

***Ending Spouse/Partner Abuse:  
A Psychoeducational Approach  
for Individuals and Couples***

**Robert Geffner, Ph.D., ABN, ABPP**

Licensed Psychologist and Licensed Marriage & Family  
Therapist

Diplomate Clinical Neuropsychology, and Family Psychology

President, Family Violence & Sexual Assault Institute

President, Institute on Violence, Abuse and Trauma,

Alliant International University, San Diego

10065 Old Grove Rd., San Diego, CA 92131

(858) 527-1860 x 4050

Fax (858) 527-1743

email: bgeffner@pacbell.net

**Presentation Outline:**

- **Current Research Concerning IPV Offenders**
- **A Bioecological/Biopsychosocial Framework**
- **Readiness for Change, Motivational Interviewing, and Empowerment**
- **Types of Intervention Approaches**
- **Abuse Specific Couples Approach**
- **Treatment Techniques for IPV Offenders**

**What Issues Do You Address/Ask  
About During Intake or  
Assessment With The Offender?**

**What Information Do You Want  
From The Victims ?**

**What Are The Main Issues You/Your  
Program Address in Treatment of  
DV Offenders?**

**Do You Address/Ask About  
Trauma and Attachment Issues  
During Intake or Assessment With  
The Offender or the Victim?**

**How?**

**Do You Address Attachment  
and Trauma Issues in Your  
Treatment of IPV Offenders or  
Victims?**

## ISSUES/QUESTIONS

1. Who is the primary/dominant aggressor in the relationship?
2. Past victimization/trauma/abuse?
3. Depression history?
4. Relationship history?
5. Emotional expressiveness?
6. Issues of child abuse and parenting?
7. Conflict management styles?
8. Neuropsychological impairment?
9. Substance abuse/dependence history?
10. Attachment issues?
11. Motivation to change/accept responsibility?

## DIFFERENT TYPES OF MALE BATTERERS

Assaultive Type	Characteristics
Family Only	High dependency on partner Low levels of impulsivity Poor communication skills Family of origin violence

## DIFFERENT TYPES OF MALE BATTERERS

Dysphoric/ Borderline	Parental rejection Child abuse ( <i>family of origin violence</i> ) High dependency on partner Poor communication Poor social skills Hostile to women Low remorse
--------------------------	---

## DIFFERENT TYPES OF MALE BATTERERS

Low Level Antisocial	Antisocial behaviors but not at level of personality disorder; substance abuse often present
Generally Violent/ Antisocial	Family-of origin violence Juvenile delinquency Deficits in communication, social skills Violence viewed as appropriate response to provocation

Adapted from Holtzworth-Munroe and colleagues, 2001-2002

## **Recidivism by disposition**

<b>Arrest only</b>	<b>33.2%</b>
<b>Probation only</b>	<b>36.1%</b>
<b>Incarceration</b>	<b>56.7%</b>
<b>Certified BIP</b>	<b>35.1%</b>
<b>Counseling unspecified</b>	<b>47.4%</b>
<b>Treatment non-completers</b>	<b>67.6%</b>

**Summarized by Rosenbaum, 2004**

## **What does it mean?**

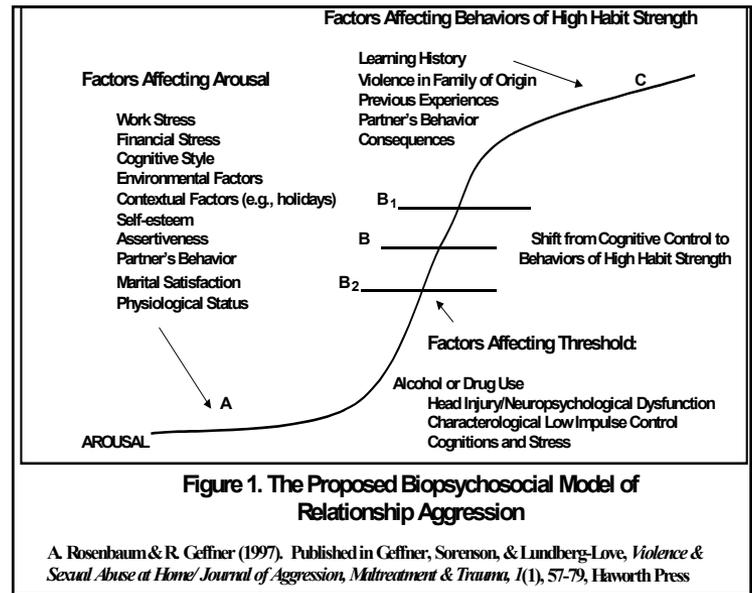
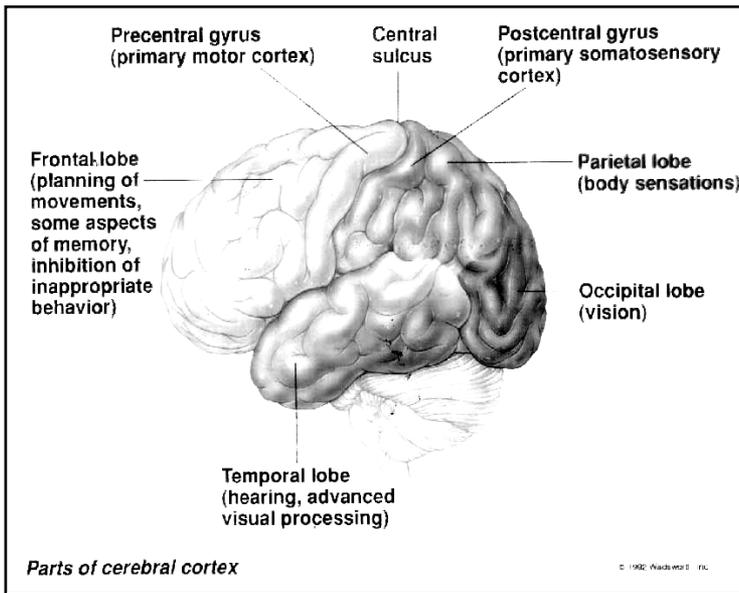
**The largest single category consists of batterers who are arrested and charges are dropped**  
**Incarcerated batterers have high recidivism rates**  
**Treatment non-completers had the highest recidivism rates**

## **ALCOHOL/DRUG USE ABUSE AND DOMESTIC VIOLENCE**

**Treatment for alcohol or drug problems must occur prior to or currently with the treatment for battering. There is no evidence that alcohol treatment by itself will be effective in changing abusive behaviors - however alcohol and drug problems most likely seriously interfere with the process of change and must be addressed.**

## **Executive Function Issues/Deficits for Offenders and Victims of Family Violence: A Biopsychosocial Approach**

**General organization and planning**  
**Ability to solve problems**  
**Regulation of activity/Impulsivity**  
**Learned aggression, power and control**  
**Low threshold for frustration/stress**  
**Closed head injuries or other neuropsychological impairments**



## Processes of Change

### HOW people change

Affective, Cognitive, and Behavioral strategies and techniques used to change attitudes, beliefs, & behaviors

Facilitate transitions between stages

Used as basis of intervention design

Adapted from Deborah Levesque, 2002

## Stages of Change (Transtheoretical Model)

Precontemplation

Contemplation

Preparation

Action

Maintenance

Termination

From Prochaska, J.O., DiClemente, C.C., & Norcross, C.C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*, 102-1127.

## Precontemplation Stage

**No intention to change in next 6 months**

**Cons > pros**

**Defensive**

**Resistant**

**Demoralized**

**Change experienced as coerced**

**About 40% of population at risk**

**From Deborah Levesque, 2003; 2007**

In the first stage, *precontemplation*, individuals with violent behaviors have no intention of changing and are likely in strong denial. *Contemplators* accept or realize that they have a problem with violence/abuse and begin to think seriously about changing it, but they have not made a commitment to take action in the near future. Individuals who are in the *preparation* stage are planning to take action within a short time period. They think more about the future than about the past, and more about the benefits of being non-violent than about the losses. *Action* is when the client is overtly expressing a genuine belief that violence/abuse is unacceptable and is actively utilizing the therapeutic interventions to change him/herself and the relationship. *Maintenance*, often far more difficult to achieve than action, can last a lifetime. Maintenance is a long, ongoing process. Three common internal challenges to maintenance are overconfidence, daily temptation, and self-blame for lapses.

## Contemplation Stage

**Intend to change next 6 months**

**Pros = cons**

**Ambivalent**

**Lack commitment**

**Lack confidence**

**'Chronic' contemplation**

**About 40% of population at risk**

## Preparation Stage

**Intend to change in next 30 days**

**Pros > cons**

**Have a plan**

**Have taken small steps**

**Decisive/committed**

**More confident**

**Ideal program participants**

**20% of population at risk**

## Action Stage

Overt change  
Greatest risk of relapse  
Inappropriate goals  
Inadequate preparation  
Not enough time  
Give up too easily

## Maintenance Stage

Relapse prevention  
Dynamic, not static  
Self-efficacy  
Consolidate gains  
Improve coping skills  
Life-long struggle

## Decisional Balance

- Pros of Change
  - perceived positive consequences
  - facilitators
- Cons of Change
  - perceived negative consequences
  - barriers

50

## Redefine Success

- Successful change takes time
- Don't expect immediate action
- Intermediate markers of success
  - Progress through stages of change
  - Increased Pros of change
  - Decreased Cons of change

51

# Motivational Interviewing

**Motivational Interviewing:** Miller & Rollnick, 2002)

**Step 1:** Building a Bond

**Step 2:** Gathering Information & Providing Feedback

**Step 3:** Summarizing & Reconnecting

52

# TREATMENT ISSUES

1. Who is the primary/dominant aggressor in the relationship?
2. Past victimization/traumatization/abusiveness.
3. Depression history.
4. Relationship histories.
5. Emotional expressions.
6. Issues of child abuse (women who are physically abused are twice as likely to abuse their children as women who are not assaulted; Straus, 1990) and parenting.
7. Conflict management styles.

# INTERVENTION PROCESS

## TREATMENT/AMELIORATION

- Reducing symptoms/effects (via medical, mental health, community based resources, education, judicial intervention as needed) based upon assessment
- Educational/community programs (parenting, support, etc.)

# TREATMENT MODALITY:

**INDIVIDUAL vs GROUP**  
**GENDER SPECIFIC vs**  
**COUPLES**  
**CONJOINT vs PARALLEL**  
**FIXED vs OPEN**  
**ENDED/ONGOING**

## **TREATMENT OBSTACLES IN DOMESTIC VIOLENCE TREATMENT**

The potential or possible clash between the legal system and the treatment system

The resistance to take responsibility for one's actions

Past history of abuser

Mental disorders

Financial and time concerns

From a systems perspective, dealing with only one part of a system, with often little or no attention given to the other part(s) of that system

## **THE STIGMA OF LABELING**

- For most perpetrators, the label of “Batterer” or “Stalker” is difficult to handle
- For the most part, they don't see themselves as these labels and there is a lot of resistance - which can create treatment obstacles if not dealt with relatively early in treatment
- Many of them have a difficult time with seeing themselves as stalkers because their intent was loving, protective, meant in a positive manner-they often have a difficult time understanding that their victim felt fear

## **Understanding Repeat Offenders & Barriers to Change: Implications for Batterer Intervention Programs**

Jesse L. MacLaurin and  
Robert Geffner, 2007

Institute on Violence, Abuse & Trauma, AIU

66

## **Focus of Inquiry**

What are the experiences of repeat offenders in terms of:

- Intimate Partner Violence
- Court-Mandated Treatment
- Barriers to Change

67

## **Repeat Offenders**

- Approximately 1/3 of batterers continue to engage in intimate partner violence
- Data show 10% of these men engage in the most severe violence (Dunford, 2000; Gondolf, 2002)
- Results seem to suggest:
  - **Arrest on its own is not working**
  - **Treatment on its own as now practiced is not working**
  - **Need for alternatives and options**

68

## **#1 Childhood Victimization**

- Severe, Frequent, & Cumulative
- Physical & Emotional Abuse and/or Neglect
- Harsh Physical Discipline
- Exposure to Domestic Violence

**From Jesse MacLauren, 2007**

69

## **#2 Early Attachment Trauma**

- **Chronic Loss or Separation**
- **Abandonment**
- **Deprivation and/or Rejection**

70

## **#3 Maladaptive Socialization**

- Dysfunctional Home
- Deviant Peer Association
- Antisocial Norms

71

## #4 Mental Health Problems

- Chronic or Acute
- Coping Competency Deficits
- Problematic Personality:  
Traits/Characteristics/Disorder
- Clinical Disorder/Diagnosis

72

## #5 Substance-Related Problems

- Early Onset/Chronic Use
- Family/Peer/Partner Use
- DV & Substance Use

73

## #6 Intimacy & Attachment Problems

- Early/Ongoing/Pervasive
- Aggressive Problem Solving
- Imbalance of Power
- Detached/Hostile  
Emotional Climate

74

## #7 Motivation Limitations

- Lack of Internal Motivation
- Lack of Prosocial Goal Orientation
- External Locus of Control
- Negative Attitude & Attributions
- Low Self-Efficacy
- Poor Self-Regulation

75

## #8 Readiness Limitations

- Early, Unchanged or Regressed Stage of Change:
  - **Precontemplation:** Defensive/Resistant
  - **Contemplation:** Immotiv
  - **Preparation:** Ambivalent
- Lack of Authentic Change Engagement:  
“Just going through the motions”

76

## #9 Treatment Need Deficits

- Lack of Comprehensive Care
- Lack of Collaborative Care
- Lack of Continuity of Care

77

## #10 Treatment Responsivity Deficits

- Failure to Relate
- Failure to Respond
- Failure to Resonate

78

## Potential Barriers to Change

- **One-Size-Fits-All-Approach**
- **Uncooperative/Unmotivated Batterers**
- **Too Little/Too Late**

79

## **COUPLES TREATMENT**

### **Arguments against doing couples treatment:**

Using a systemic framework involves placing blame and responsibility for the problem on all members of the relationship instead of placing responsibility for the violence on the violent partner.

Safety issues for the victim. It is often felt that the victim (usually female) may not be able to speak freely without fear of repercussions. In addition, the victim may be lulled into a feeling of safety and speak out in the therapeutic setting and then pay dearly for it later.

The violence may be escalated instead of stopped..

The truth: may not be told by either party.

The victim is not the one with the problem; the abuser is the one with the problem.

This can be seen as further victimizing the victim.

### **Arguments for doing couples treatment:**

Most couples stay together. They are going to need help to make it work, while still holding the abuser responsible for the violence.

It is difficult on a relationship when one person is changing and learning new healthier behaviors and the other person is still stuck doing the old unhealthy behaviors. In couple's treatment, both members of the couple are learning the new skills and can work on them together.

The therapeutic setting allows therapists a more accurate view of what happens in the relationship and adjustments/feedback can be done immediately.

The therapeutic setting may empower the victim to feel that there are ways of making the abuse stop, and that the abuser will be held accountable for abusive behavior.

The therapists can also model appropriate nonviolent behaviors and communication that can serve to reinforce these behaviors in the relationship. The victim and abuser can both learn that abuse is not acceptable behavior.

## **SOME PRECONDITIONS FOR CONJOINT COUPLES THERAPY**

The victim and perpetrator desire this type of treatment.  
The victim has a safety plan and understands the potential dangers.

An adult must accept responsibility if child abuse has occurred.

No custody issues if divorcing.

Lethality evaluation suggests low probability of danger.

The perpetrator does not harbor obsessional ideas toward the victim.

Therapists are trained in both family therapy and domestic violence.

Not currently abusing drugs or alcohol.

If there has been substance abuse, then treatment for this is required.

Neither partner exhibits psychotic behavior.

## **Treatment Modalities**

**Group Treatment**

**Individual/Conjoint/Family Therapy**

**Social Skills Development**

**Support Group for Protective Parenting**

**Family Therapy**

**School Based Services**

**After School-Recreational Activities**

**Community Resources**

## INTERVENTIONS

STRESS MANAGEMENT  
ANGER/AFFECT REGULATION  
IMPULSE CONTROL  
PSYCHOEDUCATION  
TRAUMA TREATMENT  
SUBSTANCE ABUSE TREATMENT  
COMMUNICATION & SOCIAL SKILLS  
EMPATHY TRAINING  
POSITIVE ROLE MODELS  
RELAPSE PREVENTION  
PARENTING

## Clinical Implications

- Integrated Treatment Approach
- Coordinated Service Delivery
- Trauma & Attachment Informed Treatment
- Comprehensive /Collaborative /Continuous Care
- Readiness Assessment & Treatment Matching
- Risk-Need-Responsivity Assessment & Matching
- Incorporation of Motivational Interviewing.

## Clinical Implications (Cont'd)

- Enhancing Interviews and Follow Ups
- Empathy Training Emphasis
- Avoid Confrontational Approach – Need to Connect More and Exhibit Caring
- Give Homework Assignments and Exercises
- Family Therapy If Have Children
- Conjoint Therapy if in a Relationship
- Supplemental Interventions
- Time-Oriented Treatment Not Working – Need Behavior and Attitude Based System

### Shame-Based System

- Attacks and condemns you as a person (which leads to negative painful feelings *about the self*)
- Presumes that you are bad/worthless/inadequate/defective/unlovable
- Presumes that you are not responsible for your feelings and actions through the use of psychological defenses such as blaming, denial, minimizing, and justifying
- Based on a system of perfectionism that breeds isolation, despair, fear, discouragement, and, ultimately, more shame

### Empowerment-Based System

- Evaluates and assesses your behavior (which may, at times, lead to negative painful feelings *about your actions*)
- Presumes that you are human, that you have “flaws” and problems, and that you will make mistakes at times
- Presumes that you are responsible for your thoughts, feelings, and actions (*and your inaction!*)
- Based on a system of accountability that leads to personal growth and a respect for your own and others’ rights

## Sequence of Questions – Eve Lipchik, MSW

### 1. Define problems and goals from clients' point of view

#### 2. Ask for exceptions to problem:

- When don't you or didn't you have this problem?...even a little bit?
- What is different at that time?
- What will have to be different for more of that to happen?
- How do you usually solve problems like this?
- What percentage of the time is this situation problematic as compared to not?
- To what degree would it have to change for you to feel things are tolerable?
- What would a small change towards that goal be?
- How would that make a difference for you? for others?
- What would you notice about yourself...others...what would they notice about you?

### IF THERE ARE NO EXCEPTIONS:

**Ask:** If a miracle happened tonight and you woke up tomorrow morning and your problem is solved, how would things be different? Describe from your point of view and that of others.

#### In response to clients' answer:

- Does some of that happen already at times? a little?
- What would have to happen for more of that to happen?

### 3. When clients are reluctant to offer positives or to stay with them:

- This may seem like a strange question, but do you think it is an advantage for you in some way to have this problem?

#### In response to clients' answer:

- How can you have that advantage without having to maintain this problem? What could you do instead?

### 4. When clients are very negative:

- How come things aren't worse? What have you done to keep them from being worse?

(If examples are given of positives, build on them as above)

#### If the client still remains negative:

- Explore in detail how the client imagines things will be at their worst ... for themselves ... for others.

**Then ask:** What is the smallest thing you think might make a difference?

## OBSTACLES IN IPV TREATMENT

The potential or possible clash between the legal system and the treatment system

The resistance to take responsibility for one's actions

Past history of abuser

Mental disorders

Financial and time concerns

From a systems perspective, dealing with only one part of a system, with often little or no attention given to the other part(s) of that system

## Good Therapeutic Techniques

1. Focus on Change, Not Blame
2. Establish Rapport; Use Humor When Appropriate
3. Set Up Model of Equality, Good Communication
4. At First, Don't Get into Details; Leads to Defensiveness
5. When in Denial, Ask About His/Her Story
6. Validate Feelings (e.g., How Uncomfortable Feels)
7. Help Feel in Control; Give Choices
8. Reframing – Move to Feelings or Solution Focus
9. Use Role Play, Demonstration, Homework

## Phase-Oriented Treatment

- Safety and Stabilization.
- Symptom Reduction
  - ◆Regulating emotion
  - ◆Processing trauma.
- Developmental skills.

## Stosny's Compassionate Approach to Treating Attachment Abuse

### Compassion and Self-Building



108

## EMPOWERMENT FORMULA

Stosny, 2006

Listen

Reflect

Validate Feelings

Respectfully State Disagreement with  
Idea or Problem with the Behavior

Ask for Input on Solutions

## Special Trauma Treatment Considerations

- Locus of Control
- Relationship Development
- Traumatic Reminders/PTSD
- Depression/Anger
- Separation, Grief and Loss
- Risk Taking Behaviors

110

## ENDING SPOUSE/PARTNER ABUSE: A PSYCHOEDUCATIONAL APPROACH FOR INDIVIDUALS AND COUPLES

Robert Geffner, Ph.D.

Family Violence & Sexual Assault Institute, San Diego, CA

With

Carol Mantooth, M.S.

Andrews Center, Tyler, TX

Springer, 2000

### TREATMENT OUTLINE

#### Foundations and Brief Interventions

1. Ground Rules and Assumptions; House of Abuse
2. Safety and Control Plans
3. Basic Anger Management
4. Effective Stress Control
5. Desensitization Techniques for Reducing Anxiety and Anger
6. Social Roots of Aggression and Alcoholism Issues

## Communicating and Expressing Feelings

7. Communication: "Fair Fighting, Dirty Fighting"
8. Communication: Rules and Barriers
9. Communication: Expression and Listening
10. Communication: Handling Criticism
11. Identification of Feelings
12. Emotional Awareness and Expressing Feelings

## Self-Management and Assertiveness

13. Dynamics of Self-Esteem
14. Improving Self-Esteem
15. Self-Talk and Irrational Beliefs
16. Changing Distorted Self-Talk
17. Stress Inoculation for Anger Control
18. Dynamics of Assertiveness
19. Becoming More Assertive

## **Intimacy Issues and Relapse Prevention**

- 20. Problem-Solving, Decision-Making, and Negotiation**
  - 21. Most Violent and/or Most Frightening Incident**
  - 22. Most Violent/Frightening Incident Continued**
  - 23. Intimacy and Love**
  - 24. Empathy Training and Role Reversals**
  - 25. Relapse Prevention Plans**
  - 26. Future Plans**
- Monthly Group Follow-Up Sessions**

## **THE WEAVER PROGRAM**

**Koonin, Devine, & Geffner**

- **Addresses female specific concerns-PMS, economic depression, conflict of roles, demands of life, family issues**
- **Addresses issues of parenting-very often there is child abuse going on in addition to the domestic violence**
- **Addresses victimization issues - from past abuse**
- **Addresses societal influences**
- **Addresses cultural influences**
- **Addresses alcohol/drug issues**
- **Deals with self-esteem and how violence/abuse is impacted by the lack of self-esteem**

## **Specific Techniques and Programs**

### **Modules and Order of Treatment for Couples vs Abuser Only**

**20-52 Week Sessions**

### **Examples of Techniques**

## **Anger: A Misunderstood Emotion**

**What is Anger**

**Anger Triggers Stress**

**Three Components of Anger**

**Anger in Relationships**

**Power and Control**

**Unproductive Self-Talk**

**Anger at Work**

## Anger Styles

- Internalized Anger
- Dealing Effectively with Anger
  - ◆ Stress Management
  - ◆ Communication
  - ◆ Handling Criticism
  - ◆ Changing Self-Talk
  - ◆ Coping for Stressor Situations
  - ◆ Acting Assertively

## Relaxation Exercise - Stress Management - Session #4

**8. Personal Relaxation Program**  
 Usually, such a program would include three components: **Progressive Muscle Relaxation, Breathing Exercises, and/or Mental Imagery.** An example of such a program is:

### ***WEEKLY BEHAVIOR INVENTORY***

Robert Geffner, Ph.D., & Carol Mantooth, M.S.

Happened to Me

- Slapping \_\_\_\_\_
- Kicking \_\_\_\_\_
- Punching \_\_\_\_\_
- Hair Pulling \_\_\_\_\_
- Throwing Things \_\_\_\_\_
- Throwing Mate or Shoving \_\_\_\_\_
- Hitting w/Physical Object \_\_\_\_\_
- Choking \_\_\_\_\_
- Threat of or Use of Weapon \_\_\_\_\_
- Burning \_\_\_\_\_
- Sexual Abuse \_\_\_\_\_
- Destruction of Property \_\_\_\_\_
- Verbal Abuse \_\_\_\_\_
- Emotional Abuse \_\_\_\_\_

Happened to Children

- Slapping \_\_\_\_\_
- Hair Pulling \_\_\_\_\_
- Kicking \_\_\_\_\_
- Punching \_\_\_\_\_
- Throwing Child \_\_\_\_\_
- Hitting w/Physical Object \_\_\_\_\_
- Scarring Child \_\_\_\_\_
- Use of Weapon \_\_\_\_\_
- Threat of or Use of Weapon \_\_\_\_\_
- Burning \_\_\_\_\_
- Sexual Abuse \_\_\_\_\_
- Verbal Abuse \_\_\_\_\_
- Emotional Abuse \_\_\_\_\_

I Did to Partner

- Slapping \_\_\_\_\_
- Kicking \_\_\_\_\_
- Punching \_\_\_\_\_
- Hair Pulling \_\_\_\_\_
- Throwing Things \_\_\_\_\_
- Throwing Mate or Shoving \_\_\_\_\_
- Hitting w/Physical Objects \_\_\_\_\_
- Choking \_\_\_\_\_
- Threat of or Use of Weapon \_\_\_\_\_
- Burning \_\_\_\_\_
- Sexual Abuse \_\_\_\_\_
- Destruction of Property \_\_\_\_\_
- Verbal Abuse \_\_\_\_\_
- Emotional Abuse \_\_\_\_\_
- Act Assertively \_\_\_\_\_
- Communicate Effectively \_\_\_\_\_
- Use Time Out \_\_\_\_\_
- Control Anger Behavior \_\_\_\_\_
- I Did Homework \_\_\_\_\_

I Did to Children

- Slapping \_\_\_\_\_
- Hair Pulling \_\_\_\_\_
- Kicking \_\_\_\_\_
- Punching \_\_\_\_\_
- Throwing Child \_\_\_\_\_
- Hitting w/Physical Object \_\_\_\_\_
- Scarring Child \_\_\_\_\_
- Use of Weapon \_\_\_\_\_
- Threat of Use of Weapon \_\_\_\_\_
- Burning \_\_\_\_\_
- Sexual Abuse \_\_\_\_\_
- Verbal Abuse \_\_\_\_\_
- Emotional Abuse \_\_\_\_\_
- Act Assertively \_\_\_\_\_
- Communicate Effectively \_\_\_\_\_
- Use Time Out \_\_\_\_\_
- Control Anger Behavior \_\_\_\_\_
- Spent Quality Time \_\_\_\_\_
- I Don't Feel Safe to \_\_\_\_\_
- Talk in Group \_\_\_\_\_

## PROGRESS EVALUATION FORM

Please rate the client named above on each of the listed criteria, based upon progress to date, and specify individual or group sessions. Use the 0 to 5 rating scale below, based on your impressions and observations. Obtain ratings from the client's partner, if possible, on a separate form.

5=occurs very often; 4=often; 3=occurs sometimes; 2=not often; 1=occurs rarely; 0=unknown; na=not applicable

- \_\_\_\_\_ Attendance: arrives at group session on time; attends regularly; contacts program in advance about absence; has legitimate excuse for absences.
- \_\_\_\_\_ Nonviolence/Nonabusiveness: has not recently physically abused partner, children, or others; no apparent emotional or verbal abuse, threats, intimidation, or manipulation.
- \_\_\_\_\_ Sobriety: attends meeting sober; no apparent abuse of alcohol during week; complying to ordered or referred alcohol treatment.

\_\_\_\_\_ Acceptance of responsibility: admits that violence and/or abuse occurred; not minimizing, blaming, or excusing problems; accepts responsibility for abuse, and contribution to problems.

\_\_\_\_\_ Using techniques/skill development: takes steps to avoid abusiveness; takes time-outs, watches self-talk, practices conflict resolution skills, etc.

\_\_\_\_\_ Homework: does homework assignments regularly, thoughtfully, and completely; follows recommendations for outside activities.

\_\_\_\_\_ Help-seeking: seeks information about alternatives; discusses options with others in the group; calls other participants for help; open to referrals and future support.

\_\_\_\_\_ Actively engaged/participates: attentive body language and positive non-verbal response; maintains eye contact; speaks with feeling; follows topic of discussion in comments; lets others speak; asks questions of others without interrogating; acknowledges others' contributions; participates constructively.

\_\_\_\_\_ Self-disclosure: reveals struggles, feelings, fears, and self-doubts; not withholding or evading issues; not sarcastic or defensive.

\_\_\_\_\_ Respect: respectful of partner and other gender in general; uses non-sexist language and no pejorative slang; demonstrates non-controlling attitudes.

\_\_\_\_\_ Empathy: understands the fears and trauma the abuse causes; realizes the negative impact of using power, controlling behaviors, and intimidation in relationships.

\_\_\_\_\_ Insight: shows insight concerning abusiveness, its effects on partner(s) and children, and its dangerousness; understands the changes that are needed to ensure non-abusiveness.

Adapted by Robert Geffner, Ph.D., 2001, from E. Gondolf, R. Foster, P. Burchfield, & D. Novosel, 1995

## What is Successful Completion of Treatment for DV Offenders?

1. Client is taking real and practice Time-Outs on a weekly basis.
2. Client completes anger journal on a weekly basis.
3. Client demonstrates ability to identify physical and behavioral signs of anger.
4. Client demonstrates positive communication of anger as well as other feelings.
5. Client demonstrates positive social problem-solving skills.
6. Client has completed all additional homework assignments.

7. Client can recognize negative self-talk and transform it to positive self-talk.
8. Client is able to teach other clients behavioral skills and education concepts.
9. Client is able to recognize minimization, denial and blaming in self and others.
10. Client has not perpetrated violence or abuse for at least six months.
11. Client can recognize and address volatile situations with self and others.
12. Client has attended the minimum number of group sessions.
13. Client has paid all outstanding balances.
14. Client has actively participated in group sessions.

## **What is Successful Completion of Treatment for DV Offenders?**

15. Client acknowledges complete responsibility for his/her violence.
16. Client evidences control over psychoactive substances, if applicable.
17. Client can recognize power and control behaviors.
18. Client utilizes the equality wheel behaviors to solve domestic conflict.

Adapted from Daniel Sonkin, 2002, by Robert Geffner, 2002

## **EVALUATION OF INTERVENTION PROGRAMS**

**Credentials of Therapists/Facilitators/Consultants**  
**List of Goals and Objectives**  
**Indication of How Goals Are Met**  
**How Techniques Fit Into Theoretical or Clinical Framework**  
**Specify Reasons for Particular Methods and Procedures**  
**Structured or Written Outline of Program**  
 (Is Program Structured, Unstructured, or Both?)  
**Length and Frequency of Sessions; Duration of Program**  
**Multidisciplinary, Multimodal, Comprehensive Intervention**

## **EVALUATION OF INTERVENTION PROGRAMS**

**Safeguards to Reduce Risk of Re-Victimization**  
**Assess Behavioral and Attitudinal Change**  
**Monitor Effectiveness and Provide Evidence of Progress**  
**Techniques to Prevent Relapse**  
**Long-Term Follow-ups**  
**Feedback From Victims/Significant Others**  
**Substantial Cooperation and Networking with Agencies, Etc.**  
**Different Options Available Depending Upon Situation**

R. Geffner, 1991; Revised 8/96