

THE STATE OF NEW HAMPSHIRE



**GOVERNOR'S COMMISSION ON
DOMESTIC VIOLENCE**

**MENTAL HEALTH:
DOMESTIC VIOLENCE PROTOCOL**

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**Prepared by the
Governor's Commission on Domestic Violence**

GOVERNOR'S COMMISSION ON DOMESTIC VIOLENCE PROTOCOL COMMITTEE

HUMAN SERVICES SUBCOMMITTEE

Scott Hampton (Chair)
Strafford Guidance Center

Reverend Carole Carlson
The New Hampshire Conference
United Church of Christ

Reverend Philip Mahrer
The New Hampshire Conference
United Church of Christ

Madeline Ulrich
Monadnock Family Services

Toinette Shearer
RTT Associates

Julie Mahrer Lewis
RTT Associates

Linda Griebisch
A Safe Place

Lynda Ruel
Carroll County Against Domestic Violence and Rape

Dalia Vidunas
Division for Children, Youth and Families

Rogers Lang
Division for Children, Youth and Families

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INTRODUCTION AND STATEMENT OF PURPOSE

The Human Service Agencies Subcommittee of the **Governor's Commission on Domestic Violence Protocol Committee** was formed to generate protocols for the proper handling of cases involving domestic violence or spousal assault. The following guidelines discuss the role that mental health centers play in working with perpetrators and victims of domestic violence.

These guidelines are based on the experience and knowledge of the Subcommittee members, as well as on recent literature and discussions with representatives from other organizations both within and without New Hampshire. Organizations whose members have had a particularly powerful influence on the authors of these guidelines include:

- The Pennsylvania Coalition Against Domestic Violence;
- The Domestic Abuse Intervention Project in Duluth, MN;
- The NYS Office for the Prevention of Domestic Violence; and
- The work of both Michael Durrant and Alan Jenkins from Australia.

There is currently no consensus among those working with perpetrators and victims of domestic violence on THE most effective ways of promoting the change we seek. Therefore, the primary goal of these guidelines is to articulate elements of the most sensitive and crucial issues. Our hope is that practitioners will be better prepared to make decisions in the assessment, intervention and referral aspects of domestic violence work in ways that will not further endanger victims or child witnesses. Our long-term goal is to promote effective and consistent approaches to this work. We also hope to encourage mental health professionals to hold each other accountable for their work, in much the same way as we try to hold perpetrators of abuse accountable for their behavior.

THE MENTAL HEALTH PROFESSIONAL GUIDELINES

Mental health professionals represent a variety of educational and training experiences on both a master's and doctoral level. Few programs in any of these disciplines require much training in the area of domestic violence. Therefore, an advanced degree in social, behavioral, medical or pastoral studies offers little assurance of adequate training for domestic violence work. Some states (e.g., MA, CO) certify intervention programs or individual providers that meet minimum standards of operation. Recommendations about certification (or registration) of programs in the State of New Hampshire are currently being considered by the "Batterers Intervention Subcommittee" of the Governor's Commission on Domestic Violence. Until such recommendations are published, it will be left up to referral agents to determine whether an individual clinician, doctor or program is qualified to handle such a case.

We believe that mental health practitioners who deliver domestic violence services should possess at least a master's degree in one of the above-mentioned disciplines. In addition, specialized training in family violence through course work, battered women shelter training, and/or institutes such as ones offered by the Domestic Abuse Intervention Project in Duluth or EMERGE in Boston, is highly recommended. Also, education and training in family therapy and substance abuse treatment can be helpful. (This is not to suggest that any particular family therapy or substance abuse model is applicable to domestic violence work.) Many experts in the field also suggest that the group work with those who batter is more like teaching than counseling. Therefore, being an effective teacher may be an important attribute for the domestic violence "counselor."

Providers of domestic violence services should receive peer supervision weekly or biweekly at a minimum. This supervision needs to be obtained from someone trained in and experienced in the delivery of domestic violence services.

Continuing education is essential in domestic violence work since approaches and standards of intervention with batterers are rapidly changing. Certification or registration standards, when completed by the Batterer's Intervention Subcommittee of the Governor's Commission on Domestic Violence will specify minimum requirements for ongoing training. These standards will include reference to:

- Qualifications of trainers;
- Scope or content of training; and
- Minimum yearly training requirements.

REFERRAL TO MENTAL HEALTH

REFERRAL PROCESS

There are several ways in which mental health professionals come into contact with domestic violence cases including:

- Mandated treatment for batterers from the courts as a pre-trial diversion or as a sentencing alternative for assault or stalking;
- Self referral for domestic violence counseling by the batterer (e.g., in response to partner's threat to leave) or by the victim (e.g., for supportive services);
- In the context of therapy for other concerns (e.g., alcohol or other drug abuse, marital conflict, anger problems, depression, academic or conduct problems of children who witness domestic violence, etc.); and
- Referrals from other agencies for mental health concerns, drug/alcohol abuse, or domestic violence. Such referral sources include: DCYF, Employee Assistance Programs, hospitals or physicians, schools, clergy, battered women's shelters, attorneys, etc.

BATTERER REFERRALS

Most people who batter are referred by the judicial system. Those who come "voluntarily" usually are responding to other external motivators, such as the threat of a divorce. Thus, they may be better identified as "non-court mandated." Counselors who work with these referrals need to be aware of the possibility that coming to treatment is one of many attempts to control or manipulate the "victim." Therefore, the counselor needs to educate the victim about this limitation/risk of treatment for those who batter. See the section "Partner Contacts" on page 6 for suggestions on how to educate the partner.

Since the major referral source is the criminal justice system, it is vital for treatment programs (often referred to as "intervention" programs to avoid the implication that battering is *caused* by mental illness necessitating "mental health treatment") to coordinate their efforts with criminal justice agencies such as the police, probation and parole, prosecution, public defenders' office, county jail, state prison, and the court. This is best facilitated by participation in local domestic violence coordinating councils where counselors coordinate with, and are accountable to, several community agencies such as battered women's services, criminal justice agencies, etc. In areas where coordinating councils are not active, direct contact with the service providers should be made.

Suggested elements of an intervention program-justice system collaboration include:

- Information exchange such as:
 - Obtaining pertinent court orders;
 - Reporting violations of court orders;

- Documenting any further incidents of violence;
- Submitting periodic participant evaluations;
- Reporting threats of violence (i.e., Duty to warn); and
- Providing training and technical assistance to the justice system on domestic violence.
- Obtaining immediate appointments with the intervention program at the time of sentencing;
- Developing a formal contract between the justice system and the intervention program to clarify issues such as:
 - The information exchange outlined above;
 - Fee requirements for the program participants and financial support by the court (if any) for batterer intervention services;
 - Confidentiality of communications between the intervention program and victims of domestic violence.

A more thorough discussion of some of these suggested elements can be found in Pennsylvania's Program Standards for Batterer Intervention Services. A copy of this can be obtained by contacting the National Resource Center (see the resource list in the Appendix).

Some clients who have battered their partners have not been identified as "batterers" and are presenting for treatment for other concerns. Appendix A is a list of indicators that someone may be abusive.

VICTIM/SURVIVOR REFERRALS

Frequently, victims of domestic violence are served by battered women's services or shelters. However, many victims choose mental health centers instead or need services that extend beyond those offered by a shelter. For instance, many women who struggle with substance abuse or depression, live with violent partners. These women may not even see their partners as abusive, or may blame themselves for the abuse. Thus, they may be unlikely to seek help for the abuse. It is essential that the substance abuse or mental health workers who interview any clients for treatment carefully screen for domestic violence. The treatment provider must then apprise the victim/survivor of the services available in the community (e.g., emergency housing, hotlines, counseling, victim advocacy, etc.). Currently there are fourteen domestic violence/sexual assault programs in the State of New Hampshire available to assist victims. **The New Hampshire Coalition Against Domestic and Sexual Violence** can provide an up-to-date listing of the services offered by each by calling 224-8893. (see appendix) Their toll-free number for other services is **1-800-852-3388**.

Appendix B is a list of guidelines for interviewing a potential victim about domestic violence. Appendix C is a list of indicators that a woman may be a victim of domestic violence. See the protocols for victims' services for a more thorough discussion of how to help victims of domestic violence.

COUPLES COUNSELING

Many victims or perpetrators of domestic violence seek couples counseling for help in resolving their differences. While there are many benefits to providing couples counseling or marital therapy, such work may prove dangerous to victims of domestic violence. Clinicians should question the appropriateness/safety of couples counseling if any of the following conditions exist:

- Physical violence within the last several months;
- Either partner is afraid of the other;
- Either partner is afraid of reprisal for expressing feelings, needs, concerns, etc.;
- Either partner does not believe that the other can express feelings other than anger or jealousy;

- Either partner does not experience a sense of self-control over the choice to be violent or abusive;
- Either partner feels or seems unable to freely choose how to think, behave, etc. due to partner's efforts to control, manipulate or coerce.

If none of these conditions exist, then couples counseling may be appropriate, but only if both partners freely express a desire for such counseling. It is important for the clinician to interview the members of the couple separately so as to minimize the possibility of one partner coercing the other into agreeing to counseling.

RATIONALE FOR GROUP TREATMENT FOR THOSE WHO BATTER

Numerous studies report promising results from group treatment. Advantages of this approach over individual or couples treatment include:

- The opportunity for group members to challenge each other's attitudes and beliefs while mutually supporting efforts to change;
- Group members feel less isolated and hopeless;
- Group members have the opportunity to develop friendships based on equality rather than on power and control.

Group leaders must be careful to not allow the sessions to become a forum for one gender to complain about the other. Also, a frequent concern about groups for men who batter is that they may help men become better batterers by providing them with a pro-feminist vocabulary. Men may use the information from such a program to further control or manipulate their partners, despite the best efforts of talented counselors.

CONCURRENT ALCOHOL OR OTHER DRUG TREATMENT

Over fifty percent of clients presenting alcohol or other drug problems also experience domestic violence. Likewise, over fifty percent of those presenting for help with domestic violence also struggle with substance abuse. Therefore, clients who present with either problem need to be screened for the presence of the other problem.

Some domestic violence programs require chemically-dependent batterers to participate in drug treatment programs for several months prior to domestic violence treatment. While such sequential work is an option, there are several reasons to consider doing this work concurrently. These reasons include:

- Many of the treatment issues are the same (e.g., denial, minimization, projection of blame, etc.);
- Batterers often blame their use of violence on psychoactive substances;
- Batterers often blame their partners for "forcing" them into alcohol or other drug treatment;
- Violence sometimes becomes more frequent or severe once the "batterer" attains sobriety;
- Integrated treatment allows for an examination of the complex relationship between substance use and violence;
- Several studies suggest that addicts or alcoholics have more control over their behavior when actively using than is commonly thought;
- Victims and potential victims may remain at higher risk of being abused while their partners go without domestic violence treatment;
- Postponing domestic violence treatment may imply that stopping the violence is not as important as some other issue such as substance abuse.

Note: Providing chemical dependency treatment concurrently with domestic violence intervention does not imply that clients should be allowed to attend either program while under the influence of psychoactive substances.

ASSESSMENT OF THOSE WHO BATTER

Before the client enters treatment, the clinician must first assess whether that client is appropriate for the program. Appendix F is a set of guidelines for interviewing those who may have battered their partners. Treatment programs may exclude an otherwise appropriate referral if any one of the following exclusionary criteria are met:

- The client exhibits an active psychosis;
- The client requires detoxification;
- The client has repeatedly participated in domestic violence programs without demonstrating either an interest in changing or the ability to not reoffend;
- The client has a history of generally assaultive behavior such that it appears that staff or other group members would be at risk were this client to join the program; or
- The client is still in the pre-trial stage and has been advised by an attorney not to disclose information about the alleged offense(s).

Other obstacles to program admission relate to both client characteristics and limitations of program resources. These include services needed for:

- Gay or lesbian batterers;
- Deaf clients;
- Heterosexual women who are primary aggressors;
- Non-English speaking clients; and
- Clients whose level of intellectual functioning seems too low to allow them to learn the material as presented in the program.

LIMITS OF CONFIDENTIALITY

The general principles of confidentiality are consistent across professions. However, mental health professionals need to consult their own professional codes of ethics for specific guidelines. Exceptions to confidentiality need to be discussed with the clients including:

- The duty to report instances of child/elder abuse;
- The duty to warn potential victims;
- The duty to protect the client from suicidal ideation; and
- Reporting requirements to referral agents such as the courts and probation/parole.

Statistically, women are more likely to be killed by their partners when their partners threaten suicide than when their partners threaten homicide. However, confidentiality laws do not provide for the warning of battered women whose partners contemplate suicide. Therefore, treatment programs may wish to specify an exception to confidentiality in the program contract for "all threats of harm to self and others." This would allow programs to contact the battered spouse in the event that the client has threatened suicide.

ASSESSMENT PROCEDURE

Information in several areas needs to be collected during the assessment. These areas include:

- Interpersonal violence history;
- Alcohol and other psychoactive drug history;

- Legal history (e.g., restraining orders);
- Exceptions to the problem (i.e., examples of non-abusive choices the client already makes);
- Life stressors;
- Resources for change;
- Relevant medical history (e.g., head injuries);
- Family of origin (e.g., violence, alcohol/drug);
- Individual treatment goals; and
- Safety assessment.

DISCUSSION OF PROGRAM GOALS AND LIMITATIONS

Clients need to be informed that treatment programs for those who batter are primarily psychoeducational rather than “therapy.” This is not to suggest that what happens is not therapeutic. However, the primary focus is on disseminating information that will assist the client in getting personal needs met without harming self or others. A primary goal is the safety of all involved, especially the victim(s) of the abuse.

The client needs to be held solely responsible for the use of violence. The program can provide useful information, but cannot guarantee, predict or control the client’s actions, especially actions taken outside of the treatment facility.

PARTNER CONTACTS

Some programs make periodic contact with their clients’ partners. Following is a list of the most frequently cited reasons for such contact:

- To gather information about the extent and nature of violence and other forms of abuse;
- To encourage the client to disclose information about abusive behavior;
- To hold the client accountable for the abuse;
- To disseminate information to the client’s partner about:
 - goals and limitations of the program;
 - information about local victims’ services;
 - characteristics of those who batter.
- Many victims report usefulness of partner contacts.

Other programs do not make such contacts believing that the risks outweigh the benefits. They often cite the following contraindications:

- Partner contacts imply that she is responsible to track or change the “batterer;” this should not be her job;
- She may be punished for disclosing;
- The clinician may not be able to hide knowledge from a suspicious “batterer” even by honoring her request not to share information with the batterer;
- The partner contact sends a message of distrust which may erode the working alliance with the “batterer;”
- Her report may not be accurate anyway due to her fear of reprisal should she disclose;
- The counselor may not need information from her to educate him about how to be nonabusive;

- Other methods may be available to disseminate information to her, including:
 - informational packet sent to the partner after the client joins the program (Appendix E is an informational brochure sent to partners titled "ABOUT MEN WHO BATTER");
 - periodic informational meetings co-led by shelter and program staff for victims of domestic violence. Women who attend these meetings (1) do not need to have a partner currently enrolled in a batterer intervention program; (2) are not asked to identify themselves; and (3) may be encouraged by shelter staff to bring along a friend for support to the meeting. The primary purposes of this meeting are to educate victims about the nature/scope/limitations of programs for those who batter and to encourage them to avail themselves of resources for victims.

Programs that choose to do partner contacts should:

- Clearly state the purpose of the contacts;
- Develop written protocols detailing how the partner's safety will not be jeopardized by the contact(s);
- Implement partner contacts only if sanctioned by the local battered women's services or shelter.

DIAGNOSIS

There is much debate centering on the advantages and disadvantages of using diagnostic labels with those who batter. Common diagnoses include:

- Impulse control disorders such as intermittent explosive disorder;
- Adjustment disorder with disturbance of conduct;
- Various substance abuse/dependence disorders;
- Antisocial personality disorder; and
- Narcissistic personality disorder.

An advantage of using diagnostic labels is that it increases the likelihood of third party reimbursement, thus making treatment more affordable for the client. Many programs would have difficulty surviving without such reimbursement. Labels may also help clients to focus on a treatment issue much in the same way that "alcoholics" often say that they feel empowered by knowing what their "problem" is.

A disadvantage of using diagnostic labels is that the label provides another excuse for the abuse (e.g., "I couldn't help it because I am/was mentally ill"). The use of such labels also sends the message to the community that the problem is one of mental health rather than one of people not taking responsibility for their own behavior.

Personality disorders may be the most problematic diagnoses since they are considered relatively fixed and stable. Someone who has battered may feel hopeless in his efforts to change when he learns that his "disorder" has such a poor prognosis.

The latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), introduced a new diagnosis, "Physical Abuse of an Adult." The diagnostic code, "61.10" is called a "V-Code" which means that it is not attributable to a mental disorder but is otherwise worthy of attention by mental health treatment providers. It has the advantage over other diagnoses of not pathologizing clients (i.e., it makes no suggestions as to the cause or etiology of the condition); it merely states that the focus of "treatment" is on the physical abuse of one adult by another. It is unclear to what extent insurance companies will choose to pay for services when this "V-Code" is the primary or only diagnosis given.

Another disadvantage of using diagnostic labels relates to the impact of his being labeled on her ability to receive insurance reimbursement for mental health services. Many women have been denied insurance

coverage or have received increases in premiums when they have been identified as “battered women.” Some insurance carriers suggest that she is a high risk subscriber much like a race car driver. They use this analogy to justify the higher rates. The analogy, however, breaks down due to the fact that race car drivers choose that profession; battered women do not choose to be battered.

New Hampshire is the first state to provide victims of domestic violence protection against discrimination by the insurance industry. The Insurance Commissioner has established a toll-free hotline (**1-800-852-3416**) for use by battered women who feel that they have suffered discrimination due to their status as victims.

In sum, clinicians need to consider the impact of using and selecting diagnoses on the client’s prospects for change, the victim’s ability to receive affordable services and on the program’s financial survival.

Finally, no elements of the foregoing discussion preclude giving the client a diagnosis for treatment needs unrelated to the violence.

INTERVENTION WITH THOSE WHO BATTER

As stated above in the referral section, group treatment is the most widely accepted modality for work with those who batter. This section describes elements of what are considered to be the most effective programs.

Early work in domestic violence focused on teaching anger management techniques. Researchers and clinicians then realized that many angry people were not violent and many violent people were not angry. In addition, recent studies have shown that some people become less visibly angry when they become abusive (including the widely-reported studies conducted by Neil Jacobsen, Ph.D.). Therefore, these people do not need to learn how to control their anger better. In fact they may control it too well already.

Similarly, other programs have focused on communication skills, stress management and other tangentially related concerns. Currently, most experts in the field conceptualize domestic violence on a socio-political level. Domestic violence is seen as an example of how oppression is supported by the use of violence. (See David Adams 1988 article, “Treatment Models of Men Who Batter: A Pro-Feminist Analysis.” in *Feminist Perspectives on Wife Abuse*, for a thorough discussion.) Thus, treatment for those who batter focuses primarily on the reasons that some people use violence and other forms of abuse to get other people to comply with their demands.

The scope of treatment typically includes most of the following:

- The cessation of physical and other forms of abuse;
- Oppression (power and control issues);
- Male/female socialization and issues of entitlement;
- Emotional awareness (e.g., anger, fear, jealousy, etc.);
- Victim empathy;
- The impact of violence on child witnesses;
- Mutual respect and trust;
- Honesty and accountability;
- Control plans (e.g., time outs) to ensure safety;
- Cues for violence;
- Responsible parenting;
- Developing social supports;

- Taking social action to promote a nonviolent/nonoppressive community;
- Communicating needs nonabusively; and
- Taking responsibility for managing one's own stress.

The selection of topics, group exercises and interventions should take into account the impact it is likely to have on the safety and welfare of victims and potential victims. This is important due to the opinion of many experts that any intervention taught in such a program could be used, by a "batterer" against his partner, if he so chooses.

Groups vary in size from fewer than 6 to more than 12 members. A group of 8 to 10 members seems to provide enough interaction among the members without sacrificing individual attention.

Groups typically last for 90 to 120 minutes per week. They also vary in length with 26 weeks (six months) being the most common length of time that a court will mandate someone to treatment. Ideally, treatment will be much longer as it is in Rockland County, New York where the typical court mandate is for 52 weeks, or in San Rafael, CA where the Manalive program lasts for two years. Courts in New Hampshire have the option of mandating attendance for longer than 26 weeks.

Whenever possible, groups should be co-led by a female/male team. This allows the group leaders to model appropriate male/female relations. Programs need to ensure that the male co-leader does not appear to have more power or influence in how the group is run. If he does, the group members may receive the message that men should tell women what to do.

It is not always possible to have a female/male team. Same gender teams have also proven to work well. Some programs have even used one leader to facilitate the group, though this should be considered less than optimal. However, the education, training, experience and attitudes of the group leader(s) are more important than the gender or even number of group leaders.

Referral sources such as the courts or the client's partner often request progress reports or termination summaries. It is important to not overstate the client's progress or our ability to predict violence. One sexual assault treatment program settled out of court for over 5 million dollars for implying that a client (who ultimately reoffended) was a low risk for reoffense. In light of this concern, it is recommended that treatment programs report on a client's "compliance" with the court order and program requirements, rather than stating that a client has "completed" or been "graduated" by the program.

See Appendix F for a sample progress report addressing a client's compliance with program requirements.

ASSESSMENT OF VICTIMS/SURVIVORS

Work with victims/survivors will be addressed more fully in the Victim Service Agency Protocols. However, many people who have been victims of domestic violence approach community mental health centers for treatment, either to deal with the abuse or to deal with some seemingly unrelated concern (e.g., depression).

While many victims of violent crime present for treatment with mental health concerns such as depression, anxiety, substance abuse etc., "mental illness" is not a prerequisite for being victimized. Nor is mental illness an automatic consequence of such victimization.

DIAGNOSIS

Clinicians should be careful not to overpathologize battered partners. What appears to be maladaptive functioning in a nonviolent relationship (e.g., "co-dependent traits") may represent a survival strategy for a

battered partner. Other common diagnoses that may overpathologize a victim of domestic violence include the personality disorders (e.g., borderline, dependent, histrionic). These diagnoses wrongly imply that some character defect or mental “illness” (rather than someone else’s criminal behavior) has caused, or perpetuates the client’s victimization.

Clinicians should consider the impact of any particular diagnosis (or of giving a psychiatric diagnosis at all) on the client. When a label is necessary (e.g., for insurance reimbursement) the least pathologizing and least enduring label should be used. Adjustment disorders may be appropriate. Post Traumatic Stress Disorder often is the most accurate and least damaging label since it identifies trauma as the precipitant for the change in functioning. As was mentioned in the section on diagnosis for those who batter, a new diagnostic category is available in the DSM-IV, “Physical Abuse of an Adult.” A different code is used when the focus of “treatment” is on the person who has been abused (i.e., 995.81) than when the focus is on the person who has been abusive (i.e., V61.10). Consultation with the local domestic violence program should precede the development of a mental health center’s policy regarding diagnostic guidelines for battered partners.

TREATMENT FOR VICTIMS/SURVIVORS

Safety and empowerment are the two most widely-cited goals of treatment for victims of domestic violence. Clinicians working with these clients need to select interventions based on the potential impact on their clients’ safety. For example, women who present themselves for treatment because they are trying to deal with their alcoholic partner, are often “assisted” by the substance abuse counselor in giving up their “co-dependent tendencies.” The goal is for her to stop overfunctioning so that he will stop underfunctioning. The intended result is greater balance in the relationship. The unintended result (when the alcoholic partner is also violent) may be further violence as the alcoholic partner punishes her for not doing what he wants, or for going to counseling in the first place.

“Co-dependency counseling” may also blame the client for being battered in the first place, since the relationship is “co-created.” Clinicians need to be clear with these clients that although it takes two to be in a relationship, it takes only one to be violent. And only the violent person is responsible for that violence.

Listening to the stories of abuse victims is at times very difficult. Clinicians understandably want the violence to end and are often eager to help the victims leave their abusive partners. What many clinicians do not realize is that battered women are at greatest risk of serious physical harm, even death, during the process of leaving. It is not clear whether the risk increases because the woman leaves (i.e., her over-invested partner panics and then retaliates) or the woman leaves because the risk has already increased. It may be a combination of the two. In any event, it may be a (literally) fatal flaw for a clinician to encourage a battered woman to leave an abusive partner before she is ready and before she has developed a detailed and realistic safety plan.

A sample safety plan adapted from the model used in Pennsylvania is included in the appendix. If a woman who has been battered by her spouse chooses to not take the written safety plan home with her, it is not because she is “resistant” to treatment. Rather she may quite appropriately fear that her partner will discover it and punish her for having it.

Another area of concern relates to psychiatric medication. Medication that affects cognitive processing or psychomotor functions may interfere with her ability to leave an abusive partner. Therefore, psychiatrists need to be aware of the presence of domestic violence so that their prescription decisions can be made within that context.

Finally, when clinicians are in doubt about how to safely empower a victim of domestic violence, they should consult with the local battered women’s shelter or domestic violence council (at which the battered women’s shelter should be represented). Clinicians may also refer their clients to the shelter for support groups, housing, victim advocacy, etc.

APPENDIX A

COMMON CHARACTERISTICS OF THOSE WHO BATTER

- Sense of entitlement
- Feels like a victim
- Witnessed abuse as a child
- May have been abused
- Difficulty controlling (experiencing) anger
- Possessive
- Suspicious
- Intrusive
- Drug and alcohol concerns
- Denial, minimization, projection of responsibility
- Intimacy problems
- Assertiveness problems
- Low self-concept
- Few social supports
- Sees himself and partner as "one"
- May have military/police background
- Traditional views of marriage
- Not always abusive
- Perceives violence as a means of control

APPENDIX B

GUIDELINES FOR INTERVIEWING BATTERED WOMEN

- Do not ask her about his violence while he is in the house
- Listen
- Ask direct questions
- Believe her
- Don't be judgmental
- Assess for injuries and safety
- Help her to dispel myths about abuse
- Validate her feelings
- Don't tell her what to do
- Ask her what she wants
- Provide referrals to police, shelters
- Help her to develop a safety plan
- Empower her by respecting her choices
- Don't try to persuade her husband to be nonviolent
- Do not intervene in a violent episode

APPENDIX C

CHARACTERISTICS OF BATTERED WOMEN

- Unexplained injuries
- Frequently "sick"
- Fears her intimate partner
- Feels that she does not deserve better
- Blames herself for the abuse
- Accepts responsibility for her partner's actions
- Accepts responsibility for maintaining the relationship in spite of his actions
- Spends much energy trying not to anger her partner
- Is secretive about the problems in the relationship
- Cuts herself off from her family and friends
- Continually hopes things will get better and that he will change
- Feels guilty, depressed, angry, and worthless due to her partner's actions
- Has to constantly account for her every action to her jealous partner
- Her children either cling to her or treat her disrespectfully

APPENDIX D

GUIDELINES FOR INTERVIEWING MEN WHO BATTER

- Be specific
- Help him to identify the abuse
- Identify exceptions to the problem
- Acknowledge the courage to disclose
- Redefine strength, power, control
- Confront with discrepancies
- Do not ask him to verify her story
- Do not trap him
- Avoid enduring labels
- Challenge excuses
- Listen for all or none thinking
- Validate feelings, not behavior
- Reinforce his concern for his family
- Invite him to accept responsibility
- Refer him to an intervention program

APPENDIX E

INFORMATION PACKET FOR BATTERED PARTNERS ABOUT MEN WHO BATTER

Why do men go to a group for those who batter?

The overwhelming majority of men who call have experienced a separation from their mates and/or experienced police intervention because of their abusive behavior. Some of them have had a protection from abuse order filed against them. Frequently they tell us that it was only after their partners left or got a Protection Order that they realized the seriousness of their violence.

Unfortunately, some men are not ready to change even after a crisis. Some men will come to the group only because it looks good to others or because it persuades their partners to take them back. But real change is only possible if he decides he wants to change, regardless of whether you remain together or not.

Am I to blame for his violence and abuse?

Absolutely not. The primary goal of the group is to help each man accept total responsibility for his violence, regardless of whatever problems may exist in the relationship. We believe that there is no place for violence in any relationship and that it is never justified. Men who are violent often blame other people or circumstances or their own upbringing. Many men say that they are out of control or that their wives provoke them to be violent. Our belief is that the decision to abuse is made by choice and that the decision to stop is also made by choice. His behavior is intentional infliction of physical and/or emotional abuse in order to control. He is making a conscious choice. Violence can only make matters worse because it creates a climate of fear and mistrust. When you are afraid of your partner, you cannot be straight with him about how you are really feeling.

Wouldn't marriage or couples counseling be a better solution?

Not if violence or the threat of violence still exists in the relationship. Although many people have said that "it takes two to tango", it only takes one person to be violent. Men who come to the group learn that their violence is not a response to their partners or to their relationship; it is a reaction to their own feelings and frustrations. It is his attempt to control you. Even if other problems do exist in the relationship, they can only be made worse by violence. You cannot communicate with someone when you are afraid of him. A marriage counselor can never prevent you from being afraid of your partner if he is still violent. It is only after the violence has ended that communication problems can be worked out. After you and your partner are confident that he has his violent behavior under control marriage counseling might be a worthwhile next step.

Doesn't drinking or other drug use cause him to be violent?

No. While some men are abusive only after they have been drinking, this does not mean that the alcohol causes the violence; it just makes it easier for the man to avoid taking responsibility for the violence. In other words, the alcohol provides a convenient excuse for the men to say, "It wasn't me, it was the alcohol." When a man drinks and is violent, he has two problems for which he must take responsibility. Unfortunately, the use of alcohol seems to block people from getting help for their other problems. Since the person who drinks is not the best judge of his ability to handle alcohol and how his drinking affects others, it is important that an assessment be made to determine whether a drinking problem exists and how much it may sabotage his work in other areas, such as violence. Batterers' groups typically ask for a drug free commitment during the time that a man attends the group. If by coming in obviously drunk or high or too hungover to participate a man demonstrates that he has a second serious problem (drugs or alcohol) he is referred to the appropriate agency.

What if he's sorry?

Many men who abuse their partners are sorry about it afterwards. Many women are willing to forgive and forget at this point only to become abused again when the man's guilt evaporates or turns to resentment and violence erupts again. However, it takes more than flowers and apologies to end abusive behavior. It takes a willingness on the part of the man to accept total responsibility for his violence and its effects on others as well as a commitment to change. Without these, guilt and apologies will only perpetuate the violence.

Can he really change?

Yes, but only if he wants to and only if he gets help. Experience has shown that men who are violent are extremely likely to continue being violent unless they receive confrontation and support. Change does not occur overnight, however, and some men drop out along the way. Some drop out after only a few sessions. Although many groups ask for a minimum commitment of several months, we in no way want to convey the idea that after that time he is cured. Groups do not graduate anyone.

Should I leave if he is violent again?

Batterers' groups do not claim to be able to control anyone's behavior in or out of the group. His or yours. We believe our responsibility is to identify, confront and help him to end his abuse. We do not take it upon ourselves to give anyone direct advice about leaving or staying in a relationship. Only you know what is best (e.g., safest) for you. We do strongly urge you to seek the counsel of other women who are learning how to protect themselves from violence. Your first consideration should be your own physical safety and support. The enclosed material includes information on support services and legal options for women who have been abused by their partners. For additional information you can call the local shelter.

What happens in a group for those who batter?

Before being accepted into the group, an individual assessment and a group orientation session are held where the structure of the program and responsibilities of the participants are explained. A man who is accepted into the program is then either admitted to the group the following session, put on a waiting list or referred to other services. When a space opens in one of the groups he joins that ongoing group and affirms his commitment to attend the full program. During his time in the group the discussions a man participates in are aimed at helping to accomplish the following goals:

- End all forms of abuse toward his partner and family.
- Increase his awareness of how he behaves toward others.
- Stop denying that he has a serious life threatening problem.
- Stop blaming his partner for any of his abusive behavior.
- Redefine abuse and recognize the real damage that it does to him and others.
- Assess the damage he has done and become responsible to those he has abused.
- Become more flexible and tolerant toward sex-role expectations for both men and women.
- Break out of his isolation from family, friends, society and his own non-violent, nurturing self.
- Recognize and better manage the stress in his life. Also to stop blaming stress (or poor management of it) for his violence.
- Support other men who have been abusive in their efforts to change and confront other abusive men in their denial.
- Face up to any conflict in his relationships by learning to become non-violent, nurturing and assertive.
- End any threat of retaliation toward his partner because of her efforts to protect herself from his violence.

How do I know when he's changed?

There can be no simple answer to this question. Only you can make this judgment based on your own perceptions of your partner and your own sense of safety. The proof is in the pudding-you will know he has changed when you see and hear him react non-violently and non-abusively to the demands of an intimate relationship. There are some questions you can ask yourself, in the mean time, which might help you decide whether he has changed enough for you to feel safe and secure with him.

These include:

- Has he stopped being violent or threatening towards you and others?
- Does he still make you afraid when you are with him?
- Is he able to be angry without becoming verbally or physically abusive?
- Are you able to express anger towards him without being attacked?
- Are you able to make decisions about your own life without fear of his retaliation?
- Is he able to hear and respect what you are saying even though he may not agree?
- Can he negotiate with you without being attacking or controlling?
- Can he respect your right to say no?
- Is he able to let you know what he is feeling most of the time?
- Is he able to express feelings other than anger?
- Does he blame you for his anger, frustrations, and violence?
- Does he respect your right to be different and to make your own decisions?

We would like to thank the Second Step organization of Pittsburgh, PA for letting us use this modified version of their handout. We would also like to express our gratitude to all formerly battered women and the battered women's shelter movement for their guidance and leadership in ending male violence against women.

APPENDIX F

SAMPLE PROGRESS REPORT

Date

To Whom This May Concern:

The purpose of this letter is to report on _____ compliance with the program requirements of Strafford Guidance Center's Domestic Violence Program. To date, _____ has attended _____ of the required 26 week program. By "attended" we mean that s/he has: been physically present, has paid the fee and has not been asked to leave the session for any violations of the group contract.

The following topics have been covered during _____ attendance in the program:

- _____ Defining abusive behavior and its alternatives;
- _____ The impact of abusive choices on self and others;
- _____ Male/female socialization;
- _____ Beliefs and attitudes as reflected in language;
- _____ Oppression and its violent consequences;
- _____ Myths and realities about why people batter;
- _____ Gaining control by giving up control of others;
- _____ Stages of change;
- _____ Relapse prevention strategies;
- _____ Accepting responsibility for one's own anger;
- _____ Managing one's own stress;
- _____ The Cycle of Violence;
- _____ Substance abuse and domestic violence;
- _____ Parenting skills (includes the impact of abuse on children);
- _____ Developing social supports;
- _____ Restitution;
- _____ Equal partnership;
- _____ Intimacy (e.g., physical and emotional);
- _____ Intergenerational transmission of abuse (and its alternatives);
- _____ Timelines (includes family of origin work).

Currently, no group member has been mandated to our program for more than six months (26 weeks) by an outside agency (e.g., district courts). We believe that changing what may be a lifelong pattern of making harmful choices (harmful to self or others) requires more than 90 minutes per week for 26 weeks. Therefore, we report on “compliance” rather than “completion” or “graduation” from the program.

In addition, we only have access to “in-session” behavior. Therefore, we do not make judgments on how much progress a particular group member makes, or how much better a spouse or partner he has become. (We will report on any specific in-session behaviors that are deemed by staff to be abusive).

Our service is largely an educational one, designed to provide each member with the information necessary to make nonabusive choices, should s/he choose to do so. But the choice is entirely up to the client. Anyone could choose to use the information presented in this program to control, manipulate or otherwise harm someone, if that person is motivated to do so. It is the responsibility of our entire community to discourage such harmful behavior. Our program can only play a small (though vital) part in that process.

We hope that this information has been useful to you. We are eager to hear any comments or suggestions you may have to improve our program.

Sincerely,

Group Co-Leader

