Chapter 3

Health Care Responses to Perpetrators of Domestic Violence

By Anne L. Ganley, Ph.D.

HEALTH CARE RESPONSES TO PERPETRATORS OF DOMESTIC VIOLENCE[1]

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INTRODUCTION

Patients who batter their intimate partners appear in a variety of health care settings, including emergency departments, specialty clinics and primary care settings. Some seek medical care for issues directly related to their abusive behavior, while others seek assistance for issues that are unrelated to their violence. While the major thrust of the health care effort is appropriately focused primarily on domestic violence victims and their children, this chapter is written to assist health care providers in determining when and how to respond when they encounter perpetrators of domestic violence in their practice.

This chapter is divided into six sections. The first addresses strategies for maximizing the safety of the victim when interacting with a patient who is the perpetrator. The second section reviews the multiple ways clinicians learn that their patient is a perpetrator of domestic violence. The third is an overview of the information gathered as the practitioner interacts with perpetrators. The fourth discusses the specific factors to consider in evaluating the lethality of the domestic violence and the risk of future injury or death. The fifth presents crisis intervention strategies. The chapter ends with a discus-

[1] This chapter was taken from a longer article, *Identification, Assessment, and Interventions with Perpetrators of Domestic Violence*, by the same author. The author gratefully acknowledges the editing of Patrick Letellier for this current version.

sion of additional health care strategies that may be implemented when treating perpetrators.

When the patient is a perpetrator of battering, the health care provider should be guided by the same understanding of domestic violence and by the same principles used in responding to victims of domestic violence.

These principles are discussed in Figure 3-1. Ultimately, the health provider will be more effective in responding to perpetrators when these principles are followed.

FIGURE 3-1

GUIDING PRINCIPLES

1. Regarding the safety of victims and their children as a priority
2. Respecting the integrity and authority of each battered woman over her own life choices
3. Holding perpetrators responsible for the abuse and for stopping it
4. Advocating on behalf of victims of domestic violence and their children
5. Acknowledging the need to make changes in the health care system to improve the health care response to domestic violence

I. STRATEGIES FOR INCREASING THE SAFETY OF VICTIMS WHEN INTERACTING WITH PERPETRATORS OF DOMESTIC VIOLENCE

Perpetrators of domestic violence react in multiple ways to discussions of their abusive behavior with health care providers. Some use such conversations with clinicians as one more excuse to retaliate against victims, while others are receptive to such discussions. Some perpetrators express relief that the issue has been raised and others become angry or indignant. Certain perpetrators will use the information provided by the practitioner to start the process of changing their abusive conduct. Others reject the information and their responsibility for their violence. Unfortunately, there is no way to predict from the initial presentation of the patient which perpetrators will benefit from a discussion about their behavior and which will not. Regardless of the response of the individual perpetrator, all interactions with batterers must be made with the safety of victims as the highest priority. The following are strategies for increasing the safety of victims when talking with patients who are perpetrators.

A. Information from the Victim Must Be Kept Confidential

Relaying any information provided by the victim about the abuse to the perpetrator may put that victim in danger. Victims may talk about the abuse in hopes of getting help. Some want all information kept confidential, some want part of the information kept confidential, while others want the information they provide raised with the abuser. Given the lethality of domestic violence, the practitioner should avoid repeating to the abuser what victims have said. The victim's wishes about confidentiality must be respected (principle 1 in Figure 3-1). Furthermore, respecting her request for confidentiality (whether or not she is the health care provider's patient) conveys to her that she has the right to make decisions about her own life and to have others abide by those decisions (principle 2 in Figure 3-1).

Even when a victim asks the provider to talk directly with the abuser about the abuse, the health care worker should first explore with her the possible consequences of such action. The clinician should review with the victim how the perpetrator would respond to knowing that she has revealed the abuse. Is she in danger? Will he retaliate? Will she be safe if the health care provider discusses the topic directly with the abuser? The health care provider should not presume that talking directly with perpetrators will automatically decrease or increase her safety. Some victims have not considered the outcome and may, with further thought, want the information to remain confidential. Sometimes victims have carefully considered the consequences and want the health care provider to proceed (e.g., the victim who says, "I told him I was going to tell you and if you don't say anything, he will think you agree with him that I am crazy"). If the health care practitioner is going to communicate any of a victim's information directly with the abuser, there should be a specific agreement with the victim about which information will be shared and how the discussion will take place.

What is also problematic and dangerous is revealing to the perpetrator what a third party (e.g., an EMT worker) has said, when the comments are based on victim reports. This information should not be revealed to the perpetrator. Obviously, use of information provided by the victim would be an exception rather than a rule and in even these limited circumstances would be used only for victim safety and advocacy.

B. Discussions with the Perpetrator About Domestic Violence Should Never Be Done in the Presence of the Victim

When the health care provider wishes to discuss abuse with the perpetrator, the discussion should be carried out with him in private. Victims, children, friends, and family should not be present during these interviews. Since medical personnel often see patients privately for assessment or treatment procedures, domestic violence issues can be discussed during that individual time. Discussing the abuse with the perpetrator alone is one more way that the provider can emphasize the perpetrator's responsibility for the abuse and for stopping it.

C. Taking Care in How Domestic Violence is Discussed with Perpetrators

The health care professional must exercise care in how the discussions are

carried out. Some approaches will increase the likelihood that the perpetrator will become defensive and retaliate against the victim, while others lower the risk. Even when the clinician uses all of the approaches described below, there is no guarantee that the victim will be safe. Unfortunately, simply remaining silent in the face of batterers' reports of their abusiveness may also endanger the victims. Some batterers use the silence of those whom they know are aware of the abuse as further justification for it. And sometimes they will batter their partners with statements such as "I told the doctor that you deserved what I did, and he agrees. He knows about my hitting you, but he has never said anything to you about it, right?"

The health care provider should use approaches that:

1. VIEW DOMESTIC VIOLENCE AS A HEALTH CARE ISSUE.

When talking directly with the perpetrator about the abuse, the health care practitioner should emphasize that such issues are discussed with patients in order to best meet their health care needs. The issue of abuse is a health care issue for the patient who is abusive as well as for victims and their children, and this should be communicated to that patient who is a perpetrator.

2. EMPHASIZE THE ROUTINE NATURE OF THESE DISCUSSIONS.

As with all health care issues, the health care provider is often in the position of educator, providing patients with information necessary for their health. The purpose of the discussion is not to investigate or prosecute a crime. While it is appropriate at times (e.g., when there is a duty to warn, state mandatory reporting requirements, or victims seeking legal protections) to refer specific domestic violence cases to legal entities and to remind perpetrators that domestic violence is a crime, the primary role of the health care provider is to meet the health care needs of patients. If the health care worker functions as a police officer, prosecutor, or judge then some perpetrators' defensiveness will increase and they may retaliate against the victim or health care worker.

3. FOCUS ON DESCRIPTIONS OF THE ABUSER'S BEHAVIORS.

When initially talking with perpetrators of domestic violence, the provider should use descriptions of their behaviors rather than terms like domestic violence, abuse, or battering. It is helpful with perpetrators to make comments such as: "When you threw her to the couch" rather than "when you abused your wife," or "you hit your girlfriend with a closed fist" rather than "you beat her," or "your use of physical force against your partner" rather than "your domestic violence."

Terms like "wife beater," "perpetrator," "batterer," and "abuser" should also be avoided in initial contacts about this issue. When the health care provider has had multiple contacts with the patient and has established a working relationship with him about the domestic violence, those terms can be used, but not when first encouraging the patient to discuss the abuse.

4. FOCUS ON THE ABUSER'S BEHAVIOR RATHER THAN THE VICTIM'S.

As abusers talk about their domestic violence, they often focus on the victim's behavior rather than their own. They gloss over their actions and will go into long stories blaming victims or others for their problems. It is easy to be confused by some of these rationalizations and to unintentionally reinforce the abuser's behavior by making sympathetic comments about these explanations (e.g., "I can understand why you are mad at her"). The discussion should avoid such commentary and be

focused on the abusers' behaviors and their negative consequences (e.g., "hitting never solves problems," "your violence is destroying all of you").

Even when the victim is available and has given specific permission for the clinician to share information with the perpetrator, it is safer for the victim when the provider's comments focus on the abuser's behaviors rather than on the victim (e.g., "you said you threw your wife" rather than "your wife told the police officer you threw her"). The provider can also focus on what the health care worker or third party directly observes (e.g., "your injuries look like someone tried to free themselves from a hold" rather than "your wife said she did this when you were choking her").

5. USE A DIRECT AND CALM APPROACH.

Care should be taken to approach the topic directly, matter-of-factly and calmly. A health care practitioner who vents his or her anger, disgust or shock about this issue to the perpetrator may well endanger the victim. While the health care practitioner can take a stand against the use of force in intimate relationships and can point out to patients who are perpetrators their responsibility for making changes, the methods selected to convey those points can increase or lower defensiveness. For some batterers, their defensiveness with the health care provider translates into retaliation against their victim.

D. When Perpetrators Display Anger, Resist or Reject the Discussions of Abuse

If the perpetrator is not open to talking about this issue with the health care practitioner, then forcing the issue will raise resistance in the patient and may endanger the victim. As stated earlier, some perpetrators are willing to talk and listen about abuse when it is presented as a health care issue by a concerned provider while others will reject this or any other approach to the topic. While principle 3 is holding the abuser, not the victim, responsible for the abuse, it is important to remember that the health care system's role is not to force patients, but to educate them about how to care for themselves and, ultimately, for others. The perpetrator's display of anger and other tactics of control in the session with the health care provider indicates that the perpetrator is not motivated to change at that time. It is more productive to make a summary statement, calmly bring the subject to a close, and then move back to the presenting medical issue:

"Your using force against your partner and property is damaging both of you. I am concerned and will be glad to make a referral whenever you want it."

"You've indicated that you are concerned about your violence with your wife. Let me (or a referral) know when you want to talk about it further."

"Unfortunately, drinking or drugging is only part of the problem. I would like you to think about how your abusiveness is damaging to you and your family."

II. LEARNING THAT YOUR PATIENT IS A PERPETRATOR

Perpetrators of domestic violence are identified in a variety of ways by the health care system:

A. Medical Records or Written Referrals

The domestic violence perpetrator may have been identified by another health care practitioner and this may be noted in the medical records. Such information may be indicated by a clinician in the following ways:

- "patient violent with spouse,"
- "patient broke (hand, leg, arm, ribs, etc.) when attacking spouse,"
- "patient missed appointment; in jail for domestic violence assault,"
- "patient's wife unable to participate as caregiver following the bone marrow transplant due to no contact order, secondary to spouse abuse,"
- "patient referred to clinic by domestic violence program, requests evaluation for high blood pressure (or any other medical condition),"
- "counseling note in chart from an on-site domestic violence perpetrators group," etc.

The more knowledgeable health care providers and referral sources become about domestic violence, the more frequent such notations may appear in medical records. In medical facilities serving large numbers of male patients, such as Veterans Administration Medical Centers or U.S. military medical facilities, trained practitioners note domestic violence as a health care issue in perpetrators' medical records. As health care systems are integrated and become more comprehensive (HMO's, managed care systems, etc.) then notes about domestic violence may appear from other parts of the health care system (e.g., substance abuse programs, domestic violence programs).

B. Reports by Victims or Children

Sometimes victims or children accompany the perpetrators to their medical appointments and are present with the perpetrator patients. Victims or children may also be patients in the same setting (such as a family practice). The victim or children accompanying the perpetrator may tell the provider directly that the patient is abusive. In the course of giving a medical history about the patient, the victim may describe his violent behavior (e.g., "His asthma attacks have been more frequent since he got arrested for assaulting me," "My daddy broke his hand hitting mommy," "Something is wrong with him, he drinks and hits me," "He just kept throwing furniture out the front window. I told him he would injure his back").

The victim or children may talk about abuse with the health care practitioner in the presence of the abuser or privately. They provide such information seeking medical help for the problem, believing that the abuser's behaviors are caused by a medical issue, or believing that health care professionals have the authority or influence to stop the violence. It is critical to treat the information seriously and respectfully and to be aware that all parties will observe how the situation is handled by the provider.

If the victim tells the provider about the

abuse in front of the abuser, it is important for the provider to respond calmly to the information and indicate (a.) that some patients act in these ways, (b.) that the provider appreciates knowing about it, and (c.) that the provider will be glad to be of as much assistance as possible because this kind of behavior hurts the health of all family members. At this stage the clinician is welcoming all information and is not attempting an intervention. Additional information will be needed before taking further action. The clinician should speak, then or later, separately and confidentially with the victim.

If the victim or the children discuss the abuse privately with the practitioner, the clinician should inform the victim that their conversation is confidential unless she requests otherwise or unless the health care practitioner is required to make a report (see section on mandatory reporting on page 100). In addition to referring the victim for a confidential follow-up conversation for further assessment and safety planning (see victim's chapter), the health care practitioner should ask victims if they want their conversations to remain confidential. It is essential to obtain the victim's permission to discuss the abuse with the perpetrator, and the victim's perspective of the risks of talking with the perpetrator about abuse. The practitioner should also give the victim a referral to a local domestic violence program.

Always advise the family member that the information is valuable and that you are glad they shared it with you, even when the information is provided by telephone and the victim is asking for strict confidentiality. Such reports provide opportunities for responding to the victim's needs and may help the health care practitioner to understand what a perpetrator may be struggling to conceal or disclose.

C. Reports by Third Parties

The patient may be identified as a perpetrator of domestic violence by a third party such as the responding police officer, the Emergency Medical Technician, the person accompanying him to the emergency department, or through phone calls by other family members or friends. For example, the EMT worker states that when he arrived at the house, he observed the patient lying unconscious, the wife with a split lip and swollen left eye, and the Christmas tree lying outside, having been thrown through the picture window. The wife told the EMT that the husband had a chronic heart condition and that he had passed out during the assault against her. She had called the hospital emergency room for medical help for "his heart attack."

D. Self-Reports by Perpetrators

Some patients who are perpetrators self-disclose their abusiveness. They may do this because they are seeking help for the problem or because they believe that their abusive behavior is a symptom of some medical condition (e.g., patients report increasing fights with their partners in which they strike out or "lose it," report incidents where they hit their partners or furniture, or reports that family members are afraid of them). For those batterers who are not in total denial and who are troubled by their behaviors, the health care system may be their choice for seeking assistance. While they may be minimizing their behaviors and may not use the terms domestic violence or abuse, they describe behaviors that clearly fit the definition of domestic violence and ask for help for their "tempers," "marital problems," etc. Occasionally because of public education or the intervention of another party, the patient may actually identify his behavior as domestic violence and turn to the health care system for assistance (e.g., "I saw this program on TV and realized that I am a wife beater and I thought you could give me some medications for it").

Sometimes patients self-disclose

abusive behaviors not to seek assistance but because they do not believe that what they are doing is wrong. For example, in the course of the medical treatment a patient acknowledges using force against family members. "I had to give her a pop or two to keep her in line." "She pulled a knife when I threw her down the hall. That's how I got cut." "We were arguing in the car. I just wanted to scare her so she would shut up. I lost control of the car and we hit the embankment."

Perpetrators will talk about their violence in many different ways. They will minimize, justify, or blame their violence on others. Some will brag about the violence, while others will deny or lie about it. Whether or not the patient sees it as domestic violence, the practitioner can matter-of-factly characterize the patient's behaviors ("popping her," "driving to frighten someone," "throwing someone," etc.) as a serious and potentially life-threatening problem for him as well as for other family members. Once again, a matter-of-fact approach is important in gathering information about battering and conveying to the patient the provider's concern about abuse.

E. Observation of Perpetrators' Abusive Behaviors in a Health Care Setting

Health care providers may identify patients who are perpetrators of domestic violence by direct observation of their abusive behavior. Emergency department personnel have described incidents where a perpetrator followed the victim into the health care setting and continued the beating. "While they were waiting to be seen by the emergency doc, he started yelling at her to stop bleeding and suddenly he started punching her." "One battered woman ran into the emergency department yelling for help, followed by her knife wielding boyfriend." "Just as the nurse entered the cubicle to prepare him for stitches for a minor cut over his eye, the man threatened to kill his partner if she told the doctor what had really happened."

When the violence and/or threats of violence occur within the health care setting, health care providers should intervene to immediately stop that particular abusive episode by calling security and by separating the victim and perpetrator. The victim should be provided emergency assistance while still at the medical facility (see victim's chapter). The victim should also be given information about the local domestic violence program and assisted in contacting the program while still in the health care setting if she wishes. Direct observation of violence and/or threats of violence should be noted in the perpetrator's medical records. The information is relevant to the continued treatment of this patient and is essential to the safety of the victim. Copies of police reports should also be included in the patient's records.

When the health care provider observes incidents of non-violent, coercive control used by the batterer against his partner (e.g., during treatment, the staff observe the perpetrator conducting surveillance of his partner through excessive telephone checks), further assessment would be necessary to determine if that patient is a domestic violence perpetrator before a provider can respond.

F. Observation of the Effects of Abusive Behavior

There may be no observable incident or direct report that clearly identifies a patient as a perpetrator of domestic violence. However, the health care worker may observe the results of possible domestic violence: scratches, cuts, or bruises to the perpetrator's face, arms or hands secondary to his own violent

behavior; injuries to his body caused by his attempts to terrorize the victim (e.g., reckless driving, suicide attempts, breaking windows, doors); or a medical condition that is aggravated by his abusive behavior toward the victim (e.g., asthma attacks, heart attacks, etc.). As the patient talks about the presenting medical concern, the domestic violence may be revealed.

The health care provider may observe the effects of the perpetrator's abuse on victims or children who accompany the perpetrator to his health care appointments: visible injuries, their fear of the patient, their excessive attention to his every move or wish, his attempts to control them, etc. These may be indicators that the patient is abusive, but they alone would not warrant a patient being positively identified as violent.

III. ASSESSMENT OF LETHALITY WHEN THE PATIENT IS THE PERPETRATOR

One of the major issues in responding to identified domestic violence cases is the reality that domestic violence is lethal. Domestic violence dramatically increases the risk for serious injury or death to any family member. Injury or death occurs either through the acts of the abuser, the victim, or the children. Typically it is abusers' violent conduct against victims that results in serious injuries or death to victims. Sometimes in pursuit of controlling victims, perpetrators also injure or kill children, others, or themselves. Sometimes it is the victim or children who injure or kill themselves or others as a response to the violence of the perpetrator.

Assessment of risk for injury or death is difficult as illustrated by the controversy about the efficacy of assessments for predicting homicides.[2] The debate stems from the fact that ultimately we cannot know with absolute certainty which batterers will commit homicide. Dangerousness assessments are not precise, scientific tools; they are attempts to identify batterers who are more likely to kill their partners. Furthermore, predicting homicides is only one way to understand the risk in domestic violence for injury or death. Unfortunately, there are similar difficulties when attempting to predict injuries or death due to domestic violence as those found in predicting homicides. Overpredictions of injury or death and underestimations of risk are always possible. Nonetheless, since domestic violence can result in significant injury or death, the responsible health care provider should, at a minimum, attempt to determine the danger of immediate harm.

Assessment of risk for injury or death should be conducted every time the health care provider has contact with an identified perpetrator or victim of domestic violence. The lethality assessment is used to determine whether or not there is immediate danger and what steps can be taken to reduce the danger level. The primary source of the information is the patient present, whether perpetrator or victim. A complete assessment of lethality involves gathering information from all who have information relevant to the lethality question.

While more research is needed to improve predictions of danger in domestic violence cases, the lethal nature of the violence makes it imperative that clinical assessments of lethality are routinely carried out, using clinical judgment as a guide. The following are factors to consider in assessing the lethality of the

[2] Hart, B. J. & Gondolf, E. W. (June 1994). Lethality and dangerousness assessments. *Violence UpDate*, 4(10), 7-10.

domestic violence (see Appendix K for Lethality Assessment with the Perpetrator). Each of these factors is important individually and in interaction with the others.

A. Pattern of Abuse

While it is difficult to predict which perpetrator will escalate the severity of his physically abusive behaviors, an examination of the current pattern will reveal who is already engaging in high risk behaviors such as choking, use of weapons, burning, throwing, and beating. By considering the following areas, the health care provider can assess danger based on the current level of violence:

a. frequency and severity of abusive acts in current, concurrent, and past intimate relationships; possible escalation of frequency and severity;

b. availability of and use of weapons;

c. threats to kill self or others; credible plans and means to kill;

d. hostage taking behavior;

e. use of violence outside family;

f. stalking behavior;

B. Perpetrator's Access to the Victim

When the batterer's level of current violence is high and the perpetrator has access to the victim, the danger potential is high. Reduced access, such as when the victim is in hiding or the perpetrator is in jail, reduces the risk of injury or death. Since battering is about having the opportunity to abuse, then not having access reduces the opportunity.

C. Factors that Reduce Cognitive Controls

- alcohol/drug dependence or abuse
- certain medications
- psychosis or brain damage

For perpetrators, any one of these factors combined with their violence increases the risk for injury or death. Certain prescribed medications (e.g., anti-anxiety drugs) as well as alcohol or illegal drugs may act as dis-inhibitors, making the use of physical force against partners more dangerous. For example, while under the influence, perpetrators may become less concerned about potential negative consequences, which have served as deterrents for some of the more lethal acts of abuse. As previously noted, alcohol and other drugs do not cause domestic violence. However, by reducing inhibitions they may increase a batterer's potential to commit serious harm or murder. If present, psychosis or brain damage may lessen the abuser's cognitive controls over his behavior, and those perpetrators may engage in more dangerous behaviors.

Victims who are substance abusers, who are on certain medications, or who have psychosis or brain damage may be at higher risk for serious injury or death. Any of these factors may compromise their ability to protect themselves from their partner's violence. For example, these factors make it more difficult to escape or carry out any part of a safety plan.

D. Perpetrator's State of Mind

- obsession with victim
- increased risk taking by perpetrator

- ignoring negative consequences to his abusiveness
- depression; desperation

Batterers who seem obsessed and preoccupied with controlling their victims, who have been taking increasing risks (e.g., assaulting partner in public, being more public with their tactics of control by including family and friends in the abusive tactics, stalking), who have been ignoring negative consequences (e.g., arrests for violations of no contact orders), and who are expressing more depression or desperation (e.g., repeated, public displays of crying, agitation, etc.) are escalating their tactics of control and becoming more dangerous.

E. Suicide Potential of Perpetrator, Victim, or Children

Suicide potential in domestic violence cases also needs to be evaluated using the same techniques as any suicide assessment (threats, attempts, plans and means for suicide). In domestic violence cases, suicide assessments should be done for all family members, including the victim, children, and perpetrator.

F. Situational Factors

- separation violence
- increased autonomy of victim
- other major stresses

As discussed in the overview chapter, there is growing evidence that one of the most dangerous periods for the victim of domestic violence is the point of separation. Some batterers will go to extreme measures to maintain their control over victims, by escalating their violence and even committing homicide. Even when there is not an obvious, physical separation, the batterer may perceive the victim as increasing her autonomy (e.g., returning to school, getting a work promotion, being more focused on parenting) and may attempt to re-establish control by resorting to increased violence. Since many batterers expect victims to take responsibility for virtually everything in the batterer's life, situational stresses like lost jobs, conflicts with friends, and increasing financial pressures can become excuses for the perpetrator to increase attacks against the victim.

G. Past Failures of the Community to Respond

One factor often overlooked in evaluating danger is the previous encounters batterers have had with the community about the abuse. For example, when batterers are rewarded (e.g., peer support, jokes by responding police officers) or not held responsible for their abuse (e.g., charges are dismissed, guns are returned, court orders are not enforced, others engage in victim blaming), then batterers come to believe that they can do anything to their partners and they will suffer no consequences. Their abuse escalates. While there has been concern about the potential for retaliation by some abusers against their victims when the community does act (e.g., by granting a protection order), equal attention needs to be given to the increased danger victims face when a community fails to act appropriately and thereby sanctions the perpetrator's abuse.

IV. CRISIS INTERVENTION STRATEGIES

When the potential for injury or death is high, there are multiple crisis intervention strategies that can be used with the patient who is the abuser. The crisis intervention strategy selected will depend on (1) the nature of the threat, (2) who is in danger, and (3) the resources that are available to deal with the crisis. This section focuses on strategies to use with an abuser who represents a danger to victims or self.

A. Duty to Warn When the Health Care Professional Believes the Victim Is in Danger

Health care practitioners must be aware of their legal and ethical responsibilities to warn victims about potential assaults against them. There is a duty to warn when there is a clear and present danger to a specific victim or victims. In domestic violence cases, a specific victim is targeted and thus if the health care provider believes that the patient is a serious threat, then the victim of that patient should be notified. In some circumstances other appropriate authorities must be notified. Health care personnel should be aware of their facility's policies and procedures for duty to warn.

B. Legal Recourses and Mandatory Reporting

At some time, providers may be faced with the abuser who is likely to kill if not contained. Depending on the situation, a mental health commitment or call to law enforcement may be appropriate. Given the variance in law enforcement interventions, involuntary mental health commitments, and involuntary substance abuse commitments, it is beyond the scope of this manual to make specific recommendations. Health care practitioners should become familiar both with local laws and the policies and procedures of their practice settings. If there are no procedures in effect, they should be developed before the crisis emerges.

While mandatory reporting is not a crisis intervention strategy, the issue is often raised in response to the most serious and lethal situations of domestic violence. Since health care providers may be required to report injuries they suspect result from domestic violence, it is important that providers become familiar with their state's reporting laws. Mandatory reporting laws are widespread. For example, 40 states and the District of Columbia mandate reporting by health care personnel under certain circumstances where the patient has an injury that appears to have been caused by a deadly weapon. Statutory mandates regarding reporting vary greatly from state to state about who is required to report, what kinds of injuries need to be reported, and penalties for failure to report and/or immunity from liability, and so forth. To find out more about individual practitioner reporting responsibilities, contact the legal department of the facility and/or call the legal department of the state medical society. (Refer to Appendix N for a more lengthy discussion of the potential consequences of mandatory reporting and a summary of state statutes).

In addition to duty to warn procedures and legal interventions, practitioners can use a variety of other crisis intervention strategies, depending on whether the lethality risk is from homicide or suicide and depending on who is in danger of harming whom. Some of the strategies require the perpetrator's cooperation and some do not (e.g., being jailed for crime, mental health

commitment, victim going to the battered women's shelter).

C. Recommending Temporary Separation

One cluster of crisis intervention strategies for domestic violence is designed to interrupt perpetrators' access to victims by having victims and abusers separate. Health care providers can recommend that the perpetrator temporarily separate from the victim during a crisis period (e.g., the abuser moves in with a friend, sleeps in his car, or somehow stays separated from the victim). The practitioner can engage the patient in suggesting ways to temporarily separate from the victim. Providers can also indicate to the perpetrator that they support the victim's decisions to temporarily separate through protection orders or through stays in a shelter. The patient should be reminded that these temporary steps are helpful in preventing injury and the perpetrator will need to take additional steps to stop his violence permanently. By recommending crisis strategies the health care provider can emphasize to the perpetrator the serious nature of the current crisis and his responsibility for stopping his abusiveness.

D. Strategies to Diffuse the Crisis

When the perpetrator refuses to even temporarily separate from the victim, the health care provider may recommend a different set of strategies: those designed to defuse an immediate episode where the batterer is highly likely to strike out at the victim. Examples of diffusion strategies include: referrals to domestic violence intervention programs or substance abuse programs, recommendations to temporarily discontinue use of alcohol or other drugs until further interventions can be established, advising perpetrators about the danger of weapons and recommending that weapons be removed from the crisis, and advising perpetrators about the potential for arrest and incarceration. All of these crisis intervention strategies require the cooperation of the abuser to act to stop his violence. Some perpetrators will ignore whatever suggestions are made, while others will surprisingly comply simply "because the doc told me to." Since there is no way to predict which strategy to use with which batterer, it is helpful for providers to suggest several and to encourage perpetrators to list out their own approaches to stopping their violence.

V. OTHER HEALTH CARE INTERVENTIONS WITH PERPETRATORS

In addition to crisis intervention strategies, the health care practitioner can provide to the perpetrator important patient education and referrals to batterer intervention programs, where available. The practitioner's interventions will vary according to the presenting issues, the practice setting, and the amount of contact between the provider and patient. Furthermore, the interventions used will vary from individual patient to individual patient depending on what is learned about the nature of the abuse, its impact on the patient, other medical or mental health issues of the patient, the patient's motivations, resources, and abilities to deal with his abusiveness, his willingness to take responsibility for his battering behavior,

and the resources available to the practitioner. In spite of these variations there are basic steps that can be taken.

A. Patient Education: Abusive Conduct and Health Issues

A health care provider treats the presenting medical (and/or mental health) concerns of the patient. When the patient is a perpetrator of domestic violence, part of that treatment is evaluating how the abuse may be a causative factor in the presenting problem or how it may be a factor in the patient's recovery or how it may lead to future injury or death. These connections will have to be pointed out to the perpetrator (e.g., "your violence is self-destructive," "your behavior isn't good for your heart," "your violence leads to ____(medical condition)").

In addition to seeing the connection between their behavior and their own health, batterers often need assistance in acknowledging the destructive impact of their abusiveness on victims, children and others. Those health care systems (e.g., family practitioners or HMO's) that respond to all members of the family are well aware of how one person's high risk behavior shows up as the injury or illness of a family member in another part of the system. Conveying to perpetrators general information about the health impact of victimization can assist some to identify their behavior as an issue worth addressing.

B. Patient Education: Domestic Violence, Its Impact on Victims and Children, and Perpetrator's Responsibility

Because of their lies, distortion, and justifications for individual episodes of domestic violence, batterers are able to keep themselves from looking at the true nature of their domestic violence. Patient education about abusive conduct as well as the impact of that pattern on victims and the children should be explored with the perpetrator. For some perpetrators, the reality that domestic violence is a crime and that there are specific consequences must be pointed out ("Did you know you could go to jail for hitting your wife?").

Most importantly, batterers need to be educated about their individual responsibility for battering. Because domestic violence is so embedded in social customs, this education may be the first time they have heard from someone that they are responsible for what they are doing and for changing it.

This patient education can be direct and brief. It can be presented calmly and respectfully.

- Your behavior is damaging to everything that is important to you and the fastest way to stop that damage is for you to change those behaviors (listing specific examples of physical abuse disclosed to the practitioner).

- Using force will never solve the problems in a relationship or family. In fact it makes them worse.

- I see other patients with this problem and they said they were able to change only when they started taking responsibility for what they were doing.

Patient education can be repeated during future appointments, and if

combined with other community efforts may result in some individual batterers changing their abusive patterns. At a minimum such patient education by a practitioner ends the silence of the health care system and its perceived collusion with the batterer.

C. Listening to the Patient's Concerns

Listening to and working with abusers without colluding with them or participating in their victim blaming is a very difficult task. Some batterers are highly manipulative and will attempt to engage the health care provider in blaming their victims. At this point it is crucial to keep the focus on their abusive behavior and their responsibility to stop it. However, it is also important for the practitioner to listen for what may be a motivation from the abuser's perspective for him to change. Listening to the perpetrator's concerns about his conduct may reveal his awareness of the legal consequences to his actions as well as the negative impact on his partner, his children, his job, his standing within his community, his health, etc. By identifying those negative consequences and connecting them to the abusive conduct he chooses to use, he starts the process of changing his destructive patterns.

In listening to the perpetrator, the health care provider may hear information about all or some of the following:

1. THE PATTERN OF ABUSIVE CONDUCT:
   - types of abuse
   - frequency and severity of the physical force used

2. IMPACT OF THE ABUSE ON THE VICTIM:
   - injuries and other health issues
   - depression, withdrawal, rage, fear
   - impact on her relationship with others
   - employment and legal issues (See Victim's Chapter regarding impact on the victim.)

3. IMPACT OF THE ABUSE ON CHILDREN:
   - injuries
   - behavior problems
   - relationship problems
   - emotional difficulties

4. IMPACT OF THE ABUSE ON THE PERPETRATOR:
   - health issues
   - impact on his relationship with victim and children
   - legal issues
   - employment problems
   - prior interventions or attempts to get assistance

5. PERPETRATOR'S CURRENT MOTIVATION TO VIEW HIS ABUSIVENESS AS A PROBLEM HE WANTS TO ADDRESS.
   - This information is useful in developing responses to individual perpetrators and in engaging the perpetrator in taking responsibility for changing his behaviors. There are very real time constraints in health care contacts with perpetrators and consequently the information from one contact may be incomplete. Furthermore, many perpetrators minimize, lie and deny and will not provide a complete

picture of the abuse. Therefore, it is helpful to note any information about abuse in the chart. A more accurate description of the domestic violence is more likely to emerge through the record of these multiple contacts.

It is important to reflect back to him the ways in which his behavior is having a negative impact on him (list any of those he has already indicated in his discussion of his concerns, such as the impact on the children) as well as his power to change his behavior and stop the abuse. These identified consequences may become motivators for change. If the provider joins the abuser in blaming the victim or some other external factor (e.g., drinking, stress) for his abusiveness, then the abuser will use the health care practitioner's comments or silence to shore up his belief that he has a right to use violence to control his family.

It is important not to let the abuser use the patient/doctor privilege as a way to further control the victim. The health care provider has a unique and potentially powerful role as one who helps the perpetrator by holding him responsible for changing this self destructive behavior. While this approach may not be successful with all abusers, it can be very effective with some and can become part of a comprehensive, coordinated community response to domestic violence.

D. Discussing Options

Part of the purpose of discussing options such as safety planning with victims is to support their self-empowerment and their safety. That is not the purpose of discussing options with batterers. Batterers are already powerful in their use of violence and abuse to control others. They are misusing that power. Instead, the purpose of discussing options with batterers, such as time-outs or temporary separation or referrals to specialized programs, is to engage the patient in taking responsibility for changing his abusive conduct. Abusers come from diverse backgrounds and have multiple issues (cultural, sexual, substance abuse, mental or physical abilities, HIV, etc.) which may relate to interventions for the domestic violence. Practitioners need to be sensitive about these without letting abusers use them as a way to avoid taking responsibility for their violence. The typical response of a batterer is to make the victim responsible for fixing whatever is wrong in their life. Discussing options is one way to keep the focus of responsibility for change on what the individual batterer can do.

E. Making Appropriate Referrals

Unless the health care setting has on-site specialized programs for batterers,[3] the provider will most likely be referring batterers to available community programs. In making these referrals, the practitioner should exercise caution and care. Traditional counseling (couples, individual, or family) or traditional rehabilitation programs (substance abuse, mental health, etc.) do not appear to be effective. For this reason, it is important for health care professionals not to encourage perpetrators to seek traditional couples counseling for their abusive behavior. Couples counseling may endanger victims of battering even further, as they face violence or threats of violence for revealing information about the abuse during therapy sessions. Additionally, couples counseling may inappropriately indicate to both victims and perpetrators that the perpetrator's violence is somehow a "relationship

[3] For example, some Veterans Administration Medical Centers, some military medical facilities, and certain substance abuse programs have specialized programs for perpetrators of domestic violence.

problem" that the victim has some responsibility to fix. Unless the counselor is skilled in keeping the responsibility for changing the abusive behavior squarely with the abuser, the traditional approaches quickly become means for the abusers to continue to manipulate the victim.

The health care provider needs to know which community resources are known to be effective in responding to batterers. The health care practitioner can contact the state or local domestic violence coalitions for information about perpetrator programs. A limited number of states have established standards for abuser programs and some require a certification process for those programs. If there are no specialized domestic violence perpetrator programs, the domestic violence coalitions may know of other appropriate resources available for abusers. (See Appendix K for Assessing Services for Perpetrators.)

Specialized rehabilitation and educational programs have been evolving for batterers. These programs use group treatment and education for men who batter and focus on the responsibility of the abuser to change their abusive conduct. The outcome data on their effectiveness remains limited. Those programs that seem to be the most effective are embedded in a coordinated community response that has both a legal and a rehabilitative component.[4] For example, the batterers' treatment program operated by the Domestic Abuse Intervention Project of Duluth, Minnesota involves a close working relationship with law enforcement and the courts. The institutions work together as part of a community-wide response to hold abusers accountable for their violence, to prosecute them for criminal conduct, and to provide them with the opportunity to seek educational groups for their abusive behavior. What appears to be changing their abusive behavior is not just the participation in the abuser groups, but the coordinated effort of the community to reinforce the message that batterers are responsible for their abuse and that abuse has serious, negative, legal and social consequences.

For some batterers no treatment program will be effective and incarceration may be the only way to protect their victims. When making a referral to an outside agency, it is important to know that at a minimum the perpetrator program follows the same guidelines as outlined at the beginning of the chapter: victim safety, victim integrity and authority to direct her life, and abuser responsibility for the abuse and for stopping it. Furthermore, it is important for the practitioner to tell the patient directly that the purpose of the referral is to assist him in stopping his abusive behavior, and not to use euphemisms like "anger management" or "family counseling" which masks the true nature of the problem and only plays into the abuser's denial of his problem.

F. Establishing a Follow-Up Process

Domestic violence is a pattern of behavior that is supported by the victim-blaming tendencies rampant throughout the community. Too often the response of peers or other community institutions reinforce the perpetrator's abusive control. An individual's abusive conduct does not go away after one or two short interventions. Consequently, it is important that the health care practitioner follow up with inquiry about abuse in future contacts with the patient. The health care practitioner can raise the issue directly by statements such as:

> "The last time we talked, we were talking about how you could stop your abusive behavior. I would like to check on how you are doing. Since I last saw you, have you used physical force against person or property in fights in

4Sheppard, M. (1988). *Evaluation of the educational curriculum — Power and control: Tactics of men who batter.* Duluth, MN: Domestic Violence Intervention Project.

the family? Any shoving, pushing, or throwing things? Any threats of violence?"

Also, if referrals were given, ask about follow-through. If the patient claims that everything is fine, remind him that domestic violence is a problem that does not go away on its own. Encourage the patient to talk about it. This follow-up provides the practitioner with the opportunity to reassess the patient's abuse pattern, to confront distortions when found, and to reinforce progress if made.

CONCLUSION

There is still much evolving concerning appropriate responses to patients who are perpetrators of domestic violence. While this chapter attempts to provide some guidance for approaches, systematic study is needed to determine which approaches are most effective with which perpetrators.

This chapter is written with an understanding that no one system alone can stop domestic violence. Perpetrators may change over time due to multiple, cumulative experiences. Unfortunately, domestic violence remains embedded in many community customs and institutions. The interventions described in this chapter will be most effective as they become part of an overall coordinated community response, which places a priority on victim safety, victim integrity and authority, and perpetrator responsibility. The interventions described in this chapter are only one way to communicate that violence and coercive control are criminal and never justified in intimate relationships. There is no excuse for domestic violence and that message is just the beginning of change.

Chapter 4

Establishing an Appropriate Response to Domestic Violence in Your Practice, Institution And Community

By Carole Warshaw, M.D.

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Introduction

In order for clinicians to develop and sustain an appropriate response to domestic violence, they must have the support of the institutions in which they practice. As health care professionals attempt to incorporate routine inquiry about abuse into the standard of care for all women patients, the need for a coordinated institutional response to domestic violence becomes increasingly evident. This chapter addresses strategies for changing institutions and practice settings to support and encourage health care providers to meet the needs of victims of domestic violence.

Providers acting alone simply cannot meet all of the needs of domestic violence victims and their children. The optimal response to domestic violence requires the coordinated efforts of all members of the community, including health care providers, community-based domestic violence advocacy groups, child welfare and protective service agencies, and the civil and criminal justice systems. This chapter will describe how to work within clinical practice settings, health care institutions, and communities to develop such a coordinated response. It will also describe strategies to assure that battered women receive appropriate care within individual practice settings. The following issues will be addressed:

- Creating a practice environment that enhances rather than discourages identification of abuse.
- Educating health care staff about domestic violence intervention.
- Developing an integrated response to