Part 1: The Intake Procedure For Men Who Enter The Domestic Abuse Group Treatment Program

From *Stopping The Violence: A Group Model To Change Men's Abusive Attitudes And Behaviors* (Published by Haworth Press [New York] in 1999)

The assessment is a critical part in the treatment of a controlling and abusive man. This is a time when he begins to learn about what abuse is and its impact on his own and others' lives. This process ideally determines the extent of the problem and what type of intervention is most appropriate. Our intake process is tends to be longer and more involved than the process used in many domestic abuse treatment programs.

Our intakes generally last anywhere from four to six individual sessions of fifty minutes each and may, with certain individuals, take even longer. This, for us, is an important first step in a man becoming an active and motivated participant in the domestic abuse group and sets the tone for his entire involvement in the process. It gives the man the opportunity to get to know the therapist and what will be expected in group and it gives the therapist the chance to get to know the man and to decide whether he is a good candidate for the domestic abuse program. The following areas outline the process that is used when a man first comes to treatment.

Gathering Basic and Necessary Intake Information about the Abusive Man

Throughout the entire process, we are involved with collecting the standard intake information that is an important part of any mental health assessment (some of this information is also collected prior to the intake, when he is asked to complete preliminary paperwork that is sent to him or that he fills out at the office prior to the first intake session, e.g. *Personal and Family Background Information; Symptom/Problem Checklist;* and *Intake Problem Rating Scale*). The information gathered would include:

- **The presenting problem** (both his and others' versions)
- **His current life situation**, including his relationship with his partner and his children, his work/school life, his current alcohol and drug use, and other areas where stress may be present in his life (e.g. finances, physical health, issues with his children or past partners)
- **His relevant history/background**, including descriptions of and relationships with parents and siblings, his parents' relationship with one another, discipline he experienced as a child, family "rules" and values, significant childhood experiences, and histories of his relationships with partners, his school/work endeavors, his chemical use, and his abuse and violence with others (including prior legal involvement related to violence or to other criminal activities)
- Addressing any current or past mental health concerns he has experienced (e.g. depression, anxiety, ADD)
- **A ICD-10-CM/DSM-5 diagnosis**, which is necessary to meet state licensing requirements and to satisfy third party reimbursers' expectations (i.e. if a man wants to use his mental health insurance to pay for the domestic abuse treatment); see a section below for more specific information about mental health issues and diagnosis

Addressing a Man's Chemical Use/Abuse Issues

An important part of the intake, as is noted above, is to discuss his current and past chemical use/abuse and determine the appropriateness of a chemical dependency evaluation, chemical dependency treatment (prior to domestic abuse treatment), or asking the man to agree to a ***Sobriety Contract*** (i.e. not using mood-altering chemicals) for the duration of the therapy he undergoes. If chemical use concerns are identified, the man is asked to commit to, sign, and date the following statement:

"I, _____, agree not to use any mood-altering chemicals (alcohol and/or drugs) during my domestic abuse treatment involvement."

This ***Sobriety Contract*** is a commitment to himself, his therapist(s), and the other group members that he will completely abstain from any chemical use throughout the group program. This becomes an especially important issue when much of the abuse and violence has occurred during the time a man has been under the influence of alcohol or drugs, as is the case for a good number of men (Byles, 1978; Fagan, Stewart & Hansen, 1983). It may also become an issue if he has an extensive history of chemical use/abuse and/or consequences related to past chemical use (e.g. DWI's, chemical dependency treatment) and the therapist becomes concerned about whether his continuing to use chemicals would interfere with his benefiting as much as possible from the domestic abuse group program. This involves assessing if you, as a clinician, have concerns that he has the potential to use chemicals to attempt to blunt the emotional pain that might arise in his therapy as a result of beginning to address his feelings about himself, his control and abuse, and his life in general.

Men often initially excuse their abuse and violence by seeing their alcohol and drug use as "the real issue." For example, some men go through chemical dependency treatment and believe that their "abuse problem" has also been "solved" through their decision to remain sober. Our experience is that the abuse and violence toward others may increase or decrease if a man abstains from using chemicals. The man needs to understand that, in the end, these are two freestanding issues that are most effectively addressed separately. In our experience, some men who have been sober for several years have reported that their abuse and violence actually became more frequent or severe because the chemicals are no longer there to "numb" their emotional reactions to life stresses.

If a man agrees to a ***Sobriety Contract*** and violates it during the therapy process, he then needs to further address the chemical issues if he is to continue in treatment. This might mean going through a chemical dependency evaluation at that time if one was not done during the intake, completing and discussing in group the ***Violation of Sobriety Contract Assessment*** (you can read more about this assessment in the "Individual Member Tasks" section in the description of the domestic abuse program on this website), attending weekly Alcoholic Anonymous (AA) or Narcotics Anonymous (NA) meetings and bringing proof of attendance, or participating in regular urinalyses which can often be arranged through a probation officer, if he is involved with the court system.

Addressing Mental Health Issues and Medication Needs and Coming Up with a Formal Diagnosis

Other mental health issues should not be overlooked as a part of addressing the domestic abuse and there are a variety of diagnoses that are common with the men we work with. Many of the men who enter the domestic abuse group have significant issues related to either depression or anxiety. Some of this may relate to their current circumstances (e.g. being in the midst of a separation or a conflictual divorce process, being involved with the legal system) but we also frequently see longstanding patterns of depression or anxiety, often masked by chemical abuse or the irritability and explosive anger. In order to diagnose a client, therapists should have training and experience using ICD-10-CM/DSM-5, and, depending upon the clinical setting, a licensed therapist may need to oversee and "sign off" on any diagnoses that are given.

It appears to us that, for many of these men, their mood disorders are longstanding, often existing since childhood, and simply have not been addressed in any effective manner over the course of their lives. We are careful not to "excuse" their abusive and violent behavior with a diagnosis of some other emotional disorder or the use of psychotropic medication. But, at the same time, if other mental health problems that exist and complicate the treatment picture are not identified and treated, a man is significantly less likely to understand and put into practice the ideas, tools, and strategies presented in the treatment program. For this reason, we have access to psychiatrists who provide psychotropic medication evaluation whenever this is indicated or might be helpful. This is especially critical if a man is actively suicidal, homicidal, particularly obsessive in his thought process, or tends to be very reactive with his partner and others. The medications most often prescribed are anti-depressants for negative and obsessive thoughts and low self-esteem. In addition, mood stabilizers can also be

helpful in addressing a man's "over-reactivity" (which is often a part of anger expression that is abusive).

In terms of specific diagnoses, the following are the most commonly used with men in our program (from ICD-10-CM and DSM-5): Dysthymia (F34.1/300.4), Major Depression (F32.x/296.xx), Depressive Disorder Not Otherwise Specified (F32.8/311), Generalized Anxiety Disorder (F41.1/300.02), and Anxiety Disorder Not Otherwise Specified (F41.9/300.00). In addition, Adjustment Disorders (F43.x/309.xx) and Personality Disorders, especially Paranoid PD (F60.0/301.0), Antisocial PD (F60.2/301.7), Narcissistic PD (F60.81/301.81), Obsessive-Compulsive PD (F60.5/301.4), Borderline PD (F60.3/301.83), and Personality Disorder NOS (F60.89/301.89) may be a part of the clinical picture. Substance Abuse Disorders, especially Alcohol Abuse (F10.20/305.00) and Unspecified Alcohol-Related Disorder (F10.99/291.9) may also be diagnostically relevant. Two Z/V codes that are part of ICD-10-CM/DSM-V that can address domestic abuse, Relationship Distress with Spouse or Intimate Partner (Z63.0/V61.10) and Encounter for Mental Health Services for Perpetrator of Parental Child Abuse (Z69.011/V61.22) can also be helpful in presenting a more complete overview diagnostically. However, the Z/V codes, in and of themselves, will generally not satisfy most third party expectations regarding reimbursement for clinical services.

Using Psychological Testing and Screening Instruments

Psychological testing is not necessary to make a sound clinical decision about whether a man is appropriate for admission into the domestic abuse group program. This is especially true if the therapist has experience and competency in domestic abuse issues. However, the instruments below can be used as a way to get a "second opinion" to validate the therapist's clinical judgment, if this is desired.

Administering the *MMPI 2* (Butcher et al., 1989, a personality inventory, is one means to validate the therapist's clinical judgment and can also serve as a way to determine a man's level of motivation and whether he could benefit from the group. It can also be helpful in offering more information about relevant mental health diagnoses. This psychological test can be useful in identifying issues related to major mental illness (i.e. thought disorder and psychotic symptomology), severe depression with pronounced suicidal ideation, intense and debilitating anxiety, and extreme levels of anti-social personality features. In addition, the MacAndrew scale can be helpful in detecting the potential for substance abuse issues. Two content scales, Anger and Anti-social practices, may be used in pre- and post-test evaluation of the effectiveness of the program.

In addition to the *MMPI-2,* the following instruments can be used to assist in gathering more assessment information. The *Beck Depression Inventory* (Beck et al., 1961) is a helpful tool in addressing the severity of a man's depressive symptoms. The *Michigan Alcohol Screening Test* (Pokorny et al., 1972) is a commonly used instrument to assess the severity of alcohol and drug abuse. Levels of anger and hostility can be assessed using the *Buss-Durkee Hostility Inventory* (Buss & Durkee, 1957) or the *Novaco Anger Scale* (Novaco, 1975). The *Shipley Institute of Living Scale* (Shipley, 1940) can be used to assess reading skills and intellectual functioning. Finally, in the *Clinical Measurement Package: A Field Manual* (Hudson, 1982), the Generalized Contentment Scale (GCS) measures the level of depression and The Index of Self-Esteem (ISE), measures self-esteem problems.

Providing Education about Anger and Abuse as a Part of the Intake Process

During the assessment process, several educational components are discussed. Handouts are given to the man during the first session and throughout the assessment to take home and read in the weeks prior to the next meeting. Whether he actually follows through with the reading and the homework helps assess his level of motivation in this and subsequent sessions.

One handout (*Understanding Your Anger*) defines what anger is and what it isn't. It highlights the difference between anger the emotion that everyone experiences and the destructive attitudes and behaviors that may arise from it which are, in fact, distortions of what anger the emotion is intended to be. Another handout

(*Types of Abusive Behavior*) defines what controlling and abusive behavior is and begins the process of addressing the effects of abuse on partners and others. A third handout (*How Abuse and Violence Occur in a Relationship*) discusses how violence occurs in relationships using a cyclical model originally developed by Lenore Walker in 1979. Two other handouts (*Time-Outs: They're Not Just For Kids* and the *Time-Out Plan*) discuss the concept of taking a respectful "time out," which forms a cornerstone for this domestic abuse treatment program. Men are encouraged to discuss the idea of time-outs with their partners as a recommendation for a first step to begin to intervene in the explosive and abusive incidents that have been occurring. Many partners have been initially uncomfortable with time-outs because they view them as just another way that the man can avoid addressing significant relationship issues. But an important part of taking a respectful time-out is making a commitment to return after a predetermined time and then actually following through with that commitment. Discussing time-outs is also part of the agenda when the therapist contacts a man's partner later in the assessment process.

Finally, this model's domestic abuse philosophy (the *Domestic Abuse Philosophy*), and our group program (the *Domestic Abuse Group Description*) are discussed in detail. Important parts of this include the ideas that men are making choices when they are violent, that abuse and violence are learned behaviors, and that men can un-learn these destructive attitudes and behaviors and respond more effectively when they are escalating to potential abuse. It is also helpful to go through the major group objectives one by one and ask the man whether any of these fit for him. Most men can relate to the majority or all of the group goals.

This information provides education about abuse and the program that immediately lets the man know what he is becoming involved with. The therapist needs to begin to immediately assess the man's openness to the information being presented. In addition, it is helpful to start to notice his levels of internal (e.g. feeling genuine sadness, guilt, and remorse about the effects of his abuse on his partner and children) rather than simply external (e.g. legal involvement, fears about separation and divorce) motivation. Initially, most motivation, in this model's experience, primarily involves external factors. Even men who are not court-ordered to treatment are almost always "partner-mandated" to do something about the abuse. Thus the goal is to move him toward a more internal locus so that he is involved with the program "for himself" and "for his own good" rather than simply to *"get the court off my back"* or to *"salvage my relationship."*

Handing out written materials is also helpful in identifying literacy issues since a relatively high level of literacy is necessary to be involved with and benefit from our treatment program. If the client has difficulty with reading, writing, or comprehension, he is then referred to literacy classes if he wishes to continue his involvement with this program. The relationship between illiteracy and low self-esteem can also be addressed at this point. If he is willing to become involved with literacy classes, he can also get additional individual assistance from the group therapist(s) and other group members to work on tasks, group homework, and the like.

If a man is unwilling to do remedial work regarding his literacy skills, we would then refer him to another program where literacy is not as significant a factor in his ability to benefit from and complete the group. We have, however, had a number of men actively pursue literacy classes simultaneous to their involvement in group and complete the program. For these men, their initial problems with his reading abilities served as a bridge to other group members, who often became mentors and tutors after the literacy issues were raised during the member's first night in group.

Discussing and Beginning Work on Writing Out His *Escalation Prevention Plan*

Another important part of the intake is to begin work on the ***Escalation Prevention Plan***, which is the foundation of this domestic abuse program. It serves to begin the process of developing self-awareness and behavioral and cognitive self-monitoring that will help him better recognize the build-up that occurs prior to his making the choice to be abusive or violent. Generally, early in the assessment, in session, we discuss and go over the ***EPP*** and assist him in coming up with specific examples from each of the cue/trigger categories and also some ideas and strategies for the de-escalation plan portion of the ***EPP*** to help him handle his anger and his desire to control more effectively (with the "time-out" at the top of his list of calming strategies). We then request that he add to his ***EPP*** between sessions and return with additional examples for the next meeting. What he does with the

EPP in the intake serves as an indicator of both his understanding of the process and his level of motivation. It also gives us answers to the following questions:

- Can he understand and does he begin to recognize that there is a gradual escalation process, that he does not just "react," and that his explosive anger does not just "erupt out of nowhere?"
- Is he willing to begin to identify specific cues and triggers that are part of his escalation process?
- Does he begin to acknowledge that he can make conscious alternative choices to his abusive and violent behavior?
- Is he willing to put in additional time and effort outside of the individual intake sessions?

The primary reason that we use four to six individual sessions in our assessment process is to get a clearer picture over a longer period of time about whether the man sees himself having a problem with explosive and abusive anger and whether he has the energy and motivation to effectively address this problem. The ***Escalation Prevention Plan*** is discussed in more detail in the "Tasks" section of this program under "Tools" on this website's home page.

Administering the *Abuse Questionnaire* to Get a History of a Man's Controlling and Abusive Behavior (with His Partner and Others)

Near the end of the intake, we work with the man in session to complete an ***Abuse Questionnaire***, which addresses the frequency of verbal and emotional abuse over the past year, the frequency of physical abuse over the course of the entire relationship with his partner, the most recent and the most severe violence in the relationship, and abuse and violence with past partners, parents, siblings, friends, acquaintances, and strangers.

The questionnaire is adapted from some of the ideas in the *Conflict Tactics (CT) Scales* developed by Straus, Gelles, and Steinmetz (1980). For the purpose of our assessment, we needed a more comprehensive questionnaire since we wanted to identify the very specific ways that a man has abused his partner emotionally, verbally, physically, and sexually and to have him recall abuse and violence perpetrated toward others as well. This serves as a means to prepare a man to report honestly in the group the extent of his abuse and violence throughout the course of his life, not just with his current partner (which helps take the focus off her as *"the only person I get angry with")*.

The questionnaire is generally administered near the end of the assessment so that he may be able to be more honest as a result of beginning to develop some trust through the process of feeling joined by the therapist and seeing some potential benefit for him in becoming involved with the program. However, many men still tend to minimize and deny the extent of their abusive and violent behavior (usually significantly more than their partners do). For example, one client, who reported three incidents of violence directed toward his partner in the intake, eventually acknowledged scores of incidents in the group itself. The group atmosphere and the mutual sharing there tend to significantly decrease the shame associated with perpetrating violence and the denial and minimization that arises from that shame.

It is important, after completing the ***Abuse Questionnaire***, to check in with the client about how the process of going through the questionnaire has affected him. This process often triggers shame, remorse, sadness, and other powerful feelings that can be acknowledged as part of the reason he may want to change how he has related to his partner and others in the past. Men also frequently say things like*"I never knew I was so violent"* or "*I never thought of myself as that abusive*," which can be helpful in their becoming more aware of the impact of their behavior on others.

The final reason that this questionnaire is so important is that it offers a "reality test" if the man joins the group and begins to minimize or deny having a problem with being abusive or violent. This tends to occur most frequently when he is first introducing himself to other members or during a group member task called the ***Abuse Inventory***, when he is asked to recount in detail a history of the abuse and violence he has perpetrated toward others. These discrepancies between what he says in group and what he said in the intake can be confronted in an individual session if what he had told his therapist in the intake process is different from what he is now reporting in the group.

Addressing the Needs and Expectations of Court-Ordered Clients

If the client is court-ordered, we request that he sign a release of information so that we can talk with his probation officer about the arrest records and the court order. This release also allow us to regularly apprise the probation officer of his ongoing treatment issues, concerns, and progress. If the client says he doesn't have a probation officer, it is often difficult to discover whether he actually has one. However, if he has been in court, the judge can still be contacted to discuss his situation. It works best, if the probation officer is referring him to specific programs, to have the probation officer arrange to have the client sign a release to talk to the programs recommended when the probationer is in his office initially.

If the client is court-ordered and wishes to be involved with our program, he has no choice about signing a release to talk to his probation officer. If he is unwilling to do this, he is offered referrals to other programs. Contact with the probation officer is a critical part of helping court-ordered men remain accountable to the program expectations. During the initial contact with the probation officer, police reports related to the court order to treatment, copies of any Orders For Protection that exist, and the actual court order to treatment are requested.

Generally, we call to notify the probation officer when the client initially becomes involved with our program, when the man actually starts the group, and to inform the PO of any concerns that may arise at various times during the group (e.g. if the man is not working effectively in the program or if he appears close to quitting or being terminated from the group). The final contact occurs when we send a written treatment summary within two weeks after a man has quit, been terminated, or completed the group to discuss the client's progress, concerns, and recommendations at that point.

If the client is extremely resistant about addressing his abuse issues or becoming involved with the program, we can use the probation officer and potential legal consequences (usually stayed jail time) as leverage. This could also be a time when we have the probation officer meet with the client at our office (or at his PO's office) during the intake process.

Having Contact with a Man's Partner to Get Her Perspective about the Control, Abuse, and Violence in their Relationship

We also have the client sign a release to talk with his partner, by phone or in a session, about the history of the control and abuse in their relationship. This is especially important if the client is resistant to addressing his issues around domestic abuse and is denying any violence or is unwilling to acknowledge any issues related to abusive anger.

In addition, this is an opportunity for us to tell his partner about groups for women who have been in abusive relationships and about other therapy and support options for her at our agency and in the community-at-large (e.g. women's shelters; other domestic abuse programs). It is also a time to do some protection and safety planning with her, to give her some information about abuse, violence, and our men's treatment program, and to encourage her to call us during the process with any observations and concerns that she has about her partner's involvement. This is especially important if there are violent incidents during the course of the man's group program, as he may make the decision not to report these to the group. It is still her decision, even if she calls to report violence during the program, to decide whether she feels safe enough to allow us to use this information directly with her partner in the group setting.

We also offer men the opportunity to sign a release to inform his partner of our perceptions about his progress in treatment. However, he does not need to do this in order to participate in the group (although men in our program consistently have signed this release). Some programs require this release due to concerns about the woman's safety (e.g. if he is terminated from group) but there are also ethical issues that are part of a therapist's responsibility to a client (e.g. coercing a client to violate his own confidentiality). Since he may be unwilling to sign a release to allow us to discuss his progress and concerns with her, we let her know in our initial contact with her that she is the best judge of whether he is truly making progress and that she should look for a "consistent

pattern of behavior change over time" in her relationship with her partner to determine whether he is truly benefiting from the program. This is, in our opinion, the most effective way to help her figure out whether he is, indeed, changing and to assist her in making her decision about whether to work with him to reconcile (if she has an interest in doing this). Unfortunately, it is all too easy for a man to comply with our expectations and appear to us to be benefiting even if he is not actually changing how he relates to his partner and his children, which is, by far, the most important issue.

As is mentioned above, she is also encouraged to contact her partner's therapist(s) at any point in his group involvement to express her concerns about his behavior with her outside of the group setting. She is also continually reassured that any information she provides will not be used without her explicit permission but that her perspective is, nonetheless, always helpful in working with her partner in the domestic abuse program.

Identifying and Setting Treatment Goals for His Therapy

Near the end of the intake, we also ask the man to set some specific and concrete behavioral goals about what he wishes to change about himself and how he wishes to be different as a result of his involvement in the group treatment process. His input is helpful, at this point, as a way of involving him in treatment planning and as another means of assessing his level of motivation and whether he identifies and includes issues related to explosive anger and abusive behavior in his goals. If he has no goals related to anger, abuse, and control, his resistance to directly identifying these as treatment issues needs to be explored further prior to his starting the group.

Recognizing and Addressing an Abusive Man's "Defenses" in the Intake Process and in His Treatment Program

Abusive men offer a variety of psychological defenses to avoid taking clear responsibility for themselves, both in the intake process and throughout the group program. Some of the most common defenses a therapist is likely to have to confront are listed below with specific examples of statements that indicate their presence.

- **Denial: Completely refusing to acknowledge that any kind of problem exists:**
  - *She's lying*
  - *Nothing really happened*
  - *I didn't do it*
  - *I don't remember the incidents (i.e. it was so long ago)*
  - *I was completely "out-of-control,"I was just "just seeing red"*
  - *I was drinking and I was in a "black-out"*
  - *I'm sober now and my anger is no longer a problem for me*
  - *I don't get angry anymore (i.e. I'm over it now)*
  - *Our real problem is that we just can't communicate*
  - *I don't have an anger problem (I'm not an abuser)*
- **Blaming: Having an attitude of focusing on his partner, her behavior, and her "problems:"**
  - *She knows how to push my buttons*
  - *She's always "ragging" on me*
  - *She's the one who should be here in your office (i.e. She's a lot more angry/violent than I am)*
  - *She hit me first*
  - *She's a fucking drunk*
  - *I wouldn't have slapped her if she hadn't given me the finger*
  - *She acts "crazy"/"out-of-control" sometimes*
  - *She's always flirting with other guys*

- **Minimizing: Making the problem less than it really is:**
    - *She exaggerates everything*
    - *I only hit her once*
    - *I didn't really hurt her*
    - *She bruises easily*
    - *It's really not that big a deal*
    - *This is nothing compared to what my friends do with their wives*
    - *I didn't hit her very hard*
    - *She's a big woman (i.e. She can take it)*
    - *I "kind of" pushed her*
    - *I only gave her a little shove*
    - *She just "fell down" after I pushed her*
- **Intimidation/Fight for Control : Bullying, acting threatening, or trying to control what will happen in therapy to prevent the therapist from addressing his control and abuse issues:**
    - *What would you have done in my situation?*
    - *You would have reacted the same way that I did*
    - *Are you married?*
    - *Do you have kids?*
    - *I'm not willing to go into a group program*
    - *I would only willing to attend 12 weeks of group*
    - *I have to be out of town for business once a month. Is that OK?*
    - *What I do isn't really abuse (i.e. it shouldn't be defined as abusive behavior)*
    - *I'm not willing to tell anybody else about my problems*
    - *I'm not willing to listen to other peoples' problems*
    - *I want couple therapy*
    - Interrupting you, arguing with you, talking over you, and being unwilling to listen to your feedback; becoming "intense," reactive, and defensive in the sessions

Working with Abusive Men in a Treatment Setting

Abusive men tend to be difficult clients. They can frequently be self-absorbed, self-centered, blaming, defensive, reactive, argumentative, hostile, intimidating, and controlling, although they may, at times, appear to be compliant and passive and/or friendly and likable. In any case, they are often unhappy to be in therapy and are almost always externally motivated, whether they are court-ordered or not. Abusive men generally do not come into therapy to address their controlling and abusive attitudes and behaviors. They may come for other reasons, such as depression, anxiety, "communication problems," and to attempt to satisfy his partner's expectations of him. But, if abuse is identified as a presenting problem, there is always some sort of coercion at work for the man who comes to treatment. The most obvious form is involvement with the legal system and a court order to treatment. The less obvious form is pressure from a partner to change, generally because she is threatening to leave or has already left the relationship by separating from him.

Directly addressing the defenses mentioned above is a critical part of the assessment and the ongoing work that is done in the group. For court-ordered men, close contact with their probation officer is a must. Probation officers can generally provide arrest reports, information from Orders For Protection and a pre-sentence investigation (if one was done), and specifics around the court order to treatment, all of which can add data that may contradict the man's denial and minimization around his domestic abuse and chemical use issues. If a client remains adamant that he has no problem, actually bringing the probation officer into a therapy session to confront the client's defensiveness or sending the client back to the probation officer or to the judge to argue that he is not angry and abusive and should not have to attend domestic abuse treatment can be helpful strategies.

Contact with the man's partner can also assist in addressing his defensiveness. As was mentioned above, the partner is called during the intake to get her perspective about the history of control and abuse and chemical use in the relationship. This is also information that can be used to confront denial and minimization if she feels safe enough to allow us to do that. In any case, her input is helpful in the assessment and throughout the group program even if it cannot be used directly because it can offer a clear picture of whether the man is being honest and actually putting into practice the tools that he is being taught.

Important for all men, court-ordered or not, is to appeal to their self-interest. Because of his self-centeredness and self-absorption, this is a more pragmatic strategy initially than trying to help him immediately empathize with the victims of his abusive behavior. This process involves assisting him to focus on himself and the parts of his behavior that he sees as self-destructive and counterproductive to his life goals and priorities. An important part of this is helping him to begin clearly identifying the past, present, and possible future consequences that have occurred or will occur if he continues his controlling and abusive behavior. These can include legal, relationship, financial, and family-related consequences. Most men do not want to spend time in jail, lose their partner, or end up with less time being around and parenting their children. This strategy helps point out how his abusive behavior is affecting him personally and what he says that he wants from his life. It is also helpful to talk about how his controlling and abusive attitudes and behaviors may have affected past relationships and will continue to affect future relationships if he is not willing to begin to change them in the present.

A final area worth noting has to do with the impact on the therapist of working with abusive men. It is relatively easy, in therapy sessions, for the therapist to become a "secondary victim" to his abusiveness. The therapist may begin to feel intimidated by his escalations, his defensiveness, and his attempts to control the therapy process. It is helpful to point out and discuss escalations that occur in the assessment and in the group as these represent the kinds of interactions that are also frightening and difficult for his partner. It is also vital to set clear limits around his escalations which include interrupting his escalations and not allowing him to lapse into name-calling, swearing, or put-downs with you in the session. If these occur, it is important to call a halt to the session and encourage him take a time-out or, if necessary, to terminate the session completely at that point. It is not helpful for him to continue to practice his abusive ways with you as a therapist; this only reinforces what he is doing outside of your office with his partner and others. Stating things like *"You don't need to agree with me, but I want you to at least listen and think about the feedback that I give you"* communicates clearly that he will not be allowed to control what you say and what happens in the therapy process.

Equally important is to avoid getting caught in the power struggle of trying to convince him that he "needs" treatment or attempting to "sell" him on the idea that he "should" involve himself in a treatment process. This sort of power struggle "goes nowhere." What is helpful is to provide him with your perspective on what abuse is and how it is affecting his life and let him make the decision about whether he wishes to do anything about it. This again addresses the whole issue of his level of motivation. Make it clear to him that, if he is not interested in working on changing his controlling and abusive behaviors, he does not need to continue to come to therapy with you and then refer him elsewhere. Part of the challenge in this situation is to work at being direct but "matter-of-fact" in doing this rather than allowing yourself to become provoked into a shaming or punishing response to his unwillingness to look at his issues, his attitudes, and his behaviors. Part of the learning for abusive men has to do with hearing the same message about their behavior from a number of different people and going through the very real consequence of setting up and going to a number of different therapists and programs.

Making Recommendations with the Client about the Most Effective Treatment Option(s)

At this point, the therapist will make recommendations regarding a treatment plan. Group therapy is the preferred and most effective method of treatment for abuse and violence issues and this is generally the recommendation that would be offered. If he is not court-ordered and if he wishes to remain in individual therapy, we would consider this as an option as long as there is no more violence in his relationships with his partner and his children. While he is in individual therapy, we would continue to re-visit the issue of entering the

group if that seemed appropriate. For some men, it takes more than the four to six individual sessions that we normally allow to prepare them to enter the group.

If there is ongoing violence during an individual therapy process, he would need, at that point, to enter the group program or to discontinue the individual therapy at our agency and receive referrals to other domestic abuse programs. Couple and family therapy are not options in our program, especially at the beginning of his therapy, unless we have a strong belief that he has the tools and the willingness to use them to remain non-violent with his partner, no matter what she says or does in the couple therapy or in their life together.

Doing the Final Group Preparation (if it is Decided that He Will Attend the Group Program)

Finally, if a decision is made that he will enter the domestic abuse group program, the man receives the domestic abuse group member booklet and we discuss the group goals, rules, and expectations. Especially important are issues around safety for the men in the group, reporting any violence that occurs outside the group, absences from the group, and staying current on weekly payments. We also go through each of the individual tasks that he is expected to do in order to complete the group program. In addition, this is a point when it is important to address the man's anxiety and apprehension regarding participating in the domestic abuse group treatment program, particularly if he has not been involved with any prior group therapy experiences.