

Guidelines for Doctors on Identifying and Helping their Patients Who Batter

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While there are a growing number of medical guides for assisting physicians to identify and help victims of domestic violence, there has been scant attention to how physicians can best respond to perpetrators. The medical model's deficient grasp of violence, combined with the minimizing and excuse-making strategies employed by batterers hinder physicians' ability to detect batterers in their practices and to prescribe the right solutions. Earlier detection is possible, however, when doctors adopt routine diagnostic procedures for all patients and ask informed follow-up questions when there are indications of domestic violence. Finally, physicians should become aware of the effective batterer treatment programs in their areas and make this information easily available to their patients who batter.

Physicians often treat patients who batter their partners, but rarely knowingly. It is rare for the battering man to disclose his violence to health care workers, and physicians overwhelmingly discover violence through the victims or third parties, even when their primary patient is the perpetrator.¹ Though there is no medical treatment for the batterer, doctors can practice preventive medicine by identifying patients who batter and making informed referrals.

The aim of this article is to increase the odds of physicians identifying domestic violence by providing information about batterers with a particular emphasis on their patterns of denial and excuse making. Guidelines for physicians

on talking to patients who batter and making the appropriate referrals are provided. The author refers to the batterer as "he" and the victim as "she" since this reflects the norm, particularly with regard to physical injuries due to domestic violence.²

One major reason that battering is often not identified in health care settings is that stereotypes about batterers persist. Many physicians and other helping professionals still tend to harbor the false belief that the man who batters is an easily discernable type — someone who comes across as aggressive, domineering, and extremely macho. Others only suspect battering among their poor and uneducated patients, or among patients who come from ethnic backgrounds that they assume to be highly violent or patriarchal. While some batterers match these personal and demographic characteristics, many do not. If physicians "turn on the radar" only when treating patients who fit their preconceived notions about men who batter, some patients will be treated differently solely because of their public demeanor, or worse, because of their class or racial background, while batterers who don't fit these stereotypes will avoid detection.

Inconveniently, most battering men are not easy to spot in a crowd. The battering man's public demeanor usually betrays no hint of violence, and he comes across as polite, reasonable, and likeable. When police respond to domestic violence calls, the battering man frequently appears more calm and rational than the victim.³ Even in court and family counseling settings, batterers often seem more cooperative and willing to compromise than their victims. Since violence is more psychologically damaging to victims, they often present more symptoms of mental illness than their perpetrators, thereby skewing our picture of the real issues.⁴ As many feminist therapists have pointed out, battered women are labelled in psychopathological terms because of sexist biases in mental health treatment.⁵ Battering men also avoid detection by

employing a variety of minimizing and excuse-making strategies.

Identifying Men Who Batter

Violence will usually not be disclosed directly by a patient, whether victim or perpetrator. Most often, it comes up tangentially in response to questions about other issues. Physicians should therefore be aware of the common "code words" that abusers use in referring to their violence, including such vague terms as "fighting," "anger," "not getting along," "temper" or "loss of temper," "self-defense," "stress," and "drinking." Violence can sometimes be inferred by the batterer's numerous derogatory references to his partner. When the batterer is a patient, the physician can pursue these indirect references to violence with more direct questions such as: What happens when you fight? Have you or your partner ever been injured? What's the furthest you've gone with your anger? The efficacy of these queries is increased if the physician asks them in a caring, rather than an accusatory tone, making it clear that he or she is concerned about the patient's own, as well as his family member's, health and well-being.

Sometimes physicians do not ask these questions because of their own discomfort rather than the discomfort they ascribe to their patients. For the most part, however, patients expect a certain degree of probing from their physicians and believe that doctors who ask personal or detailed questions are merely being thorough. Analogously, while most male patients would not ask for a rectal exam, many appreciate their doctor's insistence on doing one. Because many batterers feel guilty or otherwise troubled by their violence, they frequently feel relieved when a professional helper poses direct questions about it. Physicians should therefore guard against transferring their own personal hesitancy about discussing violence onto their patients. Ideally, physicians will ask all their patients about domestic violence as a normal part of intake. In explaining these as standard

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questions, physicians will minimize suspicions on the part of some patients that they are being singled out or that the doctor has some kind of inside information. These questions can easily be included in the medical history questionnaire that patients normally complete when they register with a health care clinic or hospital.^{6,7}

If domestic violence is disclosed by the patient, physicians should be aware that the vast majority of abusers minimize both the frequency and the severity of their abusive behavior.⁸ Minimization takes many forms. Often, offenders accuse their victims of falsely reporting violence in order to gain legal or economic advantage or to take revenge against them. While this undoubtedly happens in some cases, research shows that victims are much more likely to underreport violence than to fabricate or exaggerate it.^{9,10} In many cases, abusers minimize their violence by not defining their actions as violent. An individual's understanding of violence is determined by social, cultural, and familial norms pertaining to the use of force and persuasion. This is reflected by the statements of many abusers in the beginning stages of batterer treatment. As one man in group counseling put it "I never thought I was being violent to her because I would never hit her like a man." (He had always slapped her rather than hitting her with a closed fist.) Another misconception common to batterers is that since their violence has been only occasional, they are not "batterers." Even when such acts have occurred as frequently as five to ten times a year, many batterers view them as isolated incidents and not as a pattern of violence. Many health care and social service providers are vulnerable to believing the perpetrator's common claim that his violence was a first-time occurrence.¹¹ Batterer treatment providers often find, however, that the batterer's account of when his violence started is often inaccurate. Batterers frequently "remember" earlier incidents of abuse once they are engaged in treatment and provided with education, feedback, and opportunities to discuss their abusive behavior in an environment that promotes self-reflection.

Physicians should respond to these statements by pointing out that violence is not likely to go away on its own and that specialized help is available. Program

brochures should be readily available at the health care setting; sometimes the presence of the brochures alone will prompt the batterer to raise the issue of violence with his physician or to seek help.

Understanding the Causes, Prescribing the Right Solutions

Batterers engage in a variety of excuse-making strategies that obscure the reasons for their violence and therefore hinder our ability to respond effectively. Excuse making is understood by social psychologists as the means by which those engaged in socially undesirable behavior attempt to mitigate responsibility for their behavior in order to preserve or salvage their reputation with others.¹² If successful, excuse making enables the violent offender to avoid legal as well as social consequences for his violence by suggesting, for instance, that it was essentially beyond his control and is not likely to be repeated.

Because of their training in the medical model, physicians may be vulnerable to accepting some of the batterer's excuses. Chief among these is that the battering was caused by mental illness or "temporary insanity." In describing their violence, battering men often use expressions such as I lost control, Something in me snapped, or It was my insecurity. These rationalizations fit comfortably within the disease model for violence, which sees it as deviant behavior arising primarily out of individual psychopathology. According to proponents of this view, the battering man becomes violent because psychological deficits lead him to react to stress or frustration in an irrational, impulsive, and spontaneous manner.¹³

This contrasts with social learning theory, which holds that violence is socially learned behavior that is likely to be repeated because it has positive outcomes for the violent individual.¹⁴ People learn violence not so much from their individual psyches as their social environments and their personal learning of what works for them. Far from being irrational, battering is purposeful and helps the batterer to gain and maintain control over his victim. With their seemingly spontaneous and unpredictable outbursts, batterers do not "lose control" so much as "take control." Those knowledgeable about the dynamics of abuse

point out that batterers learn to intimidate and manipulate their partners by alternating episodes of abusive and "making up" behavior.¹⁵ For instance, batterers often angrily accuse their partners of having affairs or spending too much time with other people, frequently followed by retractions or apologies. A common result of this sequence is that the victim curtails her interactions with friends and relatives for fear that it will again arouse his anger or suspicions. In this way, the batterer benefits from his abusive behavior no matter how much he may apologize for it afterward. The batterer's unpredictable outbursts serve to keep the victim on the defensive; putting her in the position of continually anticipating his needs and neglecting her own. Physical violence combined with psychological abuse undermines the victim's sense of self-worth and autonomy, putting the abuser in control of the relationship. While treatment based on the social learning approach emphasizes that violence is purposeful behavior, it also teaches communication and coping skills as alternatives to violent and coercive behavior.¹⁶

Besides seeing domestic violence as arising from a dysfunctional psyche or relationship, some doctors believe that battering is caused by alcohol or drug abuse, which they view as diseases in and of themselves. But while studies have shown fairly high correlations between substance abuse and domestic violence, researchers and treatment experts posit that this connection is not a causal one. Alcohol or drug use does not cause a person to batter; rather the individual drinks or uses drugs with the intention to be violent.¹⁷ Batterers often blame alcohol or drugs because there is less stigma attached to spouse abuse when it is committed "under the influence." While alcohol and drug use don't cause violence, they may make it worse. Frequent use of alcohol and drugs is associated with lethal levels of domestic violence.¹⁸ Ongoing substance abuse may also prevent the batterer from getting help for violence or making use of batterer treatment programs. When a patient abuses substances as well as his partner, he should be referred for treatment of both problems.

The significance of the disease model's interpretation of battering is in the pre-

scriptions it calls for. Physicians who view battering as a disease are more likely to refer batterers (as well as victims) to individual psychotherapy, family therapy, or alcohol/drug treatment. The vast majority of batterers do not suffer from major mental illness and should be referred primarily to specialized batterer intervention programs.¹⁹ A minority of batterers have mental health problems and would benefit from inpatient or outpatient psychotherapy and/or medication, *in addition* to specialized batterer treatment. Experts in the domestic violence field overwhelmingly advise that couples or family therapy is *not* appropriate until the batterer has stopped being violent and completed a batterer treatment program.

In making referrals, physicians should not assume that a particular psychologist, psychiatrist, or other mental health professional is trained to handle domestic violence cases any more than they should assume that a general practitioner has the training or expertise to treat a cancer patient. Though he/she may have expertise in related areas such as child abuse, family therapy, or substance abuse, a psychotherapist who is not specifically trained in batterer treatment is likely to do more harm than good. Though they do not treat the couple, most batterer treatment providers maintain contact with the victim in order to gain her perspective about the violence, assess for lethality, and make referrals for victim support and advocacy services. These programs also have more limited confidentiality than in traditional psychotherapy. For instance, clients are required to sign an informed consent agreement specifying that the program will inform victims and/or the court about the client's progress or lack of progress in the program.

Physicians should become aware of the batterer treatment programs and other social services in their areas. Many states have established standards for certifying batterer treatment programs, and doctors should know which are the certified programs and refer only to them. While much is still not known about which approaches are most effective, state standards for batterer intervention programs have been designed to maximize the safety of victims by requiring practitioners to receive training about victims, to gather information from victims about the per-

Summary of the Emerge Batterer Treatment Program

The Emerge Batterer Intervention Program consists of two phases: an 8-week introductory class designed to introduce men to basic information and a 40-week second-phase group. Each group meets weekly for two-hour sessions co-facilitated by male and female counselors. Eighty percent of Emerge clients are court referred. Upon enrollment, clients are required to sign a program contract specifying Emerge's expectations pertaining to client behavior and attitude change, attendance, payment for services, reporting of violence, and group participation. An informed consent stating that we will be in regular contact with victims in order to assess client violence and progress as well as to provide victims with information about safety planning and battered women's services is also included. The contract also specifies that Emerge counselors will be in regular contact with probation officers, child protective workers, and other service providers to coordinate treatment and exchange information about client progress.

Introductory Class (Weeks 1-8)

Basic education includes:

- definition of physical and sexual violence and coercion;
- somatic and cognitive cues to violence and how to use these to avoid violence;
- effects of abuse on victims;
- quick fixes versus long-term steps toward avoiding violence, restoring trust with partners, and improving self-care;
- psychological and economic forms of abuse and how these harm relationships;
- constructive and respectful ways of communicating with partners;
- effects of violence on children who witness it at various ages.

Second-Phase Group (Weeks 9-48)

Second-phase groups differ from introductory classes in the following ways:

- sessions are less structured and more interactive;
- clients are assigned individualized goals as well as homework assignments;
- direct feedback is provided by group leaders and other group members;
- attention is devoted to changing attitudes and expectations that contribute to violence.

petrator's violence, to assess for lethality, and to report continued acts of violence to courts. In states without certification standards, consideration should be given to established programs that have a proven track record of safe and effective treatment. Generally, safe and effective programs use a group approach, are at least 24 weeks in duration, provide education rather than psychotherapy, avoid couples counseling, and have consistent procedures for assessing dangerousness and protecting victims.²⁰

Since the vast majority of spouse abusers resist getting help of any kind, physicians should have batterer program pamphlets available for their patients. These pamphlets typically explain what battering is and describe what the intervention program offers. Physicians can supplement this information by giving their own knowledge about the benefits of batterer intervention. This information helps the

patient make a more informed choice about whether he would benefit from such services and which programs are likely to be most beneficial for him. One long-time batterer treatment provider with practice in a health care setting advises physicians to provide education to their patients who batter just as they provide patient education on a variety of other health risks. In particular, doctors should provide expert information about the damaging effects of domestic violence on the the physical and emotional well-being of the patient's partner and children, as well as on himself.²¹

Battering men resist treatment not only because of denial, but also because of their pride about not accepting help from others, a feeling that is socially programmed in many men. Doctors may help their clients to overcome this resistance by addressing these attitudes directly and by dispelling any myths they

might have about batterer treatment programs. Doctors should point out the benefits of accepting the need for treatment. By seeking help, the abuser is more likely to avoid additional violence as well as criminal charges.

Because they often blame their partners, men who batter tend to have only a superficial understanding of their problem with abuse. They tend to be “quick-fix” oriented and the solutions they attempt are cosmetic rather than long-term.²² Some merely replace physical violence with verbal or psychological forms of abuse. Batterers who are estranged from their partners will frequently drop out of treatment once their partners return to them. Doctors may play a critical role in helping their patients to insure their long-term health and well-being by getting the help they will need to avoid causing additional physical and psychological injuries to their partners, their children, and themselves. Physicians who educate themselves about domestic violence and treatment options are in a much better position to practice this kind of preventive medicine. ■

References

1. Goldberg W, Tomlanowich M. Domestic violence victims in the emergency room: New findings. *JAMA*. 1984;251:3259-3264.
2. Abbott J, Johnson R, Koziol-McLean J, Lowenstein S. Domestic violence against women: Incidence and prevalence in the emergency department population. *JAMA*. 1995;273:1763-1767.
3. Adams D. Identifying the assaultive husband in court: You be the judge. *Boston Bar Journal*. 1989;33:23-25.
4. Saunders D, Hamberger K, Holvey M. Indicators of women abuse based on a chart review at a family care center. *Arch Fam Med*. 1993; 2:543-543.
5. Pagelow M. *Woman-Battering: Victims and Their Experiences*. Beverly Hills, Calif: Sage; 1981.
6. Fullin J, Cosgrove A. Domestic violence: How physicians can respond. *NCADV Voice*. Winter 1994;8:12.
7. Colorado Domestic Violence Commission. *Domestic Violence: A Guide for Health Care Providers*. 4th ed. Denver, Colo: CDVC;1992.
8. Sonkin D, Martin D, Walker L. *The Male Batterer: A Treatment Approach*. New York, NY: Springer; 1985.
9. Edleson J, Brygger, MP. Gender differences in reporting violence. Paper presented at the Third Annual Family Violence Researchers Conference, University of New Hampshire, Durham, NH, 1987.
10. Szinovacz M. Using couple data as a methodological tool: The case of marital violence. *J Marriage Fam*. 1983;45:633-644.
11. Gondolf E. *Psychiatric Responses to Family Violence: Identifying and Confronting Neglected Danger*. Lexington, Mass: Lexington Books; 1990.
12. Scott M, Lyman S. Accounts. *American Sociological Review*. 1968;33:46-62.
13. Kutash S. Psychoanalytic theories of aggression. In: Kutash I, et al, eds. *Violence: Perspectives on Murder and Aggression*. San Francisco, Calif: Jossey-Bass; 1978:56-82.
14. Bandura A. *Social Learning Theory*. Englewood Cliffs, NJ: Prentice-Hall; 1977.
15. Jones A, Schechter S. *When Love Goes Wrong: What To Do When You Can't Do Anything Right*. New York, NY: HarperCollins; 1992.
16. Adams D. Treatment models for men who batter. In: Yllo K, Bograd M, eds. *Feminist Perspectives on Wife Abuse*. Newbury Park, Calif: Sage; 1988:176-199.
17. Kaufman-Kantor G, Straus M. The drunken bum theory of wife beating. *Soc Probl*. 1984; 24:17-33.
18. Browne A. *When Battered Women Kill*. New York, NY: Free Press; 1987.
19. Tolman R, Bennett L. A review of quantitative research on men who batter. *Journal of Interpersonal Violence*. March 1990;87-118.
20. Gondolf E. Reconceptualizing batterer program evaluation. Paper presented at the Third Annual Conference for Professionals Working with Men Who Batter, Minneapolis, Minnesota, 1993.
21. Ganley A. Health care responses to perpetrators of domestic violence. In: Lee D, Durborow N, Falber P, eds. *Improving Health Care Responses to Domestic Violence: A Resource Manual for Health Care Providers*. San Francisco, Calif: Family Violence Prevention Fund; 1995.
22. Adams D. Stages of anti-sexist awareness and change for men who batter. In: Dickstein L, Nadelson C, eds. *Family Violence: Emerging Issues of a National Crisis*. Washington DC: American Psychiatric Press; 1989:61-98.