Typologies of Intimate Violence and Assessment

Making the Distinction
The identification of typologies of intimate violence is part of an emerging paradigm towards a multi-faceted, multi-theoretical approach to the understanding, assessment, and treatment of intimate violence (Chase, O’Leaerly, & Heyman, 2001; Greene & Bogo, 2002; Johnson & Ferraro, 2001). Several typologies have been identified that range in scope from interactional characteristics of intimate violence (Johnson, 1995; Olson, 2002; Whitchurch, 2000), to individual characteristics of male batterers (Berns, Jacobson, & Gottman, 1999; Chase et al., 2001; Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000; Waltz, Babcock, Jacobson, & Gottman, 2000), to recent promising work on individual characteristics of female batterers (Babcock, Miller, & Siard, 2003; Swan & Snow, 2002).

Findings from this research indicate that the motivation, characteristics, and effects of intimate violence vary widely across multiple spectrums of individual and interactional characteristics, and that treatment effectiveness depends upon the type of violence present.

A Need to Integrate Typologies of Intimate Violence with Assessment and Treatment

Current accepted clinical practices and policies for the assessment and treatment of intimate violence do not yet make distinctions between types of violence. In essence, we are still using a “one type fits all” model to address a complex phenomenon that is clearly not one-dimensional. Two consistent factors that have plagued intervention effectiveness statistics are high drop out and low effectiveness rates (Dutton, 1995; Hamby, 1998; Lawson, 2003). This may be due to the fact that we are not adequately tailoring treatment approaches to match the particular needs of the client. In addition, intense debates around the issues of gender and power, and the appropriateness of using couples counseling to assess and treat intimate violence, has often led to polarization among well-intentioned researchers, clinicians, and policy-makers who share the common goal of stopping family violence. Typologies of intimate violence open the door for a more well-informed dialogue around these issues that may help to bridge this divide.

Commonalities and Distinctions Among the Typologies

George (2004) conducted an extensive comparison of the existing intimate violence typology literature and identified two distinctive themes. One theme is the presence of a type of violence that has low levels of control, none to low levels of severe physical violence, and tends to be reciprocal and gender symmetric in nature. Perpetrators of this type of violence typically have high levels of remorse, low support and/or history of violence within and outside the home, low externalization of blame, and none to low rates of unresolved psychopathology and substance abuse. This type of violence appears to have a relatively low potential for long-term physical or psychological harm, and shows promise of being amenable to couples therapy.

The existing literature also suggests that couples therapy may not be effective for treating some types of intimate violence. A second prominent theme in the typology research indicates the presence of a type of violence enacted by one or both partners (predominantly males) that involves high levels of control typically accompanied with high levels of severe physical violence. The perpetrators of this type of violence typically have low levels of remorse, high support and/or history of violence within and outside the home, high levels of externalization of blame, and high levels of unresolved psychopathology and substance abuse issues. This type of violence has a high potential for long-term physical and psychological harm, as well as a high potential for retaliation. Attempting to treat this type of violence with couples
counseling could cause significant harm to these individuals and their families. Individual therapy, gender-specific groups, and appropriate treatments to resolve the substance abuse and psychopathology issues are most suitable for this type of violence.

**Integrating Intimate Violence Typologies with Assessment and Treatment Protocols**

Figure 1 is a conceptual assessment tool that integrates current assessment protocols with the common themes identified in the typology literature to assist clinicians in identifying the type of violence present, and whether couples counseling is a viable treatment option. Because of the complex and often covert nature of intimate violence, current assessment protocols recommend that all couples be evaluated for intimate violence when entering treatment. Several authors have developed guidelines for this assessment process that ensure client safety (Bograd et al., 1999; Lipchick & Kubicki, 1996; Stith, Rosen, & McCollum, 2002; Walker, 1995). Because safety of the client is paramount during the assessment process, it is recommended that clinicians assume the extreme type of intimate violence may be present until it can be ruled out. Below is a summary of the key indicators for making this determination.

**Indicators of Intimate Violence Linked to Imminent Harm**

**Identifying a Pattern of Coercive Control.** In 1995, Johnson made a significant contribution to the intimate violence field when he proposed that physical violence embedded in a pattern of coercive control is distinctly different, and more harmful, than physical violence not embedded in a pattern of coercive control. Johnson developed a theoretical coercive control construct that includes: inhibiting the will (e.g., psychological abuse, legitimization of control) and ability (e.g., economic control and social isolation) to resist; threats and intimidation (violence enacted to show there is an ability and will to impose punishment); surveillance (e.g., stalking and monitoring partner’s behavior); and contingent punishment (violence enacted as punishment for a failure to comply with the explicit or implicit demands).

Johnson’s coercive control construct is based on the Duluth Abuse Project’s (2003) Power and Control Wheel, a widely-accepted, feminist-based model that accounts for the complex dynamics that create and maintain the cycle of violence that can lead to the battered woman syndrome. Johnson’s coercive control construct also encompasses many of the established constructs used to measure non-physical violence (Dutton, 1995). Making the distinction between types of violence linked to imminent harm based on a pattern of power and control is consistent with the existing literature that suggests that non-physical violence often precedes and predicts physical violence (Gordon, 2000; O’Leary, 1993; Straus & Sweet, 1992; Vivian & Malone, 1997), and that the long-term effects of non-physical violence may be more harmful than the long-term effects of physical violence (George, 2004; Johnson & Leone, 2000; Vitanza, Vogel, & Marshall, 1995).

**Identifying a Pattern of Severe Physical Violence.** A history or pattern of severe physical assault behaviors increasing over time or requiring medical care have been shown to be highly correlated with patterns of coercive control (George, 2004). Straus’ (2000) Modified Conflict Tactics Scale (CTS-2) is one of the most widely used assessment tools that measures frequency, severity, and range of physical assault behaviors by both partners. The current assessment literature suggests that couples therapy should not be undertaken if there is a history of two or more acts of severe physical violence within a 12-month period, or when it is used to establish control, intimidate, punish, demoralize, exploit, or instill fear (Bograd et al., 1999; Jory, 2004; Stith et al., 2002).

One of the limitations to using Straus’ CTS in a clinical setting is that overtly assessing for physical violence can create a safety risk for extreme types of violence. Jory’s (2004) Intimate Justice Scale (IJS) is a safe, alternative assessment tool that captures several of Johnson’s coercive control criteria, and that has also been highly correlated to the CTS. Jory suggests that the IJS be administered as a written questionnaire to all couples presenting for couples therapy. The IJS includes 15 questions about partner behaviors evaluated on a scale from 1 (I do not agree at all) to 5 (I strongly agree). Total scores are obtained by summing the responses for all 15 items, with a possible range of 15 (no reported violations) to 75 (pervasive violations and a high likelihood of physical violence). Scores ranging from 15 to 29 indicate little risk of physical violence; scores ranging from 30 to 45 indicate a likelihood of minor physical violence; and scores greater than 45 may be a predictor of severe physical violence.
### Intimate Violence Linked to Imminent Harm

#### Pattern of Coercive Control?\(^2,3\)
- Threats and intimidation; surveillance (stalking, monitoring); contingent punishment; inhibiting/reducing will and ability to resist (psychological, economic, social); pattern of multiple tactics increasing over time (> 3 behaviors in one incident)

#### Pattern of Severe Physical Assault?\(^1,2,8\)
- Frequency, range, severity of physical assault increasing over time (more than 2 acts of severe physical violence in 12 months); signs/history of severe physical injury requiring medical care; Jory’s\(^5\) Intimate Justice Scale score > 45

#### Lethality Risk Factors?\(^1\)
- Unresolved substance abuse; history of violence inside or outside of home; unresolved or ongoing child custody cases; availability of weapons; threats to retaliate, hurt, kill self or partner; obsession with partner (jealousy, stalking); bizarre forms of violence;

#### Other Potential Risk Factors?\(^1,7\)
- Low anger and remorse? High hostility, support of violence, and externalization of blame Unresolved psychopathology (APD, BPD, ICD, NPD); Depression, PTSD by one or both Perceived fear of partner, or belief of imminent harm by partner

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#### Conjoint Treatment Checklist\(^1,6,7,10\)
- Reduced concern of escalation, retaliation, or harm
- Both agree to conjoint without coercion
- Both evidence respect of partner feelings, boundaries
- NVP not afraid to express views with VP present
- NVP expresses desire for intimate violence to cease
- VP can tolerate hearing NVP description of violence
- VP evidences accountability for use of violence
- VP can tolerate hearing NVP description of violence
- VP evidences awareness of escalation process
- VP able to manage anger and conflict without violence
- VP recognizes differential effect of gender and power
- VP committed to stop all violence as experienced by NVP
- VP takes responsibility for quality of relationship

**Conjoint Treatment Indicated\(^1,2\)**
- Primary focus is on eliminating violence
- Both agree to No Violence Contract
- Develop Safety Plan: boundaries, limits; alternative; self-monitoring; plan if VP doesn’t follow through
- Skill building (identify process, de-escalation tools)
- Building trust, caring, respect, empathy
- Combine with individual session to monitor safety

**Recommended Intermediate Treatments**
- Individual Therapy
- Gender-specific Group Treatment
- Substance Abuse Treatment
- Treatment of Unresolved Psychopathology

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**STOP! Conjoint Treatment Not Indicated\(^6,3\)**
- Primary focus is on maintaining safety of NVP
- Maintain direct primary conversation with VP
- Explain conjoint therapy will not meet their needs
- Use respectful language that invites responsibility
- Ask questions to VP that alert NVP to danger
- If possible, develop a preliminary safety plan
- Refer to appropriate intermediate treatment

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![Figure 1. Conceptual Clinical Assessment Tool for Identifying Appropriate Treatment Based on Type of Violence Present. Intimate Violence = Any act of physical or non-physical aggression used against an intimate partner without consent. VP = violent partner (if unclear, assume partner with most amount of physical, mental, psychological, or economic power); NVP = non-violent partner. Numbers indicate references.](image-url)
IDENTIFYING LETHALITY RISK FACTORS. Several lethality risk factors have also been associated with extreme types of intimate violence. Bograd et al. (1999) suggest that conjoint treatment should be ruled out if any of the following lethality risk factors are present, even if no physical violence is disclosed: unresolved substance abuse; a history of intimate violence; a history of violent crimes or violations outside the home (convictions and/or accusations of assault on spouses or non-family members); unresolved or ongoing child custody cases; availability and use of weapons (including martial arts) on the partner or other family members; threats to retaliate, hurt, or kill the partner or self; obsession with the partner (intense jealousy, repeated accusations of infidelity, ongoing monitoring, stalking, social isolation); and bizarre forms of behavior (sadistic, depersonalized abuse with elements of torture such as rape, burning, starvation, sleep deprivation).

IDENTIFYING OTHER POTENTIAL RISK FACTORS. The typology research indicates that extreme types of male (and some female) perpetrators often have unresolved psychopathologies, including antisocial personality disorder (APD), bipolar disorder (BPD), narcissistic personality disorder (NPD), and impulse-control disorder (ICD), often accompanied by unresolved symptoms of depression and post-traumatic stress disorder (PTSD) by one or both partners (Anderson, 2002; Cascardi, O’Leary, & Schlee, 1999; George, 2004; Johnson et al., 2000). Other potential risk factors associated with extreme types of violence include a perceived fear of partner, and a belief that serious harm is imminent (DeMaris & Swinford, 1996; George, 2004; Greene et al., 2002).

Identifying Readiness for Couples Work
The interactional dynamic of power and control in relationships is complex, and most likely exists on a multi-dimensional continuum. To date, no criteria have been established that can be used to identify the point at which intermittent coercive control behaviors become a harmful pattern. A few existing studies indicate that three or more behaviors in one incident, or multiple behaviors over time may constitute a pattern of coercive control (George, 2004; Johnson et al, 2000). Further research is needed in this area. In addition, ruling out extreme types of intimate violence that could cause imminent harm does not necessarily imply that couples therapy is the best treatment option. Additional assessment is needed to determine if both partners are committed to and capable of stopping the violence. The Conjoint Treatment Checklist (Figure 1) provides a summary of key assessment criteria found in the literature that can be used to evaluate whether a couple is ready for conjoint treatment. If the presenting couple meets all or most of the criteria from this checklist, then the focus of the initial conjoint sessions should be on eliminating the violence (versus saving the relationship), and should include the development of a No Violence Contract (George, 2004) and a Safety Plan (Bograd et al., 1999) for both partners. It is also recommended that conjoint sessions be interspersed with individual sessions to monitor the safety and efficacy of continuing the conjoint work.

Implications for Research and Practice
Integrating typologies of intimate violence with assessment and treatment is a step towards the development of a multi-faceted, multi-theoretical approach that may improve the way we measure, predict, theorize, and make policy about intimate violence. From a clinical perspective, an assessment approach that makes distinctions between types of violence based on multiple indicators (rather than on physical violence alone) may provide earlier detection of physical violence, as well as provide detection for individuals who experience psychological abuse not accompanied by physical violence. In addition, an assessment and treatment approach that tailors treatment based on the type of violence present may improve treatment effectiveness and client retention. And lastly, the proposed assessment tool uses a non-gendered format that can be used to assess both men’s and women’s violence, as well as same-sex couple violence, which adds needed depth and complexity to our current assessment protocols. (It
should be noted that the assessment tool is conceptual in nature and requires further testing and evaluation before being implemented into clinical practice).

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REFERENCES


