PSYCHOTHERAPEUTICALLY APPROACH IN WORKING WITH FAMILY AGGRESSORS

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Abstract:
Domestic violence is an current issue, with recently increase because of the social insecurity, lack of jobs and in general the pressure that a family has to bear with the uncertainty of tomorrow. We started, inspired by the models from the civilized countries, starting with 2007, the psychiatric, psychological, juridical counseling and social assistance in one of the first two Centres for Family Aggressors in our country. In our practice we were inspired by some of the main theories: e.g. the psychodynamic approach, the cognitive-behavioral theories, family psychotherapy and Bowlby’s attachment theory. Two representative clinical cases report reflect the psychotherapeutically approach of these patients.

Key words: domestic violence, family aggressor, psychotherapy.

Rezumat:
Violenţa domestică este o problemă de actualitate, cu acutizare recentă ce ţine de inseguritatea socială, de lipsa locurilor de muncă şi în general de presiunile la care este supusă o familie datorită nesiguranţei zilei de mâine. La noi în țară s-a început, preluând și adaptând modelele din țările occidentale, începând cu 2007, asistența psihiatrică, psihologică, juridică și socială a agresorilor întrafamiliali, în cadrul unuia dintre primele două Centre de Asistență Destinate Agresorilor Familiali. În practica noastră am fost influențați de câteva dintre principalele teorii: psihodinamică, terapia cognitiv-comportamentală, psihoterapie de familie și teoria atașamentului dezvoltată de Bowlby. Două cazuri clinice reprezentative vin să ilustreze modul de abordare psihoterapeuțică a acestor pașiți.

Cuvinte cheie: violența domestică, agresor întrafamiliar, psihoterapie

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Working as a psychiatric counselor in the project Establishment, Organizing, Sustaining of a Social Service for Recovery and Social Reintegration of Aggressors that Abuse their Families at East European Institute for Health Reproduction – one of the two first centers in our country for family aggressors that is open since January 2007 - I became very interested in the psychotherapeutically approach that is best for these people. We offer psychiatric, psychological, juridical counseling and social assistance. The persons that address to us are sent usually by the police, but there are no legal constrictions or advantages that they can obtain by participating to our sessions. It’s their choice, and those that addressed to us came because they “wanted to change”, or simply to prove to their wives that they are better people and they deserve another chance. We usually have a weekly session or a two weeks session for three months and then, one following session monthly for three months.
In our practice we were inspired by some of the main theories: e.g. the psychodynamic approach (1), the cognitive-behavioral theories, family psychotherapy (2) and Bowlby’s attachment theory (3).

It was Holtzworth-Munroe and Stuart (4) that established the main subtypes of domestic violence (DV) offenders and this model was sustained by the numerous studies conducted mainly in the 1990s. Those three types are: family-only batterers, dysphoric/borderline offenders, generally violent / antisocial offenders. The family only batterers have a low severity of violence, moderates levels of anger and preoccupied attachment and overdependent of their partner while the dysphoric/borderline offenders have high levels of anger and preoccupied and fearful attachment style. The third category, the violent/antisocial offenders have moderated anger levels and they are dismissing in their attachment style (positive self-model, negative other-model).

As we know the borderline structuring of personality is the intimate base of cluster B personalities including antisocial personality.

**PSYCHODYNAMIC THEORIES**

Andre Green (1) describes the borderline psychodynamic construction of personality. The maternal nurturing (the environment, the auxiliary self) can ensure the frame/ the support for the self development, the space in which the separated/ splitting off bad object can return and integrate into the self. That means that the child can consider that a person can be in some situations good and in others bad (and this can be frustrating) but it doesn’t mean that he/she doesn’t love him. The child perceives him/her as a complex person, not only in absolute terms as good and bad. Those with borderline structure, when the environment is inadequate (deficit in maternal nurturing, abuses, trauma) as a result of the split off they cannot see others as a mix of positive and negative features. They are perceived even as gods (the good object inaccessible) or as devils (bad object) (5).

They cannot integrate the aggressive and libidinal aspects of the other persons and that reduces their ability of really perceiving the internal experiences of other people. Their perception of others can alternate between idealization and devaluation , and that can be distressful for the people they interfere with. In a similar way their incapacity of integrating positive and negative representations of self determines a **profound diffusion of identity**. The bad object must be excluded, denied, it is impossible to be represented so it is eliminated (splitting off). It will return but as a intrusive persecutory object and the main defense mechanism will be the projective identification. The dissociation and split off is between outside and inside, psychic and soma, sensations and affects, psychic and motor activity, affects, representations and ideas. The cleavage determines defense mechanisms as : projective or introjective identification, denial, omnipotent behavior.

Acting-out reveals the absence of symbolization and the action becomes expulsive, evacuator, apparently without any significance. So, somatic reactions and acting-out are discharges that shortcuts the psychic. The difference between repression (the main mechanism in neurosis) and splitting off is that when we have repression the psychic is relatively whole, there are links between the other representations, affects, the psychic energy is connected and the connections are intact (1).

Their speech reflects the psychic: it is dissociated, with ideas that are not interconnected.

**BOWLBY’S THEORY OF ATTACHMENT**

Bowlby’s attachment theory can be situated between the behavioral cognitive approach and psychodynamic theories. When a child is separated by his attachment figure he can show distress, that is more intense if separation is prolonged and the child is kept in an unfamiliar place. There are three phases that follow: protest (separation anxiety), despair (grief and mourning) , and finally emotional detachment (defense) . Those are phases of mourning separation and loss. Depending on the family’s attachment behavior towards the child, they may facilitate the expression of grief by
responding sympathetically to the child’s distress, or to adopt an inhibiting attitude that causes the child to suppress or avoid feelings of fear of abandonment, yearning and anger. In the last situation the child’s unexpressed, ambivalent feelings of yearning for and anger with will split off the attachment figure into segregated or dissociated systems of personality, and in the absence of a substitute attachment figure he will move to a defensive condition of emotional detachment, internalizing a mental model of attachment that is dismissing or avoidant of affective states associated with separation and loss. The child’s attachment behavior system remains deactivated because attachment related information is being defensively and selectively excluded from consciousness. This theory is important for us when working with family aggressors because Bowlby suggests that this mechanism appears not only with the actual death or separation from the attachment figure but also when there are: threats of abandon, parental rejection, depression, neglect and/ abuse, loss of love (3).

Most of our clients were subject of abuse, neglect in their childhood.

**BEHAVIORAL COGNITIVE THERAPY**

As for the behavioral cognitive approach we have to mention the essential contribution of professor Arnold P. Goldstein and his colleagues Dr. Barry Glick (7) and Dr. John Gibbs in developing since 1987 an effective program in preventing, reducing and replacing aggressive behaviour in youth aged 12 to 20. Skillstreaming is its behavioral component, anger Control Training is emotion-targeted component, and Moral Reasoning is its cognitive component. The ART (Aggression Replacement Training) is a part of the family “multimodal programs” containing three parts: anger control, social skills, and moral reasoning (7). The program consists of 10 weeks (30 sessions) and the clients attend a one-hour session in each of these components each week. The program includes incremental learning, reinforcement techniques, and guided group discussions enhance skill acquisition and reinforce the lessons in the curriculum.

*Social Skills Training:* Social skills training teaches youth what to do in threatening or stressful situations. ART Structured Learning is based upon a social learning process, and activities include modeling, role-playing, and performance feedback.

*Anger Control Training:* As part of their homework, participants relate examples of anger arousing experiences from situations that had occurred during the previous week. The group facilitator uses a structured reporting checklist (hassle log) to reinforce the skills from the lesson.

*Training in Moral Reasoning:* This component of ART aims to raise participants’ awareness of others’ points of view (perspective taking) and teaches youth to view their world in a more fair and equitable way (7).

**FAMILY THERAPY**

According to A. Vetere and J. Cooper (8) men are rarely seen as fathers or in their role as fathers. They often say that the level of abuse they were subjected to as children was far worse than the accusation of abuse leveled at them against their own children. In their opinion this is a important moment of therapy when the therapist should be confident of his own beliefs and judgements about responsibility. Not all the persons that are abused in their childhood become violent, that’s why we can make a progress only by admitting the responsibilities that a person has regarding his own behaviour.

As a general approach we try to encourage them to think of the effects of violence on their children:

„As a father, what do you want your son/ daughter to learn about how men and women get on?”

„As a father how will you teach your daughter to keep her safe?”
“As a father how will you hold responsible to your children for your violence towards their mother and towards them- how will you talk to them about it when they are older?” (2).

“What’s the inheritance that you let to your child when all you inherited from your father is alcohol and promiscuous life? What can you teach him?”

We evaluate the contexts of violence, management of anger responses, use of substances (mostly alcohol), lack of empathy (incapability of thinking of the consequences upon their victim), resiliency (positive adaptive behavior to life’s adversities), internal motivation for change (2).

We agree contracts that involve the fact that he is not allowed to have an aggressive behavior during the psychotherapy and we will not keep information about repeat violence confidential.

FIRST CLINICAL CASE REPORT: JOHN

John is 28 years old and grew up with his mother and stepfather (the 2nd stepfather), his mother has had 3 marriages and he’s the only child. Now John is married, has a 2 years old boy and his wife is pregnant. We asked him about his stepfather, he said that they are getting along pretty well, instead his mother is overprotective and she doesn’t like his wife interfering often in his family. He completed his education at 18 years (ten classes high school + two years of professional school). He never consumed drugs or alcohol, fact sustained by his wife. They had a long and stable relationship for a period of 10 years and she was the only woman in his life. The problematic behavior towards his wife was jealousy and possessiveness and three episodes of violent outbursts, during their entire marriage, after giving birth to their first child two years ago. At the age of 22 he was caught driving a stolen car and he did prison. He never betrayed his friend that actually stole the car and he assumed the entire blame. His wife was a teacher and her parents didn’t accept him at all. The index offence was committed a few days before the consultation and consisted of a serial assaults on his partner. He came home tired from work and they argued because she accused him that didn’t took care of their fence. John attacked her with his fists and feet in a blind uncontrolled rage, causing serious injuries to her head and body, and the danger was increased since she was pregnant. She made a complaint at the Police Department and they referred him to us. I will describe three most important sessions we had.

I. The first contact. Our first impression was of a very well dressed polite person. He alluded to the attack on S., saying “I don’t remember anything, I was very tired”. He denied the assault on Elena (5 months pregnant), but he remembered that they started arguing in the kitchen and then all he remembered was her wife lying on the living room floor and him strangling her. The initial assessment, after asking about the history of alcohol abuse and criminal problems, we asked if there were other situations when he hit his wife. He admitted that it happened two times after giving birth to their first child. There was the same pattern, he came tired from work, they argued and then he hit her, but he had no recollection of how he did it.

First I asked him specific questions about childhood experiences, in respect of separation, loss and abuse. After a initial hesitation, he said that his mother had 3 husbands, and he doesn’t remember anything about the first one, his father, neither his mother talked about him. We asked how old was he when they separated, he was 8 years old, but he didn’t remember anything before that. He told me those things, including his assaults in a state of emotional detachment.

Soon it was clear that his ideal view of himself was of a passive, nonviolent person, a family support that because of his wife fault becomes sometimes violent. He was very determined to regain his family, and for that he was in therapy with a psychologist in the same time with our session.

In my experience there is usually present a past of abandon, neglect or abuse and I suggested him to talk to his mother about his father and what happened until he was 8 years old. He claimed that no child has memories about what happened before 8 years old, and that is a commune thing.

II. The second session. We started focusing on his childhood and on the fact that he didn’t remember anything that happened during the violent act. He talked to his mother that told him that
she divorced his father because he was very aggressive. He started to remember a scene with blood on the walls and his father injured mother, and his mother confirmed that it was real, that it really used to happen that way. After her divorce she never talked about those things considering that it was best for him, building a image of a perfect lady as he said, as a compensatory mechanism to what had happened. He doesn’t know what caused the second divorce either, his mother was emotionally detached while talking about her life ("her perfect life"). Probably he developed an insecure avoidant pattern of attachment organization. Fonagy (9) suggests that there is a connection between this attachment and criminal behavior, and more then that, this pattern acts as a protective mechanism in order to help the child to cope with the parental care giving deficits. One of the hypothesis at this point was that J. has a carrying powerful unprocessed emotional pain and he doesn’t recognize his feelings of anger and hatred because he lacked the capacity to contain and transform such emotions, these build up a response to stressor events generating intense internal conflict which became overwhelming. From this perspective it seems that the traumatic affects has a disorganization effect on his mental functioning.

He had insight deficiency, with an externalized and acting-out behavior. He’s attention was centered on the outside, trying to find a solution and also an excuse by working hard, participating to our meetings and in the same time seeing a psychologist. This is how he tried to regain his son, he didn’t assume the blame or being sorry, but wanted to be appreciated and pitied for the “major” efforts that he made. He had a dependent relation with his wife, as well as with his mother. His wife was the only woman in his life (he had no friends) they were together since he was 18 years old. With an anxious behavior, he depended on her but was also distrustful and suspicious. His speech was flat, with no emotional impact, orientated strictly to the narrative part – describing actions with all the details, avoiding to talk about feelings, or how did people and their actions affect him.

III. The third session. During a relaxation exercise he started to remember things from his childhood. He had no recollection about the moment when he hit his wife and that was during the entire therapy, but it was not our purpose, we preferred to concentrate our discussions on emotions, feelings, and his incapacity of recognizing them. He admitted that he had strong emotions (like anger) and long periods when he hated his wife, feeling betrayed by her and her parents.

During psychotherapy we tried to make J. think of his relationships with people he grew up with and cared for him: mother, father, grandparents or brothers and friends. We tried to find experiences that were harmful, humiliating, dangerous and tried to explore the feelings and emotions that the subject had at that moment, feelings that are often suppressed or denied in present.

Our purpose is to make them integrating the suffering in his own personal history. But we do not insist on his bad experiences (for example I do not agree with hypnotic regression for reliving the suffering in these cases) because I don’t want to increase their significance and their importance. We may face up with the danger of making these memories uncontrollable and a justification for his current aggressive behaviour.

By exploring these relationships most important is that we try to find the good things that they experienced, that can support building up a resiliency. We try to find the “positive models of masculinity” (8) in his live and use them as a model in the attempt of changing their behavior.

For those grew up with unsecure attachments and were traumatised by their attachment figure, there is no safety anywhere. Activities that consolidates and gives comfort to a couple, like sex, are perceived as a source of danger. People have to find ways to deal with this reality so they become: hypervigilant, distrustful, and hyperaroused or they numb out and become hypoaroused. (10).

John’s relationship with his 2 years old boy child was a good one, as he described, in my opinion it was also a dependent relation with an ambivalent note – he started the violent behavior against his wife after she gave birth to his son. This is a relatively frequent feature that I
encountered in the cases of that abuse their wives. Their relationship is in a blocked symbiotic stage, when the attention of his partners diminishes focusing on the child, there is a reaction of hatred and violence, excessive jealousy. Besides the three extreme violent episodes and jealousy John is a quiet person, a devoted one as his wife said, with no aggressive behavior, no alcohol consumption. But those episodes when he bursts out were terrifying and she ended in hospital each time.

He participated to our session without missing any, even if sometime he said that he didn’t understand the use of them. As I said his main purpose was at first to regain his wife and child and that’s why he worked very hard. We were able to build up a therapeutic alliance. It was a difficult task, his personal history was fragmented – he recalled episodes with no connection between them - and we tried to put those fragments together. Probably the traumatic events from his early life and the fact that he didn’t get a proper explanation – those were locked in a box and he and his mother threw the key - led him to a sort of attention deficit/ attention focused on few stimulus and a dissociated speech. We facilitated a mourning process of that period when he’s reaction was of deep emotional involvement. That helped him to increase his active need of telling his story, improved his capacity of self evaluating his mental status, affects, behavior and thoughts. He identified moments when he was furious (in traffic, at work) and recognizing them gave him the possibility to decrease their intensity.

He developed a better relation with his wife, he wanted to get back but not so intensely as at the beginning of the sessions, now he thought that is was better for her to take this decision and he began to understand that helping her with little things like: visiting her to the hospital, taking care of her pregnancy and of their boy were more important then his demonstrative actions of him participating to a lots a sessions (with our team and separated, with a psychologist) trying to put pressure on his wife.

IV. Discussions. There was indeed a childhood amnesia built up on a dissociation mechanism. His mother never offered him an explanation about what happened, she never talked about that; probably she had to protect herself against the painful memories and preferred to deny the entire history. But by choosing this solution she wasn’t able to ensure for John the comfort, the stable matrix/ environment that could help him to evolve, and to develop an secure attachment. His mentalisation processes were diminished, as a defense mechanism that protected him from pain, leading him to an acting-out behaviour characteristic for the borderline structure of personality. He could no longer deal with his emotions in result of her mothers behaviour that hided her one, she was cold and insensible, wearing a mask of perfection (perfect wife, perfect lady). So she didn’t give him an appropriate emotional feedback that would help him to recognize and understand his emotions. In this context, he developed an disorganized behavior along with a dissociative disorder. It would seem reasonable to hypothesize that John’s childhood attachment was insecure avoidant and his mother was characterized by the term ‘proximal separations’(3).

It’s a usual practice for the family batterer to deny their violent actions, as in John, to say that they don’t remember anything. This is the only case (from more than 50 cases) where it seems to be a dissociative disorder and probably John is telling the truth.

It’s a case with certain results but with the next client, George, a typical antisocial personality, things were totally different. I may say that the traps of the psychotherapeutically intervention in antisocials described by Millon (11) were all present in a way or another. They often fight against the system (police and us in our case) trying to beat it; besides that only a few part of the men that address to our services wants to change their behavior.

THE SECOND CLINICAL CASE REPORT: GEORGE

George is 28 years old and grew up with his mother and father, he’s the second child with one elder brother and one little sister. He was married for 5 years and had a four years old child.
He consumed alcohol and stayed in prison for two years because of stealing from houses with his brother. He used to assault his wife about once a week in a very brutal manner, because he said that she is lazy, - “she doesn’t clean the house”, “she doesn’t take care of our child”.

According George’s mother, his father was also aggressive and alcoholic, and George had a cruel behavior against the animals in childhood. His father died and now George lived with his wife in the same courtyard with his mother. His mother agreed with him concerning his wife inability of taking care of her family.

His main purpose was to take his child from his wife (she ran off with his child). His wife wanted to participate to our sessions and we had two, when their child was also present. George practically ignored his wife, he hardly looked at her, and he addressed only to our staff and to his child.

As a first impression seemed charming, polite but he got angry in an instant when we brought up subjects that bothered him and represented them as a personal attack. He frequently justified his violent acts: it was his wife’s fault, she made him angry and that’s why he consumed alcohol and beat her.

During our sessions (three months) they lived separately but he encountered his wife once and he threatened her. Gradually we discovered that one of the reasons of coming to our sessions was a way of finding out where his wife was hiding and to take back his child. He participated regularly to our meetings (once a week), but there was little involvement in the therapeutic process.

We discussed about his past and he considered that it was normal for his father to beat his mother. So the image that he built up in his childhood about how a normal family should be was distorted. He appreciated more his mother then his wife, but according to his mother he started to terrorize her in the past few months. She was convinced that she would have to rise the nephew.

After three months his wife moved back with him but after two days she came beaten to death. He taught her a lesson so she won’t dare to leave again with his child. In fact that’s what he told us in our session that proved to be the last one because he never came back.

There are some therapeutic traps when working with antisocials that Millon (11) assessed, and that I find very useful in our practice. Some therapists can feel threatened by their clients – I felt that indeed when in our last session G. told us showing no remorse or emotions what he did to his wife: he gave her a lesson so she won’t run again from him. And as I said he never came to our sessions again as it was like punishing her was his only purpose. During the therapy we talked about his childhood and our discussions had an impact on his behavior, he tried to change but it didn’t last. When he was put again in the situation of confronting his wife his old resentments appeared and he could not control himself. Perhaps, the reason that he didn’t come again to see us is that he perceived his behavior inevitable and that he could never change. We will never know, but inspite this failure we continue dedicated our work, knowing that our success in these cases comes sometime in small amounts, but even a little change can deeply influence a life.

George had a great difficulty in expressing his emotions and also a minimal level of empathy. For the antisocial personality, the emotional detachment – unlike in the borderline and narcissistic personality disorders - is a characteristic feature with minimal abilities of emotional interpersonal attachment. Along with a low level of anxiety, these can alter communication and the therapeutic relation. The emotional interactions are minimal, ignoring the affective significance of language and actions. Consequently, there are anarchic affective manifestations that induce hostile behaviour. The tendency of controlling his entourage, takes sometime a compulsive aspect in the vulnerability periods characterized by anxiety and depression, but with a significant opening to the therapeutic relation. The ability of denigrating and blaming others (“my wife gets on my nerves, she makes me lose control”) is associated with their incapacity of building up sustainable social relationships even though sometimes they may initiate them with extreme difficulty. Along with the absence of tenderness and humor is obvious the lack of feelings of guilt and remorse that his actions
cause on his companions he has a behaviour oriented to the unconditional fulfill of his own desires and needs in a egocentric manner (12).

Other therapeutic trap described by Milon (11) is that antisocials show remorse, they seem to be ashamed for what they did and they seem to change completely but not as a result of the therapy that takes time. This attitude can mislead a therapist and this is another therapeutic trap described by, especially for young therapists, when they perceive their regrets as a real change, when the client “seems to have returned to the flock, with the therapist as his or her proud shepherd”.

Another possibility is that of a countertransference when the psychotherapist becomes “suspicious, angry, and resentful” so he cannot build a therapeutic alliance in the few cases when it would have been possible. The therapist and his client, especially when they are both males may try to dominate, or they may even take a “sadistic delight in sabotaging their own progress, and some therapists may even take a sadistic delight in allowing it.” Therapists with compulsive traits that adhere rigidly to social norms that antisocial violate may lead the client to an acting-out behavior to test him, so the therapist will judge him and sabotage the therapy (11).

When working with family aggressors we can assess after a few sessions if they can really benefit from therapy or if they cannot respond to it. Vetere and Cooper (2) determined some of the contraindications for the treatment that can help us in decision-making:

1. Unable to acknowledge that violence is a problem
2. Unable to accept responsibility for violent behaviour
3. Unable to work constructively to solve problems around violence
4. Lack of appropriate boundaries around anger expression and control
5. Problem drinking and drug-taking and an unwillingness to seek treatment
6. No internal motivation for change
7. No acknowledgement that relational factors may contribute to the problem,
8. Inability to empathize to the victim or to listen to another point of view
9. Consistent blaming of others, either family or professional workers
10. Lack of consistence between verbal descriptions and reports
11. Unable to agree on the purpose or usefulness of therapeutic intervention
12. Unable to work with professionals co-operatively, or to see them as potentially helpful

I presented the two cases because they were representative, with J. results were tangible, but G’s case was a failure, we could not build a therapeutic alliance with him, he had the criteria of antisocial personality, he had most of the contraindications described above, we had no means to change anything in his beliefs and this was in a way clear from our first sessions. He had an acting-out behavior – externalize, with no insight – for him it was perhaps just “another game, another annoying encounter with the constraining forces of society” (11).

This rigidity, inflexibility makes our work very difficult, and the therapy to be rather a failure then a success when working with family aggressors, but the cases when we and our client succeed are highly important both for us and definitely for the families.

REFERENCES


