

Treatment of Partner Aggressive Women

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Most research conducted on partner aggression has examined male to female violence, due to findings from crime surveys demonstrating that most perpetrators of partner aggression are male (Gaguin, 1977-1978). However, national surveys asking respondents about family problems have found that approximately equal numbers of men and women assault their partners (Straus & Gelles, 1990). While, much research has been conducted about male-perpetrated aggression, little research about female to male aggression has been conducted, and with the exception of work by Hamberger and Potente (1994) and Dowd (in press), little information is available to guide those engaging in the treatment of partner aggressive women. This chapter will provide a brief summary of the controversy surrounding women's aggression, an overview of the characteristics of partner aggressive women, and a description of the similarities and differences between group treatment formats for partner aggressive men and women.

The Controversy Surrounding Women's Aggression

Female perpetration of relationship aggression has been a controversial topic (Saunders, 1986; Straus, 1993.) For various reasons it has been suggested that aggression by women should not be examined. One reason to avoid addressing women's aggression is the fact that male to female partner aggression is considered to be more serious and damaging than female to male aggression. This is in part due to the difference in the severity of consequences resulting from aggression perpetrated by men and women. Cascardi, Langhinrichsen, and Vivian (1992) found that wives were more likely than husbands to be negatively affected by marital aggression, and

wives were more likely than husbands to have clinical levels of depressive symptomatology. Injuries resulting from male to female aggression occur more frequently and tend to be more severe than injuries resulting from female to male aggression (Cascardi et al., 1992; Vivian & Langhinrichsen-Rohling, 1994). In addition, Stets and Straus (1990) found that female victims of partner aggression were more likely than male victims to require medical treatment as a result of partner aggression.

Addressing women's aggression has also been discouraged due to fear that attending to women's aggression may be invoked as an excuse for male perpetrated aggression and result in victim-blaming (Kurz, 1993). Because many partner aggressive women are also victimized by their partners (Hamberger & Potente, 1994; Stets & Straus, 1990), female aggression is often viewed as self-defensive or retaliatory, and not as the mirror image of male aggression. However, even if true, it may not explain all instances of female perpetrated partner aggression. Understanding the dynamics and consequences of this form of aggression, as we will argue, might have implications for the safety and well being of women and children that are too significant to ignore out of fear that this information might be misinterpreted or misused. Helping women to take responsibility for their own behavior and to choose non-violent ways of solving conflict does not place the responsibility for all relationship aggression on them.

According to family violence surveys, approximately 12% of women and men assault their romantic partners per year (Straus & Gelles, 1990). Severe assaults against partners are perpetrated by 4.8% of women and 3.4% of men each year (Straus & Gelles, 1990). Women's violence has been explained as occurring in self-defense (Saunders, 1986). Women who have been arrested for partner aggression have been described as primarily battered women who are fighting back in self-defense, in retaliation for prior abuse by their partners, or to protect themselves from imminent violence by their partners (Hamberger, 1997; Hamberger & Potente, 1994). This may be the case for some, and perhaps for a significant portion of the population. However, women have been found to initiate aggression in relationships as often as men (Straus & Gelles, 1990) and women have been found to be the sole aggressor within the past year in

25.5% of violent couples (Straus, 1993). Men were the sole aggressor in 25.9% of cases, and both partners were violent in 48.6% of the cases (Straus, 1993). Thus, the degree to which women are aggressing against their partners in self-defense is unclear.

Although there are realistic concerns about attending to, or addressing, female to male aggression, women are being arrested and sent to diversion programs for treatment. Without sufficient research examining women's aggression, clinicians working with partner aggressive women cannot look to the literature for effective interventions. Programs designed for aggressive men may not be well suited for aggressive women. At UMass, the treatment program for male batterers has been substantially modified to fit the needs of aggressive women presenting for treatment.

The Importance of Addressing Women's Aggression

Family violence researchers have pointed out that relationship aggression affects all family members in destructive ways (Straus & Gelles, 1990). Aggression perpetrated by women, as well as by men, negatively affects child witnesses (Jaffe, Wolfe, & Wilson, 1990; Straus, Gelles, & Steinmetz, 1980). Children exposed to violence in their family of origin are more likely than other children to develop psychopathology including depression, anxiety, conduct problems, and aggressive behavior (Cummings & Davies, 1994; Jouriles, Murphy, & O'Leary, 1989). Rosenbaum and O'Leary (1981) found that 45% of male batterers witnessed partner aggression in their families of origin while growing up. Witnessing aggression in one's family of origin is one of the most consistent predictors of male-perpetrated partner aggression (Feldman, 1997). Prevention of aggression by men *and women* may reduce the rates of child psychopathology and the intergenerational transmission of domestic violence.

In addition, successfully treating aggressive women may ultimately prevent aggression perpetrated against women. Feld & Straus (1989) found that women's mild aggression toward their spouses predicted future severe violence perpetrated by their husbands against them. Murphy and O'Leary (1989) found that even psychological aggression perpetrated by women

predicted future physical violence by their husbands. Furthermore, women's use of psychological aggression has been shown to predict future physical aggression by husbands who have not previously been physically aggressive (Murphy & O'Leary, 1989). Thus, not only are women who engage in psychological aggression at risk of engaging in future physical aggression themselves but they are at risk of being physically victimized by their partners even if their partners have not previously been physically violent. Slapping their husbands or putting their husbands down may be placing women in danger of being assaulted by their partners in the future.

Murray Straus (1993) has argued that women's use of aggression may change the rules regarding aggression in relationships. By using aggression, women may be giving their partners the message that it is acceptable to use aggression in their relationships. Thus, if a woman has slapped her husband when he has said something that she does not like, what is to stop the man from hitting her if she says something that he does not like? Women's actions do not justify men's violence and women should not be blamed for the actions of men. Men must be held accountable for their perpetration of domestic violence. Similarly, women should also be held accountable for their use of verbal and physical aggression.

Characteristics of Women Who Assault Their Partners

Unfortunately little research has been done to shed light on the nature of this population, and much of the information available is embedded in the literature in a way that is fragmented and difficult to access directly. As is the case with male batterers, domestically violent women are likely a diverse group, ranging from those who engage in infrequent and mild aggression which has been called "ordinary marital violence" (Straus, 1990, p. 405) and "common couple violence" (Johnson, 1995), to women who use or threaten to use weapons and who inflict serious injury on their partners. To date, only a few small samples of domestically violent women have been described in the literature. Issues of context, and motivation in particular, have not been fully explored across groups of domestically violent women. There are problems in making

assumptions and generalizations across potentially dissimilar groups of domestically violent women, such as representative community samples and clinical samples (Kwong, Bartholomew, & Dutton, 1999; Straus, 1993; Straus, 1999).

While the focus of this paper is primarily on heterosexual women who assault male partners, there exists a substantial literature on partner assault in lesbian couples. The prevalence of violence in lesbian couples is thought to equal, or exceed, that in heterosexual couples, ranging among studies from 30% to 75% (Waldner-Haugrud, Gratch, & Magruder, 1997). Sexual assault in lesbian relationships has been identified as an issue as well (Waldner-Haugrud & Gratch, 1997). Domestically violent lesbians present for treatment through self-referral as well as by way of court-mandate, and have been treated in lesbian-only group and family formats (Margolies & Leeder, 1995), as well as in groups with members of mixed sexual orientation (Leisring, Dowd & Rosenbaum, 1999). Partner aggressive lesbians have been described as unable to relate empathetically to their partners, fearful of abandonment, dependent, jealous, and as having poor communication skills (Leeder, 1988; Renzetti, 1988).

A picture of heterosexual women who are treated for partner aggression is beginning to emerge, based on several court-mandated samples that have been described in the past few years (Abel, 1999; Hamberger, 1997; Leisring, Dowd, & Rosenbaum, 1999). The Abel (1999) and Hamberger (1997) samples were composed of women who were arrested specifically for domestic violence, while the women in the Leisring et al. (1999) sample were mandated to anger management treatment for a variety of interpersonally aggressive acts, including partner aggression. The mean age across studies was approximately 30, and women were divided according to marital status into roughly equivalent numbers of married, separated or divorced, and never married women. The women in all three samples reported high rates of childhood victimization of all types, as well as physical victimization in adulthood. Over a third of the Leisring et al. (1999) sample and over a half of the Hamburger (1997) sample reported having witnessed parental aggression. Past and current substance abuse was a significant problem for many women across the samples. In the Leisring et al. (1999) sample, nearly two thirds of the

women had a history of outpatient mental health treatment, and nearly a third had attempted suicide at least once. It has also been found that approximately 45% of the women in the anger management program at UMass were experiencing clinical levels of posttraumatic stress disorder symptoms at the time of admission into the program (Leisring, Dowd, & Rosenbaum, 2000). Able (1999) found that women in batterer treatment programs appeared to be more similar to female domestic violence victims than to male batterers in terms of arrest history, victimization history, social service utilization, and trauma symptomology. In summary, women mandated to treatment for partner aggression are likely to be relatively young, previously traumatized, and at high risk for substance abuse, PTSD, and other mental health problems.

It has been suggested elsewhere that clarifying the relationships among trauma, substance abuse, attachment style, and affect-regulation will be crucial to our understanding of domestically violent women and how to treat them (see Dowd, in press, for a more thorough discussion). As indicated above, women in treatment for partner aggression often present with significant trauma histories and current symptoms of PTSD. Riggs and Gallagher (2000) present a persuasive argument for the role of PTSD as a marker for domestic violence in men. Their theory, based on an information processing model of PTSD, contends that traumatic memories and symptoms interfere with cognitive processes necessary to formulate and execute appropriate and constructive responses to actual or perceived social conflict. This application could be especially useful in understanding women's partner violence, due to their high rates of childhood and adult victimization, which place them at high risk for affective and behavioral instability.

While the relationships among trauma, substance abuse, and other mental health issues have not been well articulated for the population of women in treatment for partner aggression, it is evident that strong associations exist among these issues in several populations. For example, it is known that women are at high risk for depression if they are involved in domestic violence as perpetrators (Bland & Orn, 1986), as victims (Tuel & Russell, 1998), and as partners in reciprocally violent couples (Cascardi, et al., 1992). In a study of college women it was found that witnessing parents' marital violence was associated with higher rates of sexual and physical

victimization in childhood, as well as dating violence and depression in later years (Maker, Kemmelmeier, & Peterson, 1998). The women who had witnessed parental aggression reported higher rates of both perpetration and victimization in dating relationships than did women who had not witnessed parental aggression. The high overlap among female aggression, trauma, and depression is evident in the Leisring et al. (1999) sample, in which 63% of the women reported a history of depressive symptoms, and 85% were victimized in one or more ways as children and/or adults.

While little is known about the effect of women's substance abuse on domestic violence, it is evident from the samples above that female perpetrators have a high incidence of substance use and substance abuse problems. A study on women's verbal aggression found that increasing frequency of episodes of intoxication increased women's incidence of verbal aggression (Straus & Sweet, 1992). This relationship held for both alcohol and drug use. Furthermore, a strong link has been found between PTSD and substance abuse, resulting in a dual condition that is more resistant to treatment than either disorder alone (Najavits, Weiss, & Liese, 1996). Further support for this connection is provided by a study in which women with alcohol problems reported high rates of childhood physical and sexual victimization (Miller, Downs, & Testa, 1993).

In addition to the above areas of investigation, a growing literature on adult attachment has begun to focus on marital violence in recent years. A number of studies have explored attachment styles and their correlates in domestically violent men (e.g., Dutton, Saunders, Starzomski, & Bartholomew, 1994) and their victims (Dutton & Haring, 1999; Kesner & McKenry, 1998). Dutton et al. (1994) found that anxious attachment was associated with abusiveness in men. We are unaware of any parallel findings about attachment style and domestically violent women, although the link between attachment disturbances, trauma, and complex posttraumatic stress disorder has been noted for women hospitalized for trauma-related disorders (Allen, Coyne, & Huntoon, 1998). Based on the above discussion, it is tempting to speculate that a problematic attachment style, formed in an environment of ongoing

psychological, physical, and/or sexual injury, and exacerbated in later years by accompanying mental health and substance abuse issues, could be a significant vehicle for the intergenerational transmission of domestic violence for women.

Group Treatment for Aggressive Women

Lacking treatment models tailored to domestically violent women, a natural strategy was to base treatment for aggressive women on male batterer treatment programs. General guidelines and many treatment modules typically included in treatment programs for men are also relevant to the treatment of aggressive women, and will be reviewed here. However, as Hamberger and Potente (1994) have pointed out, treatment for aggressive women should differ from treatment for aggressive men because aggressive women have unique needs. Six modifications to men's treatment protocols, based on current knowledge of aggressive women and our experiences treating them over the past four years, will be described.

Description of Guidelines for UMass' men's and women's programs:

An initial intake evaluation is performed, with special attention to circumstances surrounding the referral incident, previous aggression, and patterns of initiation and interaction in relationships in which aggression has occurred. Treatment is offered through groups, which meet weekly for 90 minutes, for 20 weeks. Attendance and promptness are required. Group rules include a commitment to keeping information about each other confidential, and abstinence from drugs or alcohol prior to coming to group. Group leaders use dry-erase boards to write down members' responses during brainstorming exercises. Handouts covering session content are provided to reinforce learning and to serve as visual reminders, and videos are shown to augment information discussed in group.

Clinical Experience With Partner Aggressive Women

The first and second authors of this paper have experience leading both men's batterers'

groups and women's anger management groups. The observations described in this section are derived not from research, but on experience working with both partner aggressive men and women treated in the domestic violence programs at UMass. The women's groups seem to build more cohesiveness than the men's groups. Women seem on average to be less resistant during initial sessions than men and they are more willing to take responsibility for their actions than men. As might be expected with this age group, the majority of the women are parents, and many are motivated to change for the sake of their children. The women typically provide each other with support, encouragement, and information about resources in the community. They require more referrals for treatment of depression, PTSD, substance abuse, and parenting skills in addition to the anger management program. It is not unusual for numerous group members in a given session to discuss pressing issues such as severe depression, suicidal ideation, addictions, and homelessness in addition to difficulties with anger or aggression.

Treatment Components Modeled from Treatment Components for Men

Partner abusive women, as we have stated, are often victims, as well as perpetrators, of domestic aggression. Group leaders must remain aware of this possibility and sensitive to its implications for treatment. Many of these considerations are discussed later as modifications of batterer treatment programs. However, in each of the strategies employed in group, whether borrowed from batterers treatment, or unique to the treatment of female perpetrators, safety considerations are always paramount. Nine components typically incorporated in treatment programs for men will be described here in detail. We feel that these components should be incorporated into treatment for aggressive women.

Component 1: Teach women to be responsible for their own actions

Partner aggressive women need to recognize that their partners do not "make" them engage in psychological or physical aggression. Women are taught that engaging in aggressive behavior is a choice that they have made. They are encouraged to recognize that there are

usually alternative ways to handle situations and that aggression is not their only choice. This goal is accomplished by brainstorming various ways of handling a conflict. For example, options may include taking time-outs, explaining to their partner why they are angry in a non-threatening and constructive way, ignoring the situation temporarily while using skills to reduce arousal, or calling someone for support and/or guidance.

Component 2: Teach women to recognize anger signs

Women are taught that anger occurs on a continuum. Learning to recognize anger cues, such as the physical sensations in their bodies, the cognitions, and the behavior that they typically engage in at various points along the continuum, is emphasized early in the program. They are encouraged to use these as early warning signs to become aware that their anger is escalating. Once they recognize that their anger is escalating they can stop and think about the various options available for handling their present situation and de-escalating their anger. Women are also taught to identify situations and times when they are most likely to have difficulty with anger management. Women are encouraged to recognize anger signals in their partners as well. Though their partners are responsible for their own anger and behavior, learning to recognize warnings signs in others will enhance women's ability to protect themselves in potentially dangerous situations.

Component 3: Teach women how to use time-outs safely

The time-out technique is presented as a method to prevent the dangerous escalation of anger in one or both partners. Women are taught the steps involved in taking a time-out: making the decision to leave, knowing all available exits, engaging in calming activities during the time-out, and calling the partner prior to returning to determine if he is calm enough for her to return. Women are encouraged to talk to their partners about the purpose and elements of time-out at a time when they are both calm. In addition, women are encouraged after each time-out to discuss the original problematic issue with their partner or to set a time in the future to discuss the issue.

Discussing the technique ahead of time and eventually discussing difficult issues will increase the likelihood that the partners of the women will agree that time-outs should be used in their relationship. However, despite these efforts some partners may feel threatened or abandoned by their partners' attempts to take time-outs and may attempt to struggle with the women to keep them from taking a time-out. Women are encouraged to evaluate whether they can feel safe in a home with a partner who will not allow them to take time-outs.

Component 4: Teach women about the consequences of their own aggression

A brainstorming exercise is used to help group members identify the consequences, for themselves and others, of their own aggression. Most poignant is the discussion about the effects of aggression on witnessing children and the effects of the aggression directed toward children. Many women in the program have open cases with child protection agencies because, in Massachusetts, exposing children to inter-parental aggression is considered a form of child neglect. The loss of child custody is a fear for some group members, and a reality for others. Increases in child behavior problems and psychopathology as a result of witnessing aggression is discussed. Potential consequences of aggression for their partners, such as injuries, fear, and depression are mentioned, but are not emphasized as much as in men's treatment due to the lower frequency of these consequences resulting from women's violence. The consequences of their anger and aggression for themselves are discussed at length by the women. These often include: relationship strain or loss, guilt, stress, legal charges, financial strain, effects on their job, and effects on their health. Women are also informed about the research findings of Feld and Straus (1989) and Murphy and O'Leary (1989) suggesting that their use of physical and psychological aggression may place them at risk for being physically victimized by their partners in the future.

Component 5: Teach women about the "anger suitcase"

The feelings typically underlying anger are identified in a brainstorming exercise. The

"anger suitcase" is described as a container for a mixture of important feelings that may be difficult to identify and communicate. Identifying feelings that underlie anger guides us in determining how to handle a situation. Women typically identify any combination of the following underlying feelings: jealous, sad, hurt, powerless, confused, afraid, frustrated, irritated, anxious, insecure, humiliated, trapped, unheard, overwhelmed, betrayed, embarrassed, disrespected, abandoned, stressed, and insulted. Many women describe feeling angry when they engage in psychological or physical aggression. It is hoped that helping them to recognize and label the feelings underlying their anger will aid them in generating appropriate behaviors to reduce their negative feelings. They are encouraged to communicate with others in an effective manner instead of escalating a situation by engaging in psychological or physical aggression.

Component 6: Communication Training

Effective communication skills are discussed and demonstrated through role-plays. Women are encouraged to communicate their feelings in non-threatening ways. They are taught to attend to the content of their speech and their tone of voice and they are urged to communicate using "I statements" instead of "you statements." It is suggested that they avoid using words like "never" and "always" and they are encouraged to suggest reasonable compromises to problems. Many women describe communicating in an aggressive manner and some women alternate between using a passive and aggressive communication style. Women are taught to communicate in an assertive, non-aggressive manner to get their needs met. This is similar to communication training in treatment for partner aggressive men but a focus on maintaining the safety of the women in the program is given priority. Previously it has been suggested that teaching abused wives to be more assertive may place them at risk of being victimized by their partner's in the future (O'Leary, Curley, Rosenbaum, & Clarke, 1986). Women remaining in abusive relationships are encouraged to continually monitor their safety. If they are concerned that their partners may respond aggressively to assertive communication, they are urged to communicate in ways that will ensure their safety and the safety of their children. Meanwhile, they are

supported to make their own decisions about whether they want to remain in relationships in which they feel unsafe.

Component 7: Changing Cognitions

Emphasis is placed on the role of thoughts in anger escalation and de-escalation. Women are taught to recognize several types of thinking errors that can lead to increased distress and they are urged to engage in alternative ways of thinking that can reduce distress. The role of extreme thinking, false assumptions, and inappropriate attributions is discussed. Specifically, women are encouraged to avoid the following: labeling themselves and others, mind reading, fortune telling, and exaggerating. They are taught to take responsibility for their own actions but not for the actions of others. These techniques are often used in cognitive therapy for depression (see Beck, 1995, for a thorough description of cognitive techniques).

Component 8: Alcohol and Substance Abuse

While alcohol and other substance use do not directly *cause* aggression, their use does significantly predict marital aggression in males (Pan, Neidig, & O’Leary, 1994). The differences among substance use, substance abuse, and addiction are discussed by group members. Treatment options for substance abuse are discussed and group members are given handouts with contact information about local substance abuse treatment facilities. Typically each women’s anger management group has several members in it who are in recovery from addiction. These members often share their experiences with others, including the relationships between their substance use and aggression in their lives, and their use of 12-step recovery programs. Group members currently abusing substances are strongly encouraged by group leaders and other group members to seek substance abuse counseling in addition to anger management.

Component 9: Stress Reduction

Group members often describe themselves as being under significant stress. Straus, Gelles, & Steinmetz (1980) found that over 50% of women with 10 or more life stressors were aggressive toward their husbands. Group members are taught problem-solving skills to help them relieve stress. Cognitive-behavioral skills such as deep-muscle relaxation, deep breathing, and mental imagery are demonstrated during group sessions. In addition women discuss other appropriate methods for handling stress such as exercising, listening to music, reading, etc. Group members are encouraged to engage in stress-reducing activities on a regular basis.

Modifications of Group Treatment for Men

The treatment program for partner aggressive women at UMass has been evolving since it began in 1996. Since the start of the women's program, it has become evident that several modifications to the men's program were necessary due to women's unique needs. Over the years, this program has been evolving in response to our awareness of the relevant issues. The following modifications to men's treatment have been incorporated into the women's treatment program at UMass.

Modification 1: Increased emphasis on the safety of the group members.

Safety of the women in treatment programs for aggressive women should be a top priority. Results from the 1975 and 1985 National Family Violence Surveys suggest that two-thirds of women who assault their partners are also victimized by their partners (Straus, et al., 1980; Stets & Straus, 1990). By the time women are referred to a treatment program it is expected that some women will have left their partners and some women will have remained in their relationships. Despite the status of the relationship, group leaders need to be aware of the potential danger that these women could be victimized in the future.

Treatment of aggressive women has been described as a means of providing support and treatment to battered women (Hamberger & Arnold, 1990; Hamberger & Potente, 1994). Safety

plans are discussed with group members to ensure that women are capable of getting away from an abuser quickly. This may involve keeping money, extra car keys, important documents, or clothes packed and ready for a quick escape from danger. Women should have a clearly articulated plan about where they would go in the case of an emergency and how they would get to their destination. Group members are provided with phone numbers for local women's centers and shelters, and they are given information about the services available to them, including instruction about how to obtain restraining orders.

Because some women are currently in abusive relationships and some are contemplating returning to an abusive relationship, information is provided about the effects of abuse on women and witnessing children. Characteristics of healthy and unhealthy relationships are discussed at length during treatment. Group leaders express concern about the safety of group members in abusive relationships while staying mindful that in order to empower their female clients, the leaders cannot instruct or pressure a woman to leave her relationship. If a woman is not feeling ready to leave a relationship, her group leader may only succeed in alienating her or causing her to drop out of treatment by suggesting that she must leave an abusive partner.

Modification 2: Attention to Women's Hierarchy of Needs

Maslow (1970) put forward the belief that humans need to satisfy their lower-order needs (e.g. food, sleep, money, security) before they will be motivated to work toward higher-order goals such as attaining knowledge, having high self-esteem, and maximizing one's potential. Many women in treatment programs may be dealing with urgent issues that take precedence over learning to control their anger and aggression. While this is also an important issue in treatment for many men, it seems to be a more frequent and pressing issue for aggressive women. Many women referred to treatment are dealing with issues like lack of shelter, food, and employment if they have just left an abusive partner or if their partner has left them due to their own aggression. It is important to raise women's awareness of housing options available in their communities. In addition, women are in need of information and referrals to guide them through the process of

applying for welfare, health insurance, legal counseling, financial counseling, and vocational counseling. Once women have consistent shelter and food for themselves and their children, they are better able to address their higher needs and work on taking responsibility for their actions and changing their behavior patterns.

Modification 3: Increased emphasis on Posttraumatic Stress Disorder

Dutton (1995) has emphasized the potential importance of PTSD symptoms in male batterers. While we agree that PTSD and previous trauma need to be addressed in men's treatment, due to the high rate of trauma suffered by aggressive women as indicated above, we feel that a greater emphasis on PTSD ought to be incorporated into treatment for women. Trauma symptom checklists such as the PTSD Checklist-Civilian Version (PCL-C; Weathers, Huska, & Keane, 1991) are used to quickly assess the presence and severity of trauma symptoms in group members. The PCL-C is a 17-item measure which assesses the severity of each PTSD symptom for the past month. It takes only 15 minutes to complete and scores are compared to the cutoff of 50 suggesting a clinical level of PTSD symptoms. PTSD may contribute to women's difficulties in controlling their anger and aggressive impulses, as well as coping with stress in general. Women are educated about the symptoms and treatments for posttraumatic stress disorder. We feel that many of the women in our groups would benefit from learning grounding techniques to cope with flashbacks and dissociation. While such techniques are beyond the scope of our program, many group members are given appropriate referrals for treatment of PTSD.

Modification 4: Increased emphasis on conditions that undermine mood stability

Leisring et al. (1999) found that almost two-thirds (63%) of women in the anger management program at UMass reported a history of depressive symptoms and 7.4% reported having a diagnosis of Bipolar Disorder. Approximately one third (32.3%) of women in that sample had made at least one suicide attempt (Leisring et al, 1999). Group members are educated about the symptoms and treatments for mood disorders and given appropriate referrals

for treatment. In addition, many women in the anger management program at UMass have described having problems with their mood related to premenstrual syndrome and menopause. Thus, discussions of the symptoms and treatments for PMS and menopause have been incorporated into the treatment program as well. Menstrual diaries are distributed to the group members so that they can track the presence and severity of their symptoms across three months.

Modification 5: More emphasis on parenting behavior

While parenting behavior is a critical topic to be included in treatment for aggressive men, we feel that this issue should be especially emphasized in women's treatment due to the fact that women continue to be more involved in child care than men (Lamb, Pleck, Charnov, & Levine, 1987.) Children raised in maritally violent homes are four times more likely to have psychological difficulties than children raised in nonviolent homes (Jouriles et al., 1989). Furthermore, findings from the 1985 National Family Violence Survey indicate that families in which the husband or wife has been aggressive toward their spouse have an increased risk of child abuse (Straus & Smith, 1990). Women who have been abused in childhood by family members may need guidance and information about appropriate parenting behavior.

The parenting module of our program emphasizes the main points often covered in parent training groups (see Barkley, 1997 and Barkley, Edwards, & Robin, 1999). Women are taught how to give clear and effective commands and consequences. Consequences should be as immediate as possible and in proportion to the misbehavior. For example, one woman in treatment grounded her teenage daughter for the entire summer for breaking a curfew, but grounding her for a few days or a week would have been more effective. Group members are encouraged to set consequences that they know they can follow through with, and avoid assigning consequences that they will not be able to effectively enforce. Women are urged to avoid the use of corporal punishment because it has been shown to lead to child aggression and delinquency (Straus, 2000) and to child cognitive difficulties (Straus, & Paschall, 1999). Furthermore, many of the women in treatment describe having difficulties managing anger, and

spanking a child while angry may result in the parent spanking harder than intended. It may be frightening for a child to be hit by an angry parent and children may learn from the parent's example that hitting while angry is acceptable.

Time-outs, grounding, and privilege removal as alternatives to corporal punishment are described in detail. Women are given the names of books on parenting and/or child development such as *Your Defiant Child* (Barkley & Benton, 1998) and *Touchpoints: Your Child's Emotional and Behavioral Development* (Brazelton, 1994). In addition group leaders are knowledgeable about parenting resources in the community and make referrals for parenting groups and respite care as needed.

Clinicians are mandated in Massachusetts to report suspected cases of child abuse to child protection agencies. At intake and during the first group session, group members are informed about this during a discussion of the limits of confidentiality. Group members are promptly notified if/when their actions are reported to child protection agencies by group leaders.

Modification 6: Less emphasis on power and control

Modifications 1-5 described above involve adding components to treatment for partner aggressive women. However, determining how to add treatment modules while being constrained by program length can be difficult. Power and control issues are discussed and emphasized in the great majority of treatment programs for partner-abusive men (Rosenbaum & Leisring, in press), but we advocate spending less time on these issues in treatment programs for women. Women typically exert power and control in different ways than do men and the consequences of women's behavior are far different. For example, by intimidating and assaulting women, men control women by placing them in fear of their safety. Women may also use aggression to control others. For example, they may verbally assault or slap their partners if their partners come home late from an evening out with friends. The men may decide in the future to return home on time so that they do not have to listen to their partners yelling and to avoid being physically assaulted by them. However, men in violent relationships are less likely

than women to fear bodily injury (Tjaden & Thoennes, 2000). In most cases it is likely that men who alter their behavior do so less out of fear of serious bodily injury than their female victim counterparts.

The Power and Control Wheel developed by battered women in Duluth, Minnesota (Pence & Paymar, 1993) is typically discussed and distributed in treatment programs for male batterers. It describes tactics that are used by men to establish and maintain control over their partners. Though we acknowledge that some women may "batter" men (Steinmetz & Lucca, 1988) the majority of women being mandated to treatment programs for domestic violence are not considered batterers because their aggressive behavior is not severe and does not result in the victim changing his behavior due to fear of bodily injury. While women should be encouraged during treatment to examine the degree to which they use emotional and physical abuse to obtain power and control in their relationships, overall we believe that less emphasis should be placed on these issues.

Future Research Needed to Inform Treatment

Further research examining women's aggression is needed and may benefit aggressive women, their partners, and their children. This chapter offers guidelines to be considered when treating aggressive women. However, it is acknowledged that treatment programs for aggressive women have yet to be evaluated. It is unknown how many women arrested and mandated to attend anger management or batterers treatment go on to assault their partners again after completing treatment.

Considerable research is needed examining the characteristics of partner aggressive women as well as predictors and precursors of aggression perpetrated by women. Such research may highlight additional treatment components that will enhance the effectiveness of intervention programs for women, and inform prevention efforts.

Leisring, et al. (1999) found that only 53% of court-mandated women who had an intake for the anger management program actually completed a 20-session program. Research studies

comparing the characteristics of women who complete treatment with those of women who drop out of treatment have not been conducted. If predictors of treatment drop-out are identified, adjustments to interventions can be made in an attempt to increase treatment completion.

Previous research has found that partner aggression perpetrated by women results in fewer and less severe injuries than partner aggression perpetrated by males (Vivian & Langhinrichsen-Rohling, 1994). However, women who engage in partner aggression may be placing themselves at risk of future victimization at the hands of their partners (Feld & Straus, 1989). The mechanisms by which this occurs warrants further study. Does women's aggression give men the idea that aggression is acceptable in their relationship as Straus (1993) suggests? Does women's violence cause relationship discord which in turn leads to aggression perpetrated by men? Marital discord is one of the strongest predictors of men's partner-aggression (Pan, et al., 1994). Do men retaliate with aggression because they are trying to use fear and intimidation to stop further assaults by their female partners? These questions remain unanswered.

Summary

It is hoped that this chapter will guide clinicians interested in treating partner aggressive women. While treatment for partner aggressive women should incorporate some of the same components of treatment for men, aggressive women also have unique needs which must be addressed. Many of the aggressive women have been victimized by their partners and the safety of women needs to be the top priority of treatment. Women should be aided in developing safety plans to facilitate their ability to leave dangerous situations as quickly as possible. It must be recognized that most partner aggressive women have been victimized in some way either in childhood, adulthood, or in both. Symptoms of posttraumatic stress disorder (PTSD) and mood disorders should be assessed and additional treatments recommended when warranted. Helping women discipline their children in a non-aggressive manner should be a major goal of treatment, in addition to reducing partner-violence. Many women in treatment will need help in fulfilling their basic needs of shelter and food. Once women's basic needs are met it is hoped that they

will benefit from cognitive-behavioral anger management skills, and will be less likely to engage in partner aggression in the future. Men, women, and children have the right to live in a non-violent home.

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