

Why is Anger Management/Anger Control Counseling or Treatment never an appropriate strategy to address abusive behavior, especially domestic violence?

The first dilemma with finding appropriate intervention with an abusive person is to challenge the tendency to mislabel the problem as anger. Anger management treatment and anger control therapy attribute an abusive person's violence to a "momentary outburst of anger" as opposed to tactics of power and control manipulation. From most accounts, domestic abuse is actually systematic terror inflicted upon victims through direct and indirect controlling, manipulating, and degrading behaviors. It is not merely a series of impulsive, angry incidents, but often premeditated, systematic, debilitating power and control tactics.

Abusers use their anger instrumentally and strategically. If a situation calls for the effective use of anger, an abusive person will summon their anger to do the job. They also may use, just as effectively, sorrow, sadness, or shame as effective and coercive means to establish, maintain, or regain control. Simply stated--abuse is purposeful, instrumental, and strategic behavior designed to bring about a result.

Anger management or anger control programs fail to take into account the premeditated and calculated controlling behaviors associated with abuse. Anger programs focus on the premise that an abusive person is unable to control certain violence or anger tendencies as a result of a triggering factor. This approach supports two dangerous myths:

1. That the victim shares responsibility for the violence because they trigger it, and
2. The abuser is not responsible for the violence because they are unable to control it.

Thus anger management tends to decrease abuser accountability and can even reinforce the abusive person's tendency to blame the victim. The treatment focuses on "what makes the abusive person feel angry" resulting in the abusive person focusing on what they feel the victim has done wrong instead of their own behavior. This is particularly harmful in light of the fact that an abusive person taking responsibility for past abuse is an essential part of any sort of successful change.

Although abusers often explain their behavior as a result of feeling angry, that behavior is in fact always the result of a choice to exert power and control over another person. Abusers actually almost always control themselves very well. For example, they rarely strike out at their bosses or co-workers. They are often calm with the police and in court. They know how to control themselves when they believe they need to be socially appropriate, but do not feel the need to do so with people they abuse.

Anger control techniques widely used with abusers are typically based upon cognitive psychological strategies. Unfortunately, the cognitive beliefs being targeted are those that result in angry feelings, not the cognitive beliefs that justify, excuse, minimize, and enable abusive behavior. The model presumes that "being provoked" instigates a physiological arousal that is labeled anger. This "anger" is then translated into aggression and/or abuse.

Anger control is designed to enhance the ability to recognize provocation cues and physiological signs of arousal. Anger logs are often used to promote this awareness. Cognitive restructuring skills include adjusting expectations and reappraising the circumstances that provoke arousal. Role plays often are used in this regard. Positive self-talk is commonly used to reduce arousal. Arousal reduction also uses stress management techniques such as progressive relaxation exercises and calming visualizations. Communication enhancement includes "time outs" to inform the annoyer of the arousal and more assertive expression of feelings. Problem-solving takes the form of identifying the triggers in one's environment that may provoke arousal.

Anger control no doubt contributes to redirecting or reducing anger and aggression in many individuals; the question is how well suited is it for abusers and batterers. Does anger control help end abuse, or does it only reduce anger?

My experience, and most of the research I've read over the years, indicates anger management does not end abuse. If an abusive person stops hitting someone or verbally degrading them, the abuse does not necessarily end. In fact the psychological abuse of manipulative and isolating behaviors may continue and be as emotionally devastating as physical abuse. Thus, the end result of anger management or anger control treatment is a "calm" perpetrator of controlling, coercive, manipulative, and violent behavior rather than an "angry" one. And in fact, anger management could leave the victim in a more dangerous environment than they were in prior to the treatment. Because the abuse problem was mislabeled as an anger problem, and outside observers take notice of a decrease in anger, the psychological abuse and coercion goes unrecognized. The abusive person has simply learned to adapt; to use more subtle and effective power and control tactics resulting in the victim being more vulnerable and more scared to reach out and seek assistance in the future.

Anger control may, furthermore, feed an abusive person's tendency toward self-pity and self-deception. The focus on their anger causes some abusers to dwell on their own emotional discomfort rather than the more severe pain that they have caused others. While this can be therapeutic, it can also lead to self-justification and victim blaming.

Abusive behavior is how an abusive person gains power and control. (An example is that yelling scares the victim, which gets them to say or do what the abusive person wants.) Anger control reinforces the willfulness of many abusers. The "official recognition of control" in anger control leads many abusers to believe that the way to stop abuse is to extend their control to one more aspect of their lives -- their emotions. Instead, the batterer needs to be encouraged to "let go" of much of his need to control. Furthermore, directing the focus upon controlling the feeling of anger promotes the tendency to ignore the need to focus on more relevant feelings such as guilt. Guilt is a feeling our conscience uses to inform us we are saying or doing the wrong thing. Focusing on controlling anger is at the expense of ignoring feelings of guilt. Worse yet, focusing on feelings of anger may increase the abusive person's tendency to justify, minimize, and make excuses for their abuse. This shifts blame to the victim and suppresses the abusive person's feelings of guilt for acting abusively.

Anger control is often misrepresented as a quick-fix, but it may actually endanger victims. The vast majority of men who "voluntarily" join batterer programs do so in response to their partner leaving them, threatening to leave, or taking legal action. The men therefore tend to use the program the same way they use their violence -- to manipulate and control their partners. After learning a few anger control techniques, many batterers will claim they have the problem "under control" and lure their partners in to returning. The men in anger control treatment usually enter a self-congratulatory phase in which they feel that they are really getting better and deserve praise. Their partners, however, are hardly ready to reward them for the humane treatment which they inherently deserve, or to be trustful of a man who has unpredictably abused them long-term. A woman's failure to be congratulatory as the man expects may lead to further abuse.

Anger control too frequently lets the community off the hook. It would have the community think that the problem of partner abuse is being "treated." Abuse becomes, then, a problem of psychologically deficient individuals who lose their temper and impulsively abuse rather than of inadequate protection services. In sum, anger control is less threatening to the community and therefore an easier way for counselors to gain acceptance for their programs. This of course is a challenging notion for some community leaders to accept, because it suggests that they too have a responsibility in working to end abuse, not just the program counselors.

Anger management programs are not geared toward perpetrators of violence. They have no oversight and are not certified. There is no assurance of operational policies and procedures that adhere to protocols and standards for safety and accountability concerns. There is no participation by domestic violence projects, or safety monitoring by domestic violence advocates. It is left to agency discretion whether domestic violence training or experience is required for clinicians or therapists conducting anger programs. And abusers will tend to seek services from anger management as program fees are often subsidized by health insurance and/or grants, and the length of treatment is typically only 8 to 15 weeks.

The justice system should not order, encourage, or even allow anger management programs as a tool for addressing domestic violence. It is an insufficient response to criminally abusive behavior. Diverting an abusive person out of the criminal justice system and into treatment may lead him to conclude that his behavior is not a serious criminal act. And because domestic violence is not the result of an anger control issue, anger management programs are not effective in stopping domestic violence and should never be used by the judicial system as a substitute for strong law enforcement and thorough judicial oversight of domestic violence offenders.

Anger is a feeling; abuse is immoral, inappropriate, and often criminal behavior. Courts are dealing with domestic violence as criminal behavior; court policies should require the behavior be addressed as criminal behavior, not angry feelings, or a mental health problem.

Anger management is a mental health approach to an issue of criminal behavior. It can give victims a false sense of safety because they may mistakenly believe that such a program can end the violence. In reality, the victim may be placed in grave danger, and the likelihood of further violence could increase.

Anger management programs as a tool for addressing domestic violence have not been demonstrated to be an effective way to stop the violence. Experts in the field of domestic violence have repeatedly stated that the most effective way to stop domestic violence is through a coordinated community policy of zero tolerance for domestic violence, which includes coercive and controlling tactics.

Why is Mental Health Counseling or Treatment usually not the appropriate strategy to address abusive behavior, especially domestic violence?

Anger management providers are usually licensed clinicians. They will often diagnose, or label, abusive behavior as a “medical condition” or “mental health problem”. They will assign a DSM label such as “Impulse Control Disorder” and will then draft an individualized treatment plan to treat the disorder. This labeling serves to provide abusers with more justifications and excuses for their behavior such as, “I couldn’t help it; I have a problem. I am sick.”

The two most common diagnoses used with abusive men are Intermittent Explosive Disorder and Impulse Control Disorder Not Otherwise Specified. These disorders frame the client as a victim of neurological misfiring, and assert that the client, who is now a victim, has no control over their behavior.

If abusiveness were the result of individual pathology, it would make sense to provide mental health treatment as a response to it. Framing abuse as pathology in need of treatment goes something like this:

1. He must be sick to act that way. That is, he wouldn’t be abusive if he didn’t have an underlying psychological problem (Intermittent Explosive Disorder, Antisocial Personality Disorder, substance abuse, insecurity, anger, trauma, etc.).
2. If I treat his underlying disorder, he will quit being abusive.

This way of understanding abuse hands the abusive person an excuse for their behavior. The likely result is that they will begin to say, “It’s not my fault; my (fill in the blank mental health disorder) made me do it.” They beg or pressure their partner to hang in there with them while they work on their problem, and promise that things will get better. Because that’s what their victim wants, they may agree to stay in the relationship, deferring their own need for safety and freedom. The therapist has unintentionally become the abuser’s ally in continuing to control their partner.

To avoid feeling guilty and accepting personal responsibility for their behavior, abusers will (consciously or subconsciously) blame anyone or anything they can. In addition to blaming the victim for provoking them, they will blame alcohol, drugs, stress, etc. Regardless of whether these factors contribute to abuse, abusers need to accept full responsibility for their behavior in order to begin the process of personal change. Mislabeling abusive behavior as a medical condition or mental health problem exacerbates the real problem of the abusive person accepting personal responsibility to end their self-delusional beliefs that excuse, justify, minimize, and enable their abuse.

Therapy should not be the standard response to abusers generally, because those attitudes that lead to domestic violence are often not specifically addressed in treatment, including:

1. Entitlement attitudes. Most abusers believe that there is something that entitles them to control their partners. In the case of men’s abuse of women, that something is often a belief in male dominance. Some abusers choose to examine and change these attitudes during therapy, but treatment cannot be reliably used to change attitudes – especially ones that operate to the abusive person’s benefit.
2. Cultural and social support for entitlement attitudes. Social support is a powerful reinforcement that keeps abusive behavior going, and clinicians cannot stop abusers from receiving it.
3. Tactics of control. Abusive behavior is not random. It often boils down to carefully chosen tactics, which are used intentionally to achieve the abusive person’s goal of control. Co-occurring

mental health or substance abuse problems do not make tactics into a sickness that can be cured.

As I previously stated, probably the most common diagnoses used with abusive men are Intermittent Explosive Disorder and Impulse Control Disorder Not Otherwise Specified. These disorders frame the client as a victim of neurological misfiring, and assert that the client, who is now a victim, has no control over their behavior. Yet abusers often perpetuate abuse in a premeditated systematic manner using tactics of power and control. Abusers themselves will often claim to be “triggered” to become abusive. Thus neither of these diagnoses applies, and to use them in order to seek third party reimbursement is at minimum unethical and more likely illegal. The client is then left with an inaccurate diagnosis as part of their medical record which may be problematic for the client in the future. This also could be harmful for the reputation of the clinician.

Let’s say for a moment, upon the recommendation of their physician, a person wants to quit smoking to avoid a potential medical problem. They enroll in a class to learn techniques to successfully change their behavior and quit smoking. If the facilitator of the class is a Licensed Mental Health Counselor (LMHC) is it ethical and appropriate for them to diagnose the client with an anxiety disorder in order to get health insurance to pay for cost of providing the class? Suppose the client revealed to the counselor that they’ve been smoking for a real long time and they feel a little anxious about “giving it up?” Is it appropriate now for the counselor to diagnose the client to seek reimbursement to fund the class?

An ICADV-Certified Batter Intervention Program (BIP) does not call what it does “treatment.” Treatment is a term for service provided to address a “medical condition” or “mental health” problem. BIPs advocate against viewing abuse as anything other than immoral, inappropriate (often criminal) behavior. Labeling abuse as a “medical condition” or “mental health problem” provides an excuse, “I couldn’t help it, I have a problem.” Thus abusers avoid accepting personal responsibility for their behavior.

Mental health-related problems such as anxiety, depression, anger, substance abuse, personality disorders, intermittent explosive disorder, and childhood trauma are not the cause of abusive behavior toward a partner and/or children. These problems are often correlated with domestic abuse and may influence the shape it takes in a particular case, but wanting to quit drinking or feel better emotionally is not the same thing as wanting to treat one’s partner or children better. Abusive behavior pays off for the abusive person, regardless of its cost to his partner and children, and treatment is unlikely to get him to stop it for their benefit.

If an abusive person is found to have concurrent mental health disorders along with their violent or abusive behavior, they should be referred for appropriate treatment to address those concerns prerequisite to attending a certified BIP. However, the mental health treatment should never be allowed to substitute for attending a certified batterer intervention program.

Why is couple's counseling/marriage counseling never an appropriate strategy to address abusive behavior, especially domestic violence?

As unbelievable as it may seem, in the State of Indiana, there is no requirement for Licensed Marriage and Family Therapists (LMFT) to have education, training, or experience in domestic violence. Thus, many couples counselors have absolutely no training or knowledge in this area. If they did have proper training, they would never agree to couple counseling without first screening each partner privately for domestic abuse.

Resolving the kind of conflicts between people for which couple counseling is intended will not stop one person from abusing the other. Conflict is a pretext for abuse, not a cause of it. While conflict happens between people, abuse is something one person does to another, and abusers seldom change their behavior in response to changes made by their victims.

Couple counseling (like family therapy and mediation) is often both dangerous and ineffective in domestic violence cases, and should be avoided. Many abusers skillfully use the treatment process to manipulate their partners, avoid having to change their own behavior, and keep counselors from seeing them accurately.

No victim should have to attend therapy with someone who has criminally abused them, just because that person is their partner. It's unfair to ask a victim to "meet her partner halfway" by giving up her legitimate needs or changing her own behavior in return for an end to violence. When clinicians take this approach, victims feel re-victimized.

In couples counseling, victims often take responsibility for instigating the violence or participating in activities that supposedly precipitate the violence. They do it because couples counselors often assume a family-systems interpretation of abuse in which the victim acts to provoke the anger. One of the first steps then is to identify a hierarchy of provocations, which in the case of wife abuse includes annoying behaviors of the wife or lover. Such an assumption wrongly implies that the wife is an accomplice in the abuse, and should in some way change her behavior in order to reduce the abuse. Accountability is shifted from the batterer's criminal behavior to the victim thus sending or reinforcing messages that the victim shares responsibility for the violence, and the batterer is justified in the violence.

Couples counseling depends upon an open dialogue between partners. It cannot work without the presence of openness, flexibility, and the willingness to listen to one another. These traits are not possible when one person is emotionally or physically abusive to another. People who are being hit, intimidated, or controlled through threats or other coercive means by their partners are not free to engage in an open dialogue. If placed in couples counseling, a person would be encouraged to speak openly about their partner's behavior and address problems in the relationship in the presence of an abusive partner. People who do so are often at risk of retaliatory tactics from the abuser, thereby jeopardizing their safety.

The justice system should never order or encourage couples counseling in cases where there is an indication that a party is committing physical abuse or employing non-physical coercive or controlling tactics. If the system were to do so, it could be placing victims at risk of experiencing additional abuse and/or control.

Suggestions for couple's counselors:

- 1) Never agree to couple counseling without making a thorough assessment that includes a private interview with each partner in which you screen for domestic abuse. Do not ask about it in a joint session!
- 2) Do not offer couple counseling if there is ongoing violence or intimidation.
- 3) Make sure the victim understands that couple counseling can endanger her and keep her blaming herself for her partner's behavior.
- 4) Do not mention her disclosure to her partner unless he brings it up. Find some other basis for refusing couple counseling.
- 5) If both partners disclose past domestic violence (many months or years ago, not just a few weeks ago), it is still better to refuse to see them together if:
 - a) There is an ongoing custody or visitation case.
 - b) There is an active order of protection or the victim is still afraid of their partner.
 - c) The abusive person has ever committed felony-level assaults on their partner.
 - d) You see evidence that the abusive person does not take full responsibility – going way beyond lip service – for his behavior.

Judicial Response

As part of the community response to domestic violence, it is necessary for the justice system to look carefully at the programs to which defendants are referred. Anger management programs, mental health treatment, and couple's counseling are sometimes requested or petitioned for in the court.

When presiding over cases involving domestic violence, judges are often asked by victims and defendants or their attorneys to either require or permit couples counseling or anger management as part of the resolution of the proceeding. When this type of request is made, it is recommended that judges never require participation and respond by informing the parties of this policy statement.

While these methods may be effective for other types of problems, courts should not require couples counseling, mental health treatment, and/or anger management programs whenever domestic violence is present. These programs focus on therapeutic or treatment models, which disregard the dynamics of domestic violence and do not demand defendant accountability.

When victims of domestic violence suggest that the parties participate in couples counseling, the court should not encourage this approach. The victim should be advised that although the court cannot prohibit couples counseling, the policy of the judicial system is that couples counseling is neither a safe nor appropriate approach to ending domestic violence. Victims should be made aware that neither anger management nor couples counseling is a substitute for a strong law enforcement and judicial response to domestic violence. Victims should be cautioned that it may be dangerous to believe that anger management counseling will stop the violence.