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Couple Therapy for Intimate Partner Violence:

Topics and Strategies in Successful Therapy Processes

Abstract

Despite controversy over the indications of couple therapy for Intimate Partner Violence (IPV), current research has indicated some benefits. This article examines some crucial aspects when dealing with couple therapy for IPV, such as how dominance and power abuse are present, and which important issues should be taken into account during the therapeutic process and be brought up in therapeutic conversations. It also proposes strategies for therapists conducting couple therapy for IPV. Ten studies conducted within the Jyväskylä Research Project on Couple Therapy for IPV were reviewed. Findings highlighted the importance of the therapists' awareness of the presence of violence, dominance and power during the sessions, and of how cultural issues could prevent their recognition. Responsibility and couple agreement on the violent behavior seemed especially relevant at the beginning of the treatment. Potentially useful therapeutic strategies are directedness, use of reflective dialogue, and continuous assessment.

Suggested Running Head: Topics and Strategies in Couple Therapy for IPV

Practitioner points:

- In couple treatment for IPV therapists should (a) actively bring up violence, responsibility and parenting, and (b) reflect on the culturally dominant understandings of IPV.

- To regulate the presence of dominance, therapists' directivity might promote equal distribution of talk, and increase the therapeutic alliance.
- Therapist strategies such as multivoiced addresses, reflective dialogue and directive approach may promote clients' responsibility and reflexivity.

Results of the Jyväskylä Research Project on Couple Therapy for Intimate Partner Violence:

Topics and Strategies in Successful Therapy Processes

There is considerable controversy in the field over the indications for couple therapy in cases of Intimate partner violence (IPV). However, a growing body of research has emphasized its benefits. It has been reported that couple therapy can (a) strengthen each person's willingness to take responsibility, (b) enable validation of the victim's experiences, and (c) promote a focus on the couple's relationship dynamics (Bograd & Mederos 1999; Hrapczynski, et al., 2012; McCollum & Stith 2008; Stith & McCollum, 2011). Together with these ideas, a paradigm shift in the focus of research has occurred, with increased interest placed on the role of dyadic interactions in the production of violence (Langhinrichsen-Rohling & Capaldi, 2012). It is important to view dyadic interactions as an effort to understand both members of the couple; not as a systemic causality of violence thus allowing victim blaming. Despite promising results, little is yet known about how to promote successful outcome in couple therapy for IPV (Stith & McCollum, 2011; Todahl et al., 2012; 2013), what seems clear from a recent review is that couples therapy has a positive impact in decreasing violence recidivism, and that couples therapy is a slightly better treatment approach than standard treatments when working with violent couples (Karakurt, Whiting, Esch, Bolen, & Calabrese, 2016).

This paper presents findings from the Jyväskylä Research Project on Couple Therapy for IPV. This project involved cooperation between several research centers around Finland. The project was coordinated by the Psychotherapy Training and Research Centre at the University of Jyväskylä, Finland. The aim of the project was to find out how IPV is dealt with in couple treatment provided by various social and health care services. This article will review studies

conducted in the project with the aim of enhancing understanding of successful couple treatment processes for IPV.

Several apprehensions emerge when conjoint IPV treatment is planned. Safety continues to be a topic of serious concern in couple therapy for IPV. Couple treatment is thought to increase emotional intensity, which may in turn increase the danger of violence in the relationship. Also, psychological and coercive control can increase and may manifest in therapy sessions. Conjoint treatment can also imply that the victim is partly responsible for the violence and for accomplishing the change (Stith, et al., 2003). Moreover, when the victim and the perpetrator are treated by the same therapist, it is possible that the perpetrator's version will dominate the conjoint sessions. Thus, the issues of power and dominance are important concerns, particularly in the case of male perpetrators. Female victims have on occasion reported not being heard and not feeling satisfied with conjoint treatment (Husso, 2003).

Notwithstanding, some couples with a history of IPV actively seek couple treatment. Conjoint treatment does not seem to increase the risk of physical violence when the treatment is designed specifically for IPV and the participants are carefully screened (Stith & McCollum, 2011). It has been found that in carefully selected couples the partners valued similar aspects of the couple therapy to a greater extent than expected, and reported feeling safer after participating in couple therapy for IPV (Lechtenberg et al. 2015). Lechtenberg and colleagues (2015) showed that the therapists' emphasis on emotional safety was highly valued by both male and female participants. In the same vein, Todahl and colleagues (2013) reported that clients felt safe, pointing out, however, that feeling safe is conditional on screening, voluntary participation, and the program format. In sum, clients seem to value screening and an emphasis on safety when participating in couple treatment for IPV.

Some issues seem to be of special relevance in cases of couple therapy for IPV, such as for example conversations about the violent behavior. Those conversations might be especially beneficial in order to assess the different types of violence. Some authors have stressed the importance of assessing the frequency, severity, and intensity of the violence (Karakurt, et al., 2013) while others its bidirectionality (Bogard & Mederos, 1999). Stith and colleagues (2005) proposed the level of violence should be low to moderate if couple treatment is considered. In the case of psychological abuse this severity means infrequent and mild. Also, according to Bograd and Mederos (1999) and Stith et al. (2005), both partners should voluntarily agree to participate in conjoint therapy and wish to remain together. More recently, Stith and McCollum (2011) have added discrepancy as an exclusion criterion, referring to the importance of both members of the couple sharing similar views about the nature and occurrence of the violence. In an effort to offer more concrete inclusion criteria, Todahl, and colleagues (2012) propose assessing whether the primary aggressor demonstrates willingness to receive input from the other party, to weigh the latter's point of view, and in consequence change his/her attitudes and behaviors. This criterion resembles that proposed by Bograd and Mederos (1999), who argue that the perpetrator has to take responsibility and be motivated to change his/her behavior before couple treatment is started. These caveats indicate that couple therapy for IPV should include scrutiny and conversations about violent behavior, spouses view of their relationship, and of perpetrator's responsibility in order to guarantee a good therapeutic outcome.

The complexity of the conjoint IPV treatment may place therapists in a challenging position. The main worries for therapists are their own anxiety, fear that the violence will increase, and feeling burdened about keeping people safe (Karakurt, et al., 2013). It should be mentioned that in IPV treatment it is not the safety and viewpoint of the couple alone that is

important, but also that of their children's (Cooper & Vetere, 2005). Todahl et al. (2013) noted that participants reported improvement in their parenting skills in multicouple group treatment for IPV. These complexities and concerns reflect the high amount of uncertainty experienced by IPV therapists. Karakurt and colleagues (2013) also found bias among therapists toward male perpetrators versus female perpetrators, such as downplaying situations and struggling with the seriousness of the violence when women were the perpetrators. Bias towards male perpetrators was also found in assessment, where there was a tendency to detect male-perpetrated violence more easily than female-perpetrated violence and to view male perpetrators as a more serious issue than female perpetrators. The need for a better understanding and knowledge of issues related to male victims of partner abuse has also been raised by other authors (Tsui, et al., 2010). To this end, a dyadic or equalitarian approach may provide novel and more profound explanations for abusive relationships, and might help therapists overcome the cultural constraints embedded in the issue of IPV.

Taking into consideration the above mentioned issues, it seems that power and dominance have a special relevance in couple therapy in IPV. Moreover, conversations about violent behavior, couple's view about their relationship and responsibility, and parenthood also seem crucial for assuring safety during the treatment process. Finally, the importance of female violence is also an issue that therapists should take into account. This article reviews the results of the studies conducted in the Jyväskylä Research Project on Couple Therapy for IPV that dealt with these topics, which in turn, are related to treatment success. A top-down thematic analysis was used in the review process. The articles were read and the main themes in them were used as a frame of reference in organizing their findings. The themes that were chosen as frame of reference were 1) power and dominance, and 2) central topics for discussion in couple therapy

for IPV. Both themes were also reviewed concerning how the therapists in their practice should address them.

Method

Participants

The Jyväskylä Research Project on Couple Therapy for IPV was conducted within a cooperative multicenter research network. The project data were gathered between 2009 and 2013. The following four Finnish treatment centers contributed data from couple therapy sessions:

- the Crisis Center Mobile in co-operation with the Psychotherapy Training and Research Centre at the University of Jyväskylä (project coordinator)
- the Crisis Center of the Finnish Association for Mental Health, Helsinki
- the Addiction Clinic in Kamppi, Helsinki, (A-Clinic Foundation)
- the Federation of Mother and Child Homes and Shelters (Oulu and Helsinki)

Procedure and Instruments

The procedure for processing couples seeking IPV couple therapy was the same at all four research centers: first, both partners were interviewed together and individually. In the individual interview, the objective was to assess the willingness of both partners to participate in couple therapy. Moreover, both partners signed a non-violence contract before starting the couple therapy. At the end of the therapy, both members of the couple were again interviewed individually. Finally, a two-year follow-up interview was conducted with each partner. In connection with these interviews both partners filled in the Abusive and Controlling Behavior Inventory (ACBI; Davies, Holmes, Lundy & Urquhart, 1995). The ACBI assesses various dimensions of violence: emotional and psychological, sexual, physical, as well as the global

impact of the abuse. The assessment period is the past 12 months. Moreover, violence is assessed bi-directionally, so each member answers the questionnaire, focusing, first, on his/her own violence towards his/her partner, and then on the violence committed by the partner.

At the end of each therapy session, both the couple and the treatment providers filled in the Session Rating Scale (SRS; Johnson, Miller, & Duncan, 2000). The SRS comprises a brief self-report visual analogue scale that covers three areas of the therapeutic alliance and a fourth scale that measures the general sense of the alliance: (a) Relationship ‘‘I felt heard, understood, and respected’’ versus ‘‘I did not feel heard, understood, and respected’’; (b) Goals and Topics ‘‘We worked on or talked about what I wanted to work on and talk about’’ versus ‘‘We did not work on or talk about what I wanted to work on and talk about’’; (c) Approach or Method ‘‘The therapist’s approach is a good fit for me’’ versus ‘‘The therapist’s approach is not a good fit for me’’; (d) Overall session ‘‘Overall, today’s session was right for me’’ versus ‘‘There was something missing in the session today’’. Both partners and therapists completed the SRS at the end of each session independently. They put a hash mark at the preferred spot on the line to indicate their experience of the alliance in the session. The cut-off point is 90 % of the line from the positive pole; scores below that indicate risk for a negative outcome (Miller and Duncan 2004). If they appeared, low scores were discussed at the end of the session.

The treatment was conducted as it is usually done in each service provider, the only difference is that the therapists were trained on IPV specific treatment including for example assessing safety, bringing up IPV in the conversation, and making the non-violence contract Thus the therapists were aware of some important issues when dealing with IPV but they could follow their own orientation or treatment approach.

All therapies were conducted in the format of co-therapy, and, as previously mentioned, each couple signed a non-violence contract at the beginning of treatment. The therapies followed a need-adapted approach, meaning for example that there was no minimum or maximum number of sessions agreed beforehand and this provoked a large variation in the number of sessions between cases.

Procedure

In the Jyväskylä Research Project on Couple Therapy for IPV, seventeen couple therapy cases were conducted. The therapy varied in length from 2 to 40 sessions, with a mean of 8.5 sessions. The therapy sessions were video-recorded with written consent from the clients. Parallel to the couple therapy sessions, individual sessions were also conducted in five cases (in one case individual sessions with both partners, and four cases individual sessions with the male partner only). In one case, the man was attending perpetrator group treatment.

The data gathered in this project have been analyzed in various studies. Ten studies were chosen for the purposes of this article. The choice was made based on the main dimensions in couple therapy for IPV which were also approached as the main frame of reference of this article: Dominance and abuse of power, and Themes/issues to be included in therapeutic conversations. Once the articles were chosen, they were organized according to these two main themes.

Results

The studies were divided according to how they relate to 1) power and dominance and 2) crucial issues/topics to address in IPV couple treatment. Table 1 summarizes the aims, sample, methods, and results of each study.

[Table 1 near here]

[Table 2 near here]

Discussion

This paper reviewed results of ten studies conducted in the Jyväskylä Research Project on Couple Therapy for IPV, with a focus on first the studies that were related to two themes: first, dominance and abuse of power, and second, to the therapeutic interaction and process, with a special attention to the topics or issues that should be brought up in therapy. Such issues included discussion of abusive behavior, responsibility, parenthood, and female perpetrated abuse. The analysis of these themes also included an analysis of the related therapists' strategies. Dominance and abuse of power have to be tackled by the therapist and on the other hand certain issues have to be introduced and highlighted by them.

Results of this review are discussed together without taking into account the fact that the studies followed different methodologies. For the purposes of this study the objective was to follow a process research focus, and thus to analyze the processes that the treatment follows according to some themes or issues important in couple therapy for IPV. For this reason, the main results and conclusions of the studies reviewed are discussed together in a holistic manner, and limitations to this approach will be discussed at the end.

In what refers to the first theme findings on dominance and the abuse of power showed that when discussing violent episodes, clients tended to position themselves as either perpetrator or victim (Keltinkangas et al., 2014). Dominance, in turn, could be detected by analyzing the dialogue in the conjoint sessions. The findings of such analysis showed that the male client dominated the sessions by talking more often and for longer periods (Keltikangas et al., 2014; Kulta, et al., 2013; Vall, Seikkula, Laitila, & Holma, 2016). Moreover, the findings indicated that the female client showed more semantic dominance (Vall, et al., 2016, Keltikangas et al. 2014), thereby regulating the topics under discussion, for example by changing the focus of the

conversation. It might be that semantic dominance presented by female clients is a strategy for making her voice heard, and returning to the issue she was originally talking about. It has been argued that the male partner might seek to diminish the female partner's experience of violence (Husso, 2003). In the findings of the Jyväskylä Research Project on Couple Therapy for IPV, female clients were in fact found to complain about their male partners repudiating their feelings and challenging descriptions of the violence they had received (Kulta, Kyrö, & Holma 2013). Focusing on the clinical aspects of this results, they help to raise awareness on the issue of semantic dominance, it is important that therapists are aware that male perpetrators have pressure to justify their behavior, and that the female client tries to change the topic from the justification to what has happened and which has been the violent fact. Female clients do not feel comfortable with the male justification of their attitudes, and thus they need the facts of what has happened to be recognized. Therapists have to try to give power to the marginalized voices, give voice to the female client, while acknowledging the male client at the same time. It is important to remark that therapists should not bypass the issue of semantic dominance, but follow the change of topic that (usually) female clients try to promote. This has effects on the therapeutic alliance, as it helps on the fact that everyone can feel heard in therapy.

The findings on interactional dominance differed across the studies reviewed: Vall and colleagues (2016) reported equally low interactional dominance for both partners, as opposed to Keltinkangas and colleagues (2014), who found that the male client showed more interactional dominance than the female client. These differences could be explained by the fact that in the study of Keltikangas et al., (2014) there were more cases analyzed, whereas Vall et al., (2016) was a case study, in which the couple presented some special characteristics (i.e. bidirectional violence). Detecting abuse of power and dominance seems to be crucial for the therapeutic

outcome. Unequal distribution of the floor was linked to partner's dissatisfaction with the session. Kulta et al. (2013) and Vall et al. (2016) found that the session in which the male client showed more quantitative dominance was the one that he gave a lower assessment of on the SRS; this referred in particular to the item on "feeling heard during the session" (Vall, et al., 2016). One might hypothesize that the man was using more quantitative dominance in the session in order to make his voice heard. Kulta and colleagues (2013), for example, reported complaints by the male client about not feeling heard. It can also be hypothesized that quantitative dominance is a way to suppress victim's semantic dominance, that is, her experiences. Findings from the dialogical analysis also showed that monologue was more present in therapy generally (Keltinkangas, et al., 2014). Dialogical dialogue mostly took place between a therapist and either one of the clients (Vall, et al., 2016, 2014).

Related to the issue of dominance and power, there is the process of positioning that the members of the couple negotiate together with the therapists. The positioning of clients usually manifested in terms of binary opposites (Keltinkangas et al., 2014). Typically, the partner was positioned as guilty. However, being positioned in this way was often rejected, at least partially, by the target. The findings of Keltinkangas and colleagues also showed how dealing with the clients' positioning of responsibility becomes more multiple and complex because clients commonly speak about responsibility in a contradictory manner. Positioning the partner as a perpetrator and oneself as a victim has been found to be used as a conversational tool in perpetrator treatment to diminish own responsibility (Partanen & Wahlström, 2003).

As for the therapists' strategies, they should promote the dialogical dialogue and symbolic language as this seems to help the couple acquire a new understanding of violence. On the contrary, focus on exceptions to the problem should be avoided as it seems to be more related

to monological dialogue (Vall et al., 2016). Moreover, weak agentic positioning of the clients should be challenged by the therapists as it helps promoting the client's positioning as strong agents (Keltinkangas et al., 2014). Finally, therapists should be directive in trying to promote equal distribution of talk as this seems to be related to higher therapeutic alliance, whereas a focus on the male client's speech seems to be related with a decrease on it. On the other hand, talk about the abuse of power also seems to be related to a decrease in therapeutic alliance. However, Kulta and colleagues (2013) argue that the therapists should still promote talking about the abuse of power, but this needs to be done very carefully as it might affect the therapeutic alliance. They highlight that when abuse of power is addresses, it should also be accompanied with strategies to increase the therapeutic alliance.

The second theme, aimed to elucidate the important issues to be brought up in couple therapy for IPV. In the research project, violent behavior, responsibility, parenthood, violence perpetrated by women, and client satisfaction emerged as such crucial topics.

First, it is important to define and ask about the violent behavior. Results of the project indicated that the ACBI gave limited information and did not detect intimate terrorism (Nieminen & Nokelainen, 2012). Therefore there is the need to include conversation about forms of violence in the therapy process. Violence should be discussed starting right at the very beginning as the project findings highlight the importance of the couple sharing similar views about the IPV at the beginning of therapy (Rantanen, Bunda & Holma, 2014). Rantanen and colleagues found that similarity of views was linked to a positive outcome whereas diverging views may predict a poor therapeutic outcome. This finding supports Stith and McCollum (2009), who have proposed that discrepancies in views about the nature and occurrence of the IVP should be considered an exclusion criterion to couple treatment. Rantanen and colleagues

(2014), in turn, showed that in cases where the violence was psychological, couples evidenced more disagreement. Their results further indicated that clients actually talk about these issues during the therapy. This result on the need of tackling the issue of violence might seem an obvious, however earlier research has shown how therapists tend to focus on other issues than the violent behavior as the therapy advances (Keskinen, 2005). Some of those issues that shift the focus from the violent behavior might be the custody of the children, the family background, and so on. Even if those issues are important to discuss, they should always be linked to the violent behavior, on how it has affected it. Therefore, those issues should not be used as a justification or explanation of the violent behavior, otherwise, as our results have shown, the female clients will use the semantic dominance to try to go back to the issue of the violent behavior. Therefore, it is important, that the issue of the presence and forms of the violent behavior is assessed throughout the therapy process, and addressed continuously to detect possible changes in it.

Moreover, project findings point to the importance of continuous assessment of violent behavior (Nieminen & Nokelainen, 2012). It is argued that assessment cannot be delivered only through filling in inventories. Comprehensive assessment requires that therapists are familiar with the different forms of IPV and are able to pay attention to signs of, for example, coercive psychological violence. Therapist strategies in talking about violent behavior include bringing up conversation about the violent behavior form the beginning of the session, while trying to reach an agreement of how violence happens and who has responsibility for it. Moreover, it is important to have this conversation also over the therapy process and to pay attention to each partner's view of what happens in the relationship (Rantanen, Bunda & Holma, 2014). Finally, it is also important that the therapist pays attention to the forms of violence that are present in the

session, so as to have in-situ information of how the cycle of violence starts and develops (Nieminen & Nokelainen, 2012).

Second, results elucidated the importance of the issue of responsibility during therapeutic discussions; it can be observed a process of negotiating responsibility. It was found that in cases of psychological abuse, clients may have more difficulties in positioning themselves as responsible for the violence, and might ask for their partner also to be held responsible for it (Vall, Seikkula, Laitila, Holma, & Botella, 2014). Therefore, accepting responsibility would seem to be especially crucial when starting couple therapy for psychological IPV. Another relevant aspect during conversation about abusive behavior is related to trust. The project findings indicate that the couple might have serious difficulties in trusting each other (Vall, et al., 2014). Also, the clients' pattern of communication may present a disrupted pattern in which each tries to impose on the other their view of the situation. As for the therapist strategies, it is important to focus on the need for clients to become aware of their responsibility, which in turn will help developing reflexivity (Kytölä & Lehto, 2013). Therapists can try to promote the acquisition of responsivity through the use of multivoiced addresses strategy, including the reflective dialogue between the therapists as to increase the clients' reflective positioning, and being directive in their approach (Vall, et al., 2014).

Referring to the issue of parenthood, in line with the guidelines of other IPV-specific couple treatment modalities (Cooper & Vetere, 2005; Todahl, et al., 2013), the present findings also highlight parenthood as an important theme in IPV couple therapy conversations (Hakala, Jalava & Holma, 2014; Juntunen & Holma, 2011). It is essential that therapists take into account the views of the children affected by the violence between their parents. Parenting is also a central theme in IPV couple treatment for the reason that parenthood may strongly motivate IPV

perpetrators to take responsibility and work to change their behavior (Cooper & Vetere, 2005; Hakala, Jalava & Holma, 2014). In their study, Hakala, Jalava and Holma (2014) showed how the therapists can be active in underlining the negative effects of violence on children without putting the therapeutic alliance at risk. On the contrary, discussing inadequate parenting can motivate change in violent behavior. To counter-balance this emphasis on the negative, discussing good parenting can assuage possible guilt feelings aroused by restricting the discussion to inadequate parenting. Hope is also created through the construction of good parenting.

The project findings show how focusing on violence perpetrated by women requires particular acknowledgement from the therapist. In the study of Koskinen and Peltoniemi (2015) violence perpetrated by women tended to be ignored by therapists, who changed the topic when it was brought up by either the woman or the man. Violent behavior by women was mostly brought up by the women themselves. However, they mostly explained their violence through justifications resting on a low level of agency. Compared to previous studies of male perpetrators, Koskinen and Peltoniemi argue that men may position themselves as having greater agency when talking about their violent behavior than female perpetrators. As proposed by Karakurt and colleagues (2013) as well as Tsui and colleagues (2010) there is a need to further explore such differences among male and female perpetrators. The therapists were also more concerned about the safety of the female partner than that of the male partner, even in cases where the violence was bidirectional. These findings suggest that therapists should be reflexive in their view of IPV, as the dominant discourse of a male perpetrator and female victim may not work for all couples.

Finally, another important topic refers to assessing the clients' satisfaction and the quality of the alliance on a day-to-day basis, as results have shown that these monitoring activities can give important information about the process (Kulta, Kyrö & Holma, 2013; Mäkinen & Lempinen, 2015; Vall, et al., 2016). Listening to feedback from clients during the session is also crucial and has to be acknowledged in making decisions on how to proceed with therapy (Mäkinen & Lempinen, 2015). Findings showed that clients tend to be dissatisfied when the therapists make judgements or blame the client, when they are undertaking few actions, when they ignore perspectives or when they take sides. Therefore, it seems important that therapists are active in their approach, try to make everyone feel heard, and are able to focus on the abusive behavior. Focusing on the abuse should be done by pointing out the harmful way of behaving not blaming the person's identity by for example naming him/her the perpetrator. Identity blaming has been noticed to be very affect provoking (Päivinen et al. 2016). Balancing between confrontation and creating therapeutic alliance has been found essential issue in group treatment for perpetrators as well (Räsänen, Holma & Seikkula, 2012). Assessing clients' satisfaction and therapeutic alliance regularly might also help to securing safety and ensure an equal distribution of *floor* among the couple members.

Limitations

The limitations of the studies conducted in the Jyväskylä Research Project on Couple Therapy for IPV include the small number of cases and studies, which did not allow analyses according to couple characteristics nor conclusions to be drawn based on certain types of cases. It will be interesting, in the future, to add more research, and be in a position to drawing conclusions for different kinds of couples. Thus, more studies are needed to corroborate our results, including longitudinal research to determine the effects of couple therapy for IPV.

Moreover, this review did not aim to analyze the efficacy of therapy, but to highlight some important aspects of process in IPV couple treatment. For a more systematic study of the factors that promote efficacy, other aspects should be taken into account in the data such as the therapeutic model, high dispersion within the length of sessions in each case, the number of individual sessions conducted with the participants, and so on. The variability of the data also influences the conclusions drawn in this review and thus any generalizations should be made with great caution.

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