ANGER, EMPATHY, AND ROMANTIC STYLES OF ATTACHMENT IN COURT ORDERED DOMESTIC VOILENCE OFFENDERS

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ABSTRACT

ANGER, EMPATHY, AND ROMANTIC STYLES OF ATTACHMENT IN COURT ORDERED DOMESTIC VOILENCE OFFENDERS

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This study utilized a prospective design to examine the impact of empathy and attachment beliefs on various dimensions of anger. More specifically, the study explored whether pre-treatment empathy scores in domestic violence offenders were the best predictor of post-treatment anger. The subjects (n=24) were male (14) and female (10) court referred domestic violence offenders. Correlation coefficients were calculated for attachment styles from pretreatment to post treatment to determine if the treatment response scores in anxiety were negatively correlated with anger turned inward. A series of hierarchical multiple regressions were used to examine whether pretreatment empathy accounted for any significant unique variance in post treatment anger in. This data suggested the concept of empathy is more about a lack of self-awareness and less about self-deception.

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CHAPTER ONE: INTRODUCTION

The causes of domestic violence in romantic relationships have been extensively explored in research over the years (Dutton, Saunders, Starzomski, & Bartholomew, 1994; Murphey, Meyer, & O'Leary, 1994; Proctor & Beail, 2007; Sonkin & Durphy, 1982; Vignemont & Singer, 2006; Winters, Clift, & Dutton, 2004). Consequently, various treatment interventions have been derived from different theoretical perspectives to address the cause of aggressive behaviors of Domestic Violence Offenders (DVOs) (O'Leary & Curley, 1986; Pence & Paymar, 1993; Tafrate, 1995). Each treatment intervention is simply an extension of the theory. For instance, the cognitive behavioral model focuses on the DVO's cognitive distortions and the inability to regulate emotion. This model teaches the DVO how to manage the anger. The family systems model of intervention focuses on the DVO's family of origin and current family structure and the styles of communication within the structure. This model works at manipulating the structure of the family in order to increase healthy styles of communication. The feminist model focuses on male DVOs who have created an unequal balance of power in the romantic relationship. This model empowers the female victim to bring equality to the romantic relationship (Buttell, Muldoon, Carney, 2005; Rosenbaum & Leisring, 2001; Winters, Clift, & Dutton, 2004).

Empathy and DVOs

One theoretical approach to the problem of domestic violence in romantic relationships that is not addressed in the treatment literature, however, has to do with the

level of emotional intelligence of DVOs in general, and more specifically, their level of empathy (Buttell, Muldoon, Carney, 2005; Dutton & Golant, 1995; Feder & Dugan, 2002; Holtzworth-Monroe, Meehan, Herron, Rehamn & Stuart, 2000). Empathy is simply the awareness and understanding of how one's partner is feeling in the midst of an emotional situation (Bar-On, 2007). DVOs are not likely to have the knowledge, skills, ability, and motivation to correctly read the emotional state of their partner (Vignemont & Singer, 2006). This lack of empathy may be a result of the style of attachment the DVO has in the romantic relationship (Buttell, Muldoon, & Carney, 2005; Dutton & Golant, 1995; Feder & Dugan, 2002; Holtzworth-Monroe, Meehan, Herron, Rehamn, & Stuart, 2000). Feeney and Noller (1990) reported early childhood experiences of empathy produce different enduring styles of relating for persons. These foundational styles of relating and styles of attachment are manifested in adult romantic relationships (Fraley & Shaver, 2000).

Romantic Attachment Beliefs and DVOs

Romantic attachment beliefs involve a tendency to seek and maintain a secure close proximity to a specific person, particularly when presented with biopsychosocial stressors. It is a mutual regulatory system that provides a sense of security for romantic partners such that the partner is comforted when the other is present and more anxious when the other is not present (Feeney & Noller, 1990; Fraley & Shaver, 2000; Potter-Efron, 2005). Romantic partners with secure styles of attachment have more empathy than romantic partners with insecure styles of attachment. DVOs tend to communicate from an insecure style of attachment. This impacts the romantic relationship when the

DVO is emotionally disconnected, lacks empathy, and is unmotivated to instigate, cultivate, and/or maintain intimacy in the relationship (Sonkin & Dutton, 2003). Sonkin and Dutton note how DVOs with an insecure style of attachment are emotionally deregulated when they perceive the partner will potentially reject/abandon them. Additionally, Sonkin and Dutton define attachment beliefs as a way to describe "observable or manifest patterns of behavior" (p. 22) in a DVO, such as violent anger and the absence of empathy in an interpersonal relationship.

Anger, Empathy, and Romantic Attachment Beliefs of DVOs

While both anger and violence in DVOs are addressed in literature, the capacity of DVOs to be empathic and utilize their attachment beliefs in a healthy intimate relationship is not (Buttell, Muldoon, & Carney, 2005; Dutton & Golant, 1995; Feder & Dugan, 2002; Holtzworth-Monroe, Meehan, Herron, Rehamn, & Stuart, 2000). Previous research has examined the link between empathy and anger and found that, for DVOs who lack empathy, an inverse relationship to anger is more likely to be present (Holtzworth-Munroe & Stuart, 1994). Wexler (1999) reports domestic violence is due to "empathic failure" (p. 12). Research has also found that when empathy is absent from a romantic relationship, anger can quickly turn into violence (Holtzworth-Munroe & Stuart, 1994; Wexler, 1999). DVOs tend to quickly become overwhelmed with the emotions of anger, frustration, abandonment, and rejection, and thus have great difficulty regulating anger and tolerating interpersonal conflict (Stosny, 1995). Previous research has examined attachment beliefs and domestic violence and found that an insecure style of attachment in a romantic relationship utilizes few social controls over anger and negative

emotions (Silver & Teasdale, 2005). Conversely, a person with a secure style of attachment will resolve interpersonal conflict without physical violence (Vignemont & Singer, 2006).

Relationship of Anger, Empathy, and Romantic Attachment with DVOs

To date, few, if any, studies have examined the relationship between empathy, attachment beliefs, and anger in DVOs. Furthermore, the majority of the previously mentioned studies (O'Leary & Curley, 1986; Pence & Paymar, 1993; Tafrate, 1995) utilized male only DVOs for subjects and were primarily cross-sectional, thus leaving open the question of the direction of the relationship. This present study utilized a prospective design to examine the impact of empathy and attachment beliefs on various dimensions of anger in a sample of DVOs, both male and female, which were court ordered to treatment. More specifically, this study explored whether or not pre-treatment empathy scores in DVOs would be the best predictor of post-treatment anger, after controlling for the influence of pre-treatment attachment, pre-treatment anger, and various potential confounding variables such as age, gender, and previous offenses. The results of this study may provide additional research and theoretical support for creating a treatment intervention that directly targets DVOs' empathy and attachment beliefs in the romantic relationship.

Background to the Problem

It is difficult for DVOs to express both empathy and anger in an interpersonal relationship due to an attachment style of relating. Moreover, DVOs can experience

cognitive dissonance as they begin to process how their violent self and their personal view of a nonviolent self can co-exist in the context of the romantic relationship with their partner. Therefore, because DVOs are unable to emotionally regulate their own fears and anxieties of intimacy, they project their fears on the partner using violence (Winters, Clift, & Dutton, 2004). The anxieties and fears that tend to dominate the DVO's perception of the romantic relationship result in maladaptive emotional regulation (Babcock, Jacobson, Gottman, & Yerington, 2000; Buttell, Muldoon, & Carney, 2005; Mahalik, Aldarondo, Gilbert-Gokhale, & Shore, 2005; Sonkin & Dutton, 2003). Winters and associate further report the DVO is cognitively aware of being aggressive to the partner; however, the DVO does not have the emotional intelligence necessary to utilize affective empathy to stop the potential violence. Self awareness is needed to utilize empathy in order to understand the experience of the partner in the midst of an angry conflict. This self awareness can be difficult for the DVO (Goodrum, Umberson, & Anderson, 2001).

Cognitive/Behavior Theory

Some treatment interventions for DVOs target cognitive restructuring, relaxation coping skills, (Rosenbaum & Leisring, 2001) and assertiveness training (O'Leary & Curley, 1986). Rosenbaum and Leisring (2001) reported generic treatment models of intervention that include, but are not limited to 1) the victim involved in therapy with the DVO; 2) the DVO being in group therapy; and/or 3) individual therapy for both. Group sessions ranged from ten weeks to over one year where the group members were males only (Gondolf, 1999). Eclectic models of intervention exist as an intervention choice

(Gondolf, 1999; Rosenbaum & Leisring, 2001). Models of this type chose to focus on the psychosocial costs of anger and aggression in the relationship, loss of intimacy in the relationship, and potential loss of employment. However, none of these interventions focus on teaching DVOs how to embrace anger in a healthy manner (Rosenbaum & Leisring, 2001).

Feminist Theory

The majority of the aforementioned treatment interventions were put in place after a DVO had been arrested for assault and battery. Gondolf (1999) reported how batterer programs have been introduced due to over-whelming court mandated requests. Pence and Paymar (1993) worked in Duluth with DVOs and created a treatment intervention from a pro-feminist cognitive behavioral model. Pence and Paymar stated "batterers, like those who intervene to help them, have been immersed in a culture that supports relationships of dominance" (1993, p. 3). Rivettt and Rees (2004) noted how the Duluth treatment model effectively treated men as intrinsically bad and how the DVO was fighting for control and power, not that he had any psychological dysfunction (Gondolf, 1999; Rosenbaum & Leisring, 2001; Wexler, 1999).

Emerge, another pro-feminist intervention model, directly addressed the male DVOs. Emerge focused on (a) issues of power and control for the DVO; (b) involving the victims and children; (c) creating community programs; and (d) not providing confidentiality for the DVO (Rosenbaum & Leisring, 2001). Additionally, some models of interventions for DVOs utilized a pro feminist informed, cognitive-behavioral approach. These models seemed to ignore both the possibility that the DVO may be

female and the attachment style for the DVO. The same models did not account for the individual and familial differences of each DVO; rather, homogenous interventions were the therapies of choice for a heterogeneous population of DVOs (Buttell, Muldoon, & Carney, 2005).

Family Systems

Over 130 studies show that when it comes to domestic violence, women offend as much as men. Female offenders were as violent, or more violent, than their male counterparts (Pizzey, 1995, cited in Thomas, 2006). Moreover, several of these studies focused on the motivation for a female to assault her partner such as self defense, abusive personality traits, inability to regulate anger, and an insecure style of attachment (Goldenson, Geffner, Foster, & Clipson, 2007; Thomas, 2006). Thomas (2006) reported "unfortunately" the feminist models changed the focus of domestic violence treatment programs to a gender specific model based on "feminist theories about male violence against woman, and thus the response to family violence shifted to punishing and re-educating the males while protecting and advocating for the female victim to leave the relationship" (p. 4). He challenged clinicians to treat DVOs through a family systems approach in order to decrease the gender specificity of treatment. Thomas suggested the feminist models separated families while the cognitive behavioral models advocated for the families (2006).

Thomas (2006) asserted that most DVOs were physically abused as children and will continue what they know into adult relationships. From a systemic model of treatment, this involved the DVO, the partner, and all children. Thomas (2006) found that

domestic violence impacts the entire family system. If the family desires to stay intact, then the partner and other family members need to be safe. They need to experience relationships within the system without violence. Family systems therapy works at changing the pattern of violence in the system (Thomas, 2006). Family treatment adjusts to each type of DVO: male assaulting female, female assaulting male, and mutual severe assaulting (Johnson & Leone, 2005).

Romantic Relationships

Murphey, Meyer, and O'Leary (1994) report DVOs tend to be overly dependent on their partner, thus they are ineffective in initiating and preserving the interpersonal relationship in an emotionally supportive manner. Due to the emotional dysregulation for the DVO, there is a lack of empathy and the propensity for intense anger in the romantic relationship that is not conducive to being emotionally supportive. DVOs experience a need for intimacy with the partner, yet due to their ineffectiveness in achieving the desired emotional connectedness, they choose instead to use violence and intimidation to guarantee physical closeness. DVOs use these negative behaviors to try to draw the partner closer, hoping the physical closeness will satisfy their own need for emotional connectedness (Dutton, Saunders, Starzomski, & Bartholomew, 1994; Murphey, Meyer, & O'Leary, 1994; Proctor & Beail, 2007; Sonkin & Durphy, 1982; Vignemont & Singer, 2006; Winters, Clift, & Dutton, 2004).

Regardless of gender, DVOs have great difficulty being self-aware and understanding their partner's perspective in the midst of conflict (Goodrum et al., 2001; Holtzworth-Munroe & Stuart, 1994). Men and women can become physically aggressive

to one another within the confines of the interpersonal relationship. Research notes there is no significant difference between genders on physical aggression within interpersonal relationships (Burton, Hafetz, & Henninger, 2007). In fact, domestic violence is simply defined as "any physical act of aggression…..in an intimate (i.e., sexual – emotional) relationship" (Dutton, 1995, p. 203), a definition with no differentiation of gender. Millions of persons in intimate relationships are harmed each and every year in the United States (Mahalik, Aldarondo, Gilbert-Gokhale, & Shore, 2005). Moreover, Mahalik and associates purport that domestic violence not only includes both genders, it crosses all socioeconomic, ethnic, and racial barriers.

The degree to which empathy could be utilized was dependent on the emotional intelligence of the person (Bar-On, 1992; 1997; 2002; 2006). Emotional intelligence is the ability to 1) comprehend emotions as well as express one's own emotions and self; 2) understand another person's emotions and relate to him/her; 3) manage and regulate one's own emotions; 4) name, change, and solve problems of an interpersonal nature; and finally to 5) be appropriate in mood regulation and to motivate the self towards positive change (Bar-On, 1997, 2006; 2007; Boyatzis, Goleman, & Rhee, 2000; Goleman, 1995; Salovey & Mayer, 1990). For instance, in the midst of an interpersonal conflict, an emotionally intelligent person is able to stop, understand, and experience what the partner is experiencing in the moment. DVOs experienced great difficulty in following the process of empathy due to diminished emotional intelligence (Proctor & Beail, 2007; Spinella, 2005; Vignemont & Singer, 2006).

DVOs, who engaged in empathy, were able to stop and imagine how the partner was experiencing pain in the moment. The DVO was motivated to relieve the suffering of

the partner and thus stopped the violence (Proctor & Beail, 2007; Spinella, 2005; Vignemont & Singer, 2006). However, the anxieties and fears that dominated the DVO's perception of the intimate relationship resulted in maladaptive emotional regulation (Babcock, Jacobson, Gottman, & Yerington, 2000; Buttell, Muldoon, & Carney, 2005; Mahalik, Aldarondo, Gilbert-Gokhale, & Shore, 2005; Sonkin & Dutton, 2003). DVOs experienced great difficulty in being empathic while experiencing anger fed by fear and anxiety.

The aforementioned fear was manifested as chronic anger in highly anxious DVOs, and made it almost impossible for them to empathize with their partner (Sonkin & Dutton, 2003). Sonkin and Dutton noted the same fear was also present for DVOs who struggled with abandonment issues in the intimate relationship. DVOs can learn to reduce the anger, fear, and anxiety that come with an insecure style of attachment. As DVOs reduced the anger, fear, and anxiety, they became motivated to empathically respond to the partner in the times of conflict and thus experienced more security in the relationship (Sonkin & Dutton, 2003; Tweed & Dutton, 1998; Winters, Clift, & Dutton, 2004). Fear, anxiety, and anger continued to invade intimate relationships for the DVO in a multitude of ways.

DVOs who perceived the partner had criticized them usually had an immediate reaction of anxiety, anger, and aggression. This reaction of negative emotions was driven by the insecure style of attachment. Due to the inability to empathically respond to the partner, DVOs operated from their own subjective reality, and projected personal fears, instead of engaging in emotional empathy (Stosny, 1995; Vignemont & Singer, 2006; Winters, Clift, & Dutton, 2004). Winter, Clift, and Dutton noted anecdotal accounts from

therapists who report shared common themes of DVOs with low empathy. However, Winters and associates reported no research had specifically addressed this issue. This present study is a beginning attempt to address this gap of DVOs having the ability to empathize with the partner in a romantic relationship.

Purpose of the Study

This study uses a prospective design to investigate the relationship between empathy, attachment, and anger. More specifically, Domestic Violence Offenders (DVOs), who have been court ordered to anger management treatment, were administered measures of empathy, attachment, and anger at both pre and post-treatment. It is hypothesized that pretreatment empathy scores would be the best predictor of post-treatment anger, after controlling for the influence of pretreatment attachment, pretreatment anger, and various potential confounding variables such as age, gender, and previous offenses. The results of this study may provide additional research and theoretical support for creating a treatment intervention that directly targets DVO's empathy and attachment beliefs in the romantic relationship.

Assumptions and Limitations

Limitations of this study are varied. For example, obtaining data from DVOs presents a challenging research environment. In this current study, participants were recruited from an ongoing Domestic Violence Anger Management Group. Therefore, the sample consisted of recent DVOs within the Harrisonburg/Rockingham County area of Virginia. Potential limitations with this convenience sample are: low sample size,

racial/ethnic makeup of the group, and potential impact of the predominantly rural geographic environment.

Assumptions are as diverse as the sample population. One assumption is that DVOs are heterogeneous. Another assumption is that DVOs experience more emotional deficiencies than their counterparts in the general population. Finally, this research assumes that attachment, empathy, and anger are not necessarily linked to modalities of intervention.

Definition of Terms

For the purposes of this study domestic violence, anger, empathy, emotional intelligence, and attachment are defined as follows.

Domestic Violence

Domestic violence can be defined simply as a "pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that persons use against the intimate partner where the perpetrator and partner are currently or have been previously dating, cohabiting, married, or divorced" (CMFC Handbook, 1998, p. 1). A domestic violence offender (DVO) is a person who engages in the aforementioned behaviors towards a partner in an intimate relationship (Dutton, 1995; Fane, 1997). For the purposes of this paper, DVOs will be of either gender that chooses to assault a romantic partner in any manner in the relationship.

Anger

Anger is defined as an interpersonal emotion that is commonly experienced by most humans and can have biopsychosocial and interpersonal consequences (DiGiuseppe & Tafrate, 2003; Kassinove & Tafrate, 2002; Kuppens & Tuerlinckx, 2006; Tafrate, 1995). Kuppens and Tuerlinckx (2006) noted when the source of blame was a romantic partner, DVO's interpersonal behaviors, especially negative ones, tended to be magnified. This was where anger had the propensity to become violent and where empathy was crucial for the angry person.

Empathy

As a component of emotional intelligence, empathy is the ability to be in tune with and to comprehend how another person feels. Empathy is a direct negation of interpersonal violence (Bar-On, 2006; Buttell, Muldoon, Carney, 2005; Dutton & Golant, 1995; Feder & Dugan, 2002; Goodrum, Umberson, & Anderson, 2001; Holtzworth-Monroe, Meehan, Herron, Rehamn, & Stuart, 2000; Winters, Clift, & Dutton, 2004). It is the ability to accurately act upon and/or in some way acknowledge another person's values, motivations, knowledge, and skills regardless of the level of agreement between the two people, and still choose to accept that other person unconditionally (Denzin, 1984; Gondolf, 1985; Holtzworth-Munroe & Stuart, 1994; Swartz, 2002).

Romantic Attachment

An adult usually exhibits the same style of attachment that had been created in childhood. This childhood style of attachment had become prominent in adult

interpersonal relationships (Hazan & Shaver, 1987). Adult attachment style is defined by Sperling and Berman (1994) as “the stable tendency of an individual to make substantial efforts to seek and maintain proximity to and contact with one or a few specific individuals who provide the subjective potential for physical and/or psychological state and security” (p. 8). A secure child had matured as a secure adult partner in a romantic relationship where s/he was comfortable with autonomy and intimacy. A fearful angry child had now become a fearful angry adult who was not comfortable with autonomy and/or intimacy and is now involved in a romantic relationship (Babcock, Jacobson, Gottman, & Yerington, 2000; Buttell, Muldoon, & Carney, 2005; Mahalik, Aldarondo, Gilbert-Gokhale, & Shore, 2005; Sonkin & Dutton, 2003).

Significance of the Study

Buttell, Muldoon, and Carney (2005) noted two studies showing a relationship between violent men and attachment theory. However, neither study referenced by Buttell and associates included women DVOs in the sample population. Another difference between these past studies and this current one is that previous studies did not assess a relationship between empathy and anger. This present study assessed the relationship between attachment, empathy, and anger regardless of gender. Finally, this present research began to examine differences in how style of attachment, empathy, and anger presented in subtypes of DVOs regardless of motivation and subtypes (Buttell, Muldoon, & Carney, 2005).

Nature of the Study or Theoretical/Conceptual Framework

Including attachment in this study provided a broader theoretical framework for integrating anger, empathy, and domestic violence. It can be conceptualized that DVOs had an insecure attachment from childhood which is manifested in excessive interpersonal dependency in the current romantic relationship (Dutton, 1995; Holtzworth-Monroe, Bates, Smultzer, & Sandin, 1997). According to Buttell, Muldoon, and Carney (2005) attachment theory was necessary to explain why DVOs resorted to violence in the romantic relationship in order to link the theory to the examination of the relationship of the constructs. Attachment theory was also beneficial in understanding how one regulated the emotions of empathy and anger in the context of the romantic relationship of the DVO (Babcock, Jacobson, Gottman, & Yerington, 2000; Sonkin & Dutton, 2003).

Summary

DVOs are a heterogeneous population. However, most court ordered treatment interventions are homogenous (Buttell, Muldoon, & Carney, 2005; Dutton & Golant, 1995; Feder & Dugan, 2002; Holtzworth-Monroe, Meehan, Herron, Rehamn, & Stuart, 2000). The majority of these homogenous interventions are based on a cognitive behavioral approach (Gondolf, 1999; Rosenbaum & Leisring, 2001). This cognitive behavior approach has the potential to teach DVOs important choices, yet this approach alone has not been sustaining in decreasing recidivism. Empathy and the attachment style of the DVO are not addressed in the cognitive approach (Buttell, Muldoon, & Carney, 2005; Gearan & Rosenbaum, 1997; Rivettt & Rees, 2004). DVOs can become more self-aware of their own emotional state and the emotional state of their partner (Ikes, 2003;

Rosenbaum & Leisring, 2001). Interventions that approach interpersonal violence from an attachment perspective can begin to teach DVOs the necessary skills to emotionally regulate and to empathize with their partner and experience change in the self and the relationship (Sonkin & Dutton, 2003). The end result could have the potential to decrease domestic violence in their romantic relationship.

CHAPTER TWO: REVIEW OF LITERATURE

Domestic Violence

Overview

Domestic violence is a serious, preventable public health problem that impacts approximately 32 million Americans, more than 10 percent of the national population (Rennison, 2003). It can be defined simply as a

> pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that persons use against the intimate partner where the perpetrator and partner are currently or have been previously dating, cohabiting, married, or divorced (CMFC Handbook, 1998, p. 1).

Labinsky (2002) reports gender violence is defined in a more complex fashion when the term "violence" encompasses physical and verbal aggression toward a partner. A domestic violence offender (DVO) is a person who engages in the aforementioned behaviors towards a partner in intimate relationship regardless of gender (Dutton, 1995; Fane, 1997).

Physical assault on a romantic partner is a preventable health problem in the United States. Benson and Fox (2004) found there is an inverse relationship between socio-economic status and violence in the United States. They found as the household income increases, domestic violence decreases. This relationship holds true for African-Americans and Caucasians (Benson & Fox, 2004). Unfortunately, it is historically, experienced by humankind in the global village. The awareness and documentation of domestic violence differs from country to country (Wallace, 2004). In some countries

there is less attention and support offered to the victims of domestic violence. Wallace and Nosko (2003) note that given this circumstance, a lower incidence of reported domestic violence might well be expected in such countries. Johnson and Leone (2005), however, disagree and report that domestic violence occurs in a variety of cultures, across societies, and irrespective of economic status. For example, domestic violence has been reported by national surveys in Barbados (30%), Canada (29%), Egypt (34%), New Zealand (35%), and Switzerland (21%) (Rennison, 2003). Surveys in the Philippines and Paraguay report figures as low as 10% (Johnson & Leone, 2005; Rennison, 2003; Wallace, 2004). Collectively, these statistics indicate that domestic violence is a current global health problem.

Current Problem

Arrests for assault and battery charges for domestic violence place pressure on the court systems in the United States (Feder & Dugan, 2002). Probation officers and Commonwealth of Virginia attorneys are ordered to find treatment for DVOs in order to decrease domestic violence. Historically, DVOs were chastised and sent on their way (Feder & Dugan, 2002). However, with increased awareness of partner victimization, the courts have taken a more aggressive approach to deter batterers from re-offending. Even a cursory review of literature on domestic violence from the last ten years indicates that subsequent treatment approaches have been varied and haphazard at best. All reported treatments appear to have some positive results; however, none have been found that bring an effective end to this persistent health problem. Still the courts are demanding

treatment that will have maximum effect with minimum to zero recidivism (Gondolf, 1999; Rosenbaum & Leisring, 2001).

Anger at the romantic partner is one of the ways emotionally dependent DVOs get their needs met which can very quickly escalate to aggression in the relationship. Initially, DVOs withdraw, become moody, are hypersensitive to perceived slights by the partner, and over react to simple things in the relationship (Goodrum et al., 2001; Holtzworth-Munroe & Stuart, 1994; Holtzworth-Munroe et al, 1997). In a period of time, the DVO begins to experience high levels of anxiety and depression. The DVO often chooses to consume alcohol to abate anger, only to find it ineffective. DVOs become physically violent in order to lower the anxiety and to assure themselves the partner is not going to leave the relationship (Goodrum et al., 2001; Wexler, 1999). The DVO uses the act of violence to introduce an element of fear in order to deter the partner from abandoning the relationship.

Prevalence

Over eight million (United States Census Bureau, 2001) persons in intimate relationships are harmed in the United States (Mahalik, Aldarondo, Gilbert-Gokhale, & Shore, 2005). Put another way, every year in the United States 14% of married couples experience domestic violence, with no significant difference between genders on physical aggression within interpersonal relationships. Research shows that in cases of domestic violence, 26% of the time it was initiated by males and 24% initiated by females. The same research also revealed that in 50% of the cases the violence was considered couple

violence – both genders were equally violent in the assault (Burton, Hafetz, & Henninger, 2007; Clements, Holtzworth-Munroe, Schweinle, & Ickes, 2007).

The course of DVOs is varied and complex, as research has substantiated DVOs as a heteronymous population, i.e. gender. The progression can be on the spectrum from being a bully in grade school to continuing to bully as a romantic partner. The aggression can be directed only at one person – the partner. The onset of domestic violence is difficult to pinpoint, as DVOs are not a homogeneous population. Aggression in the intimate relationship may begin in the courtship stage or after the couple have been together for many years. Domestic violence implies a romantic relationship, so the onset of aggression in the relationship could be viewed developmentally and said to have the potential to begin when the person is in a dating relationship (Simon & Zgoba, 2006).

Theoretical Formulations for Addressing Domestic Violence (Past)

Introduction

The causes of domestic violence in romantic relationships have been the topic of research over the years (Dutton, Saunders, Starzomski, & Bartholomew, 1994; Murphey, Meyer, & O'Leary, 1994; Proctor & Beail, 2007; Sonkin & Durphy, 1982; Vignemont & Singer, 2006; Winters, Clift, & Dutton, 2004). From this research, various treatment interventions have been derived from different theoretical formulations to address the cause of aggressive behaviors of Domestic Violence Offenders (DVOs) (O'Leary & Curley, 1986; Pence & Paymar, 1993; Tafrate, 1995). These theories focus on protecting

the partner, changing the behaviors and cognitions of the DVO, and promoting change in governmental policies.

However, the internal working schema of the DVO is not addressed in these treatment approaches. Data has shown that DVOs are not a homogenous group of persons, so interventions based on cognitions and behaviors alone are not as effective as interventions based on the internal working model of the DVO (Buttell, Muldoon, & Carney, 2005; Dutton & Golant, 1995; Feder & Dugan, 2002; Holtzworth-Monroe, Meehan, Herron, Rehamn, & Stuart, 2000). The capacity to understand and interpret how one's environment and one's experience can be integrated to create healthy intimate relationships is not addressed fully in most interventions. So while the DVOs anger and violence are addressed, their capacity to be in a healthy intimate relationship is not (Buttell, Muldoon, Carney, 2005; Dutton & Golant, 1995; Feder & Dugan, 2002; Holtzworth-Monroe, Meehan, Herron, Rehamn & Stuart, 2000).

The following section provides a brief overview of the more prominent treatment interventions for DVOs: cognitive behavioral, pro-feminist, and family systems. For the past thirty years, DVO treatment programs have focused almost entirely on regulating anger. In the late 1980's and early 1990's cognitive restructuring of how to appropriately manage anger was introduced (Sonkin, 2005). Sonkin also noted these early programs tried to balance emotions, communication skills, and attitude change. However the default intervention program was usually centered on how to appropriately "manage" anger, leaving the other concepts unaddressed.

Rivettt and Rees (2004) note that intervention programs tended to be created out of a specific definition of domestic violence. Policies have been created to bring about

change when gender roles are addressed and interventions to stop violence against women and children are the focus, versus the actual management of anger (Gondolf, 1999). For example, Rivettt and Rees maintained that men needed to be encouraged to view their anger in a relational context, imagining how the partner could view the DVO's anger. This assumes that only men, not women, are violent towards a partner. However, studies show that females initiate violence in 24 percent of cases, males initiate violence in 27 percent of the cases, while the remaining 49 percent is common couple violence (Mills, 2008).

While there are philosophical differences among treatment interventions, there are many areas of agreement (Rosenbaum & Leisring, 2001). For example, there is general agreement that the DVO is the client and the partner is the victim. However, the main difference between the interventions is the weight and focus that the feminist perspectives of many programs assign to power and control. The cognitive behavioral programs focus on skill deficits (2001). The protection of the female victim is actively pursued in the pro-feminist intervention. Feminist programs report that naming domestic violence programs "anger management" (like cognitive behavioral programs do) implied the violence happens because of anger and not because of male-dominated power and control (2001). Family systems intervention encourages the entire system to be treated whereas, historically, the *cause* of violence is treated (2001).

Therapeutic Interventions

Rosenbaum and Leisring (2001) note there are theories of intervention that focused on the therapeutic relationship with the DVO. One intervention included the partner in the therapeutic relationship. Another was group therapy for the DVO. A third intervention was having the DVO in group and individual therapy simultaneously where the group sessions may range from ten weeks to over one year with the group members being gender specific (Gondolf, 1999).

Group therapy focused on communication skills utilizing the DVOs for role plays. DVOs tend to have the concept that when there is conflict within the interpersonal relationship, they must win at all costs (Rosenbaum & Leisring, 2001). DVOs were offered another way to speak, listen, and respond, which included the teaching of empathy. Male and female co-facilitators for DVO groups demonstrated and modeled the appropriate interplay and balance of control and power. Most groups were open-ended, court ordered, and thus were time limited (Rosenbaum & Leisring, 2001).

Other theories of intervention focused on cognitive restructuring and relaxation coping skills for DVOs (Rosenbaum & Leisring, 2001). It is difficult for DVOs who lack empathy to stop in the heat of anger and see the issue of conflict through the eyes of the partner. DVOs choose to ruminate over irrational thoughts about the situation and the partner, versus offering empathic suggestions to resolve the conflict (Gearan & Rosenbaum 1997). DVOs can also be taught to stop the irrational thinking, step away from the situation, and practice some relaxation techniques in order to calm the physiological symptoms before coming back to the partner and continuing to process the conflict in healthy ways (Rosenbaum & Leisring, 2001). The goal of relaxation treatment

was to diminish the negative reaction to anger (Tafrate, 1995). Tafrate found relaxation based treatment interventions had a high effectiveness outcome.

O'Leary and Curley (1986) noted that DVOs lack assertiveness. DVOs found it very difficult to cognitively acknowledge that they need help from the partner. The DVO also struggled with the need to be right in all conflicts. O'Leary and Curley reported how teaching DVOs appropriate assertiveness had the potential to reduce aggression (1986). Tafrate (1995) found cognitive behavioral treatment interventions had a large treatment effect.

Cognitive Behavior Theory

The theory that drives cognitive behavioral therapy is based on the hypothesis that one's thoughts and interpretations of those thoughts about an external situation translates into an emotional and behavioral outcome of said interpretation (Meichenbaum, 1977). The outcome measure of this type of intervention is to help DVOs identify and challenge irrational ways of thinking about the romantic relationship and the partner (Tafrate, 1995). Tafrate reports that under the rubric of cognitive therapy, other interventions are utilized to facilitate the control of anger in the course of intervention for DVOs. Those interventions include, but are not limited to 1) relaxation of physiological arousal due to anger, 2) the ability to manage anger in order to solve problems, 3) interpersonal skills training focused on anger provoking situations, 4) assertiveness training focused on win/win outcomes, and 5) integration of all four listed above (Edmondson & Conger, 1996). Research has shown that cognitive behavioral intervention addresses the thoughts

and interpretations of the thoughts of the DVO; however, the core issue of what actually drives those thoughts, anxiety, and fear are not addressed (Babcock, Jacobson, Gottman, & Yerington, 2000; Dutton, Saunders, Starzomski, & Bartholomew, 1994; Holtzworth-Monroe, Meehan, Herron, Rehamn, & Stuart, 2000; Tweed & Dutton, 1998).

Walker (1979) asserts there are four stages of battering that interface with the cycle of violence. Pre-battering is the throwing of objects to intimidate, the giving of verbal threats, and the beginning of abuse. The beginning stage of battering involves pushing, restraining, blocking doorways, holding the partner down, and shaking the partner. The moderate stage of battering includes slapping, punching, kicking, pulling hair, and spanking. The final stage is severe where the DVO chokes, beats with objects, uses and/or threatens to use weapons, and is sexually abusive (Walker, 1979). The scope of this diagnostic concept is limited inasmuch as it is victim-centered, ignores female DVOs, and addresses the symptoms and not the underlying causes of the anger for the DVO.

Other theories provide intervention for DVOs from an eclectic approach using cognitions, emotional regulation, and behavior modification with the expectations that the combination of several techniques will generate an effective plan of anger management over a single approach (Gondolf, 1999; Rosenbaum & Leisring, 2001; Tafrate, 1995). While theories differ, common themes among them include a focus on the psychosocial costs of anger and aggression in the relationship, a loss of intimacy in the relationship, and a potential loss of job, versus teaching the DVO how to embrace anger in a healthy manner (Rosenbaum & Leisring, 2001). Interventions also differ, however, common themes are: power and control issues, anger cues, time out, primary emotional

identification, costs of aggression, substance abuse, communication skills, cognitions, stress management, problem solving, assertiveness, and conflict mediation (Rosenbaum & Leisring, 2001). When programs measured effectiveness by recidivism, research (Tafrate, 1995) indicated that eclectic interventions of treatment had average effectiveness outcomes, while those interventions that focused more on social skills training had above average effectiveness outcomes.

Feminist Theory

Emerge is a pro-feminist treatment program founded in 1977 that is based on the theory of a male's need for power and control in the romantic relationship (Rosenbaum & Leisring, 2001). Male DVOs are only able to participate in this intervention if they are willing to relinquish all rights to confidentiality. The group leaders contact romantic partners, probations officers, and all other community agencies involved in the domestic violence programs of the community. According to Rosenbaum and Leisring (2001), confidentiality does not apply to the DVO as Emerge is "an educational service, not psychological treatment" (p. 66).

The creators of Emerge had concerns with the term "batterer treatment," as treatment implied therapy, and therapy presumes one has psychological problems. The pro-feminists creators of Emerge declared that domestic violence was exclusively about male dominance, power, and control (Rosenbaum & Leisring, 2001). Emerge was the nation's first educational program for men who batter. It is considered to be pro-feminist because it chooses to address only power and control issues in the intimate relationship.

Other characteristics of this program are: minimum of 48 two-hour sessions, two co-leaders, and 12 DVOs in group, a DVO gives consent for leaders to contact partner and others involved in the violence. Emerge included all family members in the intervention program in order to teach the DVO how inappropriate power and control issues impacted the entire family system.

Pence and Paymar (1993) worked in Duluth with DVOs after a brutal domestic homicide in 1980. Pence and Paymar noted the Duluth theory was based on the Emerge theory, a co-existing treatment plan for DVOs. The Duluth program premised a pro-feminist cognitive behavioral theory where the power and control of the male offender was central to the curriculum (Rivettt & Rees, 2004). The intervention is driven by the theory that violence is used by males to control others' behaviors (Rosenbaum & Leisring, 2001). The core of the Duluth theory is that the current culture has socialized males in assuming a sense of entitlement to power over females (Rivettt & Rees, 2004; Rosenbaum & Leisring, 2001). Pence and Paymar state, "Batterers, like those who intervene to help them, have been immersed in a culture that supports relationships of dominance" (1993, p. 3). The key ingredient of the Duluth theory was to involve the community to envision, implement, and maintain equal gender relationships. Pence and Paymar (1993) called for a community response to DV that includes changing legal policies and laws to protect women and children from violence. This same community response mandates offenders to treatment that focuses on equality in the romantic relationship and being educated on appropriate anger control (Rivettt & Rees, 2004; Rosenbaum & Leisring, 2001).

The intervention was developed to change dysfunctional family structure, not just intervene on behalf of the DVO (Rivettt & Rees, 2004). It follows a cognitive behavioral structure, addressing anger management, and teaching assertiveness training, relaxation, nonviolence, and communication skills (Pence & Paymar, 1993). Partners of the DVOs were contacted to attend an ongoing victim support group. Rivettt and Rees (2004) noted how the Duluth model effectively treated men as intrinsically bad and how the DVO fights for control and power, not that he has any psychological dysfunction (Gondolf, 1999; Rosenbaum & Leisring, 2001; Wexler, 1999). These aforementioned models of intervention are similar to the cognitive behavioral interventions.

Rosenbaum and Leisring (2001) noted feminist programs such as Duluth and Emerge share similar core beliefs with the cognitive behavioral theories. They defined domestic violence the same way with power and control being about the male in the romantic relationship. They all taught communication skills, assertiveness training, responsibility for actions, and required a log of violent and controlling behaviors. All three worked with male offenders only (Rosenbaum & Leisring, 2001). The feminist programs differed from cognitive behavioral programs by the way they emphasized power, control, and inequality in the romantic relationship. Cognitive behavioral programs placed more emphasis on skill deficits. They focused more on the DVO understanding and managing anger, where the feminist programs asserted that violence arises from the need for power and control versus the need to manage anger appropriately. Finally, feminist programs focused on the female victim and cognitive behavioral programs focused on the male offender (Rosenbaum & Leisring, 2001).

Family Systems Theory

A third approach to treatment of DVOs is rooted in the family systems theory. This model suggested that domestic violence may be more common among DVOs who have experienced and/or witnessed domestic violence in childhood (Buttell, Muldoon, & Carney, 2005; Clements, Holtzworth-Munroe, Schweinle, Ickes, 2007; Goldenson, Geffner, Foster, & Clipson, 2007; Holtzworth-Munroe, Stuart, & Hutchinson, 1997; Winters, Clift, & Dutton, 2004). For example, a child's experience in the family of origin created the foundation for future mental health problems (Goldenson, Geffner, Foster, & Clipson, 2007). Research in DVOs suggested a link between the childhood experiences of being a victim of violence and/or being exposed to domestic violence (Goldenson, Geffner, Foster, & Clipson, 2007). This exposure to violence could be brought to the intimate relationships of adulthood, as children internalized those experiences that became part of a working model of self (Buttell, Muldoon, & Carney, 2005; Clements, Holtzworth-Munroe, Schweinle, Ickes, 2007; Goldenson, Geffner, Foster, & Clipson, 2007; Holtzworth-Munroe, Stuart, & Hutchinson, 1997; Winters, Clift, & Dutton, 2004).

Thomas (2006) noted early childhood abuse and neglect had such a powerful impact on the brain wiring that it was measurable. Family violence experienced as a child impacted the quality of attachment with parents and self; it became the template for all relationships in the future, including romantic ones. Family systems approach explored the conflict dynamics of the system, not just the offender. It could be focused on the roles of couples as they work at DV (Rivettt & Rees, 2004). It called for family support services and treatment. Fiebert (1997) reported in over 130 studies of DV and families, women were as physically violent as men. Thomas reported that systems intervention

helped the nuclear family understand the nature and pattern of the relationship. Once the pattern was understood, then the family member was able to be more emotionally regulated, take responsibility for part in the known patterns, and thus be motivated to create a more appropriate and healthy response to interpersonal conflict. The goal was to change the pattern of violence within the family system. This was complex and not necessarily a matter of technique (Thomas, 2006).

Thomas (2006) challenged clinicians to treat DVOs through a family systems approach in order to decrease the gender specificity of treatment. Erin Pizzey, founder of the first shelter for domestic violence, observed that 60% of the women who came to the shelter were the offenders. The female offenders were as violent, or more violent, than their male partner (Pizzey, 1995, cited in Thomas, 2006). The motivation may be self defense, abusive personality traits, inability to regulate anger, and an insecure style of attachment (Goldenson, Geffner, Foster, & Clipson, 2007; Thomas, 2006). Thomas (2006) reported "unfortunately" the feminist theories changed the focus of domestic violence treatment programs to a gender specific assumption based on "feminist theories about male violence against woman, and thus the response to family violence shifted to punishing and re-educating the males while protecting and advocating for the female victim to leave the relationship" (p. 4). Thomas suggested the feminist interventions separated families while the cognitive behavioral interventions advocated for the families (2006).

In order for the systems theory of intervention to work at decreasing domestic violence, the therapist must find the balance between maintaining a therapeutic relationship and keeping family members safe. If the family desires to stay intact, then

the partner and other family members need to be safe. They need to experience relationships within the system without violence. Family systems therapy worked at changing the pattern of violence in the system (Thomas, 2006). Family treatment is applied regardless of the type of DVO: male assaulting female, female assaulting male and mutual severe assaulting (Johnson & Leone, 2005).

Limitations of Treatment

Tafrate (1995) noted studies done to determine the outcome measures of cognitive-behavioral therapy were done with volunteer undergraduate students rather than actual DVOs. Moreover, Tafrate (1995) went on to report there has been little replication of the studies that assess the outcome measures of cognitive therapy used in clinical DVO intervention. Emerge was developed to be an educational intervention not a clinical intervention (Rosenbaum & Leisring, 2001). Rosenbaum and Leisring (2001) reported there is no clear research that suggested the pro-feminist programs were more effective than no treatment, and there was no clear evidence feminist interventions were more effective than any of the other treatments especially around the ethical concerns of confidentiality. It was difficult to be motivated to change when confidentiality was removed from the DVO.

Existing treatment interventions complied with court ordered DVO intervention, where the focus has been on protecting the victim rather than examining the needs of the DVO. Sonkin and Dutton (2003) reported the only needs of the DVO addressed in these treatment approaches were power, control, and managing the anger for the male DVO.

This is a limitation in the existing treatment approaches. Another limitation is lack of statistically-produced comparison of the treatment approaches. Therefore, there is no research data to utilize when comparing the outcomes of one treatment to those of another (Gondolf, 1999; Rosenbaum & Leisring, 2001). These interventions do not address the issues of how style of attachment, anger, and lack of empathy impact the DVO's experience of conflict with the partner. Sonkin and Dutton's (2003) study looks at combining the two previously mentioned studies, which can facilitate an understanding of the DVO's style of attachment and why there is a perceived need for power and control in the intimate relationship. By understanding emotional regulation, the DVO can manage the fear and rage that insecure attachments bring into adult relationships. However, empathy has been absent from the combination of constructs studied in the research cited earlier in this writing.

Interestingly, as the number of DVOs being treated had increased, so has a concern about the effectiveness of treating domestic violence (DiGiuseppe & Tafrate, 2003). DiGiuseppe and Tafrate conducted 50 between - group studies and found that subjects who received treatment were less likely to engage in intimate violence than 76% of the control subjects. The same research also indicated that 83% of the subjects receiving treatment scored higher (less likely to aggress) on posttest partner violence assessments than pretest scores. The research suggested that treatments not only decreased the negative behaviors associated with anger, such as physical assault, but also increased positive behaviors such as appropriate anger management. The same research found low to moderate effectiveness on interventions that addressed the attitudes and cognitions with anger. DiGiuseppe and Tafrate (2003) also found low effectiveness for

interventions that addressed both the emotion of anger and subsequent aggression in interpersonal relationships.

The wide range of theoretical approaches and political agendas associated with treatment interventions contribute to the bewildering diversity among measurers of effectiveness of DVO treatment programs. The measurable outcomes of past and current treatment interventions range from a DVO (female and male) having significant change in the positive direction (absence of aggression) to all male DVOs being accountable and motivated to stop the woman-battering culture (government policies). Edleson (1995) reported “success” as a DVO decreasing the acts of partner violence from five to two times a week. This would be a small step toward the end goal, that is, the absence of violence in the relationship (Edleson, 1995). Edleson noted controversy enters in due to a bewildering diversity of definitions of success, effectiveness, and outcomes. This diversity researchers bring complicates the conversation about domestic violence and interventions to end domestic violence. These controversies also slow progress in the field because no one has decided what target they should really be aiming for – to stop domestic violence or to address the core issue of insecurities in the romantic relationship.

Due to a lack of research that actually compares the treatment intervention, it is difficult to evaluate whether one treatment intervention is superior over another (Gondolf, 1999; Rosenbaum & Leisring, 2001). The limitations of the programs for DVOs are anger 1) is the driving concept for the inventions, 2) must have power for the DVO in the intimate relationship, and 3) is expressed as violence by only the male perpetrator. The outcome research for each of these interventions is average at best. Gondolf (1999) notes the intervention works for those DVOs who choose to make it work. These interventions

do not address the emotional intelligence and attachment perspective where empathy and anger could be assessed together.

Regardless of the treatment intervention, all programs share the common outcome measure of recidivism as measure of success (Babcock & Steiner, 1999; Gondolf, 1999). Babcock and Steiner (1999) conducted a study of 387 DVOs. All subjects were referred to pro-feminist, cognitive behavioral, and psycho-education treatment interventions. Babcock and Steiner reported 31% completed the intervention programs and had fewer reassaults than the 58% who did not complete the intervention programs. Those DVOs who chose to complete the intervention treatment, regardless of which one, had lower recidivism then those who did not complete the program.

Gondolf (1999) completed a meta-analysis of the pro-feminists, cognitive-behavioral, family systems, and group therapy treatment interventions and found very similar results as Babcock and Steiner (1999). If the DVO completed the program, recidivism decreased. However, the research also found there were no differences in the outcomes and recidivism if the DVO attended a didactic or process oriented program of intervention, nor in the length of the program – 13 weeks versus 26 weeks (Babcock & Steiner, 1999; Gondolf, 1999). Gondolf notes with concern how difficult it is for a clinician to predict recidivism with DVOs.

The current treatment interventions share the common goal of reducing domestic violence and the anger that is expressed externally – verbally and physically. The outcomes of these interventions have limited success. Things that are not addressed in the current treatment interventions are the fear and anxiety in the romantic relationship, and the internal working schema of the heteronymous DVO. The search is still on for the key

factors that will effectively lower anger as the observable behavior. Consequently, there is not only a dearth of research on the relative effectiveness of current DVO treatment interventions, but also a paucity of research on treatment approaches outside of the prevalent anger-power paradigm. The theory of styles of attachment integrates the cognitive behavioral, feminist, and family systems models of intervention.

Attachment Theory

Attachment Overview

Bowlby, the originator of attachment styles (1970; 1980; 1988) wrote that early attachment for a person is necessary for survival. Potter-Efron (2005) defined attachment as

> An enduring emotional bond that involves a tendency to seek and maintain proximity to a specific person, particularly under stress. It is a mutual regulatory system that provides safety, protection, and a sense of security for the infant. Attachment is an intense and enduring bond biologically rooted in the function of protection from danger (p. 5).

Bowlby (1980; 1988) noted how real or imagined separations elicited illogical anger and episodes of rage for the child. He reported how attachment is ruled by three different concepts that build on one another. First, the child was frightened by something and immediately the survival system of attachment was activated. The child quickly sought out a person to comfort him/her. Second, when this survival system of attachment was activated, only physical attachment with a person would deactivate it. Finally, if the caregiver was not physically and/or emotionally available to the child, the survival

system of the child had to suppress on its own. Bowlby (1980; 1988) observed that, at this point, the child began to act out with angry behaviors. Anger is triggered by the fear of separations and loss. The anxious child will protest by crying, actively searching for the caregiver, and thus resisting others' soothing efforts.

The aggressive behaviors were followed by despair and detachment. The child would exhibit behaviors of active detachment with a seemingly defensive disregard for and the avoidance of the caregiver. Bowlby (1970; 1980; 1988) concluded from these observations that the role of anger was to bring the caregiver (mother) back to the child. In fact, the child utilized the emotion of anger and angry behaviors in order to get the mother to offer comfort and security. This anger was triggered due to fear of separation and loss (Bowlby, 1980; 1988). Dutton (1995) reported that it is extremely difficult for a battered mom to provide a nurturing and emotionally safe environment for a child while in the midst of a chaotic and dangerous home situation. This traumatized child most likely experienced an insecure attachment. As this insecure child matured and became an adult in a romantic relationship with a partner, this same dysfunctional anger functioned to create distance between the couple.

Ainsworth, Blehar, Waters, and Wall (1978) built on Bowlby's theory by offering the concept of four differentiating attachment styles as a result of the parents' sensitivity to the child's distress: secure, anxious-avoidant, anxious-ambivalent, and disorganized. The sensitive parent responds to the child's distress such that the secure child is emotionally regulated, able to self soothe, and capable to handle the stressors of life. The secure child has a positive view of self (autonomy) and of the parent (intimacy). The insensitive parent rejects the child by ignoring or rebuffing the child creates an insecure

style of attachment beliefs for the child. The child who is ignored and rebuffed suppresses the stress and does not respond to the parents' initiations of intimacy and closeness. This child learns to have a positive view of self (autonomy) and a negative view of others (intimacy). The insensitive parent who is inconsistent with meeting the child's needs in times of distress also creates an insecure style of attachment beliefs for the child. This child becomes so upset over the rejection and abandonment of the parent that it can be difficult to calm him down. In fact, there are times when this insecure child will want to hurt the parent. The child has great difficulty in regulating emotions. This child learns to have a negative view of self (autonomy) and a positive view of others (intimacy). The parent who abuses the child in any manner creates a fearful style of attachment beliefs for the child where the child learns to have a negative view of self (autonomy) and a negative view of others (intimacy) (Ainsworth, Blehar, Waters, & Wall, 1978). The dimension of anxiety is created by the fear of rejection and abandonment of the attachment figure which is manifested in the inability to be autonomous and to have a hyper-sensitivity to the need for intimacy. The dimension of avoidance is created by the need to suppress emotions around the attachment figure which is manifested in the hyper-sensitivity of autonomy and dismissal of intimacy.

Adult Attachment Styles

An adult usually exhibits the same style of attachment that had been created in childhood. This childhood style of attachment had become prominent in adult interpersonal relationships due to the internalization of the working model of self and

others as it relates to attachment beliefs (Hazan & Shaver, 1987). Adult attachment style is defined by Sperling and Berman (1994) as “the stable tendency of an individual to make substantial efforts to seek and maintain proximity to and contact with one or a few specific individuals who provide the subjective potential for physical and/or psychological state and security” (p. 8). A secure child becomes a secure adult partner in a romantic relationship. A fearful angry child becomes a fearful angry adult involved in a romantic relationship with a partner (Babcock, Jacobson, Gottman, & Yerington, 2000; Buttell, Muldoon, & Carney, 2005; Mahalik, Aldarondo, Gilbert-Gokhale, & Shore, 2005; Sonkin & Dutton, 2003). Romantic relationships will have conflict, and secure partners are still able to emotionally connect even in the midst of the conflict. For the fearful partner, conflict in the relationship is a signal to begin to inappropriately act out in anger in order to keep the partner close.

Romantic Attachment Beliefs

Romantic attachment beliefs involve a tendency to seek and maintain a secure close proximity to a specific person, particularly when presented with biopsychosocial stressors. It is a mutual regulatory system that provides a sense of security for romantic partners such that the partner is comforted when the other is present and more anxious when the other is not present (Feeney & Noller, 1990; Fraley & Shaver, 2000; Potter-Efron, 2005).

Hazan and Shaver (1987) found that each partner has the assumption that what happened in childhood in relationship to the dimension of autonomy and intimacy will be

played out in the romantic relationship. The secure partner will be appropriate with autonomy and intimacy in the context of the relationship and thus regulate emotions in a healthy manner, especially the emotions of fear, anxiety, and anger. The anxious partner will be focused on the intimacy aspect of the relationship and thus will be clingy, needy, angry, and controlling in order to maintain intimacy. The anxious partner will struggle with autonomy and will do whatever is necessary to make sure the other does not reject and/or abandon the relationship. Emotional dysregulation is the key for this relationship. The avoidant partner will be focused on the autonomy aspect of the relationship and thus will be distant and independent with minimal desire for intimacy (Babcock, Jacobson, Gottman, & Yerington, 2000; Buttell, Muldoon, & Carney, 2005; Mahalik, Aldarondo, Gilbert-Gokhale, & Shore, 2005; Sonkin & Dutton, 2003).

Therefore, recent research has begun to explore the role of attachment and anger in DVOs. DVOs tend to communicate from an insecure style of attachment. This impacts the romantic relationship when the DVO is emotionally disconnected, lacks empathy, and is unmotivated to instigate, cultivate, and/or maintain intimacy in the relationship (Sonkin & Dutton, 2002). Sonkin and Dutton also noted how DVOs with an insecure style of attachment are emotionally deregulated when they perceive the partner will potentially reject/abandon them. The DVO responds with fear, anxiety, and anger in order keep the partner in close proximity. Sonkin and Dutton define attachment beliefs as a way to describe “observable or manifest patterns of behavior” (p. 22) in a DVO, such as violent anger and the absence of empathy in an interpersonal relationship.

The sense of attachment security is based on the beliefs and expectations developed in childhood. A person’s beliefs and expectations in an interpersonal

relationship were grounded in one's style of attachment and generate such questions as "Am I worthy of love?" "Are you aware that I have emotional needs?" "Can I trust you to be there for me?" (Bartholomew & Horowitz, 1991). These beliefs and expectations were carried into adulthood and represented in the way one views the self (autonomy), the partner (intimacy), and how the relationship itself should function. Bartholomew and Horowitz referred to these adult styles of attachment as preoccupied, dismissing, fearful, and secure. The preoccupied style viewed the self in a negative way, and the dismissing style viewed the partner in a negative manner. Fearful attachment was the combination of both negative view of self and other, so this person expected the worst from the intimate relationship. Secure attachment was a combination of both positive view of self and others (1991).

Dutton (1998) noted a person with a fearful attachment style needed the relationship, yet is fearful, so the relationship is avoided. This had the potential to be damaging for both the person and the partner. The same motivational system that gives rise to the close emotional bond between parent and child was responsible for the bond that developed between adults in emotionally intimate relationships. The fearful child now is the fearful partner in a relationship. Sonkin and Dutton (2003) found in their research that when DVOs were children they were never sure what the attachment figure was going to do: actually be present, respond in a nurturing/negative (abusive) manner, and/or even be aware of what the child needs. These same three questions of childhood follow the DVO into current intimate relationships "Will my partner be actually present?" "Will my partner respond to my emotional needs?" "Will my partner even be aware that I have needs?" The theory of attachment addresses these interpersonal questions

(Babcock, Jacobson, Gottman, & Yerington, 2000; Buttell, Muldoon, & Carney, 2005; Dutton, 2000; Mahalik, Aldarondo, Gilbert-Gokhale, & Shore, 2005; Sonkin & Dutton, 2003). Some of the current research began to question the construct of empathy as it relates to DVOs and their ability to regulate anger (Winters, Clift, & Dutton, 2004).

Empathy

As a component of emotional intelligence, empathy is the ability to be in tune with, and to comprehend how another person feels. It is a direct negation of interpersonal violence. Studies have shown that persons with minimal emotional intelligence, low empathy included, have greater tendencies to express anger as violence towards the partner (Bar-On, 2006; Buttell, Muldoon, & Carney, 2005; Dutton & Golant, 1995; Feder & Dugan, 2002; Goodrum, Umberson, & Anderson, 2001; Holtzworth-Monroe, Meehan, Herron, Rehamn, & Stuart, 2000; Winters, Clift, & Dutton, 2004). Winters, Clift, and Dutton (2004), however, found an inverse correlation with anger and empathy. This result was generated from assessments on emotional intelligence, which included the empathy subscale in the study.

Empathy requires self awareness and emotional regulation, especially in time of interpersonal conflict (Buttell, Muldoon, & Carney, 2005; Dutton & Golant, 1995; Feder & Dugan, 2002; Goodrum, Umberson, & Anderson, 2001; Holtzworth-Monroe, Meehan, Herron, Rehamn, & Stuart, 2000; Winters, Clift, & Dutton, 2004). DVOs lacked empathy and when compared to persons with a significant degree of empathy, were therefore more likely to display aggressive and antisocial behaviors toward others (Hoffman, 2000;

Loper, Hoffschmidt, & Ash, 2001; Silver & Teasdale, 2005). When empathy was present, aggression and rages were absent and/or regulated in appropriate ways before violence erupts (Hoffman, 2000; Loper et al., 2001; Silver & Teasdale, 2005). Wexler (1999) reported most DVOs had psychological malfunctions stemming from an attachment injury at some point in their childhood which delayed their emotional intelligence. This lack of empathy carried over into the DVO's adult interpersonal relationships, which could be turbulent at best (Silver & Teasdale, 2005). Therefore, emotional regulation was minimal and anger had the propensity to be displayed as violence in the relationship (Wexler, 1999; White & Weiener, 1986). When DVOs became angry in the relationship, their ability to utilize empathic responses was greatly decreased or even non-existent due to fact that anxiety and fear of abandonment and rejection maximally inhibited it (Watt, 2005). However, Silver and Teasdale (2005) reported empathy could facilitate the DVO's ability to navigate anger in the interpersonal conflict in nonviolent behaviors.

Historically, the definition of empathy had encompassed emotions and the emotional aspects of an interpersonal relationship. More recently, empathy has been defined as part of the cognitive aspects of perspective taking (Eslinger, Parkinson, & Shamay, 2002; Shamay-Tsoory, Tomer, Berger, & Aharon-Peretz, 2003). This current definition of empathy is more in depth and included the sharing of experiences and being emotionally sensitive. Bar–On (2007) defined empathy as the ability to be aware of and understand how others feel. It is being sensitive to what, how, and why people feel the way they do. Empathy is the ability to accurately act upon and/or in some way acknowledge another person's values, motivations, knowledge, and skills regardless of the level of agreement between the two people, and still choose to accept that other

person unconditionally (Denzin, 1984; Gondolf, 1985; Holtzworth-Munroe & Stuart, 1994; Swartz, 2002).

Empathy also included the ability to be in tune with and comprehend how another person felt, and thus is a direct negation of interpersonal violence. Bar-On (1997) reported a person with empathy was able to be cognizant of, and identify with, the other person's experience in the moment. An empathic person was able to stay emotionally connected to the partner by expressing interest and concern, especially in the midst of a conflict. Violence was not an interpersonal skill utilized by an empathic person (Bar-On, 1997; 2006). The person was insightful to what, how, and why the partner was experiencing in the moment. Empathic partners were able to emotionally read the other (Bar-On). The ability to emotionally read another person in the midst of conflict was conducive to reducing anger in the relationship.

The concept of empathy embraced both cognitive and emotional processes for DVOs. According to Eslinger (1998), the operationalization of empathy required the ability to actually employ role-taking and perspective-taking in the relationship. The ability and choice to put oneself in another's shoes required emotional regulation and cognitive flexibility (Eslinger, Parkinson, & Shamay, 2002). Cognitive flexibility was the ability to shift the course of thought or action according to the situation, and was essential in the role of empathetic response (Shamay-Tsoory, Tomer, Berger, & Aharon-Peretz, 2003). One needed to be able to correctly identify and then interpret the emotion displayed on the other person's face in order to adopt a perspective (Bar-On, 2007). Empathy was the recognition and understanding of the states of mind, including beliefs,

desires, and particularly emotions of the partner. Simply put - this concept is often characterized as the ability to see the conflict through the eyes of the other person.

Developmentally, empathy required partners to have matured to the level that they can think beyond the needs, desires, and experiences of the self in order to understand another's experience. The ability to be empathic required a mental schema that embraced the knowledge of how the self impacts others and their experiences (Eslinger, 1998). It could be challenging to lay aside personal needs and perspectives in order to understand another's experience. Entitlement, resentment, and anger resulted if one chose not, or was unable, to exercise empathy (Eslinger, Parkinson, & Shamay, 2002). DVOs struggled with the fundamental emotional understanding of empathy necessary in healthy interpersonal relationships (Shamay-Tsoory, Tomer, Berger, & Aharon-Peretz, 2003). In order to protect themselves from the pain of not knowing how to accept or to give empathy, DVOs withdrew despite the need for the connection with their partner (Ikes, 2003).

Holtzworth-Munroe and Stuart (1994) researched DVOs of both genders and found those who lacked empathy tended to have an inverse relationship to violence. DVOs with little or no empathy had a greater propensity to engage in domestic violence. A DVO, who had gained the ability to be cognizant of and identify with the other's feelings in the moment, was strongly motivated to stop inflicting any type of pain on the partner (Wexler, 1999). When a DVO learned to shift the motivation from self to partner in the midst of a conflict, violence was no longer the necessary outcome. Wexler noted empathy was the factor that allowed this motivation shift to happen for the DVO and that most domestic violence was due to an "empathic failure" (p. 12).

DVOs who reported the inability to experience another person's emotional state also reported the tendency to engage in violent behaviors within the relationship. When empathy was absent in the relationship, anger turned to violence (Holtzworth-Munroe & Stuart, 1994; Wexler, 1999). A DVO without empathy perceived conflictual situations with the partner as negative. For example, when there was conflict between them, the DVO perceived the partner was deliberately creating the conflict in order to generate emotional distance, which increased fear, anxiety, and anger for the DVO. When empathy was utilized by the DVO, s/he was able to perceive situations as less conflictual (Holtzworth-Munroe & Hutchinson, 1993). The ability to empathize with one's partner and understand the conflict from his/her perspective has the potential to reduce anger for the DVO.

Stosny (1995) reported DVOs have great difficulty tolerating conflict and regulating the emotional fear, anxiety, and anger generated by conflict in an interpersonal relationship. Stosny continued with the assertion that DVOs quickly became overwhelmed with the emotions of anger, frustration, abandonment, and rejection, such that they were unable to regulate the emotion of anger in a healthy manner. Furthermore, the DVO would have the choice to respond to conflict with empathy and that would mean taking on the role of mediator not instigator. Violent anger that was operationalized as assault would no longer be present in the intimate relationship when empathy is utilized (Vignemont & Singer, 2006). Introducing the skill of empathy could allow the DVO to facilitate the emotional regulation of his/her anger, fear, and anxiety in appropriate ways. According to Stosny (1995), utilizing the skill of empathy could reduce the emotional anger and thus have the potential to heal the emotional injury the DVO had previously

experienced in the relationship. This propensity for emotional deregulation with anger, fear, and anxiety is interfaced with issues around the DVO's attachment (Holtzworth-Munroe & Stuart, 1994).

Not all data supported the concept that introducing empathy would reduce anger for DVOs. For example, the research of Winters, Clift, and Dutton (2004) found low scores for empathy were not necessarily related to the inclination toward abusiveness. However, Winters and associates gathered anecdotal stories from therapists who work with DVOs that negated these findings. In theory, when DVOs were able to express emotions, thoughts, and needs in a way that facilitated an emotional connection, they were also utilizing the communication skills that did not include intimidation and violence. When Winters and associates published their study, no research to that date and time had specifically addressed the issue of emotional connection for DVOs.

Silver and Teasdale (2005) summarize it well as they note from their data how insecure attachments tended to allow for emotional dysregulation in social relationships. A DVO with an insecure attachment style in an interpersonal relationship utilized fewer social controls over anger and negative behaviors. According to Silver and Teasdale, DVOs with an insecure style of attachment had no empathy, so when conflict and anger were introduced into the relationship, there was no regulation in place to inhibit violence. They reported how empathy facilitated the DVO to navigate the anger and conflict in ways that were nonviolent. A person with a secure attachment style had the ability to utilize social controls over anger and thus resolve the relational conflict without violence (Silver & Teasdale, 2005).

Styles of Attachment and DVOs

According to Tweed and Dutton (1998) the knowledge of attachment styles of DVOs has the propensity to provide additional information about the psychological underpinnings for intimate violence. Sonkin and Dutton (2003) noted how this particular knowledge enabled DVOs to understand their personal pattern of behaviors as it related to loss and separation in the relationship. Tweed and Dutton proposed that attachment styles were triggered when the intimate relationship was under stress. In fact, they noted how stress in the intimate relationship could lead to domestic violence. This domestic stress was a strong activator for the attachment style to be played out for the DVO (Holtzworth-Munroe & Stuart, 1994; Tweed & Dutton, 1998). Sonkin and Dutton (2003) suggested that DVOs would benefit by understanding and practicing emotional regulation during times of attachment anxiety in the relationships, and that DVOs did have the choice to alter the sense of self in order to reduce the anxiety and fear coupled with attachment. Others called this creating a secure base of attachment in the intimate relationship (Sonkin & Dutton, 2003).

Sonkin and Dutton (2003) further noted how treatment for DVOs and the construct of attachment were usually not connected. Yet DVO's spoken perception in the therapeutic setting indicates the presence of emotions, thoughts, and behaviors that clearly interfaced with attachment issues. For example, DVOs who were indifferent and cold were similar to those with an avoidant attachment schema. DVOs that were passive/aggressive were similar to those with disorganized attachment schema. The preoccupied DVO had a keen awareness to any real and/or imagined threats of

abandonment from the partner. When the partner chose to withdraw physically and/or emotionally from the conflict, the DVO reacted with violence which kept the partner in close proximity for a brief time (Babcock, Jacobson, Gottman, & Yerington, 2000). Preoccupied DVOs had the highest levels of anger, depression, and jealousy (Wexler, 1999). Babcock and associates (2000) reported DVOs who were dismissing and preoccupied were more domineering in interactions with the partner. These DVOs tended to mandate compliance, force submission, and use behaviors of stonewalling in order to get their way. These negative interpersonal communication styles gave evidence to the absence of empathy in the emotional repertoire of the DVO. Violence then became a choice for these DVOs (Babcock, Jacobson, Gottman, & Yerington, 2000).

Some DVOs seem to struggle with anxiety related to the fear of abandonment (Sonkin & Dutton, 2003; Winters, Clift, & Dutton, 2004). Furthermore, the authors reported that due to these similarities mentioned above, incorporating attachment theory into treatment for DVOs makes therapeutic sense. They propose that integrating anger, domestic violence, and style of attachment would, first, give DVOs a place to draw from the past and understand the present as it relates to their strong reactions to perceived responses to abandonment within the context of the intimate relationship. Second, integrating these concepts would facilitate a place for DVOs to learn about and apply appropriate emotional regulation when experiencing fear and anxiety around rejection and abandonment in the relationship. Finally, concepts around attachment theory advocate introducing a new way to think about and process intimate relationship of self and others when it comes to reducing anxiety over perceived abandonment (Sonkin & Dutton, 2003; Winters, Clift, & Dutton, 2004).

Winters, Clift, and Dutton (2004) found that male offenders were fearful and anxious in their romantic relationships, evidenced by increased levels of anxiety and the inability to effectively and appropriately manage negative emotions created from interpersonal conflicts. Due to the decreased emotional intelligence, male offenders were unaware and thus unable to identify and regulate the negative emotions generated by the interpersonal conflict. The male offender had a fear of being alone and/or rejected, yet lacked the knowledge, skills, and ability to express those fears appropriately to his partner. This emotional dysregulation is not conducive to affective empathy as demonstrated in the choice to be violent (2004).

According to research (Winters, Clift, & Dutton, 2004), DVOs scored at least one standard deviation below the general population in emotional intelligence. This is a significant difference. Winters and associates noted these scores for DVOs suggest that they, indeed, have a decreased emotional intelligence. The low scores also indicated they may not be aware of their own emotions, and they lacked the insight as to how their own emotions elicited negative responses from their partner. They also lacked the insight as to why the partner may react negatively (withdraw, reject, abandon) towards them (2004). According to the Winters and associates (2004) research, the empathy subscale was viewed from a normed population, not pertaining to the DVO. However, anecdotal narratives from clinicians have linked low empathy with domestic violence, “yet no research has specifically addressed this issue” (p. 265).

There is an increasing body of research that correlated violence in relationships with lack of empathy and anxious/fearful attachment patterns (Dutton, Saunders, Starzomski, & Bartholomew, 1994; Hastings & Hamberger, 1988; Wallace & Nosko,

2003). Wallace and Nosko (2003) described how shame, anger, and attachment are strongly related. When DVOs experienced conflict in the interpersonal relationship, they were re-experiencing shame from childhood attachment experiences. The DVO reacted by bringing the shame into the present. From this shame base, the DVO began attacking the partner verbally, emotionally, and physically in order to stop the conflict and thus reduce the experience of shame.

Dutton and Golant (1995) identified three background features necessary for DVOs to have acquired an insecure attachment style of relating. The first feature was the experience of being shamed by a parent. The second feature was an insecure attachment with the mother, and finally, witnessing abusive behaviors in the home. If the mother was not emotionally available to the child time after time when s/he desired to be nurtured, the child would have experienced neglect and rejection. This was the foundation for the insecure base (Bowlby, 1980; 1988). Thus the DVO is currently developmentally stuck at that stage of development (Dutton & Golant, 1995).

Empathy and emotional regulation have not been taught, experienced, and/or practiced by the DVO. Dutton and Golant reported that the third way insecure attachments happened was when the mother enmeshed herself in the child's life, for example, when she went to the child for her own emotional needs to be met. This DVO never had a chance to differentiate as a child. Thus s/he developed an attitude of believing partners are only intermittently trustworthy and accessible (Dutton & Golant, 1995).

Most DVOs had an insecure style of attachment stemming from an attachment injury at some point in their childhood (Holtzworth-Munroe & Stuart, 1994). This

attachment injury occurred when the caregiver violated the expectation of comfort, care, and nurture that was given to a child in times of danger or distress (Bowlby, 1970; 1980; 1988). Moreover, empathy may not have been taught to the DVO before the attachment injury occurred. This lack of empathy and developmental emotional arrest had outcomes that carried over into the DVO's adult interpersonal relationships. This resulted in the DVO having minimal emotional regulation and limited access to empathy, especially when involved in interpersonal conflict, as the fear, anxiety, and anger inhibit empathy. Anger from relational stressors now has the propensity to be expressed as violence in the relationship (Wexler, 1999; White & Weiner, 1986).

Attachment injuries required reparation in order for DVOs to experience a sense of positive self-esteem. This reparation had the propensity to happen with a partner in the intimate relationship (Wexler, 1999; White & Weiner, 1986). When the nurturing stopped, for whatever reason, the person experienced fear of rejection, disrespect, helplessness, and rage. Wexler (1999) reported DVOs tried to maintain control and power over a sense of their own deteriorating self-esteem, not over the partner. One of the ways DVOs could begin to gain power and control over their perceived crumbling sense of self was to view the partner with empathy and have a self-awareness of what the other person is experiencing in the same moment of conflict (Goodrum, Umberson, & Anderson, 2001).

Styles of attachment can be a paradigm to increase the understanding of what is at the core of domestic violence. Understanding the style of attachment is essential for the DVO to integrate empathy and anger in the middle of an interpersonal conflict. Research is unclear regarding the relationship between DVOs style of attachment and their ability

to utilize empathic responses in the heat of an angry conflict with the partner. Current research suggests that adult attachment styles can facilitate an understanding of domestic violence (Babcock, Jacobson, Gottman, & Yerington, 2000; Buttell, Muldoon, & Carney, 2005; Mahalik, Aldarondo, Gilbert-Gokhale, & Shore, 2005; Sonkin & Dutton, 2003).

The DVO can begin to understand his/her dependent traits in the romantic relationship through the lens of attachment theory. Not only did it determine the traits, it also impacted the DVO's ability to be appropriate in interpersonal relationships (Dutton, 2000). Some DVOs tended to have excessive dependency in their interpersonal relationships that carried over from an insecure style of attachment in childhood. DVOs tended to lack the necessary emotional skills to initiate and/or maintain healthy, appropriate boundaries within the interpersonal relationship. They tended to use violent and controlling behaviors in order to achieve physical closeness versus emotional closeness (Holtzworth-Munroe, Meehan, Herron, & Stuart, 1999; Murphey, Meyer, & O'Leary, 1994).

Buttell, Muldoon, and Carney (2005) highlight the limitations of Dutton's (2000) study and investigated the dependency in the interpersonal relationships of DVOs as an indicator of insecure attachment. They hypothesize DVOs "would not display higher levels of interpersonal dependency in their primary relationships than nonviolent men" (p. 213). Their findings failed to provide the empirical evidence for which they were hoping. They noted that this failure serves to add more ambiguity to the already complex issue of DVOs, dependency, and insecure attachment. This failure to provide empirical evidence where DVOs may have greater interpersonal dependency with their romantic

partner can be viewed as support to continue to search for the motivation of the internal need for this dependency. This current research is one attempt to address that need.

Attachment Beliefs and DVOs

In a review of styles of adult attachment, Bartholomew and Horowitz (1991) found that adult attachment was based on two dimensions – one dimension of self confidence (autonomy) and one dimension of other confidence (intimacy). For instance, a person with a secure style of attachment had a positive internal model of both self and others, and thus is comfortable with both intimacy and autonomy. A person with a negative sense of self and positive sense of others sought affirmation from others in order to feel good, which is a preoccupied style of attachment. A person with a positive sense of self and a negative sense of others was independent and not emotionally connected with another, which is a dismissive style of attachment. A person who had both a negative sense of self and of others is afraid to be alone and afraid to be in a relationship, which is a fearful attachment style (Bartholomew & Horowitz, 1991).

As noted earlier, the Duluth theory of intervention addressed domestic violence as anger exhibited through power and control. Dutton (1998) countered the Duluth theory with the concept that an insecure DVO was acting out of the fear of rejection and fear of abandonment. Bowlby (1980) referred to this power and control behavior as anger that had been generated out of fear of rejection and abandonment. DVOs were unable to emotionally regulate and work from a sense of self, so they quickly looked to an external source to control the fear. This was usually expressed in anger and rage in order to reduce

their own fear and anxiety and to obtain proximity from the caregiver. DVOs can be taught how to develop more appropriate coping skills through the introduction of empathy (Sonkin & Dutton, 2003).

Problem

The present research question examines whether empathy and anger can co-exist in the same relationship for the DVO where pre-treatment empathy predicts post treatment anger. Self awareness of the ability to utilize empathy in order to understand the experience of the partner in the midst of angry conflict is difficult at best for the DVO (Goodrum, Umberson, & Anderson, 2001). Empathy has been linked to problems with anger, especially anger in intimate relationships. Goodrum and associates suggest DVOs may lack empathy and that low empathy may be strongly related to anger in DVOs. Research has also shown attachment beliefs to be related to anger dysregulation in general and anger in DVOs. No research to date has examined anger, empathy and attachment beliefs simultaneously in order to better understand their relationship (Goodrum, Umberson, & Anderson, 2001).

Summary

Decreasing anger by increasing empathy through the paradigm of style of attachment for the DVO has yet to be addressed significantly by researchers in the field. Empathy has been absent from most treatment approaches for DVOs. Sonkin and Dutton (2003) found the majority of treatment approaches teach DVOs (males) how to manage the

anger, relinquish control in the relationship, and treat the woman as an equal partner. These approaches have not addressed how a style of attachment, anger, and the lack of empathy impact the DVO's experience of conflict with the partner. By understanding emotional regulation, the DVO can manage the fear and rage that insecure styles of attachment bring into adult relationships (Sonkin & Dutton, 2003).

Therefore, it is hypothesized that adult attachment theory can facilitate an understanding of domestic violence. Persons with a secure attachment have the ability to trust the relationship and thus are satisfied with the partner. Persons with insecure attachment styles tend to exhibit anger, anxiety, and aggression in the intimate relationship (Goodrum, Umberson, & Anderson, 2001). Adult attachment theory can be a measure of how one regulates emotions in the throes of chaos in the interpersonal relationship (Babcock, Jacobson, Gottman, & Yerington, 2000). Thus most DVOs have insecure attachment styles (Babcock, Jacobson, Gottman, & Yerington, 2000; Dutton, Saunders, Starzomski, & Bartholomew, 1994; Holtzworth-Monroe, Meehan, Herron, Rehamn, & Stuart, 2000; Tweed & Dutton, 1998).

CHAPTER THREE: METHODS

Research Design

This study aims to investigate the role of anger, empathy, and attachment beliefs in a sample of domestic violence offenders (DVOs) court ordered to treatment. The specific question is whether empathy accounts for unique variance in anger after controlling for attachment beliefs. It was hypothesized that pretreatment empathy scores would be the best predictor of post-treatment anger, after controlling for the influence of pretreatment attachment, pretreatment anger, and various potential confounding variables such as age, gender, and previous offenses. A prospective design was utilized in order to follow subjects over a thirteen week time frame. The strengths of a prospective study lie in its ability to establish a time line and its ability to measure antecedents without biasing the outcomes (Kazdin, 2003). A limitation of doing a prospective study is low statistical power due to a low sample size, which in this case was twenty four (Kazdin, 2003).

Participants

The subjects (n=24) were male and female court referred domestic violence subjects from Harrisonburg/Rockingham Court (Harrisonburg, Virginia) systems referred to the Center for Marriage and Family Counseling for a 13 week anger management class. The researcher is aware that great care must be taken not to implicitly or explicitly manipulate this special population. Potential subjects were from a diverse ethnic background, and typically at the poverty level or low income wage earners. The gender mix was fourteen males and ten females.

Participation in these groups was one of self-selection according to time. Prospective group members called the Center to decide which day and time best suited their work and life schedule: Tuesday morning, Tuesday evening, or Thursday evening. Group members who selected the Tuesday morning group were persons who worked second and third shift, or not at all. Group members in the Tuesday and Thursday evening groups were persons who worked daylight shifts. Subjects in this study were members in all three groups.

Procedures

This study was approved by the Institutional Review Board (IRB) in the winter of 2007. Subjects were provided with a consent form and a measurement packet on their first group meeting. When the subjects arrived at the Center for the first group session, they were asked by the researcher if they were willing to participate in this voluntary study. The subjects understood that if they chose to participate, they were free to not answer any question and could withdraw at any time without affecting their relationship with the group leader and other group members. The subjects were further informed that their choice to participate would not impact their status with the Court/parole or the Center staff. The informed consent form (Appendix A) was read together with the subjects, and signed only after they had voiced a clear understanding of what the study entailed.

Participants were given a packet which contained four instruments: The Bar-On Emotional Quotient Inventory: Short (EQ-i:S), The Experiences in Close Relationship Scale – Short Form (ECR-S), The Anger Disorders Scale: Short (ADS: S), and The

Paulhus Deception Scales (PDS). The packet was given to the subjects on the first and thirteenth (last) session of therapy. The data collected from these instruments were analyzed according to the purposes of this study.

Measures

Background Information and Court History Questionnaire

Participants completed a background information questionnaire (Appendix B) which included descriptive information such as group identification, gender, age, employment, education, and current living situation. Additionally, court history was gathered that included the current charge, relationship to the victim, previous charges, and whether or not a protective order was currently in place. Participants were also asked to identify the referral source to the group.

The Bar-On Emotional Quotient Inventory: Short (EQ-i:S)

The Bar-On Emotional Quotient Inventory: Short (EQ-i:S) is an instrument used to measure emotional intelligence, which includes empathy. Emotional intelligence is defined as the emotional, personal, and social extent of one's broad intelligence situation (Bar-On, 1997; 2006; 2007; Boyatzis, 1982; Boyatzis, Goleman, & Rhee, 2000; Goleman, 1995, 1998). According to Bar-On (2002) one needs to be able to correctly identify and then interpret the emotion displayed on the other person's face in order to adopt a perspective. Empathy is the recognition and understanding of the states of mind, including beliefs, desires, and particularly emotions of another person (Bar-On, 2007).

The EQ-i:S is a shortened version of the Bar-On Emotional Quotient Inventory (EQ-i)(Bar-On, 1997). The EQ-i:S is a straightforward, self-report questionnaire that measures emotionally intelligent behaviors. The EQ-i:S is designed for individuals 16 years of age and older who are able to respond honestly and willingly. Readability is determined to be equivalent to a North American 4th-grade reading level.

The EQ-i:S is an appropriate measure of assessment of emotional intelligence as it offers several distinct features. A large normative sample (N > 3,150) was utilized in the designing of the instrument. There are multidimensional scales to utilize the foundational constructs of emotionally intelligent behavior. Along with the multidimensional scales, there are several scales that examine the potential for one to be emotionally regulated and have a clear sense of self without having to exaggerate.

The assessment consists of 51 items, utilizing a five-point Likert response scale with the following descriptors: “1=Very seldom or not true of me”, “2=Seldom true of me”, “3=Sometimes true of me”, “4=Often true of me”, “5=Very often true of me or true of me”. The assessment generated two validity scale scores, one total EQ score and five EQ composite scale scores.

The two validity scale scores assess the degree to which the results are a valid representation of the subjects’ feelings, thinking, and behavior. The Inconsistency Index measures the response inconsistency and is an indicator of random responding. An Inconsistency Index score of 12 or greater is examined cautiously. The Positive Impression scale, created to identify an exaggerated positive impression (“faking good”), is distinguished by scores two standard deviations above the mean while scores that are two standard deviations below the mean suggest “faking bad.” The EI Composite scale

assesses a general level of EI for the subject and can present a “snapshot” of the subject’s current emotional status. It is composed of five factor scales: Intrapersonal, Interpersonal, Adaptability, Stress Management, and General Mood. The scales were created such that the higher the score, the higher emotionally intelligent behaviors, positive mood, and positive impression.

Internal consistency reliability, mean inter-item correlations, test-retest reliability, and standard error of measurement/predication were found for this instrument. Furthermore, internal consistency coefficients were found to be high across age and gender. These coefficients were presented separately by age group and by gender. The test-retest reliabilities scales ranged from .46 to .80.

Anger Disorder Scale: Short

The Anger Disorders Scale: Short (ADS: S) was created by DiGiuseppe and Tafrate (2004). The purpose of the ADS: S is to assess and measure clinically dysfunctional anger (in adults aged 18 to 76 years) as a basis for developing appropriate intervention and treatment plans. The ADS: S is an 18-item, self-rated assessment tool that identifies persons ages 18 and older who may have anger problems. The T-scores and percentiles from the ADS: S are based on a normative population sample of 1,197 and have been calculated using one of the following sets of norms: overall, gender, age group (18–29, 30–49, or 50 and older), or age and gender group.

The key features of the ADS: S is that first it assesses anger as the core issue, not just a secondary symptom of something else for the subject. Second, the ADS: S assesses externally expressed anger, addresses how anger is part of affective aggression, and

identifies the cognitions that may be associated with anger. Third, the ADS: S facilitates clinicians assessing both the emotional regulation of the subject and his/her acting out behaviors of anger. Finally, the ADS: S offers a solid foundation for developing appropriate interventions for the subjects.

The internal consistency is 0.97 for the full version Total Score. The internal consistency range begins at .70 and ends at .96 for the sub-scales and higher order factors. The internal consistency of the short version is .86. Test-retest reliability (with an interval of two weeks) range from .83 to .92 for the full scale and short versions.

Concurrent validity of the ADS: S is highly correlated with other measures of anger. Discriminate validity is apparent as the ADS: S is able to differentiate between normal and clinical samples. Anger is measured through a multidimensional composition that represents 18 subscales distributed across five domains of emotions. The scale provides a total score and scores for the three higher-order factors in anger-in (propensity to emotionally regulate anger), reactivity/expression (propensity to aggress), and vengeance (propensity to cognitively ruminate ways to get even).

The Experiences in Close Relationship Scale-Short Form

The Experiences in Close Relationship Scale – Short Form (ECR-S), developed by Wei, Russell, Mallinckrodt, and Vogel (2007), is a self-report measure that assesses the subject's adult romantic-attachment relationship with the partner. Attachment is operationalized on two continuums, where the first is anxiety and the second is avoidance. The anxious adult experiences annihilation anxiety which is the threat to the body wholeness and survival, the annihilation of one's core being (Schore, 2004).

Anxiety is the expectation of the rejection of the significant other (Cozolino, 2003). The anxiety is evident with this person due to the fact there is no internalization of safety.

For the avoidant adult, the significant other rebuffs verbally and nonverbally any attempts the partner makes in order to obtain emotional regulation. The partner seeks out the significant other in order to find a safe place to modulate the negative emotions and is consistently rebuffed. The partner then exhibits anger as s/he actively avoids reuniting with the significant other and averting any face to face interactions. Schore (2004) notes this active avoidance is a coping mechanism to emotionally regulate the experience of a rejecting mother. The avoidance of cognitions and emotions that are paired with feared stimuli (non-responsive significant other) is what activates the avoidance (Cozolino, 2003).

Subjects with low anxiety and low avoidance are secure in their attachment style. Subjects with high anxiety and low avoidance are preoccupied. Subjects with high avoidance and low anxiety are dismissive in their attachment style. Finally, subjects with high anxiety and high avoidance operate from a fear based attachment style of relating to the romantic partner.

The ECR-S was developed from the original 36 item version of the ECR and presents as a valid and highly reliable measure of adult attachment. This shorter version, developed by Wei and associates (2007) is more appropriate for the subject population assessed in this present research. Wei and associates utilized six studies to develop the short version of the ECR. They found the 12 item ECR-S preserved similar psychometric properties to the ECR and had a constant factor structure and adequate internal

consistency, test-retest reliability, and construct validity across the aforementioned six studies.

The internal consistency of the ECR-S was found to be sufficient. The coefficient alphas ranged from .77 to .86 for the Anxiety subscale, and from .78 to .88 for the Avoidance subscale and this was consistent across all six studies. The test-retest reliability results were .82 for Anxiety and .89 for Avoidance in Study Six.

Construct validity for the ECR-S was not negatively impacted by the reduction of the length of the scale. Wei, Russell, Mallinckrodt, and Vogel (2007) note the ECR-S provides a valid and reliable measure of adult attachment. The properties of the ECR-S version are analogous or equal to the ECR; therefore, the ECR-S does indeed do what it says it does. That is, it measures the attachment styles of adults, and in this case, adult subjects. Subjects who score high on either the anxiety or the anxious scale have a greater tendency to have an insecure adult style of attachment. Subjects who score low on either the anxiety or the anxious scale experience a secure adult style of attachment.

The Paulhus Deception Scales: The Balanced Inventory of Desirable Responding-7

The Paulhus Deception Scales (PDS) is designed to assess whether or not persons are responding to self-reports in overly positive terms. In order to obtain a more accurate self-report, the PDS was created by Paulhus (1998) to measure a person's tendency to give more desirable responses. The PDS has two subscales, the Self-Deceptive Enhancement Scale (SDE) and the Impression Management (IM) Scale. The SDE is able to determine honest, but inflated answers, while the IMS looks at the tendency to typically give exaggerated self-descriptions. The PDS is one assessment tool designed to

identify subjects who desire to present themselves in a more positive and/or negative manner. The PDS is useful in identifying subjects who distort their responses and in assessing the honesty of their responses. Therefore, the PDS is regarded as a valuable tool in testing situations, such as this present study, as a check on the validity of self-report test responses.

The coefficient alpha for internal reliability for the PDS subscales and the total PDS score were satisfactory for all fifty studies in the development of this measure. The coefficients for the SDE scales ranged from .70-.75 and IM and PDS total coefficients ranged from .81-.86. Internal reliability was measured using the Cronbach's alpha coefficient which indicated highly satisfactory internal reliability of .85.

The items of both scales, SDE and IM, have face validity for measuring response bias. First, the wording of the questionnaire is written in such a manner that would make it unlikely for a subject to give a desirable response. Second, the scoring of the measure with extreme responses mandates a response bias versus the personality. The face validity of the PDS differs for both scales. The SDE score clearly indicates a rigid overconfidence for the subject, while the IM reflects his/her exaggerated social traditionalism. A number of studies of the convergent validity, structural validity, and discriminate validity of the PDS and its subscales were reported in the manual. The SDE scores reflect positive correlations with self-report and other peer-related scales of adjustment, whereas the IM shows minimal to no correlation. On the other hand, IM scores are more perceptive to the situational demands for self-presentation. The PDS is the only measure with replication and validation studies that has clarified the nature of socially desirable responses on a self-report questionnaire. The PDS utilized a large adult sample (n = 441) from the

general population, university students, military personnel, and prison populations in order to standardize the norms. In America and Canada, the ages ranged from 21 to 75. There is no differentiation of gender and/or ethnic diversity.

The two scales of PDS were created to encapsulate two different styles of responses considered socially desirable for persons in general. Impression Management (IM) involves the cognitive awareness of inflating self-descriptions, faking, or lying. This includes the belief that one is hypersensitive to one's ability to behave according to the social demand at the time. Self-Deceptive Enhancement (SDE) was created to assess one's inclination to give honest but exaggerated self-descriptions – presenting the self in a more positive manner than necessary. This behavior reflects a lack of insight and an unconscious need to look good towards others. The items in each subscale are written to indicate and discriminate two distinctive biases in one's self-reporting.

There can be four combinations of scale scores. First, if the IM score is low and SDE score is low, the subject is aware of his/her issues and the responses were not influenced by others. This subject tends to be blunt and direct in his/her style of relating, and the responses are honest and valid. Second, if the IM score is high and the SDE score is low then the subject will be aware of his/her shortcomings, but still desires to look good in front of others. This is perceived as healthy, but the test results are overly positive. Third, if the IM score is low and the SDE score is high then the subject is seen as narcissistic, shows arrogance, lacks insight, and allows his/her anger to control the situation. This subject will possess trait-like tendencies to consistently present as a positive self. Finally, if the IM score is high and the SDE score is high then the subject is seen as a restrained, rigid, and socially adapt, yet lacks the insight to deal with social

problems when they arise. This person will lack the ability to see the situation from the other person's eyes while presenting a positive self in all situations.

Research Procedures

A pretest (Time 1) and post test (Time 2) design was utilized for this study. Upon entering a 13 week anger management treatment group, volunteer participants were given a packet of measurements designed to assess empathy, current level of anger (internal, aggression, vengeance), social desirability, and adult romantic style of attachment. At the completion of the 13-week program, the same packet of measurements used at pretreatment was re-administered (at post-treatment) as a means of assessing any change. The subject's chart number was used as the identifying factor during the course of the study.

The subjects completed these assessments in a private room at the Center in a location removed from the rest of the building. The researcher administered the paper assessments to the subjects on their first day of group counseling and again on the final day of group. Each subject was given the instructions by the researcher that questionnaires were to be completed in the necessary time frame of one hour. Data was acquired by the subject choosing to complete the coded questionnaires. To ensure confidentiality, all records and data were kept locked in a file in the researcher's office. When the study was completed, the data was deleted and shredded. Upon publication, no information that will make it possible to identify a subject will be included. No court/parole personnel had access to any of the data.

The risks for participating in this study were minimal, no more than the subject would encounter in everyday life. The benefit for participants was having the opportunity to add to the current data on how one can appropriately manage anger. When the subject was able to identify how his/her anger can impede his/her ability to emotionally attach to the partner then the choice could be made to relate to the other in appropriate ways. Subjects that became aware of how to minimize anger and increase empathy had the potential to become more emotionally regulated with partners, handled life stressors, and experienced diminished work related pressures by utilizing appropriate interpersonal relationship skills.

Data Processing and Analysis

It was hypothesized that pre-test (Time 1) empathy scores would be the best predictor of posttest (Time 2) anger, after controlling for the influence of pretest attachment, pretest anger, and various potential confounding variables such as age, gender, and previous offenses. In order to calculate for a positive change score (treatment response) difference score were calculated such that a positive score in anxiety meant an improvement in the sense of self worth. Negative change scores (treatment response) in anxiety meant a decrease in the sense of self (T1-T2). Likewise, positive change scores (treatment response) in avoidance meant an improvement in the sense of others. Negative change scores (treatment response) in avoidance meant a decrease in the sense of others (T1-T2). Positive scores (treatment response) in empathy reflected improvement in emotional intelligence. Negative scores (treatment response) in empathy reflected a

regression in emotional intelligence (T2-T1). Thus an improvement in scores reflects a positive change (treatment response).

Correlation coefficients were calculated for avoidant style of attachment and anxious style of attachment from pretest to post test. Coefficients for change in post test empathy from pretest empathy were also calculated. Another series of coefficient correlations were calculated to determine if a change in anxiety was negatively correlated with anger turned inward. This was calculated by running a series of coefficients with changes in anxiety, avoidance, and empathy with post test anger in (not expressed), post test anger out (expressed verbally and/or physically), post test vengeance, and total (anger in, out, and vengeance) post test anger scores.

Finally, in order to test the model, a multiple regression analysis was calculated to determine if empathy accounted for unique variance in post anger in after accounting for pretest anger in, change in avoidance and change in anxiety, and change in empathy. The stability of the outcome measure was accounted for first by entering the Time 1 equivalent into the equation. Subsequently, attachment was entered into the equation in order to account for its effect, which was followed by empathy. This structuring of the regression allows for the most conservative estimate of the empathy on anger outcomes. Finally, a series of t-tests were run with gender and pretest anxious, avoidant, anger in, anger out, vengeance, total anger score, empathy, and general mood.

Summary

A prospective design was used to investigate the relationship between pretest empathy, attachment, and pre and post test anger. Questionnaires were utilized to acquire

data that could be used to test the hypothesis of pretreatment empathy scores being the best predictor of post-treatment anger, after controlling for the influence of pretreatment attachment, pretreatment anger, and various potential confounding variables such as age, gender, and previous offenses. The model was tested using a multiple regression analysis.

CHAPTER FOUR: FINDINGS

Introduction

The purpose of this study was to investigate whether pretreatment empathy scores in DVOs would be the best predictor of post treatment anger, after controlling for the influence of pretreatment attachment, anger (internal, external, vengeance), and various potential confounding variables such as age, gender, and previous offenses. The study utilized a prospective design to examine the impact of empathy and attachment beliefs on various dimensions of anger in a sample of domestic violence offenders (DVOs), both male and female, who were court ordered to treatment. The results of this study may provide additional research and theoretical support for creating a treatment intervention that directly targets DVOs empathy and attachment beliefs in the romantic relationship. The research question was addressed using a series of multiple regressions which examined whether pretreatment empathy accounted for unique variance in post treatment anger after controlling for styles of attachment and pretreatment anger.

Demographics

The subjects were male and female court referred domestic violence offenders from the Harrisonburg/Rockingham Court (Harrisonburg, Virginia) systems referred to the Center for Marriage and Family Counseling for a 13 week anger management class. This special population was not implicitly or explicitly manipulated in any way. The prospective subjects were from a diverse ethnic background, and generally at the poverty level or low income wage earners. The gender mix varied; however, according to

statistics kept by the Center, it is typically 60/40, where 60% of the group participates are male (n=14) and 40% of the group participates are female (n=10). Fourteen of the subjects were employed and ten of the subjects were unemployed. Eleven subjects had previous assault and battery arrests and for thirteen of the subjects, this was the first assault and battery charge.

Table 1

Demographic Frequencies of the Initial Sample

Demographic	Type	*n*	Percentage
Sex	Male	14	58.3%
	Female	10	41.7%
Age	19 – 29	11	45.8%
	30 – 39	7	29.2%
	40 – 49	4	16.7%
	50 – 59	2	8.3%
Previous Offenses	Yes	10	41.7%
	No	14	58.3%
Employed	Yes	14	58.3%
	No	10	41.7%

Six participates were released from the study due to noncompliance with the program. Two of the six participates were incarcerated, and the other four were non-compliant to the Court order of attending the anger management group.

Results

In order to calculate for a positive treatment response score, difference scores were calculated such that positive scores meant an improvement in treatment for that given variable. For example, a positive score in anxiety meant there was an increase in the sense of self worth from pretreatment to post treatment. Likewise, positive scores in avoidance meant an improvement in the sense of others. Negative scores meant a negative response to treatment in a given variable. For example, a negative score in anxiety meant a decrease in the sense of self (Pretreatment score-Post treatment score). Likewise, a negative treatment response in avoidance meant a decrease in the sense of others (Pretreatment score-Post treatment score). Positive treatment response in empathy reflected improvement in emotional intelligence (Post treatment score – Pretreatment score). Thus an improvement in treatment response scores reflects a positive change.

Correlation coefficients were calculated for avoidant style of attachment and anxious style of attachment from pretreatment to post treatment. Coefficients for change (treatment response) in post empathy to pre empathy were also calculated. Another series of coefficient correlations were calculated to determine if the treatment response scores in anxiety were negatively correlated with anger turned inward. This was calculated by running a series of coefficients with changes in anxiety, avoidance, and empathy with

post anger in (emotionally regulated), post anger out (expressed verbally and/or physically), post vengeance, and total (anger in, out, and vengeance) post anger scores.

Pearson's correlation coefficients were calculated using the Statistical Package for Social Sciences (SPSS) to determine the degree and direction of the linear relationship between the two dimensions of Adult Attachment (Anxiety and Avoidance), and the dimension of Empathy. No significant findings were found in either series of correlations. Another series of correlations were run in order to see if a treatment response in anxiety was negatively correlated with anger turned inward. This was executed by running a series of correlations with treatment response scores in anxiety, avoidance, and empathy with post treatment scores anger in, post treatment scores anger out, post treatment scores vengeance, and total post treatment scores anger. The analysis did reveal a negative correlation with a change in anger in and anxiety (r = -.473, p = .021) where p is $\leq$ .05.

Table 2

Correlations of Post Anger In, Out, Vengeance, and Total Anger with Measures of Adult Attachment and Empathy

	Anger			
Attachment and Empathy	Anger In	Anger Out	Vengeance	Total Anger
TR in Avoidance	-.039	-.138	-.029	-.026
TR in Anxiety	-.473*	-.364	-.355	-.398
TR in Empathy	.049	-.062	.051	.055

*$p \leq .05$

In order to test the model, a series of hierarchical multiple regressions were used to examine whether pretreatment empathy accounted for any significant unique variance in post treatment anger in after accounting for pretreatment anger in, treatment response scores in avoidance, anxiety, and empathy. In the first series the stability of the outcome measure was accounted for first by entering the pretreatment variable equivalent into the equation. Post treatment anger in score was regressed onto pretreatment anger in score (entered first). Subsequently attachment was entered into the equation in order to account for its effect, which was followed by empathy. This structuring of the regression allows for the most conservative estimate of the empathy on anger outcomes. The first R^2 generated by this method addressed whether empathy accounted for unique variance on the target emotion of post treatment anger in. There was no significance of unique variance with empathy. The R^2 generated by change in anxious style of attachment accounted for 25% of unique variance. The probability of F was $p = .06$. It was not significant due to low power, *n* (24).

Table 3

Hierarchical Regression predicting the unique variances on post Anger

Step and predictor variable	R^2	ΔR^2	Sig. $F\ \Delta$
Step 1	.007	.007	.690
Pre Anger			
Step 2	.009	.002	.840
Pre Anger			
TR Empathy			

Step 3	.260	.250	.063*
Pre Anger			
TR Empathy			
TR Romantic Attachment			

*$p \leq .05$

A correlation was performed with the treatment response scores in empathy, anxiety, and avoidance with post treatment anger in, post treatment anger out, post treatment vengeance, post treatment total anger, pretreatment impression management, pretreatment self deception, and pretreatment total Paulhus Deception Scale (PDS) scores. There was no correlation. Due to this fact, pretreatment impression management and pretreatment self deception variables were not added to the regression model.

A series of t-tests were run with gender and pretreatment anxious, avoidant, anger in, anger out, vengeance, total anger score, empathy, and general mood. A one way ANOVA was performed on previous change with pretreatment anxious, avoidant, anger in, anger out, vengeance, total anger scores, empathy, and EQ total scores. Total EQ scores seemed to be a predictor of post anger (F = 7.14, p = .01).

Table 4

One Way ANOVA on Previous Charges-Between Groups

Variable	Sum of Squares	*F*	Significance
Pre Anxious	139.243	2.413	.135
Pre Avoidant	42.076	.945	.341

Pre Anger In	21.058	.528	.475
Pre Anger Out	22.344	.583	.453
Pre Vengeance	.171	.021	.886
Pre Anger Total Score	1.144	.006	.940
Pre Empathy	48.096	1.443	.243
Total EQ Score	120.537	7.141	.014*

*$p \leq .05$

Four series of multiple regression analyses were then conducted in order to examine the relationship between changes in empathy, avoidance, anxiety, pretreatment anger in, out, vengeance, total anger scores and post treatment anger in, out, vengeance, and total anger scores. In each analysis, stability of the outcome measure (post treatment anger scores) was accounted for first by entering its pretreatment equivalent variable, and then predictors were added hierarchically, by their treatment response scores. In order to calculate for a positive change score, difference scores were calculated such that positive scores meant an improvement in the given variable. This structuring of the regressions allowed for the most conservative estimate of the predictive relation between pretreatment measures and the outcome of interest plus change in empathy, after controlling for stability in the outcome measure.

In the first analysis post treatment anger in was regressed onto the pretreatment anger in (entered first) and followed by the treatment response score of avoidant and anxiety. The treatment response score of empathy was added third. It was hypothesized that empathy would account for unique variance in post treatment anger in after

accounting for attachment. There was no significance found as the treatment response score in empathy added only 1% of unique variance (R^2 = .260, F = .614, p = .05)

Table 5

Hierarchical Regression predicting the unique variances on post Anger In

Step and predictor variable	R^2	ΔR^2	Sig. $F \Delta$
Step 1	.007	.007	.690
Pre Anger In			
Step 2	.249	.242	.061*
Pre Anger In			
TR Romantic Attachment			
Step 3	.260	.010	.614
Pre Anger In			
TR Romantic Attachment			
TR Empathy			

*$p \leq .05$

The second analysis was post treatment anger out regressed onto pretreatment anger out (entered first) and followed by the treatment response score of avoidant and anxiety. The treatment response score of empathy was added third. It was hypothesized that empathy would account for unique variance in post treatment anger out after accounting for attachment. There was no significance found as the treatment response score in empathy added only .2% of unique variance (R^2 = .229, F = .841, p = .05).

Table 6

Hierarchical Regression predicting the unique variances on post Anger Out

Step and predictor variable	R^2	ΔR^2	Sig. $F \Delta$
Step 1	.077	.077	.188
Pre Anger Out			
Step 2	.228	.150	.169
Pre Anger Out			
TR Romantic Attachment			
Step 3	.229	.002	.841
Pre Anger Out			
TR Romantic Attachment			
TR Empathy			

*$p \leq .05$

The third analysis was post treatment vengeance regressed onto pretreatment vengeance (entered first) and followed by the treatment response score of avoidant and anxiety. The treatment response score of empathy was added third. It was hypothesized that empathy would account for unique variance in post treatment vengeance after accounting for attachment. There was no significance found as the treatment response score in empathy added only .3% of unique variance (R^2 = .223, F = .797, p =.05).

Table 7

Hierarchical Regression predicting the unique variances on post Vengeance

Step and predictor variable	R^2	ΔR^2	Sig. $F \Delta$
Step 1	.106	.106	.121
Pre Vengeance			
Step 2	.220	.114	.256
Pre Vengeance			
TR Romantic Attachment			
Step 3	.223	.003	.797
Pre Vengeance			
TR Romantic Attachment			
TR Empathy			

*$p \leq .05$

The final analysis was post treatment total anger scores regressed onto pretreatment total anger scores (entered first) followed by the treatment response score of avoidant and anxiety. The treatment response score of empathy was added third. It was hypothesized empathy would account for unique variance in post treatment total anger scores after accounting for attachment. There was no significance found. The treatment response score in empathy added only .8% of unique variance (R^2 = .206, F = .671, p = .05).

Table 8

Hierarchical Regression predicting the unique variances on post Anger Total Score

Step and predictor variable	R^2	ΔR^2	Sig. $F \Delta$
Step 1	.032	.032	.400
Pre Anger Total Score			
Step 2	.198	.166	.152
Pre Anger Total Score			
TR Romantic Attachment			
Step 3	.206	.008	.671
Pre Anger Total Score			
TR Romantic Attachment			
TR Empathy			

*$p \leq .05$

Summary

Due to the lack of unique variance for change in empathy, there is no statistical significance of findings. The null hypothesis is accepted. Pre empathy scores in DVOs are not the best predictor of post anger, after controlling for the influence of pre attachment, anger, and various potential confounding variables such as age, gender, and previous offenses.

CHAPTER FIVE: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary of Findings

The research question which framed this investigation examined whether the subscale of pretreatment empathy could predict the four post treatment subscales of anger (internal, external, vengeance, total scores), after controlling for the two dimensions of adult romantic attachment (anxiety and avoidance) in domestic violence offenders (DVOs) who were court ordered to treatment (see Tables 5-8). Due to the lack of unique variance for change in empathy, there is no statistical significance of findings, thus the null hypothesis is accepted. Based on the findings of this study, pretest empathy scores in domestic violence offenders were not the best predictor of post test anger, after controlling for the influence of pretest attachment, anger, and various potential confounding variables such as age, gender, and previous offenses.

Studies reviewed by Buttell, Muldoon, and Carney (2005) showed a relationship between violent men and attachment style. However, neither of the research studies referenced by Buttell and associates included women DVOs in the sample population, nor did the research assess a relationship between empathy and anger. This current study assessed the relationship between attachment, empathy, and anger *regardless* of gender and found no difference between males and females was present.

An independent t-test was run on gender, anger in (i.e. anger not expressed), anger out (i.e. anger expressed verbally and/or physically), and vengeance scores. As mentioned above, no differences were found between genders in regards to anger. This finding calls into question the female victim mentality that some treatment programs support. In the past, domestic violence has been framed almost exclusively around

gender, specifically the male gender. For example, Pence and Paymar (1993) argued "batterers, like those who intervene to help them, have been immersed in a culture that supports relationships of dominance" (p. 3). Rivettt and Rees (2004) noted how both the Duluth and Emerge treatment models treated men as intrinsically bad and how the DVO was fighting for control and power, with no mention of any possible psychological dysfunction in the DVO (Gondolf, 1999; Rosenbaum & Leisring, 2001; Wexler, 1999). These interventions are driven by feminist theory which states that violence is used by males to control others' (i.e. females') behaviors (Rosenbaum & Leisring, 2001). The core of the feminist theory is that the current culture has socialized males in assuming a sense of entitlement to power over females (Rivettt & Rees, 2004; Rosenbaum & Leisring, 2001). These models seemed to ignore both the attachment style for the DVO and the possibility that the DVO may be female.

Interestingly, the results of this present study's correlation analysis, (r = -.473, p = .021) where p is ≤ .05, did show one area of statistical significance. Treatment response scores in anxiety were negatively correlated with post treatment anger in scores. This finding indicates that for this population, a positive response to treatment in anxiety renders a decrease in anger. Therefore, as anxiety in the DVO decreased, the ability to emotionally regulate anger increased (the outward expression of anger also decreased). This may suggest that the anxious DVO is needier and experiences a negative sense of self, hence may be unable to appropriately regulate the interpersonal anger, tending to hold it in.

Also suggested in these findings, a person with a positive response to treatment in anxiety had a better sense of self and was motivated to resolve his/her interpersonal

conflict through dialogue rather than aggressively acting his/her anger out. These findings are supported by Rosenbaum and Leisring (2001) and Ikes (2003), who suggest that DVOs can become more self-aware of their own emotional state and the emotional state of their partner. Interventions that approach interpersonal violence from an attachment perspective can begin to teach DVOs the necessary skills to emotionally regulate and to empathize with the partner and experience change in the self and the relationship (Sonkin & Dutton, 2003). The end result could have the potential to decrease domestic violence in the romantic relationship.

As stated earlier, most court ordered treatment interventions are focused only on the outcome measures of teaching males how to identify triggers of anger and how to relax when angry (Buttell, Muldoon, Carney, 2005; Dutton & Golant, 1995; Feder & Dugan, 2002; Holtzworth-Monroe, Meehan, Herron, Rehamn, & Stuart, 2000). The majority of these court ordered interventions are based on a cognitive behavioral framework approach which does not address empathy for the DVO (Gondolf, 1999; Rosenbaum & Leisring, 2001). The findings of this study, however, suggest that this intervention strategy alone is not sustaining if empathy and the attachment style of the DVO are not addressed in the cognitive approach (Buttell, Muldoon, Carney, 2005; Gearan & Rosenbaum, 1997; Rivettt & Rees, 2004).

Sonkin and Dutton (2003) utilize Bowlby's tasks to secure attachment as a treatment modality to encourage DVOs to begin to view the world from a secure base within the therapeutic relationship. DVOs can explore their cognitions, emotions, and experiences while trying out new healthy and appropriate responses to conflict. This can be difficult, at best, for the DVO depending on his or her style of attachment. Sonkin and

Dutton report DVOs with a preoccupied style of attachment need appropriate role modeling on how to be emotionally regulated, especially during conflict. Moreover, DVOs with a disorganized style of attachment do not have an internal structure on how to manage the anxiety of being hurt and/or being rejected. Sonkin and Dutton also note how DVOs with an avoidant style of attachment will disconnect in therapy, as they are uninterested in romantic relationships and lack empathy. Sonkin and Dutton suggest the counselor who responds with empathy can begin to create a secure base for the DVO within the confines of the therapeutic relationship. Empathy is to be role modeled and then taught to the insecure DVO. Empathy is not a core treatment goal in the cognitive approach; however, it is a tangible variable in the style of attachment approach.

Sonkin and Dutton (2003) reported the male DVOs represent an insecure style of attachment lacking empathy and exhibiting defense mechanisms which are utilized in order to manage the anxiety. These DVOs that lack empathy are disconnected emotionally. Currently, as stated by Rivett and Rees (2004), Rosenbaum (1997), and Buttell, Muldoon and Carney (2005), empathy and attachment styles of DVOs are not addressed in most common treatment modalities. Rosenbaum and Leising (2001) state that the majority of interventions are framed around a cognitive behavioral approach; it is apparent the cognitive behavioral model is only treating the anger and anxiety, while ignoring the empathy aspect of attachment.

Limitations

Winters, Clift, and Dutton (2004) note that research had not been done to specifically address empathy and domestic violence, even though anecdotal accounts for

counselors support such a connection. This current study began to lay the foundation to address empathy and domestic violence. However, as seen in other studies, this study was limited given the population it examined.

The aforementioned limitations of this study were varied. First of all, obtaining data from DVOs presented a challenging research environment, as most of them had been court ordered, and thus projected their anger toward the researcher during the pretreatment data gathering. This particular limitation was consistent with most of the literature found concerning court ordered domestic violence offenders. A second limitation of this current study was that participants were recruited solely from an ongoing Domestic Violence Anger Management Group. Therefore, the sample consisted exclusively of recent DVOs within the Harrisonburg/Rockingham County area of Virginia. Potential limitations with this convenience sample include: low sample size, racial/ethnic makeup of the group, and probable impact of the predominantly rural geographic environment.

There were also several limitations with the research design itself, such as the low number of available participants (*n),* which incidentally is a regularly occurring problem with any research on this population. Originally twenty eight subjects began the study; however, four subjects were either later incarcerated or were noncompliant with the court order, which resulted in a final *n* of twenty four. A second limitation of this particular study was its use of a prospective design, where a longitudinal study would have had the potential to provide a higher *n* and increased statistical power. However, given this population, a longitudinal study was not feasible. The third design-related limitation concerned the measurements themselves, which were self-reports. As a means of

addressing this limitation, the Paulhus Deception Scale was used as a measure for self deception; the Bar-On EQ also had a self deception subscale. Finally, the fact that empathy was measured by self report rather than through a performance test is a limitation. It may be that the concept of empathy is more about a lack of self-awareness and less about self-deception.

Discussions and Recommendations

Including attachment in this study provided a broader theoretical framework for integrating anger, empathy, and domestic violence. It can be conceptualized that DVOs had an insecure attachment from childhood which is manifested in excessive interpersonal dependency in the romantic relationship (Dutton, 1995; Holtzworth-Monroe, Bates, Smultzer, & Sandin, 1997). According to Buttell, Muldoon, and Carney (2005), attachment theory was necessary to explain why DVOs resorted to violence in the romantic relationship in order to link the theory to the examination of the relationship of the constructs. Including attachment theory was also beneficial in understanding how one regulated the emotions of empathy and anger in the context of the romantic relationship of the DVO (Babcock, Jacobson, Gottman, & Yerington, 2000; Sonkin & Dutton, 2003).

Schore (2004) notes how attachment dynamics are about reciprocity between mother and child and is the dyadic regulation of emotions and the "regulation of biological synchronicity" (pg.57) between them. Schore (2004) posits attachment interactions – positive and/or negative – are wired into the child's nervous system. This now represents a neurobiological level of interaction between child and mother. The child's brain growth is directly impacted based on the interactions of the mother and

child. Cozolino (2003) builds on this concept with what he calls attachment schemas, where the "implicit memories that organize within networks of the social brain, based on experiences of safety and danger with caretakers during early sensitive periods" (p. 201). These schemas become the controlling factor for attachment in affect regulation as they play out in approach-avoidance decisions made in conflictual interpersonal situations. Cozolino (2003) also reports that because both the social and fearful brains are rooted in the amygdala, these aforementioned attachment schemas are intricately interfaced with one's biological core fear and anxiety producing experiences. The avoidant DVOs' mental schema is activated as they regulate their own emotions instead of seeking comfort from the partner. The anxious DVOs' mental schema is activated as they experience the anxiety with the expectation of rejection and abandonment from the partner.

Schore (2004) reports that attachment is connected with the orbitofrontal cortex area of the brain – the "senior executive of the emotional brain" (p. 59) which has the most access to regulation as it pertains to emotion (Cozolino, 2003). The orbitofrontal acts as an interface with emotional responses and the balance of the sympathetic and parasympathetic branches of the nervous system (Cozolino, 2003; Shore, 2004). Schore found that how one experiences attachment in childhood directly impacts the brain wiring of the orbital prefrontal cortex. As a result of this wiring, a person with a secure attachment style is able to quickly observe, interpret, modulate, and respond appropriately in an interpersonal conflict (Schore, 2004). Persons with a secure attachment belief represent the balance of the sympathetic and parasympathetic arousal and persons with an insecure attachment belief represent the imbalance (Shore, 2004;

Cozolino, 2003). This balance, then, becomes the foundation from which present and future patterns of arousal and reactivity to stress are built and maintained throughout adulthood (Cozolino, 2003; Shore, 2004). Cozolino reports that when the continual arousal of the parasympathetic system is correlated with an avoidant style of attachment, such that there are low levels of emotions, minimal eye contact, prefers to be alone, and does not give/seek emotional support to/from others. The continual arousal of the sympathetic system is correlated with an anxious style of attachment, such that there are high levels of irritability, hostility, acting out behaviors, and a significant decrease in the ability to function appropriately when stressed. This person also experiences minimal impulse control and fear of abandonment. Schore (2004) attests these attachment transactions are imprinted into the child's "memory as enduring internal working models, which encode coping strategies of affect regulation (p. 65)" and which are then carried into adulthood relationships.

The activation of the frontolimbic system is essential in order for a person to regulate emotional responses along with the physical response, both of which are centrally involved in the process of attachment (Schore, 2004). Schore goes on to purport that the right hemisphere is intricately involved with what Bowlby notes as the basic functions of attachment which is activated when the child needs to emotionally regulate in order to cope with stress inducing situations. Secure children have the flexibility to emotionally regulate with others and to regulate the internal working model of self-insecure children cannot do that (Schore, 2004). Schore implicates that a defective orbitofrontal system from childhood is carried into adult relationships and can produce the propensity towards interpersonal relationship violence. Developmental research

(Schore, 2004) shows that “hostile attributional biases” (p.297) among young men are increased when they perceived they are being threatened. This comes about due to early childhood experiences of abuse to self, witnessing abuse, and insecure attachment. The men developed a working memory of abuse and aggression while under stress that now has continued into adulthood (Thomas, 2006).

Future research should address how to measure the domain of implicit empathy. This present research measured the explicit (verbal) domain of expressing empathy. Empathy is a measurement issue, as it has been measured as a self-report based on self awareness. However, empathy accounts for self awareness not self deception. The lack of empathy could be viewed as a lack of self awareness or a low emotional intelligence for DVOs.

In this current study, the one-way ANOVA found that the total EQ scores seemed to be a predictor of post treatment anger. Emotional intelligence is a measure of self-awareness. Empathy scores alone may not have increased; however, emotional intelligence as a whole seemed to increase. Theoretically, empathy could be such an integral part of attachment that it cannot be factored out. Future research must take into account the challenges of obtaining a true empathy score.

According to the results of this study, empathy as measured by this scale is not a predictor of violence for DVOs. However, empathy is very complex and the concept of empathy in treatment could make a positive difference for DVOs as they learn how to be appropriate healthy romantic partners in a relationship. It is, therefore, imperative that future research address empathy in treatment of this population, regardless of the inherent measurement challenges.

Moreover, it appears from this study that anger and lack of empathy are two tangible variables that are manifested for DVOs under the style of attachment theory. As DVOs reduced their anger, fear, and anxieties, they became motivated to empathically respond to the partner in the times of conflict and thus experienced more security in the relationship (Sonkin & Dutton, 2003; Tweed & Dutton, 1998; Winters, Clift, & Dutton, 2004). Future research should continue to explore the relationship between anger, empathy, and attachment style. In addition, it is recommended that future research focus on how the treatment intervention and the group leader may be creating a secure base for the DVO by role modeling empathy for the DVO in session. Sonkin and Dutton (2003) challenge counselors to create a secure base for DVOs by utilizing and modeling empathy in the midst of the intervention, especially when the DVO becomes anxious. The use of empathy by the counselor provides the DVO with a safe place to examine his self awareness and to learn how to emotionally regulate without fear of rejection or abandonment (Sonkin & Dutton, 2003). The avoidant DVO can learn how to empathize in the middle of interpersonal conflict, and the anxious DVO can learn how to access empathy in the middle of interpersonal conflict (Winters, Clift, & Dutton, 2004). Finally, future research should also address the gender issues around anger, empathy, and romantic styles of attachment.

Summary

This current study continues to untangle the complexities of the internal workings of the domestic violence offender as it pertains to anger and empathy. The four subjects who did not complete the study were incarcerated due to noncompliance with the anger

management group. These four represent the complexities of the internal workings of the DVO, such that they would actively choose incarceration over therapy. This can be viewed as the extreme acting out of avoidant style of attachment.

The findings of this study can begin to challenge counselors to go beyond the familiar cognitive behavior framework of intervention with DVOs and begin to create the secure base for a DVO to understand his or her romantic relationship without aggression even when anxiety is present. Information from this current study can begin to pave the way for emotional intelligence and empathy to be addressed as the DVO works to understand the motivating force that drives the anger of conflict to be manifested in domestic violence. The information from this study will be presented to the Juvenile Domestic Relations Honorable Judge in order to begin to educate the Court on the untangling of the complexities of the internal workings of a DVO. This would have the potential to create programs where empathy and anger could be addressed more intentionally through the styles of attachment as an intervention program that would decrease anger by understanding empathy and styles of attachment.

REFERENCES

Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, N.J.: Erlbaum.

Babcock J., & Steiner, R. (1999). The relation between treatment, incarceration, and recidivism of battering: A program evaluation of Seattle's Coordinated Community Response to Domestic Violence. *Journal of Family Psychology, 13,* 35-42.

Babcock, J., Jacobson, N., Gottman, J., & Yerington, T. (2000). Attachment, emotional regulation, and the function of marital violence: Difference between secure, preoccupied, and dismissing violent and nonviolent husbands. *Journal of Family Violence, 15*(4), 391-409.

Bar-On, R. (1992). The *development of a concept and test of psychological well-being.* Unpublished manuscript. Tel Aviv: Reuven Bar-On.

Bar-On, R. (1997). Bar-*On Emotional Quotient Inventory: Technical manual.* Toronto: Multi-Health Systems.

Bar-On, R. (2002). Bar-*On Emotional Quotient Inventory: Technical manual.* Toronto: Multi-Health Systems.

Bar-On, R. (2006). The Bar-On Model of Emotional-Social Intelligence (ESI). Consortium for Research on Emotional Intelligence in Organizations, *Issues in Emotional Intelligence,* 1-27.

Bar – On, R. (2007). *Providing information and fostering discussion on emotional intelligence.* Retrieved June 12, 2007, from http://www.reuvenbaron.org/.

Bartholomew, K., & Horowitz, L. (1991). Attachment styles among young adults: A test of a four category mode. *Journal of Personality and Social Psychology, 61*(2), 226-244.

Benson, M., & Fox, G. (2004). When violence hits home: How economics and neighborhood play a role. *Community Context and Intimate Violence: An Application and Extension of Social Disorganization Theory* (NCJ 193434).

Bowlby, J. (1970). *Child care and the growth of love.* (2nd ed.). Harmondsworth: Pelican.

Bowlby, J. (1980). *Attachment and loss: Loss, sadness, and depression.* New York: Basic Books.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory.* London: Routledge.

Boyatzis, R. (1982). *The competent manager: A model for effective performance.* New York: John Wiley & Sons.

Boyatzis, R., Goleman, D., & Rhee, K. (2000). Clustering competence in emotional intelligence: Insights from the Emotional Competency Inventory (ECI). In R. Bar-On and J. Parker (Eds.), *Handbook of Emotional Intelligence* (pp. 343-362). San Francisco: Jossey-Bass.

Buttell, F., Muldoon, J., & Carney, M. (2005). An application of attachment theory to court-mandated batterers. *Journal of Family Violence, 20*(4), 211-217.

Burton, L., Hafetz, J., & Henninger, D. (2007). Gender differences in relational and physical aggression. *Social Behavior and Personality, 35*(1), 41-50.

Clements, K., Holtzworth-Munroe, A., Schweinle, W., & Ickes, W. (2007). Empathic

accuracy of intimate partners in violent versus nonviolent relationships. *Personal Relationships, 14,* 369-388.

Denzin, N. (1984). Toward a phenomenology of domestic, family violence. *American Journal of Sociology, 90,* 483-513.

DiGiuseppe, R., & Tafrate, R. (2003). Anger treatment for adults: A meta-analytic review. *Clinical Psychology: Science and Practice, 10*(1), 70-84.

DiGiuseppe, R., & Tafrate, R. (2004). *Anger Disorders Scales (ADS), Technical Manual.* New York: Multi-Health, Inc.

Dutton, D. (1995). A scale for measuring propensity for abusiveness. *Journal of Family Violence, 10*(2), 203 – 221.

Dutton, D. (1998). The *abusive personality.* New York: Guilford Press.

Dutton, D. (2000). Witnessing parental violence as a traumatic experience shaping the abusive personality. *Journal of Aggression, Maltreatment, and Trauma, 3,* 59-667.

Dutton, D., & Golant, S. (1995). *The batterer: A psychological profile.* New York: Basic Books.

Dutton, D., Saunders, K., Starzomski, A., & Bartholomew, K. (1994). Intimacy-anger and insecure attachment as precursors of abuse in intimate relationships. *Journal of Applied Social Psychology, 24,* 1367-1386.

Edleson, J. L. (1995). Interventions for men who batter: A review of the research. In S.R. Stith & M.A. Straus (Eds.), *Understanding partner violence: Prevalence, causes, consequences and solutions* (pp. 262-273). Minneapolis, MN: National Council on Family Relations.

Edmondson, C., & Conger, J. (1996). A review of treatment efficacy for individuals with anger problems: Conceptual, assessment, and methodological issues. *Clinical Psychology Review, 16*(3), 251-275.

Eslinger, P. (1998). Neurological and neuropsychological bases of empathy. *European Neurology, 39,* 193-199.

Eslinger, P., Parkinson, K., & Shamay, S. (2002). Empathy and social-emotional factors in recovery from stroke. *Current Opinion in Neurology, 15,* 91-97.

Fane, B. (1997). *The effect of structured and unstructured group therapy on the anger and attitudes of domestic violence perpetrators.* Unpublished doctoral dissertation, Western Kentucky University, Kentucky.

Feder, L., & Dugan, L. (2002). A test of the efficacy of court-mandated counseling for domestic violence offenders: The Broward Experiment. *Justice Quarterly, 19*(2), 343-375.

Feeney, J., & Noller, P. (1990). Attachment style as a predictor of adult romantic relationships. *Journal of Personality and Social Psychology, 58*(2), 281-291.

Fiebert, M. (1997). References examining assaults by women on their spouses/partners. *Sexual Harassment and Sexual Consent, 1,* 273-286.

Fraley, R., & Shaver, P. (2000). Adult romantic attachment: Theoretical developments, emerging controversies, and unanswered questions. *Review of General Psychology, 4,* 132-154.

Gearan, P., & Rosenbaum, A. (1997). *Cognitive differences between batterers and nonbatterers.* Paper presented at the 5th Annual International Family Violence Research Conference, Durham, NH.

Goldenson, J., Geffner, R., Foster, S., & Clipson, C. (2007). Female domestic violence offenders: Their attachment security, trauma symptoms, and personality organization. *Violence and Victims, 22*(5), 532-545.

Goleman, D. (1995). *Emotional intelligence.* New York: Bantam Books

Goleman, D. (1998). *Working with emotional intelligence.* New York: Bantam.

Gondolf, E. (1985). *Men who batter: An integrated approach to stopping wife abuse.* Homes Beach FL: Learning Publications.

Gondolf, E. (1999). A comparison of four batterer intervention systems. Do court referral, program length, and services matter? *Journal of Interpersonal Violence, 14(1),* 41-61.

Goodrum, S., Umberson, D., & Anderson, K. (2001). The batterer's view of self and others in domestic violence. *Sociological Inquiry, 71*(2), 221-240.

Hamberger, K., & Hastings, J. (1990). Recidivism following spouse abuse abatement counseling: Treatment program implications. *Violence and Victims, 5(3),* 157-170.

Hastings, J., & Hamberger, K. (1988). Personality characteristics of spouse abusers: A controlled comparison. *Violence and Victims, 3*(1), 31-46.

Hazin, C., & Shaver, P. (1987). Conceptualizing romantic love as an attachment process. *Journal of Personality and Social Psychology, 52,* 511-524.

Hoffman, M. (2000). *Empathy and moral development: Implications for caring and justice.* Cambridge: Cambridge University Press.

Holtzworth-Munroe, A., & Hutchinson, G. (1993). Attributing negative intent to wife

behavior; the attributions of martially violent versus nonviolent men. *Journal of Abnormal Psychology, 102,* 206-211.

Holtzworth-Munroe, A., & Stuart, G. (1994). Typologies of male batterers: Three subtypes and the differences among them. *Psychological Bulletin, 116,* 476-497.

Holtzworth-Munroe, A., Bates, L., Smultzer, N., & Sandin, E. (1997). A brief review of the research on husband violence. *Aggressive Violent Behaviors, 2,* 65-99.

Holtzworth-Munroe, A., Stuart, G., & Hutchinson, G. (1997). Violent versus nonviolent husbands: Differences in attachment patterns, dependency, and jealousy. *Journal of Family Psychology, 11*(3), 314-331.

Holtzworth-Munroe, A., Meehan, J., Herron, K., & Stuart, G. (1999). A typology of male batterers: An initial examination. In X. Aiaga & S. Oskamp, S. (Eds.). *Violence in Intimate Relationships.* (pp. 45-72). Thousand Oaks, CA: Sage.

Holtzworth-Monroe, A., Meehan, J., Herron, K., Rehamn, U., Stuart, G. (2000). Testing the Holtzworth-Monroe and Stuart (1994) batterer typology. *Journal of Consulting and Clinical Psychology, 68*(6), 1000-1019.

Ickes, W. (2003). *Everyday mind reading: Understanding what other people think and feel.* New York: Prometheus Books.

Johnson, M., & Leone, J. (2005). The differential effects of intimate terrorism and situational couple violence: Finds from the national violence against women survey. *Journal of Family Issues, 26*(3), 322-349.

Kassinove, H., & Tafrate, R. (2002). Anger *Management. The Complete Treatment Guidebook for Practitioners.* Impact Publishers: CA

Kazdin, A. (2003). *Research Design in Clinical Psychology, 4th ed.* Boston: Allyn and

Bacon.

Kuppens, P., & Tuerlinckx, F. (2006). Personality traits predicting anger in self-, ambiguous-, and other caused unpleasant situations. *Personality and Individual Differences, 42,* 1105-1115.

Labinsky, E. (2002*). Evaluating a Group Treatment Program for Male Batterers* Unpublished doctoral dissertation, Fairleigh Dickinson University

Loper, A., Hoffschmidt, S., & Ash, E. (2001). Personality features and characteristics of violent events committed by juvenile offenders. *Behavioral Science and the Law, 19*(1), 86-91.

Mahalik, J., Aldarondo, E., Gilbert-Gokhale, S., & Shore, E. (2005). The role of insecure attachment and gender role stress in predicting controlling behaviors in men who batter. *Journal of Interpersonal Violence, 20*(5), 617-631.

Meichenbaum, D. (1977). Cognitive-*behavioral modification.* New York: Plenum.

Mills, Linda (2008). *Violent Partners: A Breakthrough for Ending the Cycle of Abuse.* New York: Basic Book.

Murphy, C., Meyer, S., & O'Leary, D. (1994). Dependency characteristics of partner assaultive men. *Journal of Abnormal Psychology, 103,* 729–735.

No Author (1999). Center for Marriage and Family Counseling *Handbook for Anger Management Group Members*.

O'Leary, K., & Curley, A. (1986). Assertion and family violence: Correlates of spouse abuse. *Journal of Marital and Family Therapy, 12,* 281-290.

Paulhus, D. (1998). *Paulhus Deception Scales (PDS): The Balanced Inventory of Desirable Responding – 7.* New York: Multi-Health Systems, Inc.

Pence, E., & Paymar, M. (1993). Education *Groups for Men who Batter.* New York: Springer Publishing.

Pizzey, E. (1974). *Scream quietly or the neighbors will hear.* London: Penguin.

Pizzey, E. (1995). Interview with Erin Pizzey at her home near Siena, Italy.

Potter-Efron, R. (2005). *Handbook of anger management: Individual, couple, family, and group approaches.* New York: Haworth Clinical Practice Press.

Proctor, T., & Beail, N. (2007). Empathy and theory of mind in offenders with intellectual disability. *Journal of Intellectual & Developmental Disability, 32*(2), 82-93.

Rennison, C. (2003). Intimate Partner Violence, 1993-2001. *Bureau of Justice Statistics*.

Rivettt, M., & Rees, A. (2004). Dancing on a razor's edge: systemic group work with batterers. *Journal of Family Therapy, 26,* 142-162.

Rosenbaum, A., & Leisring, P. (2001). Group Intervention Programs for Batterers. *Journal of Aggression, Maltreatment & Trauma, 2*(10), 57-71.

Salovey, P., & Mayer, J. (1990). Emotional Intelligence. *Imagination, Cognition, and Personality, 9,* 185-211.

Shamay-Tsoory, S., Tomer, R., Berger, B., & Aharon-Peretz, J. (2003). Characterization of Empathy Deficits following Prefrontal Bain Damage: The role of the right Ventromedial Prefrontal Cortex. *Journal of Cognitive Neuroscience, 15*(3), 324-337.

Silver, E., & Teasdale, B. (2005). Mental Disorder and Violence: An Examination of Stressful Life Events and Impaired Social Support. *Social Problems, 52*(1), 62-78.

Simon, L. M. & Zgoba, K. M. (2006). *The Effects of State Mandatory Arrest Policies*

on Actual Domestic Violence Arrests. Paper presented at the annual meeting of the American Society of Criminology (ASC), Los Angeles Convention Center, Los Angeles, CA

Sonkin, D., & Durphy, M. (1982). Learning *to Live without violence: A Handbook for Men.* San Francisco: Volcano Press.

Sonkin, D., & Dutton, D. (2003). Treating Assaultive Men from an Attachment Perspective. In D. Dutton & D. Sonkin (Eds.), *Intimate Violence: Contemporary Treatment Interventions* (pp. 1-29). New York: Haworth Publishing.

Sonkin, D. (2005). *Domestic Violence and Attachment Theory: Clinical Applications to Treatment with Perpetrators*. Retrieved May 10, 2008 from http://www.danielsonkin.com/sonkin82405.htm

Sperling, M., & Berman, W. (1994). *Attachment in adults: Clinical and developmental perspectives.* New York: Guilford Press.

Spinella, M. (2005). Prefrontal substrates of empathy: Psychometric evidence in a community sample. *Biological Psychology, 70*(3), 175-181.

Stosny, S. (1995). Treating *Attachment Abuse: A Compassionate Approach.* New York: Springer Publishing.

Swartz, W. (2002). From passivity to competence: A conceptualization of knowledge, skill, tolerance, and empathy. *Psychiatry, 65*(4), 338-345.

Tafrate, R., (1995). Evaluation of Treatment Strategies for Adult Anger Disorders. In H. Kassinove (Ed.), *Anger Disorders: Definition, Diagnosis, and Treatment* (pp.109-129). Taylor & Francis.

Thomas, T. (2006). Treatment of Family Violence: A systemic perspective. In J.

Hamel and T. Nicholls (Eds.), *Family Approaches to Domestic Violence: A Guide to Gender-Inclusive Research and Treatment* (pp. 1-15). Springer Publishing.

Tweed, R., & Dutton, D. (1998). A comparison of impulsive and instrumental subgroups of batterers. *Violence and Victims, 13,* 217-230.

United States Bureau of Census. (2001). Population *and Household Economic Topics.* Retrieved from http://www.census.gov/population/estimates/nation/intfile2-1.txt.

Vignemont, F., & Singer, T. (2006). The empathic brain: when and why? *Trends in Cognitive Sciences, 10*(10), 435-441.

Wallace, H. (2004). *Family Violence: Legal, Medical, and Social Perspectives*. New York: Allyn & Bacon.

Wallace, R., & Nosko, A. (2003). Shame in Male Spouse Abusers and Its Treatment in Group Therapy. *Journal of Aggression, Maltreatment & Trauma, 7*(1/2), 47-74.

Walker, Lenore. (1979). *The Battered Women.* New York: Harper & Row.

Watt, D. (2005). Social Bonds and the Nature of Empathy. *Journal of Consciousness Studies,12*(8-10), 185-209.

Wei, M., Russell, D., Mallinckrodt, B., & Vogel, D. (2007). The experiences in Close Relationship Scale (ECR)-Short Form: Reliability, validity, and factor structure. *Journal of Personality Assessment, 88,* 187-204.

Wexler, D. (1999). The Broken Mirror: A self psychological treatment perspective for relationship violence. *Journal of Psychotherapy: Practice and Research, 8,* 129-141.

White, M., & Weiner, M. (1986). *The Theory and Practice of Self Psychology.* New

York: Brunner/Mazel.

Winters, J., Clift, R., & Dutton, D. (2004). An Exploratory Study of Emotional Intelligence and Domestic Abuse. *Journal of Family Violence, 19*(5), 255-267.

Appendixes

Appendix A: Consent Form

CONSENT FORM
The Relationship between Attachment, Empathy, and Anger
Luanne Bender Long, LPC, LMFT
Liberty University
Center for Counseling and Family Studies

You are being invited to participate in a doctoral dissertation research project for Luanne Bender Long, LPC, LMFT, a doctoral counseling student at Liberty University. You were selected as a possible participant because you have chosen to attend the Anger Management Group at the Center for Marriage and Family Counseling. Please read this form and ask any questions you may have about this project. Your participation is entirely optional.

The purpose of this research study is to collect data on whether emotions and behaviors are impacted for persons who are involved in relationships.

If you agree to be in this study, I will ask you to do the following things. First, complete four questionnaires at your initial group session and second, complete the same questionnaires at your final group session. I will be available to answer any questions you have while you are completing the forms. The questionnaires are to see if empathy, anger, and intimate relationships are connected. The total process for completing the questionnaires each time is one hour.

The records of this study will be kept private. In any sort of report I might publish, I will not include any information that will make it possible to identify you. Research records will be stored securely and only the researcher will have access to the records. Materials will not be accessed by the Center staff. In addition, Court/parole personnel will not have any access to this information. Subjects can contact the researcher for general group findings to six months after the study is completed.

Participation in this study is completely voluntary. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting your relationships with your group leader and other group members. Choosing to participate or not will not have any impact on your status with the Court/parole, the Center staff and/or the Group leader.

The risks for participating in this study are minimal, no more than you would encounter in everyday life. Instructions will be given by the researcher and I will be available for questions while you are completing the forms. Questionnaires can be completed in the necessary time frame of one hour. A private room in the Center will be offered to

complete questionnaires. The benefit of choosing to participate in this study is having the opportunity to add to the current data on how one can appropriately manage anger. The time that it will take you to complete the questionnaires for this study will be considered part of your group time for that day.

The researcher can be contacted at 540-433-1546.You may ask any questions you have now or later by calling. If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, you are encouraged to contact the Human Subject Office, 1971 University Blvd, Suite 2400, Lynchburg, VA 24502 or email at fgarzon@liberty.edu.**,** or call Dr. Garzon at 434-592-4054.

I have read the above information. I have asked questions and have received answers. I consent to participate in the study. You will be given a copy of this form to keep for your records.

_____

Client name Date

_____

Investigator Date

Appendix B: Intake Form

DOMESTIC VIOLENCE / ANGER MANAGEMENT GROUPS

Intake Form for Research

Name_____

Address_____

Social Security #_____ Age_____ Date of Birth_____

Home Phone_____Work Phone_____Cell Phone_____

Place of Employment_____

Length of Employment_____

Address_____

Education: 8th or less___ 9-11____ 12____ GED_____ 13-15____ 16___

17+_____

Current Living Situation: Married_____ Divorced_____ Separated_____

Single_____ Living with partner_____ Widowed_____

Name of spouse/partner:_____

Address of spouse/partner_____

What were you charged with and who did you allegedly_____?

What is the relationship of the alleged victim to you_____?

List previous arrests and convictions: _____

Are you currently under a protective order? _____

Are there any pending charges against you? _____

If so, Please explain: _____

Referral Source to group:

_____Social Services _____ Probation officer _____Court _____Self

_____other

Are you currently receiving any other counseling?_____ If so, with whom?_____