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Batterer Psychopathology: Questions and Implications

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Before the early seventies there was virtually no study of spouse abuse. Only five brief studies of the problem existed in the social sciences, and all incorrectly implied that it was the wife who caused the problem by provoking her mate. It was not until 1972 that "spouse abuse" was given a heading in social science indexes.[1]

Battering between intimate partners is now known to be perpetrated overwhelmingly by men against women, with women sustaining the greater and more severe injuries. When women batter it is almost always in an effort to defend themselves.[2]

There is general agreement that whether a woman will be victimized is independent of her characteristics and behaviors;[3] it is even unrelated to how much exposure she had to family violence as a child.[4] Studies comparing abused women with nonabused women in relationships fail to find significant differences.[5] It is a woman's being in a relationship with a batterer that determines whether she will be battered.[6] For most battered women, recovery from the effects of repeated traumatic abuse happens once she lives in a violence-free atmosphere, particularly if she is supported by a domestic violence program or social, family and work relationships.[7]

Therapy is generally unnecessary for battered women to recover.[8]

Much of the literature about domestic violence has claimed that batterers differ little from the general male population, with very few of them being psychopaths.[9] The best predictor of a man's violent behavior toward his partner, according to this literature, was his history of past violence, including his having witnessed or experienced violence while growing up.[10] Of men in treatment for battering their current partner, 93% had battered a previous partner.[11] Most batterers were believed to have no behaviors which would permit any DSM-III diagnosis.[12] Rather, batterers learned to be violent and were rewarded for their behavior over time.[13] Their coercive battering behavior worked and was reinforced by socialization.[14] Unlike other violent offenders, whose violent acts diminish as they grow older, batterers become more violent in both frequency and intensity over time.[15] Batterers are resistent to treatment and have high recidivism rates even when treated for their abuse: at least half of treated male batterers continue their violence with new partners.[16]

While we may not know what causes battering we do know that hormones have little effect on male violence against women.[17] Similarly, alcohol, though strongly correlated with wife beating, does not cause it.[18] Social learning is believed to be the crucial intervening variable that enables those who ingest mood altering substances to abuse their family members.[19] However,

some drugs such as barbiturates, cocaine, amphetamines and phencyclidine (PCP) may cause some users to become violent.[20]

New Theory That Most Batterers Have Pathology

In contrast to the old view that saw batterers as mostly normal, some of the recent literature on batterers claims that most and possibly all batterers do have psychopathologies. "Psychopathy is a personality disorder defined by a constellation of affective, interpersonal, and behavioral characteristics, central to which are a profound lack of empathy, guilt, or remorse, and a callous disregard for the feelings, rights, and welfare of others. . . . [P]sychopaths typically are glib, egocentric, selfish, callous, deceitful, manipulative, impulsive, sensation-seeking, irresponsible, and without 'conscience'."[21]

Edleson and Tolman have worked for over a decade with many hundreds of men who batter in Alaska, New York, Minnesota, Chicago, Israel and Singapore. They found that men with psychological disorders constitute a large proportion of batterers they have seen in treatment, especially those who have drug or alcohol problems.[22] They describe an empirical typology of three profiles of batterers based on personality test data:

> The first profile, associated with the borderline personality disorder, describes an individual who is asocial, withdrawn, moody, and hypersensitive to interpersonal slights. A man with this profile is viewed by others as volatile and overreactive. He may vacillate from calm one minute to extreme anger in the next. The men in this group exhibit high levels of anxiety, depression, and alcohol problems.

> The second profile, a cluster associated with narcissistic and anti-social personality disorders, describes a self-centered person who uses others to meet his needs and only reciprocates when it meets his advantage. Men with this profile insist their perceptions, values, and rules be accepted by others. Hesitation by others to respond to the self-centered man's demands violates his sense of entitlement to be treated according to his standards, and he responds with threats and aggression.
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> The third profile describes a tense, rigid individual who behaves in a passive or ingratiating manner and is associated with a dependent/compulsive personality cluster. These men lack self-esteem and have a strong sense of need for one or a few significant others. Rebellious hostile feelings can result from failure to meet those needs. The men in this group exhibited low anger and moderate depression. An understanding of these patterns may help in, among other things, prediction of situations in which men may be more likely to use abusive behavior, in identifying core cognitive patterns that may support their abuse, and in assessing the need for concurrent treatment.[23]

Vaselle-Augenstein and Ehrlich are clearer that both the clinical and empirical evidence suggests that "there is psychopathology in many, if not all, batterers," with batterers as a group having "an identifiable set of personality characteristics: dependence, depression, anxiety, low self-esteem, paranoia, dissociation from their own feelings, poor impulse control, antisocial tendencies, and hostility toward women."[24] Batterers differ from non-batterers who are maritally unhappy in exhibiting far more psychopathology.[25] They cite findings of Hamberger and Hastings based on administering the Milton Clinical Multiaxial Inventory to batterers. Hamberger and Hastings found three main factors that indicated personality disorders in the abusers: borderline or schizoid, narcissistic

or antisocial, and passive-dependent/ compulsive.[26] They divided batterers into eight subgroups, seven of which were pathological:

> Group 1 was volatile and overreactive with poor impulse control. Men in this group had the Jekyll-Hyde personality and conformed to the DSM-III diagnostic category of borderline personality. Group 2 was rigid about rules and regulations; for them, punishment was administered unemotionally. They conformed to the DSM-III category of narcissistic or antisocial personality. Group 3 was rebellious, hostile, dependent, and low in self-esteem. They conformed to the DSM-III category of dependent or compulsive personality. Group 4 was the classic psychopathic personality--angry, aggressive, and antisocial. Group 5 had pronounced mood swings and a borderline personality. Group 6 was superficially charming but sensitive to rejection and apt to respond aggressively when dependency needs were not met. Group 7 was characterized by marked dependency needs, anxiety, and depression. Group 8 was low on all factors, and it was the only group that showed no clear pathology.[27]

Hamberger and Hastings' data are derived from their two studies of men in batterer treatment programs. The first study involved 105 abusive men in a court-mandated program and their second replication study involving 99 abusive men attending a domestic violence abatement program.[28] All but 15% of the men in the first study and 12% of the men in the second study had clear pathology.[29] This 85-88% rate for batterers with psychopathology compares with an 80% rate for incarcerated male offenders in Canada's prisons.[30]

In evaluating well over 1,000 cases of domestic violence, Maiuro describes uncovering diagnosable profiles of batterers similar to those found by Hamberger and Hastings. Many of

Maiuro's abusers met the criteria for personality disorders, depression, impulse control disorder, unresolved learning disabilities or attention deficits, alcohol abuse, cyclic mood or arousal disorders, adjustment reactions, organic personality syndromes, and, to a lesser extent, formal thought disorders. However, although Maiuro did not include any numerical breakdown,[31] he states that batterers as a group have more psychopathology, especially personality disorders, than the general population.[32]

Vaselle-Augenstein and Ehrlich also note the similarity to Gondolf's findings based on interviews with more than 500 battered women. Gondolf found that 7% of batterers were "sociopathic" and were likely to be sexually as well as physically abusive and to have been arrested for violent and drug-related crimes; 41% of batterers were "anti-social" and were physically and verbally abusive but were less violent and less likely to have been arrested; and 52% of batterers were "typical batterers" who engaged in less severe verbal and physical abuse, were more likely to be apologetic after the battering, and most likely to have their victims return to them.[33]

Troubling Questions About Implications of Pathology

Vaselle-Augenstein and Ehrlich, citing positions held by most battered women's advocates,[34] note that there has been considerable resistance to characterizing batterers as having

pathology and not being normal men because calling the batterer pathological (1) seems to ignore the larger social context in which battering occurs, including the violence in society and social approval for violence against women; (2) absolves the batterer of responsibility for his behavior; (3) diverts attention from the main issue of needing to end the man's violence; and (4) cannot explain the high prevalence of violence.[35] Furthermore, characterizing batterers as having pathology does not explain why most batterers do not abuse their coworkers or strangers, and why many men with pathologies do not abuse their partners. While acknowledging that such objections are by no means trivial they state that:

> recognition of the role played by individual pathology in battering does not necessarily mean that social-cultural factors, developmental history, environmental factors, and other important contributing causes need to be ignored or discounted. Neither is it necessary to adopt the extreme position that nothing is important other than individual pathology. Nor does acceptance of the existence of individual pathology in batterers mean that they should not be held responsible for their actions.[36]

Nor does it mean that sanctions will not work to stop their abusive behavior.

What Do These Findings Mean?

Lawyers lack the expertise to determine the validity of these studies and their claims that almost all batterers have pathology. It is possible that the batterers studied, all of

whom either volunteered for or were court-ordered into treatment, are not representative of all batterers. It is likely that those in treatment would have more pathology than the average batterer.[37] Yet, even if these claims are true, battering may still be learned behavior which is socially sanctioned. That is, for someone to become a batterer, he may have to both have pathology and live in a society which tolerates or even encourages the abuse. Even Hamberger acknowledges that at present we cannot presume that pathology causes men to batter women. The pathology may only be "part of a final common pathway of a constellation of factors," which include both societal and interpersonal ones, that lead some men to batter their partners.[38] Maiuro argues that battering behavior has many causes "and that psychopathology variables should be viewed as vulnerability factors rather than casual entities."[39]

Implications for Batterer Treatment

However, if it is true that batterers have pathology, it should require rethinking what types of batterer treatment programs are needed, including whether there should be different programs for different types of batterers. Most current treatment programs are short-term, yet short-term programs are highly unlikely to cure personality disorders.[40] Furthermore, cojoint therapy is unlikely to work when the abuser has pathology. Even the proponents of family systems therapy

acknowledge that it is not very effective in cases where there are significant personality disorders, especially sociopathy, or exhibited psychotic behavior.[41]

Implications for Criminal Cases Against Batterers

If most batterers have pathology, an extremely troubling ramification is that batterers will argue that their pathology is a defense to their battering crimes. Yet the vast majority of criminals have psychopathology[42] and the criminal justice system does not permit them to use this excuse as a defense or justification. Even if the criminal justice system were to treat batterer psychopathology as some kind of insanity defense, the argument would remain that any batterer so out of control because of his pathology is a real danger to society, and hence must be committed to a mental institution. However, the fact that most batterers are, in fact, able to control when, where, how severely and whom they beat argues strongly that their pathology is not really a defense to their battering because it is not a cause of their criminal behavior.

Implications for Custody

Yet is also true that recognizing that batterers have pathology should help battered mothers win more custody fights. For too long courts (and therapists) saw the abusive father as basically a normal man, perfectly able to parent effectively even

though he was violent towards his children's mother. They also incorrectly believed that children were not affected by seeing their mothers beaten.[43]

But any batterer pathology has to be seen as relevant towards the abuser's parenting ability and relationship with his children. Even Hamberger and Hastings' Group 8 batterers, who show no clear pathology, would be likely to have poor parenting ability because, while they scored below 75 on all factors, they scored just below 75 on the narcissistic, aggressive and conforming scales, indicating some deficiencies.[44]

Courts (and therapists) must still catch up and recognize that the victims of domestic violence are not sick but undergoing a normal stress[45] which will most likely end if the court can protect them from their abusers.[46] Whether or not batterers have pathology, we need to educate the judiciary and medical professionals to know that virtually every battered woman can effectively parent once the batterer is removed from the household[47] and that batterers make poor parents.[48] This will insure that we are not helping to set up mothers to lose custody fights. We need to emphasize that battered women are experiencing this normal reaction to the abnormal stress caused by the batterer's outrageous behavior, and that any children in the home are also being traumatized by the batterer's abuse. Regardless of whether batterers are seen as having pathology, it also goes against all equitable principles to allow the batterer

to take advantage of his wrongdoing, even in a custody case.[49]

Courts can protect the abused mother by awarding her sole custody of her children and ordering, at most, visitation supervised by an impartial person who understands the dynamics of domestic violence. Many courts (and therapists) are still unaware that 53-70% of women batterers deliberately physically abuse their children.[50] Similarly, they are unaware that even when the children are not beaten themselves, the children are seriously traumatized by seeing their mother beaten.[51] Divorce and separation do not end this traumatization as spouse abuse generally increases after a couple separates.[52] Most abusive men ultimately stop abusing their former partner,[53] although they generally go on to beat their new partner. Even the majority of the small number of men who complete batterer training programs go on to beat new partners after they leave treatment.[54]

Conclusion

The resolution of the question of whether most batterers have pathology will not change the fact that the tried and true legal strategies must still be pursued to help battered women. Were woman abuse not so rewarding, many batterers would stop their abusive behavior.[55] This suggests that courts can do much to stop the battering by awarding a battered woman restitution whenever it is permitted for any damages resulting from her

abuser's battery, in addition to always granting her an order of protection, with custody and support orders, where appropriate. Given that battering can be lethal for the victim and her children[56] but that mental health professionals agree that they are unable to predict lethality in individual cases,[57] judges must err on the side of overprotecting battered women and their children once abuse is established. Above all, judges should not be permitted or give mutual restraining orders, both of which greatly increase the likelihood of serious violence.[58]

BATTERER

ENDNOTES

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4. Gerald T. Hotalling & David B. Sugarman, "Prevention of Wife Assault" in Treatment of Family Violence: A Sourcebook, Robert T. Ammerman & Michel Herson eds. (New York: John Wiley & Sons 1990) 385, 401.

5. Walker & Browne, supra note 3, at 180.

6. Walker, supra note 3, at 7.

7. Id. at 125.

8. Id.

9. Gondolf, supra note 1, at 25; Walker, supra note 3, at 131; Murray A. Straus "Forward" in Richard J. Gelles, The Violence Home: A Study of Physical Aggression Between Husbands and Wives (Newbury Park, CA: Sage Publications 1972) 16.

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12. Walker, supra note 3, at 131.

13. Id. at 7, 10.

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15. Id. at 130; Mildred Daley Pagelow, Family Violence (New York: Praeger 1984) 43.

16. Walker & Brown, supra note 3, at 192.

17. The Centers for Disease Control reported that married men with above-average testosterone levels were 43% more apt to divorce and 38% more likely to have frequent extra marital sex, but only 12% more likely to abuse their wives. Good Housekeeping 151 (January 1993).

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22. Jeffrey L. Edleson & Richard M. Tolman, Intervention for Men Who Batter: An Ecological Approach (Newbury Park, CA: Sage Publications (1992), 41.

23. Id. at 42.

24. Vaselle-Augenstein & Ehrlich, supra note 3, at 147.

25. Id.

26. Id. at 147-48, citing L. Kevin Hamberger & James E. Hastings, "Personality Correlates of Men Who Abuse Their Partners: A Cross Validation Study," 1 Journal of Family Violence 323-341 (1986).

27. Id. at 148.

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29. Id. at 324 and 333.

30. Hare et al., supra note 20, at 286.

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33. Vaselle-Augenstein & Ehrlich, supra note 3, at 148.

34. See, e.g., Michele Bograd, "Family Systems Approaches to Wife Battering: A Feminist Critique," 54 American Journal of Orthopsychiatry 558-568 (1984); Richard J. Gelles, "Violence in the Family: A Review of Research in the Seventies," 42 Journal of Marriage and the Family 873-885 (1980).

35. Vaselle-Augenstein & Ehrlich, supra note 3, at 148-49.

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37. Mildred Daley Pagelow, "Response to Hamberger's Comments," 8 Journal of Interpersonal Violence 137-38 (1993).

38. L. Kevin Hamberger, "Comments on Pagelow's Myth of Psychopathology in Women Battering," 8 Journal of Interpersonal Violence 132, 134-35 (1993).

39. Rosenbaum & Maiuro, supra note 32, at 284.

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42. See note 30, supra.

43. Joan Zorza, "Woman Battering: A Major Cause of Homelessness," 25 CLEARINGHOUSE REVIEW 421, 424-26 (1991); Walker, supra note 3, at 57-66; Peter Jaffe, David Wolfe & Susan

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44. Hamberger & Hastings, supra note 28, at 337.

45. Vaselle-Augenstein & Ehrlich, supra note 3, at 144; Walker, supra note 3, at 123.

46. Walker, supra note 3, at 125.

47. Susan Schechter & Lisa Tieszan Gray, Health Care Services for Battered Women and Their Children: A Manual about AWAKE (Boston, MA: Children's Hospital 1992) 31.

48. See, e.g., House Concurrent Resolution 172, passed unanimously by both the U.S. House and Senate in 1990 calling for all states to have a presumption that it is not in the best interest of children for spouse abusers to get custody.

49. See, e.g., Lewelling v. Lewelling, 796 S.W.2d 164 (Tex. 1990).

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51. Jaffe, et al, supra note 43, at 26-31, 34-36, 38-42.

52. Pagelow, supra note 15, at 43; Walker, supra note 3, at 26.

53. Schechter & Gray, supra note 47, at 31, noting that in 85% of the hospital program's cases the abuse against the mother ended once the father was removed from the family.

54. Vaselle-Augenstein & Ehrlich, supra note 3, at 150, citing Lenore E. Auerbach Walker and Angela Browne, "Gender and Victimization by Intimates," 53 Journal of Personality 179-195 (1985).

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56. Kristina Rose and Janet Goss, Domestic Violence Statistics, National Criminal Justice Reference Service, Bureau of Justice Statistics (1989) 12, noting that 31.5% of all women killed in America are murdered by their husbands, ex-husbands or boyfriends.

57. Rosenbaum & Maiuro, supra note 32, at 291, citing American Psychological Association Committee on Legal Issues "White Paper on Duty to Warn" (Englewood Cliffs, NJ: Prentiss Hall 1985); Edelson & Tolman, supra note 22, at 48.

58. Edelson & Tolman, supra note 22 at 104, noting that half of all couples experienced at least one incident of violence during the first six weeks after completing therapy together, and that all couples experienced violence at 6 months after treatment; Zorza, supra note 42, at 427; Stephen B. Herrell & Meredith Hofford, Family Violence: Improving Court Practice (Reno, NV, National Council of Juvenile and Family Court Judges 1990) Recommendation II-10 and text.