Stopping Wife Abuse via Physical Aggression Couples Treatment

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Abstract

The purpose of this chapter is to provide an overview of an empirically tested program for physical aggression: Physical Aggression Couples Treatment (PACT). Although we do not advocate standard "marital therapy" when there is ongoing husband→wife aggression, we present the rationale for, description of, and empirical support for a conjoint treatment approach to wife abuse abatement.

Key Phrases

Physical Aggression Couples Treatment (PACT)

Conjoint treatment

Communication

Couples

Outcome research

Safety

Gender-specific treatment

Feminist/social learning treatment

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Several years ago, the first author co-wrote a clinical paper entitled "Is There a Place for Conjoint Treatment of Couple Violence?" (Vivian & Heyman, 1996). The title reflected an ongoing controversy within the batterers treatment community. Some believe that battering should only be treated via single sex groups; indeed, such advocates have succeeded in some U.S. states in proscribing conjoint treatment if there is any evidence of battering.

Although we certainly do not advocate conjoint treatment for all aggressive men, neither do we believe that it is wise to prohibit it. There is no single "batterer" profile (Holtzworth-Munroe & Stuart, 1994) and there is no single approach that will be the treatment of choice for all men under all circumstances. To advocate otherwise is a political, not a therapeutic stance.

The purpose of this chapter is to provide an overview of an empirically tested program for physical aggression: Physical Aggression Couples Treatment (PACT). The name of the program was chosen purposefully to indicate that although the format is conjoint, our program is not standard marital therapy. *We do not advocate "marital therapy" when there is ongoing husband→wife aggression*. Our program is designed with the sole purpose of eliminating physical and psychological aggression in the home. Thus, the conjoint treatment approach is merely a vehicle to accomplish the same goal as other abuse abatement programs.

Why use a conjoint approach? This chapter will describe the rationale for PACT and review research evaluating that rationale. We will then provide a brief overview of how we assess and treat couples in which there is ongoing husband→wife aggression. Finally, we provide research supporting the efficacy of PACT in treating aggressive men. Readers interested in a more detailed description of the program can refer to Heyman and Neidig (1997; see also Neidig & Friedman, 1984).

Therapeutic Rationale

PACT is an expanded version of Neidig's Domestic Conflict Containment Program (DCCP; Neidig & Friedman, 1984). The initial version of PACT was used in a treatment study (O'Leary, Heyman, & Neidig, 1999) comparing PACT to gender specific groups (i.e., men's and women's groups). Although PACT, like most treatments for battering, was administered in a group format, we are increasingly modifying and enriching it for use with individual couples (e.g., Vivian & Heyman, 1996).

Neidig developed DCCP after studying wife abusive members of the U.S. military and concluding that wife abuse was "linked to specific, measurable skill deficits in the areas of anger control, stress management, and communication. The violence typically occurred in the context of a dysfunctional relationship during periods of high stress" (Neidig & Friedman, 1984, p. 1). DCCP grew out of behavioral approaches to anger (e.g., Ellis, 1977; Novaco, 1975) and marital therapy (e.g., Jacobson & Margolin, 1979; Stuart, 1980). Like many behavioral marital therapists, Neidig's marital conceptualizations were heavily influenced by systems theorists such as Bateson, Haley, and Watzlawick.

Rationale of DCCP

DCCP's rationale is as follows: most acts of physical aggression in intimate relationships occur in the context of an argument between partners (Dobash & Dobash, 1984). Conflict escalates until one or both partners strike the other. According to principles of systems theory, one must be cognizant the concept of circular causality: each spouse's behavior is both a response to the partner's behavior and a stimulus for the partner's subsequent response. In other words, most spouses punctuate conflicts as follows: partner's behavior → my behavior. Systems approaches suggest the following: partner's behavior → my behavior → partner's behavior → my behavior....

DCCP holds each spouse solely responsible for his or her own choice to use violence.

However, both partners play a role in conflict escalation and therefore *either* can take actions to reduce the likelihood of violence. Special care must be taken when explaining circular causality to avoid the implication that the woman can prevent the violence by being non-conflictual; this is the very belief that aggressors (and at times, society as a whole) use to excuse violence. Rather, to reduce the risk of violence, both partners must accept the responsibility for managing their own anger and take steps to eliminate their own use of violence.

With circular causality at the core of DCCP's rationale, the goal of treatment is to make partners more skillful at defusing conflict before it reaches the point of psychological or physical aggression. DCCP uses three approaches: (1) increase awareness about aggression (e.g., definition of psychological, physical, and sexual abuse; description of Walker's [1979] cycle of abuse); (2) increase anger management skills (e.g., time out, recognition of anger-provoking thoughts via the Antecedent-Belief-Consequence cognitive model); (3) improve communication skills.

The principles of the program are explained to participants during session one (see Heyman & Neidig, 1997):

1. The primary goal of the program is to eliminate violence in the home.
2. Although anger and conflict are normal elements of family life, violence within the family is never justified.
3. We learn to be violent and we can learn to be non violent. Violence is a choice.
4. Abusive behavior is a relationship issue in which each partner must be responsible for his or her own behavior. The consequences of violence are serious for all members of the family.

5. Abusiveness is a desperate, but self-defeating, effort to change the relationship.

6. Abusiveness tends to escalate in severity and frequency if not treated.

DCCP differed from most treatment approaches for battering (i.e., men's programs) in Neidig's insistence that perpetrator/victim distinctions are a "therapeutic dead end" (Neidig & Friedman, 1984, p. 4). DCCP adopts a "no blame" policy similar to that described by Geffner, Mantooth, Franks, and Rao's (1989, pp. 118-119): "[C]linicians actively work to have both partners accept responsibility for their own behavior...The counselors have used 'no blame' to build an alliance and trust in the counseling environment. The 'no blame' approach further suggests that counselors are nonpunitive and do not seek to punish the violent man. We are adamant about our belief that counselors should not become punishing agents.... [W]hen each is held accountable in a nonblaming manner by the counselors and their partners, the bonding and trust tends to increase, and the therapy process is enhanced."

Neidig's overall stance can be called "gender neutral," in that his "no victims or villains" approach tends to de-emphasize the physical and cultural differences in the meaning of and effects of aggressive behavior toward the spouse. Those adopting a gender neutral approach sometimes cite nationally representative questionnaire findings that demonstrated that husbands and wives are equally physically aggressive (e.g., Steinmetz, 1987; Straus & Gelles, 1990). Further, more recent observational findings documented that destructive couple conflict and mutual verbal aggression are among the strongest correlates of couple violence (see Weiss & Heyman, 1997).

This viewpoint is sharply contrasted with that of feminists, who identify the problem as being husband-based and related to issues of gender socialization, patriarchy, power, coercive

control and male psychopathology (e.g., Bograd, 1990; Yllö, 1993).. In the most extreme version of this view, all couple approaches to treating violence are considered dangerous and antithetical to feminist principles (i.e., implicitly blames the woman for her husband's violence, puts the women at risk for further violence, encourages the woman to change when it is the man who must change).

Our work has evolved from Neidig's original positions. We agree that blaming clients is a therapeutic dead end. However, we recognize that although women may be involved in interpersonal processes leading to couple violence, they (a) are more likely to be the predominant victims when considering injury and psychological impact (e.g., Cascardi, Langhinrichsen & Vivian, 1992; Stets & Straus, 1990); and (b) have less power at all levels of society, including marriage. Our program continues to feature aggression awareness, anger control, and communication training, but as our research has progressed, we have moved from away from the original gender neutral stance.

PACT attempts to be "gender sensitive," in that we increasingly assess and emphasize the gender differences in the effects and meaning of anger and aggression. Our work has been influenced tremendously by our collaboration with Dina Vivian, with whom we have attempted to assess couple violence "in context," that is, according to its multiple dimensions (i.e., severity, frequency, psychological impact, and resulting injuries) and forms (i.e., psychological, physical, and sexual; Cascardi, et al. 1992; Cascardi & Vivian, 1995; Vivian & Langhinrichsen-Rohling, 1994). This work (see Vivian & Heyman, 1996 for a summary) found that, in the majority of *marital therapy* seeking clients, both spouses report engaging in aggressive acts; however, wives suffer the worst consequences. Wives, compared with their husbands, (a) report being the target of more psychological aggression and coercion (including sexual coercion); (b) are more likely

to use severe physical aggression in the context of self-defense; and (c) are less likely to use physical aggression to get their way. Furthermore, there are distinct subgroups of aggressive clinic couples (Vivian & Langhinrichsen-Rohling, 1994; Vivian & Heyman, 1995): (a) *Mild Bidirectional* — About one-half of marital clinic couples report low frequency of mild aggression (e.g., pushes, grabs, slaps) committed by both husband and wife, with wives often reporting more negative psychological impact from the violence than husbands do; (b) *Moderate* and (c) *Severe Wife Victimization* — Between 30%B40% of cases report high levels of husband→wife aggression and much lower levels of wife→husband aggression; and (d) *Moderate/Severe Husband Victimization* — " small subgroup of couples report higher levels of husband victimization. Severe wife victimizers (group c) are poor candidates for PACT, as the descriptions of their aggressive incidents typically have little to do with couple conflict, but seem more rooted in the man's extreme power and control tactics. Thus, these spouses are more similar to those treated in typical batterer programs and women's shelters and thus are more appropriately referred for such services.

Feminist-Social Learning Perspective

PACT can most correctly be described as a feminist-social learning approach to ending wife abuse. We agree with Neidig's position that it is important to understand the couple context of violence (i.e., the factors that precede it, maintain it, and reinforce it); yet, it is important to look at the social context in which marriage itself is embedded. This context is characterized by gender inequalities at all levels of society. Husband→wife aggression represents (and perpetuates) the most extreme imbalance of power between genders.

Ganley (1989) outlined nine facets of a integrated feminist/social learning approach to aggression. We will revisit each of Ganley's points (set off in italics), and comment on their

implications for the design of PACT.

1. *"[Aggression] is conceptualized as behavior taking place in an interpersonal context but having multiple determinants: individual, interpersonal, and social. These multiple determinants stem from both the current and the historical experiences of the [aggressive man]."* (p. 218)
2. *Interventions must address all determinants of aggression.*

We believe that for many, but not all, couples, when treating a "behavior that takes place in an interpersonal context" it is important to have both members of this interpersonal system present. The design of PACT emphasizes the individual and interpersonal aspects of wife abuse. The first half of the program focuses on individual (intrapersonal) factors (i.e., learning histories, individual anger control, abuse-promoting beliefs), whereas the second half focuses on interpersonal factors (communication, problem resolution, increasing positive activities). Social factors are interwoven throughout the program (e.g., during the abuse awareness section, negotiating an equitable marriage contract). We are in the process of piloting a new version of PACT that increases the emphasis on how social factors (e.g., male power) affect risk.

3. *Aggression continues because it works. Rewards are sometimes intrapersonal and sometimes interpersonal.*

PACT principle five states "abusiveness is a desperate, but self-defeating, effort to change the relationship." The program is founded on the social-learning premise that aggression continues because it works. The man must learn other methods that work, and we believe that this is often best accomplished with both partners developing new, more effective and more just way of dealing with each other.

4. *Aggression is a product of interpretations about the partner's behavior rather than by the*

behavior itself.

The defining feature of social learning models is that our cognitions determine the meaning of behaviors in our social milieu. The intrapersonal section of PACT focuses on these interpretations (or "hot thoughts") and how they maintain anger and increase the risk for abusiveness. Because this section is intrapersonal, it is not necessary to have both partners present. We are now testing an alternative version of PACT that conducts the first half of the program with separate sessions for men and women, bringing the interpersonal system together only for the interpersonal sections of the program.

5. *Treatment of husband→wife aggression must include the husband*.

We would, of course, concur. In addition, we believe that for couples in the "mild bidirectional" and "moderate wife victimization" groups, treatment of husband→wife aggression would ideally also include the wife.

6. *The goals of intervention are (a) to stop all aggression (physical, psychological, and sexual); and (b) to foster a relationship based on equality, rather than an abuse of power.*

These are, in a nutshell, the goals of PACT.

7. *The therapist must define what aggression is and confront the aggressor when it is occurring, model and teach nonaggressive strategies, and reinforce nonaggressive behavior*.

The sequential progression of PACT (definition/awareness, intrapersonal anger control, interpersonal communication [emphasizing equality and respect]) meets Ganley's charge. Again, we would emphasize the advantage, when teaching nonaggressive *interpersonal* strategies, to have the interpersonal system in the room at the same time.

8. *Therapists must extend their efforts to foster nonviolence to contexts outside of the therapy*

room.

Although this recommendation obviously takes a variety of forms depending on the setting, our center at Stony Brook has been deeply involved in the following activities: training of wife abuse researchers and therapists; dissemination of wife abuse research findings, both in professional journals and in more mainstream media; abuse prevention programs in high schools; treatment of abuse in marriages; abuse prevalence assessment and prevention program implementation with the U.S. military.

9. *The safety of the victim is paramount*.

As will be discussed later, we will not employ conjoint treatment with severe wife victimization couples. Instead, we refer such couples to our county batterers program. Any program that treats wife abuse *must* make the safety of the victim paramount; we do not believe, nor has our research shown, that conjoint treatment of abuse violates this central tenant.

Empirical Support for PACT's Rationale

Prevalence of Aggression in Couples Seeking Marital Therapy

Although battering that arouses community intervention (via arrest and/or shelter) is the most salient form of wife abuse, the most common form is aggression within intact marriages where *neither person defines physical aggression as a problem*. Within a clinic population seeking standard marital therapy, 71% of the couples reported physical aggression in their marriage in the past year (Cascardi, Langhinrichsen, & Vivian, 1992; O'Leary, Vivian, & Malone, 1992). Although the majority were experiencing mild forms of aggression (push, grab, shove, etc.), 34% of the husbands were classified as severely aggressive and 13% of the abused wives sustained substantial injuries (e.g., broken bones/teeth or injury to sensory organs).

Interestingly, almost none were seeking treatment specifically for the physical aggression; most identified other marital problems as their presenting concern. Despite the presence of aggression, these couples were committed enough to their marriage to seek couples therapy.

The disparity between percentages of couples experiencing marital aggression and those reporting or identifying it as a marital problem is noteworthy. A recent study (Ehrensaft, & Vivian, 1996) explored reasons for this phenomenon using some of the same couples from the study by Cascardi and colleagues (1992). The top three reasons for not reporting were (1) "It is not a problem" (29%); (2) "It is unstable/ infrequent" (26%); and (3) "It is secondary or caused by other problems" (22%). Although spouses may choose not to report aggression due to social desirability, a perhaps stronger influence is the spouses' subjective definition of aggression (Ehrensaft, & Vivian, 1996). Some spouses seem not consider their own acts, be they mild or more severe, to fall into the general category of aggression (even if they would define the same act as aggression if committed by someone else). This concurs with other findings that both spouses report more partner aggression than they do for themselves (Browning & Dutton, 1986; Gelles, 1979). Taken as a whole, these findings imply that the marital therapy office may be an important site for catching and treating cases involving physical aggression, despite the couple's failure to self-identify it as a marital problem. Clearly, couples experiencing aggression present to conjoint therapy at a relatively high rate. Treatment models like PACT are highly palatable to these couples because PACT provides treatment in the conjoint format requested by the couple. PACT is also often palatable to the practitioner because it focuses on the aggression problem prior to other marital presenting problems.

Not only do couples presenting for general marital therapy report aggression, but couple

conflicts appear to be at the heart of the majority abuse precipitators. As noted in the rationale section, aggression typically occurs within an interpersonal context. Recent research has focused on a qualitative evaluation of the use and occurrence of aggression between spouses. Because most violence occurs in the context of couple conflicts (Cascardi, & Vivian, 1995), understanding the context of the aggression is critical. According to Cascardi and Vivian (1995), who interviewed over 200 aggressive couples, marital violence generally grows out of conflict in which each spouse "actively contributes — albeit not necessarily symmetrically — to the escalation of violence" (p. 282). This interview data is corroborated by observational studies discussed below. The fact that most couples label their marital problem as one of a communication deficit, and that aggression often stems from verbal conflict allows for an "easy-sell" of the treatment package PACT offers. From a feminist perspective, "communication problems are an unintended result of violence-promoting gender-based struggles" (Vivian & Heyman, p. 30). Feminist social-learning conjoint approaches allow for contextual factors involved in the escalation of conflict to violence to be the focus of treatment with both spouses. Importantly, Cascardi and Vivian (1995, p. 282) also reported that "psychologically abusive/coercive behaviors may be a crucial antecedent to marital violence." However, when husbands were interviewed individually, they tended to minimize their use of these tactics. Thus, only by having both spouses present can a therapist more accurately assess the role each spouse plays in the escalation of conflicts and the factors contributing to the use of aggression.

Communication of aggressive couples

A burgeoning area of research has evolved comparing the observed interactions of physically aggressive couples and nonaggressive couples (including nondistressed couples).

Aggressive spouses display more overall hostility than nonaggressive couples (Burman, John, & Margolin, 1992; Burman, Margolin, & John, 1993; Cordova, Jacobson, Gottman, Rushe, & Cox, 1993; Margolin, John, & Gleberman, 1988; Margolin, John and O'Brien, 1989). Aggressive couples are also more likely to show negative escalation patterns (Burman et al., 1992, 1993; Cordova et al., 1993; Vivian & Heyman, 1994). Furthermore, abused wives clearly engage in high levels of verbal hostility and reciprocity (respond with hostility to husbands' hostility), contrary to the clinical descriptions of battered women (e.g., Walker, 1979). Although complaints arising from disempowerment appear to be a strong contributor to such negativity (see the discussion of Vivian's work below), the results converge on a picture of high degrees of mutual verbal combat (and little placating) in the marriages of moderately to severely abusive couples.

An area for further exploration is the negative reinforcement effects of hostility. Burman et al., (1993) and Heyman (1992) found aggressive husbands' hostility suppressed their wives' emission of depressive affect (a pattern found in some depressive marriages, see Weiss & Heyman, 1997, for a review). Heyman (1992) also found evidence husbands' withdrawal effectively turning off their wives' hostility, and vice versa. Because both theoretical (e.g., Patterson, 1982) and clinical accounts indicate that couples act in negative ways to turn off the negativity of the partner, such patterns are of great interest.

Vivian (e.g., Vivian, Heyman, & Langhinrichsen-Rohling, in press) has argued that traditional coding systems ignore the gendered context of all marital behavior. Thus, coding systems that only code the form of the behavior (e.g., a wife is coded with "hostility", the husband with neutral problem statements) without understanding the context (e.g., the wife does

90% of the housework and wants a more equitable arrangement, the husband saying that he understands the problem but simply has no time to help) are lacking. Vivian et al. (in press) compared results from a traditional behavioral coding system and a new thematic coding system. They found that on the behavioral level, wives were more hostile, offered more negative attributions for the partner's behavior, and emitted less acceptance codes than their husbands. However, when coded thematically, the picture of the "hostile wife" changed: during the conflicts, wives were more likely than husbands to develop themes of desiring more affection/togetherness, equity about responsibilities, and public support from the partner. Husbands were more likely to display themes related to resisting change and needing to prevail or control. Furthermore, we found that clinic wives sought more respect/empowerment than did husbands or community spouses. As hypothesized, these differences were especially pronounced in clinic wives who reported being hit during conflicts in the last year.

In sum, the observational literature supports the contention that aggressive couples have communication deficits. The fact that both spouses hostile during conflicts argues for clinical attention to both spouses when intact couples seek treatment. However, as Vivian and colleagues' work demonstrates, sensitivity to gender issues is critical to understanding *why* husbands and wives are hostile. The data would support the rationale for conjoint approaches only if such treatments are sensitive to gender inequalities and struggles.

Assessment

Because we do not believe conjoint treatment is appropriate for every couple requesting this format, the assessment process is one of the most critical steps when providing couples treatment for aggression. In our program, separate interviews with each spouse are conducted to

carefully assess several factors related to treatment assignment. These interviews have two foci, assessing factors related both to the marital relationship and the individual.

First and foremost, a thorough evaluation of the aggressive episodes is necessary. This was assessed in several ways. Each spouse completed the Modified Conflict Tactics Scale (Neidig & Friedman, 1984; this is an expanded version of Straus', 1979, Conflict Tactics Scale), which requires a report on self and partner aggression. Next, in an oral interview each spouse was asked to estimate the overall frequency of aggressive episodes in the past year. Studies of couples' voluntary reporting of aggression (e.g., O'Leary et al., 1992; Ehrensaft & Vivian, 1996) found there to be differential reporting between these two techniques and thus concluded that both are necessary to get a full picture of the extent and frequency of the aggression.

In the oral interview, each spouse discussed, in detail, the most severe and the three most recent episodes in the past year. Factors such as injury, need for medical attention, intentional and causal attributions and police involvement were directly assessed. Since this treatment focuses on the cessation of aggression, at least two aggressive episodes in the past year must be reported to qualify for the program. Couples with lower levels of aggression do not generally identify this as a problem and will not find the target of intervention to be well-matched to their needs. However exclusionary criteria for couples on the severe end of the continuum are also necessary.

A few factors related specifically to the aggression indicated whether the couple was appropriate for a conjoint format.

(1) Severity of aggression — If aggression was extreme in frequency or severity, the wife's safety became the immediate focus of intervention. Couples in this situation were referred to

community agencies more suitable to their needs. Interestingly, very few couples who volunteered reported severe levels of aggression. It may be that the more severely aggressive couples naturally seek other forms of intervention.

(2) Injury or hospitalization — If the wife reported that she had sustained injuries serious enough for her to have sought medical care, the couple was referred to other modes of intervention.

(3) Husbands' admission of aggression — For the sake of group cohesion, participants must share the goals of the group and the program. Cases in which the husband denied his use of aggression were deemed inappropriate for this format of intervention.

(4) Wife's fear of husband — It was important to ensure that both partners were comfortable with the presence of the spouse in sessions. Thus, it is necessary for wives to feel able to disclose information and participate in group activities. If the wife reported fearfulness of participating in group sessions with the husband present or of increased aggression as a result of participating, the couple was given referrals.

Several other factors were assessed to determine the appropriateness of conjoint therapy for aggression. First, the couple must be married and living together. A number of activities are suggested for the week between sessions to improve anger control and enhance couple interactions. Couples not cohabitating are unable to practice frequently the necessary skills and activities. Obviously, the more severe cases in which the couple is not cohabitating because the wife has found a safer living arrangement or has acquired an order of protection against the husband would not meet this criteria. Second, each spouse's individual functioning should be assessed. As with most forms of group therapy, it is important to insure that the individual does not present with competing problems that may interfere with reaching the group's goals. A full

Structured Clinical Interview of the DSM III-R (SCID) including the supplementary module for Posttraumatic Stress Disorder was administered to each spouse individually. Exclusionary criteria at this phase of assessment included: (1) a current substance abuse diagnoses, (2) the presence of psychotic symptoms, (3) or any diagnosis of psychopathology deemed to be severe enough to interfere with successful participation in the group (e.g., bipolar disorder, schizophrenia). Finally, the husbands' past history of aggression in contexts other than their marital relationship was assessed. Men who have a pattern of violent or criminal behavior in a variety of contexts (with co-workers, friends or strangers) are not considered to be appropriate for this mode of treatment. It is hypothesized that in these cases, individual counseling, perhaps to target a personality disorder, may be more appropriate.

For those cases in which severity and frequency of aggression, injury or hospitalization and wives' fearfulness were approaching an extreme level or warranted exclusion from the program, a final step was added to the interview. Wives were individually introduced to concepts such as developing safety plans and means of help seeking (e.g., hotlines, shelters). In some situations, depending on the wife's feedback, interviewers also brought both partners together at the close of the assessment to discuss the use of a Time-out procedure to help keep defuse arguments before escalation to violence could occur.

Description of Treatment

We have already discussed the main goals and core components of our treatment of aggressive couples in great detail. Heyman and Neidig (1997) discussed PACT when conducted in groups. Vivian and Heyman (1996) discussed our more feminist-oriented version of conjoint treatment for individual couples. Both papers include treatment transcripts. Thus, in this chapter

we will only briefly outline the key objectives of the 14 sessions of the program.

Intrapersonal Sessions (1 - 7)

Our clinical belief is that spouses must learn to identify and manage their anger before it will be beneficial to focus on their marital conflicts. Thus, the first half of the program focuses on intrapersonal skills by: (a) emphasizing self-responsibility for one's own conflict behaviors; (b) guiding spouses through a heightened discrimination of their anger responses; (c) implementing a contract for nonviolent conflict management (i.e., time out); (d) teaching spouses how to identify and cope with anger provoking cognitions; and (e) exploring the effects of stress and Type-A personality behaviors on spouses' coping abilities.

Session 1: Introducing the program; disclosing past aggression. The objectives of the first session are to: (a) establish the fact that the participants are there because of their past violent behavior; (b) foster a sense of personal responsibility for their own violent behavior; (c) reduce resistance and denial; (d) explain the objectives, structure and rationale of the program; and (e) encourage realistic grounds for optimism. In the second half of session 1, each couple are asked to describe their most recent episode of physical violence. The intents of this portion of Session 1 are the following: (a) to clarify that it is the violent behavior that resulted in their selection for the program; (b) to highlight that the program's goal is the elimination of future incidents; (c) to share this common concern; (d) to assess and to reinforce their acceptance of personal responsibility for the violent behavior. Personal responsibility is emphasized by asking questions such as "What do you think you did that made the situation worse?"

Session 2: Cycle of violence; discriminating different levels of anger. We introduce Walker's (1979) three phase model of battering (tension building, abusive incident, remorse) as a

framework for understanding the processes that set the stage for and result in physical aggression. Session 2 introduces the systemic idea of mutual and circular causality of couple conflict. Prior to this, spouses typically believe that they are reacting to the partner's provocative behavior, and that the responsibility for reducing conflict lies in the partner. By realizing that they are both provoking and being provoked, spouses understand that they must take responsibility for reducing their own conflict escalating behaviors. This is the core construct on which the program is built. It is critical to reiterate, during the presentation of the model, the program principle that each partner is solely responsible for his/her aggression. Although each partner can take steps to reduce the likelihood of conflict escalation, the use of violence is a personal choice and not the result of provocation.

During the second half of this session, we use the short film, "Deck the Halls," to provide a memorable stimulus for discussing both the context of aggression and the affective, behavioral, and cognitive precipitants of abuse. Through discussion, we highlight (a) the concept that anger is not an on/off toggle switch, but rather exists on a continuum; and (b) that conflict escalates sequentially to the point of violence and that spouses have ample warning of the changes in their thinking, feeling and acting.

Session 3: Discriminating different levels of anger (cont.), Time Out procedures. For homework between sessions 2 and 3, participants map out their own affective, behavioral, and cognitive changes as anger escalates. Once participants can recognize their own anger cues, they are ready for the first anger management strategy: Time Out. The six steps of time out (self-watching, signaling for time out, acknowledging the partner's signal, separating, cooling off, returning) are outlined for the group and discussed.

Session 4: Cognitive-Behavioral (ABC) Model of anger. Session 4 is devoted to introducing the cognitive-behavioral model of anger and anger control. Affective, behavioral, and cognitive anger cues, which were first explored in the previous session, are reviewed. Participants are then introduced to the idea that anger requires cognitive mediation (as was discussed in the rationale section of this chapter). Participants typically believe that events cause their anger; the program introduces the model that events cause thoughts that cause anger. Finally, six types of cognitive distortions are covered as a means of identifying distortion. Couples practice challenging these distortions in the next session.

Session 5: Anger control techniques; challenging hot thoughts. Once participants recognize anger cues, they are typically very eager to begin modifying their anger responses. Four steps are presented: (a) recognize anger signs; (b) pause (i.e., counting to ten; repeating anger control reminders, deep breathing, and thought stopping); (c) decide what to do; and (d) control thinking. The second two steps receive the most attention in this session. The discussion about "deciding what to do" centers on the function of anger and violence (e.g., making someone shut up or do things your way). Participants explore whether the ends or the means (or both) are maladaptive, and practice more constructive alternatives. The last step, "control your thinking" involves participants taking examples of their hot thoughts and generating alternative cool thoughts.

Session 6: Stress-abuse connection; irrational beliefs. Much of this session is spent solidifying the cognitive anger control strategies from the previous session. At this point we commonly address participant questions such as, "I have no problem identifying my hot thoughts. But what do you do if they're right?" We are likely to agree with the participant's

perception that the thought seems to fit at the time. However, we then help them recognize how maladaptive the thoughts are. Thus, quite a bit of work is still necessary before participants are as comfortable with their cool thoughts as they are with their hot ones. The leader also attempts to derive some of the underlying beliefs that guide their hot thoughts and bring them into open discussion. This is accomplished through the kind of Socratic questioning familiar to cognitive therapists. The objective of the remainder of session 6 is to explore the relationship between stress and violence and to introduce some stress management strategies.

Session 7: Midterm Progress Evaluation; Review. Session 7 is the midprogram self-evaluation and review. Participants take stock of what elements they've mastered and what remains to be accomplished.

Interpersonal Sessions (8 - 14)

At this point spouses should have rudimentary abilities to (a) use Time-Out; (b) understand the definition of physical and psychological aggression and the cyclical pattern of aggression found in many marriages; and (c) take responsibility for their own anger response and manage it appropriately. At this point many couples believe that they have learned to use the "brakes," but that they have not resolved the conflicts that led them to seek treatment. Thus, although most couples feel positive about their increased ability to control arguments, they are actively pressing for some time to resolve their problems.

Session 8: Communication principles and skills; positive behaviors. The objective of this session is to introduce some basic principles of communication and to review some basic communication skills. The final segment of session 8 is devoted to increasing positive interaction. As with most discordant couples, participants often report that they derive little

pleasure from their relationships and neglect to do most of the activities that made their courtship fun. Increasing these positive behaviors directly increases their marital satisfaction and indirectly makes compromise and conflict management more appealing.

Session 9: Gender differences in communication; expressing feelings; empathy. Work on communication from session 8 continues in session 9. The goal of the remainder of the session is to explore gender-related differences in the participants' communication skills. Areas such as asking permission, decision making, request making, talking about problems, and seeking and sharing information are discussed. Because many (if not most) aggressive men have difficulty identifying and/or expressing their feelings, an exercise is devoted to this skill. This leads to a discussion of the difference between primary emotions (like sadness or anxiety) and secondary emotions (like anger) (cf. Greenberg & Johnson, 1988) and the impact each has on a partner during a conflict. Although this concept requires a bit of practice during the group, it can be a very powerful exercise as wives say that they would respond much better to husbands expressing hurt or disappointment rather than anger.

Session 10: Assertion versus aggression; equality in rights and decision making. The first half of this session is devoted to the difference between assertion (standing up for your own rights without violating the rights of others) and aggression (enforcing your own rights or will without regard for the rights of others). The second half of the session has participants complete a "Marriage Bill of Rights". In this exercise, both people respond to a list of behaviors (e.g., the right to be treated with respect; the right to express opinions; the right to come and goes as you please) with one of the following choices: "the husband only has this right," "the wife only has this right," "we both have this right," or "neither has this right." Although this straightforward

exercise will not work miracles for highly controlling men, it does result in spirited discussions, with couples agreeing with each other far more than they disagree. A similar exercise is conducted on decision making rights.

Session 11: Conflict escalation process; principles of conflict containment; Session 12: Dirty fighting techniques. Now that participants have obtained a modest degree of anger control proficiency, have begun trying to unearth their communication skills, and are reconsidering their rights and responsibilities in the marriage, the next two sessions are aimed at consolidating these gains. The goal of session 11 is to emphasize a "team" approach to conflict containment and resolution (See Baucom & Epstein, 1990 for additional material on standard behavioral couples therapy approaches in this regard). Session 12 continues to focus on conflict containment with a humorously presented workbook exercise on "Dirty Fighting Techniques" (e.g., blaming, using money, being sarcastic). Although entertaining, participants are sometimes rattled by how many of these techniques they employ. The typical result is a strengthened commitment to "play by the book," and the remainder of the session can be used to continue practicing conflict resolution.

Session 13: Sex; jealousy; expanding social support network. The goal of session 13 is to bring up three interrelated topics: sex, social support networks, and jealousy. See Heyman and Neidig (1997) for a discussion of how these topics are addressed.

Session 14: Wrap-up; maintaining gains; expressive versus instrumental violence. Among the final goals of session 14 are to (a) recognize the achievements of the group, (b) anticipate the consequences of conflict, (c) make commitments for additional change, and (d) provide a forum for airing feelings about termination. Included in this session is a violence contingency contract, in which participants list the concrete steps they will take should violence occur again (e.g., call

Time Out, separate and cool down, etc.)

Empirical Evaluation of PACT's Efficacy

The Stony Brook Wife Abuse Treatment Project aimed to compare the effectiveness of two modes of treatment for spouse abuse. We hypothesized that both PACT and Gender Specific Treatment (GST) effectively reduce physical aggression, but that PACT would result in better gains on marital adjustment, communication, and psychological aggression. At one year, we predicted significantly higher relapse in physical aggression for those who received GST. Complete results can be found in O'Leary, Heyman, & Neidig (1999).

As hypothesized, physical aggression (both mild and severe) at posttreatment significantly decreased according to both husbands' and wives' reports. This "no difference" finding between couples and gender-specific approaches to wife abuse treatment has been found in two other studies using programs similar to PACT but with participants mandated to treatment, not volunteers, (Brannen & Rubin, 1996, Dunford, 2000).

Futhermore, in both groups, husbands and wives scored significantly higher on marital adjustment and on positive feelings about the spouse at posttreatment than at pretreatment. They also scored significantly lower on measures of psychological aggression and on maladaptive beliefs (that spouses cannot change and that all disagreement is destructive). There were no differential effects for format of treatment.

At posttreatment, husbands reported significant increases in taking responsibility for their own aggression and significant decreases in placing responsibility for their own aggression on their wives. Wives significantly decreased taking responsibility for the husbands' aggression.

O'Leary et al. (1999, p. XXX) summarized the main findings as follows: "With a sample

of volunteer, intact couples, we found that commonly expressed fears about conjoint treatment by some who work with court mandated men (e.g., Adams, 1988; McMahon & Pence, 1996) did not apply to our setting. For example, compared to wives in gender specific treatment, wives in the conjoint treatment were not fearful of participating with their husbands, were not fearful during the sessions, did not blame themselves for the violence, and were not put at an increased risk for violence during the program."

Assessed one year later, husbands' physical aggression (both mild and severe) was significantly reduced, according to husbands' and wives' reports. Husbands' and wives' marital adjustment were still significantly higher than at pretreatment; husbands' psychological aggression was significantly reduced. Contrary to our hypotheses, both programs worked equally well.

Consumer satisfaction was high for both groups. At post assessment and one-year follow-up, participants were very highly satisfied (average of 8 on a 9 point scale) with both treatments (e.g., how interesting the group was, relevance of program, personality of therapist, skills of therapist, how much their concerns or goals were met by program). At follow-up, however, PACT participants rated their "interest and involvement in the program" as significantly higher GST participants. Spouses also reported feeling slightly to moderately better (6 to 7 on a 9 point scale) at controlling anger, at self-control and accepting responsibility for their own actions, in their ability to contain conflict, and in their ability to refrain from using verbal aggression. Spouses rated themselves moderately better (7 on a 9 point scale) at curtailing mild and severe physical aggression.

Two limitations were noted (see O'Leary et al. for a more expansive discussion). First,

the drop out rate in this study was 47%. This rate is similar to that often reported in the batterers treatment literature and is perhaps not surprising for a treatment that offered only in a less-preferred format (groups), conducted on Tuesday nights only, and focused on a problem (aggression) that most participants believed to be of secondary importance (nearly all couples wanted free couples therapy). Second, the aggression cessation rate of 26% at one-year follow-up may be lower than that found in programs with court-mandated men.

In summary, both groups appear to be successful in reducing physical aggression and in improving the marital quality of participants. Furthermore, some of these effects (including the significant reduction, but not elimination, of the intensity and frequency of aggression) continued one year following treatment. In general, participants who completed the program appeared to be pleased with the treatment they received. However, most GST participants wanted to add to their treatment a component that focused specifically on their couple issues following 14 weeks of gender specific treatment.

Future directions in PACT

Several states in the U.S.A. have adopted policies proscribing couples treatment when there is aggression. How this affects a treatment specifically for spouse abuse that nevertheless uses a conjoint format (i.e., PACT) is unclear. Obviously, therapists need to be aware of the legal and ethical regulations in their area. Spouse abuse is a highly political area and therapists considering employing PACT should familiarize themselves with the controversies in this field (e.g., Caesar and Hamburger, 1989; Gelles & Loseke, 1993; Yllö & Bograd, 1988).

We are in favor of a format that combines gender specific treatment and PACT. Many therapists believe that men must participate in individual therapy before they are ready for

conjoint sessions. Although this belief seems reasonable, it has not been empirically tested. In conducting the O'Leary et al. (1999) study, we noticed that, in PACT groups, a husband's failure to master anger and control strategies in the initial half of the program would interfere with his ability to focus more directly on communication enhancement, problem solving, and insight into the problems. For example, those couples who have yet to successfully monitor their own anger or to use time-out procedures (and thus remain unable to prevent their arguments from escalating) do not yet have the confidence or skills necessary to address constructively relationship issues. In other words, efforts at interpersonal improvements are handicapped by their failure to make the necessary intrapersonal improvements. We also believe that having a therapist spend seven weeks with each spouse in individual therapy will allow the therapist to develop relationships with the spouses and provide a better understanding of the spouses' individual issues before starting the couples treatment program. We are excited about the possibilities of combining the effective ingredients of both approaches. Of course, outcome data will be the final judge of whether this approach is a significant improvement.

In conclusion, we have presented the rationale for a conjoint approach to treating wife abuse and the data supporting that rationale. Further, we described the content of our program and the data supporting its effectiveness. That PACT is as effective as single-sex groups indicates that, at least for intact couples, either approach may be successful. Such research does not inform clinicians about which treatment would best suit a particular case. We can point to many couples who would not be appropriate for a conjoint approach. However, many couples would like this approach. It is especially sensible when the couple presents for standard marital therapy and the clinician discovers the presence of aggression. Despite the controversy over

conjoint approaches, we are happy to have had this opportunity to present the rationale and data supportive of its judicious use.

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Authors Notes

We wish to dedicate this chapter to the memory of our colleague Peter Neidig. Peter was to be a contributor to this chapter, but died before the writing commenced. His influence has an obvious, and profound, impact on the work that we describe in this chapter.

We would also like to acknowledge the influence of K. Daniel O'Leary, Dina Vivian. Our ongoing debates about the etiology and treatment of wife abuse have contributed immeasurably to the ideas discussed in this chapter.

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Table 1

Session by Session Summary of PACT

Session	Content
Session 1	Introducing the program; recounting violent incident
Session 2	Cycle of violence; discriminating different levels of anger
Session 3	Discriminating different levels of anger (cont.), Time Out procedures
Session 4	Cognitive-Behavioral (ABC) Model of anger
Session 5	Anger control techniques; challenging hot thoughts
Session 6	Stress-Abuse connection; Irrational beliefs
Session 7	Midterm Progress Evaluation; Review
Session 8	Communication principles and skills; positive behaviors
Session 9	Gender differences in communication; expressing feelings; empathy

Session 10	Assertion versus aggression; equality in rights and decision making
Session 11	Conflict escalation process; principles of conflict containment
Session 12	Dirty fighting techniques
Session 13	Sex; jealousy; expanding social support network
Session 14	Wrap-up; maintaining gains; expressive versus instrumental violence

1. Abstract now included.
2. I disagree. Nothing done.
3. Reference changed to 1999. Military point ignored. Neidig's rationale is provided here, but no attempt was made (or would be inferred) to comprehensively review the evidence for his stance.
4. This goes beyond the purpose or scope of this chapter and was ignored.
5. Such evidence was presented in the paragraph following the one the reviewer referred to. No changes necessary.
6. First sentence of manuscript changed to make this more clear.
7. Yes, so no change needed.
8. I don't know what the heck the reviewer is talking about. However, the high school program was primary prevention.
9. "Deficits" means "deficiencies." There is no point splitting hairs about things they do too much of and too little of.
10. I don't have the same page numbers, so I don't know exactly what is being referred to. I'm okay with it as it stands.
11. That's the whole purpose of this chapter, and I don't know if the reviewer was made aware of that.
12. Only one study has examined PACT, so it's appropriate to focus on that study. References to studies published after this chapter was originally written (about 5 years ago!) are now included, as suggested.
13. I disagree with the reviewer, especially with the small additions noted.

Bio

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