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## Chapter 3 -- Batterers: An Overview

There are myriad reasons why substance abuse counselors should address the domestic violence of clients who batter their partners. Consensus Panel members have observed that the violent behavior of a batterer client can interfere with his treatment for substance abuse, and conversely, his substance abuse can interfere with interventions aimed at changing his violent behavior (Bennett, 1995). Clients who are incarcerated, for example, or accused of assault or murder have limited access to substance abuse treatment. Practitioners have observed that for those clients in treatment, battering may precipitate relapse and thwart the process of true recovery, which includes "adopting a lifestyle that enhances one's emotional and spiritual health, a goal that cannot be achieved if battering continues" (Zubretsky and Digirolamo, 1996, p. 225).

Use of psychoactive substances, on the other hand, may interfere with a client's capacity to make a safe and sane choice against violence by impairing his ability to accurately "perceive, integrate, and process information" about another's behavior toward him (Bennett, 1995, p. 761). Intoxication appears to increase the likelihood that a batterer may misinterpret or distort a partner's remarks, demeanor, or actions by "blunting whatever cognitive regulators the abuser possesses" (Stosny, 1995, p. 36). While abstinence from drugs and alcohol does not alter battering behavior, substance abuse problems negatively affect a batterer's capacity to change and increase the chance that violence will occur (Tolman and Bennett, 1990; Bennett, 1995).

Both battering and substance abuse result in harm to the client and others. Responding to a client's penchant for violent behavior is as vital as responding to his depression or to the array of other conditions that may impede progress in treatment and interfere with recovery.

### Perspectives on Substance Abuse and The Batterer Client

Although domestic violence occurs in the absence of substance abuse, there is a statistical association between the two problems. Alcohol use has been implicated in more than 50 percent of cases involving violent behavior (Roy, 1982). Research by Kantor and Straus suggested that approximately 40 percent of male batterers were heavy or binge drinkers (Kantor and Straus, 1987). A recent study found that more than half of defendants accused of murdering their spouses had been drinking alcohol at the time (Bureau of Justice, 1994). Another study of incarcerated batterers found that 39 percent reported a history of alcoholism and 22 percent reported a history of other drug addiction. A total of 50 percent self-reported current addiction; however, this figure rose to 89 percent when the researchers examined court documents. All but one of the subjects admitted to having been drunk at the time the battering occurred (Bergman and Brismar, 1994). Higher rates of substance abuse consistently correlate with higher rates of domestic violence, although one important study concluded that "[c]hronic alcohol abuse by the male rather than acute intoxication is a better predictor of battering" (Tolman and Bennett, 1990, p. 91). As one field reviewer noted, however, "Assaultive men, in general, have high alcohol use scores. Indeed the more a man matched the gauge for having an abusive personality, the greater his alcohol consumption. When a batterer says, 'the alcohol made me do it,' he's blaming one symptom -- violence -- on another -- alcohol abuse."

Most Consensus Panelists and field reviewers concur that the exact nature of the correlation between battering and substance abuse remains unclear.

Anger and hostility are more frequently generated by interactions between people, and alcohol or other drug use is likely to be linked to violent behavior through a complicated set of individual, situational, and social factor ... The prevalence of violence between partners cannot be adequately explained merely as the consequence of alcohol and other drug abuse, nor can it be understood outside the context within which it occurs. (Gorney, 1989, p. 231)

Current research supports the finding that substance abuse is only one of many factors that influence a batterer's violent behavior (Collins and Messerschmidt, 1993). As with substance abuse, other factors are also correlated, such as depression, psychopathology, violence in the family of origin, social norms approving of violence (especially toward women), high levels of marital and relationship conflict, and low income (Tolman and Bennett, 1990; Bennett, 1995; Hotaling and Sugarman, 1986; Hotaling and Sugarman, 1990; Bograd, 1988). Although intoxication may trigger an individual episode of violence, addiction does not predispose one to be a batterer. This

distinction is crucial for a provider to understand when treating batterer clients, because *a batterer's violence does not necessarily end when he stops abusing alcohol or other drugs*.

In characterizing substance abuse and domestic violence, practitioners have observed that the two problems are "separate but similar, and they each interact and exacerbate each other. For example, both problems are passed on from generation to generation; both involve denial, with substance abusers and batterers blaming victims for their behavior; usually, neither problem decreases until a crisis occurs; and secrecy is often the rule, with victims of abuse (wrongly) blaming themselves for their partner's substance abuse or violent behavior" (Engelmann, 1992, p. 6).

## Profiling Batterers

In the past, research has focused more on attempts to identify characteristics of victims rather than perpetrators of violence (Hotaling and Sugarman, 1990). While information about batterers is relatively sparse and subject to some debate, it can provide the basis for a rudimentary understanding of their behavior. One caution is in order, however. Exploring batterers' individual characteristics addresses only one dimension of the domestic violence phenomenon. Some experts believe that battering is driven by socially supported sexism and inequitable distributions of power that feed the batterer's belief that he has an inherent right to control his partner's behavior. Others contend that analysis of batterers' characteristics has limited value if attention is not also directed to the larger culture of violence and social injustice in which battering occurs (Adams, 1988; Tolman and Bennett, 1990; Stosny, 1995). Research has clearly asserted the importance of socioeconomic factors in understanding battering: Approval of violence against women, low income, and belief in gender-based stereotypes emerge repeatedly as correlates of domestic violence (Bennett, 1995). As in the case of substance abusers, multiple internal and external risk factors appear to influence problem development among men who batter.

## Individual Characteristics

Although batterers are a heterogeneous group, research has uncovered a number of characteristics that differentiate men who batter from men who don't. Many batterers (particularly those who engage in severe physical assaults against their partners) witnessed parental violence when they were children (Hotaling and Sugarman, 1990; Pagelow, 1984). While not replicated, findings from the large-scale National Family Violence Survey that included over 6,000 families suggest that experiencing corporal punishment as an adolescent may be a risk factor for later partner abuse (Straus and Kantor, 1994). As mentioned above, chronic alcohol abuse is another predictor of violence (Tolman and Bennett, 1990), and some studies have found that batterers are more likely to suffer from depression (Hamberger and Hastings, 1986a; Saunders and Hanusa, 1986).

## Need for power and control

Many experts believe that batterers use violence or the threat of violence to achieve a sense of control, both over their victims and generally (Gondolf, 1995). Violence may also reflect a personal need for power and domination over others. Gondolf, building on McClelland's theory of alcohol and power motivation (McClelland, 1975), suggested that the need for personal power (reinforced by societal norms of male dominance) may be the factor that accounts for the high correlation between substance abuse and spousal abuse. According to this theory, men who have a high need for power over others are more likely to abuse alcohol and to use violence. Alcohol provides an illusion of power; so does beating one's wife. In some cases, a batterer who is drunk can gain instant control of his wife -- and in a sense his entire marital situation -- by terrorizing her. Furthermore, if the violent incidents are stopped through intervention, arrest, or treatment, the lack of control perceived by the batterer often increases not only the frequency of assault, but its severity as well.

In addition to inflicting physical pain and injury, a batterer may also abuse his partner psychologically and emotionally. A batterer attempts to control the thoughts and feelings of the partner by monitoring her behavior, making her accountable for his emotional highs and lows, denigrating her, criticizing and blaming her, and calling her names. Nonphysical abuse generally targets the victim's sense of self-esteem, well-being, and autonomy. *Psychological abuse* can be defined as behavior intended to control the victim's actions and functioning in everyday life (often by making her fearful). It may take the form of isolating her from her friends, family, and other sources of support or keeping her from having money to pay bills and other expenses. Another form is threatening physical harm -- not only to the victim but to family members, friends, or himself. It can also be the "silent treatment": The batterer may refuse to speak directly to the victim for extended periods, such as days or weeks, leaving her guessing about how she has displeased or offended him. *Emotional abuse* is denigrating, shaming, ridiculing, or criticizing the victim and otherwise attempting to damage or destroy her self-esteem. These types of abuse often accompany physical violence to some degree, although they can also occur in relationships that are not physically violent. It is unclear how men who batter differ from those who don't in the use of nonphysical forms

of abuse (see Figure 1-1 ).

Any intervention with a batterer that does not concomitantly address issues of power and control may simply allow the batterer to become more sophisticated at other, nonphysical kinds of manipulation. To interrupt these types of abuse, couples and/or family therapy may be recommended once domestic violence experts ascertain that the victim is out of danger.

### Role of anger

The precise role of anger in battering is unclear. When treatment for batterers was first being developed, some practitioners viewed anger as a primary cause of abuse and believed that imparting anger management skills would curtail and ultimately eliminate battering behavior; others viewed anger as just another excuse for violent behavior. Today, many researchers and practitioners consider anger as only one of a number of antecedents or precipitants for violence. Addressing the anger is not the same as addressing the larger problem of violence, but it may be a useful technique in preventing the expression of violence against intimate partners (Tolman and Saunders, 1988; Tolman and Bennett, 1990).

Consensus Panelists and field reviewers concur that although anger is a common emotional theme among violent batterers, a batterer's violence is not "caused" by anger. They also agree that while anger management groups can play an important treatment role, they caution that if such groups are not judiciously mediated by highly trained specialists in domestic violence, they may indirectly *reinforce* violent behavior. Inadequately facilitated groups can turn into "gripe sessions" that fuel batterers' anger instead of educating them about how to handle their feelings without resorting to violence. (For an informative debate about anger management and batterers' interventions, see Gondolf and Russell [1986] and Tolman and Saunders [1988].)

Another anger-related issue concerns the false belief that "explosive anger" is a hallmark of batterers (Stosny, 1995, p. 65), whereas, in reality, many batterers are afraid to reveal their anger to the outside world and successfully present themselves as victims to the clinicians charged with treating them ("nothing I do is right; she's always criticizing me"). Some clinicians look for overt anger and fail to find it, then label batterers as "in denial" about their anger. Treatment revolves around "getting batterers in touch with their anger and letting it out." Too often, this ill-conceived approach (which has been debunked by much contemporary literature) has had "disastrous consequences for both batterers and their loved ones" (Stosny, 1995, p. 66). When responding to batterers, it is important to understand the complex role that anger plays in both precipitating and sustaining violent behavior. Responsible treatment incorporates techniques for regulating as opposed to revealing anger (Stosny, 1995).

Substance abuse also skews the motivational mix of anger and battering in a variety of ways. Alcohol and other drugs often serve as mood regulators and anger management tools, which sometimes exert a calming effect, but also may intensify angry feelings. The Consensus Panel did not discuss the specific psychopharmacological effects of cocaine, amphetamine/methamphetamine, or phencyclidine or other hallucinogens on violence, because there is no evidence to suggest that these drugs have any effect on *domestic violence* (although a few studies suggest that chronic use may influence aggressive behavior in general [Brody, 1990]). Much like efforts to understand the links with alcohol, both research and experience indicate that personality, preexisting brain disorders, and environment also play important roles in the relationship between substance abuse, anger, and violence (Brody, 1990).

### Attachment deficit and affect regulation

As clinicians and researchers have learned more about battering, some have begun to consider it within the context of an individual's total personality rather than as an isolated behavior. In this view, problems with attachment when young, compounded by the experience of growing up in a home environment marred by a father's violent behavior and shaming "put-downs," contribute to the development of a "violence-prone borderline personality [who is] ... addicted to brutality to keep his shaky self-concept intact. The only time he feels powerful and whole is when he is engaged in violence" (Dutton, 1995, p. xi). At the same time, the painful experience of rejection as a child has also bred a deep-seated fear of intimacy or "engulfment" (Dutton, 1988; Dutton and Browning, 1988).

Practitioners of psychologically based approaches to understanding and treating batterers are acutely sensitive to the criticism that they are excusing batterers on the basis of their underlying psychological problems (Dutton, 1995). Supporters of what is often termed the psychoeducational approach are quick to assert that psychological insights help to explain batterers' behavior; they do not justify or excuse it (Dutton, 1995; Stosny, 1995).

### Group Typologies

While experts agree that the relationship between substance abuse and battering is far more complicated than cause and effect, some attitudes and patterns reappear in men who abuse their partners. In an effort to better understand and improve treatment for batterers, researchers have attempted to group them on the basis of common characteristics (Gondolf, 1988; Hamberger and Hastings, 1986a; Dutton, 1995; Saunders, 1992). Gondolf organizes batterers into three clusters:

1. "*Typical batterers*" (the largest group in Gondolf's sample, 52 percent) generally confine their violence to their families. For the most part, these men are not substance abusers, are unlikely to have significant mental disorders, have no arrest history, and tend to be remorseful after battering episodes. In contrast to other batterers, their behavior usually results in less severe abuse.
2. *Antisocial batterers* (41 percent of the sample) are extremely abusive and may be violent outside the home. This type of batterer is emotionally volatile; has some mental health problems, such as antisocial personality disorder, depression, or anxiety; and may be a substance abuser. He may be under the care of a physician or in mental health therapy. He may have difficulty attending or completing a batterers' program without receiving additional mental health services.
3. *Sociopathic batterers* (7 percent of the sample) comprise the most violent group. Although these men are likely to be heavy substance abusers, they are the hardest type to engage in substance abuse treatment. They have little empathy for others, no self-insight, and no feelings of guilt or remorse for their actions. They are the most likely of the three groups to have been arrested (Gondolf, 1988).

Hastings and Hamberger characterize batterers as having borderline personality disorder, antisocial personality disorder, or a form of compulsive personality disorder (Hamberger and Hastings, 1986a). Saunders looked at a range of variables including extent and levels of violence inside and outside the home, levels of anger and depression, attitudes toward women, substance abuse, conflicts in relationships, and need for power. According to his analysis, those who were violent outside the home were the most brutal batterers. They also were the most likely to abuse alcohol and to have been abused as children (Saunders, 1992).

In his work, Dutton has observed three types of batterers that he classifies as

1. *Psychopathic wife assaulters* (40 percent of the men in Dutton's program). These men meet the diagnostic criteria for antisocial behavior and resemble Gondolf's sociopaths as well as those men in Saunders' cluster of men who are violent outside the home. Dutton believes that the prognosis for treatment is poor for this group. In his words, "psychopaths don't look back. As a result, they never learn from past mistakes" (Dutton, 1995, p. 27).
2. *Overcontrolled assaultive males* (about 30 percent of the men in the program). This group consists of men with an overriding need for control. In Dutton's experience, they tend to be "perfectionistic" and "domineering." They tend to use emotional abuse, including verbal attacks, harassment, and withholding of affection to "generate submission" (Dutton, 1995, p. 30). Overcontrolled assaulters are usually the most compliant clients in treatment.
3. *Cyclical/emotionally volatile wife abusers* (about 30 percent of the men in the program). These men fear intimacy and suffer from recurrent feelings of abandonment and engulfment. They are overly dependent on their partners and, as a result, are literally "either at their wives' knees or at their throats" (Dutton, 1995, p. 42). Common traits include "flat affect, noncommittal response, and limited emotional lexicon" (Dutton, 1995, p. 44). They are incapable of describing what they feel and tend to repeat the same complaints and accusations about their partners over and over again. However, it is this group of batterers who calculate exactly how severely they can injure their partners without leaving obvious signs of abuse. It is also this group who best fits the "phases of abuse" theory first described by Lenore Walker in her pioneering work on domestic violence (Walker, 1979). These men typically undergo a buildup of tension that explodes in an episode of acute battering and is followed by a remorseful apology and so-called "honeymoon period" of concern and attention (Dutton, 1995).

By their very nature, typologies are artificial constructs, subject to change as new information develops. Despite their limitations, however, these groupings suggest that substance abuse programs will encounter those batterers who are among the most difficult to treat. As an example, members of the Consensus Panel observed that unlike the cyclical/emotionally volatile wife abuser (above), many severe batterers, among whom substance abusers are overrepresented (Roberts, 1988), do not fit the patterns of behavior seen by Dutton and Walker. Instead of following up a battering episode with a period of remorse (Walker, 1979; Dutton, 1995), they use the postviolence period as an opportunity to blame the victim for starting the abuse or to break up with her, or both.

The following section of this chapter focuses on the batterer who is more likely to be seen in a substance abuse

program. These men have multiple problems and function, for the most part, in socially and economically impoverished environments. Involvement with the criminal justice system is almost a certainty, although domestic violence may not be the cause. At this time, few evaluations exist of batterers' treatment and even the developers of the popular "Duluth model" (see Figure 3-1 ) "have no illusion that most men will stop their violence and give up their power" (Pence and Paymar, 1993, p. xiv). Nevertheless, efforts by Consensus Panel members, field reviewers, and Statewide Networks Against Domestic Violence (such as those in Virginia and Maryland, to name just two) indicate that batterers' treatment can be effective if programs place a premium on survivor safety (even though the batterer is the client), insist that batterers take personal responsibility for their behavior, mandate "no-violence contracts," impart emotional regulation techniques, follow up on treatment completers and dropouts, and evaluate program outcomes regularly (Stosny, 1995).

## **Treatment Issues for the Substance-Abusing Batterer**

### **Crisis Intervention and The Victim's Safety**

Like any client entering substance abuse treatment, the batterer is typically in a crisis state when he first presents for services. He may have been referred to treatment by the courts after being arrested for drug- or violence-related charges, or he may have been left alone by a battered partner seeking safety for herself and the children. Even when his outward demeanor is calm and accepting, violence may be imminent.

Substance abuse counselors typically regard a crisis situation as a prime opportunity to intervene with a client and engage him in the treatment process. In this context, a crisis is frequently transformed into a positive event for both the substance abuser and those who care about him. With substance-abusing batterers, the situation is different. Because batterers tend to defer responsibility and to project their anger onto others, a crisis situation may spur a violent incident at home. Examples of crises that may precipitate violence include loss of employment, the impending loss of family relationships through separation or divorce, emotional and psychological breakthroughs during psychotherapy, a citation for driving while intoxicated, court-mandated treatment for substance abuse, being served with a restraining order, a partner's pregnancy, or the birth of a child. For this reason, when a substance-abusing batterer experiences a crisis, treatment providers should have a plan in place for addressing the fallout. Although it requires a shift in focus from the client to the family, the most immediate concern when a crisis occurs is the safety of those who have been or may become the batterer's victims, in particular his partner and children, whether they remain with the batterer or not (see Chapter 5 and Appendix B for specifics on notification procedures and conformance with Federal and State confidentiality regulations).

Family members, and in particular the client's partner, should be consulted regarding what is best for their safety (although the provider should bear in mind that their version of the situation may be somewhat skewed). Extreme caution and tact should be used to avoid further endangering the victim(s). If available, substance abuse counselors should refer and defer to trained violence support professionals or the partner's advocate to develop a safety plan that includes logistics for leaving the home quickly or, if she does not want to leave him, other strategies for increasing her safety.

### **Fostering Accountability**

Because batterers tend to shift responsibility and blame onto others, the degree to which a client begins to assume responsibility for his actions can serve as a barometer for his substance abuse treatment progress. To that end, assessment and monitoring can be incorporated into the treatment plan to evaluate the degree to which the batterer is taking responsibility for his violent actions. The batterer's accountability can be highlighted by linking his actions with tangible consequences. One way to achieve this is through the use of a "no-violence contract" with clearly delineated sanctions for violation (see Chapter 4). The substance abuse counselor must also be familiar with and understand the legal status of the batterer and how it affects his access to ongoing treatment services.

In addition, the use of multiple screening measures such as the Revised Conflict Tactics Scale (CTS2) for couples (Straus et al., 1996) and the Psychological Maltreatment of Women Inventory (Tolman, 1989, 1995), both reproduced in Appendix C, can aid the treatment provider in determining the extent of abuse while focusing the batterer's attention on his behavior.

### **Batterers' Intervention Program Models**

If available, collaboration with and referral to batterers' intervention programs can facilitate the treatment of substance abusing batterers. Some of the models being used today are summarized in Figure 3-1 .

## Abstinence

During screening and throughout the treatment process, substance abuse counselors should explore the context in which the batterer client uses alcohol and other drugs in order to identify the chain of events and emotions that preceded or accompanied particular instances of substance abuse and violent episodes. Based on their experience, the Consensus Panelists recommend eliciting the following information about the relationship between the substance abuse and the violent behavior:

- Exactly when in relation to an instance of substance abuse the violence occurs
- How much of the violent behavior occurs while the batterer is drinking or on other drugs
- What substances are used before the violent act
- What feelings precede and accompany the use of alcohol or other drugs
- Whether alcohol or other drugs are used to "recover" from the violent incident.

By understanding the dynamics of intoxication and abstinence as a precursor to violence, the treatment provider can formulate a treatment plan that incorporates strategies for ensuring the partner's and other family members' safety and for helping the batterer focus on modifying the behaviors and events that precipitate substance abuse and violence. The focus in treatment must be on encouraging the batterer client to develop enough self-awareness to recognize the beliefs and attitudes as well as to control the emotions that contribute to his violent behavior.

## Bonding With Peers

Friendships with members of the same sex are generally seen as a positive expression of self-development in both male and female clients being treated for substance abuse. Treatment staff must be on the alert, however, for signs of collusion among male batterer clients who have formed close friendships during treatment. Although such bonds often help clients learn about forming close and trusting relationships with others and examine their behavior in relation to that of their peers, in some cases, violent behavior can be instigated or condoned among batterer clients who reinforce each other's excuse-making mechanisms (see Figure 3-2).

One field reviewer who works with batterers writes that

In our anger management class, we pursue a new definition of manhood through the proper exercise of personal power. Personal power does not include violence of any kind, except for self defense. Personal power involves the negotiation of a system that is often seen as indifferent and hostile in a productive way ...giving the batterer an opportunity to feel powerful in a rational manner. We redefine manhood in terms of emotional cost-benefit analysis and problem solving. Clinically, it appears to be working.

## Parenting

Many substance abusers, male and female, have poor parenting skills, whether or not they are in a battering relationship. An examination of the client's parental role is essential to understanding his violent behavior, since a batterer may use alcohol, other drugs, or violence to respond to conflict within the family structure. Young boys often learn violent behavior from male role models. Among the challenges in substance abuse treatment for batterer clients are to

- Raise the batterers' awareness of the impact of their violence on their children's future behavior
- Help batterers adopt other, nonviolent modes of behavior through anger management and coping skills training
- Reinforce the importance of modeling nonviolent behavior in their interactions with their partners as well as their children.

The effects of a batterer's violence on his children has important implications for his treatment plan. Although family therapy is often an effective component of substance abuse treatment, this approach is inadvisable for the violent batterer until he has learned to take responsibility for his behavior and has learned how to respond to crises without using violence. Given the potential for harm to both partner and children, the Consensus Panel recommends postponing family and couples counseling until the batterer has demonstrated a pattern of nonviolent and noncoercive behavior for a given period of time (usually a year). The decision to provide or refer for family or couples therapy also should be conditional upon whether or not the victim freely chooses to participate in counseling (the request should be made privately; *a victim should never be asked to make that decision in a batterer's presence*). Until these conditions are met, the batterer should be treated independently of

other family members.

### **Ongoing Support**

Over the past 50 years, the substance abuse treatment field has grown and developed into a national network of 12-Step groups, church affiliations, and social systems. In contrast, there are no ongoing organizations that support change for men who batter or for their victims. Although some batterers may enter an aftercare program following substance abuse treatment, most do not. Widely scattered groups called Batterers Anonymous (BA) (Goffman, 1984) have not been totally embraced by domestic violence workers because their emphasis on participant anonymity appears to be incompatible with the violence field's focus on accountability. Some Consensus Panel members fear that, unless a batterer has already successfully completed a batterers' program, groups like BA may unwittingly encourage misogyny (see Figure 3-2 ). On the other hand, some field reviewers who work with violent substance-abusing clients have found that the antiviolence messages of BA and similar groups appear to help batterers contain their violence by emphasizing the consequences of violent behavior. Accredited or certified domestic violence programs are sound resources for information and referrals to appropriate batterer self-help support groups.

A number of batterers' intervention programs are beginning to offer aftercare services. Some are experimenting with mentors, who fulfill roles similar to sponsors in 12-Step programs. In this approach, a recovering batterer, under the supervision of a batterers' program or shelter that ensures his accountability, mentors a batterer who has completed a batterers' program. Continuing contact is essential because program completion is not necessarily an indication of whether a participant has stopped or even reduced his use of violence and coercion.

## Boxes

### Figure 3-1: Models for Batterers' Intervention Programs

The "Duluth model," as it is commonly called, was developed at the Domestic Abuse Intervention Project in Duluth, Minnesota, (Pence, 1989; Pence and Paymar, 1993) and is probably the most widely used model for batterers' intervention programs in the United States. There are many variations on the Duluth model, but all feature victim safety and community coordination as cornerstones and require batterers' programs to be accountable to victims and to victim advocates. The Duluth model is based on confronting the denial of violent behavior, exposing the manifestations of power and control, offering alternatives to dominance, and promoting behavioral changes. It calls for communitywide intervention that employs the resources of law enforcement, courts, domestic violence shelters and advocates, health providers, and batterers' programs. A batterers' program cannot, in this model, exist without the other components in the network. Although some experts feel that the Duluth model tends to encourage shame and guilt rather than real change, it sees domestic violence not as a form of personal pathology, anger and hostility, or substance-induced behavior, but as an outcropping of men's socially sanctioned domination of women. Batterers' programs developed under this model are designed to educate men about power and control, not merely to assist them in managing anger or personal problems. Communitywide coordination ensures that batterers are arrested and prosecuted and that victims are protected.

The psychoeducational model promotes responsibility for violent behavior and the development of mechanisms for self-regulation, empathy or compassion for others, and appropriate emotional vocabulary to express intimacy. Safety precautions for significant others, no-violence contracts, provision of information, changing attitudes toward women, reinforcement or development of values via modeling, anger and stress management, and assertiveness skills are key features of this cognitive-behavioral approach (Palmer et al., 1992; Stosny, 1995). Group and individual treatment can be utilized within this model, although single-sex groups tend to be the norm. Results of one study suggest that highly structured groups (with defined curricula, homework assignments, and skilled facilitation) work more effectively than less structured groups (Edleson and Syers, 1990, 1991).

Couples therapy treats men who batter together with their partners, often in a group setting. This is a controversial approach to batterers' intervention that has fallen into disrepute because of concerns about partner safety, its "implicit message that both partners are equally responsible for the violence," and its failure to acknowledge the role of gender and historical power inequities (McKay, 1994, p. 36). Substance abuse treatment providers should not treat batterer-and-victim couples together without consulting a domestic violence expert.

### Figure 3-2: Positive and Negative Aspects of Bonding Among Batterers

#### Positive

- Support for change
- Amelioration of feelings of isolation; support for communicating experiences with others
- Help in dealing with crisis
- Friendships

#### Negative

- Support for control and dominant behavior over partners
- Support of counterproductive activities (e.g., having multiple sexual partners)
- Support of negative parenting activities (e.g., having children by different women)
- Support for a negative definition of manhood
- Support for believing he is correct and does not have to negotiate or compromise
- Access to information on how to violate laws such as orders of protection
- Use of alcohol and other drugs

- Opportunity to participate in "gripe sessions"-tirades against women under their control
- Reinforcement of perceived victim status

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