditional mental health and social service delivery systems, spawned over 400 shelters for battered women and their children in the United States during these years. By 1986, more than 300,000 women and children nationwide were being provided services by shelters each year (Hopps, 1987). Since 1983, The Family & Violence Institute (a clinical treatment, training, and research program directed by this researcher) at the California School of Professional Psychology, Berkeley, California has provided over 6000 hours of psychotherapy to over 1000 individuals, couples, and families in which there was a problem of domestic violence.

The existence and prevalence of the problem of spouse abuse in the general population is no longer in dispute. Spouse abuse is no longer viewed as an isolated

problem affecting the lower socio-economic classes of multi-problem families but a prevalent phenomenon at all socio-economic levels with complex differential psychological and social causes and consequences (Hanks, 1987; Walker, 1979, 1984). Wife abuse is no longer believed to affect only a small unique group of men and women. It has been estimated that 1.8 million wives are beaten by their husbands each year (Straus, 1978, 1979; Straus & Gelles, 1986; Straus, Gelles & Steinmetz, 1980). Wife battery has been identified as a common cause of women seeking medical treatment in hospital emergency rooms (Stark, Flitcraft & Frazier, 1979). Wife battery is a common problem encountered by divorced women. A recent study by the National Institute of Justice found that 75% of all women who are battered make up 10% of all women who are divorced. It has been predicted that one out of two women will be victims of battering at some point in their lives (Walker, 1979). Wife battery is no longer viewed as an isolated event but as a serious social and clinical problem. A history of violence within the family has been found to be high among many different clinical populations, although this history of family violence often goes unrecognized by the clinician and unreported by the patients (Goodwin, 1985; Herman, 1986, 1987; Hilberman, 1980; Hilberman & Munson, 1978; Jacobson et al., 1987).

This shift in awareness and understanding has resulted in significant changes in beliefs and attitudes about the problem of spouse abuse--not only within society in general but also within the mental health and social service systems (Hopps, 1987; Schecter, 1982). It has influenced the development of social policy in many arenas. It has resulted in a re-structuring of the delivery of social services as evidenced in the proliferation of battered women's shelters. It has affected the conceptualization and classification of psychiatric diagnostic categories, in challenging the inclusion of a history of domestic violence in the Self Defeating Personality Disorder classification. It has sparked a critique of classical psychoanalytic theory, particularly in regard to such concepts as female masochism (Caplan, 1985; Shainess, 1986; Young & Gerson, 1991).

There are numerous examples of this shift in awareness in society at large. For instance, at the national social policy level, the Federal government in 1983 recognized the magnitude of the problem of family violence by establishing a Task Force on Family Violence in the U. S. Department of Justice which studied spouse abuse and other forms of domestic violence (Attorney General, 1984). A major outcome of this Task Force was the implementation of a recommendation within the various branches of the Armed Services which mandated that family violence advocacy services be provided to military personnel and their dependents. On the State level, the California State legislature passed legislation in 1985 which established a court-based domestic violence diversion program as an alternative to prosecution for men who are arrested for battering their spouses. The California State Legislature also mandated training for police officers regarding appropriate intervention into domestic violence situations. The State Judicial Coordinating Council mandated The Family Court of the State Superior Court to study the psychological impact on children of witnessing domestic violence and to develop guidelines for determining child custody arrangements in cases of domestic violence (Family Court Services, 1991).

Since 1984, California has required that licensed mental health professionals (social workers, psychologists, and marriage, family and child counselors) complete training in child abuse assessment and reporting in order to acquire or maintain licensure. However, comparable training is neither required for licensure nor offered in typical graduate curricula focused on the problem of spouse abuse. In spite of the prevalence of the problem of domestic violence in the general population (Hotaling & Sugarman, 1987; Rosenbaum & O'Leary, 1981; Straus, 1978) and in clinical or psychiatric populations in particular (Herman, 1986; Hilberman & Munson, 1978; Jacobson et al., 1987), few graduates of traditional clinical training programs in social work, psychology, or psychiatry are specifically trained to work with this problem. A recent survey by this researcher of eighteen Northern California graduate schools of psychology, social work, psychiatry, and marriage and family counseling indicated that only three of these schools formally included

any specific courses in their curriculum on the topic of family violence treatment. Of these three courses, one is taught by this researcher and another is taught by a member of the clinical staff of a family violence treatment program directed by this researcher.

Significance of the Study

It appeared to this researcher that individuals in maritally violent relationships or families are members of a patient population at risk for receiving biased treatment in the delivery of psychotherapeutic services and for experiencing barriers to access to psychotherapeutic services. Because of the life threatening nature of family violence and the potential for psychological harm to all family members, it is important that psychotherapists make their clinical skills available to this population. In addition, because of the prevalence of this problem in many clinical populations (Goodwin, 1985; Herman, 1986; Jacobson, Koehler & Jones-Brown, 1986), it is this researcher's belief that psychotherapists are naive to think that they can avoid treating this population.

It is important to understand the attitudes, beliefs, feelings, and professional clinical and training experiences of psychotherapists regarding their work with battering men and battered women because: (a) most clinical services for maritally violent individuals and families will be provided by traditionally trained mental health practitioners working in traditional settings rather than by individuals working in specialized domestic violence treatment programs; (b) limiting availability of clinical services to men and women in maritally violent relationships is antithetical to the maintenance of fair and impartial availability of treatment; (c) although no practitioner should be forced to work with a particular type of problem, falsely held beliefs could be corrected by appropriately geared training; d) due to the prevalence of the problem, psychotherapists are unlikely to avoid this problem within their practices although they may be prone to not recognize it (Carmen, Rieker & Mills, 1984; Gelles & Straus, 1979; Goodwin, 1981); and (e) the inherent stress of the work might be minimized (Fletcher, 1982). There have been no studies focused on

the psychotherapist's experience of work with a domestic violence population. Results of this study can inform curriculum development in mental health training programs, in graduate school curricula, and in professional training efforts. Indeed, professional education has been identified as an important issue related to reducing clinician biases in decision making and improving treatment for domestic violence (Goodwin, 1985; Sonkin, 1985; White, 1988). Results of this study may also contribute to psychotherapists' longevity in the field of domestic violence treatment and enhance the quality of care received by this challenging patient population.

CHAPTER II
REVIEW OF THE LITERATURE

For the purposes of this study, relevant literatures which were reviewed encompassed three distinct areas related to the research question. They were: (a) the field of domestic violence with a specific focus on the identification, assessment, and treatment of domestic violence; (b) psychotherapists' feelings commonly evoked by psychotherapy patients and the psychotherapeutic process; and (c) psychotherapists' prediction, prevention, and management of patients' violence.

Theoretical Controversies in the Study of Domestic Violence

There has been a tremendous increase in interest in the study of domestic violence over the last two decades. Prior to 1971, no article whose title contained the work "violence" had appeared in The Journal of Marriage and the Family. A review of the literature by this researcher in 1973 resulted in only two articles being located specifically related to spouse abuse (Schultz, 1960; Snell, Rosenwald & Robey, 1964). In contrast, by the early 1990's, a vast literature existed on the topic of violence within the family. Four journals have emerged specifically related to research in the field of family violence: RESPONSE, published by Guilford Press; Violence and Victims, published by Springer Publications; Journal of Family Violence, published by Plenum Press; and, Journal of Interpersonal Violence, published by Sage Press. A National Clearinghouse at the Family Violence Research and Treatment Program at the University of Texas at Tyler became available which has catalogued many thousands of books and articles related to the topic.

Epidemiology of Domestic Violence

To date, only one representative United States survey has specifically measured violent acts among cohabitants. Sampling 3,300 families, Straus, Gelles and Steinmetz (1980) estimated that there are 3.9 million instances of spouse abuse annually; one out of every 26 (or 3.8%) American wives are physically assaulted by their husbands each year,

for a total of 1.8 million wives each year. An estimated one in eight husbands (or 12.6%) reported at least one "severe" violent episode, including punching, kicking, beating up, or attacking with a weapon. Survey data also consistently show that violence is not an isolated incident for over two-thirds of all abused women (Stark & Flitcraft, 1988). The Straus, Gelles and Steinmetz (1980) survey indicated that 47% of husbands who assault their wives do so three or more times a year (Stark & Flitcraft, 1988; Margolin, Sibner & Gleberman, 1988).

From data on injuries and death, it can concluded that violence inflicted on a woman by her husband or male partner poses a serious health problem in the United States as 30% of female homocide victims are killed by their husbands or boyfriends (Federal Bureau of Investigation, 1983). More than one million abused women each year seek medical help for injuries caused by battering.

When violence escalates to the point of homocide, men and women are both at risk. Of all murders, 25% occur within families, and 50% of these are husband-wife killings. In these cases, husbands are the victims almost as often as wives: 48% versus 52% (Federal Bureau of Investigation, 1983).

A common theme running through the literature on domestic violence is the difficulty of securing accurate estimates regarding the incidence and frequency of this problem (Margolin et al.,1988). Although Walker (1977) asserts that no socio-economic class is exempt, Gelles and Cornell (1985) hold that it is somewhat more likely to occur in low-income, low socio-economic couples. A key factor appears to be the employment status of the husband, with wife battering more likely in unemployed, as compared to employed men, or in men with low job satisfaction (Gayford, 1975; Prescott & Letko, 1977). Margolin et al. (1988) claim that a factor in interpreting results pertaining to social class is that by having more resources available, middle-class and upper-class families may have ways of keeping their violence private.

Recent research has revealed previously hidden aspects of the domestic violence problem (Finkelhor, 1983). One is that violence has been documented in the earliest phases of family formation, including dating and courtship (Hamberger & Arnold, 1988; Makepeace, 1981; Rouse, Breen & Howell, 1988). In one study of 369 couples, 40% reported that at one month prior to marriage they were experiencing physical aggression (O'Leary & Arias, 1985; O'Leary, Arias, Rosenbaum & Barling, 1985).

Controversy surrounds the fact that in a large number of couples both the man and the woman are reported to engage in violent acts. McNeeley and Robinson-Simpson (1987) claim that social policies and psychotherapeutic approaches have been formulated based on false assumptions that "view domestic violence as perpetrated solely by emotionally disturbed men against women who are physically weak, defenseless, predisposed to passivity, and philosophically nonviolent" (p. 488). Distinctions have sometimes been drawn between "one-way violence" and "mutual combat" (Gelles, 1974; McNeeley & Robinson-Simpson, 1987). In one-way violence, wives do not hit back because they are afraid that if they do, they will be hit even harder. In mutual combat, the wife retaliates and hits back in self-defense or else stages a pre-emptive attack because she fears that her husband is about to hit her. The Straus et al. (1980) survey, for example, reported that 49% of the cases reveal violence from both husband and wife. These data stand in contrast to the National Crime Survey data that indicate that between 1973 to 1977 men committed 95% of all assaults on spouses (U.S. Department of Justice, 1984). Similarly, Dobash and Dobash (1978) reported that violence was directed against women in 75.8% of 1044 police cases in two cities in Scotland, whereas violence was directed against men in only 1.1% of the police cases.

Several investigators (Fleming, 1979; Herman, 1989; Straus et al., 1980) point out that there are a number of problems in drawing parallels between wife battering and husband battering. Although sheer frequencies of violent acts may be approximately the same for husbands as for wives, the potential consequences of the violence by the wives is

considerably less. Husbands tend to engage in more dangerous and injurious forms of violence. The greater size and strength of husbands make their behaviors more dangerous despite the fact that actions by both men and women may be described with the same labels (Margolin et al.,1988). Arguing that it is primarily women who are battered, Berk, Berk, Loeske and Rauma (1983) concluded that "there is not inevitable correspondence between 'conflict tactics' and the consequences of the conflict " (p. 198). Fleming (1979) recommends assessing the intensity of the acts and the degree of damage inflicted on the victim in order to differentiate men's and women's violence.

Domestic Violence in Clinical Populations

The problem of domestic violence within medical, clinical, or psychiatric populations has often been unrecognized. In a study of emergency room physicians in a university medical center, physicians identified 1 out of 35 female patients who sought emergency medical care as battered (Stark et al., 1979). In follow-up interviews with the female patients, it was discovered that a more accurate approximation was 1 in 4. "What [the physicians] described as a rare occurrence was, in reality, an event of epidemic proportions" (p. 183).

Hilberman and Munson (1978) found that half of the 120 women referred for psychiatric consultation by the medical staff of a rural medical clinic over a one year time period were found to be victims of "serious and /or repeated physical injury as the result of assaults by their husbands/co-habitees" (p. 460). However, only four of these sixty cases had been identified as victims of domestic violence by the referring medical source.

Stark et al. (1979), in an analysis of psychiatric emergency room visits, estimated that 25% of women who utilize a psychiatric emergency room have a history of domestic violence. Herman (1986) reviewed the diagnostic summaries of 190 consecutive psychiatric outpatients for experiences of violence and found that one third of the female patients had been victimized, wife abuse being the second most common type of abuse. "Of those patients who had ever been married, 23% of the women had been beaten by their

husbands, and 20% of the men had assaulted their wives" (p. 139). Jacobson et al. (1987) reviewed charts of 100 inpatients for mention of histories of physical or sexual assault. The chart data were compared with results of research interviews in which the same 100 patients were questioned. 64% of the fifty female patients had been physically assaulted as an adult. However, only 9% of the assault histories obtained during the research interviews had been mentioned in the patients' charts.

Definitions of Domestic Violence

A methodological problem often addressed in the literature is the definition of the construct of domestic violence. The interdisciplinary literature lacks clear and consistent terms for domestic violence (White, 1988). Definitions of domestic violence are numerous and interchangeable. Definitional problems may reflect underlying philosophical differences between victimology researchers as compared to others types of researchers of marital violence (Gondolf, 1985; Okun, 1986, Walker, 1986; White, 1988).

Definitional confusion regarding wife battering also stems from whether the label of wife battering is applied only on the basis of specific behaviors or on a broader behavioral pattern. For instance, Straus et al., (1980) operationally define domestic violence by the occurrence of violent acts, regardless of their context or intentionality. Walker (1983) describes a battering syndrome which takes into account a variety of emotional and relationship issues as well. A battered woman is defined by Walker (1984) as a woman who is seriously psychologically, physically, and/or sexually abused by a man with whom she is intimate, at least two times in a specific cycle that contains both violent and loving or non-violent behavior. Walker (1984) asserts that some battered women develop the Battered Woman's Syndrome; i.e. psychological sequelae that interfere with their ability to respond appropriately to the batterers' violence. A woman who develops the Battered Woman's Syndrome in response to her battering often suffers from symptoms of chronic depression and chronic post-traumatic stress disorder. She develops distortions in feelings, thinking patterns, and actions that are based on her perception that whatever she

does will not make a significant difference in what happens to her, and that it is futile to seek help from others (Walker, 1984).

The terms that have been most frequently considered synonymous with domestic violence are wife abuse, wife beating, battering, spouse abuse, conjugal abuse, marital violence and intrafamilial violence (White, 1988). The word abuse carries a broad connotation, suggesting that physical acts are one type of behavior among many that can be directed toward a victim. Feminist researchers have categorized abusive acts other than physical which may be directed toward wives. These include psychological and verbal abuse, economic and social deprivation, and sexual violence (Russell, 1982; Walker, 1984b).

Most definitions of wife abuse focus on the use of physical force directed by a husband toward a wife. Ganley (1978) defined battering as strictly assaultive physical behavior between adults in an intimate, sexual, theoretically peer, relationship. Pagelow (1981) addressed the issue of intentionality in defining battering as a willful assault on another to cause or attempt to cause harm--with or without provocation.

The issue of intentionality is important to consider in formulating a definition of domestic violence. Physical force often occurs without the intent to do the extent of harm which results. Rouse, Breen and Howell (1988) suggest that it is sufficient to define interpersonal violence as the intentional use of physical force against another person, regardless of aims or outcome.

The differentiation of various types of marital violence has generated debate in the literature. One semantic distinction appears to be on the gender focus. The terms wife abuse, woman abuse, wife beating, and woman battering are gender-specific terms typically defined as acts of physical violence by a husband or male directed toward a wife or female (Okun, 1986; White, 1988). Conjugal violence, spouse abuse, domestic violence, battering, and marital violence are considered gender non-specific nomenclature (Ptacek, 1984; White, 1988). These terms imply heterosexual and mutually assaultive

violence, with the perception of bi-directional victimization (Margolin et al., 1987; Neidig, Freidman & Collins, 1985; Okun, 1986; White, 1988). Many authors have questioned the use of gender non-specific terminology because this view reflects stereotypic values and assumptions that women are co-perpetrators of violence, that couples are mutually combative, and that women's behaviors cause or maintain the men's violence (Edelson, 1984; Okun, 1986; Saunders, 1987; Walker, 1979, 1986).

Some authors have suggested that wife abuse has been over-emphasized in social policy reforms (McNeely & Robinson-Simpson, 1987) and asssert that wives also engage in the act of battering. These authors state that the view of a helpless, victim wife and a domineering, violent husband is inaccurate and that husband battering or husband victimization has been largely ignored as a social problem (McNeeley & Robinson-Simpson, 1987; Steinmetz, 1977).

In response to these claims, authors with a feminist research perspective have acknowledged evidence of wife perpetrated violence (Okun, 1986; Saunders, 1986, 1988; Saunders, Lynch, Grayson & Linz, 1987; Walker, 1984). Their data strongly indicate, however, that these acts are committed reactively after a woman has been battered by a spouse, or occur in the process of self-defense (Brown, 1989; Okun, 1986; Parnell, 1983; Saunders, 1987; Walker, 1984b). Feminist researchers have argued that researchers that claim an exceptionally high rate of husband abuse (McNeeley & Robinson, 1987; Steinmetz, 1977) ignore a woman's right to self-defense (Gondolf, 1988) and do not take into account the relative differences in physical strength between men and women (Saunders et al., 1987). In addition, this literature is critiqued for ignoring the relative degree of psychological and physical harm that has been documented in the clinical samples of abused women (Hilberman, 1980; Okun, 1986; Herman, 1988; Saunders, 1986,1988; Saunders et al., 1988; Walker, 1984b).

An alternate interpretation of the empirical data gathered by national surveys (Straus & Gelles, 1986) and the latest Uniform Crime Reports (Okun, 1986) suggests that well

over 90% of domestic violence is wife abuse. Ratios of wife battering compared to husband battering, as determined by police reports of assaults, indicate that one hundred wives are battered by husbands for every 13 husbands who are assaulted by a wife (White, 1988).

Research Definition

For the purpose of this study, domestic violence has been defined as a behavior which occurs between two adults in a mutually defined, significant, intimate "marital" relationship which may or may not be legally sanctioned. Domestic violence refers to the use of physical force, restraint, or threats of force to compel someone to do something against his/her will or to do bodily harm to self or loved ones. This definition includes but is not limited to: assault (pushing, slapping, choking, hitting, etc.); use of threat with a weapon; sexual assault; unlawful entry; destruction of property; keeping someone prisoner or kidnapping; theft of personal property; and, infliction of physical injury or murder. Psychological intimidation or control may also be maintained through such means as stalking, harassment, threats against children or others, violence against pets, or destruction of property. Domestic violence can occur together with other forms of violence within the family, such as child physical abuse or child sexual abuse. Domestic violence, therefore, is a behavior, or set of behaviors, and does not constitute a psychological syndrome unto itself. It is multiply determined, the result of many different sets of intrapsychic, interpersonal, environmental and socio-cultural dynamics (Family Court Services, 1991; Hanks, 1992).

During this study, the term domestic violence was used interchangeably with marital violence. The term domestic violence has been variously used in the legal, psychological, and sociological literature, and seems to allow for a comprehensive description, but also carries a gender non-specific connotation which may be preferable when investigating mental health professionals attitudes, feelings and beliefs regarding this phenomenon.

The Etiology of Domestic Violence

There is much theoretical debate in the literature regarding the etiology of wife battering. In one article alone, Gelles and Straus (1979) reviewed thirteen different theories which have been offered as explanations of violence. They argued for the need to distinguish between the two types of theories of intrafamilial violence: a macrolevel theory and a microlevel theory. Macrolevel theories attempt to explain the overall level of intrafamilial violence within a given society, or sector of society, as compared to other societies or sectors, and especially the seeming paradox that it is more frequent within the family than within any other group. Micro level theories attempt to explain why violence occurs in some families and not others, and also to explain why violence occurs when it does within the histories of specific families.

Margolin et al., (1988) assert that although the list of theories of etiology is quite long, empirical data in support of these theories is still quite meager, making it difficult to compare the relative utility of various theories. They suggest that one reason there are numerous theories and inconsistencies in the data may be that the various theories attempt to explain different patterns of wife abuse. For example, many authors have proposed typologies of battered women and men who batter. Each typology reflects considerable variability in the women's and men's individual histories, current relationships, and responses to abuse (Ceasar, 1985; Greenberg, 1987; Hanks, 1987,1992; Parnell, 1983; Snyder and Fruchtman, 1981; Young, 1990). It could be that the difference among these typologies reflects the fact that each was developed and based on a different subset of the domestic violence population. Theories of etiology can be organized around three different levels of explanation: intrapersonal, interpersonal, and sociocultural.

Intrapersonal Theories

Intrapersonal theories assume that one or both spouses possess certain characteristics that make them prone to being a man who batters or woman who is battered (Margolin, et al., 1988). In the early literature, researchers thought they were dealing with

an infrequent phenomenon which was found in special populations (psychiatric or prison populations). Because of extreme samples, individual case studies, and the absence of proper controls, the conclusions drawn reflected high levels of individual pathology. Men were seen as sadistic, passive-aggressive, addiction prone, pathologically jealous, pathologically passive and dependent (Faulk, 1974; Shainess, 1977; Snell et al., 1964), or suffering from neurological or biochemical disorders (Elliott & Schauss, 1982). Battered women were assigned negative characteristics such as masochistic, aggressive, immature, or castrating (Scott, 1974; Shainess, 1984; Snell et.al., 1964). The conclusions drawn about pathological conditions in men tended to relieve them of responsibility for their actions whereas the conclusions about women tended to hold them responsible for their own battering (Margolis et al., 1988).

More recent studies view women's symptoms as sequelae of abuse, rather than causes of, or precursors to, battering (Rosewater, 1984; Walker, 1984a, 1984b). Hotaling and Sugarman claim (1986) that after fifteen years of research, "..there is no consistent evidence...that any behaviors, attitudes, demographic characteristics, or personality traits can predict what types of women will become victimized by husband or male partner violence....Characteristics of the men with whom she is involved in intimate relationships may be better predictors of a woman's odds of being victimized by violence" (p. 120). Many researchers contend that the search for characteristics of women that cause men's violence appears to be futile. Walker (1984) reported, however, that there are events in women's lives which suggest susceptibility factors that impair the women's ability to leave the battering relationships. These include early and repeated sexual molestation and assault, high levels of violence by members of their childhood families, perceptions of critical or uncontrollable events in their childhoods, and the experiences of other conditions which place them at a high risk for depression (Walker, 1984b).

There has also been a parallel theoretical shift regarding men's responsibility for abuse. According to Hotaling and Sugarman (1986), "it is sometimes forgotten that men's

violence is men's behavior. . .as such, it is not surprising that the more fruitful efforts to explain this behavior have focused on male characteristics. . .What is surprising is the enormous effort to explain male behavior by examining characteristics of women" (p. 120). For instance, the fact that many batterers are only violent towards their wives and only in the privacy of their own home undermines hypotheses regarding poor impluse control (Schecter, 1982).

Interpersonal Theories

The interpersonal theories which seek to explain spouse abuse include social learning theory, systems theory, and the cycle of violence theory. According to social learning theory, an individual's behavior is determined by his or her social environment, in this case the family system. One of the most consistent findings regarding etiological characteristics of wife battering is the intergenerational transmission of violence (Kalmus, 1984; Kaufman & Ziegler, 1987). Exposure to violence as a child (either through being victim to parental violence or witness of parental violence) has been identified as a strong risk-factor in the histories of men who batter (Ceasar & Hamberger, 1989; Jaffe, Wolfe, Wilson, 1990; Jaffe, Wolfe, Wilson & Slusczarck, 1986; Jaffe, Wolfe, Wilson & Zak, 1986; Rosenbaum & O'Leary, 1981; Sonkin, 1982, 1989; Wolfe, Jaffe, Wilson & Zak, 1986). Hotaling & Sugarman (1986), in a comprehensive evaluation of 97 potential risk markers (i.e., characteristics or attributes associated with an increased probability of using husband-to-wife violence or being victimized by husband-to-wife violence) identified in the literature over the past 15 years, found that "witnessing parental violence is more consistently related to husband to wife violence than is experiencing parental violence in childhood" (p. 120). Similarly, Rosenberg (1984) suggests that the responses by battered women also may be a function of modeling, with women who choose avoidant, passive, and non-help-seeking responses having observed such responses in their families of origin.

Walker's (1979, 1984b) cycle theory of violence is also an interpersonal theory. According to the cycle of violence theory, there are three distinct, repetitive phases

associated with wife battering: the escalation building phase, during which there is a gradual escalation of tension with the wife maintaining an unrealistic belief that she can control the man's behavior; the acute battering incident phase, during which the man unleashes a barrage of verbal and physical violence; and, the reconciliation phase, during which the man either apologizes profusely (in the early stage of the relationship) or during which there may be simply a decrease in tension or simply an absence of violence (Walker, 1984; Margolin, 1988).

The theory of "traumatic bonding" described by Dutton and Painter (1981) is also an interpersonal theory which attempts to explain the strong emotional ties between a woman and her battering partner and is a corollary theory to Walker's cycle of violence theory. Traumatic bonding refers to the development and course of strong emotional ties between two persons wherein one person intermittently harasses, beats, threatens, abuses, or intimidates the other. Two major features in the etiology of traumatic bonding are: (a) a power imbalance wherein the maltreated person is subjugated or dominated by the other; and, (b) the intermittent nature of abuse. In situations of domestic violence, abuse is cyclical and therefore intermittent. Battered women come to blame themselves for their partners' violence as a way of re-establishing a sense of personal control.

Bowlby (1984) also postulated an interpersonal theory of spouse abuse in viewing violence in the family as a disorder of the attachment and caregiving systems. In a series of clinical vignettes, Bowlby outlined common behaviors of men who batter as rageful attacks by men who felt abandoned by their wives who left or who felt displaced by newborn children. The men threatened suicide in an attempt to coerce the battered women to return. The men also alternatively locked the women in the house and, later, also locked them out of the house as a manifestation of their intense ambivalent attachment.

Interpersonal marital or family theories indicate that it is the interaction of situational and relationship variables that produces marital violence (Cook & Frantz-Cook, 1985; Shapiro, 1986). Systemic or structural theories primarily focus on the interpersonal

transactions within a family which maintain or influence aggression, based on synergistic reactions to situations and family stressors such as poverty and unemployment (White, 1988). Marital violence is due to marital maladjustment, a couple's communication deficits or mutual combat without a victim or perpetrator (Giles-Sims, 1983; Neidig et al., 1984 & 1985). Cook and Frantz-Cook (1985) warned of the potential danger of couple therapy, wherein the husband may understate the events and the wife may be fearful of the consequences if they are addressed, thereby obscuring the recognition of violence itself.

Socio-Cultural Theories

Intrapersonal and interpersonal explanations alone do not explain why the family system, in particular, produces such high rates of violence and why women, in particular, are targets of it. Sociocultural theories examine historical, legal, cultural, and political factors that contribute to wife beating. Sociocultural explanations attempt to explain the legitimization of intrafamilial violence (Margolin et al.,1988).

Gelles and Straus (1979), from a sociological perspective, maintain that while "...some instances of intrafamily violence may be an outgrowth of social or psychological pathology... physical violence between family members is a normal part of family life in most societies and in American Society in particular" (p. 549). "Normal" in this perspective meaning statistically frequent and culturally approved (Gelles & Cornell, 1985; Gelles & Straus, 1979; Straus, 1979). Sociocultural theories challenge the intrapersonal and interpersonal theories in asserting that the proportion of men who batter family members and suffer from psychopathological disorders is no greater than the proportion of the population-at-large with psychological disorders (Straus, 1978; Straus & Gelles, 1986). Bograd (1982), writing from a feminist perspective, believes that by defining public and social concerns as private psychiatric problems, the diagnostic labeling of either partner reinforces the erroneous myth that battering is uncommon and limited to a disturbed or deviant population.

A feminist sociocultural perspective holds that spouse abuse is due less to the psychopathology of either partner and more to the unequal power relations between men and women in our society with accepts violence as the ultimate and legitimate resource of husbands (Bograd, 1982). Feminist perspectives on marital violence purport that wife abuse is an expression of patriarchy in our culture which is designed to maintain power and exert control over women (Dobash & Dobash, 1979; Griswold, 1986). A husband's desire to maintain dominance and control is presented by feminists as the primary cause of wife battering. Male socialization leads to the acceptance of aggression as appropriate male behavior, a view of the wife as property and violence as an acceptable means of controlling a marital relationship. Likewise, female socialization leads to women being socialized to maintain and nurture the primary intimate or marital relationship, regardless of abusive treatment from a partner or spouse (Bograd, 1982, 1984; Breines & Gordon, 1983; Martin, 1976; Pagelow, 1981; Walker, 1979). It has been proposed that some women who have been abused adopt a lowered self-concept, act passively, and exhibit learned helplessness due to their assimilation of the battering men's view of them (Walker, 1979). A possible critique of the feminist sociocultural perspective is that it does not address the occurrence of the same violent behavior in same sex couples.

From a feminist view, wife abuse is considered a crime, and the perpetrator of the violence is considered totally responsible (Walker, 1979). Treatment needs are focused on ending the violence, assessing for the safety of the wife, and treating the abusive husband's need to dominate (Edelson, 1984; Walker, 1979). Social interventions aimed at the establishment of safe houses and the provision of financial assistance for battered women, collectives for the treatment of abusive men, and legislative reform of family, civil and criminal law are deemed appropriate. Feminist psychotherapy approaches for domestic violence are focused on helping the wife achieve safety and assisting the battering man in taking responsibility for ending his violence. Couples therapy is deemed appropriate only

if the man can predictably stop his use of violence and if the woman chooses to remain with a formerly abusive spouse (White, 1988).

Marital or family systems theorists critique the feminist socio-cultural theories of wife abuse as politically and ideologically biased with little applicability to direct intervention strategies for individual clinical cases. Feminist therapists are critiqued specifically as biased towards marital separation or divorce as the solution to marital violence (Edelson, 1984; Gondolf, 1986). This approach is critiqued as potentially dangerous for a woman whose risk of abuse is likely to increase when she separates from her abusive partner (Harway & Hansen, 1990)

In response to family systems criticisms, feminist and other social learning scholars argue that interpersonal perspectives of wife abuse are reductionistic in viewing the problem as marital dysfunction rather than examining the broader societal problem For example, theories which focus predominantly on the marital or family interaction obscure the fact that women are more frequently victimized because of the historical legal and social sanctions of wife abuse, and patriarchal dominance over women (Dobash & Dobash, 1979). Additionally, in framing marital violence within an interpersonal context, a wife may be blamed or considered responsible for the abuse (Bograd, 1984; Walker, 1986) leading to further emotional trauma to an already injured woman (APA Task Force, 1984).

These disparate views of the causes of marital violence may lead to differential assessment and treatment decisions for therapists. But most importantly, pre-existing beliefs concerning the etiology of marital violence may lead to errors in the decision making process or result in victim blaming (White, 1988).

Psychotherapists' Influences in the Treatment of Domestic Violence

There has been concern voiced in the literature that clinicians may inadvertently introduce psychological harm to victims and perpetrators of marital violence they are treating due to existing attitudes about victims of violence and/or lack of appropriate education. Concerns noted in the literature include:

(a) therapists may blame an abused wife for precipitating the assault or misjudge her presenting symptoms as causal factors for the abuse; (b) therapists may minimize the potential for future violence by perpetrators based on either beliefs that an abusive husband unintentionally assaulted his wife or beliefs that the violence originates from a disturbed marital relationship, and (c) therapists may not detect evidence of domestic violence in their practice due to stereotyped or inaccurate beliefs about the prevalence of wife abuse (APA Task Force, 1984; Bograd, 1984; Freize, 1979; Greenberg, 1984; Harway & Hansen, 1990; Margolin et al., 1988; Rosenbaum & O'Leary, 1981; Saunders, 1986, 1988; Stark et al., 1979; Walker, 1979, 1981; White, 1988).

There is scant literature which addresses the attitudes and beliefs commonly held by practitioners relevant to the understanding and treatment of clients who present with problems of spouse abuse (Ragland, 1989; White, 1988). For example, Harway and Hansen (1990) surveyed three hundred sixty two members of the American Association of Marriage and Family Therapy. The respondents received one of two case scenarios involving family violence. One of the cases was an actual case in which the woman was later killed by her batterer. A striking 41% of the practitioners missed obvious evidence of domestic violence and 91% of the practitioners minimized the severity of the violence. Not one respondent indicated that lethality was a concern, in spite of the fact that this was the eventual outcome of one of the cases. Harway and Hansen (1990) concluded that even when violence was recognized as the problem area, "many therapists reported techniques that were inconsistent with current minimal standards of practice" (p. 18). Few psychotherapists appeared to be sensitive to issues surrounding family violence or knowledgeable about appropriate interventions. They noted that "more than 41% of family violence clients appear to be at risk for receiving improper treatment" (p. 18).

In recognition of this lack of education most professionals receive in the field of family violence identification, assessment, and treatment, there has been a movement towards establishing professional standards that would serve as guidelines for

psychotherapists. Legislation has recently been proposed in the state of California requiring coursework in domestic violence in order to qualify for licensure or licensure renewal (Lightman, 1991). According to Geffner (1990) , editor of The Family Violence Bulletin, "working with family abuse victims, survivors, or offenders without sufficient skills in family abuse treatment can produce more damage. It appears that the time has come to begin to establish minimum standards and credentials for practitioners in the family abuse field" (p. 1).

Psychotherapists' Reaction Commonly Evoked by Psychotherapy Patients and Psychotherapy Process

It is a commonly accepted notion that the process of psychotherapy elicits strong feelings in psychotherapists (Kubie, 1971; Spensley & Blacker, 1976). The inner experiences and feelings of the psychotherapist stimulated by the therapeutic session have come to be acknowledged as important variables in the process and the outcome of therapy (Burton, 1972; Farber & Heifetz, 1982; Spensley & Blacker,1976). Psychotherapists' feelings are particularly potent in clinical work with men who batter and women who are battered because violent behavior inevitably arouses human feelings from which therapists are not exempt just because they are functioning in their professional roles of psychotherapists.

In spite of the fact that the feelings generated in psychotherapists by the clinical work have been described as role, or occupational, stressors , there is a paucity of empirical research on the topic of the feelings of psychotherapists about their patients or about the nature of the practice of psychotherapy itself (Goldberg, 1991; Marmor, 1953; Spensley and Blacker, 1976). Most of the literature concerning the topic of psychotherapists' feelings is located in the clinical and impressionistic psychoanalytic literature on the topic of countertransference. Empirical research and further discussion in the literature about this phenomenon has been suggested as an aid to therapists in managing

this role stressor as a professional problem (Goldberg, 1991). One purpose of this research study is to contribute to the body of knowledge and the literature regarding the practice of psychotherapy with men who batter and women who are battered.

Countertransference

There is no single accepted definition of countertransference in the literature to date. As discussed in the classical psychoanalytic literature, countertransference has historically had a pejorative connotation (Grayer & Sax, 1986). Freud, in his 1910 address on "The Further Prospects of Psychoanalysis" focused on the need for the therapist to overcome his countertransference (i.e., his undesirable, unconscious response to the client's transference) and left the impression that countertransference is a hindrance to therapeutic work (Freud, 1910). Later psychoanalytic theoreticians such as Racker, Winnicott, and Heimann defined countertransference more broadly, viewing countertransference as the result of: (a) unconscious introjections of the client's projections; (b) conscious reactions to the actual client; and/or (c) the therapist's own personality and neurosis (Grayer & Sax, 1986). These theorists departed from the classical Freudian position and asserted that most therapists experience responses, feelings, and attitudes that, rather than interfere with the psychotherapy process, seem to enhance the therapeutic work (Grayer & Sax,1986; Kernberg, 1984).

The literature does discuss the importance of differentiating between unconscious countertransferential reactions and conscious reactions, feelings, attitudes, and beliefs in the therapist. Spensley and Blacker (1976), writing on the feelings of the psychotherapist, stated that equating all of the psychotherapist's feelings with the classical concept of countertransference may lead to confusion and malaise on the psychotherapists' part. They stressed the need to direct attention to this important area and delineate some of the strong feelings that are to be expected in a "normal" psychotherapist in the "usual" course of an intensive psychotherapeutic experience. They assert that inadequate attention has been paid to understanding the "normal" role of stress inherent in the nature of psychotherapeutic

work itself. This "normal" role stress is separate and distinct from "psychopathological" stress which is induced by complicated unconscious countertransference issues and the psychotherapists' own emotional difficulties. This is especially relevant to work in the treatment of domestic violence because the behavior of human violence itself is bound to elicit strong feelings in most human beings generally, and particularly in psychotherapists when confronted with clinical responsibility for this problem in the lives of their patients.

The focus of inquiry in this study has been on psychotherapists' conscious reactions, feelings, attitudes, and beliefs about the general nature of clinical work with this patient population, about the nature of the psychotherapists' clinical work with particular domestic violence patients, and also about the phenomenon of family violence itself. Inquiring about the unconscious introjections of the clients' projections and the therapists' own personalities and/or neuroses was beyond the scope of this study.

Role Stressors, Psychotherapy Practice, and Domestic Violence

Therapist Vulnerability

The very process of psychotherapy itself may present the therapist with real and painful psychological discomfort. The therapist is caught in the vortex of a powerful double bind. For instance, the therapist is expected to empathize, recognize emotionally, and realize intellectually the feelings of a patient. Paradoxically, he is expected to avoid being caught up in these same feelings and is required to bottle up emotions provoked by the interpersonal exchange which could lead to a reduction in his ability to understand and communicate his understanding to his patient. Yet it is also necessary for a therapist to remain vulnerable (i.e., open) to feelings in order to be most helpful to the patient. The therapist is often left with a residue of the powerful affects that the patients feel. The therapist may be induced to feel as frightened, angry, helpless, hopeless, etc. as the patient (Goldberg, 1991; Kernberg, 1984; Maltzberger & Buie, 1974; Ogden, 1982; Spensley & Blacker, 1976).

Confidentiality

A related normal role stressor inherent in the psychotherapy process is induced by professional dicta regarding confidentiality and privacy. The patient tells the therapist his/her secrets laden with upset and trauma which the psychotherapist is expected to contain in silence (Goldberg, 1991). Studies have shown that those who are able to confide in other people about their distressed feelings, rather than to hold onto them, are less susceptible to illness (Pennebaker & O'Heeron, 1984). The psychotherapist who works with situations of domestic violence is put in a double bind. Professional dictates of confidentiality and privacy impel psychotherapists to keep private the nature of their patients' distressed feelings. The psychotherapist's duty to warn third parties concerning persons potentially at risk because of the patients' violence, however, often challenges professional dictates. The Tarasoff court ruling in California enjoins psychotherapists with the duty to warn potential victims of assault by their clients and to take action to prevent the violence, but laws governing client confidentiality enjoin psychotherapists to protect privileged information regarding their clients (Beck, 1982, 1985, 1988; Brieland & Lemmon, 1985; Lion & Tardiff, 1987; Applebaum, 1985). Confronting situations which require breaking professional dictates of confidentiality often causes role stress for the clinicians (Beck, 1985; Sonkin, 1986; Sonkin & Ellison, 1986). Beck (1982, 1985), in two interview studies of psychiatrists in private practice, discussed with the psychiatrists their experiences with violent patients and their knowledge of, attitiudes toward, and experience with Tarasoff duty. Beck found evidence that Tarasoff cases in private practice have a worse outcome than Tarasoff cases in institutional settings. Typically, the private practice cases involving a Tarasoff warning eventuated in ruptures of the therapeutic alliances, and the patients eventually left treatment.

Ambivalent Attachments

Psychotherapists must repeatedly confront their ambivalent feelings about terminations. They may experience the grief and loss at termination despite their intellectual

satisfaction at the patient's successful completion of therapy. Conversely, psychotherapists may also experience guilt about their relief that certain patients leave therapy. This may be particularly prevalent in work with battered women and battering men due to the ambivalent quality of these patients emotional attachments to significant others, including their psychotherapists, and to the patients ambivalence about the often stressful nature of the psychotherapeutic work (Gilman, 1980; Young, 1991). Psychotherapists may also unwittingly be reluctant to become fully attached to domestic violence patients because of their anticipation that the patients will have difficulty sustaining a therapeutic alliance and will be difficult to treat because of the chronic crisis nature of the domestic violence. This may be particularly problematic for psychotherapists who have repeatedly experienced abandonment by domestic violence patients who commonly abruptly drop into, and out of, the initial stages of therapy (Gilman, 1980; Hanks, 1987, 1992).

Helplessness

Psychotherapists typically experience helplessness when they are not able to help patients in great distress. "There is something about being with someone in pain and not being able to do something actively to alleviate the pain that is excruciating to the practitioner" (Goldberg, 1991, p. 80). Clinical situations that potentially hold the greatest stress for psychotherapists are those in which the clients present in acute suffering and despair. When psychotherapists feel competent in their skills, work feels challenging and satisfying. However, if psychotherapists feel helpless to assuage the client's suffering and question the impact of what they do, they too may become clinically demoralized (Spensley & Blacker, 1976). Farber and Heifetz (1981), in a study of a heterogeneous sample of 60 psychotherapists investigating patterns of satisfactions and stresses in psychotherapeutic work, found that therapists may burn out when they perceive their therapeutic efforts as inconsequential or ineffective.

In addition, helplessness is a phenomenon frequently experienced by battered women, as discussed in the literature on the battered women's syndrome, and by men who batter (Sonkin, 1982, 1985; Walker, 1979, 1984). In clinical work with domestically violent patients, therapists are often not able in the early stages of treatment to avert episodes of violence between the marital pair and may experience feelings of helplessness which parallel that of their patients (Hanks, 1987, 1992).

Benedek (1984), in discussing psychotherapists' reactions to violence and victimization, states that "despite variance in individual clinicians, it is important to recognize that everyone has conflicts around reaction to violence and victimization. What seems to be important is the clinician's sense of helplessness. . .If I am presented with this information, what can I do? What should I do? What must I do? So the conspiracy of silence may go on. Perhaps the best illustration of this is the response at professional meetings when domestic violence is discussed. More often than not, someone in the audience is brave enough to talk about their individual feelings of helplessness and hopelessness when confronted with such victims" (p. 51).

Clinical Conviction

Kernberg (1968) addressed the need for psychotherapists to have a solid conceptual foundation from which to practice in order to avoid a professional identity crisis. "The more a clinician is convinced of the possibility of, and the preconditions for change. . .the more respectful he becomes of the hazards and difficulties of achieving psychological change. If the clinician has no rational, scientific conviction about the possibility of helping an individual...then he is in danger of facing a professional identity crises. . .the psychotherapist must know in what way and by means of what mechanisms he is helping the patient, in order to confirm his professional action" (Kernberg, 1968, p. 146). Kernberg (1968) proposed that confirmation of the psychotherapist's clinical conviction through frequent, repeated experiences of his/her ability to help patients by means which are objectively understandable, and independent from magic assumptions on the patient's

as well as on the psychotherapist's part, solidifies the identity of the clinician. Kernberg's clinical wisdom was empirically echoed by Farber & Heifetz (1981) in a study of therapists of a heterogeneous sample of 60 psychotherapists. The single most highly rated item on the satisfaction scale was success in helping troubled individuals.

Many psychotherapists, particularly those who completed their graduate training prior to ten years ago, have not received adequate training in the identification, assessment, and treatment of domestic violence cases. It may be that lack of training in this specialized area of practice impairs psychotherapists' ability to function successfully with this clinical population and undermines therapists' sense of clinical conviction when working with battered women and men who batter.

Clinical Responsibility

One of the most obvious sources of practitioner's stress is the therapist's level of clinical responsibility. The psychotherapist is a professional who is asked to help people, many of whom come to the practitioner after failing to find resolution with other helpers. Frank (1973) describes those who seek psychotherapeutic care as having a common characteristic of feeling demoralized: "They feel powerless to change the situation or themselves" (p. 314). Psychotherapists are given heavy responsibility for other people's lives (Goldberg, 1991). Marmor (1953) addressed the therapist's anxieties inherent in the practice of psychotherapy, stating, "The happiness not merely of individuals, but often of entire families, hinges on the outcome of his work. There are few professions that present their practitioners with so challenging a series of daily trials and responsibilities" (p. 371). This is particularly potent in clinical work with domestically violent patients due to the life-threatening nature of the abuse and violence.

Aggressive and Suicidal Patients

Psychotherapists' anxieties in treating suicidal or aggressive patients is well recognized (Davis, 1991; Lion, Madden & Christopher, 1976; Madden, Lion & Penna, 1976; Spensley & Blacker, 1976). In Farber and Heifetz's (1981) study of satisfactions

and stressors in psychotherapeutic work, the single most stressful form of patient behavior was "suicidal statements" and the next most stressful was "expressions of aggression and hostility" (p. 625).

Lion (1976), speaking on a cautionary note regarding the treatment of aggressive and suicidal patients, alerted psychotherapists to the fact that handling suicidal patients raises considerable anxiety for anyone and spoke to the psychotherapists' needs to carefully monitor countertransferential reactions to agitated patients. Lion also addressed the danger that a highly disturbed client might take physical action against the psychotherapist. In his study of assaults on therapists, Lion found that more than half of the practitioners who are assaulted by patients had acted in a provocative manner toward the assaultive client prior to the attack. Lion indicated that many of these incidents could be related to the inexperience of the practitioner who was too insistent that a client deal squarely with upsetting material. Similar to other writers, Lion asserted that "despite this ominous possibility there is very little discussion in the professional literature about the causes of these dangers and how to recognize them before an attack" (p. 82).

Aggressive acting out is the basis of the presenting problem in men who batter. The risk of suicidal acting out is commonly cited in the literature as a dynamic in both battered women (Hilberman, 1980; Hilberman & Munson, 1978; Walker, 1979, 1984) and in men who batter (Hotaling & Sugarman, 1987; Sonkin, 1982, 1985). It can be expected that work with these patients raises considerable anxiety for psychotherapists.

Personal Values

Marmor (1973) acknowledges that, although theoretically many dynamic psychotherapists try to be free from value judgements, in actual fact this is an ideal impossible of attainment. Value systems of one sort or another inevitably enter into every psychotherapeutic relationship--into the choice of patients, into the concept of what is psychologically healthy or unhealthy, into the very selection of what is interpreted or not interpreted. "When clients choose certain ways of handling their anxieties which run

counter to therapist's belief systems, anxiety and insecurity may become tripped off in both participants" (Goldberg, 1991, p. 98).

Mendes (1977) discussed the implications for practice with clients who have adopted alternative lifestyles which represent radical departures from traditional values and ways of living. "The therapist brings to each client his personal standards on which his judgements are based. . .in many instances, it is not too difficult for the therapist to avoid being judgmental in making his required interpretations. This difficulty in judgment is most likely to occur when the therapist has to control his consciously held standards" (p. 160).

Implicit in the clinical literature on spouse abuse within families is the notion that the psychotherapist cannot remain neutral in regard to the violent behavior (Bograd, 1982 & 1984; Bowlby, 1984; Breines & Gordon, 1983; Cook & Frantz-Cook, 1984; Dobash & Dobash, 1979; Gelles, 1982). Clearly disapproving of violent behavior (and thus violating clinical neutrality) often runs counter to sociocultural value systems which may condone wife battery (Bograd, 1982, 1984; Gelles & Straus, 1979; Margolin, 1988; Straus, 1980; Taubman, 1986) and which may influence the value systems adhered to by some battered women and men who batter who may feel that violence is an unfortunate yet acceptable mode of behavior. The psychotherapists working with domestic violence patients may be caught in a double-bind as they may feel they violate professional dictates of neutrality by being judgmental about domestic violence and may violate recommendations in the domestic violence literature if they remain neutral.

Psychotherapist Satisfaction and Sense of Clinical Efficacy

Burton (1975) writes of what he labels the often avoided questions of the satisfactions of the psychotherapist and what the psychotherapist seeks from his/her patient. It is Burton's contention that the satisfaction of the psychotherapist is as important as that of the patient and that there is almost a silent conspiracy in the refusal to look at the needs of the psychotherapist which arise in the course of treatment. Like Winnicott,

Burton (1975) contends that "psychotherapy is a human business, and it takes a more or less vulnerable human being to do it well" (p. 115).

Burton's impressionistic accounts are consistent with the empirically based findings of Farber and Heifetz (1981) who systematically investigated the patterns of satisfactions and stresses in psychotherapeutic work among a heterogeneous sample of 60 psychotherapists. Farber and Heifetz found that the most satisfying aspect of therapeutic work included promoting growth and change in the psychotherapists themselves as well as in their patients, achieving intimate involvement in the lives of patients, and feeling professionally respected.

Burton (1976) contends that psychotherapists leave the field or decline to work with a particular kind of patient because of lack of satisfaction in the work. Similarly, Sarason (1977) stated that dissatisfaction and burnout among therapist may potentiate "radical career changes" as well as increase demands for alternative sources of satisfaction. Writing in 1976, Burton asserted that "the vicissitudes of the satisfaction process are best illustrated in the psychotherapy of schizophrenia, where the field is strewn with defectors, and even a few corpses" (p. 118). Writing in 1990, this researcher noted a similar phenomenon occurring in the field of family violence treatment, that is the tendency for therapists to abandon the field of domestic violence treatment just at the point that some expertise has been gained (Hanks, 1990). Similarly, preventing staff burnout in shelters for battered women has been identified as a major and urgent challenge for shelter administrators in the 1990's (Epstein & Silvern, 1990).

Various writers have addressed the phenomenon of therapist satisfaction. Burton (1976) described six variables of satisfaction related to the practice of psychotherapy: (a) intrapsychic; that is the satisfaction which results from ameliorating suffering and in being a healer; (b) sensual-interpersonal; that is the cultural attraction between the therapist and patient; (c) intellectual-rational; that is fulfilling the therapists' need to dwell in the symbolic realm; (d) research-creative; that is psychotherapy as a method of inquiry and

understanding; (e) cultist-fraternal; that is allowing the therapist a a socially privileged position and membership in a special fraternity; and (f) economic gratifications.

Greenson (1966) tends to glamorize and idealize the profession of psychotherapy and tells us that psychotherapists derive satisfaction from being able to work with some of the most interesting people in the world, probably the most creative who each offer a vast unexplored world to share. However, this type of "glamor" satisfaction is unlikely to occur with domestic violence cases, typical of persons requiring psychological services, who often do not possess the required emotional and intellectual faculties necessary for traditional psychotherapy (Goldberg, 1991).

Schofield (1964), in his well known work Psychotherapy: The Purchase of Friendship, has documented that "preferred" patients typically share the qualities of being younger, attractive, verbal, intelligent, and successful (the YAVIS patient). It is not surprising that a client who is "well informed, knows what's going on in the news, is interested in talking about his problems, and can verbalize a deeper awareness about himself and can, consequently, help the practitioner do the job well is highly desired as a client" (Ames, 1980, p. 24). Domestic violence patients may not possess the qualities that are likely to make them attractive to psychotherapists and that enhance the psychotherapist's satisfactions in the psychotherapeutic process.

The "Difficult" Patient

The "difficult" patient as described in the literature generally refers to those patients that the therapist regards as " difficult to work with," "impossible to help," "resistant to therapeutic endeavor," or "recalcitrant to a relationship" (Goldberg, 1991). It has been has demonstrated that the qualities of the client (Strupp, 1969), and the client's capacity to form a therapeutic alliance (Luborsky, 1976; Marziali, Marmar & Krupnick,1981) decisively determine the outcome of psychotherapy. The term "difficult" client is generally applied to those clients who invoke anxiety in psychotherapists because of their aggressive or seductive manners, or because their psychological distancing mechanisms don't allow

them to respond to the psychotherapist's endeavors at relationship and alliance, at least not in the way the practitioner is comfortable working (Goldberg, 1983). Certain types of clients cause special distress for practitioners because of the severity of their psychopathology and propensity for acting out their pathology in ways harmful to themselves and others. The literature describes these patients as "boring" (Taylor, 1984), "hateful" (Frederickson, 1990; Graves, 1978; Maltsberger & Buie, 1974), "obnoxious" (Martin, 1975); "special problem," "provocative," and "help rejecting" (Bassuk & Gerson, 1980; Kuch, 1977). Greenson (1966), in his classic paper on "That Impossible Profession" referred to these patients as inspiring in the therapist a feeling of 'oi vay'.

"Difficult" patients deny the practitioner the recognition and admiration many psychotherapists require to feel fulfilled in their work and may succeed in threatening the psychotherapist's idealized imago as a concerned and competent practitioner (Burton, 1964; Goldberg, 1990). Marston (1984), discussing the frustrations encountered by psychotherapists in obtaining adequate feedback for good work, asserts that psychotherapists are often "more affected by their failures than successes" (p. 457).

Robbins, Beck, Mueller and Mizener (1988) studied 54 psychiatric outpatients identified by two or more therapists as difficult to treat and compared them to 54 control psychiatric outpatients matched on age, sex, marital status, and diagnosis. The psychotherapists' descriptions of difficult psychiatric patients contain five qualities, themes, or dimensions: patients who demanded extra time and attention; patients who because of limited personal and interpersonal skills appeared unable to benefit from the treatment efforts of the therapist; patients who refused to cooperate with the therapist's efforts; patients who had the potential to be violent; and, patients who presented a perplexing set of problems to the psychotherapist and did not clearly fit any established treatment alternative. Robbins et al. (1988) suggested that the defining characteristic of difficult-to-treat patients may not be the level or nature of their problems as much as their unwillingness or inability to validate efforts of the therapist on their behalf. Patients may

be viewed as difficult because they deny the special competence and authority of the mental health professional. Help-rejecting patients, for example, may be seen by the psychotherapist as difficult not because of their unreliability but because they actively resist therapists' attempts to practice the unique skills they have been trained to provide.

Violence and the "Difficult Patient"

Many studies of the "difficult-to-treat" patient cite patients' propensities toward violence as a major factor in defining them as "difficult." It is interesting to note that of those studies of violent patients that could be located, most study in-patient or emergency room populations. No studies could be located which mentioned domestic violence as a form of violence deemed "difficult."

Colson, Allen, Lolafaye, Dester, Jehl, Mayer, and Spohn (1986) studied the emotional reactions of staff to 127 difficult to treat psychiatric hospital patients. Colson et al. (1986) reported on "not only specific transference-based reactions to the patient's transference feelings and fantasies but also the range of non-pathological emotional reactions to difficult-to-treat patients" (p. 923). Colson et al. (1986) concluded that different forms of pathology elicit characteristic patterns of emotional reactions from staff. Character pathology (characterized by high demandingness, manipulation, hostility, and tendencies to sabotage treatment) elicited predominantly feelings of anger. Patients who were psychotically withdrawn and slow to change tended to elicit feelings of helplessness and confusion in the staff. Patients who were suicidal and depressed elicited non-dysphoric affects in staff characterized by protectiveness and positive interest. Patients who showed potential for violence and agitation evoked the most complex array of feelings, including helplessness, confusion, anger and fearfulness.

Lion and Pasternak (1973) studied patients who appeared in emergency rooms and clinic settings with complaints relating to assaultive and destructive urges. These and other researchers (Bach-y-Rita, 1971; Lion, 1972; Lion, Bach-y-Rita, 1971; Bach-y-Rita & Ervin, 1969; Lion, 1972; Lion, Bach-y-Rita & Ervin, 1969) cited fear and anger as being

the predominant reactions in the therapists. They suggested that fear may distort the clinician's view of the patient being dangerous and may interfere with effective management.

Psychotherapists' Reactions to the Treatment of Violence and Victims of Violence

An important component of treatment of violence is that psychotherapists understand the dynamics of violence, acknowledge their reactions to aggressive patients and victims of violence, and understand how these feelings might impact on treatment (Benedek, 1984; Dubin, 1986; Haley, 1974). Several themes are noted in the literature regarding psychotherapists' reactions common to situations of treating violence which appear applicable to treatment of domestic violence.

Denial

Denial is a frequently reported countertransferential response to abuse. A psychotherapist who happens to have a warm, ongoing relationship with an abusive man may want to deny the abusive act (Tuohy, 1987). Denial may be manifested by the clinician's failure to gather unflattering and anxiety provoking anamnestic data for fear that it will unleash unmanageable rage. Psychotherapists may deny the risk of violence by working with a patient as if there were no reason for concern, using minimal precautionary measures (Beck,1988). Madden (1983), describing his experiences treating violent patients in group therapy, cautioned psychotherapists to guard against denial manifested in an over-pathologizing of the patients. Psychotherapists may assume that an individual who has committed a violent act is incompetent or mentally unbalanced and may deny that a person with full competence could behave violently (Davis, 1991).

Psychotherapists may be knowledgeable about incidents of violence in patients' lives and not discuss the violence with the battering man in subsequent sessions (Dubin, 1986; Lion & Pasternak, 1973). Psychotherapists may also collude with the denial of a battered woman who, through the defensive utilization of the mechanism of splitting, denies the life-threatening nature of the battering relationship (Gilman, 1980; Hanks,

1990). Common technical errors early in therapy are related to denial and can include: (a) focus on intrapsychic processes at the expense of external realities; and (b) frankly overlooking material related to violence, threat , or fear of violence (Benedek, 1984; Hilberman, 1978, 1980).

Stereotyping of Patients

Sherin (1987) investigated views of out patient mental health therapists towards patients with a history of aggression. Out patient mental health therapists were found to categorize and stereotype clients with aggressive histories as a perceived threat or as an unpredictable danger and, as a result of this stereotyping, systematically deny treatment to such troubled clients.

Similarly, Dubin (1989) discusses how clinicians' may prematurely develop attitudes and feelings about patients' potential for violence based on a single piece of history of violent behavior. Fantasies may lead psychotherapists to experience anxiety, anger, rage, or despair and subsequent clinical responses to the patient may then be punitive and repressive.

Retaliation Rage & Sadism

Psychotherapists most often work with patients who have neurotic guilt over unconscious wishes or impulses and experience psychic distress at the breakthrough of such wishes or with patients who "act out", usually symbolically, their internal distress. The "crimes" of these patients are usually in the form of fantasies or non-life threatening behavior (Haley, 1974). This is quite different than working with a domestic violent patient who acts his impulses behaviorally rather than symbolically.

In discussing her work with Vietnam veterans who committed atrocities, Haley (1974) spoke to the need for the psychotherapist to confront his/her own sadistic and retaliatory feelings to an unusual degree. Psychotherapy is not useful until the psychotherapist is perceived as someone who can hear horrifying realities and can tolerate natural feelings of revulsion, yet resist an equally natural tendency to punish. Haley

(1974) maintained the importance of the psychotherapist "reminding himself that [violence is] as old as man and as close at hand as our own well-defended but none-the-less very real sadistic potential. The first task of the therapist is "confront his/her own sadistic feelings, not only in response to the patient, but in terms of his/her own potential as well" (p. 152).

Dubin (1989) asserted that an important component of treatment of patients with a history of violence is that clinicians acknowledge their reactions to aggressive patients and understand how these feelings might impact on treatment. Adverse reactions can occur when a clinician projects his own sadistic and angry impulses onto a patient and exaggerates the patient's capacity for violence. At times this projection can lead to a rejection of the patient that provokes a violent confrontation.

Feelings Towards Victims of Violence

Benedek (1984) outlined two countertransference reactions typical of clinicians working with victims: (a) reaction formation and isolation, resulting in anger at the victim rather than the victimizer; and (b) anxiety and avoidance, rather than understanding and dealing with the victim. A psychotherapist's response to a victim of family violence may be to identify a syndrome, such as the battered woman's syndrome, which allows the clinician to deny, intellectualize, and avoid dealing with the individual patient and concentrate instead on epidemiology, statistics, and measuring, rather than empathy and helping.

Another common response towards the victim of violence is the psychotherapist's conscious or unconscious identification with the victim, prompting inappropriate anger toward the abuser. Conversely, anger may be directed towards the victim whose actions are perceived as the cause of the partner's violence (Bograd, 1982, 1984; Walker, 1979).

Narcissistic Depletion

Altshul (1977) defines narcissistic depletion as the state which exists when "everything is going out and nothing is coming in" (p. 536). From Altshul's viewpoint, the psychotherapeutic situation itself predisposes the therapist to narcissistic depletion by

reversing the unspoken rule of reciprocity which governs social exchanges. In addressing the dynamics of narcissistic depletion in social workers working with abusive families, the extreme dependency needs encountered in abusive families, in combination with the frequent crises and intense negative transference reactions, often lead to workers feeling "drained," "used up," and "burned out."

Similarly, Farber and Heifetz (1982), in their study of the experiences of psychotherapeutic practice of a heterogeneous group of 60 psychotherapists, found that the majority (57.4%) of psychotherapists interviewed attributed the occurrence of burnout to the non-reciprocated attentiveness, giving and responsibility demanded by the therapeutic relationship. Most psychotherapists (73.7%) cited "lack of therapeutic success" as the single most stressful aspect of therapeutic work. "These findings suggest that therapists expect their work to be difficult and even stressful, but they also expect their efforts to 'pay off.' Constant giving without the compensation of success apparently produces burnout" (p. 298). Disillusionment occurs when psychotherapeutic work is particularly frustrating and only minimally successful--and this may often be the case when one is overworked or dealing with suicidal, homicidal, depressed, or especially resistant patients (Burton, 1969).

A variety of defenses are commonly used to combat narcissistic depletion. The therapist may deny the state of exhaustion and, through reaction formation, redouble efforts to attend to the client with "irrational total dedication" (Altshul, 1977). Another strategy is to blur boundaries between oneself and the client through over-identification. In this way, the therapist circumvents the experience of depletion, because what is given to the client is felt simultaneously to be received by oneself. According to Freudenberger (1975), over-dedication and excessive commitment is based on the

> dedicated [therapist's] guilt, his feelings that he is a super-being helper, his desire for being of genuine help, push him ever onward to work harder, because such a person believes that the only way to stem the flood of demands upon him is to put in more hours and more effort. What happens is that the harder he works, the more frustrated he becomes; and the more frustrated he is, the more exhausted, the more bitchy, the more cynical in outlook and behavior--and, of course, the less effective in the very things he so wishes to accomplish. When these and other defenses fail

> the depleted therapist, a state develops which might be called "narcissistic exhaustion"--or simply burn out (p. 74).

The phenomenon of burn-out has also recently begun to be studied in shelters for battered women. Epstein and Silvern (1990), who conducted one of the first studies of burn-out among 47 staff members in 18 shelters for battered women, assert that while in the 1980's the major challenge to women organizing shelters was responding to the shock of identifying the need of the battered women, in the 1990's the major challenge will "include finding ways of avoiding burn-out for those dedicated to helping battered women and their children" (p. 9).

Over-identification with victims also leads to stress and burn-out. Alexander, deChsenay, Marshall, Campbell, Johnson, and Wright (1989) described the unexpected reactions of several nurse researchers who assisted in a case record review of 1215 rape crisis center records to determine demographic predictors of sexual abuse. Despite the relatively impersonal nature of the method used in collection of data, the researchers experienced highly subjective responses to the often sketchy case records both during and after the study. Reactions reported by the researchers closely parallel reactions experienced by rape victims as described by Burgess and Holmstrom (1974) as the Rape Trauma Syndrome. Similarly, Pepitone-Rockwell, Phillips and Werner (1979) described the staff of rape crisis centers as acting and re-acting in a manner similar to the rape victims. Both sets of subjects suffered from symptoms of post-traumatic stress, including nightmares, unusual or extraordinary suspicions of men, irritability, hypervigilance, vague fears, and phobias, insomnia, etc.

Similar intense and unexpected emotional reactions to violence and victimization are to be expected in work with domestic violence. Psychotherapists who work solely with battered women may become preoccupied with the psychological trauma of the battered woman. Likewise, psychotherapists who work solely with men who batter have been known to perceive the abusive male as the victim of the provocative female partner (Hanks, 1990).

Psychotherapists Feelings of Fear

Although fear is one factor commonly cited in informal conversation for avoidance of domestic violence cases, it is interesting to note that no empirical research could be located related to this issue and there is little clinical discussion of this concern in the literature. Shapiro (1986), in discussing a family therapy approach to domestic violence families, maintains that psychotherapists' fears that violence will break out among family members in a conjoint family meeting, or that an aggressive male will turn on them, is a powerful inducement for deciding against family therapy and a powerful incentive to see the partners separately. Others authors (Epstein & Silvern, 1990) discuss concern for the safety of staff who work in shelters for battered women. No documented incidents of assault on therapists working in outpatient psychotherapy with women who are battered and men who batter, however, could be located. Indeed, within this researcher's own clinical experience of directing a domestic violence outpatient psychotherapy program, there have been no assaults on the therapists who provided psychotherapy to over 1,000 domestic violence cases over a period of nine years.

However, assaults on psychotherapists do occur (Madden, 1976). It is not known how many of these assaults are related to treatment focused on domestic violence. It is this researcher's view that it is important that therapists be able to differentiate between reality based fear and caution regarding potentially assaultive patients and their projection of their own fantasies regarding these clinical situations. Hence, the following section of this literature review will be focused on the literature regarding assaults on therapists and the prediction, prevention, and management of patients' dangerousness.

Psychotherapists' Prediction, Prevention, and Management of Dangerousness

One factor psychotherapists state for their reluctance to provide services to battered women and men who batter is fear for their own personal safety. As one colleague reported to this researcher prior to this study, "I don't work with those patients because I don't

want to carry a gun to my office." This prototypical statement reflects psychotherapists' beliefs that clinical situations involving domestic violence present a potential danger to them. This is a commonly stated concern in spite of the fact that there is no existent empirical data to substantiate this concern and that there are no reports that could be located in the literature concerning assaults on psychotherapists by battered women or men who batter.

In a study by Mace (1989) of the perceptions of 799 clinical social workers regarding those clients who have a potential for assaultive behavior which might be directed toward the professional, all of the findings pointed to the need of professionals to examine their own attitudes and beliefs regarding human aggression and violence. "This is especially important in making the decision to refuse to provide treatment services to the client based on a fear of potential assault of the professional" (p. 351).

This viewpoint is echoed in the National Association of Social Workers Code of Ethics (1990). The social worker's ethical responsibility to clients mandates that "the social worker should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, color, sex, sexual orientation, age, religion, national origin, marital status, political belief, mental or physical handicap, or any other preference of personal characteristic, condition, or status" (p. 4).

The literature and research on assaults on mental health workers and on their ability to predict and manage violent behavior in patients will be reviewed. Its relevance to psychotherapeutic work with women who are battered and men who batter will be highlighted.

Assaults on Therapists

The amount of published information regarding assaults on mental health professionals is surprisingly sparse. This is in spite of the fact that the literature indicates that anywhere from 14% to 42% of mental health professionals have been assaulted by one of their clients (Mace, 1989). Of the few research articles about assault on professionals

that are available, they are, for the most part, studies which provide only quantitative information as to the number of assaults that do occur. No studies could be located concerning psychotherapists' attitudes and beliefs about assault by domestic violence patients

In a comprehensive review of the literature, Mace (1989) illustrates the paucity of literature on this topic. "Prisons, psychiatric hospitals, community mental health centers, and welfare departments are all situations where a psychiatrist, psychologist, or social worker might expose themselves to individuals who may become violent and assaultive" (p. 62). Of the studies of patients who become violent within mental hospitals and/or emergency rooms (Conn and Lion, 1983; Depp, 1983; Dietz & Rada, 1983; Ionno, 1983; Lion, 1983; Ochitill, 1983; Tardiff, 1983) most of these studies describe the demographics of the assailants, the effect of the hospital milieu and staff on precipitating or preventing violence, and medication management and/or physical restraint of the violent, or potentially violent, patient.

Little data could be located which describes violence in private practice settings. Madden (1976) described the results of a survey of 115 psychiatrists regarding assaults by patients. The results of the survey indicated a reluctance on the part of clinicians to provide clinical services to patients with a history of assaultive behavior in spite of the fact that most assaults of therapists take place in inpatient or high-risk settings (such as emergency rooms or forensic services) and by psychotic or paranoid schizophrenic patients. There was a clear relationship between years of practice, work setting, and violence reported. Of the 115 psychiatrists surveyed, 48 stated that they had been assaulted in a total of 68 assaults. These psychiatrists were most often assaulted in the early stages of their career or while they were working in a high-risk setting.

Beck (1985) reported on interviews with 34 psychiatrists practicing privately outside a major metropolitan area. The primary purpose of the study was to report on the Tarasoff experience of psychiatrists who practice privately, outside major metropolitan

areas, and to examine how the Tarasoff duty affects their work with, and attitudes toward, potentially violent patients. Of the respondents, 32 (82%) reported some experience with violent patients. Nine of 13 (69%) who worked in public facility reported a violent case in the public facility. In contrast, 12 of 34 psychiatrists (35%) reported a violent case in the private office. Five of 15 (33%) who worked in a private hospital, and 2 of 7 (29%) who worked in a private clinic, reported violent cases from those settings. However, violent patients seen in private offices were significantly more likely to threaten or assault the clinician, as compared with patients seen in other settings. Twelve of 28 violent cases were reported in private office settings, and 7 of these 12 (58%) involved the physician in actual or threatened violence. Psychiatrists in this sample who practice both privately and in public settings more often reported that they have seen a violent patient in the public setting than in the private one. In violent cases that occurred in a private office, however, the psychiatrists were often involved in the violence. The psychiatrist threatened by violence in a private office lacks the safeguards that exist in other settings. Fortunately, such violence is rare, and there were no reports of serious injury to any psychiatrist or patient.

There is little information concerning assaults on social workers employed in various fields of practice. Only one study could be located that used clinical social workers as the primary source of information (Mace, 1989). No data have been published on rates of assaults by clients on social workers working in public welfare (children's protective services, adult protective services, etc.), corrections, domestic violence programs, or foster care. The risks to these social workers is unknown although incidents of client violence are known to occur. Hiratsuka (1988), in an article on client assaults on social workers, states that there are no hard statistics available on client attacks on social workers in the United States, although this is a growing concern in the profession.

Mace (1989), in the only survey of clinical social workers that could be located, studied assaults by clients upon 799 clinical social workers and how these social workers'

attitudes and beliefs affected their judgements about potentially assaultive persons. Of the social workers, 225 (28.2%) reported having been assaulted by a client.

Tardiff (1987) cited the need for psychiatrists to be prepared to evaluate and treat violent patients. In 1974 survey, Tardiff found that 46% of the psychiatrists surveyed in the Boston area had contact with individuals with a history of violence.

Bernstein (1981) reviewed the literature on assaults on psychiatrists and other therapists, and in all he could find only ten citations regarding the phenomenon. In his study of 422 psychotherapists, he found that 60 (14.2%) had been assaulted on 116 occasions, with assaults ranging from biting to shooting, that 150 (35.5%) had been threatened on 537 occasions, and that 257 (60.9%) had reported having been physically afraid of patients. Location of the assaults indicated that 33% of the incidents took place in inpatient settings, 26% took place in outpatient settings and 21% took place in private practices.

Madden et al. (1976) surveyed 115 psychiatrists and found that 42% had been assaulted. Whitman (1976) studied 101 therapists in the Cincinnati area and found the rate of assault to be 24%. Whitman (1976) concluded that "attacks on the therapist is an infrequent but also inevitable phenomenon that may occur at some time to every therapist" (p. 427).

Haffke and Reid (1983) surveyed 88 psychiatrists in Nebraska. Of the 54 who responded, 17 (31%) had been assaulted by patients.

The fact that assaults on psychotherapists occur is indisputable, and serious injury is sometimes the result (Hiratsuka, 1988; Mace, 1989). These facts must be taken into account every time a professional meets with a client, and they are undoubtedly acutely on the mind of psychotherapists who work with a domestic violence population. Data could be not located, however, about the connection between domestic violence clientele and assault on therapists.

The professional must make a decision, either consciously or unconsciously, as to the degree of threat to the professional's personal safety that the client poses. There has been little research directed toward this problem, and little information is available to help the professional deal with the possibility of assault by a client or by a person associated with a client. There are various reasons for this lack of research. Assaults are very difficult phenomena to study as they can only be studied after they occur. In addition, most research in the field of family violence is directed at client populations and the problems that affect them, not the problems which affect the professional, even though the professionals' problems affect the ability of clients to receive services (Whitman, Armao & Dent, 1976).

Prediction of Violence

The topics of violence and assault are problematic for mental health professionals who come into contact with violent individuals. Empirical research has been unable to supply predictive tools for violent and assaultive behavior. The literature on the problems of prediction, prevention, and management of violent assault on mental health professionals is relevant. The issue of prediction of dangerousness is particularly relevant to this research study because psychotherapists are likely to avoid domestic violence patients out of fear for their own safety.

Psychotherapists do not have the ability to predict a physical confrontation (Bernstein, 1981). Anyone can be assaulted by a client and predicting who and when is nearly impossible. Research points to some real problems that may be created by the over-prediction of violent behavior and biases that the evaluators may put into their decisions. The fact that professionals cannot predict violent behavior with any reasonable accuracy and may fall back to making decisions via stereotypical ideas and reactions to their own fears of violence may be problematic for domestic violence patients (Mace, 1989).

Methods of Prediction

No clear set of rules exist for predicting violence. The research presented by this review and the review of other researchers (Mace, 1989) do not support any reliable methods for predicting violence in human beings.

Monahan (1976, 1984) most clearly outlined the debate in the literature regarding psychiatrists' and psychologists' ability to predict future dangerousness. The whole field of "prediction of dangerousness" arose from two shifts in social policy--one was the shift in criteria for involuntary psychiatric hospitalization in the mental health system, and the other was the utilization of indeterminate sentencing in the criminal justice system of most states. The criteria for civil commitment in most states shifted away from assessment of a "need for treatment" and toward a prediction of "dangerousness" to others and/or to self. In addition, because of the utilization of indeterminate sentencing of felons in the United States up until about ten years ago, parole boards were required to know intuitively when a felon's rehabilitation had been achieved and the offender could be released without danger to society.

What Monahan (1984) calls the "first generation of research" in the prediction of violent behavior was in response to these social policy needs. The first generation of research consisted of perhaps five studies in the early 1970's and seemed to show that psychiatrists and psychologists were vastly over-rated as predictors of violence. Psychiatrists and psychologists seemed to be wrong at least twice as often as they were right--even with lengthly multi-disciplinary evaluations of persons who had already manifested violent proclivities on several occasions. In the "first generation of research" in the prediction of violent behavior several problems arose.

> Violence is vastly over-predicted whether simple behavioral indicators are used or sophisticated multivariate analyses are employed and whether psychological tests are administered or thorough psychiatric examinations are performed. It is also noteworthy that the population used in each of the research studies reviewed here was highly selective and biased toward positive results, primarily convicted offenders, 'sexual psychopaths' and adjudicated delinquents. The fact that even in these groups, with substantially higher base-rates for violence than the general

> population, violence cannot be validly predicted bodes very poorly for predicting violence among those who have not committed a violent act (Monahan, 1976, p. 21).

On the basis of findings suggesting little relationship between clinical forecasts of violence and later violent behavior, some authors have recommended that clinical predictions not be permitted as evidence regarding involuntary detainment or commitment (Steadman, 1980; Werner, Rose & Yesavage, 1983). A task force of the American Psychiatric Association (1974) concluded that "the state of the art regarding predictions of violence is very unsatisfactory. The ability of psychiatrists or any other professionals to reliably predict future violence is unproved" (p. 30). A 1978 task force of the American Psychological Association agreed that,

> It does appear from reading the research that the validity of psychological prediction of dangerous behavior. . .is extremely poor, so poor that one could oppose their use on the strictly empirical grounds that psychologists are not professionally competent to make such judgments (p. 1110).

Monahan (1984) challenged this position. He asserted,

> that rarely have research data been as quickly or clearly universally accepted by the academic and professional communities as those supporting the proposition that mental health professionals are highly inaccurate at predicting violent behavior (p. 10).

In the past several years, a second generation of thought on the prediction of violence has evolved. Monahan's (1984) second generation of thought on prediction of dangerousness critiqued the first generation based on the shallowness of the existing research base. The five studies that formed the core of this knowledge base (Cozozza & Steadman, 1976; Kozol, Boucher & Garofalo, 1972; Steadman, 1977; Steadman & Cocozza, 1974; Thornberry & Jacoby, 1979) all demonstrated that clinical predictions of violent behavior among institutionalized mentally disordered people are accurate at best about one third of the time. According to Monahan (1984), "the most telling criticism of the existing prediction research does not concern its methods; it concerns its scope. The studies deal with only one form of prediction, clinical prediction, and with only one setting

for prediction, long-term custodial institutions" (p. 11) such as prisons and mental hospitals. It is difficult to generalize these findings to other populations in other settings.

However, Monahan (1984) supports the findings of several more recent studies which "support at least a marginal increase in the validity of clinical prediction" (p. 11). These studies (Rothman, 1980; Yesavage, Werner & Becker, 1982) were of patients who threatened and assaulted during emergency hospitalizations. These data suggest that "more valid short-term assessments of dangerousness of inpatients might be made if factors in addition to manifest hostility were taken into account [including] indicators of psychosis, such as conceptual disorganization, and indicators of agitated behavior" (Yesavage, Werner & Becker, 1982, p. 1149).

Monahan (1981) believes that there are theoretical reasons why short-term prediction of violent behavior may be more accurate than the long-term predictive studies to date, and there is a growing body of empirical evidence suggesting that, for the small group of habitually violent persons, the probability of future violence is raised considerably. Monahan's (1981) position evolved to,

> rather than we know it is impossible to accurately predict violent behavior under any circumstances... a more judicious assessment of the research to date is that we know very little about how accurately violent behavior may be predicted under many circumstances (p. 37).

Litwick and Schlesinger (1987) present a different point of view. They take exception to Monahan's conclusions regarding the prediction of violence in their review of the literature. They point out that no research contradicts the "commonsense" notion that a recent repeated act of violence may continue unless there has been some change in the attitudes or circumstances of the violent individual; even if the violent act occurred in the distant past and the person has been confined, it can be assumed that the person may act violently again if there has been no change in the attitudes, personality traits, and physical abilities that led to the original violence. They also claim that no evidence exists regarding the validity of predictions based on threats of violence, and even in the absence of threats

of violence there may be times when it is clear that a person is about to engage in a violent act. Although critical of the research which shows the lack of predictability of violence, Litwick and Schlesinger (1987), however, do not present any research which shows good predictability of violence.

Contextual Variables

Shah (1978) states that one major problem in efforts to assess, predict, prevent, and change dangerous behavior is the manner in which such behavior is conceptualized. One way of conceptualizing behavior in general is that it stems largely if not entirely from within the person; that is, it is viewed as a stable and fairly consistent characteristic of the individual, being determined largely by the individual's personality. The assumption is often made that examples of "dangerous" behavior are fairly typical of the individual and are likely to be displayed in other situations as well. Hence, through a conceptual short-cut, certain aspects of the individual's behavior are initially defined as dangerous, and then the individual himself comes to be viewed and labeled as dangerous. This, of course, can be quite misleading inasmuch as violent and dangerous acts tend to be relatively infrequent, and to occur in rather specific interpersonal and situational contexts, may be state dependent (e.g., under the influence of alcohol or other drugs), and may not be very representative of the individual's more typical behavior. A person-centered conceptualization of behavior (whether based on personality trait or psychodynamic notions) appears to be fairly common among mental health professionals. Social learning theory and personality and social psychology, however, emphasize the importance of situational and environmental influences on behavior and the specific interactions of personal and situational variables in determining behavior. Some situational factors may evoke or provoke certain behaviors and may also have inhibiting or suppressive effects on other behaviors. Thus, efforts to understand, assess, predict, prevent, and change dangerous behaviors must consider the effects of setting and situational factors as well as the interactions between these and the characteristics of the individual. Evidence strongly indicates that the particular classes of

settings and situations must be taken into account far more carefully than they have been the past.

False Positives

Research has indicated that false positives are more probable than accurate predictions in this area (Kozol, 1975; Sonkin, 1986; Steadman, 1977). A false positive occurs when violent behavior is clinically predicted for a particular individual but is not perpetrated (Monahan, 1981).

Diagnostic Variables

Research is somewhat divided on the issue of diagnosis as a determining factor in potential for dangerousness (Mace, 1989). Available studies report conflicting findings.

Reid and Balis (1987), in regards to assessment of "current risk" and the prediction of dangerousness, caution clinicians against assuming they know when they are in danger and point out that violence is not well predicted and takes place without warning. They list conditions for which preventive measures are important, including: acute psychosis; confusion or agitation; paranoia with need to protect oneself from imagined attack; intoxication of any kind; explosive or episodic violence in the history; clouded consciousness and misperception of the environment; psychopathy or criminal escape risk; acute mania or hypomania; and "any situation in which there is little information about the patient". Reid and Balis (1987) claim that "training and common sense appear to offer good protection against injury" to mental health workers. They point out that violent episodes are "rare events," even in the lives of the most very dangerous people, making prediction very difficult.

Tardiff (1983), in a study of 5164 mental hospital inpatients, found that non-paranoid schizophrenia and mental retardation are over-represented in the assaultive population while paranoid schizophrenia was under-represented. Edwards and Reid (1983) reviewed European and United States literature of hospital staff assaults by patients and noted that schizophrenics had a high rate of assault, but personality disorders and

substance abusers did not indicate a high rate of violence. Madden (1983) and Reid and Balis (1987) place substance abuse on their lists of risk factors for assault. Depp (1983) noted that individuals with a diagnosis of "functional psychoses" accounted for 54% of all assaulting patients in a study of 238 assaultive incidents among mental hospital inpatients while those with a mental retardation diagnosis only accounted for 15%.

History of Violence

A history of violence is considered a high-risk factor in all studies reviewed (Litwick & Schlesinger, 1987; Mace, 1989; Monahan, 1981). Depp (1983) noted that a small proportion of individuals account for a large proportion of assaultive episodes amongst psychiatric in patients. A single episode of violent behavior, however, is not a good means of predicting future assault potential, whereas multiple episodes of violence may indicate increased risk for assaultive behavior.

The descriptions of violent persons often discovered in research studies have a tendency to distort the perception of who is a risk for violent behavior. What is not emphasized in these studies is the fact that the majority of the people who fit these descriptions are not violent. For instance, although males account for the majority of aggravated assault arrests, the majority of males are not assaultive. The same can be said of drug abusers, paranoid schizophrenics, and mentally retarded persons. There is not evidence to support the above factors as reliable predictors of violent behavior. The overlying fact which must be emphasized is that predictions of violence in humans is greatly over-predicted. The above facts produce an important consideration when making a judgment about a person's potential for violent behavior and when making a decision to accept or reject a battered woman or man with a history of domestic violence for psychotherapeutic treatment.

Management of the Violent Patient

Edelman (1978) points out that most mental health professionals are familiar with theories of aggression, but few have any training in predicting and managing violence.

Edelman proposes a number of precautions that can be taken when it is felt the client may become assaultive. His frame of reference is the community mental health center and his suggestions relate to physical space in which the individual is interviewed. The interviewing room should: have two exits; be in view of other staff members; be away from other clients; have no doors, but, if there are any, they should be left open; have objects which could be used as weapons placed out of sight; have a desk that separates the interviewer from the client; and have cushions in the rooms to double as a protective barrier. Also, Edelman suggests that two therapists should interview the patient, and that the session should be interrupted by phone calls from another staff member to determine if there is any trouble.

Soloff (1987) discusses management of the violent or potentially violent patient in an emergency room setting. He recommends mostly verbal interventions, meek body posturing, the use of medication, and/or, if necessary, physical restraint and seclusion.

Lion and Tardiff (1987) present information on the long term care of violent patients. They define two basic types of treatment: aftercare with reliance on medication and social intervention for manic-depressives and schizophrenics; and psychotherapy for personality disordered patients.

Female professionals in an inpatient setting are not at higher risk for assault than male professionals. Depp (1983) noted that cross-gender assaults accounted for only 11% of assaults in a study of 238 assaultive incidents when a 22% cross- gender assault rate was predicted. Levy and Hartocollis (1976) noted significant decreases in patient violence with an all-female staff.

Lion and Tardiff (1987) suggest that therapist's own anxiety regarding violent clients may produce inappropriate actions concerning clients who are not truly at risk for violence. Bernstein (1981) also noted the difference between the actual assault rate (24.2%) in his study and the fear of assault rate (60%) and described what he felt was an unrealistic fear of assault by psychotherapists. Bernstein (1981) also concluded that the

more inexperienced therapist is more often threatened or assaulted than the more experienced therapist. On the other hand, it could be that the more experienced therapist is able to recognize the potentially violent patient, intervene effectively to forestall imminent violence, and thus reduce the rate of actual acting out of violence (Werner, Rose & Yesavage, 1983).

Mace (1989), in his study regarding the beliefs of clinical social workers about clients who may be potentially assaultive, asserted that social workers' stereotypes of violence and the violent individual, together with their own imagination and fears, may complicate matters considerably. Werner, Rose and Yesavage (1983) suggested that

> to improve the accuracy [in prediction of violence] the clinician would do well to emphasize cues that were empirically found to predict violence in [the] patient group and to give minor weight to cues that were not empirically found to predict violence (p. 823).

For instance, since a history of violence is obviously used as significant indicator of potential for violence (Mace, 1989; Monahan, 1981), professionals would be advised to thoroughly investigate any past violence prior to making any judgments regarding a particular individual's propensity for violent behavior. In cases of domestic violence, this history should differentiate between the context of the violent episodes, the target of the violence, and the frequency and severity of the violence (Hanks, 1992).

Psychotherapists' Attitudes Towards Patients' Violent Behavior

It is important that the practitioner understand that his or her own attitudes and beliefs affect the outcome of the judgments made regarding the clients' propensity for violent behavior (Mace, 1989). From the researcher's point of view, these predisposing biases are antithetical to the maintenance of a fair and impartial treatment of individuals. According to Mace's (1989) study of the perceptions of social workers regarding potentially dangerous clients,

> all of the findings point to the need for professionals to examine their own attitudes and beliefs regarding human aggression and violence. . .the professionals would be wise to examine their own attitudes, beliefs, and feelings, as well as the evidence presented by the client's overt behavior (p. 351).

This is especially important when the decision to refuse to provide treatment services to a client who is a perpetrator or a victim of domestic violence is based on a fear of potential assault of the professional (Mace, 1989).

It is important that the mental health professions not fall prey to a myth and perceptual error inadvertently promulgated for many years by the law enforcement professions. Police interventions in disputes between family members were commonly believed to be a particularly dangerous assignment. It was commonly believed that "...more police officers die answering family disturbance calls (22 percent of all police fatalities) than die answering any other single type of call" (Straus, Gelles & Steinmetz, 1980). Despite the widespread acceptance of this view, a careful review and re-analysis of of all the available empirical evidence by the United States Department of Justice's National Institute of Justice demonstrated that domestic disturbance in reality accounted for only a small proportion of all police deaths (Garner & Clemmer, 1986). According to this study, instead of the twenty-three percent officers' death rate reported in 1977, the re-analysis of the data in 1983, 1984 and 1985 revealed that domestic disturbances were consistently the next to least dangerous of police activities and that robbery incidents were consistently the most dangerous.

This is an example of faulty perceptions, based on inaccurate data analysis, that significantly influenced social policy and procedural codes governing police intervention in the lives of domestically violent families. It is incumbent upon psychotherapists to carefully evaluate their avoidance of domestic violence cases in regard to their own attitudes and beliefs about the perception of danger from a battered woman and/or battering man.

Dangerousness is not a black-and-white phenomenon. Violent behavior is not clear-cut but lies on a continuum of extremes with varying degrees of "risk" in between. The clinician or evaluator must at some point, however, make a decision to act. The point at which this line is crossed will vary from situation to situation, depending on a number of factors. Dangerousness is itself a function of social and psychological factors that mediate

its expression (Megargee, 1976). The context in which a person behaves is as important a factor as is his/her particular state of mind (Monahan, 1981). For example, a man who batters his wife may not be likely to physically assault his boss. Likewise, abusers may be violent only under the influence of alcohol or drugs. It is important to pay close attention to contextual and social factors as predictors of future violence (Sonkin, 1986).

CHAPTER III

METHOD OF INVESTIGATION

This was an exploratory study of the experiences of psychotherapists in their clinical work with battered women and battering men with specific focus on the attitudes, beliefs, feelings, and professional clinical and training experiences which influence their provision of psychotherapeutic services to such clients. Methodologically the approach was influenced by phenomenological research. This was an hypothesis generating study based on the constant comparative method of qualitative data analysis (Glaser & Strauss, 1967) for the purpose of generating a grounded theory regarding the proposed topic.

According to Polkinghorne (1989), "phenomenological research emphasizes approaching the topic afresh without preconceived notions about what one will find in the investigation" (p. 47). The grounded theory method does not begin with pre-set categories derived from hypotheses. Instead, the researcher remained open to the empirical data gathered in the interviews and looked for patterns which emerged naturally between her and the data (Glaser & Strauss, 1967; Patton, 1990). Although this investigator began with her own experience and observations of the phenomenon (as described in Chapter I), this knowledge was used as an orienting frame rather than as propositions to be proved or disproved. In this approach, the psychotherapists/interviewees were seen as "respondants," "participants," or "informants" rather than "subjects."

Qualitative methodology was used in an attempt to understand the multiple interrelationships among the dimensions that emerged from the data without making prior assumptions or specifying hypotheses about linear or correlative relationships among narrowly defined, operationalized variables (Patton, 1990). This design provided the appropriate means for understanding the experience of others through sympathetic introspection and reflection from detailed description (Fortune, 1990; Patton, 1983). The qualitative analysis first focused on understanding the particular nature of each individual

psychotherapist's experience and then, through a system of cross-case analysis, built the findings into a coherent whole.

Semi-structured interviews with nine psychotherapists were conducted. Open-ended questions were utilized in order not to pre-determine categories of response, to maximize the range of possible responses, and to discover new phenomena that were reflected in the response (Bakan, 1967; Mishler, 1986; Polkinghorne, 1989, Strauss & Corbin, 1990). This approach was especially well- suited to this particular study because the phenomena under study had not been previously reported upon in the literature. Any attempt on the part of the researcher to pre-categorize possible responses would have biased the data and have reflected her experience rather than the experience of the psychotherapists. Each psychotherapist had unique experiences, attitudes, feelings, and beliefs about his/her experience with a domestic violence population and was able to describe the individual nature of these experiences. The attitudes, beliefs, feelings, and experiences that were common to all participants were then discernable for qualitative analysis.

Research Design

There were several stages in this qualitative research design. They were: conceptualizing the problem to be studied; drafting the Preliminary Interview Guide; recruiting participants; interviewing participants; transcribing the interviews; tandem coding, analysis, and interpretation of data; and formulating the theory and the hypotheses.

The constant comparative method of analyzing interview data (Glaser and Strauss,1967) was employed as a strategic method for data analysis and generation of theory. The data for this study consisted of spontaneous descriptions, prompted by open-ended questions, of experiences by psychotherapists unfamiliar with the researcher's theories or biases (Giorgi, 1985b). Two elements of theory were generated by the constant comparative method of interview data content analysis. First, conceptual categories and their conceptual properties were generated for each individual interview. Second,

hypotheses or generalized relations among the categories and their conceptual properties were compared across interviews (Glaser & Strauss, 1967; Patton, 1990).

Semi-structured interviews organized around a Preliminary Interview Guide (Appendix D) were used to elicit the attitudes, beliefs, feelings, and professional clinical and training experiences of each participant. Open-ended questions invited narrative responses freely organized within a framework of the research interests. These narrative interviews were viewed as a form of "discourse," that is, as speech events whose structure and meaning were contextually grounded and jointly constructed by the interviewer and interviewees (Mishler, 1986).

This approach differs from the traditional interviewing approach in which the question and answer format of a semi-structured interview is viewed as an analogue of stimulus and response rather than as a form of discourse. Traditionally, the interview is viewed as a face-to-face verbal interchange, in which the interviewer attempts to elicit information or expressions of opinion or belief from the informant (Maccoby & Maccoby, 1954). The interview is focused on some specific content area and supposedly extraneous material is eliminated (Kahn & Cannell, 1957). In such a research design, the set of questions is carefully worded and arranged with the intention of taking each respondent through the same sequence and asking each respondent the same questions with essentially the same words.

Mishler (1986) critiques this traditional interviewing approach because it suppresses the discourse and context of interviews, and it focuses on efforts to standardize questions and interviewer behavior under the false assumption that all respondents will receive the same "stimuli" and that the responses to these stimuli can be elaborately, technically coded and statistically analyzed. Mishler (1986) has concluded that the traditional approach to interviewing is demonstrably inappropriate for, and inadequate to, the study of the central questions in the social and behavioral sciences, namely, how

individuals perceive, organize, give meaning to, and express their understandings of themselves, their experiences, and their worlds.

The analysis and interpretation of these interviews were based on a theory of discourse and meaning rather than on a theory of quantitative analysis (Glaser & Strauss, 1967; Mishler, 1986; Strauss & Corbin, 1990). The data were analyzed according to the constant comparative method of Glaser and Strauss (1967) in a way that lead to an understanding of each individual's responses that were then cross compared to the data among all individuals. Of primary importance was attention to the individual quality of each response to insure the validity of comparison.

The generation of grounded theory, coupled with the notion of theory as process, required that collection, coding, and analysis of data be done simultaneously. As proposed by Glaser and Strauss (1967), the three operations blur and intertwine continuously, from the beginning of the investigation to its end. The process of data collection was controlled by the emerging theory. Beyond the decisions concerning the initial collection of data (see: Procedures, page 74; and Preliminary Interview Guide, Appendix D), further collection was not planned in advance of the emerging theory--as is done so carefully in research designed for verification and description. The emerging theory pointed to the next steps which the researcher could not have known until the direction of the study was guided by emerging gaps in the theory and by research questions that previous answers had suggested (Glaser & Strauss, 1967).

The constant comparative method of data analysis illuminated differences and commonalities in the particular experiences as discovered in the data. An initial classification scheme for analysis of data arose out of the interview topics (Interview Coding Form, Appendix E); however, as new information was gathered from each interview, categories were constructed as required, continuously refined, and "subdimensionalized" through constant comparison with previous data, beginning with the first interview and continuing until patterns were discovered. In that way, each interview

informed, and then was informed by, the subsequent interviews (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Common themes and patterns emerged as each unit of data was analyzed and re-examined; consequently, the results of the study were arrived at inductively by weaving the elemental structures of the separate entities sequentially into the greater combined form until the thematic or categoric content was collapsed by repetition.

The qualitative method of investigation was concerned with the substantive nature of the interview data, and the outcomes were representative of context as well as symbolic and thematic content (Fortune, 1991). "This means that the findings are grounded in specific contexts; theories that result from the findings are grounded in real-world patterns" (Patton, 1990, p. 45). What was reported reflected the psychotherapists as the primary sources of data. The psychotherapists involved in this study were encouraged to expand upon their experiences and, in a sense, define their own attitudes, beliefs, feelings, and experiences. The range of possible meanings of the data were clarified through the discourse of the interview process (Mishler, 1990) rather than based on pre-determined variables and hypotheses. Face-to-face interaction in the interview allowed the researcher to help the psychotherapists move toward non-theoretical descriptions that accurately reflected their experiences (Polkinghorne, 1989).

Validity and Reliability

In a discussion of internal validity (referring to the specific findings of a particular study) of qualitative research, Mishler (1986) questioned the assumption that there is only "one 'true' interpretation of an array of data and further that this interpretation may be determined by standard, universally applicable technical procedures" (p. 110). Mishler (1986) supported Cook and Campbell's (1979) view that the concept of validity refers to "the best available approximation of the truth or falsity of propositions, including propositions about cause...[and that one] should always use the modifier 'approximately' when referring to validity, since one can never know what is 'true' "(p. 37).

Hence, Mishler (1986) asserted that the critical issue was not the determination of one singular and absolute "truth." Rather, validity may be assessed by the relative plausibility of an interpretation when compared with other specific and potentially plausible alternative interpretations. "Systematic examination of 'threats to plausibility' in any one study provides guidelines for other investigators and helps to clarify significant theoretical and empirical issues for further study" (p. 115). Indeed, Mishler argued for the "continued viability of alternative interpretations that are sifted, compared, and evaluated for plausibility throughout the extended and diverse histories of research on particular topics....[in addition there are] alternative theoretical perspectives that generate different questions and do not compete directly with one another as 'rival' explanations" (p. 115).

Mishler spoke to the usefulness of the interview as a means to check the validity of interpretations through interactive discourse. Patton (1990) states that qualitative methods can be used both to discover what is happening and then to verify what has been discovered. Mishler contends that the sense of precision provided by technical (i.e. statistical or analytic) methods is illusory because technical methods tend to obscure rather than illuminate the central problem in the interpretation of interviews, namely, the relationships between discourse and meaning.

Glaser and Strauss (1967) hold that generating hypotheses requires evidence enough only to establish a suggestion--not an excessive piling up of evidence to establish a proof, and the consequent hindering of the generation of new hypotheses. The main purpose of grounded theory research is "to generate theory, not to establish verifications with the 'facts' " (p. 48).

In this study, it was assumed that once the psychotherapists/interviewees fully understood the purpose of the research and their protection of confidentiality, they were freely responsive and reliable sources of information. Because of the verbal, interactive and interpersonal nature of psychotherapy practice itself, the psychotherapists/interviewees were easily engaged in the narrative, discursive interview format. Indeed, it is this

researchers impression that the psychotherapists were remarkably frank and open in describing their own experiences.

The process of the tape-recorded, semi-structured interviews was used as a relatively spontaneous way to discover and verify the attitudes, beliefs and feelings of the psychotherapists. Ambiguities were resolved between the researcher and the psychotherapists within the discourse of the interviews themselves (Mishler, 1986). Mishler (1986) contends that merely noting the interview schedule and the interviewer's reports of responses are an inadequate and inaccurate record of the interview. "To assume that the question printed in the schedule is the standard stimulus for all respondents is neither a secure nor credible basis for analysis and interpretation" (p. 44). Therefore, the nine interviews were taped-recorded and transcribed verbatim.

If the initial description of the "data" was seriously and irretrievably faulty, it could not be corrected, nor could the actual discourse of the interview be recovered by increasingly sophisticated coding procedures or by statistical analysis. From transcriptions it has become clear that the meanings of questions and answers are not fixed by, nor adequately represented by, the interview schedule or coded-category systems. Instead, meanings emerged, developed, were shaped by, and, in turn, shaped the discourse (Mishler, 1986). Tape-recording and transcription of interviews, rather than written responses to questions, were found particularly useful for data gathering in this qualitative study as they guarded against the researcher's pre-structuring responses for the interviewees and the possibility of her distorting data through her own transcription of the data (Stevick, 1971). Therefore, because an accurate description of the interview was a basic requirement for reliable and valid analysis and interpretation, tape recording and careful transcription was utilized. A verbatim transcript of each tape-recorded interview was considered the empirical data utilized for data analysis.

In qualitative research, there are no formulae for determining levels of significance. There are no ways of perfectly replicating the researcher's analytic thought processes.

There are no straightforward tests for reliability and validity. Hence, the researcher did her best to fairly represent the data and communicate what the data revealed given the purpose of the study. "Because qualitative inquiry depends...on the skills, training, insights, and capabilities of the researcher, qualitative analysis ultimately depends on the analytical intellect and style of the analyst. The human factor is the great strength and the fundamental weakness of qualitative inquiry and analysis" (Patton, 1990, p. 372). The researcher explored possible alternative explanations of the data. Variations within the patterns, themes and categories, as well as deviations from, or exceptions to, the patterns, themes, and categories both within and among the cases were explored. Variations or deviations in the data are discussed (see Chapter V) in terms of how they further explicate or question the hypotheses generated.

Procedures

Nature of the Sample

This study concentrated upon a description of the influence of the attitudes, beliefs, feelings, and professional clinical and training experiences of these nine particular psychotherapists rather than on a delineation of their characteristics as a group. "The purpose of phenomenological research is to describe the structure of an experience, not to describe the characteristics of a group who have had the experience...the point of subject selection is to obtain richly varied descriptions, not to achieve statistical generalization" (Polkinghorne, 1987).

Sample Selection

This sample population of psychotherapists was prototypical. They were purposefully, rather than randomly, selected. Since the purpose of this study was to generate theory rather than to generalize the results from this sample population to a larger population, a random and statistically representative sample was not necessary (Glaser & Strauss, 1967; Patton, 1990).

The sampling procedure used is known as "intensity sampling" (Patton,1990). Intensity sampling involved information-rich cases that manifested the phenomena of interest intensely but not extremely (Patton, 1990). This sampling procedure required that the researcher have considerable information about the nature of the variation in the situation under study and thus be able to exercise considerable judgment in selecting an appropriate sample. Intensity sampling of information-rich cases was utilized and was deemed appropriate because of the recognized expertise of the researcher in this study (Hanks, 1984, 1985, 1987, 1988, 1992; Hanks & Rosenbaum, 1977, 1981; Rosenbaum, Adams, Scott, Renson, Tinklenberg & Hanks, 1981; Stullman, Schoenenberger & Hanks, 1987).

Sample Size

The sample in this study consisted of nine psychotherapists. Since this study seeks to generate rather than statistically verify hypotheses, the size of the sample was not an issue. There are no rules for sample size in qualitative inquiry. "The validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information-richness of the cases selected and the observational/analytical capabilities of the researcher than with sample size" (Patton, 1990, pp. 184-185).

Criteria for Selection

The nine psychotherapists who participated in this study were chosen for their ability to function as informants who could provide rich descriptions of the experience being investigated. Male and female psychotherapists from the professions of social work, psychology and psychiatry who were senior, licensed autonomous practitioners in their various disciplines were recruited. "Senior" was defined as having completed graduate level training at least five years previously. Experience in the field of domestic violence treatment was not required for participation in the study. Although variables such as gender, education, employment setting, years of experience, and ethnic and religious

background were not controlled, an effort was made to enlist practitioners from a range of professions, practice settings, educational backgrounds, and theoretical orientations.

Recruitment

Psychotherapists were recruited through personal networking by the researcher. They were not close professional associates of the researcher. The researcher selected potential participants on the basis of demographic variability with respect to professional orientation, gender, practice setting, years of professional experience, and theoretical orientation. Variability within these sub-criteria for selection strengthened the descriptive nature of the study and minimized demographic bias.

Thirty potential participants were contacted via a letter from the researcher (see Appendix A) containing a brief statement about the intent and the significance of the study. Those psychotherapists who were interested in participating in the study were asked to complete a brief Personal Information Form (see Appendix B) and return it to the researcher in an enclosed self-addressed, stamped envelope. Ten psychotherapists returned the completed form. Nine were chosen to participate in the study based upon their timely availability for being interviewed.

The researcher then initiated contact with the potential participants. Potential participants selected for the study were asked if they would sign an Informed Consent Statement (see Appendix C) to be presented on the day of the interview. This statement was read aloud, and, if the participant was willing to sign, an appointment was scheduled for the interview.

It was expected that positive response to recruitment and voluntary cooperation would be achieved due to the researcher's reputation in the field and the good will of her colleagues in the psychotherapy professions. This expectation was proven to be true.

The Interview

Data were gathered from individual, semi-structured, audio-taped interviews conducted by the researcher with the nine psychotherapists. Prior to interviewing the

psychotherapists chosen for participation in the study, two pilot interviews were conducted.

The semi-structured interview format was chosen as an appropriate and useful way to elicit each participant's unique feelings, experiences, attitudes, and beliefs. "The fundamental principle of qualitative interviewing is to provide a framework within which respondents can express their own understandings in their own terms" (Patton, 1990, p. 290). Each respondent had the opportunity to talk freely, in an open-ended manner, and respond in her or his own words to express her or his personal perspectives. The researcher did not supply or pre-determine the phrases or categories that had to be used by respondents to express themselves.

The discursive and reciprocal nature of the interviews encouraged responsiveness and enhanced the accuracy of final interpretations. The researcher was both a listener and a participant, and the psychotherapists were invited into the interviews as collaborators in the process of discovery (Mishler, 1986). The role of the researcher in the interview process was to establish rapport that enhanced freedom of self-expression, to facilitate the exploration through inquiry into and clarification of the material presented, and to maintain focus with a sensitivity to the richness of expansion (Fortune, 1991).

The Interview Guide

A Preliminary Interview Guide (see Appendix D) was prepared in order to assure that basically the same information was obtained from all the interviewees by covering the same material. The interview guide provided topics or subject areas within which the interviewer was free to explore, probe, and ask questions that elucidated and illuminated that particular subject. The researcher remained free to build a conversation and to word questions spontaneously so as to establish a conversational style focused on the research topic (Patton, 1990). It was not necessary to cover topics and probe questions in a specific order.

The researcher began the interview with a general opening statement reiterating the purpose of the research, assuring confidentiality, and stating that the tape would be erased by the researcher when the data analysis was completed. The researcher then invited each psychotherapist to share his or her own experiences, feelings, beliefs, and attitudes. Open-ended probe questions were selected such that they did not presuppose which dimension of feeling or thought would be salient for the interviewee. Each psychotherapist selected from his/her own unique repertoire of possible responses. The researcher utilized this format to determine what dimensions, themes, metaphors, and/or words the respondants used to describe their experiences, attitudes, beliefs, and feelings.

The selection of the topics in the Preliminary Interview Guide (Appendix D) were based on the researcher's personal experience in the field and on a review of the relevant literature. In keeping with the constant comparative method of qualitative data analysis, new topics which emerged during the course of the interviews were added to the outline in order to inform further investigation. The intent is that there be flexibility within a system which allowed for an evolution of understandings. A systematic approach to interviewing promoted wise use of time within the interview and aided the analytic process.

Each respondent was interviewed once for approximately fifty minutes. The interview took place in a mutually convenient, private, confidential setting.

Preliminary Interview Guide Topics

The following topics aided the researcher in guiding the interview and provided a framework for discussion and elaboration:

- Psychotherapists' preferred type of patient and practice setting
- Psychotherapists' willingness to work with domestic violence patients
- Psychotherapists' understanding of the dynamics of domestic violence
- The effect of personal satisfaction vs. demoralization on their work
- Psychotherapists' concerns about potential for violence by the patient, towards the patient and/or towards the therapist

- Psychotherapists' personal feelings about the patients
- Psychotherapists' personal feelings about the clinical work
- Psychotherapists' beliefs in the effectiveness of their work with domestic violence
- The influence of professional training and education on clinical work with domestic violence

Methods of Narrative Data Analysis

The constant comparative method of qualitative data analysis (Glaser & Strauss, 1967; Strauss & Corbin, 1990)) was utilized for the content analysis of the interviews. This method is designed to aid the researcher in generating a theory that is integrated, consistent, plausible, close to the data and is at the same time in a form clear enough to be readily, if only partially, operationalized for testing in quantitative research (Glaser & Strauss, 1967).

The analysis of data encompassed two equally important dimensions. First, each individual interview was content analyzed (see Interview Coding Form, Appendix E). Content analysis consisted of: (a) the narrative data from each interview being divided into the topic areas; (b) the units transformed by the researcher into meanings that were expressed in psychological and phenomenological concepts, and (c) the transformations tied together to make a general description or summary of the experience in each case study. Secondly, data from the content analysis of each individual interview was cross-case analyzed, compared and contrasted to examine common patterns and variations in the responses among all the interview protocols (Fortune, 1991; Strauss & Corbin, 1990; Patton, 1990; Polkinghorne, 1989).

Procedure for the Data Analysis

Using the broad topics of the Preliminary Interview Guide (see Appendix D), the researcher began the collection of data for analysis. These topics provided a descriptive

analytic framework for inductive analysis (Patton, 1990). The patterns, themes, and categories of analysis were then generated from the data rather than being imposed on them prior to the data collection and analysis. The data of the interview were used as evidence to illustrate the concepts (Glaser & Strauss, 1967).

As each interview was completed, it was transcribed, and summarized, and emergent themes were immediately coded. Prior to each successive interview, the researcher briefly reviewed the summaries of each preceding original interview protocol in order to keep in touch with the data and to maintain an overall sense of continuity. As the interviews proceeded, the Preliminary Interview Guide (Appendix D) was subject to revision as new information was incorporated. Upon the completion of nine interviews, all the data were reviewed and compared, and the categories refined.

The patterns, themes, conceptual categories, and their properties that emerged in the inductive analysis of the data were represented in two ways, that is, as sensitizing concepts and as indigenous concepts. Sensitizing concepts were those that the researcher had constructed herself based on theory, literature, and her personal experience. Indigenous concepts were those developed and articulated by the interviewees (Glaser & Strauss, 1967; Patton, 1990; Polkinghorne, 1987). Coding and classification was based on both the sensitizing concepts constructed by the researcher (as represented by the topic areas in the Preliminary Interview Guide, Appendix D) and the indigenous concepts constructed by the interviewees (see Interview Coding Form, Appendix E).

In beginning the data analysis, the first interview was coded and analyzed for sensitizing and indigenous thematic categories and their properties (see Interview Coding Form, Appendix E). Each successive interview was treated in the same way, with the addition of a comparative process which began the search for common features and variations. Initial categories and their properties were tested by a return to the data. Categories were collapsed, expanded, and revised in a process which moved back and

forth between categories and the data (Glaser & Strauss, 1967; Fortune, 1991; Strauss & Corbin, 1990).

This process continued until patterns emerged as the thematic categories become saturated (Glaser & Strauss, 1967). At this point, cross-comparisons defined the major thematic categories and the criteria for classification, as well as the variations within these common themes. Addressing the study questions, hypotheses were formulated by interpreting the themes and patterns. The individual interviews were then reassessed and analyzed in terms of the categories that have evolved through this process of constant comparison. In this way, the fit of the categories to the data was assessed and the emerging hypotheses were tested. Categories were revised based on this assessment (Fortune, 1991; Glaser & Strauss, 1967; Patton, 1990; Strauss & Corbin, 1990).

As qualitative data do not lend themselves readily to summary, characteristic illustrations are presented (Glaser & Strauss, 1967). The data are presented as follows. First, a descriptive summary of the characteristics of the group of psychotherapists is presented. All necessary precautions were taken in order to maintain the anonymity of the participants. Secondly, the common thematic categories and sub-categories are discussed and illustrated with excerpts from interview protocols. In addition, the individual variations are addressed (see Findings, Chapter IV).

In the final chapter (see Discussion, Chapter V), the themes and their patterning are interpreted in terms of the study questions. The data analysis is discussed in relation to the literature in the field and in relation to the researcher's own experience. Hypotheses which were generated and suggestions for further study are made. The research study's significance for clinical practice, clinical research and training, and social policy and planning is discussed.

CHAPTER IV

FINDINGS

This was an exploratory study of the experiences of psychotherapists in their clinical work with battered women and battering men with specific focus on the attitudes, beliefs, feelings, and professional clinical and training experiences which influence their provision of psychotherapeutic services to such clients. The major questions addressed in this study were:

Question 1: Is it the case that some psychotherapists are reluctant to treat domestic violence patients and that such reluctance is not informed by clinical theory, practice theory, or family violence theory but is based upon personal biases (attitudes, beliefs, and feelings) about the phenomenon of domestic violence, battered women and battering men?

Question 2: What attitudes, beliefs, feelings, and experiences influence psychotherapists' decisions to avoid versus treat domestic violence patients?

The following areas served as the bases for developing the topics outlined in the Preliminary Interview Guide (see Appendix D): psychotherapists' preferred type of patient and practice setting; psychotherapists' willingness to work with domestic violence patients; psychotherapists' understanding of the dynamics of domestic violence; the affect of personal satisfaction versus demoralization on their work with this population; psychotherapists' concerns about potential for violence by patient or towards patient and/or towards the therapist; psychotherapists' personal feelings about these patients; psychotherapists' personal feelings about the clinical work; psychotherapists' belief in the effectiveness of their work with this population; and, the influence of professional training and education on clinical work with domestic violence patients.

The major findings of this study are grouped according to categories and their dimensions which arose out of the topic areas in the interview guide combined with indigenous categories which arose from the interviews. The categories are:

1. Description of the psychotherapists: Their practices vis-a-vis domestic violence

2. Definitions of domestic violence

3. Psychotherapists' attitudes, beliefs, feelings, and clinical experiences with men who batter

4. Psychotherapists' attitudes, beliefs, feelings, and clinical experiences with women who are battered

5. Psychotherapists' feelings, beliefs, attitudes, and clinical experiences unique to psychotherapy with domestic violence

6. Impact of the interview on the psychotherapists

Description Of The Psychotherapists: Their Practices Vis-a-Vis Domestic Violence

The respondants are described according to their group characteristics, rather than individually, for the purpose of protecting their anonymity. Data which were unique enough to threaten either the anonymity of an interviewee or of the clinical material presented have been isomorphically disguised. The respondants are described with respect to their identifying characteristics, levels of expertise in the field of domestic violence, changes in their practices over the years and the impact this has had on their work with domestic violence, and their training and personal experiences related to work with violent patients in general and domestic violence in particular.

Psychotherapists' Identifying Characteristics

Recruitment

The nine respondants were senior (i. e., having completed graduate level training at least five years previously), autonomously practicing psychotherapists. They were recruited through personal networking by the researcher and were not close professional associates of the researcher. They were chosen for their ability to function as informants who could provide rich descriptions of their experiences as psychotherapists. Experience in the field of domestic violence was not required for participation in the study.

Group Characteristics

Four of the participants in this study were men and five were women. All were caucasian. Their ages ranged from thirty six to fifty seven years old. Their years of post-graduate clinical practice ranged from seven to thirty-one years.

Professional Affiliation

Three of the respondants were clinical social workers, four were clinical psychologists, and two were psychiatrists. The group included two physicians (including one trained as a psychoanalyst), two masters level practitioners and five doctoral level practitoners.

Theoretical Orientation

The nine psychotherapists described their theoretical orientations in nine different ways, reflecting the theoretical diversity of the group. Theoretical orientations included: classical psychoanalytic; contemporary psychoanalytic/self psychology/trauma theory; psychodynamic; psychodynamic/ psychoanalytic; psychodynamic/self psychology; Jungian/self psychology; psychodynamic/ cognitive; psychodynamic/behavioral/cognitive; and, psychosocial/family systems.

Modes of Practice

All nine therapists provided individual psychotherapy to adults. Five therapists also offered couples therapy. Two therapists also practiced family therapy. Two therapists also worked with individual children in play therapy.

Practice Settings

All nine therapists were currently situated in private practice. Two therapists spent one hundred percent of their time in the private practice of psychotherapy. The other seven therapists spent from fifteen percent to fifty percent of their time working in educational and/or agency based settings in addition to their private practice.

Levels of Expertise in the Field of Domestic Violence

An indigenous typology emerged from the analysis of the data (Patton, 1990). The psychotherapists interviewed clustered into three levels of expertise according to their self-defined level of expertise, perceived levels of competence, the amount of training, and clinical, forensic, and teaching experience in the field of family violence. These clusters arose coincidentally from the analysis of the data. Differentiating levels of experience in the field sheds light on the range of responses reflected in the various thematic categories which describe the findings and is directly relevant to the study question regarding psychotherapist longevity versus attrition .

These levels are reflective only of experience in the field of domestic violence treatment and intervention. They are not related to overall clinical experience. They are not related to, and are independent of, actual numbers of years of clinical practice, gender, theoretical orientation, or professional affiliation.

The three levels of expertise in the field of family violence are: (a) high amount of expertise in family violence; (b) moderate amount of expertise in family violence; and, (c) least amount of expertise in family violence.

These levels of expertise are relevant to the presentation and discussion of the data. Psychotherapists who had different levels of expertise presented a range of responses during the interviews and, at times, had different perspectives on their clinical work with this population and different feelings, beliefs, and attitudes regarding the field. Likewise, psychotherapists within the same level of expertise would at times differ in their responses regarding the same dimension of experience. In addition, psychotherapists with high and moderate levels of expertise in domestic violence also had varying degrees of longevity in the field and, thus, were able to shed light on the study question of what contributed to longevity.

High Amount of Expertise in Family Violence

Three therapists described themselves as having special expertise in the field of family violence. They actively solicited referrals of domestic cases and perceived themselves as familiar with the dynamics of the problem and with the professional literature and clinical debates in the field. These three therapists not only provided clinical services to domestic violence patients but also engaged in a number of other activities in the field, including teaching, program development and organizational consultation, forensic evaluation, research, and writing. Each had been working in the field of family violence for over ten years, although none of them had ever focused their practices exclusively in this area.

All three had provided psychotherapy to battered women and battering men in the past and continue to be willing to provide psychotherapy to men who batter. One was no longer willing to provide psychotherapy to battered women because he feels he is unsuccessful in his treatment of them; however, he is active in providing other types of psychological services (such as forensic evaluations) to battered women.

When referred to in this document, this level of expertise will be variously described as "most experienced" or "very experienced."

Moderate Amount Expertise in Family Violence

These three therapists had sought out specific clinical and/or didactic training in the field of family violence. They had experience providing psychotherapy to domestic violence patients in the past. They did not, however, define themselves as particularly knowledgeable or uniquely competent in the field. Each of them would be currently willing to accept a referral of either a battered woman or man who battered into his/her practice.

When referred to in this document, this level of expertise will be described as "moderately experienced."

Least Amount of Expertise in Family Violence

These three therapists presented themselves as not having a particular interest or expertise in the field and as not being particularly familiar with the literature or clinical debates in the field. All three, during the course of the interview, said, in effect, "I've never thought of this before." Interestingly, these three therapists made unsolicited statements at the beginning of the interview that they had not seen patients involved in domestic violence; however, during the course of the interview, each of them described specific case vignettes in which domestic violence was indeed a factor. All three expressed surprise about this incongruity in their presentations. They speculated that perhaps it was due to either their own selective inattention to the issue or lack of training in the field. One of the therapists speculated, "an awful lot is 'in the eye of the clinician' in terms of what one is watching for or asking about." All three of these psychotherapists would be currently willing to accept a domestic violence referral into their practices.

When referred to in this document, this level of expertise will be described as "least experienced" or "less experienced."

Changes in Clinical Practices and Impact on Work with Domestic Violence

All of these psychotherapists had made purposeful, major shifts in the focus and setting of their clinical practices over the course of the years. All of them had chosen to move away from an exclusively agency-based or institutional-based practice earlier on in their careers and had chosen to establish a full-time or part-time autonomous private practice. Their age, their life developmental stage, and their stage of professional development appeared to be primary influences in these shifts. There were also shifts in psychotherapists' preferences for working with domestic violence clients. Some psychotherapists were eager to work with domestic violence patients, some were reluctant, and some were ambivalent.

All of the therapists, however, in spite of the range of their various predilections concerning willingness to work with a domestic violence clientele, state that they receive

relatively few domestic violence referrals into their private practices. Several therapists speculated that this might be due to the presence of specialized treatment programs in the area which attract these patients or to the economic restrictions facing potential consumers of private psychotherapy.

Natural Shifts in Practice Not Related to Domestic Violence

These shifts affected the type and number of domestic violence patients a therapist might see due to factors such as economic constraints or practice setting. The shifts were not made in reaction to clinical experiences with this problem per se, however, often a shift from agency to private practice resulted in the psychotherapists seeing fewer domestic violence patients.

Examples of this type of shift include one therapist who used to work in a county mental health clinic, then shifted to private practice where she initially saw more lower socio-economic patients. Now that she is more established, she prefers to limit her practice to patients like herself "who are educated, middle-class, working, and have families" but who "are pretty disabled anyway." She is also one of two female therapists who had children after they completed their professional training and mentioned that they began to see more adults who were parents after they themselves became parents. Similarly, a male therapist used to see primarily very disturbed people, mostly very borderline and psychotic individuals; this was early in his career while in his role as director of several outpatient and inpatient programs. Now he sees primarily neurotic patients in private practice who are suitable for psychoanalysis or intensive psychotherapy.

Actively Seeking Domestic Violence Referrals

Four therapists (three most experienced and one moderately experienced) actively seek referrals involving some form of family violence. One of these therapists laments the shift in her patient load since her shift from an agency-based practice in a setting devoted to treatment of sexually abusive families to a private practice setting. She would prefer to work with more children who are sexually abused and adults abused as children, but fewer

referrals come to her privately because of the financial cost involved in private therapy. Another therapist, although limiting the percentage of time focused on this issue in her professional life, still actively seeks family violence referrals.

Two of the most experienced therapists share the professional identity of a practitioner who actively seeks referrals of "difficult" patients. Battered women and men who batter are one type of "difficult" case with whom they work. Both of these therapists have several characteristics in common. Both have been involved in complex forensic work as expert witnesses in legal cases involving battered women. Both share similar professional background in community mental health and correctional settings both prior to and during their training as psychotherapists and have positive things to say about working with such clients. Both have maintained these interests through such activities as teaching and consultation even since their shift into private practice. Both describe themselves as deriving narcissistic gratification out of their work with cases that other therapists find difficult.

One therapist who actively seeks referrals of difficult and domestic violence patients says,

> I tell colleagues that if you have someone who gives you nightmares, or severely disturbed borderline people, or people involved in violence, I'm happy to work with them.

This therapist relates his interest in treating domestic violence as having evolving from his early career interests in social policy, stating that,

> Implications for how does [psychotherapy] effect society seemed as important to me as an individual model of psychopathology. I've always been interested in a larger perspective than [just] examining people's intrapsychic phenomena, which is why I prefer working with couples more than anything else. . .My socially concerned political leanings, that is those kind of politics which have always been more concerned with family, community, and society. . . [differentiate me] from colleagues for whom individual psychopathology is the much more central, preoccupying theoretical orientation. . . I am especially interested in working with people who have hurt other people, for two reasons: one is the narcissistic satisfaction of 'most people can't do this well, I believe I can," and [secondly], if I do good work, not only do people live better lives in terms of psychological adjustment...but they don't cause damage in society...and I have effected a sense of decency in the world with regard to other people who will not be victimized.

Interestingly, this therapist does not now accept referrals of battered women as psychotherapy patients because he feels he has been unsuccessful in his treatment with them. However, he does continue to work extensively in the forensic arena with battered women.

The other therapist described himself as "not reserved in terms of seeing violent folks." He too traces his interest in working in the field of domestic violence to his work beginning in the 1970's with the feminist theory and his interest in, and clinical work with, issues of gender politics. While participating in men's consciousness groups, he heard other male group members

> . . .talking about anger and how it was manifested toward significant others, especially women. I remember being really struck by that because these were men that I knew and I liked. I would have never suspected that they had trouble, or that they would have beaten or grabbed or attacked. . . I couldn't imagine that people not only thought about these things but acted it out. Coincidentally, as I became more sensitized to the phenomena, I recognized it as a factor in my couples work. . . so I began working with men around violence and around impulse control issues. At that point in time, no one had been talking about it, it was sort of a closet phenomenon. [I was surprised about what I was hearing] because growing up, nobody I knew, no families that I was aware of, had violence as part of their lives. It was really not something I expected to see or hear about.

This therapist described the personal satisfaction he derives from the work.

> I sort of like the image of being able to take people that other people won't see. . . that's always been something that's appealing to me. My own ego sort of likes that, so if someone calls up with a problem that other people turn away from I'm inclined to say, 'Sure, come on!.'

<u>Retreating from Domestic Violence Work</u>

Three therapists (two moderately experienced and one most experienced) have purposely shifted their practices away from a sub-specialty of family violence over the course of the years. Their reasons range from a desire to move away from work with "dysfunctional types" to feelings of being overly stressed by the work.

One moderately experienced therapist related this to her own personal psychological changes. She stated:

> I prefer to see people who are high functioning now, partly because of my own changing. I used to be very identified with actually more dysfunctional types of

> specialties including domestic violence, suicide, sexual abuse. . . I've actually wanted to move away from those specialties somewhat to a broader range of people who are not quite so dysfunctional.

A very experienced therapist whose background was in treating children and adolescents in inpatient settings had decided to limit her teaching and practicing in the field of sexual abuse and family violence to at most fifty percent because "it was very stressful and demanding of a lot of time and energy." She is still, however, actively involved in the field.

Passively Encountering Domestic Violence Clients

The three less experienced therapists had never actively sought out, nor intentionally avoided, work with issues of domestic violence. They were willing but ambivalent about accepting a referral of a domestic violence case. They all stated they had no experience with domestic violence, in spite of the fact that they described such cases during the course of the interview. However, they all spontaneously described an unplanned shift in their practices over the years to include more issues of sexual abuse (both adults abused as children and/or children who were abused) and chemical dependency. These therapists were not sure if the changes in the nature of their patients' presenting problems were a reflection of their own capacities to be more sensitive to these issues in their patients' lives, or were a reflection of their patients' capacities to bring these issues more directly into their psychotherapies, or were a reflection of changes in the social climate. As stated by one therapist, "I don't know if the change is in me or in the clients . . . much of what is seen is 'in the eye of the clinician.'" Another therapist wondered if the absence of domestic violence in the lives of her patients was "maybe like incest was ten years ago. None of us asked about it. It was there but we were missing it." She wondered if perhaps there was a higher incidence of domestic violence in the lives of her patients than she knew but "Maybe I don't know how to make it okay for people to talk about."

Actively Avoiding Domestic Violence Clients

It is interesting that this category, although theoretically existent, is not filled. Although one of the therapists does not provide psychotherapy for battered women, he does work actively and eagerly providing other types of psychological services to them. In addition, although three of the psychotherapists are shifting a focus in their practices away from a sub-specialty in domestic violence, none of the therapists in this study would actively avoid a referral of domestic violence. However, they would approach such a referral with differing degrees of enthusiasm, as will be discussed shortly.

Training Experiences Related to Issues of Violence and/or Domestic Violence

All of the psychotherapists were asked about the amount of, and impact of, training they had received in the field of domestic violence and in the prediction , prevention, and management of patients' violence in general. Graduate, post-graduate, and "on-the-job" training opportunities were discussed.

Graduate Level Training

All of these psychotherapists completed their graduate training prior to 1984. None of the nine therapists had received any formal training in the field of domestic violence during their graduate training in social work, psychology, psychiatry, or psychoanalysis. In fact, all of the therapists stated that very little, if any, graduate education had been directed towards even the issue of violence in general.

One very experienced psychotherapist described the process of initially recognizing this lack of clinical training:

> As I became more sensitized to the phenomenon I recognized it as part of my couples work. I realized I hadn't been trained to work with it. I didn't know what to do with it. The things I was doing weren't stopping the violence. I thought, my goodness, what I'm doing should be stopping this, why isn't it?

A psychologist who currently specializes in the treatment of family violence, when asked whether there had been any formal training in the field during graduate school in the mid-1970's, stated emphatically,

> Oh no, no, no! Nothing! In graduate school, I don't remember the phrase 'domestic violence' or 'battered women' used. I don't remember at all anybody having any interest or suggesting that when you get out of school this is an issue you may confront professionally.

A psychiatrist attributed the lack of education in medical school in issues of family violence to "institutional denial. . .the people in charge denying that [family violence] was real. . .just as they denied the incidence of incest and drug abuse in families."

A social worker reiterated this experience, stating, "I don't think that it was ever mentioned in any formal training activity I've been in but then neither were incest nor chemical dependency."

One of the psychotherapists did complete an internship in a community- based, advocacy agency for battered women during her graduate school training. There she was exposed to a feminist political interventionist perspective which denigrated psychotherapy as an appropriate intervention. Unfortunately, her graduate experience did not assist her to function in the role of psychotherapist and, in fact, left her with a legacy of guilt and reticence about admitting that she was practicing "politically incorrect" insight-oriented psychotherapy with battered women.

The psychotherapist trained as a classical psychoanalyst speculated that the lack of psychoanalytic training devoted to issues of domestic violence was due to the fact that

> Issues of aggression are much less dealt with than sexuality...analysts have a much more difficult time with manifestations of aggressive conflicts than they do with manifestations of sexual conflicts... Kleinian's are more attuned to aggressive conflicts than traditional Freudians...but you would think that given the ubiquity of the problem that more analysts would remark on it...my guess is that one of the fears may be that in writing about it in any meaningful way, one would reveal some things about one's self that might be difficult to reveal.

Post-Graduate and "On-the-Job" Training

Most therapists who became knowledgeable in the field coped with this dirth of formal training by educating themselves. They talked with professional peers doing similar work, organized training conferences for themselves and other professionals, and read, wrote and discussed cases with consultants (who were often supportive but untrained themselves). Most of their clinical skills were developed while working "on the front

lines" and actually doing the work of psychotherapy. Only one moderately experienced therapist received post-graduate clinical training in sexual abuse within the agency in which she was formerly employed. This training, however, did not encompass spouse abuse.

Only the three very experienced therapists described themselves as comfortable in the knowledge base that they draw upon when working with domestically violent families. These are also psychotherapists who are active in the professional community training others in the field. The others felt anxious and inadequate when approaching the clinical work. One moderately experienced therapist commented on her inner dialogue while recently attending a court sponsored workshop on family violence:

> A judge was talking about batterers and all this kind of stuff and I'm thinking, 'Geez, I don't really know that much'...there's this piece over here, and that piece over there, and 'Oh [sigh], there's so much to know!', and I don't really know enough.

It is interesting to note, however, that this same therapist, in spite of her self-described lack of knowledge, also presented a case vignette in which she intervened appropriately and, by her own definition, "probably saved the woman's life."

Training in Prediction, Prevention and Management of Violence

It appears that none of the therapists received adequate training in the prediction, management, or prevention of violence in clinical patients in general.

A psychiatrist witnessed several incidents of staff being assaulted by violent patients on inpatient units during psychiatric residency training. This psychiatrist described training as "a huge lack....and you know it maybe even mostly didn't come up with psychiatric people in the psychiatric ward."

Another very experienced therapist sheepishly laughed in response to the question about graduate school training; she explained,

> I remember more the lack of clear help or guidance. I can remember asking a supervisor 'Should I sit closer to the door?' [when interviewing a potentially violent patient] and I remember this particular supervisor, not at that moment, falling asleep on me.

Personal Experience Influencing Work With Domestic Violence

None of the therapists were directly querried about their personal and/or family history with domestic violence. However, two of the nine therapists spontaneously raised issues related to their own personal life or family history that they felt had influenced their work in the field of domestic violence. The other seven respondants did not volunteer information about their personal background.

One therapist who was particularly sympathetic to the plight of battered women spoke of a sister who had been battered by her husband. This therapist and other siblings had futilely tried for over a decade to convince the battered sister to leave her marriage which had finally ended when the violent brother-in-law had a psychotic break. As the therapist stated, "The issue became loaded for me, not only professionally, but because of the personal component." This therapist has "tremendously passionate feelings" about the impact that witnessing the sister's battering has had on her children. These children, now functionally successful adults,

> For years both saw their father battering around their mother...if you met them you would speculate that something happened to these young women. . .there is something that seems hurt and wounded about the way they talk and look.

A second therapist described a belief that experience with this therapist's own father's expression of anger, although not physical violence, may have "unconsciously" influenced an interest in the field.

> My father had a bad temper and, upon reflection, scared me more than I thought at the time. I was a pretty active kid and coped fairly well with it...it never got into physical proportions...but it scared me. It was something I think I'm looking to conquer as well as to not have kids have to suffer through. I normally think of myself as quite controlled and am intrigued somewhat with the flip side. What happened to my aggression? I think it kind of got sat on as a result of my experience with my father.

Clinical Experience with Fear Inducing Patients

One of the commonly reported concerns of psychotherapists that has been reported to this researcher in regard to their reluctance to work with domestic violence patients is

concern about their own risk for assault by domestically violent male patients or the violent male partners of battered women. Although much has been written about assaults on therapists in general, there has been no research reported in the literature regarding psychotherapists' assault(s) by domestic violence patients themselves or their significant others.

All of the therapists were asked about their experience with physical assault by patients. They were asked if they had ever been, or felt afraid of being, verbally or physically threatened or assaulted by a patient. If so, was this patient a domestic violence patient? How had this effected their work with domestic violence patients?

None of the psychotherapists in this study had been physically assaulted by an adult patient. Three of the therapists (two female and one male) who had histories of working with children had been assaulted by child patients. None of the psychotherapists had ever been physically or psychologically threatened by the male partner of a battered woman. All of the therapists, however, screened out male patients who were violent outside of the context of their primary relationship because of concerns about patient management and also because of their concern about the man's potential for assault on the therapist.

During the interview, four of the five female therapists spontaneously raised concerns about their own fears. They were fearful not only of the battering male patient but also of the battering spouse of the female battered patient. None of the four male interviewees raised concerns about their own fear of being assaulted.

Definitions of Domestic Violence

The interviewees ways of defining domestic violence are important in this study for several reasons. First, each psychotherapist's definition of domestic violence will influence whether or not he/she defines a particular case in his/her practice as a "domestic violence case." Secondly, there is also a significant debate in the literature concerning limiting the definition of domestic violence to only physical behaviors versus expanding it

to include an emotional climate of control and intimidation in the relationship. Some researchers also argue for the inclusion of psychological and sexual abuse in the definition. Thirdly, it is important to ascertain whether interviewees believe that single episodes of physical abuse are sufficient to qualify for a definition of domestic violence or whether repetitive episodes are necessary.

Respondants' definitions of domestic violence were frequently offered spontaneously and were usually implicit in the case vignettes mentioned by the interviewees over the course of the interviews. Respondants were also explicitly asked about their definition at an appropriate time during the interview.

Strikingly, all of the interviewed psychotherapists spontaneously included the dimension of psychological and verbal violence in their definitions of domestic violence. All of the therapists perceived psychological abuse as occurring more frequently in the lives of their patients than physical abuse. Rather than perceiving psychological abuse to be a component of physical abuse, therapists typically described physical abuse as a more severe manifestation of on-going psychological and verbal abuse. They all differentiated psychological and verbal abuse from the conflicts, arguments, or disagreements present in other non-abusive, although conflictual, relationships. They all considered it seriously damaging to the psychological well-being of the battered woman.

Most of the respondants failed to mention more severe forms of violent behavior that is, in this researcher's experience, common to domestic violence situations. This could indicate that the levels of domestic violence these therapists see in a private clinical practice are not as severe as seen, for example, in a legal-justice setting or in a program specifically focused on domestic violence. Forms of domestic violence that are now incorporated under legal definitions include such physical acts as keeping someone prisoner, kidnapping, threats with a weapon, unlawful entry, and sexual assault. Psychological intimidation or control may also be maintained by stalking, threats against children or relatives, violence against pets, or destruction of property.

Only one very experienced psychotherapist who has been working in the field for thirteen years included some of the more severe forms of violence in his examples, including homocide of the battered woman. By his own description, his definition of domestic violence has broadened over the years. "It used to be more succinct than it is now." What he has been "most impressed with working in the field is the diversity." He has observed many different forms of violence, in terms of frequency and class differences. "I've had men who don't really hit as much as they have ripped every piece of her clothes in the closet and were violent to her property, her dogs, cherished things of hers." But his definition of domestic violence "still really involves something where it's moving from verbal yelling and screaming to a physical manifestation... hitting, slapping, grabbing...any single incident that puts it at another level." His definition includes single episodes of abuse and is quite inclusive. He describes physical abuse, psychological abuse (destruction of "cherished things"), verbal abuse ("yelling and screaming") and destruction of personal property and pets.

One therapist, trained as a classical psychoanalyst, defined abuse as physical, psychological, and verbal. He clearly stated that his definition of domestic violence was "any striking, anything physical, even if only one time and includes verbal abuse as well." This therapist characterized verbal abuse as "name calling, characterizing the other person as contemptible, things that undercut respect and dignity, that violate reality, that undercuts a person's sense of worth, particularly when accompanied by very angry affect." He cited as an example a case in which the husband of one patient refers to her as "dumb, stupid, idiotic, and sadistic". The patient is "certainly not dumb, in fact she is brilliant...and [the husband] is probably doing a fair amount of projecting when he is saying she is sadistic." His inclusion of "violating another person's reality" is an example of the type of psychological abuse labeled "," a term which originated after the classic movie of that name. It is also a psychological maneuver discussed in the psychoanalytic literature (Calef

& Weinshel, 1981), its purpose being to discomfirm the recipient's reality and make him/her feel "crazy."

Similarly, a moderately experienced therapist states she works a great deal with relationships "where there's non-physical abuse like verbal and emotional abuse" characterized by "constant control, humiliation, belittling, swearing, and name calling." Her definition of physical abuse "starts at pushing and shoving and goes all the way up." In addition to the physical dimensions of abuse, she also focused on the demeaning aspect of verbal abuse.

A less experienced therapist who works a great deal with children states that her definition of domestic violence is "any kind of physical violence perpetrated on another person." She considers screaming abusive language to be domestic violence, similar to parents who scream "You dirty little f-----!" or "God damn you! " to their children. By her definition, in these situations, the abuser is "out of control, ripping the other person apart...It is the impact on the other person which is really destructive." The language is abusive because, as she aptly described, it "demeans, belittles, and demoralizes the other person who begins to believe hearing time after time that they are what's being said." This therapist described a dynamic of the Battered Women's Syndrome: women believe they are all the negative characteristics which have been ascribed to them by their abusive mates.

In contrast to the above description, one less experienced therapist stated that he "could not think of an instance of where I'd seen a male abuser" because he had not worked with a case where there had been an on-going pattern of violence where "people regularly get beat up." He had worked with cases, however, in which there was "minor violence, such as an occasional slap or hit." Although he did state that this was "clearly violence," he did not define the perpetrators of "minor violence" as "male abusers." This psychotherapist's definition incorporated the variable of frequency and severity. He defined less frequent ("occasional," not "regular"), less severe ("minor violence," "slap,"

"hit") physical behavior as "clearly violence" but not as abuse. It is an interesting semantic distinction.

He, however, was clear in his inclusion of the dynamic of psychological abuse into his definition of domestic violence. He defined it as an "unrelenting attempt to control, regardless of the cost to the other person, with a complete inattention to the other person's emotional or reality objections" and as an "obsessive, rigid, moralistic attempt to assert a significant degree of dominance in the relationship."

Psychotherapists' Attitudes, Beliefs, Feelings, and Clinical Experiences with Men Who Batter

The psychotherapists were encouraged to speak about both their personal thoughts, attitudes, beliefs, and feelings and also their professional stances, clinical formulations, and behavioral responses with domestic violence clients. The interviewees tended to group their comments into discussions of either men who batter or women who were battered and, hence, their responses will be presented accordingly, beginning with men who batter.

Their responses regarding men are discussed according to the two sub-categories which emerged from the data: (1) assessment criteria for men who batter; and (2) forming an alliance: psychotherapists' thoughts, feelings, and reactions to men who batter.

Assessment Criteria for Men Who Batter

The psychotherapists spontaneously focused on the assessment and initial stages of treatment regarding the therapy of men who batter and described the thinking and decision making process in arriving at a decision to accept a man for psychotherapy. The psychotherapists' willingness to treat a particular man who battered was influenced by the interface of standard differential diagnostic criteria with specific criteria related to battering men, such as the ego-syntonicity of their behavior, the authenticity of their desire to change, and their ability to control their violent impulses. Their willingness to treat was further influenced by their attitudes, feelings, and reactions to a specific man, such as their

feelings of antipathy toward the man, their fears of physical assault, and the therapist/patient pair's capacity to form a therapeutic alliance.

Willingness to Accept Referral

All of the therapists were in general willing to accept referrals of men who battered. None were averse to considering such a referral. Two psychotherapists who defined themselves as liking to work with difficult patients would, however, approach the opportunity to work with a battering man with eagerness. Others initially felt some ambivalence, if not reluctance. (These feelings, pre-judgements, and biases about men who batter will be discussed below). Regardless of the differences in their initial feelings, all of the psychotherapists would be willing see the men for an initial assessment.

All of the therapists stated that their willingness to accept a referral of a man with a history of wife-battering depended on how the man presented himself during the initial contact. All made their decisions about whether to accept any particular referral on an individual case-by-case basis.

Differential Diagnosis

All of the therapists based their evaluations of the appropriateness of psychotherapy for the male batterers on standard diagnostic assessments made according to their various theoretical orientations and professions. None of the therapists would accept a violent man who was psychotic. Further evaluation was based upon the psychotherapists perceptions of the clients' behavior in regard to the following categories: Syntonicity of Behavior and Authenticity of Desire to Change, and Ability to Control Violent Impulses.

Syntonicity of Violent Behavior and Authenticity of Desire to Change

A factor in their clinical assessments of the potential male patient(s) was whether the violent behavior was experienced as ego-syntonic (and thus was deemed more diagnostically socio-pathic) or whether the behavior was experienced by the man as ego-dystonic (and thus some level of guilt was present). Only two of the most experienced therapists reported having seen socio-pathic men (recall their backgrounds in criminal

justice system). All the other psychotherapists were clear that the man had to have some sense of responsibility for his behavior in order to be considered appropriate for psychotherapy.

All the therapists stated that the man must convey a sense that he genuinely wants to change his violent behavior and get it under control. Without this sense, even psychotherapists who are eager to do the work would not be willing to work with a man who batters. Certainly psychotherapists who are ambivalent or reluctant to work with a battering man would refuse to treat a man who did not appear to genuinely want to change.

One very experienced therapist who welcomes referrals of difficult patients described his process of assessing a battering man's authenticity of desire to change and the ego-syntonicity of his violence:

> I'm happy to work with any man who has been involved in battering who in the first consultation gives me a scintilla of a reason to believe that there is some motivation to change. I'll work with anyone who is motivated who is violent. . . I ask a lot of questions about what they've done to women and compare it to their arrest record to determine how they feel about it. To what degree do they think the woman is responsible? Why, if at all, they'd be inclined to change. I'm listening as much for the music as to the words, for facial gestures, intonation, and voice--because a lot of guys know the words. Lawyers say, 'Tell him that you want to change.' I think I'm pretty good at distinguishing who's legit and who's not. . .and journalistic reportage [sic] doesn't make it with me. Something that indicates an observing ego, such as 'I've looked at myself and I just don't like the fact that I slap my wife or girl friend around...I really want to stop' is the scintilla I need, even if it's a weak motivation...something other than self-justification, flattery, narcissism, and grandiosity, passive-aggressive defenses ...something that suggests that there is a possibility of constructing a therapeutic alliance. When I don't see that, I don't bother.

Another very experienced therapist described how her initial reluctance to accept a referral of a battering man might be tempered by her assessment of his desire to change and the ego-dystonic quality of his violence. Her response would be,

> On first impulse, to say that I am less inclined to want to work with that person currently. Yet, I have to qualify that and say that it really depends on what I feel is coming across from that other person in the moment. If a client were to say to me: 'I am really very, very troubled that this is happening and I've got to get this under control, and I'm scared and need help and I don't know how to deal with this'...that would influence me more in the direction of taking the client...than if the client were to say 'I've got this problem and I know it's a problem'...but seemed really walled off from alarm about it.

A less experienced therapist also described how his reluctance to accept a referral of a man who battered was affected by the man's presentation. "It would very much depend on how he put it to me. If he seemed to convey a sense that he realized he was out of control and wanted to understand what that was about, I'd be interested."

Ability to Control Violent Impulses

Impulse control was spontaneously raised as an assessment criteria by all nine therapists. If the man was violent to others outside of his primary relationship and/or if he was violent in serial relationships with women, the psychotherapists believed that the man's ability to work in psychotherapy on controlling his violence was limited. They were reluctant to accept such a man for psychotherapy.

One therapist, who specializes in work with domestic violence and likes to work with difficult patients in general, feels fine about working with a man whose violence has been circumscribed within the relationship. Nevertheless, he would consider a man who is violent outside the relationship as too troublesome. He frankly stated,

> My first thought would be: 'How out of control is the violence?' If it's very out of control, if he's loosing it both externally as well as just within the couple, if it's a more generalized impulse control disorder, frankly, if this is really going to be a real pain in the ass, then I probably won't see him. I will refer him someplace else.

Another less experienced male therapist stated that if he were to get a a referral of a man who battered he would feel "wary--on both theoretical and personal grounds. The first thing that would leap to mind was poor impulse control--and that can be so problematic in a successful analytic therapy. This is the therapist who went on to say, " But it would depend on the way he put it to me. If he seemed to convey a sense that he realized he was out of control in that particular way and wanted to understand what that was about, I'd be interested." Thus his concerns regarding impulse control could be modified by his perception of the prospective client's authenticity of desire to change.

A very experienced therapist related the issue of impulse control and the issue of ego-syntonicity of the man's behavior.

> If the guy has done it with only one woman, there is a better prognosis for change. . . if he's done it with three, four, five women, it becomes internalized, it's not defensive. . .he doesn't recoil at his own behavior.

Forming an Alliance with Men Who Batter:

Psychotherapists' Feelings and Reactions

Antipathy Toward Violence and the Batterer

All therapists struggled with their negative feelings about violence in general and about the men who perpetrated violence against family members in particular. They generally tried to be conscious of how these feelings might effect their clinical decision making process. They often structured their responses by first describing how they would feel about a patient or a situation, and then describing what they actually did. Their feelings about a client were either kept separate from the work (such as feelings of antipathy) , or integrated into their clinical assessment of the client (such as feelings of fear).

A less experienced therapist described her struggles with the issue of violence:

> Violence is very hard for me. It's something I avoid as much as I can...but there's a voice in me that always says, 'I should be working on this'... not to be a better therapist, but just for my own comfort in the world...because there's so much goddamn violence I can't avoid it, and I have to find ways to desensitize myself.

A moderately experienced female therapist apologetically acknowledged that her initial feelings about a male batterer would be negative. Her feelings toward a man who batters might be similar to her initial feelings about male sexual offenders. "There's a part of me where I feel--I know this is not good to say--I feel that they do not deserve any treatment. They should just be incarcerated and punished for what they've done." Despite her frank acknowledgement of these negative feelings, she then went on in the interview to describe how she had initially assessed a male batterer for therapy; she then described a two year course of successful individual and couples therapy with him and his abused wife.

Another very experienced male therapist spoke of the need, echoed by several respondants, to overcome his countertransferential hate towards the man during the course

of the work. His feelings about the battering man are related to his feelings about children who witness parental violence.

> The image of children watching the two people that brought them into the world with the assumption that father and mother presumably love each other most and that's what people do when they love each other most...is appalling to me...it's like revolting and overwhelming to me...it's one of the things I have to come to contend with with any battering man. I would have to come to grips with the fact that a part of me hates him...I just think it's a terrible, terrible emotional crime against children.

Similarly, a less experienced therapist described initially ambivalent feelings about treating male abusers. He states that he "would probably gulp and not be real excited about it. It isn't something I would look forward to with a great deal of comfort or confidence." His initial reaction would be related to his own discomfort about anger, conflict, and violence.

> It would have to do with my own discomfort with violence and potential for violence, with my own anger and with conflict situations...clearly there's conflict being presented overtly in such a case and I'm not real comfortable with conflict.

Fear of Physical Assault

There was a difference between male and female psychotherapists concerns about their vulnerability to assault by male patients. Women were generally concerned about their own safety, whereas men were not.

Four of the five female psychotherapists reported that they would initially feel some concern for their own safety if they were to receive a referral of a man with a history of domestic violence. They would be concerned both about the possibility of his losing control during the sessions and about his harming or harassing them outside the office.

A less experienced female therapist reported her concern about the man's impulse control:

> I think of someone who batters as very explosive and unable to contain those impulses or channel them into non-physical directions...I imagine that I might be afraid. That might be one thing that would cross my mind...afraid of violence against me...so when they're sitting here in a civilized way talking with me, it's a thin veneer in my book, but that's what I would worry about.

A moderately experienced female therapist had seen male batterers in the past, but only in an institutional setting, not in her private practice. She stated she "would probably be reluctant because of fears for my own safety" to work with a male batterer in private practice.

Another moderately experienced female therapist dealt with her concerns about safety by seeing a man who battered for three initial assessment sessions. She used the office in a building which was occupied in the late afternoon and purposely scheduled his appointment at this time. One of the criteria she utilized in her decision to work with the man was "how scared I would be with him and whether there was something about him that would make me feel very uncomfortable."

Only one of the male therapists spontaneously raised the question of fear, somewhat as an afterthought, saying that "such a guy could be scary". Even he, however, was not concerned about issues of personal harm. One less experienced male therapist stated his fear is not for his own safety but for the potential for harm to others.

> My fear has to do with whether or not more concretely violence can be controlled, whether they can each be protected from violent outcomes or physical consequences. Usually clients don't have physical consequences to their interactions and it ups the ante a little bit.

The other three male psychotherapists never raised the issue of concern about their own safety and were somewhat surprised when the interviewer inquired about it. Two of these male therapists volunteered that they could appreciate why a female therapist might have these concerns working with a male patient with a history of domestic violence but did not have these concerns for themselves. A very experienced male psychotherapist described one instance of a male batterer who

> began to pace around my office and started talking louder and louder. I said to the patient, 'I'm really concerned about what's going on right now. I wouldn't want to get hurt myself and I wouldn't want you to have any more troubles than you already have, and it feels to me like you're really escalating. I wonder if we can talk about this in a way that would help you settle down.' We figured it out together. He thought I was criticizing him and that I didn't understand how his wife forces him to [be violent]. Other than this one instance, I don't ever remember being frightened of anyone involved in domestic violence.

This therapist is not afraid of domestically violent patients because he feels he has "very good clinical instincts" and his "social definition is most often that of a person who can help them if we can work together. So they have no motive or inclination to want to intimidate or menace me." He is only afraid of paranoid schizophrenics. He did recall, however, that several women colleagues had reported to him that they would be reluctant to work even with battered women for fear that the male batterer might harass them. He did not have those concerns himself.

Another very experienced male therapist also described himself as "real comfortable with the streets, having done a lot of work with very tough people. I sort of think of myself as a bit street wise and I have a good sense of how far to push somebody." He has never been physically assaulted, but he described two instances, both with male patients, that had frightened him. One situation involved a male batterer with whom he had been working individually. He saw this patient in a conjoint session with the woman with whom

> he tended to blow up. I saw how quickly he revved up and how revved up he was and asked him to take a walk and come back later. He did, but I was frightened at that point. I never had seen that in the room. You don't see how quickly volatile it can get unless you work with couples.

Another instance involved a male patient ,

> A small man, more a character disordered person, who, when he felt emotionally injured, could really rev up and needed to be in control. He would say, 'You have to do this now'... and I generally complied. Sometimes I think I erred a little bit and over-complied. It was never a threat to me personally. It was just in the interaction. It was a bit of the heart starts to beat a little bit and you go, 'Whoa. What's going to happen next!' I've never been physically touched or attacked.

He did volunteer that he knew of a well known woman expert in domestic violence who was attacked by a man when she was working in a prison setting. He also had an adolescent patient destroy property in his office and pay for the repair.

A less experienced male therapist reported that his concern about personal safety "is more theoretical than real." Although he had experience many years ago working in hospital clinics in which he was concerned about his safety, in his private practice setting he "can't remember the last time I saw somebody and I was concerned about my own

safety." He is not concerned because, in spite of the physical isolation of his private office, he does not believe a "very dysfunctional" potentially violent person would be in his private practice. He also speculates that his lack of concern about vulnerability to assault

> is a function of being a man. I envision a woman being a lot more anxious and think a female therapist would be at high risk because the transference issues that would be experienced by the patient would be more similar to those evoked by the victim. It has to do with gender socialization. Men who are so troubled in their sense of their selves are more likely to respond to the socialized authority of a man than a woman.

This therapist also commented on his

> recognition that the container of a private practice office may not have the institutional authority to contain the impulses and violence in a way that protects the health and safety of either or both parties.

A less experienced male therapist had also never been assaulted, in spite of his many years working in inpatient settings. Many years ago, however, he worked with a male batterer who was intermittently very paranoid and bought a gun which he threatened to use on his wife, his wife's lover, and the therapist. The therapist handled it within the context of the treatment. "It was scary." When asked if this experience influenced his willingness to treat another domestically violent man, he said "Golly, no. This was a professional man, nobody would ever guess he had this side to him, and I sort of liked him because he was bright and articulate and very passionate."

Forming An Alliance: The Convergence of Patient and Therapist Factors

One of the most challenging aspects of work with men who batter was seen to be forming a therapeutic alliance. It appeared that this is the arena in which the assessment factors relating to the man intertwine with the therapist's feelings about the man. For instance, the therapist's antipathy toward the man is balanced by his/her perception of the man's authentic desire to change. The therapist's fear of the man is tempered by his/her perception of the man's capacity for impulse control.

A very experienced male therapist, who "is happy to work with any man who has been involved in battering who in the first consultation gives me a scintilla of a reason to

believe that there is some motivation to change," says that he must "see the seed of a therapeutic alliance in session one; when I don't see that, I don't bother."

Another very experienced male therapist who solicits referrals of men who batter approached the task of forming an alliance as a challenge. He differentiated between forming an alliance with men who were court mandated into therapy and men who sought therapy voluntarily. The court mandated men were

> very rigid, very defended. . .Most of the men didn't want to be where they were, which was in therapy talking to me. . .For me, that is a fascinating challenge to get through, to find the small tightrope that they'll let you walk across to meet them. Sometimes they cut it, so that you're left hanging and falling, but if they come back it generally works. So that's a challenge.

In his metaphorical language, he described reaching out to the men, rather than being daunted by their dislike of talking to him initially. In contrast, forming an alliance with men who sought therapy voluntarily was not so difficult:

> They know they're in trouble. They're feeling scared. They're feeling hopeless. They're coming in really having something that they want to fix, something very specific and, if they can start feeling more in control, even a little bit, they start to feel more hopeful. . .What really kind of gets men is 'I want to feel more in control.' If you could hook men with a macho theme of 'you're not in control here,' I want you to get more in control in this one...All of their training is to be more in control, feeling out of control is really anathema to their own image of themselves.

The alliance here is formed through the therapist's ability to help the man start to feel in control and change from feeling hopeless to feeling hopeful.

A moderately experienced female therapist described a male batterer who initially dropped out of individual therapy after six visits and returned a year later, with his battered wife, for two and one-half years of successful couples therapy. She spoke of forming an alliance with this man by setting clear limits on his behavior without shaming him and without accepting that he "was a horrible person." This was in spite of her statement that her initial feelings about an abuser might be negative and that she might feel that he did not deserve treatment. She speculated that he was able to return to therapy with her because:

> I had sort of passed some test. I wasn't put off by him. I had not said I wouldn't want to see him. He presented the worst of himself and it was a kind of 'truth or

> dare' game. He had a tremendous sense of shame about him and in the moment he became aware if it, he would feel very threatening and then be very aggressive...Was I going to be be able to put up with it or not? Was he able to scare me into believing what a really horrible person he was or would I take the bluff and work with him? I just set clear limits, even though he tried to turn the limits into a test of do I like him or do I not like him.

The alliance was formed because she did not act on her initial feelings to punish him and did not treat him with contempt as he had anticipated.

A very experienced male therapist clearly articulated how the therapist's antipathy towards a battering man can be ameliorated by the man's desire to change. In order to form an alliance, this therapist has to deal with his feelings of hate towards the man:

> the intention and desire on the part of the man to move towards being a human being who doesn't abuse others keeps my hatred in check. [There is] an unconscious process... in which the man who batters, in addition to behaving violently, ...must also telegraph or communicate 'I don't endorse that behavior' and 'what ever in you, Dr. X, may elicit anger and hatred toward me is, to some extent, understandable.'

This therapist also utilizes empathic identification to deal with his hateful feelings.

> I've had so many things in my own life that I'm embarrassed about or ashamed of, that I've tried to work through, that I try to shift roles, and imagine that if I were the patient, telling the therapist about behaviors that I didn't like in myself but I wanted to change, my hope would be that the therapist wouldn't simply hate me, or have hateful feelings towards me, but would be able to overcome those feelings enough to use his professional training to help facilitate my moving to becoming the kind of person who didn't engage in it anymore.

Rather than being daunted by the toxic nature of his feelings, this therapist is "attracted to the notion of confronting toxic and damaging professional and personal feelings and tranquilizing them by getting vigorously into the clinical work." He deals with unpleasant feelings by approaching the work rather than withdrawing from it.

Psychotherapists' Attitudes, Beliefs, Feelings, and Clinical Experiences with Battered Women

The psychotherapists were encouraged to speak about both their personal thoughts, attitudes, beliefs, and feelings and also their professional stances, clinical formulations, and behavioral responses with domestic violence clients. This section describes their

discussion of their attitudes, beliefs, and feelings about battered women and about their clinical work them.

It is of interest to note that the psychotherapists' focus of discussions about their work with battered women differed from the focus of their discussions about their work with men who batter. The interviews spontaneously evolved around issues related to the psychotherapists' views of the on-going psychotherapy process with battered women rather than focusing primarily on the beginning stages of assesssment and alliance formation as emerged from the discussions related to men who batter. Their responses in regard to battered women are discussed according to the two sub-categories which emerged from the data: (a) Assessment Criteria for Battered Women; and (b) Treating Battered Women: Psychotherapists' Thoughts, Feelings, and Reactions.

Assessment Criteria for Battered Women

Willingness to Accept Referral

Eight of the nine respondants were in general willing to accept referrals of women who were battered. One of the most experienced therapists who was eager to provide psychotherapy for men who batter was no longer willing to provide psychotherapy to battered women, but he did do extensive forensic work on their behalf. He had made this choice because

> Many years ago, I had a lot of interest in working with battered women, clinically, and found that I was a failure. . .I would get them to go to shelters and they they would go back to the guy. . .my only way of marking success with those women was getting them to leave the men and never go back. . . which might be aiming much too high. . .so I stopped doing that. . . because simultaneously with what I felt to be clinical failure with them. . .attorney's were hiring me to support self-defense cases where the battered women killed husbands and lovers. . . so that's my main involvement with battered women now.

Differential Diagnosis

Similar to their work with men who batter, all of the nine therapists based their evaluations of the appropriateness of psychotherapy for battered women on standard diagnostic assessments made according to their various theoretical orientations and

professions. They made their decisions about whether to accept any particular referral on an individual case-by-case basis.

Criteria for Acceptance

The respondants made statements such as: "It would depend very much on how she put it to me, " or "It would depend on my initial reaction to her as much as to her story." The battered woman's initial presentation of her view of her role vis-a-vis the violence and the impact it has had on her affected the therapist's feelings and reactions to "her story." The therapist's feelings and reactions greatly influenced the decision of whether to accept the woman for psychotherapy.

Treating Battered Women: Psychotherapists' Thoughts, Feelings, and Reactions

Reactions to Victimization

Much of a therapist's feelings about accepting a battered woman for treatment depended on how the potential patient presented herself during the initial consultation in relation to her own experience of her own victimization as well as the amount of concrete assistance (resources, etc.) the woman might need. Psychotherapists feelings ranged from positive and empathic feelings towards a woman who was battered--which sparked a desire to help the woman--versus a more negative response to the woman's victimization which made the therapist reluctant to be involved.

Initial active engagement. One very experienced male therapist, focusing on formal assessment criteria, pragmatically outlined how he would assess the situation.

> I'd see how badly she's getting battered, what other ancillary resources she may need (outpatient psychotherapy, shelter, legal resources). I'd plug the woman into those kind of community resources immediately. I don't have a problem with seeing her if she wants to see a [male therapist], but I would want to find that out.

This therapist did not begin with a negative reaction to the woman's victimization and was able to feel comfortable assuming an active, supportive stance vis-a-vis the woman's need for concrete assistance.

Similarly, a less experienced therapist described himself as being more comfortable working initially with battered women than battering men. "It would be easier to identify with her victimization and to deal with her oppression in a supportive way" than to deal with the violent behavior of the man. He did add, however, "that my assumption is that most relationships of that sort are pretty transactional so where it might go from there, I'm not sure." He was aware that his initial feelings about the woman's victimization might change over time.

A moderately experienced female therapist also realized that her initial internal, non-verbalized response towards a battered woman would be a desire to provide support and concrete assistance. She too, however, was aware that this might change over time. Her initial feelings would be

> An instantaneous sort of sense of incredible empathy and willingness to do everything, but I have to watch out and sort of restrain myself if I'm the psychotherapist. I'm not the social worker. I'm not the counselor in the shelter for abused women. But, I think there is an instantaneous wish to come forth and protect them and to make sure that no more violence occurs....and then this sort of 'parent' equals itself out. This would not be verbally expressed but would go on inside of me.

Initially being "put off". In contrast, other psychotherapists' initial responses to a battered woman were less positive. One less experienced therapist clearly differentiated his criteria for clinical assessment from his personal, feeling response. In contrast to the above examples, this therapist would be "put off" by a woman who was in need of concrete assistance. In regard to his feeling response, he said,

> It would depend very much on how she put it to me. If she put it to me that she was victimized, wanted me to do something about it in a concrete immediate way, I'd be put off--although not to say that I wouldn't see her, I might see her, but my first reaction would be 'Oh god, why isn't she calling the cops or some other agency who could help her out!'

However, his actual behavioral response would be influenced by the woman's view of her own victimization. He goes on to say,

> But if in her tone there is some indication that she is interested in having this stopped, that she conveys a sense that she may have something to do with it--either with the violence herself or with her getting herself out of the situation, or with her

> doing something productive or positive about it--then I would not feel put off. I'd be interested.

A less experienced female therapist acknowledged that,

> I don't like super-duper victims... I probably tend to prematurely think that the victim is also very actively involved in kind of keeping the thing going...In my own life, I don't like dealing with people who are always presenting themselves as a victim.

Over-involvement vs. setting limits. A very experienced psychotherapist described the transition phase typical of many psychotherapists when working with victims of violence: they get over-involved with domestic violence or trauma cases and then either leave the field or, if they stay in the field, learn to set limits on their involvement.

> I've learned to manage the emotional stress of the work in a different way....by looking at cases where I feel like I really made a lot of mistakes with them in terms of over-extending myself. Now I have a way of extending myself very much emotionally in the work together, yet also being clear about my boundaries, clear about what I can't do. I have a way of introducing that with clients early on so that I feel better anticipating with them what my limits are--there's less surprise of my getting over-extended and having to manage to pull back from something. One of the things for me has been working through my own process--some level of guilt--some part of me that was taking responsibility, and it had to do with my own understanding and handling of anger. Client's rage--my rage--some part of me. . .there was a victim part of me that was taking in an enormous sense of guilt and responsibility when the clients would be so desperately needy. I don't get caught emotionally in a sense of responsibility. I carry a lot of responsibility to be available to them--but it's not a kind of conflictual responsibility emotionally. I feel there's a lot of responsibility I carry with these clients in general but it doesn't distress me. It's not a conflict area where I get hooked because I'm not taking inappropriate responsibility.

This therapist has learned the balance between over-involvement based on guilt and reality based responsibility.

Coping With the "Doormat Stance". Several psychotherapists expressed the gradual emotional demoralization they experienced when they worked with patients, particularly battered women, who remained entrapped in, or passive towards, abusive situations. Several therapists used the metaphor of the "doormat" to capture this position. A moderately experienced therapist frankly spoke of how

> I get depressed, or burnt out, with people that don't take care of themselves, can't or won't stand up for themselves and say: 'Enough is enough!' You see that a lot in battering situations where women aren't ready to say: 'No more.' I guess I've been lucky because I've been seeing the kind of women who have made that jump

> across the river and they're there, and saying, 'Okay, enough.' I think a lot of times therapists are seeing women on the other side, they haven't made that leap yet, and a lot of work is around helping them make that jump. I think that's really tough work. I see a lot of women who are downtrodden and discouraged and feel rotten about themselves and can't see beyond that and sort of take on a doormat stance and then they continue to take what's handed out. If a client stayed in a doormat position, I'd begin to feel discouraged--it's hard to see people in destructive situations over time, not taking care of themselves.

She handles this by telling her patients that,

> I don't have a magic wand. I can't handle people not taking care of, and not protecting themselves, and allowing themselves to be hurt. I can't make that not happen, so that's part of their responsibility. If they want to work on that, I'm happy to help them out. If they're choosing not to do that, then there's nothing I can do about it.

This clear understanding of the limits of her responsibility enables her to have an internal stance of basic hopefulness.

> As women begin to take on more understanding of the part that they can play and not play in making things better, learning to detach, as they begin to feel better about themselves, and to disconnect in terms of connecting their worth to how well they're doing in this relationship, or not being a doormat. These women are growing in their value of themselves, and as they value themselves, I watch them set limits and boundaries that they haven't been able to do before, and by becoming firmer they send the message of what they will allow or won't allow in their lives.

If she can assist women in shifting out of the "doormat stance," she "sees that as incredibly hopeful."

Another moderately experienced therapist is less successful in managing the stress of working over the long term with the "doormat stance" and is less clear about her own sense of responsibility. She recognized her tendency to take on the emotional burdens of the work and

> To feel like there was something wrong with me. What I find is that when [physical or emotional abuse] goes on for years and years and years without much change or even getting worse, I find that draining, and then I find it harder and harder and harder to relate to that client. When I work a long time with somebody who is in a horrible relationship, I find that it's harder and harder for me to relate to them. I don't understand how they could put up with it in some ways. It's not so very different from the reaction I might have to anyone who tolerates what for me would be intolerable. It's more feelings of alienation that come up. I think what I do is defensive on my part. I need to make myself feel very different from them because the material is so hard and painful. So I'm suspicious of my motivation when I'm feeling so alienated. So do I feel less attached over time? I think what I actually do with those feelings is of course turn them on myself and feel like there's something wrong with me that I can't relate to them.

This therapist is not able to achieve a clear sense of the limits of her responsibility, and, instead, blames herself for her inability "to relate." This is not unlike the battered woman who blames herself for the abusive man's behavior. This could, perhaps, be an identification with the battered woman. This therapist's process, instead of leading to a sense of hopefulness (as in the previous example) leads to clinical demoralization and a wish on the therapist's part to "" with "dysfunctional types" and retreat from work in the field.

Fear of the Woman's Violent Partner

It was not surprising that the therapists reported that they would be concerned about the current safety of the battered woman and her children. It was also reasonable to expect that therapists would have concern about their own safety when working with men who had a history of violent behavior. It was, however, not expected that there would be a difference between the female and male psychotherapists in their reported concern about their own safety when working with battered women.

Four of the five female therapists spontaneously expressed concern about the level of personal threat the male partner of the battered woman might present to them as the woman's therapist. None of the male therapists expressed such a concern and, even when querried, did not have such a concern. Female psychotherapists, however, as part of the assessment, would formulate an impression of the man's level of dangerousness and the man's potential for harming them. The reports of the battered woman about her partner's violence would, in turn, influence these female therapists' level of fear and their willingness to accept the woman for outpatient treatment in their private practice setting.

Some of the female therapists had been aware of this prior to the interview and others realized it as part of the discussion. A moderately experienced female therapist reflected,

> You know, if I really thought this through, I could even worry that [the male partners] would be violent with me; although, you know, until just now, it's really

> not something I thought about. I think I worry more about the risk to the woman and to the family. I feel like I have a great responsibility to protect them.

A moderately experienced therapist had previously worked in a advocacy setting for battered women where she encountered severely battered women. She described her concern:

> I would worry about the woman's safety and would want to ascertain if she was safe. . .I would also worry about my own safety in taking on the case depending on what the level of violence was...[and] whether the guy was crazy enough to track me down or to follow her.

When asked how she would determine this, the therapist stated that she would:

> Ask about the history of his abusiveness, how long it's been going on, the severity, has he ever been arrested, how did he respond to the arrest, has he been violent in interactions with other people. [She would be] worried if he had no impulse control in all areas of his life or at all times.

This therapist was sophisticated in her ability to reflect on her own feelings of fear prior to acting upon them. She attempted to differentiate her feelings of fear that might arise as an artifact of the countertransference versus her feelings of fear that arose from a reality-based assessment of the man's impulse control. She neither dismissed nor reacted to these feelings prior to making a such a differentiation. She stated,

> I hope I would be able to make a judgment about what was in fact a danger to me and what was kind of a countertransference feeling about what I might be picking up from [the woman] about [her] fear of being around him. I hope that I would be able to live with that fear, to contain that within myself, and [as a way of assisting the battered woman], to pay attention to that fear.

This therapist's behavior in relation to the battered woman would depend on her differentiation and level of fear. She would respond in a variety of ways, ranging from behaviorally doing nothing while containing the fearful feelings, to altering her work environment by seeing the woman during the daytime when she knew co-workers were present in her office building., to referring the woman to an agency setting. She didn't think she would be able to work with the woman if she, "thought there was a real danger to me".

One moderately experienced therapist reflected on her self-observation that:

> It is mostly the tales of the abuse through which I became frightened. My responses were actually shaped not only by the actual behavior of the man but also by my own fantasies about what was occurring between the man and the woman.

This dynamic highlights the importance of being aware of the impact of fantasies on the development of a fear-based response toward the battered woman and the importance of basing clinical decisions as much as possible on data rather than fantasy.

Thus, the issue of the assessment of the man's impulse was also a factor which influenced the therapist's decision about whether or not to accept a battered woman for psychotherapy. This is a unique finding in that most people who seek out individual psychotherapy are assessed on their own individual merits. The decision to treat an individual is usually not based on the behavior of that individual's spouse/partner. Hence this factor could serve as a barrier to treatment which battered women encounter in their attempts to acquire psychotherapeutic services for themselves or their children. It is this researcher's opinion that a sophisticated assessment of these feelings and reactions by the therapist (such as described above) is an important aspect of the assessment of battered women.

Treatment goals: Ending the violence vs. ending the relationship.

As a moderately experienced therapist volunteered, "The goal, yes, is for the violence to stop -- but there are different ways to stop it." This summed up a unresolved and on-going debate in the field of family violence treatment which is, not surprisingly, reflected in the results of this study. Most psychotherapists, researchers, authors, etc., have as a goal a violence-free family. Their views about how to achieve this goal, however, are very diverse.

All nine therapists in this study, when asked about their goals in the treatment of a battered woman, stated that "stopping the violence" in the battered woman's life was the primary goal. They did, however, differ on their views about how to achieve that goal and on what was a reasonable amount of time to devote to achieving that goal. They differed

on whether or not leaving the relationship was an essential component of this goal. If they believed that leaving the relationship was an essential component of achieving a violence-free relationship, they also differed in their opinion about whether or not a therapist should tell a battered woman that this was one of the goals in treatment.

One very experienced male therapist clearly defined his goal of treatment as "stopping the violence." He "admits" that there are times when, in order to stop the violence, his unstated goal in therapy is for the woman to leave the relationship. He does not necessarily state this as a goal but will support a woman if she has this goal for herself. When asked what was a reasonable length of time in therapy for this goal (i.e., stopping the violence) to be achieved, his response was,

> Yesterday. If I'm not seeing any progress, that would really be a concern for me. . . usually if people are here, the therapist should be doing something to have an impact pretty quickly. There's an immediacy here, there is a real kind of danger. You don't have the luxury of sitting back and seeing how things unfold.

In spite of his feeling pressured and, at times frustrated, by his own expectation to do things quickly, he felt quite confident in the outcome of therapy. "I've had such a success rate. It's really success if stopping the violence is success. Now, do they stay together? Sometimes yes. Sometimes no. But the violence gets stopped in the relationship."

A less experienced psychoanalytically trained male therapist does not see a battered woman's leaving the relationship as a "primary goal" but rather as "a beneficial side effect." He also incorporates a concern about her future well-being in relationships as part of his goal of treatment. He would

> Hope for more than her simply getting out. I would see that as a secondary thing. The primary thing would be that she get a picture as to what she's in this thing for, so that she wouldn't repeat it. If you get somebody out of a relationship like this. . .the next thing you know they're back into another one repeating the same thing. . .there's one thing I'm impressed with as a psychoanalyst and that's the repetition of our behaviors.

A moderately experienced therapist adjusted her goals in light of her sense of failure, saying,

> I initially expected the violence to stop, and I would feel like I failed tremendously if it didn't...but through my experience I lowered my goals. Therapy doesn't always change the behavior but at least it gives the person a choice.

In contrast, another moderately experienced female therapist-- who is trying to move away from being identified with the field--does not have an explicitly stated goal for the woman to leave the relationship. She expects that ending the violence will take long time in therapy. In contrast to the therapist (above) who believes he should "have an impact pretty quickly," this therapist says,

> One of my strengths as a clinician being a huge capacity to hang in there and to not ask for a woman to change...I have a lot of tolerance for people who are in bad relationships. I also know that if you set it up that the woman has to leave [the relationship], they'll leave therapy.

She, however, acknowledges that leaving the relationship may be an unspoken, internal goal she has for the battered woman and a marker of success for the therapy. She hopes she doesn't convey this to the battered woman patient as this will influence her to leave therapy and will make the woman feel like a failure.

> [Leaving the violent relationship] probably is in some way a measure for me of somebody's progress. It becomes hard for me to understand how she can keep in the relationship. I think what I hang onto clinically and personally is the belief that if the woman changes a lot internally there's a kind of personality change as a result of the therapy. She'll no longer need the relationship so that's why personality change is the more articulated and primary goal than relationship change. . . [However] I wouldn't think the therapy failed if the woman didn't leave the relationship. I hope I don't convey this to [battered women patients]. This is often the battered woman's feeling--that she's failed because she's been unable to leave.

Another female therapist with less experience was quite pragmatic. She does not have leaving an abusive relationship as a goal because some women are unable to live independently without a relationship. As she describes a case, she states she is

> Not sure I think this woman should leave this guy...I tend to think much more in terms of her capabilities and she looks a lot better, more tightly glued, than she is. I just can't open the door for her and say 'Here, go out into the world.' The focus has to be more on that immediate experience of dealing with this guy or his being an ogre. I don't think of the goal [of leaving] concretely so much as what is it in [her] that has to be developed so that [she] can choose more freely...relationships are so complicated, especially once you've made a life together...there's a lot of reality, not just financial reality, about all that enmeshment and you can't just march out and drag two children. I think having a child has improved my sense of that.

One very experienced male therapist had arrived at a very different position regarding his treatment of battered women and his belief about women leaving the relationship. He was very clear that his goal was get women to leave the relationship in order to stop the violence. Since he had "clinically failed" in his attempt to do so, he no longer provides psychotherapy to battered women. When asked if he thought there was anything a battered woman could do to stop the man's violence towards her, he stated definitively,

> Correct. Leave. My only way of marking success with battered women was getting them to leave the man and never go back...which might be aiming much too high...so I stopped doing it...because clinically I found that I was a failure. I'm very results-oriented in terms of: Does this work help people to do things? In a critical situation, and I think being battered is critical, it's not like a problem of sustaining intimacy and you have six years to deal with it. I think that helping a woman out in weeks or a couple of months is a private and professional marker of success...if I can't do that, then it seems that just talking, but nothing really effective is going on, because there is so much at stake...I can't bear to sit in the room with a woman, eight, ten, fifteen times, who is telling me that she continues to be battered and I keep asking myself, and this is clearly counter-transference: What are we doing here? How do I justify the fact I'm continuing to see her...and this continues to happen. I can't take it. I feel like like I'm in a hot room that 's getting hotter and hotter and I've got to get out. I can't take the fact that I define myself as having the training and expertise to facilitate change...and the input from the woman indicates that it still hasn't changed: 'I'm still with him and I still see you.' Then it becomes a contradiction to me. What am I doing here? How can I justify it?

This therapist did, however, speak with admiration for a Jungian analyst colleague of his who worked for three years with a battered woman who eventually left her fifteen year battering relationship and did not enter another abusive relationship. He stated that he was

> Tremendously admiring of Dr. X, who is a much more patient soul that I am, who could stay with [his patient] for that length of time with some faith, or conviction, or hope, that maybe at some point [the violence would end]. I know myself well enough to know that I could never do that.

He did not think this approach was inappropriate, just that he was unable to do it.

It is clear that the psychotherapists' goals regarding stopping the violence had implications for whether they believed the relationship must stop in order to achieve this goal. Their goal definition, in turn, influenced their feelings of success or failure. The

psychotherapists who were most likely to fail to achieve their goals were the psychotherapists who believed that change should take place quickly, and that, in order for change to occur quickly, the woman must leave the relationship. It is interesting that change in the male partner was not discussed, although implicit in this discussion was the notion that there was little the woman could do to change the male batterer's behavior, particularly in the context of her own individual psychotherapy. She could only be responsible for her own behavior.

Reactions to Disappointed "Rescue Fantasies"

All of the psychotherapists felt a responsibility to work towards stopping the violence in the battered woman's life. They all described a general protective stance towards their female patients and communicated throughout a genuine desire to be helpful to the battered women. In their attempt to be helpful, however, they all encountered troubling dynamics that arose for them in treatment of battered women which lead to feelings of frustration, hopelessness, and dysphoria. One therapist described this as the battered woman's capacity to evoke his "rescue fantasies" and described the process of his inevitable failure to live up to his fantasies of rescue. This was a theme in the narratives of many interviewees.

A psychoanalytically oriented therapist reflected on the "rescue fantasies" that are evoked by some battered women, although he was careful to qualify that this dynamic varies from person-to-person and applies only to some battered women. He was aware that he might be responding to his own "rescue fantasies" when working with some battered women. He might unconsciously be wanting to rescue her "from her own worst conflicts" as well as "from this mean man." Somewhat tongue-in-cheek, he elaborated that "being a red-blooded all-American psychoanalyst, it's the Oedipal complex...rescuing my dear lovely ol' mother from my mean ol' father, showing him up in the process, and vanquishing him." According to this therapist,

> The appeal in the rescue fantasy is to be taken care of and loved. However, there is a kind of 'sucker-punch' feature to this that is seductive on the part of the woman. She'll bring you in, with all of your vigor and therapeutic acumen, only to defeat you, unconsciously, and one of her primary aims is vengeance. . .She might initially respond very well to interpretations and use them.. .and then, any number of things might happen [like returning to the relationship]. . .that would show you that you were an impotent therapist.

For the therapist to try and rescue the battered woman, only to be rendered impotent and defeated,

> Is enraging...you like to kill 'em...This then is part of the so-called sado-masochistic dynamic...because then [the therapist] turns into the raging character.

This therapist was frank and honest in his acknowledgement that, although

> I don't rage at my patients, even the most accurate interpretations can be put in a way that is very sadistic and abusive, or one can adopt an abusive attitude. I've had that experience, I've done that, caught myself, late in the game doing that, being mean in that way, as a reaction to feeling that 'this woman has really done a number on me.' In one case, I recognized what was going on and was able to interpret it to the woman and it turned out to be a pivotal part of the analysis and was one of the contributing factors to her uncovering memories of being sexually abused.

A very experienced male therapist who currently provides psychotherapy to battered women identified two "subgroups" of battered women who led him to feel defeated. He described his version of the defeated rescue fantasy as the woman communicating, "Well, now I've changed my mind. I really kind of love [the man who is battering me] and he's hurting now and how can I leave him." He felt both angry and "frustrated, hopeless and dysphoric" and "I don't like hopeless." One sub-group of battered women

> Have impulse control problems so they're in there right ready to fight, they're not backing down and, in fact, they're screaming, yelling, very volatile and often alcohol is involved.

Another difficult group of battered women to work with are those,

> Who are in 20-25 year relationships. You see how demoralized they're getting. . .the situation isn't hopeful because the man is not going to stop what he's doing. . .the woman is really [emotionally] dependent, it's not financial dependency, and the resources have been cut-off for them or they don't have the self-esteem to go out and reach for the external resources.

He realizes that the therapy is

> Just longer work and. . .I'm wanting to get something done. On the other hand I'm aware that my kind of rush and optimism could also alienate. So, one concern is:

> how much am I pushing? It's the line between empathy and confrontation and that's the frustrating one.

The therapist also discussed his frustration with the woman's ambivalence about leaving the relationship, saying,

> The woman says that she wants to leave the relationship and you're sort of going along with this agenda. All of a sudden you realize there's another agenda that's: 'Well, now I've changed my mind. I really kind of love him and he's hurting and how can I leave him.' This is fascinating [but frustrating] . . .It's pretty hopeless and I don't like hopeless.

This therapist is aware of the effect this process has upon him. He gets "dysphoric around hopeless situations". He also described his frustration with women who "after you've worked with them and they've gotten out of the relationship, go back and select a similar kind of man. Those of us in private practice see this as they come back again to therapy." This "compulsion to repeat" (as described above by the psychoanalytic therapist) was described by several therapists.

A less experienced female therapist described a similar kind of internal process. She acknowledged that for her, part of the stress of the work is that "it's very slow," and the slowness of change in the woman's tolerance of abuse results in the therapist feeling angry. "I can feel my own projective identification. Sometimes I want to scream at [her]: 'Why the hell are you bothering with this shit, lady!'...I feel a kind of impatience." This therapist, of course, does not scream at her patient. Her anger is similar, however, to the anger that psychotherapists feel towards the women who repeat violent relationships or who are ambivalently attached to a particular violent relationship.

Another less experienced psychotherapist acknowledged his own hostility resulting from frustrated rescue attempts. He frankly disclosed that, "we don't read much about [therapists] having fantasies about strangling their patients, but we all do."

These views, in which the woman is considered a collusive partner in the relationship dynamic, are in sharp contrast to the view expressed by the very experienced male therapist who no longer provides therapy to battered women. He has experienced defeat in his clinical attempts to "rescue" battered women, although he has experienced

much success in "rescuing" battered women in the forensic arena. He explicitly works toward the goal of his clinical patients leaving the violent relationships. When asked if he believes that a woman can do anything within the context of the relationship to stop the man's violent behavior, he replied:

> Correct. Leave. My only way of marking success with battered women was getting them to leave the man and never go back. . . .I'm very results- oriented in terms of: Does this work help people to do things? . . .I think that helping a woman out in weeks or a couple of months is a private and professional marker of success. . .if I can't do that, then it seems that just talking, but nothing really effective is going on, because there is so much at stake. . .I can't take the fact that I define myself as having the training and expertise to facilitate change. . .and the input from the woman indicates that it still hasn't changed: 'I'm still with him and I still see you.' Then it becomes a contradiction to me. What am I doing here? How can I justify it?"

He told his battered women patients that they might

> Elicit anger from the man but I don't believe that you elicit violence from him. I see that as an independent decision that he has to make. So I believe that whatever you say to him, he should never hit you. Some of the more intelligent ones found that very appealing and stopped to think about and consider it. They never thought about the issue that way. The more working class and poor women I worked with thought it was cocamammey. They thought it was something some well trained, college educated professional person said that didn't make sense to them. That is, they seemed persuaded either that if they stopped saying or doing certain things, their husband would stop beating them.

In spite of this psychotherapist's belief that battered women were not responsible for the violence and that they had no control over the man's abusive behavior, he was not successful in "rescuing" the women. He resolved his feelings of "clinical failure" by withdrawing from the work of psychotherapy with battered women.

Psychotherapists' Feelings, Beliefs, Attitudes, and Clinical Experiences Unique to the Psychotherapy Process with Domestic Violence

The therapists talked about many of the challenging intrapsychic and interpersonal dynamics, theoretical conundrums, and personal concerns and dilemmas they encountered in their clinical work with battered women and men who batter. Because of the diversity of theoretical orientations, the psychotherapists described their beliefs, experiences, and

concerns in different theoretical "languages" but spontaneously addressed many of the same themes. This portion of the data analysis will present those emergent themes which were laced throughout the interviews. These themes are related to the process of psychotherapy with domestic violence in general and are not related specifically to either the battered woman or her battering partner. These issues are related to two major themes: (a) reconciling feminist theory and clinical practice; (b) managing the stressful aspects of the clinical work.

Reconciling Feminist Theory and Clinical Practice

Much of the theory building and delivery of services in the field of domestic violence arose out of the women's movement and a feminist political ideology. Without the feminist impetus and continued vigilance, the field would not have come to the attention of society at large nor would it have been legitimated by the mental health professions as an acceptable focus of practice and research. The feminist influence presents many challenges, however, for clinicians in the field of domestic violence who function as psychotherapists for battered women and men who batter. Some of the therapists in this study appeared unaware of, and unconcerned about, feminist ideology. Others were clearly knowledgeable of, and differentially influenced by, feminist ideology.

Burdened by feminist guilt

One therapist who was worked in family violence advocacy agencies "in the early days of the battered women's movement" prior to her rather traditional clinical training, spoke of the contradictions she was unable to reconcile in attempting to be politically correct while practicing insight-oriented, characterlogically changing, psychodynamic psychotherapy with battered women.

> I think that it's possible that this population needs a more active involvement than the kind of psychotherapy I do...but in general I feel like having a good grounding in psychodynamic work fits fine, especially addressing personality change. But one of the deficits in the early days of the battered women's movement was a kind of stance idealizing the women who are battered. God forbid I should ever have any feelings of this woman being at all masochistic! Clinically I see a lot of times what wrecks these women are.

She feels she is "not allowed to have those feelings" which inevitably arise in the course of the clinical work if she is to be politically correct. In addition, if she is doing personality change work, she "is working on the level of what is this person contributing to the situation. So that makes the work very difficult to reconcile with the kind of politically correct stuff." She implies, of course, that to be "politically correct" one must view the woman as a passive victim of, rather than contributor to, her abuse. She believes that she has to choose between being "politically correct" and denying the reality of the impairments she sees in women who are battered. Her solution to this conflict in values was to gradually withdraw from the work. She is now trying to " with dysfunctional types" and is minimizing her work in the field of family violence.

Uninfluenced by feminist theory

The therapist most identified with classical psychoanalytic theory was apparently not influenced by what the above therapist labeled as "political correctness." He was not constrained by the feminist critique of the concept of masochism as it applied to battered women. When speaking about his understanding of the dynamics of the battered woman, he is quick to qualify that the dynamics

> Vary from individual to individual. I'm impressed with how different, specific, particular, and unique people are in their dynamics. However, one area of inquiry I would explore in psychotherapy would be the battered woman's unconscious fantasies with respect to aggressive conflicts, so called sado-masochistic unconscious fantasies. . . working analytically one can think about transferences and resistances and through their interpretation hope to uncover unconscious fantasies which constitute an important determinant of the woman's behavior--in terms of what they do to themselves, provocations, enduring, accepting abuse, as well as what they are trying to play out in reality in terms of enacting unconscious fantasies. . .with the woman, being the receiver of beatings is often, not invariably, a defense against a sadistic wish where she imagines herself giving out the beatings.

This classically trained psychoanalyst was not at all shy about using words and concepts such as "sado-masochistic unconscious fantasies." He also clearly valued insight-oriented, characterologically focused, long-term psychotherapy but was able to do this with a clear conscience because he had not been influenced by feminist ideology. In the case vignettes

he described, however, he was clearly helpful to the men and women he treated. Although not actively seeking referrals of domestic violence, neither would he retreat from such referrals because of a conflict between his adherence to classical analytic theory versus feminist theory.

Bridging clinical and feminist theories

Also within a psychoanalytic tradition, the issue of gender and feminist theory came up in the interview of a very experienced female psychotherapist who also had a high level of expertise in family violence. She was steeped in feminist critiques and revisions of classical psychoanalytic theory and actively contributed to the development of trauma theory. She discussed the presence of similar dynamics in battering relationships; however, instead of primarily using the words "masochistic," "sadistic," or "repetition compulsion," she spoke in trauma theory terms of "dominance and submission" and "internalized victim-aggressor dynamics." She believes in the efficacy of long-term treatment focused on characterological change for both the victim and the aggressor and does not apparently consider this to conflict with her feminist theoretical leanings. She spoke of the role reversal between the abused and the abuser which occurs when the formerly abused child becomes the abusive adult. She obviously carefully avoided prescribing "maleness" to the role of "aggressor" and "femaleness" to the role of "victim":

> Most of the clients who are becoming physically violent in adult relationships have been physically abused or come from violent families where they have seen that modeled, where they haven't been able to act it out back, until they get older and they start reversing roles. I see similarities in terms of internalized victim-aggressor dynamics. [She hypothesized] that the inability to fantasize about one's aggressive and rageful feelings leads to enactment [of the original trauma which often accompanies the violence]. When the traumatic moment is walled off from the dynamic unconscious and the person can't fantasize about horror, or violence, or rage, and they can't know that it's fantasy, or allow that to be worked through in the inner landscape, then they're much more prone to act it out. . .or have it acted out upon them. There is a tendency for the victimization process to reflect a frozen trauma--that then will just erupt with a violent fit as a person tries to gain some type of control over it in a tangible way--but it is completely out of control because there are not the imaginal resources internally to process it. [Although I believes that the first set of interventions would be around trying to get control of the violent behavior, I also strongly believe that the behavior is not going to be ultimately really

> controllable until there is an internal process that's engaged where the person can begin to reflect on the inner voice, on the inner landscape of violence.

This is clearly an example of a gender neutral description of this therapist's theoretical understanding of the phenomenon of domestic violence. This psychotherapist has created a bridge between psychodynamic theory and gender neutral trauma theory without feeling guilt about betraying her feminist principles.

Managing the Stress of the Work--Antidotes to Demoralization

Due to the fact that no psychotherapist has a "magic wand" (as one therapist described her limitations), each therapist had to confront the intermittent stresses and sense of clinical demoralization inherent in clinical work with domestic violence. The stresses include needing to contain the chronic sense of urgency in work with domestic violence patients, coping with feelings about the woman's "doormat stance", and adjusting their usual and customary therapeutic stance. This group of psychotherapists described a variety of coping strategies for managing dysphoric affects and stresses--ranging from talking with peers, seeking consultation, going to workshops and reading, working in their own psychotherapies, redefining the goals of treatment, being realistic to themselves and straightforward with their patients about their own time and emotional and clinical limitations, diversifying their practices by functioning in a variety of roles, limiting the percentage of professional time focused on issues of domestic violence, and getting physical exercise.

Living with the Sense of Urgency

All of the therapists were aware of the potentially life-threatening nature of domestic violence and none of them minimized or denied this component of the work. Words like "protection," "critical," "responsibility," "safety," "immediacy," "pressure," and "life-threatening" were laced throughout the interviews.

As one very experienced therapist stated, "I think battering is a critical situation...it's not like a problem of sustaining intimacy and you have six years to deal with it." A moderately experienced therapist described it metaphorically: "It's sort of like the

house is burning and you have to put the fire out first." Another therapist stated his pressure to "stop the violence yesterday." A less experienced therapist stated that "usually clients don't have physical consequences to their interactions and so it ups the ante a bit. It makes it more immediate." Similarly, a very experienced therapist said, "There's an immediacy to this. There really is a kind of danger, and there's a pressure to do something quickly."

This awareness of the life-threatening nature of the violent behavior created a sense of urgency in the psychotherapy process and a pressure to act to stop the violent behavior and/or to protect the women and the children. Therapists reported a variety of emotional and behavioral responses regarding their handling of this sense of urgency. They also developed a variety of coping strategies for managing this sense of urgency which contributes to the emotional demands and stresses of the work.

Therapeutic Stance: Reflective or Directive

Due to this sense of urgency, the therapists felt pulled to become active and directive in the treatment and in the lives of their patients. More psychodynamically and/or psychoanalytically oriented psychotherapists expressed concern that an active, directive involvement might violate the parameters of the psychodynamic or psychoanalytically defined therapist-patient relationship and/or might negatively influence the therapeutic alliance they had so thoughtfully constructed with their patient(s). Some psychotherapists handle this role discrepancy by perceiving themselves as stepping outside their role of "psychotherapist" when acting like an "interventionist." In contrast, more behaviorally-oriented or cognitively-oriented therapists were more accustomed to a directive stance with their patients and were not as conflicted about becoming more active and directive.

For example, one less experienced psychodynamically-oriented therapist presented herself as someone who did not see domestic violence patients. She described her intervention in a situation (which was clearly a domestic violence situation) as not being psychotherapy. She had quite appropriately intervened with the husband of a female

patient who had just given birth to a baby and was being "menaced" by the husband. The husband had put his fist through the wall in a fit of anger and broke his hand which needed to be put in a cast. The therapist invited the husband into a conjoint session.

> I very much felt that there has to be a prohibition for this, if it happened again they should separate. He had to find a way to control himself. He'd already done something pretty serious and they have this totally fragile baby in the house and he's furious at her for her involvement with the baby. It wasn't the kind of dynamic that was going to go away.

The therapist differentiated this intervention from psychotherapy, explaining,

> I felt it was important to be concrete and try to nip this, but at that point I wasn't in a psychotherapeutic mode. I wasn't making a suggestion, I was saying: 'This is what has to happen.' I wouldn't see that as psychotherapy because I'm telling somebody what to do. Not that people don't get direction from what I say but I don't usually say: 'Do this. Don't do that.' Or maybe it's splitting hairs. I mean I did it, and I was me, the psychotherapist, sitting there doing it, but there was an immediacy in my shift that I only associate with when I'm worried about somebody's going to kill themselves and I would immediately get very focused on asking more about that and thinking about should I hospitalize. I don't see this as psychotherapy. It's part of psychotherapy in that moment, but I don't consider psychotherapy to be active or directive and that protective. I see psychotherapy as much more reflective than directive.

In spite of her role departure, however, she assessed the outcome of her intervention as "very helpful. They got into couples therapy and that was very helpful." It is interesting that an intervention that was defined as helpful was not also defined as psychotherapeutic.

A moderately experienced therapist with a psychoanalytic/psychodynamic orientation discussed her approach to work with battered women as also sometimes stepping outside the psychotherapeutic role:

> If the battered woman was completely naive and did not know about [the resources], I would be much more forthcoming. If she was aware of the possibilities, I would be less interventionist. I think that sometimes one has to step out of the psychoanalytic, psychodynamic mode...the important thing is you have to be aware of resources and intervene at the right time.

This therapist also compared this to the responsibility she would feel with a suicidal patient.

A less experienced therapist described his ambivalence about seeing potentially violent men as related to "that whole business. That's such a pain in the neck. That will ruin any treatment. Who wants to even begin to get into that stuff?" He does, however,

think that issuing such a warning might be experienced by a borderline or psychotic person,

> As a therapeutic intervention, an indication of the therapist's good reality testing, his concern for the patient and what could be helpful for the patient. The patient might internalize that, as well as other prohibitions and directives that the therapist might give, in a way that would be therapeutic and helpful.

Two psychotherapists coped with the the directive versus reflective dilemma by conceptualizing the appropriate treatment as sequenced into an initially active stage focused on stopping the violence being followed by a later more reflective stage. According to one moderately experienced therapist,

> First and foremost, I think it's like the house is burning, you have to put out the fire first. Limits have to be set and if somebody's abusing someone else, there has to be some separation and some sort of safety instituted so that people aren't being hurt anymore. Once that happens, then people can begin to work on what's going on...but I don't think you can go in and say, 'Let's sit down and talk about this.' and do a lot of heavy intrapsychic psychotherapy and hope that it's all going to stop.

When asked if her initial intervention would be focused on stopping the violence, she replied "Absolutely, and I wouldn't work with it if I felt that wasn't going to happen. I would just have to set in motion some sort of system for that to happen or I couldn't work with it."

Similarly, a less experienced therapist also described working with abusing men as

> An initial stage of fairly active intervention, including group support or self-help participation, with a goal of building ego strengths, gaining some control, developing alternative ways of discharging emotions, and finding more satisfactory ways of coping with the provocations in the relationship. This would be followed by a longer period of exploration of internal dynamics.

A very experienced therapist describes her integration of a behavioral/ cognitive approach with an insight oriented psychodynamic approach as

> A shot gun approach using every avenue as much as possible and juggling many baskets at once. Her approach with a violent client is to assist the client in understanding the kind of physical escalation process that happens in the body. What kind of cues the client is aware of in terms of the erupting rage. What kind of capacities for redirecting and self-soothing imagery, or soothing behaviors, that they can use to de-escalate. But while I'm doing that, all of it feels like trying to juggle many baskets at once; I'm trying to engage the client in a metaphor, in a

> symbolic process, because I think that in victims [and perpetrators] of violence the symbolization process has been shut down and frozen.

Succeeding As an "Antidote to Demoralization"

The very experienced therapist who decided not to provide psychotherapy to battered women rather than change his goals in treatment says,

> Helping a woman get out in weeks or a couple of months is a private and professional marker of success, and if I can't do that, then it seems that just talking, but nothing really effective, is really going on, because there is so much at stake.

His forensic work with battered women is a counter to his feelings of clinical failure. He says, "Few things give me as much satisfaction as six hours on the stand and the next thing the jury comes in with an acquittal instead of twenty-five years in prison."

This therapist, who prides himself on working with difficult clients, speaks of the rewards of working with violent men:

> If I do good work, not only do people live better lives in terms of psychological adjustment of how they feel about their life...but they don't cause damage in society...so it's a terrific pay off for them...they not only get to have a better life for themselves, but indirectly my professional work has effected a sense of decency in the world with regard to other people who will not be victimized...most psychotherapists don't have that...it's not a targeted behavior...the toll is so high when someone is involved in abusing women...that few things give me greater satisfaction that helping a guy that wants to change.

Another very experienced therapist, who also prides himself on work with difficult patients, states, "I've had such a success rate, if stopping violence is success. Success is a good antidote to demoralization".

Another very experienced psychotherapist comments on her work with victims of abuse, saying,

> My optimism? Or pessimism? I feel like it's very, very slow work and I do feel optimistic about it. I do feel that I've seen tremendous change in a number of my clients...and yet I am also very much aware day to day of the slowness of the work.

A moderately experienced psychotherapist described her version of success somewhat differently. Over time, she has come to redefine her goals as not changing people's behavior but as giving them a choice as to how to behave:

> I think conservatively about the effects of psychotherapy. . .some people can do a lot but most people can do just a little. . .it's better than nothing. . .it takes someone enormous amounts of time to really change somebody's character structure. . .I initially felt like I failed tremendously if I didn't [change someone's behavior quickly]. . .through experience I lowered my own goals.

Diversifying Professional Practice

The therapist who views "success as an antidote to demoralization," also structures his practice "to mitigate against the the possibility of demoralization. A number of people come in on their own, pay higher fees, are more functioning and are not character disordered folks who were more intractable." He also talks to colleagues, lectures in classes, volunteers in agencies, consults on training films, and pursues an interest in research. "I tend to keep the interest diverse enough to where I'm doing a lot of things and not just bogged down by one." He also limits the number of domestic violence cases in his practice to, at most, 30% of his practice.

He is typical of others who have described themselves as optimistic in spite of the slowness and stress of the work. The other very experienced therapist who decided not to provide psychotherapy for battered women diversifies his practice by teaching and lecturing, providing forensic consultation, and limiting his court referred patients to, at most, 25% of his practice.

Another therapist, who presents herself as cutting back her involvement with family violence issues, is cutting back to having only 50% of her professional life involved with such issues. She teaches, consults, and writes in addition to her clinical practice.

In contrast, the psychotherapists who are moving away from the field of treating domestic violence cases are those who are primarily in direct clinical practice.

Impact of the Interview on the Psychotherapists

Several of the therapists spontaneously remarked on the impact their participation in the study--receiving the researcher's letter of request, deciding to volunteer to participate in

the study, and actually participating in the interview--had had on them individually and on their practices. One less experienced therapist remarked,

> When you originally sent me the request, I mean, I thought about it. I'm surprised that I haven't seen more actual battering and I don't know what that says. It made me wonder about why I'm not dealing with this. I should just think about my caseload and who might be likely. Maybe it's like incest was ten years ago. None of us asked about it. Maybe I don't know how to make it OK for people to talk about domestic violence.

One moderately experienced female therapist reflected on her response to the interview:

> I think the questions you posed made me think a lot. For instance, why would I feel less threatened if just the woman who was being abused called me. Why would I not be as frightened, or as careful, as I would be if the abuser came with her or if he came alone. There's an instinctively different response. . .maybe some might call it sexist. There's an sort of immediate protection one feels inclined to put up when confronted with tales of the abuse.

One less experienced therapist echoed the feelings of several interviewees:

> I don't tend to think or talk about these things. Even talking and thinking about them makes me less anxious or reluctant to see such clients...getting into a more cognitive framework makes it feel like there's a more of a framework in which to operate. Making what usually remains implicit more explicit increases the comfort level. It would be fascinating to hear more about or participate in a discussion about all this stuff.

These responses speak both to the isolation of therapists in private practice who see these patients and to their interest in understanding more about the of clinical work with a domestic violence population.

Conclusion

A discussion of the data will follow in Chapter V: Discussion and Implications. The data will be interpreted in response to the study questions and in relation to the relevant literature.

CHAPTER V

DISCUSSION AND IMPLICATIONS

This qualitative study explores the experiences of psychotherapists in their clinical work with battered women and battering men with specific focus on the psychotherapists' attitudes, beliefs, feelings, and professional clinical and training experiences which influence their provision of psychotherapeutic services to domestic violence clients.

Semi-structured interviews were conducted with nine senior, autonomously practicing psychotherapists. Data from the interviews were analyzed according to Glaser and Strauss' (1967) method of constant comparative analysis. Results of this analysis are discussed below in light of the literature regarding the treatment of domestic violence, the responses of psychotherapists typically evoked by psychotherapy patients and the psychotherapy process, and the prediction, prevention, and management of patient violence (see Chapter II, Review of the Literature). This discussion of the findings will address how the present study has illuminated the research questions and contributed to an understanding of an area not anticipated prior to the study. Implications for further research and for clinical practice, graduate and professional training, and administrative policy-making within the mental health service provider community are discussed.

The two main questions of this study are:

Question 1. Is it the case that some psychotherapists are reluctant to treat domestic violence clients and that such reluctance is not informed by clinical theory, practice theory, or family violence theory but is based upon personal biases (attitudes, beliefs, and feelings) about the phenomenon of domestic violence and about battered women and battering men?

Question 2. What attitudes, beliefs, feelings, and experiences influence psychotherapists' decisions to avoid versus treat domestic violence patients?

The findings which address Question 1 are discussed in the section, "Psychotherapists' Background in Domestic Violence: Training, Knowledge, and Willingness to Treat". The sections "Psychotherapists' Views of the Unique Factors

Influencing Their Assessment and Treatment of Men Who Batter," and "Psychotherapists' Views of the Unique Factors Influencing the Assessment and Treatment of Women Who Are Battered" address Question 2.

A theme that was threaded throughout all the interviews was the emotional stress endemic to the work of psychotherapy with a domestic violence population. This had been noted by the researcher prior to the study in her conversations with colleagues and in her observations regarding the attrition of psychotherapists from the field (See Chapter I, Introduction, pp. 1-5). Unanticipated findings arose out of the analysis of the data regarding what enabled psychotherapists to cope successfully with this stress. A finding of this study was that there appears to be an optimal style of clinical practice that contributes to psychotherapists' longevity in, rather than attrition from, the field of domestic violence treatment. The factors which were discovered to contribute to, and mitigate against, this optimal style of clinical practice are discussed in the section on "Psychotherapists' Capacities Contributing to Longevity in the Domestic Violence Field" (pp. 159-168).

Psychotherapists' Background in Domestic Violence: Training, Knowledge, and Willingness to Treat

It was expected that any reluctance of the psychotherapists to treat cases of domestic violence would revolve around fears for personal safety, desires to avoid unpleasant or dysphoric clinical material, and anticipations of clinical demoralization and dislike for the client. This section addresses the question of whether or not some psychotherapists are reluctant to treat domestic violence clients and whether this reluctance is based on personal biases (i.e., attitudes, beliefs, and feelings) about the phenomenon of domestic violence and about battered women and battering men rather than being informed by clinical theory, practice theory, or family violence theory. It encompasses the sub-categories of: Training in, and Knowledge of, Domestic Violence; Definitions of Domestic Violence; and Willingness to See Domestic Violence Patients.

Training in, and Knowledge of, Domestic Violence

None of the psychotherapists who participated in this study had received any formal education during their graduate education as social workers, psychologists, or psychiatrists that prepared them to work as psychotherapists in the area of domestic violence. Nor had any of them received any formal education in the prediction, management, or prevention of violence in the lives of their clinical patients. This selective inattention in their training curriculum was related to what one psychotherapist described as "institutional denial -- people in charge just denying that family violence was real." Another psychotherapist who completed graduate school in the mid-1970s didn't even remember the terms domestic violence or battered women being used. His memory serves him correctly, since the term was not coined in the literature until the mid-1970's by feminist author Del Martin (1976). He summed up the training experiences of the group of respondants by stating that he didn't ". . .remember anybody having any interest or suggesting that when I got out of school this would be an issue I would confront professionally at all." This neglect in professional clinical education and training regarding domestic violence continues to be a major concern cited in the literature (Goodwin, 1985; Sonkin, 1985; White, 1988).

The informants in this study coped in a variety of ways with this lack of professional training. The most experienced psychotherapists who began work in this field over 10 years ago joined together with colleagues over the course of the years for peer consultation, trained one another, and eventually became trainers and educators of others. These therapists felt a sense of competence, confidence and enthusiasm in their clinical practice.

Three other psychotherapists who were moderately experienced in the field had sought out continuing education experiences for themselves by attending workshops, reading books, seeking consultation, etc. In spite of their level of training in domestic violence, their sophistication as clinicians in general, and the high quality of domestic violence clinical work they described via case vignettes, however, these psychotherapists

practiced psychotherapy with their domestic violence clients with a sense of reluctance and anxious inadequacy. As one psychotherapist stated, "There's so much to know, and I don't really know enough." (In spite of her feelings that she lacked an adequate knowledge base, she also described a life-saving intervention she had made on behalf of a battered woman).

It appears that these psychotherapists believe that if only they knew more (that is, took more classes, read more books, etc.) they would feel less anxiety, and therefore feel more successful and more confident in their work. These dysphoric feelings contribute to a lack of self-confidence which leads some therapists to be reluctant to become more involved in work with domestic violence cases. Apparently, the informal education in which they had participated had not prepared them for managing the anxiety and stressors which are inherent in clinical work with a domestic violence population. Those psychotherapists who have maintained their longevity in the field have come to know this. They do not expect that clinical experience and training alone would minimize the emotional complexities and anxiety inherent in the work, and so they have learned to structure their professional lives accordingly. A finding of this study is that an aspect of formal training in the field of domestic violence should include educating psychotherapists in anticipating and managing the emotional demands of the work.

Definitions of Domestic Violence: In the Eye of the Clinician

The interviewees ways of defining domestic violence are important in this study for several reasons. First, each psychotherapist's definition of domestic violence will influence whether or not he/she views a particular case in his/her practice as a "domestic violence case." Psychotherapists have been criticized in the literature for their failure to recognize domestic violence in clinical populations (Herman, 1986; Hilberman & Munson, 1978; Jacobson, et al., 1987; Stark, et al., 1979). Secondly, there is also a significant debate in the literature concerning limiting the definition of domestic violence to only physical behaviors versus expanding it to include an emotional climate of control and

intimidation in the relationship. Some researchers also argue for a broader definition including psychological and sexual abuse (Pagelow, 1981; Russell, 1982; Walker, 1984; White, 1988). Thirdly, it is important to ascertain whether interviewees believe that single episodes of physical abuse are sufficient to qualify for a definition of domestic violence or whether repetitive episodes are necessary and indicative of the cycle of violence described by Walker (1984).

The definition and differentiation of various types of domestic violence has generated a good deal of research and debate in the literature. Definitional debate regarding the term domestic violence stems from whether the term should apply to only specific physical behavior or encompass a broader behavioral pattern. Feminist theorists and researchers have categorized abusive acts other than physical acts which may be directed towards women, and they advocate for the inclusion of verbal abuse, economic and social deprivation, and sexual violence into the definition (Okun, 1986; Russell, 1982; Walker, 1984a, 1984b, 1986; White, 1988).

The gendered implications of the term used to describe the phenomena have also been discussed in the literature. The terms wife abuse, woman abuse, wife beating, and woman battering are gender specific and define acts of physical violence by a husband or male directed towards a wife or female (Okun, 1986; White, 1988). The term domestic violence was utilized during the course of the research and interviews because it carries a gender non-specific connotation which was thought preferable when investigating the attitudes and beliefs of interviewees. In the course of these interviews, however, it was clear that the psychotherapists in this study viewed women as those who were at greatest risk for being battered and men as those who were most likely to batter.

Respondants' Definitions of Domestic Violence

Although most psychotherapists who participated in this study did not utilize the terminology prevalent in the domestic violence literature regarding such definitional variables as frequency, severity, or type of violence, most of the psychotherapists did

implicitly include these variables in their clinical assessments, formulations, and/or case vignettes. This lack of definitional specificity may be due to the narrative, interactive aspect of the interview. For the three psychotherapists who were less experienced in domestic violence, it might also be due to the fact that they had not participated in any formal training in domestic violence and thus had not been exposed to the "language" of the field.

Respondants' definitions of domestic violence tended to be broad and inclusive. All of the respondants were clear that domestic violence encompasses physical assault ranging from minor acts, such as slapping, to major acts, such as homicide. All respondants also spontaneously described the psychological climate of intimidation, control and denigration that often serves as the relational backdrop for the physical violence. This broader definition encompasses the concerns voiced by many researchers who argue for a more inclusive definition of domestic violence which encompasses multiple forms of abuse (verbal, economic, social, sexual, and psychological) in the definition of domestic violence. (Okun, 1986; Russell, 1982; Walker, 1984a, 1984b; White, 1988).

Most of the respondants failed to mention certain behavior that is, in this researcher's experience, common to domestic violence situations (such as, verbal threats against life, threats with a weapon, pathological jealousy, sexual coercion, etc.). This could indicate that the level of domestic violence seen in these psychotherapists' private clinical practices is not as severe as that seen, for example, in a legal-justice setting or a treatment program specifically focused on domestic violence.

Strikingly, one of the findings of this study was that all of these psychotherapists perceived psychological abuse as occurring more frequently in the lives of their patients than physical abuse. They all differentiated psychological and verbal abuse from the conflicts, arguments, or disagreements present in other non-abusive, although conflictual, relationships. They all considered it seriously damaging to the psychological well-being of the recipient of the abuse.

An important finding in this study was that these psychotherapists perceived physical abuse to be a more severe manifestation of on-going verbal and psychological abuse, in contrast to the literature which presents psychological abuse as a component of physical abuse (Walker, 1979b,1984b) and also to the literature that more narrowly defines domestic violence according to measures of physically abusive behaviors only (Straus, 1979). All of the psychotherapists were aware of the severe and debilitating impact such verbal and psychological abuse can have on battered women who, as a psychotherapists aptly stated, "begin to believe, hearing time after time, that they are what's being said."

Another related finding was that all of the psychotherapists, regardless of their level of experience with domestic violence, indicated that psychological abuse was always present when physical battering is present. This is similar to the research of Walker (1984b) which identifies the Battered Woman's Syndrome as resulting from both physical and psychological abuse. The debilitating effect of psychological abuse has also been addressed in the psychoanalytic literature (Calef & Weinshel, 1981). An important implication of this finding for clinical practice is that psychotherapists should address both aspects of abuse (i.e., physical and psychological) when treating cases of domestic violence.

The importance of clearly defining violence was highlighted by the unrecognized occurrence of domestic violence in the practices of three of the psychotherapists in this study. These three psychotherapists were the least experienced in family violence and neither actively sought, nor intentionally avoided, the issue of domestic violence. They had never participated in any training in the field of family violence. They all spontaneously stated in the beginning of the interview that they had had no experience with domestic violence. In spite of this initial declaration, however, they all described, in the context of case vignettes, episodes of domestic violence in the lives of their patients. These psychotherapists had not previously labeled certain behavior or dynamics as being examples of domestic violence.

Hence, another finding in this study indicates that as a result of stereotypical or inaccurate beliefs about the definition and prevalence of domestic violence there are psychotherapists at risk for not recognizing evidence of domestic violence in their practice patients. This finding supports concern expressed in the literature regarding psychotherapists' potential to fail to recognize domestic violence and respond appropriately (APA Task Force, 1984; Benedek, 1984; Bograd, 1984; Harway & Hansen, 1990; Hilberman, 1978, 1990; Walker, 1979,1981). In the opinion of this researcher, these psychotherapists did appropriately manage the clinical situations they described. The situations described did not, however, involve severe, on-going abuse, and it is not known if other cases in these psychotherapists' practices might go unrecognized and, therefore, not be appropriately treated. As one of these therapists pointed out, a great deal of how patients' behaviors are perceived and defined is "in the eye of the clinician." This finding emphasizes the need for at least "basic training" in domestic violence as a requirement for all psychotherapists so that they will not fail to recognize this dynamic when it appears in the lives of their patients.

Willingness to See Domestic Violence Patients

All of the psychotherapists who volunteered for participation in this study were senior (i.e., having been in post-graduate clinical practice for over five years) autonomously practicing clinicians. All turned out to be willing to accept referrals of domestic violence patients. None of the psychotherapists in this study completely avoided work with domestic violence patients. It could be, however, that psychotherapists who completely avoid clinical work with domestic violence might also have chosen to avoid participating in this study.

One of the results of this study indicated that the psychotherapists in this group differed in regards to their reluctance versus willingness to see domestic violence patients. All of the psychotherapists were willing to see domestic violence cases in principal. They differed, however, in their eagerness to do such work. Some psychotherapists actively

sought domestic violence referrals, some were in the process of shifting their practices away from a sub-speciality of domestic violence, and others neither actively sought, nor intentionally avoided, such cases. According to the definition of domestic violence utilized in this study, all of the participants had worked with domestic violence patients and had, therefore, grappled with the same difficulties and challenges in their clinical work. In response to these same difficulties and challenges, however, some of the psychotherapists had maintained their level of involvement in the field over a long period of time, while others had decreased their level of involvement in, or retreated from, the field. Those who had maintained a long-term, active involvement in the field described a similar clinical practice style they had evolved over the years. This style differentiated them both from other psychotherapists who were also experienced in the field of domestic violence but were in the process of retreating from clinical work with this population, and also from other psychotherapists who were not particularly experienced in the field of domestic violence but were willing to deal with this issue if it appeared in the lives of their patients. This is discussed at greater length in the section on "Psychotherapists' Capacities Contributing to Longevity in the Domestic Violence Field" (pp. 159-168).

Psychotherapists also differed in their willingness to see specific types of domestic violence cases. One of the results of this study was that psychotherapists' reasons for avoiding versus treating specific cases of battered women differed from psychotherapists' reasons for avoiding versus treating specific cases of battering men. These differing rationales are discussed in the following two sections on "Psychotherapists' Views of the Unique Factors Influencing Their Assessment and Treatment of Men Who Batter," and "Psychotherapists' Views of the Unique Factors Influencing the Assessment and Treatment of Women Who Are Battered."

Psychotherapists' Views of the Unique Factors Influencing Their Assessment and Treatment of Men who Batter

This section addresses the study question of what attitudes, beliefs, feelings, and experiences influence psychotherapists' decisions to avoid versus treat men who batter. Two major sub-categories arose from the data relevant to this question. They are: Expecting Difficult Patients: The "Oi Vay" Reaction; and Forming a Therapeutic Alliance: The Elements and Process of Reciprocal Influence.

Expecting Difficult Patients: The "Oi Vay" Reaction

The psychotherapists in this study approach work with a man who batters with expectations that the man will be difficult to engage in treatment, that the work of psychotherapy will be hard, and that hearing about the man's violent behavior will create dysphoric feelings in them. Given these expectations, it is not surprising that some psychotherapists might prefer to avoid such patients; Greenson (1966), in his classic paper on "That Impossible Profession", referred to as inspiring in the therapist a feeling of "oi vay." Indeed, men who batter typically share the characteristics of the "difficult patient" as described in the literature. The term "difficult patient" generally applies to those clients who invoke anxiety in therapists because of their aggressive behavior, because their psychological distancing mechanisms don't allow them to respond to the therapists' endeavors at relationship and alliance, or because of the severity of their psychopathology and propensity for acting out their pathology in ways harmful to themselves and others (Bassuk & Gerson, 1980; Fredrickson, 1990; Goldberg, 1983; Graves, 1978; Maltsberger & Buie, 1974; Martin, 1975; Taylor, 1984). Studies of the "difficult to treat" patient cite patients' propensities toward violence as the major factor in defining them as "difficult." However, no studies could be located which bridged the literature about difficult patients and the literature about men who are violent towards their partners. Interestingly, domestic violence has not been a form of violence deemed "difficult" in the literature.

The therapists who managed to maintain longevity in the field were quite aware that men who batter are "difficult" patients. These therapists compensated for the "difficulties" by deriving narcissistic satisfaction from their work. It could be that the psychotherapists who avoid or withdraw from men who batter may expect that they will not be successful with these "difficult" patients. Studies of psychotherapists' satisfaction indicate that psychotherapists tend to avoid patients with whom they do not feel successful (Farber & Heifitz, 1982). Moreover, the less experienced psychotherapists in this study indicated that they anticipated experiencing dysphoric affects from exposure to violent case material and that they would prefer to avoid this experience.

Forming a Therapeutic Alliance:
The Elements and Process of Reciprocal Influence

All of the psychotherapists in this study were in principal willing to accept a referral of a man who battered his female partner. The results of this study, however, suggest that there were several mutually interacting influences on a particular therapist's decision to accept or reject a particular male batterer. The results of this study also delineated some elements of a process of mutual or reciprocal influence which occurs between the psychotherapist and a battering man during the initial assessment phase of treatment. The outcome of this process of mutual influence either facilitates or impedes the formation of a therapeutic alliance. If an alliance is developed, the work of therapy proceeds. Without the possibility of an alliance, the work of psychotherapy is impeded.

The findings suggest that these psychotherapists' decisions of whether or not to accept a particular male batterer for psychotherapy were based on the interaction of two sets of criteria: an objective set of criteria based on standard diagnostic decision making parameters combined with factors related specifically to battering men; and a subjective set of criteria based on individual, contextualized subjective conscious feelings and thoughts experienced by the therapist as a result of the initial interaction(s).

The objective assessment criteria were based on standard diagnostic assessment criteria utilized by individual psychotherapists in their assessments of any potential patient. These varied from psychotherapist to psychotherapist depending on their professional affiliation and/or theoretical orientation. These standard diagnostic assessment criteria were combined with specific assessment criteria related to men who batter, such as the history of violence in relationships, quality of impulse control, the ego-syntonic or dystonic nature of the violent behavior, and the authenticity of the man's desire to change.

The most experienced therapists included objective assessment criteria specifically related to domestic violence in their initial assessment; that is, information about the type, frequency, and severity of the violence in relationships. This is in keeping with the literature which describes the assessment parameters for men who batter (Hanks, 1992; Hotaling & Sugarman, 1987; Neidig, Freedman & Collins, 1984, 1985; Sonkin, 1985).

Most therapists believed that poor impulse control would be a poor prognostic indicator for out-patient therapy. If the male batterer had a history of being violent towards others outside of his primary relationship, or if he had a history of having been abusive to a series of women, all of the therapists would be less inclined to accept him as a patient. Female therapists would tend to decline him because of concerns for their own safety, whereas male therapists would be reluctant to accept a client who "might be a pain in the ass," that is, require containment and intervention outside of the therapy setting.

That female therapists, in concern about personal safety, would be unlikely to accept a battering man with a history of violence directed towards others outside the primary relationship, could be viewed as representing a barrier to treatment for male patients. However, the research to date does not address whether these concerns are valid. There is no research indicating that female therapists are at any higher risk of assault from a male patient who batters both his spouse and others outside the relationship, than they would be with a male patient who only batters his wife, or that a female therapist is at more risk than a male therapist.

The potential patient's ability to communicate an authentic desire to stop his violent behavior, sometimes labeled "motivation for change," is a heavily weighed factor among the objective assessment criteria. As one therapist aptly said, he looks for a "scintilla of motivation" combined with the presence of an observing ego, something that says, "I've looked at myself, and I just don't like the fact that I slap my wife or girl friend around."

Violent behavior that was more ego-syntonic was assessed as socio-pathic, and thus not amenable to outpatient psychotherapy. Violent behavior that was presented with some guilt and responsibility on the man's part was viewed as a more positive prognostic indicator for outpatient psychotherapy. The objective assessment factors which these psychotherapists weighed positively in the direction of accepting a battering man for therapy were good impulse control (indicated by violence only within the primary relationship), and ego-dystonic violent behavior coupled with an authentic desire to change.

The possibility of forming a therapeutic alliance was assessed on the interaction between subjective criteria and the above-mentioned objective criteria. The subjective assessment criteria utilized by these psychotherapists were based on individual, conscious feelings and thoughts evoked in the therapist by the potential patient's: (a) interpersonal style; (b) his manner of describing the violence he had perpetrated; (c) and his feelings about himself and about his violent behavior.

All of the psychotherapists described an initial negative subjective reaction to the male batterer because of the violent nature of the behavior for which he sought therapy. The psychotherapists described how, being aware of their own negative reactions, they listened closely to the man's presentation for clinical data or affective impressions which might mitigate this initial negative subjective response to his violent behavior. As one therapist stated, "it would depend on how he put it to me." Another described this process as ". . . listening as much for the music as to the words." The potential patient would have to communicate convincingly to the therapist that he was genuinely distressed about his behavior (i.e., had the capacity for guilt), that he was authentically desirous of change

(i.e., had motivation for therapy), and that he was capable of assuming responsibility for his behavior (i.e., had good impulse control).

A psychotherapist's initial subjective reaction to a male batterer had a major influence on his/her decision to accept or reject a particular patient. If the psychotherapist's initial negative subjective reaction to the patient was sustained, the psychotherapist would likely refer out the patient as he/she believed that a therapeutic alliance was unlikely.

Psychotherapists' Dysphoric Feelings: Antipathy and Retaliatory Rage

Both the patient and the psychotherapist must be individually and jointly capable of, and motivated to, form a therapeutic alliance. In this study, all of the psychotherapists struggled in general with their antipathy towards violence and in particular towards the men who perpetrated violence against their wives. This struggle presented a significant impediment to the psychotherapist's motivation to contribute his/her part to the formation of a therapeutic alliance. The psychotherapist's antipathy towards violence and the batterer also impaired the therapist's capacity for establishing an empathic therapeutic alliance with the potential patient.

One psychotherapist described the revolt and disgust he feels when, in the course of evaluating a male batterer, he thinks about the man battering his wife in front of their children. "It's appalling to me. . .it's like revolting and overwhelming to me. It's one of the things I have to contend with with any battering man. I would have to come to grips with the fact that a part of me hates him...It's a terrible, terrible emotional crime against children." Revolt, disgust, and hate are not typical reactions for psychotherapists to have towards their non-violent patients. An implication of this study for clinical practice is that any psychotherapist who works with men who batter must be able to consciously tolerate, and not act upon, intense and often ego-dystonic feelings, affective states, wishes, and impulses in order to do the work.

According to Haley (1974), patients who behaviorally act out their violent impulses, wishes, or fantasies may elicit sadistic and retaliatory feelings in the psychotherapist. These feelings may be especially potent toward male patients who batter their wives and who not only terrorize and injure their wives but also terrorize their children (Eth & Pynoos, 1985; Jaffe et al., 1986a,1986b; Wolfe et al., 1986). "Psychotherapy is not useful until the therapist is perceived as someone who can hear horrifying realities and can tolerate natural feelings of revulsion, yet resist an equally natural tendency to punish" (Haley, 1974, p. 152). As one therapist stated, "There's a part of me where I feel--I know this is not good to say--I feel that they do not deserve any treatment. They should just be incarcerated and punished for what they've done." This therapist was both conscious of, and guilty about, her retaliatory feelings towards men who batter.

According to Haley (1974), who worked with Viet Nam veterans who had committed atrocities, the first task of the therapist is to "confront his/her own sadistic feelings, not only in response to the patient, but in terms of his/her own potential as well" (p. 152). One therapist acknowledged that his initial reaction to a male batterer "would have to do with my own discomfort with violence and potential for violence and with my own anger."

As described in the literature, an important component of treatment for patients with histories of violence is that clinicians acknowledge their reactions to patients who have behaved violently and understand how these reactions might impact the treatment. It is essential that therapists be aware of toxic feelings and not deny or repress them (Dubin, 1989).

Colson et al. (1986) studied "non-pathological" emotional reactions to difficult-to-treat patients and concluded that different forms of pathology elicit characteristic patterns of emotional reactions. Patients who showed potential for violence and agitation evoked the most complex array of feelings ranging from helplessness, confusion, anger, and

fearfulness. Adverse reactions can occur when a clinician projects his/her own sadistic and angry impulses into a patient and exaggerates the patient's capacity for violence. Although this is theoretically possible and, in this researcher's experience, quite common in the clinical encounter (Hanks, 1988, 1992), none of the psychotherapists in this study spoke of experiencing sadistic feelings towards a male batterer. They did, however, speak about having angry and sadistic feelings in relation to battered women patients. (See "Difficult" Battered Women: Coping with Rescue Fantasies and Repetition," pp.156-157).

Patients who present with a complaint relating to aggressive and destructive urges, or a history of such behavior, produce fear and anger as predominant reactions in the therapist. Such fear may distort the clinician's perception of the patient as a potential danger to him/herself (Bach-y-Rita et al., 1971; Lion, 1972; Lion, Bach-y-Rita & Ervin, 1969; Lion & Pasternak, 1971). This projection may lead to rejection of the patient . The female psychotherapists in this study reported that they would initially feel some concern for their own safety if they were to receive a referral of a man with a history of domestic violence. They would be concerned both about the possibility of his losing control during the sessions as well as his harming or harassing them outside the office. As one psychotherapist stated, a criteria she would utilize in her decision to work with a male batterer would be "how scared I would be with him and whether there was something about him that would make me feel very uncomfortable." It is not known if these perceptions of the male patients actually negatively influenced the female psychotherapists' ability to form therapeutic alliances with their male patients. Two female psychotherapists did report that they had made special arrangements to meet in an office settings that felt safe to them in order to work with male patients. As one female psychotherapist stated,

> I think of someone who batters as very explosive and unable to contain those impulses or channel them into non-physical directions. . .I imagine that I might be afraid. That might be one thing that would cross my mind. . . afraid of violence against me. . .so when they're sitting here in a civilized way talking with me, it's a thin veneer in my book, but that's what I would worry about.

It is important to note that none of the psychotherapists' fears or fantasies were based on having been actually physically or verbally assaulted or threatened by a male batterer. Two of the male psychotherapists related incidents of having had to verbally calm an agitated male patient in their office, but neither of the psychotherapists really felt they had been at risk of personal physical assault.

Reciprocal processes. The reciprocal component of the interactive process of forming a therapeutic alliance occurs within the male patient. Although this study did not focus on the battering men's reactions to their therapists, the psychotherapists in this study were aware that they too had to pass certain unspoken tests in order for a potential patient to accept them as a person who could trusted to be helpful.

One female therapist spoke of forming an alliance with a male patient by setting clear limits on his behavior without shaming him and without accepting that he "was a horrible person." This was in spite of her statement that her initial feelings about an abuser might be negative and that she might feel that such a person did not deserve treatment. She speculated that he was able to continue in therapy with her because

> I had sort of passed some test. I wasn't put off by him. I had not said I wouldn't want to see him. He presented the worst of himself and it was a kind of 'truth or dare' game. He had a tremendous sense of shame about him and in the moment he became aware if it, he would feel very threatening and then be very aggressive. . . Was I going to be be able to put up with it or not? Was he able to scare me into believing what a really horrible person he was, or would I take the bluff and work with him? I just set clear limits, even though he tried to turn the limits into a test of do I like him or do I not like him.

The process of forming a working therapeutic alliance is a challenging aspect of psychotherapy with men who batter that has not been discussed in the literature. The results of this study describe the various elements that interact and mutually influence the process that occurs between a psychotherapist and a male battering patient. The patient must convince the therapist that it is possible for him to change--and the therapist must convince the patient that he/she can contain the disgust, revolt , hatred, and/or retaliatory rage engendered in the therapist by the man's violent behavior. As one therapist stated, the ". .

.intention and desire on the part of the man to move towards being a human being who doesn't abuse others keeps my hatred in check." Concomitantly, the therapist's non-rejecting, non-humiliating stance (i.e., empathic identification) may contribute to keeping the man's violence in check.

Iatrogenic aspects of assessment. It is important to recognize that the assessment situation itself may iatrogenically produce intimidating behavior in the man who is testing the therapist's acceptance of him. If the psychotherapist responds with negative, hostile, or punitive feelings, the man may be narcissistically injured and, as a defense, escalate his intimidation, which will in turn heighten the psychotherapist's negative reaction. A very experienced male psychotherapist described the one instance he remembered of being frightened of a male batterer:

> He began to pace around my office and started talking louder and louder. I said to the patient, 'I'm really concerned about what's going on right now. I wouldn't want to get hurt myself and I wouldn't want you to have any more troubles than you already have, and it feels to me like you're really escalating. I wonder if we can talk about this in a way that would help you settle down.' We figured it out together. He thought I was criticizing him and that I didn't understand how his wife forces him [to be violent].

Similarly, a female psychotherapist related this vignette, describing a male patient's aggressive response to his shame:

> He presented the worst of himself. . . He had a tremendous sense of shame about him and in the moment he became aware if it, he would feel very threatening and then be very aggressive. . . Was he able to scare me into believing what a really horrible person he was?

An important finding of this study is the importance of psychotherapists' being consciously aware of the complicated dynamics inherent in the assessment situation so as not to unnecessarily deny a male batterer access to treatment due to either iatrogenically produced negative interactions or due to the psychotherapists' fantasy-based, rather than reality-based, fears.

Psychotherapists' Views of the Unique Factors Influencing the Assessment and Treatment of Battered Women

This section addresses the study question of what attitudes, beliefs, feelings, and experiences influence psychotherapists' decisions to avoid versus treat battered women. The five sub-categories which arose from the data relevant to this question are: Tolerating the "Door Mat" Stance: Reactions to Victimization; Fear of the Violent Partner: Distinguishing Fantasy from Reality; Treatment Goals: Stopping the Violence Versus Ending the Relationship; The "Difficult" Battered Woman: Coping with Rescue Fantasies and Repetition; and Reconciling Ideals and Realities: Political Influences in Clinical Practice.

Tolerating the "Door Mat" Stance: Reactions to Victimization

A factor unique to the psychotherapy of battered women is the psychotherapist's exposure to the dynamics of victimization. According to Benedek (1984), it is important to recognize that despite variance among individual clinicians, everyone has conflicts regarding reactions to violence and victimization. "What seems to be important is the clinician's sense of helplessness. . . If I am presented with this information, what can I do? What should I do? What must I do?" (p. 51). Psychotherapists often feel helpless and hopeless when confronted with such victims. The psychotherapist is challenged to confront his/her own feelings not only about the woman as an individual with a unique personality and character structure but also about the abuse the woman has suffered.

As described by psychotherapists in this study, the initial reactions to a potential battered woman patient ranged from active approach to avoidance; that is, from a desire to be actively involved with the woman in protecting her from further abuse to a stance of being "put off" and actively wanting to retreat from involvement. One of the nine psychotherapists in this study would no longer accept battered women as psychotherapy patients in spite of his commitment to the cause of battered women in the forensic arena.

Similar to their work with battering men, the therapists' eagerness or reluctance to accept a referral of a battered woman depended on how the woman presented herself during the initial contact. If the woman presented herself as being a helpless victim, some psychotherapists were less eager to work with her. If the woman conveyed a sense of her own part in the violence, however, therapists were more eager to work with her. As one psychotherapists stated, "If in her tone there is some indication that she is interested in having this stopped, that she conveys a sense that she may have something to do with it--either with the violence itself or with her getting herself out of the situation, or with her doing something productive or positive about it--then I would not feel put off."

Some therapists were quick to identify with what they described as the woman's oppression and victimization. One therapist described her internal, non-verbalized response towards a battered woman as "an instantaneous sense of incredible empathy and willingness to do everything. . . to come forth and protect them and to make sure no more violence occurs." These therapists were also more comfortable working with the battered women than their battering male partners. They would quickly assess the need for adjunctive resources (i.e., legal advice, shelter, etc.) and felt that it was important to educate their potential client about available resources. This stance implied that these therapists were knowledgeable enough about the field of family violence to be familiar with the community resources and legal options available to battered women.

In spite of their initial reactions, however, all of the therapists also added that they viewed battering as "pretty transactional" and that they would purposefully temper their initial urges to intervene actively as they retreated into their role of psychotherapist. As one psychotherapist stated, "I have to watch out and sort of restrain myself if I'm the psychotherapist. I'm not the social worker. I'm not the counselor in the shelter for abused women."

Other psychotherapists would initially feel conflicted about the battered woman's victimization. "If she wanted me to do something about it in a concrete immediate way, I'd

be put off. . . my first reaction would be 'Oh god, why isn't she calling the cops or some other agency who could help her out!'". In a similar vein, another therapist stated she doesn't "like super-duper victims... I probably tend to prematurely think that the victim is also very actively involved in kind of keeping it going. . . In my own life, I don't like dealing with people who are always presenting themselves as a victim."

In spite of the range in these initial reactions, all but one of the therapists would be willing to see a battered woman. Ironically, the one therapist who was the most experienced in the field of family violence was no longer willing to accept battered women as psychotherapy patients because of what he labeled his "clinical failure." He had had an active clinical stance with the women whom he had treated, and he had worked vigorously with them to leave the relationship. His experience had been that women who left their battering partners eventually returned to them. He felt that he had failed. This therapist experienced a common dynamic reported in the literature concerning battered women's propensity for temporarily leaving and eventually returning to the battering relationship.

It is interesting that this is the only psychotherapist who experienced, as he called it, "clinical failure" with the women. The other psychotherapists, in spite of their range of initial reactions, did go on to work with many battered women and did not experience a sense of clinical failure. It could be that an initial overly zealous reaction to the woman's victimization, which leads to an expectation and therapeutic goal that the woman leave the relationship, may lead to"clinical failure."

It is of note that none of the psychotherapists in this study mentioned the possibility that a battered woman seeking psychotherapy might be suffering from a post-traumatic stress disorder or from the Battered Women's Syndrome (Walker, 1979b, 1984). Both of these conditions might affect her initial presentation to a psychotherapist and her capacity to be mobilized on her own behalf and they might contribute to what a few therapist coincidentally called the "doormat stance." Also it is not clear whether these therapists would view the "doormat stance" as a contributing to, or resulting from, having been

abused. This findings supports the need for education of psychotherapists to assist them in differentiating the impact that battering might have on a battered woman's initial presentation in psychotherapy.

Fear of the Violent Partner: Distinguishing Fantasy from Reality

Fear of the battered women's violent male partners was a factor raised spontaneously by four of the five female psychotherapists in this study. As one therapist stated, she would "worry about the woman's safety. . . and would also worry about my own safety in taking on the case, depending on whether the guy was crazy enough to track me down, or to follow her." Female psychotherapists incorporated questions about the male partner's potential for dangerousness to others outside of the primary relationship by asking about the man's history of violence towards others, his use of drugs or alcohol, and his general level of impulse control. These female therapists also related their concern to their practice setting; that is, private practice. None of these psychotherapists had ever experienced a situation in which they had been personally threatened by the male partner of a battered woman. In response to such fears, however, one therapist had altered her work environment by seeing a battered woman patient only during daytime hours when her professional building was occupied by co-workers. The female psychotherapists were clear that they would refer a battered woman to an agency setting if they felt a danger to themselves.

None of the male psychotherapists spontaneously raised this concern and, when querried, denied such a concern. Two of the male psychotherapist, however, volunteered that they could appreciate a female psychotherapist's concern about personal safety. They perceived female therapists as being a more likely target of the male partner's acting out. There is no data in the literature documenting that female psychotherapists are at higher risk than male therapists, or that psychotherapists are at any risk from a battered woman's male partner. Nevertheless, it is common knowledge among battered women's shelter workers that men who batter have been known to assault shelter workers. In addition, battered

women themselves are known to be at greatest risk for assault when they leave the relationship (Browne, 1987). On the other hand, the context of a psychotherapy practice versus a battered women's shelter is quite different and contextual variables have been shown to be important in understanding and predicting dangerousness (Shah, 1978).

A common dynamic of battered women which is addressed in the literature is their tendency to alternate between being overwhelmed by fear and being in denial of danger. A woman who is battered may at times be so psychologically entrapped in the relationship that she misperceives the abusive partner as being more dangerous and powerful than he is in reality, or, concomitantly, she may minimize his potential for dangerousness as a defense against her own anxiety. Because of the complex psychodynamics of the battering relationship, a battered woman's capacity to arrive at an accurate judgment about the male batterer's level of dangerousness is often impaired (Gilman, 1980; Hanks, 1992).

It is important that psychotherapists be able to make an accurate assessment of the battering partner's potential for danger--both toward the psychotherapist and toward his female partner. As one of the female psychotherapists astutely stated, "I hope I would be able to make a judgment about what was in fact a danger to me, and what was a kind of countertransference feeling about what I might be picking up from [the woman] about [her] fear of being around him."

A finding of this study is that this dynamic in the assessment and treatment of battered women may present a barrier to a battered woman's treatment by a female psychotherapist. It is important to identify such a barrier as one of the experiences that may contribute to the Battered Woman's Syndrome, for a sense of helplessness and hopelessness may result from repeated rejections when attempting to seek help outside of the relationship (Walker, 1984a, 1984b).

In order to avoid rejecting a battered woman out of unwarranted fear, or to avoid jeopardizing a psychotherapist's safety out of naivete or denial, it seems important that psychotherapists be aware of this dynamic. Female therapists in particular may be more

vulnerable to the enactment of this dynamic because of their higher risk for over-identifying with the woman's victimization and becoming angry at, and possibly fearful of, the batterer (Benedek, 1984). A finding of this study is that assessment of the battering partner's potential for dangerousness to both the battered woman and to the psychotherapist is an important diagnostic skill for psychotherapists to acquire.

Treatment Goals: Stopping the Violence vs. Ending the Relationship

All nine psychotherapists described "stopping the violence" in the battered woman's life as a primary goal of psychotherapy. Two factors which contributed to the formation of this treatment goal were the psychotherapists' perceived sense of urgency in the battering situation due to the life threatening potential of the physical abuse; and their perceived sense of responsibility as a clinician to use their skills to protect their patient(s).

The psychotherapists differed, however, in their views of how to achieve this goal, and they differed on what they considered a reasonable time in which to achieve this goal. For some psychotherapists, the goal of stopping the violence was synonymous with the woman leaving the relationship, while, for others, the goal of stopping the violence was not predicated on the woman's leaving the relationship.

Psychotherapists who integrated behaviorally-oriented techniques and/or a symptom-focused approach into their work with battered women felt compelled to stop the violence immediately. As one psychotherapist said, a reasonable length of time for stopping the physically violent behavior was "yesterday." He experienced a need to "be doing something to have an impact pretty quickly. . .There is an immediacy here and a real kind of danger. You don't have the luxury of sitting back and seeing how things unfold." In a similar vein, another therapist stated that,

> In a critical situation--and I think being battered is critical--it's not like a problem of sustaining intimacy and you have six years to deal with it. Helping a woman out in weeks or a couple of months is a private and professional marker of success. If I can't do that, then it seems that just talking, but nothing really effective, is going on, because there is so much at stake.

In contrast, psychotherapists who worked from a psychodynamic/ psychoanalytic perspective did not feel compelled to stop the violence in their patients' lives quickly. They also did not feel that leaving the relationship was a necessary step in ending the violence. They believed that having a goal for the woman to leave the relationship might make it impossible for the battered woman to continue in psychotherapy. They attempted to structure the therapy in such a way that the battered woman would be protected from a sense that she would fail in therapy if she were unable to leave the relationship. For these psychotherapists, leaving the relationship was not a "primary goal" but rather "a beneficial side effect." Their focus was on characterological change, and they "hoped for more than her simply getting out." These psychotherapists believed that insight and personality change were needed so that the woman "no longer needed the relationship" and would not be likely to join into another battering relationship if she left this one.

Only one therapist took an individualistic, pragmatic approach to the questions of stopping the violence and leaving the relationship. In one case, this therapist directed a couple not to live together unless the man stopped his physical violence. In another case, she assessed the women's characterological capabilities and limitations, recognized the economic and real life hardships the woman would face were she to leave her marriage and, so, did not work towards the woman leaving the relationship.

In addition to the division of differing theoretical leanings (behavioral/ symptom-focused vs. psychodynamic/insight-oriented), a personal factor appeared to distinguish the two main approaches. There was a difference in the psychotherapists' individual capacities and willingness to personally tolerate the sense of helplessness that may be endemic to an on-going therapeutic relationship with a female patient who is being intermittently battered (Gilman, 1980; Hanks, 1992) and their ability to bear the resultant sense of helplessness and alarm without a sense of clinical failure. The more psychodynamically-oriented psychotherapists were willing to tolerate dysphoric feeling states (i.e., helplessness, worry, anxiety) while maintaining the belief that eventually the woman would be able to

improve her situation. One therapist stated that "one of my strengths as a clinician [is] a huge capacity to hang in there and to not ask for a woman to change. . . I have a lot of tolerance for people who are in bad relationships."

In contrast, therapists who were more behaviorally/symptom-focused were unwilling to tolerate these dysphoric feelings. One therapist described how

> I can't bear to sit in the room with a woman, eight, ten, fifteen times, who is telling me that she continues to be battered, and I keep asking myself, and this is clearly countertransference: What are we doing here? How do I justify the fact I'm continuing to see her. . .and this continues to happen. I can't take it. I feel like like I'm in a hot room that 's getting hotter and hotter and I've got to get out. I can't take the fact that I define myself as having the training and expertise to facilitate change. . .and the input from the woman indicates that it still hasn't changed: 'I'm still with him and I still see you'. Then it becomes a contradiction to me. What am I doing here? How can I justify it?

An important finding in this study in regard to psychotherapy of battered women is the influence of the psychotherapists' affective response on the treatment goals. Regardless of theoretical orientation, some psychotherapists found it simply intolerable to bear their female patients' repeated batterings. These intolerable feeling states would often prompt the psychotherapists to insist that the battered women leave the battering relationships--with the result that the women often left psychotherapy instead. It is important that treatment goals be based on the female patients' needs and not on the psychotherapists' dysphoric feeling states.

The issue of treatment goals is central in any psychotherapy. The range of responses reported in this study regarding to psychotherapists' beliefs about whether a battered woman needs to leave her primary relationship in order to stop the violence in her life, and the amount of time the psychotherapists felt comfortable tolerating the battered woman's continued abuse, is an indication of the wide range of therapeutic experiences a battered woman might encounter were she to seek psychotherapy. One of the results of this study is that there appears to be no consensus about what might be basic and appropriate therapeutic expectations for women who are battered. As a result, a woman

who is battered who seeks psychotherapy might encounter different approaches to her life situation depending on the view of the psychotherapist with whom she were to consult.

"Difficult" Battered Women: Coping with Rescue Fantasies and Repetition

The "difficult" battered women were those who engendered a variety of dysphoric feelings in the psychotherapist, ranging from frustration, helplessness, and hopelessness, to rage. All of the psychotherapists in this study had at some time encountered strong dysphoric feelings when working with battered women. What these case vignettes of "difficult" battered women seemed to have in common were the psychotherapists' perceptions that the women had presented themselves in great need of assistance and, then, had defeated the psychotherapists' best efforts to be helpful.

It appears that these battered women had succeeded in threatening the therapist's idealized imago as a concerned and competent practitioner (Burton, 1964; Goldberg, 1990). Beck et al. (1984) have suggested that the defining characteristics of "difficult-to-treat" patients may not be the level of their pathology or the nature of their problems, as much as their unwillingness or inability to validate efforts of psychotherapists on their behalf. Patients may be viewed as difficult because they deny the special competence and authority of the mental health professional.

In this study, three types of "difficult" battered women were described. One type was presented as sharing the husband's impulse control problems and as being "in there right ready to fight." Such women are described in the literature as "mutually violent" (Neidig, Freidman & Collins, 1984). A second type of "difficult" battered women were those who had stayed in a battering relationship for many years, were extremely dependent emotionally on the batterer, and did not have the self-esteem to utilize external resources. These women appear to resemble those suffering from the Battered Women's Syndrome and learned helplessness (Walker, 1979a, 1979b, 1984a, 1984b). The third type were women described as ambivalently attached to their abuser and to the psychotherapist. These women repeatedly left and rejoined their battering spouses (Gilman, 1980; Hanks, 1992;

Young, 1991) or worked hard in psychotherapy to exit one abusive relationship, only to subsequently enter another.

One psychotherapist aptly reflected that the rescue fantasies that were evoked in psychotherapists by some battered women were followed by a "sucker-punch feature," that is, the battered woman's initial positive engagement in the therapeutic process was followed by her hostile, unconscious defeat of the psychotherapist's attempts to rescue her. The battered woman's attempt to defeat the psychotherapist is an attempt, according to this psychotherapist, "to show you that you were an impotent therapist." For a psychotherapist to try to rescue a battered woman, only to be defeated by her return to the battering relationship, or by her entry into another battering relationship, is "enraging" for the psychotherapist. Psychotherapists may respond to this dynamic by behaving sadistically in return: "This then is part of the so-called sado-masochistic dynamic because the therapist turns into the raging character." One psychotherapist frankly and honestly acknowledged that, although he doesn't rage at his patients, "Even the most accurate interpretations can be put in a way that is very sadistic and abusive; or, one can adopt an abusive attitude." Another psychotherapist described his version of the "sucker-punch" dynamic as,

> the "Now I've Changed My Mind" dynamic. The battered woman wants to leave the relationship and you're sort of going along with this agenda. All of a sudden you realize there's another agenda that's: 'Well now, I've changed my mind. I really kind of love him and he's hurting and how can I leave him?'

This therapist also spoke of his frustration and feelings of defeat when this occurs.

Another therapist described her sense of frustration with the slowness of the work and the woman's tolerance for abuse. She, too, sometimes feels like the verbally abusive husband when she wants to scream at her female patient: "Why the hell are you bothering with this shit, lady!." Unlike the woman's verbally abusive husband, however, this therapist refrained from verbalizing her angry frustration.

This dynamic of psychotherapy with women who are battered is an important finding of this study. Although this affective reaction to clinical work with battered women

is not, in this researcher's experience, uncommon, it is rarely acknowledged in the literature. It is the theoretical "hot potato" in the debate in the literature regarding women and masochism (Breines & Gordon, 1983; Brennan, 1985; Caplan, 1984; Gilman, 1980; Walker, 1979a, 1979b, 1984a, 1984b; Young & Gerson, 1991). Although it is beyond the scope of this study to analyze the etiology of this dynamic in a certain sub-set of battered women, it is important to note it's occurrence. It is equally important to educate psychotherapists about this dynamic which is likely to occur in treatment and to prepare them to respond to it in a non-sadistic manner.

Reconciling Ideals and Realities: Political Influences in Clinical Practice

Most of the moderately and very experienced therapists spontaneously introduced the influence of the "politics" of the family violence field on their practices of psychotherapy with battered women. They also frequently alluded to the "unwritten rules" concerning the appropriateness or inappropriateness of certain kinds of therapy. The "political influence" was a clear theme threaded throughout some of the interviews. The politics, however, were often referred to in a negative context; that is, a context in which the psychotherapists were apologizing for having deviated from their perception of what was "politically correct."

The psychotherapists were aware that psychological theories explaining the etiology of domestic violence have long been criticized for promulgating "victim blaming" notions that held the battered woman responsible for the batterer's violent behavior and thus held the battered woman responsible for her own abuse. In addition, certain modalities of treatment (such as couples therapy or family therapy) and certain psychological theories (such as psychoanalytic theory or family systems theory) have been criticized as ignoring the power imbalance in families and exempting the male batterer from responsibility for his behavior (Bograd, 1982, 1984). While the psychotherapists were aware of these criticisms, most of the psychotherapists were also convinced of the utility of some of these theories and treatment modalities.

It appears that these influences do not stop clinicians from practicing in self- defined "politically incorrect" manners. They do, however, apparently discourage frank dialogue and discourse among psychotherapists who wish both to be sensitive to the feminist critiques of traditional psychodynamic and psychoanalytic theories and also not deny the reality of the difficulties of the work of psychotherapy with some battered women.

Psychotherapists' Capacities Contributing to Longevity in the Field of Domestic Violence

A finding of this study is that there appears to be an optimal style of clinical practice that contributes to psychotherapists' longevity in, rather than attrition from, the field of domestic violence treatment. The factors which contribute to, and mitigate against, this optimal style of clinical practice are encompassed by these sub-dimensions: Anticipate and Manage Dysphoric Affects; Limit Professional Involvement; Diversify Professional Practice; Derive Self-Esteem from Work with "Difficult" Patients; Bridge Etiological Explanations; Develop Clinical Flexibility; and Cope with "Failures" and "Mistakes."

Anticipate and Manage Dysphoric Affects

As a group of seasoned psychotherapists, the participants in this study were very observant of, and insightful about, their own internal processes vis-a-vis their psychotherapeutic work. They were very articulate about the strong affective responses generated within them by their work with domestic violence. Affects ranged from compassion, helplessness, hopelessness, and anxiety to disgust, fear, rage, and hate. Some felt, at times, overwhelmed, incompetent and/or unrecognized in their hard work. This particular aspect of the psychotherapy work with domestic violence has rarely been discussed in the literature, although it is one of the major reasons informally reported to this researcher by colleagues for their avoidance of domestic violence patients or their retreat from the field.

One of the most experienced psychotherapists who has maintained her longevity in the field articulated this phenomenon by talking about the impact of work with family violence on her as a psychotherapist. "It's not a matter of the therapist being able to act on the client, it's more the therapist being tremendously impacted as well as the client...there has to be a mutuality and reciprocity of impact...it's a whole different ball of wax for the therapist...it's a different kind of relationship which is required." Another psychotherapist, who has also maintained clinical longevity in the field, described his process as, rather than being daunted by the toxic nature of his feelings in the work, "attracted to the notion of confronting toxic and damaging professional and personal feelings and tranquilizing them by getting vigorously into the clinical work". It was clear that the psychotherapists who had maintained longevity in the field of domestic violence had learned to anticipate, manage, and value their own strong affective responses to the clinical work.

Limit Professional Involvement

One factor which appears to contribute to psychotherapists' clinical longevity in the field of domestic violence is the psychotherapist's ability to limit the total amount of professional activity focused on issues of family violence. The three psychotherapists who were most experienced in domestic violence and had maintained clinical longevity in the field for over ten years had all limited their involvement in the field to from twenty to fifty percent of their total professional activities. One of these most experienced psychotherapists was in the process of retrenching; that is, decreasing the total amount of professional practice devoted to issues of family violence because "it was very stressful and demanding of a lot of time and energy." This psychotherapist was not, however, retreating from the field altogether but was rather restructuring her professional commitments to include, at most, a fifty percent time focus on family violence. It is likely that this psychotherapist is following in the footsteps of her other two colleagues who had already learned to intentionally limit their work with issues of family violence to twenty or thirty percent of their total practice.

One of the findings reported by the interviewees in this study was the sense of urgency which pervaded their work with domestic violence. Because of this sense of urgency, there is a tendency for persons in the helping professions new to the issue of domestic violence to become overly-involved with battered women and battering men. The dynamic of over-involvement and excessive commitment has been discussed in the literature on "burn-out" in the helping professions but has not previously been applied to the field of domestic violence. Over-dedication and excessive commitment have been identified in the literature as guilt-based responses to work with crisis-prone populations and have been shown to lead to frustration, exhaustion, and eventual narcissistic depletion (Altshul, 1977; Freudenberger, 1975). This in particular has been discussed as a problem for workers in battered women's shelters but has surprisingly received no attention in the literature as a professional hazard for psychotherapists (Epstein & Silvern, 1990). It appears that limiting the percentage of total professional activity (whether teaching, clinical practice, writing, etc.) focused on domestic violence issues is one of the strategies for containing the inherent emotional stresses and demands of the work and continuing to work in the field without abandoning it altogether.

Diversify Professional Practices

Another factor which appears to contribute to psychotherapists' clinical longevity in the field of domestic violence is the psychotherapists' ability to structure diverse activities into their professional lives. Those psychotherapists who had maintained longevity in the field and those psychotherapists who were moving toward increased involvement in the field were distinguished by the fact that their professional lives were the most diverse. In addition to private clinical practice, they also taught in graduate schools, provided mental health and forensic consultation, testified as expert witnesses, participated in continuing education and training seminars for professionals and the general public, supervised psychotherapists in training, wrote professional articles, etc. Although they did not purposefully structure their professional lives in this manner in order to work in the field of

domestic violence, they did credit the diversity in their lives with enabling them to maintain some level of involvement with the field.

Burton (1976) contends that psychotherapists leave a particular field or decline to work with a particular population because of lack of satisfaction in the work. Structuring a diverse professional life seems to address the several levels of satisfaction that a psychotherapist can derive from his/her practice as described by Burton (1976). These include satisfactions derived from ameliorating suffering through clinical practice, achieving professional status from being recognized as experts in their field, being intellectually and creatively stimulated through their research, writing, or teaching, and reaping the resultant economic rewards. It appeared in this study that psychotherapists who were solely in direct clinical practice were those who were the least likely to derive satisfaction from their work with domestic violence patients.

It could be that the successes in a variety of professional arenas serve as a counter-balance for the stressors of work and preclude the narcissistic depletion that can result from over-involvement with a demanding patient population (Altshul, 1977; Farber & Heifetz, 1982; Freudenberger, 1975). As one of the psychotherapist stated, "Success is a good antidote to demoralization."

Derive Professional Self-Esteem from Work with "Difficult" Patients

The psychotherapists in this study differed in their perceptions of themselves regarding their involvement in the field of domestic violence. Those who had maintained longevity in the field described themselves as feeling challenged by work with "difficult" patients in general, and domestic violence patients in particular. They derived a sense of self-esteem and narcissistic gratification from being perceived by their colleagues as someone who is able to work successfully with "difficult" patients. Farber and Heifetz (1981), in their study of psychotherapists' satisfactions and stresses, found that feeling professionally respected was one of the most satisfying aspects of therapeutic work. For example, one psychotherapist with a long history in the field says,

> I sort of like the image of being able to take people that other people won't see. . .if someone calls up with a problem that other people turn away from I'm inclined to say, "Sure, come on!"

Similarly, another says,

> I tell colleagues that if they have someone who gives them nightmares, or severely disturbed borderline people, or people involved with violence, I'm happy to work with them. I am especially interested in working with people who have hurt other people. . .one reason is narcissistic satisfaction of 'most people can't do this well. I believe I can!"

In contrast, the positive self-perception of psychotherapists who maintained longevity in the field differed from the self-perception of psychotherapists who were retreating from the work and who were intentionally trying to professionally dis-identify with sub-specialties of "dysfunctional types," such as domestic violence. Psychotherapists who were retreating from the work described themselves as no longer feeling the "need" or "obligation" to work with "dysfunctional" patients.

A moderately experienced psychotherapist whose work with domestic violence extends back over a ten year time period described the process of moving away from the domestic violence field. This psychotherapist

> prefers to see people who are high functioning now, partly because of my own changing. I used to be very identified with actually more dysfunctional types of specialties, including domestic violence. . .I've actually wanted to move away from those specialties somewhat to a broader range of people who are not quite so dysfunctional.

Although she is clearly not deriving the self-esteem from her work with difficult patients that her colleagues described above, she could also be viewed as moving toward diversifying her practice and may be following the footsteps of her colleagues who have maintained their longevity in the field by doing so. Only time will tell.

Bridge Etiological Explanations

Another factor which appears to contribute to psychotherapists' clinical longevity in the field of domestic violence is their ability to encompass diverse theoretical positions about the etiology of domestic violence. In the field itself, there is much theoretical debate regarding the etiology of spouse abuse. Macrolevel explanations focus on the overall level

of intrafamilial violence within a given society, whereas microlevel theories address why violence occurs in a particular family in a given society. Theories of etiology have been organized at three different levels of explanation, including intrapersonal interpersonal and sociocultural. Intrapersonal explanations assume that one or both spouses possess certain characteristics that make them prone to being a man who batters or woman who is battered (Elliott & Schauss, 1982; Faulk, 1974; Hotaling & Sugarman, 1986; Margolin et al.,1988; Scott, 1974; Shainess, 1977; Walker, 1984a, 1984b). Interpersonal explanations view an individual's behavior as being determined by his or her social environment, in this case the family system (Bowlby, 1984; Ceasar & Hamburger, 1989; Cook & Frantz-Cook, 1985; Dutton & Painter, 1981; Kalmus, 1984; Kaufman & Zigler, 1987; Rosenbaum & O'Leary, 1981). Socio-cultural explanations attempt to examine the historical, legal, cultural, and political factors that create and legitimize wife beating (Bograd, 1984; Breines & Gordon, 1983; Edelson, 1984; Gelles & Straus, 1979; Gondolf, 1986; Martin, 1976; Pagelow, 1981; Walker, 1979).

Very experienced psychotherapists who maintained longevity in the field tended to bridge both interpersonal, intrapersonal, and socio-cultural explanations of domestic violence and were not exclusively wedded to any one view. They viewed individual intrapsychic dynamics as embedded in an interpersonal and social context. As one therapist said,

> implications for how does [psychotherapy] effect society seemed as important to me as an individual model of psychopathology. I've always been interested in a larger perspective than [just] examining people's intrapsychic phenomena.

These psychotherapists also described themselves as sharing a background of liberal social/political activism. Two of them also had personal and familial experiences with situations related to domestic violence which had influenced and, quite possibly, sustained their on-going commitment to the field.

Psychotherapists who maintained longevity in the field of domestic violence also viewed their work as an extension of their interests in issues of gender and gender politics,

although this manifested itself in quite different ways. For instance, one psychotherapist spoke of his unwitting entry into the field of domestic violence over fifteen years ago when he participated in men's consciousness raising groups and for the first time heard other men talk about their abuse of their female partners. In quite a different vein, another psychotherapist (who is a contemporary feminist scholar) addressed issues of gender as they influence psychoanalytic theory, and she discussed her interest in the gendered aspects of unconscious, victim/aggressor internalized self and object mental representations.

Develop Clinical Flexibility

Another finding of this study is that several specific clinical capacities seem to have contributed to psychotherapists' longevity in the field. These capacities include: the capacity to be comfortable moving between the clinical stances of being reflective and interpretive versus being directive and interventionist; the capacity to integrate a variety of clinical theories and techniques into the work; the capacity to feel comfortable working in a variety of treatment modalities; and the capacity to work with both men who batter and women who are battered.

Psychotherapists who have maintained longevity in the field presented case vignettes which illustrated their comfort working in a variety of treatment modalities (individual, couple, and/or family therapy). They actively recommended and referred to adjunctive therapies (such as groups for men who batter or women who are battered) in their domestic violence work. They actively educated and supported their patients in utilizing community resources (such as battered women's shelters, legal advocacy, etc.) when they deemed it appropriate.

Most of the psychotherapists in this study were basically psychodynamically-oriented. The psychotherapists who maintained their longevity in the field of domestic violence also described themselves as having a mixed orientation, combining psychodynamic theory with self-psychology, cognitive-behavioral, or family systems theories. They were comfortable and creative in integrating a variety of treatment strategies

and techniques. One psychotherapist described this integration of psychodynamic theory with cognitive and behavioral strategies as a "shot gun approach using every avenue as much as possible and juggling many baskets at once."

They defined the role of a "psychotherapist" broadly and did not feel constrained to limit their interventions to verbal interpretations and did not experience any role strain when they more actively intervened in their patients' lives. A psychotherapist who was less experienced with domestic violence was obviously uncomfortable about her role when she intervened with the abusive spouse of a female patient by inviting him to a couples session and directing him to stop being violent or else leave the home in order to protect their newborn child. She also referred them to couples therapy. She found it necessary to differentiate this intervention from "psychotherapy", stating:

> I felt it was important to be concrete ...I wasn't in a psychotherapeutic mode...I wasn't making a suggestion, I was saying: 'This is what has to happen'. I wouldn't see that as psychotherapy because I'm telling somebody what to do. . .I don't usually say: 'Do this. Don't do that'. . .I don't see this as psychotherapy. It's part of psychotherapy in that moment but I don't consider psychotherapy to be active or directive and that protective. I see psychotherapy as much more reflective than directive.

This psychotherapist's active and protective stance vis-a-vis her client conflicted with her perception of the "appropriate" role of a psychotherapist.

Psychotherapists who had maintained longevity in the field were also active in discussing during the therapy hour incidents of violence in the lives of their patients. Their approach is in line with the literature on the clinical aspects of working with victims or perpetrators of violence. Some of the common technical errors in therapy with patients who are victims or perpetrators have been related to clinicians' denial and a tendency either to focus on intrapsychic processes at the expense of external realities, or to frankly overlook material related to violent threat or a fear of violence (Benedek, 1984; Harway & Hansen, 1990; Hilberman, 1978). Clinicians may collude with the denial of battered women or men who batter by knowing about incidents of violence in their patients' lives and not discussing this with them (Dubin, 1986; Gilman, 1980; Lion & Pasternak, 1973).

Psychotherapists who maintain longevity in the field were also willing to work both with men who batter and women who are battered. They thereby avoid one of the pitfalls of work in the field of treatment of violence and victims in general, and family violence in particular, which is a tendency for clinicians to become over-identified with either the victim or the perpetrator. Psychotherapists who work exclusively with women may become over-identified with them in their role of victim. They may become over-identified with the anger the women carry toward their abusive spouses and preoccupied with the psychological trauma of the victimized woman. This over-identification can influence the psychotherapist to insist prematurely that the battered woman leave her partner (Gilman, 1980). Psychotherapists who have become over-identified with their patient-victims of violence have been known to develop symptoms of post-traumatic stress disorder similar to their patients (Alexander et. al., 1989; Pepitone-Rockwell, Phillips & Werner, 1979). Likewise, psychotherapists who work exclusively with men who batter have been known to perceive the abusive man as the victim of the provocative female, to overlook the level of his dangerousness, and to unwittingly collude in minimizing his responsibility for his violent behavior (Hanks, 1990, 1992).

Cope with "Failures" and "Mistakes"

Marston (1984), discussing the frustrations encountered by psychotherapists in obtaining adequate feedback for good work, asserts that psychotherapists are often "more affected by their failures than successes" (p. 457). "Difficult" patients in particular can deny the psychotherapist the recognition and admiration that many psychotherapists require in order to feel fulfilled in their work and may succeed in threatening the psychotherapist's idealized imago as a concerned and competent practitioner (Burton, 1964; Goldberg, 1990). Psychotherapists who have been able to maintain longevity in the field describe themselves as having been able to learn from their "failures" and "mistakes" and to alter their behavior rather than become demoralized and retreat from the field.

For instance, one psychotherapist felt that he has been a "clinical failure" providing psychotherapy to battered women. His "only way of marking success with battered women was getting them to leave the man and never go back. . .which might be aiming much too high. . .so I stopped doing it. . .because clinically I found I was a failure." He could not tolerate on-going psychotherapy with women who continued to be battered and who could not leave their relationship with the batterer. "Helping a woman out in weeks or a couple of months is a private and professional marker of success. . .if I can't do that, then it seems nothing really effective is going on." Rather than adjusting his treatment goals or retreating from the field, however, he creatively switched his mode of involvement with battered women into the forensic arena, in which he achieved much success and personal satisfaction. He said, "...Few things give me as much satisfaction as six hours on the stand and the next thing the jury comes in with an acquittal instead of 25 years in prison." He told of his delight in receiving correspondence from a formerly battered woman whom he defended: "Every year she thanks me for her being free and for being able to bring up her children with a semblance of sanity."

Farber & Heifetz (1982), in a study of psychotherapists' satisfactions, cited "lack of success" as the single most stressful aspect of psychotherapeutic work. Their findings suggest that psychotherapists may expect their work to be difficult and even stressful, but they expect their efforts to "pay off." "Constant giving without the compensation of success apparently produces burn-out" (p. 298). The psychotherapist described above realized he was not achieving success in getting women to leave their relationship. Rather than revising his goal, he diversified his range of practice in the field and switched his work with battered women from the clinical to the forensic arena. He subsequently has experienced a great deal of professional success and personal gratification in the forensic arena as an advocate for battered women. His undaunted rather than demoralized approach to "failure" enabled him to preserve his longevity in the field.

Another psychotherapist spoke of "having looked at cases where I felt I really made a lot of mistakes with over-extending myself. . .it's been a big piece of my learning over the last ten years." She spoke of how she is "now able to extend myself very much emotionally in the work together, yet be clear about my boundaries, and clear about what I can't do." She initiates a discussion of these limits with her clients "early on so that I feel better anticipating with them what my limits are. . .and there's less of my getting over-extended and having to pull back from something." She no longer carries "inappropriate responsibility. . .there was a victim part of me that was taking in an enormous sense of guilt and responsibility when the clients would be so desperately needing." This psychotherapist was able to learn from her "mistake" of being overly responsible and excessively committed due to her experience of "dedicated guilt" (Freudenberger, 1975) and an over-identification with victims (Benedek, 1984). She too was able to learn from her "mistake," alter her behavior, and preserve her longevity in the field.

Similarly, another psychotherapist stated, "I initially expected the violence to stop [quickly] and I would feel like I failed tremendously if it didn't. . . but through my experience I lowered my goals." This psychotherapist was able to preserve her longevity in the field by learning to revise her treatment goals.

Summary

The nine respondants in this study were autonomously practicing, senior psychotherapists whose years of post-graduate clinical practice ranged from seven to thirty-one years. They were purposefully, rather than randomly, selected. As they were willing to be interviewed about this subject, it is likely that they are biased toward domestic violence clients and thus probably more willing to talk about their range of experiences and feelings about such clients than one might expect from a randomly selected sample of psychotherapists. Also, because this study involved a small number of participants rather than a large sample, generalizations to the larger population of psychotherapists is neither

possible nor was it the purpose of this study. The intent has been to explore the subject with experienced informants in order to discover some of the parameters of the psychotherapists' feelings, attitudes, beliefs, and professional clinical and training experiences which influenced their work with domestic violence clients. The questions addressed in this study and their related findings are as follows.

Question 1. Is it the case that some psychotherapists are reluctant to treat domestic violence clients and that such reluctance is not informed by clinical theory, practice theory, or family violence theory but is based upon personal biases (attitudes, beliefs, and feelings) about the phenomenon of domestic violence and about battered women and battering men?

None of the psychotherapists in this study had received formal education during their graduate training in domestic violence theory or treatment. Even those psychotherapists who had subsequently sought out formal education in the field had not been prepared to anticipate and mange the emotional stressors inherent in the work and this appeared to contribute to a lack of self-confidence and to a lack of self-perceived competence in their clinical work with this clientele. Psychotherapists who had maintained longevity in the field had come to expect the emotional complexities and anxieties in the work and had structured their professional lives accordingly.

The psychotherapists in this study perceived physical abuse as a more severe manifestation of on-going verbal and psychological abuse. This finding underscores the need for psychotherapists to address both aspects of abuse in their clinical work with domestic violence. It was also found, however, that some psychotherapists did not recognize evidence of physical abuse in the lives of their patients. This finding supports the need for at least "basic training" in the identification and treatment of domestic violence for all psychotherapists.

Psychotherapists in this study were willing to treat domestic violence clients in general but differed in their eagerness to do such work. Their willingness to see specific cases of men who batter or women who were battered was based on factors related to their

differential assessment of each case and their attitudes, beliefs, and feelings generated by the complexities of the clinical work.

Question 2. What attitudes, beliefs, feelings, and experiences influence psychotherapists' decisions to avoid versus treat domestic violence patients?

Psychotherapists' reasons for avoiding versus treating specific cases of battering men differed from psychotherapists' reasons for avoiding versus treating specific cases of battered women. Men who batter were viewed as "difficult patients" due to their propensities for behaviorally acting out and due to the dysphoric feelings aroused in the psychotherapists resulting from their exposure to violent case material. Psychotherapists decisions to accept a particular male batterer for psychotherapy were based on the interaction of two sets of criteria: an objective set of criteria based on standard diagnostic decision making parameters combined with factors related specifically to battering men; and, a subjective set of criteria based on individual, contextualized subjective conscious feelings and thoughts experienced by the therapist, and between the therapist and the male patient, as a result of their initial interaction(s). All of the psychotherapists described an initial negative subjective reaction to the male batterer because of the violent behavior. All described having to be able to consciously tolerate, and not act upon, intense and often ego-dystonic feelings, affective states, wishes, and impulses in order to do the work.

Several unique factors affected the psychotherapists' willingness to treat a particular battered woman. One was the psychotherapists' response to their exposure to the dynamics of victimization. The battered woman's initial presentations of her victimization and battering influenced the psychotherapists' range of responses from involvement to avoidance. Another unique factor was the psychotherapists' reaction to the level of dangerousness posed by the woman's violent partner which called for the psychotherapist distinguishing between reality based, versus fantasy based, fear of the partner. The psychotherapists agreed on the treatment goal of stopping the violence in the relationship but differed in their views of how to achieve this goal. Some felt compelled to stop the

violence immediately, while others felt this goal precluded the woman's continued involvement in psychotherapy. The goal of stopping the violence appeared to be related to psychotherapists' individual tolerance of dysphoric feeling states (i.e. helplessness, worry, anxiety) without a resultant sense of clinical failure. Battered women who were described as "difficult" were those who presented as being in great need of assistance and, subsequently, defeated the psychotherapists' best efforts to be helpful. It was speculated that many psychotherapists silently practice "politically incorrect" psychotherapy with battered women and that frank dialogue and discourse among themselves about the complexities and emotional demands of treating battered women is subsequently hampered.

An important finding in this research had to do with factors contributing to psychotherapists' attrition versus longevity in the field of domestic violence. Those who maintained longevity in the field of domestic violence developed an optimal style of clinical practice that enabled them to cope with the emotional stressors inherent in clinical work which carries with it a high level of responsibility due to the potentially life threatening consequences of domestic violence. They were able to avoid "burn-out" by anticipating and managing dysphoric affective response to the work, by limiting and diversifying their involvement in the work, by deriving self-esteem from work with "difficult" patients, by being undaunted in the face of "mistakes" and "failures", and by being able to creatively bridge and integrate clinical theories and flexibly utilize multi-modal treatment.

Limitations of the Study

This study is exploratory, phenomenological, and descriptive for the purposes of generating hypotheses and theory. As such, it describes the structure of an experience, but does not delineate the characteristics of a group or attempt to make generalizations about the thoughts, feelings, beliefs, or attitudes of therapists. This was not a random sample. Hypotheses or explanations that were generated must be accepted or rejected on the basis of comprehensiveness, closeness to the data, and the absence of a better explanation. The

material is presented in such a way that interpretations may be reviewed and critiqued. The possibility of deriving alternative explanations from the data is explored. As in any such study, the findings remain open to reinterpretation in light of new evidence or understanding. The phenomenon under study is by nature transitory. The expansion of public knowledge, through the present study and other forms of dissemination, could lead to change. This is only to be hoped for.

Implications for Clinical Practice

Although the literature has reported concerns about psychotherapists failures to intervene appropriately with battered women and men who batter, no research has been directed at the clinical and human dilemmas faced by psychotherapists when they offer their services to domestic violence clientele. The findings of this study can serve as a basis for further research, guide graduate and professional training, and inform administrative policy making within the mental health service provider community. Such education, training and policy making can, in turn, mitigate against the possibility of battered women, men who batter and children who witness domestic violence receiving biased treatment when seeking psychotherapeutic services and encountering barriers to access to such services.

It is clear that the none of the psychotherapists in this study, who represented the diverse professions of psychology, psychiatry and social work, had received adequate training in the field of domestic violence during the course of their professional educations, in spite of the fact that all of them had encountered this clinical problem in their practices. Most of these psychotherapists were practicing in isolation without the benefit of formal training or on-going peer dialogue or consultation. They were appreciative of having the opportunity to speak about the clinical dilemmas and the emotional stressors inherent in their work with this problem. They spontaneously expressed interest and curiosity about the outcome of this study. They indicated their interest in continuing to think about their interests that were sparked by their participation in the interview and about the questions

that were raised during the dialogue. This response among the interviewees in this study speaks to the unmet need among psychotherapists of diverse professional groups and theoretical orientations for the availability of on-going professional consultation and training in the field of domestic violence treatment. Such training could incorporate the results of this study regarding the influence of the psychotherapists attitudes, beliefs, feelings on their clinical work with battered women, battering men and children who witness domestic violence.

It is important for psychotherapists to learn from the experience of their colleagues about the unique stressors inherent in the work due to the sense of urgency and the level of clinical responsibility for the well-being of the patient(s) and their families which is unique to work with issues of family violence. It is important for psychotherapists to learn not only to differentially diagnose which battered women and which battering men are appropriate, or inappropriate, for psychotherapy, but also to learn to anticipate and manage the clinical demands and dysphoric feelings which will inevitably be generated by the clinical work. It is also important for psychotherapists' to recognize the impact that their own attitudes, beliefs, feelings and clinical and behavioral responses to violence and victimization may have on the willingness and capacity of battering men and battered women to enter into an effective therapeutic alliance and course of psychotherapy.

Psychotherapists must realize that not only must the patient be amenable to treatment--but the psychotherapist must also be amenable to treat. As one of the psychotherapists aptly stated,

> I imagine that if I were the patient, telling the therapist about behaviors that I didn't like in myself but I wanted to change, my hope would be that the therapist wouldn't simply hate me or have hateful feelings towards me, but would be able to overcome those feelings enough to use his professional training to help facilitate my moving to becoming the kind of person who didn't engage in it anymore.

Directions for Future Research

Domestic violence is a prevalent social and clinical problem which is likely to continue to appear in the practices of many psychotherapists and, as such, is deserving of on-going research focus. There is a current trend in research in the domestic violence field to study the effectiveness of different approaches to treatment and intervention. As one of the findings woven throughout this study was the reciprocal impact of the clinical work on the psychotherapist and, in turn, of the psychotherapist on the clinical work, it seems important to structure empirical research studies in such a way as to account for the impact of the psychotherapist on the effectiveness of different clinical interventions strategies.

It also seems important to apply the results of this study to a larger sample of psychotherapists, to a broader range of domestic violence clients, and to more diverse practice settings. There are many questions deserving of further investigation. Does work in the field of domestic violence have a traumatic impact on the psychotherapist? If so, what is this impact and how can it be mitigated? Do different types of battered women and battering men elicit different types of feelings, attitudes, and behavioral responses in psychotherapists? Do psychotherapists who are trained to anticipate and manage the stressors inherent in clinical work with a domestic violence population experience less personal stress, more clinical success, and/or more professional satisfaction than psychotherapists who are untrained? What does the impact of a childhood and/or personal history of being witness to, perpetrator of, or recipient of, domestic violence have on the adult psychotherapist's clinical work in the field?

ADDENDUM

It is this researcher's belief that it is incumbent on those within the psychotherapy professions to work towards non-violence, particularly within the family. One of the psychotherapists in this study eloquently described the importance of the work, stating,

> I like to work with people who hurt other people. If I do good work, not only do people live better lives in terms of their own psychological adjustment. . .but they don't cause damage in society. . .and I have affected a sense of decency in the world with regard to other people who will not be victimized.

APPENDIX A

Susan E. Hanks, L.C.S.W.
Board Certified Diplomate
3155 College Avenue
Berkeley, CA 94705
(510) 653-9200

Date

Name
Address

Dear_____:

I am currently involved in the dissertation phase of the doctoral program at the California Institute for Clinical Social Work, Berkeley, California. I would like psychotherapists such as yourself to participate in my research project and am writing to you as part of my recruitment effort. My particular area of interest and study is the psychotherapist's view of the psychotherapy process with battered women and battering men. You do not have to have had clinical experience with marital violence in order to participate. In fact, I would like to talk with some therapists who have not had such experience.

I will be conducting a number of tape-recorded 50 minute interviews with licensed psychotherapists to be arranged at a location and time that is convenient for them. I hope that you will be interested and available to participate in my research. Your participation is, of course, voluntary, and the interview would be confidential.

If you are able to participate in this research project, please complete the enclosed Personal Information Form (which will take approximately five minutes). Return it to me in the enclosed self-addressed envelope as soon as possible. I will then be in touch with you regarding your potential participation in this project.

Please feel free to contact me at the above number if you have any questions. Thank you for your consideration.

Sincerely,

Susan E. Hanks, L.C.S.W.

APPENDIX B

PERSONAL INFORMATION FORM

If you are interested and available to participate in this research project, please complete this questionnaire and return it to Susan Hanks, L.C.S.W., 3155 College Avenue, Berkeley, CA 94705. Phone: (510) 653-9200.
Thank you for your cooperation.

NAME _____ AGE _____

ADDRESS

_____

_____

PHONE (days) _____ PHONE (evening)_____

PROFESSIONAL ORIENTATION:
Social Worker _____ Psychologist _____
Psychiatrist _____ Counselor _____

PROFESSIONAL LICENSE:
Type _____
Year Acquired _____

CURRENT PRACTICE SETTING:
Private Practice _____%
Agency/Organization _____%
Educational Organization _____%
Other _____%
Total = 100 %

MODES OF PRACTICE:
Psychotherapy/Consultation _____%
Administration _____%
Teaching _____%
Research/Writing _____%
Other _____%
Total = 100 %

THEORETICAL ORIENTATION:
Psychoanalytic _____
Psychodynamic _____
Behavioral _____
Cognitive _____
Other _____

Have you ever worked clinically on a case (individual, couple or child) in which marital violence was a factor?

Yes _____
No_____

If yes, please describe:
(type of case(s), mode(s) of treatment, length of therapy, etc.).

_____
_____
_____
_____
_____
_____
_____

Would you be willing to accept a referral of a marital violence case in the future?

Yes_____
No _____ (If No, why not)? _____
_____
_____
_____
_____
_____
_____
_____

APPENDIX C

Susan E. Hanks, S.M., L.C.S.W.
3155 College Avenue
Berkeley, CA 94705
(510) 653-9200

INFORMED CONSENT STATEMENT

I, _____ , hereby willingly consent to participate in a research project on therapists' views of treatment of domestically violent patients to be conducted by Susan E. Hanks, S.M., L.C.S.W., under the direction of Rosemary Lukton, D.S.W., faculty member at the California Institute for Clinical Social Work. This research will examine the experiences of psychotherapists in the treatment of domestic violence patients.

I understand the procedure as follows:
1) A 50 minute audio-taped interview will occur in a private, confidential setting to be arranged between myself and the researcher. I will be talking about my thoughts and feelings as a psychotherapist in relation to treating cases of domestic violence.

2) I am aware that there is little potential risk for emotional discomfort involved in participating in this study. However, if this should happen, I will be able to contact the researcher who will make provisions for me to receive professional help for a reasonable and limited time.

3) I understand that I may withdraw from the study at any time without penalty or prejudice. I also understand that this study may be published and that my identity will be protected unless I give written consent. Otherwise, no names or individual identifying information will be used in any oral or written materials. The audio tape will be erased at the completion of the data analysis.

4) I understand that I have the option to receive feedback from the results of the study. Send me a summary of the results at the address below. Yes____ No____

Signature_____ Date _____
Address _____
_____

APPENDIX D

Preliminary Interview Guide

Introduction

Thank you very much for taking the time to assist me with my research. I hope that this will be a useful dialogue for you also.

As I mentioned when we spoke before, the purpose of this project is to understand the individual experiences of psychotherapists when they work with cases in which there has been a history of domestic (or marital) violence. Although there is a general consensus in the field that therapists have preferences about what type of cases they prefer to work with, little is known about why therapists prefer to work with one type of case rather than another. I am very interested in what you have to say about your own clinical experience working with cases of domestic violence. I will be asking you about both what you think and how you feel about working with these types of patients. Please be assured that there are no right or wrong answers.

You have already signed the Informed Consent Statement advising of the confidential nature of the study and of the anonymity of all information that you share. You also have the right to not answer any questions or to end your participation in this study at any point in time you so indicate. If you desire, I will be happy to share a copy with you of the findings of the completed study.

Do you have any questions before we proceed?

Preliminary Topics and Probe Questions

Let's begin by talking about the nature of your clinical practice in general.

Topic I -- Practice orientation and patient preference.

What are the types of patients that you typically see in your clinical practice? Are there any patients you prefer to see? Are there any patients you prefer not to see?

Topic II -- Willingness to work with domestic violence patients

Many clinicians prefer not to work with cases which involve situations of marital violence. If a client were to call for an appointment and tell you that he/she has a problem of domestic violence, what do you think your first thoughts would be? What would be your initial feelings? Can you describe for me how you would decide whether or not to accept a case of a battered woman?....of a battering man?....of a battering couple? Would your thoughts....feelings....be different if you discovered in the course of your work with a client you had already accepted that he/she were battered?....that he/she were a batterer?...a battering couple?

Topic III-- Understanding of the problem

As a psychotherapist, what is your working definition of spouse abuse? What kind of diagnostic profile would you expect a man who batterers to have? What kind of diagnostic profile would you expect a battered woman to have?

As an experienced clinician, you already know that doing clinical work with any patient(s) evokes a wide range of feelings in the therapist. I'd like you tell me about what feelings have come up for you in regards to both the patient(s) you may have seen and also in regards to the clinical work itself. Let's start with your feelings first about the patient(s) themselves.

Topic IV - Feelings about the patients

Feelings about the patient(s): Can you tell me about some of the feelings you have had (or imagine you would have) when/if you worked with a patient(s) who had a problem of domestic violence? How would you feel about a patient who was being battered? How would you feel about a patient who was battering? In what ways are these feelings different from feelings evoked by other types of patients? Have you ever been physically or verbally threatened by a client?...by a domestic violence client? If threatened: How does this event affect your feelings about work with domestic violence patients now.

Topic V -- Feelings about the nature of the clinical work

Feelings about the clinical work: Can you tell me about some of the feelings you have had (or imagine you would have) about working with domestic violence cases in general? What were some of the most difficult aspects of the clinical work? What were some of the most rewarding aspects of the case? Many clinicians become discouraged when working with domestic violence cases. Have you ever had any of these types of feelings? How did you handle them?

Topic VI -- Belief and attitudes concerning the effectiveness of psychotherapy for domestic violence cases

Some people believe that psychotherapy is at best ineffective and possibly even inappropriate in cases where domestic violence is a problem. Do you think psychotherapy is effective/useful in cases of domestic violence? Are there any situations you know of (can think of) in which psychotherapy would not be effective? would be inappropriate?

Topic VII -- Influence of professional training and education

This population of clients is generally perceived as difficult to work with. What has helped you in developing clinical skills useful in working with this population? In what ways did your graduate training and/or continuing education prepared you for this type of clinical work?

Closure

Do you have anything further that you would like to to add? Do you have any questions or comments about the interview itself? Thank you very much for your willingness to share your time and discuss your experiences with me.

APPENDIX E

INTERVIEW CODING FORM

Interview #
Sex:
Age:

Professional Orientation
•social worker
•psychiatrist
•psychologist
•license (type, year acquired)

Modes of Practice
•psychotherapy
•consultation
•administration
•teaching
•research/writing
•other

Description of Practice
•setting
  --private practice
  --agency/organization
  --educational
  --other
•current
•changes over years

Theoretical Orientation
•psychoanalytic
•psychodynamic
•behavioral
•cognitive
•other

Experience with Domestic Violence
•clinical
•personal
•other (victim advocacy, forensic consultation, social policy development, teaching, program development)

Definition of Domestic Violence
•dynamics, explanation of
  --intrapersonal
  --interpersonal
  --social/cultural
•physical abuse
•psychological abuse
•variables: frequency, severity, context

Reactions to Battered Woman
•initial contact
•personal
•clinical
  --diagnostic indicators
  --accept/avoid as patient
  --assessment
  --treatment and/or interventions provided
    ---psychotherapy (modality, orientation, length)
    ---environmental

Reactions to Battering Man
•initial contact
•personal
•clinical
  --diagnostic indicators
  --accept/avoid as patient
  --assessment
  --treatment and/or interventions provided
    ---psychotherapy (modality, orientation, length)
    ---environmental

Impact on Children
•issues related to children
•impact on children of witnessing violence

Attitudes/Beliefs Regarding Interventions
•type of intervention
  --psychotherapy
    ---goals (insight, behavior change, interpersonal, etc.)
    ---modalities of therapy deemed appropriate/not (individual, couples)
    ---stance of therapist
  --environmental manipulations
  --other (Tarisoff warnings, etc.)

Impact of Setting on Psychotherapy & Clinician
•private practice vs. agency/clinic

Feelings of Demoralization/Satisfaction
•self-defined stressors in the clinical work
•self-defined experiences of clinical success and/or failure
•experiences with satisfaction
•experiences with demoralization/burn-out
•strategies for coping with demoralization
•strategies for insuring satisfaction

Training Experiences
•domestic violence
  --formal training (graduate school, post-graduate, continuing education)
  --"on-the-job" or "on-the-front-lines" training
•dangerous/violent patients
  --formal training (graduate school, post-graduate, continuing education)
  --"on-the-job" or "on-the-front-lines" training

Previous Experience with Assaultive and/or Fear Inducing Patients
•incidents
•coping strategies
•influence of experience(s) on work with domestic violence

Attitudes Towards Violence and Violent Content of Case Material

Impact of/Reaction to Interview Process

Interviewer's Impressions

BIBLIOGRAPHY

Alexander, J., de Chesnay, M., Marshall, E., Campbell, A., Johnson, S., & Wright, R. (1989). Research note: Parallel reactions in rape victims and rape researchers. Violence and Victims, 4 (1), 57-62.

Altshul, V. (1977). The so-called boring patient. American Journal of Psychotherapy, 31 (4), 533-545.

American Psychiatric Association. (1974). Clinical aspects of the violent individual. Washington, D. C.: Author.

American Psychological Association. (1978). Report of the task force on the role of psychology in the criminal justice system. American Psychologist, 33, 1099-1113.

Ames, E. (1980). What your shrink really thinks of you. Reflections, 15, 19-31.

Ammerman, R., & Herson, M. (1990). Treatment of family violence. New York: Wiley.

Applebaum, P. (1983). Legal considerations in the prevention and treatment of assault. In J. Lion & W. Reid, Assault in psychiatric facilities, (pp.173-190). New York: Grune & Stratton.

Applebaum, P. (1985). Implications of Tarasoff for clinical practice. In J. Beck (Ed.). The potentially violent patient and the Tarasoff decision in psychiatric practice, (pp. 93-109). Washington, D.C.: American Psychiatric Press.

Attorney General. (1984). Attorney General's Task Force on Family Violence. Washington, D. C.: Department of Justice.

Bach-Y-Rita, G. (1971). Episodic dyscontrol: A study of 130 violent patients. American Journal of Psychiatry, 127, 1473-1478.

Bakan, D. (1967). On method: Toward a reconstruction of psychological investigation. San Francisco: Jossey-Bass.

Bassuk, E., & Gerson, S. (1980). Chronic crisis patients: A discrete clinical group. American Journal of Psychiatry, 137 (12), 1513-1517.

Beck, J. (1982) When the patient threatens violence: An empirical study of clinical practice after Tarasoff. Bulletin of the American Academy of Psychiatry & Law, 10, 189-99.

Beck, J. (1985). Violent patients and the Tarasoff duty in private psychiatric practice. Journal of Psychiatry & Law, (Fall-Winter), 361-376.

Beck, J. (1988). The therapist's legal duty when the patient may be violent. Psychiatric Clinics of North America, 11 (4), 665-679.

Benedek, E. (1984). The silent scream: Countertransference reactions to victims. American Journal of Social Psychiatry, IV(3), 49-52.

Benich, C. (1983). Children of battered women--A descriptive study of their behavior, ego functioning and interpersonal styles. Unpublished doctoral dissertation, California School of Professional Psychology, Berkeley/Alameda, CA.

Berk, R., Berk, S., Loeske, D., & Rauma, C. (1983). Mutual combat and other family violence myths. In D. Finkelhor, R. Gelles, G. Hotaling, & M. Straus (Eds.). The dark side of families: Current family violence research. Beverly Hills, CA: Sage.

Bernstein, H. (1981). A survey of threats and assaults toward psychotherapists. American Journal of Psychotherapy 35 (4), 542-549.

Binder, R., & McNeil, D. (1988). Effects of diagnosis and context on dangerousness. American Journal of Psychiatry, 145 (6), 728-732.

Bograd, M. (1982). Battered women, cultural myths and clinical interventions: A feminist analysis. Women and Therapy, 1(3), 69-77.

Bograd, M. (1984). Family systems approaches to wife battering: A feminist critique. Journal of Orthopsychiatry, 54 (4), 558-568.

Bowker, L., & Maurer, L. (1985). The importance of sheltering in the lives of battered women. Response to the Victimization of Women and Children, 8 , 2-8.

Bowker, L. (1983). Beating wife-beating. Lexington, MA: Lexington Books.

Bowlby, J. (1984). Violence in the family as a disorder of the attachment and care giving systems. American Journal of Psychoanalysis, 44 (1), 2-27.

Breines, W., & Gordon, L. (1983). The new scholarship on family violence. Signs: Journal of Women and Culture in Society, 8 (3), 490-531.

Brennan, F. (1985). Political and psychosocial issues in psychotherapy for spouse abusers: Implications for treatment. Psychotherapy, 22 (3), 6543-654.

Browne, A. (1987). When battered women kill. New York: Free Press.

Burgess A., & Holmstrom, L. (1973). The rape victim in the emergency ward. American Journal of Nursing, 73, 1740-1745.

Burton, A. (1969). To seek and encounter critical people. Voices, 5, 26-28.

Burton A. (1975). Therapist satisfaction. American Journal of Psychoanalysis, 35, 115-122.

Calef, V., & Weinshel, E. (1981). Some clinical consequences of introjection: Gaslighting. Psychoanalytic Quarterly, 50, 44-66.

Caplan, P. (1984). The myth of women's masochism. American Psychologist, 39 (2), 130-139.

Carlson, B. (1977). Children's observations of interpersonal violence. In A. Roberts (Ed). Battered women and their families (pp. 147-167). New York: Springer.

Carmen (Hilberman), E. Rieker, P., & Mills, T. (1984). Victims of violence and psychiatric illness. American Journal of Psychiatry, 141 (3), 378- 383.

Ceasar, P. (1985). The wife beater: Personality and psychosocial characteristics. Unpublished doctoral dissertation, California School of Professional Psychology, Berkeley/Alameda, CA.

Ceasar, P., & Hamberger, L. (1989). Treating men who batter: Theory, practice, and programs. New York: Springer.

Cocozza, J., & Steadman, H. (1976). The failure of psychiatric predictions of dangerousness: Clear and convincing evidence. Rutgers Law Review, 29, 1084-1101.

Coleman, K. (1980). Conjugal violence: What 33 men report. Journal of Marital and Family Therapy, 6 (2), 207-214.

Colson, D., Allen, J., Lolafaye, C., Dexter, N., Jehl, N., Mayer, C., & Spohn, H. (1986). An anatomy of countertransference: Staff reactions to difficult psychiatric hospital patients. Hospital & Community Psychiatry, 37 (9), 923-928.

Conn, L., & Lion, J. (1983). Assaults in a university hospital. In J. Lion & W. Reid, Assaults in psychiatric facilities, (pp. 61-69), New York: Grune & Stratton.

Cook, D., & Frantz-Cook, A. (1984). A systemic treatment approach to wife battering. Journal of Marital and Family Therapy, 10 (1), 83-92.

Cook, T., & Campbell, D. (1979). Quasi-experimentation: Design and analysis for field settings. Chicago: Rand McNally.

Davis, S. (1991). An overview: Are mentally ill people really more dangerous? Social Work, 36 (2), 174-180.

Depp, F. (1983). Assaults in a public mental hospital. In J. Lion & W. Reid, Assaults in psychiatric facilities, (pp. 21-45). New York: Grune & Stratton.

Dobash, R., & Dobash, R. (1978). Wives: the "appropriate" victims of marital violence. Victimology: An International Journal, 2, 426-442.

Dobash, R. & Dobash, R. (1979). Violence against wives. New York: Free Press.

Dubin, W. (1989). The role of fantasies, countertransference and psychological defenses in patient violence. Hospital & Community Psychiatry, 40 (12), 1280-1283.

Dutton, D., & Browning, J. (1984). Power struggles in intimate relationships. In G. Russell (Ed). Violence in intimate relationships. New York: Spectrum.

Dutton, D., & Painter, S. (1981). Traumatic bonding: The development of emotional attachments in battered women and other relationships of intermittent abuse. Victimology: An International Journal, 6, 139-155.

Edelson, J. (1984). Violence is the issue: A critique of Neidig's assumptions. Victimology: An International Journal, 9, 3-4.

Edelman, S. (1978). Managing the violent patient in a community mental health center. Hospital and Community Psychiatry, 29 (7), 460-462.

Elliott, F. (1977). The neurology of explosive rage: The dyscontrol syndrome. In M. Roy (Ed.). Battered women: A psychosocial study of domestic violence (pp. 98-109). New York: Van Nostrand.

Epstein, S. & Silvern, L. (1990). Staff burnout in shelters for battered women: A challenge for the '90s. RESPONSE, 13 (1), 9-12.

Eth, S., & Pynoos, R. (1985). Post-traumatic stress disorders in children. Washington: American Psychiatric Press.

Family Court Services. (1991,November). Guidelines for Family Court Services Intervention in Domestic Violence Cases. (Draft document). Alameda County, CA: Superior Court, State of California, Family Court Services.

Farber, B., & Heifetz, L. (1981). The satisfactions and stresses of psychotherapeutic work: A factor analytic study. Professional Psychology, 12, 621-630.

Farber, B., & Heifetz, L. (1982). The process and dimensions of burnout in psychotherapists. Professional Psychology,13, (2), 293-301.

FBI. (1983). Uniform Crime Reports. Washington, D.C.: Government Printing Office.

Finkelhor, D. (1983). Common features of family abuse. In D. Finkelhor, R. Gelles, G. Hotaling, & M. Straus (Eds.). The dark side of families: Current family violence research, (pp. 17-28). Beverly Hills: Sage.

Fitch, F. (1983). Men who batter: Some pertinent characteristics. Journal of Nervous and Mental Disease, 171, 190-192.

Fleming, J. (1979). Stopping wife abuse. Garden City, NY: Anchor.

Fortune, R. (February, 1991). Dimensions of disaster. A dissertation proposal submitted to the Center for Psychological Studies. Albany, CA.

Frank, J. (1973). Persuasion and healing. Baltimore, MD: The John Hopkins University Press.

Frederickson, J. (1990). Hate in the countertransference as an empathic position. Contemporary Psychoanalysis, 26 (3), 479-496.

Freize, I. (1979). Perception of battered wives. In I. Freize, D. Bar-Tal, & J. Carroll (Eds.). New approaches to social problems (pp. 79-108). San Francisco, CA: Jossey-Bass.

Freud, S. (1957). The future prospects of psycho-analytic therapy. Standard Edition (Vol. 11), London: Hogarth Press. (Originally published, 1910).

Freudenberger, H. (1975). The staff burn-out syndrome in alternative institutions. Psychotherapy: Theory, Research and Practice, 12 (1), 73-82.

Ganley, A. (1981). Court mandated counseling for men who batter.Washington, D. C.: Center for Women's Policy Studies.

Garner, J., & Clemmer, E. (1986). Danger to police in domestic disturbances--A new look. National Institute of Justice: Research in Brief. Washington, D. C.: U. S. Department of Justice.

Gayford, J. (1975). Wife battering: A preliminary survey of 100 cases. British Medical Journal, 1, 195-197.

Geffner, R. (1990). Family abuse, the judicial system and politics. Family Violence Bulletin, 6 (3), 6.

Geffner, R. (1990). Editor's comments: Standards for treating family abuse, victims and offenders. Family Violence Bulletin, 6 (3), 1.

Geller, J., & Wasserstrom, J. (1985). Conjoint therapy for the treatment of domestic violence. In A. Roberts (Ed.). Battered women and their families (pp. 33-48). New York: Springer.

Gelles, R. (1972). The violent home: A study of physical aggression between husbands and wives. Beverly Hills, CA: Sage.

Gelles, R., & Cornell, C. (1985). Intimate violence in families. Beverly Hills, CA: Sage.

Gelles, R., & Straus, M. (1979). Determinants of violence in the family: Toward a theoretical integration. In W. Burr, R. Hill, F. Nye, & I. Reiss (Eds.). Contemporary Theories About the Family (pp. 549-581). New York: Free Press.

Gelles, R. (1982). Applying research on family violence to clinical practice. Journal of and the Family, 2, 9-20.

Gilman, I. (1980). An object relations approach to the phenomenon and treatment of battered women. Psychiatry, 43, 346-358.

Giorgi, A. (1971). Phenomenology and experimental psychology. In A. Giorgi, W. Fischer, & R. VonEckartsberg (Eds.). Duquesne studies in phenomenological psychology. Pittsburgh: Duquesne University Press.

Glaser, B., & Strauss, A. (1967). The discovery of grounded theory. Chicago: Aldine Publishing company.

Goldberg, C. (1991). On Being a psychotherapist. New Jersey: Jason Aronson.

Goldberg, D. (1983). The function of the therapist's affect in therapeutic conflict. Group, 7, 3-18.

Goldner, V. (1985). Warning: family therapy may be hazardous to your health. The Family Therapy Networker, 9, 19-23.

Goldstein, R., & Page, A. (1981). Battered wife syndrome: Overview of dynamics and treatment. American Journal of Psychiatry, 138, 1036-1044.

Gondolf, E., & Russell, D. (1986). The case against anger control treatment programs for batterers. Response, 9 (3), 2-5.

Goodwin, J. (1985). Family violence: Principles of intervention and prevention. Hospital and Community Psychiatry, 36 (10), 1074-1079.

Graves, R. (1978). Treating the hateful patient. New England Journal of Medicine, 298, 883-887.

Grayer, E., & Sax, P. (1986). A model for the diagnostic and therapeutic use of countertransference. Clinical Social Work Journal, 14, (4), 295-309.

Greenberg, B. (1987). A psychodynamic inquiry into violent relationships. Unpublished doctoral dissertation, California School of Professional Psychology, Berkeley/Alameda, CA.

Greenson, R. That "impossible" profession. Journal of the American Psychoanalytic Association, 14 (1), 9-27.

Griswold, R. (1986). Sexual cruelty and the case for divorce in victorian America. Journal of Women in Culture and Society, 11 (3), 529-541.

Haffke, E. (1983). Violence against mental health personnel in Nebraska. In J. Lion & W. Reid (Eds.). Assault within psychiatric facilities (pp. 91-97). New York: Grune & Stratton.

Haley, S. (1974). When the patient reports atrocities. Archives of General Psychiatry, 30, 191-196.

Hamberger, K., & Arnold, J. (1988) Dangerous distinctions among "abuse," "courtship violence," and "battering." Journal of Interpersonal Violence, 520-522.

Hanks, S., & Rosenbaum, C. P. (1977). Battered women: A study of women who live with violent alcohol abusing men. American Journal of Orthopsychiatry, 47 (2), 291-306.

Hanks, S., & Rosenbaum, C. P. (1981). Battered women: A study of women who live with violent alcohol abusing men. In Social work research in the human services (pp. 60-75). New York: Human Sciences Press.

Hanks, S. (1984). The sexual revolution and violence against women: The boundary between liberation and exploitation. In J. Baum & J. Coleman (Eds.). Concilium: International Journal of Sociology and Religion, 194, 41-49.

Hanks, S. (1985). Thought problems: Values and beliefs concerning interpersonal violence. In D. Sonkin, D. Martin, & L. Walker (Eds). The male batterer (p.60). New York: Springer.

Hanks, S. (1987, July). A conceptual framework for clinical assessment, differential diagnosis, and multi-modal treatment of maritally violent individuals, couples, and families. Paper presented at the Third National Family Violence Researchers Conference, University of New Hampshire, Durham.

Hanks, S. (1988, May). The therapist in context: The organizational milieu as a contextual holding environment for clinicians working with maritally violent patients. Invitational paper presented at Annual Meeting of the American Orthopsychiatric Association, San Francisco, CA.

Hanks, S. (1992). Translating theory into practice: A conceptual framework for clinical assessment, differential diagnosis, and multi-modal treatment of maritally violent individuals, couples, and families. E. Viano (Ed.). Intimate violence: Interdisciplinary perspectives. Washington, D.C.: Hemisphere Publishing.

Harris, J. (1986). Counseling violent couples using Walker's model. Psychotherapy, 23 (4), 613-621.

Harway, M., & Hansen, M. (Fall, 1990). Therapists' recognition of wife battering: Some empirical evidence. Family Violence Bulletin 6 (3), 6-18.

Henry, W., Sims, J., & Spray, S. (1971). The fifth profession. San Francisco: Jossey-Bass.

Henry, W., Sims, J., & Spray, S. (1973). Public and private lives of psychotherapists. Washington: Jossey-Bass.

Herman, J. (1986). Histories of violence in an outpatient population: An exploratory study. American Journal of Orthopsychiatry, 65 (1), 137-141.

Herman, J. (1987). Insights: Wife beating. Harvard Medical School Mental Health Letter, 5 (10), 6.

Hilberman, E. (1980). Overview: "The wife beater's wife" reconsidered. American Journal of Psychiatry, 137 (11), 1336-1347.

Hilberman, E., & Munson, K. (1978). Sixty battered women. Victimology: An International Journal, 2 (3-4), 460-470.

Hiratsuka, J. (1988). Attacks by clients threaten social workers. NASWNEWS, 33 (8), 3.

Hobbs, J. (1987). Violence--A personal and societal challenge. Social Work, 32 (6): 467-468.

Hotaling, G., & Sugarman, D. (1987). An analysis of risk markers in husband to wife violence: The current state of knowledge. Violence and Victims, 1 (2), 101-124.

Ionno, J. (1983). A prospective study of assaultive behavior in female psychiatric inpatients. In J. Lion & W. Reid (Eds.), Assaults in psychiatric facilities, (pp. 61-69), New York: Grune & Stratton.

Jacobson, A., Koehler, J., & Jones-Brown, C. (1987). The failure of routine assessment to detect histories of assault experienced by psychiatric patients. Hospital and Community Psychiatry, 38 (4), 386-389.

Jaffe, P., Wolfe, D., & Wilson, S. (1990). Children of battered women. Newbury Park, CA: Sage.

Jaffe, P., Wolfe, D., Wilson, S., & Slusczarck, M. (1986). Similarities in behavioral and social maladjustment among child victims and witnesses to family violence. American Journal of Orthopsychiatry, 56 (1), 142-146.

Jaffe, P., Wolfe, D., Wilson, S., & Zak, L. (1986). Family violence and child adjustment: A comparative analysis of girls' and boys' behavioral symptoms. American Journal of Psychiatry, 143 (1), 74-76.

Kahn, R., & Cannell, C. (1957). The dynamics of interviewing: Theory, technique, and cases. New York: Wiley.

Kalmus, D. (1979). The intergenerational transmission of marital aggression. Journal of Marriage & Family, 47 (2), 11-19.

Kaufman, J., & Zigler, E. (1987). Do abused children become abusive parents? American Journal of Orthopsychiatry, 57 (2), 186-192.

Kernberg, O. (1968). Some effects of social pressures on the psychiatrist as a clinician. Bulletin of the Menninger Clinic, 32, 144-159.

Kernberg, O. (1984). Transference management in expressive psychotherapy. In O. Kernberg. Severe Personality disorders: Psychotherapeutic strategies (pp. 112-131). New Haven: Yale University Press.

Kozol, H., Boucher, R., & Garafalo, R. (1972). The diagnosis and treatment of dangerousness. Crime and Delinquency,18, 371-391.

Kubie, L. (1971). The retreat from patients. Archives of General Psychiatry, 24, 98-106.

Kuch, H., Scherman, S., & Curry, H. (1977). The problem patient and the problem doctor, or do quacks make crocks? Journal of Family Practice, 5, 647-653.

Levy, P., & Hartocollis, P. (1976). Nursing aides and patient violence. American Journal of Psychiatry, 133 (4), 429-431.

Lightman, J. (1991, June). Legislative update. NASW California News,17 (9), p. 4.

Lion, J., Bach-y-Rita, G., & Ervin, F. (1969). Violent patients in the emergency room. American Journal of Psychiatry, 125,1706-1711.

Lion, J. (1972). Evaluation and management of the violent patient. Springfield, Ill.: Charles Thomas.

Lion, J., & Pasternak, S. (1973). Countertransference reactions to violent patients. American Journal of Psychiatry, 130, 207-210.

Lion, J., Madden, D., & Christopher, R. (1976). A violence clinic: Three years experience. American Journal of Psychiatry, 133 (4), 432-435.

Lion, J. (1983). Special aspects of psychopharmacology. In J. Lion & W. Reid (Eds.). Assaults within psychiatric facilities (pp. 287-296). New York: Grune & Stratton.

Lion, J., & Tardiff, K. (1987). The long term treatment of the violent patient. In R. Hales, A. Frances & K. Tardiff (Eds.), American Psychiatric Association Annual Review, 6 (pp. 537-564). Washington: American Psychiatric Press.

Litwick, T., & Schlesinger, L. (1987). Assessing and predicting violence: Research, law, and applications. In I. Weiner & A. Kass (Eds.), Handbook of forensic psychology, (pp. 205-257). New York: Wiley.

Luborsky, L. (1976). Helping alliances in psychotherapy. In J. Cleghorn (Ed.), Successful Psychotherapy. New York: Brunner Mazel.

Maccoby, E., & Maccoby, N. (1954). The interview: A tool of social science. In G. Lindzey (Ed.). Handbook of social psychology. Cambridge, MA: Addison-Wesley.

Mace. J. (1989). The effect of attitude and belief on social worker judgments concerning potentially dangerous clients. Unpublished doctoral dissertation, University of California, Los Angeles, CA.

Madden, D., Lion, J., & Penna, M. (1976). Assaults on psychiatrists by patients. American Journal of Psychiatry, 133 (4), 422-425.

Madden, D. (1983). Recognition and prevention of violence in psychiatric facilities. In J. Lion & W. Reid (Eds). Assaults within psychiatric facilities, (pp. 213-223). New York: Grune & Stratton.

Main, M., & Goldwyn, R. Prediction rejection of her infant from mother's representation of her own experience: Implications for the abused- abusing intergenerational cycle. Journal of Child Abuse and Neglect, 8 (2), 203-217.

Makepeace, J. (1981). Courtship violence among college students. Family Relations, 30, 97-102.

Maltzberger, J., & Buie, D. (1974). Countertransference hate in the treatment of suicidal patients. Archives of General Psychiatry, 30, 625-633.

Margolin, G., Sibner, L., & Gleberman, L. (1987). Interpersonal and intrapersonal features associated with marital violence. In G. Hotaling & D. Finkelhor (Eds.), Proceedings: Second national conference for family violence researchers. Beverly Hills: Sage.

Margolin, G., Sibner, L., & Gleberman, L. (1988). Wife battering. In V. Van Hasselt, R. Morrison, A. Bellak, & M. Hersen, (Eds.). Handbook of Family Violence (pp. 89-118). New York: Plenum.

Marmor, J. (1953). The feelings of superiority: An occupational hazard in the practice of psychotherapy. American Journal of Psychiatry, 110, 370-376.

Marston, A. (1984). What makes therapists run? A model for analysis of motivational styles. Psychotherapy: Theory, Research and Practice, 21, 456-459.

Martin, D. (1976). Battered wives. San Francisco, CA: Glide.

Martin, J. (1975). The obnoxious patient. In P. Giovachini, (Ed.), Tactics and techniques in psychoanalytic therapy: Countertransference. New York: Jason Aronson.

Marziali, E., Marmar, C., & Krupnick, J. (1981). Therapeutic alliance scales: Development and relationship to psychotherapy outcome. AmericanJournal of Psychiatry, 138 (3), 361-364.

McNeeley, R., & Robinson-Simpson, G. (1987). The truth about domestic violence: A falsely framed issue. Social Work, November-December, 485-490.

Megargee, E. (1976). The prediction of dangerous behavior. Criminal Justice and Behavior, 3, 3-22.

Mendes, H. (1977). Countertransferences and counter-culture clients. Social Casework, March, 159-163.

Miller, A. (1983). For your own good: Hidden cruelty in child-rearing and the roots of violence. New York: Farrar, Straus, Giroux.

Miles, M., & Huberman, A. (1984). Qualitative data analysis: A sourcebook of new methods. Beverly Hills: Sage.

Mishler, E. (1986). Research interviewing. Cambridge, MA: Harvard University Press.

Monahan, J. (1981). Predicting violent behavior: Assessment of clinical techniques. Beverly Hills: Sage.

Monahan, J. (1984). The prediction of violent behavior: Toward a second generation of theory and policy. American Journal of Psychiatry, 141, 10-15.

National Association of Social Workers. (1990). Ethics of the National Association of Social Workers. Maryland: Author.

Neidig, P., Freidman, D., & Collins, B. (1984). Spouse abuse: Mutual combat or wife battering? North Carolina: Behavioral Science Associates.

Neidig, P., Friedman, D. & Collins, B. (1985). Domestic violence conflict containment: A spouse abuse treatment program. Social Casework,66 (4), 195-201.

Ochitill, H. (1983). Violence in a general hospital. In J. Lion & W. Reid, Assaults within psychiatric facilities, (297-310). New York: Grune & Stratton.

Ogden, T. (1982). Projective identification and psychotherapeutic technique. New York: Jason Aronson.

Okun, L. (1986). Woman abuse: Facts replacing myths. New York: State University of New York Press.

O'Leary, D., & Arias, L. (1985). Prevalence and development of physical aggression in marriage. Paper presented at the 17th Banff International Conference on Behavior Sciences, Canada.

O'Leary, D. Arias, I., Rosenbaum, A., & Barling, J. (1985). Premarital physical aggressions. Unpublished manuscript. State University of New York, Stony Brook.

Pagelow, M. (1981). Factors affecting women's decisions to leave violent relationships. Journal of Family Issues, 2 (4), 391-414.

Parnell, L. (1983). Fusion, differentiation of self and interpersonal perception in battering couples. Unpublished doctoral dissertation, California School of Professional Psychology, Berkeley/Alameda.

Patton, M. (1990). Qualitative evaluation and research methods. New York: Sage.

Pennebaker, J., & O'Heeron, R. (1984). Confiding in others and illness rates among spouses of suicide and accidental death. Journal of Abnormal Psychology, 93, 473-476.

Pepitone-Rockwell, F., Phillips, K., & Werne, M. (1979). Staff reactions to rape. CATHEXIS, 2, 46-50.

Polkinghorne, D. (1989). Phenomenological research methods. In R. Valle & S. Halling (Eds.). Existential-phenomenological perspectives in psychology: Exploring the breadth of human experience (pp. 41-60). New York: Plenum.

Prescott, S., & Letko, C. (1977). Battered women: A social psychological perspective. In M. Roy (Ed.), Battered women: A psychosociological study of domestic violence. New York: Van Nostrand Reinhold.

Pynoos, R., & Eth, S. (1986). Post-traumatic stress disorders in children. Washington, D.C: American Psychiatric Press.

Ragland, D. (1989). Marital violence and psychotherapeutic issues: An examination of the effects of a videotape training program on therapist attitudes about and assessment of battered women. Unpublished doctoral dissertation, Hofstra University.

Reid, W., & Balis, G. (1987). Evaluation of the violent patient. In R. Hales & A. Frances (Eds). American Psychiatric Association Annual Review, 6, (pp. 491-509). Washington, D. C.: Psychiatric Press.

Rieker, P., & Hilberman-Carmen, E. (1986). The victim-to-patient process: The disconfirmation and transformation of abuse. American Journal of Orthopsychiatry, 56 (3), 360-370.

Robbins, J., Beck, P., Mueller, D., & Mizener, D. (1988). Therapists' perceptions of difficult psychiatric patients. The Journal of Nervous and Mental Disease, 176 (8), 490-497.

Rofman, E., Askinazi, C., & Fant, E. (1980). The prediction of dangerous behavior in emergency civil commitment. American Journal of Psychiatry, 137, 1061-1064.

Rosenbaum, A., & O'Leary, K. D. (1981). Marital violence: Characteristics of abusive couples. Journal of Consulting and Clinical Psychology, 49 (1), 63-71.

Rosenbaum, A., & O'Leary, K. (1986). The treatment of marital violence. In N. Jacobson & A. Gurman (Eds.). Clinical handbook of marital therapy (pp. 385-405). New York: Guilford.

Rosenbaum, C. , Adams, J., Scott, K., Renson, G., Tinklenberg, J., & Hanks, S. (1981). Alcohol and violence: A clinical study. In D. Hamburg & J. Trudeau (Eds). Biobehavioral Aspects of Aggression (pp. 170-226). New York: Alan R. Liss.

Rosenberg, M. (1984, August). Intergenerational family violence: A critique and implications for witnessing children. Paper presented at the American Psychological Association Convention, Toronto, Canada.

Rosewater, L. (1984, August). The MMPI and battered women. Paper presented at the Second National Family Violence Researchers Conference, University of New Hampshire, Durham.

Roth, L. (1981). Dangerousness: In the eye of the beholder? American Journal of Psychiatry, 138, 995.

Rouse, L., Breen, R., & Howell, M. (1988). Abuse in intimate relationships: A comparison of married and dating college students. Journal of Interpersonal Violence, 3(4), 414-429.

Russell, D. (1982). Rape in marriage. New York: Macmillan.

Sarason, S. (1977). Work, aging, and social change. New York: Free Press.

Saunders, D. (1986). When battered women use violence: Husband-abuse or self-defense? Violence and Victims, 1, 47-60.

Saunders, D. (1988). Other "truths" about domestic violence: A reply to McNeely and Robinson-Simpson. Social Work, 33 (2), 179-183.

Saunders, D., Lynch, A., Grayson, M., & Linz, D. (1987). The inventory of beliefs about wife-beating: The construction and initial validation of a measure of beliefs and attitudes. Violence & Victims, 2 (1), 39-57.

Schecter, S. (1982). Women and male violence: The struggles of the battered women's movement. Boston, MA: South End Press.

Schofield, W. (1986). Psychotherapy: The purchase of friendship. (Second Edition). New Brunswick: Transaction Books.

Schultz, L. (1960). The Wife Assaulter. Journal of Social Therapy, 6 (2), 103-112.

Shah, S. (1978). Dangerousness: A paradigm for exploring some issues in law and psychology. American Psychologist, March, 224-238.

Shainess, N. (1984). Sweet suffering. New York: Bobbs-Merrill.

Shapiro, R. (1987). Lifting the shade on family violence. The Family Therapy Networker.

Sherin E. (1987). Effects of aggressive cues on outpatient mental health therapists. Unpublished doctoral dissertation, Temple University, Philadelphia, PA.

Snell, J., Rosenwald, R., & Robey, A. (1964). The wifebeater's wife: A study of family interaction. Archives of General Psychiatry, 11 ,107-112.

Snyder, D., & Fruchtman, L. (1981). Differential patterns of wife abuse: A data based typology. Journal of Consulting and Clinical Psychology, 49 (6), 878-885.

Soloff, P. (1987). Emergency management of violent patients. In R. Hales, A. Frances, & K. Tardiff (Eds.). American Psychiatric Association Annual Review, 6 (pp. 510-536). Washington: American Psychiatric Press.

Sonkin, D. (1986). Clairvoyance vs. common sense: Therapist's duty to warn and protect. Victims and Violence, 1 (1), 7-22.

Sonkin, D., & Durphy, M. (1982). Learning to live without violence. San Francisco: Volcano Press.

Sonkin, D., & Ellison, J. (1986). The therapist's duty to protect victims of domestic violence: Where we have been and where we are going. Violence and Victims, 3 (1), 205-213.

Sonkin, D., Martin, D., &Walker, L. (1985). The male batterer. New York: Springer.

Spensley, J., & Blacker, K. (1976). Feelings of the psychotherapist. American Journal of Orthopsychiatry, 46 (3), 542-545.

Stark, E., Flitcraft, A., & Frazier, W. (1979). Medicine and patriarchal violence: The social construction of a "private" event. International Journal of Health Services, 9, 461-493.

Stark, E., & Flitcraft, A. (1988). Violence among intimates: An epidemiological review. In V. Van Hasselt, R. Morrison, A. Bellak, & M. Hersen, (Eds.). Handbook of Family Violence (pp. 293-317). New York: Plenum.

Steadman, H. (1977). A new look at recidivism among Patuxet inmates. The Bulletin of the American Academy of Psychiatry and the Law, 5, 200-209.

Steadman, H. (1980). The right not to be a false-positive: Problems in the application of the dangerousness standard. Psychiatric Quarterly, 52, 84-89.

Steadman, H., & Cozozza, J. (1974). Careers of the criminally insane. Lexington, MA: Lexington Books.

Steinmetz, S. (1977). The battered husband syndrome. Victimology: A International Journal, 2 (3-4), 499-509.

Stevick, E. (1971). An empirical investigation of the experience of anger. In A. Giorgi, W. Fischer, & R. VonEckartsberg (Eds.). Duquesne studies in phenomenological psychology,1 (pp. 132-148). Pittsburgh: Duquesne University Press.

Strauss, A., & Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park, CA: Sage.

Straus, M. (1978). Wife beating: How common and why? Victimology: An International Journal, 2, 443-458.

Straus, M. (1979). Measuring intrafamily conflict and violence: The conflict tactics (CT) scale. Journal of Marriage and the Family, 41, 75-88.

Straus, M., & Gelles, R. (1986). Societal change and change in family violence from 1975 to 1985 as revealed by two national surveys. Journal of Marriage and Family, 48, 465-479.

Straus, M., Gelles, R., & Steinmetz, S. (1980). Behind closed doors: Violence in the American family. New York: Anchor Books.

Straus, M., & Hotaling, G. (1980). The social causes of husband-wife violence. Minneapolis: University of Minnesota Press.

Stullman, M, Schoenenberger, A., & Hanks, S. (1987, July). Assessment and treatment of the child witness of marital violence. Paper presented at the Third National Family Violence Research Conference, University of New Hampshire, Durham.

Strupp, H., Fox, R., & Lesser, K. (1969). Patients view their psychotherapy. Baltimore: John Hopkins University Press.

Tardiff, K. (1983). A survey of assault by chronic patients in a state hospital system. In J. Lion & W. Reid (Eds.), Assaults within psychiatric facilities, (pp. 3-19). New York: Grune & Stratton.

Tardiff, K. (1974). A survey of psychiatrists in Boston and their work with violent patients. American Journal of Psychiatry, 131 (9), 1008-1011.

Tardiff, K. (1987). Violence and the violent patient. In R. Hales, A. Frances, & K. Tardiff (Eds.). American Psychiatric Association Annual Review (pp. 447-450). Washington: American Psychiatric Press.

Taubman, S. (1986). Beyond the bravado: Sex roles and the exploitive male. Social Work, 31 (1), 12-18.

Taylor, G. (1984). Psychotherapy with the boring patient. Canadian Journal of Psychiatry, 29 (3), 217-222.

Thornberry, T., & Jacoby, J. The criminally insane: A community follow-up of mentally ill offenders. Chicago: University of Chicago Press.

Tuohy, D. (1987). Psychoanalytic perspectives on child abuse. Child and Adolescent Social Work, 4, (1), 25-40.

U. S. Department of Justice. (1984). Wife abuse: The facts. Washington, D. C.: Author.

VanMaanen, J. (Ed.). (1983). Qualitative methodology. Beverly Hills: Sage.

Walker, L. (1979a). Battered women: Sex roles and clinical issues. Professional Psychology, 12 (1), 81-91.

Walker, L. (1979b). The battered woman. New York: Harper & Row.

Walker, L. (1984a). Battered women, psychology, and public policy. American Psychologist, 39 (10), 1178-1182.

Walker, L. (1984b). The battered woman syndrome. New York: Springer.

Walker, L. (1986). Psychological causes of family violence. In M. Lystad (Ed.), Violence in the home: Interdisciplinary approaches (pp. 71-97). New York: Brunner-Mazel.

Werner, P., Rose, T., & Yesavage, J. (1983). Reliability, accuracy, and decision-making strategy in clinical predictions of imminent dangerousness. Journal of Consulting and Clinical Psychology, 51 (6), 815-825.

White, P. (1988). Psychologists' attributions in wife abuse: Modification of an attributional model scale. Unpublished doctoral dissertation, University of South Dakota.

Whitman, R., Armao, B., & Dent, O. Assault on the therapist. American Journal of Psychiatry, 133 (4), 426-429.

Winnicott, D. W. (1965). The maturational process and the facilitating environment. New York: International Universities Press.

Wolfe, D. Jaffe, P., Wilson, S., & Zak, L. Children of battered women: The relation between child behavior, family violence, and maternal stress. Journal of Consulting and Clinical Psychology, 53, 657-665.

Yesavage, J., Werner, P., & Becker, J. (1982). Short-term civil commitment and the violent patient. American Journal of Psychiatry, 139, 1145-1149.

Young, G., & Gerson, S. (1991). New psychoanalytic perspectives on masochism and spouse abuse. Psychotherapy, 28 (1), 30-38.

Young. G. (1990). Spouse abuse and patterns of attachment. Unpublished doctoral dissertation, California School of Professional Psychology, Berkeley/Alameda, CA.