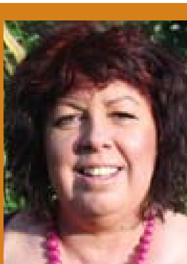
A radical reVision of domestic abuse:[1] making the case for a non-gendered, empathic approach

Sue Parker Hall challenges what she regards as a single and simplistic explanation for domestic violence – men's need for power and control – and suggests that a warm, vibrant, empathic and accepting therapeutic relationship is the best environment in which to effect change

The dominant model of state-funded interventions for domestic abuse in the USA (Duluth model) and the UK Integrated Domestic Abuse Programme (IDAP) is based on 'a ludicrous political ideology' (Pizzey, 2004) and is 'less like therapy than like thought reform' (Dutton, 2006; Lifton, 1989).

The theory that underpins these programmes stems from a solitary event in Duluth, Minnesota in 1981 where a husband killed his spouse. The dynamics of this single crime have subsequently been adopted as a universal model of male behaviour in all domestic violence incidents. Men are profiled as 'patriarchal terrorists, culturally conditioned to subjugate women' (Johnson, 2008), executing 'deliberate, calculated and conscious behaviour intended to control and intimidate a carefully chosen female target' (Parker Hall, 2008).



Sue Parker Hall

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Challenging the perpetrator stereotype

This patriarchal terrorist stereotype is based on 'non-representative shelter examples' (Dutton, 2006). In more general communities, Johnson (1995) argues that there is scant evidence for this representation and that as few as 3 per cent of the whole male population match this profile. 'Situational couple violence' (SCV) dominates general surveys, with 86 per cent of both men and women reporting using and experiencing violence in their relationships (ibid); 'SCV is not part of a general pattern of control [but] provoked [in response to] the tensions or emotions of a particular encounter' (ibid).

If domestic violence is men's attempt to dominate women we would not expect to find it in same-sex relationships, and yet research by Henderson (2003) has found that it is just as prevalent: 22 per cent of women and 29 per cent of men with same-sex partners. And in a gay men and lesbians sample (Donovan et al, 2006), 77 per cent had experienced emotional abuse, 40 per cent physical abuse and 40.5 per cent sexual abuse A much earlier survey (Lie and Gentlewarrier, 1991) found that lesbian relationships were more violent than gay relationships (56 per cent v 25 per cent) and a further survey of 350 lesbians, of whom 78.2 per cent had formerly been in relationships with men, reported less violence in their previous relationships with men than in previous relationships with women (ibid).

Within the feminist paradigm, it is deemed offensive to women and politically incorrect to ask any questions which imply that a woman may share any responsibility for her harmful relationships or that most men are not abusive:

- 'Why do some women choose violent partners, often serially, and yet others don't?'
- 'If all men are socialised into patriarchal values, how come not all men are abusers?'
- 'How come the vast majority of men don't beat their partners?'

Neither is it acceptable to mention women's violence that is constructed as self-defence, a reaction to male violence or to provoke the inevitable male attack in order to get it over with (ibid). Men are in a Salem witch trials-style (Miller, 1953) ideological loop and are damned in any circumstance.

1. Defined here as 'a continuum of behaviour ranging from verbal abuse, physical and sexual assault to rape and even homicide' (Barking and Dagenham NHS, 2008)

Critique of IDAP and Duluth interventions

The most common intervention in the UK and USA is a 'one size fits all' psycho-educational programme, with elements of cognitive behavioural therapy, underpinned by a single explanation for violence – men's need for power and control – and a single solution – men changing their sexist beliefs and modifying their behaviour away from violence and towards mutual co-operation with others. It focuses on the 'power and control wheel', which identifies eight categories of abusive behaviours to be replaced by their eight respectful counterparts on the 'equality wheel'. It is facilitated by practitioners who may not have done any personal development work themselves, may not have explored their own rage issues, have little or no understanding of the inherent power dynamics or of transference and countertransference issues.

Such programmes are blind to an individual's personal history, general mental health issues or personality disorder diagnoses, relationship dynamics, use of drugs and alcohol and, most important in my opinion, their personal explanation of events. The curriculum is 'inflexible and non-responsive to individual or group needs' (Eadie and Knight, 2002; Rees and Rivet, 2005) and, ironically, men can be related to as objects, their subjectivity denied.

'There is no unequivocal evidence that such programmes 'work' (Wilson, 2003). A recent meta-analysis conducted by Babcock et al (2004) suggested that effects due to treatment were in the small range and that 'there was no difference in terms of either modality's effectiveness [Duluth model or cognitive behavioural therapy] in reducing domestic violence recidivism'. 'In general, domestic violence treatment programs are plagued by high attrition rates, with anywhere from 15% to 58% of individuals failing to complete treatment' (Bennett et al, 2007; Rondeau et al, 2001). A practitioner says: 'We expect to get 14-15 on the first night … we tend to finish groups now with around 8 or 9' (Bullock et al, 2010).

A lack of motivation, chaotic lifestyle or substance misuse are issues that are frequently cited as reasons that men fail to complete. However, some of the men I have worked with who failed to thrive on these programmes have felt bullied, shamed and misunderstood. Dutton (2006) argues: 'How do you establish a connection with a client when you're making him feel bad about being male?' Their traumatic histories either go unvoiced and unaddressed or are dismissed as 'excuses'. The programme can be understood as a form of controlling behaviour in itself, as a 'regulatory practice' (Foucault, 1977); it is in a 'muddled state in which there is no clear delineation between treatment, social activism, and punishment' (Smith, 2006). The functions of regulation and control have become enmeshed with the therapy function (Parker Hall, 2008).

Why a relational approach?

General support for a relational rather than a technical approach comes from psychotherapy outcomes research, which has consistently found that the therapeutic relationship is a significant aspect in positive outcomes. An assessment of 40 years of psychotherapy research concluded that only 15 per cent of its efficacy could be attributed to technique; relationship factors were found to be twice as important in contributing to improvement in psychotherapy (30 per cent) (Lambert and Barley, 2002): 'What the client brings, in terms of readiness to work, is the most effective factor … 40% of the results' (Miller et al, 1997). Under the circumstances, it makes sense to adopt a client- rather than programme-centred approach, which utilises the resources a client brings and the therapeutic relationship as the vehicle for change. If 'psychological services are most likely to be effective when responsive to the patient's specific problems, strengths, personality, socio-cultural context and preferences' (APA, 2005), it is important to meet the client and involve their material as fully as possible in the process.

> “It makes sense to adopt a client- rather than programme-centred approach, which utilises the resources a client brings and the therapeutic relationship as the vehicle for change”

In the psychotherapy paradigm, domestic abuse is more likely to be referred to as a rage behaviour which has been linked to the inability to regulate affect (Schore, 1994), the 'protest' that signifies a ruptured attachment (Holmes, 2001) and to an 'abusive personality' which develops from early exposure to violence, shaming and lack of a secure base (Dutton, 2006: 231).

I define rage as 'a pre-verbal, pre-cognitive coping mechanism which functions to ensure an infant's physical and psychic survival when they are at their most vulnerable' (Kalsched, 1996). 'It is a 'self-care system' (ibid), which is mobilised in earliest infancy, primarily as a cry for help (hot rage) when the holding environment (Winnicott, 1960) fails and infant needs are not being met and, secondarily, as a means to cope with the 'overwhelming feelings evoked when help does not arrive (cold rage)' (Parker Hall, 2008).

Rage is an integral element of trauma, defined here simply as 'any emotional response to life experience, whether of epic or apparently trivial proportions, which has not yet been processed' (ibid). Emotional experience could not be processed in early infancy, and trauma occurred because 'there [was] no one there' (Janet, 1907); as a result of abandonment or cumulative 'misattunement' (Erskine and Trautmann, 2003), whereby another person was physically present but was traumatised themselves and consequently not emotionally available so regularly misinterpreted the infant's communication; or, finally, because the person present was an abuser who prioritised their own needs.

If adult rage is conceived of as the inability to process life's experiences and the build-up of a backlog of events which have not yet been come to terms with, it follows that the remedy is to develop the capacity to process emotions, to learn to 'feel things through'. I suggest that a warm, vibrant, empathic and accepting relationship is the best environment in which to do this.

Empathic anger management (EAM) model

If rage is the legacy of 'there being nobody there' at the time of a traumatic event then 'being there' in the helping

relationship is its antithesis. EAM is a therapeutic process in which men and women with rage issues are supported to develop or recover 'the organismic ability to process their life experiences … through engaging in a compassionate and humane relationship where all feelings, sensations, thoughts and images are welcomed and the practitioner has absolute trust that, given this most conducive environment, a client will spontaneously integrate their life's events' (Parker Hall, 2008: 3).

The client identifies life experiences that they believe they have not yet come to terms with. Typically, these events are all bound up together and their process is characterised by flitting from one event to the next punctuated by 'and another thing … and another thing'. These are represented in a pot and are debriefed and processed one at a time.

“ Every man and woman I have worked with on rage issues have experienced trauma as a result of abuse and neglect and have had no one to help them process their experiences ”

Jack was a 52-year-old man whose pot included having no father, being left alone by his mum as an infant with the radio for company, being estranged from her when she died due to a family argument, a road traffic accident where he thought he would die, being bullied at school and the death of a sibling.

Angela, 42-years-old, who was as violent as any man I had worked with, burst into tears when she heard my definition of rage and said, 'I thought I was just evil.' Her pot included being adopted, having a husband that she didn't feel connected to, sexual childhood abuse by a family friend, an alcoholic father and a cold, remote mother.

Luke aged 17's pot included having a broken back which put an end to his rugby career, being bullied at boarding school, domestic violence between parents and uncertainty about whether his mum and dad would get divorced, a recent split with a girlfriend, a workaholic dad and mum not seeing him for who he was.

Without exception, every man and woman I have worked with on rage issues have presented with at least traits of borderline, antisocial or paranoid personality disorder, have experienced trauma as a result of abuse and/or neglect and have had no one since to help them process their experiences.

Conclusion

In my experience, cultural background and conditioning shapes a person to a significant degree and is of course 'in the pot', but life events, familial experiences and interpersonal relationships are equally formative influences. A client does not need directing or educating to reduce their violent behaviour; neither should they accumulate more traumas as a result of engaging in a manualised programme which doesn't honour their subjectivity or their process and ignores their trauma.

What is helpful is a therapeutic relationship that, through one humane practitioner response after another, supports a client to contain their rage and to integrate their significant life events through grieving. This rhythmic, organic process supports them to 'loosen' (Rogers, 1957) layer after layer of unprocessed material, to 'articulate the meaning of what they are experiencing' (Embleton Tudor et al, 2004) and to develop a skill for life, the ability to process their life experience.

Domestic violence is a multibillion dollar industry and many have vested interests in the current modus operandi continuing. Yet it is extraordinary that so much money is spent with so little evidence-based research to support these feminist programmes and a wealth of research that refutes its relevance, appropriateness or effectiveness. As long ago as 1999, the American Psychological Association Division of Psychotherapy advocated shifting its research focus away from technical factors and commissioned a taskforce for the purpose of disseminating guidelines to advance empirically supported relationships rather than empirically supported treatments. American humanistic psychologists have been urged 'to shift the debate away from modalities and techniques and to focus on the factors that are actually responsible for therapeutic benefits … the alliance, the therapist, the relationship, and other contextual factors' (Elkins, 2007). P

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Letter to the Editor

This letter was submitted in response to Hugh Hetherington's discussion article in issue 49 of *The Psychotherapist*, 'Existential therapy – being in this together', p22

Dear Editor

The paper 'Existential therapy – being in this together' offers a somewhat prescribed view of what existential therapy and mindfulness are about, and how existential practitioners work.

First, I want to say something simple about Buddhist practice and existentialist thinking as I see it. My view is that Buddhism is founded on a direct observation of reality using the practice of meditation, and that existential thinking describes a way of being that is embodied and experiential in nature. I would argue with Hugh Hetherington's view that therapy cannot 'cure anxiety' by saying that no-one wants to suffer. It's more usual to want something more comfortable for ourselves. In practising Buddhism, I accept there is a path already laid out for us, and in following this path, eventually, in some ways, body and mind can be transformed so that we can alleviate suffering for ourselves, and, as psychotherapists, for others too.

I would also argue with his view on mindfulness. Mindfulness is embodied in the breath. In some Buddhist retreat centres, there are gentle reminders to practice greater self-understanding and peacefulness in our everyday lives. When we wash dishes, we wash dishes. Thich Nhat Hanh is saying that mindfulness is coming back to our current activity and not allowing our mind to wonder off and away from what we are doing. The simple directive of the Vietnamese monk's message is that it is nothing special. We only have to pay attention to ourselves in our daily lives.

I would also argue with Hugh Hetherington's interpretation of care in Heideggerian terms. I feel it is important to read Professor Heidegger's work for yourself, and to do the thinking he requires us to do. He is deliberately opaque and there are many interpretations of care that are not true to his thinking and therefore misleading. If we read *Existence and Being*, Heidegger says, 'the Being of Dasein is defined as Care…three important aspects emerge: (1) Dasein is concerned about its own Being…and thus for the potentialities of authenticity and unauthenticity; (2)…it is 'thrown' into a world and left there to its own devices and responsibility; (3)…Dasein always engages and spends itself in the world of its Care…Care taken in this sense, may be care of…if it concerns anything that is 'Zuhanden'; or a care for… if it concerns the Dasein of others…'

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Maureen is a trauma psychotherapist. She has a BA (Hons) in western philosophy, an MA in existential psychotherapy and counselling, as well as training in Buddhist psychotherapy and counselling and eastern philosophy. She works integratively focusing on trauma and the relief of suffering.

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