

JOINING FORCES

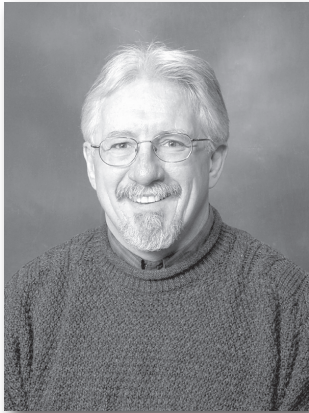


Joining Families

Volume 11, Issue 2 • July 2009

REAL WORLD RESEARCH FOR FAMILY ADVOCACY PROGRAMS

FEATURED INTERVIEW



Intimate Partner Violence: Function, Treatment and Typologies

An Interview between James E. McCarroll, PhD and L. Kevin Hamberger, PhD

L. Kevin Hamberger, PhD

Dr. Kevin Hamberger is Professor of Family and Community Medicine at the Medical College of Wisconsin and an affiliate of the Injury Research Center at the Medical College of Wisconsin. Since 1982, he has conducted treatment and research programs with domestically violent men and women and developed and evaluated health care provider training programs to deliver violence prevention services to patients. He has

published over 100 articles and chapters and six books and serves on the editorial board of six scientific journals.

Dr. McCarroll: How did you enter the field of intimate partner violence research?

Dr. Hamberger: In the very early literature on intimate partner violence there were two concepts from the predominantly feminist model that gave me pause. The first was that all men are at risk of battering. The second viewed psychopathology as not being part of the battering spectrum. My own clinical observations revealed many individual differences. Jim Hastings, one of my research colleagues, and I sought to highlight that heterogeneity within the population with which we were working. [Editor's note: See review of Hamberger and Hastings research in the review of Dr. Hamberger's research.] Our goals were to demonstrate that batterers (abusive men) constitute a very heterogeneous population and to look at the frequency of psychopathology in our clinical samples.

Dr. McCarroll: Does the term batterer describe only the man who is the severe, pathological abuser or does it refer to a broader range of abusive behavior?

Dr. Hamberger: I view battering as a factor in determining how violence works in the relationship, not as the overall severity of the violence. In a particular relationship, pushing and shoving may function to dominate or control the victim in the same way that more severe violence may function in another relationship.

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In This Issue

The focus of the summer issue of *Joining Forces Joining Families* is batterer treatment. We present features that describe many relevant treatment evaluation issues for the Army Family Advocacy Program. Our featured interview is with L. Kevin Hamberger, PhD, a distinguished researcher and practitioner. Dr. Hamberger's work addresses typologies of batterers based on personality and psychopathology, batterer assessment and treatment, and the function of violence in a relationship. We expand upon these themes in a review of his research and on civilian research on batterer treatment outcomes.

Building Bridges to Research discusses methodological issues in planning treatment evaluation research. *Websites of Interest* focuses on anger management, provides information on controlling anger, and on differentiating anger management from domestic violence treatment. We hope your summer is going well.

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The primary focus of batterer treatment is on the function of violence and abuse to dominate and control an intimate partner.

Dr. McCarroll: What is the focus of the power and control model today?

Dr. Hamberger: In clinical samples, we tend to see a predominance of male-to-female violence. Male-to-female intimate partner violence is related to and stems from broader sociopolitical forces that tend to place women in a second-class status. That second-class status is reinforced within an individual relationship through the application of force, abuse, and controlling behaviors. It may not be the whole story. One theoretical perspective does not adequately explain all of intimate partner violence.

Dr. McCarroll: Is anger management the recommended treatment for batterers?

Dr. Hamberger: Most state standards would argue against anger management as a treatment for batterers because it is too narrowly focused on the batterer's lack of skill in managing anger, and not enough emphasis is placed on using violence as a tool of power and control. The predominant model is psychoeducational using a cognitive-behavioral skills-based approach in which the primary focus is on the function of violence and abuse to dominate and control an intimate partner. Studies show

that abusive men, on average, do show more anger and hostility relative to nonviolent men. One needs to be mindful of anger issues when assessing men for treatment as well as doing treatment with them.

Dr. McCarroll: In your early work, you were not able to find enough female batterers to include in your analyses. Is this still the case?

Dr. Hamberger: A larger number of women are now being arrested as either the sole perpetrator or as part of a dual arrest scenario. Recent arrest rates indicate that women constitute upwards of 20–25% of all people arrested for domestic violence. My research on female perpetrators has focused on motivation for using force against their intimate partners rather than on personality characteristics and psychopathology.

Dr. McCarroll: Do dual arrest policies require the arrest of persons who engage in violence for self-defense?

Dr. Hamberger: That has not been adequately sorted out. Most state laws regarding mandatory arrest discourage dual arrest and promote determination of the predominant physical aggressor. My research on motivations for use of intimate partner violence by men and women reveals that about two-thirds of men are using violence primarily to dominate and control their partner. About 17% of men report self-defense or retaliation from a prior assault as a motivation. We see the mirror opposite with women. About two-thirds report their primary motivation for violence is self-defense or retaliation, and about 17–19% report domination and control. Motivations such as retaliation and self-defense may not prevent a person from being arrested, but are still important for the clinician to consider when planning treatment.

Dr. McCarroll: Do you think batterer treatment works, and if so, how?

Dr. Hamberger: The evidence across the two or three meta-analyses that I have read looks promising, but not conclusive. There is a small, but significant effect size in batterer treatment. However, one can find a lot of flaws in the research that argue against strong results. We have not looked carefully at matching treatment to the characteristics of abusive men including readiness to change, trauma history, alcohol and drug abuse, and the need to deal with a

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Joining Families

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Joining Forces Joining Families

is a publication of the U. S. Army Family Morale, Welfare and Recreation Command and the Family Violence and Trauma Project of the Center for the Study of Traumatic Stress (CSTS), Bethesda, Maryland 20814-4799, tel. 301-295-2470. CSTS is a part of the Dept. of Psychiatry, USUHS, and a partnering center of the Defense Centers of Excellence (DCoE).



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Review of Research of L. Kevin Hamberger, PhD

By James E. McCarroll, PhD and David M. Benedek, MD

Anger is frequently seen in batterers with borderline personalities, but also in depression and anxiety disorders. Abusers have anger and hostility directed at themselves, but also less anger control.

In a series of studies, Hamberger and colleagues have examined personality patterns of batterers and non-batterers using a dual approach. The first involves studying batterers only; the second compares batterers and non-batterers. These approaches yield different results. In the former, possible differences between batterers can be examined; in the latter, one can attempt to find differences between batterers and non-violent persons. To date, his research on batterer characteristics has been exclusively on males because during the time of data collection not enough female batterers had been identified for study.

Both personality and psychopathology are related to spouse abuse. An early study of personality correlates of 99 men who battered their partners and were part of a domestic violence abatement program found three categories of personality profiles reflecting general tendencies: schizoid/borderline, narcissistic/antisocial, and dependent /compulsive personality disorders (Hamberger & Hastings, 1986). Only about 12% of batterers showed no psychopathology. They concluded that there was no general batterer personality profile, that the majority of batterers showed evidence of disordered personality profiles, and that both personality types and psychopathological processes must be considered among the factors related to spouse abuse. This research was extended to comparisons between domestically violent and non-violent men (Hamberger & Hastings, 1991). The domestically violent group included men who were alcoholic and non-alcoholic. Both alcoholic and non-alcoholic abusive men showed higher levels of borderline personality organization than nonviolent men.

Hamberger and colleagues continued to pursue batterer typology in a larger study of 833 men who were court-referred for evaluation prior to participating in a domestic violence counseling program (Hamberger, Lohr, Bonge, & Tolin, 1996). They found three main clusters of batterers, which largely replicated

the typology work of Holtzworth-Monroe and Stuart (1994). Cluster 1 was characterized as dependent-submissive, passive-aggressive negativistic, and avoidant; cluster 2, as narcissistic, antisocial-aggressive, and histrionic-

gregarious; cluster 3 was non-pathological. The non-pathological men generally had the lowest maximum violence and their violence was restricted to intimate relationships. The antisocial and passive-aggressive men did

not differ in maximum violence. However, antisocial men were the most generally violent and had the most police contacts. Passive-aggressive and dependent men had the highest frequency of violence.

Batterers, particularly those with borderline personality organization, generally struggle with anger and hostility (Hamberger & Holtzworth-Monroe, 2009). Anger is a common feature of domestic violence. However, anger, hostility, and aggression are different concepts: anger is the emotion, hostility is the attitude, and aggression is the behavior (Del Vecchio & O'Leary, 2004). Anger is infrequently mentioned in psychiatric diagnosis nomenclature. In DSM-IV (American Psychiatric Association, 1994), anger is not a diagnosis or more than part of a criterion for a mental disorder, e.g., post-traumatic stress disorder (p. 428), intermittent explosive disorder (p. 612), and borderline personality disorder (p. 654).

Hamberger and Holtzworth-Monroe (2009) report that abusive men are more hostile than non-abusive men. Anger is frequently seen in batterers with borderline personalities, but also in depression and anxiety disorders. Abusers have anger and hostility directed at themselves, but also less anger control. Particularly important to the expression of anger in abusive men is the tendency to label and interpret their partner's behavior with negative intent. They note that these attributes occur in situations that most would interpret as only moderately provocative, situations that non-violent men would be likely to overlook or at least not react strongly. They ask the question as to whether

Batterers, particularly those with borderline personality organization, generally struggle with anger and hostility

In conclusion, Hamberger's research indicates that batterers are a heterogeneous group, particularly in terms of the relationship between their typology and violence as well as anger and hostility.

batterers are mentally ill. In terms of personality disorders, at a minimum, the answer seems to be that many are.

It is important for clinicians to know how anger and aggression are related to violence. Psychologists who work with personality profiles and have expertise in domestic violence have demonstrated reliability sorting batterers into profile types, particularly borderline-dysphoric and antisocial/narcissistic (Lohr, Bonge, Witte, Hamberger, & Langhinrichsen-Rohling, 2005). This research represents an effort to determine whether providers can be taught to use personality profiles to categorize the abusive clients — necessary to subsequently design treatment based on individually assessed needs.

In conclusion, Hamberger's research indicates that batterers are a heterogeneous group, particularly in terms of the relationship between their typology and violence as well as anger and hostility. For example, while many batterers show high levels of anger and aggression, some show lower levels than non-violent men. Hamberger speculates that this finding may be due to the fact that many batterers are superficially pleasant, but also that they deny or deceive when anger is inquired on self-report measures (Hastings & Hamberger, 1988; Hamberger & Holtzworth-Monroe, 2009). Whatever the pattern of personality, alcohol tends to increase violence severity and frequency. It is noteworthy that Hamberger found no alcohol-abusive men in his non-violent samples (Hastings & Hamberger, 1988). Because of the complexity of violent behavior, treatment is also complex. Given that most partner-violent men seemed to have some

form of psychopathology consisting of personality disorder, depression, anxiety, dysregulation of affect, and substance abuse, treatment may call for specific approaches that target each of these factors.

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broad spectrum of treatment issues such as recidivism. The anger management interventions alluded to earlier also need to be considered as part of a broader intervention for emotion regulation.

Dr. McCarroll: How would you advise clinicians to think about using the results of your typology research?

Dr. Hamberger: I have used the information from typologies more to assess aspects of risk of premature termination and recidivism. Borderline, dysphoric men are at a high risk of dropping out of standard treatment. We have also found that dropouts are at a higher risk of recidivating than completers. That information can inform the female partner's safety planning and decision-making. We need to ramp up our expertise in pretreatment assessment and in developing treatment plans

that are more in line with the client's needs and personality style rather than just applying a 'One size fits all' model.

Dr. McCarroll: When do you involve a non-battering spouse in the treatment?

Dr. Hamberger: Primarily, I involve the victim-partner in collateral contacts early in the abusive partner's assessment and at the end of his involvement in treatment. I gather information about the violence from her point of view, provide community resource information, conduct safety planning, discuss risks, and establish a set of criteria for ongoing contact, if necessary. We do not involve the most disordered and severely violent people in couple counseling. Couple counseling appears to be appropriate primarily when both partners are willing to attend and for people who commit less severe levels of violence,

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Methodological Issues in Batterer Treatment Outcome Evaluation

By James E. McCarroll, PhD and Robert J. Ursano, MD

Practitioners and administrators in family maltreatment continually strive to understand and use evidence-based treatments for which there are more questions than answers.

Practitioners and administrators in family maltreatment continually strive to understand and use evidence-based treatments for which there are more questions than answers. Our review of batterer treatment reveals that outcomes are inconsistent at best. Methodological difficulties are important in determining how to approach the question, “Does batterer treatment work?” The question must include qualifiers such as “With which population?” and “Under what circumstances?” If you are thinking about evaluating treatment outcome, such as in a men’s batterer treatment group, here are some of the questions you might address in planning such a study.

Question Selection

Choose a question that can have an answer. One way to tell if you have done this is to state a hypothesis. For example: People who complete treatment will have a better outcome (in terms of specific variables such as recidivism, measures on instruments, partner satisfaction, or other reasonable outcomes) than those who drop out.

The study can be descriptive or experimental. In a descriptive study, you are observing and measuring what happens in a course of events. For example, in one year, how many people complete treatment and how many do not? In an experimental study, you assign people to an experimental or a comparison condition. You do something different (e.g., treatment) with each group. The comparison (or control) condition may include an alternative treatment or no treatment.

Literature Review

A major purpose of the literature review is to state what others have found and how your work will add to the field. Literature reviews include scientific studies that are directly or at least closely related to the question you have selected. All studies are not the same. You will need to examine the description of each study to determine if it has been well-conducted and its results can be applied to your question.

Aims, Goals, Objectives, Hypotheses

Your problem statement should be in terms of objectives and hypotheses. The objectives should be general statements of the problem to be addressed. Hypotheses are specific, testable statements about the condition you are examining.

Participant Selection

- Who are the participants in the research? How will they be recruited? Who will be excluded? (These are called inclusion and exclusion criteria.)
- What ages will you include? Will you attempt to recruit a certain number by race/ethnicity, and gender?
- Can you randomly assign participants to treatment or no-treatment groups?
- If offenders are participants, have they been referred by a military or judicial system?
- Is there a requirement by the referring agency for them to attend treatment and, if so, for how long? Even if mandated for treatment, their participation in the research must be voluntary.
- Have they had previous legal involvement for domestic violence?

Treatment Plan

- Has it been previously tested?
- Will you change the program content or length?
- Is there a treatment manual for your program with a specific plan for sessions?

Measures

- Will you use standardized instruments?
- If not, what is your alternative and why?

Comparison Group

- No treatment?
- Alternative treatment?
- Wait list?

Problems in the Study

- How will you analyze data from treatment non-attendees?
- How will you analyze data from treatment drop-outs?

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Batterer Treatment: Implications of Civilian Research Literature on the Army Population

By James E. McCarroll, PhD

Conducting research on the treatment of domestic violence offenders is difficult. Limitations in both civilian and military populations include participant recruitment, random assignment to treatment and control groups, dropouts, length of follow-up time ...

In this article, we review the current civilian literature on batterer treatment outcomes that may assist in the design and research of Army treatment programs for domestic violence offenders. Conducting research on the treatment of domestic violence offenders is difficult. Limitations in both civilian and military populations include participant recruitment, random assignment to treatment and control groups, dropouts, and length of follow-up time. In the Army, further restrictions exist due to military requirements and practices.

There are a number of Army-specific variables that affect the efficacy of domestic violence treatment. These include deployment, military unit supervisory practices, and the military justice system. In the absence of military domestic violence research, we look to civilian research for assistance. To our knowledge, there is no research on domestic violence treatment procedures or outcomes in the Army.

Most treatment outcome research has been performed on batterer intervention programs (BIPs). Gondolf (1997) reported a multisite evaluation of the results of batterer treatment programs, involving a total of 840 men. The men and their partners were interviewed every three months for 15 months after intake. According to the victims, about 31% were re-assaulted during the follow up period. While verbal abuse (70%) and threats (43%) were high, most of the women reported feeling very safe. Gondolf also found that about half the men who re-assaulted did so within the first three months. He concluded that well-established batterer programs contribute to a short-term cessation of assault, but a small minority of the men were unaffected or unresponsive to the intervention.

The National Institute of Justice published an overview of batterer treatment research and reviewed evaluations of two batterer intervention programs that had attempted a rigorous research methodology (Jackson, Feder, Forde, Davis, Maxwell, & Taylor, 2003). One was in Broward County, Florida (Feder & Forde, 2003), and the other in Brooklyn, New York (Davis, Maxwell, & Taylor, 2003). Both programs used a psychoeducational model based

on feminist ideology. In both groups, batterers (males only) were court-mandated to attend a BIP. Men were randomly assigned to a treatment or control group. In the Broward County study, men in the treatment condition were assigned to a 26-week program while controls were sentenced to one year of probation. In the Brooklyn study, some men in the treatment group were assigned to a 26-week program while others attended longer, twice-weekly sessions for 8 weeks. Community service was required for men in the control group. The Broward County study found no differences between the experimental and control groups in violation of probation or re-arrests. They also found no differences in attitudes toward (a) the role of women, (b) whether wife beating should be a crime, or (c) whether the state had a right to intervene in cases of domestic violence.

The Brooklyn study found that the treatment group was less likely to be arrested again for a crime against the same victim. However, only the 26-week group had significantly fewer official complaints than the control group at 6 and 12 months. The pattern of victim reports was not significantly different between the 8-week group and the 26-week group. There were no differences between the three groups in attitudes toward domestic violence. The differences between the outcomes of the 8-week group and the 26-week group are important for several reasons. Researchers thought that batterers would be more likely to complete the shorter treatment program and have a lower re-arrest rate. From a policy point of view, an 8-week group would be more cost effective than a 26-week group. However, as noted above, the 26-week group had fewer criminal complaints against them than the 8-week group. The investigators concluded that batterer intervention suppressed violent behavior for the duration of treatment. Due to many limitations, such as problems in random assignment, measurement of violence, attrition, low response rates, and other problems, neither of these studies is conclusive.

There are many policy questions regarding batterer intervention programs (Jackson, Feder,

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Forde, Davis, Maxwell, & Taylor, 2003). These include whether they waste valuable resources, create a false sense of security for women who may believe the batterer will reform, and the prudence of mandating batterer treatment when there is little evidence that it works.

A meta-analytic review of four experimental and six quasi-experimental studies of court-mandated batterer intervention programs found conflicting results (Feder & Wilson, 2005). All the studies used a cognitive-behavior, feminist-oriented, or psychoeducational approach. The mean effect of the program from official reports showed modest benefit, whereas the mean effect for victim-reported outcomes was zero. Quasi-experimental studies without a no-treatment comparison had inconsistent findings indicating a small overall harmful effect. Contrasted with the no-treatment comparison, studies that used treatment dropouts as a control group showed a large, positive mean effect on domestic violence outcomes. The authors raised concerns about using treatment dropouts as a control, of official reports, and of the effectiveness of court-mandated batterer treatment programs. Official reports tend to underestimate the violence and victim reports are not always reliable. The authors concluded that their analysis did not offer strong support for court-mandated treatment of misdemeanor domestic violence offenders as a way to reduce the likelihood of further domestic violence.

There is a relationship between personality characteristics and both treatment dropout and recidivism (Hamberger, Lohr, & Gottlieb, 2000). Dropout was evaluated in two ways: those who completed intake but never attended treatment and those who completed intake and began treatment but dropped out prior to completing all the sessions. Dropouts after intake scored higher on a measure of paranoid personality whereas those who dropped out during treatment scored higher on a measure of borderline personality. Recidivism following treatment completion was more likely among those with greater antisocial and narcissistic personality orientations (Hamberger & Hastings, 1990).

There is a great need for treatment research in the U.S Army for both clinical and policy purposes. In addition to treatment effectiveness, research is needed in treatment partic-

ipation, effects of treatment interruption based on deployment or moves, effects of offender treatment on families, and effects of the treatment on other aspects of the offender's life such as the perception of the offender by the military unit.

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Methodological Issues in Batterer Treatment Outcome Evaluation, from page 5

Analytic Methods

- What is your data analysis plan?
- Do you have the computer software to enter and analyze your data?
- Will you need a statistical consultant?

Administration

- What approval processes are required for you to conduct your study? Research on domestic violence in the Army must usually be approved by your department, your Institutional Review Board, the Family Advocacy Research Subcommittee (FARS), and potentially other institutions,

particularly if external funding is sought or otherwise involved.

- Do you have adequate resources to conduct your study? This includes funding, personnel, facilities, travel, equipment, supplies, and miscellaneous expenses.

While these tips are not all inclusive, they will help you think about research design in your own work and as you read the work of others. Treatment evaluation research is complex. Such a task should be addressed in small steps. One study will not provide all the answers, but can give you useful information and suggest further research.

Websites of Interest

Mayo Clinic

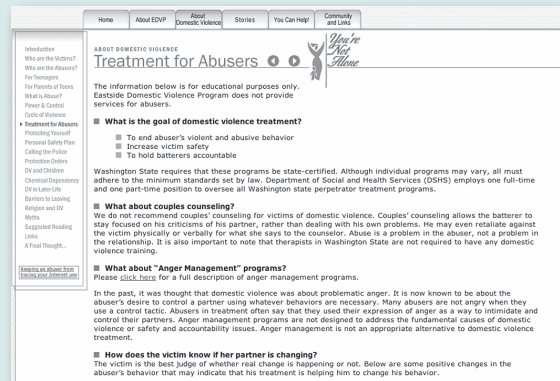
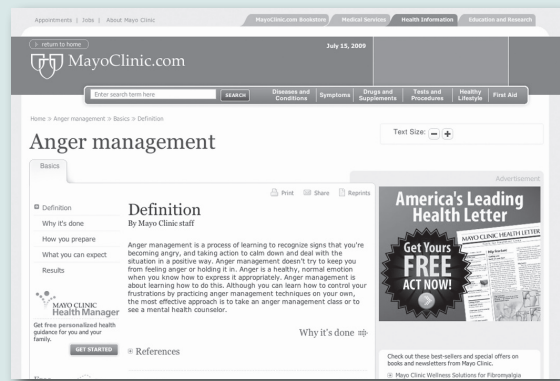
Battering is generally included in websites on anger management, of which there are many. The Mayo Clinic <http://www.mayoclinic.com/health/anger-management/MH00073> provides a discussion of anger management including a self-diagnostic tool to determine anger level, examining anger patterns, and strategies for constructive expression of anger. Also present is a set of pages devoted to other aspects of self-management such as resilience, self-esteem, and mental health.

American Psychological Association

The American Psychological Association presents a discussion on anger including strategies for control. See <http://www.apa.org/topics/controlanger.html>. Interestingly, they note that sometimes people are not angry enough. Assertiveness training is one remedy for this lack. Also of importance on this website is a list of psychology topics, from addictions to workplace issues.

Eastside Domestic Violence Program

The Eastside Domestic Violence Program (EDVP) in Seattle, Washington, has a number of interesting pages related to the impact of domestic violence. See <http://www.edvp.org/AboutDV/forabusers.htm#chart>. For example, it provides lists of possible signs of when a batterer is changing and not changing. It also describes their anger management program. Their orientation is largely feminist, based on control issues. As an example of the diversity of domestic violence treatment and, particularly anger management, is their perspective that anger is not the basis of domestic violence, but another means to intimidate a partner. Also of interest is a table that differentiates anger management treatment from domestic violence treatment.



Interview with L. Kevin Hamberger, PhD, from page 4

not for those with severe pathology that we might see in the borderline-dysphoric and antisocial-narcissistic typologies.

Another problem for couple counseling is that batterers as a whole tend to over-interpret and see their partner in a certain way such as “She’s doing this on purpose,” or “She’s always doing this to disrespect me.” In contrast, there are less drastic interpretations such as “She’s just misbehaving right now” or “We’re just having a difference and it’s not a big deal.” We would also challenge him to think about the fact that he immediately jumps to the conclusion that his partner is likely to cheat on him and to change that type of thinking, too.

Dr. McCarroll: *Since it may not be a good idea to include the spouse in the treatment of a batterer, how do you bring*

their over-interpretation of cues into therapy?

Dr. Hamberger: In batterer treatment, we frequently talk about various interactions that men are having with their partners. That is part of the ongoing homework. When they feel upset, when they feel angry, when stressors are in their relationship, they are asked to record their thoughts about what is going through their mind as they experience such a situation. Then they bring that homework into the treatment with them and we go over it.

Dr. McCarroll: *Thank you for your insights and your contribution to our newsletter.*

Dr. Hamberger: You are welcome.