

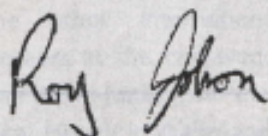
## Editorial

The development of this edition's topic has been a journey in and of itself. I initially invited a gender specialist to be a co-author, but she refused to believe that the scenario I presented could possibly happen, as she had never come across such a situation in her nearly two decades of working in the field. I could not believe that there weren't 'men who behave violently' with enough insight to ask for help. I then became aware of a psychologist who specialises in helping men who exhibit violent and controlling behaviour, and invited her to assist in preparing the article. Paradoxically, her practice has kept her too busy to make a contribution! Finally I invited Dr Marjorie Dawson to assist me. Her contributions and insights have been invaluable.

Finding the Australian *No to Violence* (NTV) website<sup>1</sup> was the final piece of the puzzle I needed and I have made extensive use of their excellent materials in preparing this article. I felt more than justified in my initial decision about the approach to use. The website states that *recent research indicates most men who behave violently had attempted to, or thought about, seeking help.*

The focus in this article is exclusively on men who have behaved violently towards women partners and their children. Other forms of violence within domestic and family settings have not been dealt with and nor have I addressed in any depth at all, the management of women or children who have experienced violence.

I make no claim that the steps outlining 'what to do when a man who behaves violently asks for help' is necessarily the most effective or most comprehensive approach to this situation. However I am convinced that recognising the situation described as a medical emergency is valid.



Roy Jobson

1. No To Violence (NTV), the Male Family Violence Prevention Association Inc. <http://www.ntv.org.au> (accessed 03 July, 2002)

## WHEN MEN WHO BEHAVE VIOLENTLY ASK FOR HELP

**Tuesday morning** after a long weekend with a public-holiday-Monday. You've been on call the whole time and are ready to get back to routine daily practice.

Your first patient is Mr X. You're surprised to see him because he's not one of your usual attenders although you've been looking after the family for some time. He is a successful businessman whose life and career appear to be on the ascendancy. You feel you don't really know him and in your previous dealings with him, he has tended to be stoic and reticent.

After the usual greetings, you become aware that he is extremely uncomfortable in your presence and has difficulty in talking to you. Without visibly showing that you're aware of the time passing and that other patients are beginning to fill up the waiting space, you try and nudge him into getting to the point.

You're not prepared for what you piece together from what he does tell you.

He had a deadline to complete a budget over the weekend and he took the work home with him. His wife had however made other plans for the long weekend which she had not told him about. An argument ensued and he locked himself into his study with the whisky bottle to try and re-focus himself on his work.

The rest of the weekend deteriorated as one altercation provoked another until he 'totally lost it' and hit her. He knocked her out cold and he initially thought he had killed her. This gave him a huge fright and he decided he better come and see you.

He asks if you don't perhaps have a medicine that will help control his temper.

## Question 1

### How do you manage this situation?

#### Answer 1 (Step 1: Brief Opportunity)

The first and most immediate issue is to recognise that this situation is equivalent to a medical emergency and requires the same kind of priority response, and putting of other patients/commitments on hold, as for other emergencies (e.g. a myocardial infarct or an ectopic pregnancy).

The reason for this being an emergency is that very few men who use violence ever ask for help and if they do, they will usually only ask once. (See Anecdote) Also, as is stated in the *No to Violence* website: 'The risks of men not gaining help quickly when needed is very real. They are at very real risk of further violence to their partners, to themselves, or to others in the general community.' If healthworkers don't respond with appropriate urgency, this brief window of opportunity may be lost and a future family disaster may occur.

The immediate response (no matter what your personal feelings about him are) is to acknowledge that he has done the right thing by telling you about the situation, and that by asking for help he has in fact taken the first necessary steps to changing it. You may tell him that this is indeed an extremely serious situation, that you are relieved that he did not actually kill his wife, that you take what he has to say very seriously, and as his doctor, you will ensure that he is helped. You tell him that you will not beat about the bush but be honest and truthful with him. In terms of this you may choose to tell him that you do not accept excuses for violent behaviour. You may need to point out that in fact his behaviour was a criminal act, and that his wife has every right to lay a charge of assault against him.

Make it clear that assaulting his wife was a choice that he made and therefore he must take responsibility for his actions, even if it means being arrested. You may want to re-emphasise that coming to you and telling you was the beginning of taking responsibility, and that it was a correct action. Taking responsibility means 'facing the music' and this is what you're going to encourage him to do.

You're deliberately sending two important messages to him at this point. The first is to affirm his decision to come to you for help, and the second is to emphasise the gravity of the situation. The balance between these messages will depend on each individual's circumstances. The vital thing is that you don't close the window of opportunity.

## Question 2

### What do you do about his wife?

#### Answer 2 (Step 2: Partner Safety)

Having established that Mr X is serious about dealing with his behaviour, you offer him the opportunity to phone his wife and tell her that he is with you, that he has told 'the doctor' about what happened, and that the doctor would like to speak to her.

If he is prepared to do this, you again acknowledge that he is doing the right thing. If he is not prepared to do so, you may challenge him on whether or not he's really serious about taking responsibility for the situation. You may then offer to phone his wife on his behalf and tell her that he is with you and what he has told you. If he still refuses, you may need to tell him that Mrs X is also your patient, you have a responsibility towards her, and it is your duty to find out what state she is in.

Your main purpose in speaking to Mrs X at this stage is to assess whether or not she needs immediate medical attention, and how she feels about her (and the children's) safety. You may need to admit her to hospital, set up an appointment (preferably that day) or arrange a house call. If she does need immediate attention, you should try to arrange for a colleague to see her or for her to be taken to hospital by ambulance.

## Question 3

### What would the next priority be?

#### Answer 3 (Step 3: Disarm)

At this point, if you are a woman doctor, you probably need to make a decision about continuing your immediate professional relationship with him. Go on to question 7 below.

Your next priority would be to ask Mr X if he has a firearm or other dangerous weapon(s) on his person or at home. If he does have one on him, you would ask him to hand it over to you for passing on to the police for safe-keeping.

## Question 4

### What happens after that?

#### Answer 4 (Steps 4&5: Practical Steps and Short Term Contract)

Various practical issues need to be dealt with. A decision needs to be taken about whether or not he should return home. In most situations, he probably should not – in which case, suitable alternative accommodation needs to be found for him. As Mr X is a successful businessman, he

can probably afford to book into an hotel. For men where this is not possible, other options will need to be explored.

An undertaking about not contacting his wife or children (depending on the circumstances) should probably be made for an immediate, specified time (e.g. 48 hours) – with the understanding that this time may be extended depending on how the situation works out.

An undertaking about not abusing alcohol or other drugs during this time needs to be made.

He needs to agree not to assault anyone, or kill himself or anyone else, during this time. He also needs to agree that he will not drive recklessly as this is often a typical reaction of men who behave violently.<sup>1</sup> (see also 'Additional Information' below)

These agreements should all take the form of an informal written contract signed by Mr X and yourself as a witness.

He will need either your emergency contact number or a negotiated alternative emergency number in case he feels he can no longer abide by this contract; if he feels that he is losing control; or for any other real crisis or emergency situation he finds himself in.

The question of tranquillizing medication is a difficult one – and no hard and fast rules can be made. It is very much up to your clinical judgement as to whether or not to give any kind of medication. Two to three doses of an intermediate acting benzodiazepine such as lorazepam 1–4mg are recommended by one source,<sup>2</sup> however another source<sup>3</sup> suggests that benzodiazepines may 'make matters worse', that anticonvulsants are usually used and that buspirone may be useful. But the possible psychological trap of now giving him 'a medicine that will help control his temper' instead of focusing on his commitment to changing his behaviour, should as far as possible be avoided.

#### **Question 5** **How would you end this emergency consultation?**

##### **Answer 5**

It would be important to re-affirm him for telling you about the issue and re-emphasising the seriousness of the situation. You need to review the short term agreements you have made and confirm that he intends to abide by them. You stress that he has just started on a whole journey of 'unlearning' his violent behaviour – that other men who behave violently have changed and it is possible for him to change too, but that it will take time, effort and commitment on his part. You would explain that he'll

need to have individual counselling as well as attend a men's support group, and that this will continue until he has learned non-violent ways of expressing himself.

#### **Question 6** **What next?**

##### **Answer 6 (Step 6: Debriefing)**

Having made a plan to see Mrs X, the next priority is to look after yourself. This is one of the most neglected under-taught areas of medicine. After an emergency like this (and maybe after any emergency), you might need to express your own feelings about the man, the woman, the situation, your ambivalences, the dilemmas, feelings of helplessness, sudden glimpses of yourself in the protagonists, etc. This can be done immediately or later, through writing your thoughts/feelings down, by talking them into a dictaphone, or by talking to a colleague. (Possibly a colleague who is also a friend?) Talking to one's own spouse without breaking patient confidentiality is also an option. The issue is not to elaborate on the details of the patient's situation, but on your personal feelings and reactions to having had to deal with them.

#### **Question 7** **Does the gender of the healthworker make a difference?**

##### **Answer 7 (Step 7: Gender of Primary Contact)**

Yes. Experience shows that it is better for men who behave violently to be dealt with by a male doctor/health worker. Many of these men will try and manipulate a woman even if it is subconsciously. Typically appeals to a woman's 'mothering' instincts are made, or he may adopt the 'little boy' tactic. Some men automatically enter a flattery or seduction mode. It is important for a woman doctor to emphasise that by asking him to see a male colleague, she is not rejecting him, but is in fact taking him very seriously. If he refuses, she will have to be clear about her boundaries and limitations – and explicitly include the option to withdraw as soon as she feels that it would be in her (and/or his) best interest to do so. In a situation where he threatens suicide or further violence if she does not continue, it is even more important for her to withdraw from the immediate situation. It may require the assistance of the police or other agency. A major tranquillizer in the form of a parenteral dose of an antipsychotic such as haloperidol may be required.<sup>2</sup> It is likely that some men who behave violently are suffering from Intermittent Explosive Disorder<sup>4</sup> and require predominantly 'medical management'. This is a highly contro-

versial and relatively unexplored area in the field of domestic and family violence and abuse, for it may challenge the prevailing dogma about one's capacity to control violent behaviour.

### Mrs X

Once the medical emergency is over, a parallel healing process needs to be set up for Mrs X. These include her immediate medical needs; her safety; accommodation if necessary; and the legal processes of laying a charge or obtaining a protection order— should she choose to – according to the Domestic Violence Act of 1998.<sup>5</sup> It may be that with her written consent, you yourself end up applying for the order on her behalf. She may need to be told (possibly repeatedly) that the assault is not her fault; that it is not her responsibility to maintain secrecy about her partner's violating behaviour; and that steps are being taken to sustain a change of behaviour in him. She would need to be told that it is likely to be a long and painful process and that 'success' cannot be guaranteed. She should also know that it is not her responsibility to change her partner's behaviour, but his alone. She needs to know that she retains the right to withdraw from the relationship if she feels that this is the correct next step for herself and the children. Her ability to access advice and support services should be ensured.

### After the emergency

Once the acute phase of the crisis has been dealt with, the man will need ongoing behaviour modification counselling and/or therapy (which may or may not include 'anger management' training). Specific attention needs to be focused on alcohol and other drug abuse. Another component of his recovery will be to participate in a men's support group which ideally consists mainly of men who have also behaved violently and have made a decision to change their behaviour. In these groups men do not permit other men to evade the issues or make excuses for their behaviour. As the NTV manual states: *Any excusing, condoning or minimising of [the man's] use of violence on the basis of his own pain and difficulties reinforces his use of violence rather than challenging it.*

Finally, as the family doctor, maintaining regular proactive contact with the members of the family in whatever situation has been worked out, could be a vital component of preventing another violent family outburst.

### Additional information paraphrased from the *No to Violence materials*<sup>1</sup>

1. It has been found that men who behave violently often behave chaotically at work as a result of episodes of

violence, family disruption, personal depression, guilt, and subsequent substance abuse.

2. Early assessments of drug and alcohol abuse and interventions, compatible with concurrently dealing with men's violent behaviour, can lead to greater protection of the safety of the men's family members as well as raising the health status of the men themselves.
3. The road driving behaviour of many men who behave violently towards their family members is often quite reckless and highly risk taking. Some drive recklessly all the time, others mainly when angry.
4. Engaging with men who have a desire to change is about constantly encouraging them to believe in themselves and to start to risk seeing the world differently. It is about believing in the fundamental good and worthwhile elements of the man, without glossing over unacceptable behaviour. This engagement must start with the initial contact and continue right through the behaviour change programme.

**Table 1:**

### What to do when a man who behaves violently asks for help

#### *The acute situation*

1. Brief Opportunity
2. Partner Safety
3. Disarm
4. Practical Steps
5. Short Term Contract
6. Debriefing
7. Gender of Primary Contact

#### *The ongoing situation*

8. Parallel Process for Partner
9. Other Legal
10. Behaviour Modification
11. Men's Group
12. Proactive follow-up of all family members

## A note on language

To some it may seem like just another round of political correctness, but the impact of the words we use in describing situations around violence is important. Here are some suggested ways of dealing with words and phrases that have the potential to be misunderstood.

'Domestic violence' has the connotation of a 'domestic squabble' and is often not taken seriously enough.

'Family violence' is non-specific in that it could also refer to a mother's violent behaviour towards a child.

'Male family violence' is a suggested alternative as it specifies the person behaving violently (male) and the context (family – which may include non-blood relatives). It also opens up the possibility of referring to 'female family violence' – which although rare, does exist.

The word 'victim' for women and children who have had violence used against them, may reinforce the sense of powerlessness of the woman or child.

The frequently favoured term 'survivor' is difficult for a woman or child to identify with when she is still feeling traumatised, powerless and indeed victimised by the experiences.

The terms 'victim', 'survivor' and 'victim/survivor' all suggest a *type of person* rather than a *type of experience*, thus obliterating all the other aspects of a woman's life, identity and experience, and defining her by reference to someone else's actions towards her.

Alternative terms such as 'women and children who have experienced violence' or 'women and children who have been violated' are suggested to keep the focus on the *types of experience*.

The term 'perpetrator' is often used to refer to men who have used violence towards their family members. This term also suggests a *type of person* rather than a *type of behaviour*. Alternative terms such as 'men who use violent and controlling behaviour' or 'men who have behaved violently' are suggested.

## An anecdote

In the 1970s a medical student in her psychiatry rotation asked what she could do to help her parents, and more specifically her father who had sporadic uncontrollable outbursts against her mother. Her father was a successful entrepreneur and her mother was a healthworker. The student was given the name of a psychiatrist for her parents to see, and after much persuasion her father agreed to go. After hearing the story, the psychiatrist said that her father's behaviour was essentially unchangeable and that the only solution was for the family to learn to live with it. Those words were the death knell of any possible further intervention and the misery continued for many years. The student found that she was able to predict when her father was about to lose control and on occasion she was able to abort

an attack of violent behaviour by dissolving a tablet of midazolam in his whisky. It was only many years later that she was able to reconcile herself to what she considered unethical medical behaviour when she was told, and she realised, that in fact she had made an excellent 'plan' under the circumstances and that her actions had probably prevented greater harm.

## Reflection

Medical students have commented on the behaviour of some male doctors towards female nurses – is this a subtle (not so subtle?) form of gender violence? Are there other examples where doctors' (female and male) sometimes arrogant behaviour could be considered to contain the seeds of violence?

## Conclusion

Family violence is largely hidden and private and surrounded by shame and secrecy; it is often condoned and colluded with, and denial about the nature and extent of it and its effects is widespread. People outside the family have been reluctant to intervene because of the 'privacy of the home'. This all exacerbates men's traditional reluctance to ask for help.

The approach in this article may not apply in traditional African communities. In these situations it is widely considered to be the responsibility of the elders or uncles to intervene where male family violence occurs. Not only is it their role to protect the woman (or women), but they are supposed to re-educate the man in terms of acceptable behaviour. There is also an element of public shaming in this process which exposes all secrecy to the wider community.

## References

1. No To Violence (NTV), the Male Family Violence Prevention Association Inc. <http://www.ntv.org.au> (accessed 03 July, 2002)
2. U.S. Pharmacist Continuing Education. Acute Agitation and Aggression in Psychiatric Illnesses (A TREATMENT UPDATE). [http://www.uspharmacist.com/newlook/ce/psychiatric\\_illness/lesson.cfm](http://www.uspharmacist.com/newlook/ce/psychiatric_illness/lesson.cfm) (accessed 03 July, 2002)
3. Belanoff JK, DeBattista C, Schatzberg AF. Adult Psychopharmacology I: Common Usage. In: Koocher GP, Norcross JC, Hill SS (eds). Psychologists's Desk Reference. Oxford University Press. USA: 1998:400. [http://www.oup-usa.org/sc/0195111869/0195111869\\_86.pdf](http://www.oup-usa.org/sc/0195111869/0195111869_86.pdf) (accessed 03 July, 2002)
4. McElroy SL. Recognition and Treatment of DSM-IV Intermittent Explosive Disorder. *J Clin Psychiatry* 1999;60[suppl 15]:12-16. <http://www.psychiatrist.com/supplenet/v60s15/02v60s15.htm> (accessed 03 July, 2002)
5. GOVERNMENT GAZETTE. Act No. 116 1998: DOMESTIC VIOLENCE ACT. Vol 402 No. 19537:10.