EARLY CHILDHOOD ABUSE, EMPATHY
AND INTIMATE PARTNER VIOLENCE

By

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AND INTIMATE PARTNER VIOLENCE

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Abstract

EARLY CHILDHOOD ABUSE, EMPATHY
AND INTIMATE PARTNER VIOLENCE

By Marnie K. Lucas, M.A., Psychology, Counseling

This study tested the relationship between empathy and childhood and intimate partner violence. Toward this end, 31 volunteers from local batterer intervention programs, and 30 non-clinical volunteers from the general population were surveyed using Batson’s (1997) empathy scale, Straus (1990) Conflict Tactics Scale (for testing the frequency and severity of intimate partner violence), and Straus and Gilles’ (1990) Very Severe Violence Scale (for detecting the presence of childhood physical abuse). No statistically significant differences were found between clinical and non-clinical populations on empathy scores; there was no significant relationship found between empathy and childhood abuse; and empathy was not found to be a significant predictor of battering behavior. However, the data did indicate that childhood physical abuse was a statistically significant predictor of both minor intimate partner violence, \( p = .001 \), and severe intimate partner violence, \( p = .02 \).
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Introduction

Domestic violence or intimate partner violence (IPV) refers to “a pattern of abusive behavior in any relationship that is used to gain or maintain power and control over an intimate partner” (National Domestic Violence Hotline, http://www.ndvh.org/educate/index.html). According to NDVH, “abuse is physical, sexual, emotional, economic or physical actions that influence another person. This includes any behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure or wound someone.” In the United States four million women experience a serious physical assault by a partner during an average twelve month period (Henise, Ellsberg, & Geottemoeller, 1999), and more than three women are murdered by their husbands or boyfriends every day (Bureau of Justice, 2000). While men in heterosexual and same sex relationships are sometimes victims of intimate partner violence, studies indicate that women are overwhelmingly the victims of this kind of abuse and are more likely to suffer injury at the hands of their male partners than the reverse (Dobash, Dobash, Wilson, & Daly, 1992; Melton, & Belknap, 2003; Tjaden, & Thoennes, 2000). Indeed, in 2001, eighty-five percent of reported abuse by intimate partners in the U.S. was against women (Bureau of Justice, 2000).

Much of research on IPV focuses on the experience and treatment of female victims and survivors of abuse, however, research on treatment for male perpetrators of IPV (batterers) remains under-researched (Eckhardt, Murphy, Black & Suhr, 2006). While new treatment models are beginning to emerge, there are two major models of
treatment that most batterer intervention programs adhere to, the cognitive-behavioral
treatment (CBT) approach, and the feminist psychoeducational approach, or ‘Duluth
Model’ (Eckhardt, et al., 2006; Hamberger & Hastings, 1993; Healey, Smith &
O’Sullivan, 1998). Most batterer intervention programs incorporate at least one of these
models into their curriculum, while many reflect a combination of both models (Healey et
al.). The high recidivism rates and mounting criticism associated with these two models,
however, provide an opportunity to rethink the structure and focus of clinical treatment
for batterers (Eckhardt, Murphy, Black & Suhr, 2006; Hamberger & Hastings, 1993;

The purpose of this study, therefore, was to provide support for the latest clinical
and neuropsychological literature that suggests that the experience of childhood abuse
can have a fundamental impact on one’s ability to empathize, regulate emotion (including
anxiety, aggression, and anger), and engage in secure trusting relationships as an adult
specifically I sought to test the relationship between childhood physical abuse, empathy,
and battering behavior in order to enhance our understanding and treatment of intimate
partner violence. Toward this end, I surveyed thirty volunteers from batterer intervention
programs and thirty non-clinical volunteers from the general population using Batson’s
Very Severe Violence Scale, to test our hypotheses about the importance of empathy in
relationship to childhood abuse and intimate partner violence.
Literature Review

The Cognitive Behavioral/Anger Management Model

To date, much of the research and group interventions used in batterer treatment programs draw heavily on the cognitive-behavioral model (Anderson-Malico, 1994; Dunford, 2000; Eisikovits & Edleson, 1989, Hamberger et al., 1993; Reeder, 1991; Rosenfield, 1992; Thomas, 1998, 2001; Tolman & Bennett, 1990). Some CBT models consider intimate partner violence to be a learned behavior that is tried, developed, repeated, and justified over a lifetime via an abuser’s direct observation of important role models (especially familial), indirect observation of cultural norms in the media and films, and direct ‘trial and error’ learning experiences (Hamberger, et al., 1993). According to this model, violent behavior is repeated over time and gradually develops into a pattern or cycle of abuse because the perpetrator finds functional value in the behavior. The functionality of violence differs across individuals and circumstances. However, some of the most commonly cited uses for violent behavior include releasing tension, avoiding unpleasant tasks, and situations and enforcing victim compliance (Hamberger, et al.).

Intervention programs following this model see violent behavior itself as the problem. Interventions begin by identifying the specific overt behaviors (i.e. types and frequency of physical and verbal abuse) and covert behavior (i.e. levels of physical arousal, disturbing imagery, faulty attributions, and negative self talk) most utilized by
the perpetrator (Hamberger, et al., 1993). These behaviors are then targeted for change by teaching the perpetrator an array of techniques designed to change maladaptive behavioral responses and replace them with more adaptive ones. Such techniques include: helping clients to assess and reframe the meaning of supposedly provocative events (including applying rules of evidence, considering alternative explanations, problem solving, and modifying rules and imperatives), conflict abeyance techniques, verbal interaction skills (including assertiveness and relaxation skills for reducing physiological arousal), and cognitive strategies for self-instructing in nonviolence and for reevaluating threat-oriented, anger-producing thoughts to more task-oriented interpretations (Beck, 1999; Hamberger, et al.).

Other cognitive behavioral models take a more ‘anger management’ approach to batterer intervention. From this perspective, perpetrators are struggling with clinically significant anger management issues and their abusive behavior is attributed to a lack of control over their anger (Beck, Rush, Shaw, & Emery, 1979; Thomas, 2001; Healey, et al., 1998). They are said to possess an overly negative view of themselves, the world and the future and, as a result, often misinterpret events in their environment as negative or hostile. Physical abuse (or maladaptive anger responses) is an automatic reaction to the ways in which batters misinterpret, personalize, and catastrophize aversive events in their lives (Healey, et al.). This skewed view of events in their environment can lead to violent behavior when individuals are faced with situations that threaten their values, moral code, or protective rules (Anderson-Malico, 1994). The magnitude of an anger response to a
perceived threat depends on the magnitude of the discrepancy between the expected and the actual outcome of an event (Novaco, 1979). For batterers, this discrepancy is often incorrectly negatively misinterpreted and extreme, and thus their resulting behavior is equally extreme.

Treatment for ‘anger management’ is often short-term and designed to help abusers become more aware of anger cues and to apply more adaptive behavioral strategies that reduce arousal, modulate anger, and break violent behavioral patterns (Hamberger, et al., 1993). Techniques are focused on the therapeutic modification of faulty cognitions and beliefs that can fuel intense emotions that can lead to abusive behavior (Healey, et al. 1998) These techniques consist of highly specific learning experiences designed to teach clients how to monitor dysfunctional private speech; how to recognize the connections between cognition, affect and behavior; how to examine the evidence for and against distorted private speech; how to substitute more reality-oriented interpretations for biased appraisals and expectations; and how to identify and alter dysfunctional appraisals and expectations that predisposes people to distortion of experiences (Healey et al.). Successful “intelligent anger management’ means that one can: (a) modulate excessive physiological arousal, (b) alter irrational antagonistic cognitions, (c) decrease environmental stimuli, and (d) modify maladaptive behaviors that do not lead to problem solving” (Thomas, 2001, p. 2).

Cognitive behavioral therapy-oriented batterer intervention models remain popular in many juridical systems across the country due to their more cost effective
group format, short term nature, clearly identifiable goals, and direct, inexpensive intervention techniques. However, despite their wide spread use, these models have been intensely scrutinized and criticized over the last twenty years both for their lack of efficacy and lack of insight and understanding as to the real causes of domestic violence in our society (Adams, 1988; Eckhardt et al., 2006; Gondolf & Russell, 1986). Indeed, research suggests that attendance at cognitive behavioral batterer intervention programs have shown little benefit for changing antisocial behavior and reducing recidivism rates among batterers (Babcock, Green & Robie, 2004; Eckhardt, et al.). Moreover, it is argued that this ‘value neutral’ approach, with its intense focus on the individual, narrowly conceptualizes wife assault as a problem of skills deficit and anger control on the part of batterers. Because it ignores the sociopolitical roots of wife assault and fails to incorporate a more comprehensive understanding power dynamics related to gender in our culture that teach, condone, and perpetuate violence against women, the CBT approach fails to account for why many men assault only their female partner, and why not all men who are stressed and skill deficient are violent (Adams, 1988).

Finally, Gondolf and Russel (1986) argue that while the anger management model’s focus on physical violence may offer a ‘quick-fix’ in terms of reducing (at least temporarily) incidents of overtly physically violent behavior, it does not address other more subtle forms of control utilized by batterers, and may, in fact, reinforce and refine their usage. Other, less obvious, manipulative control tactics such as threatening looks, gestures, isolation, ridicule, humiliation, stalking, blocking access to contraception,
health care, child care, employment, education, money, etc., are left unaddressed. Of equal concern for critics is the anger management model’s singular focus on the way abusers respond to perceived provocation. This narrow explanation for domestic violence not only smacks of the implication that victims are provocateurs of the abuse, but it also tends to misread violent behavior as a kind of ‘blown fuse’ in response to external stress, rather than as an attempt by batterers to relentlessly control their partners (Gondolf, et al.). Thus while the CBT model is useful in providing concrete behavioral tools for helping batterers to control their anger and reduce their use of overtly violent acts, the approach remains incomplete in its narrow conceptualization of what constitutes IPV, where it comes from, and in the model’s primarily symptom-oriented treatment of the problem. These deficits in the CBT/anger management approach have fueled the search for more effective and holistic solutions for batterer intervention treatment.

The Feminist Model

One of the oldest and most popular alternatives to the CBT model in the US is the Duluth, or feminist model of batterer intervention (Hamberger, et al., 1993; Healey, et al., 1998; Mills, Grauwiler & Pezold, 2006). From this perspective intimate partner violence is more about issues of power and control than anger management or unlearning maladaptive learned behavior. The feminist model understands domestic violence as a sociopolitical issue, rooted in our society’s patriarchal power relations that privilege masculine values and endorse, support and perpetuate men’s ability to occupy dominant positions of power in most public and private institutions, including the home
Implicit in this sexist power structure is the right of men to subordinate and oppress women in a multitude of ways, including through the use of violence. In this view, because men are more powerful than women, both physically and politically, men are more likely to use abusive tactics (i.e. verbal, emotional, economic, and physical abuse) that terrorize, injure, disable, or kill their partners when they feel their dominant role is being threatened. Moreover, the abusive tactics utilized by men to control their female partners and secure their dominant role in the family are reinforced by legal and social institutions such as social service, mental health, economic, religious, and medical agencies that help maintain and enforce patriarchal laws and sexist societal norms (Ganley, 1989).

According to the theoretical approach of the feminist model, these societal patriarchal norms and power structures that infantilize and disempower women lend support to batterers who want to control their female partners. They argue that the institutionalization of such beliefs in our society makes it easier for batterers to justify desires to control their wives by making it easier for men to believe and convince their female partners that women are not capable of adult activities, and thus should submit to their male partner’s expertise and authority in all aspects of life (Healey, et al., 1998). Indeed, through the use of overt tactics of control such as physical and sexual assault and other covert coercive tactics, abused women gradually lose their sense of self efficacy and confidence, have little self esteem, and begin to really believe that they are incapable of doing anything right, holding down a job, or being a good parent to their children. As a
result of their gender, batterers often feel entitled to make all the decisions for the family, to set household rules, and to punish disobedient wives and children. They typically see any kind of ‘rule breaking’ or objections to their mechanisms of control, (whether real or imagined), as a sign of disrespect and become enraged at what they perceive to be a challenge to their authority. As a result, batterers rationalize their conscious decision to engage in violence by claiming that their partner provoked the attack through their disrespectful and disobedient actions (Healey, et al.).

Because of their beliefs about patriarchal origins of IPV in our society, feminist batterer intervention programs typically rely heavily on a psychoeducational model that attempts to educate men about their attitudes concerning their perceived right to use power and coercion to control or subjugate women. The classroom style format of programs based on the feminist model means that interventions are generally conducted as didactic, consciousness raising groups that consistently focus on themes of gender equity and patriarchal ideology (Eckhardt, et al., 2006). Leaders work to raise members’ conscious about the origins of patriarchy in our society and the consequences of sex role conditioning. They highlight the way men are socialized in our society to value and express anger over sadness, aggression over cooperation, bravery over fear, rationality over emotion, etc., and how this process serves not only to constrain men’s ability to express themselves and behave in more pro-social/adaptive ways, but also how it perpetuates and feeds into a culture of sexism and male privilege (Healey, et al., 1998).
Overall the model works to raise awareness, develop critical thinking and adaptive behavioral skills around eight key themes: 1) nonviolence, 2) nonthreatening behavior, 3) respect, 4) support and trust, 5) honesty and accountability, 6) sexual respect, 7) partnership, and 8) negotiation and fairness (Healey, et al., 1998). A central tool of this model is the “Power and Control Wheel”, used to demonstrate the ways in which physical and sexual violence are connected to male power and control through the everyday utilization of multiple control tactics such as threats, intimidation, blaming, isolation, economic and emotional abuse, etc. (Healey, et al.). These controlling behaviors, they argue, are the ‘spokes’ that support and turn the larger wheel of patriarchal domination in our society.

![Power and Control Wheel](image)

*Figure 1.* Power and Control Wheel (Duluth, MN: Domestic Abuse Intervention Project).

Through the use of videos that demonstrate the various controlling behaviors depicted in the wheel, group members and leaders identify and discuss control tactics and
the maladaptive beliefs, thoughts, and motivations that are commonly associated with
those tactics. Many feminist approaches utilize a confrontational style in which members
are pushed to (1) acknowledge power and control tactics used in their own relationships,
(2) to critically examine the validity of their own motivations and justifications for their
behavior, and (3) to be fully accountable for the consequences of their behavior on
themselves, their partners and their children (Healey, et al., 2006). Thus, throughout the
program, group members are presented with a gender analysis of power in our society
that critically engages/confronts patriarchal belief systems and control tactics at the
macro and micro level. Members are educated and held accountable for the long-term
effects of their abusive behavior toward their intimate partners and are offered an
alternative model of relationship building based on egalitarianism, non-violence, love,
trust, and mutual respect (Healey, et al.).

Criticism of the Feminist Model

There have been many criticisms levied against the feminist model. First and perhaps
most obvious, is that the feminist model’s explanation of the origin of IPV is narrow in
scope. Indeed, the model’s focus on patriarchy as the root cause of IPV does not help to
explain, for example, violence between same sex partners (Letellier, 1994; Lickhart,
White, Causby, & Isaac, 1994), the abusive behavior of female perpetrators in some
heterosexual relationships (Straus & Gelles, 1986), or the fact that most men, even
though they, too, live in and benefit from a patriarchal society, do not abuse their intimate
partners (Dutton, 1995; Feldman & Ridley, 2000). These facts compel us to consider the
need to widen not only our understanding of where IPV comes from, but also how we
understand patriarchy and the role it plays in perpetuating, rather than causing, the problem.

Indeed, if IPV is to be understood as a sociopolitical issue rooted in societal power structures, as the feminist model contends, it is important that these power structures, (i.e. patriarchy), not be placed in a vacuum. A more holistic understanding of patriarchy, one that recognizes that power relationships between most men and women are themselves rooted in a wider context of Western philosophical beliefs that sanction, normalize, and perpetuate hierarchical rule, domination, and coercive authority, might help open up a better understanding of IPV by recognizing the fact that it is often more complicated in its presentation and treatment than simply ‘male-to-female violence.’ In making this argument, critics point out that the feminist approach does not situate IPV within the wider context of our extremely violent culture, (Hooks, B., 1984). Coercion (physical, emotional, psychological, economic, etc) is present and is often a socially sanctioned aspect of most unequal power relationships in Western culture, whether it is between men and women, adult and child, employer to employee, landlord to tenant, lender to borrower, teacher to student, governor to governed, etc. (Hodeg, 1989; Kipnis, Castel, Gergen, & Mauch, 1976).

This point has been made repeatedly over the years by social psychology researchers that have examined the use and effects of coercion in unequal power relationships. Indeed, studies conducted nearly thirty years ago by Cartwright (1959) and Kipnis (1972; 1974) found a positive relationship between the exertion of power and attributions of control in a broad range of unequal power relationships. More specifically,
it was found that the level of the strength of influence exerted by a powerholder, whether they were employers or husbands, over their intended target, (employees and wives respectively), was positively related to the powerholder’s belief that s/he was the cause of any subsequent behavior change in the target. The effects of such behavior, moreover, not only resulted in increased perceptions of power by perpetrators, but also the simultaneous devaluation of the target of their abuse (Kipnis, 1972: Kipnis, et al., 1976). This effect, scholars argue, can be seen in any power relationship, be it by colonizers toward the colonized, prison guards toward prisoners, factory managers toward factory workers or in intimate partner relationships.

The assertion that violence and coercive behavior are fundamental tools of control in the maintenance of unequal power relationships throughout our society is further supported by research has shown that abuse is more likely to take place when the perpetrators perceive they can get away with it (Straus, Gelles, & Steinmetz, 1980), when the perpetrators believe they have power over the victim (Kipnis, et al.,1976), and when the perpetrator feels they benefit from the behavior (Baron & Richardson, 1994). In other words, perpetrators use violence because it is socially sanctioned, because it makes them feel in control, and because it is a quick and effective means to an end. This helps explain why studies have shown that women are more likely to be victimized by their male partners than men are by their female partners (Dobash, et al., 1992; Melton, et al., 2003; Tjaden, et al., 2000), and why children who are physically abused by their birth parents are more likely to be victimized by their mothers (who are more likely occupy the role of primary caregiver) than their fathers (60% vs. 48%) (Sedlak & Broadhurst, 1996).
point is that in all of these relationships, the perpetration of violence is used by the dominator over the dominated in order to counter perceived threats to their power/control and to maintain the hierarchical structure upon which their power is based (Hooks, 1984). Therefore, batterer intervention programs that focus only on patriarchy and fail to address the wider cultural foundations and cross-generational consequences of violence in our society may fundamentally miss the mark in terms of treatment by ignoring important mediating factors such as the long term effects of childhood abuse on one’s ability to experience empathy, and the importance of a strong therapeutic alliance for developing that capacity (Schore, 2003).

Finally, the criticism most often cited about the feminist model is that its educational programs are too confrontational in tone, and that they demonstrate a significant lack of empathy for, and attention to the specific historical relational, clinical, and neurobiological etiology of a batterer’s violent behavior (Healey, et al., 1998; Lawson et al., 2001). Indeed, many feminist batterer intervention programs lack adequate treatment considerations for the experience of batterers, many of whom are adult survivors of childhood abuse (Gelles, 1987; Hotaling & Sugarman, 1986; Straus, 1990.). These program deficits, critics argue, leave batterers feeling alienated, hostile and unresponsive to treatment and are reflected in the high recidivism rates (Healey, et al.). Indeed, while limited in number, empirical studies on the effectiveness of the dominant feminist psycho-educational and cognitive behavioral batter treatment models have found that batterers who completed treatment programs were only slightly less likely to reoffend than men who completed no treatment (Rosenfeld, 1992), and that
across treatments, men often reverted back to battering with in 6-12 months (Hamburger & Hastings, 1993). One study of three feminist psycho-educational batterer programs in Baltimore found that that batterers actually recidivated at a higher rate than batterers who received no treatment (Harrell, 1991, cited in Healey, et al., 1998).

Statement of Purpose: Treatment Alternatives

Given the high recidivism rates associated with the dominant cognitive behavioral and feminist batterer intervention models, more attention is now being paid to research in social, clinical, and neurobiological psychology calling for a shift in batterer treatment programming to include a focus on things like attachment style, emotion regulation, and empathy (Hodge, 1989; Hooks, 1984; Lawson et al., 2001). The role of empathy in particular, defined as “an other–oriented emotional response congruent with the perceived welfare of another person” (Batson, Turk, Shaw & Klein, 1995, p. 300), is seen as increasingly important for improving our understanding of intimate partner violence and treatment of violent offenders. A batterer’s struggle to maintain power and control in their relationships has been attributed to a fundamental lack of empathy that batterer feels for their partner (Goodrum, Umberson, & Anderson, 2007; Holtzworth-Munroe, Meehan, Herron, Rehman & Stuart, 2003; Holtzworth-Munroe & Stuart, 1994). Indeed, the connection between the extent to which batterers show significant deficits in empathy and the role these deficits play in the frequency and severity of abusive behavior can be found across many fields in psychology.

In feminist psychology, Miller and Stiver (1997) argue that relationships can function in either in a love-empathetic mode or a power-control mode. “An empathetic
mode would lead people to actively participate together to create mutually enhancing relationships. A power-control mode becomes linked with a focus on whether one can get others to gratify oneself. It readily leads to a sense of entitlement and from entitlement the step to violation of others is not a long one” (Miller & Stiver, p. 58). Long standing research on the corrupting effects of power by social psychologists support this claim. Indeed, Kipnis et al. (1976) argued that the successful use of strong means of influence was linked to a kind of ‘metamorphosis’ that takes place in the way powerholders view themselves and the targets of their abuse (Kipnis, 1972; Kipnis et al., 1976). In their experiments they observed a tendency for powerholders who used strong and controlling means of influence to (1) increasingly devalue the worth of the targets of their coercion, (2) to view themselves as more favorable than their targets, and (3) attempt to increase social and psychological distance from the target person (Kipnis, et al.). This finding was reinforced by Raven’s (1992) study which found that attributions of power to the self and loss of empathy for the other/target person were the fundamental consequences of the repeated successful use of violence on the part of powerholders (Raven, 1992). Other social scientists have argued that measuring one’s empathetic response can be used to infer how much one values the welfare of a person in need (Batson, Eklund, Chermok, Hoyt, & Ortiz, 2007; Batson, Turk, Shaw, & Klein 1995). The results of these studies suggest a positive relationship between one’s level of empathetic feelings and one’s ability to value another’s welfare. For the purposes of this study, these findings seem to support the supposition that a powerholder’s (or batterer’s) abuse and subsequent devaluation of and emotional and psychological separation from their target (or intimate
partner) is critically linked their ability to participate in an empathetic relationship with the person they are oppressing.

Research in clinical and neurobiological psychology also point to the centrality of empathy for understanding IPV and treating batterers. Recent studies in the field of neuropsychology have linked deficits in empathy in the brain to IPV. In Schore’s (2003) exploration into the neurobiological consequences of early childhood relational trauma, early deficits in receiving empathetic care were related to the development of impaired orbital prefrontal function. Evidence of this specific type of neurological impairment has been linked to such psychopathologies as mania, unipolar depression, drug addiction, and borderline and psychopathic personality disorders. As Schore (2003) explains,

Deprivation of empathic care, either in the form of chronic excessive arousal intensification or reduction, creates a growth-inhibiting environment that produces immature, physiological undifferentiated orbitofrontal affect regulatory systems. In light of the fact that orbitofrontal function is essential to the capacity of inferring the states of others, regulatory dysfunctions of this prefrontal system would underlie the broad class of developmental psychopathologies that display “empathetic disorders”. (p. 35)

Therefore, Schore (2003) concludes that understanding the cause and effects of child abuse in our society and showing empathy for a batterer’s own experience of abuse is important for fostering a strong and reparative therapeutic alliance needed to facilitate
Behavioral change. Clinical psychologists studying the connection between attachment, empathy and IPV support Schore’s argument for the important role that empathy should play in treating batterers. For therapists, expressing empathy for the batterer’s own experience of being abused is key for building a strong therapeutic alliance, and working with batterers to regain their capacity to feel empathy is key to their long term behavioral change (Holtzwart-Munroe et al., 1994; Murphy, Meyer, & O’Leary, 1994; Schore; Dutton et al., 1995).

Clinical studies on early attachment, empathy, and IPV contend that children who have been abused tend to demonstrate insecure attachment styles (Cicchetti & Barnett, 1991) and that insecure attachment styles are associated with aggressiveness in children (Greenberg, Speltz, DeKlyen, & Endriga, 1991). While not all abused children are aggressive and not all aggressive children grow up to be violent adults, studies have shown that violent men reported more aggressive behavior as children than non violent men, more insecure, preoccupied and fearful attachment styles than non-violent men, and higher levels of jealousy, dependency, and preoccupation with their wives, and less trust in marriage than non-violent men (Dutton et al., 1995; Holtzwart-Munroe et al., 1994; Murphy, Meyer, & O’Leary, 1994; Schore, 2003; Sorkin 2005).

Hypotheses

A review of the literature on batterer intervention programs suggests the need for change in the focus of these programs. Indeed, the high recidivism rates associated with, and mounting criticisms of, the dominant feminist and cogitative/behavioral batterer intervention programs provide an opportunity to rethink the structure and focus of clinical
treatment for batterers (Eckhardt, et al. 2006; Hamberger & Hastings, 1993; Healey, Smith & O’Sullivan, 1998). Social science research on power relationships and empathy (Batson, et al. 1995; Kipnis, 1972; Kipnis, et al. 1976; & Raven, 1992) and newer clinical and neuropsychological research on attachment, empathy and therapeutic alliance point to the key role of empathy for understanding the etiology of domestic violence and facilitating long term behavioral change in batterer treatment (Lawson, et al. 2001, Schore, 2003; Sorkin 2005; Sorkin & Dutton, 2003). All of this research suggests that empathy may be a critical factor when reassessing the focus of batterer treatment programs. Thus, the proposed study specifically isolated the variable of affective empathy as measured by Batson in relationship to childhood abuse and domestic violence. Based on the above, the following hypotheses were made:

1. Batterers will score lower on levels of empathy toward their intimates than non-batterers;
2. There is an inverse relationship between empathy and battering behavior;
3. There is an inverse relationship between childhood abuse and empathy;
4. Childhood physical abuse will be an important predictor of empathy levels; and
5. Empathy and childhood abuse will be important predictors of battering behavior.

Support for these hypotheses would be consistent with the latest clinical and neuropsychological literature that suggests that the experience of childhood abuse (a known risk factor for adult violent behavior) can have a fundamental impact on one’s ability to empathize, regulate emotion (including anxiety, anger and aggression), and engage in secure, trusting relationships as an adult (Lawson, et al. 2001; Schore, 2003;
Sorkin 2005; Sorkin & Dutton, 2003). If the hypotheses are supported, this would give further evidence to the need to shift batterer intervention programs to include more targeted efforts to go beyond traditional behavioral and psychoeducational programming, and place more emphasis on the need to rebuild a batterer’s capacity to trust, regulate emotion, and experience and demonstrate empathy for others (Sorkin 2005).
Method

Participants

With permission from the group leaders, 31 volunteers were solicited from the “Breaking the Cycle” batterer intervention program and the Humboldt Family Service Center batterer intervention program in Eureka, California. For the control group, 30 gender-matched volunteers from the general population were recruited from Humboldt State University, the Arcata Airport, and the Eureka Public Library. Participants from this group were screened via a questionnaire to make sure they have not been and are not in an abusive relationship. All participants were invited to participate in a raffle drawing for a single $100.00 dollar gift certificate to Target in exchange for their participation. All participants were at least 18 years old, and each was asked to provide informed consent to participate in this study. Participation in the study in both the experimental and the control group was completely voluntary.

Instrumentation

For the purposes of this study, empathy was defined as “an other–oriented emotional response congruent with the perceived welfare of another person” (Batson, Turk, Shaw and Klein, 1995) and violence was defined as behaviors that threaten, attempt, or actually inflict physical harm (Straus, 1990; Jaden & Thoennes, 2000).

The participants in this experiment were asked to fill out a paper-and-pencil questionnaire composed of Batson’s (1997) eight-item affective empathy scale (See appendix A), Straus’ 19 item Conflict Tactics (CTS) Scales (1990) (See appendix B), and
a five item subscale of the CTS, the Very Severe Violence (VSV) scale (See appendix C), (Straus and Gelles, 1990), to measure the absence or presence of childhood physical abuse, and basic demographic information (See appendix D).

Measures

Data for the study came from a survey that assessed participants’ demographics, their experience of childhood abuse, their level of affective empathy for their intimate partner, and the level of violence participants have used against their intimate partner. Regarding the demographic information, participants were asked to indicate their age, gender, intimate relationship status, and the highest academic degree they have attained.

Empathy

For this portion of the survey, participants were asked to complete Batson’s (1997) eight-item empathy scale. This scale has been found to be moderately correlated with measures of dispositional empathy ($r = .38 \ p < .025$), and perspective taking ($r = .38 \ p < .025$) (Fultz, Batson, Fortenbach, McCarthy, & Varney, 1986; Eisenberg & Miller, 1987). Mean scores for this scale between 3.22 and 4.58 on a 1-6 scale were reported as recently as 2007 by Batson, Eklund, Chermok, Hoyt, and Ortiz, This empathy scale has been widely used over the past twenty years to assess the empathy-altruism hypothesis that empathy manipulations can manipulate empathy (Batson, Turk, Shaw, & Klein, 1995; Coke, Batson, & McDavis, 1978; Toi & Batson, 1982). On a 6 point Likert scale ranging from 0 (not at all) to 5 (extremely) participants were asked to indicate the degree to which they feel sympathetic, empathetic, concerned, moved, compassionate, warm,
softhearted, and tender towards their current or most recent former intimate partner at the
time of the rating. An example of the measure’s questions include: “I feel sympathetic
toward my partner” and “I feel warm toward my partner.” (See Appendix A for the entire
instrument.).

Intimate Partner Violence

A modified version of the Conflict Tactics Scale (Straus, 1990) was used to assess
the extent of physical violence used by respondents against their intimate partner over the
last year. The CTS is a 19-item conflict tactics scale in which participants will rate on a 7
point Likert scale. the frequency with which they have used three categories of conflict
tactics (reasoning, verbal aggression, and violence) against their intimate partner over the
past year. The Conflict Tactic Scales have moderate to high reliabilities. The reliability
coefficients are high for the Verbal Aggression scale (n = 2143, Alpha Coefficient = .80)
and Violence scale (n = 2143, Alpha Coefficient = .83) and low for the reasoning scale (n
= 2143, Alpha Coefficient = .50) (Schumm, Bollman, Jurich & Martin, 1982; Barling,
O’Leary, Jouriles, Vivian & MacEwen, 1987, Straus, 1990). The difference is likely a
function of the small number of items (only three) making up the Reasoning scale
(Straus, 1990). An example of the measure’s questions include: “Threw something at
him or her” and “Choked him or her.” (See Appendix B for the entire instrument.).

Presence of Childhood Physical Abuse

A subscale of the Conflict Tactics Scale, the Very Severe Violence (VSV) scale
(Straus and Gelles, 1990) was used to measure the absence or presence of childhood
physical abuse. Using a modified version of the CTS physical aggression subset, the VSV asks respondents to rate on a 7 point Likert scale, the frequency of behaviors by their parents or others in their family which could have resulted in the respondents’ physical injury during childhood, including: kick, bite or hit with a fist, beat up, burned or scalded, threatened with a knife or gun, or used a knife or gun. This subset was introduced to respondents as things that your parents or the people in your family might have done when they had a disagreement with you when you were growing up, that is, up to the time you finished elementary school (Straus and Gelles, 1990. An example of the measure’s questions include: “Burned or scalded you” and “Threatened you with a knife or gun.” (See Appendix C for the entire instrument.).

Procedure

Current clients in the Breaking the Cycle, Humboldt Family Service Center, in Eureka, California, were approached just before their weekly group therapy meeting and asked to participate in the survey. I explained that the purpose of the survey was to collect data on the intra- and inter- personal dynamics of intimate partner relationships. I explained the risks and benefits to the group, outlined the research protocol and provided an informed consent form (See appendices E and F), survey, and writing utensil for those that agreed to participate in the survey. Participants were instructed not to put their name on their survey and reminded that all information would be held confidentially and would only be used for the purposes of this study. They were informed that the survey should only take approximately 15 to 20 minutes to complete. Altogether 31 clients participated. At the request of some group leaders, in order to assist those clients who could not read
and/or see very well, I read the questions aloud while participants marked their answers. Once completed, participants returned the survey to me, and were then debriefed. The debriefing included a list of free and low cost counseling resources in the local area (See appendix G). For those who chose to participate in the raffle to win a single $100.00 gift certificate to Target in exchange for completing the survey, their name and contact information were recorded on separate cards that were held in separate envelopes from the survey so that there would be no way to connect the raffle cards with the survey instruments.

Members of the general population who agreed to participate in the survey were informed of the risks and benefits of participating in the experiment and explained the research protocol (See appendix E). Participants were provided with a clip board, an informed consent form (See appendix F), and a survey. I explained that the purpose of the survey is to collect data on the intra- and inter- personal dynamics of intimate partner relationships. Participants were instructed not to put their name on their survey and reminded that all information would be held confidentially and would only be used for the purposes of this study. They were informed that the survey should only take approximately 15 to 20 minutes to complete. Altogether 30 members of the general population participated. Once completed, participants returned the survey to me, and were debriefed. The debriefing included a list of free and low cost counseling resources in the local area (See appendix G). For those who chose to participate in the raffle to win a single $100.00 gift certificate to Target exchange for completing the survey, their name and contact information were recorded on separate cards that were held in separate
envelopes from the survey so that there was no way to connect the raffle cards with the survey instruments.

Risks, Benefits, and Management of Risks

There were some potential psychological risks involved with participation in this study. The possible psychological risks included feeling uncomfortable with the questions on the questionnaires. A participant might feel uncomfortable revealing the true extent of any abuse they experienced during childhood, their violent behavior toward their intimate partner, and the true level of empathy felt for the latter. This may be particularly true if the level of violence the participant inflicted on their partner had been severe.

Participants were provided with informed consent by signing the informed consent waiver provided at the start of the survey (See appendix F). They were informed that participation was voluntary and that they could opt to discontinue their participation at any time without penalty. A list of free and low cost counseling resources was made available to all participants. All data that was collected will be held confidential and used strictly for the purposes of this study. The raw data will be kept for five years on Marnie Lucas Zerbe’s hard drive on a password protected computer in a password protected file. For the survey instruments, a participant number was used to identify each participant. For those who chose to participate in the raffle to win a single $100.00 gift certificate to Target in exchange for completing the survey, their name and contact information was recorded on separate cards that were held in separate envelopes from the survey so that there is no way to connect the raffle cards with the survey instruments. Participants were
given as much information as possible without revealing the research hypothesis. They were told about the possible risks and benefits of their participation and were given the telephone number, e-mail address and office location of the supervising faculty member, the dean of graduate studies, and the principal investigator. All participants were also debriefed immediately after completing the survey. The debriefing included a list of free and low cost counseling resources in the local area (See appendix G). Every effort will be made to provide access to results when the study is completed.

The primary benefit of this study is that it has the potential to increase the effectiveness of batterer intervention programs and reduce incidents of intimate partner violence. The study could, therefore, make an important contribution to the growing body of literature on intimate partner violence and empathy. The academic community could also benefit as this study encompasses topics explored in social, clinical and neuropsychology. The study may also contribute to our understanding of the influence and function of empathy on the etiology of intimate partner violence and batterer treatment programs. Participants may benefit by having an opportunity to experience methods of data collection and measurement that are common in research psychology, and the opportunity to contribute data to a project used in the training of students in academic research.

How the Data Were Prepared for Analysis

I first calculated the mean, median, skew, kurtosis, and standard deviation of both group’s (i.e. the batterer intervention program and control group) scores on the CTS minor violence sub-scale, the CTS severe violence sub-scale, the VSV childhood
physical abuse scale, and Batson’s Empathy scale. The CTS minor violence sub-scale included items K (pushed, grabbed, and shoved), L (threw objects at him/her), and M (slapped him/her). The CTS severe violence sub-scale included items N (kicked, bit, or hit him/her w/ a fist), O (Hit or tried to hit him/her with something), P (beat him/her up), Q. (choked him/her), R (threatened him/her with a knife or gun), and S (used a knife or gun). As per the CTS scoring instructions (Straus, 1990, p. 543) the CTS scores were weighted according to frequency and severity. See Tables 1 & 2 for the raw, untransformed mean, median and standard deviation results for these scores. Note: Because of the non-normal nature of the CTS data (explained below) when looking at the descriptive statistics for the CTS scales, medians should be used.

By looking at the descriptive statistics, it was found (as expected) that all of the CTS scales (the CTS minor violence scale, the CTS severe violence Scale, and the CTS VSV childhood physical abuse scale) were skewed and kurtotic. This, according to Straus (1990) is a normal aspect of scoring the CTS and is to be expected. To correct for this I transformed the data using the log of the Minor Violence and VSV childhood physical abuse variables, and the square root of the log of the CTS Severe Violence variables. Data was statistically normal after transformation. Once the data was transformed, I was then able to run the rest of our statistical analyses and test our hypotheses.
### Table 1

**Group 1: Batterer Intervention Program Population**

<table>
<thead>
<tr>
<th>SCALE</th>
<th>Conflict Tactics Sub Scale Minor Violence</th>
<th>Conflict Tactics Sub Scale Severe Violence</th>
<th>Batson’s Empathy Scale</th>
<th>Conflict Tactics Scale for Very Severe Violence Scale for Childhood Physical Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>31</td>
<td>31</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>Mean</td>
<td>9.2067</td>
<td>3.2849</td>
<td>3.4700</td>
<td>8.6667</td>
</tr>
<tr>
<td>Median</td>
<td>9.3333</td>
<td>.6667</td>
<td>3.7500</td>
<td>.6666</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>5.40967</td>
<td>10.45123</td>
<td>1.30018</td>
<td>12.80571</td>
</tr>
</tbody>
</table>

### Table 2

**Group 2: Control Population**

<table>
<thead>
<tr>
<th>SCALE</th>
<th>Conflict Tactics Sub Scale Minor Violence</th>
<th>Conflict Tactics Sub Scale Severe Violence</th>
<th>Batson’s Empathy Scale</th>
<th>Conflict Tactics Scale for Very Severe Violence Scale for Childhood Physical Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Mean</td>
<td>2.9058</td>
<td>.0167</td>
<td>3.8967</td>
<td>.2899</td>
</tr>
<tr>
<td>Median</td>
<td>1.333</td>
<td>.0000</td>
<td>4.0000</td>
<td>.0000</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>4.50967</td>
<td>.09129</td>
<td>.9811</td>
<td>.58865</td>
</tr>
</tbody>
</table>
Results

An independent *t*-test analysis was used to test hypothesis #1 that the clinical population would score lower on empathy toward their intimates than the non-clinical population. This analysis tested the difference in the mean scores between volunteers from the batterer intervention programs and non-clinical volunteers from the general population on battering behavior, *t*(58) = 1.031, *p* = .307 (See Tables 1 and 2 for means and standard deviations of the batterer intervention group and the control group). I expected that the clinical population would score significantly lower on empathy than the clinical population; however, the data did not support this hypothesis.

For hypothesis #2, correlation analysis using scores on Batson’s empathy scale and the Conflict Tactics Sub-Scale for severe intimate partner violence were used to test hypothesis that there would be an inverse relationship between empathy and battering behavior, *r* (60) = .04, *p* = .76. The analysis revealed that, for this study, there was no significant relationship between levels of empathy and battering behavior, and thus the hypothesis was not supported.

Similarly, hypothesis #3 which predicted that there would be an inverse relationship between childhood physical abuse and empathy was analyzed using correlation analysis. The analysis used participant’s scores on the Conflict Tactics Scale for very severe violence and Batson’s empathy scale and found that, for this study, there was no relationship between the two variables, *r* (50) = .03, *p* = .82. I speculated that those who scored high on the childhood physical abuse scale would score lower on levels of empathy toward their intimates, but, again, the data did bear this out.
Hypothesis #4 that childhood physical abuse would be a significant predictor of empathy was tested using simple linear regression. Results showed that participants’ scores on Conflict Tactics Scale for childhood physical abuse did not predict scores on Batson’s empathy scale, \( t(48) = .23, \beta = .03, p = .82 \). It was expected that childhood physical abuse would be a significant predictor of participant’s scores on empathy toward their intimate partner; however, the data did not support this.

The final hypothesis (#5) that empathy and childhood abuse would be a significant predictor of battering was tested using simple linear regression. Indeed, regression analysis using participants scores on the Conflict Tactics Scale for childhood physical abuse, and the Conflict Tactics Sub-scale for severe and minor intimate partner violence, revealed that childhood physical abuse was a significant predictor of both minor intimate partner violence, \( t(46) = 3.52, \beta = .46, p = .001 \), and severe intimate partner violence \( t(47) = 2.41, \beta = .331, p = .02 \). Therefore, while the data did not support expectation that empathy would be a significant predictor of battering behavior, the data indicated that childhood physical abuse was a significant predictor. This is consistent with the findings of clinical and neuropsychology theorists cited earlier regarding the significance of the relationship between childhood trauma and adult aggressive behavior (Lawson, et al. 2001; Schore, 2003; Sorkin 2005; Sorkin & Dutton, 2003).
Discussion

Summary and Discussion of the Findings

The purpose of this study was to test the relationship between childhood physical abuse, empathy, and battering behavior in order to enhance our collective understanding of the etiology and treatment of intimate partner violence. The goal was to contribute to the current research efforts geared toward improving the effectiveness of batterer treatment programs. In particular, this study sought to provide support for the latest clinical and neuropsychological literature that suggests that the experience of childhood abuse can have a fundamental impact on one’s ability to empathize, regulate emotion (including anxiety, aggression, and anger), and engage in secure trusting relationships as an adult (Lawson, et al. 2001, Schore, 2003; Sorkin 2005; Sorkin & Dutton, 2003).

Toward this end, I used Batson’s (1997) Empathy Scale, Straus’ (1990) Conflict Tactics Scale, and Straus and Gilles’ (1990) Very Severe Violence Scale to test our hypotheses about the importance of empathy in relationship to childhood abuse and intimate partner violence.

The present data did not offer any evidence that empathy (as measured by Batson’s scale) is significantly related to childhood physical abuse or intimate partner violence. Contrary to the hypotheses, there were no differences between clinical and non-clinical populations on empathy scores, there was no relationship between empathy and battering behavior, and childhood physical abuse was not a predictor of empathy. Indeed, I was not able to replicate the Kipnis et al. (1976) and Raven (1992) findings that loss of
empathy for the other/target person was a fundamental consequence of the repeated successful use of violence on the part of powerholders.

As noted in the results section, however, the hypothesis regarding the relationship between childhood abuse and battering behavior was supported. This was consistent with attachment theorists contention that, while not all abused children are aggressive and not all aggressive children grow up to be violent adults, violent men reported more aggressive behavior as children than non violent men, more insecure, preoccupied and fearful attachment styles than non-violent men, and higher levels of jealousy, dependency, and preoccupation with their wives, and less trust in marriage than non-violent men (Dutton et al., 1995; Holtzworth-Munroe et al., 1994; Murphy, Meyer, & O’Leary, 1994.; Schore, 2003; Sorkin 2005).

General Limitations

Because the clinical population sample received their survey in an institutional or clinical office environment and the other, non-clinical population, received theirs at Humboldt State University, the Arcata Airport, and the Eureka Public Library, there was a possibility this could affect the results of the experiment. However I feel this possibility was minimal for two reasons. First, there is no known research to indicate that where one takes a survey of this type will have a systematic effect on one’s responses. Second, the random nature of the survey administration for the control group should help to neutralize any possible effect of difference in survey administration should they be present.

There may be any number of reasons as to why the data did not support the study’s hypotheses concerning the role of empathy in predicting intimate partner
violence. The first is that perhaps it would have been better to measure cogitative empathy (i.e. the ability to cognitively place one’s self in another’s position), rather than emotional empathy. It is possible that while batterers may have experienced feelings of empathy toward their intimate partner, they lacked the genuine capacity to cognitively place themselves in their partner’s shoes, especially during times of discord.

Another possible explanation is that batterer’s scores on all the measures reflected distorted perceptions of the concepts of abuse and empathy. During the course of these survey facilitations I noted that many clients would ask me questions about the nature of the childhood physical abuse they endured, and if it “counted or not.” Many clients had a tendency to minimize the abuse they were subjected to as children, citing things like “they never actually used the knife” or “I had it coming”. One participant who had been scalded by his mother on more than one occasion noted that his mother always apologized after the incidents and promised not to do it again; thus he wanted to know if it “counted” for the survey. My reply to all these types of inquiries was that if these incidents were painful enough for them (emotionally and physically) that the clients remember them even today, it counts.

Thus it is possible that participants may have underreported the frequency and severity not only of their childhood abuse, but of the abuse they themselves inflicted on their intimate partner. Indeed, there were a few participants in the batterer’s intervention program who actually denied on the survey that they had ever been in a violent relationship in which they used physical force against their intimate partner. Even more interesting was that these same participants’ scores on the Conflict Tactics Scale
indicated they had used physical force against their intimate partner (including shoving, hitting, and beating up). Just as these incidents suggest that batterers’ answers to survey questions may have reflected distorted conceptions of what constitutes childhood and intimate partner abuse, the same may be true of their conceptions and answers about their feelings of empathy for their intimate partner. This was reflected in some batterers’ comments during the completion of the empathy scale portion of the survey, including “fuck that bitch”, “yah, right”, “she never showed this for me”, etc. These kinds of comments suggest that it is possible that some batterers may have reported more empathetic feelings toward their intimate partner than they really had. Indeed, the means for these scores were slightly higher compared to the Batson, et al. (2007) findings. This may explain why no differences were found between clinical and non-clinical groups on empathy scores.

A third possible reason why the data did not support the study’s hypotheses around the role of empathy in predicting intimate partner violence is that the clients in the batterer intervention programs may have been experiencing positive results from their work in therapy. Many of the groups that participated in the survey had already been together for some time and appeared cohesive. It is possible, therefore, that in the course of their hard work in therapy in conjunction with the trusting relationships clients built with the group leader and other group members, many were able to experience empathy for themselves and redevelop the capacity to experience it for others. If this were the case, it makes sense that scores on empathy were similar for both clinical and non-clinical groups.
Also, the fact that the data did not support the hypothesis that the level of empathy would be an important predictor of adult battering behavior would suggest that an individual can have a great deal of empathy for their intimate partner while simultaneously abusing them. However this would, as noted earlier, contradict decades of research on empathy, power relationships, and coercive behavior that has shown (1) that one’s empathetic response can be used to infer how much one values the welfare of a person in need (Batson, Eklund, Chermok, Hoyt, & Ortiz, 2007; Batson, Turk, Shaw, & Klein 1995; Kipnis, et al. 1976; Raven, 1992), and (2) that loss of empathy for the other/target person is a fundamental consequence of repeated successful uses of violence on the part of powerholders. Thus, despite the findings of this study, these studies suggest at least some relationship between empathy, violence, and the valuation of the intended target.

**Directions for Future Research**

Future research could focus on the role of the brain in the emotive, cognitive and behavioral experience of empathy and their relations to battering behavior. Building on the research of scholars like Schore (2003), and using advances in neuropsychology such as magnetic resonance imaging (MRI) to compare orbital prefrontal functioning between clinical and non-clinical populations might better elucidate the connections between childhood abuse, empathy, emotion, regulation and aggressive behavior. Conducting these kinds of studies over long periods of time may help further solidify Kipnis’ theories about the consequences of the successful uses of strong means of influence over time and the ‘metamorphosis’ that takes place in the way a powerholder views themselves and the
targets of their abuse (Kipnis, 1972, Kipnis et al. 1976). If these kinds of studies could trace the neurological changes that support and reinforce maladaptive behavior over time, similar research, using MRI technology, could be used to trace the therapeutic techniques that facilitate long term neurological changes that help support and reinforce more adaptive behaviors. According to Schore (2003), the first step toward facilitating this kind of long term change is for therapists to show empathy for a batterer’s own experience of abuse and work with him/her to foster a strong and reparative therapeutic alliance needed to facilitate long term behavioral change.

Finally, it could be beneficial to create interventions aimed at educating the public and especially mental health providers about attachment and the connections between childhood abuse and adult battering behavior. For therapists, these interventions may help centralize the need to treat batterers both for the abuse they experienced as a child and for the abuse they perpetrated as an adult. This will likely involve a considerable amount of time, commitment and intensive therapy in which the growth and facilitation of a strong therapeutic empathetic relationship will likely be an important key for assisting long-term positive behavioral change.
References


Appendix A.

Batson’s Empathy Scale
Batson’s Empathy Scale

INSTRUCTIONS:

This portion of the survey concerns your feelings toward your most recent intimate partner. Please check the corresponding box for each that best represents your feelings toward that person.
INSTRUCTIONS:
This portion of the survey concerns your feelings toward your most recent intimate partner. Please check the corresponding box for each that best represents your feelings toward that person.

<table>
<thead>
<tr>
<th>Not At All</th>
<th>Very Little</th>
<th>Somewhat</th>
<th>Moderately</th>
<th>Very</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel sympathetic toward my partner.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. I feel empathetic toward my partner.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. I feel concerned for my partner.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. I feel moved by my partner.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. I feel compassionate toward my partner.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>6. I feel warm toward my partner.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>7. I feel softhearted toward my partner.</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<td>□</td>
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<tr>
<td>8. I feel tender toward my partner.</td>
<td>□</td>
<td>□</td>
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<td>□</td>
<td>□</td>
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</tbody>
</table>
Appendix B.

Straus’ (1990) Conflict Tactics Scale
INSTRUCTIONS: Please read the following instructions slowly and carefully.

No matter how well a couple get along, there are times when they disagree, get annoyed with the person or just have spats or fights because they’re in a bad mood or tiered or for some other reason. They also use many different ways of trying to settle their differences. Here is a list of things you might have done when you had a conflict or disagreement with your intimate partner. We would like you to try and remember what went on during the last year and please check the corresponding box for each of the things listed below to show how often you did it that year.
INSTRUCTIONS: Please read the following instructions slowly and carefully.

No matter how well a couple get along, there are times when they disagree, get annoyed with the person or just have spats or fights because they’re in a bad mood or tiered or for some other reason. They also use many different ways of trying to settle their differences. Here is a list of things you might have done when you had a conflict or disagreement with your intimate partner. We would like you to try and remember what went on during the last year and please check the corresponding box for each of the things listed below to show how often you did it that year.

<table>
<thead>
<tr>
<th></th>
<th>Once</th>
<th>Twice</th>
<th>3-5 Times</th>
<th>6-10 Times</th>
<th>11-20 Times</th>
<th>More than 20 Times</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td></td>
<td></td>
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<tr>
<td>B.</td>
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<tr>
<td>C.</td>
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<td>D.</td>
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<td>E.</td>
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<td>F.</td>
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<td>G.</td>
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<tr>
<td>H.</td>
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<tr>
<td>I.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A. Discussed an issue calmly

B. Got information to back up your side of things

C. Brought in, or tried to bring in, someone to help settle things

D. Insulted or swore at him/her

E. Sulked or refused to talk about an issue

F. Stomped out of the room or house or yard

G. Cried

H. Did or said something to spite him/her

I. Threatened to hit or throw something at him/her
| J. Threw or smashed or hit or kicked something | □ | □ | □ | □ | □ | □ | □ | □ |
| K. Threw something at him/her | □ | □ | □ | □ | □ | □ | □ | □ |
| L. Pushed, grabbed, or shoved him/her | □ | □ | □ | □ | □ | □ | □ | □ |
| M. Slapped him/her | □ | □ | □ | □ | □ | □ | □ | □ |
| N. Kicked, bit, or hit him/her with a fist | □ | □ | □ | □ | □ | □ | □ | □ |
| O. Hit or tried to hit him/her with something | □ | □ | □ | □ | □ | □ | □ | □ |
| P. Beat him/her up | □ | □ | □ | □ | □ | □ | □ | □ |
| Q. Choked him/her | □ | □ | □ | □ | □ | □ | □ | □ |
| R. Threatened him/her with a knife or gun | □ | □ | □ | □ | □ | □ | □ | □ |
| S. Used a knife or fired a gun | □ | □ | □ | □ | □ | □ | □ | □ |
Appendix C.

Straus and Gelles’ (1990) Very Severe Violence (VSV)

subscale of the Combat Tactics Scale
Straus and Gelles’ (1990) Very Severe Violence (VSV) subscale of the Combat Tactics Scale

INSTRUCTIONS: Please read the following instructions slowly and carefully.

Below are a list of things that your parents or the people in your family might have done when they had a disagreement with you when you were growing up, that is, up to the time you finished elementary school. Try and remember what went on during that time in your life and please and check the corresponding box for each of the things listed below to show how often your parents or care giver engaged in the following behaviors toward you.
INSTRUCTIONS: Please read the following instructions slowly and carefully.

Below are a list of things that your parents or the people in your family might have done when they had a disagreement with you when you were growing up, that is, up to the time you finished elementary school. Try and remember what went on during that time in your life and please and check the corresponding box for each of the things listed below to show how often your parents or care giver engaged in the following behaviors toward you.

<table>
<thead>
<tr>
<th></th>
<th>Once</th>
<th>Twice</th>
<th>3-5 Times</th>
<th>6-10 Times</th>
<th>11-20 Times</th>
<th>More than 20 Times</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>N. Kicked, bit, or hit you with a fist</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>O. Beat you up</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>P. Burned or scalded you</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Q. Choked you</td>
<td>☐</td>
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<tr>
<td>R. Threatened you with a knife or gun</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>S. Used a knife or fired a gun</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
<td>☐</td>
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</tr>
</tbody>
</table>
Demographic Information

INSTRUCTIONS: Please complete the following demographic questions:

Age: __________

Sex:  □ Male
      □ Female

Current Relationship Status:
  □ Dating      □ Living Together
  □ Married     □ Separated
  □ Divorced    □ Single

Are you now or have you ever been in a relationship with a romantic partner in which you used physical force to against your partner?
  □ Yes
  □ No

Highest Level of Education Completed:
  □ Elementary School □ Middle School □ High School Diploma/GED
  □ College 2 years   □ Bachelor’s Degree □ Graduate Degree
Appendix E

Research Protocol
RESEARCH PROTOCOL

The study you are participating in consists of a paper-and-pencil questionnaire. There are 41 questions altogether. Please do not put your name on the survey. Directions on how to fill out the questionnaires will appear on the forms. Please read them carefully. When you are sure that you understand the instructions, you are then welcome to turn the page and answer the questions. The survey will take no longer than 15-20 minutes to complete. Once you have completed the survey, please return it to me and receive a debriefing notice. If you wish to participate in the raffle to win a $100.00 gift certificate to Target, your name and contact information will be recorded on separate cards that will be held in separate envelopes from the survey so that there is no way to connect the raffle cards with the survey instruments. At this time, you will need to read and sign the consent form. Thank you for your participation.
Appendix F.

Informed Consent
I certify that I am over the age of 18, and I hereby agree to let Marnie Lucas Zerbe carry out the following survey on me for experimental purposes.

You will be asked to fill out some questions examining your feelings and behaviors toward your intimate partner. You will also be asked to answer questions designed to see if you have experienced childhood physical abuse. There is a risk that you may be upset by disclosing some of this information. Some questions may bring back bad memories and may leave you feeling frustrated and/or emotionally distressed. If you have little to no access to affordable mental health care, the risk may be greater. For this reason, a list of free and low-cost/sliding-scale mental health providers in the immediate area will be made available to all participants in this study. The survey should take about 15-20 minutes to complete.

I understand that my participation in this study is completely voluntary, and that I may decline to enter this study or withdraw from it at any time without penalty. I understand that I am not supposed to put my name on the survey and that my answers to these questions will be anonymous and held confidential. I understand that the survey and the informed consent forms will be held in separate envelopes so that there is no way to connect the consent forms to the survey instruments.

All participants, whether you complete the survey instrument or not, will be offered a chance to participate in a single raffle for one $100.00 gift certificate to Target. If you choose to participate in the raffle, your name and contact information will be recorded on separate cards that will be held in separate envelopes from the survey and the informed consent forms so that there is no way to connect the information on the raffle cards with the survey instruments or consent forms.

Study responses will be saved for three years on Marnie Lucas Zerbe’s hard drive on a password-protected computer in a password-protected file. I understand that Ms. Lucas Zerbe will answer any questions I may have concerning this investigation or the procedures at any time.

If I have any questions regarding the study and/or my participation, I can contact Marnie Lucas Zerbe at (707) 826-3755 or marnielz@yahoo.com. The faculty advisor is also available, Dr. Gregg Gold at (707) 826-3740 or gregg.gold@humboldt.edu. I may also contact the dean for research and graduate studies at HSU, Dr. Chris Hopper, at 286-3949.

This information was explained to me by Marnie Lucas Zerbe and I understand that she will answer any questions that I may have before, during and after the investigation.

Participant Signature Date

Researcher Signature Date
Appendix G.

Humboldt State University Study Debriefing

Early Childhood Abuse, Empathy and Intimate Partner Violence.

The purpose of the study you just completed is to examine the effects of empathy and childhood abuse on people’s behavior toward their intimate partner. It is hoped that the information found in this study will be used to develop better strategies for dealing with intimate partner violence.

Your responses in this study are confidential; if you have any questions regarding the security measures used to protect your identity please contact me directly. You can contact me, Marnie Lucas Zerbe, directly at (707) 826-3755 or marnielz@yahoo.com if you have any questions. You can also contact my faculty advisor, Dr. Gregg Gold at (707) 826-3740 or gregg.gold@humboldt.edu. You may also contact the dean for research and graduate studies at HSU, Dr. Chris Hopper, at 286-3949.

Should you experience any discomfort after completing this survey and would like support please refer to the following list of free and low cost counseling services in the area:

1. Humboldt Family Service Center: 1802 California St., Eureka CA (707) 443-7358 (FREE)

2. Humboldt County Mental Health Services (FREE)
   a. Adult out patient services: 720 Wood St., Eureka, CA (707)268-2900
   b. Crisis Services 24hrs.: toll free (888) 849-5728

3. North Country Clinic: 785 18th St, Arcata, CA: (707) 822-1385 (low cost/sliding scale)

4. Eureka Community Health Center: 2412 Buhne Street, Eureka, CA (707) 441-1624 (low cost/sliding scale)

5. Eureka Family Practice: 2675 Harris Street Eureka CA 95519 707-443-8335. (low cost/sliding scale)