April 2013

# Conjoint Therapy for Intimate Partner Violence Among Aboriginal Couples: Service Providers' Perspectives on Risk and Safety

Ellissa M. Riel
*The University of Western Ontario*

Supervisor
Dr. Jason Brown
*The University of Western Ontario*

Graduate Program in Psychology

A thesis submitted in partial fulfillment of the requirements for the degree in Master of Education

# CONJOINT THERAPY FOR INTIMATE PARTNER VIOLENCE AMONG ABORIGINAL COUPLES: SERVICE PROVIDERS' PERSPECTIVES ON RISK AND SAFETY

By

Ellissa Marie Riel

Graduate Program in Education

Submitted in partial fulfillment of the requirements for the degree of Master of Education

The School of Graduate and Postdoctoral Studies

The University of Western Ontario

London, Ontario

April 2013

## Abstract

Intimate partner violence (IPV) has been studied at length and consists of different forms including emotional, physical and sexual, which in isolation or combination have significant effects on the health of those involved. While there has been research on conjoint therapy for the mainstream population, there is no current research on Aboriginal couples. Interventions for family violence in Aboriginal communities should take a culture-based approach and focus on healing for the whole family. The purpose of this research was to identify risk and safety issues from the perspective of service providers for couples therapy with Aboriginal clients for IPV. A total of 25 service providers participated in over the phone interviews that included two questions: "How would you address risk with Aboriginal men in couple counselling who use abusive behaviour toward their intimate partner?" and "How would you address safety with Aboriginal men in couple counselling who use abusive behaviour toward their intimate partner?". Five concepts emerged from the responses to the question about risk including: 1) collaterals, 2) commitment to change, 3) violence, 4) mindset, and 5) mental health. Four concepts emerged from the responses to the questions about safety: 1) personal responsibility, 2) community involvement, 3) mandatory reporting, and 4) separate support for women. The concepts were compared and contrasted with the available literature.



***Keywords***: Aboriginal People, service providers, conjoint therapy, intimate partner violence, risk factors, safety factors, cultural factors.

## Acknowledgments

I would like to acknowledge the dedicated service providers who work in the area of family violence for sharing their time and expertise. I would like to thank Sue Languedoc for initiating and supporting this project as well as for her help in the recruitment of participants. I would also like to say many thanks to my thesis supervisor and my mentor, Dr. Jason Brown, for inspiring me to do research in this area and for providing continuous guidance and support on this journey.

Special thank you to Dr. Alan Leschied and Dr. Susan Rodger for their assistance, input and support. I would also like to thank my parents who made it possible for me to attend Master of Education Counselling Psychology program at the University of Western Ontario with their emotional and financial support. Without them, I would not be where I am today. Thank you!

**Table of Contents**

## Chapter 1: Introduction

The purpose of this study was to identify risks and safety measures for couples treatment with Aboriginal clients for intimate partner violence. The research focused on conditions under which a violent perpetrator could engage in couples therapy with his partner in a safe, therapeutic environment. Typically, male perpetrators see a therapist in group or individual counselling. A female partner may also see a therapist in group or individual counselling. In conjoint therapy, men and women, with their counsellors, meet together in sessions to address the violence. Supporters of conjoint therapy view couple counselling as a consideration following successful completion of gender specific treatment in order to monitor risk and promote safety while supporting couples who choose to stay together. Without support, there is heightened potential for violent relationships to be driven underground. Although this is not a new idea, the practice is controversial.

Family violence occurs in many forms and affects a wide range of people at different points in their lives. The most prominent forms are domestic violence, child abuse and elder abuse. Family violence constitutes the majority of violent acts (Tolan, Gorman-Smith, & Henry, 2006). In contrast to other forms of violence, family violence presupposes a relationship between those involved. Violence that occurs among family members presents a paradox in that harm is purposely inflicted by those who should be caring for one another (Jouriles et al., 2001).

The focus of the present study was on intimate partner violence (IPV). IPV has different forms including emotional, physical and sexual which in isolation or combination have significant effects on the health of those involved (Zolotor, Denham, & Weil, 2009). Although both men and women can be victims of IPV, the majority of

violence is perpetrated by men against women (Durose et al., 2005). Violent relationships have been estimated to affect one in six women worldwide (Straus, 1999). A US study (Whitaker, Haileyesus, Swahm & Saltzman, 2007), on adults aged 18-28 found that almost 24% of all relationships included violence; however, varied sampling approaches, definitions of violence and underreporting complicate conclusions based on estimates of frequency (Bograd & Mederos, 1995; Jory & Anderson, 2000; Lawson, 2003).

There has been attention by researchers to the severity and directionality of IPV. Differentiation has been made between mild-to-moderate violence and severe violence (Horwitz, Santiago, Pearson, & LaRussa-Trott, 2009). These authors suggest that mild-to-moderate violence includes pushing, slapping, grabbing and shoving while severe violence includes choking, closed-fist hitting, kicking, and the use of a weapon. With severe violence, the intent is to dominate the victim (Horwitz et al., 2009). Researchers have also noted the presence of bidirectional violence, where the victim is not necessarily engaging in self defense (Capaldi & Clark 1998; Tolan, Gorman-Smith, & Henry, 2006). Rates of bidirectional aggression among couples with any history of violence range from 59% to 71% (Capaldi & Clark, 1998). It was suggested that couple intervention may be most appropriate for mild to moderate and possibly bidirectional violence.

**Western- & Traditional-based Models of Couple Counselling**

Western-based models of couple counselling for IPV consist of changing patterns of power and control, including thinking and behavior, where there has been violence and advocate responsible and effective ways of understanding and solving interpersonal problems in relationships. These approaches are a combination of feminist and systemic schools of thought. A feminist approach is based on the assumption that violence against women occurs when power in the relationship is used to control women's behavior.

Feminist theories also look closely at culturally constructed meanings of gender, which include the exploration of other social locations of individuals and the challenges that come with oppression. A systemic approach presumes that violence against women occurs when there is an imbalance in the relationship. The intent from a systemic approach is to promote equality, fairness, empathy and caring in the relationship. By combining the feminist and systemic approaches, violence is clearly the perpetrator's responsibility and its existence a reflection of power imbalance within the relationship. Based on values from feminist and systemic approaches, solution-focused approaches have been used for IPV. These therapies are based on strengths and solution-building, emphasizing current resources and future hopes instead of present problems and past causes (Kaslow, Bhaju, & Celano, 2011).

There are no conceptual or practice models available to support intervention for IPV with Aboriginal couples (Willmon-Haque & Bigfoot, 2008). It is believed that interventions for family violence in Aboriginal communities must take a culture-based approach and focus on healing for the whole family (Alaggia & Vine, 2006). In fact, research on effective counselling with Aboriginal Peoples indicates that positive experience depends on how well the counselor understands and operates from within an Aboriginal cultural perspective, including attending to spiritual aspects of healing (Heilbron & Guttman, 2000). Furthermore, appropriate counselling for Aboriginal families where violence has been experienced must recognize the violence as a product of colonization. The contextual model must be sensitive to the historical and contemporary contexts of oppression, cultural genocide and massive group trauma across generations. The conditions of poverty, substance abuse and intergenerational violence must be countered therapeutically with an emphasis on the strengths of communities, families and

individuals. Flexible and multi-level interventions (Oetzel & Duran, 2004), that include important parts of an Aboriginal worldview such as spirituality, ceremony, and interconnections are required (Weetra et al., 2006). Due to the prevalence of family violence among Aboriginal People and history of oppression, it is essential to look for ways to develop models by and for Aboriginal Peoples.

**Aboriginal Peoples & Violence**

Aboriginal Peoples in Canada are recognized in the Canadian constitution as First Nations, Métis and Inuit Peoples. Although Aboriginal Peoples raised their children successfully for centuries prior to European contact, generations that followed have faced very different challenges in response to colonization. As a result of the overrepresentation of Aboriginal families in the child welfare system and in both provincial and federal correctional institutions, it is necessary to pay particular attention to their experiences. The prevalence of family violence among Aboriginal peoples is difficult to determine. The challenge lies in trying to map the complex factors that create and sustain violence and at the level of individuals, extended families, communities, as well as the social, economic and political contexts. Closely related to the complexities of identifying the nature and extent of the problem is the more difficult challenge of finding effective ways to end violence.

**A History of Oppression**

IPV can be understood through an explanation of oppression among Aboriginal Peoples. Europeans' intent to Westernize Canada's first peoples and systematically wipe out their cultures have had a profound impact. Treaties and Residential Schools have taken away the rights of Nations, communities and families. The Residential School System was created to assimilate Aboriginal Peoples. Government policy mandated that

Aboriginal children be taught English or French language, Euro-Canadian ways and Christian religious practices. Residential Schools operated for over a hundred years, producing intensive and systemic re-socialization and deprogramming, while destroying the cultures, languages and identities of Aboriginal children. This can be seen in the eyes of many who have come into contact with the child protection or justice systems and are either survivors themselves or who had parents that attended the schools (Richardson & Nelson, 2007).

Although Residential Schools no longer exist, the legacy lives on in the forms of pain and suffering among survivors and their families (Barton et al, 2005). As one survivor indicated: "The boarding school (residential) taught us violence. Violence was emphasized through physical, corporal punishment, strapping, beatings, bruising and control. We learned to understand this violence was about power and control" (Stonefish, 2007, p. 16). Stonefish (2007) noted that intergenerational trauma occurs when these abuses affect subsequent generations. Children who learn that physical, sexual and mental abuses are normal are at risk to follow these patterns with their own children. It is important to recognize abuse and heal from the past in order to break the intergenerational cycle. The term 'Residential School Syndrome' has been used to refer to the combined sexual, physical and emotional effects on survivors (Stonefish, 2007).

Loss of land and control over living conditions, suppression of belief systems and spirituality, as well as racial discrimination have seriously damaged confidence and led to disproportionate involvement with the law and child protection systems (Royal Commission on Aboriginal People, 1996). Indeed, the social and political violence inflicted upon Aboriginal children, families and communities by the state and the church, through the residential school and child welfare systems, not only created the patterns of

violence communities are experiencing, but promoted behaviors that impede collective healing and recovery. This marginalization of Aboriginal Peoples has perpetuated conditions that include risks for violence (Gauthier, 2010).

One way to think about why there is such a need for a counselling framework specific to Aboriginal Peoples is through the Gladue decision. In the Canadian Criminal Court, Section 718.2 (e) judges should look for alternatives to incarceration when sentencing offenders and should pay particular attention to the circumstances of Aboriginal Peoples. It requires judges to consider the unique systemic or background factors, which may have played a part in bringing the particular individual before the courts, including low incomes, high employment, lack of opportunities and options, lack of relevance of education, substance abuse, loneliness and community fragmentation (Roach & Rudin, 2000). With this in mind, counselling interventions should similarly be oriented to realities of Aboriginal couples and families with consideration for particular circumstances.

**The Impact of Violence on Families**

It is important to look for new ways to end violence because of the serious negative impact on families. According to the American Psychological Association (1996), family violence can result in physical injuries and deaths, psychological impact, and detrimental functioning as well as great costs related to health care, criminal justice, and decreased productivity. In addition, particularly when it is chronic, family violence causes serious injury and is accompanied by other harmful and dysfunctional relationship characteristics. Injuries associated with physical violence tend to focus around the head, face, neck, breast, abdomen, and genitalia. It has been noted that women who have been battered have also frequently been choked. Bruises, bites, and abrasions that do not have

a sufficient and logical explanation should be recognized as probable signs of violence (Castiglia, 1995).

Beyond the physical ramifications of IPV, research has consistently demonstrated a strong association between experiencing partner abuse and increased rates of psychopathology (Briere & Jordan, 2004; Golding, 1999; Hathaway et al., 2000). Previous research has shown increased rates of anxiety, depression, hopelessness, low self-esteem, dissociation, sexual problems, somatization, substance abuse, and suicidality in women who have experienced violence from an intimate partner (Briere & Jordan, 2004; Hathaway et al., 2000). Not only is it harmful for individuals who experience the violence directly, but it also has an effect on those witnessing the violence (either seeing or hearing). Such individuals may experience vicarious trauma as a result of witnessing violent events on a family member.

In addition to the increased rates of psychopathology, it has been theorized that psychopathology itself may be a risk factor for continued violence between partners, thus perpetuating the cycle of violence and also interfering with effective use of available community support systems (Foa et al., 2000; Perez & Johnson, 2008). Symptoms of PTSD, depression, and other mental disorders may interfere with help-seeking behaviors and the effective use of available resources that are necessary to decrease relationship violence (Foa et al., 2000). When all the negative effects of family violence are clearly identified, it is easy to see the importance of finding effective ways to decrease and eventually, eliminate violence.

**Structure of the Thesis**

Relative to non-Aboriginal Peoples, Aboriginal Peoples face a disproportionate frequency of mental health concerns (Kirmayer, Brass, & Tait, 2000). These issues have

been tracked to various socio-historical events associated with colonialism (Browne, 2007) and have had a devastating intergenerational impact on Aboriginal communities in Canada (Yellow Horse Brave Heart & DeBruyn, 1998; Nuttgens & Campbell, 2010). Intimate partner violence is a problem in Aboriginal communities. Healing services are more available than they have been, however, they most often consist of contemporary Western-based service delivery. The present study may help with the development of appropriate couples treatment programs for Aboriginal Peoples.

A review of the research literature in Chapter 2 will focus on support for and skepticism about conjoint therapy as treatment for IPV, a description of evaluated programs and important features of effective conjoint therapy, as well as a review of risk and safety factors that have been identified in the literature for IPV prediction and prevention. Chapter 3 includes an overview of the Concept Mapping methodology employed and procedures followed. In the 4th Chapter, results of the questions asked to experts are presented and in Chapter 5, the participants' views are compared and contrasted with the results of literature reviewed. The purpose of this research was to identify risk and safety issues from the perspective of service providers for couples therapy with Aboriginal clients for IPV.

## Chapter 2: Literature Review

The treatment approach most often used to address IPV involves gender-specific groups (i.e., separate men's and women's groups) focused on power and control, as well as personal beliefs that support the use of aggression tactics with a partner (LaTallaide, Epstein, & Werlinich, 2006). Research on these approaches, however, has shown that they have limited effectiveness for some populations in reducing violence; in fact, a high percentage of men who participate in such programs re-offend after treatment (Babcock & La Taillade, 2000; Murphy & Eckhardt, 2005). Research on programs targeting the most severe population of batterers, in terms of psychopathology, criminal history,

severity of violence, and their ability to instill fear in partners revealed that they were least amenable to establishing and maintaining treatment gains. There is increasing evidence in the field of violence intervention and prevention that all individuals do not benefit from the same treatment approach (Stith, Rosen, McCollum, & Thomsen, 2004).

Whereas gender-specific treatment is designed for male batterers who engage in severe IPV and female victims separately, for couples who report low to moderate levels of violence, tend to be in stable relationships, and do not fear each other, a conjoint approach that addresses power and control issues, promotes relational balance as well as addressing individual cognitive and behavioral risk factors for IPV may be an appropriate and effective treatment (LaTallaide, Epstein & Werlinich, 2006). Because relationship distress and conflict are strong predictors of IPV, failure to address these issues within the context of the couple relationship may increase the risk for violence. Therefore, it may be of value to consider the benefits and risks of conjoint therapy for IPV.

**Conjoint Therapy: The Controversy**

Conjoint therapy for IPV is a controversial choice for several reasons. First, ‘‘conjoint treatment, by definition, implies that there is a mutual problem to be solved, and this almost inevitably slides into the implication of mutual responsibility for it’’ (Goldner, Penn, Sheinberg, & Walker, 1990, p. 344). Thus, conjoint therapy may imply that the woman is also at fault for the violence within the relationship. Second, the woman's safety is of concern. Jory, Anderson, and Greer (1997) express concern that the male may learn new ways to be abusive as his partner reveals vulnerabilities in therapy and simultaneously avoid legal accountability by reporting that he is ‘‘working on the problem in therapy’’. Finally, the woman might feel unable to express herself freely and

if she does express negative attitudes toward her partner, may suffer increased abuse (after the session) as a result.

Others see some potential value in conjoint therapy. First, male-only treatment may elicit male bonding and lead men to reinforce others in an environment where attitudes and behaviors that support IPV are present (Hart, 1988). In such a setting, they could learn new ways to be controlling. Second, Madsen, Stith, Thomsen and McCollum (2010) found that a majority of couples experienced bilateral violence (74%). In cases of bilateral violence, it may be important for partners to be in therapy together. Third, many women who are battered remain with their abusive partners. Indeed, failing to provide services to both parties in an on-going relationship may inadvertently disadvantage the female partner who chooses to stay (Heyman & Neidig, 1997). Additional rationales in support of conjoint treatment include knowledge that many couples in relationships where there has been IPV want therapy, violence in relationships is not all the same and treatment should be tailored to the needs of clients, and finally, that teaching skills to one partner and not the other can leave the victim confused and further victimized (Stith & McCollum, 2011).

**Support for Conjoint Therapy & IPV**

Conjoint therapy for IPV typically involves two therapists working with couples individually as well as together. There are several studies utilizing control group designs that have been published on conjoint therapy for IPV (i.e., Dunford, 2000; Fals-Stewart & Clinton-Sherrod, 2009; Fals-Stewart, Kashdan, O'Farrell, Birchler, 2002; Fals-Stewart & Kennedy, 2005; Fals-Stewart, Klostermann, & Clinton-Sherrod, 2009; Fals-Stewart, O'Farrell, Birchler, & Lam, 2009; McCollum, & Stith, 2008; O'Farrell, & Choquette, 1991; O'Farrell, & Fals-Stewart, 2006; O'Farrell, & Murphy, 2002; O'Farrell, Murphy,

Stephan, Fals-Stewart, & Murphy, 2004; O'Leary, Heyman, & Neidig, 1999; Rosen, Matheson, Smith, McCollum, & Locke, 2003; Stith, & McCollum, 2009; Stith, McCollum, Rosen, & Locke, 2002; Stith, McCollum, Rosen, Locke, & Goldberg, 2005; Stith, & Rosen, 1990; Stith, Rosen, & McCollum, 2002; Stith, Rosen, & McCollum, 2003; Stith, Rosen, McCollum, & Thomsen, 2004; Stith, Williams, & Rosen, 1990; Stith, & McCollum, 2011; Stith, McCollum, Rosen, & Locke, 2002; Stith, Rosen, McCollum, & Thomsen, 2004).

However, these studies refer to four programs. The evaluated programs include: 1) Harvard Medical School and Research Institute on Addictions, University at Buffalo, SUNY, on the Families and Addiction Program (O'Farrell & Fals-Stewart, 2002), 2) State University of New York, Stony Brook, based on Peter Neidig's Domestic Conflict Containment Program (DCCP) or Physical Aggression Couples Treatment (PACT) (O'Leary, Neidig, Heyman, & Brannen, 1999), 3) Virginia Tech, Falls Church, Domestic Violence Focused Couples Treatment program (Stith, McCollum, Rosen & Locke, 2002) and 4) US Navy, San Diego (Dunford, 2000).

O'Farrell and Fals-Stewart (2002) designed a program intended for couples that experienced IPV and substance abuse. Therapy consisted of 12, 60-minute couples sessions and 20, 60-minute individual sessions, which focused on abstinence and enhancing relationship satisfaction by teaching communication skills, listening and expressing feelings as well as stopping the violence. Couples were followed every 3 months for 1 year after treatment. They assessed risk by interviewing partners separately and using a structured clinical interview for clinically diagnosed substance abuse and mental disorders. Researchers also used the modified version of the Conflict Tactics Scale to measure intimate partner violence. When it came to the female partner's safety, a

verbal agreement took place between the therapist and the violent perpetrator, which consisted of promising not to engage in any angry touching. Women were coached to protect themselves when the violent perpetrator relapsed during therapy (i.e., started drinking again). They were taught to 1) not engage in any kind of conflict resolution discussion with their partner, 2) use timeouts when conflicts escalated, 3) develop a safety plan if they felt threatened, and 4) avoid striking, pushing, or shoving out of frustration. These tactics were paramount to the safety of these women when they felt like their situation was out of their control.

O'Leary, Neidig, and Heyman (1999) formulated a program for couples who wanted to stay together and participate in couples therapy. Researchers assessed risk to the couple by interviewing each partner separately about previous and current violence, to ensure that there was no current violence and previous was not severe enough to elicit substantial fear or serious injury to the female partner. The risk level was not acceptable if the female partner indicated that 1) the violence was severe enough to elicit substantial fear or serious injury to her, 2) she was afraid for her life, 3) she was afraid of participating in therapy with her partner, or 4) she desired to leave the relationship. When identifying safety measures, consideration was given to whether or not clients were mandated. If the male partner was not mandated, then weekly check-ins were required to protect the woman's safety. If the male partner was mandated, more safety measures were in place such as the weekly check-ins, a close relationship with the judge who referred to treatment, close surveillance by the probation officer, and follow-up assessments. The conjoint treatment (Physical Aggression Couples Therapy; PACT) focused on eliminating the violence, accepting responsibility, controlling angry thoughts, communication, increasing mutually pleasurable activities, and respect for one another.

Couples were followed six months after treatment completion.

Stith, McCollum, Rosen, & Locke (2002) included couples who wanted to participate, end violence and improve their relationship. They did not include clients with a history of severe violence or those who had current problems with alcohol and drugs. Separate interviews were held with each partner before and after the conjoint component in order to manage potential risk to the woman. Researchers also used the Conflict Tactics Scale to determine risk of intimate partner violence. They also taught safety planning and negotiated timeout plans with the couple. To ensure woman's safety, those who refused to sign a no-violence contract prior to treatment were not allowed to participate in treatment. The conjoint therapy addressed the types of abuse, control and safety strategies, drug abuse, communication skills, relapse, and conflict resolution and accountability. Couples were followed every 6 months for 2 years after treatment.

Dunford (2000) developed a program for US Navy couples where husbands had assaulted their wives. Researchers used the Conflict Tactics Scale and interviewed both partners separately to identify risk. Furthermore, they asked women how many incidents had occurred in which they 1) felt like they were in danger of being hurt by their husbands, 2) were pushed, hit, or had hands laid on them, or were beaten up by their husbands, and 3) were physically injured by their husbands (e.g., knocked down, bruised, scratched, cut, choked, had bones broken, had eyes or teeth injured, or were still hurting the next day). Several follow-up sessions were recommended in order to protect the safety of these women. Monitoring for a year after treatment was important. A record search for new arrests was conducted every 6 months. Wives were called every month and asked if there was abuse present in the relationship. Individual counselling continued monthly as well as separate interviews every six months. Home visits were conducted

every six months and reports to the husband's commanding officer were done on a monthly basis. The conjoint therapy consisted of 26 weekly sessions plus 6 monthly sessions (1.5 hours each, co-facilitated male/female) to promote realistic and personalized role-playing, reducing "women bashing", personalizing the violence, and enhancing empathy. Couples were monitored using separate interviews every 6 months and they were followed every six months for two years (1 year post treatment).

**Important Features for Conjoint Therapy & IPV**

Based on reviews of only four programs, the literature on couples therapy for IPV has a modest basis from which to draw firm conclusions. However, the best evidence to date shows no support for couples IPV treatment that is not conjoint and that conjoint IPV treatment is at least as effective at violence cessation as men's groups. The following studies reflect some important characteristics of therapy to be considered in future development.

A significant possibility for treatment concerns the use of groups. IPV couples treatment has been conducted with both multi-couple groups and individual couples. Significant differences were found between the multi-couple group at pretest and follow-up with marital satisfaction increasing, acceptance of control tactics and aggression decreasing. The researchers concluded that conjoint treatment delivered in multi-couple groups appeared to be beneficial (Stith et al., 2004).

Another possibility concerns the use of different theoretical approaches underlying couples therapy. Cognitive-behavioral conjoint treatment was compared to a systems-theory approach. Systems approach focused on enhancing the quality of the couple's relationship to reduce violence and control while the cognitive-behavioral approach focused on thoughts and behaviors associated with control and violence. Both

attended to anger and conflict management, including communication and problem-solving. It was noted that helping the couple recover from past trauma and broken trust (e.g., any past aggressive behavior or abandonment issues within the relationship), and increasing partners' mutual support and shared activities were positive features of the intervention (Epstein et al., 2005).

Finally, there has been considerable attention to the co-occurrence of substance misuse in IPV. Indeed, "men exhibiting IPV are substantially more likely than a wide variety of comparison groups to use and misuse alcohol and drugs" (Holtzworth-Muroe, Bates, Smutzler, & Sandin, 1997). There is evidence that couples therapy for substance misuse is effective. Among couples being treated for substance misuse where researchers knew there was also IPV, effects on substance use were achieved (Fals-Stewart & Clinton-Sherrod, 2009).

In a recent review article (Stuart, O'Farrell & Temple, 2009) researchers described a study that examined IPV before and after behavioral couples therapy for 303 married or cohabiting male alcoholic patients and compared their findings to a demographically matched nonalcoholic sample. The treatment involved 10–12 weekly 1-hr conjoint pre-group sessions with each couple, followed by 10 weekly 2-hr couples group sessions. The duration of treatment was 5–6 months. Male-to-female partner violence was significantly reduced in the 2 years subsequent to behavioral couples therapy (O'Farrell, Murphy, Stephan, Fals-Stewart, & Murphy, 2004). While IPV was nearly eliminated for male clients who achieved abstinence from alcohol (O'Farrell, Murphy, Stephan, Fals-Stewart, & Murphy, 2004), a smaller proportion (18%) of men receiving behavioral couples treatment engaged in IPV in the year after treatment, relative to men receiving only individual treatment (43%) (Fals-Stewart, Kashdan, O'Farrell, & Birchler, 2002).

Findings of a meta analysis of research on treatment of substance abuse and IPV found that: 1) treatment-as-usual (individual cognitive behavioral or behavioral therapy) was the standard for treating substance abuse, and effective for treating substance abuse 2) conjoint therapy was an effective method in the treatment of IPV and substance abuse but only when violence was not severe, and 3) Behavior Couples Therapy (BCT) was one of the most effective methods to treat substance abuse when relapse occurred (Klostermann et al., 2010).

In a recent review of the controversy surrounding conjoint treatment for couples that experienced IPV (Stith & McCollum, 2011), it was noted that a lack of practice of conjoint therapy (for IPV) has led to a lack of research. Based on their review of research to date, they suggested that in order to do conjoint therapy for IPV: 1) potential clients are properly screened to make sure conjoint therapy will not be to their detriment, 2) therapists have adequate knowledge of domestic violence, 3) therapists need to be able to collaborate with the community so that women will have protection if need be, and 4) the couple should have a "third stable" (e.g., the referring agency) in place as a safeguard.

**Risk and Safety in Conjoint Therapy for IPV**

Of particular interest in the present study are the ways that risk is assessed and safety promoted. Drawn from control group research on conjoint therapy for IPV, some consistencies regarding risk and safety were observed in the research to date. There was a consensus for interviewing partners separately prior to couple counselling. Risk to the couple could be assessed this way by identifying whether both partners indicated the violence was not severe enough to elicit substantial fear or serious injury to the female partner. The Conflict Tactics Scale was used to determine risk of IPV. Programs also taught safety planning and negotiated timeout plans with the couple. In order to promote

women's safety, any men who refused to sign a no-violence contract prior to treatment were not allowed to participate in treatment.

While the topics of risk and safety have been studied a great deal in relation to IPV assessment and gender-specific treatment, there has been little research on risk and safety in conjoint therapy for IPV and none on risk and safety in conjoint therapy for IPV with Aboriginal clients. In relation to risk, several instruments have been developed for use with men who have been convicted of IPV, as well as one instrument that assesses women's safety. Although these instruments were not developed for use in couples treatment, they are used by professionals in the field of risk and safety assessment for men and women who have experienced IPV and familiar to the participants of the study. Furthermore, they provide a structure to discuss major, established factors related to risk and safety that should be considered in IPV treatment.

**Risk Factors**

In general, decisions about risk likely involve consideration of the nature (e.g., emotional, physical, sexual), frequency, and seriousness of the violence in addition to the likelihood that it will occur (Hart, 2001). Frequently used risk assessment tools for mandated clients are the Spousal Assault Risk Assessment Guide (SARA; Kropp, Hart, Webster & Eaves, 1998) and the Ontario Domestic Assault Risk Assessment (ODARA). These tools assess risk of future partner assault in addition to the frequency and severity of these assaults. The SARA consists of 20 items that represent five main risk factors: 1) Criminal History, 2) Psychosocial Adjustment, 3) Spousal Assault History, 4) Current/Most recent Offence, and 5) Other Considerations. The 20 items were identified primarily from the literature on characteristics of assaultive husbands, the predictors of violent crime, and clinical experience.

The ODARA, on the other hand, was empirically derived from an initial pool of potential risk factors gleaned from police files on 589 domestic violence perpetrators (Kropp, 2008). The thirteen risk factors include: 1) Previous Domestic Incident, 2) Previous Non Domestic Incident, 3) Prior Correctional Sentence of at least 30 days, 4) Failure on Previous Conditional Release, 5) Threat to Harm or Kill Anyone at the Index Assault, 6) Confinement of the Partner During/at the Index Assault, 7) Victim Concerned/Fearful of Future Assaults, 8) Two or More Children, 9) Victim has a Biological Child from a Previous Partner, 10) Perpetrator's Violence Against Others, 11) Perpetrator's Substance Abuse, 12) Assault on Victim when Pregnant, and 13) Any Barrier to Victim Support.

An important factor to consider in a male's risk for IPV is whether he has a past criminal history. This could include both violent and non-violent criminal charges, with special attention to any current or most recent offense(s). Generally, men who are aggressors in IPV are more likely than nonviolent partners to be violent or aggressive in other ways and with other people (McHugh & Frieze, 2006). They are more likely to have a criminal history (Roberts, 1987; White & Straus, 1981) and to have used violence outside of the home (Hotaling & Sugarman, 1986; McHugh & Frieze, 2006). White and Straus (1981) report these men are twice as likely as nonviolent husbands to have an arrest record for a serious crime, and Gayford (1975) reports that 50% of his sample of men had spent time in prison. Somewhere between one-third and 46% of men who are aggressors in IPV (Fagen, Stewart, & Hansen, 1983) have been arrested for other violence. Strauss (2004) looked at 17 studies that examined the frequency of perpetrators of partner assault who have a history of previous crime. They concluded that men whose assaults on a partner were frequent and severe and involved injury requiring medical

treatment, tended to have a history of crime, whereas men whose assaultive behavior was not frequent or severe enough were less likely to be involved in other crime.

The second important risk factor to consider is the male's psychosocial adjustment. This includes general antisocial behaviors and attitudes. While researchers have been unable to identify one specific personality profile, higher rates of certain psychiatric conditions have been found among men who are aggressors in IPV (McHugh & Frieze, 2006). Personality disorders and characteristics such as antisocial, borderline, and narcissistic occur at higher rates among members of this group (Hamberger & Hastings, 1991). Early descriptions by suvivors indicated that they had traditional sex-role attitudes (Walker, 1979). Research in the area of assertiveness appears to better discriminate between batterers and non-batterers than measures of sex-role attitudes. Negative attitudes about women also play a role in the prediction of risk for IPV (Sonkin, 1988).

The third risk factor to consider is spousal assault history. This could consist of a recent escalation in violence, and/or certain characteristics of the most recent assault. When the man has a history of IPV, he is more likely to continue this behavior. Separation and divorce typically do not end the relationship violence. In Wofford et al.'s (1994) study, 58% of men with new partners continued to be violent in their relationship. One of the primary risk factors for violence against a spouse or significant other was having committed such violence against that same person previously. Rarely did an incident of spousal abuse occur in isolation (Riggs, Caulfield & Street, 2000). Similar to prior physical violence, the man's use of verbal or emotional abuse in the current relationship appeared to be a significant risk marker for perpetrating physical spouse abuse (Riggs, Caulfield & Street, 2000).

There are other considerations including stability of the relationship, stability of employment, mental health, childhood abuse, or witnessing partner violence, motivation for treatment and attitudes toward women (Hart, 1990). One of the most consistent findings is that men who were violent were more likely to have a history of violence in their family of origin (Hotaling & Sugarman, 1986). Furthermore, alcohol abuse, and to a lesser extent drug use, have been associated with the perpetration of marital violence (Dutton & Kropp, 2000). Importantly in the search for risk markers, it does appear that couples who are experiencing severe relationship distress are at greater risk for violence than are non-distressed couples, though it is not clear whether the distress leads to violence or the violence leads to distress. Similarly, men of lower socioeconomic status (SES) are at an increased risk for perpetrating domestic violence and also tend to perpetrate more severe violence than their higher SES counterparts (Dutton & Kropp, 2000).

**Safety Factors**

Safety planning for women is important. There are fewer approaches to assessing safety for the female partner. One tool that builds upon the SARA is known as Aid for Safety Assessment Planning (ASAP). Safety assessment and safety planning take place in a dynamic and complex context of risk factors, all of which can fluctuate (Bain, 2006). ASAP identifies twelve safety support factors, which include: 1) Level of Personal Support, 2) Living Situation, 3) Level of Fear, 4) Barriers Created by Social Attitudes or Beliefs, 5) Impacts of the Abuse, 6) Employment and Financial Concerns, 7) Child-Related Concerns, 8) Substance Abuse, 9) Access to Services, 10) Responsivity of Services, 11) Provision of Information, and 12) Coordination of Services.

ASAP was designed to examine risk factors from the woman's perspective and

emphasizes the need for agencies and the woman to work together and, where appropriate, share information on known risk factors. The development of safety factors was a result of a partnership between the Victim Services and Crime PrevPublic Safety and the BC Institute Against Family Violence (Millar, 2009).

A woman's safety can be threatened by the level of personal support she has. She may not have many friends or access to family members, which increases isolation and a dependence on the partner. The woman's living situation can be further isolating depending on her geographical location. For instance, people who live in rural or remote communities, or who are not connected to others in their communities may lack access to information, resources, supports and services. The woman may fear being physically injured or killed by her partner. She may also fear for the safety of her children. There may also be barriers created by social attitudes or beliefs that can have an impact on safety. This could include literacy, language or cultural barriers lead to inability to access and supports or they may fear deportation or other complications relating to sponsorship or immigration status. Women could potentially feel social pressure to maintain a relationship and protect the family's or the community's reputation. Women may feel conflicting emotions and suffer confusion or shame. They may believe that the abuse is their fault and they will be punished for telling.

Depending on their situation, women may fear a number of different outcomes if they tell someone about the abuse. They may also have personal views about family, relationships and child-rearing that emphasize privacy and condone the use of physical punishment. They may be influenced by gender role beliefs that support inequality and violence in relationships. The impact of the abuse can have a variety of different outcomes, which influence all other safety factors. Employment and financial concerns

can also impact the woman's dependence on their partner. Women may be emotionally, physically, or economically dependent on their partners. Child-related concerns may also play a role. Women may not believe that involving child welfare authorities or the criminal justice system will stop the abuse or that these systems will be able to help or protect them. They may also fear that child welfare involvement may break up their family. The presence of substance abuse for the male partner or the woman or both, can affect the type and severity of violence, and therefore her safety. Furthermore, the woman's access to services and the way in which the services respond have a direct impact on whether she is supported and has resources available to protect herself (Department of Justice Canada, 2009).

**Present Study**

There has been little research on IPV treatment with Aboriginal families. Drawn from results of existing evaluations, some principles of conjoint practice in effective programs may be identified. However, it is not known how they may be modified to be relevant and useful with Aboriginal clients as none of the programs are located in Canada, nor offered to Aboriginal clients. In addition, none of the programs explicitly identified culture as relevant to treatment. Finally, some were offered to mandated clients and others were for substance abuse treatment with IPV as an adjunct.

Two central issues for IPV assessment and intervention concern risk and safety. There are structured professional rating instruments that have been developed and used with individuals who been convicted of spousal assault. They have been used with Aboriginal peoples. However, they have not been applied in the context of developing a conjoint approach to IPV for Aboriginal couples.

The purpose of the present study was to identify, from the perspectives of experts,

the risk and safety features associated with what they would consider to be an affective approach to IPV treatment with Aboriginal couples. The purpose was not to develop a new approach but rather to build understanding based on discussion with experts about important issues to consider for effective conjoint IPV treatment programs for Aboriginal clients.

# Chapter 3: Methodology

The purpose of the study was to identify features of conjoint IPV treatment for Aboriginal clients through interviews with experts. It was necessary to identify the important issues in relation to risk and safety as formative to development of an approach that could be further validated through additional research. Instead of focusing on developing a program, findings of the study were to identify what risk and safety features of conjoint therapy would be effective for IPV with Aboriginal clients. This was done by asking experts who had worked with individuals experiencing IPV. The focus of the study was on the professional opinions of experts in the areas of safety, protection and treatment including those who had worked as therapists, in law enforcement, or in women's shelters.

Two questions were asked: 1) How would you address risk with Aboriginal men in couple counselling who use abusive behavior with their intimate partner? (e.g., how assessed? What is acceptable?); and, 2) How would you address safety with Aboriginal men in couple counselling who use abusive behavior with their intimate partner? (e.g., what measures need to be in place to protect female safety?) The research questions in this study are part of the larger study approved by the Sub Research Ethics Board at the Faculty of Education of Western University.

## Concept Mapping Application

While initially concept mapping was used for evaluation purposes, it was later employed in the development of new programs (Cousineau, Houle, Bromberg, Fernandez & Kling, 2008), theory building (Petrucci & Quinlan, 2007) and description of research constructs (Brownson, Kelly, Eyler, Carnoske, Grost, Handy, et al. 2008). For example, concept mapping has been used to help groups reach consensus about the meaning and

composition of a construct under investigation. When describing a new concept the responses in the concepts are used to give direction for how operationalize it (Trochim, 1989).

### Concept Mapping Process

The concept mapping process included six components: 1) Preparation, 2) Generation of Responses, 3) Structuring of Responses, 4) Representation of Responses, 5) Interpretation of Responses, and 6) the Utilization of Maps (Trochim, 1989). The Concept System (Trochim, 1987) was used to perform the statistical analysis and construction of concept maps. It was expected that having experts participate in the sorting task (i.e., having an expert's opinion and input for grouping answers to questions asked), would allow researchers to develop a better understanding of the concept under investigation.

Participants generated responses to a question until a predetermined saturation point was reached. Responses were edited and redundant responses were removed. Each remaining response was printed on a separate card. Participants were asked to sort the responses into groups (Trochim, 1989). The sort data was analyzed using two procedures. Multidimensional scaling placed responses spatially on a map and cluster analysis placed responses into concepts. Following the construction of the map, the concepts were inspected and an optimal number of concepts were determined. The concepts were then labeled (Trochim, 1989).

## Procedure

**Preparation**. Participants were staff members in the areas of probation, children's services, women's shelters, as well as professionals who had experience providing treatment for intimate partner violence (e.g., therapists). Participants were invited to

participate if they could self-identify as having expertise in one of the two areas: 1) staff person in safety area, or 2) professional providing treatment for IPV. Recruitment was conducted using advertisements, which instructed those interested in participating to contact the researchers or research assistant directly by telephone and to make arrangements for individual telephone interviews. Participants were recruited through advertisement via email listserv to staff in a Canadian province through justice, family services, and health departments as well as their funded agencies.

A total of 25 professionals participated. The age range of participants was between 29 and 64, with an average age of 49. The majority of the sample was female and ¼ was male. The number of years of experience that participants had working with intimate partner violence ranged from 3 to 40 with an average of 22.

***Research instruments and questions***. The telephone interview included some demographic questions as well as several open-ended questions (see Appendices). Two of those questions were the subject of this thesis: 1) How would you address risk with Aboriginal men in couple counselling who use abusive behavior with their intimate partner? and 2) How would you address safety with Aboriginal men in couple counselling who use abusive behavior with their intimate partner?

***Generation of responses***. The author and another Research Assistant completed all interviews. Once telephone contact was made with each professional, and she or her was provided with a verbal description of the study purpose as well as what participation involved, verbal consent to continue was requested. The Research Assistants took notes during telephone interviews. Participants were asked if they would be interested in taking part in the second phase of the study, where they would be asked to group responses together. A list of interested individuals was compiled with mailing address. Complete

lists of edited responses were mailed to each participant. Each was asked to complete the sorting task and return results by telephone to the researchers.

*Interrater agreement process*. Complete lists of all responses by question were independently reviewed by three members of the research team. Responses that were unclear or redundant were identified. When the reviews were combined, all responses with at least two consistent reviews were removed. In other cases, responses that were unclear were edited for clarity. In the end of the process, questions one included 98 unique responses and question two included 65 unique responses.

**Structuring of Responses.** Telephone numbers and addresses of all participants who had expressed interest at the time of interview in the sorting task were randomized, and contacted again by both telephone. Sixteen participants were mailed out instructions on how to complete the sorting task and 14 returned their sorts.

In each package of information included a set of cards for each question. Each response was printed on a separate sheet. In addition, participants received sorting instructions summarized by Trochim (p. 5, 1989) as "each response can only be placed in one pile (i.e., an item cannot be placed in two piles simultaneously); all responses cannot be placed in a single pile, and; all responses cannot be put into their own piles (although some items may be sorted by themselves)". Each was asked to group the cards in a way that made sense to her or him (Trochim, 1989). Each sort data were obtained by telephone.

**Representation of Responses**. Two distinct statistical procedures were used to analyze the data including multidimensional scaling and cluster analysis. Multidimensional scaling placed the responses as points on a map. Responses that were closer together on the map indicated that they were grouped together more frequently by

participants. Cluster analysis of multidimensional scaling was used to group the responses into concepts. The author and her advisor decided together on the most appropriate number of concepts based on conceptual similarity or responses and average cluster bridging indices (Trochim, 1989).

***Multidimensional scaling***. Prior to performing the statistical analyses, the results of the sorting were used to construct a similarity matrix. The number of rows and columns in the matrix was equal to the number of responses generated for that question. The cells indicated if and how many times the responses were grouped together (Kane & Trochim, 2007). Concept mapping software was used to construct the sorting matrix for each participant and to sum each cell "across these matrices to include all participants, and produce a combined group similarity matrix" (Kane & Trochim, 2007).

Multidimensional scaling was a multivariate analysis that involved "scaling of the similarity matrix obtained by aggregating the sort data" to determine proximity of the generated responses (Kane & Trochim, p.93, 2007). Each response was placed as a point on an X-Y graph called a point map. Responses that were closer together were the ones that were more frequently grouped together by the participants. The map visually represented the similarity matrix (Kane & Trochim, 2007).

***Cluster analysis***. The second cluster analysis of the multidimensional scaling values was used to group the responses on the map into clusters that reflected similar concepts (Blashfield & Aldenderfer, 1988). Ward's algorithm was utilized by the Concept Mapping software because it provided "more reasonable and interpretable solutions than other approaches" and "it makes sense with distance-based data". In addition, Ward's algorithm has also been useful to reflect underlying structure of data (Kane & Trochim, p. 99). The underlying mechanism of Ward's algorithm is "[minimizing the sum of the

squares of the distances between all responses in any two hypothetical clusters that might be joined" (Kane & Trochim, 2007, p. 98). In the beginning of the cluster analysis, each response represented its own cluster. In each consecutive stage of the analysis the algorithm combined two clusters until they were all part of one cluster.

***Number of concepts***. Selection of the optimal number of concepts was based on researcher judgment. Fewer concepts gave the user "grosser features of a map" and the most prominent concepts. More concepts provided a detailed picture but in the process the overall message of the map was lost (Kane & Trochim, 2007). Trochim (1989) suggested that when choosing the optimal number of concepts to select as few as possible.

***The bridging index***. The bridging index was a statistical value that ranged from zero to one and described the relationship between a particular response with others on the map. The smaller the value of the bridging index the more often the response was sorted only with others in the immediate area. The larger the bridging index, the more often that response was sorted together with responses in other regions of the map. For each concept, an average bridging index was calculated. The smaller the average value, the more cohesive the responses within it were. The lowest individual bridging index values within a concept with a high average were used to identify the most cohesive responses within it.

**Interpretation of Maps.** After the statistical analysis, concepts were inspected to ensure that the responses within each shared conceptual similarity to one another and that the concepts were conceptually distinct from each other. Labels were assigned to each concept by the author and advisor to reflect the contents (Trochim, 1989). These results are presented in Chapter Four.

***Utilization of Maps***. Concept mapping yielded a visual product to allow users to see all major ideas as well as their conceptual organization according to the participants (Trochim, 1989). A comparison of the results of the study and the available literature is presented in Chapter Five.

# Chapter 4: Results

The purpose of this study was to identify risks and safety measures for couples treatment with Aboriginal clients for intimate partner violence. Interviews were conducted with professionals in the area of probation, children's services, women's shelters, and those who had professional experience providing treatment for IPV. Responses to two questions were separately sorted into groups by participants. The sorting data were analyzed statistically and concept maps for each question were constructed based on the analyses. In this chapter, the results of the concept mapping analysis are presented for each question: "How would you address risk with Aboriginal men in couple counselling who use abusive behavior with their intimate partner?" and "How would you address safety with Aboriginal men in couple counselling who use abusive behavior with their intimate partner?"

## Risk

A total of 98 unique responses were made in response to this question and sorted by 8 participants. The sorts were analyzed using multidimensional scaling and concept analysis. As suggested by Trochim (1989), when determining the most appropriate number of concepts for a concept map based on fewer than 100 unique responses, solutions between 20 and 3 should be reviewed. In each solution, concepts were visually examined for evidence of within concept consistency on responses and between concept inconsistency in responses. A visual inspection of the maps of 20 and 15 concepts showed a great deal of scatter, and therefore smaller numbers of concepts appeared more likely to reflect underlying conceptual structure.

To determine the final map, solutions from 10 to 4 were examined. The ten-concept solution did not show clearly differentiated clusters. Changes introduced during

the reduction to nine were insignificant. Subsequent reductions from nine, eight, seven, six and then five increased the differentiation between concepts. The four-concept solution appeared to be overgeneralized. The solution that provided the best interpretability was the five-concept solution (see Figure 1 for concept map). Responses and bridging indices are presented in Table 1.

The bridging index was used to identify the most central responses within each concept and assisted with the labeling of concepts in the final map. The bridging index was a value between 0 and 1. Responses with a low bridging index, between 0.0 and 0.25, indicated that they had been most frequently sorted by participants with other responses within the concept. Responses with a high bridging index, between 0.75 and 1.00, were equally frequently sorted by participants with responses in other concepts as well as those within their own concepts. Trochim (1989) noted that highly bridging responses might not fit conceptually with those immediately surrounding them on the map, and were therefore less likely to reflect the overall content of a concept. Based on the individual bridging index values, an overall bridging index was calculated for each concept. The lower the average bridging index values, the greater the coherence of responses within that concept. A stress value was calculated. This value represented the degree to which the map was accurate representation of the sort data. The stress value for this map was 0.27, which was within an acceptable range of 0.05-0.35 (Trochim & Kane, 2007).

Figure 1: ***Concept Map for Question One***

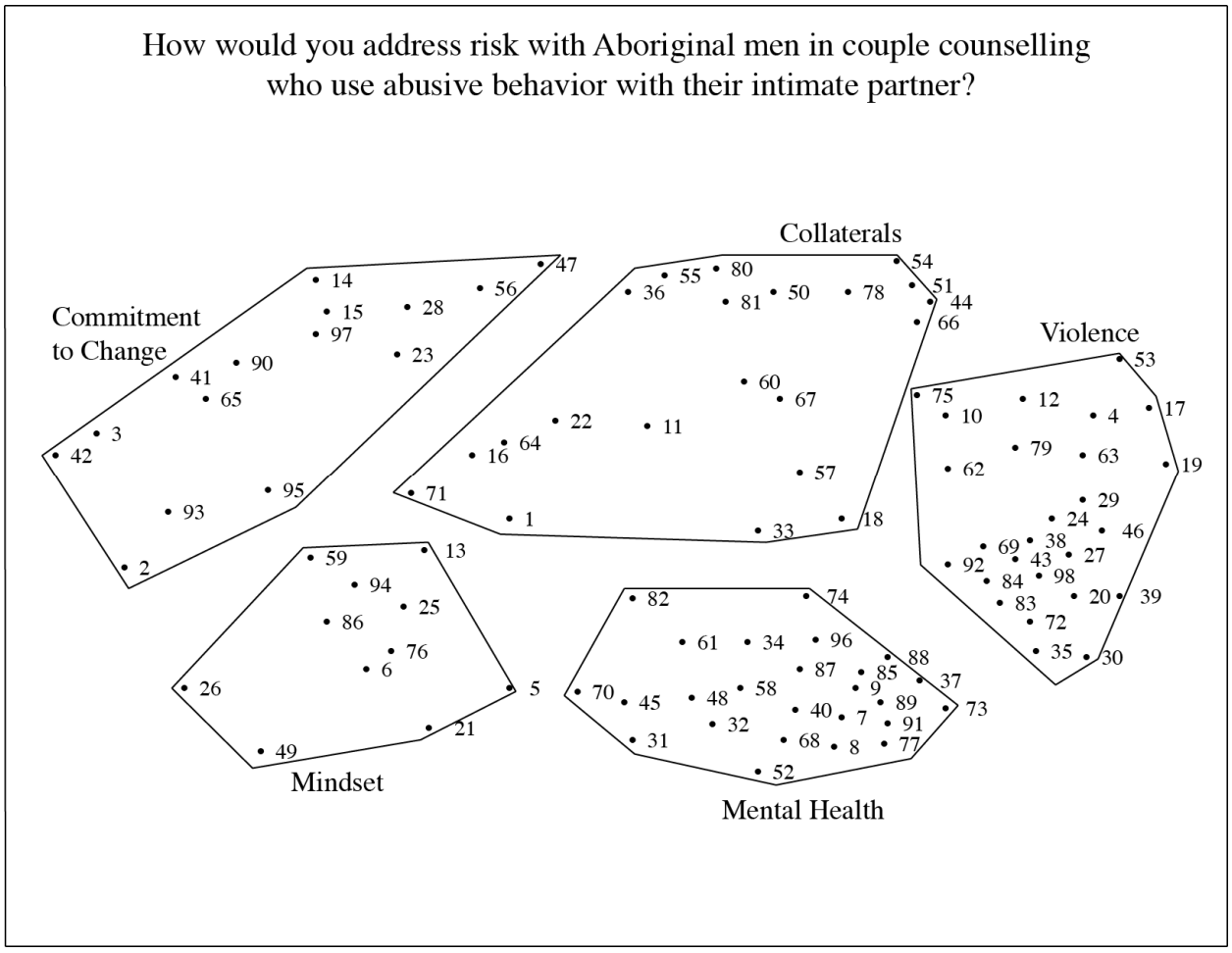


Table 1

*Concept Items and Bridging Values for Concept Map for Question One*

| Concept and Response | Bridging Index |
|---|---|
| Concept #1 - Collaterals | |
| 1. addictions history and programs | 0. 63 |
| 71. previous trauma counseling | 0. 80 |
| 11. clear expectations and consequences | 0. 60 |
| 22. do not rely solely on his self report | 0. 64 |

| | |
|---|---|
| 16. court orders | 0. 73 |
| 64. official reports | 0. 63 |
| 18. cultural factors | 0. 39 |
| 33. fighting over kids | 0. 39 |
| 57. mental health | 0. 45 |
| 60. no current violence | 0. 63 |
| 67. partner checks | 0. 51 |
| 36. formal and informal supports | 0. 60 |
| 55. making sure they're both safe | 0. 56 |
| 80. safety checks | 0. 53 |
| 78. restraining order | 0. 62 |
| 50. kids perspectives | 0. 54 |
| 81. safety planning | 0. 51 |
| 66. other agency involvement | 0. 55 |
| 44. home life of each partner | 0. 51 |
| 51. know history of couple | 0. 52 |
| 54. look at separate risk factors for each partner | 0. 58 |
| Concept Average | 0. 57 |
| Concept #2 - Commitment to Change | |
| 2. alternatives to violence | 0. 95 |
| 93. understand purpose of couple counselling | 1. 00 |
| 95. understanding of risks of couple counselling | 0. 88 |
| 3. anger management skills | 0. 67 |
| 41. healthy living | 0. 78 |
| 41. good support system | 0. 64 |
| 65. open to accessibility of information | 0. 87 |
| 90. support for males | 0. 59 |
| 14. contract in place | 0. 64 |
| 15. couples goals | 0. 76 |
| 97. views of others in the community | 0. 84 |
| 23. Elder involvement | 0. 66 |

| | |
|---|---|
| 28. evaluation of previous completed programs | 0. 72 |
| 56. mandated clients | 0. 61 |
| 47. interview victim alone | 0. 73 |
| Concept Average | 0. 76 |
| Concept #3 - Violence | |
| 4. assault history | 0. 57 |
| 17. criminal history | 0. 70 |
| 53. living together or apart | 0. 74 |
| 19. current charges | 0. 57 |
| 10. child welfare involvement | 0. 50 |
| 75. reason for referral | 0. 61 |
| 12. collateral information | 0. 49 |
| 62. ODERA | 0. 27 |
| 63. offense history | 0. 43 |
| 79. risk assessments | 0. 39 |
| 20. danger to partner | 0. 27 |
| 24. emotional abuse | 0. 07 |
| 46. increase in violence | 0. 09 |
| 98. weapons | 0. 15 |
| 38. gang involvement | 0. 13 |
| 69. pet abuse | 0. 13 |
| 84. sexual addiction | 0. 17 |
| 27. employment status | 0. 27 |
| 35. firearms | 0. 21 |
| 43. history of abuse | 0. 28 |
| 83. separation status | 0. 39 |
| 92. types and severity of abuse | 0. 22 |
| 29. extreme violence history | 0. 43 |
| 30. family background of violence | 0. 25 |
| 39. geographic location | 0. 34 |
| 72. previous violations of court order | 0. 27 |

| | |
|---|---|
| Concept Average | 0. 34 |
| Concept #4 - Mindset | |
| 5. attitudes | 0. 58 |
| 21. denial | 0. 52 |
| 6. behavior in relationships | 0. 72 |
| 86. stages of change | 0. 66 |
| 76. remorse | 0. 59 |
| 26. empathy | 0. 77 |
| 49. justification | 0. 72 |
| 13. conflict and communication patterns | 0. 61 |
| 25. emotional regulation ability | 0. 65 |
| 94. understanding of effects on their children | 0. 64 |
| 59. motives for treatment | 0. 99 |
| Concept Average | 0. 68 |
| Concept #5 - Mental Health | |
| 7. behavioral instability | 0. 06 |
| 40. going through divorce | 0. 12 |
| 68. personality disorder | 0. 15 |
| 8. biting | 0. 24 |
| 52. lethality | 0. 41 |
| 9. child abuse survivor | 0. 01 |
| 73. psychotic | 0. 03 |
| 77. residential school experience | 0. 16 |
| 85. sexual assault | 0. 18 |
| 34. financial problems | 0. 02 |
| 87. stalking | 0. 00 |
| 88. strangulation | 0. 00 |
| 89. suicidal ideation | 0. 02 |
| 37. foster care history | 0. 11 |
| 91. threats | 0. 07 |
| 31. family dynamics | 0. 19 |

| | |
|---|---|
| 32. female violence | 0. 18 |
| 96. victim vulnerability | 0. 19 |
| 74. reoffending risk | 0. 16 |
| 82. SARA | 0. 41 |
| 45. impulsiveness | 0. 27 |
| 70. power and control patterns | 0. 44 |
| 48. jealousy | 0. 22 |
| 58. minimization of his issues | 0. 32 |
| 61. no taking responsibility | 0. 32 |
| Concept Average | 0. 17 |

---

**Concept #1: Collaterals**. Concept 1 represented the concept of collaterals, which included important secondary information required for the full use of primary information in the assessment of risk. Overall, this concept attained the middle average bridging index value (0.57) of the five, indicating that some responses were sorted by participants into nearby concepts.

Responses such as "addictions history and programs", "previous trauma counseling", "court orders", "official reports", and "do not rely solely on his self report" indicated a necessity to look at additional sources of information instead of relying on one source or self-report. In order to assess the risk for violence and appropriateness for couple's therapy, it was important to the professionals that the men had completed relevant programs and evidence forming the basis of their judgment would come from multiple sources including official records.

"Cultural factors", "fighting over kids" and "mental health" were important considerations in the assessment of risk level. Significant issues with mental health and conflict over child rearing or custody were important in assessing risk. In addition, cultural factors were to be attended to in relation to risk.

There were several additional responses consistent with the general content of the concept. The response "clear expectations and consequences" suggested examination of the individual's motivations and boundaries for going into therapy. In addition, "look at separate risk factors for each partner" entailed looking at the female partner's risk factors as well as the man's risk factors. The responses "no current violence" and "partner checks" were viewed as important considerations in the assessment of risk. Both had higher bridging index values (0.63 and 0.51 respectively) relative to values of other responses in the concept, which suggested that participants might also have grouped them with responses in other concepts such as Concept 3 that represented "Violence".

"Formal and informal supports", "making sure they're both safe", "safety checks", and "restraining order" were additional considerations. It was beneficial for both partners to have formal and informal support systems in place. Checking in outside of sessions with both partners regarding safety was seen as necessary. Whether or not the man had a restraining order previously reflected risk. "Kids perspectives" and "know history of couple" represented how the children saw the relationship, how safe they felt and the couple's history and cycle of violence. "Other agency involvement" suggested that the couple likely had other information on file that would help the professional in the assessment of risk level.

**Concept #2: Commitment to Change**. Commitment to change was reflected in several responses within this concept including: "contract in place", "anger management skills" and "healthy living". The responses "anger management skills" and "evaluation of previous completed programs" represented the man's commitment by outlining what he has completed in the past to better himself and the relationship. The response "healthy living" implied how the men conducted themselves in the present (as opposed to their old

ways). The responses "contract in place" and "couples goals" represented the man's commitment to change by displaying how prepared he was for taking responsibility for his actions which included a document outlining his commitment to the program. The response "open to accessibility of information" represented the man's commitment to change by outlining his willingness to do things differently in the relationship.

Furthermore, the response "mandated clients" suggested that their commitment to change was potentially lower because of requirement to take a program. "Elder involvement" implied the presence of cultural awareness and the availability of Elders involved in the male's life. A commitment to change was reflected in the man's decision to reach out and ask for help from a community Elder. "Understand purpose of couple counselling" had the highest bridging index value within the concept (1.0), which suggested that it was sorted with responses in other concepts. This concept had the highest average bridging index value (0.76) indicating that some of the responses within it were sorted with the responses in the other clusters and that this cluster may have reflected more than one concept.

**Concept #3: Violence**. This concept contained a number of factors that were perceived as information of violence history critical to the assessment of a man's risk level to the program including "offense history", "risk assessments", "danger to partner", "emotional abuse", "increase in violence", "weapons", "gang involvement", "pet abuse", "sexual addition", "firearms", "history of abuse", "types and severity of abuse", "extreme violence history", "family background of violence", "current charges", "child welfare involvement", "assault history" and "previous violations of court order".

The response "ODARA" suggested looking into the man's violent offense history by using a risk assessment tool known as the Ontario Domestic Assault Risk Assessment

(ODARA). Other responses suggested important information pertaining to violence were "reason for referral", "geographic location", "separation status" (i.e., violence between couple) and "employment status". Overall, the concept had the second lowest bridging index value (0.34) which suggested responses were sorted with those inside this concept and less often with responses in other concepts.

**Concept #4: Mindset**. A number of responses within the concept reflected the mindset or current state of mind that the man had when evaluating his risk level for the program. Responses that reflected this mindset consisted of "attitudes", "denial", "remorse", "empathy", "justification", "emotional regulation ability" and "understanding of effects on their children". The responses "behavior in relationships" and "conflict and communication patterns" indicated a need to know what the current state of the relationship was and what behaviors and communication styles were present in both male and female partners. "Motives for treatment" had the highest bridging index value within the concept (0.99), which suggested that it was sorted with responses in other concepts. Overall, concept four showed the second highest average bridging index value (0.68) indicating that some responses were sorted with responses in other concepts.

**Concept #5: Mental Health**. This concept represented the man's mental health as an important factor in the assessment of risk. This was represented in a number of responses including: "behavioral instability", "going through divorce", "personality disorder", "biting", "psychotic", "sexual assault", "stalking", "strangulation", "suicidal ideation", "threats", "jealousy", and "impulsiveness". Other responses such as "child abuse survivor", "foster care history" and "residential school experience" were important considerations in the assessment of a man's mental health status because of their painful and detrimental long-term effects on mental state.

Furthermore, "financial problems" implied that having difficulties providing for one's basic needs may have an impact on the man's mental health and subsequently, on risk level in such a program. Other responses were related to the man's mental health and influence level of associated risk were: "power and control patterns", "minimization of his issues", and "not taking responsibility". "Reoffending risk" was a response representing the need to assess the man's risk to re-offend. In line with this response was the response "SARA", which suggested looking into the man's spousal assault history by using a risk assessment tool known as the Spousal Assault Risk Assessment (SARA). Overall, the concept had the lowest bridging index value (0.17) indicating that responses in it were consistent and most were infrequently sorted with responses from the other concepts.

**Safety**

A total of 65 unique responses were made to this question and were sorted by 6 participants. The sorts were analyzed using multidimensional scaling and concept analysis. As suggested by Trochim (1989), when determining the most appropriate number of concepts for a concept map based on fewer than 100 unique responses, solutions between 20 and 3 should be reviewed. In each solution, concepts were visually examined for evidence of within concept response consistency and between concept inconsistency. A visual inspection of the maps of 20 and 15 concepts showed a great deal of scatter, and therefore, smaller numbers of concepts were more likely to reflect underlying conceptual structure.

To determine the final map, solutions from 10 to 4 were examined. The 10-concept solution appeared fragmented. Reducing the ten-concept solution to five collapsed concepts one, two, and three, seven and eight, nine and ten, and five and six.

The solution that provided the best interpretability was the four-concept solution (see Figure 2 for concept map). Responses and bridging indices are presented in Table 2.

The bridging index was used to identify the most central responses within the concepts and assisted researchers when labeling concepts in the final map. The bridging index was a value between 0 and 1. Responses with a low bridging index, between 0.0 and 0.25, indicated participants frequently sorted them with responses within the concept. Participants equally frequently sorted responses with a high bridging index, between 0.75 and 1.00, with responses in other concepts as well as those within their own concept. Trochim (1989) noted that highly bridging responses might not fit conceptually with those immediately surrounding them on the map and therefore less likely to reflect the overall theme of a cluster. Based on the individual bridging index values an overall bridging index was calculated for each concept. The lower the average bridging index values, the greater the consistency of responses within that concept. A stress value was calculated. This value represented the degree to which the map was an accurate representation of the sort data. The stress value for this map was 0.33, which was within an acceptable range of 0.05-0.35 (Trochim & Kane, 2007).

Figure 2: ***Concept Map for Question Two***

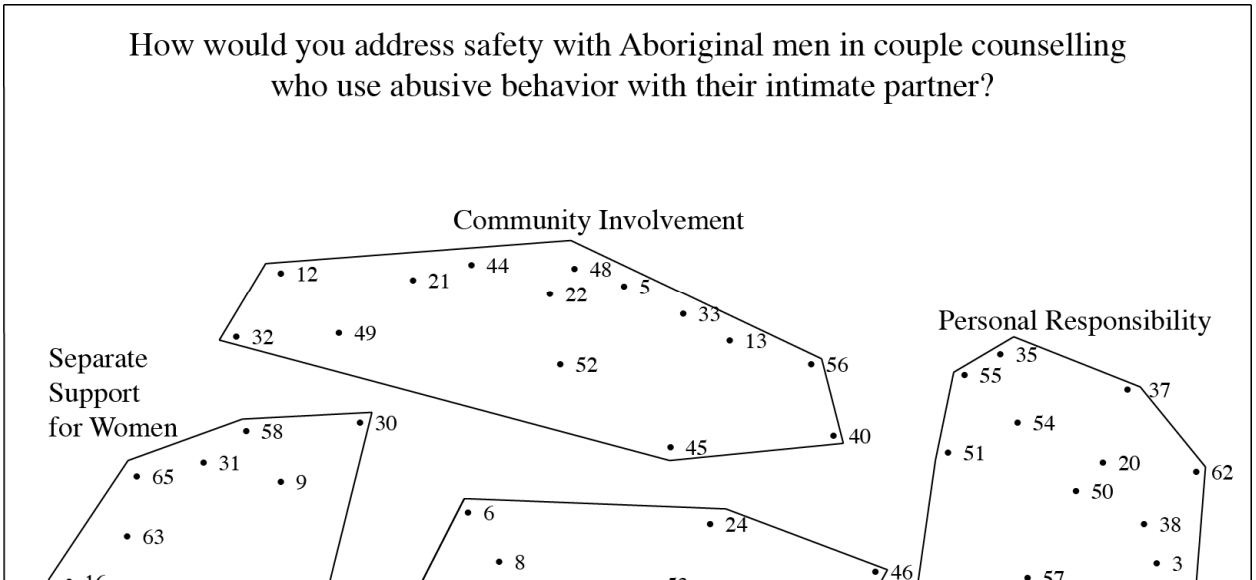

Table 2

*Concept Items and Bridging Values for Concept Map for Question Two*

| Concept and Response | Bridging Index |
|---|---|
| Concept #1 - Personal Responsibility | |
| 1. addictions maintenance | 0. 00 |
| 2. address issues in session | 0. 00 |
| 34. medication compliance | 0. 00 |
| 4. agreement to proceed | 0. 02 |
| 7. call in from each partner | 0. 21 |
| 61. threatening or intimidating behaviours out in open | 0. 19 |
| 11. commitment that either can leave if threatened | 0. 13 |
| 26. honesty agreement | 0. 15 |
| 19. each has someone safe to talk to | 0. 29 |
| 3. agreement about the process and rules | 0. 19 |
| 38. no physical violence | 0. 22 |
| 57. stressors monitored | 0. 08 |
| 20. each has someone safe to go to | 0. 22 |
| 50. responsibility plan | 0. 19 |

| | |
|---|---|
| 62. time out | 0. 31 |
| 35. mental health awareness | 0. 39 |
| 55. separate support systems | 0. 36 |
| 37. no abuse toward others | 0. 32 |
| 51. safety around self harm for the male | 0. 17 |
| 54. separate finances | 0. 22 |
| Concept Average | 0. 18 |
| Concept #2 - Community Involvement | |
| 5. appropriate relationships between kids and dad | 0. 17 |
| 22. encourage to work with Elders as appropriate | 0. 15 |
| 48. relatives positively involved | 0. 10 |
| 21. Elder involvement | 0. 11 |
| 44. other family members support | 0. 10 |
| 12. community member involvement | 0. 13 |
| 32. living arrangements of children | 0. 64 |
| 49. resources available and used | 0. 33 |
| 13. community resources | 0. 29 |
| 33. make sure family knows what is happening | 0. 29 |
| 52. safety plan for the woman | 0. 21 |
| 40. no weapons | 0. 14 |
| 56. signal with neighbour | 0. 27 |
| 45. partner feels safe | 0. 17 |
| Concept Average | 0. 22 |
| Concept #3 - Mandatory Reporting | |
| 6. be in contact with local police agency | 0. 19 |
| 8. cell phone | 0. 24 |
| 18. disclosure contract in place | 0. 18 |
| 36. monitor investment in counselling | 0. 10 |
| 23. exist planning | 0. 03 |
| 60. therapist availability outside sessions | 0. 03 |
| 24. external reporting required | 0. 11 |

| | |
|---|---|
| 53. safety pre treatment during as well as post treatment | 0. 11 |
| 39. no substance abuse | 0. 08 |
| 46. private location | 0. 05 |
| 14. contact female partner outside of the couples counselling | 0. 29 |
| 41. ongoing safety assessment | 0. 35 |
| 27. individual counselling as well as couple counselling | 0. 25 |
| 17. decision to do couples counselling is therapists | 0. 14 |
| 29. individual sessions first | 0. 18 |
| 43. open door policy | 0. 17 |
| 28. individual monitoring | 0. 07 |
| 42. open contact between therapist and partners separately | 0. 14 |
| 47. random check ins | 0. 03 |
| 59. suspend counselling as needed | 0. 02 |
| Concept Average | 0. 14 |
| Concept #4 - Separate Support for Women | |
| 9. check ins for women | 0. 32 |
| 31. inform police | 0. 51 |
| 65. woman's needs come first | 0. 64 |
| 30. inform child welfare | 0. 25 |
| 58. support group for woman | 0. 35 |
| 10. collateral interviews | 0. 62 |
| 15. controlling behaviour | 0. 72 |
| 16. cultural protocols | 1. 00 |
| 63. warning signs observed by others outside of couple and … | 0. 54 |
| 25. high risk situations | 0. 70 |
| 64. woman is safe and open in session | 0. 35 |
| Concept Average | 0. 55 |

**Concept #1: Personal Responsibility**. This concept was representative of the level of personal responsibility that the man displayed in consideration of safety for both

partners. This was represented in responses such as "addictions maintenance", "address issues in session", "medication compliance", "agreement to proceed", and "stressors monitored". In taking personal responsibility, it was important for the men to initially agree to participate, as well as to have their addictions under control including taking the appropriate medication, as well as willingness to address problems in sessions and have stressors monitored by others. "Commitment that either can leave if threatened" suggested that both partners made a commitment prior to sessions that they can both discontinue or leave the relationship if they want without fear of violence. Similarly, "threatening or intimidating behaviors out in open" suggested that both partners commit to identifying these behaviors and discussing them in sessions.

Other responses focused on taking responsibility by making agreements prior to beginning sessions such as "honesty agreement", "agreement about the process and rules", "responsibility plan". "Call in from each partner", "each has someone safe to go to", "separate support systems" and "each has someone safe to talk to" implied that both partners had someone available to them that they could call or go to in order to be safe. There were other responses that involved taking responsibility to commit to ending the Violence, which included "no physical violence", "time out", "no abuse toward others" and "safety around self harm for the male". "Separate finances" and "mental health awareness" were other responses indicative of taking personal responsibility. In terms of bridging index, the concept attained the second lowest average bridging index (0.18) indicating that few of the responses were sorted with responses in other concepts.

**Concept #2: Community Involvement**. The concept of community involvement was reflected by responses including: "appropriate relationship between kids and dad", "relatives positively involved", "other family members support", "community member

involvement", "signal with neighbour". "Encourage to work with Elders as appropriate" and "Elder involvement" were responses implying the need for culturally appropriate support systems in the community to promote and maintain safety.

"Resources available and used" as well as "community resources" reflected the need to have resources both available to the man and used by the man or couple in order to maintain safety. Other responses such as "safety plan for the woman", "no weapons", and "partner feels safe" represented the need for the woman to feel safe and have a plan if she no longer felt safe. "Living arrangements of children" was characterized by a high bridging index value of 0.64, which suggested that it was sorted with other responses in other concepts. Although the concept attained the second highest average bridging index value (0.22), it was still a low bridging index value suggesting that few responses were sorted with responses from other concepts.

**Concept #3: Mandatory Reporting**. Need for mandatory reporting appeared in responses such as "disclosure contract in place", "be in contact with local police agency", "external reporting required", "individual monitoring", "open contact between therapist and partners separately", and "random check ins". "Open door policy" suggested the need for the couple to feel open to see and disclose with their therapist whenever they felt it was needed.

Other responses concerned the need to report and have a good relationship with the therapist to keep safe, including "therapist availability outside of sessions", "safety pre treatment during as well as post treatment", "contact female partner outside of the couples counselling", "ongoing safety assessment", "individual counselling as well as couple counselling", "individual sessions first", and "decision to do couples counselling is therapists". Overall, the concept had the lowest bridging index value (0.14) indicating

that responses in it were consistent and rarely sorted with responses in the other concepts.

**Concept #4: Separate Support for Women**. This concept reflected the importance of having separate supports in place for women in order for them to be safe. This was reflected in several responses including: "check ins for women", "woman's needs come first", "support group for woman", "woman is safe and open in session", "inform police" and "inform child welfare". "Cultural protocols" had a high bridging index value of 1.00, which suggested that it was often sorted with other responses in other concepts.

This concept had the highest average bridging index value (0.55) indicating that some of the responses within it were sorted with the responses in the other concepts and that this concept may have reflected more than one concept.

## Results Summary

Eight professionals took part in sorting 98 responses to the question, "How would you address risk with Aboriginal men in couple counselling who use abusive behaviour toward their intimate partner?". After multidimensional scaling and concept analysis of the sorting data, five distinct concepts were identified: 1) Collaterals, 2) Commitment to Change, 3) Violence, 4) Mindset, and 5) Mental Health. The first concept included responses that referred to collateral information such as "addictions history and programs" and "previous trauma counselling" that were seen as additional information useful in the assessment of the man's risk level. The second concept was represented by responses such as "contract in place" and "anger management skills" and signified that the man had to be committed to the process and want to change. The third concept listed responses that centered around violence such as "extreme violence history", "weapons", and "gang involvement". The fourth concept included responses "attitudes", "remorse",

and "empathy", which emphasized the man's state of mind. Responses in the fifth concept such as "psychotic", "personality disorder", and "suicidal ideation" represented the man's mental health status in the assessment of risk.

Sixty-five responses to the question, "How would you address safety with Aboriginal men in couple counselling who use abusive behaviour toward their intimate partner?", were sorted by 6 professionals and following statistical analysis were organized into four concepts: 1) Personal Responsibility, 2) Community Involvement, 3) Mandatory Reporting, and 4) Separate Support for Women. The first concept included responses such as "medication compliance" and "agreement to proceed" and reflected whether the man was taking responsibility for himself and his actions. The second concept emphasized the man's involvement in the community and included responses "community member involvement" and "relatives positively involved". In the third concept, professionals indicated that the man was obliged to report to authorities with responses like "disclosure contract in place" and "external reporting required". The fourth concept reflected the need for separate supports to be in place for the woman such as "support group for woman" and "woman is safe and open in session".

# Chapter 5: Discussion

The purpose of this study was to identify risks and safety measures for couples treatment with Aboriginal clients for intimate partner violence. Interviews were conducted with professionals in the area of probation, children's services, women's shelters, and those who had experience providing treatment for IPV. The sort data were analyzed using multidimensional scaling and cluster analysis. In this chapter the results of the study were compared to the available literature.

## Risk

The question "How would you address risk with Aboriginal men in couple counselling who use abusive behaviour toward their intimate partner?" resulted in a map with five concepts. The concepts included "Collaterals", "Commitment to Change," "Violence", "Mindset", and "Mental Health". The first concept referred to collaterals

important secondary information required for the full use of primary information in the assessment of risk. The second concept referred to the man's commitment to change as an important consideration in risk. The third concept represented history of violence in the assessment of current risk. The fourth concept reflected the state of mind of the man in relation to risk. The fifth concept represented the mental health as an important factor in the assessment of risk.

**Collaterals.** Professionals identified several sources of collateral information that should be used in the assessment of risk. These included official reports available from professionals involved in the client's addictions history and programs, previous trauma counselling as well as court orders. Existing research on risk for IPV was consistent with the need for collateral information including sources identified by participants within this concept.

One frequently used risk assessment tool for mandated clients is the Spousal Assault Risk Assessment Guide (SARA; Kropp, Hart, Webster & Eaves, 1998). The SARA includes five major areas of risk including: 1) Criminal History, 2) Psychosocial Adjustment, 3) Spousal Assault History, 4) Current/Most recent Offence, and 5) Other Considerations. Collateral verification is necessary for all information used in the SARA, and the same can be said for the ODARA (Kropp, 2008) and ASAP (Bain, 2006) instruments. Each requires collateral verification from official reports and sources to support items in the checklist relating to potential risk and safety in relation to IPV.

**Commitment to change.** This concept emphasized the importance of the man's attitude and willingness to make an effort to change. If the man was not committed to ending the violence in the relationship then he would not be considered for conjoint therapy. Responses such as having a contract in place, identifying couples' goals, the

evaluation of previous completed programs and understanding the purpose of couple counselling were seen by participants as making a positive commitment to change the relationship. In LaTaillade, Epstein and Werlinich's (2006) Couples Abuse Prevention Program (CAPP), the first session included an overview of the program and discussion of relationship history as well as completion of a no-violence contract with identification of and commitment to a written set of goals for therapy. The understanding was that the primary goal of CAPP was for the couple to have an abuse-free relationship. Again, responses in concept such as understanding the purpose of couple counselling, setting goals, and having a contract in place were indicative of the man's commitment to change and consistent with what has been reported in the literature. The response "contract in place" was also an important feature for considering both risk and safety of the female partner (O'Farrell & Fals-Stewart, 2002).

One difference between the research literature and findings of present study was the idea of interviewing the couple separately prior to couples therapy. In all four of the primary research studies on conjoint therapy for IPV, researchers assessed risk by interviewing partners separately (e.g., Stith & McCollum, 2011). Potential clients were to be properly screened and it was done by interviewing the men and women separately. In this concept, one response was "interview victim alone", however, there was no mention of whether this needed to be done prior to couple counselling, during couple counselling, or after couple counselling as a contributor to initial and ongoing risk assessment as well as post-intervention monitoring.

**Violence.** In this concept, professionals stated a number of responses that represented the presence of violence in the couple's life. Responses included "assault history", "danger to partner", "emotional abuse", "gang involvement," "weapons", "pet

abuse", "sexual addictions", "firearms", "types and severity of abuse", and "family background of violence". In the assessment of risk, it was important to consider a range of violence in the couple's life in addition to violence toward a partner. According to Riggs, Caulfield and Street (2000), rarely, if ever, did an incident of spousal abuse occur in isolation from other violence. Similar to prior physical violence, the man's use of verbal or emotional abuse in the present relationship appeared to be a significant risk marker for perpetrating physical spouse abuse (Riggs, Caulfield & Street, 2000).

Stith, McCollum, Rosen, and Locke (2002) did not include clients with a history of severe violence or anyone who had current problems with alcohol and drugs in their conjoint therapy program. O'Leary, Neidig, and Heyman, (1999) assessed risk by determining whether both partners noted that the violence was not severe enough to elicit substantial fear or serious injury to the female partner. The risk was not acceptable if the female partner indicated that 1) the violence was severe enough to elicit substantial fear or serious injury to her, 2) she was afraid for her life, 3) she was afraid of participating in therapy with her partner, and 4) she desired to leave the relationship. This was consistent with responses in the concept such as "extreme violence history", "types and severity of abuse", and "danger to partner".

In addition, three of the primary studies on conjoint therapy for IPV mentioned using the Conflict Tactics Scale to determine risk of IPV (Dunford, 2000; O'Farrell and Fals-Stewart, 2002; Stith, McCollum, Rosen, & Locke (2002). However, the Conflict Tactics Scale was not specifically mentioned by participants in the current study as a way of measuring violence.

**Mindset.** This concept focused on the man's attitudes and beliefs concerning violence towards women. Responses included "attitudes", "remorse", "empathy",

"denial", "understanding of effects on their children", and "motives for treatment". Attitudes reflect thoughts and thoughts affect behaviours. Early descriptions of men who were violent with women found they held traditional sex-role attitudes (Walker, 1979). More recent research has replicated those findings that men who are violent with their partners hold negative attitudes about women and that this should be used in an assessment of risk for IPV (Sonkin, 1988). Responses in the concept were consistent with the existing literature, reflected in responses of "denial", "remorse", "empathy", and "justification".

**Mental health.** This concept represented the man's mental health status and how it affected his risk. Responses such as "personality disorder", "child abuse survivor", "suicidal ideation", "foster care history", and "psychotic" illustrated past and current factors associated with mental health. Previous research has outlined the increased risk for violence when mental illness is a factor. For example, personality disorders and characteristics such as antisocial, borderline, and narcissistic occur at higher rates among men who are abusive towards female partners (Hamberger & Hastings, 1991).

It has been theorized that psychopathology itself may be a risk factor for continued violence between partners, thus perpetuating the cycle of violence and also interfering with effective use of available community support systems (Foa et al., 2000; Perez & Johnson, 2008). Symptoms of PTSD, depression, and other mental disorders may interfere with help-seeking behaviors and the effective use of available resources that are necessary to decrease relationship violence (Foa et al., 2000). Researchers have also hypothesized that men's aggression and suicide-attempt history in adolescence predict poor relationship outcomes, including partner violence, in young adulthood (Kerr & Capaldi, 2011). Furthermore, there is considerable research that links childhood abuse

with later perpetration of IPV (Swogger et al., 2012). Thus, mental health is an important considering factor in the assessment of risk and was consistent with the responses by participants in the present study.

**Safety**

Analysis of responses to the question "How would you address safety with Aboriginal men in couple counselling who use abusive behaviour toward their intimate partner?" resulted in a map with four concepts. The concepts included "Personal Responsibility", "Community Involvement," "Mandatory Reporting", and "Separate Support for Women". The first concept represented the concept of personal responsibility, which represented the importance of the man taking responsibility for his actions as necessary for the safety of the female partner. The second concept referred to the couple's involvement with the community as an important factor in establishing safety for the woman. The third concept represented the need for mandatory reporting so that the woman's safety could be monitored at all times. The fourth concept reflected the importance of having separate supports available to the women to keep them safe.

**Personal responsibility.** In this concept, participants noted that the men needed to be able to take responsibility for themselves and their actions in order to work on their relationship and keep the women safe. Responses such as "medication compliance", "responsibility plan", "agreement about the process and rules", and "addictions maintenance", represented the need for the men to show their commitment to therapy and the relationship. The degree to which the men made an effort (e.g., taking their medication) was indicative of whether or not they were taking responsibility for their actions.

In their study, O'Farrell and Fals-Stewart (2002) stated that when it came to the female partner's safety, a verbal agreement took place between the therapist and the male, which consisted of promising not to engage in any angry touching (i.e., pushing, shoving, hitting, kicking partner when angry). This commitment was seen as the man taking responsibility for his actions and agreeing to terms that would keep the female partner safe. Similarly, Stith, McCollum, Rosen, and Locke (2002) concluded that those who refused to sign a no-violence contract prior to treatment were not allowed to participate in treatment. If the man could not make this commitment then the therapy was seen to endanger the safety of the female partner and he was not eligible. Although there was considerable support for a no-violence agreement to be in place, responses in the concept mentioned an agreement, but not one specific to violence. The responses included: "agreement to proceed", "honesty agreement", and "agreement about the process and rules", which reflected the importance of having an agreement or making a commitment but not necessarily a commitment not to engage in violence. However, the response "no physical violence" suggested that there had to be no violence within the relationship for couple counselling to take place.

Studies on conjoint therapy for IPV stressed the importance of teaching safety and timeout plans with the couple (Stith, McCollum, Rosen, & Locke, 2002). This was consistent with the present study where participants identified the response: "time out". The woman's safety was consistently the main priority and learning how to take a "time out" was important.

**Community involvement.** This concept reflected the extent to which the community was involved in the couples' lives. Responses included "appropriate relationships between kids and dad", "relatives positively involved", "community

member involvement", and "community resources". A woman's safety was threatened by having a low level of personal support available to her in her community (Newhouse & Peters, 2001). She may not have many friends or access to family members, which increases isolation and a dependence. The woman's living situation can be further isolating depending on her geographical location. For instance, people who live in rural or remote communities, or who are not connected to others in their communities may lack access to information, resources, supports and services (Newhouse & Peters, 2001). Again, a review of studies on conjoint therapy for IPV indicated the need to teach safety planning and negotiating timeout plans with the couple (Stuart, O'Farrell & Temple, 2009). This was reflected in the responses "safety plan for the woman" and "partner feels safe".

An assessment tool that builds upon the SARA is known as the Aid for Safety Assessment Planning (ASAP). ASAP was designed to examine risk factors from the woman's perspective and emphasized the need for relevant agencies and her to work together and share information pertaining to safety (Bain, 2006).

**Mandatory reporting.** This concept reflected the need for partners to disclose problems openly in and out of sessions both during and following treatment. Responses such as "be in contact with local police agency", "disclosure contract in place", "open door policy", "open contact between therapist and partners separately", as well as "random check ins" represented the need for constant monitoring that needed to be in place. This was consistent with previous research such as Dunford's (2000) study on conjoint therapy for IPV among military couples. Dunford (2000) recommended several follow-up sessions in order to protect the safety of these women, including monitoring for a year after treatment. In addition, a record search for new arrests would be conducted

every 6 months and the woman was called every month and asked if there was any abuse in the relationship throughout treatment (Dunford, 2000).

**Separate supports for women.** This concept represented the importance of keeping women safe through separate supports. Responses included "support group for women", "woman is safe and open in session", and "woman's needs come first". There was evidence in the literature consistent with this. For example, women were called every month and asked if there was abuse present in the relationship (Dunford, 2000). The importance of having separate supports available to women was reflected in the response "check ins for women".

One difference between the research literature and the present study was the inclusion of mandated clients. For example, when identifying safety measures, consideration was given to whether or not clients were mandated (O'Leary, Neidig, & Heyman, 1999). If the male partner was not mandated, then weekly check-ins were required to protect the woman's safety. If the male partner was mandated, more safety measures were in place such as the weekly check-ins, a close relationship judge maintained with the treatment program, close surveillance by the probation officer, and follow-up assessments. Therefore, in order to ensure the safety of the female partner, continued monitoring and support had to be made available to the woman separately from her partner. Mandated clients were not reflected in the responses of this concept, however, one response represented the value that participants placed on protecting the women. This response was: "woman's needs come first".

**Cultural Differences**

The major difference between existing research and the present study is the inclusion of cultural factors specific to the Aboriginal population. The response: "cultural

factors", and many others, represented this important distinction. Although culturally competent interventions have often been celebrated and stressed in the research literature, the actual interventions themselves are often left out (Gone, 2010). Substantive descriptions and specific forms of culturally competent interventions are needed to be included (Gone, 2010).

In the present study there were some responses that described culturally appropriate interventions for IPV counselling specifically with Aboriginal couples. For example, "Elder involvement" represented the importance of working with Aboriginal community partners such as Elders. This is an omission in the existing research on conjoint therapy for IPV and reflects a culturally appropriate support system that may be available to the couple depending on their geographical location and on how much they identify with their culture. Generally, the consensus for who an 'Elder' is will involve 'acceptance by the community as an ‘Elder’; someone who is wise and lives by the traditional teachings (Waldram, 1997). Elders can help Aboriginal couples who experience IPV in their relationships similar to the way that Elders work in a variety of communities and institutions. One Elder explained that by teaching people about their identity, they can begin to heal because they will know who they are, what their history is, and what their values are (Waldram, 1997).

In addition, the "geographic location" (or isolation of the woman and couple) was not identified in the literature. The Aboriginal population is growing and becoming increasingly urbanized but many reside in locations that are not within or near to an urban centre specialized and anonymous services for IPV are available. In 1951, the Census of Canada showed that 6.7 percent of the Aboriginal population lived in cities. By 2001, that proportion had increased to 49 percent. In 2001, thirty one percent of Aboriginal People

were living on a reserve, whereas approximately twenty percent of Aboriginal People were living in rural areas (non-reserve). Twenty-one percent of Aboriginal Peoples were living in urban areas that were not urban census metropolitan areas and approximately twenty-eight percent of Aboriginal Peoples were living in urban census metropolitan areas. Man couple may feel isolated from resources that individuals in urban settings have access to. This isolation is an important consideration in the assessment of the couple's access to supports and resources that can influence the safety of the female partner.

Other responses in the present study that were not apparent in existing research included "understanding of effects on their children" and "conflict and justification patterns". This included both the effects on children and periods of aggression and violence followed by periods of calm in relationships. In relation to risk the man's understanding of how a violent relationship affects the couple's children is an important consideration because it taps into his awareness and responsibility for the effects. This would be evident in the way he justified his actions and the way he explains conflict and violence in the relationship.

Another response in the present study that was not represented in existing research on risk assessment for IPV was "family background of violence". Aboriginal families are overrepresented in both the child welfare system and in the provincial and federal correctional institutions. Aboriginal women are three times and Aboriginal men two times as likely to be victims as non-Aboriginal women and men (Newhouse & Evelyn, 2001). The base rates for violence exposure in the lives of Aboriginal couples are high. There is great potential that the family members have had experience with violence

in the current of previous generations because of the effects of colonization, which for many also included experiences in Residential Schools.

The response "residential school experience" was also specific to Aboriginal peoples. Residential School experience could have an impact on the man's mental health and influence his risk in a number of different ways. The experiences may have included child abuse, forced removal from home and community as well as loss of cultural identity. The effects have been felt across communities and families and through tradition there is hope for healing. This is illustrated by the following:

> "We see all this sexual abuse and abuses going on, broken homes. That's because we are products of the residential school era, and so oppressed that we turned on our own people. So we are trying to fix that somehow in our own way, in our traditions, our own teachings from way back"
>
> - Elder (Waldram, 1997).

The experience of historic trauma and intra-generational grief can best be described as psychological baggage being passed from parents to children along with the trauma and grief experienced in each individual's lifetime. The hypothesis is that the residue of unresolved, historic, traumatic experiences and generational or unresolved grief is not only being passed from generation to generation, it is continuously being acted out and recreated in contemporary Aboriginal culture (Wesley-Esquimaux & Smolewski, 2004). Unresolved historic trauma will continue to impact individuals, families and communities until the trauma has been addressed – through restoration of relationships and culture - mentally, emotionally, physically and spiritually.

**Discussion Summary**

Responses to the first question "How would you address risk with Aboriginal men in couple counselling who use abusive behaviour toward their intimate partner?" resulted in five concepts, which were "Collaterals", "Commitment to change," "Violence", "Mindset", and "Mental health". There were similarities between risk factors identified by the participants in the present study and findings in the literature. Service providers in the present study and those surveyed in previous studies reported that they would assess risk using assessment tools such as the SARA, to measure the degree and history of intimate partner violence. Another similarity was the importance of the man understanding the purpose of couple counselling, setting goals, and having a contract in place, which represented his commitment to change. In the assessment of risk, it was also important to consider all aspects of violence in the couple's life, not only violence toward the partner. Furthermore, there were similarities regarding how negative attitudes about women as well as mental health factors played a role in the assessment of risk for IPV.

However, there were also differences between the research literature and the responses in the present study. In all four of the primary research studies on conjoint therapy for IPV, researchers assessed risk by interviewing partners separately (Stith & McCollum, 2011). This was not brought up in the present study nor was The Conflict Tactics Scale, which was used in existing research as a measure of violence. This may be due to the fact that participants from the study were not familiar with the scale or that it was not a common instrument used in their agencies.

Responses to the second question "How would you address safety with Aboriginal men in couple counselling who use abusive behaviour toward their intimate partner?" were grouped into four concepts including ‘‘Personal responsibility’’, ‘‘Community Involvement’’, ‘‘Mandatory Reporting’’ and ‘‘Separate Supports for Women’’. Studies on

conjoint therapy for IPV stressed the importance of teaching safety and timeout plans to keep the couple safe (Stith, McCollum, Rosen, & Locke, 2002). Consistent with results of the present study, woman's safety was a priority. This priority was reflected in the response "woman's needs come first". Consistent with existing research there was also the need for constant monitoring to protect the female partner.

Differences from the research literature with respect to safety concerned the need to have a no-violence contract in place. Responses in the present study only mentioned an agreement, which was not specific to violence. Another difference was found in the lack of discussion concerning the length and frequency of monitoring the participants, but described in the literature.

The major differences between existing research and the present study concerned culturally specific factors. In the present study, and not the existing literature, there were multiple references to cultural factors, which included the need for therapists to attend to in risk, and safety assessment for couples work in IPV with Aboriginal families. These issues included involvement of Elders in the process, attention to the geographic location and community where the couple resides, understanding of violence cycle and effects on children, as well as experience with violence in community and family within previous generations affected by colonization and residential school experience. Finally, the experience and manifestation of historical trauma should be attended to, according to participants, in relation to risk and safety.

**Implications**

The present study identified some risk and safety issues for a conjoint therapy program with Aboriginal couples who experience IPV. For the purposes of this research, the focus was on identifying features of conjoint IPV treatment for Aboriginal couples

through interviews with experts. The purpose was not to develop a new approach but rather, to develop some awareness from discussion with experts about important issues to consider for effective conjoint IPV treatment programs for Aboriginal clients. The present study is a small piece of a large picture, which identifies risk and safety as important factors to consider in conjoint therapy for Aboriginal couples who experience IPV. Other important issues include population, content, activities, monitoring, and follow-up as formative to the development of an approach that would be further validated through additional research and practice.

There is a need to recognize and include culture in research on risk and safety. However, even culturally appropriate interventions need to be sensitive to diversity within the Aboriginal population. The Aboriginal population reflects a range of cultures, with different beliefs, values, and worldviews. In addition, there may be Aboriginal individuals who were raised in non-Aboriginal foster or adoptive homes, or who for other reasons have had virtually no exposure to Aboriginal culture (Waldram, 1997). Therefore, each community will experience and define the therapeutic process in a way that is appropriate. The process needs to be grounded within the community it serves.

However, culture in general, plays a role in the assessment of risk and safety and merits attention. Previous research on risk and safety identified factors to consider. Although they are all important, additional factors should be considered in assessment, such as "residential school experience" and "Elder involvement" when working with Aboriginal families. These cultural factors, when present and appropriate, can add to our understanding of IPV risk and safety for Aboriginal couples. These factors themselves should be more rigorously studied to create a more complete picture of risk and safety for Aboriginal families.

The findings of this study also have implications for counselling with Aboriginal couples for IPV. Although attention to cultural factors was not always at the forefront of service providers' responses, results emphasized that culturally appropriate interventions should be used. The consistency between participants' responses and the existing literature supports the use of these factors with Aboriginal clients, but additional responses by participants not in the literature can be considered to reflect the cultural components of risk and safety that should also be considered. Counsellors and therapists need to build the therapeutic process on these factors and recognize that cultural identity is an essential part of healing. Application of this knowledge can improve the type of conjoint therapy offered to Aboriginal couples to promote well being and healing for couples and families as a whole.

## References

Alaggia, R., & Vine, C. (2006). *Cruel but not unusual: Violence in Canadian families.* (pp. 1-522). Waterloo, ON: Wilfrid Laurier University Press.

American Psychological Association Presidential Task Force Violence Family. (1996). *Violence and the Family: Report of the American Psychological Association Presidential Task Force on Violence and the Family.* Washington, DC: American Psychological Association.

Babcock, J. C., & La Taillade, J. J. (2000). Evaluating interventions for men who batter. In J. Vincent & E. N. Jouriles (Eds.), *Domestic violence: Guidelines for research-informed practice* (pp. 37–77). London: Jessica Kingsley.

Bain, P. (2006). *Aid for Safety Assessment Planning*. BC Injury Prevention Conference, March 2006. BC Institute Against Family Violence.

Barton, S., Thommasen, H., Tallio, B., Zhang, W., & Michalos, A. (2005). Health and quality of life of Aboriginal Residential school survivors, Bella Coola Valley*, **Social Indicators Research, 73***(2), 295–312.

Blashfield, R. K., & Aldenderfer, M. S. (1988). The Methods and Problems of Concept Analysis. In J. R. Nesselroade & R. B. Cattell (Eds.), *Handbook of Multivariate Experimental Psychology*, 2nd ed., (pp. 447– 473). New York: Plenum Press.

Bograd, M., & Mederos., F. (1995). Battering and couples therapy: Universal screening and selections of treatment modality. *Journal of Marital and Family Therapy, 25,* 291–312.

Briere, J., & Jordan, C. E. (2004). Violence against women: Outcome complexity and implications for assessment and treatment. *Journal of Interpersonal Violence, 19,* 1252-1276.

Browne, A. J. (2007). Clinical encounters between nurses and First Nations women in a Western Canadian hospital. *Social Science & Medicine, 64*, 2165–2176.

Brownson, R. C., Kelly, C. M., Eyler, A. A., Carnoske, C., Grost, L., Handy, S. L., et al.

(2008). Environmental and policy approaches for promoting physical activity in the United States: A research agenda. *Journal of Physical Activity & Health, 5*(4), 488-503.

Capaldi D. M., & Clark S. (1998). Prospective family predictors of aggression toward female partners for at-risk young men. *Developmental Psychology, 34*, 1175–88

Caplan, T. (2008). Needs ABC: Needs acquisition and behavior change - An integrative model for couples therapy. *Journal of Psychotherapy Integration, 18*(4), 421-436.

Castiglia, P. T. (1995). Family violence. *Journal of Pediatric Health Care, 9*(6), 269-271.

Cousineau, T., Houle, B., Bromberg, J., Fernandez, K. C., & Kling, W. C. (2008). A pilot study of an online workplace nutrition program: The value of participant input in program development. *Journal of Nutrition Education and Behavior*, *40*(3), 160-167.

Department of Justice Canada. (2009). Family Violence: Department of Justice Canada Overview Paper. Department of Justice Canada, Serving Canadians.

Dunford, F. (2000). The San Diego Navy experiment: An assessment of interventions for men who assault their wives. *Journal of Consulting and Clinical Psychology 68(3),* 468-476.

Durose, M. R., Harlow, C. W., Langan, P. A., Motivans, M., Rantala, R. R., & Smith, E. L. (2005). *Family violence statistics: Including statistics on strangers and acquaintances.* Washington, DC: U.S. Department of Justice.

Dutton, D. G., & Kropp, P. R. (2000). A review of domestic violence risk instruments. *Trauma, Violence, & Abuse, 1*(2), 171-181.

Epstein, N. B., Werlinich, C. A., La Taillade, J. J., Hoskins, L. H., Dezfulian, T., Kursch, M. K., et al. (2005, October). ***Couple therapy for domestic abuse: A cognitive-***

***behavioral approach***. Institute presented at the annual convention of the American Association for Marriage and Family Therapy, Kansas City, MO.

Fagan, J. A., Stewart, D. K., & Hansen, K. V. (1983). *Violent men or violent husbands? Background factors and situational correlates.* In The Dark Side of Families: Current Family Violence Research. D. Finkelhor, R. Gelles, G. Hotaling & M.A. Straus, (Eds). Sage. Beverly Hills, CA.

Fals-Stewart, W., & Clinton-Sherrod, M. (2009). Treating intimate partner violence among substance-abusing dyads: The effects of couples therapy. *Professional Psychology: Research Practice, 40*(3), 257-263.

Fals-Stewart, W., Kashdan, T. B., O'Farrell, T. J., Birchler, G. R. (2002). Behavioral couples therapy for drug abusing patients: effects on partner violence. *Journal of Substance Abuse Treatment, 22,* 87–96.

Fals-Stewart, W., & Clinton-Sherrod, M. (2009). Treating intimate partner violence among substance-abusing dyads: The effect of couples therapy. ***Professional Psychology: Research and Practice, 40***(3), 257-263.

Fals-Stewart, W., Kashdan, T. B., O'Farrell, T. J., & Birchler, G. R. (2002). Behavioral couples therapy for drug-abusing patients: Effects on partner violence. ***Journal of Substance Abuse Treatment, 22***(2), 87-96.

Fals-Stewart, W., & Kennedy, C. (2005). Addressing intimate partner violence in substance-abuse treatment. ***Journal of Substance Abuse Treatment, 29***(1), 5-17.

Fals-Stewart, W., Klostermann, K., & Clinton-Sherrod, M. (2009). Substance abuse and intimate partner violence. In K. D. O'Leary & E. M. Woodin (Eds.), ***Psychological and Physical Aggression in Couples: Causes and Interventions.*** (pp. 251- 269). Washington, DC, US: American Psychological Association.

Fals-Stewart, W., O'Farrell, T. J., Birchler, G. R., & Lam, W. (2009). Behavioral couples therapy for alcoholism and drug abuse. In J. H. Bray & M. Stanton (Eds.), ***The Wiley-Blackwell Handbook of Family Psychology.*** (pp. 388-401). Wiley-Blackwell.

xvi: 768 pp.

Foa, E., Cascardi, M., Zoellner, L. A., & Feeny, N. C. (2000). Psychological and environmental factors associated with partner violence. *Trauma, Violence & Abuse, 1,* 67-91.

Gauthier, M. (2010). *The impact of the residential school, child welfare system and intergenerational trauma upon the incarceration of Aboriginals*. Thesis submitted to Queen's University, Kingston, ON. Canada.

Gayford, J. J. (1975). *Wife battering: a preliminary study of 100 cases*. Br. Med. J. 1, 194–197.

Golding, J. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence, 14,* 99-132.

Goldner, V., Penn, P., Sheinberg, M., & Walker, G. (1990). Love and violence: Gender paradoxes in volatiles attachments. *Family Process, 29*, 344–364.

Gone, J. P. (2010). Psychotherapy and traditional healing for American Indians: Exploring the prospects for therapeutic integration. *The Counseling Psychologist*, ***38***(2), 166-235.

Hamberger, L. K., & Hastings, J. E. (1991). Personality correlates of men who batter and nonviolent men: some continuities and discontinuities. *Journal of Family Violence, 6,* 131-147.

Hart, S. D. (1990). *Assessing whether batterers will kill.* Reading, PA: Pennsylvania

Coalition Against Domestic Violence.

Hart, S. D. (2001). Assessing and managing violence risk. In K. S. Douglas, C. D., Webster, S. D., Hart, D., Eaves, & J. R. P. Ogloff (Eds.), *HCR-20 violence risk management companion guide* (pp. 13-25). Burnaby, Canada: Simon Fraser University, Mental Health, Law, & Policy Institute and University of South Florida, Florida Mental Health Institute, Department of Mental Health Law and Policy.

Hathaway, J. E., Mucci, L. A., Silverman, J. G., Brooks, D. R., Mathews, R., & Pavlos, C. A. (2000). Health status and health care use of Massachusetts women reporting partner abuse. *American Journal of Preventative Medicine, 19,* 302-307.

Heilbron, C. L., & Guttman, M. A. (2000). Traditional healing methods with First Nations women in group counselling. ***Canadian Journal of Counselling, 34***(1), 3-13.

Heyman, R. E., & Neidig, P. H. (1997). Physical aggression couples treatment. In W. K. Halford, & H. J. Markman (Eds.), *Clinical handbook of marriage and couples interventions.* Halford: John Wiley & Sons.

Holtzworth-Munroe, A., Bates, L., Smutzler, N., Sandin, E. (1997). A brief review of the research on husband violence, part I: Maritally violent versus nonviolent men. *Aggression and Violent Behavior, 2*, 65–99.

Horwitz, S., Santiago, L., Pearson, J., & LaRussa-Trott, M. (2009). Relational tools for working with mild-to-moderate couple violence: Patterns of unresolved conflict & pathways to resolution. *Professional Psychology: Research and Practice, 40*(3), 249-256.

Hotaling, G. T., & Sugarman, D. B. (1986). An analysis of risk markers in husband to

wife violence: the current state of knowledge. *Violence Vict. 1*, 101-124.

Jory, B., & Anderson, D. (2000). Intimate justice, III: Healing the anguish of abuse and embracing the anguish of accountability. *Journal of Marital and Family Therapy, 23*, 399–420.

Jory, B., Anderson, D., & Greer, C. (1997). Intimate justice: Confronting issues of accountability, respect, and freedom in treatment for abuse and violence. *Journal of Marital and Family Therapy, 23*, 399–415.

Jouriles, E. N., McDonald, R., Norwood, W. D., & Ezell, E. (2001). Issues and controversies in documenting the prevalence of children's exposure to domestic violence. In S. A. Graham-Bermann & J. L. Edleson (Eds.), ***Domestic Violence in the Lives of Children: The Future of Research, Intervention, and Social Policy***. Washington, DC: American Psychological Association.

Kane, M., & Trochim, W. M. (2007). *Concept mapping for planning and evaluation.* (pp.1-200). California: Sage Publications, Inc.

Kaslow, J. K., Bhaju, J., & Celano, M. P. (2011). Family Therapies. In S. Messer & A. Gurman (Eds.), *Essential psychotherapies: Theory and practice* (3rd ed.) (p.297-344). New York: Guildord Press.

Kerr, D. C. R., & Capaldi, D. M. (2011). Young men's intimate partner violence and relationship functioning: Long-term outcomes associated with suicide attempt and aggression in adolescence. ***Psychological Medicine, 41***(4), 759-769.

Kirmayer, L. J., Brass, G. M., & Tait, C. L. (2000). The mental health of Aboriginal peoples: Transformations of identity and community. *Canadian Journal of Psychiatry, 45*(7), 607-616.

Klostermann, K., Kelley, M., Mignone, T., Pusateri, L., & Fals-Stewart, W. (2010).

Partner violence and substance abuse: Treatment interventions. *Aggression & Violent Behavior, 15,* 162-166.

Kropp, P. R. (2008). Intimate partner violence risk assessment and management. *Journal of Violence and Victims, 23*(2), 202-220.

Kropp, P. R., Hart, S. D. Webster, C. W., & Eaves, D. (1998). *Spousal Assault Risk Assessment User's Guide.* Toronto: Multi-Health Systems, Inc.

Laforme, H. (2005). The justice system: Does it work for Aboriginal people. *Indigenous Law Journal, 4.* Retrieved on December 20th, 2012, from http://www.indigenouslawjournal.org/node/62

LaTallaide, J. J., Epstein, N. B., & Werlinich, C. A. (2006). Conjoint treatment of intimate partner violence: A cognitive behavioral approach. *Journal of Cognitive Psychotherapy: An International Quarterly, 20*(4), 393-410.

Lawson, D. M. 2003. Incidence, explanations, and treatment of partner violence. *Journal of Counseling and Development, 81*(1), 19–33.

Madsen, C., Stith, S. M., Thomsen, C. & McCollum, E. E. (2010). Therapy-seeking violent couples. Unpublished paper.

Martel, J., & Brassard, R. (2008). Painting the prison 'red': Constructing and experiencing Aboriginal identities in prison, *British Journal of Social Work, 38*, 340–361.

McCollum, E. E., & Stith, S. M. (2008). Couples treatment for interpersonal violence: A review of outcome research literature and current clinical practices. ***Violence and Victims, 23***(2), 187-201.

McHugh, M. C., & Frieze, I. H. (2006). Intimate partner violence: New directions. *Annals of the New York City Academy of Sciences, 1087*(1), 121-141.

Menzie, P. (2006). Intergenerational trauma and homeless Aboriginal men. *Canadian Review of Social Policy, 58,* 1–24.

Millar, A. (2009). *Inventory of Spousal Violence Risk Assessment Tools Used in Canada*. Department of Justice Research & Statistics Division, Government of Canada.

Murphy, C. M., & Eckhardt, C. I. (2005). *Treating the abusive partner: An individualized cognitive-behavioral approach.* New York: Guilford.

Newhouse, D., & Peters, E. (2001). *Not strangers in these parts: Urban Aboriginal Peoples*. Policy Research Initiative: Government of Canada.

Nuttgens, S. A., & Campbell, A. J. (2010). Multicultural Considerations for Counselling First Nations Clients/Considérations multi-culturelles dans le counseling de clients des Premières nations. *Canadian Journal of Counselling/Revue Canadienne de Counseling, 44*(2), 115–129.

Oetzel, J. & Duran, B. (2004). Intimate partner violence in American Indian and/or Alaska Native communities: A social ecological framework of determinants and interventions. *American Indian and Alaska Native Mental Health Research, 11*(3), 49-68.

O'Farrell, T., & Fals-Stewart, W. (2002). Behavioral couples and family therapy for substance abusers. *Current Psychiatry Reports, 4*(5), 371-376.

O'Farrell, T. J., Murphy, C. M., Stephan, S. H., Fals-Stewart, W., Murphy, M. (2004). Partner violence before and after couples-based alcoholism treatment for male alcoholic patients: the role of treatment involvement and abstinence. *Journal of Consulting and Clinical Psychology, 72,* 202–217.

O'Farrell, T. J., & Choquette, K. (1991). Marital violence in the year before and after spouse-involved alcoholism treatment. ***Family Dynamics of Addiction Quarterly,***

*1*(1), 32-40.

O'Farrell, T. J., & Fals-Stewart, W. (2006). ***Behavioral couples therapy for alcoholism and drug abuse***. New York, NY, US: Guilford Press.

O'Farrell, T. J., & Murphy, C. M. (2002). Behavioral couples therapy for alcoholism and drug abuse: Encountering the problem of domestic violence. In C. Wekerle & A. M. Wall (Eds.), ***The violence and addiction equation: Theoretical and clinical issues in substance abuse and relationship violence.*** (pp. 293-303). New York, NY, US: Brunner-Routledge.

O'Farrell, T. J., Murphy, C. M., Stephan, S. H., Fals-Stewart, W., & Murphy, M. (2004). Partner Violence Before and After Couples-Based Alcoholism Treatment for Male Alcoholic Patients: The Role of Treatment Involvement and Abstinence. ***Annual Meeting of the Association for the Advancement of Behavior Therapy, Nov 2000, New Orleans, LA, US; Portions of this research were presented at the aforementioned conference, 72***(2), 202-217.

O'Leary, K. D., Heyman, R. E., & Neidig, P. H. (1999). Treatment of wife abuse: A comparison of gender-specific and conjoint approaches. *Behavior Therapy, 30*, 475-505.

Perez, S., & Johnson, D. M. (2008). PTSD compromises battered women's future safety. *Journal of Interpersonal Violence, 23*(5), 635-651.

Petrucci, C. J., & Quinlan, K. M. (2007). Bridging the research-practice gap: Concept mapping as a mixed methods strategy in practice-based research and evaluation. *Annual Society for Social Work Researchers Conference*, Jan 2005, 34(2), 25-42.

Richardson, C., & Nelson, B. (2007). A change of residence: Government schools and foster homes as sites of forced Aboriginal assimilation – A paper designed to

provoke thought and systemic change, ***First People's Child and Family Review, 3,*** 75–83***.***

Riggs, D. S., Caulfield, M. B., & Street, A. E. (2000). Risk for domestic violence: Factors associated with perpetrations and victimization. *Journal of Clinical Psychology, 56*(10), 1289-1316.

Roach, K., & Rudin, J. (2000). Gladue: The judicial and political reception of a promising decision. ***Canadian Journal of Criminology, 355***, 369–372.

Roberts, A. R. (1987). Psychosocial characteristics of batterers: a study of 234 men charged with domestic violence offenses. *Journal of Family Violence, 2*, 81-93.

Rosen, K. H., Matheson, J. L., Smith, S. McCollum, E. E., & Locke, L. D. (2003). Negotiated time-out: A de-escalation tool for couples. ***Journal of marital and family therapy, 29***(3), 291-298.

Royal Commission on Aboriginal People. (1996). ***Report of the royal commission of Aboriginal people.*** Ottawa, Ontario. Minister of Supply and Services, Canada.

Snow, A. (1999). *Residential School trauma: A dynamic study of issues, their effects, and resolution.* Saskatoon: Native Mental Health Association of Canada.

Sonkin, D. (1988). The male batterer: Clinical and research issues. *Journal of Violence and Victims, 3*(1), 65-79.

Stith, S. M., & McCollum, E. E. (2009). K. H. Rosen: In memoriam. ***Journal of marital and family therapy, 35***(1), 1-2.

Stith, S. M., & McCollum, E. E. (2009). Couples treatment for psychological and physical aggression. In K. D. O'Leary & E. M. Woodin (Eds.), ***Psychological and physical aggression in couples: Causes and interventions.*** (pp. 233-250). Washington, DC, US: American Psychological Association.

Stith, S. M., McCollum, E. E., Rosen, K. H., & Locke, L. D. (2002). Multicouple group therapy for domestic violence. In F. W. Kaslow (Ed.), ***Comprehensive handbook of psychotherapy: Integrative/eclectic, 4.*** (pp. 499-520). Hoboken, NJ, US: John Wiley & Sons Inc.

Stith, S. M., McCollum, E. E., Rosen, K. H., Locke, L. D., & Goldberg, P. D. (2005). Domestic Violence-Focused Couples Treatment. In J. L. Lebow (Ed.), ***Handbook of clinical family therapy.*** (pp. 406-430). Hoboken, NJ, US: John Wiley & Sons Inc.

Stith, S. M., & Rosen, K. H. (1990). Family therapy for spouse abuse. In S. M. Stith, M. B. Williams & K. H. Rosen (Eds.), ***Violence hits home: Comprehensive treatment approaches to domestic violence.*** (Vol. 19, pp. 83-101). New York, NY, US: Springer Publishing Co.

Stith, S. M., & Rosen, K. H. (1990). Overview of domestic violence. In S. M. Stith, M. B. Williams & K. H. Rosen (Eds.), ***Violence hits home: Comprehensive treatment approaches to domestic violence.*** (Vol. 19, pp. 1-21). New York, NY, US: Springer Publishing Co.

Stith, S. M., Rosen, K. H., & McCollum, E. E. (2002). Domestic violence. In D. H. Sprenkle (Ed.), ***Effectiveness research in marriage and family therapy.*** (pp. 223-254). Alexandria, VA, US: American Association for Marriage and Family Therapy.

Stith, S. M., Rosen, K. H., & McCollum, E. E. (2002). Developing a manualized couples treatment for domestic violence: Overcoming challenges. ***Journal of marital and family therapy, 28***(1), 21-25.

Stith, S. M., Rosen, K. H., & McCollum, E. E. (2003). Effectiveness of couples treatment for spouse abuse. ***Journal of marital and family therapy, 29***(3), 407-426.

Stith, S. M., Rosen, K. H., McCollum, E. E., & Thomsen, C. J. (2004). Treating Intimate Partner Violence Within Intact Couple Relationships: Outcomes of Multi-Couple versus Individual Couple Therapy. ***International Family Violence Research Conference, 7th, Portsmouth, NH, US; An earlier version of this manuscript was presented at the aforementioned conference., 30***(3), 305-318.

Stith, S. M., Williams, M. B., & Rosen, K. H. (1990). ***Violence hits home: Comprehensive treatment approaches to domestic violence*** (Vol. 19). New York, NY, US: Springer Publishing Co.

Stith, S., & McCollum, E. (2011). Conjoint treatment of couples who have experienced intimate partner violence. *Aggression & Violent Behavior, 16*(4), 312-318.

Stith, S. M., McCollum, E. E., Rosen, K. H., & Locke, L. D. (2002). Multicouple group treatment for domestic violence. In F. Kaslow (Ed.), *Comprehensive handbook of psychotherapy: Integrative/eclectic*, (pp. 449-520). Hoboken, NJ, US: John Wiley & Sons Inc.

Stith, S., Rosen, K., McCollum, E, & Thomsen, C. (2004). Treating intimate partner violence within intact couple relationships: Outcomes of multi-couple versus individual couple therapy. *Journal of Marital and Family Therapy, 30*(3), 305-318.

Stonefish, B. (2007). ***Moving beyond: Understanding the impacts of the Residential School.*** Owen Sound, Ontario: Ningwakwe Learning Press.

Straus, M. A. (1999). The controversy over domestic violence by women: A methodological, theoretical, and sociology of science analysis. In X. B. Arriaga, & S. Oskamp (Eds.), *Violence in intimate relationships*, Thousand Oaks: Sage.

Strauss, M. A. (2004). Prevalence of violence against dating partners by male and female

university students worldwide. *Journal of Violence Against Women, 10*(7), 790-811.

Stuart, G. L., O'Farrell, T. J., & Temple, J. R. (2009). Review of the association between treatment for substance misuse and reductions in intimate partner violence. *Substance Use & Misuse. Special Issue: Substance Misuse and Aggression, 44*(9-10), 1298-1317.

Swogger, M., Walsh, Z., Kosson, D., Cashman-Brown, S., & Caine, E. (2012). Self-reported childhood physical abuse and perpetration of intimate partner violence: The moderating role of psychopathic traits. ***Criminal Justice and Behavior, 39***(7), 910-922.

Tolan, P., Gorman-Smith, D., & Henry, D. (2006). Family violence. *Annual Review of Psychology, 57*(1), 557-583.

Trochim, W. M. (1989). An introduction to concept mapping for planning and evaluation. In W. Trochim (Ed.) *A Special Issue of Evaluation and Program Planning, 12*, 1-16.

Waldram, J. B. (1997). *The way of the pipe: Aboriginal spirituality and symbolic healing in Canadian prisons*. Toronto: Broadview Press.

Walker, L. E. A. (1979). *The battered woman*. New York: Harper and Row.

Weetra, C., Cheers, B. Binell, M., Miller, G. Coleman, H., & Taylor, J. (2006). Family violence: An Australian Indigenous community tells its story. *International Social Work, 49*(1), 51-63.

Wesley-Esquimaux, C. C., & Smolewski, M. (2004). *Historic trauma and Aboriginal Healing*. Ottawa: The Aboriginal Healing Foundation.

Whitaker, D. J., Haileyesus, T., Swahn, M., & Saltzman, L. S. (2007). Differences in

frequency of violence and reported injury between relationships with reciprocal and nonreciprocal intimate partner violence. *American Journal of Public Health, 97*(5), 941–947.

White, S. O., & Straus, M. A. (1981). The implications of family violence for rehabilitation strategies. In S. E. Martin, L. E. Sechrest, & R. Redner, (Eds.), *New directions in the Rehabilitation of Criminal Offenders* (pp. 103–129). National Academy of Sciences. Washington, DC.

Willmon-Haque, S., & BigFoot, S. D. (2008). Violence and the effects of trauma on American Indian and Alaska Native population. *Journal of Emotional Abuse, 8*(1-2), 51-66.

Wofford, S., Elliott, D., & Menard, S. (1994). Continuities in marital violence. *Journal of Family Violence, 9*(3), 195–225.

Yellow Horse Brave Heart, M., & DeBruyn, L. M. (1998). The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health, 8*(2), 56–79.

York, G. (1990). ***The dispossessed, life and death in native Canada***. Little Brown and Company (Canada) Limited. Toronto, Ontario.

Zolotor, A. J., Denham, A. C., & Weil, A. (2009). Intimate partner violence. ***Primary Care, 36***(1), 167.

**Supporting the family circle: Couple counselling and family violence**

Researchers with Aboriginal Consulting Services Association of Alberta and the University of Western Ontario are conducting a study on the topic of intimate partner violence.

We are conducting telephone interviews with professionals in who are working in the area of treatment for intimate partner violence.

The purpose of the study is to identify important considerations for professionals providing service to Aboriginal couples.

We will collect the data over the next 6 months by phone, with the intent of having the study completed by the spring of 2012.

Participation is strictly voluntary and all information collected will be kept confidential.

If you have any questions, or are interested in participating, please contact any of the following members of the research team:

Jason Brown, University of Western Ontario,

Sue Languedoc, Aboriginal Consulting Services,

Ellissa Riel, Research Assistant(s)
xxx@uwo.ca
xxx@uwo.ca

**Supporting the family circle: Couple counselling and family violence**

LETTER OF INFORMATION* (Phase 1)

***Will be read to potential participants over the telephone.**

**Introduction**

My name is _____ and I am a Graduate Research Assistant at the Faculty of Education at The University of Western Ontario. I am working on a research study with Sue Languedoc, Executive Director of Aboriginal Consulting Services Association of Alberta and Jason Brown, Associate Professor at the University of Western Ontario.

**Purpose of the study**
The purpose of the study is to identify important considerations for professionals providing service to Aboriginal couples.

**If you agree to participate** in this study you will be asked to participate in a 30-60 minute telephone interview at a time that is convenient for you. During the interview you would be asked for your ideas about couple counselling for intimate partner violence.

At the end of the interview, I will ask you if you are interested in helping us group the results together after all of the interviews are finished. If you are interested, I will get your contact information and follow up with you in about 8 weeks. That part of the study will take about 20 minutes for the telephone call and about 60 minutes to group the results.

**Confidentiality**
Direct quotes from the first telephone interview will be used in the second part of the study, but WILL NOT include identifying (i.e. names or locations) information. The information collected will be used for research purposes only, and neither your name nor information which could identify you will be used in any publication or presentation of the study results. All information collected for the study will be kept confidential. No names will be used in the report.

**Risks & Benefits**
There are no known risks to participating in this study.

**Voluntary Participation**
Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your status as a staff member.

**Questions**

If you have any questions about the conduct of this study or your rights as a research participant you may contact the Manager, Office of Research Ethics, The University of Western Ontario. If you have any questions about this study, please contact Dr. Jason Brown.

**Supporting the family circle: Couple counselling and family violence**

CONSENT* (Phase 1)

***Will be read to potential participants over the telephone.**

Has the nature of the study been explained to you?

Have all questions have been answered to your satisfaction?

Do you agree to participate?

> Response to the questions that follow will be considered evidence of consent.

**Supporting the family circle: Couple counselling and family violence – Questionnaire (Phase 1)**

---

1) **How would you address <u>eligibility</u> with Aboriginal men in couple counselling who use abusive behaviour with their intimate partner?** (sample probes: who gets in? who doesn't get in?)

---

2) **How would you address <u>risk</u> with Aboriginal men in couple counselling who use abusive behaviour with their intimate partner?** (sample probes: how assessed? what is acceptable?)

---

3) **How would you address <u>safety</u> with Aboriginal men in couple counselling who use abusive behaviour with their intimate partner?** (sample probes: what measures need to be in place to protect female partners?)

---

4) **How would you address <u>approach</u> with Aboriginal men in couple counselling who use abusive behaviour with their intimate partner?** (sample probes: individual, group, couple, combined?)

---

5) **How would you address <u>content</u> with Aboriginal men in couple counselling who use abusive behaviour with their intimate partner?** (sample probes: Western, traditional, what concepts, what skills?)

---

6) **How would you address <u>activities</u> with Aboriginal men in couple counselling who use abusive behaviour with their intimate partner?** (sample probes: how does it get done, didactic, experiential, ceremonial?)

---

7) **How would you address <u>monitoring</u> with Aboriginal men in couple counselling who use abusive behaviour with their intimate partner? (sample probe:** how is non-violence followed?)

---

8) **How would you address <u>follow-up</u> with Aboriginal men in couple counselling who use abusive behaviour with their intimate partner?** (sample probes: what contact, services, when, after treatment?)

---

---

Demographics:

Sex (circle one): Female, Male

Age: _____

Years of Experience _____

Current Position _____

The second part of the study involves grouping together the responses from the first part. If you agree to participate in second part you will be asked to group together responses to questions from the first interview. We will mail a copy of all responses and ask you to group them together in any way that makes sense to you. We will follow up with you by telephone after the package has arrived to answer any questions you might have, and also arrange a time to call you back to get your responses over the telephone.

Can we contact you to help us with the second part of the study (group the statements)? Yes / No

If yes, ask "May we keep your name and telephone number on record and contact you again when we are ready to start the grouping task"? Your name and telephone number will be kept confidential, and your responses in the grouping task will be anonymous.

<u>All contact information is to be recorded on a separate sheet.</u>

- - - - - - - - - - - - - - - - - - - - - - -- - - -- -DETATCH - - - - - - - - - - - - - - - - - - - - - - - - -

**Sorter Information**

Name: _____

Telephone Number: _____

**Mailing Instructions**

Address: _____

_____

**Supporting the family circle: Couple counselling and family violence**

LETTER OF INFORMATION* (Phase 2)

***Will be read to potential participants over the telephone.**

**Introduction**
My name is _____ and I am a Graduate Research Assistant at the Faculty of Education at The University of Western Ontario. I am working on a research study with Sue Languedoc, Executive Director of Aboriginal Consulting Services Association of Alberta and Jason Brown, Associate Professor at the University of Western Ontario. We had been in contact with you before about this same study, and you were interviewed. At that time, you had indicated that you were willing to be contacted to participate in the next part of the study. That is the reason for my call.

**Purpose of the study**
The purpose of the study is to identify important considerations for professionals providing service to Aboriginal couples. In this second part, we will ask you to group together all of the responses made to the questions from the previous interviews.

**If you agree to participate** in this part of the study you will be asked to group together responses to questions from the first interview. We recently mailed a copy of all responses and asked you to group them together in any way that makes sense to you. We are now following up with you by telephone after the package has arrived to answer any questions you might have, and also arrange a time to call you back to get your responses over the telephone. The telephone call will take approximately 20 minutes.

**Confidentiality**
The information collected will be used for research purposes only, and neither your name nor information which could identify you will be used in any publication or presentation of the study results. All information collected for the study will be kept confidential. No names will be used in the report.

**Risks & Benefits**
There are no known risks to participating in this part of the study.

**Voluntary Participation**
Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your employment status.

**Questions**

If you have any questions about the conduct of this study or your rights as a research participant you may contact the Manager, Office of Research Ethics, The University of Western Ontario. If you have any questions about this study, please contact Dr. Jason Brown.

**Supporting the family circle: Couple counselling and family violence**

CONSENT* (Phase 2)

***Will be read to potential participants over the telephone.**

Has the nature of the study been explained to you?

Have all questions have been answered to your satisfaction?

Do you agree to participate?

> Completion of the grouping task will be considered evidence of consent.

**Grouping Task Instructions (Phase 2)**

UWO Letterhead

Date _____

Dear Participant,

I understand that you have recently talked to _____ (Research Assistant), who is assisting us with a research project, and have agreed to group responses to the interview questions. I want to thank you for your help with this project. Your continued participation is strictly voluntary and your responses will be kept confidential. In this package you will find small bundles of paper in different colors. Each color is for a different question. The colors should not be mixed together. A different response is written on each slip of paper. The responses are printed separately so that you can move them around and group them into piles in whatever way makes sense to you. I find it easiest to do this using a large table so I can spread the responses out, and then move them together into piles. Please use all of the responses. You can have as many or as few piles as you want.

You will also find blank forms in this package. Use the form that is the same color as the responses. Write the numbers of the responses that you grouped together. Give them names if you wish.

For example:

> Pile 1 included responses 23, 45, 73, 12 & 24, and was called "understand each other"
>
> Pile 2 included responses 3, 2, 67, 56 & 35, and was called "difficulty following rules"
>
> ....and so on, until you have used up all of the responses

_____ (Research Assistant) will call you back in a week to answer any questions you have. Please do not hesitate to call us at _____ any time or via email, if you want more information. We would like to get your responses over the telephone, if possible. _____ (Graduate Research Assistant) will arrange that with you when she calls.

Sincerely,
Jason Brown,
Associate Professor

| **Pile** | **Label** | **Statement** |
|---|---|---|

| | **(optional)** | **Numbers** |
|---|---|---|
| **1** | | |
| **2** | | |
| **3** | | |
| **4** | | |
| **5** | | |
| **6** | | |
| **7** | | |
| **8** | | |
| **9** | | |
| **10** | | |
| **11** | | |
| **12** | | |

*please use back of sheet if necessary

# ELLISSA MARIE RIEL

CURRICULUM VITAE

**EDUCATION:**

**Master of Education in Counselling Psychology** The University of Western Ontario, London, ON. Sept 2011-Apr 2013

- Master's Thesis: Conjoint therapy for intimate partner violence among Aboriginal couples: Service providers' perspectives on risk and safety, supervised by Jason Brown, Ph.D., C.Psych, R.S.W.

**Bachelor of Arts - Honors Psychology** St. Francis Xavier University, Antigonish, NS. Sept 2006-Apr 2010

- Undergraduate Thesis: Work-related stress among Correctional staff: Does coping style influence the impact of stress? Supervised by Margo Watt, Ph.D., C.Psych.

**ACADEMIC AWARDS:**

- Ontario Graduate Scholarship valued at $15, 000

(May 2012-Apr 2013) Ministry of Training, Colleges and Universities (accepted)

- Western Heads East Internship Travel Bursary (Kenya) valued at $6, 500

(May 2012-Aug 2012) Canadian International Development Association (CIDA) through the University of Western Ontario

- St. Francis Xavier University Entrance Scholarship valued at $1, 000

(Sept 2006) St. Francis Xavier University

**POSTER PRESENTATIONS:**

Riel, E. M. (2010) Work-related stress among Correctional staff: Does coping style influence the impact of stress? Poster presented at Student Research Day, St. Francis Xavier University, Antigonish, NS

**RESEARCH EXPERIENCE:**

Research Assistant — Sept 2011-May 2012
*Dr. Jason Brown, University of Western Ontario* — London, ON

**CLINICAL EXPERIENCE:**

**Counselling Children & Families** — Sept 2012-Present
*Madam Vanier Children Services* — London, ON

**Group Counsellor/Co-facilitator** — Jan 2013-Present
*Children's Aid Society* — London, ON

**Group Counsellor/Co-facilitator** Sept 2012-Dec 2012
*Madam Vanier Children Services* London, ON

**Supervised Clinical Practicum (14 weeks)** May 2010-Sept 2010
*Dr. Frank Kane, Kingston Penitentiary* Kingston, ON

**RELATED PROFESSIONAL EXPERIENCE:**

**Programs Assistant** June 2011-Sept 2011
*Kingston Penitentiary, Correctional Service Canada*

**Psychology Testing Assistant** May 2010-Aug 2010
May 2009-Aug 2009
*Kingston Penitentiary, Correctional Service Canada* Kingston, ON

**Canadian International Development Association Intern** May 2012-Aug 2012
*Western Heads East, University of Western Ontario* Kenya, Africa

**Special Needs Camp Counsellor/Respite Worker** June 2008-Aug 2008
June 2007-Aug 2007
*Extend-A-Family Summer Camp & Respite Program* Kingston, ON