Spousal violence: Useful parameters for assessment and intervention

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This paper presents some concepts about spousal violence, in terms of prevalence, reciprocity and risk factors. Criteria are suggested to facilitate assessment of the intensity of violence within couples. Recommendations are proposed concerning the relevance of treating violent acts in couple's therapy.

Keywords: spousal violence, reciprocal violence, dangerousness, assessment, treatment

In clinical work with couples, spousal violence is a complex issue that is often underreported or concealed, as spouses consult more often for their problems with regard to managing conflict. However, escalating conflicts are an important precursor of violence within couples. Clinicians need to properly assess the presence, frequency and forms of violence (e.g., psychological, physical and sexual) and the severity of violent behaviours within couples before embarking on interventions with the spouses. This paper provides an overview of the scientific work on the prevalence, reciprocity and risk factors of spousal violence, in addition to providing avenues for assessment and directions for treatment in the context of violence.

Statistical portrait

Many epidemiological inquiries and studies have attempted to develop a statistical portrait of male and female psychological, physical and sexual spousal violence in the general population. Desmarais and her collaborators (2012a,b) examined studies on the prevalence of spousal violence published between 2000 and 2011 and observed that 22% of adults (female = 23%, male = 19%) reported having experienced physical violence in an intimate relationship, whereas 25% (female = 28%, male = 22%) reported having perpetrated physical violence against a romantic partner. Spousal violence is a complex and persistent phenomenon with high rates of recidivism (around 67%; Feld & Straus, 1990).

In the United States, nearly one in two Americans (male = 48.8%, female = 48.4%) say they have been victims of psychological violence during their lifetime, while one-third of women (35.6%) and one-quarter of men (28.5%) reported that they had experienced physical or sexual violence (Black et al., 2011). According to Statistics Canada (2013), violence between intimate partners accounts for 20% of violent crimes reported by the police; the vast majority of victims (80%) are women. The 2004 General Social Survey on victimization, which included 653,000 women and 546,000 men, revealed that approximately 7% of Canadian women and 6% of Canadian men living as a couple reported having been victims of some form of physical or sexual violence (from mere threats of hitting the partner to sexual abuse) by their spouse in the five years preceding the survey (Statistics Canada, 2005). Quebec ranked slightly below the Canadian average, with 5% of men and 6% of women saying that they had been victims of spousal violence. Rates of spousal violence in the general

population appear to be similar for men and women. It is important to point out, however, that women are victims of more severe and violent incidents and report more psychological consequences and injuries than men (Statistics Canada, 2005).

In studies among representative samples of couples in Quebec, Godbout and her collaborators (2009) evaluated different forms of violence and observed that 27% of couples (female = 31%, male = 23%) reported having exhibited at least one physically violent behaviour towards their partner in the past year. The rates rose to 83% for psychological violence, with a mere 17% of couples reporting the absence of violent behaviours in their relationship. In addition, 17% of men and 7% of women had been sexually violent towards their partner at least once during the same period (Lafontaine & Lussier, 2005). This form of violence is more widespread in young adults; 46% of women aged 18 to 25 said they had suffered sexual violence at least once in the past year (Lussier, Lemelin, & Lafontaine, 2002).

Clearly, there are marked disparities in the estimates of violence obtained in the different studies. The nature of the study (epidemiological, clinical, samples of cases going to court, samples of volunteers), the manner in which the study is presented to participants (study on conflicts or study on crime, crime victims, personal safety), the very definition of violence and its operationalization (type and number of questions), and the samples' characteristics (age, presence of children, etc.) are important factors that may contribute to such variations. For example, retrospective studies reveal that there is an increase in violence in terms of frequency, intensity and severity in many couples over the years of living together (Holtzworth-Munroe, Beak Beaty, & Anglin, 1995). Despite the variations, the studies clearly demonstrate that violence is a real issue that undermines the quality of couple relationships and carries substantial social costs. Spousal violence, whether physical or psychological, is linked to many consequences. Some researchers highlight the particularly damaging effects of psychological violence, not only because it occurs more frequently (e.g., Marshall, 1992; Walker, 1984) but also because it often precedes physical violence (O'Leary et al., 2007) and is perpetrated by both men and women (Ehrensaft et al., 2009).

Reciprocal violence

Bidirectional spousal violence is considered the most frequent form of violence in intimate relationships, whether in the general population or in clinical populations (Langhinrichsen-Rohling et al., 2012). Because of this, it is important to consider the dyadic mechanisms that help foster or sustain spousal violence, owing particularly to their deleterious effects on spouses, on the relationship and on children who may be witnesses, and the risks of escalation associated with spousal violence.

Current data indicate that clinicians need to incorporate bidirectional violence assessment protocols and consider the relational dynamic, communication patterns, emotional regulation strategies, romantic partner selection processes, conflict management styles, and both partners' internal experiences in order to provide effective prevention and intervention services. Indeed, studies on the spousal interaction in violent couples indicate a "negative reciprocity" where each spouse tends to retaliate and contributes to exacerbating the negative communication, leading to an escalation of the gravity of negative verbal exchanges that typically precede the perpetration of physical violence (e.g., Margolin & Gordis, 2003). Researchers also observe a pairing between partners who use violence (see Serbin et al., 2004), which results not only in reciprocal violence but is also associated with a risk of escalating violence leading to police intervention (Capaldi et al., 2007). In examining both members of the couple, studies thus highlight the dynamic influence of spouses.

The two-way nature of spousal violence does not necessarily imply a symmetry between the forms of violent acts that are committed, nor the resulting effects. Studies indicate that men tend to use more severe violence, are at less risk of injury, and experience less fear towards their spouse's violent behaviours (e.g., Langhinrichsen-Rohling et al., 1995). Likewise, according to a national survey, women are more likely to report being victims of "intimate terrorism," characterized by the use of severe violence and a control dynamic to subjugate the romantic partner (4% as compared to 2% of men; Laroche, 2005). Couples who perpetrate bidirectional violence should be referred quickly to assistance and protection services. According to the study by Gray and Foshee (1997), adolescent couples characterized by mutual violence sustain and perpetrate more spousal violence and their risk of injury is greater, as compared to couples characterized by unidirectional violence.

In short, current data indicate that clinicians need to pay special attention to the intra and interpersonal mechanisms underlying spousal violence, regardless of the type. Moreover, by

viewing the couple as an interdependent unit of intervention, whenever possible, the range of personal and relational dynamics underlying the violence and relationship dissatisfaction can be observed and targeted in order to offer adapted services.

Quebec and international work on predictors of spousal violence

Whether violence is unidirectional or bidirectional, Quebec and international researchers study the risk factors or predictors of spousal violence. Their work serves to identify the individuals most likely to resort to acts of violence, but also to target mechanisms leading to violence that can be the focus of therapeutic work. In that regard, Hamberger and Holtzworth-Munroe (2009) report that a diagnosis of mental disorder in one of the partners is a factor that increases the risk of perpetrating spousal violence. Reviews of the literature on the subject further reveal that certain sociodemographic factors are linked to a greater risk of violence (e.g., low income, young age, unemployment), but that violence can be found in all social classes (Holtzworth-Munroe, Smutzler, & Bates, 1997). Other works have pointed to the role of childhood exposure to violence (Godbout et al., 2009) and childhood sexual abuse (Brassard et al., 2013) as precursors to violent behaviours in adult romantic relationships. Attachment insecurity (Fournier, Brassard, & Shaver, 2011; Lafontaine & Lussier, 2005), low empathy (Péloquin, Lafontaine, & Brassard, 2011), jealousy (O'Leary et al., 2007), anger regulation difficulties (Brassard et al., 2013; Lafontaine & Lussier, 2005), dysfunctional communication patterns where one spouse makes demands while the other withdraws (Fournier, Brassard, & Shaver, 2011), and relationship dissatisfaction (Lawrence & Bradbury, 2007) also appear to be factors that predict recourse to acts of violence against an intimate partner. More and more models are being proposed where multiple factors are included simultaneously. For example, Godbout and her collaborators (2009) have highlighted the link between childhood exposure to violence and the use of spousal violence, via the development of cognitive attachment patterns marked by discomfort with intimacy (violence used as an escape mechanism) and abandonment anxiety (violence used as a pursuit strategy). Brassard and her colleagues (2013) have tested a model where childhood sexual abuse is associated with the use of spousal violence in men via abandonment anxiety and difficulty regulating anger.

Assessment of spousal violence

Before arranging an initial meeting with a couple, it is recommended to screen for the presence of violence in the couple over the phone. Most clinicians do not complete such screening. This preliminary screening does not replace direct inquiry with the victim, and a more thorough systematic assessment should follow during initial meetings (Lussier, Wright, Lafontaine, Brassard, & Epstein, 2008).

For safety's sake, it is preferable that a detailed investigation of severe current violence be performed in both spouses, during one-on-one meetings with each partner because (1) spouses may not admit to or may underplay the nature or intensity of the violent acts because of denial or fear of retaliation, and (2) the victim may have a false impression of safety during sessions and denouncing acts of violence may result in retaliation before a violence prevention program can get underway. It is further recommended that the word "violence" not be used during the initial couple session, but rather that questions be asked regarding behaviours during conflicts (Epstein & Baucom, 2002). As Table 1 suggests, the procedure for investigating violence as advocated by Lussier and his collaborators (2008) implies a style of inquiry that is direct, yet respectful of each individual. Self-report questionnaires can also be used to validate the presence of violent behaviours, both perpetrated and sustained (e.g., conflict resolution strategies scale; Lussier, 1997) and motivations for the use of violence (e.g., Lafontaine, Péloquin, Brassard, & Gaudreau, 2013). They must be administered on an individual basis.

Decision-making model for choice of couple's therapy

The decision-making model proposed by Lussier et al. (2008) is based on clinical and empirical knowledge (e.g., Stith & McCollum, 2009) and seeks to help clinicians take the right clinical action during the assessment phase as regards the relevance of couple's therapy (CT) to treat violence in one or both partners, or individual therapy (IT) to treat the abuser's violent behaviours or the victim's behaviours. The model considers five forms of violence on a continuum of dangerousness (see Table 2). Psychological violence and physical violence are both taken into consideration, while sexual violence is included in one of those two forms of violence.

The process leading to the recommendation or not of CT (right column) is based on the clinician's strong familiarity with: (a) risk factors of dangerousness; (b) various clinical options available in cases of dangerous spousal violence; and (c) the pros and cons of couple's therapy in cases of dangerous spousal violence. Like Stith and McCollum (2009),

TABLE 1

Assessment of violence during initial contact with spouses.

1. What happens when you are angry?
2. Do you and your spouse raise your voices or shout?
3. Do you scream abuse or insults at each other?
4. Do you or your spouse do something at the height of the argument that you regret later?
5. When your arguments escalate, has either of you ever thrown objects or hit something?
6. When your conflicts escalate, has either of you ever pushed or shoved the other or done anything else of a physical nature?

who use a variety of criteria to determine the relevance of couple's therapy, the decision-making process considers 24 factors identified by Lussier and his collaborators (2008). The factors need to be assessed minutely (see Table 3). To assess the intensity of a factor, a four-point scale is proposed (0 = absence of behaviour, 1 = minor presence, 2 = moderate presence, 3 = strong presence). The first six factors directly concern the dangerousness of the acts of physical violence. It is important to remember that the presence of just one of the first six factors is sufficient reason to contraindicate CT, as they are indicators of dangerous or potentially dangerous violence. In those cases, individual treatment of each spouse is recommended. Once that treatment is completed successfully by each partner (which corresponds to *type 4* violence in Table 2), couple's therapy can be recommended on condition that there are few factors in Table 3 (*factors 7* to *24*) of moderate to strong intensity.

Throwing or breaking objects or hitting something (*factor 7*) is a strong indicator of potential physical violence. Violence is present, but it has not reached the victim physically yet. The acts are threatening and can be potentially dangerous. The abuser's ability for self-control needs to be assessed to determine whether CT is recommended: a score of 3 indicates a poor ability and is a contraindication to CT. If *factor 7* is of moderate intensity and is accompanied by severe psychological violence, CT is not recommended. In couples that exhibit minor and infrequent psychological violence or report one or a few sporadic episodes of physical violence in the past, CT would be appropriate (Cascardi & O'Leary, 1992). If *factors 8 to 24* are absent or obtain low scores (score = 1), spousal problems generally lie within the range of communication and problem-solving skills where intervention is possible so that the violence does not degenerate into more severe violence. Severe psychological violence can also be treated in CT. However, if a victim reports an intense fear with respect to his/her spouse (*factor 17*) or extreme psychological vulnerability (factor 18), it is preferable that IT be recommended before initiating CT. Likewise, if the scores are low (score = 1), but more than five risk factors are present, IT is recommended before CT. The presence of deficient relational skills, judgment or intelligence (*factor 23*) needs to be carefully assessed to determine the relevance of treatment. All in all, the intensity and the number of factors presented in Table 3 influence whether CT is appropriate for the treatment of spousal violence.

TABLE 2

Continuum of violence and recommendation for couple's therapy.

TYPE OF VIOLENCE	COUPLES THERAPY
1. Psychological violence, without physical violence	
• minor psychological violence	Recommended
• severe psychological violence	Recommended on condition
2. Sporadic psychological violence and physical violence in the past	Recommended on condition
3. Current but minor physical violence	Recommended on condition
4. Severe physical violence in the past, but no longer active	Recommended on condition
5. Dangerous or potentially dangerous current physical violence	Not recommended

TABLE 3

Factors associated with dangerous spousal violence (Lussier et al., 2008).

RISK FACTORS OF DANGEROUSNESS	
1.	Injury caused to spouse on more than two occasions in the past 12 months
2.	Injury to children on more than two occasions in the past 12 months
3.	Reprisals or threats of injury, suicide and/or homicide
4.	Sadistic behaviours (e.g., torture, burns, deprivation of food or sleep)
5.	Use of a weapon to threaten or injure, or use of martial arts to threaten or injure
6.	Rape or forced sexual relations
7.	Throwing or breaking objects or hitting something (e.g., wall or table)
8.	Criticism, insults or bullying
9.	Possessive behaviours, domination or control by coercion
10.	Substance abuse (alcohol and/or drugs)
11.	Interventions by persons from outside the couple during incidents of spousal violence
12.	Police record or police intervention for violence inside or outside the home
13.	Spousal dependence, jealousy or obsession
14.	Borderline personality (inability to trust one's spouse because of paranoid thoughts or pathological jealousy)
15.	Antisocial personality (impulsiveness, manipulation, crime, history of cruelty to animals)
16.	Non-acceptance of responsibility for violent behaviours, lack of remorse for harm caused, or lack of motivation to change
17.	Feelings of fear in victim with regard to abuser, fear of being killed, or personal blame for spouse's violence
18.	Psychological vulnerability of victim (e.g., low self-esteem, lack of self-assertiveness, submission, acquired resignation, post-traumatic stress disorder)
19.	Multiple family stressors (e.g., poverty, job loss, blended family, sick child)
20.	Poor social support network
21.	Social environment that encourages violence
22.	Past history of childhood maltreatment
23.	Deficient relational skills, judgment or intelligence
24.	Clinician does not feel safe

Finally, *factor 24* was introduced because clinicians in contact with spousal violence can experience or feel concerns for their personal safety. Extremely little documentation exists on that subject. According to Lussier et al. (2008), violent men with an antisocial or borderline personality may use that type of threat, especially with female therapists (e.g., "when people push my buttons, they know I can get nasty"). Such threats must never be taken lightly. For that reason, familiarity with the various elements of the diagnostic protocol is important, not only for the well-being of the spouses, but for that of caseworkers as well. If clinicians are fearful for their safety, they best not pursue couple's therapy and should refer the violent spouse to a specialized treatment centre or work in co-therapy (mixed dyad; Lussier et al., 2008).

These few multi-dimensional avenues for the assessment of spousal violence can be used both by therapists working with couples as well as by clinicians who intervene with clients in individual therapy. When intervening in the area of spousal violence, we recommend that clinicians proceed with caution. Solid training is necessary. The intervention models need to consider the multiple developmental, personological, interactional and cultural factors that predispose, precipitate and maintain violence within couples.

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