BREAKING THE INTERGENERATIONAL CYCLE OF DOMESTIC VIOLENCE UTILIZING BOTH EMDR™ (EYE MOVEMENT DESENSITIZATION AND REPROCESSING) AND DeTUR ™ PROTOCOLS.

by

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A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree

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is approved and is acceptable in quality and form:

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Abstract of the Dissertation Presented to
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In the United States incidents of domestic violence continue to occur in epidemic proportions. Treatment for perpetrators of domestic violence has ranged from individual therapy to group counseling. Batterer intervention programs utilizing group counseling have been the preferred mode of treatment since the late 1970s. They have employed a psycho-educational approach to group counseling with a gender-based cognitive-behavioral orientation. Evaluations of programs have yet to reveal whether the group process works in changing batterers' behavior. Recidivism rates are high and research indicates that group counseling for domestic violence does not work. Many believe that the group counseling process enables men to become more sophisticated as batterers.

This is a study employing the use of both EMDR™ and DeTUR™ protocols to break the intergenerational cycle of domestic violence. The population for the study will be men convicted of domestic violence and mandated to attend a counseling program.

Our hypothesis is that by employing these two protocols we can break the intergenerational cycle of domestic violence both quickly and permanently. We believe our post-test results will indicate major reductions, and in some cases complete elimination, of both physically and emotionally abusive incidents.

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Introduction

Domestic violence causes injuries, ruins lives, clogs the court systems, and in spite of well-meaning attempts to treat it, there remains a high recidivism rate among abusers. The question of what to do about men who batter their female partners has haunted the domestic violence field since its emergence in the late 1970s. Group counseling employing a psycho-educational approach has been the preferred modality of treatment since that time. In formulating our study we hypothesized that high recidivism rates result from using techniques that are based on theories of anger management and cognitive behavioral therapy. Our theory was that we have only been treating the symptoms. “In California, authorities receive over 197,000 emergency calls about domestic violence every year. It does not discriminate when it comes to race, religion, income, or status. It is not culturally based nor financially based, and it can happen any time of the year. Domestic violence is an equal

opportunity crime. Having money or prestige does not exempt someone from being a victim or an abuser" (Cohn, 2002, p.1).

In the United States incidents of domestic violence continue to occur in epidemic proportions. "It is estimated that approximately three million American households experience at least one domestic violence episode each year" (Sonkin & Durphy, 1982, p.1).

Nearly 5.3 million incidents of IPV (intimate partner violence) occur each year among United States women ages 18 and older, and 3.2 million occur among men (CDC, 2006).

Last year in America nearly four million women were physically abused by their husbands or boyfriends. Physical abuse of a woman occurs approximately every nine seconds in this country (Santa Clara County, 2006).

According to Lori Abrahamson (1990) of Next Door—Solutions to Domestic Violence "Four million women are battered every year. Domestic violence is the major cause of injury to women, causes more injury than mugging, rapes, and auto accidents combined. This means that the home is the most dangerous place for a woman" (Abrahamson, 1990).

California arrests for domestic violence totaled 316 in 1980. The number grew to 46,353 in 2004 (Office of the Attorney General, 2004).

Treatment for perpetrators of domestic violence has ranged from individual therapy to group counseling. Batterer intervention programs (BIPs), utilizing group counseling, have been the preferred mode of treatment since the late 1970s (Gondolf, 2003). Most BIPs have employed a psycho-educational approach to group counseling

with a gender-based cognitive-behavioral orientation. Program evaluations have not yet revealed whether the group process is the most effective means for changing batterers' behavior.

Early evaluations showed positive results from employing the group counseling process. According to Gondolf's presentation at the 8th Annual Domestic Violence Conference, 2000, "Batterer programs do appear to contribute to the cessation of violence in some men over a 6 month follow up period" (Gondolf, 2000). "The thing that makes the BIP process so effective is due partly to the collaborative approach to Domestic Violence" (Domestic Violence Council, 1993). Collaboration here means an entire community working together to end violence in the home. There are many players in the process, beginning with the arresting officers and ending with everyone involved in the successful completion of 52 weeks of group counseling and three years of formal probation. Members of the collaborative team include: those who create integrated criminal justice agency agreements and protocols, interaction and direction by battered women services and safety organizations, local community involvement, and a commitment to provide adequate community resources for victims and batterers which address cultural and language diversity (i.e.; police, district attorneys, judges, probation, shelters, therapists, medical workers, social services).

Several commentators have discussed the theories of behavior that underlie treatment for domestic violence. "It is not gene-directed hormones and neurotransmitters that control our bodies and our minds; our beliefs control our bodies, our minds and thus our lives" (Lipton, 2005, p.28).

"Most of us agree, and behavioral scientists confirm, that our behaviors are a direct reflection of our beliefs, perceptions, and values, generated from past experiences" (Williams, 2004, p. 47).

My collaborator on this study and I agreed with the theory that abusive behaviors are a result of ones belief system, and we also theorized that current treatment approaches are only addressing the symptoms and never reach the root cause of all behaviors—the belief system. If all behaviors really are a result of the belief system, then it is paramount to employ the fastest most effective way of replacing rigid, negative beliefs and cognitions with positive ones. The focus of this study was not about how ones beliefs system is created or how beliefs are formed. Rather it is about treating the cause of behavior and our hypothesis that the cause of all behaviors is one's belief system.

Background of the Study

The conventional treatment for perpetrators of domestic violence in the state of California is group counseling. Group facilitators employ a psycho-educational approach to exposing these court-mandated group members to content themes dictated by state law and county standards. The California State Legislature, through passage of Assembly Bill 226, designated sole authority to county probation departments to approve, deny, suspend, or revoke batterers' program certification and renewal (Santa Clara County Probation, 2000). In order to satisfy this mandate, the Santa Clara County Probation Department created the "Standards for Batterers Programs" to both emphasize the intent and purpose of the law and to reflect the agency's mission to protect the community. Section 1203.097(1) of the California

Penal Code mandates a minimum probation period of 36 months and the successful completion of a batterers' program lasting a period not less than one year. Groups are two (2) hours in length, once a week, for fifty-two (52) consecutive weeks.

Recidivism rates are high and research indicates a need to find out if group counseling is the most effective approach to stopping domestic violence. According to Gondolf, as many as 20% of batterer program participants repeatedly re-assault their partners despite intervention (Gondolf, 1999). Some believe that the men actually become more sophisticated batterers. Gondolf adds, "It may be that some men displace their physical abuse to heightened verbal and psychological abuse" (Gondolf, 2004, p. 613). According to the Santa Clara County Batterers Intervention committee, victims report that physical abuse is often replaced by other forms of abuse (i.e.; emotional, financial) (Bata, 1998).

For this study it is important to understand the current parameters that certified program agencies in Santa Clara County, where this study took place, must adhere to in doing this work. Individual counseling is one of the exceptions to the rule, and therefore not "legal" (under state law and county standards. Individual sessions may be in addition to, but not instead of group participation, and no studies exist today reflecting their possible effectiveness). The following is a brief look at the parameters of Santa Clara County's Standards.

Santa Clara County's standards for Batterers Programs and Certification were adopted in March of 1997 and modified in February of 2000. All certified programs must adhere to these standards, which contain a list of "inappropriate methods of intervention" (Santa Clara County Probation Department, 2000, p. 11). The individual

therapy that was used in this study is currently listed as “inappropriate” (if used alone).

Program Format

The Santa Clara County standards state that the primary method of program intervention shall be psycho-educational group discussions, “led by trained co-facilitators, within an established curriculum, which shall include strategies to hold the offender accountable for violence in the relationship. The discussion of violent and coercive incidents during a group session is used as a means to identify and confront the specific controlling behaviors in order to achieve an end to those behaviors” (Santa Clara County Probation Department, 2000, p. 6).

Program Content

The goal of the Batterers Intervention Programs is to end the Offenders Abusive Behavior. This shall be achieved by confronting and dispelling the individual batterer’s justification for the use of violence within the relationship.

Particular attention shall be paid to the **belief systems** [emphasis added] that promote the use of intimidation, violence and coercion against the intimate partners and children. Theories or methods which in any way bring the victim into the circle of responsibility for the batterer’s behavior or diminish the batterer’s responsibility for the violence are inappropriate. All program curricula shall include the following themes. That is, here in the state of California as specified in penal code section 1203.097(c)(1)(F), with cultural ethnic sexual orientation and class sensitivity.

Programs are encouraged to augment these themes in a creative way as appropriate to the special needs of the group. Once approved the curricula shall not be modified without a prior approval of the probation department.

All program curricula shall include the following themes as specified in Penal Code Section 1203.097(c)(1)(F), with cultural, ethnic, sexual orientation and class sensitivity. (Santa Clara County Probation Department, 2000, p. 8)

- Gender Roles
- Socialization
- The nature of violence
- The dynamics of power and control
- The effects of abuse on children and others

"These themes are interjected each and every week into whatever topic of discussion is presented. The program facilitators then challenge the following attitudes of group members, which promote the use of abusive behavior" (Santa Clara County Probation Department, 2000, p.10).

- Entitlement to control the activities of another
- Rigid sex roles stereotypes
- Superiority and privilege based on gender
- Restriction of a full emotional range based on gender
- Aggression as a legitimate tool of enforcement of authority and privilege (Santa Clara County Probation Department, 2000, pp. 17–19).

All batterer intervention systems in the state of California are nested within a common statutory framework that mandates a number of shared characteristics across systems. Penal Code section 1203.097, for example, mandates minimum probation terms for DV cases of 36 months, a criminal court protective order protecting the victim from further acts of violence, monetary penalties, and the successful completion of a batterer's program. Penal Code section 1203.097 also specifies how BIPs should operate. The statute requires that these programs be 52 weeks long, that they hold weekly two-hour sessions and that the components of the programs include strategies to hold defendants accountable, requirements for defendants to participate in on-going same-gender group sessions, intake procedures, specific educational programming and prohibitions on couple or family counseling (Appendix F).

Presently, the Santa Clara County Probation Department certifies only agencies that employ the gender-based cognitive-behavioral approach to group counseling. This stems from Assembly Bill 226 that grants probation departments from around the state of California sole authority to certify such agencies. This Bill also dictates the content materials that are to be addressed in the BIPs the agencies provide, that is, the mandated information that group attendees are exposed to during their time in the program.

Consequently, other approaches that may be more effective treatment modalities in permanently changing behavior are not allowed under California statues. Our study will address the need to modify this.

Statement of the Problem

Domestic violence and intimate partner violence (IPV) have been tearing families apart and ruining lives for too long. In England, in the late eighteenth century, a law on the books was referred to as the Rule of Thumb.) There is a story (though probably apocryphal) that according to English law a man was allowed to beat his wife with a stick so long as it was no thicker than his thumb. Judge Sir Francis Buller is reported as having made this legal ruling in 1782. Hence, the phrase rule of thumb that is still used in our language today (Martin, 2000). The truth is, family violence was occurring long before so-called rule of thumb laws might have been thought of, and it remains one of the most prevalent crimes committed today. Domestic violence has become a widespread social problem. Contrary to the view of the family as a haven of love and support, past findings suggest that women are at greater risk of violence in their homes than anywhere else. The umbrella of family violence includes: Spousal/partner abuse, child abuse, and elder abuse, though our focus for this study was on spousal and partner abuse. The costs incurred as a result of domestic violence are huge. Some of the staggering facts about domestic violence are as follows:

The 2006 Santa Clara County Fact Sheet presents a list of disturbing statistics on domestic violence:

- Last year in America nearly four million women were physically abused by their husbands or boyfriends. Physical abuse of a woman occurs approximately every nine seconds in this county.

- Most attacks on women (about 70%) are committed by someone the victim knows—often a husband or boyfriend.
- More women are victims of domestic violence than of burglary, muggings, and other violent crime combined.
- Over one-third of Americans have witnessed at least one incident of domestic violence, and according to a 1997 nationwide survey released by the Family Violence Prevention Fund (FUND) almost 90% of Americans say that the beating of women is a serious problem in many families of all races and ages. The same survey indicated that over 80% of Americans believe something can be done to reduce domestic violence in this country.

Occurrence

- In 1997, about 7% of American women (4 million) who were married or living with someone as a couple were physically abused, and 37% (20.7 million) were verbally or emotionally abused by their spouse or partner.
- Approximately 95% of assaults on spouses or ex-spouses are committed by men against women according to the U.S. Department of Justice.
- Domestic violence is a “serial” crime with (usually) a single victim. Approximately 1 in 5 women victimized by a spouse or ex-spouse has reported that she had been in a series of at least three assaults in the preceding six months.

Injuries and Fatalities

- When a woman is killed, in about 43% of the cases the murderer is an intimate male partner.
- In over half the cases, the physical abuse of a woman by her partner was accompanied by death threats. Almost the same number had called the police on at least one occasion; one-third of them had obtained restraining orders. Ending the relation does not always end the violence. Over one third of women who leave abusive relationships continue to be threatened, assaulted, or harassed afterwards.
- Domestic violence often causes severe injury: A study of over 200 women presenting at a metropolitan emergency room with injuries due to domestic violence showed that 28% required admission to hospital from those injuries. About 13% required major medical treatment. 40% had required medical care in the past for trauma due to domestic violence.

Costs

- Domestic crime against adults accounts for nearly 15% of total crime costs—$67 billion per year—according to a 1996 study by the NIJ.

The Rush Medical Center in Chicago has found that the average cost of medical treatment to abused women, children, and elders is about $1,630 per person per year. This suggests a national annual cost of about $850 million (Santa Clara County, 2006a).

Costs of IPV against women in 1995 exceed an estimated $5.8 billion. These costs include nearly $4.1 billion in the direct costs of medical

and mental health care and nearly $1.8 billion in the indirect costs of lost productivity.

When updated to 2003 dollars, IPV costs exceed $8.3 billion, which includes:

$460 million for rape, $6.2 billion for physical assault, $461 million for stalking, and $1.2 billion in the value of lost lives.

Victims of severe IPV lose nearly 8 million days of paid work—the equivalent of more than 32,000 full-time jobs—and almost 5.6 million days of household productivity each year (Centers for Disease Control and Prevention, 2006).

"In response to the threat that domestic violence presents, much research and clinical work has been dedicated to determining the causes of domestic violence and how to treat it. Although initial research has focused on the risk factors for domestic violence, more recent research has concentrated on the efficacy of treatment and the occurrence of post-treatment domestic violence recidivism" (Sartin, Hansen, & Huss, 2006, p.426). The prevalence data imply that over two-thirds of domestic violence victims in California do not involve law enforcement. About 197,000 domestic violence calls were reported by law enforcement in 2000. There were 51,225 arrests for spousal abuse in the state that year and 12,132 convictions. Domestic violence was the precipitating event in at least 147 homicides, although the number was probably higher since law enforcement officials sometimes do not identify the precipitating event as domestic violence at the outset (Bugarin, 2002).

The percentage of women who indicated that their parents abused them doubled from 12% in 1997 to 24% in 2005. One in four (25%) witnessed domestic violence as a child, which is about the same as in 1997 (23%), (Dan Jones & Associates, 2005).

According to the California Attorney's Generals Office 125 women were killed by their husbands, ex-husbands, or boyfriends in California in 2005, and 26 men were killed by their wives, ex-wives, or girlfriends. California law enforcement received 181,362 domestic violence calls in 2005—93,027 calls involved weapons, which include firearms and knives. Each call is based on information from a written incident report (Office of the Attorney General, 2004).

The Centers for Disease Control reports that domestic violence is a serious, preventable public health problem affecting more than 32 million Americans that is more the 10% of the U.S. population (Centers for Disease Control, 2006).

The California Research Bureau reported that the California Department of Health Women's Health Project's 2000 survey found that about "6 % of California's women (approximately 700,000) have been victims of domestic violence. A 1999 Kaiser Permanente of California telephone survey found that 5 to 8.5% of the plan's members had experienced domestic violence within the last 12 months, and 34.3% had experienced it within their lifetime. A Commonwealth Fund 1998 Survey of Women's Health in the United States found high rates of violence and abuse rates among women crossing income, ethnic, and geographic lines; nearly two of five women (31%) reported violence or abuse in their lifetime. Of those women that experienced childhood abuse, nearly two-thirds (62%) of women experienced

domestic violence as adults" (Bugarin, 2002, p.1). In summary, the statistical problems associated with the costs and occurrences of domestic violence are no longer in the closet. This information is now mainstream.

Though the problem of domestic violence has been recognized and much effort and expense had been put into developing treatment programs, there remains a high recidivism rate.

"High recidivism rates are common, however, with over 25% of offenders engaging in physical aggression within one to two years after treatment" (Murphy, 1994, p.877).

"The recidivism rates for domestic violence are high. One study shows that 47% of admitted batterers report three or more assaults per year" (Potowmack Institute, 1999, §I).

A community blog to the Democratic Party claims, "Four American women die daily from domestic violence, two of them each week are Floridians. When survivors meet in shelter groups, we find that our initially charming partners had histories that we discovered too late; like pedophiles, perpetrators of domestic violence have sky high recidivism rates" (Chandler, 2007).

In the 1980s practitioners were optimistic about using the group process to treat domestic violence. "The figures appear to confirm an emerging trend in the treatment of Domestic Violence. The supervised self-help groups appear to be the most effective format for dealing with batterers" (Gondolf , 1985, p.15). "With group counseling, the main advantage is the opportunity to talk with and get support from

other men who are experiencing the same problems" (Sonkin & Durphy, 1982, p. 109).

Baba, Galaka, Bicakci, & Asquith (1999) published research based on a study of the Domestic Abuse Project of Minneapolis (i.e., 16 sessions of cognitive behavioral treatment) They queried the partners of male participants six months after the program, and no further violence was reported for 77% of men completing the program (n=27), while the figure was just 54% for men who had dropped out (n=30) (p.4).

By the 1990s some were still guardedly optimistic, but doubts had begun to arise. Gondolf reported that batterer program evaluations showed 50–80% of the program completers to be nonviolent at the end of a six-month to one-year period, as verified by their partners. The reduction of other forms of abuse was less clear, but one study showed that only about 40–50% of the participants were free of terrorist threats at a six-month follow-up (1993).

> Doubts also arose about the effectiveness of the evaluation studies.
>
> A recent report from the National Institute of Justice (NIJ) concluded that it is impossible to say how effective batterer intervention program's are. Referring to numerous evaluation studies over the last 15 years and to recent studies using experimental designs, NIJ found that methodological problems undermined the results of even well designed studies. These methodological problems vary, but certainly include recruitment and retention of participants (Task Force—Office of the Attorney General, 2005, p. 63).

Later evaluations began to show “holes” in the process. Experts began questioning whether group process techniques were as effective as earlier evaluations had indicated. According to Jane Browning, Executive Director, International Community Corrections Association:

> The effectiveness of the court-mandated programs is a source of debate. There is no national data that address these programs’ results. Anything that makes a person address the problem has value as far as I’m concerned, I will not say counseling is not good, I’m skeptical about the programs, I believe they fail to address the root cause of the convicted defendant’s anger (Foo, 2006, pp.1–2).

Several studies have examined the effectiveness of domestic violence programs in recent years, but the results have been inconsistent. Sartin et al. (2006) have reported that “53–85% of men who completed treatment were not violent 6 to 18 months later, with lower rates of repeat behavior being associated with longer follow-up periods. A recent meta-analysis of 22 studies evaluating treatment efficacy found treatment for domestic violence perpetrators to have only a small effect on post-treatment recidivism; however, this small effect could be very meaningful for some victims of domestic violence. That said, as research continues to increase knowledge about the factors related to treatment efficacy, and risk for post-treatment domestic violence recidivism, the hope is treatment efficacy can be improved” (Sartin et al., 2006, p. 426).

The National Institute of Justice agrees that there are questions about effectiveness, but since the evaluations are faulty, the NIJ finds difficult to determine how effective the programs are.

> More than 35 BIP evaluations have been published. Early studies that used quasi-experimental designs consistently found small program effect; when more methodologically rigorous evaluations were undertaken, the results were inconsistent and disappointing. Most of the later studies found that treatment effects were limited to a small reduction in re-offending, although evidence indicates that for most participants (perhaps those already motivated to change) BIPs may end the most violent and threatening behaviors.
>
> The results, however, remain inconclusive, because of methodological flaws in these evaluations. Although early evaluations suggested that BIPs reduce battering, recent evaluations based on more rigorous designs find little or no reduction. The methodological limitations of virtually all these evaluations, however, make it impossible to say how effective BIPs are (National Institute of Justice, 2003, p.2).

Two evaluations of programs in Broward County, Florida, and Brooklyn, New York have raised concerns about the effectiveness of BIPs. Based on more rigorous experimental designs than earlier evaluations, the studies claim that these BIPs have little or no effect. In the Broward County study, 404 men were randomly assigned to probation plus a Duluth-based BIP or probation only.

> At follow-up, there were no significant differences between the BIP and the probation-only groups in attitudes toward wife beating, attitudes toward women, or self-reported likelihood they would hit their partner in the future. The men in the BIP were less likely to view their partner as responsible for the violence, and as more dangerous to his partner than men in the control group. At one-year follow-up, men in the BIPs were no less likely than men in the control group to be re-arrested for domestic violence.
>
> In the Brooklyn study, men were randomly assigned to either a 40-hour Duluth-based BIP (n=186) or 40 hours of community service (n=190). Evaluations occurred at 6 months and again at 12 months, and included both official records of complaints/arrests and victim interviews, although only half of the victims could be interviewed. Results suggest significantly lower recidivism for men in BIPs using official reports, but no difference between BIPs and community service using victim reports (Bennet & Williams, 2001, pp.12–13).

In a four-site study Gondolf (2000) found that approximately half (42–47%) of the men re-assaulted their initial or new partners sometime during the 30-month follow-up, but most of the new re-assaults occurred within the first 6 months of program intake. The percentage of new re-assaults progressively decreased over time, with the vast majority of the men not re-assaulting their partners between 15 and 30 months after program intake. However, nearly a quarter (23%) of the men repeatedly re-assaulted their partners during the follow-up; these men accounted for the vast

majority of the reported injuries. The re-assault rates are similar across the four sites despite differences in the intervention systems" (Gondolf, 2000).

Purpose of the Study

The purpose of this study was to test our hypothesis. If our outcome measures proved favorable then more exploration of these protocols, as well as more research would be demonstrated.

The goal of this study was to take a step toward providing clinicians and researchers with a more effective means of reducing, and ultimately eliminating, incidents of physical and emotional violence within abusive relationships.

This study has its beginnings following an EMDR™ training that I attended in San Diego. It was there that I met A.J. Popky, one of the founding fathers of EMDR. He is also the author and developer of the DeTUR™ protocol. The treatment plan used in this study came from the many hours we spent together discussing clients, case presentations, and the comparison of treatment modalities that we used with (2) two of the primary populations that we were serving: addicts (encompassing all addictive behaviors) and batterers.

For example, the learned behavior theory of domestic violence says that domestic violence stems from beliefs created during childhood by witnesses and victims of domestic violence. This theory parallels the trauma-based theory of addictions. So we wondered if we could reprocess trauma (using EMDR and DeTUR protocols) and change the cognitions (beliefs), thereby changing behaviors. The first tier of the study was created from this question.

The reactive triggers (button pushing) experienced by batterers also parallels the levels of urge (LOU's) stage of A.J.Popky's DeTUR protocol that he uses to work with addicts. Could we desensitize the reactive triggers as effectively as DeTUR reduces addicts desire (LOU) to engage in self-defeating behaviors? The second tier of the study was created from this question.

The final tier was born of thousands of intake interviews, where clients described the trauma surrounding recent violent episodes and subsequent arrests. The trauma of current arrests often opened up the trauma of childhood experiences, and this uncovering paralleled the experiences of addicts, where the treatment process of the DeTUR protocol often revealed traumas buried under self-medicating behavior(s). This information put tier number three of the study firmly in place.

This study employed the use of both EMDR and DeTUR protocols to attempt to break the intergenerational cycle of domestic violence. These two protocols seemed custom fit for our study. The theory of intergenerational cycle of domestic violence stems from the fact that the cycle of domestic violence is both learned and then passed along from generation to generation. That is, what was learned by great-grandfathers was passed along to grandfathers, then passed along to fathers, and so on. Another part of this theory is that violence is a "learned" behavior and therefore can be "unlearned." The population for the study was made up of men convicted of domestic violence and under court order to attend a certified counseling program. In addition to the groups, they volunteered to receive five (5) individual sessions, ninety (90) minutes in length, utilizing these protocols. Again, our study indicated a need for exploration of these protocols and the need for more research. Post-tests results

showed substantial reductions and in some cases complete elimination of incidents of abuse. The study also revealed the need for new legislation that allows for more flexibility in treatment methods (i.e., individual therapy, couples).

Hypothesis

- Are beliefs, and one's belief system the root cause of violence?
- Can a treatment methodology that changes beliefs be effective in stopping domestic violence?

We predicted that (5) individual sessions of treatment utilizing our protocols would result in a significant reduction, if not complete elimination, of both physical and psychological incidents of domestic violence as measured by the Conflicts Tactics Scale (CTS2).

This study aimed to propose more evidence on the necessity of establishing therapeutic policies and guidelines for "individual" treatment methods, which remain listed as "an inappropriate method of intervention" in Santa Clara County.

Importance of the Study

The importance of this study is paramount. The costs associated with domestic violence, the prevalence of abuse, and the recidivism rates demand an effective way to stop the violence, that is, to break the cycle of domestic violence permanently.

Citing prevalence data and recidivism rates is never ending, yet effective treatment(s) would drastically reduce recidivism. Recent research has questioned the effectiveness of current BIP programs, but viable alternatives have not been found. There is a great need for an alternative method of treatment that will stop the

recidivism. We hoped that the testing of our hypothesis and the use of our protocols to quickly change beliefs would have a dramatic impact on violence and provide just the alternative that is needed.

This study presents data necessary to establish foundations for further research in this area and implications for treatment policies of this population. Recommendations for areas of treatment and levels of intervention, and a sample of the treatment program for this population, are made based on the literature review and the results of this study.

Scope of the Study

In this study participants (men) convicted of domestic violence, and sentenced to three years of formal probation and court mandated to attend 52 weeks of group counseling, were investigated. The study began with 12 men, 5 completed the process.

The male batterers participating in the study ranged from 33 to 51 years of age. Sixty percent (60%) were White, twenty percent (20%) were Asian, ten percent (10%) were Black, and ten percent (10%) were Hispanic. The variables examined in the study were: 1) type of abuse (i.e., physical or psychological/emotional) and 2) the frequency of the abuse over a twelve-month period. We examined these variables twice, before the study and two years later. We administered the CTS2.

The point of the study was to test our initial hypotheses, and we wanted to test the idea that all behavior comes from one's belief system. Additionally, coming from this frame of reference, we wanted to take it a bit further with the theory that if you change the beliefs, the behavior will follow. Dr. Popky and I began our collaborative

work with the question of how we could best apply his DeTUR protocol to students of the psycho-educational process. The DeTUR protocol at that time had, and still has, very successful treatment outcomes with addicts. We theorized that an addict's "level of urge" to use was similar to the batterer's "level of reactive triggers" that resulted in abusive incidents. We then added the tiers of the EMDR treatment to address issues of trauma and early belief development. We then set out to test our hypothesis in (5) five sessions.

Limitations of the Study

1) The most obvious of the limitations is that there was no control group(s). Our original intent was to see if testing our hypothesis was effective. The need for a comparative study with control versus study groups is outlined in Chapter 5.

2) The results were dependent upon self-reports. While the CTS2 may have been the most commonly used instrument at that time, it carried with it the history of limitations related to the self-reporting aspect.

3) Because of the controversy surrounding the self-report aspect it proved necessary to validate study results by searching the Criminal Justice Information Control (CJIC) database for re-arrest statistics.

4) Additionally, without controls who had no individual sessions and were tested before and after the BIP group, it would be hard to tell the effect of sessions from the effect of the BIP group.

5) The number of participants needed to be larger.

6) Finally, because this was not an actual comparative study, we were unable to do a statistical analysis. Therefore, we could not draw any final conclusions from our data.

Even though we could not draw any final conclusions from our data, the results were very promising and point toward further research. Future research will focus on presenting data of recidivism rates for control versus treatment groups. Conclusions can then be drawn, statistical analysis performed, and so on.

Definitions

Abuse means intentionally or recklessly causing or attempting to cause bodily injury, or sexual assault, or to place a person in reasonable apprehension of imminent serious bodily injury to that person or another (Santa Clara Probation Department, 2000).

Battering is patterned abuse in the presence of terrorizing tactics. This is abuse that, at least once, has been physical, sexual, or involved the destruction of property and is either repeated or repetition is threatened in such a way as to engender fear in the mind of the victim. It is the systematic domination and/or terrorization of one person by another (Santa Clara Probation Department, 2000).

DeTUR is an eclectic treatment model, and the theories involved are based solely on experience from personal client observation and anecdotal reports received from other therapists using this same protocol. It is an eclectic model and combines many methodologies, including but not limited to, cognitive-behavioral, solution-focused, Ericksonian, narrative, object relations, NLP, etc. The bi-lateral stimulation

seems to form the catalyst for rapid processing and change, the turbo-charger that speeds the healing process.

Successful results have been reported across the spectrum of addictions and dysfunctional behaviors: chemical substances (nicotine, marijuana, alcohol, methamphetamine, cocaine, crack, heroin/methadone, etc.), eating disorders such as compulsive overeating, anorexia, and bulimia, along with other behaviors such as sex, gambling, shoplifting, anger outbursts, trichotillomania, and so on. As new information becomes available it is incorporated into the protocol.

There are similarities and differences between this treatment protocol and the EMDR protocol. The EMDR protocol addresses affect and known traumatic issues. It utilizes positive and negative cognitions. The DeTUR protocol addresses triggers and uses positive body states. Where EMDR uses SUDs and VoC this model uses only Level or Urge (LOU) as measurement. Both use bi-lateral stimulation and installation of the positive, and require a thorough history taking, assessment, and diagnosis for insuring client safety before starting treatment. This protocol addresses present and future and addresses past as it opens up. The EMDR protocol addresses past, present, and future (Popky, 2000).

Domestic violence as defined in the California civil statutes is abuse perpetrated against the following persons: spouse or former spouse, cohabitant or former cohabitant, person with whom one is having or has had a dating relationship, person with whom one has had a child, any person related by consanguinity (blood relative or close relationship) or affinity (relationship by marriage or a close relationship) within the second degree (Santa Clara Probation Department, 2000).

EMDR or eye movement desensitization and reprocessing (EMDR) is a controversial treatment that claims to resolve long-standing traumatic memories within a few treatment sessions. During EMDR treatment, the client is asked to hold in mind an image of the trauma, a negative self-cognition, negative emotions, and related physical sensations about the trauma. While doing so, the client is instructed to move her or his eyes quickly and laterally back and forth for about 15 to 20 seconds, following the therapist's fingers. Other forms of left-right alternating stimulation (auditory, tactile) are sometimes used. The client then reports the images, cognitions, emotions, and physical sensations that emerged. This recursive procedure continues until desensitization of troubling material is complete and positive self-cognitions have replaced the previous negative self- cognition (Shapiro, 2001).

Recidivism **is reoffending or recommitting** previous undesirable types of behavior, to include repeating the offense of domestic violence.

Victims are persons against whom the perpetrator directs abuse of battering. This may include partners, children, and other family or household members. The perpetrator is never a victim, even if those abused direct violence against the perpetrator to defend themselves or to stop the perpetrator's abuse (Santa Clara Probation Department, 2000).

Chapter 2

Review of the Literature

The Grassroots Movement

The review of the literature begins with a brief history of the grassroots pro-feminist domestic violence movement and its contributions to treatment. According to Thomas (2006), the first domestic violence shelters were created in London by Erin Pizzey beginning in the early 1970s. She also wrote the first book on domestic violence in 1974. Her shelters used approaches that would now be considered leading edge; for example, the women themselves, not professional staff, ran their shelters. Pizzey advocated that shelters be established for men; she insisted that child abuse and domestic violence were linked; and she regularly spoke out about women's violence (Thomas, 2006, p. 4).

Here in the United States it was not until 1977 that the state of Oregon became the first state to enact legislation mandating arrest in domestic violence cases. Shelter workers and feminist advocates were the first to venture into designing interventions with male perpetrators of domestic violence. The beginnings were unstructured

consciousness-raising and peer self-help groups. They independently grew into more structured formats, infused with feminist beliefs about the role patriarchy plays in violence. For example, Gondolf in his 1985 book *Men Who Batter* believed that the most effective mode of treatment was a psycho-educational format that helped hold men accountable. He considered the supervised "self-help" groups to be the most effective format for "dealing with batterers" (Gondolf, 1985, pp 17–19).

The question of what to do about men who batter their female partners has haunted the domestic violence field since its emergence in the late 1970s. Many advocates working with battered women felt, and many still feel, that few batterers could be changed, given the social reinforcement for and the tolerance of violence against women. Trying to counsel or educate such men might, in fact, raise false hopes in battered women and worsen their already difficult circumstances. Protection for women and separation from their male batterers, therefore, became the overarching intervention objective. In the late 1970s, however, some men's counselors allied with the battered women's advocates and began anti-sexist consciousness-raising groups primarily for men who professed that they wanted to change. Group facilitators led discussions that exposed men's socialization to dominate women and, in some cases, use violence to maintain that dominance. (Babcock, Canady, Graham, & Schart, 2006, pp. 122–123).

In 1989, Daniel Sonkin, PhD, and Michael Murphy, MD, wrote in their updated book *Learning to Live without Violence: A Handbook for Men*.

> We have learned over a number of years, and from many clients, that domestic violence is a potentially lethal situation that must be dealt

> with directly by both client and counselor. Our experience, and that of many other counselors in this field, has shown that a style of counseling which focuses on anger management, communication, education about sex role attitudes, power and control in relationships and self-esteem building has proven to be most effective in helping men to eliminate family violence from their lives. Most professional training has traditionally omitted theoretical and practical work in the field of domestic violence (p. vi).

In June 1989, the Domestic Abuse project reported from their study that 12-session educational groups appeared to be more effective than other formats in helping men with their post-group use of both violence and terrorist threats. These findings were consistent with other studies that found structured, time-limited batterers treatment successful in reducing future violence (Appendix D).

Batterer programs gradually became more sophisticated by adopting cognitive-behavioral techniques from the counseling of other violent men. Some of these programs emphasizing gender issues have been accused of being too "confrontive," while others that emphasize skill-building are often criticized for being naively superficial and lacking a clear message of change. Numerous curricula have been developed incorporating both gender issues and cognitive-behavioral techniques (Gondolf, 2003, p. 606).

The most prominent type of clinical intervention with batterers is a feminist psycho-educational approach. This intervention, originated by the Duluth Domestic Abuse Intervention Project program in Minnesota, is frequently referred to as the

Duluth model. According to this model, the primary cause of domestic violence is patriarchal ideology and the implicit or explicit societal sanctioning of men's use of power and control over women. This program is anti-psychological. It eschews diagnoses of the type outlined in the Diagnostic and Statistical Manual of Mental Disorders and does not consider the intervention to be therapy. Rather, group facilitators lead consciousness-raising exercises to challenge the man's "right" to control or dominate his partner. Didactic and confrontational approaches are used to attack the man's defenses, excuses, and devaluation of his partner. A fundamental tool of the Duluth model is the power and control wheel, which illustrates that violence is part of a pattern of behavior, including intimidation, male privilege, isolation, and emotional and economic abuse, rather than isolated incidents of abuse or cyclical explosions of pent-up anger, frustration, or painful feeling The treatment goals of the Duluth model are to help men refrain from using the behaviors on the power and control wheel that result in authoritarian and destructive relationships and to adopt the behaviors on what was called the equality wheel, which form the basis for egalitarian relationships. It seems the feminist approach to batterers' intervention may be more theoretically compatible with a criminal justice perspective than a psycho-therapeutic or couples therapy approach (Babcock et al., 2006, p.218).

While a gender-based cognitive-behavioral orientation is the most prominent approach, other more psychodynamic or emotive approaches have been forwarded as well. These approaches attempt to address the psychological issues and emotional hurts of men that may contribute to their abuse. According to the research a variety of other therapies have also emerged: anger management (a stream lined adaptation of

cognitive-behavioral treatment), dialectical counseling, neuron-psychological treatment, wrap-around services, and couples counseling (Gondolf, 2004).

Whether treatment for the individual is in couple's therapy, or as deemed appropriate for the group counseling process, the goals and treatment strategies remain the same. That is, holding batterers accountable for their actions, providing them with resources, and teaching them alternatives to violent behaviors. Historically, the only acceptable approach to behavior change has been the group process.

> Unfortunately, the DV movement was quickly co-opted by feminists in the mid-70s & 80s. The focus was changed from a gender-inclusive, family treatment model to a gender-specific focus based solely on feminist theories about male violence against women. The response to this family violence also shifted to punishing and re-educating the (male) perpetrators, and protecting and advocating for the (female) victim to leave the relationship (Thomas, 2006, p. 4).

In an email to the author on September 13, 2006, John Hamel, LCSW, co author of *Family Interventions in Domestic Violence: A Handbook of Gender-Inclusive Theory and Treatment* said:

> In the past couple of years, there has emerged a convincing body of research indicating that BIPs, overall, are no more effective at reducing IPV (Intimate Partner Violence) than for a defendant to simply be supervised by probation." The good news is that BIPs are only marginally effective overall; which means that some programs are more effective than others. Let's keep in mind that most BIPs follow the Duluth model, which

has not shown to be very effective, and which is based on faulty premises to begin with. Outcome studies also lump short term and long term programs together, and don't take into account a facilitator's experience or knowledge base.

Alternative Theories

The high recidivism rates result from techniques that are based on theories of anger management and a form of cognitive behavioral therapy. Anger management treatment is often facilitated in the group format utilizing a psycho-educational approach. Anger management is mainly a tailored-down version of cognitive-behavioral therapy. Some of the components of anger management include: Time outs, thought stopping, assertive communication training, and stress management. According to Santa Clara County Standards (Santa Clara Probation Department, 2000), programs based on anger management models "fail to explain or confront the batterer's selective targeting of abuse and may serve to increase the batter's skills in non-physical control over others" (p. 11).

There are a number of theories as to what causes violence. According to the Santa Clara County Standards for Batterers Programs and Certification (Santa Clara Probation Department, 2000) "Abuse is not caused by provocation or anger. Rather, it is the means batterers use to gain, maintain or demonstrate control over their partner and children and to get what they want" (p. 3). Under this theory batterers do not "lose control" but carefully select the targets of their abuse. The decision to control and the choice to violently enforce control is independent of the behavior of the victim. Santa Clara County subscribes to the philosophy that violence stems from a

patriarchal socialization process, and that violence in a relationship is all about power and control, and that domestic violence is a byproduct of male and female roles that result in an imbalance of power. This stems from the early feminist theories about male violence against women.

According to the American Psychological Association there are several factors that contribute to violent behavior. They include:

- Peer pressure;
- Need for attention or respect;
- Feelings of low self-worth;
- Early childhood abuse or neglect;
- Witnessing violence at home, in the community, or in the media;
- Easy access to weapons. (American Psychological Association, 2004)

The American Psychological Associations also cites several reasons for violence that include:

- Expression: Some people use violence to release feelings of anger or frustration. They think there are no answers to their problems and turn to violence to express their out of control emotions.
- Manipulation: Violence is used as a way to control others or get something the abusers want.
- Retaliation**:** Violence is used to retaliate against those who have hurt them or someone they care about.
- "Violence is a learned behavior**:** Like all learned behaviors, it can be changed. This is not easy, though. Since there is no single cause of violence,

there is no one simple solution. The best you can do is to learn to recognize the warning signs of violence and to get help when you see them in your friends or yourself" (American Psychological Association, 2004).

And from the Intimate Partner Violence Prevention (IPV) facts sheets, (Centers for Disease Control and Prevention, 2006, pp.6–8) causative risk factors for perpetration are broken down into factor categories:

Individual Factors

- Low self-esteem;
- Low income;
- Low academic achievement;
- Involvement in aggressive or delinquent behavior as a youth;
- Heavy alcohol and drug use;
- Personality disorders;
- Prior history of being physically abusive;
- Having few friends and being isolated from other people;
- Unemployment;
- Economic stress;
- Emotional stress;
- Belief in strict gender roles (e.g., male dominance and aggression in relationships);
- Desire for power and control in relationships;
- Being a victim of physical or psychological abuse (consistently one of the strongest predictors of perpetration);

- Marital conflict—fights, tension, and other struggles;
- Marital instability—divorces and separations;
- Dominance and control of the relationship by the male;
- Unhealthy family relationships and interactions.

Community Factors

- Poverty and associated factors (e.g., overcrowding);
- Low social capital – lack of institutions, relationships, and norms that shape the quality and quantity of a community's social interactions;
- Weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence);

Societal Factors

- Traditional gender norms (e.g., women should stay at home and not enter workforce, should be submissive) (Centers for Disease Control and Prevention, 2006, pp. 6–7).

To date, there have been no clear answers at to what causes violence. Since this study was based on the theory that violence stems from one's belief system it is important to note that there are a number of theories as to how belief systems are created and maintained.

Societal Influences

Many subscribe to the "learned behavior" theory (Sonkin & Durphy, 1982, p.1) or how we were indoctrinated into society (i.e., parents, the media, music, the church, school, teachers, military, friends). Also, how we "learn" from the "modelers" in our life (parents, friends, heroes, etc). Sonkin states that 65–85% of

batterers came from a home where they watched dad abuse mom, or were abused themselves, or both. Ultimately, regardless of how we were indoctrinated, or who we modeled our behavior after, we learned to be violent (learned beliefs) (Sonkin & Durphy, 1982, p.1).

Personality Factors

How do developmental factors and mental health issues come into play in the creation of beliefs? Causative factors of violence and abuse may include: rigid, misogynistic views of women (see societal influences), or the Antisocial Personality Disorder, the Intermittent Explosive Disorder, and/or a host of other Clinical Personality Disorders as listed in the DSM-IV™.

Ultimately, beliefs developed and created under this umbrella are often; skewed, faulty, and either fluid or rigid. Furthermore, they are unpredictable at best. A variety of theories about this issue have appeared in the literature.

Attachment Theory

Many practitioners adhere to "Attachment Theory." Attachment theory is a biologically rooted bond that "drives" behavior based on internalized models of attachment. "Attachment is an intense and enduring bond biologically rooted in the function of protection from danger" (Thomas, 2006, p. 6).

Positive Beliefs

This theory is that all behaviors really are a result of ones' belief system and rigid, negative beliefs and cognitions (based on early indoctrinations) can be replaced with positive ones. This remains in line with the current cognitive-behavioral approach. This approach has its beginnings in the early 1950s when Norman Vincent

Peale wrote his book *The Power of Positive Thinking* (1952). Mr. Peale proposed that by following his very structured techniques, one could modify and change the circumstances in one's life. That is, that one could assume control over one's situations rather than being directed by them. "Think positively, for example, and you set in motion positive forces which bring positive results to pass. Positive thoughts create around your self an atmosphere propitious to the development of positive outcomes. On the contrary, think negative thoughts and you create around yourself an atmosphere propitious to the development of negative results. Your relations with other people will improve" (p. 176). Peale's great law, briefly and simply stated, is that "if you think in negative terms you will get negative results. If you think in positive terms you will achieve positive results." (p. 176) That is the basis of his law of prosperity and success. He explains this in three words: "Believe and succeed" (p. 176).

In his book *The Hidden Messages in Water* (2004), Masaru Emoto states "I have talked with many people about their health problems, and I have come to see that ailments are largely a result of negative emotions. If you can erase the cause of such emotions, you have an innate capacity to recover from illness. The importance of being positive cannot be underestimated" (pp 76–77).

In his book *The Biology of Belief* (2005) Dr. Bruce Lipton proposes that, contrary to modern day thought, we are not driven by our DNA; we are driven by our thought process. "Thoughts, the mind's energy, directly influence how the physical brain controls the body's physiology" (p. 125). "It is not our genes but our beliefs that

control our lives…Oh ye of little belief! Beliefs control biology!" (p. 144). Lipton says:

> What those positive-thinking dropouts haven't understood is that the seemingly "separate" subdivisions of the mind, the conscious and the subconscious are interdependent. The conscious mind is the creative one, the one that can conjure up "positive thoughts." In contrast, the subconscious mind is a repository of stimulus-response tapes derived from instincts and learned experiences. The subconscious mind is strictly habitual; it will play the same behavioral responses to life's signals over and over again, much to our chagrin. How many times have you found yourself going ballistic over something trivial like an open toothpaste tube? You have been trained since childhood to carefully replace the cap. When you find the tube with its cap left off, your **buttons are pushed** [emphasis added] and you automatically fly into a rage. You've just experienced the simple stimulus-response of a behavior program stored in the subconscious mind (pp 127–128).

Many others believe that one's thought process or consciousness/belief system creates behaviors. For example: Deepak Chopra writes in his book *Quantum Healing* (1989) that "Change is a defining characteristic of the universe, which, needless to say, includes people, ideas, and books. What has not changed—indeed and, I am more firm in this than ever before—is my belief that consciousness creates reality… that expectation decisively influences outcome…and that awareness, attention, and

intention should be as much a part of health care as drugs, radiation, and surgery" (p. v.).

Stan Hall in the book *The Marriage of Sex & Spirit* (2006) adds:

> The subconscious controls everything that does not require conscious attention, from biological functions to emotional reactions and perception of memories. The quality of all experience is a direct function of how we perceive our environment. Change your perceptions and your experience will change. Making change at the subconscious level is essential, and requires special intervention (p. 204).

Ray Dodd the author of *The Power of Belief* (2006b) states:

> Belief is power. The power to create. You create your own reality simply by what you agree to believe. Your deepest beliefs about everything hold your attention and propel you into action, or keep you from taking action. What you believe impacts your performance at work, your attitudes about money, how you navigate through the world and how you conduct all relationships (p. ix).

And in another book, *Beliefs Works*, (2006a) Dodd adds "What you believe dominates your attention, controls your behavior, and significantly impacts your biology" (p. 150).

And finally, Rob Williams in his book *Psych-K – the Missing Peace in Your Life* (2004) sums it up as follows:

> It's disturbing enough that negative beliefs may be a reflection of reality, but what's more disturbing is that they actually help to create that reality. Beliefs establish the limits of what we can achieve. As Henry Ford once said, if you believe you can, or if you believe you can't…you're right! It is especially true when the beliefs are subconscious. Most of us agree, and behavioral scientists confirm, that our behaviors are a direct reflection of our beliefs, perceptions, and values, generated from past experiences" (p. 47).

The great Mahatma Gandhi shared with us the following:

> Your beliefs become your thoughts;
>
> Your thoughts become your words;
>
> Your words become your actions;
>
> Your actions become your habits;
>
> Your habits become your values;
>
> Your values become your destiny (Lipton, 2005, p. 144).

Modalities for Changing Beliefs

Several modalities for changing beliefs have been discussed in the literature. We will start with hypnosis. This author's training in hypnosis began in college. We were given the acronym (SOCJAIST), which was used to define hypnosis: It stood for the Suspension of Critical Judgment and the Imposition of Selected Thinking. Hypnosis as a tool allows us to address the subconscious areas of the mind where all memories (the storehouse) exist. From birth to about the age of six we live in a very hypnotic state weaving in and out of alpha and theta brain-wave states. These are the

very states that hypnotherapists create in order to access those early induced, entrenched beliefs. Positive belief inductions can also be used in this process. Once positive beliefs are induced, changes in behavior would be expected.

Rob Williams developed a process of changing ones belief system that he reported in his book *Psych-K The Missing Peace in Your Life* (2004). His PSYCH-K™ process is simple, direct, and verifiable. It utilizes a mind/body interface of muscle testing (kinesiology) to access the self-limiting "files" of the subconscious mind. Like the protocols in our study, it also makes use of left brain/right brain integration techniques to effect swift and long-lasting changes. The negative software (beliefs) can be re-written.

Another approach, Thought Field Therapy (TFT), is an energy-based approach developed by Roger Callahan. "The treatment protocol, simply stated, is as follows: the client thinks about a problem, subjectively measures the degree of emotional disturbance associated with the thought via SUDs (Subjective Units of Disturbance) levels, finger taps various acupressure points on his/her body according to prescribed recipe patterns ('algorithms') based on the particular emotions elicited by the thoughts, and intermittently reassesses the SUDs level to determine more specific protocol required—until there is no more negative affect connected to the thought" (Vernon, 1998, p.2). After any negative affect is removed, the previous negative behaviors should be removed as well.

EMDR was one of the modalities used in this study. Francine Shapiro states in her book *Eye Movement Desensitization and Reprocessing* (2001) that "While the term **cognition** [emphasis added] has often been used to define all of the conscious

representations of experience (behavior), in EMDR we use it to signify a belief or assessment. Therefore, the cognition represents the client's current interpretation of the self, not merely a description" (p. 58). She uses the EMDR protocol during the installation of positive cognitions (beliefs). She continues, "The fifth phase of treatment is called the installation phase because the focus is on accentuating and increasing the strength of the positive cognition that the client has identified as the replacement for the original negative cognition" (p. 73).

Chapter 3

Research Methods

Research Design

Santa Clara County Program

The goal of this study was to test a hypothesis. This author began working with perpetrators of domestic violence as an intern in 1989. At that time in Santa Clara County, treatment for convicted batterers consisted of 12 weeks of group counseling. The focus of the counseling was anger management. Most of the content themes used in the program had been borrowed from Gondolf's 1985 book *Men Who Batterer*, and Sonkin and Durphy's 1982 workbook *Learning to Live Without Violence*. All of the collaborative team players had agreed on the program content themes to be used, but length of program soon became an issue. Typical content themes to be addressed during the 12 week group process often included time outs, assertive communication, stress management, self esteem exercises, and so on. This was the standard treatment for a number of years.

The Domestic Abuse Project had been experimenting with both program length and philosophy. Both Santa Clara County and neighboring San Mateo County were listening to the outcries of victim advocates, and with the support of battered women shelters, people in charge of the programs began to listen. California began to listen to the Minnesota project, and in particular the Duluth approach. All agreed that programs needed to be longer.

Santa Clara County and its neighboring county San Mateo began discussing the process of standardizing batterers counseling programs. In 1991 San Mateo County submitted its first proposal for program standardization. This proposal was in line with recommendations from San Jose's Domestic Violence Task Force. San Jose's task force went on to become one of California's first domestic violence councils. This author was one of the founding commissioners appointed in 1992.

At the same time, San Diego County was searching for better treatment and responses. City Attorney Casey Gwinn spearheaded their county's Domestic Violence Council. Mr. Gwinn wrote in a November 1992 letter to Judge Len Edwards:

> I am in receipt of your letter dated October 28, 1992. As you are aware, we have chosen a one-year, 30 session treatment program for batterers here in San Diego. Our treatment program standards are based on the Colorado standards created by therapist Michael Linsay. The Colorado standards build on the Duluth model for treatment.
>
> We have experimented with 10, 12, and 16 week treatment programs in San Diego in the past and have found such a length is not effective. The Department of the Navy has previously used a 10 week

program that has now been eliminated in San Diego and many other parts of the country as we learn more about the need for long-term treatment.

Enclosed is a copy of a recent article in Response magazine which discusses varying types of treatment as well as our local handout for court ordered abusers. I am only aware of two studies and both were conducted informally by prosecutor's offices. In Jacksonville, Florida, the State's Attorney has been working with Hubbard House to monitor (over a two year period) those who complete the 24 session, six month long treatment program. They are finding a 5 % re-arrest, re-prosecution rate for those who complete the six month program.

San Diego conducted a similar review from 1987 to 1989, for the Auditor General's office and found similar results. We found a 5 % re-arrest, re-prosecution rate for those completing the program. For those who failed to complete the program, we found a 75% re-arrest, re-prosecution rate during the 24 months after they dropped out or failed to enroll. Obviously, our study was not a rigorous research project and we did not interview victims to check for violence that had not been reported to a law enforcement agency.

Our decision to reject shorter programs was based on philosophical arguments for long-term treatment and anecdotal evidence of high recidivism rates with 10, 12, and 16 weeks program.

Santa Clara County immediately began raising the bar. The years 1992 and 1993 saw an increase in program length to 32 consecutive weeks, followed by four monthly follow-up sessions for a total of 1 year of treatment. The year of 1994 to 1995 was the final tweaking of program length to the 52 weeks of group counseling that we still use today. AB 226 and penal code section 1203.097 gave us the certification process for BIPs as well as the mandated content themes and arrest/probation protocols.

Development of the Study

These protocols and the certification process for BIPs led this author to begin questioning the effectiveness of BIPs, considering that the literature and treatment studies for the last 25 years were contradictory and confusing. BIP providers in Santa Clara County began to wonder whether or not our work with batterers was effective. This author began pondering the question, have we only been treating the symptoms? Maybe the true cause of violence is one's belief system.

This author began a training in 2002 that was geared toward providing immediate and permanent relief from the symptoms of Post Traumatic Stress Disorder (PTSD). The name of this approach is EMDR (Eye Movement Desensitization and Reprocessing). One of the treatment steps in the process consists of changing the negative, often looping, cognitions (beliefs) into positive cognitions. It was at that training that I met my colleague and collaborator A.J. Popky. Dr. Popky is one of the founding members of EMDR and is the developer of the DeTUR protocol used in this study. The DeTUR protocol addresses a variety of symptomatic

issues that include: addictions, phobias, anxiety, and anger. Dr. Popky's role quickly grew from facilitator to mentor to friend, and ultimately co-collaborator in this study.

Together we reviewed the existing outcome studies and pondered, could the combination of protocols (EMDR/DeTUR) address the reactive triggers so often seen in domestic violence, and permanently restructure negative beliefs (i.e. misogynistic, controlling beliefs and entitlements) that seem to contribute to abusive behaviors? Could we then replace the reactive triggers with positive cognitions? The study to test our hypothesis was born. This study was conceptualized initially as a way to fill in the gaps not typically addressed in the group setting (i.e. reprocessing of trauma and grief and loss work).

We were very clear that the review of the literature and the review of domestic violence studies for the last 25 years provided mixed messages and did not seem to provide any real means of measuring change. The psycho-educational group process was educating, and it was helping group members identify many of their existing beliefs, but seemed to fall short of addressing the cause. That is, the process did not address the causative factors (beliefs) that came into play. We began brainstorming about what we already knew, what we consistently saw regarding men who batter. Reflecting on seventeen years of intake interviews and our experience reading thousands of police reports, we compiled the most reoccurring themes. These were the characteristics most consistently seen in the men who batter their partners.

First of all, anywhere from 60 to 80% of perpetrators of domestic violence came from a home where they witnessed violence as children or were on the receiving end of violence, or both. This traumatic time period is often when early

faulty beliefs become entrenched. This is when most group members began internalizing negative and controlling beliefs, coupled with the sense of entitlement. We theorized that we needed to address the early childhood traumas. EMDR seemed a custom fit for this process.

Secondly, most of the group members were mandated to attend the group counseling following a domestic violence incident. Typically, that incident was fraught with trauma as well. For most, the trauma of the incident is overwhelming (i.e., victims, family, neighbors, the police, the arrest, the jail), and for too many, the incident transports them back in time to their families or origin where many of them were first exposed to violence. This experience, in addition to present day traumas, can unlock memories long thought buried away. Again, we felt that EMDR appeared to be the perfect and most effective tool to assist in reprocessing these traumas.

Lastly, we brainstormed about a common phenomenon known as **button pushing.** A high percentage of clients over the years have referred to this concept. These are the reactive triggers that we designed the treatment in the study to address. The DeTUR protocol was to be used for this. We felt that this protocol would most effectively address the reactive triggers and more specifically help in the desensitization of these reactive urges.

We had no limitations forced upon us because of any legal situation (i.e.; county standards, probation), nor because of the certification overview. The certification committee and the probation department's main concern for BIPs is that the men receive 52 weeks of group counseling. What we provided the subjects was

"in addition to" the group work. No permission was required, and we provided the treatment pro bono.

How the Study Was Conducted

This study employed the use of both EMDR and DeTUR protocols to break the intergenerational cycle of domestic violence.

All of the men who initially volunteered to be a part of this study were enrolled in the 52-week program, attending weekly group sessions that were two hours in length. A flyer was posted on the agency's office wall calling for volunteers to participate in a study. The flyer offered five free sessions of psychotherapy, 90 minutes in length.

For those who had access to computers and to the Internet we sent them to the EMDR.com website, so they could get a little information as to what EMDR was all about. For those who did not have access to the Internet, we had literature from the website that we give to potential clients prior to beginning any work using EMDR. Then we began the interview process, which included a question-and-answer period. Individual sessions were then scheduled. Before any treatment was administered, the Conflicts Tactics Scale pre-tests were administered. We met with each of the participants individually for 90 minutes. For most of the sessions both my colleague and I were in the room at the same time. At other times, due to scheduling, it could only be one of us. The length of time to complete all the sessions was less than four months. The treatment included the employment of two (2) protocols primarily developed for addressing trauma and addictive behaviors: EMDR and DeTUR. All of the participants were contacted two years later for the post-test.

Tier #1

This tier focused on the beliefs created during childhood. Most of the subjects witnessed or experienced domestic violence as a child in their family of origin. It was then that many of their socialized negative beliefs (supporting sense of entitlements, power and control issues, male privileges, misogyny, etc.) were created. We combined beliefs identified during the intake interview with beliefs gleaned from group exercises and client control logs. We began with the use of our protocols.

During the reprocessing of early traumas we also reprocessed any concurrent traumas that may have surfaced (utilizing our two protocols). For example, fallout from domestic violence incidents often include the trauma of seeing a loved one hauled off to jail, experiencing medical attention, or witnessing a loved one being mistreated. Most of the subjects witnessed domestic violence as children. Many watched their dads, step-dads, or mom's boyfriends being arrested then taken away to jail. We found out about these incidents during the intake interviews, which included very thorough family and relationship histories.

Tier #2

This tier focused on the reprocessing of the current incident(s) and related traumas. That is, when and how the subjects entered into the criminal justice system to begin with. We started with intake information and then used the control log to gather present beliefs related to the current incidents. By way of direct questioning regarding their intent(s) we would uncover the belief(s) from which they were operating. Telling how one got into the "system" and relating ones' incident is typically loaded with emotional trauma. Current incidents can often recharge

incidents experienced as children. That is, recent incidents will often generate feelings and emotions from their families of origin (F.O.O) (or allow long buried memories to resurface). These memories often become very fresh and clear, and can become just as charged as the recent traumas. So, this second Tier reprocessing was crucial. Staying true to the EMDR steps of reprocessing trauma, the most recent traumas are always processed first.

We did this by looking for, asking about, and addressing issues of PTSD. Part of the relating of their current incident included asking questions such as: How many police came? Who called the police? Was there yelling? Worse? Were children present? Were neighbors watching or involved? The most helpful tool in this process was the use of the Control Log.

Tier#3

This tier addressed the issue of provocation and focused on the desensitization of reactive triggers**.** For example we have often heard, “Man, we really knew how to push each others buttons.” Items that would fall under this category would include: tones of voice; body language; name-calling; references of a negative nature, such as “You are just like your father;” dredging up the past, and so on. The concept of button pushing or having one’s buttons pushed is really about how we react. This is when we employed the Detur protocol developed by A.J. Popky. The Detur protocol includes methodology to reduce the levels of urge, as well as levels of reactivity. This was one of the most important pieces of treatment.

All of the subjects learned in their 52-week groups about a concept called the Dance of Anger. The Dance of Anger is an exercise done by the clients as homework.

The purpose of this exercise is to help them identify the physiological symptoms and behavioral cues when they are in an escalation of feeling episode. Once these are identified, the men become better prepared to exit potentially volatile situations by taking a time out. They are instructed to solicit feedback from their partners, loved ones, family members, friends, and so on, people that would give them some honest feedback. This begins by the clients' asking, "What is it that I look like on my way from being calm, collected to the point to where I'm ready to explode? What are the things you're able to see in me, that I can't see in myself?" Paperwork is then filled out identifying the various physiological and behavioral cues. Everybody's dance is different. This is the process of escalation. It is about learning to identify those cues, those reactive steps that the abusers go through, beginning at zero and ending with an explosion.

For behavior cues, the participants often get feedback about how their eyes seem to get wide, ears get red, breathing patterns start to change, and so on. They often learn that they pace, point, elevate their voices, or sometimes yell. A wide variety of different components comprise ones' Dance of Anger. Everybody has this dance, and it is unique to each person.

In terms of physiological cues, some people may get a very bad stomach as the adrenalin rises when they get angry and hydrochloric acid gets released into the stomach. They may feel a little nauseated. Some people have some difficulty swallowing or they will have a dry mouth. Some can actually feel their ears heating up, or some people notice that they will start tapping their toes or their fingers. The list is endless.

By employing the use of the Detur protocol we were able to desensitize those cues/steps that used to be reactive triggers. We theorized, "**No** reaction may equal **no** abuse."

Both the EMDR and DeTUR protocols address the process of changing negative cognitions (beliefs) into positive cognitions (beliefs) the same way. By utilizing the protocols as mentioned, we revisited the issues surrounding the early installations of negative belief systems established in their families or origin. We focused on desensitizing, removing, and substituting the negative cognitions (beliefs) that reinforce or contribute to the issues of power, control, and entitlements and ultimately, violence. We then replaced them with positive cognitions (beliefs) and started the wait for behavior shifts to begin.

To summarize, the methodology used in this study was a three-tier process. The first tier addressed beliefs that were created during childhood, typically in the families of origin. We identified, reprocessed trauma, and replaced the traumatic memories with positive beliefs.

The second tier was the reprocessing of the traumas related to current incidents that got clients into the criminal justice system to begin with. As history was gathered during the initial intake interview, many of the participants revisited some of their early childhood memories and revealed traumas that had not yet been addressed. Now was the opportunity to install healthy belief systems. Many of these men were operating from negative beliefs formulated either from the current incident itself or from early childhood.

The third and final tier was the use of the Detur protocol to desensitize the client's reactive triggers. The desensitization of reactive triggers and the replacement of negative cognitions with positive cognitions parallel the "induction" stage of hypnosis. This means that at this stage, subjects are very open to suggestion. It was the part of the process where again, early traumas were reprocessed and negative cognitions and beliefs were being replaced with positive ones. The Detur protocol was used to desensitize the triggers and the "cognitive interweave" process from EMDR was often used to replace negative cognitions.

Shapiro discusses the cognitive interweave in her book (1995). She states "The cognitive interweave is used to break through abreactive looping, or blocked processing, as well as to allow new information to be assimilated for use in appropriate future behaviors." (p.267) "The clinician should use the cognitive interweave to incorporate needed information." (p. 275). The needed information was the installation of positive cognitions, ultimately healthy beliefs, coupled with the reduction of reactive triggers.

To further validate the study we obtained clearance to the CJIC database through the District Attorney's office. This database contains all arrests in the State of California. Our last check of the database was November 2006. We did the check to look for any recidivism. All of the subjects had completed the treatment, pre- and post-tests, as well as their 52-week programs. Additionally, all of the subjects were no longer on formal probation.

Research Hypothesis

- Are beliefs the cause of violence?
- Can a treatment methodology that changes beliefs be effective in stopping Domestic Violence?

We predict that (5) individual sessions of treatment utilizing our protocols will result in a significant reduction if not complete elimination of both physical and psychological incidents of Domestic Violence as measured by the CTS2.

This study aimed to provide evidence for the necessity of establishing therapeutic policies and guidelines for "individual" treatment methods, which remain listed as "an inappropriate method of intervention" in Santa Clara County.

Subjects

A flyer was posted in the agency asking for volunteers (Appendix E). Twelve men initially volunteered to be part of the study. These subjects were men convicted of domestic violence and mandated to attend 52 weeks of group counseling as a part of their three-year formal probation grant. This grant was in lieu of doing actual jail or prison time.

The male batterers participating in the study ranged from 33 to 51 years of age. Sixty percent (60%) were White, twenty percent (20%) were Asian, ten percent (10%) were Black, and ten percent (10%) were Hispanic.

All of the participants were employed. All had high school diplomas, and half had some college. All had engaged in both physical and psychological attacks on their partners. None of them were child abusers.

The twelve men who volunteered for the study were already enrolled in the certified 52-week program. They inquired about the free sessions either from me or one of my facilitators. My study partner and I speculated as to why these men would volunteer. After much debate we surmised:

1. To appear more compliant, and serious both to us and to their probation officers about making changes. To look favorable.
2. Curiosity, maybe this was a chance to deal with old trauma, heal, learn new techniques, and so on.
3. The sessions were free.

Instrumentation

The Conflict Tactics Scale 2 was administered as the pre- and post-test measurement tool. The CTS2 is an instrument that assesses the extent to which partners in a dating or domestic relationship have engaged in psychological and physical attacks on their partners. It is also designed to assess whether reasoning or negotiation strategies have been employed with partners when dealing with interpersonal conflict. This instrument was not developed for formal clinical assessment, placement, or treatment and was only used as a research tool in the current study.

The CTS2 can be scored using a number of different methods. The CTS2 has five scales: Negotiation, Psychological Aggression, Physical Assault, Sexual Coercion, and Injury. Our focus was on the Psychological Aggression items scale, and the Physical Assault scale.

The CTS2 was developed by Murray A. Straus (1979). Mr. Straus is currently Professor of Physiology and Co-Director of the Family Research Laboratory at the University of New Hampshire. The usage of the CTS2 is by permission only. Permission to administer this instrument was requested of and approved by Mr. Straus himself.

The idea for using this particular instrument came from the EMDR community. We asked Nancy Smyth, PhD, of the University of Buffalo, School of Social Work about how best to measure the changes from our study. She is also the Chair of the EMDR International Association Research Committee. She pointed us toward the CTS2.

Pre-test accuracy was verified from two sources. The first source came from the police reports submitted by the batterers. The second source was the history of abuse in their relationships beginning with their families of origin and ending with their current partners. This information was obtained during the intake interview process.

Following the administering of the pre-tests we began the treatment process and employed our three-tiered dual-protocol treatment approach. All of the subjects' five treatment sessions were completed within four months.

Post-test accuracy was verified by way of the CJIC database. Permission to access the database was granted through the Domestic Violence Unit of the District Attorney's Office. All subjects completing the study were checked for recidivism through this database.

Data Collection Procedures

Our review of the literature and early evaluations revealed an earlier attempt to measure changes in behavior. Edleson (1989) did a four-year evaluation study and used a variation of the original Conflict Tactics Scale. For our study, we employed the most current version of the CTS2. Seventy-two items on the CTS2 were presented with pencil for self-scoring. CTS2 instructions require only incidents from within the previous 12 months to be reported.

This approach was also adopted because this author wanted a modality in which actual results could be measured. Furthermore, current treatments in BIP programs do not include the administering of the CTS2. In fact, there are no pre- and post-tests administered at all.

Subjects were assessed two ways. First of all, clients were required to have an extensive intake interview focusing on relationship and violence history prior to entering the 52-week program.

Secondly, they were required to complete (as a pretest) the CTS2.

Pre-Test

We administered the pre-tests in January of 2003, identifying their behaviors during the 12 months prior to beginning the study. Following the treatment, we waited two years before we administered the post-tests. The reason was that these men were still in the 52-week program when compliance with their conditions of probation is at its highest. Compliance with the law and lower recidivism rates are typical during this time period. We waited an additional year after that to check with

the District Attorney's office to have the CJIC database checked to see if there had been any violations, infractions of the law, new charges, etc. There were none.

By administering pre- and post-tests and the testing of our initial hypothesis we began paving the way for comparing this to other studies. This study may begin the process of standardizing the usage of both pre- and post-testing for comparative studies.

Post-Test

Post-tests were administered two years after the pre-test. The CTS2 outcome results scoring showed a decrease of 45% in the number of emotionally abusive incidents, and a decrease of 65% in the number of physically abusive incidents.

Data Analysis Procedures

As stated earlier in Chapter 1, statistical analysis could not be done. There was no control group to compare with, so we compared pre treatment and post treatment behavior as reflected on the CTS2's. The statistics were calculated in terms of occurrence. The CTS2 has five scales: Negotiation, Psychological Aggression, Physical Assault, Sexual Coercion, and Injury. For the purposes of this study, we employed the two (2) scales that are the focus of treatment here in Santa Clara County—Psychological Aggression, and Physical Assault.

From the 78 statements listed on the CTS2, we focused on Psychological Aggression—(Items 5, 25, 29, 35, 49, 65, 67, 69) and Physical Assault (Items 7, 9, 17, 21, 27, 33, 37, 43, 45, 53, 61, 73) and then compared the number of occurrences (frequency) as reported on the pre-test to the number of occurrences on the post-test two years later.

Chapter 4

Findings

Were the five (5) individual sessions employing our treatment protocols effective in reducing or eliminating both physical and psychological incidents of abuse as measured by the CTS2? Our outcome findings showed favorable results.

For example, compared to pre-tests results the CTS2 post-test results, two years after treatment, showed a decrease of 45% in the number of emotionally abusive incidents and a decrease of 65% in the number of physically abusive incidents. The percentage of deceased changed was calculated by comparing total recorded number of pre-test psychologically aggressive occurrences (22) with the total number of post-test occurrences (10). This revealed a reduction of 45%. The total number of incidents at pre-test versus the total number of post-test incidents was (22) versus (10).

Then we compared (using the same formula) the pre-test number of reported physical assault occurrences (3) with the total number of post-test occurrences (1).

This revealed a reduction of 65%. Again, the total number of pre-tests incidents was compared to the total number of post-test incidents (3) versus (1).

Review of the CJIC database revealed that after three and a half years none of the subjects had re-violated. Recidivism had ceased. No recidivism means that no one had been re-arrested, even though one of the subjects self-reported an incident of pushing and shoving. Law enforcement had not been called. For the purposes of this study (and keeping with local law enforcement statistics) recidivism is defined as being re-arrested. All five of the participants had been physically abusive prior to entering into the criminal justice system. Only three occurrences were recorded on the pre-test CTS2 because they fell within the 12 months prior to the test window as defined per the Straus Scoring Method Criteria. All other incidents had occurred outside the previous 12 months.

PRE TEST

PSYCHOLOGICAL AGGRESSION

SUBJECT #	*TALLY*	*FREQUENCY*
1	**II**	**2**
2	**I**	**1**
3	**IIIII**	**5**
4	**IIIII III**	**8**
5	**IIIII I**	**6**
		SUM = ***22***

POST TEST

PSYCHOLOGICAL AGGRESSION

SUBJECT #	*TALLY*	*FREQUENCY*
1	**III**	**3**
2	**IIII**	**4**
3		**0**
4		**0**
5	**III**	**3**
		SUM = ***10***

PRE TEST

PHYSICAL ASSAULT

SUBJECT #	*TALLY*	*FREQUENCY*
1		**0**
2		**0**
3		**0**
4	**II**	**2**
5	**I**	**1**

SUM = ***3***

POST TEST

PHYSICAL ASSAULT

SUBJECT #	*TALLY*	*FREQUENCY*
1		**0**
2		**0**
3		**0**
4		**0**
5	**I**	**1**

SUM = ***1***

Subject #1 – had an increase of psychological aggression incidents from two (2) as reported on his pre-tests to three (3) as reported on his post-test.

Subject #2 – had an increase of psychological aggression incidents from one (1)

as reported on his pre-tests to four (4) as reported on his post-test.

Subject #3 – had a decrease of psychological aggression incidents from five (5) as reported on his pre-tests to zero (0) as reported on his post-test.

Subject #4 – had a decrease of psychological aggression incidents from eight (8) as reported on his pre-tests to zero (0) as reported on his post-test. He also had a decrease in the number of physical assaults incidents from two (2) as reported on his pre-tests to zero (0) as reported on his post-test.

Subject #5 – had a decrease of psychological aggression incidents from six (6) as reported on his pre-tests to three (3) as reported on his post-test. The one physical assault incident was repeated on the post-test.

In summary, for the five (5) subjects from pre-tests to post-tests there was a 65% decrease in physical assault incidents, and a 45% decrease in psychological aggression incidents.

Chapter 5

Summary, Discussion, and Recommendations

Summary

Problem

Not only does domestic violence pose a major problem, causing injuries, ruining lives, clogging the court systems, but, in spite of well-meaning attempts to treat it, there remains a high recidivism rate. There has been an on going debate of what to do about men who batter their female partners, which has haunted the domestic violence field since its emergence in the late 1970s. The high recidivism rates seem to result from the lack of effectiveness of psycho-educational techniques that are based on theories of anger management and cognitive behavioral therapy.

Treatment for perpetrators of domestic violence has ranged from individual therapy to group counseling. Batterer intervention programs (BIPs), utilizing group counseling, have been the preferred mode of treatment since the late 1970s (Gondolf, 2003). Most BIPs have employed a psycho-educational approach to group counseling with a gender-based cognitive-behavioral orientation. Evaluations of programs have

yet to reveal whether the group process is the most effective means for changing batterers' behavior.

If all behaviors really are a result of ones' belief system, then it is paramount to employ the fastest, most effective way of replacing rigid, negative beliefs and cognitions (based on early indoctrinations) with positive ones. This still remains in line with the current cognitive-behavioral approach, however, instead of treating the symptoms, we believe in treating the cause. The focus of this study was not about how ones beliefs system is created or how beliefs are formed. Rather it is about treating the cause of behavior. We believe the cause of all behaviors originates from one's belief system. To date, there have been no clear answers as to what causes violence and no proven ways of breaking the intergenerational cycle of domestic violence. Additionally there was no known means of measuring change utilizing a pre- and post-test. This study may have set a base line to work from.

Method

We based our hypothesis on the idea that the real cause of domestic violence is ones' belief system. If negative beliefs can be permanently changed and replaced with positive ones, then maybe non-abusive behaviors will follow. Current approaches are based on the belief that we can appeal to reason to change these behavior patterns and that by exposing clients to mandated themes and ideal beliefs, behaviors will change. Practitioners using these approaches seem to hope that by repeatedly exposing clients to particular sets of positive beliefs (Appendix B) that clients might internalize those beliefs and begin employing new shifts (behaviorally

speaking) in their lives with positive outcomes. Both the research and program evaluations reflect that these results are not achieved.

This study employed the use of EMDR and DeTUR protocols to break the intergenerational cycle of domestic violence. The participants in this study were men convicted of domestic violence. They were court mandated to attend the standard BIP program with 52 weeks of group counsel. Twelve group members volunteered for this study. Five completed the process. The batterers participating in the study ranged from 33 to 51 years of age. Sixty percent (60%) were White, twenty percent (20%) were Asian, ten percent (10%) were Black, and ten percent (10%) were Hispanic. The variables examined in the study were: 1) type of abuse (i.e., physical or psychological/emotional) and 2) the frequency of the abuse over a twelve-month period. These variables we examined twice, before the study and two years later. We administered the Conflicts Tactics Scale (CTS2). In addition to their group counseling they volunteered to receive five individual sessions ninety minutes in length utilizing our protocols.

The treatment methodology was one of a three-tiered approach:

Tier number one (1) focused on beliefs created during childhood in families of origin. We identified unaddressed traumas experienced by subjects either as witnesses or victims of early violence. We then identified the associated negative cognitions and beliefs (i.e.: entitlement, misogyny, male privilege, power and control) and began the process of replacing them with positive ones.

Tier number two (2) was two pronged. First we reprocessed the traumas associated with the subjects arresting incident and entrance into the criminal justice

system. The we addressed any residual traumatic memories (childhood) that may have surfaced and addressed cognitions (beliefs) as in tier number one, that contributed to self defeating abusive behaviors.

The third (3) and final tier focused exclusively on the DeTUR protocol to assist clients in desensitizing their reactive triggers also, when necessary, early traumas were reprocessed and negative cognitions and beliefs were replaced with positive ones.

By employing the protocols utilized in this study we may have found a way to install healthy beliefs both quickly and permanently. This in turn would allow clients to operate from a different frame of reference; one of a positive and non-abusive outlook versus the original socialized negative beliefs that encouraged issues of entitlement and privilege. If beliefs cause violence, then it makes sense that positive cognitions should produce positive behaviors.

Discussion

Psycho-educational approaches (CBT and Anger management slants) have been and remain the most widely used approaches to ending the intergenerational cycle of domestic violence. These approaches treat only the symptoms, and have not proven effective in breaking the intergenerational cycle of domestic violence. Additionally, no means of measuring change utilizing a pre- and post-test have been used to evaluate these approaches. This study may have set a base line to work from in future research.

The most significant findings support our initial hypothesis:

1) That these protocols can be used to effectively break the intergenerational cycle of domestic violence as supported by CTS2 scoring and CJIC database checks.

2) That all behavior is a result of one's belief system. If there is a way to alter those beliefs, will behaviors change? They did. By replacing misogynistic or entitlement and controlling beliefs (negative cognitions) with ones based on positive beliefs of equality and cooperation, shifts in behavior occurred and incidents of abuse declined.

Our most significant findings support this notion: Change the beliefs and change the behavior. If we stop treating the symptoms then the epidemic can be stopped.

Additional findings:

- Conventional domestic violence treatments are not enough. They do, however, serve a purpose in helping clients develop social skills (i.e.: improving their communication, stress management, anger management).

Recommendations

Recommendations for future research should include: A classic research study utilizing control and experimental groups. That is, groups should have the CTS2 administered at both pre- and post-test. This would be a true comparative study, providing a statistical analysis from which to draw actual conclusions.

For example, group #1 would receive the standard 52 weeks of psycho-educational counseling. That would mean exposing clients to the state-mandated content themes that are currently in place.

Group #2 would receive both the 52 weeks of psycho-educational counseling, coupled with the 5 sessions employing our dedicated protocols.

Group #3 would receive only the 5 sessions without the 52 weeks of psycho-educational counseling.

The timeframe for CTS2 measurements is the 12 months prior to taking the pre-test (one year) according to Straus instructions respondents are asked to indicate the number of times in the past year they engaged in a particular behavior. I suggest that the post-test be administered two years later, because the client may still be involved with the criminal justice system. Compliance during this time may be the result of stayed jail terms.

What causes violence? Maybe it is one's belief system. If so, the sooner that controlling beliefs, fueled by the need to exhibit power and control and entitlement are replaced with positive non-abusive beliefs, producing non-abusive behaviors, the sooner that families can start putting their lives back together. And maybe then we can put this epidemic to rest.

Appendices

Appendix A

Beliefs=Behavior

The following are examples of negative beliefs that can lead to domestic violence:

Codependent Beliefs:

- I'm so strong. I can handle crisis without help.
- When I think someone is out of control, I have to control them.

Controlling Beliefs:

- No one can control me.
- I am the boss here. Things go my way.
- I can't let a woman control me.
- I'm the man of the house.
- I pay the bills here, therefore, I get what I want.
- I deserve respect. How dare they disrespect me?
- My partner should always listen and validate me.
- This person will listen to me.

Revenge Beliefs:

- People need to pay for their mistakes.
- They made me angry. I have a right to show them.

- When someone hurts me, I have the right to hurt them back.
- They deserve what they are getting.

Religious Beliefs:

- God will make everything all right.
- God will keep me non-abusive.
- The Bible says I can hit my wife.
- The Bible says I can spank my children.

Victim Beliefs:

- Things never go my way. (They will now.)
- I am the victim here.
- This person is supposed to take care of me.
- I can't take this anymore. I will show them they can't do this to me anymore.
- This person doesn't take me seriously. (Now they will.)

Self-Righteous Beliefs:

- This makes sense to me. It should make sense to them.
- I am right, and they are wrong.
- This person is so stupid. I have to take over here.
- This person is driving me crazy. I have to stop them.

Apathetic Beliefs:

- I don't care if I hurt them.
- I don't care anymore. (I don't need to watch what I do.)
- They don't care about me, why should I care about them?

- I don’t care what they think/want.

Exercises

1. Identify one of your negative beliefs that led to your incident.
2. How exactly did that negative belief lead to your incident?
3. Identify where you got that negative belief. (childhood exposure/experience).
4. What positive belief will you adopt to counteract the negative belief?
5. If you had this positive belief during the incident, what would you have done differently?

Beliefs

Webster’s unabridged Dictionary: belief: 1. Something believed; an opinion or conviction. 2. Confidence in the truth or existence of something not immediately susceptible to rigorous proof. 3. Confidence; faith; trust. 4. A religious tenet or tenets.

Some samples of beliefs that affect domestic violence:

Men are the head of the household.

Men are smarter than women.

Men are stronger than women. Might makes right.

Women are emotional and illogical.

A woman’s place is in the home.

Women make better parents than men.

A woman is the heart of the home. A man is the head of the home.

A man’s home is his castle.

A man deserves to rest when he comes home; after all, he’s worked hard all day.

Jealousy shows that I care.

Women are seductive.

Women don't know how to handle money.

A husband has the right to choose his wife's friends.

A man deserves a night out with his friends.

A good wife stays at home and takes care of the kids.

Men should make the big decisions. They know better.

Since I make the money, I have a right to say how it is spent.

Since I make the money, I have a right to keep a certain amount to play with.

All women know how to do is spend money.

It is my house and my stuff, since I earned the money to buy it.

Women are sexually naïve. They can easily be seduced by other men.

All men want is sex from a woman.

Men and women cannot be just friends.

Men cannot be trusted with women.

A husband should be able to control his wife.

What a wife does reflects on the husband.

What a husband does reflects on the wife.

If I don't like some of your friends, then you shouldn't see them.

I only want what is best for you.

Women are easily influenced by others.

A woman should respect her husband.

A wife should be supportive of her husband, no matter what.

If you really loved me, you would do what I want.

Words don't hurt as much as hitting.

If you do something wrong, you are stupid.

A woman's job is not as important as a man's job.

Men work harder than women.

If a woman stays at home, she isn't really working.

Anyone can do housework or take care of the kids.

Women should not be angry.

Bringing up the past doesn't help anything.

If there are problems in our relationship, one of us is to blame.

If you love me, you will have the same thought and opinions that I have.

The best way to make up after a fight is to have sex.

There are many misconceptions about domestic violence. Perhaps the most damaging is the belief that abuse is caused by anger and lack of impulse control. Most people think that someone gets into an argument, proceeds to get enraged, then "loses control" and gets violent.

We hear things like:

I ***lost it.***

I ***freaked out.***

I ***was so mad that I couldn't control myself.***

I ***wasn't even thinking. I just did it.***

I ***don't know why I did it. I'm not a violent person.***

I ***was defending myself. It was my natural response.***

These comments are excuses for violence. They say, “If I don’t know why I did it, then my violence doesn’t count in some way.” Or, “If I wasn’t in control of myself, then I don’t have to be fully accountable.” Instead of making excuses, we need to analyze why we get abusive. The human mind is the greatest computer ever made. Unless we are deemed psychotic, meaning that we have lost touch with reality, we know what we are doing every minute of our waking lives. We may pretend not to know, but we know.

Our beliefs are what drive our behavior. Negative beliefs that lead to violence and abuse are most often formed in childhood. For example, if I saw my father scream at my mother when he wanted something, I formed beliefs around that behavior. The abuse I witnessed may have caused me to believe that it is okay to yell at people in order to get what I want. I could have adopted the belief that women are supposed to do what a man says to avoid being yelled at. I most certainly would have come to believe that yelling is an option for problem solving.

As I grow into adulthood with the beliefs that were internalized from my childhood, I behave according to those beliefs. I find myself in relationships where I yell and allow myself to be yelled at. I find that I cannot resolve conflict in healthy ways. I see that I choose the same abusive relationships over and over.

It is our responsibility as adults to identify and analyze where we learned our negative beliefs. Finally, we need to create new, positive beliefs that will direct us toward positive behavior.

Appendix B

Examples of Cognitions

NEGATIVE COGNITIONS	POSITIVE COGNITIONS
I don't deserve love.	I deserve love; I can have love.
I am a bad person.	I am a good (loving) person.
I am terrible.	I am fine as I am.
I am worthless (inadequate).	I am worthy; I am worthwhile.
I am shameful.	I am honorable.
I am not lovable.	I am lovable.
I am not good enough.	I am deserving.
I deserve only bad things.	I deserve good things.
I cannot be trusted.	I can be trusted.
I cannot trust myself .	I can (learn to) trust myself.
I cannot succeed.	I can succeed.
I am not in control.	I am now in control.
I am powerless.	I now have choices.
I am weak.	I am strong.
I cannot protect myself.	I can (learn) to take care of myself.

I am stupid.	I have intelligence.
I am insignificant (unimportant).	I am significant (important).
I am a disappointment.	I am okay just the way I am.
I deserve to die.	I deserve to live.
I deserve to be miserable.	I deserve to be happy.
I cannot get what I want.	I can get what I want.
I am a failure (will fail).	I can succeed.
I have to be perfect (please everyone).	I can be myself (make mistakes).
I am permanently damaged.	I am (can be) healthy.
I am ugly (my body is hateful).	I am fine (attractive/lovable).
I should have done something (I am a bad person).	I did the best I could.
I did something wrong (I am a bad person).	I learned (can learn) from it.
I am in danger.	It’s over; I am safe now.
I cannot stand it.	I can handle it.
I cannot trust anyone.	I can choose whom to trust.
I cannot let it out.	I can choose to let it out.
I do not deserve.	I can have (deserve).

Appendix C

Control Log

NAME : _____ DATE:_____

1. **ACTIONS:** Briefly describe the situation, and the actions you used to control your Partner (statements, gestures, tone of voice, physical contact, facial expressions).

_____

_____

2. **INTENTIONS:** What did you want to accomplish?

_____

_____

3. **BELIEFS:** What beliefs do you have that support your actions and intentions?

_____

_____

4. **FEELINGS:** What feelings were you having at the time?

_____

_____

5. **MINIMIZATION, DENAIL AND BLAME:** In what ways did you minimize or deny your actions? Blame her?

_____

_____

6. **EFFECTS:** What happened as a result of your actions?

To you?_____

To your partner?_____

To others? _____

7. **PAST VIOLENCE:** How did past acts of violence effect this situation?

_____

8. **NON-CONTROLLING BEHAVIORS:** What could you have done differently?

_____

***Adopted from Duluth Domestic Violence Treatment Model**

Appendix D

The Domestic Abuse Project

The Domestic Abuse Project
A-6
Minneapolis, Minnesota
Number Two, June 1989
Research Update
Scanned Newsletter from DAP (1989)

Many people have requested information on the Domestic Abuse Project's (DAP) Evaluation and Research Program. Inserted in this Update is a list of publications available from DAP and information on how to obtain copies of them.

In addition to research and clinical papers already published, DAP is continuing to develop a variety of new research projects. We expect that as research is completed or new projects are undertaken new issues of the Update will be published.

The Domestic Abuse Project is now ten years old. Its programs, staff and facilities have grown dramatically. From the start, DAP has seen itself as an experimental organization. In the past six years the Evaluation and Research Unit has expanded to include research on community interventions, men's treatment groups and, most recently, support and education groups for children of battered women. This research is conducted in close collaboration with faculty and students of the University of Minnesota School of Social Work.

This issue of Update is devoted almost entirely to reporting on the results of our recent research into the effectiveness of various group treatments for men who batter. On the last page of this issue you will find brief updates on our criminal justice and children's research projects, the Evaluation and Research Unit's staff and a note about the foundations that support our research efforts.

We mail copies of the Update to practitioners, activists, researchers and policy makers around the world. Let us know if you would like to be on our permanent mailing list.

Studies favor structured, time-limited men's groups
The Domestic Abuse Project has just released the results of the nation's first comparative study of group treatment for men who batter. The study, reported here,

found 12 session educational groups to be more effective than other formats in helping men end their post-group use of both violence and terroristic threats. These findings are consistent with other studies that have found structured, time-limited batterers' treatment successful in reducing future violence.

Group treatment for men who batter has been available in North America since the late 1970s. As the number of such programs have grown so have the variety of treatment methods advocated.

Most group treatment for batterers varies along two major dimensions: group structure and number of group sessions offered. Debates about the effectiveness of one group over another often focus on the degree of structure provided by group leaders. Groups vary from highly structured, educational programs to minimally structured, self-help groups. Most batterers' groups offered in North America fall somewhere in between these two ends of the continuum.
The number of sessions a treatment group should meet is also the source of debate. Some advocate "long-term" treatment of several years but most offer some form of "time-limited" groups ranging from 6 to over 30 sessions.

Recent calls for batterers treatment programs to be more accountable to battered women and to more carefully evaluate their effectiveness require new research efforts. Published evaluations provide optimism for the success of treatment but shed little light on the debates over the relative effectiveness of various group structures and amounts of service.

To address these concerns, the Domestic Abuse Project, with support of the Bush Foundation and in close cooperation with the University of Minnesota School of Social Work, set out to study the relative effectiveness of three different treatment models offered in two intensities.

Several hundred men were randomly assigned to receive one of six possible treatment combinations. Attempts were made to interview all men and their partners six months after the last group session. The data "•presented in this Update are based on these interviews. We have also collected data using several pre- and post-group measures, from focus group interviews with program completers and from 18 month follow-up interviews with men and their partners. These other data will be the subject of future Updates.

Since there is only limited space in this Update, we have reported only those data that appear most important. For the interested reader, we have composed a 39-page manuscript describing this study in much greater detail. It is titled The Relative Effectiveness of Group Treatments for Men who Batter (by J.L. Edleson and M. Syers) and may be ordered from the Domestic Abuse Project using the reprint order form inserted in this Update.

Appendix E

Flyer

Volunteers Wanted

To participate in a research study looking at ways to break the Cycle of Violence patterns / and related triggers by way of brief therapy.

Sessions will be given at Bata/Starr Counseling Associates.

Research results will be available upon completion of study.

For more information / and if interested contact Rick Bata, LMFT

at (408) 450-8370.

Bata / Starr Counseling Associates is a for profit counseling agency that is County Certified to provide services to perpetrators of Domestic Violence. Bata / Starr Counseling Associates also provides services for Domestic Violence victims and their families. Services are also provided for the Punjabi and Spanish speaking communities, as well as conventional individual, couples, and family therapy.

Appendix F

Penal Code Section 1203.097 Requirements

Sampling plan

A11 batterer intervention systems in the state of California are nested within a common statutory framework that mandates a number of shared characteristics across systems. Penal Code §1203.097, for example, mandates minimum probation terms for DV cases of 36 months, "a criminal court protective order protecting the victim from further acts of violence," monetary penalties, and the "successful completion of a batterer's program." Penal Code §1203.097 also specifies how BIPs should operate. The statute requires that these programs be 52-weeks long, that they hold weekly two-hour sessions and that the components of the programs include strategies to hold defendants accountable, requirements for defendants to participate in on-going same-gender group sessions, intake procedures, specific educational programming and prohibitions on couple or family counseling.

Within the statewide framework, however, batterer intervention systems can vary considerably. A wide range of discretion as well as resource constraints and operational practices exist across county boundaries making it possible to utilize a stratified sampling design. The 58 superior courts jurisdictions (corresponding to the 58 counties in California) constitute the first stratum; BIPs in each county make up the second stratum. The characteristics of case processing in different courts and the BIPs will be used to construct the variables necessary to measure unique *system interventions.* Within each of

the BIPs, individuals convicted of DV charges and mandated to complete a 52-week BIP constitute the principal unit of analysis for evaluating *outcomes.*

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Biographical Sketch

Richard A. Bata, Licensed Marriage, Family and Child Therapist, has over 18 years of experience in the prevention, intervention, and treatment of domestic violence offenders/victims. He is Program Director for Bata/Starr Counseling Associates, one of Santa Clara County's certified 52-week Domestic Violence Intervention Programs. He was a Commissioner on the Santa Clara County Domestic Violence Council for 12 years and is currently a member of the Domestic Violence Council's Batterers Intervention Committee. Mr. Bata is also a member of the California Association of Marriage and Family Therapists and maintains a private practice as a Licensed Marriage and Family Therapist. He is also a regular Guest Speaker/Trainer at Evergreen Colleges' Criminal Justice Training Center (Santa Clara County's Officer Training Program).