Texas Council
on Family Violence

HELPING MEN WHO BATTER: A Profile of Programs in the U.S.

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Prepared for the
Texas Department of Human Resources
August, 1984

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EXECUTIVE SUMMARY

The Texas State Senate Committee on Human Resources' Interim Study on Family Violence, prepared for the 1983 Legislature, included a recommendation that "existing model treatment programs for batterers in Texas and other states [be examined] to analyze their effectiveness in reducing or preventing violence toward family members." This recommendation was adopted as part of Senate Concurrent Resolution (SCR) 87.

In response to the directive of SCR 87, the Texas Department of Human Resources (TDHR) contracted for the conduct of a research project to study batterer treatment programs across the country. Primary goals of the project were to gather information about methods currently in use to help batterers change their behavior, and to collect program evaluation information in order to examine effectiveness of the methods used. The major component of the project was a nationwide survey of batterer programs.

Procedure

The survey was conducted in two phases. The first phase requested information in a number of different areas. These included: (1) structural and general characteristics of the program; (2) characteristics of program personnel; (3) referral processes; (4) intervention formats; (5) theoretical bases of program methods and goals; (6) treatment goals; (7) treatment methods; (8) relationships with other family violence service providers; and (9) assessment and evaluation procedures used in the program. The first questionnaire was mailed to 228 programs across the U.S., and 75 replies were received.

In the second phase, 15 respondents were sent follow-up questionnaires, based on their responses to selected items in the first questionnaire. The second phase's purpose was to gather demographic information on program participants (batterers) as well as in-depth evaluation and assessment information.

Results

The majority of batterer programs studied in the first phase are operated either by a battered women's shelter or by a mental health or social service agency. Nearly two-thirds of the programs are located in urban areas. Most of the respondents reported that their services are funded through a variety of sources; 44.4% received partial funding from their state. Most of the programs are very small; the median number of direct service workers per program was four.

Nearly all respondents reported that some portion of their participants enter the program voluntarily, either through self-referral or referral by other professionals or agencies. Many programs also receive clients through the judicial system, either through diversion to counseling in lieu of prosecution (about 40% of sample) or by order of the court (35%). Over half of the respondents reported that they receive requests to work with women who batter as well as men. However, they identified about three-fourths of these women as being victims of abuse as well as perpetrators.

Three factors that contribute to battering are closely linked with the goals and methods of the respondents' programs. These factors are social learning of violent behavior, social skill deficits, and external stresses. Over ninety percent of all respondents stated that their program's primary goal is to stop the batterer's violent behavior. Other goals of importance are improvement of the batterer's communication skills; improvement of his self-esteem; and change in his attitudes that lead to battering behavior. Improving or saving the batterer's relationship with the battered wife or partner is not typically a goal of treatment; only one program ranked this as a primary goal, and nearly 40% indicated that this was not a program goal at all.

The two most frequently used modalities in working with batterers are group counseling (in groups consisting of batterers only) and individual counseling. Couple counseling is used by many programs but mostly as a secondary modality. Most programs use a variety of intervention methods; the average number of methods used per program is twelve. The following methods are used by 75% or more of the respondents: anger management training, emotional awareness training, exploration of personal and family histories, emotional expressiveness training, building social support systems, exploration of sex roles, problem-solving skill training, and communication skill training.

Individual assessment procedures used by most of the programs are generally informal, with the intake interview being the most common procedure. Fewer than half of the respondents reported that they conduct exit interviews when participants leave the program, and only a third do follow-up to determine whether the participant has abstained from violence following treatment. Program evaluation activities are minimal.

Relationships between batterer programs and the battered women's shelters in their communities are well-established and mutually supportive. Most batterer programs provide public education as well as direct services, and network actively with other agencies that deal with family violence in their communities.

Only two of the six respondents in the second phase were able to provide demographic data about their clients. One, a couple-oriented program in which most clients participated voluntarily, served mostly white, married couples. The other, a court diversion program oriented mostly toward the male batterer, served an ethnically-mixed group of mostly married men.

The two treatment goals that were most often espoused, were measured most objectively, and were most successfully met by respondents in the second phase were to stop the violent behavior and to improve communication and relationship skills. No information was available from any of the six about outcome or follow-up studies. Finally, four of the respondents agreed that voluntary programs were somewhat effective in helping batterers change, while opinions were mixed about the effectiveness of court-referral programs. One respondent thought that court-referred treatment was not very effective, while the others thought it was somewhat effective or too soon to tell.

Conclusions

One of the study's goals was to examine the effectiveness of different treatment approaches by collecting evaluation information from batterer programs. However, although services have been provided to batterers for as long as seven years in some localities, evaluation information is still nearly non-existent. Therefore, it was not possible to meet this research goal.

There are several reasons for the paucity of evaluation information. Several respondents indicated that although they had been collecting data for some time, they did not have adequate resources of money, personnel or time to analyze and use the information. Lack of resources may be an important reason not only for the poor return rate on the second phase of this study but also for the scarcity of outcome data nationwide. Another possible reason is that the initial rush to provide badly-needed services, originators of batterer treatment programs may have tended to neglect evaluation issues in their planning.

Finally, inadequate data management systems may make retrieval of even simple demographic data tedious and time-consuming.

The majority of batterer programs studied have adopted a broad theoretical and methodological approach to working with batterers. They use a wide variety of treatment methods to work on a number of different factors that are believed to contribute to violent behavior. While a broad theoretical perspective is appropriate to understand and intervene in a problem as complex as family violence, a methodological approach that does not account for individual histories, situations and needs may be inadequate to effect lasting behavior change.

A number of questions remain for future study. The biggest unanswered question remains, "What approaches are effective in helping batterers change?" We have learned, however, that this question is not simple, and that to begin to answer it definitively, we must also explore related issues, such as the dynamics of battering, differences as well as commonalities among batterers, and how to identify and address different causal factors of battering in treatment.

INTRODUCTION

The Texas State Senate Committee on Human Resources' Interim Study on Family Violence, prepared for the 1983 Legislature, includes a recommendation that "existing model treatment programs for batterers in Texas and other states [be examined] to analyze their effectiveness in reducing or preventing violence toward family members." This recommendation was adopted as part of Senate Concurrent Resolution (SCR) 87.

In response to the directive of SCR 87 to the Texas Department of Human Resources, TDHR contracted with Melissa J. Eddy, M.A., to conduct a research project about batterer treatment programs across the country. Ms. Eddy was assisted in the research by Toby Myers, Ed.D.; William Stacey, Ph.D. and Anson Shupe, Ph.D. of the Center for Social Research at the University of Texas at Arlington; and the staff of the Texas Council on Family Violence.

This document includes a review of current literature relating to the batterer and a report of a nationwide survey of batterer programs. Appendices to the report include copies of the survey questionnaires, an annotated bibliography, and tables of descriptive statistics.

Need for Study

Family violence is a worldwide problem of epidemic proportions. Spouse battering, a manifestation of family violence, has a strong adverse impact not only on the family members it touches, but also on society as a whole. Over the past decade, shelters have been established to help battered women and their children escape the immediate violence. More recently, a few programs have started to address the problem closer to its source, through helping abusive men stop their violent behavior and improve their relationship skills. In the past five years, such programs have pioneered treatment techniques and procedures, organization plans, and ideas for community outreach and education.

Though articles have begun to appear about counseling those who batter, a preliminary review indicated that very few have addressed treatment effectiveness or outcome. Thus there is no reliable means of determining whether or not the programs are worth replicating. Organizations desiring to initiate such programs do not want to "re-invent the wheel," and wish to avoid replicating ineffective methods. They need to determine reliably what works, so their hard-won financial resources can be used efficiently and effectively. A need exists for evaluation of treatment methods to end abusive behavior.

We also need to investigate factors other than therapeutic interventions that may influence the effectiveness of treatment programs for batterers. For example, a current controversy is whether "forced" counseling of abusers (e.g. court diversion programs) is more, less, or equally effective compared with programs in which batterers participate voluntarily. Other factors which might have effects include cultural factors such as ethnicity; geographical factors,

such as whether a program draws primarily from an urban or a rural population; and individual factors, such as a personal history which might place a person at high risk of being an abuser.

Goals of Study

The major goal of the study was to gather and analyze existing information about the effectiveness of current treatment approaches for spouse abusers. This goal was to be accomplished by conducting an exhaustive literature search and compiling an annotated bibliography on the subject, and by surveying batterer programs nationwide. A primary objective of the survey was to identify those programs that conducted program evaluation, and to obtain outcome data from them in order to examine program effectiveness. A secondary goal of the project was to disseminate the information that was gathered through the literature review and the survey to interested parties nationwide, including survey respondents.

Definitions

Terminology is an issue which must be addressed at the outset of our report. Differing theoretical perspectives about family violence as well as differing philosophies of service have led to controversy in the family violence movement about what words to use to describe the phenomena we observe. What are the implications of characterizing a battered woman as a victim? Is it appropriate to bluntly label the man who abuses her a batterer? (Some workers prefer "men who batter," to avoid the implication that "batterer" is a summation of an individual's entire identity.) If we say "men who batter," do we then ignore the fact that women can also be violent in intimate relationships?

"Treatment" is another loaded concept in the family violence field. A basic philosophical tenet of many shelters is that most battered women do not require mental health treatment or therapy because they are not mentally ill. Family violence professionals are less sure about whether this tenet should extend to batterers as well. Although many battered women colloquially refer to their abusers as mentally "sick," professionals differ about whether battering should be considered a mental illness, a personality defect, a behavior disorder, a manifestation of social attitudes, or a combination. Each perspective uses different terminology to describe the nature of the help needed to overcome the problem. Should we call it "treatment"? Is it "counseling," "re-education," or "training"?

It is not within the scope of this report to grapple with these issues. Rather, we acknowledge them here, and will define our terms, realizing that not all readers will be in agreement with them.

Throughout the report, the terms "batterer," "spouse abuser," and "those [or men] who batter" are used interchangeably to refer to individuals who physically abuse their spouses or intimate partners. In discussing programs to help batterers, these persons may also be termed "program participants." We refer to those who batter as being male, using masculine pronouns, and to those who are battered as female. We acknowledge that the reverse is also true in some cases. However, most of the literature and the programs we studied focus on the man who batters, so our terminology reflects that emphasis.

Work with batterers to help them change is generally characterized as treatment. Although not entirely satisfactory because of medical-model implications,

"treatment" is the most generic term we could find to encompass the various approaches of counseling, education, and training which are used in work with batterers. "Intervention" is used synonymously with "treatment," as is "work with batterers."

REVIEW OF THE LITERATURE:

THEORETICAL PERSPECTIVES AND IMPLICATIONS FOR TREATMENT

A literature review was conducted in preparation for the study, using both computerized and manual search methods. The search produced references including books, scholarly articles, unpublished monographs and dissertations, manuals from programs for batterers, book excerpts and popular literature. Most are included in the Annotated Bibliography, Appendix B.

Rounsaville (1978) reviewed a number of theoretical perspectives on the causes of wife beating which focused mostly on the victim. Similarly, the literature on those who batter may be categorized by theoretical perspective. Effective planning and evaluation of treatment for batterers requires an understanding of theoretical assumptions about the causes of battering behavior. Following is a review of several theoretical perspectives identified in the literature on spouse abusers and brief discussion of the treatment implications of each perspective.

Traditional, Intrapsychic, or Psychoanalytic

This perspective explains one's behavior as being the result of one's intrapsychic attempts to cope with problems in life. Extreme or inappropriate behavior results from an exaggeration of normal ego defense mechanisms in response to unusually difficult or stressful problems, particularly internal conflicts. Breiner (1979) examined, from a psychoanalytic point of view, factors contributing to violence. He identified problems stemming from unresolved childhood conflicts, such as identification with another violent individual, unresolved passive-aggressive tendencies, and ego defects in perceiving and dealing with reality.

Elbow (1977) categorized wife-beaters according to four personality syndromes: the Controller, the Defender, the Approval-Seeker, and the Incorporator. The author relates these syndromes to dysfunctional parenting during the abuser's childhood.

Breiner emphasizes that the individual in treatment for violent behavior must receive continuous emotional support from the therapist. Treatment should focus on improving the individual's ability to express himself verbally, bolstering his ego control, and enhancing his reality-testing skills. Finally, the therapist should attempt to improve the violent individual's self-awareness, not only with regard to his violent behavior but also with regard to his emotions in general.

Behavioral

This perspective on battering is organized around the central theme that most human behavior is learned. It is based on both the stimulus-response-reinforcement sequence and on social learning theory. The latter theory is preponderant in the literature (Ball, 1977; Margolin, 1979; Rounsaville, 1978; Ganley, 1982; Rosenbaum and O'Leary, 1981; Adams and McCormick, 1982; Coleman, 1982; Gelles, 1982; Myers and Gilbert, 1983).

Social learning theory suggests that men involved in wife battering have learned violent behavior as a result either of being beaten themselves as children, or of witnessing their fathers beat their mothers. In either case, violent behavior was modeled to the child as an acceptable response to conflicts with family members. Stacey and Shupe (1983) found that 57% of the battered women they studied reported that their abusers had witnessed violence between their own parents, and 38% reported that their abusers had themselves been abused as

children. (However, contrary to myth, relatively few of the battered women themselves reported violent childhoods.) Rosenbaum and O'Leary (1981) reported that violent husbands they studied were significantly more likely than non-violent husbands to have been abused or witnessed interparental abuse during childhood. Ball (1977) reported similar findings. Chimbos (1976) studied individuals who had been convicted of killing their spouses, and found that most had experienced parental violence in their families of orientation.

Another aspect of the behavioral perspective on battering is that the victim may inadvertently reinforce the abuser's violent behavior. Most battered women report that their abusers claim that they would not have beaten their victims if they had not been "provoked." The putative provocation usually consists of her having done something he thought she should not, or not having done something he thought she should (Coleman, 1982; Ryan, 1982). The victim then attempts to alter her behavior in order to avoid a future beating. Unfortunately, such alteration of the victim's behavior has the opposite effect: it reinforces the batterer's violent behavior, because he perceives that the beating produced the desired results. Behavior that produces the desired outcome tends to be repeated, and so the victim's attempt to change herself in order to reduce the abuser's violent behavior is ironically just as likely to increase it.

Operating on the idea that whatever can be learned can also be unlearned, behaviorally-based batterer treatment approaches emphasize teaching new behavior to the men. In fact, Adams and McCormick (1982) report the use of a "social unlearning" model, in which violent behavior is "unlearned" in treatment, and more constructive social skills are taught to replace it. Margolin (1979) does not allow violent individuals to ventilate anger freely, having concluded

that decreasing verbal aggression can decrease physical aggression as well. Coleman (1979) and Brygger, Long, and Morse (1982) advocate behavioral methods to extinguish anger. Both Ganley (1981) and Sonkin and Durphy (1982) employ behavioral treatment approaches, including "anger logs" and experiential assignments, to work toward eliminating the violent behavior.

Humanistic

The humanistic perspective views people as more than victims of their unconsciousnesses or reactors to stimuli in their environment. Rather, they are viewed as proactive and able to exert active, significant influence over the events of their lives. With information and insight, they can assume responsibility, take charge, and make changes which will make their lives more satisfying. An objective of many batterer programs is for the individual to assume personal responsibility for his actions, rather than blaming factors outside of himself or beyond his control (Matsakis-Scarato, 1980; Watts and Courtois, 1981; Adams and McCormick, 1982; Geller, 1982; O'Reilly, 1983). Myers and Gilbert (1983) described a program participant who "acknowledged that no matter how provoked he was, the final decision to hit was his—his was the hand that struck. Control of that hand was up to him" (p. 245). Similarly, in a spouse abuser workshop in New York, a 50-year-old participant stated at the end of six weeks, "If a husband takes control of himself, a wife cannot make him hit her" (O'Reilly, p. 26).

Interpersonal, Transactional, or Systemic

This perspective focuses on the interactional aspects of violent behavior between intimate partners. Faulty communications and inadequate transactions are viewed as primary causes of relationship problems that lead to abuse. Geller

(1982) subscribes to family systems theory, which postulates an interactive element in the violence. However, he emphatically states that the violent behavior is the sole responsibility of the violent partner. Rounsaville (1978) describes the intense, exclusive, and tenacious nature of the relationship in which a violent couple is usually enmeshed. Coleman, Holley, and Myers (1977) illustrate the principle of enmeshment by their description of the woman who would not eat unless her husband was also hungry. Stacey and Shupe (1983) describe the batterer's erratic and often desperate behavior after his mate, having had one beating too many, leaves home. In fact, it is often the immediate, impending loss of the relationship that influences a battering partner to come into treatment. Myers and Gilbert (1983) reported that 29 of the 30 inquiries they received about their treatment program were from men who were already separated and wanted to reunite. Matsakis-Scarato (1980) also reported that motivation for counseling frequently arises from the batterer's desire to maintain or re-establish a relationship with his mate. Hilberman (1980) concluded that most husbands do not believe they need treatment, and that "treatment options may expand if the victim is protected from further violence, and/or her husband is motivated to seek help. The latter situation is more likely to occur when the assailant no longer has access to the victim" because she has sought refuge outside the home (p. 1345).

Treatment approaches focusing on interpersonal dynamics involve development of communication skills (Watts and Courtois, 1981; Garnet, 1982) and interpersonal social skills (Koval, Ponzetti, and Cate, 1982). Margolin (1979) employs a conjoint intervention strategy based on the premise that spouse abuse is a mutual problem. Others (Myers and Gilbert, 1983) favor group counseling as the treatment of choice because it serves to diminish the intensity of the

husband-wife relationship. Once the couple are not so dependent on each other and have learned to gratify some of their needs outside of the marriage, then conjoint therapy may be recommended.

Sociocultural

Individual behavior both influences and is influenced by the larger society—its institutions, norms, values, ideas, and technology. Violent behavior within the family is no exception. Richard Gelles, a prominent researcher in family violence, made the now-famous statement that men beat women because they can. This simple phrase powerfully points out that the norms and values in a patriarchal society such as ours support male dominance of women. For women to have less social power than men is considered normal, and for women to attempt redress of that power imbalance is considered unfeminine or worse. Male violence against women, both within and outside the home, is the ultimate expression of men's greater power as well as a means of maintaining it. As a result, wife beating has historically been not only tolerated but condoned in many cultures.

The sociocultural perspective maintains, therefore, that in order to stop family violence from occurring at the individual level, changes must be effected in norms and attitudes on a societal level. Treatment for abusive men based on this perspective is geared toward creating both behavioral and attitudinal change and goes beyond work with individuals to social change efforts as well. Counseling often involves exploration and encouragement of new role behavior: for example, that it is all right for men to cry, be emotional, and nurture (Straus, 1979; Coleman, 1982; Ponzetti, Cate, and Koval, 1982; Myers and Gilbert, 1983). The EMERGE model teaches more androgynous, less sex-stereotyped attitudes and behaviors (Adams and McCormick, 1982). Bygger,

Long, and Morse (1982) suggest that the initial treatment focus be on violence as one of a number of traditional male controls over women. Schechter (1982) and Adams and McCormick advise that programs for batterers should go beyond intervention with individuals to public education and other social change activities. Such activities support the contention that male violence is culturally based and must be challenged on a society-wide as well as an individual basis. Many workers and writers agree that male violence will abate only when equality between the sexes is achieved in society as a whole.

Another sociocultural factor is stress that is created by societal forces and other factors external to the individual. Such stress may result in psychological disturbance which then precipitates or increases incidences of family violence. This view predicts that someone who under normal circumstances would not beat his wife might do so if enough stress from other sources had been heaped upon him. For example, Ball (1977) and Stacey and Shupe (1983) found that abusive marriages frequently are characterized by financial difficulties. Combined with inadequate problem-solving or coping skills on the part of one or both partners, external stresses may contribute to the eruption of violence. Treatment would involve teaching the batterer (and if appropriate, the partner) to deal more effectively with stress-producing factors, both within and outside of the relationship (Ponzetti, Cate, and Koval, 1982; Ball, 1977; Brygger, Long, and Morse, 1982; Koval, Ponzetti, and Cate, 1982; Margolin, 1979).

Biochemical

Schauss (1982) points out that physiological reasons for undesirable behavior, including violence, are often overlooked in favor of pure psychosocial etiology.

He cites an example of a violent subject whose hair analysis showed a high copper level with evidence of associated zinc deficiency. This combination has been related to hyperaggression and hyperkinetic behavior, both of which often characterize batterers.

Physical and emotional stresses cause physiological responses in the body. Under continued and prolonged stress, the body becomes accustomed to those physiological responses and in fact comes to crave them. The director of the American Institute of Stress notes that "today's pressures have created a breed of thrill seekers who, often to their own detriment, prefer excitement over tranquility . . . People today have become addicted to their own adrenaline secretion" (Roshe, 1982, p. 49). Some researchers suggest that batterers, and battered women as well, may become dependent on the adrenaline secreted during the stress of violent fights. They then continue to create excitement in their lives through violent interactions in order to satisfy their biochemical craving. In "To Have and To Hold," a film produced by EMERGE, a man describes being caught up in an adrenaline rush when beating his wife, and not being able to stop until the rush is spent. Pizzey (1982) describes women who have become violence-prone because they have been conditioned to this adrenaline rush, much the same as men.

Alcohol or drug abuse are also chemical factors that contribute to spouse abuse in many cases. The disinhibiting influence of consciousness-altering substances is well-known, and may unleash violent behavior in individuals who have a tendency toward abusiveness. However, substance abuse alone cannot be considered to directly cause battering. Most of the literature recommends that if alcohol or drug abuse is a factor in a given case, the substance abuser

should receive treatment for the chemical dependency prior to any intervention for his violent behavior (e.g. Brygger, Long, and Morse, 1982).

The Houston Chronicle of February 5, 1984, reported that Dr. Daniel Luchins of the University of Chicago Medical Center had observed a decrease of aggressive behavior in violent patients who were taking a drug used to control convulsions. Luchins believes that this drug, carbamazepine, could be a new tool for helping violent patients.

Biochemical contributions to violent behavior, and the use of chemical interventions to control such behavior, are relatively new concepts requiring a great deal more research. Thus, their applicability to helping batterers remains undetermined. However, the biochemical perspective on violent behavior is based on compelling evidence which should not be ignored.

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(*Denotes inclusion in Annotated Bilbiography, Appendix B)

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SURVEY OF BATTERER PROGRAMS IN THE U.S.

Method

Survey Design

The survey instruments used in the study were developed by the researchers in consultation with staff of TDHR. The first phase questionnaire requested information in a number of different areas. These included: (1) structural and general characteristics of the program; (2) characteristics of workers providing direct services to batterers; (3) referral processes; (4) intervention formats (e.g. group, individual, etc.); (5) theoretical bases of program methods and goals; (6) treatment goals; (7) actual intervention techniques; (8) relationships with other family violence service providers; and (9) assessment/evaluation procedures used in the program. The questionnaire contained 28 items and the format was primarily multiple-choice, with one open-ended question at the end.

The second phase questionnaire was used to gather demographic information on program participants (batterers), as well as in-depth evaluation and assessment information, from those programs whose responses to the evaluation portion of the first questionnaire indicated that they might have such information available. The second questionnaire included several open-ended questions about program activities or processes; fill-in items regarding demographic characteristics of batterers admitted to the program and batterers who completed the program in a one-year period; questions relating to program goals, evaluation measures, and degree of success shown; an open-ended request for any available follow-up or evaluation data; and opinion questions about the relative effectiveness

of intervention with voluntary clients versus court-referred cients. Both survey instruments are shown in Appendix A.

Survey Subjects

The subjects to whom the initial questionnaire was sent were gathered from a variety of sources. The major source was the directory of programs providing services to batterers that appeared in a program manual published by EMERGE in 1982. Despite the fact that this list was a year old, it was the most complete and recent listing of programs known to the researchers. From this list, all programs that provided some kind of direct services were mailed a first phase questionnaire. Additionally, the Canadian Clearinghouse on Domestic Violence was contacted for addresses of batterer programs in Canada. However, that agency did not reply in time for any Canadian programs to be included in the study. Finally, several other U.S. batterer programs whose addresses had been obtained through personal knowledge or contacts of the researchers also received initial questionnaires. A cover letter explaining the nature and purpose of the survey was enclosed with each questionnaire along with a stamped, self-addressed return envelope.

The researchers and TDHR were particularly interested in learning more about services being provided to batterers in Texas. Therefore, all shelters and developing service groups in Texas were also mailed an initial questionnaire, with a cover letter requesting that they pass it along to any program in their own communities which provided services to batterers, and/or complete the questionnaire themselves if they were providing such services.

The initial questionnaire was mailed in early September, 1983 to a total of 228 programs. Of these, 173 were identified as service providers to batterers; the remainder were shelters and developing shelter groups in Texas. Responses were requested within four weeks, but six weeks elapsed before tabulation of the returns to allow for late replies.

The second questionnaire was mailed in late October, 1983 to programs that had responded to the first questionnaire and that met the following criteria: (1) They had conducted program evaluation procedures for at least one year; and (2) they had used one or more of the following procedures as part of their evaluation process: (a) Exit interviews, either with the batterer or with a third party such as the abused partner, (b) follow-up interviews, with the batterer or a third party, or (c) program staff evaluation of the batterer along with batterer evaluation of the program.

Responses were requested within four weeks. When only one reply was received after five weeks, follow-up letters were sent to the other fourteen, reminding them to complete and return the questionnaire. The letter also requested that they let the researchers know if they were unable to complete the questionnaire and why.

Returns

Initial Phase

A total of 75 responses were received in the initial phase of the survey, representing a 32.8% return rate. Four more questionnaires were returned by the U.S. Postal Service as undeliverable. Of the 75 respondents, twenty (including 7 in Texas) indicated that they were not presently providing services

to batterers. Another questionnaire was filled out incompletely, so was unusable. Therefore, our sample consists of 54 agencies or organizations that provide services to batterers. Ten of these are in Texas.

Respondents were divided into subgroups according to administrative structure. The subgroups were identified by combined responses to Item 1 (regarding whether the batterer program is an autonomous organization or is operated under the auspices of another agency); Item 23 (regarding program's relationship with local shelter, including whether program is operated by shelter); and the name of the batterer program. Because some respondents interpreted Item 1 in an unanticipated fashion (see "General Characteristics of Programs"), subgroupings had to be made by reviewing and analyzing responses to all three of the above-mentioned items on individual questionnaires.

Six subgroups of service providers to batterers were identified. These were (with number of programs in each subgroup): batterer services that are provided by battered women's shelters (17); batterer programs that are operated by "traditional" social service or mental health agencies (such as Family Services agencies, community mental health centers or YM/YWCAs) with the batterer program as a separately structured component of the agency's overall services (22); traditional social service/mental health agencies that provide services to batterers as part of their regular services but which have no separate programmatic component for them (6); independent batterer programs (3); police crisis teams (2); and grassroots agencies (such as a private non-profit counseling center specializing in services to blacks) that operate batterer programs (3).

Two of these subgroups, shelter-run batterer programs and batterer programs operated as separate programs by traditional agencies, were deemed large enough to warrant separate examination. Hereafter in this report, the former group will be referred to as "shelter-run programs" and the latter as "traditional-agency programs." Frequencies were computed for these subgroups, but sample sizes were too small to make statistical comparisons.

Second Phase

Fifteen of the 54 respondents in the first phase, were found to have met the criteria to be mailed the second phase questionnaire.

Only one response was received by the stated deadline, so all nonrespondents were sent follow-up letters. Six replies were received. Of these, two respondents indicated that they had not compiled their data and were unable to complete the questionnaire. Another two could not supply any demographic data on program participants, but did fill in other parts of the survey. The remaining two provided some demographic data and completed the remainder of the questionnaire.

Because of the poor return rate in the second phase, responses were not tabulated nor analyzed by computer.

Data Management and Analysis

All returns of both questionnaires were mailed directly to the project's data management consultants at the Center for Social Research, University of Texas at Arlington, for computer tabulation and analysis. Frequencies were computed for all items in the initial questionnaire, both for the whole sample and for

subsamples as described previously. Sample and subsample sizes were inadequate to perform tests of significance. The low return rate on the second questionnaire did not warrant computerization of the raw data. The authors reviewed each individual questionnaire in both phases of the survey.

For the initial questionnaire, there were a few missing responses to almost every question. This could be attributed simply to a respondent's having overlooked the question, or to a choice on the part of the respondent not to reply to that particular question. It was decided that the data would be more accurately represented by discarding the few missing responses. Therefore, the percentages given in the narrative report and tables are adjusted; that is, the stated percentages reflect those respondents who actually answered each question.

The exceptions are the questions in which respondents were asked to rank response items. For these questions, a missing response had meaning, i.e. that the respondent intended that the item not be included in the ranking because it is not used, is not significant, etc. For these questions, unadjusted percentages are shown.

For a few items, descriptive data are given in the narrative report of results without a corresponding table. In some cases, the data were simple enough that they could be clearly and completely presented in the narrative, and tabular presentation would be redundant. In others, a decision was made not to present in tabular form data that were questionable or confusing (for instance, questions for which some respondents gave information with regard to their entire agency and others with regard only to their services for batterers).

All tables are presented as Appendix C, with page number given for each table when it is cited in the narrative.

Results

Profile of Respondents in First Phase

Administrative Characteristics of Programs

The majority of respondents (59.3%) indicated that their program for batterers is operated under the auspices of another agency. Although 33.3% indicated that their program is operated autonomously, review of the individual surveys suggested that many of these were referring to their overall program or agency, not their batterer services. Individual analysis of the returns showed that only three programs could accurately be categorized as independent batterer programs. Data about length of program operation were likewise clouded by some respondents who gave this information with regard to their overall program rather than specific to their batterer services. Table 1 (page C-1) shows length of program operation.

Table 2 (page C-2) shows funding sources of the programs. It was often unclear, in reviewing individual questionnaires, whether responses to this question referred to the agency's overall program or to the specific services for batterers. Nearly all respondents reported multiple funding sources. Sources cited most frequently were participant fees, received by 55.6% of the respondents; United Way (50.0%); and state government (44.4%). Other funding sources mentioned with some frequency were local government (31.5%); private contributions (37.0%); and foundations (24.1%).

Nearly 65% of the shelter-run programs received state funding, compared with 36.4% of the traditional-agency programs. More shelter-run programs (11, or 64.7%) than traditional-agency programs (4, or 18.2%) reported private contributions as a funding source.

Populations of respondents' service areas are shown in Table 3 (page C-3). Not surprisingly, 64% of the programs are located in urban areas of over 100,000. Only two programs reported serving an area of population less than 10,000.

Direct Service Personnel

Respondents were asked to indicate how many people in all (paid or unpaid) provided direct services to batterers in their programs. For the whole sample, answers ranged from one to 75 persons. Because four programs reported 30, 31, 60, and 75 service personnel respectively, with the rest reporting 13 or fewer, the mean of 8.5 persons is somewhat biased. The median of 4.3 gives a better picture of the "average" number of direct service workers per program. For the shelter-run programs, the median was 3.1 persons, and for the traditional-agency programs, the median was 4.2 persons.

Respondents indicated how many of their direct service personnel were male and how many were female. Again, because of extreme ranges, medians gave the most accurate picture. For the whole sample, the median number of male direct service providers was 2.3, while the median number of female workers was 3.1.

Respondents were asked to indicate the ethnicities of their direct service personnel. Of the whole sample, 88.0% indicated that one or more of their direct service personnel are white; 39% reported one or more black staff members; 16.7% reported that one or more of their service personnel are of Spanish origin; and 7.5% reported having staff of American Indian, Asian, or other origin.

Another question inquired whether direct service personnel were salaried, contractual, volunteer, or student intern workers. Of the respondents, 81.5% indicated that one or more of their service providers are salaried professional staff. Contractual workers or consultants are used by 27.8% of respondents to provide services, and 38.9% of the programs use volunteers. The number of volunteers ranged from one to 60 per program. Only 18.5% utilize student interns to provide services. Just three of the respondents, or 5.7%, reported that any of their direct service providers, of any status, were themselves former batterers. Of these three, one had three former batterers providing services, one had 20, and one had 30.

Referral Processes

Respondents were asked in what ways batterers could enter their programs; more than one answer could be given. Results are shown in Table 4. Nearly all programs receive some of their clientele through voluntary self-referral; 92.5% of respondents indicated that batterers could enter their programs in this fashion. The majority of programs also admit clients through referral from other agencies or professionals.

Somewhat fewer, though still a substantial number, receive clients through the judicial system, at various points in the prosecution process. (See questionnaire, Appendix A, for definitions of court diversion, pre-plea; court diversion, post-plea; and court order.) Many respondents receive program participants through court diversion, either pre-plea (40.7%) or post-plea (38.9%), and 35.2% through court order.

Nearly half (49.1%) of all the respondents indicated that they receive more referrals than their program can accommodate at one time. Those who reported too many referrals indicated that they deal with the overflow by maintaining a waiting list (73.1%), redirecting the referral to another agency or program (65.4%), or by referring to private counseling (72%). A higher percentage of the traditional-agency programs (80%) than of the shelter-run programs (50%) maintain waiting lists.

Respondents were asked to indicate reasons for which their programs might refuse a batterer for services and/or refer him elsewhere for more appropriate immediate services. Results are shown in Table 5 (page C-5). The most frequently cited reasons were active psychiatric problems (70.2% of whole sample), active alcohol or drug abuse (59.6%), language limitations (46.8%), and a history of serious psychiatric problems (42.6%). A higher percentage of the shelter-run programs (64.3%) than of the traditional-agency programs (35%) would refuse or redirect a batterer due to a history of psychiatric problems. Over 85% of the shelter-run programs said they would redirect a batterer who evidenced active psychiatric problems, compared with 70% of the traditional-agency programs.

Thirty respondents (57.7% of the whole sample) indicated that they receive requests to provide services to female batterers (i.e. women who batter). Of these, twenty-four (72.7%) provide direct services to women who batter. Respondents who provide direct services to female batterers were asked to estimate what percentage of female batterers seen in their programs have also been victims of battering. Of all such respondents, the median estimate was 77%. Traditional-agency programs estimated that a median 47.5% of the female

batterers they see are also victims, and shelter-run programs estimated that a median 92% of the female batterers they serve are also victims of abuse.

Intervention Formats

Respondents were asked to rank a number of intervention formats in terms of how much they were used in the programs (1 = most used, etc.). Respondents were instructed not to rank at all any listed format which was not used in their program. Choices included batterers groups, individual counseling, couple counseling, couples groups, family counseling, family groups, crisis-oriented counseling, criminal justice system, and other. Results are shown in Tables 6-8 (pages C-6, C-7, C-8). Batterers groups and individual counseling are generally the formats of choice for the whole sample and both subsamples. Couple counseling is also used by a number of programs but was ranked as a secondary or third-choice format by most. The only other format ranked first by more than a handful of programs was crisis-oriented counseling, ranked first by 20.4% of the whole sample and by 29.4% of the shelter-run programs.

All respondents who indicated that batterers groups were used in their programs, regardless of ranking, were asked for more detailed information about the groups. These data are shown in Table 9 (page C-9). Relatively few of the groups were described as time-limited; most were either ongoing or a combination of ongoing and time-limited. Most programs (68.4%) indicated that clients could enter at any time rather than at certain intervals only. The mean number of participants per group was 7.5. Of those respondents who indicated that their groups are time-limited or a combination of ongoing and time-limited, 13% reported duration of the groups as six weeks or less, 34.8% reported duration from 6 weeks up to three months, 17.4% three months up to six months, and

8.7% more than six months, while 26.1% indicated that their groups are mostly ongoing and did not specify a time limit.

Respondents were asked how they monitored batterers for recurrence of violence while they were participating in the program. More than one method could be cited. Table 10 (page C-10) shows the results. Self-report by the batterer is used by 82.7% of the whole sample, while over 95% of the traditional-agency programs but only 68.8% of the shelter-run programs use this monitoring method. Some programs corroborate the self-report with a report from the victim. Other monitoring sources are used relatively little, especially by the shelter-run programs. The traditional-agency programs appear to have somewhat more contact with police and probation officers for monitoring purposes than do the shelter-run programs. Finally, more than 21% of the whole sample reported that they do no regular monitoring for recurrence of violence, and 31.3% of the shelter-run programs reported no regular monitoring.

Respondents were also asked how their programs dealt with a recurrence of violence by the batterer while participating in the program. Results are shown in Table 10 (page C-10). None of the listed approaches were used by a clear majority of respondents, but special counseling for the batterer was used by the most programs (44.9%). Relatively few respondents indicated that they would drop a batterer from the program because of recurring abuse. A substantial percentage indicated that they had no standard policy or procedure to deal with recurrence of battering. The majority of respondents have a policy that excessive absences will result in discontinuation of services to the batterer, with 62.7% of the whole sample, 62.5% of the shelter-run programs, and 66.7% of the traditional-agency programs reporting such a policy.

Theoretical Bases of Program Goals and Methods

In designing the question intended to elicit theoretical bases of program goals and methods, the researchers desired to avoid language that implied a direct causal connection between any one factor and violent behavior. Therefore, a number of factors that are believed to contribute to battering were listed. Respondents were asked to indicate the extent to which each factor influenced their program's goals and methods. Response format for this question was a 5-point Likert scale labeled "not at all influential" on the low end (1) and "very influential" on the high end (5). Middle increments were not labeled. The reader should keep in mind that the Likert rankings and the percentage of respondents choosing each one indicate the degree to which the contributing factor influences the respondents' goals and methods, not the extent to which the respondents believe the factor to be a cause of violent behavior.

To simplify the data presentation for this question (Tables 11-13) (pages C-11, C-12, C-13), points 1 and 2 are collapsed into one category labeled "Little to none [influence]." Point 3 is labeled "Some [influence]," and points 4 and 5 are combined in a category labeled "Much [influence]."

As shown in Table 11 (page C-11), three contributing factors are most closely linked with the goals and methods of all the respondents' programs: social learning of violent behavior, social skill deficits, and external factors. "Social learning of violent behavior" had much influence on the goals and methods of 82% of all respondents, and "social skill deficits" was rated as having much influence by 74%. "External factors" (described in the survey as "job stress, financial difficulties, conflicts about children, etc.") had much influence on 62% of the programs.

Most of the other listed factors are also quite influential on the programs' goals and methods. For these, there were some differences between the subsamples, with a higher percentage of the traditional-agency programs than of the shelter-run programs rating them as having much influence. "Interactional dynamics of individual relationships" had much influence on the goals and methods of 60% of all respondents, 56.3% of the shelter-run programs, and 75% of the traditional-agency programs. The factor "traditional family roles and sex role stereotypes" was rated as having much influence by 60.8% of the whole sample, 56.3% of the shelter-run programs, and 70% of the traditional-agency programs. The factor "patriarchal structure of society/cultural sanction of violence against women" was rated as having much influence by 60% of the whole sample, 50.1% of the shelter-run programs, and 75% of the traditional-agency programs. The factor "drug and alcohol abuse" was rated as having much influence by 55% of the whole sample, 50% of the shelter-run programs, and 65% of the traditional-agency programs.

The only factor that had slightly less influence on goals and methods of the programs was "individual psychopathology of batterers." This factor was rated as having much influence on program goals and methods by 32.6% of the whole sample, 47.3% of the traditional-agency programs, and 31.3% of the shelter-run programs.

Goals of Intervention

Respondents were presented with a list of possible goals for change in individual batterers. Respondents were asked to rank the goals in terms of priority in their programs (1 = primary change goal, 2 = secondary change goal, etc.). Goals that were not stated program goals were not to be ranked.

While most respondents ranked just one goal as primary, one as secondary, etc., some respondents chose to designate more than one goal as primary. Only a few respondents assigned rankings below 3. For ease of data presentation (Table 14, page C-14), rankings of 2 and 3 are collapsed into a category labeled "secondary," and the few rankings of 4 or below are not shown.

Overwhelmingly, the respondents agreed that to stop the violent behavior was the primary goal of their programs. Over 90% of all the respondents, 88.2% of the shelter-run programs, and 95% of the traditional-agency programs ranked this as their primary change goal. This was the only goal clearly ranked as primary by a majority of respondents.

Other intervention goals that were ranked as either primary or secondary by 50% or more of all the respondents were to improve communication skills, to improve self-esteem, to decrease the batterer's social isolation, and to change attitudes that contribute to violence.

Most of the respondents agreed that to improve or save the relationship with the victim was not an immediate or primary goal of their programs. Of the entire sample, only one program ranked this as a primary change goal. Nearly a quarter of the respondents ranked this goal seventh out of seven listed, and almost 40% did not rank it as a goal at all.

Intervention Methods

Respondents were presented with an extensive listing (24 items) of intervention methods which might be used in working with batterers, and were asked to indicate those used in their programs. No ranking was required.

Table 15 (page C-15) shows the results. Most programs use a variety of intervention methods. The average number of methods used per program is twelve. The following methods are used by 75% or more of the whole sample: emotional awareness training; emotional expressiveness training; anger management; exploration of personal family histories; building social support systems; exploration of sex roles; problem-solving skill training; and communication skill training.

Other commonly used intervention methods (variously used by 50% to 75% of the whole sample) include behavior contracting; client role-playing; stress management training; and separate support groups for the batterers' partners. Many programs also provide some means of support outside regular sessions for their participants, such as telephone access to program personnel.

Methods which are used somewhat more by the shelter-run programs than by the traditional-agency programs are assertiveness training, education about the laws relating to battering, emotional awareness training, parenting education, and vocational assistance.

The traditional-agency programs use the following methods somewhat more than the shelter-run programs: anger management techniques, behavior contracting, communication skill training, criminal-justice-related interventions, emotional expressiveness training, exploration of sex roles, journal-keeping, client role-playing, and support groups for victims.

Relations with Other Family Violence Service Providers

Nearly all respondents (92.3%) indicated that there is a shelter for battered women in their program's service area. Respondents were asked to indicate the nature of their program's relationship with their area's shelter. Twenty-five percent indicated that the batterer program is operated by a shelter. Nine respondents, or 18.8% said that their program is operated separately from the shelter, but that formal mechanisms exist for shelter input to the batterer program, while 16 or 33.3% are separate with informal input mechanisms. Ten, or 20.8%, said they have little or no relationship with the local shelter.

Respondents were asked whether, in their opinion, shelter input to batterer programs is very helpful, somewhat helpful, not very helpful, or not helpful at all. The majority of respondents were appreciative of shelter input, with 61.4% describing it as very helpful, and 29.5% as somewhat helpful. Fewer than five percent described shelter input as either "not very helpful" (4.5%) or "not helpful at all" (4.5%).

Respondents were asked to indicate other activities related to family violence prevention and intervention in which their program personnel participate. Results are shown in Table 16 (page C-16). Activities reported by most of the respondents include public education and networking with other community services dealing with domestic violence. The shelter-run programs are also active in advocacy with the criminal justice system.

Evaluation and Assessment Procedures

Respondents were presented with a list of assessment and evaluation procedures which might be used in a batterer program, and asked to indicate which of these are used in their programs. The results are shown in Table 17 (page C-17).

Many of the respondents conduct an intake interview with the batterer when he first receives services; 80.4% of the whole sample, 62.5% of the shelter-run programs, and 95% of the traditional-agency programs use this procedure. Other commonly-used assessment procedures include interviews with the victim as part of the intake process, when possible, and ongoing assessment of the batterer while in the program.

Relatively few programs utilize other types of assessment or evaluation procedures. Fewer than half of the sample conduct an exit interview with the batterer when he completes or leaves the program, and only a third of all the respondents attempt to conduct follow-up interviews with participants after they leave the program. Some programs use staff evaluations of the program participants and/or batterers' evaluations of the program. Only 15.7% of the whole sample indicated that they use data on police involvement with the batterer.

Respondents were also asked how long evaluation data had been collected. Twenty-one respondents or 38.8% did not answer the question. Of those who did, 41.2% had collected such data less than one year; 20.6% had done so for one to two years; 11.8% from two to three years; and 26.5% said they had collected evaluation data for over three years.

Other Statements

The survey concluded with an open-ended question in which respondents were invited to describe anything unique or unusual about their program. Half of the respondents commented in response to this question. Several expressed appreciation that the survey was being conducted, indicating that they felt they were working in isolation with little knowledge of what others were doing.

DESCRIPTION OF SECOND PHASE RESPONDENTS

The small number of replies received from the second survey did not warrant descriptive statistics. A summary of information provided by the six responses is shown in Table 18 (page C-18). In this table and the following section, the six respondents are identified as A, B, C, D, E, and F.

Demographic Characteristics of Program Participants

Only two of the six programs were able to provide demographic data about their programs' participants. Only one of these, Respondent B, could provide the requested data completely.

Respondent B indicated that a total of 47 batterers were screened for admission to its program from 9/1/82 through 8/30/83. Of the 36 who were admitted during this period, 34 were white, one was black, and one was of Spanish origin. Twenty-eight of those admitted were married and living with the victim, while three were married but not living together and five were not married but living together. Thirty of those admitted had entered the program voluntarily, while six had entered through pre-plea court diversion.

For the same period of time, Respondent B indicated that 27 batterers completed its program. Of these, 26 were white and one was black. Twenty-one of those who completed the program had been married and living with their spouse at the time they had entered the program; three had been married but not living together, and three had been unmarried but living together. Twenty-one of those completing the program had entered it voluntarily, while six had entered through pre-plea court diversion.

Respondent C was able to provide demographic information only about batterers who had been screened for admission to its program from 10/1/82 through 10/1/83; information about those actually admitted or those who completed the program during the same period was not available. This respondent reported screening 240 batterers during the one-year period, and admitting 142 to the program. Of those screened, 120 were white, 55 were black, and 65 were of Spanish origin. Ninety-one were married to the victim and living together; 50 were not married but living together; 25 were neither married to nor living with the victim; and two had a familial relationship with the victim other than marriage. Of those screened, 96 were to enter the program voluntarily, four through pre-plea court diversion, 130 through post-plea court diversion, and 10 through court order.

The other four programs which replied to the second survey provided no demographic data.

Goals, Evaluation Measures, and Degree of Success Shown

A rather complex question in the second-phase questionnaire was designed to elicit information about several aspects of the respondents' program evaluation processes. First, we wanted to identify specific evaluation instruments or procedures used by respondents. We also wanted to determine what outcome (i.e. change in individual batterers) each instrument or procedure was intended to measure. Finally, respondents were asked to indicate what degree of success in achieving each outcome was shown by the related evaluation measure.

Of the six respondents, four provided some response to this item. A fifth, Respondent A, indicated which goals it tried to achieve, but stated that no

objective evaluation measures were used for any of the goals, and did not indicate degrees of success. The sixth respondent, E, did not answer this item.

The program goals of Respondents B, C, D, and F, the evaluation measures used by the respondents for each goal, and the degree of success toward meeting the goal (as shown by the evaluation measure) are shown in Table 19 (page C-19). The two goals that were most often espoused, were measured most objectively, and seemed most successfully met by the four programs were to stop the violent behavior and to improve communication and relationship skills.

Follow-up or Outcome Studies

Four of the respondents said that they had conducted no follow-up or outcome studies. The remaining two stated that they had such studies in progress but that no data were presently available. The studies include pre-treatment and post-treatment testing of program participants, using various standardized instruments. One was also studying changes in number of police calls to batterer's residence before, during, and after treatment.

Opinions About Program Effectiveness: Voluntary vs. Court-referred

Respondents were asked to give their opinion about the effectiveness of voluntary programs, as well as of the various types of court-referred programs, in helping batterers change. Four of the five respondents who answered this item agreed that voluntary programs were somewhat effective; the fifth said it was too soon to tell. Opinions were mixed about the effectiveness of the various types of court-referral programs. Respondent A thought that court-referred treatment is not very effective, while the other respondents thought it is somewhat effective or too soon to tell.

Discussion

This section recapitulates and interprets important findings of the survey, elucidating them in some cases with information from individual questionnaires. The survey produced no surprises about the general and administrative characteristics of the respondents' batterer programs. Most are operated under the organizational auspices of another agency. The agencies, and therefore the batterer services, are funded by a variety of sources, both public and private. Batterer services are offered predominantly in urban areas, with rural areas being underrepresented in our sample. Most of the programs are very small, with about four direct service workers per program. Three programs that reported a larger number of "service providers" are actually peer support organizations in which the batterers help each other. The sample reflects slightly more women than men providing direct services to batterers around the country. While we might assume that men who batter would relate better to male counselors, apparently many programs have found that this is not necessarily the case. It may also be that women are represented slightly more because women, who have spearheaded the family violence movement, are at the forefront of batterer services as well.

Batterer programs seem to be trying to achieve equitable ethnic representation among their counselors. While Anglos are the predominant service personnel, blacks, Hispanics and other minorities work in the programs as well. Most of the programs hire professionally-trained counselors, either as salaried staff members or in a consulting capacity. Fewer than forty percent of the programs utilize volunteers in service provision. The programs that use volunteers extensively operate on a self-help model, in which the "volunteers" are the clients themselves. These programs were also the only ones that reported

having former batterers as service providers. It appears that volunteer energy is underutilized by the programs in our sample, and also that they have either not tried or not been successful in recruiting former batterers to help others.

Nearly all the programs receive voluntary clients, either through self-referral or through referral from another source. Several respondents commented that they believe batterers can only be helped to change if they participate voluntarily and are self-motivated to take personal responsibility for their behavior.

Around 40% of the sample accept clients who have been diverted to counseling through the court system. Diversion refers to the process in which an alleged spouse assaulter is referred to counseling in lieu of prosecution, with the charges often dropped if the program is successfully completed (pre-plea diversion); or in lieu of jail time and/or a fine following prosecution and conviction (post-plea diversion). In diversion, which might be characterized as semi-voluntary, the offender has a choice either to enter a program or face the charges and/or the punishment. He has no choice when a judge directly orders him to go to counseling. Slightly fewer programs (35%) reported receiving clients through direct order of the court, which can occur at any point in the prosecution process from initial hearing to probation. It was not possible to draw any conclusions from the study about the relative merits of voluntary versus court-referred counseling for batterers. While respondents to the second questionnaire gave their opinions on this issue, the sample was too small for responses to be significant.

Many respondents said that they received requests to work with women who batter their male partners, and most programs do try to work with these women. However, it is important to note that many of these women are identified as victims of battering as well, indicating that the violence is reciprocal, or that some female battering victims fight back in self-defense. While respondents in the traditional-agency subgroup identified fewer than half of the female batterers they served as also being victims, the shelter-run programs identified over 90% of female abusers as simultaneous victims. Although the subgroups were too small to show that this discrepancy is significant, the difference is noteworthy.

About half of our sample reported receiving more requests for services to batterers than they could accommodate. The overflow is usually either put on a waiting list or redirected to another counseling resource. The shelter-run programs tended to use waiting lists less than the traditional-agency programs. It may be that shelters, committed to providing services in immediate response to crisis, are more reluctant to maintain waiting lists than more traditional or long-established agencies, particularly those that normally do not deliver crisis-oriented services, which may be more accustomed to having clients wait.

The most frequently cited reasons for refusing a potential program participant and/or making an alternative referral for him (besides program overload) were active psychiatric problems and active alcohol or drug abuse. Because most services for batterers are targeted specifically at the violent behavior and related issues, many batterer programs may not be prepared, either programmatically or professionally, to deal with psychiatric or substance abuse problems requiring intensive treatment or therapy. This is particularly true of shelters, and thus it is not surprising that the shelter-run programs tended

more than the traditional-agency programs to refer individuals with such problems elsewhere.

Our sample's methods of monitoring batterers for recurrences of physical abuse while in treatment may be less than adequate. Most of the programs use batterer self-report as a monitoring method, but barely half corroborate his story by contacting the victim or another third party. Other monitoring methods are used even less. Self-report is generally considered to be an inadequate monitoring method, either to insure the safety of the victim or to assess change in the program participant in the course of treatment, because denial and minimization of the abusive behavior are characteristic of most batterers. The programs' responses to recurrences of battering are minimal. The response mentioned most frequently is special counseling, and even that is done by less than half of the sample. The lack of immediate, firm response by a program to recurrences of violence could undermine the anti-violence messages it is trying to convey, and may diminish treatment effectiveness.

Our respondents' program goals and methods are based on multivariate theoretical perspectives. Nearly every contributing factor to battering listed in the survey was cited as having "much influence" on program goals and methods by a majority of the sample. However, a behavioral emphasis in the programs was suggested, in that the top two factors were social learning of violent behavior (cited as having much influence on program goals and methods by over eighty percent of the respondents), and social skill deficits, cited as having much influence by nearly three-quarters of the sample.

The traditional-agency programs focused more heavily than the shelter-run programs on interactional dynamics of individual relationships. Because family services agencies were heavily represented in the former subgroup, such a systems emphasis is not surprising. A more unexpected result is that traditional family roles and sex role stereotypes as well as patriarchal structure of society/cultural sanction of violence against women were cited as highly influential factors by a greater percentage of the traditional-agency programs than of the shelter-run programs. Since these factors relate to issues frequently considered "feminist," and since shelters are commonly assumed to be feminist organizations while longer-established agencies are often seen as guardians of traditional values, the opposite result might have been expected with regard to these two factors. The results suggest that such assumptions need to be reconsidered.

Stopping the violent behavior is overwhelmingly the first-priority goal of nearly all the programs. However, a commonly-voiced dilemma in setting intervention goals for batterer programs is suggested by the refusal of a number of respondents to designate only one treatment goal as primary. While to stop the violence was almost universally agreed upon as one primary goal, other goals were cited by many respondents as having equal priority. Although stopping the physical abuse is important, it is not enough unless the relationship is improved and emotional abuse is ended as well. One respondent indicated that women in support groups associated with the program voiced continuing feelings of dissatisfaction and mistrust in their relationships, even though their partners were no longer physically violent. In many cases, the verbal abuse did not decrease when the physical violence ended. In fact, the women often reported that the verbal abuse increased, perhaps to compensate for the

batterer's loss of a physical outlet for his aggression and need to control. No one disagrees that stopping the physical abuse is of primary importance; but many assert that dealing only with the physical violence is not an adequate response to the overall problem of intimate abuse.

Consistent with descriptions in other publications, the intervention formats most often used by our sample are batterers' groups and individual counseling. Intervention with couples is used mostly in a secondary capacity, reflecting the philosophy that the violence must first be brought under control before relationships can begin to be examined and changed. Batterers groups are usually fairly small, with about seven participants at a time. In most programs, participants can enter the group any time, and it is ongoing rather than time-limited. Many different intervention methods are used by the respondents, and the majority of methods used are behavioral or cognitive-emotive in nature.

Relationships between the batterer programs and the battered women's shelters in their communities are well-established and mutually supportive overall. Most of the batterer programs in our sample provide public education as well as direct services, and network actively not only with shelters but also other agencies that deal with family violence in their area. However, a higher percentage of the shelter-run programs than of traditional-agency programs are active in advocating for legislative or procedural changes in the criminal justice system with regard to domestic violence. This difference may reflect the shelter movement's philosophy that activism for social change is equally as important as provision of services, or it could reflect limitations imposed on batterer programs within traditional agencies.

Individual assessment procedures used by most of the programs are generally informal, with the intake interview being the most common formal procedure. Because basic information about the individual is necessary to provide services, this is not surprising. However, program evaluation activities conducted by our sample are minimal.

One of the original goals of the survey study was to evaluate effectiveness of existing batterer programs in the U.S. by collecting evaluation information from our sample. However, we learned that although services have been provided to batterers for as long as seven years in some localities, outcome information is still nearly non-existent. Of a total of 75 respondents to the survey, only one had completely compiled, analyzed, and evaluated the data it had collected. A handful of others had attempted some program evaluation, but their results were not available at the time the survey was conducted.

There are several reasons for the lack of program evaluation activities on the part of the respondents. Several respondents indicated that although they had been collecting data for some time, they did not have adequate resources of money, personnel or time to analyze and use the information. It is common for new family violence programs, struggling to stabilize funding for services and stretching their personnel to the limit, to neglect or ignore program evaluation, which seems like a luxury. Batterer programs, which are very small and may be struggling both financially and programmatically, are no exception. Lack of resources is probably an important reason not only for the poor return rate in the second phase of our survey but also for the scarcity of outcome data nationwide.

Several other reasons may also apply. One is that many agencies providing services to batterers do so as part of their overall service delivery, but do not have specific programming for these men. It is not surprising that such programs would not compile outcome or evaluation information specifically about their work with batterers. Two other possible reasons are inadequate program design and inadequate data management systems. Inadequate program design does not at all imply that the actual services being delivered are inadequate. Rather, it suggests that in the initial rush to begin providing badly-needed services, originators of batterer treatment programs tend to neglect evaluation issues as they decide how their programs will be organized for service provision. In such cases, evaluation is often an afterthought, and as such, may be difficult because mechanisms were not in place from the start to allow for comparisons, follow-up, etc. As one respondent pointed out, "Theory follows services and evaluation follows theory" in the typical developmental process of service delivery programs. The one program in our sample that was able to provide all the requested data is based in a university setting and had a dual emphasis on services and research from its inception, unlike most other respondents whose initial focus was on services.

A related problem is inadequate data management systems. Our supposition is that most programs keep files on each program participant, but the nature of the information collected and the way it is organized may vary greatly, not only from program to program but even from case folder to case folder. This makes retrieval of even simple demographic data on program participants extremely tedious and time-consuming, as it requires going back through the files case by case and extracting the information. This may be another reason for the poor return rate in the second phase.

The majority of programs we studied have adopted a broad-based theoretical and methodological approach to working with batterers. The programs use a wide variety of treatment methods to work on a number of different factors that they believe may contribute to violent or abusive behavior.

A broad theoretical perspective is appropriate in trying to understand and intervene in a problem as complex as spouse battering. There is no doubt that the causes of battering behavior are many and interrelated. However, it seems self-evident that in individual cases, the relative importance of different causal factors, the resulting individual needs of the batterer, and the treatment methods indicated will vary.

In summary, we imagine that a worker in a batterer program might characterize the "state of the art" as follows:

> We know what some of the causes of battering are, but we don't know which are the predominant ones, nor how the causes interact, either in general or in individual cases. We don't have the resources to do in-depth assessments nor to tailor treatment to exact individual circumstances. So what we have done is adopt a multivariate perspective on causes of the problem, and a multidimensional approach to intervention. That way, regardless of the nature of the individual problems involved in a particular violent relationship, we hope the participant will get something out of the program that will fit his needs. But we don't know if that's happening because we don't have the capability to do research and evaluation right now. We just keep working with these guys and hope we're helping.

Limitations of Study and Issues for Future Research

The project had several methodological limitations that must be mentioned. First, our literature review may have omitted important references. While the domestic violence literature was sketchy until just a few years ago (it did not merit its own heading in Psychological Abstracts until 1982), it is now burgeoning. Our search for scholarly and other literature pertaining to batterer dynamics and treatment was as exhaustive as possible, but it is likely that a number of resources were overlooked.

The sample for this study was based primarily on one listing of organizations dealing with batterers. That listing was compiled in 1982 and was somewhat out of date. A more recent, comprehensive listing might have produced different results.

The return rate of 32.8%, while generally considered acceptable for direct-mail surveys, was somewhat low for purposes of this study. If the estimate of two hundred batterer programs extant nationwide is accurate, only about a fourth of those were represented by our sample of 54 respondents currently providing such services. A higher return rate might have produced a different profile of batterer programs. Also, since the sample in the second phase of our study was based on responses in the first phase, the second phase sample might also have been larger and produced different results had the original subject pool been larger.

A number of topics that were beyond the scope of the present study remain for future examination. One such topic is batterer programs that make extensive use of the criminal justice system, either for getting participants into the

program (through diversion or court order) or as a component of the intervention plan. Such programs were minimally represented in our study, and their processes and outcomes may be quite different from those of our sample.

A related question not addressed in our study is whether batterer programs should be based within mental health, social service, criminal justice or shelter settings. The issue is not only which system is best equipped administratively and has the greatest expertise to design and implement such programs, but also what kinds of subtle messages are conveyed to batterers by the nature of the administrative entity. For instance, a program run by a mental health center might convey a subtle message that a batterer is mentally disturbed. If intervention is conducted through the criminal justice system, the message that battering is a crime might be reinforced. No opinion is offered hereabout the relative advantages or disadvantages of different settings, nor about the messages they might convey to potential program participants. The question is raised as a topic for future consideration.

This report made no attempt to show relationships between programs' theoretical bases and their treatment goals and methods. Further research including well-planned program evaluation is needed to elucidate such relationships.

The survey did not inquire whether respondents attempted, in planning treatment for individual batterers, to tailor intervention formats and methods to individual differences and needs. It is likely, however, given the respondent programs' personnel limitations, high level of service demand, and typically limited nature of individual assessment, that such individualized treatment planning is still rare in batterer programs.

Such a supposition is supported by the fact that most of the literature we reviewed focused on identification of commonalities among batterers; there was little attempt to identify differences. Only two authors identified different types of batterers according to individual and relationship dynamics (Elbow, 1977; Deschner, 1984). A comprehensive model is needed to make sense of both commonalities and differences, to understand the interrelationships among different causes of battering behavior in a given individual, and to tailor treatment methods to individual needs.

In conclusion, the biggest unanswered question remains, "What approaches are effective in helping batterers change?" We have learned, however, that this question is not a simple one. To answer it, we must also explore related issues, including:

- How can we better identify and understand the causes and dynamics of battering, both in individuals and in general?
- What are the commonalities as well as the differences between types of batterers?
- How can we identify the different causal factors in individual cases, and tailor treatment approaches to intervene most effectively in these factors?
- How can we best design assessment, service delivery, and follow-up systems to facilitate outcome evaluation of treatment?
- What is the best setting for programs for batterers? Might some settings, and the indirect messages they convey, be more effective with certain types of batterers and other settings be more effective with others?

- Could volunteer resources be used more extensively in work with batterers, as they are in shelters, to increase cost-effectiveness without sacrificing quality of services?
- How can the resources be generated for these costly activities without sacrificing the overarching objective of keeping victims safe?

Working with men who batter to help them stop their abusive behavior is a major link in the chain of efforts to end our society's epidemic of family violence. We hope that this study, having gathered information about helping men who batter and generated questions about how that help can be made more effective, will encourage and accelerate further work in the field, both in service provision and in research and evaluation.

APPENDIX A

SURVEY QUESTIONNAIRES

SURVEY: PROFILE OF PROGRAMS FOR BATTERERS IN THE U.S. AND CANADA
prepared for the TEXAS DEPARTMENT OF HUMAN RESOURCES
in collaboration with the TEXAS COUNCIL ON FAMILY VIOLENCE

Dear Colleague:

We are requesting your cooperation in helping us learn more about the services currently offered to batterers in the U.S. and Canada. We would greatly appreciate information on your program. All the information you provide will be coded, computer analyzed, and retained in strictest confidence. A stamped return envelope is provided for your convenience. Thank you for your help.

Name of Program _____

Mailing Address _____

Name of person completing survey _____ Title or position _____

DEFINITIONS

"Batterer" refers to one who physically abuses an adult intimate partner or household member, whether formally married or not. In some survey items, the batterer is referred to as "(program) participant". "Victim" refers to the adult who is abused.

"Program" refers to any intervention services offered to batterers, whether formally structured or not.

"Shelter" refers to a center which provides shelter and/or other services to battered women or other victims of family violence.

"Court diversion, pre-plea" refers to a procedure whereby a batterer, upon whom assault charges have been filed, may choose to enter an intervention program before any plea is entered or any prosecutorial action is taken.

"Court diversion, post-plea" refers to a procedure whereby a batterer, upon whom assault charges have been filed, enters a plea and/or is tried on the charges, and may then choose to enter an intervention program in lieu of paying fine, serving jail time, etc.

"Court order" refers to a procedure whereby a batterer, upon whom assault charges have been filed, is ordered by the court, at any point in the judicial process, to enter an intervention program (e.g. as a condition of probation).

SERVICES TO BATTERERS

1. Does your program operate: (check one)
   1. _____ Autonomously, as a free-standing organization
   2. _____ Under the auspices of another agency/organization (name of organization _____)
   3. _____ Other (specify: _____)

2. How long has your program been in operation? (check one)
   1. _____ less than one year, 2. _____ 1-2 years, 3. _____ 2-3 years, 4. _____ 3+ years (specify _____)

3. What are your program's funding sources? (check all that apply)
   1. _____ Local government(s)
   2. _____ State government
   3. _____ Federal government
   4. _____ United Way
   5. _____ Private contributions
   6. _____ Foundations
   7. _____ Participant fees
   8. _____ Program is not funded
   9. _____ Other (specify_____)

4. What is the population of your program's service area? (check one)
   1. _____ under 10,000
   2. _____ 10-25,000
   3. _____ 25-50,000
   4. _____ 50-100,000
   5. _____ 100,000+

GIVE ACTUAL NUMBERS FOR ITEMS 5-8

5. In your program, how many people in all provide direct services to batterers (include volunteers) _____.

6. How many service providers are: 1. male _____ 2. female _____

7. How many service providers are:
   1. _____ White
   2. _____ Black
   3. _____ Spanish origin (any race)
   4. _____ American Indian, Alaskan native
   5. _____ Asian origin
   6. _____ Other

8. How many service providers are:
   1. _____ salaried professional staff
   2. _____ contractual workers or consultants
   3. _____ volunteers
   4. _____ student interns
   5. _____ other (specify _____)
   (Of these, how many are former batterers? 6. _____)

9. In which of the following ways do batterers enter your program? (check as many as apply)
   1. _____ voluntarily, through self-referral
   2. _____ voluntarily, through other agency or professional referral
   3. _____ through court diversion, pre-plea
   4. _____ through court diversion, post-plea
   5. _____ through court order
   6. _____ other (specify _____)

10. Does your program ever receive more referrals than it can accomodate at one time? 1. _____ Yes, 2. _____ No
    (If No, skip to #12)

11. If yes, do you (check as many as apply):
    1. _____ place on waiting list
    2. _____ redirect the referral to another agency or program
    3. _____ refer to private counseling
    4. _____ other (specify _____)

12. Does your program receive requests to work with female batterers? 1. _____ Yes, 2. _____ No (if No, skip to #13)

A. If Yes, does your program provide any direct services for female batterers?
1. _____ Yes, 2. _____ No (if No, skip to #13)

B. If Yes, what percentage of female batterers seen in your program have also been victims of battering? _____%

13. For which of these reasons would your program refuse a batterer for services and/or make a referral for more appropriate immediate services? (check as many as apply)

1. _____ Felony level spouse assault
2. _____ Active psychiatric problems
3. _____ History of serious psychiatric problems
4. _____ Has already gone through program
5. _____ Active alcohol or drug abuse
6. _____ Not of legal age
7. _____ Subnormal intelligence
8. _____ Language limitations
9. _____ Other (specify _____)

14. Please rank the following intervention formats in terms of how much they are used in your program (1 = most used). Do not rank any which are not used at all.

_____ batterers groups
_____ individual counseling
_____ couple counseling
_____ couples groups
_____ family counseling
_____ family groups
_____ crisis-oriented counseling
_____ criminal justice system
_____ other (specify_____)

A-3

15. If all or part of work with participants is conducted in batterers' groups, please complete Items A-D.

A. Groups are (check one): 1. _____ time-limited; 2. _____ ongoing; 3. _____ combination of time-limited & ongoing

B. If time-limited, how long does each group meet (check one)?

1. _____ 6 weeks or less
2. _____ 6+ weeks - 3 months
3. _____ 3+ months - 6 months
4. _____ More than 6 months
5. _____ Not applicable, groups are ongoing

C. Participants may enter group (check one): 1. _____ only at certain times (e.g., when a new time-limited group starts)
2. _____ at any time

D. Average number of participants per group: _____

16. How does your program monitor batterers for recurrence of violence while they are participating in the program? (check as many as apply)

1. _____ batterer self-report
2. _____ ongoing contact with victim by program personnel
3. _____ police reports
4. _____ probation officer reports
5. _____ reports from other sources (specify_____)
6. _____ no regular monitoring is done

17. How does your program deal with a recurrence of violence by the batterer while participating in the program? (check as many as apply)

1. _____ the batterer received special counseling
2. _____ the batterer may be discontinued from program
3. _____ the batterer is referred to the courts
4. _____ the batterer's probation officer is notified
5. _____ there is no standard policy or procedure to deal with recurrences
6. _____ other (specify_____)

18. Does your program have a policy that excessive absences from the program will result in discontinuation of services to the participant? 1. _____ Yes 2. _____ No

19. The following are some factors that are believed to contribute to battering. Indicate the extent to which each factor influences your program's goals and methods. (Circle one number for each factor.)

	Not at all Influential				Very Influential
1. Drug or alcohol abuse	1	2	3	4	5
2. External factors (job stress, financial difficulties, conflicts about children, etc.)	1	2	3	4	5
3. Individual psychopathology or emotional disturbance	1	2	3	4	5
4. Interactional dynamics of individual relationship	1	2	3	4	5
5. Patriarchal structure of society/cultural sanction of violence against women	1	2	3	4	5
6. Social learning of violent behavior	1	2	3	4	5
7. Social skill deficits (e.g. communication, problem-solving, etc.)	1	2	3	4	5
8. Traditional family roles/sex role stereotyping	1	2	3	4	5
9. Other (specify _____)	1	2	3	4	5

20. The following are some goals for change in individual batterers. Please rank them in terms of their priority in your program. (1=primary change goal, 2=secondary change goal, etc.) Do not rank any which are not stated goals of your program.

_____ Stop the violent behavior
_____ Improve communication and relationship skills
_____ Promote more flexible sex role behavior, decrease sex-stereotyped behavior
_____ Decrease isolation, improve social support system
_____ Improve self-esteem
_____ Improve or save relationship with victim
_____ Change attitudes which contribute to violence
_____ Other (specify _____)

21. The following are some intervention methods which may be used in working with batterers. Please indicate those which are used in your program (check all that apply):

1. _____ Anger management
2. _____ Assertiveness training
3. _____ Behavior contracting
4. _____ Buddy system
5. _____ Building social support systems
6. _____ Communication skills training
7. _____ Criminal justice - related interventions
8. _____ Drug-alcohol intervention or treatment
9. _____ Education about the criminal laws related to battering
10. _____ Emotional awareness training
11. _____ Emotional expression training
12. _____ Exploration of individual personal/family history
13. _____ Exploration of sex roles
14. _____ Journal-keeping
15. _____ Parenting education
16. _____ Problem-solving skill training
17. _____ Radical therapy
18. _____ Role-playing by clients
19. _____ Role-playing by group leaders
20. _____ Stress management (relaxation training, etc.)
21. _____ Support group for victims
22. _____ Support outside sessions (e.g., hotline, access to program personnel, etc.)
23. _____ Vocational assistance
24. _____ Other (specify _____)

RELATIONS WITH SHELTERS AND OTHER ACTIVITIES

22. Is there a shelter* in your service area? 1. _____ Yes 2. _____ No

23. What is the nature of your program's relationship with the local shelter*? (check one)
1. _____ Batterer's program is operated by shelter
2. _____ Program is operated separately from shelter, with mechanisms for formal shelter input and/or monitoring
3. _____ Program is operated separately from shelter, with shelter providing informal input
4. _____ Little or no relationship with shelter
5. _____ Not applicable, no shelter in area

24. What is your opinion about the value of shelter* input into batterer programs? (check one)
1. _____ Very helpful 2. _____ Somewhat helpful 3. _____ Not very helpful 4. _____ Not helpful at all

*refer to definition at beginning

25. What other activities related to family violence prevention and intervention do program personnel participate in? (check all that apply)
1. _____ Public education
2. _____ Active involvement in the battered women's movement (e.g. volunteering in shelters)
3. _____ Work for procedural change in the criminal justice system
4. _____ Work for legislative change in the criminal justice system
5. _____ Networking with other community services which deal with family violence
6. _____ Active solicitation of input from women's groups to ensure their concerns about battering are addressed in program
7. _____ Other (specify_____)

ASSESSMENT/EVALUATION

26. Which of the following are used in your program's assessment/evaluation procedures? (check all that apply)

1. _____ Intake interview with batterers
2. _____ Standardized tests for batterers
3. _____ Interview with victim as part of intake process, when possible
4. _____ Ongoing assessment while batterer is in program
5. _____ Exit interview (self-report)
6. _____ Exit interview (victim or 3rd party)
7. _____ Follow-up interview(s) after batterer has left or completed program (self-report)
8. _____ Follow-up interview(s) after batterer has left or completed program (victim or 3rd party report)
9. _____ Program personnel's evaluation of batterer
10. _____ Batterer's evaluation of program
11. _____ Control group of non-batterers for comparison
12. _____ Data on police involvement with batterer
13. _____ Other (describe: _____)
14. _____ No assessment/evaluation procedures are used

27. How long have evaluation data been collected? (check one)
1. _____ Less than 1 year 2. _____ 1-2 years 3. _____ 2-3 years 4. _____ More than 3 years

28. (optional) What is unique or unusual about your program that we haven't asked about?

Please attach the name, address, and phone number of any batterer programs that you know about which have developed since 1981.

We would welcome your comments, questions, etc., as well as any additional written materials about your program such as brochures, program descriptions, etc. Thanks again for your participation.

Return survey to: Department of Sociology, University of Texas at Arlington, Arlington, Texas 76019.

FOLLOW-UP SURVEY: PROFILE OF PROGRAMS FOR BATTERERS IN THE UNITED STATES AND CANADA
prepared for the TEXAS DEPARTMENT OF HUMAN RESOURCES
in collaboration with the TEXAS COUNCIL ON FAMILY VIOLENCE

Dear Colleague:

Not long ago you cooperated in our survey of batterer programs in the United States and Canada. We deeply appreciate your help. We would also like to request a further favor. We are sending this brief follow-up questionnaire designed to gather more specific information about the characteristics of your program participants and procedures you employ in outcome evaluation. Again, we assure you that all information for every program will be kept anonymous and confidential. Thank you for your cooperation.

Name of Program _____

Mailing Address _____

Office Phone _____

Name of Person completing survey _____ Title or Position _____

DEFINITIONS

"Batterer" refers to one who physically abuses an adult intimate partner or household member, whether formally married or not. In some survey items, the batterer is referred to as "(program) participant". "Victim" refers to the adult who is abused.

"Program" refers to any intervention services offered to batterers, whether formally structured or not.

"Shelter" refers to a center which provides shelter and/or other services to battered women or other victims of family violence.

"Court diversion, pre-plea" refers to a procedure whereby a batterer, upon whom assault charges have been filed, may choose to enter an intervention program before any plea is entered or any prosecutorial action is taken.

"Court diversion, post-plea" refers to a procedure whereby a batterer, upon whom assault charges have been filed, enters a plea and/or is tried on the charges, and may then choose to enter an intervention program in lieu of playing fine, serving jail time, etc.

"Court order" refers to a procedure whereby a batterer, upon whom assault charges have been filed, is ordered by the court, at any point in the judicial process, to enter an intervention program (e.g. as a condition of probation).

1. What current program processes or activities do you want to change or delete? How would you change them and why would you change or delete them?

2. What activities or processes are not currently part of your program that you believe to be important and would like to develop? Why are they important?

3. What suggestions do you have about future directions in research and evaluation of batterer programs?

PARTICIPANT (BATTERER) DATA

For questions 4 through 8, please provide data for the most recent 12-month period for which data are available. Give actual numbers of program participants who fall in each category.

Dates of 12-month period reported: ___/___/___ (mo day yr) through ___/___/___ (mo day yr)

4. How many batterers were screened during the 12-month period? _____

5. How many batterers were admitted to the program during the 12-month period? _____

6. How many batterers completed the program during the 12-month period? _____

7. Batterers Admitted to Program		8. Batterers Who Completed Program
	Ethnicity	
1. _____	1. White	1. _____
2. _____	2. Black	2. _____
3. _____	3. Spanish origin (any race)	3. _____
4. _____	4. American Indian or Alaskan native	4. _____
5. _____	5. Asian origin	5. _____
6. _____	6. Other	6. _____
	Relationship to Victim (at time of admission to program)	
7. _____	7. Married, living together	7. _____
8. _____	8. Not married, living together	8. _____
9. _____	9. Married, not living together	9. _____
10. _____	10. Not married, not living together	10. _____
11. _____	11. Familial relationship other than marriage	11. _____

How Entered the Program

12. _____	12. Voluntarily	12. _____
13. _____	13. Court diversion, pre-plea	13. _____
14. _____	14. Court diversion, post-plea	14. _____
15. _____	15. Court order	15. _____

9. The following are some goals for change in individual batterers. In the last survey, you ranked them in terms of their priority in your program. For this survey, please check at left those which are goals in your program (you need not rank them again); for each one checked, list what evaluation measure is used to identify individual participants' progress toward reaching the goal; and indicate on the scale at right what degree of success the measure has shown in reaching the goal. If your program does not have an evaluation measure for one or more of its goals, check the goal at left and leave the other columns unmarked for that goal.

Goal	Evaluation Measure(s)	Degree of Success Shown		
		Little or No Success	Some Success	Much Success
___1. Stop the violent behavior	1.	1	2	3
___2. Improve communication and relationship skills	2.	1	2	3
___3. Promote more flexible sex role behavior, decrease sex-stereotyped behavior	3.	1	2	3
___4. Improve social support system, decrease isolation	4.	1	2	3
___5. Improve self-esteem	5.	1	2	3
___6. Improve or save relationship with victim	6.	1	2	3
___7. Change attitudes which contribute to violence	7.	1	2	3
___8. Other (specify _____)	8.	1	2	3

10. Have you conducted any follow-up or outcome studies of batterers who were program participants? 1. ____ Yes 2. ____ No

11. If yes, would you briefly describe your follow-up or outcome study procedures; include a copy of the follow-up questionnaire or other instrument used; and describe your findings, giving actual data if possible. If a report or summary is available, please supply a copy.

    If no, for what reasons have follow-up or outcome studies not been conducted?

For questions 12-15, circle one number for each question.

	Too Soon to Tell/ No Opinion	Not Very Effective	Somewhat Effective	Very Effective
12. How effective do you think voluntary programs are at helping batterers change?	1	2	3	4
13. How effective do you think court diversion (pre-plea) programs are at helping batterers change?	1	2	3	4
14. How effective do you think court diversion (post-plea) programs are at helping batterers change?	1	2	3	4
15. How effective do you think court-ordered programs are at helping batterers change?	1	2	3	4

16. (optional) What issues or topics have we not addressed in this or the earlier survey? or What else would you like to know about other batterer programs?

Return survey to: Department of Sociology, University of Texas at Arlington, Arlington, Texas 76019

APPENDIX B

BATTERER DYNAMICS AND TREATMENT:

AN ANNOTATED BIBLIOGRAPHY

I. ISSUES IN RESEARCH AND APPLICATION

Gelles, R. Applying research on family violence to clinical practice. Journal of Marriage and the Family. 44:1, February, 1982.

While not specific to wife abuse or batterer treatment issues, this article by one of the best-known researchers in the family violence field makes some points of relevance to the design of batterer treatment programs. Gelles states that "the present knowledge base (about family violence) is limited and immature." He cites six major limitations to current research and theory: (1) Most studies are based on "caught" samples of victims who have sought help or who have been referred to the authorities, rather than random samples. (2) Comparison groups of non-victims or non-abusers are seldom used. (3) Due to non-random sampling, generalizability of results to larger populations is questionable. (4) Overly simplistic theories about the causes of family violence have been advocated in various reports. Gelles states, ". . . it is extremely unlikely that family violence will be amenable to the simplistic, single variable explanations which have proliferated in the early years of research on this emotion-laden social problem." (5) The so-called "Woozle effect" has caused various pieces of research on family violence (especially early ones, which filled a knowledge void even if their methods were less than precise) to assume a status of "law," without benefit of further investigation. (6) New myths about family violence have been created due to the previous five factors, and these myths have found their way into clinical applications.

The author goes on to say that some solid research on family violence has been done, with more on the way. In sum, this portion of the article suggests that parsimony be used when applying research findings in the field to clinical practice with victims and abusers alike.

Schechter, S. An agenda for the battered women's movement: internal issues. Chapter 11, Women and Male Violence. Boston: South End Press, 1982.

This section in Schechter's history of the battered women's movement presents a feminist perspective on batterer intervention programs. The discussion opens with feminist guidelines for funding programs for batterers, developed jointly by battered women's activists and members of EMERGE, a batterer's program in Boston. The guidelines are: (1) No program for batterers should be funded unless and until there is a shelter in the immediate area. (2) Where competition exists between batterer programs and shelters for limited funds, shelters should be the priority. (3) Batterer programs should work cooperatively with their local shelters, and share the same philosophy about causes, intervention, and prevention of wife beating.

Schechter points out that treatment for batterers, as practiced by feminist batterer programs such as EMERGE and RAVEN in St. Louis, focuses exclusively on male violence as the problem, not male-female relationships. Batterers are required to accept accountability for their violent actions, and to find new ways to express feelings (including anger) and to relate to women. Group counseling is the preferred format. Feminist batterer programs go beyond intervention with individual batterers to public education and other social change activities, consistent with the viewpoint that male violence is culturally based and must be challenged on a society-wide as well as an individual basis.

2. DYNAMICS AND CHARACTERISTICS OF BATTERERS

Breiner, S. J. Psychological factors in violent persons. Psychological Reports. 44:1, February, 1979.

This article examines, from a psychoanalytic point of view, factors contributing to violence. The major factors are identified as: early childhood identification with a disturbed or violent individual; inadequate resolution of passive-aggressive problems originating prior to two years of age; and ego defects in perceiving and coping with reality. Denial is the defense mechanism most used by violent individuals. Further, the denial of their own destructive impulses leads to projection, i.e. perceiving such impulses as being directed from others toward themselves. Several social characteristics and experiences leading to violence are also mentioned, including early encouragement to play "war" and other pseudo-violent games, and familial acceptance of corporal punishment.

A number of implications for treatment are discussed. Emphasis is placed on continuous emotional support from the mental health practitioner during treatment; increasing and improving the client's use of verbal expression; improving client self-awareness with regard to incipient violence as well as emotions in general; and bolstering ego controls and reality-testing skills. While the article is not specific to batterers and outdated assumptions are made during a brief discussion of wife-beating, several of the findings and implications are consistent with others in the literature.

Chimbos, P. D. Marital violence: a study of interspouse homicide. In Dissertation Abstracts International, 1976. Unpublished dissertation, York University.

In this study, information was gathered about the social conditions under which interspouse homicide occurred. Semistructured personal interviews were conducted with 29 husbands and 5 wives serving time for murder or manslaughter of spouses. Data were gathered about the offender's early life experiences; interactional processes in his or her marriage; and aspects of situations surrounding the actual homicidal incident.

It was found that the offenders had experienced violence and parental rejection in their families of orientation. Their marital relationships had been characterized by serious conflict, related to the offender's perception that the spouse posed a threat to his or her personal identity. The offenders demonstrated a tendency to use simplistic and immediate responses to such perceived threats, which contributed to a buildup of hostilities between the spouses. Conditions identified as contributing to the homicidal behavior were: previous experience with violence in childhood and later life; the absence of an intervening third party, both prior to and during the homicidal incident; and intoxication from alcohol or drugs. Treatment implications are not discussed in the abstract.

Elbow, M. Theoretical considerations of violent marriages. Social Casework. 58:9, 1977.

This early article in the field categorizes wife beaters according to four different personality syndromes. The "Controller" is said to view his wife as a possession and to dominate her in order to avoid being controlled by her. The "Defender" is said to fear personal harm to himself, so harms his wife then "rescues" her from himself during the affectionate period typically following an abusive episode. The "Approval-seeker" suffers from poor self-esteem, and, constantly anticipating criticism from his spouse, loses control when he believes such rejection from her is forthcoming. Finally, the "Incorporator" perceives his wife as an extension of himself, and strikes out in frustration if he believes she is withdrawing from him.

The article relates all these syndromes to dysfunctional parenting during the abuser's childhood, and suggests that the violent behavior is part of a systematic psychological projection.

Gillman, I. S. An object-relations approach to the phenomenon and treatment of battered women. Psychiatry, 43, 1981.

In this article, Gillman formulates a treatment approach to battered women based on Kernberg's object-relations theory. Although a treatment strategy for the batterer is not stated, information about the male partner serves to illuminate the interaction of the couple. Gillman writes, "Although both husband and wife are unaware of the process involved, they alternate in making each other the 'bad guy.' She becomes the 'dumpee' which makes him into the 'animal who would be so low as to hit a woman.'" A therapist would work to demonstrate how each partner perceives a split (bad/good) in the other, and to facilitate clearer perceptions of each spouse about the other. This presumably would be the prelude to dealing with other dysfunctional aspects of the relationship, including abusive behavior.

O'Reilly, J. Wife beating: the silent crime. Time, September 5, 1983.

This segment of a Time cover story on "Private Violence" is on wife-beating. Though the focus of the story is on the women, people working with those who batter are also quoted. One worker described a batterer with whom he had worked as emotionally stunted and having tantrums like a two-year-old. Another told of the difficulties the battering men had in trying to live up to the strong, dominant male image. Control is said to be a key issue. Typically, as a batterer becomes more desperate to hold onto his wife, he does not realize his behavior is driving her away. Without her, he feels as though he is nothing, though this is hard for him to admit. A beating is often followed by displays of tenderness.

The EMERGE batterer program in Boston is described, including their experience that most men do not enter counseling unless the partner is gone or threatening to leave, or if they have been mandated by court order to seek treatment. Initially, the abusive men do not believe they have done anything wrong. However, EMERGE workers told of one man who, at the end of six weeks in the program, made the statement that if a husband had control of himself, then a wife could not make him hit her.

Ponzetti, J., Cate, R., and Koval, J. Violence between couples: profiling the male abuser. Personnel and Guidance Journal. 61:4, December, 1982.

The article provides a systematic review of the characteristics of male batterers, as reflected in the literature on spouse abuse. While pointing out that few studies to date have attempted to create a multivariate perspective on the spouse abuser, a number of associated factors have been identified. Categories of internal and external factors are defined and examined. The internal factors discussed are (a) learned predisposition toward violence; (b) alcohol and drug problems; (c) inexpressiveness; (d) emotional dependence; and (e) lack of assertiveness. External factors explored are economic stress, social isolation, and cultural norms about violence.

In discussing intervention implications, the authors conclude that effective treatment efforts focus on changing stereotyped sex-role attitudes in abusive men, and training them in interpersonal skills. They also suggest that several issues require further exploration, such as the degree to which (or whether) abuse is a function of other aspects of a couple's relationship; the relative merits of group versus individual intervention; and possible approaches to prevention of family violence as well as remediation. The 29-entry reference list includes many of the well-known works on family violence.

Rounsaville, B. J. Theories in marital violence: evidence from a study of battered women. Victimology, 3:1-2, 1978.

Rounsaville, a Yale psychiatrist, discusses three types of theory which have been advanced to explain wife beating. Psychological explanations postulate that abuse is encouraged by masochistic women or tolerated because the women are in a state of "learned helplessness." Socio-political explanations ascribe culpability to the patriarchal structure of society. Interactional theories of family systems point to dynamics in the individual marriage which contribute to eruption of violence. Each theory has different implications for treatment.

After considering evidence supporting the differing theories, Rounsaville describes an important feature, found in his study of battered women, leading to the syndrome of wife battering: the intense, exclusive, tenacious dyadic relationship in which the couple is enmeshed. As individuals in other social situations, the man may not be violent and the woman not be willing to tolerate abuse. But once in the relationship, a dynamic is set up such that violence recurs in a remarkably stable, though dysfunctional, context. This dysfunctional stability is seen as an issue for intervention.

Husbands in the study were described as jealous, possessive, impulsive, and needy. Many of them reported violence in their backgrounds. Stress was cited as a factor that could cause violence to erupt.

Roy, M. (Ed.) The Abusive Partner: An Analysis of Domestic Battering. New York: Van Nostrand Reinhold, 1982.

The editor, founder of Abused Women's Aid in Crisis (AWAIC) in New York, has compiled a book of articles about the abusive partner. Among its topics are the

psychosociology of abusive behavior; the current status of information about its medical, environmental, and criminal justice aspects; and treatment of the abuser. Some articles, of particular relevance to treatment issues, are reviewed separately in this bibliography.

In one article, Roy analyzes power and powerlessness. She examines five kinds of power, following Rollo May's model. Of the five types, two—exploitative and manipulative—have negative consequences for society, and Roy relates them to battering., She also presents a trend analysis of battering, based on information from four thousand female victims of domestic violence who sought help at AWAIC. Her data cover demographics as well as the nature of abuse and injuries, frequency of episodes, use of drugs and alcohol, and issues around money, jealousy, sexual difficulties, unemployment, and disputes over the children. Her analysis is intended to create a better understanding of the batterer as well as the victim.

Ryan, D. M. Patterns of antecedents to husbands' battering behavior as detected by the use of the critical incident technique. In Dissertations Abstracts International, 1982. Unpublished dissertation, United States International University.

Interviews were conducted with a sample of ten battering husbands, using a structured format consisting of five questions. The questions were designed to elicit factors which were typically present in a situation immediately prior to the onset of a violent incident with their wives. Findings were that the husband's thoughts, immediately prior to an incident, centered around how to cope with the situation through other than forceful means, and that he felt vulnerable. A further finding was that the husband's behavior prior to an incident typically involved a request made to the wife, or a demand for a change in her behavior, and that the wife's behavior typically consisted of refusing to meet the request or demand.

Treatment implications are not discussed; however, due to the extremely small sample, the usefulness of the results for any application is doubtful.

Schauss, A. G. Effects of environmental and nutritional factors on potential and actual batterers. In M. Roy (Ed.), The Abusive Partner: An Analysis of Domestic Battering. New York: Van Nostrand Reinhold, 1982.

Potential physiological reasons for unwanted behavior are often overlooked in favor of pure psychosocial etiology. This article describes methods of analyzing environmental and nutritional factors to discover possible links with abusive behavior. Examples of behavior resulting from geographical elevation or from deficiencies of certain elements are cited. For example, hair analysis of one violent subject showed a high copper level with evidence of associated zinc deficiency, which has been related to hyper-aggresivity and hyperkinetic behavior. The author suggests that any program working with male batterers should consider biochemical imbalance as a possible area for further evaluation.

Stacey, W.A., and Shupe, A. The Family Secret. Boston: Beacon Press, 1983.

In one of the first books on domestic violence written specifically for a popular audience, sociologists Stacey and Shupe draw on a number of sources including reports from hundreds of battered women about themselves and their abusers. A chapter entitled "Men: The Perpetrators of Violence," examines demographic and behavioral characteristics of batterers, the influence of violent childhood experiences on adult battering behavior, and batterers' reactions after violent episodes.

They found that among their sample, violence seemed to have been affected by economic vulnerability of the families, related to relatively low educational levels of the men and to current financial stresses. They also found evidence supporting the generational transfer hypothesis among men: about six out of ten batterers had witnessed physical violence between their parents, while four out of ten had themselves been physically abused as children. Finally, they found that about half the batterers in their study typically tried to make up with their victims following an abusive incident, but the other half simply felt the violence had been justified and did not attempt to make amends. It was among the latter group that the abuse was likely to be most frequent and severe.

This sociologically-oriented book does not address batterer treatment issues, but paints a vivid picture of the incidence and patterns of family violence.

Symonds, M. The psychodynamics of violence-prone marriages. The American Journal of Psychoanalysis. 38:3, 1978.

The author, director of the Victimology Program at the Karen Horney Clinic, cites three issues in marriage which may trigger violence: power, intimacy, and boundaries. She then describes two broadly-defined types of violence-prone marriages. In the first type, the husband uses violence to resolve conflict. For him, violence is ego-syntonic, and in these cases, the wife is an "accidental" victim. Symonds goes on to describe three personality syndromes of battering husbands in this first type of violence-prone marriage. The husband may be the type of person who has a "short fuse," is action-oriented, and sees nothing wrong with the violence. This syndrome resembles the personality pattern of most violent criminals. Another type of wife-beater often appears anxious and guilt-ridden, has a "kiss and make up" marriage, and is described as a dependent individual with compliant as well as aggressive tendencies. This person represents the majority of wifebeaters, in the author's opinion. The third variety is the overly controlled, compulsively hostile individual who has an arrogant, vindictive character structure. He is preoccupied with the struggle for power and tries to keep his partner off balance, often by denying her perceptions of reality.

In therapy, the partners in this type of violence-prone marriage feel helpless. Each spouse may view the therapist as an authority figure to rebuke or punish the other, rather than as a resource for making real changes in the relationship. The wife usually just hopes that therapy will make her husband stop being violent.

In the second type of violence-prone marriage, each partner is described as both participant and victim of the abuse. Violence emerges after other attempts at communication have been tried and failed. Marriages most amenable to counseling are believed to be those where failure of communication has been the major

source of trouble. Marriage is defined as being most functional when partners listen receptively and respond to one another in the communication of their needs. Thus, with this second type of violence-prone couple, improvement of communication may be viewed as a primary goal of treatment.

3. COMPARISON STUDIES

Coleman, K. H. and Weinman, M. L. Conjugal violence: a comparative study in a psychiatric setting. In J. R. Hays, K. Solway, and T. K. Roberts (Eds.), Violence and the Violent Individual. Englewood Cliffs, N.J.: Spectrum of Prentice Hall, 1981.

Coleman compared two groups of patients seeking treatment for marital problems at the Texas Research Institute for Mental Sciences Marriage and Family Clinic. One group was involved in physical violence and the other group was not. Each group consisted of 30 couples. The study's goals were to gather information on intact couples who were involved in marital violence, and to discuss implications of the study's findings for treatment. (Study is similar to Rosenbaum and O'Leary [1981]). It is stressed in the discussion of findings that any "model for the eruption of conjugal violence must integrate societal, familial and psychological" factors. The author also advises those who are treating individuals involved in conjugal violence to attend to the violence specifically and not discount its severity.

Rosenbaum, A., and O'Leary, K. D. Marital violence: characteristics of abusive couples. Journal of Clinical and Consulting Psychology. 49:1, February, 1981.

This study compared groups of couples who were (1) maritally satisfied; (2) maritally dysfunctional, nonviolent; and (3) maritally dysfunctional, violent. A battery of standardized tests was used to measure factors including marital adjustment (self-report), attitudes about sex roles, alcoholism, and assertion.

The group of maritally dysfunctional, violent couples differed from the maritally satisfied group on almost all measures. However, there were no significant differences between maritally dysfunctional wives who were involved in marital violence and those who were not, while maritally dysfunctional violent husbands differed from maritally dysfunctional nonviolent husbands in three areas. Abusive husbands were less verbally assertive with their wives, were more likely to have been abused as children, and were more likely to have witnessed abuse between parents during childhood than the non-abusive husbands.

It was also found that physical abuse is not necessarily associated with marital discord; however, alcoholism was strongly associated both with discord and with abuse. Husbands and wives in abusive couples were more dissimilar to one another in attitudes about sex roles than were non-violent couples. There were also significantly more mixed-religion marriages among the violent couples. Intervention strategies are not discussed in the article.

4. TREATMENT CONCEPTS

Ball, M. Issues of violence in family casework. Social Casework, 58:1, January, 1977.

This early article in the literature describes the experiences of staff in a family service agency in providing spouse abuser treatment. It was found that many abusers and victims had several commonalities in their personal histories. These included being abused as children; authoritarian and punitive parents; and often, early loss of one parent. Abusive marriages were frequently characterized by social isolation, financial difficulties, and low self-esteem in one or both spouses. A further impression was that personal losses or threats of losses were a common trigger to violence.

Interventions described deal primarily with client self-awareness and with problem-solving. The abuser is assisted in learning to alter situations and feelings which typically lead to a violent reaction; to exercise self-control and self-awareness; and to identify options and alternatives to cope with problematic situations. The importance of the therapist's empathic concern for the abusive client, accessibility to the client, and prompt therapeutic response to the client's needs is emphasized. The author also suggests that confrontive interpretations be postponed until later in treatment.

Brygger, M. P., Long, D., and Morse, J. Working with men who batter: a discussion paper. Paper presented at Institute on Battering Males, Second National Conference of the National Coalition Against Domestic Violence, Milwaukee, WI, August, 1982.

Treatment for males who batter is viewed as necessarily an adjunct of the movement to end violence against women. Although the movement's first priority is women, the authors point out that programs for men who batter are justified because they can help men end all types of woman abuse. A further value of such programs is to demonstrate to mental health and social service professionals effective ways to work with abusive men. Finally, batterer programs contribute to the promotion of safety for women as well as equality in relationships, while emphasizing the concept that the victim should not be blamed for the violence.

It is suggested that the initial focus be on violence and other male controls over women. In later phases of counseling, the focus should be on developing alternative modes of expression and conflict resolution skills, including stress and anger management, relaxation techniques, and others. The authors believe that treatment should consist of at least six months of weekly meetings, and that after counseling is completed, a self-help network and/or peer support group should be available. Couple counseling should not be initiated until there is no further possibility of violence, and then only if both parties are still interested in working on the relationship.

It is recommended (1) that anger extinction methods be used, rather than anger catharsis techniques; (2) that monitoring for recurrence of abuse be done through safety checks with women (victims) rather than reliance on reports from the men; and (3) that if men have alcohol or drug abuse problems, these should be treated before the violent behavior is addressed.

Coleman, K. H. Conjugal violence: what 33 men report. Journal of Marital and Family Therapy. 6:2, 1982.

This study was conducted by a former Board member of the Texas Council on Family Violence at the Texas Research Institute of Mental Sciences (TRIMS). Subjects in the study were thirty-three men coming to the Marriage and Family Clinic of TRIMS who had been involved in conjugal violence over the previous year.

It was observed that the men came to treatment initially without having fully accepted responsibility for their behavior. They cited as reasons for the violence dissatisfaction with the spouse, retaliation to physical or verbal abuse from the spouse, and jealousy of their partner's past or present relationship with other men.

The study supports a social learning theory of violence, observing that once physical aggression is established as a learned response to stress, it is difficult to unlearn. Attitudinal difficulties regarding self-esteem and sex-role stereotypes were also present. The men embraced the belief that they should be strong and dominant, superior and successful.

Choosing a treatment strategy (among individual, group, or conjoint) is dependent on several issues. In cases of severe violence, individual counseling is preferred by the author over conjoint, because when sensitive issues between a couple are aired in a session, they could cause tension and violence to escalate at home. Therapists are admonished to remain unruffled by bombastic, intimidating behavior. Once a man recognizes his feelings, controls his anger, and learns appropriate ways to express his tension, he may be ready to examine the effect of his behavior on others, particularly his spouse. Contracts are developed and maintained, the use of time-out periods at home is encouraged, and relaxation techniques are taught. Finally, the author suggests that paradoxical intervention, a therapeutic technique in which the counselor "prescribes" the inappropriate behavior or symptom, may be employed to intervene in the pattern of intense symbiosis often evident in violent couples.

Ganley, A. L. Court-Mandated Counseling for Men Who Batter: A Three-Day Workshop for Mental Health Professionals. (Participants' manual). Center for Women Policy Studies, Washington, D.C., 1981.

Ganley has pioneered work with batterers in both inpatient and outpatient settings, and on a voluntary as well as a court-mandated basis. This manual, while of particular interest to those providing or planning court-mandated batterer counseling, gives information that can be useful to providers of voluntary services as well.

The manual opens with a discussion of the philosophy underlying the suggested program. Battering is considered to be a crime, and thus properly to be within the jurisdiction of the court. It is also considered to be learned behavior rather

than symptomatic of "mental illness." The primary goal of treatment is to stop the battering. Further sections give a clinical overview of the dynamics of battering and of the batterer, followed by a detailed conceptual description of a court-mandated counseling program, from initial assessment to termination and follow-up. Ganley illustrates the conceptual description with information about her own program, which is offered as a model. An interesting feature of the model is its use of "anger logs," in which participants document and examine their own angry feelings and violent behavior.

The manual does not discuss the program's connections, either formal or informal, with the court system through which clients are ordered to counseling.

Geller, J. Conjoint therapy: staff training and treatment of the abuser and the abused. In M. Roy (Ed.), The Abusive Partner: An Analysis of Domestic Battering. New York: Van Nostrand Reinhold, 1982.

The author describes the conjoint treatment concept used with violent couples at Information Bureau of Suffolk County, where he was the former director. Workers there have found that those abusers who can benefit from a psychotherapeutic treatment model typically lead quite normal lives, showing no other signs of abnormal behavior besides the abuse. Although they report feelings of depression and loss of self-worth, the abusers use a number of psychological defense mechanisms to avoid responsibility for their behavior. Usually the abuse has escalated into a systematic pattern before the couple is ever seen in treatment. Periods of "normal" behavior alternate with the abuse, each time renewing the abused wife's hope that violence will not occur again. Further, the abuser may blame her for their problems, and she may incorporate the blame. Thus, psychological as well as economic factors keep women in violent marriages, and may delay the couple in seeking help.

Individual therapy is indicated when dissolution of the marriage is desired, but if the choice is to stay, then the author recommends conjoint. Geller subscribes to systems theory, which postulates an interactive element in the violence. However, Geller emphatically states that the violent behavior is the sole responsibility of the violent partner, and that abusers must be treated for their own violent behavior. At the same time, account must also be taken of the interpersonal context of the abusive relationship. When the couple is treated together, not only the husband's abusive behavior but also the effects of the abuse on the wife must be dealt with. In addition to stopping the violence, conjoint treatment also focuses on developing a mature love relationship, so that the couple can learn to live together again with mistrust and suspicion.

Geller spells out several caveats to therapists working with wife-battering couples. In order to be effective, therapists must deal with their own unresolved aggressive impulses, must increase their awareness of their own attitudes about sex roles, and should be aware of their own potential for burnout. Programs should support therapists in dealing with these issues.

Hilberman, E. Overview: "The Wifebeater's Wife" reconsidered. American Journal of Psychiatry. 137:11, November, 1980.

Hilberman examines wife-beating and touches only tangentially on the husband. She states that a common condition in cases of spouse abuse is that the husband does not think he needs treatment. The author concludes that "treatment options may expand if the victim is protected from further violence, and/or her husband is motivated to seek help. The latter situation is more likely to occur when the assailant no longer has access to the victim" (p. 1345).

Koval, J., Ponzetti, J., and Cate, R. Programmatic intervention for men involved in conjugal violence. Family Therapy. 9:2, Spring, 1982.

A number of possible causative factors for conjugal violence are reviewed, and the point is made that a multidimensional approach to intervention with abusive males seems crucial. It is stated that the initial goal of treatment should be to stop the abuse, and that intervention should also enhance clients' understanding of the attitudes and values underlying and supporting their abusiveness. Interpersonal skill training is also recommended, and a rationale is given for group intervention as the most appropriate format. Initial client resistance is explored, and several reasons given for postponing direct confrontation about the inappropriateness of abusive behavior until later in treatment.

Specific intervention strategies, along with suggestions for sequencing, are discussed. The first group of strategies focuses on increasing participants' awareness of their own needs and their attitudes about the use of the violence. Suggested methods include didactic and behavioral approaches to stress management; exploration of cultural and personal values and behaviors with regard to sex roles; and enhancement of emotional self-awareness and expressiveness. The second group of strategies, focused on interpersonal skill development includes "reframing" violent behavior as a type of non-verbal communication; identifying what underlying messages it is intended to relay; and training in empathy, self-disclosure, feedback, and assertiveness skills. The article includes a lengthy and broad-ranging reference list supporting the suggested multidimensional approach to intervention.

Margolin, G. Conjoint marital therapy to enhance anger management and reduce spouse abuse. American Journal of Family Therapy. 7:2, Summer, 1979.

The article explores spouse abuser treatment from a social learning perspective. The clinical controversy over whether violent individuals should be encouraged to ventilate anger freely (catharsis) or rather to dissipate anger through other means is reviewed. The author concludes that social learning theory indicates that decreased verbal aggression can lead to decreased physical aggression. Therefore, treatment should focus on intervention to dissipate anger and enhance problem-solving skills.

Three basic concepts underlie the suggested conjoint intervention strategy: that abusiveness is learned, that it is a mutual problem, and that it is related to inadequate problem-solving skills. Treatment requires both spouses to take

responsibility for their own behavior, through identifying cues in their interactions that can lead to arguments and abuse; establishing a plan for changing conflict patterns, including ground rules with consequences for violations; modification of cognitive patterns associated with conflict; and learning more effective problem-solving skills.

There is little direct attention given in treatment to the actual violent behavior. However, emphasis is placed on screening couples to determine appropriateness for this approach. Factors to be considered in the screening are: Are both spouses committed to improving the relationship? Does the abuse have a basis in other relationship problems? Can the couple gain control over the physical violence quickly so the danger is immediately reduced? The last question seems particularly crucial, and suggests that all but the mildest sort of physical abuse might be screened out for this treatment approach.

Matsakis-Scarato, A. Spouse abuse treatment: an overview. Aegis, Winter/Spring, 1980.

This article justifies programs to treat spouse abusers as being crucial to the prevention of domestic violence. Lack of information in the mental health professions about family violence is documented, and the need for it is stated.

Based on the literature and her own experience, the author describes the "typical" batterer not as psychotic or a psychopath, but as an individual with an inadequate personality characterized by low self-esteem and poor impulse control. One of the problems in helping such men is simply getting them into treatment. Those operating therapy programs for battering couples have found that motivation frequently arises from the batterer's desire to maintain or reestablish a relationship with the mate.

The author found that those providing treatment for batterers concurred that the abusive man must take responsibility for the battering, and that a primary goal of treatment should be to end the violence. Further, they felt that another goal should be to strengthen the individual, to enable him to build new, healthier relationships, rather than necessarily strengthening the existing relationship. If the individual is strengthened, whether or not the existing relationship survives, treatment is deemed successful.

One program stressed the need for groups composed only of batterers, having found that general therapy groups did not meet batterers' needs and they usually dropped out early in treatment. Workers at the Harborview Medical Center batterer program, in Seattle, emphasized the need for groups designed specifically for the batterers, organized around the goal of abstinence from battering, with provision of peer support and controls unavailable from other groups. The article also describes the Ganley and Harris program at the American Lakes Veteran's Administration, which was a residential program based on a social learning model. The author encourages further development of treatment programs for batterers.

Purdy, F., and Nickle, N. Practice principles for working with groups of men who batter. Social Work with Groups. 4:3/4, Fall/Winter 1981.

This article sets forth a series of working assumptions about batterers and how best to work with them in groups. The assumptions are followed by descriptions of specific phases of group treatment as practiced by the authors. They emphasize that the first priority must be to establish a system of checks to ensure the victim's safety while the batterer is in treatment, preferably through ongoing direct contact with the victim. Subsequent objectives that are outlined include breaking through the batterer's denial, through identifying types of abuse and defining anger, and learning to control angry responses.

The authors also emphasize the importance of unlearning abusive communication patterns and of examining destructive myths and attitudes which are frequently held by batterers.

Watts, D., and Courtois, C. Trends in the treatment of men who commit violence against women. Personnel and Guidance Journal. 60:4, December, 1981.

Treatment trends for rapists and incest offenders as well as wife batterers are reviewed in the article. General characteristics of men who are violent with women are listed, including dependence in personal relationships; insecurity; the use of anger to express any unpleasant emotion; and rigid beliefs and values about sex roles.

Treatment formats mentioned are group counseling and relationship therapy. Areas of intervention include sex education, sex role awareness and expansion, communication skill training, and modeling of appropriate behavior. It is viewed as critical to successful treatment that the offender acknowledge responsibility for his own violent actions.

Only about one page of this short article is devoted specifically to batterer treatment programs, and the discussion focuses on three prototypical programs: Harborview Medical Center in Seattle, the Ganley and Harris program in Washington state, and EMERGE in Boston. The article concludes that "none has demonstrated long-term success through experimental outcome studies," suggesting that such studies are greatly needed.

5. DESCRIPTIONS OF SPECIFIC BATTERER PROGRAMS

Adams, D. C., and McCormick, A. J. Men unlearning violence: a group approach based on the collective model. In M. Roy (Ed.), The Abusive Partner: An Analysis of Domestic Battering. New York: Van Nostrand Reinhold, 1982.

The intervention approach used by EMERGE, a pioneer program for batterers, is described in this article. EMERGE uses a "social unlearning" model to change batterers' attitudes regarding the acceptability and legitimacy of male violence. The authors agree with the common observation that men come to counseling because the woman is leaving or threatening to leave the relationship. Early counseling sessions focus on the man's fears, anxieties, and reservations about coming to group counseling. The primary goal at this stage is to build linkages between group members. The second phase encourages group members to assume more leadership tasks and give each other direct feedback. Members become more responsible for self-helping. Typically, they begin to talk about themselves more than about their wives, and to express intimate feelings. They realize that they are required not to devalue women, nor to blame them, and to assume responsibility for their own violent behavior and to unlearn that behavior. In the ending phase, members are encouraged to develop contacts outside the group so that they will become less socially isolated and therefore less dependent on their spouses. Issues of separation and loss are dealt with, and finally, group evaluation and recommendations are conducted.

Deschner, J. The Hitting Habit. New York: The Free Press, 1984.

This book provides a fresh, in-depth analysis of batterer dynamics and treatment. The author, director of the Anger Control Project in Arlington, Texas, bases her discussion both on her observations of violent couples in treatment and on specific data generated by her program.

In chapters on social and personality factors in battering, the author examines cultural, substance-abuse-related, and familial factors contributing to abusive behavior, reviewing both historical and current aspects of each factor. She takes a new look at the "cycle of violence," identifying variations and nuances in the well-known three-stage cycle. She also discusses the emotional damage that invariably accompanies physical abuse. A chapter on physiological reactions controlling violence gives an extensive review of biochemical factors affecting violent behavior, and in another chapter, Deschner describes cognitive regulators of violence.

Eight different typologies of batterers are described, in an unusual effort to identify differences as well as commonalities among abusers. The author points out the need to learn to match intervention methods to batterer types. Overall, her discussion of dynamics and causal factors is one of the most sophisticated and original to date.

Following a brief review of other treatment programs and approaches, the latter half of the book details a model for anger-control treatment for violent couples,

based on the Arlington project. Based on a combination of couples' groups and batterer peer groups, the approach is highly behavioral and structured. An appendix presents outcome data, based on testing with standardized instruments, that indicate the program is effective in decreasing violent behavior.

EMERGE: A Men's Counseling Service on Domestic Violence. Organizing and Implementing Services for Men Who Batter. Monograph, 1981.

Written by members of the EMERGE collective in Boston, this manual gives a comprehensive overview of how the collective is organized as well as its approach to working with men who batter. One chapter examines the applicability of various traditional counseling modalities to work with batterers, while another presents practical information on how EMERGE's counseling services are structured and implemented. A rationale is given for group counseling as the primary format, followed by specific descriptions of how group members are selected and prepared to enter the group. Counseling techniques and exercises employed by the facilitators are also described.

EMERGE considers community education to be equally as important as counseling in the overall effort to end domestic violence, and its approach to community education and organizing is outlined in another chapter. The approach is based on a series of "organizing principles," which constitute the philosophical basis for EMERGE's outreach efforts.

Everett, S. The SAM project. Machomania (newsletter). Champaign, Illinois. March 3, 1981.

This brief article describes the Stop Abuse by Males (SAM) program in Champaign, which was developed by Steven Everett in 1978. The unique aspect of the SAM Project was that the program organizer and the counselors were themselves former batterers who worked on a volunteer basis. Treatment included an individual intake session, group counseling, men's consciousness-raising groups, and a hotline.

Frank, P. B. and Houghton, B. D. Confronting the Batterer: A Guide to Creating the Spouse Abuse Educational Workshop. New City, New York: Volunteer Counseling Service of Rockland County, Inc., 1982.

This program manual describes the developmental process and the programmatic structure of a court mandated educational workshop designed specifically for men who batter. The programmatic elements of the six-session workshop and the rationale for each element are outlined, in exhaustive detail, including a description of the content and process of each session. The manual also addresses therapeutic and process issues such as creating a sense of safety for participants, dealing with client resistance, dealing with anger, and examining victimization and power. Evaluation criteria and procedures are also described, and preliminary findings are presented in the manual. Of 28 men with whom follow-up was maintained for a year after completing the program, 71% were reported to have remained violence-free.

The manual also describes the Men's Ongoing Voluntary Exchange (MOVE), an ongoing support group for graduates of the educational workshops and other interested men. Related services, including adjunctive individual, couple and family counseling for men who batter as well as community education and consultation with other agencies and professionals, are briefly outlined.

Garnet, S. E. How to set up a counseling program for self-referred batterers: the AWAIC model. In M. Roy (Ed.), The Abusive Partner: An Analysis of Domestic Battering. Van Nostrand Reinhold, 1982.

This article describes a program of voluntary, individual counseling for battering males. An eight-week treatment contract was negotiated with each man, with the option to renew. The initial focus was on examination of the battering behavior, improvement of communication patterns, and reconstruction of a healthier self-concept.

Workers in the program described the self-referred men as bright, articulate individuals who used aggression as a protective mechanism. Many also showed accompanying depression; for them, one task of counseling was to express and cope with such feelings. Therapists viewed as critical the establishment of trust between the client and therapist through finding a basis for mutual identification. They further found that, for these clients, achieving insight was a slow and difficult process. Some men pursued intensive, reconstructive psychotherapy after the initial eight-week treatment period.

AWAIC is collecting data through this program on the demographics, psychodynamics, and response to treatment of battering males, and hopes to use this information to provide a model of effective treatment for batterers.

Goffman, J. M. Batterers Anonymous: Self-Help Counseling for Men Who Batter Women. San Bernardino, CA.: B.A. Press, 1295 North "E" St., 1984.

This manual is a revised edition of the first Batterers Anonymous handbook that appeared in 1980. Essentially a how-to book, it describes the background, structure, content and process of Batterers Anonymous groups. Loosely based on the Alcoholic Anonymous model, Batterers Anonymous features a set of goals for individual change ("steps") as well as a pocket-size program guide which the participant is encouraged to carry with him at all times for reference during an anger crisis. Another feature is the sponsor or buddy system, a one-to-one pairing of participants for mutual feedback and support. The program regards gaining control over violent behavior as an incremental process requiring lifelong commitment.

Myers, T. and Gilbert, S. Wifebeaters' group through a women's center: why and how. Victimology: An International Journal. 8:1-2, 1983.

The article describes a group for wifebeaters that was developed as a demonstration project by a women's center. The center also operated a battered women's shelter. The center's justifications for the demonstration project are presented, including a perceived community need as well as the center's desire to maintain programmatic control over services to batterers.

The treatment regime was based on the following assumptions: that battering is learned behavior and can be unlearned; that because power and control are issues in violent relationships, increased egalitarianism within the relationships should lead to decreased battering; that rigidity of sex role attitudes and behaviors leads to battering, so teaching more androgynous behavior should decrease battering; and that poor self-concepts are common among batterers, so enhancing self-esteem should assist in stopping violent behavior.

Group was the treatment modality selected, in order to intervene in overly-dependent marital patterns and to allow the benefits of peer support. Twelve sessions were planned. The demonstration group was to consist of up to twelve men who had histories of repeated physical abuse of their wives and who met several other criteria, including willingness to participate.

Referrals were received through social service agencies and announcements in the local media. Thirty men contacted the program to express interest in participating. Of these, 29 were separated from their wives, and one called under threat of separation. The authors point out that this confirms the observation that violent husbands frequently are not motivated for counseling until their wives have left them.

Although outcome measures were included in the design of the demonstration project, the final number of group participants was too small for the data to be significant.

Roberts, A. R. A nationwide survey of services for batterers. In M. Roy (Ed.), The Abusive Partner: An Analysis of Domestic Battering. New York: Van Nostrand Reinhold, 1982.

Between 1975 and 1980, the number of programs for men who physically abuse their wives increased from approximately 5 to 80. The purpose of this study was to collect data and develop basic information about these programs. In Summer 1980, the author sent a 29-item questionnaire to 84 programs listed by the Center for Women Policy Studies. Forty-four of the 84 responded (55%). Most nonrespondents were services for battered women which had developed an assailant counseling component. Respondents provided information about telephone hotlines, treatment services, staffing patterns, problems encountered, and community education.

In addition to providing crisis intervention and information for batterers not in counseling, hotlines were thought to function as call-in safety valves for those already in treatment. However, not all programs had hotlines, and none had 24-hour access. Stated service goals of the programs were to stop wife abuse by educating and treating assailants to change their behavior. Methods included anger control, stress management, communication skills, and examination of belief systems. Services used individual, group, or conjoint counseling, or combinations thereof.

Treatment providers fell into three categories: (1) programs organized solely to provide services to violent males; (2) programs that were part of shelters or other women's programs; and (3) programs in established social service or mental health agencies. Most programs in all three categories complained of not having enough resources. The referral sources most frequently listed were courts and battered women's programs. Least were clergy and child protective agencies.

Future research was suggested to investigate which methods of service delivery are the most effective in eliminating assaultive behavior patterns, and with which types of abuse.

Sonkin, D. J., and Durphy, M. Learning to Live Without Violence: A Handbook for Men. San Francisco, Volcano Press, Inc., 1982.

This unique workbook was developed as part of a group counseling program for batterers, but could also be used as a self-help tool or in individual counseling. Written as if speaking directly to the batterer, the handbook is introduced by a straightforward but simply-stated analysis of domestic violence. The balance of the book consists of fourteen weekly "lessons," each one a mix of didactic material (with easy-to-understand examples), self-awareness exercises, practical suggestions for anger control, and practice assignments. An "anger journal" is suggested as a record-keeping tool throughout.

While it would probably still be rare to find batterers motivated enough to work all the way through the course on their own, the book is an excellent resource for ideas and techniques to use in counseling with batterers.

Star, B. Helping the Abuser. New York: Family Service Association of America, 1983.

This book is an excellent introduction to abuser treatment programs and issues. The author's survey of 116 abuser treatment programs nationwide is presented in the first portion of the book. About a fourth of the respondents were programs for spouse abusers, with programs for child abusers and sex offenders also represented. A wide-ranging analysis of the survey results covers program formats (e.g. counseling, education, peer support); program components (e.g. individual counseling, group work, or marital therapy); and program development issues such as the use of paraprofessionals or volunteers, and how to obtain funding and generate community support. Program evaluation is also discussed; the author's main finding is that most program evaluation activities are informal.

Based on anecdotal comments and observations from survey respondents, Star gives a description of assaulter characteristics. The book also includes an overview of treatment methods and issues, although the discussion is not specific to spouse batterers. Some of the methods are deemed effective in terms of process, but no mention is made of specific treatment objectives or outcome. Star also examines some of the currently controversial issues in abuser treatment.

The major portion of the book is devoted to detailed descriptions of six of the respondent programs. One of these, the Domestic Abuse Project in Minneapolis, deals with spouse abusers and is considered a model project.

APPENDIX C

TABLES

TABLE 1

LENGTH OF PROGRAM OPERATION

	All Respondents		Shelter-run Programs		Traditional-agency Programs	
	N	%	N	%	N	%
Less than 1 year	4	7.4	1	5.9	3	13.6
1 - 2 years	8	14.8	5	29.4	2	9.1
2 - 3 years	11	20.4	3	17.6	5	22.7
3 - 9 years	25	46.3	7	41.2	10	45.5
More than 9 years	6	11.1	1	5.9	2	9.1

TABLE 2

FUNDING SOURCES[1]

	All Respondents		Shelter-run Programs		Traditional-agency Programs	
	N	%	N	%	N	%
Local government(s)	17	31.5	5	29.4	8	36.4
State government	24	44.4	11	64.7	8	36.4
Federal government	7	13.0	0	0.0	4	18.2
United Way	27	50.0	10	58.8	11	50.0
Private contributions	20	37.0	11	64.7	4	18.2
Foundations	13	24.1	6	35.3	1	4.5
Participant fees	30	55.6	10	58.8	11	50.0
No funding	4	7.4	1	5.9	1	4.5
Other	10	18.5	4	23.5	0	0.0

[1]Percentages total more than 100.0% because more than one funding source could be cited.

TABLE 3

POPULATION OF PROGRAMS' SERVICE AREAS

	All Respondents		Shelter-run Programs		Traditional-agency Programs	
Population	N	%	N	%	N	%
Under 10,000	2	4.0	0	0.0	1	5.0
10 - 25,000	1	2.0	1	6.7	0	0.0
25 - 50,000	6	12.0	2	13.3	3	15.0
50 - 100,000	9	18.0	3	20.0	3	15.0
Over 100,000	32	64.0	9	50.0	13	65.0

TABLE 4

PROCESSES THROUGH WHICH PARTICIPANTS ENTER PROGRAMS

	All Respondents		Shelter-run Programs		Traditional-agency Programs	
	N	%[2]	N	%	N	%
Voluntary self-referral	49	92.5	17	100.0	19	90.5
Voluntary referral from other source	47	88.7	15	88.2	20	95.2
Court diversion, pre-plea[1]	22	40.7	7	41.2	11	50.0
Court diversion, post-plea[1]	21	38.9	6	35.3	11	50.0
Court order[1]	19	35.2	5	29.4	11	50.0
Other	9	17.0	3	17.6	1	4.5

[1]See questionnaire, Appendix 1, for definition.

[2]Percentages total more than 100.0 because respondents could cite more than one process.

TABLE 5

REASONS TO REFUSE OR REDIRECT A POTENTIAL PROGRAM PARTICIPANT

	All Respondents		Shelter-run Programs		Traditional-agency Programs	
	N	%[1]	N	%	N	%
Felony level spouse assault	6	13.0	3	21.4	1	5.3
Active psychiatric problems	33	70.2	12	85.7	14	70.0
History of psychiatric problems	20	42.6	9	64.3	7	35.0
Already gone through program	3	6.4	2	14.3	1	5.0
Active alcohol or drug abuse	28	59.6	9	64.3	12	60.0
Not of legal age	7	14.9	5	35.7	2	10.0
Subnormal intelligence	11	23.4	4	28.6	3	15.0
Language limitations	22	46.8	6	42.9	9	45.0
Other	9	19.1	2	14.3	3	15.0

[1]Percentages total more than 100.0 because respondents could cite more than one reason.

TABLE 6

RANKED USE OF INTERVENTION FORMATS BY ALL RESPONDENTS

	Rank 1 (Most used)		Rank 2		Rank 3[1]		Not Ranked/ Not Used	
	N	%[2]	N	%	N	%	N	%
Batterers groups	25	46.3	8	14.8	3	5.6	12	22.2
Individual counseling	20	37.0	20	37.0	5	9.3	8	14.8
Couple counseling	4	7.4	12	22.2	13	24.1	15	27.8
Couples groups	1	1.9	4	7.4	2	3.7	45	83.3
Family counseling	2	3.7	5	9.3	8	14.8	26	48.1
Family groups	0	0.0	2	3.7	2	3.7	50	92.6
Crisis intervention	11	20.4	9	16.7	5	9.3	23	42.6
Criminal justice system	0	0.0	6	11.1	3	5.6	41	75.9
Other	3	5.6	6	11.1	2	3.7	41	75.9

[1]Because few respondents ranked more than three formats, rankings below 3 are not shown.

[2]All percentages are unadjusted.

TABLE 7

RANKED USE OF INTERVENTION FORMATS BY SHELTER-RUN PROGRAMS

	Rank 1 (Most used)		Rank 2		Rank 3		Not Ranked/ Not Used	
	N	%[2]	N	%	N	%	N	%
Batterers groups	8	47.1	1	5.9	0	0.0	4	23.5
Individual counseling	4	23.5	11	64.7	1	5.9	1	5.9
Couple counseling	1	5.9	3	17.6	7	41.7	6	35.3
Couples groups	0	0.0	1	5.9	0	0.0	15	88.2
Family counseling	0	0.0	1	5.9	1	5.9	9	52.9
Family groups	0	0.0	1	5.9	0	0.0	16	94.1
Crisis intervention	5	29.4	3	17.6	2	11.8	6	35.3
Criminal justice system	0	0.0	2	11.8	0	0.0	13	76.5
Other	1	5.9	1	5.9	0	0.0	13	76.5

[1]Rankings below 3 are not shown.

[2]All percentages are unadjusted.

TABLE 8

RANKED USE OF INTERVENTION FORMATS BY TRADITIONAL-AGENCY PROGRAMS

	Rank 1 (Most used)		Rank 2		Rank 3[1]		Not Ranked/ Not Used	
	N	%[2]	N	%	N	%	N	%
Batterers groups	13	59.1	3	13.6	3	13.6	1	4.5
Individual counseling	10	45.5	6	27.3	2	9.1	3	13.6
Couple counseling	2	9.1	6	27.3	3	13.6	4	18.2
Couples groups	0	0.0	3	13.6	2	19.1	17	77.3
Family counseling	2	9.1	4	18.2	4	18.2	8	36.4
Family groups	0	0.0	1	4.5	2	9.1	19	86.4
Crisis intervention	3	13.6	5	22.7	1	4.5	10	45.5
Criminal justice system	0	0.0	2	9.1	3	13.6	15	68.2
Other	1	9.1	3	13.6	2	9.1	15	68.2

[1]Rankings below 3 are not shown.

[2]All percentages are unadjusted.

TABLE 9

DETAIL ON BATTERERS' GROUPS

	All respondents who use batterer's groups		Shelter-run programs who use batterer's groups		Traditional-agency programs who use batterer's groups	
	N	%	N	%	N	%
Groups are:						
Time-limited	8	20.0	0	0.0	7	35.0
Ongoing	21	52.5	9	75.0	8	40.0
Combination (time-limited & ongoing)	11	27.5	3	25.0	5	25.0
Duration of time-limited groups:						
Less than 6 weeks	3	13.0	1	20.0	2	16.7
6 weeks - 3 months	8	34.8	1	20.0	6	50.0
3 - 6 months	4	17.4	0	0.0	3	25.0
More than 6 months	2	8.7	1	20.0	0	0.0
Not applicable (groups are ongoing)	6	26.1	2	40.0	1	8.3
Participants may enter group:						
Only at certain times	12	31.6	2	18.2	8	42.1
At any time	26	68.4	9	81.8	11	57.9
Number of participants per group:						
Mean		7.5		7.2		6.8
Median		6.4		6.3		6.5
Range		3-20		3-15		3-10

TABLE 10

METHODS OF MONITORING AND RESPONDING TO RECURRING ABUSE

	All Respondents		Shelter-run Programs		Traditional-agency Programs	
	N	%[1]	N	%	N	%
Monitoring Method(s) Used						
Batterer self-report	43	82.7	11	68.8	20	95.2
Report from partner (victim)	27	51.9	8	50.0	13	61.9
Police report	5	9.6	0	0.0	3	14.3
Probation officer report	12	23.1	2	12.5	7	33.3
Other sources	7	13.5	2	12.5	5	23.8
None	11	21.2	5	31.3	2	9.5
Program's Response to Recurrence						
Special counseling	22	44.9	6	40.0	9	45.0
Drop from program	11	22.4	4	26.7	3	15.0
Refer back to court	9	18.4	3	20.0	4	20.0
Notify participant's probation officer	9	18.4	1	6.7	5	25.0
No policy about responding to recurrences	21	42.9	9	60.0	8	40.0
Other	11	22.4	3	20.0	4	20.0

[1]Percentages total more than 100.0 because more than one method could be cited.

TABLE 11

FACTORS THAT CONTRIBUTE TO ABUSE, SELECTED BY DEGREE OF INFLUENCE ON PROGRAM GOALS AND METHODS: ALL RESPONDENTS

Factor	Degree of Influence					
	Little to None		Some		Much	
	N	%[1]	N	%	N	%
Drug or alcohol abuse	6	11.8	17	33.3	28	55.0
External factors	3	6.0	16	32.0	31	62.0
Individual psychopathology	17	34.7	16	32.7	16	32.6
Interactional dynamics	7	14.0	13	26.0	30	60.0
Patriarchal society/sanction of violence against women	8	16.0	12	24.0	30	60.0
Social learning of violent behavior	1	2.0	8	16.0	41	82.0
Social skill deficits	2	4.0	11	22.0	37	74.0
Traditional sex roles/ stereotypes	2	4.0	18	35.3	31	60.8
Other	0	0.0	1	9.1	10	34.2

[1]Percentages may not total precisely 100.0 due to rounding.

TABLE 12

FACTORS THAT CONTRIBUTE TO ABUSE, SELECTED BY DEGREE OF INFLUENCE ON PROGRAM GOALS AND METHODS: SHELTER-RUN PROGRAMS

Factor	Degree of Influence					
	Little to None		Some		Much	
	N	%[2]	N	%	N	%
Drug or alcohol abuse	3	18.8	5	31.3	8	50.0
External factors	0	0.0	5	31.3	11	68.8
Individual psychopathology	6	37.5	5	31.3	5	31.3
Interactional dynamics	3	18.8	4	25.0	9	56.3
Patriarchal society/sanction of violence against women	3	18.8	5	31.3	8	50.1
Social learning of violent behavior	0	0.0	2	12.5	14	87.6
Social skill deficits	0	0.0	4	25.0	12	75.1
Traditional sex roles/ stereotypes	1	6.3	6	37.5	9	56.3
Other[1]	0	0.0	1	20.0	4	80.0

[1]12 respondents (70.6% unadjusted) did not cite "other."

[2]Percentages may not total precisely 100.0 due to rounding.

TABLE 13

FACTORS THAT CONTRIBUTE TO ABUSE, SELECTED BY DEGREE OF INFLUENCE ON PROGRAM GOALS AND METHODS: TRADITIONAL-AGENCY PROGRAMS

Factor	Degree of Influence					
	Little to None		Some		Much	
	N	%[2]	N	%	N	%
Drug or alcohol abuse	2	10.0	5	25.0	13	65.0
External factors	2	10.0	7	35.0	11	55.0
Individual psychopathology	6	31.6	4	21.0	9	47.3
Interactional dynamics	3	15.0	2	10.0	15	75.0
Patriarchal society/sanction of violence against women	3	15.0	2	10.0	15	75.0
Social learning of violent behavior	0	0.0	4	21.1	15	79.0
Social skill deficits	1	5.0	4	20.0	15	75.0
Traditional sex roles/ stereotypes	1	5.0	5	25.0	14	70.0
Other[1]	0	0.0	0	0.0	3	100.0

[1]19 respondents (86.4% unadjusted) did not cite "other."

[2]Percentages may not total precisely 100.0 due to rounding.

TABLE 14

GOALS FOR CHANGE AS PRIORITIZED BY PROGRAMS

Goal	Primary			Secondary		
	All Respon-dents %	Shelter-Run Pgms. %	Trad.-Agency Pgms. %	All Respon-dents %	Shelter-Run Pgms. %	Trad.-Agency Pgms. %
Stop violent behavior	90.7	88.2	95.5	3.7	5.9	0.0
Improve communication skills	25.9	35.3	18.2	46.3	41.1	45.4
Promote flexible sex role behavior	14.8	11.8	13.6	29.7	35.3	27.3
Descrease social isolation	18.5	17.6	18.2	31.5	23.5	36.3
Improve self-esteem	27.8	35.3	13.6	31.5	23.5	45.5
Improve or save relation-ship with partner	1.9*	5.9*	0.0	25.9	29.4	22.7
Change attitudes that contribute to violence	27.8	35.3	22.7	38.9	35.3	54.6
Other	9.3	5.9	9.1	3.7	11.8	0.0

*N=1

TABLE 15

INTERVENTION METHODS USED BY PROGRAMS

Method	All Respondents N	All Respondents %	Shelter-run Programs N	Shelter-run Programs %	Traditional-agency Programs N	Traditional-agency Programs %
Anger management	40	76.9	12	75.0	20	95.2
Assertiveness training	33	63.5	12	75.0	13	61.9
Behavior contracting	31	59.6	8	50.0	14	66.9
Buddy system	12	23.1	4	25.0	4	19.0
Building social support system	39	75.0	13	81.3	15	71.4
Communication skill training	37	71.2	11	68.8	17	81.0
Criminal justice system	18	34.6	5	31.3	9	42.9
Drug/alcohol treatment	26	50.0	9	56.3	10	47.6
Education re: laws	16	30.8	7	43.8	7	33.3
Emotional awareness training	42	80.8	15	93.8	18	85.7
Emotional expressiveness training	40	76.9	12	75.0	18	85.7
Exploration of individual history	41	78.8	13	81.3	18	85.7
Exploration of sex roles	39	75.0	10	62.5	19	90.5
Journal-keeping	15	28.8	4	25.0	8	38.1
Parenting education	22	42.3	9	56.3	6	28.6
Problem-solving training	39	75.0	12	75.0	17	81.0
Radical therapy	2	3.8	0	0.0	0	0.0
Role-playing: client	28	53.8	7	43.8	12	57.1
Role-playing: group leader	17	32.7	5	31.3	8	38.1
Stress management training	35	67.3	10	62.5	14	66.7
Support group for victims	28	53.8	9	56.3	15	71.4
Support outside sessions	34	65.4	11	68.8	15	71.4
Vocational assistance	10	19.2	5	31.3	3	14.3
Other	8	15.4	2	12.5	1	4.8

TABLE 16

OTHER ACTIVITIES IN THE FAMILY VIOLENCE FIELD

	All Respondents		Shelter-run Programs		Traditional-agency Programs	
Activities	N	%[1]	N	%	N	%
Public education	49	96.1	16	100.0	20	95.2
Volunteering in battered women's movement (e.g. shelters)	26	51.0	10	62.5	12	57.1
Work for procedural changes in criminal justice system	23	45.1	12	75.0	9	42.9
Work for legislative change	21	41.2	10	62.5	10	47.6
Networking with other family violence-related services	48	94.1	15	93.8	20	95.2
Input from women's groups	24	47.1	11	68.8	7	33.3
Other	10	20.8	3	21.4	3	14.3

[1]Percentages total more than 100.0 because more than one activity could be cited.

TABLE 17

EVALUATION AND ASSESSMENT PROCEDURES

	All Respondents		Shelter-run Programs		Traditional-agency Programs	
	N	%	N	%	N	%
Intake interview - batterer	41	80.4	10	62.5	19	95.0
Standardized testing	12	23.5	3	18.8	4	20.0
Interview with victim at intake	33	64.7	9	56.3	16	80.0
Ongoing assessment - batterer	34	66.7	11	68.8	14	70.0
Exit interview - batterer self-report	22	43.1	6	37.5	11	55.0
Exit interview - victim/ third party	14	27.5	4	25.0	7	35.0
Follow-up interview - batterer self-report	17	33.3	7	43.8	6	30.0
Follow-up interview - victim/third party	9	17.6	4	25.0	4	20.0
Staff evaluation of batterer	22	43.1	6	37.5	9	45.0
Batterer evaluation of program	22	43.1	7	43.8	9	45.0
Control group - non-batterers	1	2.0	1	6.3	0	0.0
Police data - involvement with batterer	8	15.7	0	0.0	6	30.0
Other	3	5.9	0	0.0	2	10.0
None	10	19.6	5	31.3	2	10.0

TABLE 18

SUMMARY OF RESPONSES TO SECOND SURVEY

Respondent	Participant (Batterer) Data	Goals, Evaluation Measures Degree of Success Shown	Follow-up or Outcome Studies Conducted
A	Not available	No objective evaluation measures used	None
B	Provided (see text)	Provided (see Table 19)	None
C	Partially provided (see text)	Provided (see Table 19)	Pre- and post-treatment testing; police calls to participants' households; re-assaults. (In progress, data not available.)
D	Not available	Provided; based on interviews and observation of program participants, no objective evaluation measures used. See Table 19.	None
E	Not available	None provided	None
F	Not available	Partially provided (see Table 19)	Pre- and post-treatment testing. (In progress, data not available.)

TABLE 19

PROGRAM GOALS, EVALUATION MEASURES, AND DEGREE OF SUCCESS SHOWN

Goal[1] and Respondents That Try to Meet It	Evaluation Measures	Degree of Success Shown
1. Stop the violent behavior		
B	Weekly anger diary	Much
C	Check w/victim; # repeat police calls to residence	Some
D	Interview with batterer, victim, and/or third party	Much
F	Phone follow-up with victim 2 years after program completion	Not available
2. Improve communication skills		
B	Marital happiness scale	Much
C	(No formal measure)	Some
D	Behavior observation in group	Much
F	Self report scale	Not available
3. Promote more flexible sex-role behavior		
C	Pre/post testing of social role skills	Not available
D	Observation in group	Some
F	Attitude toward women scale	Not available
4. Improve social support system		
D	Observation; report from family	Some
5. Improve self-esteem		
B	Rosenberg self-esteem scale	Little
D	Observation; reports from family	Some
F	Beck Depression Inventory	Not available
6. Improve/save relationship		
C	(No formal measure)	Some
7. Change attitudes about violence		
B	Tennessee Self-Concept Scale	Much
C	(No formal measure)	Some
D	Observation	No response
F	Novaca Anger Inventory	Not available

TABLE 19

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Goal[1] and Respondents That Try to Meet It	Evaluation Measures	Degree of Success Shown
8. Other		
B: Master anger control skills	Weekly anger diary	Much
Master assertive skills	Weekly diary	Some
Reduce stress responses	Pre/post EMG	Some
C: Reduce # of repeat police calls to batterer's residence	Police reports	Some/much
D: Master anger control techniques	Observation, reports from family	Much

[1]Goals are not ranked in this table.