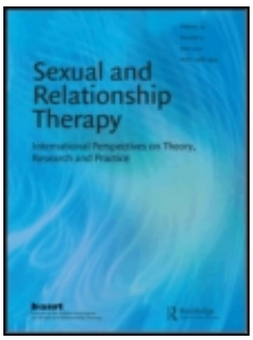

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Domestic violence and intimacy: what the relationship therapist needs to know

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ABSTRACT *This paper looks at victims of violence perpetrated by their intimate partners, offering a contemporary, multifactorial understanding of why it occurs. The focus is on these issues for women as victims, men as perpetrators, and on the environments that maintain them. Reference is made to certain papers from the available literature on violence in same-sex relationships, which informs an understanding of the broad issues in domestic violence. Contextual analysis is advocated as the contemporary approach to domestic violence, to assist therapists in keeping their observations of such violence within the wider context. Therapists working with couples are encouraged to acknowledge the existence of domestic violence and to become more mindful of it in relation to other presenting problems in their clinical practice.*

Introduction

Domestic violence is a well used term that encompasses a wide range of experiences. The original meaning of assault or attempted assault between two people living together as a couple is now considered too narrow. Strauss and Sweet (1992), Gelles (1976) and Mezey (1995) have proposed that the term imply the deliberate physical, psychological and/or sexual abuse of another person within an intimate relationship. Mirlees-Black (1995) has indicated in her computer-assisted self-interviewing (CASI) questionnaire, that 'domestic' should involve all intimate relationships, whether or not there has been co-habitation. It may include within that term any persons who are related in any way or who live within the same household. The term, therefore, can include victims and their former partners, parents attacked by their children, same-sex partnerships that are violent and, occasionally, men attacked by women (Stanko, 1995; Mirlees-Black, 1999).

Until recently, the police and courts were reluctant to enter the private domain where domestic violence typically occurs. The police would typically attend to

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incidents and record 'domestic dispute', advocating counselling or referring to social services. In the past two decades there has been a significant shift, both in police practice and in legislation, to recognize the seriousness of domestic violence and to provide adequate legal remedies. The provisions contained in the Family Law Act 1996 and the Protection from Harassment Act 1997, offer a number of useful legal remedies, including the consideration of domestic violence—defined in terms of harassment—as a criminal offence.

In mental health classification systems such as *The Diagnostic and Statistical Manual of Mental Disorders Fourth Edition* (DSM-IV, 1994), there is reference to the perpetrators of domestic violence through the following codes: "committing physical abuse" (V61.12), "sexual abuse" (V62.83), "victims of physical abuse" (999.81) and "victims of sexual abuse partner from a partner" (995.83). These codes do not define disorders, but "other conditions which may be the focus of clinical attention". What is meant by this is that these conditions may or may not be causally connected to mental disorder, *or* that such conditions contribute in part to a mental disorder, but do not stand alone as one. For example, a person can be diagnosed as suffering from depression, and have one of these additional codes. This paper will draw attention to how domestic violence is associated with disorders such as drug or alcohol dependence, post-traumatic stress disorder or personality disorder, and the way couple relationships may be affected.

The paper draws attention to the extent of the problem of domestic violence, recognizing the issue of under-reporting. The overview of theoretical constructs about causation looks at the issues in the perpetrator, in relationships and family, and in the wider sociocultural context. The nature of abusive relationships is considered in terms of what goes on between the individuals. A discussion of mental health problems in the victims draws particular attention to post-traumatic stress disorder (PTSD). In describing the nature of help-seeking behaviour which occurs in domestic violence, the authors go on to offer information to assist the therapist in addressing the issue of domestic violence in clinical practice.

Domestic violence has been addressed as a medical/psychopathological problem, a social problem and a legal problem over the years. A fundamental concern is whether any public body or policy can deal with what is seen as a private matter. Professionals engaged in mental health work are increasingly encouraged to understand and accept the different perspectives on domestic violence and to adopt practices which offer practical solutions to the affected individuals.

Domestic violence against women—the extent of the problem

In the UK it has been calculated that one in four households experiences domestic violence and that this is in the main violence inflicted on women by their partners, who are usually, but not always, men (Mental Health Act Commission, 1997). The British Crime Survey of 2000 (Kershaw *et al.*) estimated one million incidents of domestic violence, of which two thirds were directed at women. Between 1981 and 1999 there has been an upward trend in reported crimes of domestic violence from 292 000 to 761 000, with a peak in 1995 of 990 000 incidents reported. Even when

under-reported, domestic violence accounts for nearly a quarter of all violent crime reported in the UK.

In the USA domestic violence causes more injury than road accidents, muggings and rapes put together. A total of six million women suffers each year and 4000 are killed by their partners. The Surgeon General found that domestic violence against women is the "single largest cause of injury to women in the United States", accounting for one-fifth of all hospital emergency room cases (cited in Zorza, 1992). Short (1995), Strauss and Gelles (1986) estimated that 12% of persons suffering post-traumatic stress disorder (PTSD) were women who had been battered by their spouses (based on data from recent national studies on PTSD). The available literature does not reveal specific studies of PTSD in battered women but several smaller studies of refuges and community self-help groups show a PTSD rate of 45% (Astin *et al.*, 1990; Houskamp & Foy, 1991).

In Canada the picture is similar. In women over the age of 16 half reported at least one incident of violence at the hands of their partner. Of these, 29% were partners/ex-partners; 16% were boyfriends/dates; 23% were other known men; and 23% were unknown men. For every incident reported to the police, three incidents go unreported. One woman in 10 who are currently experiencing domestic violence is in fear for her life. Nearly half of all separated women report violence in their previous relationship. A quarter of all women in heterosexual relationships have experienced violence from a current or previous partner (Statistics Canada, 1993)

In Northern Ireland there is evidence that up to 25% of women suffer from domestic violence and in Scotland a newspaper survey of 1503 women indicated that over half of the respondents were frightened of the men with whom they lived (Stanko, 1995).

Mirlees-Black (2000) found in her questionnaire that 99% of assailants of women were men, of whom half were a spouse of ex-spouse, a third were current non-married partners and one-tenth were ex-lovers. They covered all ages, all socioeconomic groups, all ethnic groups and all health categories. Men as victims reported similar numbers of incidents as women in the previous year. The survey showed that when the violence was less serious, men were less likely to seek medical help, and that they were less frightened. The survey concludes that men are more likely to report any violence, including 'trivial' incidents, which women would have thought inappropriate to mention. Men are seen as physically stronger than women and endure less violence. They earn more and are therefore more likely to perceive themselves as able to leave a violent household.

While there is less said about women abusing men in the literature, there is interest in the small number of women victims of domestic violence who harm or kill their perpetrating partners. Mezey (1995) describes the characteristics of 11 women who had killed their abusive male partners. She found that in seven cases the women had experienced prolonged physical and psychological assault, as well as sexual abuse. All 11 reported non-consensual sexual intercourse, although they were reluctant to define this as rape. There was much emphasis on humiliation, threat and complete control by their partners. Typically, the victim would be verbally abused and threatened before sex, and beaten or tortured if she

offered any resistance. The descriptions of these cases do not address sexual dysfunction in the abusive relationships; the emphasis is on sex becoming the means of abuse within apparently dysfunctional relationships.

Same sex relationships

Most incidents of domestic violence are reported in heterosexual couples, which perhaps explains the paucity of literature about violence in same-sex relationships. Ferri (1998) quotes figures showing that rates of domestic violence within the gay community are the same as in the heterosexual community, and reminds clinicians of the need to enquire about this also with bisexual and transgendered clients.

Fortunata (1999) looked at the lesbian experience of domestic violence, comparing the personality and psychological characteristics of violent lesbians with non-violent lesbians. Her study explored violence in relation to family history of violence, substance misuse history, life stressors, perception of power imbalance in the relationship, personality features, jealousy and dependency. She found that violence correlated with everything except dependency and perception of power. She also found that the personality and psychological characteristics of women who batter women in stable relationships (of more than five years) were similar to those of heterosexual male perpetrators.

Jennings and Murphy (2000) attempt to explain heterosexual violence by looking at male–male issues that can subsequently displace onto future male–female relationships. They cite in particular 'humiliation' as a powerful and endemic social construct which pervades male psychology and which causes significant problems in male self-esteem and psychosexual relationships. They postulate that humiliation is the social form of shame, and that it has its roots in early life same-sex relations, rites of passage and disturbed father–son relationships.

Tjaden *et al.* (1999) compared men and women with a history of same-sex cohabitation with their counterparts who had been married or lived with the opposite sex, looking at violence over the lifespan of their relationships. They found that the same-sex co-habitants were more likely to have been raped as children and as adults, to have been physically assaulted as children by adult carers, and to have been assaulted by all types of perpetrators, including intimate partners. There were differences, however, between lesbian and gay couples. Gay men were more likely than their heterosexual counterparts to perpetrate violence, but lesbian women were less likely than their heterosexual assailant counterparts to commit violence. This was a telephone survey, with all the method bias common to such studies, but a picture emerges of men as the initiators of violence in all relationships, whether against same-sex or opposite-sex partners.

Theoretical constructs about causation

The debate about causation of domestic violence in heterosexual relationships continues, reflected in the literature from a wide variety of perspectives, including

biological, psychological, social and cultural dimensions; many of these overlap. In broad terms, the theories can be considered as being:

(a) about the male perpetrator, looking at internal dysfunction or disorder;
(b) about psychological functioning in relationships and the family, including social learning models;
(c) about society and culture, reflected in gender issues raised in feminist literature.

Men as perpetrators of domestic violence

Ridley (1999) describes the discourse around male aggression as a biological reality quoting Bancroft (1989) and Pool (1994). Taubman (1987) examines the causes and correlates of men's violence, and identifies psychosocial violence against young boys that can result in a sense of powerlessness, isolation and retaliatory rage. The result of this, combined with the biological effects of testosterone, account for men's greater propensity than women to violence against others of both sexes.

Alcohol abuse or dependence is commonly implicated in domestic violence, typically in the male perpetrator, but also in the women victims. Inappropriate use of alcohol affects cognitive functioning, distorts reason and perception and interferes with communication, leading to aggression. Murphy and O'Farrell (1997) compared the communication of 60 aggressive couples containing alcoholic men with 30 non-aggressive couples containing alcoholic men during a period of abstinence. In general they found that alcoholic husbands in both groups were less likely than their wives to express facilitative or enhancing communication. What distinguished the aggressive male partners, however, were their higher levels of aversive or defensive statements, and their negative reciprocity. Nevertheless, in a study on aggression in 647 newly married couples in the USA, Leonard (1999) found that, although alcohol was a significant feature in marital aggression, its role should not be overstated. Alcohol would aggravate aggression and would prevent other more functional strategies being considered, but it was neither a necessary nor sufficient cause of marital aggression.

Two interesting studies have investigated types of batterers with more precision, and found that it is not always helpful simply to compare violent men with non-violent men in marital relationships. Hultzworth-Munro *et al.* (2000) identified sub-types based on the severity of the violence, the extent of the violence and whether or not personality disorder was involved. They defined their subtypes thus.

- FO (Family Only) Batterers were men who were the least violent, who only hit their wives, and appeared to be the least accepting of their own violence.
- BD (Borderline-Dysphoric) men were moderately violent and would hit their wives but would also have fights with non-family members. They scored highly on preoccupied and fearful attachment and impulsivity.
- GVA men (Generally Violent and Antisocial) demonstrated the least social skill, were the most accepting of their own violence, and tended to relate to everyone in violent or antisocial ways.

Waltz *et al.* (2000) attempted to replicate this typology, and although they had some difficulty in distinguishing the personality disorder, they were able to identify the first two groups of men.

Self-esteem (Rosen, 1991) in male perpetrators appears to feature significantly in domestic violence, where small slights become a threat to men's 'ego ideal'. Rosen (1991) writes about the importance of healthy upbringing of young men who develop a realistic sense of self. Otherwise there is recourse to violence as an expression of the self. He quotes Mason and Blankenship (1987) who found that abuse occurred more in committed relationships, but does not offer any explanations as to why this should be so.

Nedergaarrd (1999) found that battering men are not socially unskilled, but they do differ in their beliefs from distressed non-abusers and non-distressed non-abusive men. The author describes specific decision-making deficits when embarking on abusive behaviour. These included beliefs about the usefulness of anger as a means of solving marital conflict and as a way of staying in control of the relationship, and the belief that violence had a low impact on the partner's self-esteem.

Male perpetrators of violence, whether with intimates or with strangers, have troubled sexual and psychosexual lives (Bancroft, 1989). Bownes (1993) found that sexual and relationship dysfunction featured significantly in all sexual offenders, although the exact correlation had not been established. He recommended, however, that perpetrators of sexual crimes be given help with those sexual dysfunctions, and especially with relationship skills. In his work with convicted rapists he found that the more serious their sexual dysfunction, the more violence they were likely to use during their attacks, and the more serious the violence, the greater number of attacks they were likely to have made in the past. Marshall (1993) points us to the role of disrupted early attachments, loneliness and deficits in intimacy as key features in the histories of men who offend sexually. It has not been established that sexual dysfunction causes sexual offences, or that sexual offending causes sexual dysfunction, but both problems are connected in an important way to the absence in early life of secure attachment and intimacy.

Psychosocial functioning in relationships and families

What appears to predict marital aggression may be the aversive family communication of the individuals in their adolescence. Andrews *et al.* (2000) found, when they interviewed 254 young people of both sexes ($\bar{X}$ age 17) and then in early adulthood ($\bar{X}$ age 23), that the most physically aggressive men and women were those who were already behaving antisocially, and who had more aversive exchanges with their families of origin than those who were non-violent. Contrary to their hypothesis, married couples were less tolerant of aggression than those who were courting or co-habiting.

A history of violence in the male perpetrator's family of origin is probably the

most widely accepted risk factor predicting domestic violence. Stanko (1995) cites the work of a number of crime surveys (Hindelang *et al.*, 1978; Hough & Mayhew, 1983; Mayhew *et al.*, 1993) and argues that men also experience violence in a wide range of settings, including domestic, which is usually perpetrated by other men. She argues that, developmentally, men's peer relationships form in childhood to early adulthood, and support violence against women. Men begin their violence in earlier intimate relationships before establishing their own families, whereupon they exercise "their own power and status" (Connell, 1987). Rosen (1991) states: "the painful devaluations of the self which trigger and result from violence are often found to be repetitions of earlier childhood experiences".

The transmission of violence across generations has been considered in the case of the woman victims as well. Gelles (1976) describes the 'social heredity' of women with abusive childhoods ending up in abusive adult relationships. Simons *et al.* (1993) conclude that women subjected to abusive parenting may develop "hostile, rebellious orientation" and thereafter are more likely to affiliate with similar men.

There is a debate about the so-called 'symmetry of violence' in sexual relationships—that is, that both women and men are violent, but that women suffer more, (Strauss & Gelles, 1990). Frieze (2000) challenges the position that violence is mainly meted out to women in marriage and argues that women also show violence in dating and marital relationships—it is just that they are also more likely to be injured. Feminists are quick to point out that the overwhelming majority of reported violent crimes, including killings between partners, are by men against women. O'Leary *et al.* (1989) compare the degree of aggression pre-marriage, at the start of marriage, after 18 months and after 30 months of marriage. In self report measures, women and men reported the same amount of aggression towards each other, and that the main means of expressing such aggression was through pushing, shoving and slapping. What emerges is a picture where men initiate violence, women respond violently, but that overall men inflict more serious injury when they become aggressive (O'Leary *et al.*, 1989, Strauss & Gelles, 1990).

Studies about men in abusive relationships have looked primarily at communication. Berns *et al.* (1999) examined the patterns of 47 couples talking on videotape, and compared them with 28 unhappy but non-violent couples, and 16 happy and non-violent couples. What they found was that men who batter their wives were more likely both to demand and to withdraw than either of the non-violent groups of men. Battered women were also different—demanding more change of their husbands than non-victimized women, although they did not withdraw as much as their abusive partners.

Some authors emphasize life stressors. Epperly and More (2000) see domestic violence as a sign of psychosocial distress, suggesting it may occur in 16% of relationships—a figure much lower than in those studies looking at female victims of such violence. These figures are in some measure affected by the source of the reports; in this case, questions were put to couples who had already been selected and indicated a willingness to discuss the nature of their violence.

Sociocultural issues

The equalization of gender roles in relationships may threaten some men, and when this is coupled with any inherent problems they have around self-esteem or tendency to aggression, domestic violence can occur. Dobash and Dobash (1992) state: "the sources of conflict leading to violent events reveal a great deal about the nature of relations between men and women, demands and expectation of wives, the prerogatives and power of husbands and cultural beliefs that support individuals' attitudes of marital inequality".

Domestic violence has been widely reported in many cultures, and in many socioeconomic contexts. (Fischbach & Herbert, 1997; Long & Martinez, 1994; Fleming *et al.*, 1999; Marais *et al.*, 1999; Haj-Yahia, 1997; Peled *et al.*, 2000; Wadsby & Svedin, 1992 Jejeebhoy, 1998; Deyessa *et al.*, 1998). All these studies point to deeply entrenched societal values that enable the justification of violence between partners, and to local cultural mores which may further aggravate stereotypical attitudes to victims as being deserving of their abuse.

Fischbach and Herbert (1997) describe gender-based violence as "a pervasive global issue". They describe domestic violence as "ubiquitous, grave and variable, requiring recognition, intervention and prevention at a local level, but with a requirement for international understanding".

Balakrishna (1998b) concludes: "the meaning of violence for each party lies within the individual, the collective and the cultural understandings of being male or female. Hence, an understanding of spousal violence needs to take account of social, ideological and economic forces which shape relationships between men and women, in the home and in society."

The nature of violent relationships

The term 'traumatic bonding' was first used to describe the torturer and the victim, the hostage taker and the hostage (Dutton & Painter, 1981). The parent and the child, the batterer and the battered woman have something in common. Their relationship evolves over time, and mutual dependencies emerge. In the setting of sexual and marital relationship, the couple may have strong emotional bonds that will make it difficult for the woman to leave her partner or be 'disloyal' by disclosure to others. Bergman *et al.* (1988) describe 55% of the battered women in their sample as feeling pity, compared with only 12% expressing hatred or loathing.

Traumatic bonding with the batterer should not be seen as affection but as an indication of the victim's terror and permanent vigilance (Mezey, 1997). In its most extreme form, the victim identifies so closely with her assailant, that she becomes violent and kills him as a means of escaping a disordered relationship. The effect of such traumatic bonding on the sexual functioning is that sexual activity for the victim is used as a currency with which to buy favours such as safety and affection. For the aggressor, it becomes the main mechanism for establishing control within the partnership, and of extending abuse beyond violence, or the threat of it (Mezey, 1997; Dutton & Painter 1981; Graham *et al.*, 1988).

Herman (1992) focuses on the pathological changes in the relationship between perpetrator and victim. Although she is actually describing people in captivity (e.g. hostages, prostitutes in brothels, prisoners in concentration camps and members of religious cults), many of these changes are found in domestic settings. The perpetrator establishes control of the victim's body and bodily functions, thereby destroying the individual's sense of autonomy. Over time, the perpetrator seeks to isolate his victim, destroying the victim's emotional ties to others. Herman (1992) states: "as the victim is isolated, she becomes increasingly dependent upon the perpetrator, not only for survival and basic bodily needs, but also for information and emotional sustenance".

Women victims and mental health consequences

Mawby and Gill (1987) indicate that there is greater harm done when the assailant is known well to the victim, than through violence that comes from a stranger. The victim is more likely to blame herself and her judgement, and she is more likely to have trouble in establishing trust in other close relationships as a result. Mezey (1997) observes that, in all types of attack, the degree of control a woman has over the violence that is meted out is more likely to affect outcome than the severity of the violence, or the certainty of its occurring. Domestic violence involves participants well known to each other, where the victim has few escape options, and may perceive herself or himself as having little control over events leading up to violence. For this reason, the effects of domestic violence are grave.

Balakrishna (1998a) examines the impact of domestic violence in terms of diagnosis of mental disorder in mental health services. Not surprisingly, he found that psychiatric morbidity was high. Severe depressive symptoms, generalized anxiety and fearfulness, and stress-related disorders all feature in domestic violence.

Dutton (1992) suggests three main sequelae of domestic violence in the areas of:

- psychological functioning—e.g. depression or trauma-related symptoms;
- cognitive functioning—especially attributions and attitudes;
- maintaining relationships—both within and without the abusive relationship.

Psychological problems

Where violence is such as to leave the woman in fear of her life or distressed about her well-being, there is the possibility that she could develop post-traumatic stress disorder (PTSD). A significant number of women go on to develop PTSD (Dutton, 1992; Walker, 1984, 1991; Douglas, 1987), although it is accepted that not all domestic violence victims go on to develop PTSD. The diagnosis requires that the victim believed that she or a close member of her family was threatened with death or serious injury, or was harmed in any way that made her believe that she would die. PTSD is diagnosed in the presence of intrusive symptoms where the trauma

continues to be re-experienced, for example in unwanted memories or nightmares. The victim will suffer avoidance symptoms, where she will consciously avoid others, or situations where she fears the trauma will reoccur, or where she will be reminded of its occurrence. She will have arousal symptoms (APA, 1994), which may include irritability, poor concentration, sleep disturbance, anxiety and rage. All these symptoms will have a significant negative impact on her ability to go about her everyday activity.

In the specific context of domestic violence (Turner & Shapiro, 1986; Dutton, 1992) the clusters of symptoms relating to PTSD may also include depression and grief, shame, lowered self-esteem, self-destructive behaviours, including alcohol and drug use, and impaired occupational and social functioning.

Cognitive functioning

Within a cognitive framework the victims of domestic violence are seen as having core beliefs, called cognitive schemas, which affect their capacity to establish intimacy and trust. These schema include assumptions about personal safety; loss of view of the world as meaningful; diminished choices for self-protection; and negative self-evaluation. Most of all, there is an increased tolerance of abuse within an intimate relationship—and the cognitive inconsistency within that belief which threatens sexual integrity (Dutton, 1992). As with the adult victims of child sexual abuse, victims of domestic violence experience sexual difficulties in subsequent relationships, even where they have succeeded in breaking from the initial abusive partner

Attitudes about relationships

Women in abusive relationships—especially in chronic ones—increasingly attribute blame for the violence to themselves. They believe that it is they who are failing in the relationship, and that if they were better wives, their husbands would love them more and not attack them. They grow to trust the relationship less and are more likely to withdraw from other close relationships with family and friends. They become more isolated, less able to confide in, or derive support from, others, and therefore more vulnerable to abuse.

Psychosexual function within the relationship is likely to be affected, but must be seen within a complex and interactive picture. A good example of this is the impact of domestic violence on the victim's ability to form trusting relationships. A paradoxical effect here is that the victim may be over-attached and over-dependent on the abuser, whereas trust in people outside the relationship may be seriously impaired (Dutton & Painter, 1981). Bergman *et al.* (1988) interviewed 49 battered women and found that over a third stated they were highly dependent on their batterers, not just financially and materially, but emotionally. They also highlight the social isolation of these couples, their heavy use of alcohol, and the absence of witnesses other than their children.

Help-seeking by victims of domestic violence

Stanko (1995) observes that women victims of domestic violence do not necessarily seek help from the police, nor do they reveal domestic violence at times when outside agencies are available. When victims have acknowledged the harm, sought help, and then made a decision to leave, they then face their greatest danger. Victims who tell their partner they are about to leave the relationship, and then leave the abusive relationship are at greatest risk of being seriously attacked or even killed by their partner.

In the British Crime Survey (BCS) regarding domestic violence, Mirlees-Black (2000) found that only 10% of victims were likely to turn to the medical and nursing professions and that, of these, younger women and those who were not married to their partners, were most likely to seek help. Older women, married women and those experiencing chronic violence, were more likely not to seek help. If they did, it was in a crisis, and they would go to the police but not necessarily to seek arrest of the abuser, rather, they would be seeking immediate protection. Such women were more likely to blame themselves for causing the violence or not doing enough to prevent violence. They were also more likely to accept their partner's protestations of remorse without requiring any behavioural change.

Men seek help if they are victims, but express more embarrassment or shame. Their shame may contribute to under-reporting, but men in general report violence more, and think it is appropriate to mention it. They do not see themselves as having contributed to the emergence of the violence. Men may be physically stronger, and therefore able to endure violence better. They often earn more, but even where they do not, they are less likely to see themselves as financially dependent on their assailant.

Other factors were found by the survey (Mirlees-Black, 2000) that would determine whether victims sought therapeutic help. These were:

- the victim was physically injured;
- the victim was very frightened and emotionally upset after the attack;
- the victim did not feel to blame for the attack;
- the attack took place in front of children,
- the victim had already involved friends, relatives or the police in help seeking.

Domestic violence in relationships—some issues for therapists

Domestic violence has been a neglected topic

Not so long ago, important texts on human sexuality (Bancroft, 1983; 1989; Cole & Dryden, 1988; Jehu, 1979; Hawton, 1995) did not mention 'violence' in their indexes, or discuss its impact on human sexual functioning. Violence instead is referred to in the context of *sexual* violence, criminality and sexual variation. Bancroft (1989) discusses rape and marital rape within the section on sexual offences, but the impact of non-sexual violence is not included. Jehu (1979) prepared a checklist of 70 topics intended for therapists to select for couples to

discuss, which included 'traumatic sexual experiences and 'sexual assault and rape', both *outside* (our italics) the current relationship. For therapists working in a contemporary context, domestic violence may feature as trauma that is everyday, here and now and embedded within a long-standing and established relationship.

Violence is no respecter of class, creed or social status

All the surveys mentioned in this paper indicate the global and pervasive nature of domestic violence. Studies that have attempted to identify perpetrators or victims have been able to identify cognitive and behavioural patterns of violence that transcend educational status, socioeconomic status and culture.

Violence is the result of poor early attachments

Marshall (1993) points us to the role of disrupted early attachments, loneliness and deficits in intimacy as key features in the histories of men who offend sexually. It has not been established that sexual dysfunction causes sexual offences, or that sexual offending causes sexual dysfunction, but that both problems are connected in an important way to the absence in early life of secure attachment and intimacy.

Perpetrators of domestic violence have difficulty with intimacy

The perpetrators of violence have troubled sexual and psychosexual lives. Bownes (1993) found that sexual and relationship dysfunction featured significantly in all sexual offenders, although the exact relationship had not been established. He did recommend, however, that perpetrators of sexual crimes be given help with those sexual dysfunctions, and especially relationship skills. In his work with convicted rapists, he found that the more serious their sexual dysfunction was, the more violence they were likely to use during their attacks, and the more serious the violence, the greater number of attacks they were likely to have had in the past.

Women under-report violence, and blame themselves more than male victims

Kershaw *et al.* (2000) found that the single most frequent reason why intimate partners did not report assaults was that these were judged to be 'a private matter'. There were, however, gender differences. When invited to self-report, men were more than three times more likely than women to acknowledge violence against themselves, and yet men still accounted for only a third of reported violence. Men are quicker to grasp the significance of an assault and to take action, although there are taboos also for them. Men, however, seem more able to overcome these taboos, and to blame themselves less for what has happened to them, and are less likely to rationalize violence as an inevitable part of intimacy.

Furthermore, women suffer whether they report or not. Women, rather than male victims, perceive the violence as having particularly adverse emotional effects on them and their relationships (Kershaw *et al.*, 2000). They describe the

violence as longstanding, i.e. enduring for more than three years (Binney *et al.*, 1981). These studies are concerned with the reporting of domestic violence; there is little commentary on the long-term impact of this violence on the sexual and relational well-being of either the victims or their partners.

Seeking help requires courage and persistence

McFarlane and van der Kolk (1996) describe in some detail just how difficult and shameful it may be for the victim to reveal abuse. There is the issue of whether she will be believed or not; the shame of not being loved any more by one's spouse, and of being unable to protect herself or her children, shame about acknowledging one's financial and social dependence, and ultimately about being abandoned. Health workers themselves may be reluctant to hear her story; and when she begins to create a new story to protect her partner, she will be only too relieved that no action is required that will involve the abuser.

Additionally, the woman victim who discloses domestic violence fears being found out by her partner and suffering further abuse. Therapists should be mindful of supporting the victim appropriately and, if necessary, ensuring her safety, bearing in mind the prevailing law about confidentiality and disclosure to others.

Therapy has to start with reducing risk

Bouchard and Lee (1999) have reviewed the scientific evidence for the appropriateness of couple therapy for violence against a spouse, comparing systemic and cognitive–behavioural (CBT) approaches to violence within marriage. Systemic models see violence as a relationship dysfunction; CBT with couples proposes a model that violent men have specific difficulties with assertiveness, and have poor communication and dysfunctional thoughts that are strongly linked to the escalation of conflict. In contrast to this, they describe therapy studies of women who are deemed to have characteristics that make them susceptible to victimization—or being coerced, or to have tendencies that reinforce the man's violence. The authors point out that the most successful therapies are those that seek first to eliminate violence or the threat of it from the relationship and that, second, focus on dysfunctional or coercive interactions between the partners. What is implied is that those therapies that are not concerned with risk reduction are unlikely to be appropriate for violent couples.

Domestic violence can be tackled as a problem for a couple to share

Crowe and Ridley (1990) refer to violence in the context of the sexual and marital dynamic, and remind us that good sex is bound to be affected by resentful, untrusting and angry relationships. They even suggest that some violence, however dysfunctional, can have a stimulating effect on sexual activity! The do, however, remind their readers of the role of fear in suppressing all sexual desire in the victim. Once the symmetry of the relationship is unbalanced, and is based on aggression and

fear, then sexual arousal and activity for both parties will actually decrease. They suggest that therapeutic goals should rest not only on finding other ways of negotiating differences, but that couples in therapy can also learn how to improve communication, identify feelings and learn better self-control techniques, as well as how to argue constructively. Their approach is fundamentally centred on the couple as the agent of change, which has the advantage of breaking through the perpetrator–victim mould and empowering both parties. Relationship therapists are accustomed to working with the strengths of the couple and this approach is ideal for the context of a couple acknowledging violence and taking joint responsibility for it.

Ridley (1994) sees domestic violence within the context of the 'Invisible Intimacy Screen'. She describes this as a filter through which men and women perceive each other with five elements; in emotionally arousing situations; under social and interpersonal pressures; within a physical sexual relationship; within communication; and within aggression.

Therapists' awareness of violence makes it easier for your client to report

The literature of the past 20 years has focused on increasing the awareness of professionals for potential violence in the home It is important to routinely ask about violence within intimate relationships as this introduces the opportunity for a victim to seek help.

Therapists should mind any impact on the professional self

Balakrishna (1998), writing about the impact of working with sexual abuse material, cautions us about the effects on professional workers in the field and the individual effects of complex cases. The therapist dealing with domestic violence should be mindful of personal attitudes, values and judgement. Balakrishna draws attention to differing attitudes adopted by legal, social and healthcare agencies in dealing with the intimate lives of individual families. The nature of domestic violence is that it is ultimately a private matter, which some may want to provide assistance for, and others may not.

Violence or the threat of it is endemic in women's lives

Stanko (1995) and Short (1995) observe that violence, or the threat of it, is an acute reality for most women, and that fear of sexual violence results in wide restrictions on all women's lifestyles. They argue.that domestic violence and sexual assault are woven within all women's heterosexual relationships with men—from pestering in the street to harassment in the workplace to bullying in educational settings—and have consulted widely to eliminate domestic and sexual violence against women in the UK. Endemic threat, however, creates a culture where an assault will need to be particularly grievous if a women is likely to want to report, or indeed to feel that her complaint will be listened to by help-seeking agencies.

Concluding remarks

The American Medical Association (1992) produced a set of guidelines to help clinicians enquire about the incidence of domestic violence and to assess the impact of abuse on their patients' health and well-being. Readers are encouraged to refer to this as a useful tool for maintaining one's awareness of domestic violence. Additionally, the guidelines draw attention to the perpetrator's control of the sexual relationship. This could take the form of such health risks as failure to use contraception, or failure to disclose HIV status or other STDs. It is significant that the Association identifies sexual dysfunction as one of a number of medical conditions that can *result* from domestic violence.

A growing body of work in the field of post-traumatic stress disorder is focusing on the specific needs of the woman victim of domestic violence, and is aimed at three clinical concerns (Dutton 1993; Foa *et al.*, 1991; Meadows & Foa, 1998):

- safety;
- choice-making;
- post-traumatic reactions.

This agenda provides a helpful structure around formulating practical solutions for such individuals, as well as minimizing risk.

Finally, whatever constructs might be applied in understanding domestic violence, mental health professionals, counsellors and therapists would do well to apply contextual analysis—examining both the individual and environmental factors—which clearly we do all the time. In analysing psychological and social problems in our clients, we are constantly informed by the theories of social learning, family systems and gender-based perspectives in psychotherapy, among others. As professionals we should now acknowledge the different dimensions of the problem of domestic violence. Pragmatism suggests a multifactorial approach to deal with the here and now needs of the individuals affected by domestic violence.

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