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Common Practitioners' Concerns about Abusive Men

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During the past several years we have had the opportunity to interact with many advocates, batterer intervention workers, clinicians, judges, police, and probation officers working to end domestic violence. Their questions and concerns expressed in training sessions, extended discussions, and informal hallway conversations have helped shape how we understand and approach the issue of domestic violence. Some of their most frequently asked questions are the subject of this chapter. For clarity of presentation we organized the questions according to their relevance to understanding, assessing, and intervening with abusive men in heterosexual relationships.[i]

UNDERSTANDING DOMESTIC VIOLENCE

When should a person be considered an "abuser" or a "batterer"? Can you "diagnose" battering?

Practitioners in the legal, social services, and mental health systems can be easily confused with the broad range of definitions of battering which are part of the public conversation about domestic violence. A physically abusive man or "abuser" is someone who has a consistent pattern of coercive control of an intimate partner. Coercive control includes different forms of psychological abuse, intimidation, inflated and intrusive self-entitlement, and some form of physical abuse. This is a behavioral profile.

Intimidating behaviors are actions that instill fear. Such behaviors may have a wide range. They vary from more subtle acts such as looks, changes in tone of voice and "body language" or posture, constant interruptions when another attempts to speak, to more severe acts such as constant rageful behavior, swearing, uttering threats of physical harm to the partner or others, screaming, and throwing things, etc.

Psychological abuse is an attack directed against another person's self-confidence and self-esteem. It involves behaviors that range from constant criticism, ridicule, jealous accusations, and a hostile inability to tolerate disagreement, to undermining a mother's authority with children, constant accusations of infidelity, monitoring her whereabouts and asking her to closely account for her time, humiliating her in public or in front of children, etc.

Intrusive and inflated self-entitlement involves requiring or demanding services from another person. This entitlement can be based on gender. Behaviorally, it may include pressure through a range of behaviors-- ranging from abusive reactions when a partner fails to meet the abuser's expectations, repeated demands (not taking no for an answer) to giving direct orders and resorting to violence-- in order to have the other person yield in arguments, to be generally compliant, or to provide household services, child care or sexual contact. Abusive self-entitlement can be indirect, such as when a physically abusive man does not directly state his expectations, but reacts strongly when his partner does not read his mind, so to speak. Direct self-entitlement within heterosexual relationships involves more transparent behaviors such as giving orders or telling a woman she must comply in some manner because she is the "wife."

The physical abuse that occurs in battering relationships varies in type, frequency, and severity. It ranges from less severe assaults like pushing, slapping and throwing things at someone, to injuring pets, assaulting children and marital rape and homicide.

Psychological abuse isolates victims of violence and erodes their self-esteem. It tends to make them more vulnerable to coercion and weakens their capacity to resist the abuser's controlling conduct. Intimidation, by constantly evoking the threat of violence, pressures many women to become less assertive and to hold back in many ways with their partners as a means of self-protection. Intrusive and inflated self-entitlement manifests the abuser's unilateral expectations and his pressure to comply. Violence cements the abuser's control and magnifies the impact of psychological abuse and intimidation.

In making more discriminating determinations about whether someone is an abuser, it should be noted that a very low-level, one-time act of physical aggression alone does not constitute battering unless it involves coercive control, it serves to enhance the abuser's control of his partner, leads the woman to modify her behavior or daily life and instills fear and intimidation (Ganley, l989; Hamberger & Barnett, l995; Hart, l986). Thus, an act of moderate violence such as, pushing or shoving without bruising or injury, that is accompanied by ongoing psychological abuse and coercion should be considered battering. On the other hand, the same act, when not accompanied by or reinforced by an ongoing pattern of psychologically abusive or coercive behavior, does not constitute battering. Additionally, self-defensive violence that occurs in response to a physical assault, to impending assault or to a credible threat of assault by a person who does not have a pattern of coercively controlling behaviors should not be considered battering.

Determining whether someone is a "batterer" is not a clinical decision. It is not a diagnosis of a psychological disorder, but a determination based on reviewing information provided by collateral sources (such as social service

reports and criminal, mental health and medical records), by the alleged abusers and victims and by observing and documenting abusive or coercive conduct that appears in meetings with practitioners, clinicians, and other relevant personnel.

It is important to stress that "physically abusive man," "abuser" and "batterer" are neither psychological diagnoses nor adjudicated designations dispensed by the criminal justice system. As with child abuse, the criminal justice system is incident-driven and it only records incidents about which there is sufficient evidence to successfully prosecute in an adversarial legal environment. Many men who are physically abusive are never arrested or brought to trial despite a long history of violence toward a partner. In a 10-year follow-up study of physically abusive men and their spouses, Bodnarchuk et al. (1995) found that on the average, thirty assaults occur for each arrest, so an absence of convictions for assault or for violations of protective orders does not signify that a person is not an abuser. In effect, the criminal record may omit an abuser's history of violence or it may reflect only a small portion. Most importantly, the lack of a record does not mean a client is not an abuser.

Is domestic violence a problem primarily among the poor?

Many domestic violence practitioners, particularly those in the criminal justice system, child protection agencies, and departments of social services, may have come to define domestic violence as a problem of the poor. It is, however, a mistake to equate domestic violence with poverty. Most low income and poor families are not characterized by domestic violence. Battering occurs in all socioeconomic and educational levels. Having said this, however, it is important to recognize that higher levels of spousal violence are consistently associated with lower levels of socioeconomic resources (Aldarondo, 1998; Holtzworth-Munroe, Smutzler, & Bates, 1997). As poverty becomes more acute the level of violence increases in a fairly consistent way across ethnic groups. Research has not clarified the reasons for this effect. It seems reasonable to assume that lack of economic resources and reduced freedom to lead the kind of life we have reason to value, would act as added stress, thus increasing the levels of violence. It is also reasonable to assume that financially strapped women seeking protection and respite from violent partners may resort to the criminal justice system and other social agencies more than their counterparts with sufficient economic resources to take alternative steps to assure their safety.

The correlation between poverty and reported rates of domestic violence highlights the importance of viewing poverty as an obstacle that affects both an abuse victim's capacity for self-protection and a man's resolve to end the use of violence. Therefore it is crucial to address poverty and resource-related issues such as shelter, financial assistance, transitional housing, vocational counseling, and job training in all domestic violence cases.

Are men of color more violent against their female partners than white

European American men?

Battering occurs in all ethnic and racial groups. However, it is commonly believed that men from some groups are more violent—that in some ethnic and racial groups physical abuse of women by men is more prevalent and more acceptable than among white European Americans. This belief reflects, in part, the fact that higher rates of domestic violence are often reported for African American and Latino populations and other ethnic and racial minority groups as compared to European Americans. In addition, African Americans, Latinos and other ethnic and racial minorities represent a disproportionately high number of the domestic violence cases that come to the attention of social services and the criminal justice system. However, racial and ethic differences in rates of domestic violence essentially disappear when demographic characteristics of men of color such as youthfulness, unemployment, and poverty are taken into account (Mahoney, Williams, & West, 2001).

In our experience the commonly held assumption that men from certain ethnic and racial minority populations have higher levels of spousal abuse also stems from culturally-based misinterpretations of men's patterns of self-entitlement. Men from different cultures have different types of role expectations or systems of self-entitlement with respect to women. In some cultures, men's self–entitlement is more direct. They often say they expect their partners to obey and that they have a right to use violence against her if she "rebels." Instead of denying their behavior, they say that their partner was disrespectful, that she argued or yelled or that she refused to do what he told her to do. Men who have a direct sense of inflated self-entitlement *sound* more convinced of their right to be violent and are usually viewed as more violent. In other cultures, the self-entitlement is more indirect: men may not directly state what they want their partners to do, but they may react angrily or abusively when their expectations are not met. Instead of claiming they have a right to use force with their partners, they usually deny and minimize their abusive behavior. They also say that their partner provoked them or made them lose control and launch into a story of how their partners disappoint them, are irresponsible, and worthless. Men who have an indirect sense of self-entitlement *sound* less violent and more likely to change, though their abusive and violent behavior is just as harmful.

In European American culture it is more common for men to have an indirect sense of self-entitlement, while a direct sense of self-entitlement is more common among African Americans, Latinos, and other men of color. This factor tends to drive the assumption that men of color are more violent than European American men, and this assumption creates problems in practice. It affects service planning, perceptions of risk and decision-making about how to engage with men, about whether to interview them, and so on. The tendency may be either to "throw the book" at some men based on the nature of their sense of self-entitlement (be more strict about service plan requirements) or to let some of these men "off the hook" (assume that they really believe in violence, so nothing

can be done).

The assumption that men from certain cultural and racial minority populations have higher levels of spousal abuse and are more dangerous also arises because many men of color attempt to use their native culture as an excuse for assaultive behavior against partners. "I have a right to tell her what to do. It's the way we do things." "Where I come from everybody does it." "It's just about being a man. This is normal." "Back home, all men beat their wives." Though they are misrepresenting their culture, their hope is that others will believe them and will not hold them accountable for their behavior. Field experience shows when domestic violence practitioners accept the idea that violent behavior is normal in certain cultures, the man's potential for change is overlooked and partners unfairly become the focus of all attention. Consequently, men's service plans may not reflect sufficient emphasis on obtaining treatment and the partners' service plans may unduly stress restraining orders, reliance on the criminal justice system, and shelter. In practice, it is important both to consistently attempt to hold all abusers accountable for stopping physical and other forms of abusive behavior and to avoid displacing responsibility for the man's behavior onto his partner.

Finally, when men of color are considered more violent, there is often little effort made to identify and understand elements of their culture (e.g. values and traditions) that support nonviolent, responsible and nurturing relationships. For example, self-determination, equality, and fairness are central ideals in European American culture. Many European American men respond positively to suggestions for changing oppressive and abusive conduct that are based on these values. However, different cultural values may be more meaningful to men with other cultural backgrounds. For example, fighting or resisting oppression and acknowledging the impact of oppression and self-empowerment are central for many African American men. Accordingly, they are responsive to suggestions for change that highlight their partners' experiences of oppression and allow them to address the impact of their own oppressive behavior on their partners. How can they empower themselves or want recognition of the obstacles they face without doing the same for their partners? In Latino cultures, respect and the importance of the family are often central values. Therefore many Latinos respond to suggestions for change that focus on respect as something one may earn for responsible fatherhood, for meeting family obligations, and for treating their spouses (and their children's mother) with respect. For this reason, we think it is essential for domestic violence practitioners to identify the values and practices of other cultures that support nonviolence and healthy relationships and learn to reflect these values to the men in interviews and in connection with their service plans.

There is also the reality that some ethnic groups prefer not to use formal sources of help to take care of their own. Instead, they resort to informal helping sources such as elders, friends and extended family networks for support,

protection and guidance. Although the existence of an informal helping network should not be assumed, practitioners must recognize the potential value of such systems and consider whether they can be activated in supporting and protecting battered women and restraining men's abusive behavior.

Isn't it true that most men who batter their female partners were raised in violent homes?

Although many men learn to be controlling and abusive in their families of origin, most men raised in violent homes do not go on to abuse their intimate partners. About a third of men in batterer intervention programs report witnessing and experiencing violence in their families of origin (Gondolf, 1999). In terms of violence risk, however, studies have consistently found that men who have experienced abuse in their family of origin are more likely to use violence against their female partners as adults than those who did not (e.g., Dutton & Hart, 1992; Kalmus, 1984). The relationship between witnessing violence between parents and resorting to violence against an intimate partner later in life appears to be even stronger (Aldarondo & Sugarman, 1996; Hotaling & Sugarman, 1990).

Do men who batter have poor social and problem solving skills?

In general, physically abusive men do not seem to be less assertive than nonviolent men are. However, men who batter appear to have more problems being assertive with their female partners and to have particular deficits in dealing with situations involving rejection or abandonment than nonviolent men (Holtzworth-Munroe, 2000).

Are men who batter mentally disordered?

Men who batter are generally found to score higher than nonviolent men on measures of psychopathology such as depression, aggressiveness, and psychopathy. They have also been found to be more likely than nonviolent men to show evidence of personality disorders, particularly antisocial and borderline disorders (e.g., Hamberger & Hastings, 1991; Gondolf, 1999; Riggs, Caulfield, & Street, 2000).

Efforts to identify key psychological characteristics of men who batter have led some researchers to propose various profiles or typologies of these men. To date, no consensus on a psychological profile has emerged from the research community. One of the typologies that has gained most recognition in recent years postulates that there are three main types of men who batter: family-only, dysphoric/borderline, and generally violent/antisocial (Holtzworth-Munroe & Stuart, 1994, Holtzworth-Munroe, 2000)

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According to this classification, as many as 50% of men who batter their female partners may be classified as family-only. These men engage in the least

severe violence and are the least likely to engage in psychological and sexual abuse. As the name suggests, men in this group generally direct the violence to family members and are the least likely to perpetrate acts of violence outside the home and to have legal problems for this reason. The family only batterer shows little evidence of psychopathology or personality disorder and is thought to have the best prospects for ending the use of violence in their intimate relationships.

Dysphoric/borderline men are estimated to constitute approximately 25% of batterer samples. These men engage in moderate to severe wife abuse, including psychological and sexual abuse. Like family-only men, dysphoric/borderline men direct their violence primarily toward their family members. However, unlike the family-only men, they may engage in violence outside the home and may engage in other criminal behavior. In terms of psychological functioning, these men are considered to be the most dysphoric, distressed, and emotionally volatile among the population of men who batter. Alcohol and drug abuse may be common in this group of men. These men are similar to what some researchers call the abusive personality characterized by a cycle of fear and rage directed towards the women to whom they are emotionally connected.

According to this typology, the remaining 25% of men who batter are classified as generally violent/antisocial. However, the number of generally violent/antisocial men may be considerably higher in treatment programs with court-mandated men. These men engage in moderate to severe violence, including psychological and sexual abuse. They frequently engage in violence outside their intimate relationship and have extensive criminal records. In addition, they are likely to show symptoms of substance abuse, antisocial personality disorder, and psychopathy.

Does alcohol and drug abuse lead to domestic violence?

There is some truth to the widespread belief among practitioners that alcohol and drug abuse is an important determinant of domestic violence. Men with alcohol problems are about three times more likely to be physically violent in their intimate relationship than men without drinking problems (Leonard, et al., 1985). More than half of the men in batterer intervention programs show alcoholic tendencies (Gondolf, 1999). However, not all forms of excessive drinking are associated with violence. Frequency and drinking amount does not appear to significantly increase the risk of assault. The highest rates of abuse occur among binge drinkers (Kaufman-Kantor & Jasinski, 1998). Abuse of drugs other than alcohol has also been correlated with domestic violence but research on this topic is less conclusive.

Is domestic violence also a problem in gay and bisexual relationships?

The prevalence of intimate violence in communities of gay and bisexual men is believed to be as high or higher than in heterosexual populations. More than a decade ago, Kelly and Washafsky (1987) found that 62% of gay men reported using some form of physical aggression over the course of their intimate relationships. That same year Bologna, Waterman, and Dawson reported that 18% and 14% of gay men acknowledged being victims or perpetrators of violence in their current or most recent relationship, respectively. More recently, Island and Letellier (1990, 1991) suggested that 15-20% of gay men experience violence in their intimate relationships. Unfortunately, the domestic violence field and the gay community have been very slow to recognize and respond to the needs of gay and bisexual victims and perpetrators of violence (Letellier, 1994).

Abusive gay relationships show similar patterns and forms of abuse to those found in heterosexual relationships (Merrill & Wolfe, 2000). However, abused gay and bisexual men are thought to engage in higher levels of self-defensive and retaliatory violence than other abuse victims (Letellier, 1994). In addition, a special report by the National Coalition on Anti-violence Programs (2000, p. 5) notes that domestic violence in gay relationships may include the following specific forms of abuse: "outing" or threatening to out a partner to friends, family, employers, police or others; reinforcing fears that no-one will help a partner because he is gay; justifying abuse with the notion that the partner is not "really" gay bisexual or transgender; telling the abuse victim that violent behavior is a normal part of same-sex relationships; and portraying the violence as mutual and consensual.

ASSESSMENT ISSUES

How can I tell if he will try to beat her again?

Practitioners working with abusive men are increasingly being asked to assess the risk for violence recidivism. Although it is difficult to predict if a specific man will re-abuse his partner, researchers have found recidivism to be associated with the chronicity of violence in the relationship, the men's youthfulness, history of substance abuse, history of violence in the family of origin, presence of personality disorder, history of violence outside the home, continuous drunkenness, and noncompliance with court orders and batterer intervention programs (e.g., Aldarondo, 2002; Dutton, et al., 1997; Gondolf & White, 2001). Clinical judgement in individual cases can be aided by abuse victims' predictions (Weisz, Tolman, & Saunders, 2000) and the use of instruments designed to identify the risk of re-assault in domestic violence cases, such as the Spousal Assault Risk Assessment Guide (Kropp & Hart, 2000) and the Kingston Screening Instrument for Domestic Violence (Gelles, 1998).
What is the best way to assess dangerousness in men who batter?

Nothing worries practitioners more than the possibility that a man under their supervision and care may go on to kill his partner. There is good reason for

this concern. Male partners commit approximately 30% of all female homicides (Bureau of Justice, 1998). And of all intimate partner femicides, about two thirds are characterized by a history of domestic violence (Moracco, Runyan, & Butts, 1998; Campbell, 1992).

Studies of dangerousness in men who batter highlight the need to assess the following risk factors for intimate partner femicide: (a) prior history of domestic violence; (b) access to handguns; (c) estrangement from the abuse victim; (d) history of depression; (e) stalking behavior; (f) abusive behavior during her pregnancy (Campbell, Sharps, & Glass, 2001; McFarlane, et al., 1999). In addition, the clinical literature on men who batter suggests that the likelihood of lethality increases with (a) the presence of threats or fantasies of homicide or suicide, (b) history of dependency or jealousy, (c) rape history, access to abuse victim or her family, (d) sense of entitlement, (e) “ownership” of the abuse victim, and (f) sociopathic and narcissistic tendencies (Campbell, 1995; Hart, 1990; Mederos, 2001; Saunders, 1995).

Given the complexity and seriousness of this issue, the best way to assess the risk for intimate partner femicide is to combine clinical and actuarial methods of risk assessment. Clinical assessments of risk has been promoted and used by victim advocates and batterer intervention workers for more than a decade (e.g., Hart, 1988; Sonkin, 1987). In general, the more factors identified in clinical assessments the greater the risk of lethal violence is presumed to be. Actuarial instruments such as the Danger Assessment (Campbell, 1986, 1995; Campbell et al., 2001) and the Msaic-20 (Trone, 1999) have been developed by researchers to identify risk factors supported by empirical research and follow specific formulas for determination of risk categories.

A good risk assessment depends on accurate and reliable information. For that purpose it is widely recommended by experts in the field that the information be obtained from multiple sources including police records, abuse victims, men, and their families (see Roehl & Guertin, 1998). Within this context, it is also important to recognize that risk assessment has its own dangers. Incorrect predictions of violence (i.e., false positives) are the rule because homicides are relatively rare events. Therefore the presence of one or more of the above mentioned risk factors does not necessarily mean impending lethal violence. It means that the situation must be monitored and the possibility of lethal violence should be specifically addressed with the man, the abuse victim, and other concern parties. Clinical wisdom suggests that it is never too early to help a women take responsibility to secure safety for herself and her children (Hamberger & Holtzworth-Munroe, 1994).

When should psychological evaluations of abusive men be used?

There is some confusion within legal and social service systems about the proper role of psychological evaluations in domestic violence cases. At times,

such evaluations are ordered in the misguided belief that battering can be "diagnosed" in much the same way that medical conditions such as cancer and anxiety disorders are diagnosed. This is not possible. As we discussed earlier, determining whether someone is a batterer is not a clinical decision, but a determination based on reviewing information provided by collateral sources, the alleged abuser, and victims. Based on this information, the assessor can determine whether a person's behavioral profile includes a consistent pattern of various forms of psychological abuse, intimidation, intrusive and inflated self-entitlement and some type of physical abuse.

Even if a client or defendant denies all violent behavior, has no criminal record, and presents a prior "psychological evaluation" stating that he is not physically abusive, he should be considered to be physically abusive and be required to address these behaviors in his service plan if the case record documents a clearly-defined and consistent pattern of behavior including coercive control and physical abuse. A psychological evaluation is not credible if it ignores a documented and consistent pattern of coercive control and physical abuse which is corroborated by sources such as the criminal record, police arrest reports and information provided by partners or children. At worst it may echo the abuser's victim-blaming and denial of violent behavior. At best it will be based on incomplete information.

A forensic model should be followed for psychological evaluations to be useful in the assessment of abusive men. Here the person being evaluated is required to waive confidentiality and to give the evaluator access to all sources, including his child protection file, his criminal record (including police arrest reports) and his mental health record. In addition, he must authorize the evaluator to interview his partner, probation officers, and other clinicians with which he has worked. Failure to waive permission in this manner invalidates the evaluation process, since the evaluation will be based on incomplete information.

In following a forensic model, the evaluator carefully weighs the collateral information and utilizes it to structure an interview that probes the client's account thoroughly and his reactions to the information the evaluator is presenting. This allows the evaluator a key opportunity to assess the abuser's defensive structures. In addition, clinicians evaluating physically abusive men should understand the dynamics of abusive relationships and should have practice in dangerousness assessment and the characteristics and heterogeneity of this population. The clinician has to be prepared to balance a thorough information-gathering process with an understanding that the client may be committed to utilizing the evaluation in a self-serving manner. For example, he may want to employ the evaluation to get declared non-abusive or to obtain support in avoiding attending a Batter Intervention Program (BIP). On the other hand, the clinician must be prepared to make distinctions among different levels of dangerousness and abusiveness and to recognize the genuine strengths and capacity to change that many of these men have.

In our experience psychological evaluations of abusive men are most appropriate in the following circumstances: (a) The abuser is minimally violent abuser, and social services agencies or the court want expert recommendations to clarify the best alternative for treatment. (b) There are secondary conditions, such as mental illness or substance abuse, and the involved agencies or the courts want expert recommendations to clarify whether a BIP can be supplemented by a concurrent treatment or whether it is appropriate to supplant the BIP with an alternative treatment. (c) There is a need to explore the abusive man's capacity for parenting and the involved agencies or the courts want an expert opinion to inform custody and visitation determinations.

INTERVENTIONS WITH ABUSIVE MEN

Do different types of men who batter require different interventions or treatments?

It is important to understand that the main goal of typology research is to generate a common language that can be used by practitioners and researchers to describe men who batter. This fund of knowledge makes it possible to share information about interventions that work and those that fail with different groups of men who batter. Existing typologies, however, neither explain men's abusive behavior nor prescribe group specific interventions.

The available data on the interaction of "batterer types", based on personality profiles, and treatment is scant. One study reported that men with dependent personality characteristics had better outcomes in process-psychodynamic groups and those with antisocial traits had better outcomes in cognitive-behavioral groups (Saunders, 1996). However, a recent comparison of men in four cognitive-behavioral batterer intervention programs found different types of abusive men to be equitably suitable for treatment (Gondolf, 1999).

What is the best treatment for abusive men?

To date, the most appropriate treatment modality for physically abusive men is men-only specialized groups operating within coordinated community response networks. When properly done these groups have the ability to promote the men's accountability for changing their violent behaviors, develop nonviolent resolution skills, get specialized services, such as alcohol and drug addiction treatment, and help them regain a sense of balance and direction in life while increasing safety for abuse victims.

In the next chapter we review data which suggests that approximately two thirds of men who complete group intervention programs for domestic violence remain nonviolent in their intimate relationships. However, somewhere between 10% and 20% of the men that come to the attention of batterer intervention programs are found to continue being severely violent in their intimate

relationships. Most of these men drop out of group treatment and many are known to have substance abuse problems. Thus, it is crucial that efforts be made to insure that these men attend and complete appropriate batterer intervention programs and receive substance abuse screening and treatment. This will improve the chances for many men to achieve non-violence. However, domestic violence practitioners should be mindful that approximately one in five men in BIP will continue the abuse even if they attend treatment. Therefore, monitoring abusers and supporting partners must remain a core practice even if men attend treatment. In addition, if men refuse to attend treatment or do not complete treatment, it should be understood that their likelihood of achieving nonviolence is lower and this should be taken into account in safety planning with victims of violence.

Although there is no clear consensus about what a good group program for abusive men should look like we believe that, at a minimum, such a program should: (a) concentrate on behavioral change for abusers, focusing on helping men stop violent and other abusive behaviors and teaching positive alternative skills for non-abusive and responsible relationships; (b) assess needs for concurrent treatment, such as substance abuse or other forms of treatment; (c) carry out confidential and safety-oriented contacts with victims of abuse; (d) hold abusers accountable for changing behavior by maintaining close coordination with probation, the criminal justice system, and other concerned agencies regarding the abuser's compliance with program standards, restraining orders and conditions of probation; (e) report to others in the domestic violence network and terminate participation in the program if an abusive man fails to comply with program standards or continues violent or threatening behavior; (f) provide treatment for indigent men at no cost; (g) have strong collaborative relationships with local shelters for battered women; and (h) have staff that understands and knows how to deal with sociocultural issues such as alcoholism, drug addiction, discrimination, homophobia, poverty, and racism that may affect the programs ability to engage men with diverse needs and backgrounds in treatment.

Is couples counseling an effective and safe way to work with men who batter?

Some clinicians argue that couples therapy offers a safe and structured environment in which abusive men and their partners can express feelings, discuss emotionally charged issues, and learn about violence and how to deal with it. They argue that couples counseling gives participants an opportunity to identify and attempt to alter relationship patterns that promote and sustain violence while helping men monitor their emotions and helping abuse victims identify the cues that signal potential anger and aggression from their partners. However, the prevailing opinion among couples counseling experts is that traditional couples counseling theories and interventions do not deal well with issues of oppression, coercion, and violence in intimate relationships. Abusive behaviors tend to get lost within systemic formulations and the men’s

responsibility for their actions is diffused by implying that abuse victims should work with their assailants to stop their victimization. Unfortunately, no study has explored the safety of women when couples counseling is used in domestic violence cases.

We believe that bringing the abuse into the open in traditional couples counseling can cause emotional and physical harm for abuse victims. An abuse victim who discloses prior incidents of violence with a partner who has not made a strong and healthy commitment to refrain from violence and other forms of abuse may be at an increased risk of intimidation and violence retaliation. Furthermore, coercive control can be very subtle. Couples counseling can easily become an arena where an abusive man presses demands upon his partner or uses subtle threatening signals in an environment where the abuse victim is still inhibited by realistic fears of retaliation. Under these conditions many abuse victims are reluctant to discuss their (protective) reasons for not endorsing or agreeing with recommendations made by therapists. Their “resistance to treatment” then fuels an unbalanced alliance between abusive partners and therapists.

In our experience, couples counseling is contraindicated if the abusive man expresses no remorse, denies his actions, blames the abuse victim or has little commitment to change. Similarly, if the abuse victim shows fear of further violence, assumes responsibility for it, or feels deserving of maltreatment, couples counseling should not be considered. The abuse victim’s participation in couples therapy should not be pressured in any way. It is inappropriate and potentially harmful to require couples counseling in a service plan if the abuse victim is reluctant and if conditions outlined here have not been met.

Given these considerations we suggest that couples counseling be considered only if all the following conditions are met: (a) the abused partner has chosen to enter in couples counseling after being informed of all other intervention options including support groups for abuse victims and individual psychotherapy. (b) The abusive man’s violence is limited to few (no more than one or two) incidents of minor violence, such as slaps, shoves, grabbing and restraining, without resulting bruising or injury. (c) The man’s use of psychological abuse has been infrequent, mild, and has not created a climate of constant anger or intimidation. This guards against attempting therapy in a context where the effect of powerful intimidation and psychological abuse is still present. (d) No risk factors for lethality are present even in the absence of severe physical and psychological abuse (see below). (e) The man admits and takes responsibility for his abusive behavior. (f) The abusive man has made an unshakable commitment to refrain from further violence and intimidation and understands that he will feel "provoked" or justified to abuse his partner again in couples counseling. He must demonstrate an ongoing commitment to contain his explosive feelings without blaming others or acting them out, so that they do not provide a justification that propels him into a relapse of violent behavior

during the course of treatment. (g). The abuse victim reports, in a confidential interview (when the abuser is not present), not being afraid of speaking honestly in therapy and not being afraid of retaliation by the abusive partner. (h) In addition, to further promote a climate of safety, responsibility and freedom from coercion, the following agreements should be in place as conditions for beginning and continuing couples counseling: (i) If the man is violent or intimidating while in treatment, couples counseling therapy will stop and he will enter a specialized batterer's intervention program. (ii) The primary goals of therapy are ending the man's psychological and physical abuse and facilitating the woman's repair and recovery from his violence, in order to establish a reliable and tested climate of safety in the relationship. It should be clear that no substantive issues can be addressed unless this goal is fulfilled. (iii) The woman has a confidential safety plan. (iv) The abusive man has a behavioral safety plan that is the ongoing focus of his work in the therapy.

The abusive man's refusal to agree to such conditions before engaging in couples counseling is indicative of insufficient conditions for safe therapy even in the presence of other positive indicators. In addition, the therapist must be familiar with the subtle dynamics of battering relationships and must be willing to set limits with the abusive man. It is also the therapist's responsibility to suspend couples counseling if the abusive partner renews assaultive and intimidating behavior and to notify the proper authorities about this action. The therapist must be willing to take this step even if the abuse victim wants to continue couples counseling.

In terms of the effectiveness of couples counseling for domestic violence, the available data is scant and hard to interpret. Lindquist et al (1985) found that 50% of the couples reported at least one incident of violence 6 weeks following treatment. Moreover, all couples reported acts of violence after 6 months. Harris (1986) reported an undefined success rate of 73% among 30 couples assessed somewhere between 2 months and 3 years after treatment. Taylor (1984) reported a 6-month violence cessation rate of 65% among 50 couples. However, as pointed out by Edleson and Tolman (1992), this report omits both the source of data and the techniques used to obtain this information

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Under what conditions is psychotherapy an appropriate intervention for abusive men?

Most batterrer intervention programs are psychoeducational, rather than clinical or therapeutic programs. These programs focus primarily on persuading men that violent and abusive conduct is inappropriate and harmful behavior that must stop and on helping them develop nonviolent conflict resolution skills. These programs require that men be able to discuss sensitive, anxiety provoking, and potentially embarrassing issues in a group context with limited confidentiality. Although, as previously indicated, this structure is appropriate for most men referred to BIP, there are men who are not suitable for this structure. In our

experience this group of men includes abusive men with severe substance abuse addictions and men with major mental illness or post-traumatic stress disorder with symptoms so severe that they become disruptive in the group, are highly disturbed by the group process, or cannot make sense of the group experience.

Abusive men with major mental illnesses, post-traumatic stress disorder or substance abuse problems whose symptoms are not severe or who are stabilized through psychopharmacological treatment frequently participate in a BIP as well as in individual psychotherapy. In instances where individual psychotherapy is recommended as concurrent or alternative treatment due to the abuser's mental health or substance abuse status or to the lack of a local BIP, the following minimum conditions should be met to promote both safety for abuse victims and the man's accountability for the cessation of violence: (a) The abusive man gives written permission for the clinician and other authorities (e.g. probation officers, social services) to share and obtain verbal and written information about him for the duration of treatment. This information may include, but not be limited to, the attendance record, information about compliance with safety plans (including abusive conduct reported in psychotherapy), about compliance with restraining orders and with concurrent treatment such as substance abuse or psychopharmacological interventions. (b) There is an agreement that the therapy will maintain a substantial focus on stopping violence, developing and maintaining compliance with a safe behavior plan, and learning alternatives to abusive behaviors. The abuser must prepare to respond in a different fashion when he feels provoked by his partner. It should be clear that adversity, conflict, frustration, and loss are not acceptable excuses for violent or abusive conduct; the abuser has to be prepared to follow a different course of action whenever he feels provoked. (c) The clinician must have permission to notify local authorities if the physically abusive man is not following his safe behavior plan or complying with other conditions of treatment. This means that the therapist adopts a monitoring role that is commonplace in forensic clinical interventions--the clinician is a potential "whistle blower," accepts this role and uses this stance in the therapeutic process. The clinician agrees to communicate regularly with other concerned authorities and to notify them if the psychotherapy is not having a positive effect or if there are signs of increasing dangerousness. (d) Depending upon the abuser's capacity and treatment progress, psychotherapy should also address the impact of violence on abuse victims and their children and do reparative work with them, if this can be done safely.

The above mentioned conditions are necessary but may not be sufficient to protect abuse victims and promote the men's accountability for stopping the violence. The particulars of the situation at hand should determine if other safety provisions need to be added to the treatment plan. In our view, failure to meet these minimal conditions, by either abusive men or their psychotherapists, indicates that the individual intervention lacks the proper structure to address domestic violence.

Do abusive men stop the use of violent behavior and change the way they relate to their partners?

Studies consistently find that a considerable number of abusive men cease or interrupt the use of physical violence against their female partners (e.g., Aldarondo, 1996; Gondolf, in press). Within this context, violence cessation can be viewed as a gradual process which includes building a resolve or discovering a motivation to stop the violence, developing nonviolent conflict resolution skills, and maintaining the resolve to cease the violence. This process is influenced by individual and contextual factors reinforcing normative pressure against the use of violence and neutralizing the rewarding effects of violent behavior.

Abusive men differ in their motivation to stop the use of violence. It is hardly surprising that after being arrested, many men decide that violence does not pay. Some men want to stop for fear of loosing their partners or their children. Others are more concerned about the social and financial cost of violence. There are also some men who are motivated to end the violence by the need to redefine themselves as nonviolent men. To this we can add in a group of men who stop because they want to do the right thing. What these men have in common is that they now perceive a significant personal cost to the continued use of violence in their intimate relationships.

The ability to maintain the resolve to stop the use of violence is often unrelated to the initial reason for ceasing. Sustaining this motivation requires that men develop nonviolent conflict resolution skills, take responsibility for their past abusive behavior, develop empathy for their partner's victimization, and reduce the level of dependency on their partners (Scott & Wolfe, 2000). In our experience, the men's commitment to the relationship, and his ties to family, employment, and community networks that clearly disavow the use of violence also help sustain his resolve to end the violence.

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[i] The domestic violence literature to date has focused primarily on presumably heterosexual men's violence toward their female partners. We use the term "presumably" because most researchers and service agencies do not collect sexual orientation data from abusive men and their victims. Serious inquiry into domestic violence involving gay and bisexual men has only recently begun to inform the domestic violence intervention and research. Thus, the majority of references we cite and recommendations we make focus on and are geared toward battering men in relationships with women. Throughout this chapter we attempt to use inclusive language, but revert to heterosexual language at times. We address violence within gay communities, but not as thoroughly and consistently as violence within presumably heterosexual relationships. By no means do we wish to perpetuate the myth that domestic violence is exclusively a heterosexual phenomenon.