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ABSTRACT

Research directed toward combatting the problem of domestic violence involves consideration of certain variables related to implementing treatment regimens for battering males. The various characteristics of this population are discernable; the relationship of these factors has important implications for therapeutic intervention. The design and implementation of treatment programs for male batterers can be enhanced by recognizing and dealing appropriately with the psychological patterns of these men. Legal, agency, and staff resources can be educated to effective methods of treating male batterers. A program outline for therapy is provided, as well as contact information for those interested in the field. (PK)

Domestic Violence: Issues in Designing and Implementing Programs for Male Batterers

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Domestic Violence: Issues in Designing and Implementing Programs for Male Batterers

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In recent months the problem of Domestic Violence has commanded increased national attention. Presently the two houses of Congress are considering Bills to meet the multiple needs of families caught in the throes of violence. Research and clinical experience have multiplied as evidenced by the literature now available on child abuse, incest, and battered women. More and more community groups are responding to the problem by establishing crisis lines and/or shelters for the estimated 1.8 million battered women (Straus, 1977) and their children.

Contrary to popular myths about domestic violence, the physical assaults are not caused by the victim's behavior or by her masochism (Walker, 1977; Martin, 1976). Furthermore, it is the position of these authors that except for physical self defense, the use of violence is NOT justified in intimate relationships. Consequently, providing treatment for or doing research on the victim will not stop the violence of the batterer. While the victims and their children must be given priority in support services, prevention of domestic violence requires treating the offender.

Sociological Factors:

If the victim does not "cause" the violence of the offender, who or what does? Sociologist Murray Straus (1977) outlines several cultural norms that facilitate violent behavior in the family. He

states that this society views violence as a legitimate means of resolving conflict. Thus, it should not be a surprise that family conflict is sometimes resolved in this way. Not all family violence is a response to family conflict. Some of this violence is related to stresses on the job or elsewhere. Until recently society considered what went on in the home as outside the domain of public concern. Thus, there are fewer sanctions against violence taking place in the home than anyplace else. If a man is assaultive as a reaction to the stress of living, he is more likely to be violent at home than elsewhere. One myth used to justify violence is that any person will be violent given the right provocation. Social learning theorists such as Bandura (1973) indicate that actually there are a wide variety of responses to stress or frustration, with violence being only one of them. While these and other cultural norms about male dominance (Martin, 1976) influence people to be violent, they do not explain fully why some men are assaultive and others are not. Nor do these sociological factors suggest clearly what can be done for those who do batter.

At this point there are no clearcut answers to those questions. There has been little research on men who batter spouses.[1] However, we do have some clinical impressions gathered from 1) our work with batterers on a individual basis, 2) our experiences as co-directors of a pilot project for male veterans who assault adult family members and 3) our conversations with other clinicians working in the area of domestic assault. This information raises significant issues in designing and implementing programs for male batterers.

1. This article is limited to a discussion of men who batter other adults with whom they have intimate relationships. For our population the abused person has been female. The authors refer child abusers to other resources.

Characteristics of Male Batterers:

In order to develop treatment programs, attention must be given to an understanding of the men who batter. There seems to be concensus on two points. First, men who assault adult family members come from all races, socio-economic classes, and occupations. There is some controversy as to whether there is a higher percentage of batterers in one socio-economic class than another and if so, what does it mean (Straus, 1976). While this controversy is not fully resolved, it is clear that we can no longer assume that domestic violence is limited to only one group. Secondly, men who batter seem either to have been battered as children or to have witnessed physical abuse in their families. Our own limited research sample indicates that 63% had that experience.

While there appears to be some concensus on those two points, it is more difficult to generate a definitive profile of a "typical batterer." The comprehensive research on men who batter has yet to be done. Thus, our understanding rests on a list of characteristics which seem to apply in varying combinations to batterers. This is not an exhaustive list but a select one on which the aspects of the Domestic Assault Program at American Lake Veterans Hospital was based.

Many men who batter women have intense, dependent relationships with their victims. They seem to experience a great deal of fear of losing the relationship and take extreme measures in controlling it. These controlling behaviors include the violence itself, monitoring all activities of the victim, limiting who she sees, and so forth. The men appear excessively possessive and jealous about their partners. For example, one man's wife was fired from her job because he called her sixteen times a day to check on her whereabouts. Before she was fired, he insisted that she stop taking her lunchbreak out of the office because he was fearful of her meeting someone and starting an affair. Her compliance did not reassure him as he then went to her office each day to sit with her while she ate. It is

possible that the men feel so dependent on their relationships because they see themselves as having few other supportive relationships. Although they may appear to socialize easily and know many people, the men do not see these friendships as affirming of them. As one man put it, "everyone wants something from you... you can't trust anyone." The Domestic Assault Program at the hospital attempts to confront that dependency by placing the man in a four week residential program. There he is forced to function somewhat more independently of his victim, while being encouraged to build other relationships with his peers. Both the buddy system (pairs of men are expected to cooperate in certain tasks and activities) and the group nature of most activities were designed in part for those purposes.

Battering men seem to have difficulty in identifying many of the emotions except for anger. Their experiences of fear, anxiety, frustration, hurt, irritation, guilt, disappointment, etc., get lumped together and are expressed as anger. Usually the target of this anger becomes someone or something in the batterer's immediate environment (such as a spouse) and yet that person may have nothing to do with the distress. One man in the treatment program who was experiencing a great deal of anxiety about another resident's abrupt departure from the hospital became enraged when another veteran attempted to beg a cigarette. Most states of arousal get labeled as anger. During treatment the residents are encouraged to become more attuned to small cues of arousal and to appropriately label that emotion.

Even as the men begin to identify and label more appropriately their emotions, they seem to have difficulty in verbally expressing what they think, feel, or want. They may have highly developed verbal skills for their professional lives as lawyers, businessmen, contractors, etc., but do not have the verbal skills to express their personal needs. Instead they expect their intimates to know what they want without their asking for it and to automatically fulfill those needs. The Domestic Assault Program attempts to deal with these deficits through assertiveness training. A part of that approach

focuses on confronting the irrational beliefs which prevent them from being assertive. One example of their irrational beliefs is "if she really loved me, she would know what I want without my asking."

These men may be impulsive, acting without thought of the consequences. One man cited a time where he had quit his job suddenly because his boss had asked him to stay overtime. He said he was very shocked when he realized that quitting meant he would have to look for a new job. He had acted impulsively without considering how his quitting would effect him. This impulsivity can greatly effect their motivation and follow-through in treatment programs.

The men are not always violent. They also can be charming and quite loveable both with their victims as well as with others outside the family. Some of the men in the veteran's project experience periodic depressions and are sometimes suicidal. For some of the men, but not all, those suicidal feelings are connected to their recognition and disapproval of their own violent behavior. For some it occurs when the victim makes a move independent of his control, such as seeking therapy or separation.

One characteristic that seems common in most men who batter is their minimizing and denying. They tend to minimize the seriousness of their violent behavior to themselves as well as to others. Although at one time they may answer in detail specific questions about their severe beatings, they may then turn around and say "it wasn't that bad." Even in a treatment program they will alternate between full recognition of their violence to a denial that they have any problem with it. Thus, any treatment program for these men requires that staff have access to corroborative data. Phone calls and weekly separate group meetings for family members serves this function in our treatment program.

The men who batter may or may not have a problem with drug and/or alcohol abuse. Some battering men do not drink or use drugs at all. One reported that he did not like the feeling of being out of control when drinking. Some have a drinking problem but batter

whether they are drinking or not. Others batter only when drinking. In referring men to treatment programs, the issue of alcohol or drug abuse must be carefully assessed. Stopping the drinking will not necessarily stop the battering. For men who have both problems treatment should focus on both as separate but related issues. One does not necessarily cause the other. If the two cannot be dealt with simultaneously our preference has been to recommend the substance abuse treatment first. Often the men resisted looking at their battering as a problem until they had dealt with the drug or alcohol abuse.

Violence Repeated:

The men we have interviewed or seen in treatment have been violent in more than one relationship. For example, our small research sample of nine men had a total of twenty-one long term relationships, only three of which were not violent. It is our assumption that battering men will continue to be violent even if they change partners, unless a major change occurs within the individual men. It is not a matter of his finding the right partner who will solve his problem of assaulting others. Our experience has led us to believe that the violence is not a function of the intimate relationship but a function of how he expresses and resolves stress. In treatment there is an emphasis on stress reduction skills such as relaxation training and daily physical activities, accompanied by assertive skills training to increase non-aggressive communication and problem solving.

Implications for Therapeutic Intervention:

An understanding of these characteristics of battering men clarifies why traditional individual psychotherapy and traditional marital therapy do not seem to be effective interventions in domestic violence. In traditional individual therapy a great deal of stress is placed on the one to one therapeutic relationship between therapist and client. In order to assess change, the therapist needs to

have an accurate picture of the batterer's emotional state and his behaviors. Typically the therapist does not seek external input from family members or client's peers. Without this corroborating data the therapist may become lost in the batterer's maze of verbal reports "that everything is fine now" because of minimization.

In traditional marital therapy the one to one therapeutic relationship is between the therapist and the couple as a unit. Usually the therapist does not see one member of the couple separate from the other. Thus, in such therapy one often finds that both members of the couple are minimizing or denying a great deal. The victim sees her survival as dependent on her supporting most everything the batterer says. Also, marital therapy as initial intervention may give a false impression that the violence is caused by the woman as well as by the man. While the woman may be contributing to the dysfunctions in the relationships, she is not responsible for his assaults. If both members of the couple want to improve the relationship then follow-up therapy is provided after he gains control of his violent behavior.

The design of treatment programs for batterers should not only reflect the characteristics of the batterers but also the specific goal of treatment. At the Domestic Assault Program of American Lake Veterans Hospital, the primary goal is to stop the battering, not to improve the relationship. The batterer may or may not be in a marriage or intimate relationship upon admission. Our theoretical orientation is that violence is learned behavior. The focus is on the batterer's skills and deficits. This attention to behavioral deficits rather than to the psychodynamics of the batterer or the battering relationship provides clear guidelines for treatment and clear measures of change. The therapist routinely assesses how well the man is doing by noting changes in assertiveness skills, in use of timeouts and other arousal reduction techniques, in aborting jealous reactions, etc. Changes in his behavior are more significant than his self reports given the batterer's tendency to minimize.

Court Directed Treatment and Follow-up:

As previously noted, the men can be impulsive and this affects both their motivation to be in treatment and to follow through. The Domestic Assault Program at ALVAH is strictly voluntary. During stressful points of the program the veteran's first reaction was to leave the hospital and some did. Those who remained throughout the four week phase reported that they felt they had to stay until they officially finished the program or the spouse would divorce them. Thus, the main motivation appeared to be one externally provided by the victim or a family member. Initially the men may need an externally directed motivation for remaining in treatment. However, expecting the victim, who also is in crisis, to provide consistent expectations which will motivate the offender is unrealistic. Court directed treatment would be one way to provide at least temporary external reasons for batterers to seek intervention. This court directed treatment should include an outpatient follow-up phase of at least a year. For men who remain in relationships with their victims, the follow-up phase is necessary to maintain anger control skills as they renegotiate a relationship without battering. This follow-up can include marital therapy to improve communication between the two. For men who no longer are in a relationship with the abused person, the follow-up phase should be long enough to include a period of time where he is involved in another significant, intimate relationship.

Agency Issues:

The reality of working with this particular population raises issues for the agency where such treatment programs are offered. Since domestic violence is just being recognized as a public concern, myths about the nature of the problem still abound. This lack of understanding about the violence isolates the offender from treatment. To break through this isolation, the agency first needs to educate its own staff. Sometimes a batterer or his victim are already utilizing general medical and/or mental health facilities but

do not reveal the violence as part of their problems. In order to identify and to serve the clients more effectively, agencies should include specific questions about family violence as part of the intake interview. When that problem is uncovered, the batterer and his family should be referred to staff members who have developed treatment strategies specifically for this issue.

Secondly, in order to reach the batterers who have not sought any assistance before, the agency must provide education for the general public as well as for the potential referral sources. This education needs to cover not only information about domestic violence in general but also information about the agency's programs for batterers. This outreach requires an agency commitment of staff time for that purpose and a willingness to be visible in its use of the media. Agencies seeing victims or batterers report an increase in the number of clients seeking treatment following any media coverage on the problem or treatment programs. This indicates the effectiveness of media coverage. The messages to the batterer must be: 1) battering is destructive, will no longer be ignored and must stop; 2) battering is a learned rather than inherent response to stress; and 3) rather than feeling shame for what he has done, he must accept the responsibility for learning new and less destructive behaviors.

Impact on Staff:

Working therapeutically with batterers has an impact on staff. As mentioned before, batterers frequently demonstrate such characteristics as rapidly changing levels of treatment motivation, instant escalation of anger (sometimes directed toward therapist), their tendency to minimize any problems that may exist, or the generation of insight one day which is denied the next. These factors individually or in combination increase the probability of non-helpful therapist responses. A partial list of these responses are: anger toward client for not wanting to change; a total distrust of anything the client might say; the conviction that

treatment can never succeed because of the nature of the problem or conversely the conviction that we, as therapists, are incompetent.

In addition, the potential for suicide or serious assault must be considered real and requires that the therapist carefully monitor this factor. However, in spite of the amount of caution that is exercised, it seems inevitable that any ongoing treatment program for batterers will experience a death by homicide or suicide. One implication of this reality is the likelihood of lawsuits and/or court subpoenas of staff and records. A more obvious implication is the emotional stress for the therapist in coping with the death of a client or his spouse. These and other factors often combine to result in staff "burnout": It is our conviction that the reduction of non-helpful responses to clients and the prevention of staff "burnout" is best accomplished by adjusting our level of expectations to approximate the reality.

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Description: DOMESTIC ASSAULT PROGRAM
Prepared by LANCE HARRIS and ANNE GANLEY
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DOMESTIC ASSAULT PROGRAM: PILOT PROJECT (Feb-August, 1978)
Four Week In-Patient Program
for Male Batterers

I. Assumptions underlying program construction:

A. Domestic assault is a learned behavior;

B. The assaultive behavior is not a function of the quality of the relationship.

C. The primary goal of the program is the cessation of violence. The program is not designed to repair or otherwise salvage the relationship.

D. Relationship therapy is seen as viable only after the man has learned to avoid violent behavior.

E. A period of time-out from the relationship is helpful in the initial learning of new behaviors and attitudes. It will also help to protect against further violence by limiting the opportunities for contact.

II. Program Outline.

A. Intake Data Collection. Effected in the first week of the program.

1. Content: Beck Depression Inventory; Shipley-Hartford Scale; Rotter Internal-External Locus of Control; MMPI; Graham-Kendall Memory for Designs; Self-administered and structured face-to-face questionnaires designed by the program authors.

2. Primary Goals:

(a) To provide an initial data base for the description of batterers and battering behaviors.

(b) To effect a structure within which the resident must begin to face the nature and extent of his dysfunctional violent behavior.

B. Orientation to the Program and the Problem. Effected during first week of the program.

1. Content: An introduction to the program segment, rules, and resident responsibilities. Coverage of the nature and prevalence of battering in America, the 3-phase theoretical cycle of abuse, the socio-cultural and intra-personal bases for abuse, and an explanation of the model of learned violence in reaction to stress.

2. Primary Goals:

(a) To minimize confusion and maximize individual responsibility for program rules and regulations.

(b) To provide for an initial common perspective of the problem of domestic violence.

(c) To clarify the resident's responsibility for making concrete and specific changes in behavior.

C. Assertive Skills Training. Accomplished throughout the 4-week program for a total of 12 classroom hours.

1. Content: Didactic and experiential training accompanied by regular homework exercises including reading "The New Assertive Woman".

2. Primary Goals:

(a) To teach the residents a skill that will help preclude a chronic high level of tension resultant from the inability to clearly communicate needs and feelings.

(b) To increase the resident's sense of responsibility for the consistent use of assertive techniques.

D. Male Role Group. A total of 6 hours.

1. Content: Group discussion of male/female role characteristics and the ways in which these characteristics apply to, or are avoided by, the residents.

2. Primary Goals:

(a) To increase the resident's awareness of the ways in which he may limit himself by automatically subscribing to narrowly-defined cultural stereotypes.

(b) To facilitate an increase in role flexibility.

E. Coping Skills Group. A total of 9 hours

1. Content: A group discussion of the sources of chronic tension for each resident. Various means of resolving the problem areas are explored. RET principles are explained and applied.

2. Primary Goals:

(a) To facilitate an initial reduction in stress.

(b) To increase the resident's sense of responsibility for constructively coping with sources of tension.

(c) To teach the residents some approaches for problem resolution.

F. Physical Activities: A total of 20 hours of physical exercise and a minimum of 7 hours of relaxation training.

1. Content: Exercise consists of various muscle and circulatory activities with the specific content negotiated between the resident and the staff member in charge of the exercise segment. Deep muscle relaxation training is done with the use of pre-recorded audio tapes.

2. Primary Goals:

(a) To provide both passive (relaxation) and active (physical exertion) methods of tension reduction.

(b) To facilitate the resident's body awareness.

(c) To teach the residents that they have ultimate control over their responses to stress even if that response is physiological (e.g., reduction in blood pressure or frequency of headaches).

(d) To provide for daily structured activity.

G. Vocational/Avocational Training.

1. Content:

(a) Vocational input, where indicated, is provided by Counseling Psychology on a referral basis.

(b) Avocational experiences (Occupational Therapy, Educational Therapy, Library facilities, etc.) are mandated by program rules. The specific nature of a resident's involvement is negotiable after the first week.

2. Primary Goals:

(a) To provide the resident with the opportunity to obtain career guidance and training/retraining.

(b) To provide for various avocational experiences that can initiate the resident's interest in a constructive use of spare-time.

H. "Buddy" System.

1. Content: A system of rules specifying certain mandatory contacts between assigned resident pairs (e.g., in order for a resident to request individual therapy he must first discuss his concerns with his "buddy"). This system is in effect for the program duration.

2. Primary Goals:

(a) To preclude the resident's tendency to isolate himself from others.

(b) To foster a sense of empathy and reciprocal peer aid.

(c) To provide for an accountability mechanism.

I. Follow-Up. The authors consider the following to be important aspects of post-graduation treatment.

A. Relationship therapy.

1. Only if requested by both partners.

2. Only if the violent behavior has been terminated.

3. Dissolution of the relationship must be considered as a viable option by both the clients and the therapists.

B. An on-going, regularly scheduled support group consisting of program graduates.