# FAMILY VIOLENCE: TREATMENT OF PERPETRATORS AND VICTIMS

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# FACT SHEET ON MARITAL DISTRESS, MARTIAL VIOLENCE AND PARTNER ABUSE

***(Information gleaned from Baucom et al.,2006; Greenfeld et al., 1998; Koss et al., 1994; La Taillade, 2006; Logan et al., 2002; Markman et al., 2006; O'Leary et al., 2000; Schumacher et al., 2001; Slep & Heyman, 2001; Slep & O'Leary, 2001; Wathen & MacMillan, 2003; San Diego Domestic Violence Council, 2006 – http://www.sandiegodvcouncil.org/about/mission.php. The difficulties in estimating the exact prevalence of domestic violence was underscored in a recent Government Accountability Report – GAO 07-148R obtainable from the GAO office, Washington, DC, 20548)***

## Incidence of Marital Distress

In the U.S., approximately 90% of adults will marry.

Approximately 45% to 50% of first marriages will end in divorce.

In the 1920's, 1 of 7 marriages ended in divorce. By the 1950's, the divorce rate was 1 in 5 and by the 1990's, almost 1 in 2 marriages ended in divorce.

Approximately 25% of couples are divorced within 3 years of marriage. The average divorcing couple will stay married for approximately 7 years.

Following divorce, 80% of individuals will eventually remarry; with an average of a 3 year period before remarriage.

Sixty percent of remarriages will end in divorce. The average length of the second marriage is 5 years.

A factor contributing to divorce is the occasion of an extramarital affair. Baucom et al. (2006) report that approximately 22%-25% of men and 11%-15% of women indicated that they had engaged in extramarital sex on at least one occasion. In any given year, between 1.5% and 4% of married individuals will engage in extramarital sex in the U.S. 40% of divorced women and 44% of divorced men report having had affairs. Infidelity doubles the likelihood of divorce.

When considering these statistics on marriage and divorce, and often the accompanying occurrence of intimate partner violence, it is important to consider important racial and ethnic differences, as highlighted by LaTaillade (2006). For instance:

- African-American women are less likely to enter marriage than other racial groups. Only 30% of African-American women are living with a male spouse, as compared to 47% Hispanic women, 55% of non- Hispanic white women, and 60% of Asian women. Overall, 51% of women in the U.S. are now living without a spouse.

- While the vast majority of white women marry by their mid to late 30's, only 65% of Black women have done so

- The rate of separation and divorce for African-American couples has increased nearly five fold in the last 30 years, and are double the rate of the general population

- Approximately 47 % of Black women separate from their first husbands within 10-15 years of marriage, compared with 28% of marriages among their white female counterparts

- Only 32 % of African American women remarry within 10 years of being divorced, compared to 66% of white women

- The greater marital instability and declining rate of marriage in African-American communities has been attributed to the disproportionate amount of stress including economic strain (unemployment and underemployment), exposure to poverty and violence, due to the continued experiences of racism and discrimination

Exposure to such chronic stressors can contribute to marital distress and separation and the resultant consequences.

## Incidence of Marital Violence and Partner Abuse

Spouse abuse or marital violence is frequently cited as grounds for divorce. Physical abuse refers to kicking, punching, hitting with a closed fist, hitting with an object, threatening with a weapon and/or the use of a knife or a gun. Not included in this definition are pushing, shoving or grabbing. This definition does not include psychological abuse, although it often accompanies physical abuse. **Such psychological abuse is a better predictor of depression in the victimized spouse, than is physical abuse.**

Domestic violence has been characterized as a "state of siege in which discrete battering episodes occur as intermittent events within a cycle of violence" (Dutton, 1992).

A World Health Organization and United Nations' Report (2006) indicates that violence against women is "severe, pervasive and worldwide." At least one in three women is subjected to intimate partner violence in the course of her lifetime. Women subjected to violence are more likely to abuse alcohol and drugs and report sexual dysfunction, suicide attempts, Post Traumatic Stress Disorder, and central nervous system disorders. Partner abuse is also associated with increased levels of depression, anxiety and eating and personality disorders. Partner abuse is often hidden and only a small fraction is reported to the authorities.

One out of 6 American households experience some violence between husbands and wives every year. Put otherwise, severe violence is a chronic feature of almost 13% of all marriages in the U.S. and 1.6 million women are severely assaulted by their partners. Men report a lifetime incidence of being a victim of domestic violence of 7.5%.

The highest rate of domestic violence in the U.S. is among American Indian women and native Alaskan women.

In the U.S., a woman is battered by her partner every 15 seconds. In general, men's physical aggression leads to more injuries than aggression by women.

Between 25% and 30% of married women in the U.S. have experienced some form of spouse abuse at some point in their marriage. Of some 50 million married persons in the U.S., some 15 million have experienced violence in their marriage.

Thirteen percent or 5 million American wives have been chronically and severely abused by husbands (1 in 6 wives or 16% have violence as part of their relationship).

One and one half percent experience a severe violent act such as "beating up" within a given year.

When violence occurs, it tends to be repeated. Violent abuse was reported as occurring 3 or more times during the year by 47% of husbands who beat their wives and by 53% of wives who beat their husbands.

Violence is not reported during the year in 1/3 of violent families.

While these statistics are alarming the good news is that the domestic violence rates have fallen sharply between 1993 and 2004, as reported by the U.S. Justice Department. In 1993, there were about 5.8 incidents of non fatal violence for every 1000 U.S. residents above the age of 12. By 2004, the number had fallen to 2.6 per 1000.

Half of homicides are a result of intimate partner violence. The homicide rate due to domestic violence in the U.S. was 2269 in 1993 and 1544 in 2004.

Half of homicides among couples occur during the course of an argument. Most homicide victims know their assailant. Thirteen percent of homicides in U.S. are husband-wife killings. 1300 deaths occur in the U.S. each year as a result of intimate partner violence.

Forty-two percent of women who are murdered are killed by another member of the family, most often their husbands.

Among pregnant women in developed countries, the rate of partner abuse is from 4% to 8%. Women abused during pregnancy are more likely to have pregnancy complications and to give birth to low-birth-weight infants. They also delay entry into prenatal care. Women with unintended pregnancy are most vulnerable to abuse.

Women who experience partner abuse are at increased risk of injury, death and a range of physical, emotional and social problems. Partner abuse is associated with such problems as depression, suicidality, anxiety, PTSD, eating disorders, substance abuse and personality disorders.

Forty percent of newly married couples report physical aggression against their partners. While serious violence is relatively uncommon prior to marriage, a progressive pattern can be seen as verbal aggression is often followed by throwing objects, before physical violence occurs.

Among 50% to 65% of clinically maritally discordant couples, the men are physically aggressive. The level of marital distress relates to the likelihood of marital violence.

Aggression in intimate relationships typically occurs in the context of an argument between partners. Most problematic areas include finances, household management, personal disagreements over child rearing and sexual relations. These arguments may lead to throwing, pushing and shoving. The most frequent problems involve issues of commitment, communications and sexuality.

In marital clinic samples, aggression is <u>often</u> <u>mutual</u> and is in the form of self-defense in less than 20% of the cases.

Johnson (1995) has identified two kinds of violence in couples: normally, (1) **Common Couple Violence** which reflects conflict between partners that are poorly managed and occasionally escalate to minor violence and tends to be mutual and are of low frequency and less likely to persist. In this instance, both distressed partners engage in mild to moderate physical aggression. This form of violence is less likely to endanger the female, nor cause her ongoing fear.(2) **Severe Physical Aggression** or **Patriarchical Terrorism** which is much more frequent, persistent and almost exclusively perpetrated by men who have been court-ordered to violence treatment programs. Such male violence often reflects efforts to exert control and dominance. Women who use low level aggression with their spouse, may do so as a form of self-defense.

Almost one-half of the violent episodes reported in intimate relationships involved men <u>and</u> women being <u>mutually aggressive</u>. A substantial amount of violence in intimate relationships is initiated by women rather than by men. Although women do use aggression in rates comparable to males when a range of mild to moderate aggressive acts are considered, research indicates that women are more severely victimized than men and women are more likely to sustain

injuries requiring medical attention ***(See www.melissainstitute.org for a discussion of gender differences in aggressive behavior and Capaldi, 2004)***

A meta-analysis of sex differences in injuries found almost equal injury rates for both sexes (age groups of 14 to 22), whereas older age groups had higher rates of injuries in women.

Women are 6 times more likely than men, to throw objects, destroy possessions, and make threatening gestures.

Burke and Follingstad (1999) report that "Research suggest that lesbians and gay men are just as likely to abuse their partners as heterosexual men, although it is unknown whether the severity of abuse is comparable between these two groups. Risk markers and correlates of intimate violence in same-sex relationships are notably similar to those associated with heterosexual partner abuse." (p. 508)

Marital conflict increases the likelihood of parent-child conflict. Spouse abuse and child abuse often co-occur. Fifty percent (50%) of abused women have children less than 12 years of age.

Dating violence literature revealed that the rates of intimate violence ranged from 9% to 69% among young dating couples.

Serious violence is relatively uncommon prior to marriage. The pattern is one of verbal aggression often followed by throwing things, before physical violence occurs.

There is a need to ask explicitly and directly about the occurrence of physical violence and psychological abuse. As to be discussed below, there is a need to delineate the type, severity and impact of violence and consider the typology of the batterer.

# INCIDENCE OF CHILD ABUSE AND MALTREATMENT

Since partner abuse is often accompanied by child abuse and maltreatment, it is important to consider violence as a "family matter," as the following numbers indicate.

Two million cases of child maltreatment (physical abuse and neglect) occur each year in the U.S.

1.6 million children are seriously injured or impaired each year as a result of neglect.

3.3 million children in the U.S. witness assaults against their mothers annually.

In California, it is estimated that 10% to 20% of all homicides are witnessed by children.

Partner and child physical abuse **co-occur in families in 6%** of all households in the U.S. This estimate increases to 40% in homes where there is evidence of physical abuse. **Thus, one form of family violence significantly increases the risk of another form of violence.**

For husbands, the risk of child abuse escalates from 5% with a single act of partner aggression in a year to nearly 100% when the incidence of partner aggression occurs once a week.

In Canadian two-parent families, fathers are alleged perpetrators in an estimated 71% of physical abuse cases and 69% of the cases involving emotional maltreatment. In sexual abuse cases, fathers or step-fathers are about three and half times more likely to be perpetrators than mothers or step-mothers (24% vs. 7%). Only in the case of neglect are mothers more likely to be the perpetrators (Trocome et al., 2001).

Children who witness battering have higher rates of symptoms in areas of behavioral and emotional functioning, school performance, cognitive skills, such as attentional focusing, and interpersonal relationships. Since spouse abuse is often accompanied by various forms of child abuse, such maltreated children have lower problem-solving, self-efficacy and higher rates of aggression, as a result of holding hostile attribution biases, than those children who have not experienced maltreatment. Such maltreated children are more likely to feel threatened and helpless. They are more difficult to parent, even though they may retain emotional connections with the maltreating parent, even in the face of abuse. Such "traumatic bonding" is more likely to occur when maltreatment involves intermittent fear and kindness. They evidence "disorganized attachments".

Interventions for children who have been maltreated should include making the environment structured and predictable in order to convey a sense of physical and emotional safety. Help the maltreated children develop and tighten bonds with others. Address any specific behavioral and emotional problems (depression, PTSD, anxiety, aggression, academic difficulties). See below for a discussion of ways to treat traumatized children.

# CHARACTERISTICS OF MALTREATING FATHERS

***(See Scott & Crooks, 2004; Waldrop & deArellano, 2004)***

What are the features of potentially abusive fathers who are likely to engage in both partner violence and child maltreatment?

- Demonstrate overly controlling behavior, a sense of entitlement, self-centered attitude, and poor parent-child boundaries

- Hold abuse-supportive cognitions, attitudes and a sense of entitlement in the father-child relationship - They view conflict with their children as "power battles." - Take pride in that they have to tell their children to do something "only once" - Feel "victimized" or "cheated" if they do not receive unconditional love

- Are hypervigilant to any signs that they may be rejected

- Show poor recognition of parent-child boundaries - Have a sense of insecurity, oversensitivity to rejections and develop a reliance on their children for emotional validation - Turn to children for relief of emotional distress, and allow children to take care of them

- Attribute negative intent (intentionality) to children for noncompliant behavior and are more likely to coerce and retaliate to child noncompliance with physical abuse - Perceived "badness" of their children

- Parent (especially abusive mothers) may feel that their children have more power than they do – "low power" parent.

- May hold beliefs that harsh physical punishment is needed to "toughen boys up for life"

- Have adult-focused attention on meeting own needs

- Maltreating fathers are often unable to provide basic information about children such as names of children's best friends, their children's favorite activities or their children's most recent disappointments.

- Has stereotypical rigid and authoritarian views of parenting and tend to use power-assertive and coercive parenting practices - Hold beliefs that children should obey commands unquestioningly - Perceived "impertinence" must be answered with harsh discipline which is justified and necessary. - Preoccupied with maintaining control rather than nurturance- Restrict their children's independence

- Nevertheless, some maltreating fathers are over-invested in being viewed as successful in their parenting role.

- They almost inevitably undermine the authority of the children's mother, overrule her parenting decisions, ridicule her in front of their children or tell their children that she is an incompetent parent. Use children as "weapons" against partner.

- There is a subgroup of maltreating fathers who may also evidence psychopathology, as well as cognitive and social incompetence.

- Maltreating fathers typically do not seek intervention voluntarily, nor access social supports. Moreover, they are distrusting of the treatment system. In general, they have difficulty admitting to trouble in their relationships.

# RISK FACTORS FOR INTIMATE PARTNER VIOLENCE: HOW TO MAKE GOOD DECISIONS ABOUT MATES IN THE FIRST PLACE

***(The following risk factors have been identified by research findings, as reported by Campbell et al. 2001; Feindler et al., 2003; Hart, 1990; Kropp & Hart, 2000; Kubany et al. 2003; La Taillade et al., 2006, Meichenbaum, 2004; ODARA, 2004; Straus et al., 2003; Trone, 1999)***

**One of the best ways to reduce partner violence is to help women avoid establishing intimate relationships with potential abusers, in the first place. What are the characteristics of potential abusers? How can one identify a potential abuser early on? In using this Checklist, it is important to keep in mind that the individual's "gut reactions" about personal safety are more critical than any objective set of indicators. Moreover, what constitutes "warning signs" early on in a relationship may change over time after a commitment (e.g., marriage, having children, and the like).**

As a personal aside, I should note that I have developed a clinical interview and Checklist to assess the **Violence Potential of Prospective Partners (VPPP)** of all dates that my children and friends introduce me to. This like the movie, Meet the Parents, but in this case the parent is Don Meichenbaum instead of Robert DeNiro. The **VPPP Checklist** assesses the:

**Characteristics of the Prospective Partner, both present behavior and developmental factors**

**Characteristics of the Current Relationship with the Prospective Partner and the Prospective Partner's History of Past Relationships**

**Family Characteristics of the Prospective Partner**

**Community Characteristics of the Prospective Partner**

## CHARACTERISTICS OF THE PROSPECTIVE PARTNER

- How he responds to high level of stress such as dislocation, job instability, current unemployment and self-perceptions of being underemployed (i.e. not achieve desired occupational level), and other stressors. Responds by a attacking others such as being ill-humored, critical and / or withdrawing.

- Current substance abuse and problem-drinking, especially presence of binge drinking. **(60% of domestic violence incidents involve offenders who are drinking. The likelihood of male to female aggression is 8X higher on days of drinking.)**

- Presently engages in aggressive behaviors outside of the current relationship (Been in fights, brawls, easily offended, needs to prove himself)

- Engages in low level, but persistent antisocial behavior

- Currently on bail, probation, parole or sentenced to prison/jail within the last 30 days

- Noncompliance with court orders and batterer intervention programs ***(Note, abusers do <u>not</u> necessarily have a criminal record.)***

- Tends to be fearful, jealous, easily threatened when sense of power or control are challenged. Men who are <u>highly</u> <u>dependent</u> on their partners and hypervigilant regarding potential threats to security of their relationship are more likely to resort to violence when they fear potential loss of their partner.

- Explosive temperament and evidences highly reactive anger with an accompanying hostile "attribution bias." Tends to blame others and believes others provoke him "on purpose." Rarely considers alternative explanations. Views the use of aggression as a form of justified retaliation and the use of violence as acceptable

- Tends to ruminate and not "let go of past hurts." Engages in stalking behaviors

- Presence of depression and self-injurious behaviors (suicidal thoughts and acts). While most spouse abusers do not have diagnosable Mental Disorders, some clinical patterns are more common in violent versus nonviolent men (e.g. some personality disorders such as Borderline Personality Disorder and Antisocial Personality Disorder, Anxiety and Depression disorders, Substance abuse disorders, Psychotic disorders).

- Anxious, dependent attachment pattern is perceived as being insecure. Refusal to accept the end of the relationship ***(Spouse violence is highest when partner tries to leave.)***

- Moody, irritable, argumentative, impulsive, suspicious, resentful, hostile, oppositional, sense of inadequacy, feels powerless

- Evidences limited verbal facility to that of partner - Poor communication, negotiation and organizational skills ***(For example, "I am hurting her like she hurt me." Uses physical aggression in lieu of words)*** Deficits in assertive skills and verbally aggressive communication.

- Difficulty getting along with others (e.g., keeping a job) and tends to be impulsive and distractible (e.g., difficulty completing tasks and following through or being "reliable")

- Holds a positive attitude toward the use of violence and aggression to resolve conflicts

- Inability and lack of desire to resolve conflict in a mutually respectful and satisfying manner. How couples resolve conflict is critical in the development of Intimate Partner Violence.

- Preoccupation with violent media and violent activities

- Has a weapon or ready access to weapons and is involved in martial arts activities. Use threats to instill fear in partner.

- Can be charming when things are going well, but abusive especially when conflict arises

**DEVELOPMENTAL INDICATORS**

***(This information is not likely to be disclosed readily at the beginning of a relationship. There is a risk that concealment or denial by a potential abuser may lull a woman into trusting him. With this warning in mind, it is important to be cognizant of the following potential indicators.)***

- Level of education (did not complete high school) - Solicit information about grade retention, school suspensions and expulsions.

- Low reading comprehension skills

- History of getting into trouble with the law before age 12 (Early onset of aggressive behavior) History of violence outside of home

- A bully or a victim of bullying in school or the combination of being a bully-victim in school and in his neighborhood and violent acts toward his siblings

- Member of a gang-- note role in the gang--leader, henchman, follower - Carried a weapon or used a weapon

- Ever injured in a fight that required medical treatment

- History of substance abuse

- Presence of a developmental psychiatric diagnosis ***(For example, Attention Deficit Hyperactivity Disorder accompanied by Conduct Disorder behavioral problems, antisocial behavior and substance abuse problems in childhood and adolescence that are predictive of later aggression toward a partner for <u>both</u> young men and young women)***

- History of relationship instability - Solicit the history of friendship patterns, especially note the characteristics of "best" friends. The affiliation with prosocial peers and the presence of a positive adult mentor(s) are counter-indicators of domestic violence.

- Raised in home where shame and fear were major socializing procedures - Father was a harsh disciplinarian or absent and mother was demanding and inconsistent.

- Absence of positive ethnic identification and heritage and fails to participate in church or other activities that could provide instrumental and emotional support to the couple.

**CHARACTERISTICS OF RELATIONSHIP BEHAVIORS OF PROSPECTIVE PARTNER, BOTH PRESENT AND PAST**

- Unmarried cohabitation with partner
  ***(Living together before marriage increases the likelihood of violence. Abusive men rarely abuse women before they have had sex or before they move in together or they wait until after the wedding day. They try not to be abusive before women are emotionally involved. Implication is that women should <u>not</u> be rushed into a relationship).***

- Having a child prior to marriage, especially if the child is unwanted and if there is a dense family size

- Presence of psychological abuse and use of "put-downs" about the partner's looks, accomplishments, activities. ***(Emotional and verbal abuse during dating period predicts violence after marriage.)***

- Uses constant and frequent criticism and complaints, belligerent, hostile interactions and engages in negative reciprocity and adversarial interactions.

- Couple has difficulty resolving conflicts, handling negative emotions, engaging in forgiveness and communicating wants/needs.

- Has rigid gender stereotypes or ideas about a man's and woman's roles. For example, a man should make all of the big decisions; man should make more money; man should drive the car, and she should want sex when he does.

- Male has fewer resources than female (educational attainment, income, occupational skills, social connections). This can lead to status incompatibility. Also incompatibility in race and religion <u>can</u> <u>be</u> sources of conflict.

- Relationship with prospective partner focuses on having one's needs met continually and when confronted becomes verbally and physically aggressive
  ***(Implication: Kubany et al. 2003 propose that before becoming involved with a prospective partner one should run a "mini-experiment" and "intentionally***

***disagree" in order to find out what kind of guy he is when conflicted. Look for warning signs!)***

- Partner evidences a high incidence of hostile intentions and justified retaliation explanations, with accompanying accusations, contempt, defensiveness and stonewalling (withdrawing) ***(See Gottman, 2002).***

- Conveys a sense of exaggerated or one-sided self-entitlement. For example, "He should be obeyed"; "If she disagrees, he is being disrespected"; "He has a right to control money"; "He should have greater authority as a man."

- Has persistent controlling behaviors. Thing have to be done his way. He is rigid in choosing which television programs, movies, restaurants, activities to go to. Becomes bad-tempered if things do not go his way. Tends to force his will on his partner. Violence functions to establish and/or maintain "power and control" in the couple relationship.

- He is jealous and suspicious. He does not want her to talk to other men and questions her about contacts with other men. Tends to isolate partner and feels threatened when fears of abandonment are threatened.

- "Falls in love" very rapidly. Feels attached and committed very quickly and wants partner to return the same level of affection right away.

- Evidences a high demand-withdraw pattern of interaction. Also, may evidence an anxious, dependent, insecure attachment pattern. Refuses to accept interruption or end of a relationship ***(Spouse abuse is highest when partner tries to leave)***.

- Manifests an unequal decision- making pattern. Makes decisions unilaterally. Issues of power, control and dominance are a central feature of the relationship.

- Limited social resources. Few social contacts outside of the relationship. Not participate in male prosocial groups. Less socially connected. Tends to be a loner.

- Limited or no overlap between respective partners' social networks.

- Member of a social group that practices substance abuse and supports the use of aggression to achieve interpersonal goals.

- Lack of family support, both present and in the past

- If children are involved in the relationship, then see the list of characteristics of maltreating fathers, as noted above. Obtain a sample of interactions of prospective partner with children. Assess attitude toward children. Argumentative, especially over disagreements over child rearing – If prospective partner has children, determine if he uses physical punishment as a disciplinary procedure. ***(Between 42% and 60% of parents who abuse children also abuse-or are abused by- their partners.)***

- Violence in previous relationships and history of dependency or jealousy ***(Implication: Should probe about the reasons for break-up of previous relationships. Tell prospective partner you have "Zero Tolerance for any form of violence or abuse.")***

- Keep in mind that relationships are two-way interactions. Almost one- half of violent episodes reported in intimate relationships involve both men and women being mutually aggressive. Women may initiate and help maintain violence in intimate relationships.

**FAMILY CHARACTERISTICS OF THE PROSPECTIVE PARTNER**

***(These family indicators are of particular importance when accompanied by evidence of relationship characteristics. Keep in mind Virginia Satir's 1964, cogent observation that "One's parents are the architects of the family")***

- Exposure to family violence while growing up. History of violence in family of origin. History of child abuse victimization is an inconsistent predictor of Intimate Partner Violence, while witnessing parental violence is a more consistent predictor of IPV.

- Intergenerational transmission of violence. Exposed to inflexible family role models who hold patriarchal belief systems.

- Recipient of harsh physical punishment - Absence of positive affectionate relationships - Have difficulty formulating attachment relationship while growing up - Evidence of little empathy for others.

- Recipient of physical punishment during adolescence (especially boys by fathers).

- Loss and/or absence of support by extended family and absence of non- blood social supports.

**COMMUNITY CHARACTERISTICS OF PROSPECTIVE PARTNER**

- Exposure to and victim of neighborhood violence.

- Community or cultural group's attitude toward the use of violence and toward gender stereotypes.

- Lack of resources to stop violence and the absence of support for victims of violence.

- Absence of community consequences for domestic violence.

# "DANGER SIGNS" OF VIOLENCE POTENTIAL IN PROSPECTIVE PARTNER (VPPP)

**I. Characteristics of Prospective Partner**

- Evidences aggressive behavior
- Current trouble with the law
- Evidences substance abusing behaviors (e.g. binge drinking)
- Poor response to high stress. Attacks others or withdraws
- Is depressed (feels helpless, hopeless)
- Has difficulty using words to express concerns / needs and difficulty resolving conflicts
- Availability of a weapon and preoccupied with violent media

**II. Developmental Indicators**

- History of aggressive behavior toward others or toward self
- Poor academic achievement
- History of substance abuse
- History of psychiatric disorders
- Exposed to harsh discipline, father absent, mother inconsistent and demanding
- Exposed to harsh discipline
- Absence of positive ethnic identification

**III. Relationship Behaviors**

- Demanding, controlling, jealous, suspicious, dependent
- Uses “put downs” and is argumentative. Adversarial negative reciprocal interactions
- Holds rigid gender stereotypes
- Wants things his way – exaggerated self-entitlement
- Poor current relationships with family members, peers, coworkers, authority figures

**IV. Family indicators**

- Countless family conflict and violence
- Recipient of harsh punishment
- Absence or loss of family support

**V. Community Indicators**

- Aggression and violence condoned in both the past and the present
- Exposed to community violence
- Lack of resources to stop violence, nor support for victims of violence

# ASSESSMENT OF PARTNER VIOLENCE

***(See La Taillade, 2006, La Taillade et al., 2006; Logan et al., 2002; Straus et al., 1996; Tolman, 1999; Wathen & MacMillan 2003 for examples of assessment measures.)***

Three different Assessment strategies for family violence will be considered.

1. **Assessment of women for IPV**. Women who may come to emergency rooms, or to a physician or therapist's office
2. **Assessment of distressed couples** who may come for counseling
3. **Assessment of children** who experience or witness the trauma of family violence

## Assessment of women

- Women tend to underreport abuse. Part of the reason for such underreporting is that doctors and other providers fail to routinely ask patients about abuse.

- Screen women for domestic violence in a private setting or use written or a computerized screening, rather than a face-to-face interview. Research indicates that women found face-to-face assessment least favorite.

- Examples of questions that can be asked, as suggested by Koziol et al. (2001) and Rhodes and Levison (2003):

  ***"Has your partner ever hit you, or otherwise physically hurt you?"***
  ***"Are you in a relationship with anyone who has hurt or threatened you?"***
  ***(If the answer to either questions is "yes," then ask about the nature of the injuries.)***
  ***"Do you feel safe in your current relationship?"***
  ***"Is there a partner from a previous relationship who is making you feel unsafe?"***

- Also probe about the nature of the relationship.

  ***"Is your partner (husband) very jealous or controlling?"***
  ***"Does your partner keep you away from family and friends?"***
  ***"Can you come and go as you please?"***
  ***"Has your partner ever made you have sex when you didn't want to?"***

- These questions can be supplemented by a variety of self-report scales such as the Revised Conflict tactics Scale (Straus et al., 1996) and the Psychological

Maltreatment of Women Inventory (Tolman, 1999). See Wathen and MacMillan (2003) for a list of possible screening scales for intimated partner violence.

- In addition, the assessment should also cover the following areas:

  - Ask about the degree of tension in the relationship
  - The couples' ability to work out arguments
  - Whether arguments result in feeling put down or bad about yourself
  - Whether arguments ever result in physical aggression
  - Whether she feels frightened by what her partner says or does
  - Whether the partner has ever abused her physically, emotionally or sexually
  - Severity and history of various forms of abuse
  - Risk of being re-abused
  - Level of adjustment and quality of life indicators
  - Presence of psychopathology (depression, anxiety, suicidality, PTSD, substance abuse, physical health issues, such as presence of HIV and sexually transmitted diseases [STD])
  - Level of social supports
  - Signs of resilience and "strengths"

- There is also a need to assess for risk factors for abuse, in order to determine the likelihood of revictimization.

A major concern in working with family violence is the issue of ongoing risk assessment. See Meichenbaum (2002) for ways to conduct such assessments. Also see the **Ontario Domestic Risk Assessment ODARA**, which can be obtained from ***sdey@mhcp.on.ca*** or call the Mental Health Centre Penetanguishene, Ontario, Canada (705-549-3181). (Cost $20 U.S. Funds)

# ADDITIONAL QUESTIONS THAT CAN BE ASKED ABOUT PARTNER ABUSE (PRESENT AND PAST)

## How is your relationship with your partner these days?

***At times we all get into arguments with our partners. What happens when you and your partner argue at home? What happens when you and your partner have a fight at home?***

***Has your partner ever threatened you or physically hurt you?***

***Do you ever feel afraid of your partner?***

***Has your partner ever destroyed things you cared about or stolen your things?***

***Do you have calm discussions, arguments, yelling, name-calling or blaming, throwing things, pushing, shoving, hitting? (Address each separately.)***

***Has your partner ever threatened you badly in other ways? What happened?***

***Has your partner ever threatened or abused your children?***

***Has your partner ever made you do something sexually that you didn't like?***

***Has you partner ever prevented you from leaving the home, getting a job, seeing friends or continuing your education?***

***Has there been any stalking behavior?***

***Do you feel your children are safe?***

## Questions about the Partner

***What happens when your partner gets angry?***

***Do you or your partner use alcohol or drugs?***

***How does your partner act when he (or she) has been drinking or using other drugs?***

***Have you or your partner been treated for substance use in the past or presently?***

***Have you or your partner had legal and occupational problems due to the use of substances?***

***How does your partner manage frustration or stress?***

***Does he/she use aggression (including threats or put downs) to resolve conflicts in the relationship?***

***Are there guns (or other weapons) in your home?***

***Has your partner (or anyone else) ever threatened to use weapons against you and your families?***

***Does he/she tend to blame others (including the partner) or does he take responsibility for his/her mistakes?***

***Does your partner undermine your authority as a parent, cause tension between siblings, or interfere with your relationship and parenting with your children?***

## Assessment from previous episodes of Intimate Partner Violence

***Have you ever been in a relationship where you were hurt or threatened?***

***With regard to your previous abusive events, what actions, if any did you take? What happened?***

***Ask about family history of violence. Were your parents divorced? (Assess whether divorce was caused by abuse.) What lingers from that experience?***

# ASSESSMENT OF DISTRESSED COUPLES

When conducting assessment with distressed couples, La Taillade et al. (2006) highlight the need to:

- initially foster a therapeutic alliance that conveys "respect" and "collaboration"

For example, the therapist should not assume familiarity by using the partner's first name without asking for permission and the therapist should refrain from using jargon that implies the couple is "defective" or that may inadvertently reinforce "blameworthiness". Instead, collaborative goal-setting should be employed, whereby the couple will come to be viewed as "co-therapists" incorporating the joint expert knowledge of the couple and therapist.

> ***"While the therapist is an expert on treatment, the couple holds expert knowledge on their experiences of the strengths and difficulties on their relationships. The goal of treatment is to bring these two sources of expertise together".***

The therapist can convey to the couple the following message that lays the groundwork for the assessment procedures and helps the couple acknowledge that some changes are needed. The therapist may observe that :

> ***" My job is to find out how things are going in your relationship and how you both would like it to be? Moreover, I want our current efforts to improve things to be informed by what you have tried in the past. What has worked, as evident …? What has not worked, and what do you think has gotten in the way of your achieving these goals in the past?***
>
> ***If we work together, and I hope we will, how would we notice changes in your relationship? What exactly do you think would change in your partners (husband's/wife's) behavior? What exactly do you think would change in your behavior? What would other's notice? How would we know we were making progress? How could we tell if you were achieving your treatment goals?***
>
> ***Let me ask one last question, if I may. What barriers or obstacles do you think might get in the way of you both achieving your goals?***
>
> ***Where do you think we should begin the process of working on your goals of improving your relationship?"***

Following this open-ended joint discussion the assessment procedure can continue by asking each member to fill out separately and in private a set of self-report measures. (Note that couples who present for treatment usually do not spontaneously report spouse abuse as a presenting problem. There is a need to explicitly probe for intimate partner violence. The couple should be asked to complete the self-report measures seperatly and in privacy (e.g. The Conflict

Tactics Scale-Revised-CTS2; Straus et al., 1996, as well as measures of psychological abuse, as noted below).

-Separate interviews should be conducted with each partner covering such topics as the precipitants and sequence of events leading up to each violent incident (conduct a chain analysis of violent sequences), the severity and duration of violence and abuse including injuries sustained, presence and impact on children,

-Whether the police or other outside parties were summoned as a result of the incident, efforts to avoid or reduce violence and the presence of safety plans, level of commitment to the relationship, as evident in the diverse pattern of extramarital affairs (see Snyder et al., 2007).

The extent, depth and timing of the assessment measures should match the couple's comfort level. The therapist can select from the following list of assessment measures as recommended by La Taillade (2006) and La Taillade et al (2006). ***(See their articles for list of specific references)***

| | |
|---|---|
| **Relationship Functioning** | Dyadic Adjustment Scale (DAS; Spanier, 1976) |
| | Communications Patterns Questionnaire (CPQ; Christensen, 1987, 1988) |
| | Marital Satisfaction Inventory (Snyder, 1997) |
| **Psychological Abuse** | Multidimentional Measure of Emotional Abuse (MMEA; Murphy & Hoover, 2001) |
| | Psychological Maltreatment of Women Inventory (PMWI; Tolman, 1999) |
| **Physical Abuse** | Conflict Tactics Scale-Revised (CTS2; Straus et al.1996) |
| **Gender Roles** | Provider Roles Inventory (Perry-Jenkins & Crouter 1990) |
| | Who Does What Questionnaie (Cowan & Cowan, 1988) |
| **Economic Strain** | Family Economic Strategy Scale (FESS; Hilton & Devall, 1997) |
| **Experiences with Discrimination** | Schedule of Racist Events |

| | |
|---|---|
| | (SRE; Landrine & Klonoff, 1996) |
| **Individual Psychological Functioning** | Beck Depression Inventory (BDI; Beck et al., 1979) |
| | Trauma Symptom Inventory (TSI; Briere, 1995) |
| | Spielberger State-Trait Anger Expression Inventory (STAI; Spielberger, 1996) |
| **Cognition's About Relationships** | Marital Attitude Survey (MAS; Pretzer et al. 1991) |
| | Style of Conflict Inventory (SCI; Metz, 1993) |
| **Social Support** | Social Support Questionnaire (SSQ; Sarason et al. 1987) |
| **Spirituality and Religionity** | Spiritual Well-being Scale (Paloutzin & Ellison, 1982) |
| **Racial and Ethnic Identity** | African Self-Consciousness Scale (ASC, Baldwin & Bill, 1985) |
| | Black Racial Identity Attitude Scale (RIAS; Helms & Parham, 1996) |
| | Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992) |
| | Multiculture Experience Inventory (MCE; Ramirez, 1998) |

When conducting both interview and self-report assessment of couples, there is a need to be sensitive to racial and ethnic differences and there is also a need to incorporate into the assessment process cultural and couple "strengths" and "resources".

For instance, La Taillade (2006) suggests that the therapist, who may be a member of a different race than his/her clients should ask the following questions:

> ***"What are you concerned that I may miss in understanding your concerns because I am someone from a different racial group (White, Asian, Black)?"***
>
> ***"Are there aspects of your racial background, ethnicity or culture that you think are important for me to know in working with you?"***
>
> ***"How have particular experiences of racism and discrimination that you***

***may have experienced affected your relationship, both negatively and positively?"***

The following set of questions should be included in the assessment process **in couples** to tap the presence of **"strengths" and potential protective factors.**

***-How did they meet?***

***-How long did they date before marriage?***

***-What did they find attractive and interesting in each other?***

***-How did they come to the decision to marry?***

***-How did they come to the decision to have children?***

***-What challenges (stressors) did they, as a couple, have over the course of their relationship? How did they handle these stressors?***

***-What did they learn about each other and about their relationship as a result of these experiences?***

***-What kind of issues have they had conflicts with in the past or presently? How have these conflicts been addressed or resolved?***

***-What did they learn from their own families (family of origin) that impacts currently on their relationship?***

There is also a need to access for the presence of any culturally-specific strengths or protective factors that can buffer the couple. Does the couple:

-have access to extended family, non-blood kin and community supports;
-participate in church, religious or social activities (spirituality, religiosity, ethnic identification) that are associated with supportiveness?

Such supports are particularly important to the maintenance of stable marriages when the couple is interracial or homosexual.

# ASSESSMENT MEASURES FOR CHILDREN

***(See AACAP, 1998; Scheeringa et al., 2001)***

**Indicators of Behavioral Problems and Overall Adjustment**

| | |
|---|---|
| Child Behavior Checklist (CBCL) | Achenbach, 1991 |
| Children and Adolescent Functional Assessment Scale | Hodges, 1997 |

**Measures of Exposure to Traumatic Events and Impact**

| | |
|---|---|
| Exposure to Adverse Childhood Experiences (ACE) | Edwards et al., 2005 |
| Trauma Symptom Checklist for Children | Briere et al., 2001 |
| Trauma Symptom Inventories | Briere, 1995 |
| Child PTSD Reaction Index | Friedrich, 1998 |
| Children's Impact of Traumatic Events Scale | Wolfe & Gentile, 1991 |
| Child Sexual Behavior Inventory | Friedrich, 1988 |
| Childhood Traumatic Grief | Cohen et al., 2005; Fox 1985; Webb, 2002 |

**Measures of Concurrent Problems**

| | |
|---|---|
| Fear Survey Schedule for Children-Revised | Ollendick, 1978 |
| Children's Depression Inventory | Kovacs, 1992 |
| Revised Children's Manifest Anxiety Scale | Reynolds & Richmond, 1985 |
| Dissociation Scale | Putnam, 1997 |

# ASSESSMENT OF NON-OFFENDING PARENT

Symptom Checklist-90 Revised (SCL-R-90) Derogatis, 1992

Interpersonal Support Evaluation Cohen et al., 1985

**Supplement Self-report with a <u>clinical interview</u> that covers the following information from the <u>parent</u>.**

- ***Has your child experienced or witnessed an event that caused, or threatened to cause, serious harm to him or herself or to someone else?*** If so, obtain the following information:

  ***Where did the event occur?***
  ***Who was with your child?***
  ***Who hurt your child?***
  ***How often did this happen?***
  ***How long did it last?***
  ***How badly was your child hurt?***
  ***Did he or she require medical care?***

- In the case of physical/sexual abuse and neglect, solicit the following information:

  a) frequency and duration of the exposure, abuse or neglect of the child and evidence of injuries sustained by the child;

  b) any evidence about concurrent abuse (physical and psychological) of the partner or family members;

  c) the relationship with the perpetrator;

  d) ways in which the perpetrator may have avoided detection (e.g., use of threats to the child);

  e) protective actions taken by the nonoffending parent;

  f) emotional responses of nonoffending parent both in the past and present (amount of help and support);

  g) information about reporting of the abuse to authorities;

  h) current status of the case (legal, medical, treatment services);

i) assess for safety of family members and vulnerability to revictimization.

***See the Child Interview for children who have witnessed violence (Pynoos and Eth, 1986).***

- Use free drawing and story telling, play and puppet activities for assessment and treatment options.

**Assess for Evidence of Resilience**

Individual Resilience
Familial / Social Resilience
Systemic / Societal Resilience

**Assess for Possible Barriers of Participating in Treatment and Adhering to a Treatment Plan**

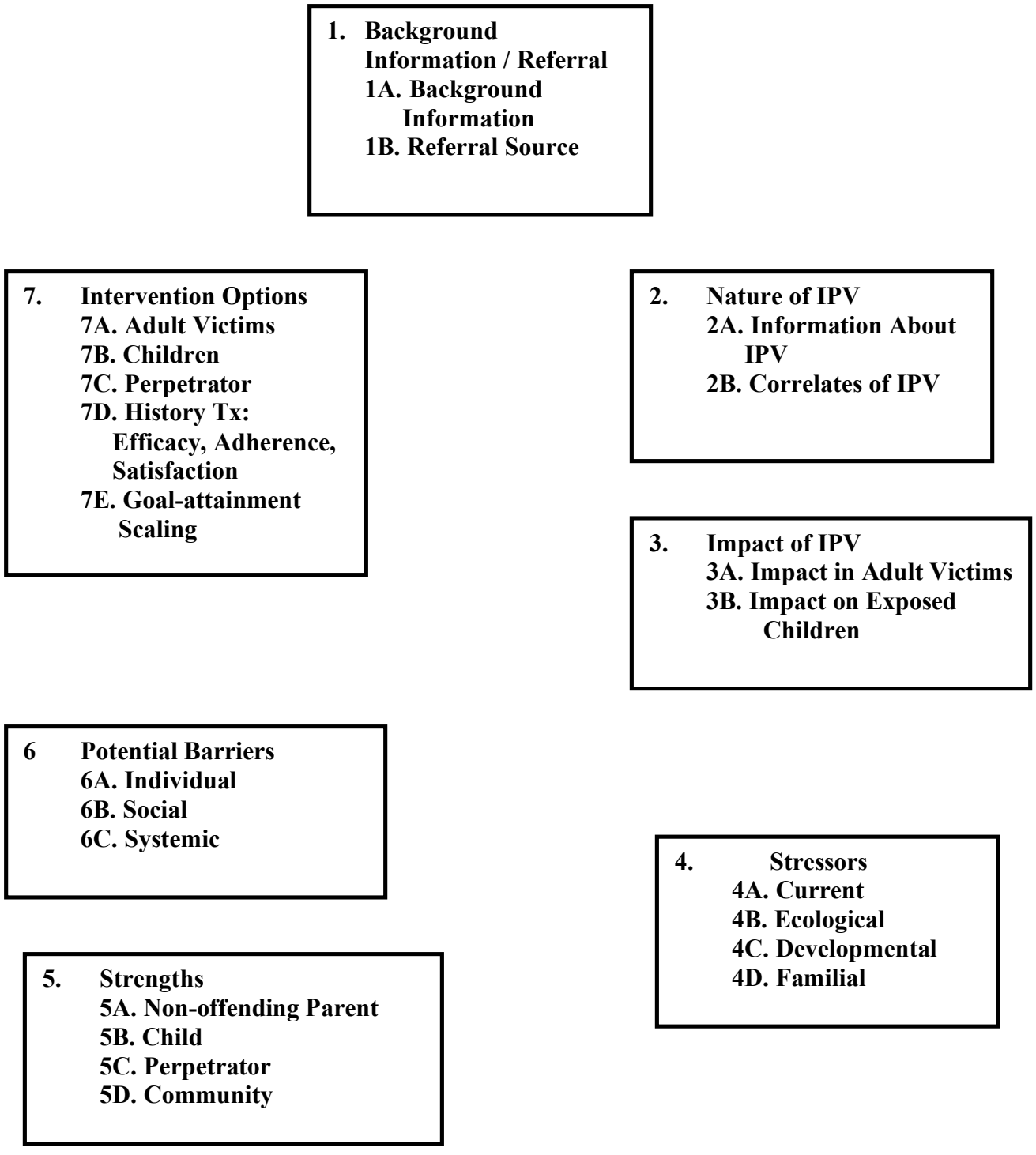
Individual Barriers
Familial / Social Barriers
Systemic / Societal Barriers

## CONSIDERATIONS IN FORMULATING ASSESSMENT AND TREATMENT DECISIONS IN WORKING WITH CHILDREN

- Maltreated children may experience social problems, aggression, depression, posttraumatic stress and somatizing symptoms.
- About half of sexually abused and one third of physically abused children will meet diagnostic criteria for PTSD and more will have at least some posttraumatic stress symptoms.
- Sexual behavior problems are noted in about one-third of sexually abused children.
- Anger control problems and aggression are frequently observed in physically abused children.
- Abused children often evidence high level of anxiety and depression and may evidence suicidal behaviors.
- Abusive families tend to be more socially isolated, have more rigid patterns of interaction, value family control over individual behavior, are more likely to have authoritarian interpersonal styles, and have significantly higher levels of marital and sexual relationship dissatisfaction.
- High level of parental distress and poor parenting skills occur in abusive families.
- The level of emotional distress in the nonoffending parent has proven to be an important predictor of the abused child's long-term adjustment.
- Individuals from ethnic minority groups are less likely to initiate mental health treatment and they are more likely to end treatment prematurely.

There is a need to integrate all of this assessment information on victims, children and batterers into an integrative **Case Conceptualization Model (CCM)** that informs treatment decision-making. The following **Case Conceptualization Model – CCM** provides a procedural flow-chart of the various elements that need to be considered in formulating intervention plans. ***(See www.melissainstitute.org - Downloads 8th Annual conference, Meichenbaum PDF for a detailed description of CCM for intimate Partner Violence)***

# CASE CONCEPTUALIZATION MODEL OF INTIMATE PARTNER VIOLENCE



# HOW CAN DOCTORS RESPOND TO DOMESTIC VIOLENCE?

***(See article by Meichenbaum & Keeley (March, 2004) Miami Medicine. Available on www.melissainstitute.org)***

In one national survey, 92% of women who are physically abused by a partner did not discuss these incidents with their physicians. It is clear that physicians cannot rely on victimized individuals to introduce their difficulties. Doctors need to actively seek this kind of information. Such active questioning is especially important when patients report chronic pain or many symptoms or are overusing the healthcare services. The following data underscore the importance of medical screening.

- It has been estimated that hospital emergency department personnel in the U.S. treated 1.4 million people for injuries from confirmed or suspected intimate violence and about half of female victims of intimate violence were injured.

- Over a 5-year period, half of all women who were victims of an intimate partner homicide had been in the emergency room at least once in the 2 years before their death.

- Less than 10% of women who experienced abuse told a physician; less than 50% had told anyone.

- Only 10% - 15% of physicians reported ever asking about victimization.

- Only one in five women who were asked reported that their doctor raised the subject of abuse and of those who discussed their abuse with the doctor, less than half were referred to a support services and less than one quarter were referred to the police.

- Studies consistently show that the medical community identifies only between 2% and 5% of intimate violence victims.

- The major barriers offered by physicians for assessing victimization of domestic violence include: lack of adequate training; lack of knowledge regarding prevalence; skepticism about treatment effectiveness; uncertainty about appropriate referrals; patient resistance; physician discomfort with the issues; time constraints; fear of losing patients; financial constraints and fear of safety.

- Brief nurse and physician interventions, or both, have been found to make a difference in the education and referrals for women in violent relationships.

# TREATMENT OPTIONS

**Batterer's Intervention Programs**

These gender specific groups focus on anger management procedures and participants' beliefs that support the use of aggression toward partners during conflicts. Address accompanying patriarchal beliefs.

**Integrated Multifaceted Community-based Programs** that are culturally-sensitive, consisting of **Crisis Management** designed to reduce imminent risk of violence and increase family members' safety. Provide victims with telephone numbers of crisis hotline, shelter locations, counseling services, legal system resources (e.g. ways to initiate protection orders). Review safety plan.

**Support groups** for battered women and advocacy services.

**Conjoint Treatment**- individual and group structured time-limited treatment for couples who experience low to moderate IPV (See Heyman & Schlee, 2003; La Taillade et al., 2006; Stith et al. 2004).

**Treatment of Victims of Family Violence**- individual and group interventions

**Prevention and Relationship Education Programs**

**We will briefly consider each of these treatment options.**

a) **Batterer's Program**
b) **Integrated Multifaceted Community-based Interventions**
c) **Conjoint Couple's Treatment**
d) **Treatment of Victims of IPV (Adult and Children)**
e) **Prevention and Relationship Education Programs**

# DO BATTERERS' TREATMENT PROGRAMS WORK?

***(See Babcock, J. C., Green, C. E., Robie, C., 2004, Clinical Psychology Review, 23, 1023-1053. jbabcock@uh.edu )***

A number of treatment models have been employed with batterers. The most popular are those that follow the feminist psychoeducational DULUTH Model (Pence & Paymer, 1990; 1993) and the Cognitive-behavioral group model (Meichenbaum, 2004 and Sonkin et al. 1985).

**Psychoeducational DULUTH Model** views domestic violence as a result of both patriarchal ideology and implicit and explicit societal sanctioning of men's use of power and control over women. A Power and Control Wheel is used to illustrate the pattern of abuse that includes intimidation, male privilege, isolation, emotional and economic abuse. An Equality Wheel that fosters a more egalitarian marital relationship is used to nurture more adaptive interactions and to affect the batterer's attitudes and values.

**Cognitive-behavioral Group Treatment** adopts a social-learning information-processing perspective that violence occurs because it is functional for the user ("It works, at least in the short term") and because the perpetrator has cognitive and behavioral distortions and deficits. A variety of skills training programs that focus on communication, assertiveness, anger management techniques (e.g., timeouts, relaxation techniques, cognitive restructuring, self-instructional training and relapse prevention) are employed.

Various **Other Models of Intervention** that combine features of both feminist psychoeducational and cognitive-behavioral skills-oriented approaches have been developed such as MANALIVE (Sinclair, 1989; 2002), Compassion workshops (Stosny, 1995; 2002), Skills-based workshops (Wexler, 2000; Wexler & Willard, 2002 – Hispanic version), Couples behavior therapy that focuses on alcoholism (Dunford, 2000; Farrell & Fals-Stewart, 2000), Supportive therapy (Taft et al., 2001).

More recently, interventions have been developed that focus on the emotional components of domestic violence. These interventions highlight the role of jealousy and empathy (Dunford, 2000) and nurture relationship enhancement (Guerney, 1977; Johnson, 2000; Waldo, 1988). These interventions include role-plays and assigned homework targeted to improve expressive skills, empathy communication with the partner, and identification and management of emotions.

Many treatment programs of batterers include a mixture of features of these various approaches, supplemented by a Coordinated Community Treatment Approach.

# FEATURES OF TREATMENT WITH BATTERERS

- The most appropriate treatment modality for physically abusive men is men-only specialized groups operating within a coordinated community response network. This promotes men's accountability for changing violent behaviors, develop nonviolent resolution skills, receive specialized services such as treatment for substance abuse, PTSD and help them establish nonviolent relationships (Aldarondo & Mederos, 2002).

- The recommended duration of intervention ranges from 12 to 52 weeks. According to current standards, group intervention is the format of choice.

- Couples therapy is deemed inappropriate or engaged in with caution. There is concern that women's disclosures in the presence of the partner may lead to later retribution or imply that she is at least partially to blame for the victimization. Aldarondo and Mederos (2002) observe:

> ***"Couples counseling is contra-indicated if the abusive man expresses no remorse, denies his actions, blames the abuse victim or has little commitment to change. Similarly, if the abuse victim shows fear of further violence, assumes responsibility for it, or feels deserving of maltreatment, couples counseling should <u>not</u> be considered."***

- Bancroft and Silverman, (2004) have proposed the following guidelines when assessing the degree of change in abusers.

> ***Has he made full disclosure of his history of physical and psychological abuse?***
>
> ***Has he recognized that abusive behavior is unacceptable?***
>
> ***Has he recognized that abusive behavior is a choice?***
>
> ***Does he show empathy for the effects of his actions on his partner and children?***
>
> ***Can he identify his pattern of controlling behaviors and entitled attitudes?***
>
> ***Has he replaced abusive with respectful behaviors and attitudes?***
>
> ***Is he willing to make amends in a meaningful way?***

***Does he accept consequences for his actions?***

- Note, however, that there is research indicating that for females who have a history of conduct disorders, the female partner has been found to initiate and contribute to mutually aggressive partner episodes. One-half of violent episodes reported in intimate relationships involve men and women being mutually aggressive (Capaldi et al., 2004).

- The use of the group format is designed to have participants address the batterer's denial and victim blaming. There is a need to ensure that "female bashing" does not also occur. Such groups for males are often led conjointly by a male and female therapist.

- There is a high dropout rate from batterer's treatment programs, even among court-mandated batterers. There is a need to focus on retention techniques and on motivational interviewing procedures that are designed to increase the batterer's participation and investment. The participants need to perceive that the program facilitators are invested in their welfare and aware and concerned about any absences (i.e., use of follow-up contacts and the like). See Wexler's (2006) recent book on ways to establish a therapeutic alliance with batterers.

- Men who complete the batterer's treatment programs tend to be more educated, more likely to be employed, married and Caucasian, and less likely to have a criminal record. Completers tend to have a higher stake in social conformity and are "socially bonded," not isolated and have something to lose, as a result of continuing battering (Hamberger & Hastings, 1993; Sherman et al., 1992).

- Battering treatment programs need to be one component of a Coordinated Community Response that involves police response, prosecution, probation, as well as treatment options. These legal responses may include:

  (1) strong legal response during initial sentencing;

  (2) court-mandated treatment with ongoing supervision

  (3) monitoring and sanctioning offenders who fail to comply with treatment (Need to develop a system that detects early failure to comply with court orders and treatment.)

- Some observations on legal alternatives:

  (1) Arrests tend to have a stronger deterrent in employed than for unemployed men.

  (2) Permanent civil protection orders (12 months) are more effective than temporary (2 week) protection orders. In fact, temporary protection orders

have been found to be associated with a significant increase in psychological abuse, but no change in physical abuse (Babcock et al., 2004).

(3) Various sentencing options (pretrial diversion where defendants' criminal records would be cleared pending treatment completion; going to jail; paying a fine; post conviction probation interventions) have not yielded differential effectiveness (Babcock et al., 2004).

(4) The potency of the legal system that sanctions men for treatment noncompliance can have the most effect.

- Men need to develop nonviolent conflict resolution skills, take responsibility for their abusive behavior, develop empathy for their partner's victimization, develop and implement non-gender stereotypic views and behaviors of their relationship with their partners and reduce the level of dependency on their partners.

- The man's commitment to the relationship and his ties to family, employment and community networks are favorable indicators. (Aldarondo & Mederos, 2002).

- Dutton and Golant (1995, p.114) highlight the developmental features that often contribute to male abusive relationships. They observe:

> ***"A boy with an absent or punitive father and a demanding, but unavailable mother, learns that men don't give emotional comfort, and that women appear to be supportive, but are ultimately demanding and can't be trusted" (Dutton & Golant, 1995, p.114)***

- Wexler (2000, 2004) highlight how to address these needs in batterer's treatment interventions.

# OUTCOMES OF TREATMENT WITH BATTERERS

Approximately two thirds of men who complete group intervention programs for domestic violence remain nonviolent in their intimate relationships. However some 20% of men continue to be severely violent in their intimate relationships. These men tend to drop out of treatment and they tend to have substance abuse problems. Thus, one in five men who attend intervention programs will continue to abuse, even if they attend treatment. There is a need to monitor abusers and to carry out confidential and safety-oriented contacts with victims of abuse.

Another way to evaluate the efficacy of Batterers' Treatment Programs is to conduct what are called **meta-analyses**. This approach pools all of the outcomes of multiple treatment studies, diverse populations, and varied outcome measures. The good and the poor studies are all placed in the same evaluative pot. Such meta-analyses provide only a general overall impression of relative efficacy. With this caveat in mind, one can consider the conclusions drawn by Babcock et al's. (2004) meta-analysis: They observed:

> ***Based on experimental studies, the effect size due to treatment of batterers is .09 and .12, based on victim report and police records, respectively. This means that treatment is responsible for approximately one-tenth of a standard deviation improvement in recidivism (an effect size less than .20 is considered small, .50 is medium, and .80 is large) (Babcock et al., 2004, p. 1044).***

The spontaneous violence cessation rate in nontreated samples is about 35%. Battering treatment programs have to do better than this recovery rate.

Treated batterers have a 40% chance of being successfully nonviolent. But nontreated batterers have a 35% chance of maintaining nonviolence. ***There is only about a 5% increase in success rate attributable to treatment.*** A woman is 5% less likely to be re-assaulted by a man who was arrested, sanctioned and went to a batterers' program than by a man who was simply arrested and sanctioned. Babcock et al. (2004, p. 1044) observe however, that while this 5% decrease is modest, this would "equate in the U.S. to approximately 42, 000 women per year no longer being battered."

To put the differential 5% efficacy rate of battering programs in perspective, consider that psychotherapy with children and adolescents with aggression programs yields a 16% success rate over no treatment; correctional treatment with adult prisoners yields a 12% improvement; and psychotherapy yields a 70% improvement rate.

Moreover, there are no significant differences between various forms of batterers' treatment programs (e.g., DULUTH model versus Cognitive-behavioral interventions).

## HOW CAN WE IMPROVE THE EFFICACY OF BATTERERS' TREATMENT PROGRAMS?

(1) Choose carefully who goes into treatment.

(2) Exert more effort on pre-intervention preparation, use motivational interviewing procedures and work on developing and maintaining a therapeutic alliance.

(3) Have close monitoring of treatment noncompliance and legal sanctions for nonadherence.

(4) Target specific subsamples of batterers (e.g., different types of batterers – family only, borderline personality disorder) who have a history of victimization, and antisocial/generally violent types ala Holtzworth-Munroe et al. (1995).

(5) Tailor interventions to diverse ethnic minority differences. (For example, review See et al., 2000, on ways to adapt batterer's programs to the features of African American males; and Ferrer, 2002, to the needs of Hispanic males.)

(6) Use an out-reach program that includes community-based interventions. ***(See www.melissainstitute.org for a description of these outreach programs and on ways to involve doctors into the assessment and intervention processes.)***

(7) Assess needs for concurrent treatment, such as substance abuse and trauma-focused interventions.

(8) Maintain close coordination with other agencies (probation, criminal justice system) regarding the abuser's compliance with program standards, restraining orders and conditions of probation.

## CONJOINT TREATMENT OF COUPLES WHO EXPERIENCE LOW TO MODERATE INTIMATE PARTNER VIOLENCE

The therapist must collaboratively with the couple assess the appropriateness of conjoint treatment. Factors going into this decision include:

1. The level of violence should be low to moderate;

2. Neither partner is perceived to be in imminent danger of physical harm;

3. The couple acknowledges that abuse is a problem and they are willing to work toward having an abuse-free relationship;

4. The couple is committed to staying together;

5. The female partner must feel safe in both living with her partner and participating in conjoint treatment;

6. The female partner feels comfortable being honest in the presence of her partner;

7. The couple recognizes that the conjoint treatment is designed to reduce risk factors for aggression behavior and is designed to enhance protective factors;

8. More specifically, as outlined by La Taillade et al (2006), the goals of conjoint treatment include:

    a) Educate couples about the patterns of violence that can occur in close relationships, negative consequences and alternatives to IPV.

    b) Increase personal responsibility for the use of violence. Decrease blaming spouse and self-blame.

    c) Ultimately eliminate IPV through Anger Management and conflict resolution skills.

    d) Increase relationship satisfaction and strengths and positive couple interactions through communication and problem-solving skills training.

    e) Help couple recover from any past trauma and broken trusts due to affairs.

    f) Increase positive interactions in couple. (see discussion below of PREP Skills Training).

Baucom et al. (2006) have developed an integrated program for treating couples who have had extramarital affairs. The intervention program incorporates procedures derived from cognitive behavioral approaches (boundary settings, setting limits on negative interactions, self-care guidelines, time-out and venting techniques, coping with flashbacks, problem-solving and communication skills training, behavioral exchange programs); insight-oriented approaches (exploring family-of-origin, explore factors that contributed to the affair, role of external stressors) and forgiveness approaches ( use of acceptance and tolerance building, empathic focusing techniques, unified detachment procedures).

# COGNITIVE-BEHAVIORAL COUPLE TREATMENT PROTOCOLS

Such **Cognitive-behavioral Couple Treatment Protocols** usually consist of 10 weekly 90-minute treatment sessions conducted over approximately 3-4 1/2 month period (See La Taillade et al., 2006).

**Session 1** Relationship history, includes both strengths, as well as consideration of presenting problems. Couple completes a no-violence contract committing to reduce all forms of aggression and help establish an abuse-free relationship. Collaborative goal-setting is conducted.

**Session 2** Refine treatment goals and couple is taught anger management strategies such as self-soothing and acceptance procedures, time outs and cognitive restructuring procedures. Couple is taught how to notice and interrupt problematic interaction patterns. Couple engage in behavioral change agreements and agree on ways to experiment with new interactional patterns.

**Sessions 3 and 4** Expressive and listening skills are taught and practiced with moderate to severe conflict situations. Cognitive Restructuring procedures are employed that focus on hostile attribution biases, expectations and gender- role beliefs (See Epstein & Baucom, 2003, Heyman & Neidig, 1997).

**Sessions 5 through 7** Problem-solving and communication skills are taught to resolve couple conflict without abuse (See Rathus & Sanderson, 1999). Consider beliefs (e.g. "compromise is a sign of giving in or a sign of weakness") and teaches communication strategies such as "editing" (not having to express every thought one has). Train couple to anticipate possible barriers to implementing learned skills. For example, avoid blaming, criticizing, defensive withdrawal. Instead develop tolerance building, acceptance and conflict resolution skills.

**Sessions 8 through 10** Skills training is supplemented with relationship recovery and enhancement strategies. Themes covered include the need for couple collaboration and support of the experience of prior traumatic events. For example, the value of taking individual responsibility, forgiveness, acceptance, reconciliation and negotiation skills are addressed (See Gordon & Baucom, 1998).

## WHAT WOULD AN INTEGRATED MULTIFACETED PROGRAM FOR REDUCING FAMILY VIOLENCE LOOK LIKE?

Any comprehensive intervention program needs to consider the treatment of victims of abuse, children exposed to domestic violence, perpetrators and what can be done on a preventative basis. As noted below, professionals from various areas of expertise need to combine their efforts, if the incidence of family violence is to be reduced. As Mederos and Perillo (2004) describe, **Coordinated Community Response Initiative (CCRI)** programs have been developed that include:

- Implementation of pro-arrest policies by police
- Proactive prosecution that is focused on victim safety
- Effective judicial oversight of convicted offenders
- Ongoing monitoring of abuses by probation officers
- Batterer intervention programs, that focus on behavior change
- Imprisonment for abusers who violate probation or who re-assault or harass victims
- Ongoing coordination with battered women's services
- Oversight of the process by battered women's advocates

There are, however, two **important caveats** that have to be recognized when considering such Coordinated Community Research Initiatives (CCRI). First, as Aldarondo and Mederos (2002) observe, these treatment elements apply only when the perpetrators of violence are brought under the auspices of authorities or social service agencies. In fact, 75% of intimate partner assaults are not reported to authorities and the majority of women whose partners are arrested for assault do not pursue charges for a variety of reasons that may include fear and mistrust of the criminal system. An alternative to the CCRI approach is to implement **Outreach Programs** for high-risk populations as described by Mederos and his colleagues. ***(See Website Building Partnerships Initiatives www.endabuse.org/bpi.)*** A related problem is the very high drop-out rate and noncompliance with court orders and intervention programs.

The second major caveat to CCRI intervention programs is the limited demonstration of the effectiveness of various interventions in the area of family violence. A report by the National Research Council and The Institute of Medicine (2004) provides a major warning. They conclude:

***"The Nation spends billions of dollars each year to curb family violence, but most of the money supports an array of treatments and intervention efforts that have not been evaluated for their impact or effectiveness."***

They go on to observe that:

***"Health care, law enforcement and social service interventions for family violence commonly exist side by side within a community, in an uncoordinated system that is largely undocumented."***

The National Research Council Report edited by R. Chalk and P. King is worth examining. ***To see the full Report, go to http;//www4.nationalacademies.org/news.nsf/isbn/0309054966? Open document or call 1-800-621-6242 and ask for the repost Violence in families: Assessing prevention and treatment programs.***

With these important warnings in mind, we can now consider the variety of interventions for victims of family violence that have been tried and note those that are most promising.

# CORE TASKS OF TREATMENT WITH VICTIMS OF DOMESTIC VIOLENCE

***(See Dutton, 1992; Kubany et al. 2003, 2004; Meichenbaum, 2002; Roberts, 2002)***

**1. Establish and maintain a therapeutic alliance.**

- Therapist should work to establish a nonjudgmental, trustworthy, compassionate and validating relationship.
- Encourage the client to tell his/her "story" of abuse at own pace.
- Solicit client's feedback on session
- Become an "advocate" for the client. Help the client create options. Help mediate with various agencies. Some treatment programs have involved law students to act as consultants and advocates for victims of violence.

**2. Collaborate with the client in developing and implementing a safety plan.**

- Help client conduct an informed risk-assessment.
- Conduct a detailed process analysis of the client's decision- tree in deciding to stay or leave.
- Assess for strategies that the client has used in the past to avoid violence.

**3. Educate the client about the nature of domestic violence.**

- Use the "art of questioning"
- Address "myths" concerning domestic violence that address issues of self-blame and shame.
- Educate about the various types of domestic violence (e.g. use Pence and Raymer's 1986 Power and Control Wheel), use assessment measures of Domestic Violence.
- Help the client label emotions and use a "clock metaphor" to illustrate the interconnection between triggers, feelings, cognitions and behaviors and resultant consequences.

| | |
|---|---|
| ***12 o'clock*** | -external and internal triggers |
| ***3 o'clock*** | -primary and secondary emotions |

| | |
|---|---|
| ***6 o'clock*** | -automatic thoughts, images, self-statements, attributions, styles of thinking and thinking errors, schemas and beliefs |
| ***9 o'clock*** | -behaviors taken and resultant consequences |

- Use the **"vicious cycle"** procedure. View emotions (3 o'clock) as a **"commodity"**

  ***What do you do with feelings of X? If you do that with such feelings, then what is the impact, what is the toll, what is the price you and others pay?***

- Help client appreciate the bi-directional nature of conflict and violence without "victim blaming."

- Conduct assessment using the Case Conceptualization Model and provide feedback.

- Have client fill out a Genogram of family patterns of violence, victimization and abuse. Note pattern of intergenerational violence and consider implications.

- Use bibliotherapy and films/videotapes (e.g. See Kubany et al. 2003, Workbook for Women).

**4. <u>Nurture</u> <u>hope.</u>**

- Engage the client in a <u>collaborative</u> <u>goal-setting</u>.

  ***"Let me describe what I do for a living. I work with folks like yourself and try to find out how things are right now. Then I work with them to find out how they would like things to be and what <u>we</u> can do to help you get there. Moreover, I would like our current efforts to be informed by what you have tried in the past. What worked? What did not work? How did you know if it worked or not? What difficulties or obstacles did you have in achieving your goals?***

  ***If we work together, and I hope we do, how would we know if we were making progress? What would change? What would other people notice?***

  ***Let me ask one last question, if I may. Can you foresee or envision anything that might get in the way of your working on and achieving your goal of X? What would that obstacle be and what can <u>we</u> do to help you anticipate and address those barriers?"***

- Use Goal Attainment Scaling of Short-term, Intermediate, Long-term goals.

- Use Time Lines

***Time Line 1*** ***Trace from birth to the present, the stressors and treatment.***

***Time Line 2*** ***Trace from birth to present examples of how the client, the client's family members and members of the client's cultural group "coped" <u>in the past</u> with traumatic events. Can the client extend the Time Line back in time? Determine "what" and "how" the client "<u>in spite of</u>" events noted in Time Line 1, "survived."***

***Time Line 3*** ***Trace from the present into the future how the client would like things to be and what can be done to achieve these goals.***

- Use videotape modeling films, "alumni club" members and group interventions to nurture hope.

**5. <u>Treat</u> the client for the <u>aftermath</u> <u>of</u> <u>violence</u>.**

- Tailor the intervention to the client's particular symptom profile and comorbid problems (e.g. PTSD, avoidance behaviors, depression-suicidality, anxiety, substance abuse disorders, somatic complaints).

- Teach stress management skills (tension relief procedures and soothing techniques) and self-monitoring procedures.

- Use Cognitive-behavioral Trauma -Focused intervention of "retelling" procedures (imagery, drawing, taping). (See Meichenbaum's Clinical Handbook on PTSD for a discussion of a Constructive Narrative Perspective of trauma and Meichenbaum, 2006, discussion on posttraumatic growth).

- For use with children see ***<u>www.musc.edu/tfcbt</u>*** and ***<u>www.nctsnet.org</u>***.

**6. <u>Empower</u> <u>the</u> <u>client</u> by nurturing problem-solving, choice-decision-making, and teach ways to garner and sustain social supports in her community.**

- Highlight the importance of self-care behaviors. Work on a specific "game-plan" and possible barriers to engaging in self-nurturant behaviors.

- Help foster additional coping skills such as child-rearing, assertiveness skills, work-related skills and ways to self-protect.

- Address practical barriers to change (housing, safety, finances, child care, transportation).

- Ensure that the client has skills on how to access and employ social supports.

- Ensure the client "takes credit" for changes (engages in self-attributions).

**7. Address grief reactions and bereavement.**

- Address the sense of loss, past, present and future.

- Help the client make sense of his/her responses. Address reasonableness of reactions and guard against "hindsight bias" guilt reactions.

- Use cognitive-behavioral interventions for complicated grief reactions.

**8. Transform pain and nurture meaning-making.**

- Use Feminist perspective of violence and the partner's use of power and control strategies.

- Examine cultural expectations that engender violence and act as barriers to reporting domestic violence.

- Address cultural barriers to change that may engender feelings of stigmatization, fear, shame, guilt.

- Help the clients use culturally-sensitive interventions (e.g. Caminer Latino or Latino Journal, see Perilla et al. 2006) exploring cultural histories of survival. Have clients keep journals where they document their healing process. Use community-based interventions where they build an "Action Road" plan. A component of this Action Plan may involve a complementary men's program for batterers that involve some 24 sessions and 50 hours of community work in which such topics as the definitions of masculinity, cultural norms regarding gender roles, parenting issues, as well as various forms of abuse are addressed. Also see Intervention programs by David Wexler, cited in references.

- Address issues of Reasons for Living.

- Help the client "make a gift" of experience to others. Foster interest in social justice issues and causes.

**9. Help client avoid revictimization and engage in relapse prevention procedures.**

- Consider how to develop new relationships that are "safe". Discuss who to trust and be aware of warning signs. ***(See the ODARA and Checklist for Violence Potential of Prospective Partner-VPPP).***

- Consider how to manage contacts with former partners, especially if children are involved.

- Consider relapse plan in overcoming fear of exposing yourself to reminders of abuse and abuser.

- Consider high-risk situations. (See Meichenbaum Handbook on Anger-Control and Aggressive Behavior on ways to conduct such Core tasks as Relapse Prevention, Collaborative Goal-setting, Self-monitoring, Self-attribution training).

**10. Address Vicarious Trauma and ways to nurture coping skills in health care providers who work with victims of domestic violence.**

- See Website ***www.melissainstitute.org*** (Click on Resilience conference download) for a discussion of ways therapists can use individual, social and organizational coping skills to deal with vicarious traumatization.

**11. Train police, teachers, social workers and others who work with children who were exposed to Domestic Violence. For example, see such resources as:**

a) Cops, kids and domestic violence. Available from the National Child Traumatic Stress Network www.nctsn.org (919-682-1552)

b) Children exposed to domestic violence: A teacher's handbook to increase understanding and improve community responses. Available from the Center for Children and Families, London Ontario, Canada.
http://www.lfcc.on.ca
(519-679-7250 x 206)
Email: pubs@lfcc.on.ca

# TRAUMA – SPECIFIC TREATMENT COMPONENTS FOR ABUSED CHILDREN AND FOR CHILDREN WHO WITNESS FAMILY VIOLENCE

***(See Cohen, J. A., Mannarino, A. P. & Deblinger, E. 2006. Treating trauma and traumatic grief in children and adolescents. New York: Guilford Press; Geffner et al. 2003; Wexler, 2004, 2006. Also visit www.musc.edu/tfcbt and www.nctsnet.org for training materials. Also see Hester et al. 2006 of how to meet the needs of children who have been exposed to domestic violence)***

1. Ensure safety of child and family.

2. Develop a therapeutic relationship with the child.

3. Provide the child with information about the abuse. Discuss the range of feelings that they might have experienced during and after abuse. Use cognitive-behavior play procedures (art expressive techniques, puppet play, story-telling)

4. Use affect-regulation procedures – review basic emotions of happy, sad, afraid and angry. Consider the facial expressions and other nonverbal bodily signs that go with each emotion. Consider examples of situations that might trigger each emotion. Have the child monitor feelings.

5. Anxiety management training – teach breathing and progressive relaxation exercises. Conduct relaxation exercises in a child-friendly manner (e.g., put a stuffed toy on tummy and give it a ride by controlling breathing – focus on slow deep breaths like blowing at a candle without blowing it out or without spilling spoon of soup. Show raw and cooked spaghetti and have child draw pictures of the two types of spaghetti and put it over his/her bed). Compare tension/relaxation to raw/cooked spaghetti. Involve parents to model and practice relaxation procedures. Teach Turtle Technique.

6. Use exposure-based interventions with accompanying training in cognitive restructuring or "rethinking" skills. Help the child appreciate the link between thinking, feeling and doing. Use story-telling and hypothetical examples of other children who have experienced abuse. Use imagery-based procedures and reading books (see Rhue & Lynn, "safe-place in imagination" and see Nass, 2000 for an example of a book that could be used). Have child create a puppet of perpetrator and discuss what happened and how it felt. Use clock metaphor of 12 o'clock as a beginning point – what happened; 3 o'clock how the child felt; 6 o'clock – what thoughts such as self-blame and 9 o'clock what the child did – consider how these 4 parts make up a "circle." Follow child's lead during process. Permit the child to play with other games or engage in other activities during these descriptions. Have parent learn to respond calmly and in a supportive manner when

his/her child discusses abuse. Provide reassurances. Help parent address reactions to trauma and ongoing treatment.

7. Provide parallel interventions for abused child and parent and then provide joint sessions (see work of Deblinger).

8. Work on parent/caregiver-child relationship; parent-child communication; improve affectional connection; improve discipline practices; improve conflict management; and improve the level of trust.

9. Build in generalization guidelines, self-attribution (taking credit for changes), and relapse prevention training ("planning ahead").

10. Cohen et al. (2006) treatment protocol for traumatized children has been summarized with the acronym PRACTICE

**P** **Psychoeducation and Parenting**

**R** **Relaxation Skills**

**A** **Affect Modulation Skills**

**C** **Cognitive Coping and Processing Skills**

**T** **Trauma Narrative**

**I** **In Vivo Mastery**

**C** **Conjoint Child parent Sessions**

**E** **Enhancing Future Safety and Development**

## PREVENTION AND RELATIONSHIP EDUCATION PROGRAM (PREP)

**(*See Halford et al., 2003; Markman et al., 2006)***

- Brief, time-limited educational format, not counseling, but rather preventative psychoeducation.

- Targets key protective factors such as friendship, commitment, teamwork, fun, spiritual connection and sensuality.

- Couple learns a variety of coping strategies about how to stop the flow of negative interactions such as how to take time-outs, engage in positive and respective ways to communicate and how to engage in such speaker-listener techniques as safe ways to talk about difficult issues and how to be emotionally supportive (See Markman et al. 2004).

# HOW CAN I OBTAIN MORE INFORMATION ABOUT INTIMATE PARTNER VIOLENCE?

We have put on The Melissa Institute Website ***(www.melissainstitute.org)*** handout materials from the presenters of the Eighth Annual Conference of The Melissa Institute on Family Violence. Please see the Website. For example, Aldarondo and Mederos (2002) have addressed the following questions:

1. When should a person be considered an "abuser" or a "batterer"? Can you "diagnose" battering?

2. Is domestic violence a problem primarily among the poor?

3. Are men of color more violent against their female partners than white European American men?

4. Isn't it true that most men who batter their female partners were raised in violent homes?

5. Do men who have poor social and problem solving skills batter more?

6. Are men who batter mentally disordered?

7. Does alcohol and drug abuse lead to domestic violence?

8. Is domestic violence also a problem in gay and bisexual relationships?

9. Assessment Issues:

    a) How can I tell if he will try to beat her again?
    b) When should psychological evaluations of abusive men be used?

10. Interventions with Abusive Men

    a) Do different types of men who batter require different interventions or treatments?
    b) What is the best treatment for abusive men?
    c) Is couples' counseling an effective and safe way to work with men who batter?
    d) Under what conditions is psychotherapy an appropriate intervention for abusive men?

11. Do abusive men stop the use of violent behavior and change the way they relate to their partners?

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# WEBSITES

**American Psychological Association Adults and Children Together (ACT) Against Violence**
***www.actagainstviolence.org***

**Books Available on Domestic Violence**
***http://www.growing.com/nonviolent/index.htm***

**Cangleska Inc.: Serve Oglala Lakota Nation**
***www.cangleska.org***

**Canadian Clearinghouse on Family Violence**
***http://www.hc-sc.ca/hppb/familyviolence***

**Children Exposed to Domestic Violence: A Teachers Handbook**
***http://www.lfcc.on.ca***
**(519-679-7250 x 206 email pubs@lfcc.on.ca)**

**Couples Communication Program**
***http://www.couplecommunications.com***

**Family Violence Prevention Fund**
***www.endabuse.org***

**Greenbook Initiative on Domestic Violence and Child Maltreatment**
***www.thegreenbook.info***
***www.thegreenbook.info/documents/Accountability.pdf***

**Institute on Domestic Violence in the African American Community, University of Minnesota School of Social Work**
***(E-mail nidvaac@che.umn.cdu)***

**Melissa Institute for Violence Prevention**
***www.melissainstitute.org***

**Mental Health Net Self-Help Resources**
***http://www.mentalhealth.net/selfhelp/***

**National Center for Injury Prevention and Control (NCIPC/CDC)**
***http://www.cdc.gov/ncipc***
***Email cdcinfo@cdc.gov***

**National Child Traumatic Stress Network**
**Cops, Kids and Violence**
***www.nctsn.org (Phone 919-682-1552)***

**National Coalition of Anti-violence Programs:**
***http://www.avp.org/dv/NCACVPDVReport2000.pdf***

**National Latino Alliance for the Elimination of Domestic Violence**
***www.dvalianza.org***

**Office of Violence Against Women**
***http://www.ncjrs.gov/notices/ovw/dvam2006.html***

**Ontario Domestic Assault Risk Assessment (ODARA)**
***e-mail address sdey@mhcp.on.ca***
***(Phone 705-549-3181)***

**Preventive Education**
**http://www.loveyourrelationship.com**
**http://www.okmarriage.org**

**Psych Central**
***http://www.psychcentral.com***

**Smart Marriages**
***http://wwwsmartmarriages.com***

**Supporting Healthy Marriage. Guidelines for supporting healthy marriage demonstration.**
**http://www.supportinghealthymarriage.org/resources/32/shm_guidelines.pdf**

**Web-based training in Trauma-focused Cognitive Behavior Therapy**
***www.musc.edu/tfcbt***