



Counseling and Education to Stop Domestic Violence

Emerge is a Member of:

[Emerge Discussion Forum](#)



E-Mail Newsletter

November 2007
Volume 2; Issue 10

Happy Harvest!

In our October 2007 E-Mail Newsletter, Laurie VanLoon offered suggestions on ways that abuser education and therapy can overlap. This month is a continuation of her article, this time providing case study examples. If you would like to read last month's newsletter, please visit our [newsletter archive](#) on our website.



Overlaps Between Abuser Education and Therapy: Part Two

by Laurie VanLoon, LICSW

The following are case study examples of how abuser education and therapy can overlap.

Accessing Individuals: Marta

Initial presentation:

Marta came to see me because she felt a kind of desperate anxiety tinged with hopelessness; she'd just had her first panic episode, which she thought was a heart attack. She talked about how stressful her job with the welfare department was, and how her teenage son Nelson was acting out, skipping school and starting to use marijuana. She said she was beginning to have a couple of drinks in the evening "to help her sleep."

Her husband Carlos worked the late night shift and she hardly spoke about him, except to say he was a good provider and didn't have much of a relationship with their son. She came from a war-torn Central American country and missed her extended family, most of whom were still there. She was raised by her mother who worked two jobs; her father had left the family when she was a baby, and keeping her own family together is



important to her. Her little brother died of dehydration when she was eight while her mother was working. With difficulty, she was able to finish high school and had two years of college before she met Carlos. Marta worked her regular job plus take-home piecework, and sounded chronically sleep-deprived.

Issues to follow up on:

the immigration story, war trauma, alcohol, son's role in family therapy terms, depression, anxiety, health of marriage, social supports, personal outlets.

Follow-up information:

Marta witnessed traumatic events in her home country prior to coming here: her uncle was murdered. She still has nightmares about that, and about being unable to save her little brother. Carlos came a year before her (their baby was just born) and was able to begin work right away, though not in the field he was trained for. She described him as chronically irritable and frequently loud and insulting to her; sometimes he would throw things, but she said he'd "only hit me twice, and shoved me a few times."

He had been especially verbally upsetting (mocking her) the evening before her panic attack, yet she said she's not afraid of him. She denied being physically violent herself, but said that sometimes she would scream at Carlos when she felt especially upset with his treatment of her, and she locked him out of the house a few times when she had been drinking. She said Carlos pays little attention to Nelson except occasionally bonding with him around sports. She said Carlos made fun of her in front of their son, and did nothing when Nelson was disrespectful to her. She said she had no time for friendships, and she had stopped going to church. Her sister lives two hours away, and she would visit with her every few months.

I asked Marta more questions about her own behavior, and was satisfied that she was abuse-reactive rather than proactively abusive. Because it appeared that Marta lived in an atmosphere of chronic depreciation and disrespect that directly impacted her mood, we looked together in our third session at a version of the abuse checklist in Spanish. Also, as part of my assessment, I then used an evaluating trauma responses tuning in to her body, emotions, and self-talk now and when she recalls the past.

We assessed her strengths and her resources, and considered whether additional resources were accessible. We assessed in greater detail her commitment to her marriage. We evaluated triggers for her alcohol use and where she fit on the sequence of readiness for change. We looked at various factors, including economics, to construct a safety plan for her. Then we began to assess options for improved self-care.

Additional thoughts related to therapy with Marta:

Marta has never had support to address her childhood or her expectable trauma responses from her experiences in Central America. Her husband's behavior and attitude toward her are likely even more destructive because of this, but may not be recognized by her as contributing to her panic and depression. Increasing her inner sturdiness is complicated since she's continuously re-exposed to what feels like assault, so developing her assertiveness must be done very gradually, with a safety focus, respecting her wishes to keep her family intact, but reflecting back to her what she

reports.

Alcohol is an understandable medication: can it be replaced with physical activity? Is there a way to get help for Nelson without Carlos sabotaging it? Might Carlos himself be willing to get help if he feels it will improve his level of happiness? He may be depressed and war-traumatized as well, and his domestic abuse could be exacerbated by those factors, because they likely increase his self-centeredness and impulsivity. Helping Marta understand the power of intermittent controlling patterns in strengthening attachment allowed her to recognize both her attachment and her feelings of craziness for sustaining it, and provided her greater psychological space to make choices both immediate and long-term. Throughout our work we continually assessed emotional and physical safety.

Two years later Marta, much stronger and discussing her wish to leave Carlos, revealed to me that her residency documents were falsified, as were his. So she did not feel she could go to court, and was trying to decide how to proceed safely toward separation. She also didn't want to do anything that might get her husband deported.

Assessing Individuals: Paul

Initial presentation:

Paul came because he was distraught after his wife took out a restraining order. He appeared restless and his speech was pressured, and he engaged very rapidly, appearing to assume I was an ally. He reported he had gotten drunk and thrown things, yelled insults and "been pretty scary," so it appeared that Paul had taken the initial step himself: admitting that he had a problem.

He reported tachycardia, insomnia, and nightmares; he related these to recurring obsessive thoughts of being taken away in a police cruiser, which he had found terrifying. This was Paul's second restraining order. After the first he had gone to an anger management program that he felt had "been very helpful." He said he'd be willing to go to an abuser education program if he could afford it, but his economic situation was tight, and he was spending additional money for housing while separated.

Paul has four children, the oldest 17. He is a self-employed electrician and prides himself on providing for his family. He has had chronic health problems (high blood pressure, elevated cholesterol, overweight). He felt he'd made it possible for his wife to stay home to raise the children by working long hours. He denied that alcohol is currently a problem for him, and said that in the past he'd gone to AA "a couple of times, and hated it, all those druggies."

He expressed great love for his wife and a wish to reconcile, says "she's all I ever wanted." He reported he grew up in a second-generation Greek family with, "very traditional values."

Issues to follow up on:

Details of his marital history, attitudes/opinions about marriage in general and his own, beliefs about his wife and his children, self-image related to the restraining orders, degree of anger/hurt/entitlement about his behavior and his "right" to get back with his wife, self-talk at the time of the incidents he reports; self-care, level of desperation about reconciliation, willingness to address his own behavior and attitudes.

Follow-up information:

Paul expressed fixed opinions about what his marriage should look like, what he is like, and what his wife is like. He minimized that his wife has been working for several years. He described chronic irritation about what he believes are certain aspects of her personality. He expressed resentment that when he was injured on the job. 10 years ago, she "didn't give a damn,"

Alternately with his anger, he expressed deep longing, loneliness and sadness that his family has been disrupted. Sometimes Paul's demeanor was almost manic. He switched rapidly from moments of empathy, to moments of single-minded entitlement, to looking like a frightened child. He spoke a great deal, repeated himself, and between sessions left many messages on my machine, wanting me to know all the details of his feelings and actions.

I asked Paul many of the evaluation questions from the list. I also asked him to respond to the abuse checklist as he thought his wife would answer. He denied any wish to harm or any act of physical abuse or threat of it. However, he was able to acknowledge that he is domineering, does most of the talking in the couple, and that he has not typically tried to imagine his wife's perspective on their situation, and that he "has no patience."

Additional thoughts related to therapy with Paul:

Besides domestic abuse, is there also mental health diagnosis to address? Paul accepted a referral for a psychiatric evaluation. I had told him that it seemed possible he was suffering symptoms of a mood disorder, and a psychiatrist diagnosed him with bipolar disorder. He was prescribed medication and the hypomanic behavior (at least in my office) slowly stabilized. How much of an accelerant has alcohol been, and what is he willing to do about it?

Not all of the abusive behavior Paul admitted to happened while he was drinking. However, he was very willing to use antabuse to prevent drinking. The underlying dynamics of self-medication were still evident, but seemed more a part of his choices and his personality than related to addiction. How could I help him make sense of his contradictions and ground himself to make thoughtful decisions rather than impulsive ones?

We used parts work; i.e., "a part of you feels this a part of you that" as a model and he made some pros toward self-reflection. Nevertheless, he unapologetically continued to violate the restraining order (phone contact), without legal consequence. He did not seem willing to consider releasing his at times desperate clinging to his image of being part of an intact family again. This raised the question of whether he will keep himself and his family safe if his wife does not choose to reconcile.

Initially he refused to discuss this possibility. At that point I reminded him that we had made a safety-first contract at the start of therapy, and that I considered this part of that agreement.

Assessment with those who turn out to be perpetrators of some form of domestic abuse will usually bump up against common responses such as defensiveness, justification, denial, minimization, and blaming. To be effective, we keep alive both respect for the client's personhood and empathy for the difficulty of adopting new ways of thinking and behaving. But we also see functionally why clients maintain these behaviors and why,

long-term, they will probably not accomplish what most truly wish for: love, respect, and trust.

Asking about values and long-term goals, asking about what clients really want, and What they want to be able to say about themselves (or have others, like their children, say about them), can move the assessment conversation to a meta level that is sometimes transformative. However, with many therapy clients, if domestic abuse perpetration is uncovered, it is sometimes more effective to stop individual work and refer to an abuser education program unless there are additional concerns that warrant treatment.

Our assessment questions about relationships signal to clients not only that we are curious, but that being a client in therapy involves asking ourselves about ourselves, and lets them know that we support them in this inquiry. Such questions also signal that we are interested in and attentive to power, influence, boundary violations, abuse, and beliefs about their intimate partnerships. By asking about these, we show them that the decisions they make in these areas are essential elements in becoming healthier and keeping those around them safe.

Producer: Christopher Hall 617-547-9879

Editor: Susan Cayouette 617-547-9879