THE UNIVERSITY OF CALGARY

CURRENT PRACTICES AND BELIEFS ABOUT CONJOINT THERAPY FOR COUPLES EXPERIENCING VIOLENCE

by

LUANNE NIXON

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

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DEGREE OF MASTER OF SOCIAL WORK

FACULTY OF SOCIAL WORK

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled, "Current Practices and Beliefs About Conjoint Therapy for Couples Experiencing Violence" submitted by Luanne Nixon in partial fulfilment of the requirements for the degree of Master of Social Work.

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ABSTRACT

Spousal violence is a complex social problem requiring many different levels of intervention. This study addressed the appropriateness and viability of conjoint therapy as one option in the treatment continuum for couples experiencing violence in their relationship.

Survey questionnaires were mailed to 120 marriage and family therapists and 80 women's shelter workers in Alberta to assist in integrating practice experience with theoretical knowledge. The responses were used to describe current practices and beliefs about key issues in this work.

Both therapists and shelter staff identified the same assessment criteria, treatment goals and treatment options when violence occurs with similar frequency. It was concluded that therapists must be willing to expose spousal violence and address it directly in both assessment and treatment. It must also be recognized that a multimodal approach is often necessary with this clientele and that although all violence is unacceptable it should not be treated as the same for all couples.

ACKNOWLEDGEMENTS

I would like to express my appreciation to the marriage and family therapists and shelter staff who participated in this study. In addition to a gratifying number of responses to the survey, many participants included encouraging and validating comments about the importance of this endeavour.

I would also like to thank my thesis supervisor, Dr. Michael Rothery, for his encouragement, guidance and accessibility throughout this project.

Thanks to Debi Perry, M.Sc., for her willing and patient proof-reading and suggestions.

I especially appreciate the day-to-day love and encouragement of my husband, Dwight, who supported me through many trying moments during this past year. His efforts ranged from managing the household to photocopying questionnaires, stuffing envelopes, and proof-reading manuscripts.

A special thank-you to our children, Jarrett, Chad, and Daniel who not only stuffed envelopes but supported me in their love and understanding on the many days I was not available to them.

DEDICATION

To all therapists who work with couples experiencing violence in their relationship, especially those practising in rural settings with limited referral resources.

To our sons, Jarrett, Chad, and Daniel,
in hope that their generation will continue the work to diminish all forms of violence in our society.

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CHAPTER 1

INTRODUCTION

The documented pervasiveness of wife assault indicates that one in every eight women in Canada experiences marital violence (MacLeod, 1987). Family violence permeates all areas of social work practice requiring examination of one's values and beliefs about neutrality, client self-determination and the family. The discussion of practice approaches for family members affected by wife assault is often characterized by polarized views and high emotion.

Treatment programs have primarily focused on protecting women and children and long-term treatment of the batterer. The appropriateness of conjoint therapy has been continually debated. Feminists have accused family therapists of contributing to the problem of spouse abuse by denying and/or minimizing its existence, victim-blaming or colluding with men to maintain the status quo (Avis, 1992; Cook & Frantz-Cook, 1984; Kaufman, 1992). Couples therapy has usually been considered helpful only after the batterer and victim have received extensive individual counselling (Alberta Social Services and Community Health, 1985; Goldner, 1992; Pressman, 1989a). Those committed to systemic thinking argue that, although victim-blaming must be avoided, the abandonment of any application of systemic analysis ignores that couples may

be involved in a recurring vicious cycle that neither are able to stop (Cook & Frantz-Cook, 1984; Erchak, 1984; Goldner, 1992). The fact that many women return to their husbands after seeking help in shelters also attests to the power of these relationships (MacLeod, 1987; Neidig, 1984). In working with violent couples, attempts to reconcile the polarities of systemic and feminist approaches creates many ethical and moral dilemmas for therapists.

PURPOSE OF THE STUDY

The purpose of this study was to explore the current practices and beliefs about safe, effective assessment and treatment of physically violent couples who wish to continue their relationship. Several models for work with violent couples have been proposed in recent literature (Goldner, Penn, Sheinberg & Walker, 1990; Gutsche & Murray, 1991; Jenkins, 1990; Lipchik, 1991; White, 1989). The purpose of this study was to identify the guiding principles and common themes that transcend different models of practice with this population and are commonly recognized both by practitioners and the literature.

The definition of violence within intimate relationships has been a persistent problem, both for research and general discussion of the social condition. The words "abuse" and

"violence" have often been used interchangeably although they differ conceptually. "Violence" usually refers to aggressive acts while "abuse" often includes nonphysical acts of maltreatment (Gelles, 1980; Straus, 1991). Although nonviolent abuse has been shown to frequently precede violence (Follingstad, Rutledge, Berg, Hause & Polek, 1990), this study has focused on physical violence because it is more easily defined and can therefore be separated from the abusiveness (or perceived abusiveness) found in all distressed marriages. The terms "violent couples" and "violent relationships" are not used with the intent of "blaming the victim" but are used to acknowledge the systemic quality of these relationships. Also, both men and women can be victims of domestic violence although the severity of women's victimization is greater due to their smaller size and strength and lower socio-economic status (Saunders, 1987; Straus, 1988). "Domestic violence", "family violence", "spousal violence", "wife assault", and the words "abuse" and violence" have been used interchangeably to promote readability.

Information obtained from a review of the literature was used to develop survey questionnaires that would access Alberta women's shelter workers' opinions and marriage and family therapists' experiences with developing safe, effective assessment and treatment for couples experiencing violence in their relationship. Shelter staff were chosen as part of the

sample because their work focuses on the problem of spousal violence. Marriage and family therapists were included because their work was expected to focus on marital dynamics. It was believed that an analysis of the convergence of these two perspectives would determine the importance of the various issues presented in the questionnaires.

BACKGROUND

As my approach to social work practice is influenced by both feminist and constructivist thought, I am prompted to describe the position I began this study from. As a founding member of the Lloydminster Interval Home Society, I was part of a grassroots movement to provide shelter and support to "battered women" in the early 1980s. Although the group (primarily women) who founded Interval Home would not have described themselves as feminists, most believed that violence against women was a social problem which must be countered by public awareness and social action as well as providing service to victims.

Concurrently, as a marriage counsellor in the local Community Mental Health Centre, I began to see couples who did not wish to separate and yet were experiencing violence in their relationship. These couples requested marriage counselling and were not interested in travelling 200 miles to

therapy groups. Consequently, I became exposed to some interesting dynamics. One woman had thrown her partner's expensive camera down the stairs and followed him around the kitchen berating him with her face only a few inches from his, yet felt absolved of any responsibility for their fights because "it doesn't matter what I do, he has no right to hit me". Other situations occurred in which women, abused in childhood, continually "tested" their partners' love and commitment until he reacted violently and was left feeling shameful and appalled at his actions. Other couples described "phases" in their relationship where there had been physical abuse but due to various reasons, the behaviour was discontinued and neither feared a reoccurrence of violence. These experiences led me to question the doctrine that all women needed to be "protected" with men needing "punishment" and "treatment". I also began to question the tenet put forth by Walker (1979) and Pagelow (1981) and advocated in Alberta (Alberta Social Services and Community Health, 1985) that the cycle of violence <u>always</u> increases in severity and frequency until either separation or death of the victim. Feld and Straus (1990) also challenge this assumption, concluding that many men desist from assault without formal intervention. Suitor, Pillemer and Straus's (1990) research found a positive relationship between increased age and decreased marital violence.

In my practice in marital therapy, there were many instances in which I followed my feminist beliefs and supported and advocated for women in the process of separation from abusive husbands. As described above, other situations were not as clear and the systemic view seemed more appropriate. However, I noted that therapy with couples experiencing violence in their relationship needed to be different than other marital therapy and the desire to define these differences prompted this study.

SUMMARY

The problem of spousal abuse is a complex issue requiring intervention at the political, community, family and personal level. Treatment models for couples experiencing violence in their relationships have primarily focused on separation and individual treatment for both the "victim" and the "perpetrator". My clinical experience has indicated that these approaches are limited and do not necessarily meet the needs of couples who are committed to their relationship. Recently, conjoint therapy models have been proposed which recognize the desire of some women to persist with a relationship despite past abuse. These models advocate for work with couples which focuses on the abuser's responsibility for his or her violent or abusive actions while attending to the interactive difficulties and attitudes which promote

violent behaviour. This study examines the viability of conjoint therapy as one option of treatment and endeavors to describe criteria for assessing the appropriateness of conjoint therapy as well as identifying primary issues in safe and effective intervention with this population.

CHAPTER 2

LITERATURE REVIEW

Interventions or treatment models for family members affected by spousal violence have been influenced by both research and theoretical perspectives. This chapter reviews various theories which have been developed to explain spousal violence and the relationship of these theories to interventions. Due to the complex nature of this issue, the total context must be reviewed to provide a rationale for the consideration of conjoint therapy as a useful and viable treatment option in the continuum of services.

THE EMERGENCE OF SPOUSAL VIOLENCE AS A SOCIAL PROBLEM

Prior to 1970, wife assault was not viewed as a societal problem. Social science literature of the 1960s reflected the view that spousal violence was an isolated incident among pathological individuals (Gelles, 1980; Jennings, 1987). Several socio-cultural influences on the development of this problem have been suggested by Straus (cited in Gelles, 1980). First, the resurgence of the women's movement during the 1960s highlighted many issues for women. Violence against women and the grassroots organization of women's shelters was a highly visible example of women working for women. Secondly, the sensitivity of social scientists and the general public was

increased towards the issue of violence by the controversy over American involvement in Viet Nam, numerous assassinations of public figures and civil disturbances. Thirdly, academic models of social science study were changing from the consensus model of society to a conflict or social action model. Gelles (1980) suggests a fourth factor in that "someone had to demonstrate that research on family violence could be conducted" (p.874).

The pervasiveness of spousal violence was empirically demonstrated by the landmark National Family Violence Surveys of 1975 and 1985 (Finkelhor, Hotaling, Yllo & Conrad, 1988; Straus & Gelles, 1988). From these studies and other comparative investigations (Straus & Gelles, 1988), it is estimated that one out of six cohabitating American couples experience violence in the course of a one year period.

In Canada, prevalency discussions usually quote MacLeod's (1987) study of women in shelters which revealed that one in eight women are battered per year. A 1981 study of 562 Calgary couples, conducted by Brinkerhoff and Lupri (1988) found that one couple in three were involved in violence during a year and one couple in five engaged in severe violence. The authors note that this is an unusually high rate and suggest, as a possible explanation, that Calgary's boom town status in 1981 may have contributed to

family stress levels. Stress has been empirically associated with spousal violence (Lloyd, 1990; Straus, 1990; Sugarman & Hotaling, 1989).

Most empirical research has addressed prevalence, attempts to identify risk factors, and the effects of family violence on victims (Finkelhor et al., 1988). These studies have yielded few consistent and conclusive results, which emphasizes the complexity of this problem. It is generally agreed that spousal violence is not confined to geographical, cultural or economic boundaries, although family violence of all types is more prevalent among the poor, particularly if it is compounded by social stress, social isolation (Gelles 1980), and a history of violence in the perpetrator's family of origin (Pagelow, 1981; Rosenbaum & O'Leary, 1981; Telch & Lindquist, 1984).

There do not appear to be any identifiable characteristics that predict whether or not a woman will become involved in a violent relationship (Finkelhor et al, 1988; Rosenbaum & O'Leary, 1981; Russell, Phillips, Lipov & Sanders, 1989; Walker, 1988). However, there has been much study of the mystifying enigma of the woman who stays in an abusive relationship (Berrios & Grady, 1991; Flynn, 1990; Okun, 1988; Smillie, 1991; Strube, 1988). MacKenzie (1985) notes that many women suffering spousal abuse are doubly

disadvantaged by their colour or ethnicity and, particularly in Canada, are physically as well as socially isolated.

Attempts to delineate common characteristics of batterers have provided increasing information that they are not a homogeneous group (Rosenbaum & Maiuro, 1990). Research has focused on exposure to violence as a child (Rouse, 1984; Schuerger & Reigle, 1988; Sugarman & Hotaling, 1989); alcohol abuse (Rosenbaum & O'Leary, 1981), conflict strategies (Lloyd, 1990), and sex-role egalitarianism (Crossman, Stith & Bender, 1990).

Gelles (1980) stresses that social factors cannot be interpreted as causes of family violence as only mild associations have been empirically evidenced. In 1978, Rounsaville examined both psychological and sociological factors as preludes to marital violence. He concluded that no single determinant could explain the phenomenon and favoured a multifactorial model of explanation. More recent discussion concurs with this conclusion (Gelles & Maynard, 1987; Rosenbaum & Maiuro, 1990).

FEMINIST/STRUCTURAL THEORY

Many of the contributions of the feminist perspective started with critiques of existing theory. Initially, spousal

violence was explained by psychoanalytic theory. Women were defined as masochistic and it was implied that women somehow provoked or deserved physical attack. Societal forces contributing to spousal violence were not considered. Proponents of a feminist perspective critiqued this practice of "victim blaming" and maintained that no action by a woman called for violence against her person.

In a feminist analysis, all violence against women is perceived as an expression of our patriarchal or "male-ruled" society and another means whereby men exert their control over women (Dobash & Dobash, 1979). Women's freedom to choose a non-violent life is curtailed overtly by male control over legal and financial resources and covertly by submissive roles in marriage and society generally (Dobash & Dobash, 1979, L. Walker, 1979). There are two major tenets of this perspective which have guided societal strategies for dealing with this problem: "1) no woman deserves to be beaten" and 2) "men are solely responsible for their actions" (Bograd, 1984, p. 560).

Feminists are very particular about using the terms "battering", "male violence", and/or "wife assault" to reflect these beliefs. The use of this language is viewed as important to ". . . counter neutralizing and degendering alternatives such as 'spouse abuse' and 'inter-spousal violent episodes'" (G. Walker, 1990, p. 68). The term "male violence

against women" was utilized by the Canadian Advisory Council on the Status of Women in March 1980 to tie wife battering to the many areas of oppression experienced by women and demonstrate that battering (in some form or another) is shared by all women (G. Walker, 1990).

Liddle (1989) cites a major contribution of the feminist analysis as this move from "victim blaming" and "pathologizing" of the perpetrator to holding offenders accountable for their actions and advocating for increased criminalization of their behaviour. He also recognizes the feminist impetus for study of gender stratification and societal structures which perpetuate the subordination of women.

Criticisms of Feminist Theory

A criticisms of the feminist analysis is that adequate definitions have not been given to the concept of violence. In attempts to link violence to the patriarchal system the concept has been "stretched beyond recognition in some feminist work" (Liddle, 1989, p. 768). Also, in an attempt to conclude patriarchal linkages, the situation has been overly pathologized and generalized. This is exemplified by statements like "everything oppressive to women is in the interests of men" (Liddle, 1989, p. 765). Straus (1976) notes

that the movement's agenda to "eliminate violence producing inequities" (p. 67) may be an honourable long-term goal but more immediately could produce the opposite results as many men will not easily relinquish their traditional roles. A U.S. study by Yllo and Strauss (1990) which reviewed the relationship between wife beating and the economic, educational, political, and legal status of women by state indicated curvilinear results. Women with improved status experienced relatively less abuse to a point and then violence was shown to increase as status increased. The authors surmise that these results reflect role confusion and the struggle to reconcile structural opportunities for women with the prevailing societal norms which require women's subordination within marriage.

The feminist perspective of "male violence" has been challenged by the information from the National Family Violence Surveys of 1975 and 1985 which indicated that "assaults by women on their male partners occur at about the same rate as assaults by men on their female partners, and women initiate such violence about as often as men" (Straus & Gelles, 1988, p. 31). Brinkerhoff and Lupri (1988) reported higher rates of wife-to-husband violence than husband-to-wife violence. Although Straus and Gelles and Brinkerhoff and Lupri recognize that an equal number of assaults in no way reflects equal context, quality or consequences, Saunders

(1987) believes an equality has been implied and often misconstrued. He conducted a study to specifically focus on the context of husband abuse and found that most women use violence in self-defense and/or retaliation. Women are more likely to use weapons in an attempt to equalize the power differential but many more women than men are murdered by their spouses. Bowker (1983) found that retaliation was one of the least successful strategies for women to use as it often escalated the violence to a more dangerous level.

Feminist research has primarily relied on data from shelters or transition houses which utilized reports from women only. Straus (1991) discusses the difficulties of generalizing data from shelter populations to the larger population or generalizing from representative samples to shelter populations. He maintains that each have validity but cautions the cross application of results from this data. The differences in these populations are exemplified by the varying rates of assault between these groups. In the studies Straus reviewed, an average of 65 to 68 assaults per year were experienced by women in shelters in comparison to an average of six assaults per year on women in the National Family Violence Survey. He suggests that these women's experiences likely differ qualitatively as well as quantitatively, with both experiences having equal validity. Additionally, although there is a high rate of wife-to-husband violence

reported in the national survey, women in shelters rarely assault their partners. This suggests that there are two very different populations to consider when discussing "wife battering" or "spousal violence". The feminist perspective tends to ignore these differences and include everyone under the umbrella of "battered women" without considering that for certain parts of the population violence may occur in a more interactive context.

FEMINIST INTERVENTIONS

Shelters

The "shelter movement" sprang directly from the women's movement of the 1960s (McDonald, 1989b; Russell, 1988). Early shelters tended to be the result of grass roots women's projects which recognized the need for physical safety for women and children (McDonald, 1989b) The focus of intervention was on the crisis. The plight of battered women was seen to be determined by women's oppressed condition and consequent inability to access necessary resources to leave the violent/abusive situation or control and punish perpetrators (Jennings, 1987; MacLeod, 1987). Early groups involved in sheltering were active in pressing for greater legal protection for battered women and more active enforcement of consequences for batterers. Shelters also

sought to provide information, emotional support, and referrals to community resources to help women start new violence-free lives.

The force of this movement is evident in the fact that the number of shelters for battered women in Canada tripled from 85 in 1982 to 264 in 1987 (McLeod, 1987). However, even in this short time period, the nature of sheltering changed. McDonald (1989b) describes the development of two distinct shifts in ideology supporting sheltering. One approach to sheltering remains very much connected to the feminist perspective in that shelters are seen as a short-term solution to a larger problem. The goal of the woman's experience in the shelter is to expand her awareness of the true nature of the problem; that is, the domination of women by men in all spheres of society. The organizational structure of these shelters tends to follow a more informal, non-professional and non-bureaucratic format. "Professionalized" shelters focus more on the woman at risk and her immediate situation. Solutions are seen to be in offering therapy to women, their children and abusers rather than in social action. McDonald (1989b) suggests that this shift away from social action reflects the co-option of shelters by government and local service clubs on whom shelters rely for financial support.

Although it is often denied, the implicit purpose of shelters has been to help women leave the violent relationship. Various theories have been developed to explain why women return to their abusive partners (Boulette & Anderson, 1985; Johnson, 1992; McDonald, 1989a; Okun, 1988; Smillie, 1991; Strube, 1988; Walker, 1988). Most conclude that women's decisions to leave or return are affected by a complex interaction of perceptions of themselves, their partners and the costs and benefits of the decision. Follow up studies of women who have used shelters show that between one-third and two-thirds of the women return to their spouses (Gondolf, 1984; Russell, 1988). The response of the sheltering movement to this information has been to advocate for better follow-up services to these women including more second-stage housing. However, battered women have expressed a need for services not only for themselves but for their partners and their children. McLeod's (1987) report indicates that increased professionalization has come from a call from women.

Legal Remedies

Legal remedies for wife battering have been strongly advocated by the feminist movement. Much progress has been made in Canada even in the last ten years (McLeod, 1987). In 1983, it became possible to charge a husband for raping his

wife. Amendments were made to the Canada Evidence Act increasing the number of situations in which wives or husbands must provide evidence in relation to wife battering or child abuse. Policy statements have been issued by the Canadian government indicating an unwillingness to tolerate family violence. Provincial and territorial governments have developed policing policies which encourage the arrest of assaultive husbands. Following changes to the Criminal Code in 1983, police are no longer required to witness the assault but may arrest on "reasonable and probable grounds". In an attempt to implement these policy changes, training packages have been developed to help police deal with sensitive domestic matters and the number of crisis intervention teams utilizing social workers as well as police officers have increased.

Several studies have shown that immediate arrest is a strong deterrent to wife assault (Jaffe, Wolfe, Telford & Austin, 1986; Russell, 1988; Sherman & Berk, 1984). However, the effectiveness of arrest is largely dependent on the extent to which various levels of law enforcement (police, prosecuting attorneys and judges) believe that wife battering is a crime rather than a marital problem (Cragg & Rothery; Fusco, 1989; Hilton, 1989; Kantor & Straus, 1990). Criticisms that legal intervention is only a temporary and partial solution have been raised (Gondolf and Fisher, 1988; Horton,

Simonidis & Simonidis, 1987; Russell, 1988). Even if the relationship is terminated and one woman is protected, the batterer may repeat his behaviour with another woman later. Also, as reported by McLeod (1987) many women do not want their marriages to end and see use of the justice system as a short-term measure which may jeopardize their long term goals. Fusco (1989) concludes that it is impossible to address wife battering without including both a comprehensive criminal justice response and social service intervention.

Community Organization and Prevention

Both community organization and prevention are social action strategies influenced by the feminist perspective and address more than the individual needs of victims, perpetrators and their families.

Community organization to coordinate services around any one issue is often a struggle due to shrinking resources, competing ideologies of the various players and the physical hurdles of assembling many people. Spousal violence is a very complex issue, affecting every member of the family in some way. When a wife/mother is assaulted, she and/or other family members may require law enforcement, medical services, shelter, legal assistance, social and mental health services and employment assistance (Hamlin, 1991). Coordination and

networking among these services is a continual process.

The concept of community development as an intervention strategy for family violence has received little attention. Cameron (1989) provides as ecosystemic analysis of the problem of wife assault and argues that present strategies are inadequate solutions. Wife assault occurs at a higher rate in poor, highly stressed populations and Canadian women using shelters tend to be of low and unstable income, with limited formal education and work experience (McLeod, 1987). They face many physical barriers due to lack of child care, poor housing and social isolation. Cameron (1989) notes that this group shares many of the problems of other consumers of social services. Research on vulnerable families has shown that traditional treatment and services are not sufficient solutions. Community strategies which utilize informal help sources, such as supportive peer relationships, as well as formal agencies have been found to be more effective.

Developing better service packages for vulnerable families would be preventive as well as solution-oriented. Violence is associated with poverty, stress and social isolation. Even when violence is not a presenting problem, breaking into the social isolation and developing resources for these families may decrease the potential for violence.

Prevention strategies are visible at the municipal, provincial and federal level as public education. Public statements from the Mayor of Calgary, the Alberta Office for the Prevention of Family Violence and federal offices have focused on increasing public awareness of the problem with seemingly little recognition of the structural inequalities in which the problem is rooted. According to McLeod (1987), this individualization of the problem of wife abuse initially occurred to mobilize action on the issue. The problem was admittedly simplified, focusing on the violent act and provision of support and protection for individuals.

Westhues (1989) indicates that, in Canada, "there appears to be the political will to end wife assault" (p. 155). G. Walker (1990) questions this assumption, indicating that the problem of wife assault has been "absorbed into the social problem apparatus" (p. 87) whereby it is seen by society as just another social problem that is being dealt with "somehow". The political statements and government strategies may be spreading a thin veneer upon the problem when, really, little has changed. Evaluation of preventative programs as well as treatment programs are necessary to formulate future strategies.

PSYCHOLOGICAL AND SOCIO-CULTURAL THEORIES

Psychological theories of spousal abuse describe violence as resulting in intrapersonal deficiencies such as low self-esteem, higher susceptibility to anger and psychopathology (Margolin, 1988). Poor impulse control, disinhibition due to drug or alcohol abuse, and "container" theories which describe violent men as "bottling up" their anger until they explode are popular with perpetrators because they support denial of responsibility for the violent behaviour (Jenkins, 1990). Research attempting to define personality profiles of perpetrators of spousal violence has been inconclusive. Gondolf and Fisher (1988) define a typology of abusers based on behavioral characteristics which they identify as helpful in predicting treatment prognosis.

Gender role theory notes that men are socialized to be aggressive and in control while women are encouraged to be passive and submissive (Russell, 1988). Rosenbaum (1986) looked at sex-role identity and similarity/differences between spouses in relation to spousal violence. In terms of sex-role identity, the sample scores were low on both masculine and feminine identification supporting the theory that violent men have no sex-role identity and therefore behave in a manner they perceive as masculine. More recent work by Thompson (1990) criticizes socialization theories and structural

(feminist) theories of continually contrasting men and women and continuing ". . . to construct a reality that men and women are always more different than similar." (p. 4). From the research on the prevalence of violence by both sexes, Thompson concludes that there may be more of a difference within gender than between gender in relation to spousal violence. Due to difficulties in operationalizing male and female attributes, his study results were not conclusive. However, he suggests that the "masculine mystique" may be a contributing factor to violent behaviour.

The ambiguity of cultural norms restricting violence in society is discussed by Gentemann, (1984), Straus (1976), and Stets and Strauss (1989). Within the family, there is an explicit legitimization of force in parent-child relationships whereas it is much more implicit (although still present and powerful) in husband-wife relationships. In society, peace and harmony are valued but violence is glorified. There is also hesitancy to criminalize violence in the family (Straus, 1991). Subculture of violence theories indicate possible explicit approval and acceptance of violence among some groups within society (Russell, 1988).

A prominent socio-cultural theory in discussions of spousal violence is social learning theory (Jenkins, 1990; Pagelow, 1981; L. Walker, 1979). This theory gained wide

acceptance with Lenore Walker's (1979) research and subsequent publications. The basic tenet of this theory is that men learn to become violent in their families of origin either by viewing their fathers assaulting their mothers or by being battered themselves (Palmer & Brown, 1989; Russell 1988; Thompson, 1990). Violence is viewed as a learned strategy for solving problems or expressing anger. L. Walker (1988) suggests that

> ". . . it is the interaction of sex-role socialization patterns along with socially learned aggressive responses that differentiate why some men who witness violence as children do not grow up to batter, while others who did not come from abusive backgrounds later turn to violence to control their wives and children." (p. 142).

Margolin (1979) and other proponents of anger management approaches view perpetrators as deficient in problem-solving and communication skills (Shupe, Stacey & Hazelwood, 1987). Another basic premise following from learning theory is that men are socialized to believe that abuse of women is normal and acceptable behaviour (Neidig, 1984). However, in a study conducted by Neidig, Friedman & Collins in 1986, measures of stress and marital adjustment were found to be better predictors of spousal violence than attitudinal and personality measures.

Walker's (1979) theory of learned helplessness for women follows from learning theory as well. "Learned helplessness" is the belief of the victim that there is nothing she can do

to change her situation. Some battered women constantly manipulate situations in an attempt to control the abuse which can result in seemingly "crazy" behaviours. However, according to Walker (1988) most ". . . change how they think, feel, and respond to conform to their newly necessary need to feel as safe as possible from a potential attack." (p. 143). Gondolf and Fisher (1988) challenged the concept of learned helplessness, proposing a theory of "battered women as survivors" who continually seek help and are usually handicapped by limited resources and multiple problems. Brekke (1987), Burris and Jaffe (1984), Davis and Carlson (1981) and Dickstein (1988) also note that the secrecy of wife abuse has persisted due to poor response from the helping professions. All of these authors advocate for more accessible and effective aid for women wishing to leave abusive relationships.

PSYCHOLOGICAL AND SOCIO-CULTURAL INTERVENTIONS

McLeod's (1987) study found that women need more than a safe place to hide and the provision of material resources to optimize their ability to leave abusive relationships. In the wake of learning theory analysis, support groups for women and treatment groups for men have proliferated.

Programs for Battered Women

Abused women are seen to require concrete resources such as crisis accommodation, legal assistance, information about community resources, low cost housing and an opportunity to become economically independent in order to either leave abusive relationships or address their ambivalence about leaving (Davis & Hagen, 1992; Greaves, Heapy & Wylie, 1988).

Women's groups function primarily in an educational and supportive capacity, allowing women the opportunity to regain self-esteem, increase assertiveness, decrease isolation, and understand how women's oppression in society relates to their victimization (Ball & Wyman, 19878; Paquet-Deehy & Robin, 1991). Depending on the level of feminism, these groups follow a continuum from a consciousness-raising focus on women's rights and struggles in a patriarchal society to self-esteem building and general sharing on issues of parenting and loneliness or may incorporate both. Paquet-Deehy and Robin (1991) and Pressman (1989) advocate initial determination of the woman's safety, whether she is separated from the abuser or not, individual attention to her personal trauma of victimization and a group experience encompassing both educational and trauma processing agendas. Many women also utilize individual counselling.

The Calgary YWCA Support Centre advocates immediate group involvement with the concurrent support of individual counselling if necessary. The rationale for this approach is the clinical experience that immediate connection with peers is more meaningful to abused women as it addresses isolation, denial and shame more effectively than individual therapy (J. Wagar, personal communication, November 17, 1992).

Programs for Batterers

Group programs for men who assault their wives vary in format but often use a combination of education, anger-management techniques and stress reduction (Palmer & Brown, 1989). There has been considerable debate regarding the necessity of attitude changes in men who have been violent to their partners (Saunders & Hanusa, 1986). Neidig, Friedman & Collins (1986) attempted to verify a number of attitudinal characteristics such as rigid adherence to traditional sex-role stereotypes which have been attributed to abusive men. They concluded that measures of stress and marital adjustment were better indicators of domestic violence than attitudinal and personality measures. However, they also acknowledged that their sample may not have been representative of the wide range of personality types involved in spousal violence. Neidig (1984) advocates for a skill building approach in treatment of violent men whereas Jenkins (1990) and others

(Jennings,1987; Shupe, Stacey & Hazelwood, 1987; Sonkin, Martin & Walker, 1985) maintain that acceptance of responsibility for the violent behaviour and empathy for one's partner are crucial. In general, most treatment programs for batterers have structured, psycho-educational formats with the central training goals of increasing anger management, assertiveness, relaxation and communication and problem-solving skills (Edleson, 1984; Jennings, 1987; Rosenbaum & Maiuro, 1990)..

Both Neidig and Friedman (1984) and Gondolf and Fisher (1988) have developed assessment criteria based on abusive and violent behaviour. Neidig and Friedman developed a continuum of violence based on Steinmetz and Straus's (1974) descriptions of "expressive" and "instrumental" violence. They define "expressive" violence as resulting from poor impulse control in the midst of conflict but state that violent behaviour is generally in conflict with the perpetrator's value system and thus true remorse and desire to discontinue the behaviour is evident. In "instrumental" violence, the violent act is used to control or exploit the victim. Stets (1988) notes that expressive violence can become instrumental when the abuser is "rewarded" by compliance from the victim. Gage (1990) proposes that men engaged in expressive violence are more amenable to treatment.

Gondolf and Fisher (1988) discuss the importance of screening men for treatment. In the typology of batterers identified in their study, 37% were described as "sociopathic or antisocial batterers" who inflicted severe abuse on family members, often used weapons, and were also violent outside the home. The 30% of their sample described as "chronic batterers" committed severe physical and verbal abuse but caused less physical injury and were not violent outside the home. These men tended to blame or threaten the victim following abusive incidents. The "sporadic batterer", consisting of 33% of the sample, engaged in less severe and less frequent abuse and was more likely to be apologetic after incidents of abuse. These authors express concern that offering treatment programs to sociopathic or antisocial batterers may offer false hope of change to their partners and society. They advocate for responsible use of treatment and argue that some batterers may be "beyond the scope of conventional treatment" (p.66).

In 1987, 45 groups for abusive men were being offered in Canada (McLeod, 1987). As with other treatment strategies, little empirical research has been done regarding the effectiveness of these groups (Gondolf, 1987). They continue to be the treatment of choice with the rationale that peer pressure may be enlisted to break through the perpetrator's denial and minimization of the problem.

Additionally, McLeod (1987) outlines several concerns battered women, shelter personnel and group leaders have about batterer's groups. One concern is that although physical violence may subside or totally stop, other coercive behaviour may increase. Secondly, men may use counselling groups as a way to avoid incarceration without effecting honest change. Third, scarce funds may be diverted away from women's needs. Finally, the focus on counselling may detract from other ways of dealing with men's behaviour such as removing them to residential treatment when violence occurs.

Children's Programs

In recent years treatment programs for children have been emerging, although shelters have long recognized children's need for attention and have usually provided some type of informal intervention (Moore, Pepler, Mae & Kates, 1989). Formal interventions usually focus on identifying and dealing with feelings, particularly anger; building self-esteem; problem-solving; and issues specifically relating to violence, such as attitudes and feelings of responsibility for the violence. The rationale for these groups is based on the assumption that violence is learned behaviour and that children may suffer trauma when exposed to violence against their mother or towards themselves.

SYSTEMIC THEORY

In 1973, Murray Straus published his conceptualization of the application of general systems theory to violence in families. He was attempting to view violence as a product of the system rather than endemic to individual pathology. The result was a complex description of the interactions which take place between the family and society in the fostering of family violence. Other early theories or models which have been utilized are resource theory, conflict theory and the social exchange model. These theories tend to be somewhat limited in their scope and proffer relatively simplistic explanations of interpersonal dynamics which contribute to violence in intimate relationships.

Resource theory sees the use of violence as a "last resort" measure. If an individual has power in a relationship there is no need to actually use that power. As people feel more powerless, violence is used as a resource of last resort (Gelles, 1980).

Conflict theory describes the family as a conflict-prone group due to the nature of its structure. The extensive amount of time families spend together, the variety of tasks they must accomplish, the intensity of the interaction required, the natural difficulties of dyadic relationships and

the hierarchial structure of the family all contribute to the potential for conflict and violence (Brinkerhoff and Lupri, 1988).

The social exchange model focuses on marriage as an exchange relationship involving benefits (rewards) and costs (punishments). Brinkerhoff and Lupri (1988) describe the marital relationship as relying on norms of reciprocity to stabilize the exchanges. However, the reciprocal behaviour may not be equal, the imbalance often resulting from an unequal distribution of resources. Consistent difficulty in the reciprocity of the relationship can result in strain, conflict and, possibly, violence.

Systems theories which have explained violence as a function of an overadequate wife/underadequate husband or as a method of regulating closeness and distance (Cook & Franz-Cook, 1984) have been criticized as contributing to "victim-blaming" (Bograd, 1984). Another family therapy concept which is frequently criticized by feminists is "circularity". This concept is denounced because it implies equal responsibility for problems and dismisses explanations of why a problem exists as irrelevant (Bograd, 1984; Lamb, 1991; Nichols & Schwartz, 1991; Pressman, 1989a). The focus is on the interactional patterns and family structure or "problem maintenance" rather than on the violence. It is assumed that

change will occur for the whole system with intervention at any point in the cycle of interactions (Nichols & Schwartz, 1991). Pressman (1989b) argues against the viability of this view in violent situations, maintaining that only with the termination of the husband's violence will the wife be able to make any changes in the relationship. Bograd (1984) emphasizes that recognizable systemic patterns are more a result of the violent relationship than the cause.

Those committed to systemic thinking argue that, although victim-blaming must be avoided, the abandonment of any application of systemic analysis ignores that couples may be involved in a recurring vicious cycle that neither are able to stop (Cook & Frantz-Cook, 1984; Erchak, 1984; Goldner, 1992). The fact that many women return to their husbands after seeking help in shelters also attests to the power of these relationships (Neidig, 1984; MacLeod, 1987). A landmark research study by Giles-Sims (1983) used a systemic analysis to understand the process by which women leave or remain in abusive relationships. She denied the simplistic interpretation of a family system and described violence as:

> the product of interdependent causal processes including the preexisting behavior patterns of system members and the system processes that lead to stability or change in patterns of behavior over time. (p. 143)

Giles-Sims also emphasized that each member of the family is considered accountable for their actions. In Bowker's (1983)

study which recruited women who felt they had "beaten wife beating", it was concluded that some women were able to stop the violence by involving formal and/or informal resources. One of Bowker's conclusions is that women have a certain amount of responsibility for remaining in the violent relationship.

The concept of "neutrality" has also been critiqued for implying equal responsibility for the maintenance of problems. Bograd (1992) describes neutrality as "both an epistemological position (that is, that all stories or realities are relative and/or valid) and a therapeutic stance" (p. 247). Epistemologically, she observes that there is usually great disparity in the constructed reality of the man and woman in a battering relationship and her position is supported by empirical research (Bograd, 1988; O' Leary & Aria, 1988; Stets & Straus, 1990). The fact that men often deny and minimize their behavior also contributes to the danger of neutrality. When neutrality is a therapeutic stance, no one person is perceived to have any more power in the family than another and people are not held accountable for their actions because symptomatic behaviour is seen to be an expression of the dysfunctional system (Pressman, 1989a; Bograd, 1984). Bograd (1992) and Avis (1992) call neutrality dangerous, in that silence on a moral issue such as violence against women may indicate consent and result in collusion with the abuser.

Some proponents of a systemic view argue for inclusion of accountability of the male batterer in the systemic approach and acknowledge that couples work is not appropriate for all violent couples (Bograd, 1992; Douglas, 1991; Magill, 1985; Margolin, 1979; Weidman, 1986; Weitzman & Dreen, 1982). Others are concerned that a blaming victim/victimizer stance is not helpful (Flemons, 1989; Gage, 1991; Lane & Russell, 1989; Neidig, 1984). Flemons maintains that "Battering *is* a problem of the couple as long as they remain a couple. Encapsulating blame restricts one to solutions of dismemberment" (p. 9).

Additionally, arresting coercion with greater coercion may not be effective. Nichols (1986) and Giles-Sims (1983) relate that when a woman leaves an abusive situation the violence may increase or the pattern of abuse may change even though she lives apart from her abuser. Lane & Russell (1989) perceive therapists as frequently operating from a social control model of "instructional interaction" whereby they "instruct" the victim to live separately from the victimizer and have little impact on disrupting the pattern of violence. Stulberg (1989) describes how helpers may become involved in the dysfunctional system of the battered woman by inadvertently assuming either the complementary or symmetrical role previously held by the husband. She discusses the importance of understanding the systemic forces of

complementary relationships whereby the woman may become overly dependent and submissive or symmetrical situations in which the helper and client subtly argue over the course of action to take (as in the helper telling the wife she needs to leave her husband and the wife defending or proclaiming her love for him). Gage (1991) regards the blaming stance and individualized treatment as contributing to the victimization of both partners by a social system which provides limited choices.

Pressman (1989a) identifies a third concern of feminists regarding the family systems therapy approach to treating wife assault as the inattention to the traumatic effects of abuse on victims. When the violence is not the focus of therapy, the woman may be unable to account for the emotional damage and consequential symptomology she may be experiencing. Abusers who were victimized in childhood may not be encouraged to explore their past as a contributing factor to the abuse. Pressman recognizes that Bowenian therapists do not omit past traumas and relationships in their work and that many others are striving to address the individual pain experienced by family members. As identified by Nichols & Schwartz (1991), family therapists influenced by constructivism are now attending as much to the meaning actions have for individuals as the actual interactions. This is evidenced in the work of

Gutsche and Murray (1991), Goldner, Penn, Sheinberg & Walker, (1990), Jenkins (1990), and White (1989).

SYSTEMIC INTERVENTIONS

Cook & Frantz-Cook (1984) comment on the similarity in the development of treatment approaches for family violence to the process of developments in the field of alcoholism. Early alcoholism treatment depended upon informal, individual resources such as "A.A." groups and treatment facilities staffed by recovered alcoholics and have since added more family focused approaches. The sheltering movement is similar in that it was also started through voluntarism and provided instrumental, individual assistance. MacLeod (1987) asserts that individualization of the problem of wife abuse and subsequent treatment approaches initially occurred to mobilize action on the issue. The problem was admittedly simplified, focusing on the violent act and the provision of support and protection for individuals. However, she reports "Battered women were not always prepared to support the simplistic "bad man-good woman" assumption at the basis of most crises responses" (p. 2).

The number of women returning to their partners after a shelter stay has been estimated at 50% (Gondolf, 1984) or between one third and two thirds (Russell, 1988). These women

often express a need for services for their spouses and children. Greaves et al. (1988) and Johnson (1992) report that battered women utilizing non-residential services also report high ambivalence about leaving the relationship and that economic means are not as important as the weighing of relative costs/benefits in making the decision to leave.

Throughout the literature (Goldner, 1992; Gutsche & Murray, 1991; Lane & Russell, 1989; Lipchik, 1991; Magill & Werk, 1985), examples are recorded which reflect my clinical experience with women who were either not willing to leave the marital relationship or felt they could not leave for more than economic reasons. Magill and Werk (1985) ascertain that if the woman wishes to stay with her husband and only he can stop the violence, he must be involved in the therapeutic process from the beginning. Lane and Russell (1989) talk of "dangerous love" where the strong bond between the couple blinds them to the severity of their situation. Goldner (1992) relays personal experiences of being "politically correct" in referring women to support groups and men to batterer's groups which they never attended, as they did not define themselves as being "battered" or "battering". She speaks of the shame women feel about being deeply attached to the men who abuse them and how this is often not addressed by traditional approaches. Sedlack's (1988) study confirms the reluctance of couples involved in violent relationships to

utilize these terms unless severe injuries have resulted from the violent incident. Additionally, Mack (1989) notes that couples often do not enter therapy with abuse as the presenting problem. Using this rationale, practitioners have sought models for safe, effective practice with couples.

Psycho-educational Groups for Couples

Psycho-educational groups for couples experiencing violence in their relationships have been utilized for many years but have not enjoyed great popularity (Deschner & McNeil, 1986; Margolin, 1979; Neidig, Friedman & Collins, 1985b). These groups require a commitment for change and consistent attendance from both partners and focus primarily on cognitive-behavioral approaches aimed at improving both partners skill levels in communication and conflict resolution. Some groups run parallel men's and women's groups while others include couples initially. Deschner and McNeil (1986) report finding 85% of their group members violence-free eight months after completion of the group. However, they were only able to contact half of these group members which likely biased their results. Also, screening criteria for admittance to group therapy was not identified.

The YWCA Support Centre in Calgary has recently added a couples group component to the series of groups offered to

couples experiencing violence in their relationship. The group approach provides opportunity for addressing issues of blame and shame, involves peers in maintaining accountability, and provides opportunities to learn new behavior to replace violence (J. Wagar & M. Johannson, presentation, November 17, 1992). The process of developing peer support, and group collaboration to co-create new relationships between men and women is seen as helpful for both men and women. Screening involves individual assessment with emphasis on the client's commitment to the program. Also, both men and women must complete 75% of a gender-segregated group before progressing to the couples' group. Groups are also offered for children who have witnessed spousal violence and women whose partners do not wish to be involved.

Conjoint Therapy

Conjoint therapy for couples, either in groups or alone, is usually only seen as appropriate after considerable individual work has taken place, the violent behaviour has stopped and the couple are committed to the relationship (Magill, 1989; Pressman, 1989b). Recently, models have been developed to work with couples who have had little or no previous counselling (Gage, 1991; Goldner et al., 1990; Gutsche & Murray, 1991; Jenkins, 1990). Early models describing work with violent couples tend to be unclear on

their moral stance towards violence, in fear of ascribing blame to any one partner (Cook & Frantz-Cook, 1984; Flemons, 1989; Geffner, Mantooth, Franks & Rao, 1989; Geller & Wasserstrom, 1984; Gelles & Maynard, 1987; Lane & Russell). The general application of popular family therapy models is critiqued as viewing violence as simply another symptom of a dysfunctional system (Pressman, 1989a) when it has been suggested that the violence may also be influencing the system (Bograd, 1992; White, 1989).

Conjoint therapy can be a viable practice option when family focused groups are not available and selective screening is employed. Goldner (1992), Gutsche & Murray (1991), Lipchik (1991), and Magill & Werk (1985) screen for substance abuse and clear commitments to ending the violence. Calgary therapists Gutsche and Murray (1991) strictly enforce a "Peace Agreement" that outlines coercive and escalating behaviour that either partner may engage in as well as specific descriptions of the violent acts. Goldner (1992) states that the violence must stop before conjoint therapy begins in situations where

> the man's violence is already frequent and severe; the woman has little or no financial independence and social support; and/or when the man is not willing, or able to own, and then renounce, his use of violence and intimidation". (p.58)

Goldner considers the woman's level of financial independence and social support as a measure of how much free choice she

has in remaining in the relationship. Goldner, Lipchik, and Magill & Werk also assess the severity of the violence while Gutsche & Murray assert that all violence is unacceptable and therefore equally severe. In light of the work of Gondolf and Fisher (1988), and the reports of wife to husband violence (Straus & Gelles, 1988), the assumption that all violence is the same is questionable. It is my belief that evaluation of the severity of the violence in terms of duration, frequency, and extent of injury can have prognostic value.

Many conjoint approaches include both partners in the initial interview and Goldner (1992) and Lipchik (1991) utilize individual interviews extensively to assess the woman's safety both initially and throughout the course of therapy. These interviews can also determine the possible minimization of the abuse by either partner and counteract the misuse of therapy by men to control their wives. Jenkins (1990) prefers to begin with an individual interview with the man in order to emphasize his responsibility for the violence and "invite" him to take charge of his behaviour. He would then meet with the woman to assess her safety and release her from any feelings of responsibility for the violence she may be harbouring.

A central and unique concept of the model developed by the Gender and Violence Project (Goldner et al., 1990) is the

focus on and understanding of gender scripting not only at the psychological, cultural and political levels but as an inter-generational part of "the politics of family relations". The individual's "premises and paradoxes" of gender are examined across the generations to determine how both the man and the woman are bound to seemingly irrational behavior, including the violence. As with Lane and Russell's (1989) concept of "dangerous love", Goldner et al. also recognize the powerful bonds present in volatile relationships.

Goldner and her colleagues (1990) advocate for the analysis of gendered motivations and prohibitions even through separation. Particularly for women, the subliminal forces tied to feelings of failing the relationship, guilt, and inadequacy must be addressed. Couples counselling is not terminated until the man is able to acknowledge his actions, accept full responsibility for them and empathize with the pain his wife has experienced. It is my view that this clear definition of and commitment to change is crucial. Not only does it signify a change in the relationship; it is a small step toward a larger goal. Goldner (1992) describes the feminist "personal is political" effect of this change:

> In political terms, he has taken the first step toward repudiating the cultural prerogatives of male supremacy. Thus, the therapist's morally informed work challenges, rather than reinforces, dominant patriarchal social norms. (p. 61)

Jenkins (1990) focuses his model on "responsibility". Rather than the therapist taking responsibility for the violence by directly challenging the man's explanations of his abuse or instructing him in techniques to control his anger, the man is "invited" to take charge of his violence, "examine his misguided efforts to contribute to the relationship" (p. 63) and is assisted in planning new action to improve the relationship. In couples therapy or with women individually, Jenkins focuses on "inviting" the woman to take responsibility for her safety. He will then encourage the man to verbalize his support for his partner's safety plan to third parties she has identified as resources. I expect this is a powerful technique in promoting the couple's commitment to violence prevention.

White (1989) begins therapy by helping couples identify the theories they hold about men's aggression in general and why violence occurs in their lives. He challenges these theories and encourages both partners to "break free" from their past ideology and experiment with new ways of being with each other. White sees the integration of feminist and systemic theory as helping to resolve violence issues for both men and women:

> . . . it is my experience that in conjoint therapy the man's responsibility for the violent acts can be emphasized, that notions regarding women's provocation of such violence can be countered, and, that because the constraints of gender stereotyping and the co-opting of women's identity can be effectively undermined, conjoint

> therapy can render the option of separation a more viable option if the woman loses her desire to persist with the relationship. (p. 101)

Goldner (1992) and Mack (1989) identify the contradictions involved in utilizing both systemic and feminist frameworks. Rather than attempting a synthesis of the two as White and Jenkins describe, Goldner advocates a both/and stance, stating that neither the systemic or the feminist perspective adequately address the problem of spousal violence. Goldner maintains that anyone who works with these couples will be subject to a constant processing of the dilemmas involved and will need to adopt a position which includes the "necessary contradictions" that both perspectives offer. Goldner explains:

> This means making room for the idea that violence can be an expression of helplessness or dependency, and even the hateful idea that sexual pleasure can accompany coercion without, however, *losing hold of one's ethical stance condemning the abuse of power,* i.e. without blaming the victim, shaming the victim, or allowing the perpetrator to misuse psychological insight to avoid taking responsibility for his actions. (p. 60)

SUMMARY

This literature review underscores the complex nature of the issue of spousal violence. Research attempts to qualify and specifically define both the nature and causes of this social problem have not been conclusive. It is known that

domestic violence is pervasive in our society, affecting one in eight Canadian women and possibly as many men. Studies of men who batter indicate that abuse varies in intensity, frequency and severity and that evaluation of these factors may have prognostic value in determining individual or marital treatment with batterers.

A wide variety of theories have been proposed in an effort to explain spousal violence. No one theory appears able to encapsulate the issue and thus, it is necessary to review each theory's contribution to the general description of spousal violence. Similarly, the most effective interventive approach has not yet been defined. The literature indicates that different treatment approaches are required to meet the variety of needs of family members affected by spousal violence.

Feminist/structural theory views all violence against women as an expression of our patriarchal society. Women's freedom to choose a non-violent life is perceived to be curtailed overtly by male control over legal and financial resources and more covertly by submissive roles in marriage and society generally. This assumption has been challenged by research which indicates that women engage in violent behaviour as frequently as men although their violence may differ in quality and purpose.

Psychological theories have sought to explain spousal violence in the context of intrapersonal deficiencies. Attempts to identify a personality profile of batterers has yielded inconsistent results suggesting that this group is more diverse than homogeneous.

Socio-cultural theories include gender role theory, analysis of cultural norms and social learning theory. Social learning theory is perhaps the most well known as L. Walker's work in this area is extensively quoted by the Alberta Social Services Office for the Prevention of Family Violence (1985). Most psycho-educational groups for both men and women are based on social learning theory and attempt to retrain both batterers and victims in new behaviours and attitudes.

Purely systemic theories perceive violence as erupting from interpersonal dynamics within a system where all persons have equal power. Theories such as conflict theory, the social exchange model, and early family systems theory subscribe to these beliefs. Although the awareness of power differentials has increased among most marriage and family therapists, those committed to systemic thinking maintain that dismissing the couple relationship ignores the possibility that both partners may be involved in a recurring vicious cycle that neither are able to stop.

Most interventions in spousal violence focus on offering shelter and support services to women and children as the victims of spousal violence and community education which promotes the belief that domestic violence is unacceptable. Legal consequences for batterers have been further defined and utilized in the past ten years although there remains a discretionary quality to arrest. Treatment programs exist for batterers on a more limited and inconsistent basis than concrete resources for women who are victims of spousal violence.

Increasingly, spousal violence is becoming identified as a family problem and the goal of ultimate separation of the violent couple is being reconsidered. Many violent couples do not identify themselves as "batterers" or "beaten" and may present at family service agencies with another presenting problem.

Recently, several therapists have attempted to bridge the gap both theoretically and practically between the two ends of the hypothetical continuum which includes feminist theory on one extreme and systemic theory at the other. They have been challenged by the need to develop a supportive and collaborative relationship with these clients while declaring the moral stance that violence is unacceptable. They struggle with the difficulties of encouraging violent partners to take

responsibility for their behavior in the face of denial and minimization that is often presented by both abuser and victim. They must reconcile the positions of therapist and social control agent in order to work safely and effectively with this population.

This study is concerned with the description of current practices and beliefs about conjoint therapy for couples experiencing violence in their relationship. The literature indicates that models are being developed to meet the needs of this population despite conflicting opinions on the suitability of conjoint therapy with violent couples. From the literature and clinical experience, it is speculated that this is an area of concern for marriage and family therapists and there is a need to identify the common themes and guiding principles for this work. This speculation gives rise to several questions. What is the opinion of people with experience with this population regarding the appropriateness of marital therapy and the attending criteria for assessment and treatment? Is counselling couples in violent relationships a common experience for Alberta therapists? In what ways are they involved with this population? Current research has not investigated practitioners' experience with this population in an attempt to discern commonalities but has rather been limited to self-reported model descriptions. Through this study, it is hoped that both theoretical

knowledge and practice experience can be integrated to identify prominent issues for practice with this population.

CHAPTER 3

METHODOLOGY

To provide a thorough description of current practices and beliefs about conjoint therapy for couples experiencing violence in their relationship, a survey questionnaire was designed to gather information on the practice experience of persons working with this population. This chapter reviews the process of sample selection, questionnaire development, the method of data collection, and methodological limitations of the study.

SAMPLE SELECTION

The sample population included 120 marriage and family therapists and 80 shelter staff employed in Alberta. Persons on the membership roster of the Alberta Chapter of the American Association for Marriage and Family Therapy (AAMFT) were chosen for the marriage and family therapist sample for several reasons. Membership in AAMFT implies involvement or, at least, strong interest in marriage and family therapy. Therefore, the likelihood of contacting persons with involvement in couples therapy was anticipated to be high. The specific coursework and practical experience required for membership in AAMFT emphasizes a family systems perspective and is standardized internationally (AAMFT, 1990). Thus, it

was presumed that this group would have considerable internal homogeneity and would represent the systemic perspective described in the literature. Additionally, sampling of the total population (120 persons) was feasible due to the group's relatively small size. The sample population represented a much lower rural population than shelter staff with only 14% residing outside of Edmonton, Red Deer, Calgary and their suburbs.

Shelter staff were surveyed for two reasons. Although their involvement focuses primarily on crisis intervention and the consequences for victims of family violence rather than on couples therapy, shelter staff have the most direct experience with the social problem of family violence. The literature identifies women's shelters as arising from the efforts of the women's movement and their primary mandate continues to reflect the position that physical, economic and legal aid will provide victims with the freedom to choose a non-violent life (Alberta Family and Social Services, 1991b). Due to this work environment, it was expected that shelter staff would view conjoint therapy from a feminist perspective, providing contrasting opinions to those of marital therapists.

In determining the sampling frame for shelter staff, Satellite Accommodations and Safe Home Networks were excluded. These services are not permanently staffed, continuously

operating facilities although many provide the same functions as shelters (Alberta Social Services, 1991). Recently, a few shelters which focus on the special needs of Native women have opened in the province. In accordance with the assumptions of McGoldrick, Pearce and Giordano (1982) who state that ethnic differences have resounding implications for any treatment, these shelters were also excluded. Consideration of ethnic and cultural differences in decisions regarding the appropriateness of referral to marital counselling was deemed to be beyond the scope of this thesis.

Subsequently, sixteen permanently staffed and continuously operating shelters were chosen for the survey. Nine of the shelters are located in rural areas and seven exist within the cities of Edmonton, Red Deer, Calgary and their suburbs.

QUESTIONNAIRE DEVELOPMENT AND DATA COLLECTION

Given the geographical dispersion of the prospective respondents and the descriptive intent of the study, mailed survey questionnaires were chosen as the most feasible method of data collection. Two separate questionnaires (Appendixes A and B) were designed for the two groups, utilizing the organizational and presentation suggestions noted by Dillman

(1978) and McMurtry (1993). The questionnaires were designed to address the following research questions and provide some descriptive information regarding the respondents and their communities.

1. Do marriage and family therapists provide conjoint therapy to couples who are experiencing physical violence in their relationship and wish to continue cohabitation?
2. How often do therapists and shelter staff see referral for marriage counselling as appropriate for couples who are experiencing physical violence? Is there a relationship between the perceived appropriateness of marital counselling for this population and the number of treatment resources available in the community?
3. When conjoint therapy is provided, what are the criteria utilized in assessment and treatment? Do shelter staff agree with these criteria or define others?
4. Is follow-up utilized to determine the outcome of treatment?
5. When therapists do not provide conjoint therapy, to whom do they make referrals?
6. Do practice and/or referral choices of the two sample groups vary with location (rural vs. urban) or gender?

Shelters were contacted by telephone to solicit the staff's participation in the study and establish a contact person who would facilitate the distribution and collection of

the questionnaires. Five questionnaires were mailed to each shelter in March, 1993, with the expectation that the contact person would distribute, collect and return the questionnaires when completed. A follow-up letter was mailed to the contact persons one month later (Appendix C), improving the return rate from 42% to 71%. The return rates are presented in Table 3.1.

Permission to access the AAMFT membership roster was granted by the current president of the association (Appendix D). In March, 1993, 120 survey questionnaires were mailed to marriage and family therapists. Of this group, 17 resided in rural areas and 104 lived in an urban location. After sending a follow-up letter one month later (Appendix E), the return rate increased from 52% to 60% (Table 3.1).

Table 3.1
Survey Return Rate

	Therapists	Shelter Staff
Sent	120	80
Excluded[1]	11	0
Returned	66	57
Useable[2]	64	57
Return Rate[3]	60%	71%

[1] Excluded returns include those returned due to incorrect addresses.
[2] Useable refers to questionnaires returned completed.
[3] Return rate is computed by subtracting excluded and unusable surveys from the total sent divided by the number of useable returns.

METHODOLOGICAL LIMITATIONS

A primary drawback to the use of mailed survey questionnaires is the uncertainty of receiving an acceptable return rate (McMurtry, 1993). Fortunately, a gratifying response was received, supporting the position that this was a feasible method with which to approach the target populations.

One of the greatest strengths of survey research is also one of the most profound weaknesses. Although a written instrument is highly reliable, ensuring that exactly the same information is administered to each participant, there is no opportunity for clarification or new understandings of the questions being considered (McMurtry, 1993; Rubin & Babbie, 1993). Despite every attempt at clarity and extensive pre-testing, language may be used on the questionnaire which does not hold the same meaning for the respondent as for the researcher. For example, shelter staff frequently took exception to the use of the words "group therapy" and wrote comments that "support groups" or "group programs" were available while "group therapy" was not.

Also, the specificity of wording in questionnaires reduces validity. That is, respondents are less likely to report "strongly agree" or "strongly disagree" to items which

are not of their own wording, thereby increasing the response to "middle" answers. Small, but important differences may be lost as so-called round pegs are fit into square holes resulting in a picture which reflects more similarities than differences (Rubin & Babbie, 1993). Efforts were made to counteract this difficulty by encouraging comments from respondents.

Several therapists (5) criticized the choice of identifying men as abusers and women as victims, stating that both men and women can be either victims or abusers. One man felt so strongly about this issue he requested that his responses be destroyed. A short statement explaining my position on this matter was included at the beginning of the questionnaire (Appendix B) but obviously was not viewed as adequate by all respondents. No complaints were received from shelter staff regarding this as the questionnaires were written more from their perspective with the hope that it would be the least offensive format. Considering the emotional nature of this topic, I would have expected at least as many reactions if I had worded the questions in a more gender neutral manner.

It is difficult to ascertain whether or not the two groups of respondents were commenting on experience with similar populations. There may be both quantitative and

qualitative differences in the violence experienced by couples involved with these different types of intervention. Straus (1991) cautions that information from shelter populations and the general population is not necessarily comparable. In this study, it has been assumed that the two sample groups would be viewing the issues presented from different perspectives and thus, would provide a broader view of treatment possibilities.

SUMMARY

Survey questionnaires were utilized to describe the practice experiences of persons working with couples experiencing violence in their relationship as part of the process of developing guidelines for this practice.

Members of the Alberta Chapter of the American Association for Marriage and Family Therapy (AAMFT) were chosen as a sample group as they were readily identifiable as therapists likely to be involved in providing marital therapy. Due to the training required prior to AAMFT membership, it was expected that these respondents would ascribe to the systemic perspective identified in the literature. As the group included only 120 persons, total sampling was employed.

Staff from sixteen women's shelters across Alberta constituted the other sample and were chosen because of their high level of experience with spousal violence. As shelters historically emerged from the women's movement, it was expected that shelter staff would represent a feminist perspective. Questionnaires were dispersed by mailing five questionnaires to a contact person at each shelter who distributed them and later collected and returned the responses. Response rates for these groups were 60% for therapists and 71% for shelter staff.

Methodological limitations included the validity problems inherent in the use of questionnaires, inability to provide clarity to respondents who were confused by wording in the questionnaire, and the questionability of comparing the responses of two groups who may be involved with couples having both quantitatively and qualitatively differing experiences with violence in their relationship.

CHAPTER 4

ANALYSIS AND FINDINGS

This chapter presents the characteristics of the sample populations and the composite responses of therapists and shelter staff to the questionnaire items. These items have been categorized as 1) the respondents' opinions on whether or not marital counselling is ever appropriate for couples experiencing violence in their relationship and 2) assessment and treatment issues for conjoint therapy with this population. Analysis included the reporting of frequencies and crosstabulation between the two sample groups on most variables. Referral practices of therapists were crosstabulated by gender. Crosstabulation of assessment and treatment responses by gender and location did not yield any remarkable differences and were therefore omitted. Due to the descriptive nature of the study, the lack of random sampling, and the necessity of comparing shelter staff's opinions to therapists' experiences, inferential statistical analysis was not considered to be appropriate. Rubin and Babbie (1993) describe bivariate analysis as useful for both descriptive and explanatory purposes. In this study, comparative analysis both between groups and within groups has been conducted to provide a more thorough description of opinions and experiences rather than to explain phenomena.

CHARACTERISTICS OF RESPONDENTS

Location and Gender

Of the 64 therapists who responded, 55 (86%) resided in an urban location and 9 (14%) lived in rural settings (Table 4.1). The gender distribution was more equitable with 33 female and 31 male respondents. As expected, the majority of shelter staff respondents were female (96%) with 56% from an urban location and 44% residing in a rural area.

Table 4.1
Distribution of Survey Respondents
by Gender and Location

Gender	Therapists n	Therapists %	Shelter Staff n	Shelter Staff %	Totals n	Totals %
Female	33	51	54	96	87	73
Male	31	49	2	4	33	27
Total...	64	100	56[1]	100	120	100
Location						
Rural	9	14	25	44	34	28
Urban	55	86	32	56	87	72
Total...	64	100	57	100	121	100

[1] Missing = 1.

Work Setting of Therapists

The type of work setting described by therapists is illustrated in Table 4.2. Approximately half of the respondents were engaged in private practice or worked for a private or semi-private agency where it is assumed that fee-for-service applies. This may mean that persons with lower economic resources would be excluded from these therapist's services. This has implications for the comparability of responses from therapists and shelter staff as it is reported that most women using shelters have low income (Alberta Family and Social Services, 1991a; Gondolf & Fisher, 1988; MacLeod, 1987). One private practitioner commented that he rarely sees women who have used the local shelter due to their inability to pay for his services. This suggests that the shelter staff and therapists in this study may be responding from experiences with very different clientele.

Table 4.2
Work Setting of Therapists

Setting	n	%
Private practice	21	33
Semi-private or private agency	12	19
Hospital or government funded agency	22	34
Combination of private practice & agency	9	14
Total...	64	100

Work Setting of Shelter Staff

Ninety one percent of shelter staff described the shelters of their employment as providing individual counselling for battered women. Additionally, 68% reported the provision of group programs for women in the shelter (Table 4.3). Outside of these treatment options, 12% of rural shelter staff identified their shelter as offering the option of group therapy for abusive men. Twenty-eight percent of urban shelter staff indicated that group therapy for men was offered, 12% marked individual counselling for abusive men, and 6% stated that group therapy for couples was a treatment option provided by the shelter organization. Comments added by respondents indicated that group programs for both men and women focus more on peer support and education and this was not considered to be "therapy". Comments also clarified that programs for men were not offered within the shelter but under the umbrella organization administering the shelter. If the question was understood by respondents to mean "men's groups or individual counselling offered within the shelter", these treatment options may be underreported. For the purposes of this study, all group programs were collapsed under "group therapy", although it is now evident that "group programs" may have been more acceptable to respondents.

Table 4.3
Treatment Options Provided by Shelters

Response	Rural		Urban		Total	
	r	%	r	%	r	%
Groups/women	18	72	21	66	39	68
Groups/men	3	12	9	28	12	21
Individual/women	25	100	27	84	52	91
Individual/men	4	7	0	0	4	12
Groups/couples	2	3	0	0	2	6
Conjoint/couples	0	0	0	0	0	0

This is a multiple response variable:
r = number of responses to this value.
% = percentage of total respondents choosing this value.

Total number of respondents: Rural = 25, Urban = 32.

In terms of the total number of treatment options offered in shelters as described by shelter staff, 79% indicated that only one or two options were provided. There were no remarkable differences in reporting between rural and urban respondents. This reflects the standardization of treatment options provided by shelters across the province.

Years of Work Experience

Due to the membership requirements of AAMFT which includes documentation of extensive post-graduate training and experience, it was assumed that therapists would have at least two years experience in their field. Therefore, they were not questioned about their years of work experience. Shelter staff reported their years of experience with this population with 14 (42%) indicating employment with the shelter of

between 2 and 5 years. Twenty-four (25%) noted more than five years experience and 19 (33%) reported less than 2 years of employment with the shelter.

Theoretical Perspectives

A question asking respondents to identify the theoretical perspective primarily influencing their practice as either family systems theory, feminist theory or other was included to test the assumption that therapists would represent the systemic perspective and shelter staff the feminist perspective. Therapists responded as expected with 73% indicating family systems theory to be most influential to their practice. A surprising number of shelter staff (52%) also chose family systems theory with 38% indicating they were influenced by both family systems and feminist theory (Table 4.4). More shelter staff (38%) identified with feminist theory than therapists (5%), although more therapists (14%) noted they were influenced by both than shelter staff (8%).

Table 4.4
Theoretical Perspectives
of Therapists and Shelter Staff

Theoretical Perspective	Therapists n	%	Shelter Staff n	%
Family systems	47	73	27	52
Feminist	3	5	20	38
Family systems and feminist	9	14	4	8
Other	5	8	1	2
Total...	64	100	52[1]	100

[1] Missing = 5.

Perceptions of Availability of Community Resources

Both therapists and shelter staff perceived their communities as providing a wide complement of both service and treatment resources (Table 4.5)

Table 4.5
Service and Treatment Resources Available in the Community as Reported by Therapists and Shelter Staff

	Therapists						Shelter Staff					
Service Resources	Rural		Urban		Total		Rural		Urban		Total	
	r	%	r	%	r	%	r	%	r	%	r	%
Law (police)	8	89	51	93	59	92	25	100	29	91	54	95
Legal	7	78	49	89	56	88	24	96	32	100	56	98
Medical	8	89	51	93	59	92	24	96	30	94	54	95
Shelter	7	78	55	100	62	97	25	100	32	100	55	96
Social	8	89	50	91	58	91	25	100	31	97	56	98
Mental health	7	78	49	89	56	88	22	88	30	94	52	91
Employment	3	33	30	55	33	52	17	68	20	63	37	65
Other	2	6	1	2	3	5	3	12	1	3	4	7
Treatment Resources												
Groups/women	5	56	48	87	53	83	15	60	31	97	46	81
Groups/men	4	44	51	93	55	86	7	28	31	97	38	67
Individual/women	9	100	54	98	63	98	25	100	31	97	56	98
Individual/men	8	89	52	95	60	94	12	48	30	94	42	74
Groups/couples	0	0	19	35	19	30	3	12	16	50	19	33
Conjoint/couples	5	56	43	78	48	75	8	24	17	53	25	44

This is a multiple response variable:
r = number of responses to this value.
% = percentage of total respondents choosing this value.

Seventy-five percent of therapists and 86% of shelter staff indicated awareness of six or more service resources

available in the community (Table 4.6). Therapists appeared more cognizant of treatment resources with 86% indicating knowledge of four to six resources available in the community versus 63% of shelter staff choosing four or more responses. This difference may be due to the fact that the group of shelter respondents consisted of a much higher rural component. Table 4.5 shows the differentiation of responses by location and it is apparent that fewer treatment resources are available in rural communities with "individual counselling for battered women" given as most commonly available. "Group therapy for men" was noted as available by only 28% of rural shelter workers and 51% of rural therapists compared to 97% of urban shelter staff and 93% of urban therapists.

Table 4.6
Total Number of Service and Treatment Resources Reported by Therapists and Shelter Staff

Total No.	Service Resources				Treatment Resources			
	Therapists		Staff		Therapists		Staff	
	n	%	n	%	n	%	n	%
1	1	2	0	0	3	5	6	10
2	2	3	1	2	3	5	4	7
3	1	2	0	0	3	5	11	19
4	5	8	0	0	12	19	14	25
5	6	9	7	12	26	41	9	16
6	17	26	13	23	17	25	13	23
7	30	47	33	58	0	0	0	0
8	2	3	3	5	0	0	0	0
Total...	64	100	57	100	64	100	57	100

Coordination of Community Resources

The majority of both shelter staff (81%) and therapists (63%) perceived service resources in their community to be "partially" coordinated (Table 4.7). Sixteen percent of therapists and 14% of shelter staff believed these services were "not at all coordinated". Similarly, 67% of shelter staff and 55% of therapists indicated that treatment resources were "partially" coordinated in their community. The second most frequent observation made by both therapists (19%) and shelter staff (15%) was that treatment resources were "not at all" coordinated. In both response sets, therapists were more likely to mark "unknown" than shelter staff.

Table 4.7
Level of Coordination of Service and Treatment Resources as Reported by Therapists and Shelter Staff

Response	Service Resources				Treatment Resources			
	Therapists		Staff		Therapists		Staff	
	n	%	n	%	n	%	n	%
Extensively	2	3	2	3	2	3	4	7
Partially	39	63	46	81	35	55	37	67
Not at all	10	16	8	14	12	19	8	15
Unknown	11	18	1	2	15	23	6	11
Total...	62[1]	100	57	100	64	100	55[2]	100

[1] Missing = 2. [2] Missing = 2.

APPROPRIATENESS OF COUPLES COUNSELLING

Data relevant to this section was obtained from shelter staff's estimates of women returning to their partners from shelters and the staff's perception of the appropriateness of marital counselling. Information from therapist's responses included their perception of the appropriateness of referral to marital counselling, their own experience with providing marital counselling and referrals to other community resources. The frequency with which marital counselling is requested by couples, and the frequency in which they find physical abuse to be revealed after couples therapy has commenced for other reasons was also recorded.

Estimates of Women Returning to Their Partners

Shelter staff respondents (54%) estimated that over 50% of the women using shelters return to their partners (Table 4.8). Written comments from respondents indicated that their shelter's official statistics did not coincide with their personal observations because many women do not return to their husbands immediately from the shelter but will do so within one year. The comments suggested that this is therefore a low estimation.

Table 4.8
Estimated Number of Women Returning to Their Partners

Response	n	%
Greater than 75%	9	17
75% - 50%	21	37
50% - 25%	14	25
Less than 25%	9	16
Total...	53	100

Missing = 4.

Appropriateness of Referral to Marriage Counselling

The majority of shelter staff (68%) perceived marital counselling as only "occasionally" appropriate for this population with 15% viewing it as "never" appropriate. This contrasts with 68% of therapists responding to this question who saw it as an appropriate option either "frequently" or "almost always" (Table 4.9). It was speculated that the lack of alternative resources in rural areas might increase the frequency with which marital counselling was seen as appropriate. The responses from therapists suggest this could be true but the number of rural therapists in the study is too small to provide evidence worth consideration. In respect to shelter staff, both rural and urban groups responded with the same frequency (83%) when the categories of "occasionally" and "never" were collapsed. This suggests that there is no relationship between an increased perception of the

appropriateness of marital counselling and the availability of treatment resources within this sample.

Table 4.9
Appropriateness of Referral to Marriage Counselling

	Therapists						Shelter Staff					
Response	Rural		Urban		Total		Rural		Urban		Total	
	r	%	r	%	r	%	r	%	r	%	r	%
Almost always	3	75	6	25	9	3	21	4	1	4	2	4
Frequently	1	25	9	38	10	36	3	13	4	13	7	13
Occasionally	0	0	8	33	8	28	15	62	22	73	37	68
Never	0	0	1	4	1	3	5	21	3	10	8	15
Total...	4	100	24	100	28[1]	99	24	100	30	100	54[2]	100

[1] Missing = 36. [2] Missing = 3.

Only 28 therapists responded to the questionnaire item regarding appropriateness of referral to marriage counselling for violent couples due to the question's placement in the section on indirect involvement in the questionnaire. Therapists who were not involved in referring couples to community resources did not complete this section. However, an additional 30 therapists of the total 64 respondents indicated direct involvement with this population in the provision of therapy (Table 4.10). This implies that they perceive marital counselling with couples experiencing violence in their relationship to be appropriate at least occasionally.

Table 4.10
Therapists' Type of Involvement With Couples

Responses	Direct		Indirect		None	
	r	%	r	%	r	%
Single category	20	31	3	5	6	9
Direct/indirect/supervision	12	19	12	19	0	0
Indirect & direct	13	20	13	20	0	0
Direct & supervision	9	14	0	0	0	0
Indirect & supervision	1	2	1	2	0	0
Total...	55	86	29	44	6	9

This is a multiple response variable:
r = number of responses to this value.
% = percentage of respondents (N=64) choosing this value.

Of the 55 respondents indicating direct involvement with couples experiencing violence in their relationship, 20 (31% of the total 64 respondents) provided only direct therapy. Twelve people (19%) were involved in supervision of other therapists and referrals with 13 (20%) providing direct and indirect services and 1 person (2%) indicating a combination of supervision and referral. Of the 29 persons indicating indirect involvement, only 3 (5%) were singularly involved in referral. Only 6 persons (9%) indicated that they were uninvolved with this population. It can be concluded that the majority of respondents (86%) had direct involvement with this population.

Frequency of Requests for Marital Counselling by Couples

The 29 therapists with indirect involvement with this population reported on the frequency with which marital

counselling was requested by couples. Forty-one percent indicated that they "sometimes" received these requests while 34% chose the response "frequently" (Table 4.11). This suggests that couples often perceive conjoint therapy as appropriate in meeting their needs.

Table 4.11
Frequency in Which Couples Request Conjoint Therapy

Response	n	%
Almost always	2	7
Frequently	10	36
Sometimes	12	43
Rarely	4	14
Total...	28[1]	100

[1] Missing = 1.

Referrals to Community Resources (Indirect Involvement)

The four service resources most frequently reported to be utilized by therapists were "shelter services" (86%), "social services" (65%), "mental health services" (55%), and "law enforcement" (52%) (Table 4.12). Interestingly, the males in this group indicated using "law enforcement" much more frequently (75%) than females (35%). Males also made referrals to "social services" (75%) and "legal assistance" (58%) more frequently than females of whom 59% marked "social services" and 29% marked "legal assistance".

In regard to treatment resources, therapists chose "group therapy for abusive men" (86%) and "group therapy for battered women" (69%) most frequently. Almost twice as many male therapists (92%) chose "group therapy for battered women" as female therapists (53%). This may be reflecting these therapists' sensitivity to women's need for validation of their experience by other women. Men also selected "group therapy for abusive men" more frequently (100%) than women (76%). Other response frequencies were similar across gender.

Table 4.12
Therapists' Referrals to Service and Treatment Resources by Gender

Service Resources	Females		Males		Total	
	r	%	r	%	r	%
Law enforcement	6	35	9	75	15	52
Legal assistance	5	29	7	58	12	41
Medical services	7	41	4	33	11	38
Shelter services	14	82	11	92	25	86
Social services	10	59	9	75	19	65
Mental health services	10	59	6	50	16	55
Employment services	2	12	2	17	4	14
Treatment Resources						
Groups/women	9	53	11	92	20	69
Groups/men	13	76	12	100	25	86
individual/women	7	41	7	58	14	48
individual/men	7	41	6	50	13	45
groups/couples	2	12	2	17	4	14
conjoint/couples	8	47	5	42	13	45

This is a multiple response variable:
r = number of responses to this value.
% = percentage of total respondents choosing this value.

Total number of respondents: Female = 17, Male = 12.

In terms of the total number of community resources therapists reported making referrals to, there was little difference between service and treatment resources. Fifty-five percent indicated using three or less service resources and 62% chose three or less treatment resources for referral purposes (Table 4.13).

Table 4.13
Total Number of Therapist Referrals to Service and Treatment Resources

Total No.	Service Resources		Treatment Resources	
	n	%	n	%
0	1	3	0	0
1	6	21	3	10
2	2	7	10	35
3	7	24	5	17
4	3	10	5	7
5	4	14	4	14
6	3	10	2	7
7	3	10	0	0
Total...	29	99	29	100

Estimated Frequency With Which Couples Follow Through With Referrals

The majority of therapists (76%) estimated that couples followed through with their referral recommendations "sometimes" with only one person indicating that this occurred "almost always" (Table 4.14).

Table 4.14
Estimated Frequency in Which Couples
Follow Through With Referrals

Response	n	%
Almost always	1	3
Frequently	4	14
Sometimes	22	76
Rarely	1	3
Unknown	1	3
Total...	29	99

Preference for Individual Counselling Despite Cohabitation

Of the 28 therapists responding to the question of whether or not they preferred to see only one partner while cohabitation continues, 75% indicated they would not. The most consistent reason given (13 of 19 comments) was that it was necessary to work with the whole system rather than part of the system. Of those 25% who said they would see one partner individually, 3 persons said they would do so to emphasize the man's responsibility for the violence and 3 stated they would do so in order to assess the woman's safety.

Therapists were also asked if they would then refer the other partner elsewhere while involved individually with one. Of the 21 respondents, 71% replied that they would do so, with 7 persons giving referral for groupwork as the reason. Of those responding "no" to this question, 2 provided the reason of referring both to separate groups and 2 preferred to see both individually.

Frequency in Which Abuse is Revealed Later in Therapy

All 64 therapists were given the opportunity to identify the frequency with which couples present with other problems, revealing the problem of physical abuse later in therapy. Overall, 42% reported this situation occurring "frequently" and 40% indicated that it occurred "sometimes". Although four people responded that this circumstance "rarely" occurred, three of those were from the group reporting no involvement with this clientele (Table 4.15).

Table 4.15
Frequency in Which Abuse is Revealed Later in Therapy by Type of Therapist Involvement

Response	Type of Involvement						Total	
	Direct		Indirect		None			
	n	%	n	%	n	%	n	%
Almost always	5	9	3	10	0	0	7	11
Frequently	24	44	12	41	1	20	26	42
Sometimes	24	44	13	45	1	20	25	40
Rarely	1	2	1	3	3	60	4	6
Total...	54[1]	99	29	99	5[2]	100	62[3]	99

[1] Missing = 1. [2] Missing = 1. [3] Missing = 2.

ASSESSMENT AND TREATMENT ISSUES

Assessment was addressed in the questionnaires in terms of the frequency with which therapists routinely assess violence in couples counselling and their use of screening criteria prior to working with violent couples. Shelter staff were asked their opinion on the same screening criteria. Treatment issues asked of both samples included treatment goals for therapy with this population, choices of treatment options if violence should occur while therapy is in progress, and the use of individual interviews with the woman to assure her safety and uncoerced willingness to attend therapy. Additionally, therapists were polled on the format they prefer for the initial interview, how effective they believe their work with this population to be and their awareness of treatment outcome.

Assessment

Routine assessment of violence in couples counselling

Awareness of the need for assessment of physical abuse in all couples counselling was high among the therapists surveyed. Although social desirability bias may have elevated reports of frequency of assessment, there is an obvious awareness of the need for such assessment. Sixty-one percent responded that physical conflict was explored "almost always"

with another 38% divided equally between the responses of "frequently" and "sometimes" (Table 4.16). The only person responding "rarely" also reported having "no involvement" with this population and therefore may work in a setting where couples counselling does not occur.

Table 4.16
Frequency of Conducting Routine Assessment of Physical Abuse in Couples Therapy

Response	Type of Involvement						Total	
	Direct		Indirect		None			
	n	%	n	%	n	%	n	%
Almost always	34	62	19	65	3	50	39	61
Frequently	11	20	6	2	0	0	12	19
Sometimes	10	18	4	14	2	33	12	19
Rarely	0	0	0	0	1	17	1	1
Total...	55	100	29	100	6	100	64	100

Screening criteria

The screening criteria identified by therapists and shelter staff is depicted in Table 4.17. More internal agreement on the criteria was apparent with therapists than with shelter staff. However, both chose the same four criteria most frequently, identifying "both partners are willing to attend therapy" (therapists - 71%; shelter staff - 87%), "both partners have made a verbal commitment to stop the violence" (therapists - 82%; staff - 65%), "assessment of the frequency, duration and severity of past violence" (therapists - 76%; staff - 65%) and "both are willing to sign a 'no-violence' contract" (therapists - 49%; staff - 62%) as the most useful.

57% of shelter staff also indicated the importance of recent participation in individual or group therapy while only 13% of therapists marked this option. Comments were written by respondents concerning assurance that the woman feel free to speak in the sessions and that the man be willing to take responsibility for his behaviour.

Table 4.17
Screening Criteria Chosen By
Therapists and Shelter Staff

Response	Therapists		Staff	
	r	%	r	%
Both are willing to attend therapy	39	71	47	87
Both/verbal commitment to stop violence	45	82	35	65
Both will sign "no-violence" contract	27	49	33	62
Both have a "sponsor" for support	0	0	20	37
Both/attended individual/group therapy	7	13	31	57
No violence for six months	4	7	18	33
Assessment of past violence	42	76	35	65
Clear safety plan for the woman	3	5	6	11
Batterer completed treatment program	3	5	5	9
Other	7	13	4	7
Does not use screening criteria	1	0	0	0

This is a multiple response variable:
r = number of responses to this variable.
% = percentage of total respondents choosing this variable.

Shelter staff showed less internal agreement in their choice of screening criteria than therapists and also selected more options (Table 4.18). Only 15% of therapists chose more than four options with only one choosing over six. In contrast, 41% of shelter staff selected more than four options with several choosing as many as seven or eight. This suggests that shelter staff are concerned that a thorough assessment

which covers a multitude of aspects is undertaken before commencing couples therapy.

Table 4.18
Total Number of Screening Criteria
Chosen by Therapists and Shelter Staff

Total No.	Therapists		Staff	
	n	%	n	%
0	1	2	0	0
1	3	5	1	2
2	10	18	9	17
3	20	36	11	20
4	13	24	11	20
5	6	11	4	7
6	2	4	4	7
7	0	0	9	17
8	0	0	2	4
Total...	55	100	54	100

Total respondents: Therapists with direct involvement = 55, Shelter Staff = 54 (57 less 3 who stated marital counselling is "never" appropriate).

Treatment

Format of the initial interview

Thirty-four therapists (63%) indicated a preference for a combination of both individual and conjoint interviews for the first session. Seventeen (32%) reported preferring conjoint sessions with only three (5%) preferring individual interviews for the initial session.

Frequency of individual sessions with the woman to assure safety and uncoerced involvement

Shelter staff perceived a need for more vigilance regarding the woman's safety and uncoerced involvement in therapy than therapists (Table 4.19). In respect to assuring the woman's safety, 47% of shelter staff indicated that individual sessions should be held "after every session" with only 11% of therapists in agreement. Thirty-four percent of shelter staff also believed these interviews should occur "after every session" to assure the woman's uncoerced involvement in therapy as compared to only 5% of therapists.

Table 4.19
Frequency of Individual Sessions With the Woman to Assure Safety and Uncoerced Involvement

Response	Safety				No Coercion			
	Therapists		Staff		Therapists		Staff	
	n	%	n	%	n	%	n	%
After every session	6	11	24	47	3	5	17	34
As needed	39	72	25	49	29	54	25	50
Periodically	6	11	2	4	15	28	7	14
Never	3	6	0	0	7	13	1	2
Total...	54[1]	100	51[2]	100	54[1]	100	50[3]	100

[1] Missing = 1. [2] Missing = 3. [3] Missing = 4.

These results are congruent with the expectation that shelter staff would be most sensitive to the safety issue because it is the first priority in their work setting. Both groups recognize this as an important issue with only three therapists (6%) indicating they would "never" hold individual

sessions with the woman to assure her safety. Similarly, only seven therapists (13%) and one shelter staff (2%) chose the "never" category in reference to individual sessions for assessment of the woman's uncoerced involvement in therapy.

Treatment goals

The five most frequently chosen treatment goals were the same for both therapists and shelter staff (Table 4.20). "Termination of all violent behaviour" was most frequently indicated by therapists (80%), taking second place in frequency for shelter staff (72%). Eighty-five percent of shelter staff marked "change in the man's belief that he has a 'right' to abuse his wife" as a treatment goal of primary importance with therapists selecting it with the third greatest frequency (67%). Other treatment goals with primary importance were "improved anger management skills for both husband and wife" (therapists - 71%; staff - 66%), "changes in the couple dynamics you perceive to be supporting the violent behavior" (therapists - 67%; staff - 52%), and "expression of empathy regarding the woman's fear and hurt by the man" (therapists 51%; staff - 37%).

Several written comments stated that both partners must take responsibility for their actions. If the woman is not abusive, she has a responsibility to make plans for her own safety. An editing error resulted in the omission of the

response "an understanding of the impact of childhood history on one's choices of behaviour" from the shelter staff questionnaire. Although two persons identified this under the "other" category, it may have been underreported due to this oversight.

Table 4.20
Treatment Goals Identified by
Therapists and Shelter Staff

Response	Therapists		Staff	
	r	%	r	%
Decrease in violence	13	24	6	11
Changes in the couple dynamics	37	67	28	52
Termination of all violent behaviour	44	80	39	72
Expression of remorse by the man	23	42	16	30
Expression of empathy by the man	28	51	20	37
Change in belief of "right" to abuse	37	67	46	85
Improved anger management skills	39	71	36	66
Understanding childhood history	20	36	2	4
Other	8	14	2	4

This is a multiple response variable:
r = number of responses to this variable.
% = percentage of total respondents choosing this variable.

Total respondents: Therapists = 55, Shelter Staff = 54.

Therapists tended to identify more treatment goals as important to achieve before the termination of therapy than shelter staff. Although over 50% of both groups chose between three and five responses to this question, 35% of therapists chose six to eight treatment goals with only 15% of shelter staff falling into this frequency category (Table 4.21). This suggests either a greater concern with or higher awareness of

treatment goals for couples by therapists than by shelter staff.

Table 4.21
Total Number of Treatment Goals Identified by Therapists and Shelter Staff

Total No.	Therapists		Shelter Staff	
	n	%	n	%
0 - 2	8	14	14	25
3 - 5	28	51	32	59
6 - 8	19	35	8	15
Total...	55	100	54	100

Treatment options when violence occurs while therapy is in progress

The majority of both therapists (73%) and shelter staff (72%) chose "individual sessions for both the man and the woman" as the most preferable option when violence occurs while conjoint therapy is in progress (Table 4.22). Shelter staff selected "referral of both partners to other programs" with the second greatest frequency (37%) while only 29% of therapists marked it as an option. The response of second greatest frequency for therapists (38%) was "continued conjoint therapy" with only 17% of shelter staff respondents indicating it as a treatment choice. The total number of options selected by both groups clustered at three or less (therapists - 94%; staff - 96%). This is likely due to the fact that some of the responses were mutually exclusive.

Table 4.22
Treatment Options When Violence Occurs
While Therapy is in Progress

Response	Therapists		Shelter Staff	
	n	%	n	%
Individual sessions/both	40	73	39	72
Individual sessions/woman	1	2	5	9
Individual sessions/man	2	4	3	6
Referral/both	16	29	20	37
Referral/woman	0	0	1	2
Referral/man	13	24	5	9
Termination of therapy	8	14	10	18
Continued conjoint therapy	21	38	9	17
Other	5	9	4	7

This is a multiple response variable:
r = number of responses to this value.
% = percentage of total respondents choosing this value.

Effectiveness of work with violent couples

Forty-eight (87%) of therapists viewed themselves as somewhat effective in their work with this population. Six (11%) viewed themselves as "very effective" in contrast to one person (2%) who believed themselves to be "not at all effective". Of this group (n=54), 29 (54%) indicated that they had followed up on clients whom they believed had achieved successful resolution of their problems with violence (Table 4.23). The follow up occurred at varying time intervals with 12 persons reporting positive results, 2 reporting mixed results and 15 not identifying the outcome. Two people also commented that positive results do not necessarily mean the couple is still together as they view successful separations without violence as positive also.

Table 4.23
Follow-up With Clients Who Achieved
Successful Resolution of Violence

	Outcome		
Time Interval	Positive	Mixed	Unidentified
Less than 3 months	0	0	2
At 3 months	2	0	0
3 - 6 months	2	0	2
6 months	4	2	1
6 months - 1 year	0	0	3
1 year	3	0	0
Yearly for 3 years	1	0	1
Unspecified	0	0	6
Total...	12	2	15

SUMMARY

In respect to demographic characteristics of the respondents, therapists were predominantly from urban areas and divided almost equally by gender. Approximately 50% worked in private practice or private/semi-private agencies and the majority responded that their work was primarily influenced by a family systems perspective.

Shelter staff were predominantly female with 44% reporting from rural locations and 56% from urban areas. Most had at least two years experience in the shelter they were employed by and reported that the shelters provided primarily individual and group counselling for women as treatment options. Contrary to expectations, they did not indicate a primarily feminist perspective influencing their work but

rather chose either family systems theory or a combination of both theoretical frameworks.

Shelter staff's estimation that at least 50% of women using shelters return to their husbands is consistent with the literature. Thus, despite violence, couple relationships persist.

Therapists were more likely to view referral to marriage counselling as appropriate with 68% choosing the response "frequently" or "almost always" compared to the majority of shelter staff (68%) who considered it an option "occasionally". In addition to perceiving referral to marital therapy as appropriate for this population, the majority of therapist respondents (86%) were directly involved in the provision of this treatment modality.

Other referral practices of therapists were described as involving referral to "shelter services" (86%), "social services" (65%), "mental health services" (55%), and "law enforcement" (52%). Group therapy for both men (86%) and women (69%) were the most frequent treatment resource choices. Interestingly, male therapists indicated referrals to "law enforcement" and group therapy for both women and men much more frequently than female therapists.

The majority of referring therapists (75%) stated they would not prefer to see one partner individually while cohabitation continues with the most frequently cited reason being that it is preferable to work with the whole system.

In respect to the frequency with which abuse is revealed after commencing therapy for other reasons, 53% of the total therapist respondents indicated "frequently" or "almost always". Another 40% of therapists noted this would likely occur "sometimes". These responses suggest that there is a high possibility that therapists will encounter problems of physical violence in their work.

On the subject of the need for routine assessment of physical abuse in couples counselling, the responses of therapists indicated a high level of involvement in this process.

Both shelter staff and therapists most frequently identified the same four criteria as important in screening violent couples prior to conjoint therapy. These criteria included establishing that both partners were willing to attend therapy, a verbal commitment to end the violence and/or the signing of a "no-violence" contract, and the assessment of the frequency, duration and severity of past violence. Shelter staff indicated a greater number of criteria than

therapists which suggests concern with thorough assessment prior to the commencement of conjoint therapy.

In the area of treatment issues, most therapists indicated a preference for using a combination of individual and conjoint interviews for the first session.

Shelter staff were more concerned about the constant monitoring of the woman's safety and uncoerced involvement in therapy than therapists although therapists did not negate the importance of these issues. As shelters are primarily concerned with the safety of women and children during domestic crisis, the responses of shelter staff could be expected to be influenced by their work environment.

There was also mutual agreement between the two survey groups regarding treatment goals. Although there were some differences in the frequency ranking of these goals, the same five were most frequently chosen by both groups. These goals included termination of all violent behavior, change in the man's belief that he has a "right" to abuse his wife, improved anger management skills for both husband and wife, changes in the couple dynamics which are perceived to be supporting the violent behaviour and an expression of empathy by the man in regards to the woman's fear and hurt. Therapists identified more treatment goals than shelter staff which could be

attributed either to a greater concern with or awareness of treatment goals.

When violence does occur while couples are attending therapy, individual sessions for both the man and the woman were the most frequently indicated treatment option. Referral to other programs for both the man and the woman and continued conjoint therapy were also chosen by both groups of respondents.

Over half of the therapists (53%) directly involved with this population, indicated providing follow-up at varying time intervals to clients whom they perceived as achieving successful resolution with problems of violence. Of these 29 therapists, 12 reported a positive outcome after follow-up, 2 reported mixed results and the remaining 15 did not report outcome findings. There was no indication provided of actual follow-up methodology or precise documentation of these results. Therefore, the responses simply convey an anecdotal impression that some therapists believe they are successful in their work with this population.

CHAPTER 5

DISCUSSION AND CONCLUSIONS

Spousal abuse is a pervasive social problem in our society requiring a multitude of interventions at the political, community, family and personal levels. It permeates many areas of social work, requiring self-examination of one's values and beliefs about neutrality, client self-determination and the family (Moltz, 1992). Those who are directly affected by spousal violence often utilize a variety of treatment options in their efforts to attain a violence-free life.

This study focused on the use of conjoint therapy as one option in the continuum of services available to couples experiencing violence in their relationship. The literature depicts diverse opinions regarding the appropriateness of marital counselling with this population, with the greatest theoretical controversy between feminist theory and systemic thinking.

In order to describe practices and beliefs about conjoint therapy for couples experiencing violence in their relationship, a survey questionnaire was designed to gather data on the practice experience of persons working with this

population. Questionnaires were sent to marriage and family therapists currently on the membership roster of the Alberta chapter of the American Association for Marriage and the Family (AAMFT) and staff employed by women's shelters across Alberta.

STUDY FINDINGS

In this chapter the study findings will be discussed in relationship to the research questions listed in chapter 3.

Do marriage and family therapists provide conjoint therapy to couples who are experiencing physical violence in their relationship and wish to continue cohabitation?

Of the 64 therapists responding to the survey, 86% indicated direct involvement with couples experiencing violence in their relationship. Although this group is not representative of all marriage and family therapists in Alberta, AAMFT requires stringent qualifications for membership which suggests considerable homogeneity of the membership throughout North America. The frequency of these practitioners' involvement with this population was not probed as the assumption was made that <u>any</u> involvement requires guidelines for assessment and treatment. Of the 55 people (86%) who were involved directly with this population, 35

(64%) also indicated other levels of involvement including supervision of other therapists and referral activity.

Additionally, therapists reported that couples "sometimes" (43%) and "frequently" (36%) request conjoint therapy and that physical abuse is "frequently" (42%) or "sometimes" revealed after therapy has commenced.

It can be concluded that some Alberta marriage and family therapists are providing conjoint therapy to couples experiencing violence in their relationship. The information provided by the study concurs with my personal clinical experience and practice descriptions found in the literature.

How often do therapists and shelter staff see referral for marriage counselling as appropriate for couples who are experiencing physical violence? Is there a relationship between perceived appropriateness of marital counselling for this population and the number of treatment resources available in the community?

Marriage counselling was perceived as an appropriate referral for violent couples either "frequently" or "almost always" by 68% of therapists while 68% of shelter staff perceived it to be appropriate "occasionally". Although only a small number of therapists answered this question due to it's location on the questionnaire, an additional 30

therapists identified themselves as directly involved in providing therapy and/or supervision to other therapists for this population. Also, 75% of therapists involved in referral activity indicated that couples "sometimes" or "frequently" request conjoint therapy.

As the number of rural therapists was small, it is difficult to arrive at any conclusions when rural and urban responses are compared. Rural therapists did indicate that fewer treatment resources were available while responding that marital counselling was "almost always" or "frequently" appropriate. The shelter staff sample contained a more equitable split in geographic location and also indicated that there were fewer treatment resources (primarily for men) in rural areas. However, when the categories of "occasionally" and "never" were collapsed, 83% of both rural and urban shelter staff held the same views on the appropriateness of marriage counselling for this population. Therefore, there is no suggestion that a relationship exists between availability of treatment resources and the perceived appropriateness of marital counselling.

This difference in perception of appropriateness of marital counselling also cannot be explained by differences in theoretical perspective. Part of the rationale for selecting these sample groups was the assumption that shelter workers

would hold a feminist perspective while therapists would be primarily influenced by family systems theory. Although more shelter staff identified with feminist theory completely (38%) or partially (8%) than therapists (feminist -5%; feminist and family systems - 14%), 52% of shelter staff indicated family systems theory as the primary influence in their work. As expected, the majority of therapists (73%) indicated that they were primarily influenced by family systems theory.

No other possible explanations for this difference were addressed by the questionnaire data. The literature suggests that shelter populations differ from violent couples in the general population in several ways (Straus, 1991). The primary difference is in the frequency, duration and severity of abuse experienced by women. MacLeod (1987) also notes that most women using shelters suffer from poverty and other disadvantages. The 1991 Annual Report for Alberta Women's Shelters (Alberta Family & Social Services, 1991a) does not specify income brackets but identifies the source of income for women using shelters. Fifty-eight percent of the 3,398 women using Alberta shelters in 1991 received income from social allowance or other government income. Only 42% of the battering spouses (N=2655) were reported to be employed on a full-time basis with 40% having attained only a Grade 10 education or lower. This information suggests that most

families using shelters fall into the lower socio-economic brackets in Alberta.

In contrast, 50% of therapists responding to the survey were self-employed in private practice. Many others worked in private or semi-private agencies where fee-for-service would apply. This information leads to the conclusion that the two sample groups would usually be involved with different clientele whose experience with violence differs in both a quantitative and qualitative sense. Also, shelter staff are usually dealing with crisis situations, when protection is more of an issue than treatment. If therapists were to assess the same persons as shelter staff regarding appropriateness of marital counselling, they might also perceive marital counselling as only "occasionally" or "never" appropriate. Similarly, shelter staff might share the perceptions of therapists if they were to assess their clientele. In conclusion, although all violence is unacceptable, it may be a disservice to this population to treat all involvement in spousal violence as the same.

When conjoint therapy is provided, what criteria are utilized in assessment and treatment? Do shelter staff agree with this criteria or define others?

The study findings show a high level of agreement between shelter staff and therapists despite the possibility that they

are exposed to different populations with differing experiences of violence. This suggests that there are some general guidelines which can be applied to conjoint therapy with violent couples.

In terms of screening criteria, both groups most frequently identified the same four screening criteria. The response that "both partners are willing to attend therapy" is an obvious prerequisite for conjoint therapy but also refers to the couple having a basic commitment to continue their relationship. The criteria of "no current drug or alcohol abuse" was not included to avoid using too many obvious prerequisites to therapy. Only one respondent added this response to the "other" category. Both groups of respondents perceived a necessity for both partners (and particularly the batterer) to make a commitment to stop the violence verbally and/or in written form.

Both therapists and shelter staff indicated that assessment of the frequency, duration and severity of abuse was an important criterion in screening violent couples for conjoint therapy. This implies that without mutual commitment to stop the violence and/or in situations where there is a long history of frequent and severe abuse, conjoint therapy would be inappropriate. Magill & Werk (1985) suggest that offering marital counselling when there is a poor prognosis

for ending violence only serves to offer the woman false hope and further endanger her. Comments received on the questionnaires noted that conjoint therapy may assist violence-free separation if the resolution of the couples differences is not possible or desired. White (1989) also holds this position. Considering the number of media reports of women who have been seriously injured or killed despite separation, I believe more thorough assessment must be undertaken and if satisfactory separations cannot be achieved, more effort must be made to incarcerate men who are not willing to change their violent behaviour.

Both therapists and shelter workers identified the same treatment goals as most important to achieve before termination of therapy. These included "termination of all violent behavior", "change in the man's belief that he has a 'right' to abuse his wife", "improved anger management skills for both husband and wife" and "expression of empathy regarding the woman's fear and hurt by the man". "Improved anger management skills" is not a treatment goal emphasized by the more recent models proposed by White (1989), Jenkins (1990), Lipchik (1991), and Goldner et al. (1990). Earlier models with a more psycho-educational approach such as those employed by Neidig & Friedman (1984) and Margolin (1979) included a focus on improving anger management skills. The more recent models cited above focus more on the gender issues

which were operationalized on the questionnaire as changing the man's belief that he has a "right" to abuse his wife, expressions of remorse and empathy, and change in the couple dynamics. The intergenerational impact of gender beliefs is also recognized in some of the literature (Goldner, et al., 1990; Gutsche & Murray, 1991) and although it was operationalized on the questionnaire as "an understanding of the impact of childhood history on one's choices of behaviour", respondents did not give it preference.

Unfortunately, this method of inquiry only provides a superficial description of the complex issue of treatment. Of most importance, however, is the recognition that the termination of all violence must be the primary goal. Bograd (1984) notes that violence has a powerful effect on a relationship causing the system to become organized around the violence rather than vice versa. Specifically how the goal of termination of all violence can be reached is a matter for further research. Both the literature and this study suggest that attitudinal change must accompany behavioral change if the cessation of violence is to be sustained. From the information presented here, I conclude that the most helpful treatment models focus upon gender beliefs and how those beliefs are sustained intergenerationally and behaviourally. I do not believe that couples can learn new ways of being with each other until the premises which lock them into their

behaviours are "unpacked" and "reconstructed", to use Goldner et al.'s (1990) terms. Jenkins (1990) refers to this issue in terms of "inviting" couples to take responsibility for their actions and find ways to "contribute" to the relationship.

Conjoint therapy has been criticized as increasing the danger for the woman because she may make statements which displease her spouse and result in later retribution. Similarly, conjoint therapy has been reproached for colluding with the man to further control and dominate his wife even if he should stop beating her (Avis 1992; Kaufman, 1992). Responses from both groups indicated an awareness of the need to hold individual sessions with the woman to assure her safety and uncoerced willingness to be involved in therapy. Shelter staff were more concerned with these issues and this greater concern is likely due to the somewhat different population they are exposed to and the fact that they more frequently observe the aftermath of crisis situations.

In response to the fear of men denying and minimizing abuse and further endangering women through conjoint counselling, some of the literature recommends that the therapist have a plan to deal with recurring violence. "No-violence contracts" have been in use for some time and Gutsche and Murray (1991) utilize a detailed "Peace Agreement" which defines the behaviours both partners are to desist from and an

action plan to utilize when their anger escalates. If violence occurs while therapy is in progress, whomever has initiated the violence is asked to attend an anger management group prior to resuming conjoint therapy. The majority of both therapist and shelter staff respondents identified "individual counselling for both partners" as the most preferable treatment option in this situation. Comments were made that couples therapy with this population often requires utilization of both individual and conjoint interviews. This response is also described most frequently in the literature (Lipchik, 1991; Goldner, 1992; Jenkins, 1990). From the literature and the survey results, it can be concluded that the utilization of individual interviews and group work may be necessary in the course of treatment and particularly if violence reoccurs.

Is follow-up utilized to determine the outcome of treatment?

Twenty-nine therapist respondents (54%) indicated that they followed up on clients whom they believed had achieved successful resolution of their problems with violence. Most follow-up occurred within 3 months to 1 year following therapy with 12 people indicating positive results, 2 reporting mixed results and 15 giving no indication of the couples' status. Written comments on the questionnaires described "successful resolution of violence" as not necessarily meaning the couple remained together. Again, this method of inquiry provides

only a superficial "sense" that therapists are making some effort to evaluate the outcome of their work. The difficulties of conducting stringent, valid and replicable outcome research is daunting for most therapists. The nature of therapy demands the flexibility to tailor therapeutic response to the specific and idiosyncratic needs of each client while valid and generalizable research requires uniform application of a well-defined model of treatment, a definable population receiving the treatment and a clear definition of the desired therapeutic outcome (Letich, 1992). In this situation, anecdotal information has been provided to indicate that some couples have achieved successful resolution of their problems with violence. This information suggests that it is possible to help people with this problem utilizing conjoint therapy. However, details regarding how frequently and under what circumstances this can be achieved are not conclusively defined.

When therapists do not provide conjoint therapy, to whom do they make referrals? Do practice and/or referral choices of the two sample groups vary with location (rural vs. urban) or gender?

Therapists involved in referring couples to other services reported referral to shelter services, social services, mental health services and law enforcement most frequently. Group therapy for both men and women were the

most frequent responses in respect to treatment resources. Referral choices of therapists were compared by gender, disclosing that almost twice as many male therapists as female therapists indicated referring women to group therapy. Men also reported referring men to groups more frequently and utilizing the service resources of law enforcement, social services, and legal assistance more frequently than female therapists. This suggests that the men in this sample are sensitive to women's need for protection and validation of their experience by other women.

Analysis between groups in respect to assessment and treatment variables was not meaningful as shelter staff were predominantly female and therapists were predominantly urban. When these analysis were performed within the groups in respect to the assessment and treatment criteria, there were no remarkable differences between male and female therapists or rural and urban shelter workers.

PRACTICE IMPLICATIONS

This study supports the assumption that therapists who work with couples are likely to be confronted with the problem of spousal violence. Regardless of the frequency with which therapists deal with spousal violence, they must be prepared for the unique challenges this population presents. Now that

the pervasiveness of spousal violence is common knowledge, therapists have the ethical responsibility to routinely question couples about the extent of conflict in their relationship.

Despite the position that all violence is unacceptable, the findings of this study show that others support my belief that all violence is not the same. Assessment of the frequency, duration, and severity of abuse as well as the assessment of both partners commitment to end violence in their lives was seen as valid screening criteria for conjoint therapy. Assessment of these issues is also important due to the tendency for both batterers and their partners to minimize the abuse.

The respondents in this study also supported the assumption that the termination of violence must be the primary treatment goal with couples who are experiencing violence in their relationship. This implies that it cannot be assumed that violence is no different than other interpersonal conflict which may resolve once structural or other systemic change has occurred. Pressman (1989a; 1992) has critiqued notable family therapists for this approach and it appears that the respondents to this survey are in agreement. Jenkins (1990) describes a non-blaming stance which demands accountability of the batterer through inviting him to take

responsibility for his actions. He also presses the victim to take responsibility for her safety. In his model and other models reviewed here, the issue of violence is the pivot around which the other dynamics in the relationship are addressed. It is my conclusion that this focus is crucial to responsible therapy with violent couples.

In conclusion, therapists must be willing to unveil spousal violence and address it directly in both assessment and treatment. They must also recognize the need for a multimodal approach, with conjoint therapy perhaps only one part of a continuum of treatment for violent couples. Due to the difficult nature of this work and the fact that it is fraught with many ethical and moral dilemmas, therapists must question their own values and beliefs to develop clarity of purpose and action in their work with this population. As more therapists dare to engage in conjoint therapy with couples experiencing violence, continued documentation of methods, models and outcome is necessary to evaluate when and with whom conjoint therapy is appropriate and viable.

POLICY IMPLICATIONS

Since the definition of the problem of spousal violence there has been difficulty in defining ownership of the problem. In terms of interventions, it has been defined as

"women's problem" and services have been developed and enhanced to help women. Through public education, attempts have been made to define it as "society's problem" and now the current use of the term "family violence" implies that it is also a problem for children and, possibly, men. The legal system has been mobilized to deal with men who are violent towards their partners but little outreach has been done for men and fewer programs are available for them. This study notes the need for a multimodal approach to this problem. Support for treatment programs for men and couples needs more attention and inclusion in policy and funding. Programs which can be supportive to families such as the group programs offered by the Calgary YWCA or the crisis counselling for abusive men offered by the Calgary Women's Emergency Shelter are crucial to a multi-modal family approach. This study indicates that conjoint therapy also has a place within the treatment continuum. If families are to be assisted to remain together in positive, nurturing relationships, policies cannot continue to focus on one treatment or one answer to this complex problem.

SUGGESTIONS FOR FURTHER RESEARCH

Due to the exploratory nature of this study, several areas requiring further research can be identified. On the micro or practice level, further research could address the

whom? and 2) How can each type of treatment (individual, group and conjoint) be the most effective? More detailed descriptions of assessment criteria are needed. Assessment tools such as questionnaires or scaled instruments which could be administered to couples to help assess their level of commitment to the relationship and severity of past abuse could be developed and tested. Studies of the relationship between the use of screening criteria and therapy outcome would also benefit therapists. One respondent commented that conjoint therapy is always appropriate for violent couples but dilemmas occur over the appropriate timing of the intervention. The questions of "When do couples need groupwork first?" and "When can treatment begin with conjoint therapy?" need to be addressed. It is often too easy to fall into the same formula of treatment for everyone. I am not convinced that conjoint therapy would <u>always</u> be appropriate even when both partners state a commitment to stop the violence. The impact of utilizing the assessment criteria or treatment goals described in this study could be assessed against outcome analysis.

On the macro or policy level, research which could demonstrate the usefulness of crisis counselling for men and other outreach efforts which further define spousal violence as a <u>male</u> problem would be helpful. Unfortunately, policy and

program development often reaches only the tip of the iceberg in terms of resolving social problems.

In terms of replicating this study, a broader representation of marriage and family therapists could be consulted in order to improve the generalizability of the results. Several of the areas which were addressed in a cursory manner in the interests of brevity could be examined more thoroughly.

SUMMARY

This chapter reviewed the initial research questions and their relationship to the study data and pertinent literature. The study findings supported the expectation that marriage and family therapists are involved in therapy with couples experiencing violence in their relationship. Therapists are also aware of the need to routinely explore the possibility of physical violence with all couples.

Therapists tended to see marriage counselling as appropriate more frequently than shelter staff and this may be attributable to the likelihood that these professionals are exposed to different populations of violent couples. This leads to the conclusion that although all violence is

unacceptable, it may be a disservice to clients to treat all involvement in spousal violence as the same.

Shelter staff and therapists chose the same assessment and treatment criteria with comparable frequency. In addition to both partners' willingness to attend therapy, the sample groups identified a verbal and/or written commitment to stop the violence and assessment of the frequency, duration and severity of past violence as the most important prerequisites to commencing conjoint therapy.

A somewhat superficial description of treatment goals resulted from the survey. Of note was that "termination of all violent behaviour" was chosen with most frequency by both groups as the most important goal of therapy. Indication was also given that therapeutic goals should include attitudinal change as well as behavioral change.

Both therapists and shelter staff indicated awareness of the need to take steps to assure both the woman's safety and her uncoerced involvement in therapy. It was noted that it is often useful to include both individual and conjoint interviews with these couples. Individual sessions and group treatment were seen as especially desirable options if violence should reoccur.

Therapists indicated providing follow-up to clients after termination of therapy but the information provided was vague and anecdotal. It was concluded that although therapists maintain that it is possible to help couples experiencing violence in their relationship, they are usually unable to specifically define how frequently or under what circumstances success can be achieved. The difficulties in undertaking this type of research were discussed in terms of reconciling the necessary rigors of research and the flexibility required in an effective therapeutic relationship.

Analysis of differences in practice and referral choices by both gender and location yielded few notable differences. Comparisons on these criteria could not be made between groups as therapists were predominantly urban and the majority of shelter staff were female. Therapists referral practices were compared by gender indicating that men were more likely to refer to law enforcement and therapy groups for both men and women than female therapists.

Suggestions for further research included the development of more specific assessment and treatment criteria and the testing of the use of these criteria against treatment outcome. Research supporting a focus on either individual, group or couple treatment with men would perhaps help to

broaden policy and assist in encouraging male ownership of the problem of spousal violence.

It is hoped that this study will provide encouragement and guidance for those who feel a responsibility to work with these couples due to their refusal to attend other programs or due to the inaccessibility of programs specifically designed for this population. I believe that all therapists working with couples must grapple with the dilemmas surrounding couples for whom violence is a problem. Hopefully, the circulation of the study questionnaires served to encourage thought, debate and discussion on this controversial issue.

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APPENDIX A

SURVEY QUESTIONNAIRES FOR SHELTER STAFF

SAMPLE OF LETTER TO SHELTER CONTACT PERSON

March 19, 1993

Name of Contact Person
Shelter
Address
City

Dear Name of Contact Person;

Enclosed are the questionnaires I described in our telephone conversation February 18. Please distribute the questionnaires to five staff persons of your choice. Staff who have had the most involvement with women who have experienced physical violence in their relationships would be preferable respondents. A brief description of the study and my reasons for requesting the participation of shelter staff are included in the covering letter attached to each questionnaire.

Once the questionnaires have been completed, please return them in the self-addressed, stamped envelope I have provided. Thank-you for your time and help with this portion of my thesis.

Yours sincerely,

Luanne Nixon, B.S.W.
80 Ranchridge Cr. N.W.
Calgary, Alberta
T3G 1V2

COVERING LETTER

March 19, 1993

Dear Respondent;

I would appreciate ten minutes of your time in completing this questionnaire for my M.S.W. thesis on defining guidelines for safe, effective conjoint treatment with couples who are experiencing violence in their relationship and wish to stay together.

The problem of wife assault is a complex issue and I am focusing on this area as one possibility in the broad spectrum of treatment approaches necessary for this population. Women's shelters are the agencies most involved and, often, most experienced in treatment approaches with this population and I believe your contribution will be a valuable part of my study.

Your replies will be kept confidential and used only in aggregate form. The identification number on your questionnaire is solely for the purpose of tracking data entry. If you are interested a summary of the survey results please include your name and address on the returned questionnaire.

Please return your completed questionnaire in the self-addressed, stamped envelope provided as soon as possible. Thank-you for your time and contribution.

Yours sincerely,

Luanne Nixon, B.S.W.
80 Ranchridge Cr. N.W.
Calgary, Alberta
T3G 1V2

A SURVEY ON SAFE, EFFECTIVE CONJOINT THERAPY WITH COUPLES EXPERIENCING VIOLENCE IN THEIR RELATIONSHIP

Shelter Staff

Please keep in mind that these questions are in reference to women who have been physically assaulted and have returned to their husbands. Please circle the response that best matches your experience or reflects your opinion. If you have any comments on any of the questions, please write them in the comment section at the end of the survey.

1.0 COMMUNITY RESOURCES

1.1 Which of the following service resources for couples experiencing spousal violence are available in your community? (Circle more than one, if applicable)

(a) law enforcement (b) legal assistance (c) medical services (d) shelter services

(e) social services (f) mental health services (g) employment services

(h) other (please specify) _____

1.2 To what extent are these resources coordinated in providing services to these couples?

(a) extensively (b) partially (c) not at all (d) unknown

1.3 Which of the following treatment resources for couples experiencing spousal violence are available in your community? (Circle more than one, if applicable)

(a) women's shelter (b) group therapy for battered women (c) group therapy for abusive men

(d) individual counselling for battered women (e) individual counselling for abusive men

(f) group therapy for couples (g) conjoint therapy for couples.

(h) other (please specify) _____

1.4 To what extent are these resources coordinated in providing treatment to these couples?

(a) extensively (b) partially (c) not at all (d) unknown

2.0 GENERAL INFORMATION

2.1 Please indicate the geographical location of your workplace.

(a) rural (less than 50,000 people) (b) urban

2.2 How long have you been employed by the shelter?

(a) more than five years (b) two to five years (c) less than two years

2.3 What is your gender? (a) female (b) male

2.4 Which of the following theoretical perspectives primarily influences your work?

(a) family systems theory (b) feminist theory

(c) other _____

2.5 Does the shelter you work in provide any of the following treatment options?

(a) group therapy for battered women (b) group therapy for abusive men

(c) individual counselling for battered women (d) individual counselling for abusive men

(e) group therapy for couples (f) couples therapy

(g) other (please specify) _____

2.6 In the past year, how many physically assaulted women using your agency returned to their partners?

If you keep these statistics, please provide an actual percentage _____.

If you do not, please estimate:

(a) greater 75% (b) 75% - 50% (c) 50% - 25% (d) less than 25%

2.7 How often do you see referral for marriage counselling as appropriate for woman who have returned to their husbands?

(a) almost always (b) frequently (c) occasionally (d) never

3.0 MARITAL COUNSELLING

I am interested in your opinion on the following guidelines for safe and effective marital counselling with couples who have a history of violence.

3.1 Before proceeding with couples counselling, which of the following screening criteria should be utilized? (Circle more than one, if applicable)

(a) both partners are willing to attend therapy

(b) both partners have made a verbal commitment to stop the violence

(c) both partners are willing to sign a "no violence" contract

(d) both partners have a "sponsor" to provide support in the community

(e) both partners have previously attended individual or group therapy

(f) there has been no violence for at least six months

(g) assessment of the frequency, duration and severity of past violence

(h) other (please specify) _____

3.2 How frequently should individual sessions with the woman be conducted to assure her safety?

(a) after every session (b) as needed (c) periodically (d) never

3.3 How frequently should individual sessions with the woman be conducted to assure her uncoerced willingness to be involved in marital therapy?

(a) after every session (b) as needed (c) periodically (d) never

3.4 If violence occurs while therapy is in progress, which of the following options is <u>most</u> preferable with couples who both wish to continue the relationship? (Circle more than one, if applicable)

(a) individual sessions for both the man and the woman

(b) individual sessions for the woman

(c) individual sessions for the man

(d) referral of both partners to other agencies/programs

(e) referral of the woman to another agency/program

(f) referral of the man to another agency/program

(g) termination of therapy

(h) continued conjoint therapy

(i) other (please specify)_____

3.5 Which of the following treatment goals do you believe are most important to achieve before therapy is terminated. (Circle more than one, if applicable)

(a) decrease in the severity and frequency of violence

(b) change in the couple dynamics you perceive to be supporting the violent behaviour

(c) termination of all violent behaviour

(d) expression of sincere remorse for abusive actions by the man

(e) expression of empathy regarding the woman's fear and hurt by the man

(f) change in the man's belief that he has a "right" to abuse his wife

(g) improved anger management skills for both husband and wife

(h) other (please specify) _____

4.0 COMMENT SECTION

Thank you for your time and effort.

Luanne Nixon
80 Ranchridge Crescent N.W.
Calgary, Alberta

APPENDIX B

SURVEY QUESTIONNAIRES FOR MARRIAGE AND FAMILY THERAPISTS

COVERING LETTER

March 19, 1993

Dear Respondent:

HELP! I need **ten minutes** of your time to complete this questionnaire as part of my **M.S.W. thesis** on defining guidelines for safe, effective conjoint treatment with couples experiencing violence in their relationship.

AAMFT members have been selected as the survey population because you are most likely to be providing marital therapy to the general population. **If you do not have experience with couples of this description,** please complete the first part of the questionnaire to assist in the description of the survey population.

Your replies will be kept **confidential** and used only in aggregate form. The identification number on your form is solely for the purpose of tracking data entry. If you are interested in a **summary of the survey results,** please include your name and address on the returned questionnaire.

Please return your completed questionnaire in the **self-addressed, stamped envelope** provided as soon as possible. **Thank-you** for your time and contribution.

Yours sincerely,

Luanne Nixon
80 Ranchridge Crescent N.W.
Calgary, Alberta
T3G 1V2

A SURVEY ON SAFE, EFFECTIVE CONJOINT THERAPY WITH COUPLES EXPERIENCING VIOLENCE IN THEIR RELATIONSHIP

Marriage and Family Therapists

Please keep in mind that these questions refer to work with couples experiencing physical violence in their relationship and who want to stay together. As there is no standardized or more adequate term to describe this population, the words "couples experiencing violence" or simply "couples" have been used. Although both men and women may exhibit violent behavior, I believe that women are more vulnerable due to social and economic disadvantage as well as size and strength. Please circle the answer that best matches your experience. If you have any comments on any of the questions, please write them in the comment section at the end of the survey.

1.0 COMMUNITY RESOURCES

1.1 Which of the following service resources for couples experiencing spousal violence are available in your community? (Circle more than one, if applicable)

(a) law enforcement (b) legal assistance (c) medical services (d) shelter services

(e) social services (f) mental health services (g) employment services

(h) other (please specify) _____

1.2 To what extent are these resources coordinated in providing services to these couples?

(a) extensively (b) partially (c) not at all (d) unknown

1.3 Which of the following treatment resources for couples experiencing spousal violence are available in your community? (Circle more than one, if applicable)

(a) women's shelter (b) group therapy for battered women (c) group therapy for abusive men

(d) individual counselling for battered women (e) individual counselling for abusive men

(f) group therapy for couples (g) conjoint therapy for couples

(h) other (please specify) _____

1.4 To what extent are these resources coordinated in providing treatment to these couples?

(a) extensively (b) partially (c) not at all (d) unknown

2.0 PRACTICE INFORMATION

2.1 What is the geographical type of the population primarily seen in your practice?

(a) rural (less than 50,000 people) (b) urban

2.2 What is the setting of your work?

(a) private practice (b) private or semi-private agency

(c) hospital or other government funded agency

2.3 What is your gender? (a) female (b) male

2.4 Which of the following theoretical perspectives primarily influences your practice?

(a) family systems theory (b) feminist theory

(c) other (please specify) _____

2.5 In your agency or practice, is the occurrence of both current and past physical abuse routinely explored in assessment of couples seeking counselling?

(a) almost always (b) frequently (c) sometimes (d) rarely

2.6 How frequently would couples present with other problems, revealing the problem of physical abuse later in therapy?

(a) almost always (b) frequently (c) sometimes (d) rarely

3.0 TYPE OF INVOLVEMENT WITH COUPLES

3.1 How would you describe your involvement with couples for whom physical violence in their relationship is a problem? (Circle more than one, if applicable)

(a) indirect involvement: referral to other agencies/practitioners

(b) direct involvement: therapy directly provided to this population

(c) direct involvement: consultation/ supervision provided to a therapist providing direct therapy

(d) no involvement

If you answered NO INVOLVEMENT, there is no need to continue the questionnaire. Thank-you for your time and effort.

If you answered INDIRECT INVOLVEMENT, please continue with Section 4.0.

If you answered only DIRECT INVOLVEMENT, please proceed to Section 5.0.

4.0 INDIRECT INVOLVEMENT

4.1 Please indicate the service resource(s) to which you have referred either both partners or one partner of a couple when they wish to remain together. (Circle more than one, if applicable)

(a) law enforcement (b) legal assistance (c) medical services (d) shelter services

(e) social services (f) mental health services (g) employment services

(h) other (please specify) _____

4.2 Please indicate the treatment resource(s) to which you have referred either both partners or one partner of a couple when they wish to remain together. (Circle more than one, if applicable)

(a) women's shelter (b) group therapy for battered women (c) group therapy for abusive men

(d) individual counselling for battered women (e) individual counselling for abusive men

(f) group therapy for couples (g) conjoint therapy for couples

(h) other (please specify) _____

4.3 How frequently would these couples follow through with these referrals?

(a) almost always (b) frequently (c) sometimes (d) rarely (e) unknown

4.4 How frequently would these couples request conjoint therapy rather than individual or group therapy?

(a) almost always (b) frequently (c) sometimes (d) rarely (e) unknown

4.5 Would you prefer to see only one partner when the couple plans to continue living together?

(a) yes (b) no Reasons: _____

_____

4.6 Would you then refer the other partner to another practitioner, agency or program?

(a) yes (b) no Reasons: _____

_____

4.7 How often do you see referral for marriage counselling as appropriate for couples who are experiencing physical violence in their relationship and want to stay together?

(a) almost always (b) frequently (c) occasionally (d) never

If you also indicated direct involvement, please proceed to Section 5.0. If not, thank-you for your contribution of time and effort.

5.0 DIRECT INVOLVEMENT

5.1 Before proceeding with counselling couples who have experienced violence in their relationship, which of the following screening criteria do you utilize? (Circle more than one, if applicable)

(a) both partners are willing to attend therapy

(b) both partners have made a verbal commitment to stop the violence

(c) both partners are willing to sign a "no violence" contract

(d) both partners have a "sponsor" to provide support in the community

(e) both partners have recently attended individual or group therapy

(f) there has been no violence for at least six months

(g) assessment of the frequency, duration and severity of past violence

(h) other (please specify) _____

5.2 How frequently would you conduct individual sessions with the woman to assure her safety?

(a) after every session (b) as needed (c) periodically (d) never

5.3 How frequently would you conduct individual sessions with the woman to assure her uncoerced willingness to be involved in marital therapy?

(a) after every session (b) as needed (c) periodically (d) never

5.4 Which format do you prefer for the initial interview?

(a) individual sessions (b) a conjoint session (c) a combination of both (a) and (b)

5.5 If violence occurs while therapy is in progress, which of the following options would you be most likely to choose with couples who wish to continue the relationship? (Circle more than one, if applicable)

(a) individual sessions for both the man and the woman

(b) individual sessions for the woman

(c) individual sessions for the man

(d) referral of both partners to other agencies/programs

(e) referral of the woman to another agency/program

(f) referral of the man to another agency/program

(g) termination of therapy

(h) continued conjoint therapy

(i) other (please specify)_____

5.6 Which of the following treatment goals do you believe are most important to achieve before therapy is terminated. (Circle more than one, if applicable)

(a) decrease in the severity and frequency of violence

(b) change in the couple dynamics you perceive to be supporting the violent behaviour

(c) termination of all violent behaviour

(d) expression of sincere remorse for abusive actions by the man

(e) expression of empathy regarding the woman's fear and hurt by the man

(f) change in the man's belief that he has a "right" to abuse his wife

(g) improved anger management skills for both husband and wife

(h) an understanding of the impact of childhood history on one's choices of behaviour

(i) other (please specify) _____

5.7 To what extent do you believe your work is effective in helping couples resolve violence in their relationship?

(a) very effective (b) somewhat effective (c) somewhat effective (e) not at all effective

5.8 Have you followed up on any clients whom you believe achieved successful resolution of their problems with violence?

(a) yes (b) no

If YES, please indicate the length of time between termination and follow up and the outcome of this follow-up.

_____

_____

_____

6.0 COMMENT SECTION

Please provide any further comments regarding the safe, effective assessment and treatment of couples when one or both partners are experiencing physical abuse.

Thank-you for your time and effort.

Luanne Nixon
80 Ranchridge Cr. N.W.
Calgary, Alberta T3G 1V2

APPENDIX C

FOLLOW-UP LETTER TO SHELTERS

April 19, 1993

Dear Respondent,

Approximately one month ago, five questionnaires focusing on guidelines for safe, effective conjoint treatment with couples experiencing violence in their relationship was mailed to you. As discussed previously by telephone, these questionnaires were to be distributed to shelter staff and then returned in the stamped, self-addressed envelope. If you have already collected and returned these questionnaires, please disregard this reminder. If they not yet been returned, I would appreciate a response within the next ten days as I am nearing my completion deadline.

Thank-you for your time and contribution.

Yours sincerely,

Luanne Nixon, B.S.W.
80 Ranchridge Cr. N.W.
Calgary, Alberta
T3G 1V2

APPENDIX D

AUTHORIZATION TO ACCESS THE MEMBERSHIP LIST OF AAMFT

February 6, 1993

Ms. Elaine Douglas
President, AAMFT
11711 - 29 Avenue
Edmonton, Alberta
T6J 3P3

Dear Ms. Douglas;

I am writing to request authorization from the executive of the Alberta Association of Marriage and Family Therapists to use their membership list as a sampling frame for my MSW thesis research. I intend to use a mailed survey questionnaire to address the topic of defining safe, effective and ethical assessment and conjoint treatment with couples who have histories of violence in their relationship and wish to remain together.

The questionnaire is designed for response from both practitioners who are directly involved in therapy with couples where there is a history of violence and those who may be making referrals to alternate agencies or services within the community. The questionnaire addresses this referral process and the respondent's perception of community resources. For respondents who are directly involved with this population, the questionnaire focuses on assessment criteria, treatment goals and their perception of treatment outcome.

Of course, all responses will be anonymous and therefore confidential. As the questionnaire will be mailed, response is voluntary. During the past five years, there has been increasing discussion in the literature regarding the feasibility and ethical dilemmas of conjoint treatment with couples with histories of violence. Through my literature search and the results of this survey research, I hope to identify the components of safe and effective treatment with this population. I am requesting the assistance of AAMFT members as they are an identifiable group of practitioners in Alberta most probably involved in marital counselling.

I would appreciate your reply as soon as possible. If it is not convenient to send me an updated membership list, I can obtain a copy from Elaine Bucknum, to whom I have already spoken about this matter. Thank-you for your time and consideration.

Yours sincerely,

Luanne Nixon, B.S.W.
80 Ranchridge Cr. N. W.
Calgary, Alberta T3G 1V2
Telephone: 239-2577

ALBERTA ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY

A DIVISION OF THE AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY

February 19, 1993

Ms. Luanne Nixon, B.S.W.
80 Ranchridge Cr. N.W.
Calgary, Alberta
T3G 1V2

Dear Ms. Nixon:

I have received your letter dated February 6, 1993 requesting authorization to access the membership list of the Alberta Association for Marriage and Family Therapy as a research sample for your M.S.W. thesis.

I am not aware of our membership being polled for such purposes in the past however have forwarded your letter to the members of the Executive with the request that they respond to me on or before March 8th as to whether they are in agreement and support of providing you with our membership list.

I am aware that in the past our membership list has been released to conference committees at a charge of approximately $100. As I am aware that this is primarily for educational purposes the fee may be reduced however there would be a charge for the duplication, postage and preparation of this mailing list to be provided to you.

If you are unable to assume the cost and wish to withdraw your request, please notify me either by fax at 488-9733 or on my voice mail telephone at 448-7205 before March 8th.

I do hope that a response by March 15th will be satisfactory for your time lines.

Yours Sincerely,

Joyce Aulenbach for

Elaine P. Douglas, M.S.W., R.S.W.
President, Alberta Division
A.A.M.F.T.

P.S. I am out of town until February 25th.

EPD/ja

Verbal permission received by telephone March 16/93.

APPENDIX E

FOLLOW-UP LETTER TO MARRIAGE AND FAMILY THERAPISTS

April 19, 1993

Dear Respondent,

One month ago, a questionnaire focusing on guidelines for safe, effective conjoint treatment with couples experiencing violence in their relationship was mailed to you. If you have already completed and returned this questionnaire, please disregard this reminder. If you have not yet returned the questionnaire, I would appreciate a response within the next ten days as I am nearing my completion deadline.

Thank-you for your time and contribution.

Yours sincerely,

Luanne Nixon, B.S.W.
80 Ranchridge Cr. N.W.
Calgary, Alberta
T3G 1V2