THE O.W.N. (OTHER WAYS NOW) PROGRAM:

DEVELOPING GROUP TREATMENT FOR MALE SPOUSE ABUSERS

J. Edward Carey

A Practicum presented to the Faculty of Graduate Studies
in partial fulfilment of the requirements for the degree

MASTER OF SOCIAL WORK

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CHAPTER ONE: INTRODUCTION - VIOLENCE IN THE FAMILY

The quest for understanding of spousal abuse, and what it is that might bring about a decrease in or an end to the pain and suffering which the abuse causes, leads one into a morass of seemingly competing theories and models, of imprecise and/or partial definitions, of unrepresentative sample populations, and of unobtained or unobtainable data. But, in spite of all the difficulties of theory and/or research method, a picture is becoming clearer of a serious social problem which affects more people and in more ways than we could have imagined as little as twenty years ago (Carlson, 1987; Gelles and Maynard, 1987; Glaser, 1986).

It has been said (Sprey, 1969) that conflict within the family is normal and to be expected, given the needs, resources, and interdependence of the family members. But, while conflict may be a part of intimate family relationships, the choice of abusive means to resolve conflict is maladaptive and unacceptable.

The phenomenon of spousal abuse is just one of a constellation of interrelated issues which form the larger problem of family violence. Our increasing knowledge of family violence is precipitating responses including further research, development of specialized treatment and other interventive social programs, and study of the relationship of violence to societal values, norms, and social policy with respect to resource provision and the education of the general public.

Garbarino (1980) contends that much of the violence in families is born in the family's "socially and economically impoverished environments" which "feed the fires of personal inadequacy and permit vulnerability to become risk" (pp. 277, 276).

Hotaling and Straus (1980) state that violence in families is "the result of socially learned and socially patterned behaviour" (p. 4). It follows that spousal violence is not random behaviour but "patterned into the very structure of marital and family relations" (p. 11).

The societal context within which violence against female partners takes place is one which has traditionally been characterized by male socialization within a patriarchal order, social toleration of men's violence against their partners, and the institutionalization of the domination and control of women by men. "Within this structure women are expected to conform to behavioral criteria that are decided upon and enforced by men" (Adams and McCormick, 1982, p. 174).

Ultimately any acceptance of the abuse of women by men is rooted in the patriarchy; "women are dominated by men in ways that stem from men's struggles with other men. Patriarchy is a dual system in which men oppress women and in which men oppress each other as well. Challenging one aspect leads to challenging the other" (Turkel, 1980, p. 306).

The institutionalization and toleration of men's abuse of women is evident in the very system which one would think that women could turn to for

protection from abusive (i.e., criminal) behaviour, the criminal justice system - the police, the public prosecutor, the courts, and the legislative assemblies - which reflects societal positions on and provides appropriate sanctions of abusive behaviour. While there is movement being made to ensure that the criminal justice system performs in such a way as to protect those who are victimized by abusive behaviours (Berk and Newton, 1985; Buzawa and Buzawa, 1985), there is considerable evidence that the scope of change required is broad (Burris and Jaffe, 1983; Eisenberg and Seymour, 1979; Field and Field, 1973; Fields, 1977, 1978; Lerman, 1986).

One might take everything that Gil proposes with respect to the levels of manifestation and the causal dimensions, as well as the primary prevention of child abuse (Gil, 1975), and only change "child" to "wife" to have a clear and relevant conceptualization of the phenomenon of wife abuse. One would then conclude that "the complete elimination of [wife] abuse on all levels of manifestation requires a radical transformation of the prevailing unjust, non-egalitarian, irrational, competitive, alienating, and hierarchical social order into a just, egalitarian, rational, cooperative, humane, and truly democratic, decentralized one...Primary prevention of [wife] abuse is a political issue which cannot be resolved through professional and administrative measures" (p. 355).

Abusive men perform a function, in our patriarchal society, of maintaining the balance of men's domination over women. Intervening in this system of domination, in a way that changes the rules and norms which support the

abuse of women, will require the joint efforts of educators, social service providers, the police, and the courts. Women need to be supported in their efforts to protect themselves from abuse. Men need to be challenged to acknowledge this problem and to begin to oppose and change abusive behaviours. A combination of community education and treatment groups will help to change community attitudes, to increase the base of support for addressing problems of family violence of all types, and to establish equality of opportunity and function for men and women in both their personal relationships and our societal structures and institutions.

In addition to the areas of enforcement and education, changes in the areas of shared information (Dutton, 1986; Feazell et al, 1984) and coordinated intervention (Berghorn and Siracusa, 1982; Harris and Sinclair, 1981) between those who are attempting to provide treatment to all the victims of family violence - the women, the children, and the offender, himself, are of critical importance.

The effects of family violence go far beyond the family context - the effects upon the victims, the witnesses, and the abusers - into every corner of our society. Steinmetz (1986) states "even if we don't experience family violence directly, we all experience indirectly, the fallout resulting from family violence: higher insurance rates, higher taxes to support needed social services to victims and their families, as well as the legal cost of prosecuting and punishing offenders, and the social and emotional stress of living in an environment characterized by violence" (p. 64). It is clearly in our collective best interests to

devote, to the eradication of family violence, sufficient resources of all kinds - financial, educational, intellectual, treatment, and personal.

Learning goals

As a husband (for almost 20 years) and a father (for 17+ years), the writer has been aware of some of the impact that he and his work and other interests have had upon the lives of his partner and children. His influence has been generally positive.

In his child welfare social work practice, he has had much opportunity to witness the negative impact on families of the unhealthy parenting and relationships of some men. He has tried, in all of his work with families, to present a strong and healthy male role model as an example of an alternate way of being and behaving as a man, a partner, and a father.

Compared with the struggles which many families have in getting along and getting by, the writer's family life experience has been relatively easy. During the tough times there was always abundant information and wise counsel available to guide in the resolving of problems. Sometimes the writer finds it hard to comprehend what it is which keeps a man and woman from achieving and maintaining, at least in their own relationship, a healthy process of solving problems and resolving conflict.

The writer reflected upon his own experience in families - his family of origin and current partnership - and with others' families. He also

reflected upon his responsibilities as a social worker to challenge and to assist others toward healthy growth and change. As his interest in family violence, and particularly the role which men play in it, began to develop, he identified a number of areas which he felt a need to explore and/or about which he needed to learn.

The writer undertook to review the literature on the abusive man and interventions to change his behaviour and to develop the practical experience which followed, and which is described in the body of the report below, with these personal learning objectives:

1. To assess his values, attitudes, and expectations with respect to the roles of men and women in society and to the rights and responsibilities of men and women in relationships and in family life.

2. To assess his behaviour, toward his partner and other women, with respect to those espoused values, attitudes, and expectations.

3. To explore means of bringing spousal violence interventions into his current social work practice.

4. To assess whether or not his experience of the response of the wider community, of the criminal justice system and other "helping" agencies, of abusive men and their partners, and the process of conducting a treatment group for abusers will be consistent with the

literature and the experience of others' involvement with men who abuse and their victims.

Practicum goals

"Violence in individuals is a function of how physiological arousal is shaped by learned ways of interpreting experience, and verbally justifying behaviour. The prospects of acquiring norms and values that prevent violence, as well as skills and habits necessary to settle differences amicably, are greatly affected by a person's learning environment" (Glaser, 1986, p. 27).

As part of a larger plan to provide for abusive men in the Kenora area a special learning environment, a primary goal of the writer's practicum was to develop, implement, and evaluate a treatment group program for men who perpetrate physical, sexual, and/or psychological abuse against their partners. The second major goal was to have the group members stop their abusive behaviour in spousal and other family relationships.

The writer hoped to develop social work skills, to receive feedback, and to enhance his skills in the following areas:

1. program development and developmental issues;
2. small group process and leadership;
3. identifying and assessing violence in relationships;
4. the use of cognitive-behavioral interventions; and
5. the evaluation of clinical interventions.

The pursuit of his goals was not without challenge and criticism from those, in the writer's community, whose primary concern is to meet the needs of the victims of marital violence, and who have trouble accepting that men may also be victims and otherwise legitimate treatment clients. His work was not free from the frustration and doubt engendered by working with resistant clients and in the relatively uncharted waters of interventions with abusers. The writer was always firm, however, in his belief that treatment for abusive men is both appropriate and necessary. The challenges and rewards of this work were real, both for the group leaders and for the group members.

The literature review, upon which the development of the practicum described in this report is based, covered only material published up to early 1988. However, the tasks of evaluating, on a ongoing basis, the needs of the community and the need for change in the community, as well as the group intervention itself, has continued beyond the involvement described in this report. The writer's work with the Other Ways Now Program from November, 1988, to December, 1989, is described here. The O.W.N. program has continued to grow and, in 1993, is an important part of the community's efforts to stop men's violence against women and to promote healthy family life.

CHAPTER TWO: THE LITERATURE REVIEW

A. The Problem

1. Types of abusive behaviour

Violence by men against their partners includes physical abuse (ranging from pushing and slapping, through punching and choking, to injuring with a weapon and homicide); verbal/emotional abuse (including insults, name-calling, swearing, etc.); psychological abuse (including threats of violence, threats against or to remove children, and threats to leave); sexual violence (including coerced or physically forced sexual activity, the withholding of sex, cruel or bizarre sexual practices), and social/environmental abuse (including isolation of the partner from friends or family, withholding money, forced confinement and the destruction of personal property and pets). The power of any of these behaviours to injure and/or control the victim of the abuse is often based in a primary physical battering incident.

Certain abusive behaviours could be placed within more than one of the above-mentioned categories. Specific abusive acts may be differentiated according to the distinct type of abuse, for study purposes. The critical thing for the practitioner to be mindful of is that, from the perspective of the victim(s), one or more "types" of abuse may be experienced at the same time and it is the destructive impact of the abuse, the violation and the pain of it, which needs to be eradicated. In a treatment

intervention, all forms of abuse will be described, identified in each abuser's repertoire of behaviours, and replaced by non-abusive alternative behaviours.

Hoffman (1984) defines psychological abuse as "behaviour sufficiently threatening to the woman so that she believes that her capacity to work, to interact in the family or society, or to enjoy good physical or mental health has been or might be threatened" (p. 37).

Ganley (1981a) draws a distinction between psychological and emotional abuse. Psychological abuse is behaviour which occurs in a context in which at least one incident of physical violence has occurred. Verbal abuse and undermining and belittling behaviours without physical violence is identified as emotional abuse.

Threats and other forms of non-physical abuse will not be underestimated either in their effects upon the victims of abuse or in the development of treatment interventions with the abusers. Threats function to maintain the abusers' manipulation and control of their partners in the absence of any physical violence. Edelson and Brygger (1986) state that "nonphysical abuse in the context of continuing violence creates an environment filled with fear - fear that acts to impose the man's will upon his partner" (p. 382).

2. The incidence of abuse in intimate relationships

It has been estimated that violence of some sort and degree will be found in from twenty-five to fifty percent of all spousal relationships (Gelles, 1974; Gelles and Straus, 1979; Steinmetz, 1977, Straus, 1978, Straus et al, 1980). One study (MacLeod, 1987) reported that one in ten Canadian women will be battered every year by her partner. Deschner (1984) defines battering as a "series of physically injurious attacks on an intimate or family member that form part of a repeated, habitual pattern" (p. 2). She found that between 2 and 4 percent of relationships experience this level of violence.

Studies of premarital dating relationships suggest that the incidence of violent acts within such relationships range from 20% (Cate et al, 1982; Makepeace, 1981; Roscoe and Kelsey, 1986) to 35% (O'Keeffe et al, 1986) to as much as 49% (Roscoe and Benaske, 1985). O'Keeffe and her co-researchers (1986) believe that "teenagers who experience violence in their premarital dating relationships may run the highest risk of abusing or being abused frequently and severely in their later intimate relationships" (p. 468).

Studies of marital rape have found that from ten to fourteen percent of the married women in their samples were victims of forced sex by their partners (Bowker, 1983; Finkelhor and Yllo, 1985; Russell, 1982, cited in Bidwell and White, 1986).

Consideration of any data on the incidence of spousal abuse will include the acknowledgement that abusive behaviour is likely to be under-reported both by the abuser and by the victim (Bowen, 1983; Colapinto, 1979; DeMaris and Jackson, 1987; Dutton, 1986; Edelson and Brygger, 1986; Finn, 1985b; Gelles, 1974; Jouriles and O'Leary, 1985; Knight and Hatty, 1987; Macleod, 1987; Straus, 1979; Straus, Gelles, and Steinmetz, 1980) and often goes undetected by practitioners who may be involved with abusers and victims for other reasons (Brekke, 1987). There are also limitations in the consideration of frequency data alone in assessing the nature and scope of spousal abuse and in developing appropriate treatment interventions (Margolin, 1987). There is also a need to attend to the intent of the abuser in choosing to behave in a particular way, the intensity of the specific abusive act, and the impact of the abusive act upon the victim(s).

Browning and Dutton (1986) found that "gross discrepancies in perceptions of violence often occur between spouses, and despite a positive correlation, the wives almost always rate more husband violence than the husband does" (p. 378).

Straus and Gelles (1986), in their study of a nationally representative sample of families, found that the rate of the incidence of severe violence had fallen in the decade between 1975 and 1985. During the same period there was a significant increase in both the availability and the use of services provided to the victims and perpetrators of violence. They concluded that their findings were the result of a combination of

changed public attitudes toward violence and norms concerning abusive behaviour, and changes in individuals' overt behaviour. However, while studies such as these indicate movement toward the goal of eliminating family violence in our society, there are still too many people being victimized and too many offenders continuing their abuse.

3. The effects of spousal abuse

It is important that abusers be treated whenever possible in order to minimize the damage that they might inflict on one victim, or on a series of different victims, in the form of physical injuries and psychological scars. If there are children present in the family where spousal abuse is occurring, they will be affected both in the short and the long term. In addition to the effect that the abuse has on the victim(s), there are on-going effects on the abuser. These effects will often intensify many of the problems or characteristics which the abuser has which play a role in his use of violence in the first place. The writer will describe the potential effects of the experience of abuse upon each of these three groups below, beginning with the woman victim.

a. effects on the woman

It was assumed by many people that the problem of spousal abuse was restricted to the context of the marital relationship. The findings of a significant number of studies (Bernard and Bernard, 1983; Bernard et al, 1985; Billingham, 1987; Carlson, 1987; Cate et al, 1982; Laner and

Thompson, 1982; Lloyd, 1987; Makepeace, 1981, 1983, 1986; O'Keeffe et al, 1986; Roscoe and Benaske, 1985; Roscoe and Kelsey, 1986; Stets and Pirog-Good, 1987) have shown that the violence often begins in the intimate relationships of high school and college students. The behaviour of these adolescents and young adults appears to be a rehearsal of behaviours which are then highly likely to be repeated in their later marital relationships.

The most obvious signs/effects of abuse are the physical injuries which result from assaults of various kinds - slaps, punches, shoves, being struck with objects, being attacked with weapons - and which can range from bruises, cuts, and broken bones to near-fatal injuries and death (Currie, 1988; Ganley, 1981a).

The initial response of the victim to having been abused will depend on her own psychological and emotional state at the time of the first battering episode. If she has come from a family in which she witnessed or was victim of abuse and/or in which sex roles were rigid and females were subject to the control of males, she may consider the abuse to be a normal or expected part of an intimate relationship. If she has a low sense of self-esteem, in addition to an abusive family background, she may consider herself responsible for bringing the abuse upon herself. If she does not hold the man responsible for the abuse and remove herself from the abusive relationship soon after the primary battering incident, she will likely find herself subjected to increasingly frequent and severe incidents of abuse (Ball and Wyman, 1978; Bern, 1982; Carlson, 1977;

Ferraro, 1983; Gelles, 1974, 1976; Hatty, 1987; Hilberman and Munson, 1978; Martin, 1976; Pagelow, 1981; Rosenbaum and O'Leary, 1981a; Shupe et al, 1987; Straus et al, 1980; Walker, 1979, 1984; Weitzman and Dreen, 1982).

Harris and Sinclair (1981) state that five psychosocial factors characterize the experience of the abused woman: fear, helplessness, internalized blame, isolation, and low self-esteem. Because of these factors many victims do not share their experience with others. Often traditional services have not identified symptoms of spouse abuse or been able to adequately meet the needs of abused women.

Smith (1984) describes the situation of the woman whose victimization has progressed to the point of considerable severity and high frequency:

> "The battered woman has low self-esteem. Already uncertain about her self-worth, abuse reinforces her worthless feelings. She usually accepts responsibility for the batterer's actions, blaming herself for causing the abuse. Because she feels guilty, she denies the terror and anger she feels. She believes in the traditional values of home, family unity and sex-role stereotypes. Usually she is socially isolated, and as a consequence believes that no one can help her resolve her predicament. If she does have friends, she hides the abuse from them because she is ashamed. Generally, the battered woman is emotionally and/or financially dependent upon her mate. Finally, she clings to the false hope that her abuser will change" (pp. 3f.).

Women who have been severely abused may subsequently develop psychological or psychiatric disorders. As many as half of the women referred to psychiatric treatment may have been battered (Hatty, 1987; Hilberman and Munson, 1978), though care will be taken not to assume that being abused is a direct cause of psychiatric problems. Psychiatric referrals may be

made, when more appropriate intervention could have been utilized (e.g., victimization counselling, shelter programming or advocacy for social policy changes and development of new resources), by medical or social work practitioners who have misread the presenting problems or symptoms or have avoided a tough issue by engaging in traditional practice. (Brekke, 1987; Davis, 1984; Hatty, 1987).

Walker (1984) describes the pattern of symptoms of the Battered Woman Syndrome: "features of both anxiety and affective disorders, cognitive distortions including dissociation and memory loss, reexperiencing traumatic events from exposure to associated stimuli, disruption of interpersonal relationships, and psychophysiological disturbances" (p. 4). The hypersensitivity to potential violence which characterizes many abuse victims, and the tremendous energy which they put into trying to ensure that their environment is safe, sets them apart from the rest of us who believe that we are relatively safe in our world.

Eisenberg and Micklow (1977) describe the battered woman's encounter with the criminal justice system. They found that, as in many other contexts, the perceived roles of wife-victim and husband-assailant were related to societal views of male and female behaviour. They state: "In a culture where violence is a commendable pattern of masculine behaviour, men will continue to act out their aggressions in the home without the fear of criminal or societal sanction...Until women refuse to accept a subordinate position in their homes, their work, and their marriages, they will continue to be devalued, victimized, and virtually helpless" (p. 161).

To ensure that the welfare of the victims of abuse is kept as the highest priority of intervention in domestic violence, victims of wife abuse need to be involved in the design and development, the delivery, and the evaluation of services provided for both victims and offenders. And, as Knight and Hatty (1987) contend, "although women subjected to domestic violence need to be portrayed realistically as oppressed and victimised, there is a need to recognise their 'agentic' characteristics" (p. 460). These women need to be empowered through attention given to their essential qualities, their successes in coping with very difficult situations, and their critical role in what needs to be a coordinated effort to educate potential victims and perpetrators of abuse about their experience and the alternatives.

b. effects on children

There is much evidence that the experience of violence as a child, either as direct child-abuse or as the witnessing of parental violence, is a significant factor in adults' experience of violence (Gelles, 1973; McCord et al, 1961; Owens and Straus, 1975; Straus, 1980d; Ulbrich and Huber, 1981). Children may come to believe that men can control women, that women are destined to be controlled, and that abusive and controlling behaviour is useful in getting for people what they want. Long term effects of experiencing violence in the parental home will include the increased likelihood, through the mechanism of role modelling, that boy children will abuse their future partners and that girl children will be abused by theirs. The tendency of modelling the same-sex parent's

behaviour in an abusive relationship has been found, however, to be high and statistically significant only for male children (Elbow, 1982; Rosenbaum and O'Leary, 1981a; Ulbrich and Huber, 1981).

Children may experience or exhibit a number of psychological, emotional, somatic, and behavioral problems (Elbow, 1982; Hershorn and Rosenbaum, 1985; Rosenbaum and O'Leary, 1981b). Children will feel fear at the intense anger displayed by their father or step-father and at the pain which they will know that their mother is suffering. They may believe that they are somehow responsible for the parental conflict because of their own demands and imperfections. This may result in a need to achieve or excel based not upon personal growth but as a way of removing a "cause" of parental fighting. Children may feel anger and lack of trust towards one or both parents because of the anxiety that the parental behaviour creates in them.

The child's natural attachment to his/her parents may be hampered by fear of the abusive father, by fear of losing the abused mother, or by the ambivalence felt as a result of neglect. For a male child, attachment may be marred by the resentment for a father, who by his words and actions invalidates or disallows the child's natural feelings for his mother, or a mother, who by allowing herself to be beaten puts herself and his welfare in jeopardy (Bowlby, 1984).

When, in adolescence, the youth's self-identity is undergoing its final stages of restructuring and incorporation, he/she may have some

maladaptive cognitive schemata with respect to gender specific issues and to issues of relationships to the opposite sex (Guidano and Liotti, 1983). These issues may surface and be played out in a future relationship in the form of battering. There is also the likelihood that the male youth will engage in verbally or physically aggressive behaviour towards his mother (Hershorn and Rosenbaum, 1985).

Children may get injured themselves in violent incidents, either indirectly or directly, should they try to intervene to assist or protect their mother (Blumberg, 1974; Gil, 1971b, 1977). They may get abused by their father/mother's partner. They may also get abused by their mother/father's partner as a result of her helplessness, frustration, and rage at the violence she is receiving.

c. on the abuser

The abuser will likely be very remorseful about having abused his partner after the primary battering incident. He will also likely minimize the effects of his abuse, project the blame for the incident on his partner and her behaviour, etc. He may learn from the aftermath of the abuse that it served the functions of getting him what he wanted prior to the incident, and of controlling his partner. The positive reinforcement which comes as a result of the functional "success" of his abusive behaviour will make it easier and more likely that he will abuse again.

Purdy and Nickle (1981) state that men who batter are victims inasmuch as

they are "the products of a society that trains men to be: 1) unaware of their own feelings, 2) dependent on women to take care of feelings in the family or relationship, 3) problem and action oriented as opposed to process oriented, and 4) programmed that anything less than perfect behaviour is failure" (p. 111).

"Male sex role strain - a form of psychosocial violence - results not only from harsh and rigid socialization, shaming, and pressures toward overconformity, but also from unattainable standards and from role conflict" (Taubman, 1986, p.16).

Inasmuch as an individual man's abusive behaviour is related to emotional dependence and other emotional problems, he may be a victim of a socialization process which has left him unprepared for a mature, healthy relationship with his partner. It is important, particularly for the development of a treatment intervention, to fully understand the potential life experiences of men and to build that understanding into the treatment approach. However, for those abusers who have an attitude problem - a belief that a short temper and the ability to control women are a natural part of being a man, the designation of 'victim' would "trivialize the entire family violence problem" (Shupe et al, 1987, p. 44). Therefore, it will be equally important in treatment to ensure that abusers not be allowed to get stuck in the perception of themselves as "victims."

One of the possible consequences of abusive behaviour and its attendant effects is the subsequent cessation of the abuse. Some men will come to

realize that, no matter how stressful the situation or how difficult to cope with is another's behaviour, abusive actions follow a personal decision to behave that way and it will also be an individual decision to stop the abuse. No one is responsible for the abuse but the abuser. Though it is quite limited (Margolin and Fernandez, 1987), there is evidence that men have come, in the aftermath of one or more abusive incidents, to take their responsibility seriously and stopped making the choice to abuse.

B. The Theory

1. Etiological theories

In the early efforts to research and explain the phenomenon of violence within the family, the focus was often on determining individual causes of the violence. A review of these theoretical approaches identifies three categories of theory according to etiology: a) the intra-individual or psychopathological, b) the social-psychological, and c) the sociocultural or structural.

a. intra-individual/psychopathological theories

Some theorists felt that the cause of violent behaviour could be found by looking for individual medical/organic conditions (Deschner, 1984; Elliott, 1982; Geller and Walsh, 1978; Scott, 1974), emotional disorders

(Saul, 1972; Schultz, 1960; Snell, Rosenwald, and Robey, 1964), or psychiatric problems (Faulk, 1974; Scott, 1974).

While a medical or psychiatric explanation of violent behaviour needs to be considered, particularly when treatment of the offender is being planned, the number of cases in which the cause of the violence lies mainly or only in this area is so small as to be almost irrelevant (Shupe et al, 1987; Steinmetz and Straus, 1973; Symonds, 1978).

The exploration of the intra-individual factors which are related to abusive acts will focus upon the physiological and cognitive components of rage and aggression patterns (Deschner, 1984; Goldberg, 1982).

b. social-psychological theories

As the belief that violent behaviour was a result mainly of individual psychopathology was questioned by researchers, attention was turned to those things which had a broader effect upon both the offender and his family. Researchers examined the offenders' coping and problem-solving methods, their families of origin, their personal socioeconomic circumstances, external environmental factors or stressors, family interaction patterns, support networks or the lack thereof, and the particulars of the experiences of their abusive relationships.

As they concentrate on the interpersonal relationships experienced by the batterer and his victim(s) in their families of origin and in their dating

and courtship periods, these theories help us to understand the specific mechanisms which initiate and perpetuate violence in relationships.

Gelles (1974) noted the particular importance of the family of origin as "the primary mechanism for teaching norms, values, and techniques of violence" (p. 169).

Following the lead of studies of courtship violence among teens and young adults in high school and college, Flynn (1987) suggested that the concept of relationship violence would better characterize the continuum of violence that is evident in the relationship career of many batterers.

Some of the theories which developed from this direction of study are briefly described below:

i) frustration-aggression theory (Miller et al, 1941; Parsons, 1947; Roberts and Jessor, 1958; Sears, 1941)

Aggressive behaviour occurs in response to emotion felt when some personal goal is blocked or frustrated. The views that this is an innate response and that it is a learned response are both represented.

ii) catharsis theory (Feshbach, 1961; Steinmetz and Straus, 1973)

"Normal" aggression in families should be expressed not held in so that tension is released and the likelihood of serious violent incidents is reduced.

iii) theory of disinhibition of aggression (Goldstein, Davis and Herman, 1975)

Once a person responds to another's behaviour by administering a punishment, s/he will tend to become more extreme in that response as time goes on.

iv) linkage theory (Steinmetz, 1971; Straus, 1971)

Individuals will tend to be raised and taught, as children, in ways which will provide them with the type of personality which will allow them to cope with the life experiences they will likely face as an adult.

v) exchange theory (Brown, 1980; Goodstadt and Hjelle, 1973; Safilios-Rothschild, 1970; Star et al, 1979; Straus, 1974)

Each individual in a relationship will attempt to maximize his/her own benefits while minimizing costs. Violence may result when one individual perceives that the costs and benefits are distributed inequitably.

vi) attribution theory (deTurck and Miller, 1986; Ellis, 1976; Hotaling, 1980; Kalmuss, 1979; Kaplan, 1972)

Within the context of a set of relational rules, conflict may occur when one partner attributes malicious intent to the rule-breaking of the other partner.

vii) theory of learned helplessness (Maier and Seligman, 1976; Steinmetz, 1978c; Walker, 1978)

An individual may come to believe, through experiencing a series of assaults against which she has had no defense and from which she could not

escape, that she cannot control the outcome of even those situations in which she does have some control.

viii) social learning theory (Bandura, 1965, 1973; Bandura, Ross and Ross, 1961, 1963a, 1963b, 1963c; Bernard and Bernard, 1983; Carroll, 1980; Cline, Croft and Courrier, 1973; Ganley, 1981a; Gentemann, 1984; Kalmuss, 1984; LaBell, 1979; Makepeace, 1986; Margolin, 1979; McCord, McCord and Howard, 1961; O'Leary and Curley, 1986; Pagelow, 1981; Reynolds and Siegle, 1959; Star, 1978)

Individuals learn to accept and to use abusive behaviours as a result of 1) socialization practices based on cultural norms, 2) of the modelling of the behaviour of significant others, and 3) of experiencing the "successful" use of such behaviours to get them what they want.

ix) a general stress model (Dohrenwend, 1961; Farrington, 1980; Garbarino, 1980; Gil, 1971a; Hotaling and Straus, 1980; Makepeace, 1983; Peterson, 1980; Schlesinger et al, 1982)

Abusive behaviour may issue from the effects of structural and/or personal stressors upon an individual. While not a sufficient cause, stress may be a necessary factor to produce abuse in a relationship.

c. sociocultural/structural theories

It also became increasingly clear, as the study of family violence expanded, that attention needed to be given, not only to those factors which impinged upon the individual offender, within the context of his particular circumstances, but also to factors whose influence/effect appeared to be common for all violent individuals (Gil, 1986).

Researchers have examined familial, ethnic, cultural, and societal

structures which have an impact on the lives of individuals. They have looked at all of society's major institutions - the family, the educational system, religious institutions, the economic system, the political system, the legal/criminal justice system, the military - and have considered the impact that any and all of these may have on the life experience of individuals within particular families.

Among the theories which developed in this area were:

i) the subculture of violence theory (Erlanger, 1974; Hepburn, 1973; Long, 1986),

The incidence of violence in families will be higher in certain populations where socialization practices and community expectations support the use of violence.

ii) conflict theory (Gelles and Straus, 1979; Lloyd, 1987; Sprey, 1969, 1971, 1972; Steinmetz, 1977; Straus, 1979; Symonds, 1978)

Conflict is inevitable in families due to competing interests and goals. Violence may be the result when other means fail to resolve issues of authority and power between family members.

iii) resource theory (Allen and Straus, 1980; Emerson, 1962; Goode, 1971; Hauser, 1982; Hornung et al, 1981; Katz and Peres, 1985; Kolb and Straus, 1974, Rogers, 1974; Rollins and Bahr, 1976; Steinmetz, 1974)

"A resource is any attribute, circumstance, or possession that increases the ability of its holder to influence a person or group" (Rogers, 1974, p. 1425). Violence may be used when no other resource will meet a

person's need to influence another. This theory could also be listed with the social psychological theories above.

iv) structural theory (Ball-Rokeach, 1973; Bograd, 1984; Brienes and Gordon, 1983; Bronfenbrenner, 1974; Foss, 1980; Gelles and Straus, 1979; James and McIntyre, 1983; Owens and Straus, 1975; Sprey, 1972; Straus, 1978)

Violence in the family is partly a function of the nature of institutional structures. Factors which produce violence have different effects in different parts of society.

v) functional theory (Averill, 1983; Billingham, 1987; Carroll, 1980; Flynn, 1980; Kaplan, 1972; Shainess, 1979; Turkel, 1980)

The use of violence validates societal values, norms, beliefs and expectations with respect to interactions between individuals. It serves a number of functions including social control.

v) socio-political theory (Balswick and Peek, 1971; Carlson, 1977; Dobash and Dobash, 1978, 1981, 1983; Eisenberg and Micklow, 1977; Eisenberg and Seymour, 1979; Gill, 1975; Gillespie, 1971; Goldberg, 1973; Hare-Mustin, 1987; Kolb and Straus, 1974; Krause, 1971; LeMasters, 1971; London, 1978; Martin, 1976; Rueger, 1973; Schuyler, 1976; Shotland and Straw, 1976; Stark et al, 1979; Straus, 1976, 1980a; Turkel, 1980).

Violence against women is understood in the context of a patriarchal societal system where control and domination of women is supported and inequities according to gender are present in all the major social institutions.

vi) social control theory (Gelles, 1982)

Social control theory focuses on factors that restrain violence. What is required to reduce abusive behaviours in families is a set of societal

controls which would encourage the following of appropriate social behaviours and provide negative sanctions for family members who choose to abuse others.

d. multifactorial

The above-mentioned theories and approaches provide part of the theoretical base upon which to build an understanding of violence in relationships. But one of these theories' major limitations is that they have trouble explaining the difference between abusive and non-abusive relationships. None of them can explain why an individual who, according to the theory, would be highly likely to be abusive is not or why the presumed "non-abuser" behaves in an abusive manner.

A number of researchers believe that it tends to be unhelpful, in trying to understand family violence (and, ultimately, in the development of treatment interventions), to concentrate on individual theories or exclusive groupings of causal factors in attempting to explain family violence (Bagarozzi and Giddings, 1983; Belsky, 1980; Carlson, 1984; Eddy and Myers, 1985; Gelles, 1980; Gelles and Maynard, 1987; Lesse, 1979; Lystad, 1975; Makepeace, 1987; Owens and Ashcroft, 1985; Rounsaville, 1978; Straus, 1978, 1980c; Toch, 1980). They hold that an integrated, multifactorial approach is required.

Schumm and his associates (1982) contend that many variables proposed by other researchers as key in the understanding of the causes of family

violence "may be either 'marker' variables, which are in some way associated with family violence but have no causal relationship to it, or they may be variables with a spurious relationship to family violence that is idiosyncratic to either the sampling procedure, sample composition, or study methodology" (p. 334). The authors suggest that "perhaps the only valid indicators of violence in the home are those related to specific family interaction patterns" (p. 336).

Eddy and Myers (1985) state that there is a group of variables, factors which exist within the individual, which mediate the translation of potential causal conditions or events into overt interpersonal behaviour. Among potential causal variables, they include the effect of individual and cultural history, the nature of relationships with a partner and others, environmental stresses and/or supports, and biochemical factors (with organic or behavioral roots). The key factors which, Eddy and Myers suggest, make the difference in performance between abusive and non-abusive behaviour are the individual's feelings, thoughts, perceptions, values, physiological responses and the process by which he learns. This position that mediating variables play a critical role in the individual's final choice of action finds support elsewhere (Bedrosian, 1982).

This multifactorial approach to the etiology of violence may help to explain why individuals from widely varied backgrounds may all exhibit abusive behaviours. It may also help us to understand why, for any two individuals with highly similar backgrounds, one may be abusive and not the other. This consideration of the full range of etiological factors

may allow for the development of treatment programs which will target a wide range of potential external causes and internal processes for a variety of interventions -- educational, affective, cognitive, and behavioral -- tailored to the individual needs of each identified abuser.

2. An ecological perspective

Researchers and theorists in the field of family violence have approached the phenomenon from a variety of different levels of analysis (Bronfenbrenner, 1977; Garbarino, 1977; Gelles, 1980; Gil, 1986). It had been suggested (Belsky, 1980; Carlson, 1984) that there are four levels at which the many issues of violence between spousal partners may be analyzed. The levels of analysis described by these students of family violence suggest an ecological model or perspective which views the various levels as nested within one another. Following this perspective, one can only fully understand the whole phenomenon of family violence if one looks at each individual part of the whole in its contexts - historical, environmental, ideological, and cultural.

While it is critical, ultimately, to look at the phenomenon of family violence in a holistic way, it is useful to examine each of the individual levels separately so that all factors will be identified which need to be considered in the development of a comprehensive treatment intervention. The writer will turn to such an examination now.

a. the individual context (ontogenic)

The first level is the ontogenic (Belsky, 1980). Analysis at this level will consider the abusive individual's family of origin, the way he was socialized, and the context in which his attitudes and behaviours developed. The individual brings values, beliefs and attitudes, personal resources, skills and abilities, subjective perceptions of reality and worldview, and personal weaknesses, problems and pathologies into the spousal relationship.

Kalmuss (1984) contends that "the occurrence and transmission of family aggression across generations tends to be role specific" (p. 17). As the result of the experience of the context of his socialization, a man will come into his spousal relationship(s) with well developed and practised role expectations of himself and his partner.

Belsky's (1980) comments with respect to preparation for child-rearing are germane to the area of adult intimate relationships. The lack of comprehensive information about and practice in the marital partner role increases the likelihood of an aberrant response to the demands of the marital relationship.

b. the family context (microsystem)

The second level is that of the microsystem. This represents the relationship setting; that is, the immediate context within which spousal

abuse takes place. The history of the spousal relationship, the family role structure, the dynamics of interactions between the abuser and his partner, and the way in which the couple copes with stress are the focus of this level of analysis.

It has been noted (Foss, 1980; Hotaling and Straus, 1980; Sprey, 1969; Straus, 1980c) that it is no surprise that the family is often the locus of conflict because there is a particular combination of factors which predispose the family, as no other social unit, to conflict and violence.

Some researchers contend that there is a certain role which the victim/partner plays in the development of the abusive relationship (Buckley et al, 1983; Hanks and Rosenbaum, 1977; Kalmuss, 1979; Kleckner, 1978; Shainess, 1979; Weitzman and Dreen, 1982). Taking this position has left them open to charge of "victim-blaming," but this charge is a too easy way of avoiding the difficult task of explicating the dynamics of the interaction between partners in the relationship. It is possible to believe that both partners contribute to the dynamics of conflict creation and resolution, without having to assign blame, and still maintain that the violent individual is fully responsible for his (or her) abusive behaviour.

c. the social structural context (exosystem)

The third level of analysis considers the exosystem, that is, the contemporary environmental context in which the family is embedded. It

represents the social structures, both formal and informal, that do not themselves contain the developing person and relationship but impinge upon or encompass the immediate settings in which they are found, and thereby influence, delimit, or even determine what goes on there.

This would include support systems, or the lack thereof, socioeconomic factors and the attendant stresses put upon the family, and the presence or absence of community sanctions or resources required to bring about a change in the abusive relationship. These factors are often closely linked to those which have a major effect at the last and broadest level of analysis - the sociocultural context.

d. the sociocultural context (macrosystem)

The final level of analysis is the macrosystem, which subsumes the cultural values and belief systems which foster the abuse of women through the influence they exert upon ontogenic development and the micro- and exosystems. At this level would be considered cultural norms and values with respect to marriage and family life; societal attitudes about sex roles and responsibilities and about the use of violence; and the structures built into the major social institutions, which reflect the above values, beliefs, and attitudes, and which influence the realities of men and women and tend to maintain the status quo with respect to the exercise of power and control.

Carlson (1984) argues that, while these factors probably do not directly

cause spousal abuse, "they are the most influential and pervasive factors contributing to domestic violence, as well as the least amenable to change" (p. 579).

One study, of a number of factors which had historically fostered a belief that the arrest of the offender in an instance of marital violence had no deterrent value (Sherman and Berk, 1984a, 1984b), led to new legislation, changes in police department policies, and the beginnings of a greater efficacy in women's bringing their victimization to the attention of the criminal justice system. In a follow-up study (Berk and Newton, 1985) it was found that an arrest intervention was the most effective in reducing wife-battery incidents especially for the individuals with the highest propensity for offending.

Buzawa and Buzawa (1985, p. 147) comment on the trends, across local legislative jurisdictions, in the response to domestic violence. They found the responses provide "an adequate understanding of existing structural impediments to agency action" and "a high degree of understanding of what role the criminal justice system should play in the societal effort to limit domestic violence." What is missing, and this is critical, is the statutory provision of incentive structures or mandatory training - in the effects of abuse and the appropriateness of outside intervention - for system personnel, which might produce actual change in response to spousal abuse within the justice system.

Some theorists (McCall and Shields, 1986) point out that the movement to

define and explain family violence has brought together many groups with interests in particular aspects of the problem. The resulting theoretical formulations have tended to address only one aspect or another of violence in the home, "as the centrifugal tugs of all the special-interest groups have tended to overpower the centripetal force exerted by the sociological formulation" (p. 116). Rather than pursue the causal antecedents of family violence, social scientists and policy-makers might better help the victims of family violence by seeking to change societal norms and values which legitimate abusive behaviour within families.

Expanding on these reservations concerning the activities of researchers and legislators, and including our educators as part of the problem, Wodarski (1987) challeges the social work professional, to go beyond the provision of resources to victims and the development of treatment interventions for abusers, to provoke discussion of the prevailing system of values, beliefs and attitudes which maintain, if not condone, abusive behaviour and to actively engage in offering the next generations of potential marrieds constructive alternatives - to assist them in learning problem-solving and coping skills and the social skills needed to develop and maintain healthy interpersonal relationships.

3. The Abuser

In order to understand the individual and to identify the requisite treatment, it is important to identify and assess the problem behaviours and characteristics common to many abusive men. The reader will note

that, while these characteristics have been isolated for purposes of description, there is a considerable amount of overlap among them. Their impact upon and their experience by the abuser and his victim(s) comes as an integrated whole. Studies of the abuser consistently identify some combination of the following characteristics:

a) a general aggressiveness, or a general passivity which from time to time flares into abusive outbursts (Bernard and Bernard, 1984; Maiuro et al, 1987; Purdy and Nickle, 1981)

Rather than responding with hostility and aggression to specific situations, many abusive men have a confrontative approach to all interactions. Others interact with apparent composure and placidity, until their "stuffed" and untended frustrations explode into abusive behaviours.

b) rigid gender-related role perceptions and role expectations (Aldous, 1974; Ball and Wyman, 1977-78; Balswick and Peek, 1971; Bandura et al, 1963b; Biaggio, 1980; Boles and Tatro, 1980; Carlson, 1977, 1984; Cline, Croft, and Courrier, 1973; Coleman, 1980; Currie, 1982, 1983, 1988; Dobash and Dobash, 1978, 1981; Elbow, 1977; Erlanger, 1974; Fields, 1977; Flynn, 1977; Gentemann, 1984; Gillespie, 1971; Goldberg, 1973; Gondolf, 1985; Hare-Mustin, 1978, 1987; Hare-Mustin and Broderick, 1979; Harris and Sinclair, 1981; Joslyn, 1982; Krause, 1971; Lamb, 1979; Lesse, 1979; Martin, 1976; Purdy and Nickle, 1981; Richmond, 1976; Shainess, 1979; Solomon, 1981; Sprey, 1969; Star, 1978, 1980; Star et al, 1979; Steinmetz, 1974; Straus, 1973, 1980b; Walker, 1978, 1981, 1984; Weitzman and Dreen, 1982)

Abusers tend to have different sets of behavioural rules and attendant tasks which they believe are appropriate for males and females. Their gender role expectations are rigidly held, but often practised and enforced with a degree of variation and unpredictability which creates uncertainty and confusion for others.

c) patriarchal attitudes with respect to power, status, authority, and control (Aldous, 1974; Allen and Straus, 1980; Ball, 1977; Ball and Wyman, 1978; Bandura et al, 1963b; Bern, 1982; Boles and Tatro, 1980; Carlson, 1977, 1984; Carroll, 1980; Chafetz, 1980; Cline, Croft, and Courrier, 1973; Coleman, 1980; Currie, 1988; Dobash and Dobash, 1978, 1981, 1983; Eisenberg and Micklow, 1977; Elbow, 1977; Emerson, 1962; Ferraro, 1983; Fields, 1977; Flynn, 1977; Geller and Walsh, 1978; Gelles and Straus, 1979; Gentemann, 1984; Gil, 1975; Gillespie, 1971; Goldberg, 1973; Gondolf, 1985; Gordon and Shankweiler, 1971; Hare-Mustin, 1978; Harrell et al, 1981; Kalmuss, 1979; Kolb and Straus, 1974; Kraus, 1971; LeMasters, 1971; Lesse, 1979; Martin, 1976; Maurer, 1974; Nichols, 1976; Pagelow, 1981; Purdy and Nickle, 1981; Rice and Rice, 1977; Richmond, 1976; Roberts and Jessor, 1958; Schuyler, 1976; Shainess, 1979; Sprey, 1969; Star et al, 1979; Stark et al, 1979; Steinmetz, 1974; Straus, 1976, 1980b; Symonds, 1979; Turkel, 1980; Walker, 1978; Weitzman and Dreen, 1982)

Many men have been taught that they are superordinate to women, with respect to status and authority, and have the right of servitude from women, i.e., to have all their wishes and needs met on a priority basis. For the abusive man, these traditional societal norms and values issue in stereotypic and rigid role definitions and dominating interpersonal behaviours (cf. item "b", p. 37, and item "g", p. 39).

d) having witnessed and/or suffered abuse in the family of origin (Bach-y-Rita and Veno, 1974; Ball, 1977; Bandura, 1965; Bandura, Ross, and Ross, 1961, 1963a, 1963b; Bernard and Bernard, 1983; Bowlby, 1984; Cantoni, 1981; Carlson, 1984; Carroll, 1977, 1980; Coleman, 1980; Coleman et al, 1980; Curtis, 1963; DeMaris and Jackson, 1987; Flynn, 1977; Ganley, 1981a; Ganley and Harris, 1978; Gayford, 1975a, 1975b; Gelles, 1973, 1976a; Gelles and Straus, 1979; Goodstadt and Hjelle, 1973; Jayaratne, 1977; Kalmuss, 1984; King, 1975; Knowles et al, 1984; Kozol et al, 1972; LaBell, 1979; Laner and Thompson, 1982; Martin, 1976; Maurer, 1974; McCord, McCord, and Howard, 1961; O'Leary and Curley, 1986; Owens and Straus, 1975; Raschke and Raschke, 1979; Reynolds and Siegle, 1959; Rosenbaum and O'Leary, 1981a; Rounsaville, 1978; Rouse, 1984; Roy, 1982; Schultz, 1960; Shainess, 1979; Shupe et al, 1987; Sonkin et al, 1985; Sprey, 1969; Star, 1978, 1980, 1983; Symonds, 1978; Symonds, 1979; Welsh, 1976; Whitehurst, 1971)

The experience of violence, as a witness or a victim, may lead a person to re-enact similar behaviour at a later date, especially if, in their experience, the violence served a function for the offender and was

positively reinforced by a "successful" outcome. A higher proportion of males who witnessed the abuse of their mother by her partner, compared to males who were only victims of abuse, went on to be abusive of a future partner.

e) externalizing the blame for his violence (Aldous, 1974; Bernard and Bernard, 1984; Biaggio, 1980; Currie, 1982, 1983, 1988; Dutton, 1986; Elbow, 1977; Ferraro, 1983; Ganley, 1981a; Goodstadt and Hjelle, 1973; Green, 1976; Harris and Sinclair, 1981; Neidig, 1986; Purdy and Nickle, 1981; Shields and Hanneke, 1983; Star, 1980; Straus, 1971)

The abusive man will often lay the responsibility for his own abusive acts upon his partner's abuse-provoking behaviour or some other factor or circumstance outside and apart from himself (e.g., alcohol, job stress, unemployment).

f) denial of the existence or minimization of the extent of his abusive behaviour (Bernard and Bernard, 1984; Dutton, 1986; Feazell et al, 1984; Ferraro, 1983; Ganley, 1981a; Ganley and Harris, 1978; Green, 1976; Purdy and Nickle, 1981; Sonkin et al, 1985; Star, 1980, 1983; Walker, 1981)

This sort of rationalization of his behaviour by the abuser ranges from claiming that it is normal and acceptable under the circumstances (i.e., that it is not abuse at all) to believing that it produces no significant impact upon the victim(s). The abuser's denial reflects a lack of understanding of the true effect of his behaviour and/or a lack of empathy for the experience of his victim(s).

g) controlling and dominating behaviour (Allen and Straus, 1980; Bern, 1982; Bowker, 1983; Carlson, 1977, 1984; Chafetz, 1980; Coleman, 1980; Currie, 1988; Dobash and Dobash, 1978, 1981; Elbow, 1977; Faulk, 1974; Fiora-Gormally, 1978; Ganley, 1981a; Ganley and Harris, 1978; Gelles, 1977, 1982; Gondolf, 1985; Goodstadt and Hjelle, 1973; Hare-Mustin and Broderick, 1979; Martin, 1976; Star, 1980; Stark et al, 1979; Steinmetz, 1978c; Stets and Pirog-Good, 1987; Symonds, 1978, 1984; Walker, 1981; Weitzman and Dreen, 1982; Whitehurst, 1971)

Control and domination generally issue from one of three situations: 1) where it is a person's belief that he is entitled to be obeyed and cared for at his pleasure and without question, 2) where a person knows of no alternative method of getting his own way, or 3) where a person is so emotionally needy and dependent that he believes that the other will abandon him if he gives her any independence or autonomy.

h) social isolation (Ball, 1977; Bernard and Bernard, 1984; Carlson, 1984; Currie, 1988; Feazell et al, 1984; Ganley, 1981a; Ganley and Harris, 1978; Gelles, 1982; Shainess, 1979; Star, 1980; Steinmetz, 1978c; Symonds, 1979)

While not technically a characteristic of a person, social isolation is certainly one natural outcome of abusive behaviour, both for the abuser and his victim(s). Whether born of shame or need to control, social isolation protects the family secret.

i) difficulty in differentiating among various emotions and in expressing feelings other than anger (Ball, 1977; Bedrosian, 1982; Bernard and Bernard, 1984; Biaggio, 1980; Ganley, 1981a; Ganley and Harris, 1978; King, 1975; Maiuro et al, 1988; Martin, 1976; Purdy and Nickle, 1981; Schachter and Singer, 1962; Shainess, 1979; Symonds, 1979; Symonds, 1984; Walker, 1981; Whitehurst, 1971)

Like many men, some who do not abuse, the abuser was likely taught that feeling emotions other than happiness, anger, pride, and jealousy is not "manly." Having never recognized the range of normal human primary emotions, he is content in the good times and responds to the bad times with secondary emotions, such as anger. Sometimes shame, at having primary feelings provoked, or a lack of communication skills prevents him from expressing his feelings before they turn into anger.

j) extreme dependency upon the victim to meet his emotional needs coupled with dependency ambivalence and/or dependency conflict (Adams and McCormick, 1982; Ball, 1977; Bernard and Bernard, 1984; Bowlby, 1984; Carlson, 1984; Coleman, 1980; Currie, 1982, 1983; Elbow, 1977; Faulk, 1974; Feazell et al, 1984; Fiora-Gormally, 1978; Flynn, 1977; Ganley, 1981a; Ganley and Harris, 1978; Harris and Sinclair, 1981; Kalmuss, 1979; Krause, 1971; Maiuro et al, 1987; Martin, 1976; Masumura, 1979; Purdy and Nickle, 1981; Reynolds and Siegle, 1959; Rounsaville, 1978; Schultz, 1960; Shupe et al, 1987; Sonkin et al, 1985; Star, 1980; Star et al, 1979; Steinmetz, 1978c; Symonds, 1978; Walker, 1978, 1979, 1981; Weitzman and Dreen, 1982)

Men who lack social skills or self-esteem and have a low sense of self-worth will tend to seek out and then come to depend upon a partner who can manage his life for him and make him feel good about himself. The abusive man hates this dependent need of his partner. Often an irrational fear of losing her issues in controlling an abusive behaviours.

k) low self-esteem and depression (Aldous, 1974; Ball, 1977; Bern, 1982; Bowlby, 1984; Carlson, 1984; Coleman, 1980; Currie, 1982, 1983; Elbow, 1977; Feazell et al, 1984; Geen and Berkowitz, 1967; Geller and Walsh, 1978; Goldstein and Rosenbaum, 1985; Goodstadt and Hjelle, 1973; Green, 1976, Harris and Sinclair, 1981; Kaplan, 1972; King, 1975; Krause, 1971; Martin, 1976; O'Brien, 1971; Reynolds and Siegle, 1959; Schultz, 1960; Shainess, 1979; Shupe et al, 1987; Snell, Rosenwald, and Robey, 1964; Sonkin et al, 1985; Steinmetz, 1978c; Symonds, 1978, 1984; Turkel, 1980; Walker, 1981; Weitzman and Dreen, 1982)

The effects of a serious lack of self-esteem - a low sense of self-worth, impaired social and relationship skills and a fear of unfamiliar or stressful situations - are felt equally by abusive and non-abusive individuals. The abusive man tries to compensate for this personal "failure" through controlling behaviours and responds to anxiety and stress with anger. He may be prone to depression and suicidal thoughts.

l) faulty thought patterns or cognitive styles (Bedrosian, 1982; Biaggio, 1980; Ellis, 1985; Epstein, 1965; Ganley and Harris, 1978; Harrell, Beiman, and Lapointe, 1981; Margolin, 1979; Purdy and Nickle, 1981; Reynolds and Siegle, 1959; Schachter and Singer, 1962)

As he tries to process his life experience, the abuser often gets caught up in rigid or irrational thinking. In so doing, he only allows himself a very narrow world view, he creates mental scenarios which have limited or no bases in reality, and he often escalates his own emotional state to the point of conflict prior to ever having engaged another individual.

m) poor impulse control (Ball, 1977; Bernard and Bernard, 1984; Biaggio, 1980; Coleman, Weinman, and Hsi, 1980; Currie, 1982, 1983; Ganley, 1981a; Ganley and Harris, 1978; Harris and Sinclair, 1981; Reynolds and Siegle, 1959; Rounsaville, 1978; Shainess, 1979; Shupe et al, 1987; Star, 1980; Symonds, 1978, Symonds, 1979)

A desire for instant gratification of some need, or for quick resolution of a stressful or conflictual situation (including the release of pent-up emotion), may lead the abuser to act precipitously and without thought of the potential impact of his chosen action upon those around him.

n) a low tolerance for stress (Carlson, 1984; Farrington, 1980; Ganley, 1981a; Neidig, 1986; Neidig and Friedman, 1984; Straus, 1980c)

As mentioned above, the abuser often has trouble managing stressful, emotion-charged situations and may choose to resolve them through abusive actions. Because of a lack of effective problem-solving or communication skills, the abuser may not have the necessary tools to reduce stress levels in a more appropriate manner.

o) the use of psychological and sexual, as well as physical, abuse (Bowker, 1983; Currie, 1988; Ganley, 1981a; Gelles, 1977; Glasgow, 1980; Purdy and Nickle, 1981; Reynolds and Siegle, 1959)

It is common to think of the abusive man as a physically violent individual. The experience of psychological and sexual forms of abuse can

produce damage to the victim(s) which is more painful and harder to heal than physical injuries. The abusive man's ability to inflict these kinds of abuse is usually based in at least one incident of physical battering with the attendant threat of another assault.

p) the abuse of alcohol and other chemical dependencies (Bedrosian, 1982; Cantoni, 1981; Carlson, 1984; Coleman et al, 1980; Flynn, 1977; Ganley and Harris, 1978; Gayford, 1975a, 1975b; Knowles et al, 1984; LaBell, 1979; Martin, 1976; Neidig and Friedman, 1984; Rosenbaum and O'Leary, 1981a; Rounsaville, 1978; Roy, 1982; Shapiro, 1982; Star, 1978, 1980; Star et al, 1979; Symonds, 1978; Symonds, 1979; Walker, 1981)

A large proportion of abusive acts occur when the abuser is under the influence of alcohol or some other drug. By lowering his inhibitions and facilitating irrational thinking, intoxicants make it easier for an individual to rationalize his unacceptable behaviour. The criminal justice system's reduced sentences, for crimes committed while intoxicated, support the abuser's rationalizations. Chemical dependencies need to be treated prior to attempting to eradicate abusive behaviour.

All of the above factors have been found to be related to increased rates of wife abuse, but none of them is sufficient to cause an incident of abuse and not one among them is necessary for abuse to occur. Each episode of abuse is the result of a combination of factors rather than any single factor operating alone.

Some studies (Neidig, 1986; Neidig et al, 1986) maintain that the study of individual characteristics using attitudinal variables may not distinguish the abusive from the non-abusive individual. Because of methodological problems with population samples, operational variables, control groups,

standardized measures, and generalizing experimental results to other populations, it may be that we cannot characterize the abusive male in any way which will be helpful in developing a standardized treatment program to change the behaviour of any abusive individual.

Some theorists (Bern, 1982; Neidig and Friedman, 1984; Neidig et al, 1986) contend that abusive behaviour would be more meaningfully divided into two main types - expressive and instrumental - and that there may be differences in the individual and differences in the dynamics of marital relationships depending upon which type of abusive behaviour is exhibited. Neidig and his co-researchers (Neidig et al, 1986) state that "interspousal violence could be represented as a continuum ranging from violent episodes which occur in the context of escalating conflict which are typically followed by remorse ('expressive violence'), to the deliberate use of violence to control or punish for which there is little regret ('instrumental violence')" (p. 231). It may be that abusers who fall on the ends of such a continuum would require different treatment approaches and have differing prognoses for the termination of their abusive behaviour.

C. Theory and treatment intervention

There are several theoretical approaches to intervention with the batterer: an individual approach, a social structural approach, and a systems approach.

The individual approach focuses on the personality and behaviour of the batterer. The roots of his abusive behaviour are sought by looking for organic causes, psychopathological tendencies, personality disorders, and maladaptive behavioral choices (Bernard and Bernard, 1984; Deschner, 1984; Faulk, 1974; Weitzman and Dreen, 1982).

The social structural approach looks at the social environment in which the abuser has been brought up and in which he lives. This would include his family of origin, his previous and/or present marital relationship(s) and family, and the wider societal context in which he and his family live and work. This approach also considers the cultural and institutional structures and values which have influenced and do influence the abuser and his family (Carlson, 1984; Dobash and Dobash, 1981; Gelles, 1974; Gondolf, 1985; McLeod, 1987; Owens and Straus, 1975; Steinmetz, 1977).

The primary strength of the systems approach "lies in its emphasis on multiple paths of causation" (Shupe et al, 1987, p.19) in the development of abuse in marital relationships. The systems approach is not distinct and separate from the other approaches mentioned above, but its special focus is on the interactions among the various factors - identified in the other approaches as being related to abusive behaviour - the transactions between the members of the violent family, and the connections and reciprocal influences between the family, its social networks, and the other societal contexts within which it is nested. The systems approach also holds that, as any part of a system or subsystem undergoes change, there is a tendency for the other parts to either change also or to resist

change and attempt to maintain the status quo. These dynamics are important to consider both in the understanding of the development of an individual's abusive behaviour within a relationship and in assessing the potential for and the effect of changes produced as a result of a treatment intervention (Bedrosian, 1982; Carlson, 1984; Cook and Franz-Cook, 1984; Gelles, 1975; Gelles and Maynard, 1987; Shupe et al, 1987; Straus, 1973; Traicoff, 1982; Weitzman and Dreen, 1982).

Cook and Franz-Cook (1984) maintain that "the feminist view that the man is fully responsible for the battering and the systemic view that the couple are locked into a recurrent vicious cycle which each has a part in maintaining are not mutually exclusive" (p. 84).

Deschner's (1984) seven-stage model incorporates this mix of feminist-systems approaches into a model of a cycle of violence which includes the phases proposed by Walker (1979, 1984). Deschner's stages are: 1) mutual dependency, 2) a noxious event, 3) coercion exchange, 4) a "last straw" decision, 5) primitive rage, 6) withdrawal, and 7) repentance.

Shupe and his partners (1987) contend that seeking the causes of family violence has meant abandoning "single-cause explanations such as sexism, psychological insecurity, media influence, and economic strains and yet simultaneously embrace them all" (p. 19). The systems perspective on spousal abuse opens up the treatment situation to the possibility "that women and couples, not just men, can be violent and that they are important factors in improving the violent situations" (p. 20). Because

men's potential for inflicting severe physical injury, and thereby creating a foundation for severe psychological abuse, is so much greater than women's, it is critical that stopping men's abusive acts be the first goal of treatment interventions. Once the man's abusive behaviour has ceased other problematic areas of the spousal relationship may be addressed.

The process of developing programs which will address the range of needs of the family impacted by spousal abuse will include (and the development of the Other Ways Now Program did include) something of the focus of each of the above-mentioned approaches. Otherwise, important aspects and dynamics of the phenomenon of spousal abuse might remain unidentified, untreated, and unchanged.

Davis (1987) calls attention to the trend, in social workers' perspectives on wife abuse over the last two decades, to move from a focus on the sociopolitical context of the abuse to a focus on treatment for the individual, couple, and family. She cautions that, as social workers continue to develop services and policies in the area of domestic violence, they need to remember that wife abuse is a "social problem that requires social solutions" (p. 311).

The Dobashes state that "the achievement of short-term goals [e.g., the development and implementation of treatment groups] should not become an end in itself and imply a termination of action but should be a part of an unfolding new social order in which violence toward women would cease to

be actively taught and institutionally supported and would truly become a deviant and abhorrent act" (Dobash and Dobash, 1981, p. 459).

Attempts to understand and to eradicate spousal abuse will be undertaken not only to free the abusers' victims (his partner, her children, and, ironically, the offender himself) from violence and the fear of violence, but also to make our society a more equalitarian and fulfilling one in which to live.

When moving from the theory of violence in the family, and particularly violence within the marital partnership, to the development of treatment interventions, the theory will be applied to the areas of 1) client identification, intake, and assessment, 2) the choice of treatment modality, 3) the structure of the treatment intervention, 4) the didactic content of the individual sessions and 5) the specific techniques incorporated into the treatment process.

It needs to be noted here that, in 1987/88 when the writer was making decisions about a theoretical framework for the program intervention as well as what to incorporate in terms of program structure, treatment modality, didactic content, and therapeutic techniques, there was no empirical research evidence available to indicate which structures or components would be efficacious in treating spouse abuse.

The literature, upon which the writer was able to draw for guidance, was full of conjecture and theory about the etiology and maintenance of

spousal abuse but it was very limited with respect to research into how to go about changing the abusive behaviour. The research in support of social learning theory (Bandura, 1965, 1973; Bandura, Ross and Ross, 1961, 1963a, 1963b, 1963c, Bernard and Bernard, 1983; Cline, Croft and Courrier, 1973; Makepeace, 1986; McCord, McCord and Howard, 1961; Reynolds and Siegle, 1959) was the notable exception with respect to empirical support for a particular understanding of the etiology of violent behaviour. One study (Edelson et al, 1985) did provide empirical support for the efficacy of small groups in the treatment of men who batter. However, it did not compare group to other modalities of treatment, nor did it compare groups with differing session content or techniques. Its research design was also described as weak by the authors.

Apart from these few exceptions, the literature presented anecdotal evidence and described experiences which their authors had in order to explain abuse in spousal relationships and suggest ways of ending the abuse and treating the abuser. In summarizing, below (pp. 49-56), the factors which were taken into consideration in the development of the O.W.N. Program, and in making choices about theoretical framework, program structure, treatment modality, didactic content, and therapeutic techniques, the writer was guided by the weight of this anecdotal evidence.

The writer's intention, at that time, was to proceed with those structures and techniques - which appeared, from the literature, to be producing some change and stopping some abuse - and then to modify the program as

suggested by empirical research which was certain to follow in the ensuing years.

- Client identification, intake, and assessment

There is much support (Currie, 1982, 1983; Ganley, 1981a) for the position that participation in a treatment program needs to be mandatory for abusers who come before the courts. It does not always follow, however, that every man so ordered is appropriate to include into the treatment group. The man who is not able to acknowledge that he has a problem and a responsibility to do something about it, is probably not a good candidate (Toseland and Rivas, 1984). Because of any unwillingness or inability to communicate or more active resistance to the process, not only will he be unlikely to benefit from the group, he will likely inhibit the change process for other members of the group (Yalom, 1975).

Weist (1981) cautions that for treatment to have the maximum potential for success in changing the offender's behaviour it needs to take place early in the abusive career. If the abuser is punished, i.e., incarcerated, before treatment is attempted, he may get stuck at the stage of perception of his actions where he accepts his punishment and believes that his debt to society has been paid and that nothing further should be required from him. Early treatment has the potential of moving him on to the point, of feeling grief for the victim, where he has the greatest motivation to change his behaviour and the greatest potential to learn new ways of relating to others.

A study of three programs for abusive spouses (Shupe et al, 1987), identified "three essential ingredients for family violence programs:

> 1. Holding the violent person personally responsible for his or her violent actions and stressing that he or she is not powerless to stop it.
>
> 2. Trying to get objective, independent information on the violent persons and monitoring whenever possible their behaviour during the time they are in the counselling program.
>
> 3. Creating a moral atmosphere in counselling sessions that says physical violence and emotional abuse is not appropriate or excused. It is not macho or normal" (p. 119).

The incorporation of these three ingredients will begin at the first moment in which the abuser makes contact with the program, so that consistent messages and expectations are received by the abuser throughout.

In the gathering of data from potential treatment subjects it is necessary to develop a picture of the offenders' pattern of abusive behaviours. This will include the systematic collecting of data concerning the frequency and intensity of behaviours, the function of the behaviours for the offender and/or his intention in performing them, and the impact of the behaviours on himself and, particularly, on the victim(s).

The fundamental purpose of the initial screening of potential clients for treatment is fourfold: 1) to substantiate a history of abuse of a marital partner, 2) to identify any situations of risk with which the treatment intervention may not deal, 3) to gather data required to determine the content of the intervention and the goals of treatment, and 4) to convince

the potential client that they have a serious problem which is likely to become more serious [perhaps the most important in terms of the potential success of the treatment (Shupe et al, 1987)].

Owens and Ashcroft (1985) recommend the utilization of an "ABC ('Antecedents-Behaviour-Consequences') framework" (p. 122) to gather as much information as possible about the abusers' actual behaviours and the dynamics of his relationship with his partner.

Ganley (1981a) states that data needs to be gathered for crisis intervention and for treatment. For the former purpose information will be sought about the incidence of physical violence, about the abusers motivation to change, about potential child abuse or neglect, and about the lethality of the situation. If high lethality is identified than the safety of the victim becomes of paramount importance. For treatment purposes information will be gathered concerning chemical dependencies, psychiatric problems, the victim's needs and point of view, a complete history of the violence in the relationship, and intellectual and/or neurological functioning. Standardized testing may also be utilized if appropriate.

In order to gather as complete a set of data - following the above direction from those who had experience working with abusers in groups - the writer prepared comprehensive intake and assessment forms (Appendix A, pp. 169-210, below) to be used as a guideline in the conducting of intake interviews with prospective group members and their partners. In

preparing the interview guidelines, the writer found the intake interview forms of three existing programs particularly helpful (Currie, 1988; Neidig and Friedman, 1984; Sonkin et al, 1985).

Billingham's (1987) study found that, when violence is present in courtship relationships of high commitment, "it may be present because the relationship has accepted violence as a legitimate conflict tactic from the earliest levels of emotional commitment" (p. 288). Interventions developed to prevent or treat relationship violence, will consider "the characteristic of the particular couple rather than...a nebulous label such as 'violent couple'" (p. 289).

Makepeace (1986) believes that, during the initial assessment/ intake process, the therapist will need to determine whether the violent couples has developed a "violence enabling cognitive structure" (p. 387) which shapes the initiation process and the perceived roles and holds clues for the motivation for violent behaviour within the relationship. That motivation may be self-defense, retaliation, intimidation, the need to get something, anger, or the influence of some substance such as alcohol.

In order to maximize the abuser's potential to join, to remain in and to work at changing, the intake process needs to answer concerns that he may bring with regard to confidentiality, safety, nature of the leadership and membership, as well as the effectiveness of the program and the potential for success. The O.W.N. Program's intake process and the difficulties encountered will be discussed later in this report (pp. 91-95).

□ Choice of treatment modality

One study (Knowles et al, 1984) found two distinct situations in which violence between spouses who are living together occurs. In one scenario a mutual argument escalates into verbal attacks and, finally, into physical abuse. This was the most frequent situation. The second scenario was one of an unpredictable and spontaneous attack of one party upon the other.

While the situation presented by potential clients for treatment may not fall into such clearly delineated categories, the nature of the abusive behaviour, who the active parties are, and whether or not they live together will effect the choice of or combination of treatment modalities. If group treatment is the modality of choice, the practitioner will also be mindful of the development of the group dynamics in managing the flow and the content of the intervention.

The writer chose the small group modality as the most appropriate for the initial intervention with the abusive man. The support and reasons for choosing this modality will be considered at greater length later in this report (pp. 61-65).

□ Structure of treatment intervention

Many treatment programs use a psycho-educational approach to intervention in which educational techniques are used in a therapeutic setting.

Information is provided, concepts are discussed, values and attitudes are explored, behaviours and their natural consequences are assessed, and new skills are taught and practised by the abuser.

There are a number of choices with respect to how the intervention may be structured. One choice could be to have undifferentiated meetings in which the content of any meeting will be dependent upon items (issues, needs, concerns) raised by the client(s). Another choice could be a content structure laid on by the therapist combined with input from the client(s) restricted to the chosen topic. Still another choice could be a combination of these two - a series of meetings with a therapist chosen agenda, didactic in nature, followed by a series of meetings with member chosen topics and discussion guided by the therapist (Deschner, 1984; Gondolf, 1985; Neidig and Friedman, 1984; Sonkin et al, 1985).

The writer decided to follow the practice of the majority of the programs described in the literature and chose a psycho-educational approach with the content of the individual group sessions chosen and directed by the group leaders.

- Didactic content of therapy sessions

Men learn, through their socialization experience, to be aggressive and dominant in relating to others. These values are reinforced - by parents, teachers, and others in positions of authority, by the information and entertainment media, and by the police and the military,

by their sanctioned use of violence - and supported by the societal norms of our patriarchal society. It is a life long learning process which, unless it is interrupted and countered with alternative information, will continue to produce new generations of abusive men (Ganley, 1981a; Purdy and Nickle, 1981; Star, 1983; Taylor, 1984).

"A theory and practice of work with battered women and abusive men, which includes attempts to change individuals as well as the social structures which support and encourage the use of violence, is possible when we maintain an open-system perspective in which the effects of the social environment and the history of human relationships are included as pertinent facts" (Adams and McCormick, 1982, p. 176).

Social learning theorists (Bandura, 1973; Carroll, 1977; Kalmuss, 1984; Peterson, 1980; Steinmetz and Straus, 1973) state that spousal abuse is a learned behaviour of men and, as such, can be replaced through the learning of new and alternative behaviours. In order that the abusers, who took part in our treatment program, would experience challenges to learn or relearn more appropriate ways of thinking and behaving in the areas of their particular need, a wide range of topics were included in the curriculum. Among the most important were:

1. Traditional vs. equalitarian gender role socialization and the effects upon spousal relationships of rigid role stereotypes;

2. The various types of abusive behaviours and their impact upon the victim(s), the abuser, and the relationship;

3. The abuser's experience of abuse in his family of origin, how that history may have translated into current patterns and cycles of abusive behaviour in his present relationship, and how to take control of his own behaviour and end the abuse;

4. The function of abusive behaviour in controlling and dominating others, the relationship of the need to control to the abusers other emotional needs, and non-abusive ways in which to have his needs met; and

5. The ways in which certain relationship skills deficits - in the areas of impulse control and anger management, relaxation and stress management, and communication, problem-solving and negotiation - may leave the abuser in the position of choosing to abuse.

□ Therapeutic models and techniques

The treatment of the abuser will begin with a multidimensional and multifactorial approach to understanding the etiology and maintenance of abusive behaviour. It will include content particular to the history, current circumstances, and behaviour of each client and will focus on the needs of the victim(s) and the abuser, supporting appropriate behavioral choices and confronting abusive attitudes and behaviours. And it will focus on the client(s) unlearning abusive behavioral responses and learning new ways of interacting with others and coping with stressful situations, using cognitive behavioral techniques and social skill building exercises.

1. Treatment: targets, structures, and goals

Among the targets for intervention in the matter of battering one could certainly include the general public and look for the broad dissemination of information on the incidence, the effects, and something of the phenomenon's causal factors. Teenagers and young adults, as particular groups, would seem to be likely targets for information about the use of

violence in relationships and, specifically, for information on how their individual responses to violence directed at them might serve to reinforce that behaviour. Women and child victims of battering are also obvious target groups for intervention, but apart from references to the inclusion of woman victims in conjoint therapy later in this paper, these and the other groups of people mentioned immediately above are beyond the scope of this report.

Harris and Sinclair (1981, p. 14), through their experience with the Domestic Violence Project of Metropolitan Toronto, have identified four essential components of counselling in the area of spouse abuse intervention: 1) case identification procedures, 2) a crisis intervention capacity, 3) on-going counselling programs, and 4) follow-up services.

Gelles (1982) notes some implications, from a exchange/social control perspective on family violence, for treatment. Treatment goals would include: 1) increasing the degree of social control (e.g., moving the abuser to accept the responsibility for his abusive behaviour) and raise the costs of violence (e.g., direct the offender to accept the pejorative label 'abuser'); 2) reducing the social isolation experienced (e.g., develop community linkages); and 3) changing the power structure of the relationship and reduce the inequity in decision making.

The primary goal of therapy for batterers is the cessation of violent behaviour in his relationships with others. Attainment of secondary goals helps the batterer to reach that primary goal (Buckley et al, 1983;

Currie, 1982, 1983; Sonkin et al, 1985; Weidman, 1986). These secondary goals include: 1) decreasing his social isolation and developing interpersonal support systems, 2) increasing his feelings of self-control, of self-esteem, and of the ownership of power to effect change, 3) increasing a sense of responsibility for his behaviour and its consequences and an awareness of the dangerousness of violent behaviour, 4) developing the ability to identify and appropriately express the feelings related to his violence and the ability to empathize with his partner and other victims, 5) increasing his understanding of the relationship between violence and rigid gender-role stereotypes, attitudes and expectations, 6) developing interpersonal skills, and 7) developing control over his use of alcohol and other substances.

Among those who deal with abusive and violent offenders, in both the research and the treatment contexts, there is support for the use of a cognitive behavioral approach to interpersonal relationships and the change of maladaptive behaviour (Cohen, 1985). This theoretical model suggests that there is a continual interaction between the offender's cognitions, affect, and observable behaviours. In order to eliminate the overt abusive acts, it is necessary to effect concurrent change in the cognitive and affective realms of behaviour.

Neidig and Friedman (1984) contend that any treatment program will address 1) "predisposing" factors, 2) "precipitating" factors, and 3) "maintaining" factors. It is critical that the therapeutic work not get caught up in trying to identify the "real causes" of past behaviour. "The

focus of intervention [will] continue to be positive and future oriented, expressed in terms of conditions to be changed and skills to be learned" (p. 10).

a. possible modalities

In addition to the various considerations as to why treatment is justified and necessary, there are various modalities through which the intervention may be delivered. In what follows the focus will be upon therapy which can be offered to meet the treatment needs of abusive men. The needs of the victims may also be met at the same time but it is not within the realm of this report to detail the potential choices with regards to therapy which might be available to the victims.

The modalities of treatment intervention available for the abusive man would include:

i. individual counselling (Ball, 1977; Cantoni, 1981; Ellis, 1976; Hashimi, 1981; Kozol et al, 1972; Schultz, 1960; Snell et al, 1964; Sprey, 1969; Taylor, 1984; Weitzman and Dreen, 1982),

ii. conjoint marital therapy (Bagarozzi and Giddings, 1983; Bograd, 1984; Cook and Franz-Cook, 1984; Geller, 1982; Geller and Walsh, 1978; Harris, 1986; Jacobson, 1977; Knowles et al, 1984; Margolin, 1979; Neidig, 1986; Neidig and Friedman, 1984; Neidig et al, 1985; Reynolds and Siegle, 1959; Rice and Rice, 1977; Schlesinger et al, 1982; Snell et al, 1964; Sprey, 1969, 1971; Straus, 1974; Taylor, 1984; Weitzman and Dreen, 1982),

iii. group therapy (Adams and McCormick, 1982; Bernard and Bernard, 1984; Currie, 1982, 1983, 1988; Deffenbacher et al, 1987; Deschner et al, 1984; Finn, 1985a; Ganley, 1981b; Gold, 1981; Gondolf, 1985; Koval et al, 1982; Kozol et al, 1972; Myers and Gilbert, 1983; Nichols, 1976; O'Leary and Curley, 1986; Purdy and Nickle, 1981; Rosenbaum, 1986; Schlesinger et al,

1982; Sonkin et al, 1985; Star, 1983; Taylor, 1984; Toseland and Rivas, 1984; Weitzman and Dreen, 1982; Yalom, 1975), and

iv. family therapy (Boudouris, 1971; Cantoni, 1981; Hare-Mustin, 1987; Latham, 1986; Raschke and Raschke, 1979; Schlesinger et al, 1982; Sprey, 1969, 1971).

These treatment modalities can be used singly or in some combination depending on the needs of the particular people and the nature of the battering relationship. The one general rule which would seem to govern the choice of modality is that the one is indicated which produces the maximum positive change in the behaviour of the abuser and the relationship without jeopardizing the health or safety of the victim. It is particularly important to have a comprehensive intake assessment to enable appropriate matching of the abuser with the intervention.

Some (Geller, 1982; Taylor, 1984) believe that, in cases of mild or moderate level abuse and where the woman chooses to remain in a violent relationship, the treatment modality of choice is conjoint couples therapy. If the responsibility for controlling his abusive behaviour is left with the abuser and he is successful in controlling his violence, this approach is effective because it takes into account the context of the abuse and the effect of the abuse on the partner.

General goals of conjoint treatment would include: 1) an immediate cessation of violence, 2) awareness of and intervention in the pattern of escalation by the couple, 3) improved problem-solving abilities, and 4) expanded marriage contracts and a general decrease in relationship

rigidity, sex role expectations, and projection of hostility (Weitzman and Dreen, 1982).

Conjoint therapy is contraindicated when: 1) reconciliation is unlikely, 2) the abuser is unwilling to refrain from physically abusive behaviour, 3) the victim cannot stop exhibiting cues and behaviour which may elicit violent behaviours, and 4) there is a history of frequent and severe acts of violence (Bagarozzi and Giddings, 1983).

Ganley (1981b) states that an effective program for the treatment of men who are abusive of their partner will have "a clear treatment goal, client accountability, use of confrontation techniques, a psycho-educational program orientation, a structured format, a directive role for the counsellor, and use of a group format" (p. 3).

The experience of practitioners who work with batterers (Purdy and Nickle, 1981) is that interventions need to be based in assumptions and values without which the likelihood of failure will be high. We need to believe that the batterer chooses to be abusive; the abuse is his responsibility alone. The batterer will not be likely to cease his abusive behaviour without outside intervention; it is "addictive and immediately effective" (p. 112). The batterer has learned his abusive behaviour from someone else. It can be unlearned and new non-abusive alternatives can be taught to him. The initial focus of intervention needs to be ensuring the safety of all of the members of the family, especially the victims of the abuse.

Group counselling will be the treatment of choice, according to Purdy and Nickle, because it is more effective than individual counselling, because men will see that they are not alone in their abuse, and the group offers more opportunities to "teach and practice skills already learned or learn from positive role models" (p. 112). Groups will be led by individuals who are aware of their own attitudes toward and experience of abusive behaviour and who will be positive role models and will confront and challenge abusive values, attitudes, and behaviours.

2. The small group process

The small group modality for therapy is a key element in working with batterers, particularly those individuals who have not ceased their abusive behaviour and/or were involved in severely abusing their partner (Adams and McCormick, 1982; Currie, 1988; Neidig and Friedman, 1984; Purdy and Nickle, 1981; Sonkin et al, 1985; Weidman, 1986).

One of the most comprehensive presentations of the power of the small group as a treatment modality has been that of Yalom (1975). He identifies eleven interdependent "curative factors" as the basis of the small group therapy process. These are: instillation of hope, universality, altruism, existential factors, catharsis, the corrective recapitulation of the primary family group, development of socializing techniques, imitative behaviour, imparting of information, interpersonal learning, and group cohesiveness.

Instillation of hope happens as the man sees and hears of successes involving others in the group. The men know that they are not alone in struggling with this heavy burden. The imparting of information can be augmented by the sharing of personal experiences among the men. The men can learn to be there, in a supportive role, for one another. The men can take part in role playing the experience of their original family group in order to work through situations and relationships in a more controlled setting. Social skills can be learned particularly well when they can be modeled by other group members as well as by the group leader. The group setting provides more opportunities for interpersonal interaction and learning than other modalities. There can be a tremendous feeling experienced by the whole group when they, as a group, are successful or when one of their number meets with success. Cathartic experiences are not unique to group work, but refer to the sense of release or relief following the working through of some difficult task.

In the group setting, batterers learn that they are not alone, that other men have similar problems. The group milieu helps men begin to overcome their emotional isolation from other men and to develop a new peer group which will support them as they change. Being with other men who are attempting to make similar behaviour changes acts as a powerful reinforcer for the batterer. The group experience offers each man a variety of alternative models of behaviour and a source of feedback, necessary to develop a more flexible understanding of himself as a man (Currie, 1988; Toseland and Rivas, 1984; Yalom, 1975).

Over the period of time in the group, the batterer will hopefully tear down the facade of normalcy behind which he hides. He will replace denial with an acceptance of the fact of his violence and its effect upon his victim(s). He will accept his responsibility for perpetrating, and ultimately ending, the violence.

Men, working in the group, receive the reinforcement and the permission that they need in order to change in the face of their hitherto held gender role expectations. They gain experience in practising new behaviours and making new choices in relating to others. The useable role models that men are exposed to, particularly in open groups which are composed of both new members and more experienced members, inspire emulation and raise their hopes that they can indeed change.

Modelling, behavioral rehearsal, role playing and provision of feedback will be important, particularly in the early stages of group development. The use of a buddy system and group contingency contracting will be helpful in building group cohesiveness and keeping the group's work focused on the treatment goals.

There is also an increased probability, through the use of the small group, that the changes and the successes gained by the batterer will be generalized to the other contexts of his life (Yalom, 1975). The group setting allows for simulation of situations that occur in the batterers' natural environment and for supervised rehearsal of alternative responses to various situations. The probability of generalization of change may

also be enhanced through the input of women, either as co-therapists or special guests, possibly sharing their personal experience as a victim or role playing conflict situations as the batterer's partner. The writer found no empirical support for women's involvement in the group, either as leader or guest. The potential benefits of involving women was reflected in the anecdotal experiences described in the literature (Ganley, 1981a, 1981b; Gondolf, 1985; Purdy and Nickle, 1981; Rosenbaum, 1986; Shupe et al, 1987; Sonkin et al, 1985).

a. phases of treatment

Though differences between the following suggested models include the number of phases, the individual phase descriptors, and whether they concentrate on general group dynamics or on specific tasks, they tend to complement one another and, taken together, outline a preferred sequence of treatment targets and direction of group process.

Purdy and Nickle (1981) suggest that there need to be six phases of a treatment group: 1) ensuring the safety of the victim and any children in the family, 2) eliminating denial and accepting responsibility for the abuse, 3) learning to control anger, 4) learning non-abusive communication, 5) changing maladaptive beliefs and destructive attitudes, and 6) maintaining non-abusive behaviour.

It is important, for the development and implementation of group work, to consider the developmental stages of small group dynamics. Gold (1981)

presents a five-stage model of group development comprised of pre-affiliation, power and control, intimacy, differentiation, and separation stages.

Another of the models of group dynamics (as used by Adams and McCormick, 1982; Bernard and Bernard, 1984; Buckley et al, 1983; Currie, 1982, 1983; Star, 1983; Toseland and Rivas, 1984; Weidman, 1986) divides the life of the group into three stages: the beginning, the middle and the ending stage. Each of these stages has characteristic issues which need to be addressed in order that the work of successive stages can be accomplished.

Early stage group issues include: denial of the violence, defensiveness and the projection of blame, lack of trust and fear of failure/hurt, male bonding (e.g., talking tough and putting women down), homophobia, and a focus on the partner, often in very deprecating ways, and on the group leader(s).

In response to these issues, early group tasks for the leader(s) will include: developing agreement on the primary group task, identifying individual needs and establishing individual goals, building linkages among the members, encouraging the members to verbalize their feelings, and considering a set of alternative, non-violent behaviours.

Middle stage issues include: accepting responsibility for one's own violence, moving away from conventional male behavioral norms, learning alternative behaviours, risk-taking and feedback.

The group leader(s), in the middle group stage, will become less directive as group cohesion is established, as the members interact and help each other more. The leader will provide support, guidance (including corrective confrontation), and direction. Both informal, through on-going feedback, and formal evaluation will be part of this stage. This will involve both confrontation about irrational thinking and unacceptable behaviour and acknowledgment of success and change.

The late and ending stage group issues will include: strengthening of self-esteem, shaping one's personal environment, extragroup contact between members, developing social support network, separation and loss issues.

Leader tasks, in the final stage of the group, will include assisting the members to express their feelings about termination (e.g., separation, individuation, ambivalence toward intimacy), to review the progress made by the group, and to assist in setting future goals and identifying resources for continued growth.

In addition to the consideration of group development and group dynamics, it is also important to decide in what order changes in behaviour of the members of the group need to be sought. Though there is some support (Rosenbaum, 1986) for focusing on attitudinal change before working toward behavioral change, most programs (Adams and McCormick, 1982; Biaggio, 1980, 1987; Coleman, 1980; Currie, 1983, 1988; Deschner, 1984; Edelson et al, 1985; Ganley and Harris, 1978; Geller and Walsh, 1978; Gondolf, 1985;

Margolin et al, 1988; Purdy and Nickle, 1981; Star, 1983; Taylor, 1984; Walker, 1981, 1984) stress the initial necessity of terminating any physically abusive behaviour prior to focusing on changing attitudes and developing interpersonal skills.

Koval and his co-workers (Koval et al, 1982) divided the life of the treatment group into two parts. Because of the likelihood of involuntary group membership, the group leaders focused first on personal issues such as stress and its management, physiological cues, relaxation exercises, and the expression of emotions. This allowed the men to get in touch with themselves, to manage their anger and to stop the physical abuse. The focus of the second half of the group turned to the discussion of norms and values regarding gender roles and stereotypes and to the development of interpersonal skills such as communication, empathy, self-disclosure and feedback skills, and assertiveness skills. These assisted the men in maintaining the non-violence and choosing other ways of resolving conflict.

b. educational content

The overwhelming evidence (Adams and McCormick, 1982; Bandura, 1973; Carroll, 1977; Ganley, 1981a; Kalmuss, 1984; Pagelow, 1981b; Peterson, 1980; Star, 1978; Steinmetz and Straus, 1973) that abusive behaviour is learned behaviour, maintained by societal norms, supports the choice of a psycho-educational model of intervention.

Star (1983) suggests a three part model in which the session content would focus first on changing the abuser's behaviour, then on learning about the origins of his abusiveness, and finally on the acquisition of interpersonal skills. Currie (1983) identifies three main process themes which are particularly important for men dealing with abusive behaviour and which correspond well with the parts of Star's model: the internalization of responsibility for one's actions, consciousness raising (i.e., about the influence of one's family and of the wider society, and about the effect of one's behaviour upon others), and the individuation of self. These three general groupings of content integrate well with the three stages of the development of group dynamics described above.

A critical part of the intervention involves content with a particular emphasis on the social/societal context, both present and historical, of the abuse. Among the areas which need to be addressed are 1) the traditional process of socialization of males and its negative impact on men's health and happiness, and 2) the experience of women, including both the general effects of the patriarchy and the specific experience of the victim of spousal abuse. The former will attempt to provide the abuser with "a counterculture that gives him permission to accept masculine and feminine traits and teaches the values and skills of intimacy, nurturance, and respect for self and others" (Taubman, 1986, p. 17). The latter will assist the batterer to develop a better understanding of women and empathy for the victim(s) of his violent behaviour.

The nature and the development of the cycle of violence (Walker, 1984)

will be one framework upon which to build an understanding of the batterers violent behaviour and within which to develop a program of behaviour control.

Another useful framework (Owens and Ashcroft, 1985) will be the differentiation between reactive aggression (expressive violence) and operant aggression (instrumental violence). An educational program component would teach the individual to prepare for aversive situations and interactions, to rehearse positive, non-abusive resolutions, and to exert self-control when confronted with these inevitable circumstances. A psychological program component would assist the individual to identify the reinforcers and the functions of abusive behaviours and to develop alternative non-abusive means of having his needs met and influencing his environment.

Some (Neidig and Friedman, 1984; Solomon, 1981) suggest that treatment will include interpretation and confrontation with respect to changing masculine role behaviour, offered within a cultural framework and with an emphasis on the symptoms that are currently causing discomfort to the individual - jealousy, dependency ambivalence, and gender role strain, among them.

Among the content items and techniques used by programs (Gondolf, 1985; Neidig and Friedman, 1984) were: 1) teaching the men to recognize their own physical cues to escalating emotions, 2) the check-in, i.e., the practice in identifying and expressing the way they are feeling, 3)

empathizing with and respecting the feelings of others, and 4) confrontation on their behaviour and their need to accept responsibility for it.

c. treatment techniques and skill-building

i). anger management (Biaggio, 1980, 1987; Coleman, 1980; Deffenbacher et al, 1987; Deschner, 1984; Ganley, 1981a; Ganley and Harris, 1978; Geller and Walsh, 1978; Gondolf, 1985; Maiuro et al, 1987; Margolin et al, 1988; Neidig and Friedman, 1984; Rubin, 1986; Walker, 1981)

Anger dyscontrol is a key issue in the psychological profile of physically abusive men. Anger serves as one of the primary triggers for abusive episodes (Deschner, 1984; Gondolf, 1985) and its management is, therefore, essential to the process of stopping the abuse.

Biaggio presents Leventhal's Perceptual-Motor Theory of Emotion as an appropriate way of understanding anger in order to develop control techniques which can be taught to those for whom anger control is a problem. According to this theory (Leventhal cited in Biaggio, 1987, p. 418), anger is viewed as a "subjective perceptual experience" which is "mediated by motor processes, memories of previous emotional experiences, and conceptual processes" and that can be modified by a number of strategies. The idea that anger is not energy requiring release but, rather, learned behaviour which can be modified is well supported (Averill, 1983; Berkowitz, 1973; Ellis, 1976). Biaggio (1987) suggests that successful anger management approaches will address the physiological, behavioral, cognitive, and affective domains of treatment.

Rubin (1986) defines anger as "the elicitation of one or more aggression plans by the combination of threat appraisal and coping process" (p.116). When the threat is appraised to be high, the aggression plan may involve covert or overt aggression. Whether or not covert or overt aggression is the response will, in part depend upon the man's belief about the respective consequences of either choice. Along with a feeling of anger, the person may also feel either hope or fear depending upon his normal inclination to be optimistic or pessimistic. One final factor, which will impact upon the behavioral choice the man makes, is whether or not he views the situation as hopeless or as a challenge.

In order to learn to manage his anger, with the intention to make the choice to behave in non-abusive ways, the batterer will first need to identify his personal arousal cues and learn to interrupt the automatic reactions which tend to follow physiological and emotional arousal (Margolin et al, 1988; Rosenbaum, 1986). The batterer will need to appropriately label the attendant emotions, particularly the primary emotions which tend to escalate into anger, and learn alternative, constructive ways to express his frustrations, disappointments, and differences of opinion.

The "time-out" as an anger management tool is recommended by many authors (Bernard and Bernard, 1984; Cook and Franz-Cook, 1984; Currie, 1983; Deschner, 1984; Ganley, 1981a; Knowles et al, 1984; Neidig et al, 1985; Rosenbaum, 1986; Taylor, 1984). This will be a first response to arousal and anger cues, used to allow the man to regain control over his feelings

and thoughts in order to choose a non-abusive means of dealing with his immediate circumstances. The simple time out will later be combined with relaxation and cognitive exercises, in order to maximize the man's self-control.

One technique used by many groups (Currie, 1988; Deschner, 1984; Gondolf, 1985; Neidig and Friedman, 1984; Purdy and Nickle, 1981; Star, 1983; Taylor, 1984) for tracking the members' emotional state is the keeping of a daily diary or anger log. In this log is recorded a description of any anger-provoking situations, of the antecedent anger cues and negative self-talk, of the feelings aroused by the situation, of how he responded, of the reactions of others in that situation, and of how he felt afterwards. The success of the anger log, as a tool to heighten the man's awareness of the dynamics of the conflict situation and the effect of his behaviour on others and to encourage the practice of stress management and non-abusive coping techniques, depends upon the man's willingness to record incidents in a timely and honest fashion and to openly share his record with the other members of the group.

The abusive man will need to identify his own beliefs regarding the consequences of his expressing his anger (Averill, 1983; Bandura, 1973; Harris, 1986; Rubin, 1986). In order to be able to choose to control his anger, the man will need to acknowledge the negative consequences, for himself and the victim(s), of the ways in which he has chosen to express his anger, and to identify the functions (including control and punishment) served by his behaviour.

ii). cognitive restructuring (Bedrosian, 1982; Biaggio, 1980; Cohen, 1985; Coleman, 1980; Deschner, 1984; Ellis, 1985; Feazell et al, 1984; Ganley and Harris, 1978; Goldstein and Rosenbaum, 1985; Harrell, Beiman, and Lapointe, 1981; Neidig and Friedman, 1984; Turk and Salovey, 1985; Walker, 1981)

Major themes which appear in men's dysfunctional cognition are: the tendency to personalize, rigid and unrealistic expectations of self and others, overgeneralization, catastrophizing, mislabelling of affect, negative predictions, and rumination (Bedrosian, 1982).

Dutton (1986) identifies patterns of externalization and blaming which abusive men use to avoid taking responsibility for their own behavioral choices. They use victim behaviour, their own personal attributes, the situational context, and cultural norms as excuses for their abusive behaviour. Dutton suggests that "confronting the man's use of minimizing may require reference to sources other than his wife's report, since he may tend both to blame and to discredit her" (p. 389).

A technique which is used to modify these types of unhealthy and abuse maintaining cognitions is cognitive restructuring; that is, identifying and changing the irrational belief systems and faulty thinking styles that support the abuser's maladaptive behaviour, as well as changing from negative to positive his internal dialogue which usually tends to precipitate and escalate the abusive situation. Through confrontation of maladaptive and/or irrational thinking and the presentation of a contrasting set of healthy, positive and non-abusive thoughts and attitudes, the abuser can be helped to choose the adaptive alternatives which will not maintain the abusive behaviour. Central to a cognitive

treatment strategy is the intent to modify the ideation which accompanies psychological distress. This would include, in addition to confrontation of maladaptive ideation, the use of reframing, modelling, role-playing, and analysis of reality situations (i.e., becoming sensitive to and studying thought styles and their consequences, both during the group sessions and between group meetings).

Group members can be instructed to relate and reexperience crisis situations and abusive incidents in order to identify and process the automatic, generally negative, thoughts which accompany these events (Bedrosian, 1982).

While recent cognitive behavioral research suggests an approximately 2 to 1 ratio of positive to negative coping thoughts as being healthy, there is some disagreement (Schwartz, 1986) on whether successful therapy will focus on increasing the positive or decreasing the negative thoughts.

One treatment program (Edelson et al, 1985) dealt with the problem of self-talk by attempting, through their description and analysis of their beliefs and thinking styles, to increase the incidence of self-talk which demonstrated empathy for their partner's point of view. This ability was judged by the program participants as the single most important skill they had acquired.

Cohen (1985) suggests that the practitioner can elicit cognitive responses which are new to the offender's pattern of thinking by using cognitive

stimulation. "Taking the client's verbalizations at face value, building on them with some irony and paradoxical intent, non-judgmentally allowing the client to reverse his or her previously stated positions - these are the components of a tactic which can stimulate new and different responses in the client's cognitive, emotive, and behavioral repertoires" (pp. 630f.).

Individuals' perceptions of their own capabilities influence their thinking, their emotional responses, and their overt behaviours (Turk and Salovey, 1985). It will be critical, then, to assist those who have serious reservations about their abilities to develop a more positive outlook and to reinforce successes and their particular areas of competence.

iii). stress management (Coleman, 1980; Deschner, 1984; Feazell et al, 1984; Ganley and Harris, 1978; Gold, 1981; Gondolf, 1985; Hazaleus and Deffenbacher, 1986; LaBell, 1979; Neidig and Friedman, 1984; Rosenbaum, 1986; Walker, 1981; Weidman, 1986)

Progressive relaxation techniques are often taught as a means of coping with stressful situations. In combination with an awareness of personal cues to heightened levels of stress and the taking of time out, the ability to physically relax is one way of preventing an angry outburst as it is physiologically impossible to be fully relaxed and angry at the same time.

Another technique which is part of many treatment programs is stress inoculation (Meichenbaum, 1977; Novaco, 1975), a combination of

progressive relaxation exercises, an educational-cognitive phase of preparation for particular stressors, and rehearsal of coping/mastery behaviour prior to dealing with the stressful situation. As there is generally a particular and repeated pattern of situations and behavioral responses which characterizes the escalation to an abusive incident, stress inoculation is more effective than a simple relaxation exercise as a means of dealing with the perceptions of threat or provocation and increasing the possibility of non-abusive behavioral responses. Other studies (Hazaleus and Deffenbacher, 1986) supported the use of this combination of exercises for dealing with high stress situations.

Interventions designed to teach control of abusive behaviours often combine the above techniques of anger management, cognitive restructuring, and stress management in an integrated approach. Some practitioners (Deffenbacher et al, 1986) have suggested that teaching such a integrated group of techniques should precede the introduction of social skills interventions such as those discussed below.

iv). communication skills (deTurck and Miller, 1986; Ganley and Harris, 1978; Gold, 1981; Gondolf, 1985; Knowles et al, 1984; Neidig and Friedman, 1984; Neidig et al, 1985; O'Leary and Curley, 1986; Sonkin et al, 1985; Walker, 1981)

Many abusers are able to communicate effectively in contexts outside of their spousal relationship while having difficulty expressing anger and other emotions appropriately to their partner (Sonkin et al, 1985). It is important that abusers learn to express their feelings in other than abusive ways.

Ways of accomplishing this include: the introduction of a model of the communication process, so that the men develop some understanding of the various ways in which communication can be ambiguous, misdirected, misunderstood, or blocked (Toseland and Rivas, 1984), and the teaching of communication skills such as careful listening, validation of the others ideas, feeling talk (including sharing one's own feelings - both positive and negative), "I" statements (focusing on the self and not the other), and request-making (instead of demand-making) (Gondolf, 1985).

It is important to assist men to understand and to communicate with their partners as unique individuals and not simply as an occupant of some stereotyped cultural or social role.

v). conflict resolution skills (Cohen, 1985; Ganley and Harris, 1978; Gold, 1981; Gondolf, 1985; Lloyd, 1987; Neidig and Friedman, 1984; Taylor, 1984; Walker, 1981; Weidman, 1986)

The men will be helped to realize that conflict is a normal part of almost every relationship and that the conflict-containment skills taught in the program are used by every couple to some extent.

These skills will include problem-solving and negotiation skills. The focus here will be the enhancement of mediating cognitive processes by identifying specific problems, formulating possible causal hypotheses, generating alternative resolutions, using means-end thinking to assess possible consequences of each option, developing an action plan, evaluating the results and adjusting the process in light of the evaluation.

vi). assertiveness skills (Deschner, 1984; Feazell, et al, 1984; Ganley and Harris, 1978; Gold, 1981; LaBell, 1979; Weidman, 1986)

Assertiveness training focuses on the means and the meaning of assertive versus aggressive behaviours and increases an individual's ability to choose assertive behaviours. There is a good deal of overlap between the teaching of assertiveness skills and of communication and negotiation skills. While it may help to describe the various dynamics and functions of these skills - i.e., so that the group leader can clearly understand the behaviour he is attempting to change, the treatment intervention will likely present them as a package of skills necessary to avoid relationship violence.

Parenting education is sometimes identified as part of an intervention, especially if an agency is able to provide an integrated family program. In addition to the above-mentioned combination of relationship skills, this would include information about child developmental levels, family developmental stages and family dynamics.

d. prediction of success

Treatment programs (Sonkin et al, 1985) have identified factors which may support the prediction that a man will successfully cease all abusive behaviour. These factors include: 1) the length of time in counselling, 2) court mandated treatment, 3) violence-free time with partner, 4) use of anger-management techniques, 5) generalization of skills beyond treatment, 6) desire to change, 7) willingness to change other antisocial behaviours,

8) abstinence from drugs and alcohol, 9) duration of the abusive behaviour, and 10) frequency and severity of the abusive behaviour.

Others (Neidig and Friedman, 1984) have identified factors which tend to reduce the likelihood of successfully completing treatment and ceasing the abuse: 1) significant alcohol and/or drug abuse, 2) manifestation of extreme distortion of reality, denial of violence, and absence of remorse, and 3) a history of antisocial and aggressive behaviour.

CHAPTER THREE: THE INTERVENTION

A. Historical Background

Like many other cities and towns in Ontario, Kenora has experienced a significant level of violence within families. This fact became clearer and more public following the development and building of a shelter and support network for the victims - women and children - of family violence. Those who worked with victims came to feel that a part of the required intervention for the prevention of violence was missing and began discussing with other concerned people in the Kenora area the possibility of developing a treatment program for the abusers.

After about three years of preparatory work, by a large group of members of social service, criminal justice, and religious service providers, the Other Ways Now (O.W.N.) Program was funded as a pilot project by the Ontario Ministry of Correctional Services in October, 1988.

B. Program Structure and Issues

The treatment group was run in affiliation with the Kenora Assembly of Resources (K.A.R.), a non-profit umbrella organization which coordinates and facilitates the provision of a variety of social services in the Kenora area. The group meetings were held in the lounge of the Community Counselling office at the St. Joseph Health Centre in Kenora. This was a comfortable, informal setting which at the same time was equipped to allow

for observation, videotaping, and audio recording of the proceedings of the group.

The program was co-led by one female and one male leader, Jane Van Toen and Ted Carey, this writer. Jane is a probation officer with Probation and Parole Services in Kenora. Her involvement with the group was over and above her regular duties with Correctional Services. The writer was seconded from his position with Kenora-Patricia Child and Family Services to work as Program Coordinator and Group Co-leader. He continued to work one day a week at the C.A.S. office. Clinical supervision was provided by Dr. Peter Hettinga, Director of Mental Health Services at the Lake of the Woods District Hospital in Kenora. A part-time staff person (10 hours a week) provided clerical support and book-keeping duties.

There was no empirical evidence to support a particular choice of group leadeship with respect to numbers of leaders or gender. The weight of the anecdotal evidence, however, supported co-facilitation (Currie, 1988; Edelson et al, 1985; Ganley, 1981a, 1981b; Gondolf, 1985; Purdy and Nickle, 1981; Rosenbaum, 1986; Sonkin et al, 1985; Stordeur, 1985). Three programs (Purdy and Nickle, 1981; Rosenbaum, 1986; Harris and Sinclair, 1981) favoured the inclusion of women as part of the leadership team. It was noted (Ganley, 1981a; Purdy and Nickle, 1981; Sonkin et al, 1985) that, with respect to group leadership, the individual's own attitude towards violence and commitment to confronting the abuser to cease and to accept responsibility for his violence were more important than the leader's gender.

1. Advisory Committee

The overall program was administered by a committee, comprised of representatives from various service agencies in Kenora, which was responsible to the K.A.R. board. This "Batterers Committee" functioned as an advisory body to the program staff and acted as liaison with the funder and the K.A.R. board. Regular monthly meetings were held to discuss the development of the group intervention and, later, any issues which arose from the group meetings and developmental issues such as 1) how to get more clients, 2) development of a permanent location for the program, 3) the availability of funding beyond the end of the pilot program, 4) the relationship with other agencies in the area.

2. Funding

The initial funding agreement was for a sixteen (16) week period from November, 1988, to April, 1989. The writer was hired as the Program Coordinator in October, 1988, and developed a twelve week session which ran from January 4 to March 15, 1989. During this session the program was able to purchase 80% of the writer's time from his regular employer. The meetings were held one evening a week and lasted from one and a half to two hours. The rest of the time allotted for the program was divided between developmental tasks and preparation of the session content and the final evaluation and preparation of a written report for the funder.

The second session was of sixteen weeks' duration, from August 28 to

December 11, 1989. The level of funding, which had been designated for the pilot period, was held constant but spread over a full year. As a result, for the second session only 20% of the writer's time was able to be purchased for O.W.N. work. In addition there was no funding available for clerical support and these tasks were assumed by the writer.

The reasons for choosing the particular length of meeting, frequency of meeting and both the choice of a 12 meeting session followed by an increase to a sixteen meeting session will be outlined below (Procedures and Format - treatment group component, pp. 95ff.).

3. Accountability

The staff and advisory committee were accountable to the Ministry of Correctional Services to provide the best treatment program possible for abusive men, with first choice of client members being given to men referred by Probation Services or ordered into the program by the Provincial Court.

The program staff felt a need for the O.W.N. Program to also be accountable to victims and potential victims for the quality of treatment being provided to abusive men. Attempts were made to open communication links with the local women's shelter and, as part of the intake/assessment process and on-going, with the partners of the men in the treatment groups.

4. Relationship to Other Agencies

The staff of the O.W.N. Program were members of and attended meetings of the Kenora Family Violence Team, the local coordinating committee to deal with issues of family violence. The staff also made attempts to meet with representatives of local providers of services to women (i.e., the women's shelter), but was not successful in convincing them of the benefit, if not the necessity (Davis, 1984), of joint discussion, training, and service provision.

O.W.N. Program staff also attempted to develop a dialogue with the local police departments, the Crown Attorney's office, and the criminal court judge. This effort was undertaken in order to initiate discussion (Lerman, 1986) about what changes in the criminal justice system's approach to dealing with cases of wife abuse might help prevent offenses, bring about increased protection for victims, and assist in the process of changing men's attitudes and behaviours.

At the time of writing, no regular routine of communication has been established apart from the monthly meetings of the Family Violence Team. This group consists of representatives of the local and provincial police forces, the Crown's office, the women's shelter, rape crisis centre, the local board's of education, as well as the O.W.N. program. The focus of the efforts of this group has been on the dissemination of information to the public on family violence, its effects, and means of combatting it.

The impediments to cooperation, in the development of an integrated system of service delivery - from crisis intervention, through police and court activity, to treatment - to both the victims and the abusers, are money and time. The issue of money has to do with the source of funding for the provision of services. The Ontario government allocates funds through its Ministry of Community and Social Services for the provision of services to woman and child victims of abuse. Funding to support services to the abuser flow through the provincial Ministry of Correctional Services. The use of public funds to support men's services is seen as taking money, of which there is never enough, from victim's services. From the point of view of the agencies which provide victim's services in Kenora, the development of joint ventures with the O.W.N. Program and Correctional Services to improve the treatment of the abusers would lead to the provision of more funding to men's programs and the reduction of funding to victims.

The issue of time is centred around the tremendous demands of the workloads of everyone involved in combatting family violence - the crisis lines, the shelter, the police, the court, the probation officers, and the O.W.N. program staff. When combined with the resistance to cooperation from the women's groups, created by the reality of limited funding, time restraints forced O.W.N. program staff to make difficult choices in setting their work priorities. The writer's choice was to concentrate on the development of the treatment intervention for the men, in the hope that the results of the program's work would prove its worth and lead to closer working relationships with the other service providers.

The writer felt that, under the circumstances, the O.W.N. Program advisory committee could take upon itself the task of strongly advocating for such an integration of service but, during the period from November 1988 through December of 1989, the committee had little success and the part-time nature of the Program Co-ordinator's job made it impossible for the writer to devote more than a token amount of time and effort to this task.

The lack of close coordination and communication between the Program and the two other major players (i.e., victims' services and the justice system) is an important gap in the effort to combat spousal abuse. At that time the expeditious commencement of the second session was deemed necessary due to the number of potential group members awaiting treatment. Were the writer able to begin again, the wiser approach would be to make sure the coordination of approach, of information, and of services was in place prior to accepting any men into the group.

C. Development of Treatment Group

1. Theoretical Treatment Framework

The literature on social learning theory holds that maladaptive behaviours can be unlearned and replaced by more acceptable and healthy behaviours. The small group modality has been identified either as the primary choice or as an important part of a combination of modalities for the treatment of abusive behaviour in men. As there was a serious problem with respect to spouse abuse and no other service available in Kenora, dedicated to

helping abusive men change their behaviour, the writer chose to develop a small group intervention. This was conceived as a necessary step toward an eventual co-ordination of services to eliminate spousal violence in the Kenora area.

Beyond the use of the small group process and the conviction that men could learn to be non-abusive, there was a wide variety of suggestions in the literature about what "causes" of abuse to target, what treatment theory to follow, and how to structure the process with respect to factors such as leadership style, session content, and the duration of each group. There is one thing which the literature on the treatment of abusive men did clearly indicate. That is, there has not been enough research and/or practice knowledge accumulated to say with conviction which theory, approach, or practice will maximize the chances of success in changing men's behaviour. Because of this, the writer decided to use an inclusive approach, addressing as many causal factors as possible and incorporating a wide range of information, therapeutic techniques, and skill-building content. A psycho-educational format was used in developing the content of group meetings. A combination of didactic presentations, cognitive-behavioral techniques, social skill building exercises, and opportunities for discussion, rehearsal, and feedback were provided.

The literature which described the development and implementation of treatment for abusive men supported the inclusion of the following content in the individual meetings:

a) immediate cessation of physical abuse through goal-setting, the development of safety and control plans, and behavioural

contracting (Currie, 1988; Purdy and Nickle, 1981; Star, 1983; Stordeur, 1985); use of a check in and check out (Currie, 1988, Sonkin et al, 1985; Stordeur, 1985); use of a buddy system between meetings (Star, 1985; Stordeur, 1985); the identification of anger arousal cues (Currie, 1988; Ganley, 1981a; Gondolf, 1985; Koval et al, 1982; Purdy and Nickle, 1981; Rosenbaum, 1986; Sonkin et al, 1985; Star, 1983; Stordeur, 1985); and the use of time-outs (Edelson et al, 1985; Ganley, 1981a; Gondolf, 1985; Rosenbaum, 1986; Sonkin et al, 1985; Stordeur, 1985);

b) discussion of the cycle of violence (Deschner, 1984; Star, 1983; Stordeur, 1985; Walker, 1979, 1984);

c) discussion of male socialization with respect to gender role stereotypes and expectations and attitudes toward women (Adams and McCormick, 1982; Currie, 1988; Feazell et al, 1984; Gondolf, 1985; Koval et al, 1982; Purdy and Nickle, 1981; Rosenbaum, 1986; Star, 1983; Stordeur, 1985);

d) discussion of men's attitudes towards violence, their responsibility for their abusive acts, and the effects/costs of abusive behaviour on their victims, their children and themselves (Currie, 1988; Gondolf, 1985; Koval et al, 1982; Purdy and Nickle, 1981; Rosenbaum, 1986; Stordeur, 1985);

e) discussion of anger and other emotions and their expression (Adams and McCormick, 1982; Edelson et al, 1985; Koval et al, 1982; Purdy and Nickles, 1981) and the dependence of men upon their partners for emotional health and self-esteem (Adams and McCormick, 1982; Currie, 1988);

f) development and use of an anger journal/log (Currie, 1988; Edelson et al, 1985; Ganley, 1981a; Gondolf, 1985; Purdy and Nickle, 1981; Sonkin et al, 1985);

g) discussion of stress and the development and use of relaxation and stress management techniques (Edelson et al, 1985; Feazell et al, 1984; Ganley, 1981a; Gondolf, 1985; Purdy and Nickle, 1981; Rosenbaum, 1986; Star, 1983; Stordeur, 1985);

h) presentation and discussion of each man's most violent incident (Sonkin et al, 1985; Star, 1983; Stordeur, 1985);

i) discussion of irrational thinking and how internal dialogue/self-talk escalates arousal and the use of cognitive restructuring techniques (Edelson et al, 1985; Feazell et al, 1984; Ganley, 1981a; Gondolf, 1985; Purdy and Nickle, 1981; Rosenbaum, 1986; Star, 1983; Stordeur, 1985);

j) discussion of the man's family of origin and its relationship

to his current abusiveness (Gondolf, 1985; Star, 1983; Stordeur, 1985);

k) discussion of the various types of abusive behaviour (Currie, 1988; Gondolf, 1985; Purdy and Nickle, 1981; Stordeur, 1985) and issues of power and control (Adams and McCormick, 1982; Purdy and Nickle, 1981; Star, 1983);

l) discussion of and the development of skills in the areas of assertiveness (Feazell et al, 1984; Gondolf, 1985; Koval et al, 1982; Star, 1983; Stordeur, 1985) and effective communication (Adams and McCormick, 1982; Gondolf, 1985; Knowles et al, 1984; Koval et al, 1982; Rosenbaum, 1986);

m) the discussion of and the development of skills in the areas of problem-solving and negotiation (Edelson et al, 1985; Gondolf, 1985);

n) the use of mid-session and/or termination evaluations of individual members and the group (Adams and McCormick, 1982; Currie, 1988; Sonkin et al, 1985; Stordeur, 1985); and

o) the use of theme-centred meetings (Star, 1983) and films to identify behaviours and stimulate discussion (Currie, 1988).

This content was directly related to the characteristics of abusive men as presented in the section of this report on the abuser (pp. 35-43, above). The combination of material included in the content of the meetings would cover, in the writer's judgement, whatever constellation of individual problems and behaviours presented itself in the particular men who were chosen to become members of the treatment group.

The way in which these topics of information, themes for discussion, behaviours to be put into practice and skills to be developed were structured into a 12-meeting and a 16-meeting treatment session is presented on pp. 214f., of Appendix B.

By emphasizing the impact of abuse on the victim, the ultimate failure of

abusive behaviour to meet their needs, the changing social expectations and legal sanctions regarding spousal abuse, the potential rewards of learning non-abusive means of dealing with others, and the fact that they are in control of, and responsible for their own choices and actions, the program was designed to enable men to make the choice for a non-abusive relationship with their present or future partners.

2. Procedures and Format

The O.W.N. Program was designed to have an intervention format comprised of three components: an intake/assessment component, a treatment group component, and a follow-up/support group component.

Each member's progress through each component and the process of implementing planned procedures in each component was recorded in the following:

i) the individual member's file, and

ii) the group record (including the agenda for each meeting, the process recording of each meeting, an assessment of the group process, and the statement of the objectives set and achieved for each meeting).

a. intake/assessment component

When a man was referred to the program, an appointment was set up for an initial intake interview. At this first meeting the man's present

circumstances were discussed, particularly the presence of abusive behaviours towards a partner. (In the absence of such behaviour the man was referred to more appropriate counselling elsewhere.) The program was described (its philosophy, rules/expectations, policies, content, duration, etc.) and the man was asked to commit himself to the assessment process. If he chose to proceed, he was asked to sign a consent form which covers: 1) the possible use of gathered data in ongoing research, and 2) the contacting of his partner. Appendix A (pp. 169-210) contains the above-mentioned consent form and all other informational, contractual and release forms which were completed by either the abuser or his partner as part of the intake/assessment process.

Throughout the intake/assessment procedures, the potential group member was advised of the program's position on abusive behaviour: 1) that it is unacceptable and illegal; 2) that it does not solve problems and has serious detrimental effects on all those involved; 3) that he chooses to behave in an abusive manner and he is responsible to change his behaviour; and 4) that, if he chooses, he can learn non-abusive alternative ways of relating and responding to others. As part of the process, the interviewer took care to inquire about and to answer any concerns that the man might have brought with regard to confidentiality, safety, nature of the leadership and membership, as well as the effectiveness of the program and the potential for success.

It has been suggested (Browning and Dutton, 1986; Edelson and Brygger, 1986) that, in selecting the membership of the group and to fully inform

the development of the content of the treatment sessions, information on the nature and frequency of violence in the relationship be gathered from each of the partners. If the leaders were able to contact the victim of a man's abuse, and she was willing to take part in the process, an interview was arranged to complete the wife or partner questionnaire. Any information gathered from the woman was used only to assess the veracity of information gathered from the abuser, to complete as accurate an assessment as possible of the abuser and the nature of his behaviour, and to assess the man's progress toward changing his behaviour (if ongoing contact with the woman was accomplished). None of this information was ever shared directly with the abuser.

The next step, for the man, was the completion of an intake and assessment form (see Appendix A, pp. 179ff.). This lengthy recording required, for its completion, the setting up of two or three interviews. The data gathered through this form covered information about personal demographics, current emotional state and stressors, information about the man's current and past relationships, information about his family of origin and his current family, connections in the community and any support network which might be available to him. At the completion of the assessment form, the man was considered for membership in the treatment group. If his membership was considered, by program staff, to be appropriate and if he still wanted to participate, the man read and signed both the program's confidentiality policy and a program contract. At this point he was advised of the date of the next group session.

The last part of the intake process was completed either following the intake/assessment form or just prior to the first meeting of the next session depending on the length of time before that session began. The final task was the completion of a package of standardized measurement instruments by each man accepted into the group. These instruments will be described in the "Evaluation" section (pp. 112ff.) below.

The information gathered, during the intake/assessment process, about each man who was ultimately admitted into the group was compared to the causal factors of abusiveness and the profile of characteristics and behaviours of abusers presented in the literature on family violence. There was a fair degree of congruence between the literature and the particulars and circumstances of the men who were seen during the intake/assessment process and, therefore, the writer decided to proceed with the general session content which had been tentatively prepared for the first group session (p. 214, below).

While intake information was gathered in order to protect the victim and to understand the offender, and with as much thoroughness and care as possible, two major considerations need to be stated with regard to the accuracy of that information. The first is that only one partner agreed to complete the partner assessment questionnaire and neither she nor any other partner would take part in regular scheduled follow-up contacts. The second consideration, therefore, is that the leader had only police/probation and member information upon which to base the initial

needs assessment and the on-going evaluation of the effectiveness of the program.

b. treatment group component

The writer chose the small group modality because of its power as a treatment milieu (the factors in the group process which contribute to the small group's potential as a vehicle for change were described above on pp. 61-65) and because of the economy of a small number of leaders being able to deal with a potentially large number of abusers at the same time. The fact that the group sessions, described in this report, ended up with small numbers through attrition does not disqualify the choice of small group modality nor argue against its potential. A small number of members does, however, reduce the potential power and effectiveness of the group.

There was no empirical support for a particular number, length, or frequency of group meetings in the literature. A couple of programs used six (6) meeting sessions (Feazell et al, 1984, Rosenbaum, 1986); one program (Star, 1983) held an eight (8) meeting session; one program (Currie, 1988) held ten (10) meetings; two programs (Edelson et al, 1985; Purdy and Nickle, 1981) held twelve (12) meetings; and two programs (Stordeur, 1985; Adams and McCormick, 1982) held fifteen (15) and twenty-four (24) meetings, respectively. The length of meeting held by these programs ranged from 1.5 to 2.5 hours and, except for one program (Star, 1983), they held the meetings once a week. After considering what content would be included in the O.W.N. group session (described above pp. 54-56

and 88-90), the writer decided that a twelve (12) meeting session of two (2) hours meetings held once per week would allow coverage of the material without exceeding the members attention span or ability to focus on the work required. The format of each meeting was chosen to provide a combination of leader and member input, formal and informal presentation, and breaks.

The content of each of the sessional meetings was finalized by the group leaders following the intake/assessment component and prior to the beginning of the treatment group component, in order to ensure that all content necessary to address the needs of the identified group members would be covered. The co-leaders met prior to each meeting to review the content planned for that meeting and to prepare the agenda. They assessed the process which had taken place in each meeting immediately after the members had left the meeting. Any issues which arose which required following up at the next meeting were noted. The writer completed a process recording of the meeting and shared copies of that recording with his co-leader and the clinical supervisor. Sessions were arranged for feedback from the clinical supervisor.

After the first session, which was twelve meetings long, the co-leaders decided that an increased number of meetings would be planned for the next session in order to cover the content more thoroughly. They also thought that some more objective means of evaluating, from meeting to meeting, what had been accomplished would improve the service being delivered. The

following changes were incorporated into the plan for the second session to address these issues:

1) The session was increased to sixteen meetings in duration, giving more time to both cover the content in greater depth and allow for greater response to group member issues. An additional meeting was taken to deal with each of assertiveness and communication, the "most violent incident", and cognitive interventions. As well, separate meetings were utilized for stress and stress management and mid-session and final evaluations.

Due to limited contact (described in the "Follow-up" and "Evaluation" sections below) with partners of the men in the first group session, the writer had little other than the self-reports of the men and the results of the standardized measures with which to determine the effectiveness of the intervention. However, the members of the first group indicated that they had found the content on anger control, communication and stress management to be of the most help to them in their day-to-day life. They also indicated that, had they had more time to connect the cognitive techniques to their personal way of thinking and to practice the suggested changes, they would possibly have found this area of intervention to be more helpful. The group leaders believed that there would likely be more members in the second session and, if so, two full meetings would be required for the most violent incidents of the members to

be fully processed and a full meeting would be required to allow for comprehensive mid-session and final evaluations.

The assessment of the men admitted to the second session, all of whom were either living or having regular contact with their partners, indicated a particular concern on the part of most of them with their ability to communicate with their partner. For this reason the leaders decided to deal with communication issues and skills earlier than they had in the first session.

2) Before each meeting the leaders developed a number of behavioral objectives, based upon the agenda items planned for that meeting and targeting group member behaviours, to assess member involvement with the process and interaction with each other. How well the objectives were met was noted after the members left, during the regular leader debriefing time, and were shared with them during the mid-session evaluation in order to inform them of their progress in engaging in the group process. The leaders found an increase over the life of the second group of the level of accomplishing the meeting objectives by those members who remained in the group.

In both the first and second sessions, meetings followed a format which generally included a check-in time (feelings, state of mind, emergency issues, homework assignments), a review of the previous meeting and the meeting agenda, the sharing of anger log entries, a structured educational

presentation, an unstructured discussion/sharing time, distributing homework and/or handouts, and a check-out time (feelings, state of mind).

The approaches taken to treatment issues and needs of the members included individual, structural and systemic considerations. The leaders found that trying to understand the members problems and needs from a systemic perspective was helpful in terms of understanding the dynamics of his relationship with their partner(s), but could not be incorporated into the actual group discussions because such attempts tended to just allow opportunities for the men to turn the responsibility for their behaviour on their partners, to blame others for their problems and to externalize what were their own issues.

The leaders touched on structural issues in discussions of some of the practical problems the men were having in their lives - with work, with money, with housing, with their peer group - and in discussing gender role socialization and the ways in which our society has been structured to support control and abuse of women by men.

By and large the focus of the treatment group was on an individual approach to dealing with issues, because this approach was the most manageable and most likely to produce the required short term behavioural changes related to immediate cessation of the men's abuse of their partners.

At the mid-point of the session and at the end of the session formal

evaluations were completed by the group members. If any of the members were court-ordered attenders, formal reports concerning their progress in the group were shared with their probation/parole officer(s) at these points in the program. At the point of termination of the session, contracting was done, with any member who so desired, concerning attendance of the subsequent session.

c. follow-up/support group component

At the time of the final group meeting of each session, the idea of an on-going support group was discussed with the members. Issues of need, timing, numbers of potential attenders, and whether such a group would have Program staff leadership or run in a self-help format were discussed. It was the consensus of the group at the end of the first session that, because the support group would likely include both men who had already taken part in a group and those who were waiting for the start of the next group session, it would be preferable to have one of the group leaders be involved. A support group night was chosen, the length of the meeting was set for one hour, and the group decided that the agenda should be whatever those who showed up needed to talk about.

Meetings were held each Monday night for approximately four weeks following the first session. There was one member of the first group who came out and two men who were waiting for the next group. All men on the waiting list had been informed of the availability of the support group. By the fifth week even that small attendance had tapered off to none. The

writer opened the meeting place up at the appointed hour for another two or three weeks, but when it became clear, after a couple of phone calls, that no one felt the need or had the time to maintain their attendance, no more meetings were held.

At the end of the second session, the same arrangement was offered, but none of the men chose to attend. The writer believes that issues of lack of motivation, lack of development of a strong group cohesiveness in the second session, and the apprehension of new members about dealing with strangers were factors in the poor attendance at support group meetings. In spite of these circumstances, the leaders believed that it was still important to offer this kind of opportunity and intended to continue to try to set up support meetings.

3. Meeting Content

The choice of content for the meetings of each session was made in consideration of the causal factors, abuser behaviours, and treatment issues identified in the literature.

These connections are set out in Table 1 (p. 102, below). The core content of each of the group meetings (outlined in Appendix B, pp. 214f.) was incorporated through leader presentation, film and written material, and was often reflected by the men from their own thoughts and personal experiences.

TREATMENT ISSUES AND CORRESPONDING TREATMENT AND EVALUATION COMPONENT		
Treatment Issue	Treatment Component	Evaluation Component
General aggresiveness or passivity which issues in outbursts; poor impulse control	Goal setting; control plan; contracting; check in/out; buddy system; anger cues; time out; cycle of violence; anger log	Short Trait-State Anger Scale
Rigid gender role perceptions and expectations; patriarchal attitudes to power, status, authority, and control	Male socialization with respect to gender role stereotypes and expectations and attitudes towards women	Short Attitudes Toward Women Scale
Having witnesssed and/or suffered abuse in the family of origin	Family of origin and its relationship to current abusive behaviour	
Externalizing blame for his abusive behaviour; denial or minimization of abuse	Men's attitudes toward violence; responsibility for their actions; effects/costs of their abuse; presentation of "most violent incident"	Rotter Internal-External Locus of Control Scale
Controlling and dominating behaviour; use of sexual and psychological as well as physical abuse	Description of the various types of abuse; issues of power and control	
Social isolation	Membership in treatment group; buddy system; individual evaluation	
Difficulty differentiating and expressing emotions other than anger; extreme dependency on partner	Primary and secondary emotions; interdependence vs. dependence; assertiveness skills	
Low self-esteem; depression	Assertiveness skills; irrational vs. rational thinking; individual evaluation	Rosenberg Self Esteem Scale Short Beck Depression Inventory
Faulty thought patterns or cognitive styles	Irrational vs. rational thinking; internal dialogue; self talk; cognitive restructuring; anger journal/log	
Low tolerance for stress	Relaxation and stress management techniques; problem-solving and negotiation skills	
Abuse of alcohol and other chemical dependencies	Referral to external treatment resources	

Table 1.

The progression of content was generally from a focus on individual goal-setting and stress and anger management to a dealing with the individual's experience of abusive behaviour and, finally, to the development and strengthening of interpersonal skills. The discussion of gender socialization, myths, and stereotypes and the resulting attitudes towards women was undertaken relatively early in the session and woven throughout the remainder of the meetings. The one exception to this, from the second session, was described above.

4. Clientele

The clients who are eligible for this program are males, eighteen years of age and older, who exhibit abusive behaviour within an intimate relationship. They come to the program through self-referral or referral from their partner, the courts, or another agency. In order to be eligible for the program they are residents of Kenora or its environs. This geographic area includes fourteen First Nations communities within about sixty miles of Kenora. The distance of these communities proved to be an obstacle to group membership by any of their residents. The local Provincial Court judge was not willing to order First Nations community residents, who might have otherwise attended the program, into the group because he felt that this would set them up to fail meeting the program's attendance expectations.

If there is such a thing as a non-mandated consumer of an abuser's treatment program - that is, a truly voluntary client who is not motivated

by the threat of losing his partner, of being brought before the court on charges, or of potentially losing his freedom - the writer believes that it is unlikely that mixing "mandated" and "voluntary" members in a treatment group will have, in and of itself, a significant negative effect upon the potential of any individual's experiencing success in the group.

Both types of individual have something to offer to the other. The "voluntary" member comes to the group with some level of acceptance that his abusive behaviour is a problem and having made a decision to seek assistance in dealing with this problem. His presence will offer a challenge to the "mandated" member to recognize that there are different attitudes among men about abusive behaviour and a chance to discuss those differences. The "mandated" member of the group provides the "voluntary" member with a foil against which to examine and test his own position with respect to abusive behaviour and also an opportunity to be a positive role model.

The writer's experience of these groups, which included both "voluntary" and "mandated" members, was that over a period of time it became evident that some of the initial reasons for attaching the particular label to particular individuals were less and less valid. Some "voluntary" members began to show significant resistance to real change in their behaviour and some "mandated" members showed increased acceptance of their responsibility for their own behaviour. The extremes in behaviour and attitude among the group members tended to moderate toward a middle ground. An outsider, viewing the group sometime past the halfway point,

would have had a difficult time separating those who began as "voluntary" from those who began as "mandated" members.

5. Group Process

The men began the group sessions with a degree of anxiety about what was going to be expected of them and about how the other members of the group would view them. This response was common to both those who were most prepared to acknowledge their abuse and those still in some degree of denial and minimization. This was evident from the reserve with which they engaged one another and the reticence with which they entered into the work of explaining to the rest of the group the circumstances which brought them into the program.

There was an almost universal blaming of someone or something else for the misfortune of their being in the program - their partners, the police, the court, alcohol, or a personified "temper." Even the men who acknowledged that they were responsible for their abuse struggled with their tendency to put their partners in the role of the one who left them no choice but to abuse.

Early in the group process most of the men engaged in posturing and face-saving behaviours, from explaining that the abuse was really quite atypical of them, and really hadn't been that serious, to describing and repeating, in great detail, the events which led up to the abusive action and the reasons why any man would have acted, under similar circumstances,

in a similar fashion. In a couple of cases, with men who later dropped out of the group, there was a sense of competition in the spinning of the tale.

The perception of the group leaders by the members was different for different members, dependent upon their position with respect to their own behaviour, and changed over the life of the group. The transition was from seeing the leader as a judge (out to get them) to a saint (from a world apart and, therefore, irrelevant) to a teacher (with the answers which would "fix" things) to a supporter (challenging, but with them in their struggle to change). It was the few men who completed the group who were able to make the shift from working against the leaders (who represented outside authority with some control over their lives) to working with the leaders and for themselves and their choice to learn to behave in non-abusive ways.

While there is no research to be found in the literature aimed at discovering what it is that causes the individual man to decide to remain in treatment or what differences there are between those who stay and those who quit, some explanations are offered. A key factor in the dynamics of staying is the ending of the individual's denial of his abusive behaviour and a concomitant commitment on his part to try to change his behaviour (Feazell et al, 1984). Factors which are involved the decision to leave the group include: the abuser's tendency to project the blame for his troubles on others and, in this regard, the group leader may take the place of the partner or the police as the target of that

blame (Adams and McCormick, 1982). Another factor is the abuser's need to be in control and his unwillingness to remain in the group where the leaders are perceived to be intent on controlling him (Star, 1983).

In dealing with the early resistance of the group members to being in the group or to doing the group work, the leaders kept bringing the focus of attention back to the individual and his responsibility for his behaviour and his present circumstances. The men were encouraged to accept that they were in control of their lives; that exercising self-control would help them feel better about themselves and that continuing to try to control others would prevent them from developing healthy and lasting relationships.

In both sessions, it was not until approximately the halfway point that the focus of the men's attention shifted from the leaders to each other. In the early meetings, the men challenged the leaders' beliefs and expectations regarding gender roles, marital partnerships, and the need for behaviour and attitude change by the men. Toward the middle of the session, and as some of the men began to accept their need and express their desire to effect change, members began to challenge one another's positions, statements, and resistance to change. By the end of the session the few men who were left were working together on ways they could more successfully cope with the stresses and problems in their lives and incorporate more appropriate behavioral choices.

There was no research evidence concerning the reasons why men drop out of

treatment, but one program's (Currie, 1988) experience was that attrition tends to occur at the point that the individual decides that he is getting nothing out of the program. Some men come to the group with a particular goal in mind - to get their partner to return home or to avoid criminal charges or being sentenced to serve jail time - and, when they discover that the goal will not be reached through participation in treatment, they drop out.

Another program (Star, 1983) found that men tended to drop out early in the program because their stress level was lowered and they felt they were cured or because they could not cope with the intimacy of the group experience.

Other men leave the group through expulsion because of non-participation, non-attendance, or other breach of rules and/or contractual obligations. Of the ten men who enroled in the two sessions described in this report, four dropped out of the group. One man came expecting that he could attend and just put in time, then quit when he was confronted about his behaviour. One man did not want to drive the hundred miles from his home and the others made their jobs a higher priority, even though they could have made the arrangements to both work and attend the group meetings.

The recording of the progress of the members, individually and as a group, is contained in the following:

i) assessment of the individual's progress in the weekly process recording

ii) mid-term evaluation by the leaders of each individual's progress

iii) mid-term evaluation by each member of his own progress

iv) final evaluation, both subjective and as reflected by the standardized measures, by the leaders of the members' progress

v) final evaluation by each member of his own progress

vi) follow-up evaluations (one month, three month, and one year following completion of the program).

6. Follow-up

Despite the possibility that response to a follow-up survey questionnaire would not be high and that the trustworthiness of the information gathered in this manner would be somewhat suspect (Sirles, 1984), the writer decided that some outcome information would be better than none.

Follow-up questionnaires were sent out to each of the members of the group at one (1) month and again at three (3) months following each session. Twelve month post-group follow-up questionnaires were not sent out as the whereabouts of the members who had completed the program were not known. Of the five questionnaires which were sent out one (1) month and three (3) months post-group, two were returned, by the same two people each time.

One man indicated that he had no incidents of physical abuse in his recent relationship, but that he had one incident of verbal abuse. He continued

to use stress management and problem-solving techniques with success. He indicated that the time spent, in group and after, evaluating his approach to life and relationships had allowed him to become more at peace with acknowledging who he is, what he had done, and the slow process of changing the things that he still doesn't like about himself.

The other respondent also indicated that he continued to use learned techniques such as recognizing and avoiding the types of situations which used to be stress-provoking, using relaxation techniques, and diffusing anger by focusing on his own thoughts and concentrating on controlling himself instead of the other.

D. Evaluation

The writer intended and attempted to utilize an AB research design to evaluate the effectiveness of the treatment intervention but was unable to do so for the following reasons:

1. The group members' inability/unwillingness to develop the individualized measures, i.e., a self-anchored anger rating scale and a goal attainment scale, which were needed to provide the data to make intermediate assessments of the effectiveness of each of the components or combinations of components of the treatment intervention;

2. The unpredictability with regards to delivering any particular

unit of content in any particular meeting because of group numbers, membership changes, and the need at times to deal with the demands of individual members' immediate crisis situations; and

3. The difficulty, because of the mix, in the group, of member personality and need, in keeping the units of content discrete. It is in hindsight that the writer believes that this would have caused problems in the implementation of the AB design. The attempt to utilize the design, because of member non-compliance, had been abandoned before this particular issue arose. It will be noted that, while the requirement to engage in crisis intervention may have had a negative impact on the success of a research design, the counselling need of the group member would have been the group leaders' priority.

Procedures which were used to evaluate the intervention included the following:

- process recording of each meeting;
- a one-group pretest-posttest research design combined with case study; pretest-posttest utilizing a battery of standardized measures (scores are charted on pp.119-123, below);
- mid-term and termination evaluations by members;
- follow-up reports at specified intervals up to one year post-intervention;
- subjective evaluation by the leaders; and

- Corrections staff reports of any offence or re-offence during or following the intervention.

A battery of standardized measurement instruments was chosen and utilized in the evaluation of the intervention; it included:

Short Beck Depression Inventory (SBDI)

The SBDI (Beck, 1967) is a thirteen (13) item scale which measures the severity of depression. It has been used extensively in both clinical and non-clinical populations. It has been shown to have high levels of reliability and validity. Clinical cutting scores are available for various degrees of depression. The short form produces a range of scores from 0-39; higher scores reflect higher levels of depression.

Rosenberg Self-Esteem Scale (RSE)

The RSE (Rosenberg, 1979) is a ten (10) item Guttman scale designed to measure self-esteem. It has been utilized in studies of high school and college students and a wide range of adult populations. Half of the items are worded positively and half worded negatively. The scale can be scored by summing the items after reverse-scoring the negatively worded

items. It has been shown to have high levels of reliability and validity and has significant positive correlation with other measures of self-esteem. The range of possible scores is 10-40, with higher scores reflecting higher self-esteem.

Short State-Trait Anger Scale (SSTAS)

The SSTAS (Spielberger et al, 1983) is composed of two ten (10) item subscales, one measuring state anger (an emotional condition consisting of subjective feelings of tension, annoyance, irritation, or rage) and one measuring trait anger (how frequently an individual feels state-anger). It has been shown to have high levels of reliability and validity. Both state and trait anger scores range from 10-40, with higher scores reflecting higher levels of anger.

Short Attitudes Toward Women Scale (SAWS)

The SAWS (Spence et al, 1973) is a twenty-five (25) item Likert scale designed to assess where an individual's attitudes, about the rights and roles of women, are on a continuum from traditional conservative to contemporary pro-feminist. Extensive use of this scale has found it to have high levels of reliability and validity. Scores range from 0-75, with higher scores reflecting more liberal, profeminist attitudes.

Rotter Internal-External Locus of Control Scale (RIES)

The RIES (Rotter, 1966) was designed to measure an individual's expectancy that reinforcement, reward or success in certain circumstance is dependent upon their own behaviour choices or upon external sources such as luck, chance, or another's behaviour. It is a forced-choice, twenty-nine (29) item scale, which has been shown to have high levels of reliability and validity. Scores range from 0-23, with the higher score reflecting a higher external locus of control.

Client Satisfaction Questionnaire (CSQ)

The CSQ (Larsen et al, 1979) is an eight (8) item questionnaire designed to measure a client's perspective on the value of services received. It has been found to have high levels of reliability and validity. Scores range from 8-32, with higher scores reflecting greater satisfaction.

Ganley (1981a) suggests that "the decision to use standardized tests should be made with a careful consideration of the counselling program's goals, the purpose of the testing, and the availability of resources to carry out and make use of such testing" (p. 60f.)

These instruments (excluding the Client Satisfaction Questionnaire) were

chosen because they addressed factors, of personality and emotional response to one's environment, which have been described as characteristic of abusive men (see pp. 35ff. and Table 1, p. 102, above). They have been shown to have relatively high levels of validity and reliability (Beck, 1967; Rosenberg, 1979; Rotter, 1966; Spence et al, 1973; Spielberger et al, 1983). Where short versions of a chosen measure were available (e.g., SBDI, SSTAS, and SAWS) and had similar high levels of validity and reliability as the long version, the writer chose to use them. Because some of the men referred to the program were likely to come with a certain non-compliance to expectations made of them, the writer wanted to keep the battery of measures as brief and uncomplicated as possible in order to reduce the reasons the men might have not to complete them properly.

Only one treatment group (Currie, 1988) has described in the literature its reasons for including a structured evaluation component; i.e., because they are "useful in supporting the specific clinical impressions, as well as in furthering the research component of working with abusive husbands" (p. 14). Currie's program utilized the Beck Depression Inventory, the Attitudes Towards Women Scale, the Rosenberg Self-Esteem Scale, and the Rotter Internal-External Locus of Control Scale. He stated (Currie, 1988, p.15) that these standardized instruments will be administered prior to each man's beginning the group and "can be given again during and after treatment to evaluate change and progress."

With respect to any individual man, the lower his level of depression, the

higher his level of self-esteem, the lower his level of anger, the more equalitarian his attitudes toward women, and the more his locus of control over events is felt to be internal, the less likely he will be to choose to behave in an abusive manner. The writer was aware of the difficulty of drawing causal connections between personality characteristics and abusive behaviours. He also recognized the danger of assuming that any standardized instrument will accurately identify the variable which it purports to measure in anyone who completes it. Nevertheless, the writer believed that the above battery of standardized instruments would have the potential for giving a general sense, when the results were considered together, as to whether or not there was change evident in each member of the group over the course of the treatment intervention.

The subjective mid-group evaluations were somewhat helpful, in that the effort which each member put into completing it was indicative of how seriously he took the group process and how likely he was to be intent or able to generalize anything from the program to his life outside of the program. There was some reticence about offering any negative criticism about their experience in the first half of the session. The two members who were still living with their partners during the group session (Client 1 and Client 8, whose case descriptions are found below on pp. 125ff. and 136ff., respectively) indicated that their partners had commented on how the group seemed to be having an impact on them, as evidenced by their changed behaviour. Brief, unplanned contacts with these two partners was quite helpful in putting the respective group member's "success" into perspective.

The writer happened to encounter the partner of Client 1 in a local supermarket. She indicated a desire to share her recent situation and the writer found she had a quite unrealistic sense of what the changes she had seen in her partner's behaviour, over the short term, would mean for the future of her relationship. She believed, despite a caution that it would require a lot of work by Client 1 to continue to control his abusive behaviour, that her problems were over and her relationship would be free of violence from then on.

While visiting a local library, the writer met the partner of Client 8. While acknowledging that her partner had become much easier to get along with since he began the program, she was not totally confident that he would be able to maintain the changes after the group session was over.

The writer also had a chance contact with the ex-partner of Client 3. The information which she shared about her concerns and her perception of how he was doing is recorded below in the individual case study on Client 3 (pp. 131ff.).

The Client Satisfaction Questionnaire (Larsen et al, 1979), completed at the last group meeting, indicated a general positive response to participating in the program. The scores on the CSQ of the five men who finished the whole program ranged from 27-32, the mean score being 29.2, which indicates that they found attending the group to be a valuable experience.

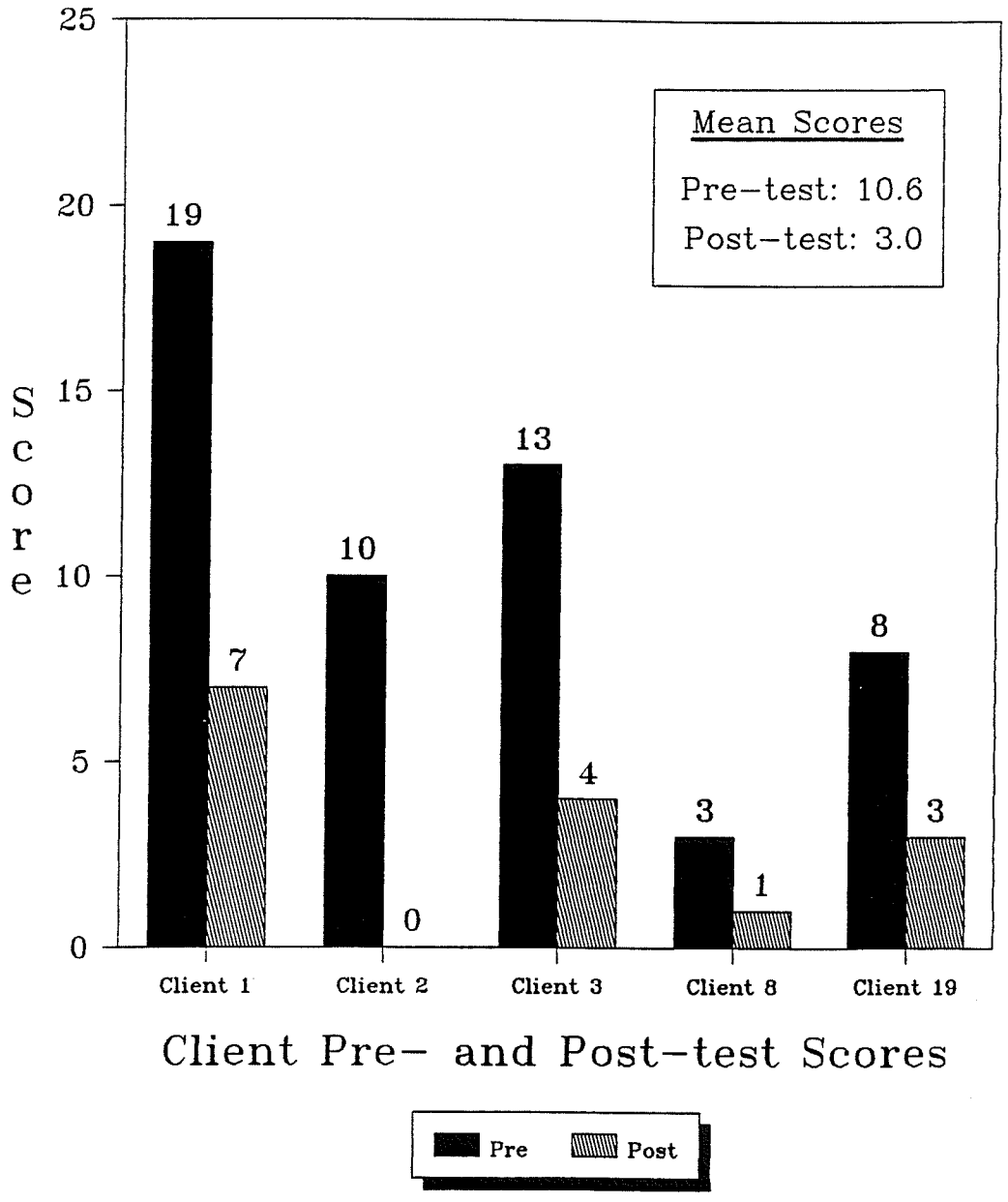
In addition to the CSQ each member was asked to complete a group evaluation. An increased appreciation of how their behaviour impacted upon others and the value of learning relationship skills and behaviour management techniques were the main benefits noted by the members. They found the group discussions with others who had similar problems to be helpful; they could express their thoughts and feelings in a supportive setting and get honest feedback from the other group members and the leaders.

1. Standardized Measurement Instruments

As can be seen from the charts (Fig. 1 to Fig. 5, below), the changes in each individual man's scores, from pretest to posttest, were generally in the direction which each instrument indicates to be positive change in emotional state and/or attitude. Due to the small combined number of members from the two groups, any attempt to do a statistical analysis of the change in mean scores pretest-posttest would have very little meaning.

Except for one man, Client 8, the RSE reflected a decline in the group's level of self-esteem at the end of the session. The mean pre-test and post-test scores were 21.2 and 20.2, respectively, reflecting a very small change. These scores could be interpreted as indicating a lack of hopefulness in the group about their ability to change their behaviour. The scores could also be a reflection of an acknowledgment that their past

Short Beck Depression Inventory



Client Pre- and Post-test Scores

Figure 1.

Rosenberg Self Esteem Scale

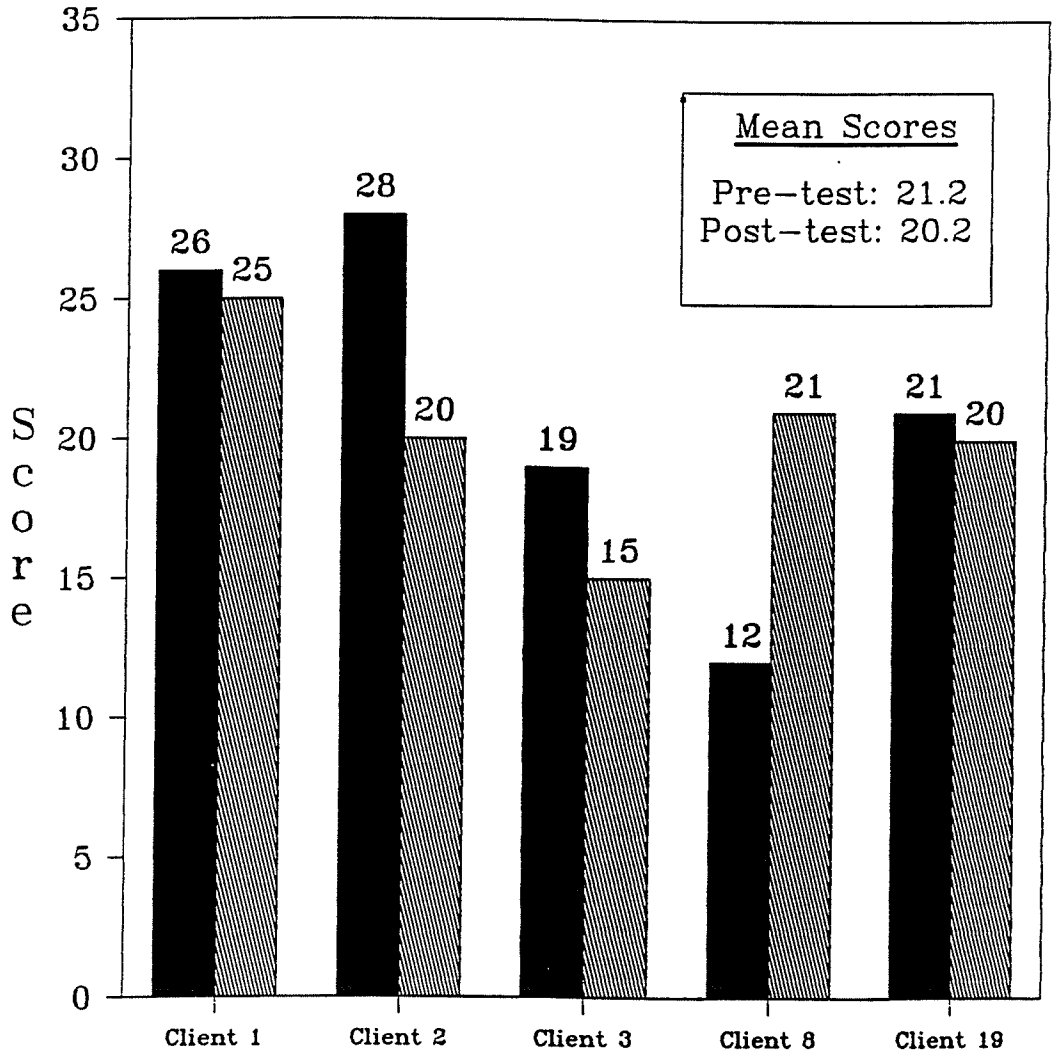


Figure 2.

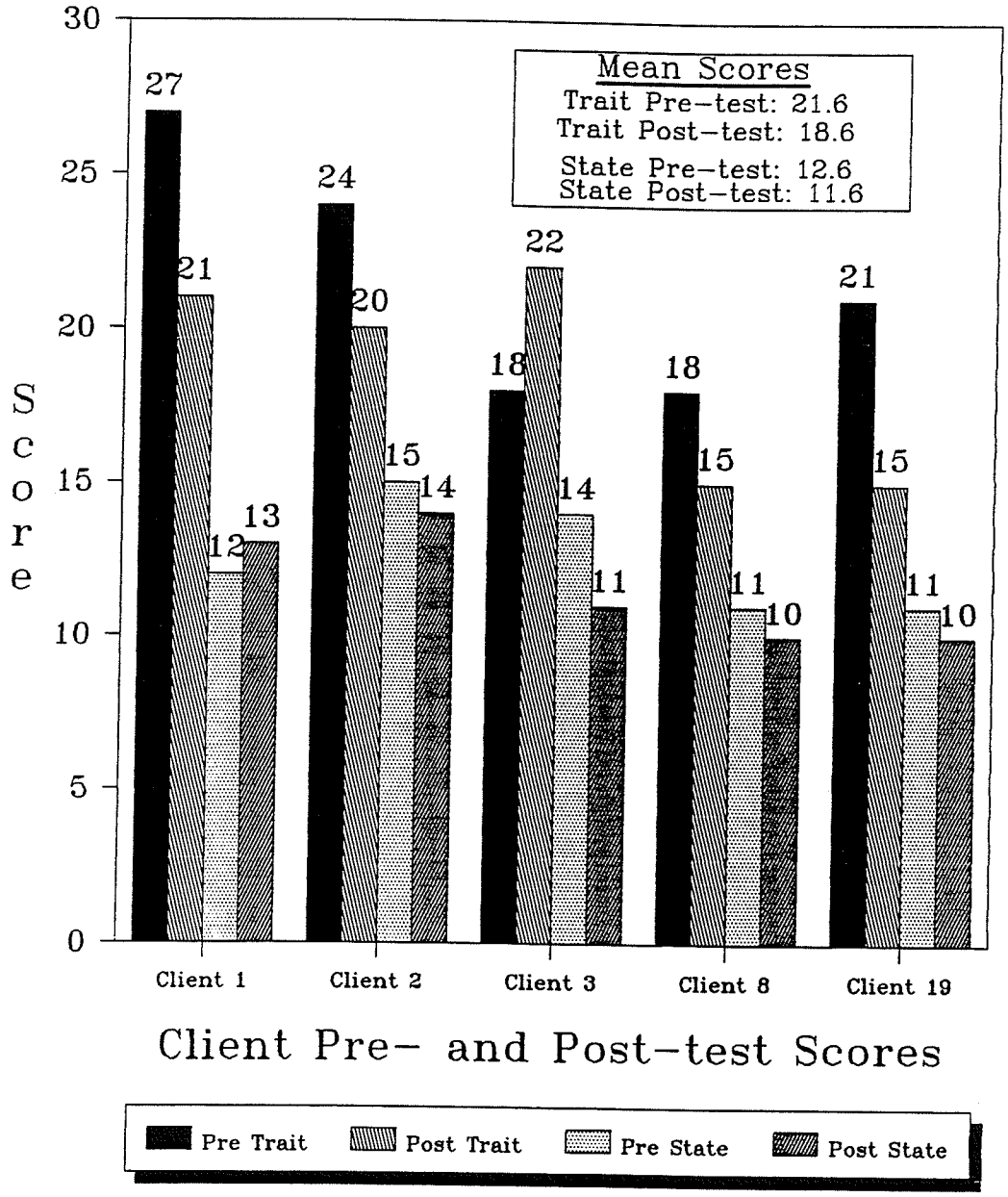
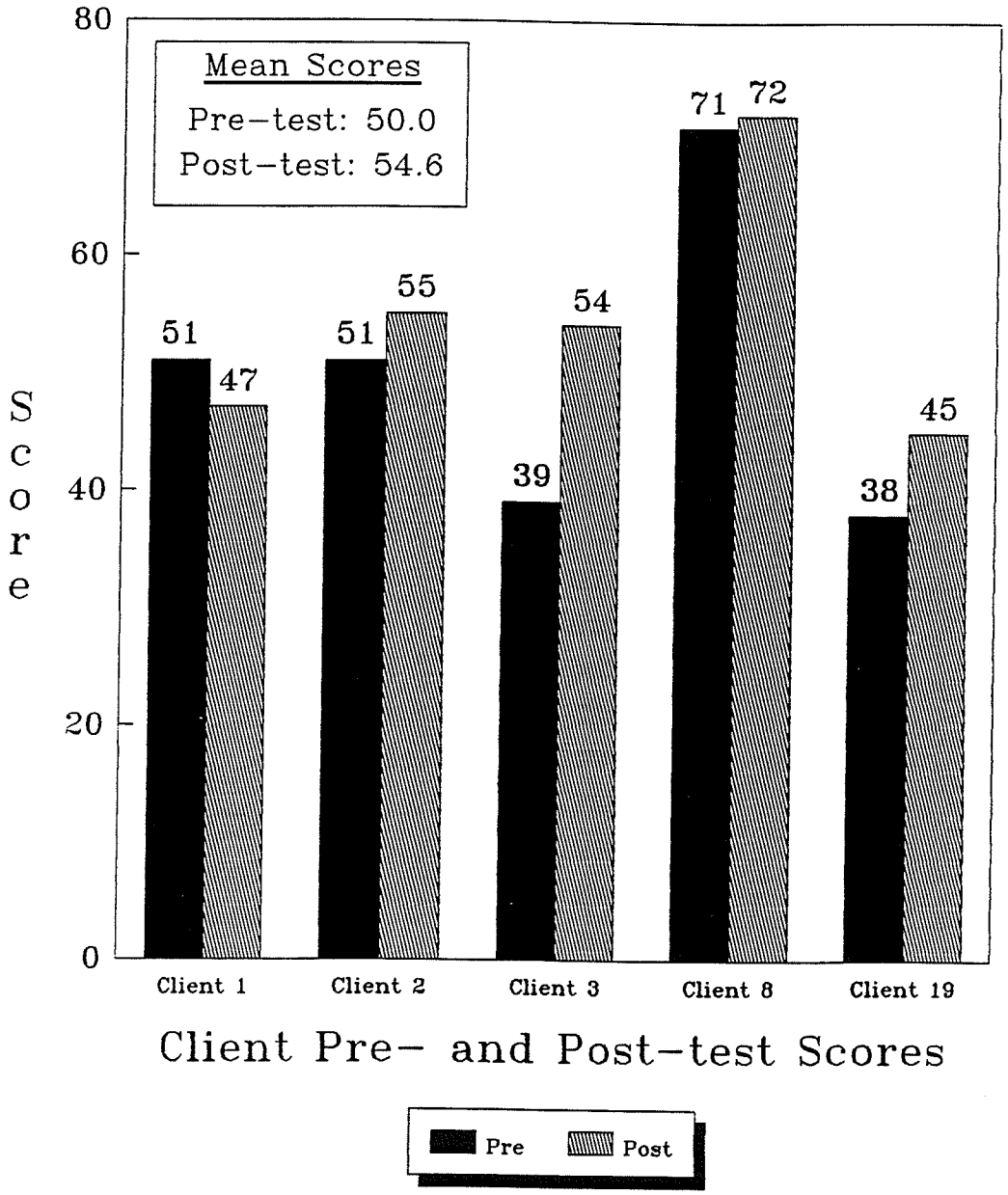

Short State-Trait Anger Scale
Mean Scores
Trait Pre-test: 21.6
Trait Post-test: 18.6
State Pre-test: 12.6
State Post-test: 11.6
Score
30
25
20
15
10
5
0
27
21
12
13
24
20
15
14
18
22
14
11
18
15
11
10
21
15
11
10
Client 1
Client 2
Client 3
Client 8
Client 19
Client Pre- and Post-test Scores
Pre Trait
Post Trait
Pre State
Post State

Figure 3.

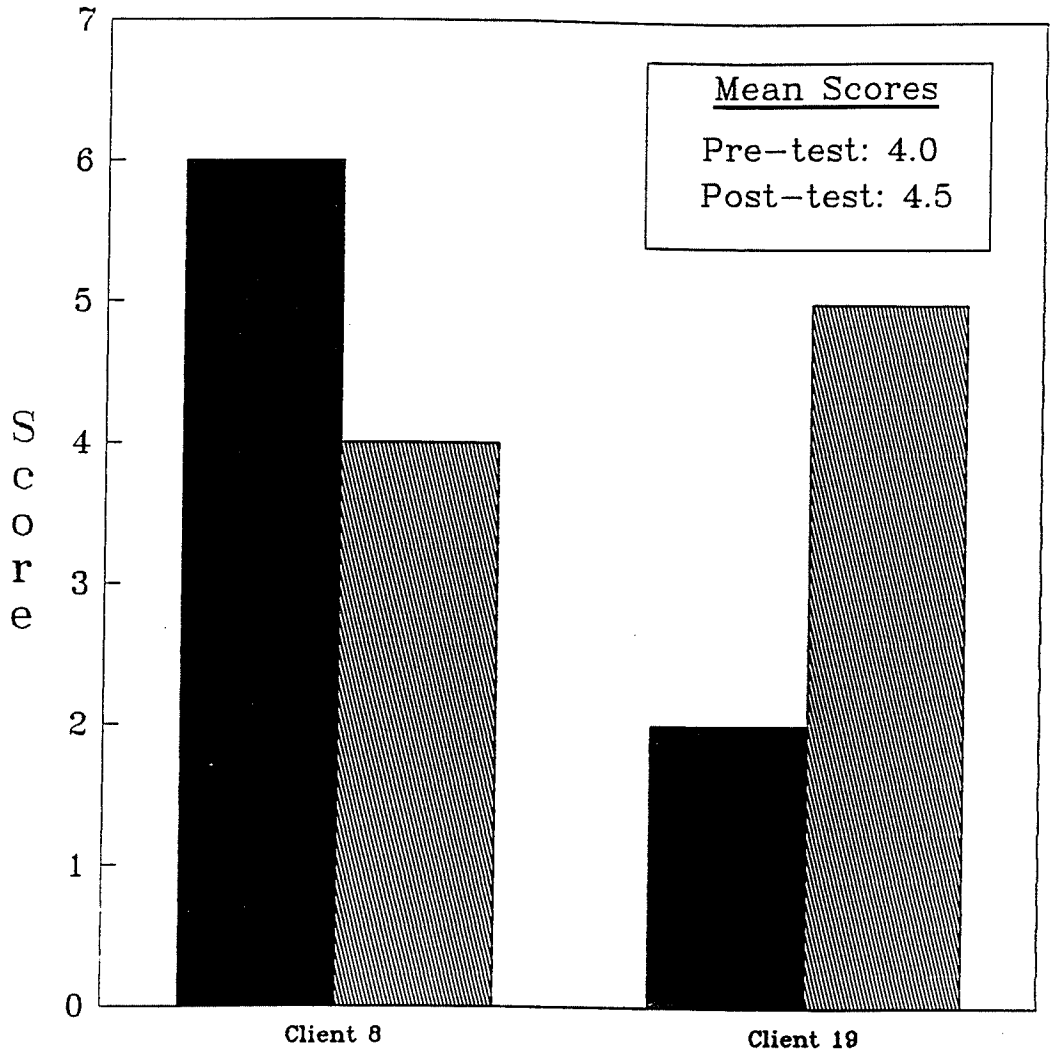
Short Attitudes Toward Women Scale



Client Pre- and Post-test Scores

Figure 4.

Rotter I–E Locus of Control Scale



Client Pre– and Post–test Scores

Figure 5.

behaviour was unacceptable, that their partners had suffered because of it, and that they had a lot of hard work yet to do. That is, the scores may reflect a new awareness on the men's part of the real consequences of abusive behaviours. The men certainly had been unanimous, in their final personal evaluations, that they needed to attend either another group session or a follow-up support group to learn more and to maintain the changes already begun.

The RIES was only added to the battery of instruments after the first group session. From the second group, only Client 8 and Client 19 completed the program. Their mean pre-test and post-test scores were 4.0 and 4.5, respectively, reflecting a very small change in the strength of an internal locus of control.

The mean pretest and posttest scores on the SAWS were 50.0 and 54.6, respectively, reflecting a small move in the direction of profeminist attitudes towards women.

The changes in scores on the SSTAS, again, were generally in the direction expected. The mean pretest and posttest scores for the SSAS were, 12.6 and 11.6, respectively and for the STAS, 21.6 and 18.6, respectively.

2. Individual Case Studies

The following cases are the only five (5) men who completed the full program. These descriptions are based on intake information, my

experience of them in the group meetings, the results of a battery of standardized measurement instruments, self-reports, and, in the cases of Client 1 and Client 3, one contact with their respective partners, the victims of their abusive behaviour.

a. Client 1

Client 1 was a thirty (30) year old Caucasian man who was separated from his common-law partner of four (4) years. He was an unemployed labourer with a grade ten (10) education, earning less than ten thousand dollars ($10K) the previous year. He had been abusive of his partners in four (4) previous relationships and had abused his current partner ten (10) months into the relationship. He came to the program because his partner told him that she would leave him if he did not get some help for his problem of violence.

Client 1 had a long history of assault, of his partners and other people, and had spent time in prison. His assaultive behaviour was usually linked with the abuse of alcohol. While in prison for assaulting his current partner, Client 1 had taken part in a group for spouse abusers. He presented as quite concerned about his abusiveness and wanting to change his behaviour. He also generally had the "correct" answer for group questions and confrontation. While he spoke with some emotion about the abuse of his family members by his alcoholic father which he had witnessed and suffered, he described his own abuse of his partner in a rather detached, unemotional way. He tended to minimize his abusiveness and to

blame it on "learned behaviour" (a phrase he had picked up in his previous group experience), his bad temper, and his use of alcohol.

In the early stages of the group, Client 1 seemed intent on using the anger management techniques and indicated that he was getting more in touch with his emotions and better able to share them with his partner. He stated that he was not drinking, that he was regularly using relaxation techniques to deal with stress and that his physical abuse had ceased.

During the middle group meetings, Client 1 appeared to be working quite hard to understand how, by tending to think irrational thoughts about his partner's behaviour and intentions when the thoughts had no factual basis, he set himself on the road to angry confrontations and the potential of re-offending. He also appeared to be putting more importance on the needs and wishes of his partner and children - taking part in more activities with them, starting to attend church, and trying to be more accepting of her partner's friends.

Toward the end of the group session, Client 1 assaulted his partner again. When he returned after missing one meeting, he acknowledged the assault to the group, with some remorse, but again blamed alcohol and his partner (he felt that her complaining about him to her friends had resulted in his having been beaten up) and seemed more concerned about the inconvenience of probably having to spend more time in jail. It became apparent that Client 1, despite his many words to the contrary, had never truly accepted that he alone was responsible for his abusive behaviour.

At the end of the group session, Client 1's major outstanding issues remained a low level of self-esteem, a significant level of denial of responsibility and externalizing blame for his abusive behaviour, and an ongoing chemical dependency problem (which caused some attendance problems late in the session). The writer believed that he was the most likely, of the men who completed the program, to re-offend against his partner or another partner.

Client 1 was moderately depressed at the outset of the group, according to the SBDI scores, but was not depressed at its conclusion. Given his behaviours in and beyond the group, the group experience may have given him enough support to rationalize and feel less guilty about his behaviour.

There was some discrepancy between Client 1's score on the RSE and the writer's experience of him in group. This discrepancy may have been due to a tendency to minimize both in his completion of the pretest and in his discussion in group of his success in managing his abusiveness.

With respect to the SSTAS, the increase in the "state anger" score of Client 1 is consistent with the writer's experience of him in group. That is, he allowed himself to be aroused and aggravated by many people and situations. The writer does not think that this is necessarily in contradiction to his score with respect to "trait anger". The writer's experience of him in group meetings was that he did not present as an angry, brooding person, but, rather, as someone with a hot temper and

prone to over-reacting to specific situations and then cooling down quickly.

Client 1's score on the SAWS scale moved, at the posttest, away from the profeminist attitude. It was, the writer believes, a reflection of his propensity to deny his responsibility for his violence and to attribute blame to his mother, who didn't protect him from abuse as a child, and his various partners, who "provoked" abuse by their behaviour.

The case of Client 1 clearly underscores the necessity for on-going contact with the partner's of men in the group. The leaders found out too late, though they had suspicions that his apparent successes had come too easily given his past record, that he had been less than thoroughly honest about his behaviour while in group. His partner also minimized the riskiness of her situation, but more regular contact would likely have helped her to more realistically assess her relationship with Client 1 and may have given the leaders the wherewithal to confront him more effectively.

b. Client 2

Client 2 was a twenty-nine (29) year old Caucasian man who was separated from his wife of eleven (11) years. He was an self-employed tradesman with a grade twelve (12) education, earning about twenty-five thousand dollars ($25K) the previous year. He had not been violent in any previous relationship but began to be abusive in the early months of his marriage

to his current partner. He came to the program "voluntarily"; he realized he had a problem when his wife finally left him a couple of months prior to contacting the program.

Client 2 was raised in a family where his parents, although not abusing each other or him, were unaffectionate and distant. His own relationship with his wife mirrored that of his parents. Client 2 was a closed, unresponsive man, choosing to fulfil a very traditional male role - breadwinner, disciplinarian, outdoorsman. He tended to become verbally and physically abusive of his wife when she attempted to interact with him. His perception, of some fairly normal expectations on the part of his partner, was that she was pressuring him to share his feelings, to take part in family decisions, and to change his chosen lifestyle and recreational activities.

Client 2 was also an extremely jealous man and became enraged at relatively innocuous interactions between his wife and other men. He kept his feelings inside and depended on his wife to be the "feeler" of the family. He had a very low level of self-esteem and needed his partner to validate him. When she questioned his style of non-interaction and asked him to share of himself, at an emotional level, with her and their children, he became angry, stuffed the anger until he could not stuff any more, and then made her cease her demands through the use of verbal and physical abuse.

Client 2 was able to acknowledge and begin to explore the connections

between the interpersonal dynamics of his family of origin and his current self-concept and resistance to efforts by others to get him to open up. His ability to get in touch with the primary feelings which developed into anger and to communicate them to the other members of the group improved during the session. His low self-esteem and his use of control tactics in response to perceived threats were areas which he identified, at the end of the group, as needing further work to change. Client 2 had used the techniques of identifying anger cues, time-out, "cool" thoughts, and relaxation with some success in managing encounters with his partner without becoming abusive. The writer thinks that he is not likely to physically abuse another partner. However, until he is better able to deal with stressful situations through good communication and negotiation and not by attempting to control the other, he may be prone to the use of forms of verbal or psychological abuse.

Client 2's score on the SBDI dropped from very low on the pretest to zero on the posttest. His score on the RSE, on the other hand, dropped by a margin that was notable. This apparent discrepancy became understandable as the writer watched Client 1, over the course of the group, come face to face and accept full and sole responsibility for his abuse of his partner. While he was not satisfied with where he was at that moment, he was quite determined and hopeful that he could and would change his behaviour.

Client 2's scores on the SSTAS are among the highest among the men and the changes in his scores, from pretest to posttest, indicate a modest

decrease in the levels of both types of anger. This was consistent with the writer's experience of Client 2 in the group.

The writer's experience of Client 2's attitudes towards women, as they were developed in a fairly traditional male upbringing, was congruent with both the level and change of score, from pretest to posttest, on the SAWS.

The writer believes that the treatment approach used with this group was very appropriate for Client 2 and his circumstances. He responded enthusiastically to almost every meeting's content and indicated at the end of the group that he found something, of what the group had offered him, to be useful almost every day. If anything, a bit more time in the group would have helped him to solidify some of the real gains he made.

Client 2 was registered to take the next group session when he got a job offer which took him to another town. He left with intentions of pursuing the outstanding issues with another program, or an individual counsellor, if necessary. I am hopeful that, because of his acceptance of his responsibility for choosing abuse as a means of controlling his partner and his acknowledgement of the pain that he had inflicted on her, that he will seek to continue the process of change begun in our program.

c. Client 3

Client 3 was a thirty-nine (39) year old Caucasian man who was separated from his partner of three (3) years. He was a self-employed service

provider with a grade thirteen (13) education, and one (1) year of college, earning forty-five thousand dollars ($45K) the previous year. He had been violent in one previous relationship, a marriage which had ended in a legal separation after approximately five years. At the time he joined the program, Client 3 was in the throes of a contested divorce with this previous partner. Client 3 had realized, when he had acknowledged his being an alcoholic in 1981, that he also had a serious problem with violence. He thought that resolving the alcohol problem had also resolved the violence. However, when he abused his current partner, he realized that he had not and sought out the program out of fear of what he might do next if he didn't get some help.

Client 3 had a long history of both being physically and sexually abused and inflicting physical abuse upon others. He left home as a young teenager and spent the next ten years living the life of a renegade - heavily using alcohol and drugs, spending a lot of time in jail, and unable to develop any meaningful relationship of any duration. At approximately age thirty (30), Client 3 found himself incarcerated once again, extremely distraught at having absolutely no recollection of how he got there, and made the decision to join Alcoholics Anonymous in order to change his lifestyle of substance abuse and violence. He was successful at remaining sober from that day forward. The one outstanding item of business from his past was the completion of the divorce process with his ex-wife. She was not allowing it to proceed uncontested and this was and area of extreme stress for him.

An interview with Client 3's current partner (the only partner who would agree to complete an intake questionaire) revealed that he was generally a very intense man who allowed the stresses of running his business, settling his divorce, and the normal minor irritations he experienced from relationships with others to build up inside. Client 3 had a good sense of humour and was generally able to talk freely, but his partner indicated that she was often nervous about saying the wrong thing. Out of his insecurity about his ability to keep the lid on his past self-destructive tendencies and his need to get a lot of affirmation of himself from others issued a mode of relating to others characterized by controlling and dominating behaviours. His partner indicated that this behaviour was often quite subtle but that, knowing of his history of violence, she often felt under pressure to try to keep his life stress to a minimum. She indicated that his recent acts of physical abuse toward her had made it impossible for her to continue in their relationship.

Client 3 was devastated and confused by his violence toward his partner. He was genuinely remorseful about having abused his partner; he stated that she had done nothing to deserve it. However, the thing that disturbed him the most, it seemed, was the fact that he had lost control of himself after eight years of successfully coping with the stresses in his life. He accepted complete responsibility for the abuse and understood why his partner could not continue to live with him. At the same time he felt that his behaviour had been beyond his range of control and this was quite a scary feeling.

Client 3 found the stress and anger management techniques to be very helpful. During the group, and in his post-group follow-up reports, he indicated that he was very vigilant to his physical arousal cues and his "hot" thoughts. He tried to incorporate the relaxation exercises and relaxing activities as a part of his regular daily routine. He also maintained regular attendance at A.A. meetings and regular contact with his A.A. sponsor.

When the group was dealing with getting in touch with emotions, communication skills, and gender role socialization and expectations, it became clear that Client 3 had some very real issues of trust in considering his relationships with others and particularly his many past relationships with women. He felt that his suspiciousness of others' intentions was a function of his having been sexually abused by an older male cousin when he was a teen and of his having been rejected by a number of partners as a young adult.

He was able to acknowledge that people in his present life context are not responsible for what was done to him in the past and found that the program content on recognizing and changing irrational thoughts to be somewhat helpful in dealing with conflictual situations. He was also able to acknowledge the incompatibility between his need for acceptance by others and the presentation of anger and mistrust which drives them away from him.

Were the writer to consider the admission of Client 3 into another

treatment group, Client 3 would be encouraged to seek some concurrent individual counselling to assist him to come to terms with the victimization and rejection which he experienced as a young person. Had this advice been given and taken, Client 3 may have been freed from his state of unhealthy self-control and have better utilized the group process to deal with his abusive acts.

Client 3's scores on the SBDI and on the RSE were consistent with this writer's experience of him in the group. While he tended to exhibit a lot of self-confidence about his abilities as a businessman and as a person, this was a function of his need to be perceived as being in control of himself. He did acknowledge in the group that he often felt very differently inside than how he appeared on the outside.

Client 3's scores on the SSTAS were somewhat lower than this writer would have expected in listening to him describe his experience of his own anger. Client 3, in my experience, was a man who held a lot of anger and frustration inside. He often commented that he felt very stressed in his day-to-day life though he appeared relaxed and under control most of the time in group. He had some deep and unresolved issues which needed some resolution; these may be reflected in his "trait anger" score.

Client 3 struggled really hard with the changing roles and expectations of women and this is reflected in the pretest to posttest changes in his scores on the SAWS. His personal experience - both family and peer group

-had taught him to undervalue women and he made some significant gains with respect to his attitudes about women through the group.

Client 3 is a very perceptive man who has some good relationship skills. He is, however, caught in the on-going effects of a childhood and young adult experience of victimization and anti-social, out-of-control behaviour. He has a great need to come to terms with the pain he suffered and the tremendous anger which remains locked up inside him. Until these issues are resolved, even with regular use of stress and anger management techniques, he is at great risk of re-offending against a partner or other person.

d. Client 8

Client 8 was a forty-five (45) year old Caucasian man who was, at the time living with his common-law partner of three years. He was a self-employed tradesman with a university degree, earning twenty-seven thousand dollars ($27K) the previous year. He had been in two previous relationships; in neither was he violent (self-report), though both marriages had ended in divorce. Client 8 came to the program at the suggestion of his current partner, whom he had recently assaulted, who felt that he might get some help by so doing. He also had a charge, related to the above-mentioned assault, pending in criminal court.

Client 8 had a relatively normal upbringing, in a problem-free family, with parents who were happily married and who raised their children in a

very appropriate manner. Despite this kind of upbringing, he identified a number of personal characteristics which had been part of the reason his marriages had failed and which were problems in his relationship with his current partner.

Client 8 described himself as a perfectionist, and overly sensitive, whose expectations of himself and others often led to frustration and anger. His anger was counterproductive and often misdirected, he felt, and his usual method of coping with the anger was to withdraw, often leaving home for periods of from a day to two weeks. Client 8 identified, as things he wanted to change, his ways of responding to conflict and expressing his feelings. He wanted help in recognizing and controlling his anger and developing better communication skills. He acknowledged that, when in conflict with his partner, he tended to express himself in ways which limited her range of responses and tended to put her on the defensive. He would then use her response as an excuse to withdraw and avoid resolving the conflict.

In group, Client 8 was somewhat intimidating to the other members. He seemed to be far ahead of the rest of the group in the thinking he had done about his problems and what he needed to change. Toward the later stages of the group, the leaders had to be careful not to allow Client 8 to remove himself from the role of client and take on the role of quasi-leader. As he experienced some success in modifying some of his expectations of his partner and their child, and in learning and applying new ways of communicating his feelings and his needs, Client 8 took on

more of the role of "expert" within the group. It was another incident at home, where Client 8 slipped into his old ways and "ran away" from a conflict, which snapped him back to reality, i.e., the necessity of a lot more practice and hard work in order to get to where he wished to go.

At the end of the group, Client 8 was left still struggling with his high expectations for himself and his family, though these had moderated somewhat over the course of the group. The majority of conflicts which arose between him and his partner had been worked out successfully, without him removing himself from the home. Given the number of times he had removed himself during the year prior to contacting the group (12+), this was a significant gain. He had been involved in the support group which had been run between the first and second group sessions and expressed his desire to be involved in the third session.

The SBDI indicated that Client 8 had no problem with depression at the time he was in the treatment group. He was the only man whose score on the RSE increased from pre- to posttest. He had relatively low scores on the SSTAS, with a slight decrease from pre- to posttest. The results shown by each of these instruments was consistent with the writer's experience of Client 8 in the group.

Client 8 presented in the group as one who felt that he had the ability to effect what happened to him and this was supported by his scores on the RIES. He was very optimistic about being able to bring about change in his life and his relationships. Client 8's very high score on the SAWS

remained virtually the same from pretest to posttest and accurately reflected the attitudes towards women which he expressed and modeled in the group.

As with Client 1, and all the other men, Client 8's potential for growth and change within the group process would have been greater had the leaders had regular, on-going contact with his partner. Had they been able to confront him on the accuracy of his perceptions of how well he was succeeding in changing his behaviour at home, because sometimes it seemed too good to be the whole truth, the leaders may have been better able to assist him in consolidating his successes. They may also have been able to provide the program with a potential support or treatment group leader.

Of all the men who completed the program, Client 8, in the writer's judgement had the best chance of remaining free of abusive behaviour. Unfortunately, a market slowdown in his business field took him away from the area and the program lost contact with him.

e. Client 19

Client 19 was a fifty-six (56) year old Caucasian man who was separated from his wife of thirty-seven (37) years. He had a grade four (4) education, was employed part time in a trade, and had earned fourteen thousand dollars ($14K) the previous year. He had become abusive to his partner within the last two years of their time together. Client 19 was

ordered into the program by the court when he re-offended against his partner while still under probation from a charge six (6) months prior.

Client 19 was a very traditional man whose family was changing around him and who was not able to adapt to their changing roles and the attendant demands upon him to change. He had worked extremely long hours most of his married life, coming home each day only to have his supper and then to retire for the night. His wife carried all the responsibility for caring for the home and the children. This arrangement lasted until the last child left home. Client 19 and his wife had long since become relative strangers to one another and, when she was no longer satisfied to stay at home and cater to his needs, he was not able to understand or cope with the changes. They had both been heavy week-end drinkers for many years. When Client 19 assaulted his wife he was intoxicated.

It was a very bewildered and hopeless Client 19 who came to complete the intake process to join the group. He was totally embedded in the role which he had fulfilled for so many years; successfully, he thought, meeting his family's needs. He was able to acknowledge that perhaps his wife had needed more from him than a pay-cheque, but was somewhat resentful that she was not more grateful for what he had been able to provide. Client 19 was unable to see why his wife was refusing to continue to "be there for him." He believed that he was too old to be able to change.

Client 19's scores, and the changes in score from pretest to posttest, on

the SBDI, the RSE, and the SSTAS, were consistent with the way in which he presented and interacted in the group - not depressed, nor particularly angry, but having lost some of his sense of worth, particularly since his retirement.

The low score on the RIES was probably an accurate reflection of the sense that Client 19 had of being able to control most contingencies in his life. The one area in which such a perception was not consistent with how he presented in the group was in his relationship with his partner. Client 19, at the age of 56, presented as someone who had been too many years in a rut to be able to change his lot in life. While he did acknowledge that his physical abuse of his wife had been wrong, and the writer believes he would not have repeated it, he felt at the mercy of new expectations on the part of his wife, which he would never be able to understand or meet.

Client 19 was unable to significantly change his attitudes about women so late in his life. Ironically, he contracted a mysterious infection during the last few weeks of the group and was dead within six months of completing the program.

His scores on the SAWS reflected a fairly traditional set of attitudes towards women and were supported by the way in which he described his relationship with his partner and the expectations which he had of her and their life together.

Client 19 attended the group faithfully and appeared to be very attentive to and interested in the various topics presented and discussed in the session. He did not, however, talk very much in group and, when pressed for an opinion or a comment or to engage with other members of the group, Client 19 usually had nothing to say. On the rare occasion when he did say something, it was evident that he was struggling to understand how what was being discussed had any bearing on or utility for his life situation. At the same time, whenever he was asked if he found it helpful to be part of the group, he answered in the affirmative. The writer believes that he was sticking it out, for the most part, to satisfy the expectations of the court. The writer also believed him when he said that he was helped to go on, week by week, by having a group of people to spend some time with.

Client 8 was unique among the men who attended the treatment group in that he had no network of support apart from his partner and had developed no interests beyond his employment, which now had ended. The main source of frustration for him was the tremendous number of changes which had impacted his life all at once. The type of treatment group which he found himself in was geared to dealing with men whose crises were generally in the limited realm of interaction with their partner and who were coping more effectively in situations outside of the family context. He would probably have benefited more from an intervention focused on getting him connected with a group of his peers and presenting content related to needs of their particular developmental life stage. Another component of

a more effective intervention for Client 19 may have been some conjoint counselling with his partner.

E. Evaluation of Practicum Goals

1. Goal #1: The treatment group for abusive men is developed, implemented, and evaluated

At the outset of this report the writer indicated that a primary goal of this practicum was to develop, implement, and evaluate a treatment group program for men who perpetrate physical, sexual, and/or psychological abuse against their partners. He believes that this goal has been accomplished in the stages which are described below.

In the first stage, the writer went through the mechanics of searching out knowledge about the causes and effects of family violence, about the role which men play in perpetrating abuse upon their victims, about the abusers' attitudes and behaviours which need to be changed in order to end the abuse, and about the ways in which other programs and practitioners have attempted to bring about the requisite behaviour change. The theoretical and practical information which was supported by empirical and anecdotal evidence informed the development, by the writer, of program philosophy, procedures, structure, and treatment intervention.

The next stage involved the writer's working with the O.W.N. Program Committee in disseminating program information, in developing community connections, and opening a dialogue with other agencies and programs

concerned with family violence and working towards its eventual eradication. While, as has been mentioned in the above section of this chapter entitled "Relationship to Other Agencies," these connections were not all strong and the dialogue not always extensive, these endeavours created an awareness of the program, what it stood for, and what it was attempting to offer which was critical to the building of acceptance by and relationship with others who were providing services to families marred by violence.

The following stage, beginning with the receipt of the first referrals of men to the program, developed as a result of the activities undertaken in the previous stages. This stage included the intake/assessment and the treatment group components of the program and a continuation of the efforts of the previous stage to develop an effective network of intervention services.

The final stage included attempts to follow up with those who had experienced the treatment group, both from within and from the outside, the results of their involvement with the program. It also included the final steps of the on-going evaluation process (which is described in this report and of which this report will become a part) which hopefully will lead full circle and back into a continuation of the review of the latest theoretical and practical knowledge and the making of changes to the program required to deliver an effective service for its clients and their families. The final stage, then, becomes another first stage and the process continues.

Along the way through these stages there were a number of unexpected circumstances, reactions and outcomes which made it more difficult for this writer to say with confidence that his Goal #1 has been met with a high degree of success.

The literature described many different theoretical and practical approaches to understanding how abusiveness develops in some men, what changes in the attitudes and behaviours of abusers need to occur, and what sorts of treatment could bring about this needed change. However, it offered next to no empirical research evidence to support the theory or effectiveness of these approaches and offered somewhat limited anecdotal evidence or practical experience to guide the process of development of effective treatment interventions.

The writer chose the components of program, procedure, and process whose use had the most support in the literature for dealing with abusive men and combined them to create a service designed to address the broad range of treatment issues concerning the attitudes and behaviours of the abusive man.

The physical distance of the practicum site from the university social work community, combined with turnover in both the writer's practicum committee and the role of on site clinical supervisor, allowed for the development of isolation of the writer from potential support and direction. He did not think, at the time, that this was a critical problem and chose not to bother others with it. In hindsight, however,

the potential was certainly there for burnout and the lack of dialogue likely made the learning experience somewhat less rich for him.

The writer's expectation that close working relationships would quickly develop between O.W.N. Program staff and those of others agencies in the area, which also provide service to offenders or the victims of their behaviour, was not fulfilled. This "network" did not get much beyond listening to and discussing each other's concerns. The only concerted effort, and this was by no means unimportant or insignificant, was in the area of public education.

One small success in this area was the open contact between the group leaders and the Probation Officers of the men who attended under court mandate. This allowed discussion of concerns, such as non-attendance or lack of participation, which might have some negative impact on the what the individual member would gain from the group experience.

Of special concern, and the focus of consistent efforts on the part of the O.W.N. group leaders, was the inability to gain more than a grudging acceptance of the existence of the program by providers of services to women. From the outset, it was the writer's belief that monitoring and evaluation of the program and its effectiveness by women's groups is appropriate and highly desirable. It has been very frustrating not to have been able to develop this critical alliance and the potential for success of the program is diminished by this situation.

One of the real effects of this lack of cooperation, from those who probably had some contact with the partners of the group members, was the leaders' inability to discuss safety issues with the partners and to get their perception of the men's current behaviour, behaviour change, and the effectiveness of the group intervention. As a result extra care was taken, during check-in/out time, to encourage full disclosure by the men of their thoughts, feelings, and behaviour between meetings and as they left each meeting.

The decision by the Ministry of Correctional Services, after the pilot period, to drastically reduce the level of funding to the program reduced the ability of the program to provide an effective intervention. Because of the other demands on the time and energy of the co-leaders, less was available to respond to the kinds of program development issues outlined above.

The writer, along with his co-leader was put in the position of providing the highest quality of practice that they could, during the group meetings, and hoping that no crises would arise between meetings. Immediate response was certainly undertaken when either leader was contacted, but there was little possibility for any kind of proactive activity by the leaders outside of the meeting time. It is difficult to assess, without having outside contacts, the impact of such lack of contact on the potential effectiveness of the group process.

One final reality which affected the writer's ability to successfully

accomplish the evaluation component of this first goal was the relatively small number of men who took part in the first two group session and the very small number who completed the sessions. Though beyond the control of the writer, these small numbers disallow any but the most tentative conclusions about the success of the treatment intervention to be drawn from the evaluation component.

The writer thinks that a modest level of success was realized in working toward his first practicum goal. Clearly, the contingencies described above have prevented a high level of success as well as the implementation of a comprehensive evaluation of just how much success was attained.

2. Goal #2: Group members have ceased their abusive behaviour

The second major goal of the writer's practicum was to have the group members stop their abusive behaviour in family, especially spousal, relationships. During the group sessions, the men indicated that they made use of the skills that were being taught to them and that they were free from physically abusive behaviours. One man, though, acknowledged that he had assaulted his partner near the end of the session.

Because of limited contact with partners, during and following the sessions, and a small response rate to program follow-up survey questionnaires, there was no way of knowing how accurate were the men's self-reports. The writer thinks that it is highly likely that, if the physical abuse did in fact cease, the emotional and psychological abuse

continued. His reasons for so thinking are that the men had not had enough time in group to incorporate the new relationship skills into their repertoire of behaviours and there is little fear of legal sanction for the non-physical types of abusive behaviour.

On the positive side, the men were generally dissatisfied with the way that their relationships with their partners were going. They seemed to be genuinely searching for ways of making their lives happier and more fulfilling. The majority of them were able to acknowledge that they often did not like the way that they behaved with their partner and to identify something that they wanted to change in themselves. Some of the men were admittedly relieved to be "free" after the final group meeting, but many left the group feeling quite positive about their chances at maintaining their new-found methods of controlling themselves and working out problems with their respective partner. As mentioned above, the men's scores on the standardized measures indicated changes in the direction which would support a tentative positive prognosis.

Beyond these relatively subjective impressions, the writer has little evidence to show whether his work and the group process were able to achieve this goal of cessation of abusive behaviour by the men who completed the program.

In summary, the writer would list the positive and negative factors, as he sees them, of the intervention described in this report. The writer's

personal experience of these is similar to that recorded in the literature by others.

The positives are: the potential power of the small group process in effecting change; the ability of the small group format to deal with relatively large groups of clients within the context of limited resources; the use of the directive approach in leading the group meetings; and (despite the comments above on the difficulty of developing a network of agencies and programs) the development of a relatively high profile in the community and the support of a community sanction against abusive behaviour by men.

The negatives are fewer, but not insignificant nor were they taken for granted: the fact that the potential strength of the small group process suffers when the number of men in the group is small and/or the attrition rate is high; and the reality that this program (along with most similar programs in Ontario, if not all of Canada) can provide only part-time group leaders.

3. Personal objectives

The writer described certain personal objectives which he hoped to reach along the road to accomplishing the above-mentioned practicum goals - to develop social work skills, to receive feedback upon and to enhance his skills in certain areas:

- program development and developmental issues

- small group process and leadership
- identifying and assessing violence in relationships
- the use of cognitive-behavioral interventions
- the evaluation of clinical interventions

The writer would like to comment on what he believes he has accomplished toward attaining each of these objectives.

a. Program development and developmental issues

The development of an appropriate and effective social work service intervention, to meet an identified client need like abusive behaviour within a spousal relationship, depends initially on a clear understanding of the problem - where does it come from, what are its negative effects and upon whom does it impact? It is important, also, to understand the context(s) in which the problem appears, the roles of the various people involved in initiating and maintaining it, and what changes in structures, attitudes, and/or behaviours are necessary in order to reduce or eliminate the problem.

Through a review of the literature, the development of tools (see Appendix A) to be used for collecting data and assessing the individual needs of each man, and the use of those tools and other existing instruments in the intake process, the writer gained experience in assessing men's fit with the admission criteria, their motivation for coming to the program, and the issues, problems, and needs of their current circumstances. These assessments were used for purposes such as the development of

safety/control plans and shaping the content of the individual meetings to meet the members' needs.

Next it is necessary to choose the treatment modality best suited to effecting change in the target client population, with respect to the identified problem(s), through the development of a therapeutic relationship. Therapeutic techniques and educational content will be chosen which will maximize the clients' potential to succeed in the change process. The writer's reasons for choosing the small group modality have been discussed previously.

Finally, it is necessary to incorporate into the process on-going assessment of the clients and of the intervention, in order that the intervention will be dynamic and flexible, and as responsive as possible to the unique and potentially changing needs of each individual client. The writer found, in assessing the group process, that the structure, controlled content, directive leadership, and consistent expectations with natural consequences, which had been planned at the outset, were necessary all the way through. This was a function of the nature of the men in each group and also of the problems the group had with small numbers, attrition, and attendant lack of group cohesion.

The writer believes that, by undertaking the thorough review of the literature on relationship violence and its treatment, described in Chapter Two of this report, he was able to acquire a knowledge base which allowed him to develop a treatment intervention built upon an

understanding of the problem of spouse abuse and its various contexts, an appropriate treatment modality, and an assessment process which ensured that the group meeting content met the needs of the individual members.

The writer shared the products of his work to develop this program with the O.W.N. Program committee on a regular basis, i.e., at monthly meetings, and received their approval of the program components, the intake, assessment and evaluation tools, and the meeting content for each session. They were also kept apprised of issues such as the low number of group members, the consequencing of members who broke their contract, and lack of contact with partners of the group members.

Beyond receiving information about and approving the direction and content of the group, as it had been organized by the writer and his co-leader, the committee was not actively involved in the day-to-day operations of the program. The main concerns of the committee were in the areas of fiscal and administrative responsibilities and public relations.

The writer believes the committee members had put so much time and effort into getting the program proposal and funding approved, in hiring staff and organizing the office and meeting spaces for the group, and trying to get other agencies support for their endeavour, that they had little energy left for and, therefore, left the treatment function in the hands of the group leaders. With the acknowledgement that some issues (such as numbers and attendance) were beyond the control of either the leaders or

the committee, there were no problems with the group work which the leaders could not handle.

What the writer learned from involvement with this volunteer committee was that committees are often over-extended and expect to have their program staff work quite independently, though not in isolation, at the business of running the program. It was important for the writer to keep focused on the objectives of the program and to work creatively toward meeting them while, at the same time, informing the committee about new issues as they arose and challenging them to continue to work on things which were beyond the control and/or time availability of the staff to accomplish. Attempts to deal, at the community level, with some of the men's vs. women's services issues is a prime example of the kind of challenge which was pushed back onto the committee.

b. Small group process and leadership

The writer had done very little work with groups prior to this practicum. He believes that the limited review of the methodology and issues of treatment group work prepared him well enough to engage in his first group practice. The writer reviewed the material for assistance and clarification and debriefed with his co-leader whenever he came up against a situation in group which he felt he could have handled better. Because of the relatively small number of members in the first group, and their high level of motivation to engage in the process, the process and the writer's "learning-by-doing" felt fairly comfortable. This is not to say

that it was always easy for the writer, dealing with his own lack of experience and with the men's struggle to change or to resist change.

The writer had to work hard to overcome his personal tendency to be non-directive in working with people and to learn to challenge and confront the member's attitudes and behaviours. He also had to work hard at clearly communicating the program expectations and following through with appropriate consequences when the expectations were not met.

The writer believes that the members learned that they could trust him to model what he expected from them, to judge what they did and not who they were, to support them in their struggles, to challenge them to change and grow, and to celebrate their successes with them.

The writer learned a lot from working through the first group session and was successful in applying what he learned to make the second group process more consistent from meeting to meeting. Keeping focused on the fundamental principles that abusive behaviour is unacceptable and that men are responsible for the results of their abuse and for changing their behaviour, meant challenging and confronting the members' statements and behaviours (and the underlying values and attitudes) and maintaining the program rules - a combination of leader imposed and membership proposed rules. While it was necessary to maintain the integrity of the message that the program has for the men, the leaders (and the committee) had to face the dilemma that maintaining integrity sometimes meant losing group

members. Four members of the second group did not complete the program because of their lack of motivation to change and commitment to the group.

The writer believes that maintaining the message to and the expectations of members and potential members, as we did, produced long-term gain in spite of the short-term pain. In the last couple of years, the group leaders have needed to run two groups, concurrently, to deal with the increased number of referrals. Because of positions taken by the writer, and supported by the committee, early in the life of the program, today's leaders can act to ensure that the men commit themselves to do the work or try again another time when they are prepared to make the necessary commitment.

c. Identifying and assessing violence in relationships

Being a pacifist male - despite growing up in a world where men have too often have dominated, controlled, and abused others by virtue of their perception of "gender rights" and/or because they knew of no other way to cope with certain situations - the writer had often witnessed, with some bewilderment and distaste, how both men and women abused one another. As a result of his review of the literature on family violence and numerous private discussions with many of his married and divorced peers, he had come to believe that, while the effects of abusive behaviour by men are usually more severe and more damaging, in order to fully understand abusive relationships he would need to consider the abusive behaviours of

both men and women. It would also be necesssary to be able to speak to both partners in order to gather the requisite data for a balanced view.

The writer was not surprised or particularly challenged, personally, by the values, attitudes, and behaviours of the men with whom he worked in the group. He knew pretty much what to expect and found that the issues and problems of these abusive men were highly consistent with those presented in the literature. However, individual male profiles and their personal recounting of their abusive acts only offer so much (and much less if they are not honest) for the understanding of their problems and circumstances.

The writer was able to arrange an intake session with only one of the men's partners and to have one brief contacts with two other partners. As a result, he was not able to gather the kind and quantity of data upon which he may have been able to draw balanced conclusions about violence in the context of intimate relationships. The writer had to be content with making individual assessments of the group members and only partial and very tentative conjectures about their partners and the dynamics of the interactions between them.

This problem of collecting balanced data will be a major issue to resolve on the way to developing any form of integrated service delivery with those who service the victims of spouse abuse.

d. Use of cognitive behavioral interventions

As detailed in Chapter 2 (pp. 71-79, above), a cognitive behavioral approach to behaviour change was a central part of the program's intervention. The writer reviewed the literature on cognitive behavioral techniques and their use in other similar programs and engaged the members of the group in a selection of these techniques. He believes that success in changing an individual's behaviours using this kind of intervention depends upon three factors: 1) an accurate identification of the behaviour requiring change, 2) the choosing of a technique designed to address the particular behaviour, and 3) the individual's acknowledgement of the need to change and his desire to engage in the change process.

The writer learned that there is no magic in engaging in this kind of intervention, especially if the above-mentioned factors are in place. It is really a matter of the time taken, by the man, in learning and practising a new behaviour and his acceptance that the new behaviour might make a difference in the response of his partner. This would, hopefully, be confirmed in and reinforced through subsequent interaction with his partner.

The writer has come to believe, in retrospect, that the length of time required to accomplish this change in behaviour is longer than the twenty-four (24) to thirty-six (36) hours, over a four-month period, which the men put into our program. He believes that, without on-going contact with the men's partners, it is next to impossible to know what success the men

have in maintaining the behaviour changes they may have made. The writer believes that the chances of a relationship, where the male partner has found his way into this kind of treatment program, becoming and remaining without incident of abuse is related to the man's acceptance of the sole responsibility for his abusive behaviour and his subsequent efforts to change, the woman's willingness to consider a potential need for her to change some of her behaviours, and both partners working and changing together (likely with the assistance of a counsellor) to create a renewed and different relationship.

e. Evaluation of clinical interventions

The writer thinks that my decision to include a battery of standardized measures was the right one, in spite of the problem which he encountered with insufficient data from which to draw any empirical results. Beyond the actual experience of having administered the instruments, the writer found the limited results to be helpful as something with which he could compare his own clinical judgement about the men's attitudes and perceptions about their behaviours and their relationships and about the changes which they made over the duration of the group session.

The writer attempted in each session to work with the men in the development of a goal attainment scale and an anger rating scale, in the hopes that these would provide them with an individualized tool to help them keep in touch with their behaviours and to provide an on-going record of their progress. In neither session was he able to accomplish this

goal. Had he been able to succeed, the writer believes that these tools would have given him another valuable cross-reference for the battery of measures and his own subjective assessment of the men's work.

If the writer were to do another group, he would include the task of developing these individualized measures in the intake and assessment phase of the program; i.e., make it a prerequisite of admission into the group. The writer believes that much of the difficulty which he had with the whole evaluation process may have been reduced had the intake process been more intensive and demanding. The inclusion of only those men who showed sufficient commitment, by preparing these measures among other things, would perhaps have resulted in a better clinical evaluation over all.

CHAPTER FOUR: CONCLUSIONS

A. Personal Learning

During the course of his quest for a positive Practicum experience, the writer stumbled across a wide variety of things and pieces of knowledge which he either did not know about or knew only in a somewhat foggy or tentative way prior to this protracted journey. The following are some of the most important ones:

1. Program related items

- In a context of political uncertainty, when there is a perceived choice between potentially providing an improved service to clients and the survival of an agency or a program, there is within some agencies a tendency to choose survival. The O.W.N. Program was faced with this choice at the point when the Ministry of Correctional Services made a funding decision which left the program in the position of being very part-time. It is frustrating to be denied the opportunity to try to help improve an important service. On the other hand, it is probably less frustrating to avoid a context of fear and recrimination by trying to do "more with less."

- The writer has identified a great need for the O.W.N. Program to develop regular communication and working relationships with women's resource organizations, educational institutions, and people working in the

criminal justice system in the Kenora area. The Program needs contact with these people and the partner's of the men clients in order to maximize its ability to effect change in the men's behaviour and to help to ensure the safety of their partners and children. In addition, the writer believes that the problem of relationship violence will not be eradicated without a coordinated effort on the part of all the involved agencies.

If the writer were to have the opportunity to start the program development over again, he would do a number of things differently. He would approach the funder and indicate that the time frame of the pilot project is too short to do the work required to ensure the development of a quality program which will meet the needs of all those involved in the problem of spouse abuse. Assuming that the funder could be convinced that the following work plan is appropriate, the writer would:

1. Develop the program procedures, program components, intake/assessment tools and contracts, treatment framework and approach, group meeting content and process, and program and clinical evaluation plans (which would include involvement of women's programs, criminal justice programs, and any other appropriate outside people).

2. Prior to implementing any of the above, take what he had developed to the funder, to the O.W.N. committee, and to the other agencies and programs whose consumers have a stake in the success or

failure of the O.W.N. program to meet or honour its goals and objectives, for their input and discussion about the proposed men's treatment program and ways in which barriers to working together might be removed. The intended goal of this second step would be a network of service providers committed to sharing information and resources and working together toward the elimination of spouse abuse.

3. Add an additional requirement to the intake and assessment component of the program. This would involve developing a short series (a maximum of 4) of mandatory meetings of an introductory and preparatory nature. Acceptance of any man into the treatment group would assume perfect attendance at these meetings.

The first meeting of the series would involve the leaders engaging in a review of the program's beliefs about abuse and its effects, the various etiological contexts and the causal factors, the cycle of abuse, the need to develop a control plan with the abuser and a safety plan with the victim of his abuse (including a discussion of the law and the role of law enforcement), and the program expectations of group members. Invitations to attend would be extended to the partners of prospective members and packages of the information sent to those partners who did not choose to attend.

The rest of the meetings would be used for discussing emotions and introducing anger management techniques, discussing issues of

control and developing control plans, developing self-rating scales and using them to create a set of behavioural baselines for both treatment and evaluation purposes, and engaging in further discussions about male socialization and the societal context of abuse.

The writer believes that this additional piece would improve the program's ability to maximize the men's readiness for the treatment group, reduce attrition, better protect the partners, and allow the development of a more effective evaluation component.

4. Implement the balance of the program as intended at the outset of this practicum and outlined in the body of this report. All of these ways the writer would change the intervention, if he could start again, beg the whole issue of the level of funding and other supports for providing treatment to offenders. That issue will be touched upon in the last section of this report, "Future Directions".

- The writer had first hand experience in teaching behavioral techniques and relationship skills and saw, as the sessions progressed and the men attempted to incorporate their learning into their lives with their partners, the reinforcement of positive behaviour change which comes from the "success" of making different choices in how they thought about and responded to their partners and describing perceived improvements in their home life.

□ It has been impressed upon the writer, through the words and actions of the men whom he came to know through this intervention, just how much pressure to "be a man" is put on them (or perceived by them) by their lifestyle and socioeconomic circumstances, by their peer group and/or by certain segments of society at large. We are still faced with an enormous task in the freeing of men from their own attitudes, their emotional straight-jackets, and their chosen methods of coping with problems.

2. Personal identity and growth related items

□ The experience of working in the field of child welfare is an invaluable preparation for practice in any other area of social work endeavour. The writer's work with his protection clients allowed him to engage with men, in this treatment group, without judging their value as persons, without being incapacitated by hearing what kinds of abuse they had done to their partners, and without owning the success in bringing or the failure of not bringing peace to troubled relationships.

□ Having attained a certain level of maturity is a real resource in working with involuntary clients, particularly those who attempted to make the writer feel like some kind of alien from outer space because of the special relationship he has with his partner.

□ The writer's openness to working with offenders, and his desire to do more of it at some point in the future, is largely a function of the writer's belief that he is a good role model for men, his even temperament

and his positive outlook on life. The writer believes in men, he believes in women, and he knows it is possible for them to live together and thrive.

- The writer experienced the feeling of fulfilment at watching troubled men begin to wrestle with self doubts and troublesome behaviours and to start down that long road to non-violence. The changes which he saw were tentative, they were, perhaps, temporary, but they were real.

- The writer experienced the combined feelings of wonder and sadness at the picture which the group members painted, from their life experience, of a town full of relationships in trouble. These feelings were made a motivating factor, for the writer as a change agent, when he discovered too many men who believed that troubled relationships between them and their partners - past, present, and future - were inevitable.

- The writer discovered the power of the small group process to bring about change. He knows that he needs to learn a lot more about small group dynamics and hopes, some day, to work with a more experienced practitioner to continue to develop his group leadership skills.

- The writer witnessed the development of the "instant expert." As the fact of the O.W.N. Program and his involvement as group leader became more widespread, the writer was approached more and more by people wanting to know how he could work with "those men", wanting to understand family violence, and wanting advice on how to deal with the "abusive father" on

their caseload. It was an experience which served to heighten the writer's own sense of "greenness" in this endeavour.

B. Future Directions

It is likely that abusive behaviour in marital relationships occurs when there is a combination of family background factors, multiple stressors, and certain personality traits and interpersonal coping styles. One study found that "the simultaneous assessment of theoretically relevant variables across time appears necessary to help us unravel the complexities of spouse abuse....Longitudinal research on the etiology of wife abuse is sorely needed." (O'Leary and Curley, 1986, p. 288). Research studies designed to increase our understanding of the contexts, causes, and dynamics of wife abuse will also be theoretically eclectic, multifactorial and multivariate, and built upon the best of research methodologies and results of the past decade (Walker, 1986). We will need excellence in scientific research, combined with the experience of social service providers, in order to develop and evaluate public policy and treatment interventions capable of significantly reducing the incidence of wife abuse.

There is much support (Berghorn and Siracusa, 1982; Deschner, 1984; Feazell et al, 1984; Flynn, 1987; Geller, 1982; Harris and Sinclair, 1981; Knowles et al, 1984; Neidig and Friedman, 1984; Neidig, 1986; Rhodes and Zelman, 1986; Shupe et al, 1987; Swift, 1986; Weidman, 1986) for the position that the range of treatment programs dealing with family violence

will be provided in an integrated and coordinated fashion in order to maximize protection for the victims, elimination of the violence, and healing for all those involved - victims and abusers, alike. Finn (1985a) contends that "the coordination of programs for men and women involved in marital violence will present difficulties both philosophically and structurally, but it is a necessary first step in providing comprehensive services for the prevention and treatment of marital violence" (p. 349). The writer will be taking advantage of every possible opportunity to be an advocate for acceptance of the idea of and provision of sufficient resources for such a co-ordination of services in the Kenora area of northwestern Ontario.

Hare-Mustin (1987) offered a clear challenge to future policy makers and clinicians: "When we alter the internal functioning of families without concern for the social, economic, and political context, we are in complicity with the society to keep the family unchanged" (p. 20). Among the ways we can avoid this dangerous trap and complicity with the abuser is, through education and prevention programs, to become proactive in challenging the current system of attitudes and beliefs which support the use of violence and abuse and to educate our youth in the requisite knowledge and skills for interpersonal relationships and family life. It is the writer's intention to be involved in this on-going effort wherever he may find himself, in his work life or his home life, in the future.

APPENDIX A

INTAKE AND ASSESSMENT MATERIALS

O.W.N. (OTHER WAYS NOW)
GROUP TREATMENT PROGRAM FOR BATTERERS
REFERRAL FORM

Client's Name: _____

Name of Referral Agency: _____

Address: _____

_____

Telephone: _____

Name of Service Provider: _____

_____

Will you be providing service to the client concurrently? ___

After completion of the Group Treatment Program? _____

Will you be providing service to the client's spouse or children? _____

Please specify: _____

_____

_____

_____

Are you aware of any factors which will seriously hamper the client's successful completion of the Group Treatment Program?

_____

_____

_____

Please return to: O.W.N.
P.O. BOX 49
KENORA, ONT.
P9N 3X1
ATTENTION: PROGRAM COORDINATOR

O.W.N. (OTHER WAYS NOW)
GROUP TREATMENT PROGRAM FOR BATTERERS

INTAKE AND ASSESSMENT CONSENT

I, _____, agree to participate in the O.W.N. Group's intake and assessment process. I understand that I must complete the intake and assessment process in order to be eligible for the treatment program.

I understand that some of the information provided by me will be used for purposes of program evaluation and may be included in on-going research in the area of group treatment for batterers. I understand that such use of information will be for the purpose of improving services to men and enhancing the group treatment program. It has been explained to me that all identifying information will be kept strictly confidential; that answers will be identified by code numbers; and that information will be published as aggregate (group) data only. I understand that a copy of any published material will be made available to me upon request.

I agree to give permission to have my partner contacted by the program staff for the purpose of completing the assessment procedure.

Signature: _____

Witness: _____

Date: _____

O.W.N. (OTHER WAYS NOW)
GROUP TREATMENT PROGRAM FOR BATTERERS

CONTRACT

I, _____, agree to join the O.W.N. Group Treatment Program. I understand that the purpose of the program is to help me to end my use of violence against my partner.

I understand that the program will provide me with an opportunity to:

1. Understand why I have been violent toward my partner;
2. Accept responsibility for my violent behaviour;
3. Learn constructive ways of handling my thoughts and feelings;
4. Learn more constructive ways of coping with stress and difficulties in my life; and,
5. Learn more positive ways of behaving in my relationships with others - men, women, and children.

I also understand that participation in the group involves talking about my thoughts and feelings and hearing feedback from others, as well as listening to what others say about themselves and giving feedback to them. The group discussion is an important part of helping all members to make changes.

In order to ensure the smooth functioning of the group and the well being and protection of all group members, I agree to accept the responsibility to:

1. Attend all meetings regularly and on time;
2. Work on my commitment to stop violent behaviour;
3. Keep confidential all personal information shared in the group;
4. Support the rights of all group members, including the right to be treated with respect and dignity;
5. Support all group members in attaining their goal of non-violence;
6. Confront any actions or attitudes which promote violence;
7. Identify sexist behaviour or attitudes in myself and other members;
8. Raise and discuss in the group all abusive incidents which occur;
9. Provide constructive feedback to other members;
10. Complete all homework assignments, including weekly Anger Log entries;
11. Use prevention techniques (e.g., relaxation, time-out) and to contact another group member if I need support in maintaining non-violence; and

12. Refrain from consuming alcohol or drugs prior to group meetings. I understand that, if my weekly alcohol or drug consumption is determined to be impairing my ability to achieve the group purposes, I will be denied further access to the group until I have completed a drug or alcohol abuse program.

I understand that meetings will be held every _____ from ____ _____ to _____ at _____.

I understand that my group membership is contingent on my productive participation in the group and maintenance of these rules.

Signature: _____

Witness: _____

Date: _____

O.W.N. (OTHER WAYS NOW)
GROUP TREATMENT PROGRAM FOR BATTERERS
CONFIDENTIALITY POLICY

All statements that you make (both written and verbal) while in counselling are **confidential**. No information will be released to anyone without your written or verbal consent. This is your right.

If you are on diversion or probation, you will be asked to sign a release of information form so that your probation officer will be kept aware of your progress in the program. Only the following information will be released:

1. Attendance
2. Participation in treatment
3. Additional acts of violence

If there are additional acts of violence, we will encourage you to notify your probation officer first. If you are unable or unavailable to do so, we will contact that person.

If you and your partner are seeing another counsellor, we will ask you and your partner for permission to speak to that counsellor. Of course, you have the right to refuse, but the more closely the counsellors work together, the more we will be able to help you. In some cases, this contract may be a condition of treatment.

If you are seeing another counsellor by yourself, we may also want to speak to that person so that we are working together. Again, it is your right to refuse this consent and it may also be a condition of treatment.

If you continue to have letter, phone, or in-person contact with your partner, or get involved in a new relationship, we will want to have contact with that person(s).

Through these conversations, we will continue to respect your confidentiality by only discussing your progress in the program with regard to taking time-outs, additional acts of violence, and the risk of continued violence. We will not discuss the specifics of what you say in session that are not relevant to these issues.

If you are seeking treatment on your own, that is, not referred by the courts, and there are additional acts of violence, we will inform and encourage your partner (or the person you have been violent with) to utilize the police and the courts for relief.

THERE ARE SEVERAL INSTANCES WHEN WE WILL VIOLATE CONFIDENTIALITY WITHOUT YOUR PERMISSION

1. If it is assessed during your participation in this program that abuse or neglect of children is occurring, we will report this to the Children's Aid Society and the police. We will make an attempt to let you know when we are going to make such a report. We will also encourage you to report yourself.

2. If you threaten to kill or harm another person in our presence, while you are in this program, we are obligated to warn the potential victim as well as notify the police. We will attempt to tell you if we are going to do this.

3. If you commit a criminal offense while you are in this program, we may report such information to the police and/or probation. We will encourage you to do the same. In such cases, we may be subpoenaed by the court and have to violate confidentiality.

4. If at any time during the course of treatment we determine that you are a danger to yourself or another person, we will inform you of that opinion and in the case of the latter, we will also inform the other person. In some cases, this may also include notifying the police.

As it is your privilege to have guaranteed confidentiality, so it is your fellow group members'. Please respect their right to confidentiality. Always ask first before discussing someone else's thoughts outside the group.

Thanks!

I have read the above confidentiality policy and agree to these conditions of treatment.

_____ _____

Client Name Signature

_____ _____

Date Witness

O.W.N. (OTHER WAYS NOW)
GROUP TREATMENT PROGRAM FOR BATTERERS

RELEASE OF INFORMATION

I authorize the O.W.N. Group Treatment Program staff to release the following information to _____

_____

_____

1. Attendance
2. Participation in treatment
3. Additional acts of violence
4. Information relevant to enhancing treatment

_____ _____
Member's Name Signature

_____ _____
Date Witness

O.W.N. (OTHER WAYS NOW)
INTERVIEWER QUESTIONS

Does the client have an alcohol or drug problem? Yes___ No___

If yes, which one? _____

What is the client's current emotional state?

1. anxious _____
2. agitated _____
3. enraged _____
4. depressed _____
5. sad _____
6. other _____ Specify _____

Does there appear to be any risk to the safety and protection of his partner at the present time? Yes ___ No ___ If yes, what steps have you taken to address this? _____

_____

_____

How motivated does the client appear to be to stop violent behaviour?

1. not at all _____
2. only somewhat _____
3. fairly motivated _____
4. extremely motivated _____

Explain: _____

_____

_____

Does the client show evidence that he is willing to take responsibility for his own behaviour? Yes ___ No ___ Explain: _____

_____

_____

_____

Date(s) of intake interviews: #1 __/__/__ #2 __/__/__ #3 __/__/__

O.W.N. (OTHER WAYS NOW)
Group Treatment Program for Batterers

INTAKE FLAG SHEET

Date: _____

Name: _____ File/I.D.# _____

Counsellor: _____

1.	Court mandated client	Yes ___ No ___
2.	Current restraining order	Yes ___ No ___
3.	Past/current Child Welfare involvement	Yes ___ No ___
4.	Possible chemical dependency	Yes ___ No ___
5.	Homicidal lethality moderate to high	Yes ___ No ___
6.	Suicidal lethality moderate to high	Yes ___ No ___
7.	Current evidence of child abuse	Yes ___ No ___
8.	Evidence of marital rape	Yes ___ No ___
9.	Currently on prescribed medication	Yes ___ No ___
10.	Victim of extrafamilial sexual assault	Yes ___ No ___
11.	Victim of incest/sexual abuse	Yes ___ No ___

OTHER SIGNIFICANT INFORMATION: _____

_____

_____

12.	Accepted for group	Pending ___ Yes ___ No ___
13.	Client referred out	Yes ___ No ___

If yes, to whom and for what reason(s)? _____

_____

_____

14. Day(s)/time(s) available for group _____

_____

15. Best time to contact member _____

16. Date of first group meeting: ____/____/____

O.W.N. (Other Ways Now)
Group Treatment Program for Batterers

INTAKE/ASSESSMENT FORM

PART A: GENERAL INFORMATION - MEMBER

☐ File/I.D. #:_____ ☐ Referral Date:_____

☐ Last Name:_____ ☐ First Name:_____

☐ Address:_____

☐ Town/City:_____ ☐ Postal Code:_____

☐ Home Phone #:_____

☐ Employment:___Yes ___No ☐ Usual occupation:_____

☐ Employer:_____ ☐ Length of employment:_____

☐ Work Address:_____

☐ Town/City:_____ ☐ Postal Code:_____

☐ Work Phone #:_____ ☐ Any problems?____ If yes, please explain

_____

☐ If unemployed, how long?_____ ☐ Income source:_____

☐ Age:____ D.O.B.:___/___/___ ☐ Education:_____

☐ Income: gross annual_____ monthly (approx.)_____

☐ Ethnic Origin:_____ ☐ Religion:_____

☐ Religious affiliation? ___Yes ___No If yes, which?_____

How important is this for you? ___Very ___Not very

☐ Are you involved in any clubs or voluntary organizations? ___Yes ___No

If yes, which?_____

☐ Non-work/Leisure Activities:_____

_____

☐ Military Service: ___Yes ___No If yes, please describe_____

_____

☐ Possession of weapons: ___Yes ___No If yes, please explain

_____

☐ Willing to remove weapons during program? ___Yes ___No If so, how?___

_____

☐ Medical History: Present concerns/illness?_____

History of ___ serious head injury ___ seizures ___ fainting

___ blackouts/unconsciousness Last seen by doctor when?_____

_____ For what reason?_____

☐ Have you ever been hospitalized for mental health reasons? ___Yes ___No

If yes, please explain_____

_____

☐ Relationship Status: ___Married ___Common-law ___Separated ___Divorced

☐ What was the longest time you were ever separated from your partner?

_____

☐ If you are currently separated from your partner, how long have you been separated?_____

☐ If separated, what is the primary reason for the separation?_____

_____

_____

☐ How often do you see your current partner?_____

☐ Has your partner ever gone to a shelter? ___Yes ___No If yes, please explain_____

_____

☐ Living situation: Live with_____ Live alone_____

☐ Dependents: ___Partner ___Children Other:_____

☐ Referral Source: ___Court ___Self ___Other, please specify_____

_____

☐ Currently seeing another counsellor? ___Yes ___No If yes, who?_____

_____

PART B: GENERAL INFORMATION - PARTNER

☐ Last Name:_____ ☐ First Name:_____

☐ Address:_____

☐ Town/City:_____ ☐ Postal Code:_____

☐ Home phone #:_____

☐ Employed:___Yes ___No ☐ Usual occupation:_____

☐ Work address (If applicable):_____

☐ Town/City:_____ ☐ Postal code:_____

☐ Work phone #:_____

☐ Age: D.O.B.___/___/___ ☐ Education:_____

☐ Income monthly (approx.):_____

☐ Ethnic origin:_____ ☐ Religion:_____

☐ Length of relationship with member:_____

☐ Cross reference to file/I.D.#:_____

PART C: BACKGROUND - FAMILY OF ORIGIN

☐ Where were you born?_____

☐ Where were you raised?_____

☐ Were you raised primarily by:___Mother and father ___Mother only ___Mother & stepfather ___Father only ___Father & stepmother ___Grandparents ___Other family ___Foster family

☐ Siblings:

Age	Sex	Living/ Date of Death	Live in Kenora District	Married	Divorced
___	___	__/__/__	_____	___Yes ___No	___Yes ___No
___	___	__/__/__	_____	___Yes ___No	___Yes ___No
___	___	__/__/__	_____	___Yes ___No	___Yes ___No
___	___	__/__/__	_____	___Yes ___No	___Yes ___No
___	___	__/__/__	_____	___Yes ___No	___Yes ___No
___	___	__/__/__	_____	___Yes ___No	___Yes ___No

☐ Father/stepfather's occupation_____

☐ Mother/stepmother's occupation_____

☐ Did your parents ever separate when you were a child? ___Yes ___No

If yes, how many times?_____

☐ Did they separate permanently or divorce? ___Yes ___No If yes, how old were you at that time?_____

☐ How would you describe your relationship with your father?

___Close ___Distant How so?_____

_____

☐ How would you describe your relationship with your mother?

___Close ___Distant How so?_____

_____

☐ Did your father/stepfather ever hit his partner? ___Yes___No If yes, how often?_____

☐ Did your mother/stepmother ever hit her partner? ___Yes___No If yes, how often?_____

☐ As a child, were you ever hit by your parent(s)? ___Yes___No If yes, How often?_____

☐ Who usually administered physical punishment? ___No physical punishment ___Father ___Mother ___Both/either

☐ Did you consider yourself physically or psychologically abused as a child? ___Yes ___No If yes, please explain_____

_____

☐ As a child, were you ever subjected to sexual abuse? ___Yes ___No If yes, what was the relationship of the abuser to you?_____

_____

☐ If applicable, Have you ever told anyone about being physically or sexually abused? ___Yes ___No If yes, what happened after you told?

_____

_____

☐ Did you ever physically attack one of your parents? ___Yes ___No If yes, please explain_____

_____

☐ Were any of your brothers or sisters physically, sexually, or psychologically abused as a child? ___Yes ___No If yes, please explain

_____

_____

☐ Did you have any problems with your own violent behaviour as a child or teenager? ___Yes ___No If yes, please explain_____

_____

☐ Did any of your brothers and sisters have problems with their own violent behaviour while they were growing up? ___Yes ___No If yes, please explain_____

_____

☐ During the time you were growing up:

Did your father:

	Never	Sometimes	Often	Always
Comfort or help you when you had troubles?	___	___	___	___
Scold you or yell at you?	___	___	___	___

Did your mother:

Comfort or help you when you had troubles?	___	___	___	___
Scold you or yell at you?	___	___	___	___

☐ Was either your father/stepfather or your mother/stepmother an alcoholic? ___Yes ___No If yes, which?_____

If yes, how did this affect your life?_____

_____

☐ Has any one in your family committed or attempted suicide? ___Yes ___No

If yes, please explain_____

_____

☐ Were there any other events or circumstances regarding your childhood that may help to understand your particular counselling needs? ___Yes ___No If yes, please explain_____

_____

_____

☐ Under what circumstances did you leave home to live on your own?_____

_____

_____

_____

☐ What were your expectations at that time about relationships with women?

_____

_____

with men?_____

_____

☐ What were your expectations of the future regarding: Money?_____

_____

Family?_____

Career?_____

Education?_____

☐ How old were you when you entered into your first intimate relationship/ marriage?_____

PART D: HISTORY OF VIOLENCE

☐ Did your violence begin "out of the blue" or have you always had difficulties controlling your anger?_____

☐ With whom have you ever been physically, psychologically, or sexually abusive?

	Yes	No	N/A
Spouse	___	___	___
Ex-spouse	___	___	___
Partner	___	___	___
Ex-partner	___	___	___
Parents	___	___	___
In-laws	___	___	___
Other family members	___	___	___
Children	___	___	___
Friends	___	___	___
Helpers/counsellors	___	___	___
Others	___	___	___

☐ **Intake counsellor(s): If there has been violence against the children, contact Kenora-Patricia Child and Family Services as soon as possible. You are obligated under the C.F.S.A. to do so.**

☐ How many intimate relationships (including teenage relationships) have you had prior to the current relationship?_____

Have you done any of the following in any of these relationships?

Please check the appropriate number:

	Once	Twice	Three Times	More Than Three times
Slap	___	___	___	___
Grab	___	___	___	___
Punch	___	___	___	___
Push	___	___	___	___
Kick	___	___	___	___
Push to the ground/floor	___	___	___	___
Choke	___	___	___	___
Bite	___	___	___	___
Pull hair	___	___	___	___
Twist arm(s)	___	___	___	___
Pin to ground or wall	___	___	___	___
Hold	___	___	___	___
Hit with an object	___	___	___	___
Beat up	___	___	___	___
Use a gun	___	___	___	___
Use a knife	___	___	___	___
Use another weapon	___	___	___	___
Force sexual intercourse	___	___	___	___
Force other sexual activity	___	___	___	___
Force sex with other people, objects, animals,etc.	___	___	___	___
Break objects	___	___	___	___
Throw objects	___	___	___	___
Break down a door	___	___	___	___
Throw food	___	___	___	___
Punch fist through wall	___	___	___	___
Harm or neglect her pet	___	___	___	___
Threaten to hit or abuse	___	___	___	___
Threaten to destroy property	___	___	___	___
Threaten to sexually abuse	___	___	___	___

	Once	Twice	Three Times	More Than Three times
Express intense jealousy	____	____	____	____
Threaten to kill	____	____	____	____
Threaten to commit suicide	____	____	____	____
Force partner to do something against her will	____	____	____	____
Tell her what she can/can't do	____	____	____	____
Be verbally aggressive	____	____	____	____

☐ Were any of these women pregnant when you did any of the above acts?

___Yes ___No If yes, please explain_____

_____

☐ How long had you and your current partner been together at the time of the first incident of violence?_____

☐ When was the last violent incident with your current partner?_____

_____ Approximate date?_____

What were the initiating circumstances?_____

_____

_____

How did your anger escalate?_____

_____

Were there weapons involved? ___Yes ___No If yes, please explain_____

_____

☐ Did any of the following get involved at the time of the incident? ___

Law officers ___Neighbours ___Other family members ___Medical personnel

___Counsellor(s) ___Priest or minister ___No one ___Others (specify)__

_____

☐ Here is a list of things you may have done when you and you partner had a dispute, or at any other time. These are ways of being violent that people in our program report. How often have you done any of these things during your current relationship?

Key: 1 - Never
2 - Once or twice
3 - Sometimes
4 - A lot

1. Not physically violent

a) Discussed an issue calmly _____
b) Sulked, refused to talk, withdrew affection or sex in order to punish _____
c) Stomped out in order to punish _____
d) Screamed or swore at or insulted the other _____
e) Verbally pressured the other to have sex _____
f) Threatened to leave marriage or relationship _____
g) Threatened punishment other than physical (e.g., withholding money, taking kids away, affair, etc.) _____

2. Indirect threats of violence
a) Prevented leaving or seeing other people _____
b) Intentionally interrupted other's sleeping/eating _____

3. Direct threats of violence
a) Directed anger at or threatened the pets _____
b) Threatened to hit or throw something at the other _____
c) Threw, hit, or kicked something _____
d) Drove recklessly to frighten the other _____
e) Directed anger at or threatened the children _____

4. Direct violence
a) Threw something at the other _____
b) Pushed, carried, restrained, grabbed, shoved, wrestled with the other _____
c) Slapped or spanked the other _____
d) Bit or scratched the other _____
e) Threw the other bodily _____
f) Pulled the other's hair _____

5. Severe violence
a) Choked or strangled the other _____
b) Punched or kicked the other _____
c) Burned the other _____
d) Kicked or punched the other in the stomach when she was pregnant _____
e) Beat the other into unconsciousness _____
f) Threatened with knife, gun or other weapon _____
g) Used any weapon against the other _____

☐ Describe the most violent incident which has occurred in your current relationship. Include what happened before, during, and after the incident._____

_____

_____

_____

_____

_____

☐ The following are different types of behaviours which you may have engaged in. In even the best of relationships some of these occur. As honestly ass you can, please indicate how often you have done any of these things in your current relationship.

Key: 1 - Never
2 - Once or twice
3 - Sometimes
4 - A lot

1. Emotional
a) Criticized or put her down _____
b) Called her names _____
c) Told other people untrue/secret things about her _____
d) Threatened to kill yourself _____

2. Financial
a) Made her get your permission to spend money _____
b) Made her justify any spending that she did _____
c) Kept all the family money, including hers _____
d) Forced her to support you financially _____
e) Refused to give her money when she needed it _____

3. Social
a) Controlled her activities _____
b) Followed her around to check up on her _____
c) Telephoned her to make sure she was where you thought she should be _____
d) Did not allow her to work outside the home _____
e) Made her obey your orders _____

4. Sexual
a) Insisted that she have sex when she didn't want to _____
b) Made lewd, vulgar remarks or suggestions about her _____
c) Insisted that she engage in unpleasant sexual acts _____
d) Hit her or beat her up during or after having sex _____

☐ What do you usually do after the violence?_____

_____

☐ What do you think about after the violence?_____

_____

☐ How do you feel after the violence?_____

_____

☐ How do you feel, right now, about describing these episodes (most recent or most violent)?_____

_____

☐ How often in the last few days have you felt angry with anyone?

___Always ___Never ___Sometimes

☐ How do you usually deal with your anger towards other people besides your partner and children?_____

_____

☐ How do you usually deal with other people's anger towards you?_____

_____

_____

☐ Are you currently thinking about hurting your partner or the children?

___Yes ___No

☐ Intake Counsellor(s): If "yes," is there a thought-out plan? Are thoughts being translated into an intention? Homicidal risk? Elaborate.

☐ Is there a pattern to the incidents of violence in your current relationship? ___Yes ___No ___Unsure

☐ Have you noticed that the violence is increasing in severity over time? ___Yes ___No If yes, please explain_____

_____

☐ Could the pattern of your assaultive behaviour be described as cyclical? ___Yes ___No If yes, where are you in the cycle now?_____

_____

☐ In the past year, what is the average length of time between assaults: Days _____ Weeks _____ Months _____

☐ What kinds of injuries has your partner sustained as a result of these acts of violence? ___Knocked or choked unconscious ___Bleeding ___Swelling ___Wounds from use of objects/weapons ___Broken nose ___Broken bones ___Scratches ___Bruises ___Black eye(s) ___Muscle sprains ___Needed surgery ___Other (specify)_____

_____

☐ Has your partner ever needed/got medical treatment because of the violence? ___Yes ___No

☐ Has your partner ever not got medical treatment when injured as a result of your violence? ___Yes ___No If yes, please explain_____

_____

☐ Within your current relationship, how many times have the following kinds of medical attention been administered to your partner as a result of your violence:

1. X-rays/examination only (no treatment) #___
2. treatment for cuts, bruises, bumps #___
3. stitches for gashes/lacerations #___
4. setting of broken bones #___
5. hospitalization (inpatient) #___
6. other (specify)_____ #___

☐ Has your partner ever been violent toward you? ___Yes ___No If yes, was your partner's violence preceded by your violence or threat of violence? ___Yes ___No

☐ What types of physical injuries have you received in the past year as a result of your partner's violence?

1. none ___
2. bruises #___
3. black eyes #___

4. broken bones #___
5. other (specify)_____ #___

☐ Have the police ever been called in relation to violence between you and your partner? ___Yes ___No If yes, has it been ___one time only ___2 to 5 times ___more than 5 times?

☐ Have you ever been arrested? ___Yes ___No If yes, list (starting with the most recent charge:

Offence	Month/Year	Conviction? Yes/No	Sentence
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

☐ Have you ever been charged as a result of assaulting your partner? ___No ___Yes, by the police (# times___) Yes, by my partner (# times___)

☐ Were you convicted? ___Yes ___No If no, please explain_____

_____

☐ If convicted of assaulting your partner, were you incarcerated? ___Yes ___No If yes, what is the combined length of the sentence(s)?

Days:____ Weeks:____ Months:____

☐ If you were not incarcerated upon conviction, please explain_____

_____

_____

☐ If you were referred to this program by the court, please indicate:

1. Sentencing date:_____
2. Name of the judge:_____
3. Name of your probation/parole officer_____
4. What you were charged with_____
5. Conditions of probation/parole_____

_____

☐ Is there currently any kind of court order forbidding you from contacting either your partner or children? ___Yes ___No Has there ever been such an order? ___Yes ___No If yes, where and when was it made?_____

☐ Have you ever been charged for violating such an order? ___Yes ___No If yes, what were the circumstances and what was the result?_____

_____

_____

☐ Do you have any other legal involvements at this time? ___Yes ___No If yes, please explain_____

☐ What do you and your partner argue over most? Rate the subjects in terms of frequency:

Key: 1 - Never
2 - Rarely
3 - Sometimes
4 - Frequently
5 - Very frequently

1. Housekeeping ___
2. Sex ___
3. Socializing ___
4. Money ___
5. Children ___
6. Commitment to the relationship ___
7. Ways of talking to each other ___
8. Other (specify)_____ ___

☐ Who has the final say in family decisions such as the following:

Key: 1 - Both
2 - Wife
3 - Husband

1. Buying a car ___
2. Having children ___
3. What house or apartment to choose ___
4. What job your partner should take ___
5. What job you should take ___
6. Whether you should continue or quit a job ___
7. How much money to spend on food each week ___
8. How much money to spend on entertainment each week ___
9. Where to go out for an evening ___
10. When to have sex ___
11. How to discipline the children ___
12. Whether or not you can go out for the evening ___
13. Whether or not she can go out for the evening ___
14. Whether or not to spend holidays with relatives ___

PART E: CHILDREN

☐ Do you have children? ___Yes ___No

Child's name	Sex/age	Natural parent	Lives with
1.			
2.			
3.			
4.			
5.			
6.			

☐ Are child protection authorities already involved? ___Yes ___No

☐ Has there been previous child protection contact? ___Yes ___No If yes, who was the worker involved?_____

Agency name_____ City/province_____

☐ What do you feel good about or like about your relationship with your children?_____

_____

☐ What don't you like or want to change about your relationship with your children?_____

_____

☐ What do you do when the children do something wrong?_____

_____

_____

☐ If physical punishment is used, please describe method and frequency__

_____

_____

☐ Do you ever feel like you lose control with your children? ___Yes ___No

If yes, what happens then?_____

_____

☐ Have there ever been bruises or marks on a child as a result of physical punishment by you? ___Yes ___No If yes, specify date (__/__/__) and location of marks_____

☐ Do you ever use any objects (e.g., belt, ruler, brush)? ___Yes ___No

If yes, please explain_____

_____

- What, if any, are your concerns about the way you discipline children?

_____

_____

- What does your partner do when the children do something wrong?_____

_____

_____

- If she uses physical punishment please describe method and frequency

_____

_____

- Do you ever feel that your partner loses control? ___Yes ___No If yes, what happens then?_____

_____

- Have there ever been bruises or marks as a result of her physical discipline? ___Yes ___No If yes, please specify date (__/__/__) and location of marks_____

_____

- Do you have any concerns about the way your partner disciplines the children? ___Yes ___No If yes, please explain ----------

_____

_____

- When was the most recent incident either of you disciplined the children?_____ Date __/__/__ Please describe_____

_____

_____

- Do you ever have any uneasy feelings about how your partner touches the children? ___Yes ___No If yes, please explain_____

_____

_____

- Does any of your partner's behaviour with the children seem inappropriate or sexual? ___Yes ___No If yes, please explain_____

_____

_____

☐ Have the children ever expressed to you fears or uneasiness about the way your partner touches them? ___Yes ___No If yes, please explain

_____

_____

☐ Do you ever feel your behaviour with the children seems inappropriate or sexual? ___Yes ___No If yes, please explain_____

_____

_____

☐ Have any of your children been involved in or observed any violent episodes between you and your partner? ___Yes ___No If yes, please explain_____

_____

_____

☐ Do you think that the children have been affected by the conflict and violence in your home? ___No ___Slightly ___Moderately ___Greatly ___N/A

☐ Do any of your children have behaviour problems at home? ___Yes ___No If yes, please explain_____

_____

_____

☐ Do any of your children have behaviour problems at school? ___Yes ___No If yes, please explain_____

_____

_____

☐ Do any of your children have problems relating to other children outside the home? ___Yes ___No If yes, please explain_____

_____

_____

☐ Do any of your children have on-going medical or physical problems? ___Yes ___No If yes, please explain_____

_____

_____

☐ Do any of your children act violently toward each other, you, or your partner? ___Yes ___No If yes, please explain_____

_____

_____

☐ Intake counsellor(s): Should child protection authorities be contacted concerning sexual or emotional abuse of children or risk thereof?

Reported to:_____ Date: __/__/__

Agency:_____

☐ Is there any other information you could share which would help in understanding or assisting with your parenting concerns?_____

_____

_____

PART F: SUBSTANCE USE INFORMATION

☐ Do you drink? ___Yes ___No If yes, how often?_____ How much?_____ With whom?_____

Where?_____ If no, have you ever? ___Yes ___No

☐ Do you use drugs (non-prescription or prescription)___Yes ___No If yes, what drugs?_____ How often?_____

How much?_____ With whom?_____

Where?_____ If no, have you ever? ___Yes ___No

☐ Have you ever been violent toward your partner while under the influence of alcohol? ___Yes ___No

☐ Have you ever been violent towards your partner while under the influence of drugs? ___Yes ___No If yes, which drugs?_____

_____ Prescription drugs? ___Yes ___No

☐ Have you ever assaulted your partner without having taken any alcohol or drugs? ___Yes ___No

☐ Have you ever taken alcohol or drugs and <u>not</u> assaulted your partner? ___Yes ___No

☐ What percentage of the time are you under the influence of alcohol or drugs when violent?_____%

☐ Which alcohol or drugs have you used in the past (but are not currently using)?_____

☐ If you have changed the substance which you are using, what were the reasons for changing?_____

_____

☐ How often have you stopped using alcohol or a particular drug and then started again?_____ Please describe the circumstances_____

_____

_____

☐ What have people said you act like when you are using? Positive?_____

_____

Negative?_____

Who commented?_____

☐ Has anyone ever told you they were concerned about your use? ___Yes ___No If yes, who?_____

☐ Have you ever received treatment for alcohol or drug abuse problems?

___Yes ___No If yes, where?_____

and when?_____

If yes, was it successfully completed? ___Yes ___No

☐ Have you ever been charged with, or arrested for, any of the following after drinking or using drugs:

	Yes	No
1. Driving violation	___	___
2. Open bottle in vehicle	___	___
3. Impaired driving	___	___
4. Possession	___	___
5. Creating a disturbance	___	___
6. Assault (not your partner)	___	___

☐ Have you ever had trouble with the law when <u>not</u> using substances?

___Yes ___No If yes, please explain_____

_____

_____

☐ Does your partner use alcohol or drugs? ___Yes ___No If yes, please describe her use and how she behaves under the influence_____

_____

_____

_____

_____

_____

☐ Are you concerned about your partner's use? ___Yes ___No If yes, explain your concerns_____

_____

_____

☐ Do you think you have an alcohol or drug abuse problem? ___Yes ___No

PART G: SEXUALITY INFORMATION

☐ How satisfied are you, in general, with the sexual relationship that you and your partner have?_____

With the frequency?_____ With the quality?_____

☐ What do you do when you wish to engage in sexual activity and your partner doesn't?_____

_____

_____

☐ What do you do when she wants to engage and you don't?_____

_____

_____

☐ If you argue about sex, what happens?_____

_____

_____

☐ Have sexual conflicts ever led directly to violence? ___Yes ___No

☐ Have sexual conflicts ever led indirectly to violence? ___Yes ___No

☐ Have you ever, through physical or emotional pressure, forced anyone to have sex when she/he didn't want to? ___Yes ___No If yes, please explain_____

_____

_____

☐ Do you use sexually explicit magazines, books, or films? ___Yes ___No

If yes, how do you use these in your relationship with your partner?

_____

_____

☐ Have you ever been convicted of rape or other criminal sexual conduct? ___Yes ___No If yes, please explain_____

_____

_____

☐ Have you experienced problems in your sexual functioning that concern you? ___Feeling inadequate ___Excessive interest ___Lack of interest ___Fear of rejection ___Impotence

PART H: PRESENT STATUS

☐ Who are your current sources of support, understanding, or assistance? Please be specific_____

☐ How often do you see these persons?_____

☐ Who knows about your violence?_____

☐ How have they reacted in finding out?_____

_____

☐ Do they hold you responsible for the violence? ___Yes ___No Your partner? ___Yes ___No

☐ Do they make excuses for you? ___Yes ___No If yes, please explain____

_____

☐ Do the responses you receive from these others help you to change or keep you from changing? Please explain your response_____

_____

_____

☐ Do you consider yourself to be isolated or a loner? ___Yes ___No If yes, please explain_____

_____

☐ Counsellor's estimate of social isolation: Enter #___

1. Lack of contact with people outside of immediate family.
2. Minimal contact with people outside of immediate family; minimal social support.
3. Some contact with people outside of immediate family; some social support.
4. Quite a bit of contact outside the family for social support.
5. Very good support system outside of the family.

☐ Counsellor's rating of client as over/undercontrolled: Enter #___

Overcontrolled type	Undercontrolled type
This person exhibits a pattern of behaviour that shows suppression of aggression with eruptions of violence after periods of passivity. Tends to deny anger in self, not likely to be violent outside his family.	This person's pattern of behaviour shows little control or inhibition over the expression of aggression, including violent acts against others. May be violent towards others, as well as family.

1. Extremely close to description of overcontrolled.
2. Moderately close to description of overcontrolled.
3. Leans toward being overcontrolled.
4. Cannot put in either category.
5. Leans toward being undercontrolled.
6. Moderately close to description of undercontrolled.
7. Extremely close to description of undercontrolled.

☐ Have you ever been tempted or attempted to hurt yourself? ___Yes ___No
If yes, do you have:

1. ___ Isolated suicidal thoughts?
2. ___ Frequent, persistent suicidal thoughts?
3. ___ Suicide attempts?

	Date	Means	Precipitating event(s)?
a)	__/__/__	_____	_____
b)	__/__/__	_____	_____

☐ Are you currently thinking of hurting yourself? ___Yes ___No

___Isolated thoughts? ___Persistent thoughts? Intent to commit suicide?

☐ Do you want to die? ___No ___Not sure ___No, but no alternative ___Yes, but..... ___Yes

☐ Do you have a plan in mind? ___Yes ___No If yes, how will you carry it out? ___Unspecified ___Overdose ___Slashing ___Hanging ___Jumping ___Firearm ___Vehicle accident ___Other (specify)_____

☐ Are the means readily available? ___Yes ___No

☐ **Intake counsellor(s) assessment of suicide lethality:**

___ High ___ Moderate ___ Low

☐ Client presentation:

Appearance:_____

_____

_____

Behaviour (reflecting emotions):_____

_____

_____

_____

_____

Consciousness: ___Alert ___Confused ___Drug intoxication ___Alcohol intoxication

Attention and concentration: ___Normal ___Impaired

Short term memory: ___Normal ___Impaired

Present mood:

	Highly	Moderately	Slightly	Not at all
1. Anxious	____	____	____	____
2. Depressed	____	____	____	____
3. Angry	____	____	____	____
4. Euphoric	____	____	____	____
5. Mood swings	____	____	____	____
6. Inappropriate	____	____	____	____
7. Overcontrolled	____	____	____	____

Thoughts:

	Yes	No
1. Are client's statements bizarre?	___	___
2. Does client appear to be in touch with reality?	___	___
3. Do client's statements appear to follow each other in a logical manner?	___	___
4. Beyond expected/normal fears, does the client have bizarre/strange fears or beliefs?	___	___

☐ Symptoms: Have you been troubled with any of the following within the past two months?

Key: 1 - Never
2 - Occasionally
3 - Fairly often
4 - Very often

1. Avoiding social contact	___
2. Insomnia	___
3. Restless sleep	___
4. Nightmares	___
5. Early morning awakenings	___
6. Weight loss (over 5 lb.)	___
7. Feelings of isolation	___
8. Loneliness	___
9. Sadness	___
10. "Flashbacks"	___
11. "Spacing out"	___
12. Headaches	___
13. Stomach problems	___
14. Anxiety attacks	___
15. Uncontrollable crying	___
16. Trouble controlling temper	___
17. Trouble getting along with others	___
18. Dizziness	___
19. Passing out	___

20. Desire to physically hurt others ___
21. Desire to hurt others ___
22. Fear of men ___
23. Fear of women ___
24. Unnecessary or over-frequent washing of hands, hair, etc. ___

PART I: INSIGHT/MOTIVATION

☐ When did you first consider that you had a problem controlling your anger?_____

_____

☐ What is your understanding of the causes of your abusive behaviour?

_____

_____

_____

☐ What kind of problems lead to increased levels of stress for you?_____

_____

_____

_____

☐ What part do you think your partner plays in your violence?_____

_____

_____

☐ What is the impact of your abusive behaviour on the relationship with your partner?_____

_____

_____

☐ How has your violence affected your partner?_____

_____

_____

Your children?_____

_____

_____

You?_____

_____

☐ Have you ever tried to control your violence in the past? ___Yes ___No

If yes, what did you do?_____

_____

_____

_____

☐ Have you had prior counselling because of violence toward a partner?

___Yes ___No If yes, where and when?_____

☐ Have you ever received counselling or mental health services (non-violence related) prior to this date? ___Yes ___No If yes:

1. Agency/counsellor?_____

   Date?_____ Problem area?_____

   Feelings about service?_____

   Outcome?_____

2. Agency/counsellor?_____

   Date?_____ Problem area?_____

   Feelings about service?_____

   Outcome?_____

3. Agency/counsellor?_____

   Date?_____ Problem area?_____

   Feelings about service?_____

   Outcome?_____

☐ Have you ever attended a spousal abuse treatment program before?

___Yes ___No If yes, please indicate:

1. When you were involved_____
2. The program name and location_____

   _____

3. Did you complete the program? ___Yes ___No

☐ How did you come to seek counselling (again) at this time?_____

_____

_____

_____

- Do you feel your use of violence is an acceptable way of resolving conflict and/or disagreements? ___Yes ___No If yes, please explain___

_____

_____

- Do you wish your present relationship to continue? ___Yes ___No ___Unsure If yes, for what reasons_____

_____

_____

- Does your partner wish the relationship to continue? ___Yes ___No ___Unsure
- Are there any positive qualities you value in your partner? ___Yes ___No If yes, please describe them_____

_____

_____

_____

_____

- What are the major criticisms you have of your partner?_____

_____

_____

_____

_____

- What qualities do you believe your partner values in you?_____

_____

_____

_____

_____

- What are the major criticisms you believe your partner has of you?____

_____

_____

_____

_____

- What do you hope to receive from attending the O.W.N. Program group?

_____

_____

_____

- Please indicate three things which you would like to gain/learn:

1. _____

2. _____

3. _____

- What do you wish to change about yourself? _____

_____

_____

- Do you feel that you will be able to receive and accept constructive criticism in group ___Yes ___No ___Unsure
- Is there anything else you think we should know? _____

_____

_____

- Do you think that we have an accurate understanding of you and your present circumstances? ___Yes ___No If no, what is not accurate? _____

_____

_____

O.W.N. (OTHER WAYS NOW)
GROUP TREATMENT PROGRAM FOR BATTERERS

INTAKE AND ASSESSMENT CONSENT - PARTNER

I, _____, agree to participate in the O.W.N. Group's intake and assessment process.

I understand that some of the information provide by me will be used for purposes of program evaluation and may be included in on-going research in the area of group treatment for batterers. I understand that such use of information will be for the purpose of improving services to men and enhancing the group treatment program. It has been explained to me that all identifying information will be kept strictly confidential; that information will be published as aggregate (group) data only. I understand that a copy of any published material will be made available to me upon request.

Signature: _____

Witness: _____

Date: _____

O.W.N. (OTHER WAYS NOW)
GROUP TREATMENT PROGRAM FOR BATTERERS

Assessment Questionnaire - Wife/Partner

Date: D___M___Y___ I.D.# W_____

Husband

1. Surname:_____ First Name:_____

Wife/Partner

2. Surname:_____ First Name:_____

Present Relationship

3. If separated, primary reason for current separation:

_____

4. Do you wish your present relationship to continue?

1. Yes___ 2. No___ 3. Unsure___

5. Are there any positive qualities you value in your partner?

1. Yes___ 2. No___ If yes, list: _____

_____

6. What are the major criticisms you have of your partner?

List: _____

7. What qualities do you believe your partner values in you?

List: _____

8. What are the major criticisms you believe your partner has of you?

List: _____

History of Violence

9. Date of most recent physical violence: D___M___Y___

10. Within the current relationship, how many times have the following kinds of medical attention been administered to you as a result of domestic assault?

1. ___ X-rays/examination only (no treatment) #___
2. ___ Treatment for cuts, bruises, bumps #___
3. ___ Stitches for gash/lacerations #___
4. ___ Setting broken bones #___
5. ___ Hospitalization (inpatient) #___
6. ___ Other (specify): _____
7. ___ No treatment required

11. Have the police ever been called in relation to violence between your partner and you?

    1. Yes ___ 2. No ___

12. If yes,

    1. Once ___
    2. 2 to 5 times ___
    3. More than 5 times ___

13. What is your understanding of why your partner is violent towards you?

    Explain: _____

14. Is there a pattern to the violent incidents?

    1. Yes ___ 2. No ___ 3. Unsure ___

    If yes, what is the pattern? _____

    _____

15. If yes, where are you in the cycle now?

    Explain: _____

16. In the past year, what is the average length of time between assaults?

    Days: ___ Weeks: ___ Months: ___

17. In the past year, how many times has your partner done the following to you?

    1. ___ Physical abuse #___
    2. ___ Psychological abuse #___
    3. ___ Sexual abuse #___
    4. ___ Property damage #___

18. What types of physical injuries have you received in the past year?

    1. ___ None
    2. ___ Bruises #___
    3. ___ Black eyes #___
    4. ___ Broken limbs #___
    5. ___ Other (specify) _____

19. What types of physical injuries has your partner received in the past year?

    1. ___ None
    2. ___ Bruises #___
    3. ___ Black eyes #___
    4. ___ Broken limbs #___
    5. ___ Other (specify) _____

20. Over how long a time period has your partner been assaultive/violent towards you?

1. ___ <1 month
2. ___ 1-5 months
3. ___ >5 months-12 months
4. ___ >12 months-2 years
5. ___ >2 years-5 years
6. ___ >5 years-10 years
7. ___ >10 years

21. Have you ever been pregnant with your partner?

1. Yes ___ 2. No ___

22. Does your partner accuse you of being unfaithful to him?

1. Often ___ 2. Sometimes ___ 3. Never ___

23. Does your partner demand to know the details of your past sexual relationships, to an unreasonable extent?

1. Yes ___ 2. No ___

24. How long had you and your partner been together at the time of the first incident of violence? Months ___

25. How many times has your partner assaulted you in the total time you have been together> Times ____

26. How do you feel after you have been assaulted by your partner?

Describe: _____

27. How does your partner seem to feel after assaulting you?

Describe: _____

28. What is the impact of your partner's violent behaviour on your relationship?

Describe: _____

29. Has you partner ever assaulted you while under the influence of drugs?

1. Yes ___ 2. No ___

If yes, which ones? _____

30. Has your partner ever assaulted you while he was under the influence of alcohol?

1. Yes ___ 2. No ___

31. Has your partner ever assaulted you while he was sober?

1. Yes ___ 2. No ___

32. What effect has your partner's violence had on your life?

Describe: _____

Background Information

33. Where were you born? _____

34. Where were you raised? _____

35. Education: _____

36. Occupation: _____

37. Did your father or stepfather ever hit his wife?

1. Yes ___ 2. No ___

If yes,
1. ___ < Once a month
2. ___ Once a month
3. ___ > Once a month
4. ___ Once a week or more

38. Did your mother or stepmother ever hit her husband?

1. Yes ___ 2. No ___

If yes,
1. ___ < Once a month
2. ___ Once a month
3. ___ > Once a month
4. ___ Once a week or more

39. As a child, were you hit by your parents?

1. Yes ___ 2. No ___

If yes,
1. ___ < Once a month
2. ___ Once a month
3. ___ > Once a month
4. ___ Once a week or more

40. Who usually administered physical punishment?

1. ___ No physical punishment
2. ___ Father
3. ___ Mother
4. ___ Both/either
5. ___ Other (specify): _____

41. (a) As a child, were you ever subjected to any sexual abuse?

1. Yes ___ 2. No ___ If yes, how old were you? ___

(b) If yes, what was the relationship to the abuser to you? Relationship: _____

42. Do you have any children in your present relationship?

1. Yes ___ 2. No ___ If yes, how many? _____

43. Do you have any suicidal thoughts at the present time?

1. Yes ___ 2. No ___

If yes, explain: _____

44. Are you familiar with what resources are available to you which concern your safety and protection (e.g., police, women's shelter, legal clinic, support group, friends, family counselling service)? _____

_____

_____

45. Do you have a safety plan of action for yourself and your children? (Specify): _____

_____

_____

O.W.N. (OTHER WAYS NOW)

PROTECTION PLAN

The objective of our program is to prevent future violence. We know from research and experience that violence repeats itself and gets worse. Now is the time to plan what to do if there is further violence. A protection plan gives you a way to protect yourself and your children, both by using personal and community resources and becoming aware of signs that precede your partner's violent actions.

1. What are some of your internal warning signals that tell you that you might be in danger or that you are afraid of?

2. What are some external circumstances leading up to an explosive situation in your home? (Time of day, chemical use, money, children, location, partner's cues, outside stresses, etc.)

3. How have you protected yourself and/or your children from being hurt in the past, how effective was it?

4. The following people or organizations that you can turn to for help:

PERSONAL:	Friends _____	
	Relatives _____	
	Neighbours _____	
SHELTERS:	Family Resource Centre (24 Hours)	468-5491
	or	1-800-465-1117
COUNSELLING:	Family Resource Centre	468-5491
	Woman's Place	468-9095
	Community Counselling	468-6099
	O.W.N. Program	468-4703
	RAPE Crisis Line	468-7233
	Cameron Bay Children's Centre	467-5437
MEDICAL:	Lake of the Woods District Hospital (24 Hours)	468-9861

If I am in a situation today where I am afraid violence will occur, or where it is occurring towards me or my children, I know that the following options are available to me:

APPENDIX B

PROGRAM AND MEETING CONTENT
and
EVALUATION AND FOLLOW-UP FORMS

O.W.N. (OTHER WAYS NOW) PROGRAM

PROGRAM OUTLINE

INTAKE AND ASSESSMENT:

- -interviews with batterer (for intake form(s) and for standardized measurement instruments)
- -interviews with victim
- -agreement of consent and confidentiality
- -admittance to group program
- -referral to alternative resource/program

TREATMENT GROUP SESSION:

- -contracting
- -10-12 group meetings
- -referral for concurrent counselling
- -contact with victim and significant others

FOLLOW-UP:

- -re-admission to next group session
- -self-help group
- -follow-up interviews/surveys at 1, 3, and 12 months
- -consultation with corrections re: re-occurrence of abuse

EVALUATION:

- -intake and follow-up interviews
- -standardized measures (initial, mid-program, and termination
- -individualized measures (eg. goal attainment scale)

O.W.N. (OTHER WAYS NOW) PROGRAM

MEETING OUTLINE

Check/In:

-feelings at beginning of the meeting
-state of mind of each member
-emergency issues
-homework assignments due

Recap:

-review of previous meeting's highlights
-agenda for current meeting - members' input

Core Content:

-film
-presentation
-speaker - group member or guest speaker
-discussion
-group exercises - skill rehearsal, role play, etc.

Break:

Anger/Abuse Log:

-member's share their entries with group

Semi-Structured Sharing:

-homework assignments
-core material
-log entries
-individual issues/concerns

Homework/Hand Outs:

-assignment(s) for next meeting
-general information

Check/Out:

-feelings and state of mind upon leaving
-emergency/safety issues

Social Time:

SESSION #1 - MEETING CONTENT

Week 1 (Jan. 4)
- introductions of program and people
- rules/contract review
- control plan
- time out
- individual goal attainment scale
- individual anger rating scale

Week 2 (Jan. 11)
- film "Killing Us Softly"
- progression and cycle of violence
- socialization/societal norms
- gender roles - myths and stereotypes

Week 3 (Jan. 18)
- film "Up the Creek"
- advantages/disadvantages of the use of physical violence
- feelings - primary and secondary
  - guilt vs. shame
  - anger log

Week 4 (Jan. 25)
- film "Shifting Gears"
- stress and stress management
- relaxation skills
- most violent incident reports

Week 5 (Feb. 1)
- film "Loved, Honoured, and Bruised"
- most violent incident reports
- depression and suicide

Week 6 (Feb. 8)
- rational and irrational thinking
- cognitive controls - self-talk, thought stopping, etc.
- mid-program evaluation

Week 7 (Feb. 15)
- film "To Have and to Hold"
- socialization - role expectations/change
- sexuality/jealousy
- family of origin

Week 8 (Feb. 22)
- family of origin
- effects of violence on women and children

Week 9 (Mar. 1)
- types of abuse
- power and control wheel
- psychological abuse

Week 10 (Mar. 8)
- sexual abuse
- communication skills

Week 11 (Mar. 15)
- problem solving skills
- conflict resolution/negotiation skills

Week 12 (Mar. 22)
- termination
- self-help/support group/follow-up process
- evaluations

SESSION #2 - MEETING CONTENT

Week 1 (Aug. 23) - introductions
- group rules/contract review
- what is abuse? - brainstorm
  - personalize items
  - types of abuse
  - cycle of violence

Week 2 (Aug. 30) - control plan and time out - anger cues
  - relaxation
- group goal setting/goal attainment scale
- anger rating scale and anger log

Week 3 (Sept. 6) - feelings - primary and secondary
  - anger, shame, empathy

Week 4 (Sept. 13) - assertiveness
- communication skills

Week 5 (Sept. 20) - communication skills

Week 6 (Sept. 27) - most violent incident

Week 7 (Oct. 4) - most violent incident - continuation

Week 8 (Oct. 11) - mid-session evaluations - peer review
  - leader review
  - feelings

Week 9 (Oct. 18) - learned behaviour - family of origin
  - socialization
  - gender role expectations

Week 10 (Oct. 25) - learned behaviour - continuation
  - issues of control

Week 11 (Nov. 1) - cognitive techniques
- rational and irrational thinking

Week 12 (Nov. 8) - cognitive techniques
- self talk, thought stopping, stress inoculation

Week 13 (Nov. 15) - stress and stress management - problem-solving
  - negotiating

Week 14 (Nov. 22) - dependency and self-esteem
- jealousy and sexuality

Week 15 (Nov. 29) - open session - member topics
- termination

Week 16 (Dec. 6) - termination
- evaluations
- follow-up and support group

O.W.N. (OTHER WAYS NOW)
GROUP TREATMENT PROGRAM FOR BATTERERS

GROUP EVALUATION

Name:_____ Day ___ Month ___ Year ___

An evaluation of the group sessions is important so that we can determine what items are most helpful to the group members. Your assistance in completing this evaluation will help to plan for future group programs.

1. What were the most helpful aspects of the group program?

2. What were the least helpful aspects of the group program?

3. What are things you would have liked to get out of the group, but didn't?

4. What changes would you suggest that might make it more effective?

5. If you have had individual counselling, how did the group experience differ?

6. Would you have preferred more or less direction from the counsellor? Explain:

7. Did you feel that the topics discussed in the group sessions were generally related to your own problems?

8. Has your experience in the group changed the way you think about violence? Explain:

9. Do you have any suggestions for future group sessions of this sort?

10. Do you think you need any further help either with stopping violence or any other aspect of your life?

11. Are you together with your partner at the present time?

12. How would you describe any changes in your relationship with your partner as a result of the group experience? Explain:

13. What would you say to other people about your experience in the group program?

14. Do you have any suggestions for encouraging other men to participate in this kind of program?

15. What would you do if you were violent again or felt you might be?

16. What plans do you have for continuing to improve the quality of your life?

17. Any other comments?

Group Evaluation Page 3

Listed below are a number of topics or exercises which were a part of the group sessions. Please indicate your evaluation of each item according to the following scale:

A = No help at all
B = Unsure
C = A little help
D = Very helpful

1.	Learning about types of abusive behaviours	A B C D
2.	Learning about pre-violence cues	A B C D
3.	Developing alternatives to violence	A B C D
4.	The Anger Log	A B C D
5.	Check-in/Check-out	A B C D
6.	Films/videos	A B C D
7.	Discussion of male/female, husband/wife roles	A B C D
8.	The Goal Attainment and Anger Rating Scales	A B C D
9.	Working with a group of men	A B C D
10.	Analyzing my personal situations	A B C D
11.	Using the flip chart	A B C D
12.	Reviews of previous sessions	A B C D
13.	Discussing the causes of violence	A B C D
14.	Discussions about ourselves as men	A B C D
15.	Group Evaluation	A B C D
16.	Other _____	
	_____	
	_____	

O.W.N. (OTHER WAYS NOW) PROGRAM
GROUP TREATMENT FOR MALE BATTERERS

INDIVIDUAL EVALUATION

Client Name _____ Client Number _____

Session Number _____ Date of Completion _____

Estimate of Success in Program

Scale:	1 Poor	2 Fair	3 Average	4 Good	5 Excellent	6 N/A

A. ___ Ability to be non-violent at this time.

B. ___ Improvement in ability to avoid use of violence at this time.

C. ___ Ability to avoid use of threat of violence at this time.

D. ___ Improvement in ability to avoid use of threat of violence at this time.

E. ___ Improvement in attitudes that lead to violence (eg., accept responsibility for violence, capacity to empathize, decrease in sexist attitudes and sex-role rigidity, etc.)

F. ___ Ability to recognize and stop destructive self-talk at this time.

G. ___ Ability to avoid and/or stop destructive self-talk in the future.

H. ___ Level of group participation (eg., extent of participation, providing and receiving feedback, taking risks, etc.).

I. ___ Decrease in unhealthy dependency on partner.

J. ___ Use of group members for support outside of group.

K. ___ Degree to which client recognized and dealt with violence in family or origin and present day effects.

L. ___ Prognosis of ability to empathize about victimization to avoid further violence.

M. ___ Increase in ability to parent and to nurture since intake.

Individual Evaluation Page 2

Comments: _____

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Recommendations: _____

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Group Leader: _____ Date of Evaluation: _____

I have read and received a copy of this individual evaluation.

Name: _____

Date: _____ Witness: _____

O.W.N. (OTHER WAYS NOW) PROGRAM
GROUP TREATMENT FOR MALE BATTERERS

GROUP ASSESSMENT FORM
(Example from first session)

Group Name: Men's Treatment Group Session: #1

Assessment Period: January 4, 1989 to March 15, 1989

Communication: Over the period of the session the communication moved from a leader to a member focus, though to a certain extent the leader focus remained to the end. It was about half-way through the session that members began to interact directly with one another, providing more unsolicited confrontation and feedback. The pattern of interaction moved from a round robin in early meetings, to a hot-seat pattern, and to a free floating pattern toward the end of the session. All members shared equally, in terms of time taken to speak, during the session. A moderate level of interpersonal liking developed between the members and no apparent sub-groups formed.

Group Cohesion: Every member was clear that grappling with the common problem of abusiveness was a major attraction to the group. The members tended to compete with each other, in the early stages of the group, in the presentation of their unique circumstances. A cooperative spirit began to emerge slowly and the members took part in the decision-making process. Evaluations of the group experience by the members reflected a sense of having had some success in meeting the expectations and needs with which they came to the session. To a greater or lesser extent, each member completed the session with confidence that he had made some important changes and with an improved sense of self-worth.

Social Control: All members incorporated the expectation of non-abusiveness within the group into their interaction in group. The expectation of work within the group was accepted and generally followed by each member. There were a couple of areas in which the leaders' control would have benefitted the group process: a) repetition of details of past incidents of violence; and b) tangential discussions. The focus of the group work suffered at these times. The functioning of the group was generally predictable. The members accepted leadership controls with respect and without feeling restricted or coerced.

Group Culture: The ramification of a fairly traditional socialization for the men were evident in this area. Dealing with traditional gender role perceptions and behaviours was a continuous process in this session. The issue of blaming women was one which was dealt with on many occasions. The men attempted to understand each other's uniqueness and background. They saw the group as one anchor point in their lives and looked to other members for support. Sometimes silence was used when confrontation might have been more appropriate.

I have read and received a copy of this group evaluation.

Date: _____ Client: _____

O.W.N. (OTHER WAYS NOW) PROGRAM
GROUP TREATMENT FOR MALE BATTERERS

1 MONTH FOLLOW-UP EVALUATION

Name:_____ Date: Day___ Month___ Year_____

1. a) In the past month since the group ended, how many times have you done the following to your partner?

   1. No violent behaviour at all____
   2. Physical abuse #____
   3. Psychological abuse #____
   4. Sexual abuse #____
   5. Property damage #____

   b) If you have been violent, did you handle it any differently than you might have before the group? Describe:

   _____

   _____

   c) If you have been violent, why do you think you continue to be violent toward your partner. Describe:

   _____

   _____

2. Are you together with your partner at the present time? ___Yes ___No

3. How has your behaviour over the past month affected your relationship with your partner? Describe:

   _____

   _____

4. a) How have you handled yourself in your relationships with others? Describe:

   _____

   _____

   b) How is this different from before the group? Describe:

   _____

   _____

5. Do you think you need any further help either with stopping violence or any other aspect of your life? Describe:

_____

_____

6. In looking back now, what was the most useful part of the group program for you? Describe:

_____

_____

7. Did you learn anything in the group that you still use in your day to day life? Describe:

_____

_____

8. What would you do if you were violent again or felt you might be? Describe:

_____

_____

9. What are you doing at present to improve the quality of your life? Describe:

_____

_____

10. Any other comments?

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O.W.N. (OTHER WAYS NOW) PROGRAM
GROUP TREATMENT FOR MALE BATTERERS

3 MONTH FOLLOW-UP EVALUATION

Name:_____ Date: Day___ Month___ Year_____

1. a) In the past two months since the one month evaluation, how many times have you done the following to your partner?

   1. No violent behaviour at all____
   2. Physical abuse #____
   3. Psychological abuse #____
   4. Sexual abuse #____
   5. Property damage #____

   b) If you have been violent, did you handle it any differently than you might have before the group? Describe:

   _____

   _____

   c) If you have been violent, why do you think you continue to be violent toward your partner. Describe:

   _____

   _____

2. Are you together with your partner at the present time? ___Yes ___No

3. How has your behaviour over the past two months affected your relationship with your partner? Describe:

   _____

   _____

4. a) How have you handled yourself in your relationships with others? Describe:

   _____

   _____

   b) How is this different from before the group? Describe:

   _____

   _____

5. Do you think you need any further help either with stopping violence or any other aspect of your life? Describe:

_____

_____

6. In looking back now, what was the most useful part of the group program for you? Describe:

_____

_____

7. Did you learn anything in the group that you still use in your day to day life? Describe:

_____

_____

8. What would you do if you were violent again or felt you might be? Describe:

_____

_____

9. What are you doing at present to improve the quality of your life? Describe:

_____

_____

10. Any other comments?

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O.W.N. (OTHER WAYS NOW) PROGRAM
GROUP TREATMENT FOR MALE BATTERERS

ONE YEAR FOLLOW-UP EVALUATION

Name:_____ Date: Day___ Month___ Year_____

1. a) In the past nine months since the three month evaluation, how many times have you done the following to your partner?

   1. No violent behaviour at all____
   2. Physical abuse #____
   3. Psychological abuse #____
   4. Sexual abuse #____
   5. Property damage #____

   b) If you have been violent, why do you think you continue to be violent toward your partner. Describe:

   _____

   _____

2. Are you together with your partner at the present time? ___Yes ___No

3. How has your behaviour over the past nine months affected your relationship with your partner? Describe:

   _____

   _____

4. Please comment on how well you have been able to maintain the changes which you have made since the group:

   _____

   _____

5. At this time, do you think you need any further help either with stopping violence or any other aspect of your life? Describe:

   _____

   _____

6. Did you learn anything in the group that you still use in your day to day life? Describe:

   _____

   _____

7. What would you do if you were violent again or felt you might be? Describe:

_____

_____

_____

8. What are you doing at present to improve the quality of your life? Describe:

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9. Any other comments?

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