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Conjoint Therapy for Intimate Partner Violence Among Aboriginal Couples: Service Provider's Perspectives on Therapeutic Content and Activities

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CONJOINT THERAPY FOR INTIMATE PARTNER VIOLENCE AMONG
ABORIGINAL COUPLES: SERVICE PROVIDERS' PERSPECTIVES ON
THERAPUTIC CONTENT AND ACTIVITIES

By

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Abstract

The purpose of the study was to identify characteristics of a conjoint therapy program for Intimate Partner Violence with Aboriginal couples. Participation in telephone interviews by professionals in a Canadian province included two questions: "How would you address content with Aboriginal men in couple counselling who use abusive behaviour toward their intimate partner?" and "How would you address activities with Aboriginal men in couple counselling who use abusive behaviour toward their intimate partner?" The results were analyzed using a structured conceptualization procedure called Concept Mapping. Six concepts emerged in response to the first question including: 1) Cultural, 2) Western, 3) Traditional Ways, 4) What a Healthy Relationship Is (and Is Not), 5) Men's Self Responsibility and 6) Accountability to Family and Community. Three concepts emerged in response to the second question including: 1) Working with Community, 2) Teaching and Learning and 3) Traditional Ways. The results were compared and contrasted with the literature.

Keywords: Aboriginal Peoples, intimate partner violence, conjoint therapy, therapeutic content, therapeutic activities, service providers.

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Chapter 1: Introduction

Conventional treatments of Intimate Partner Violence (IPV) typically involve gender-specific treatment groups (i.e. men-only groups) for male perpetrators. However, there is increasing recognition that couples remain together following violence as well as court-mandated intervention, and that many interventions are not culturally responsive for Aboriginal couples (Bent-Goodley, 2005). Conjoint therapy has the potential to be an appropriate and effective treatment for Aboriginal couples who report low to moderate levels of IPV following successful gender-specific treatment (LaTallaide, Epstein & Werlinich, 2006).

Conjoint therapy for IPV involves two therapists working with couples individually as well as together in conjoint sessions. Although some consider the use of conjoint therapy controversial (Goldner, Penn, Sheinberg, & Walker, 1990), two reasons can be offered to support its use for IPV with Aboriginal couples. First, unhealthy relationship dynamics often maintain violence among couples and conjoint therapy can be used to address these dynamics with the couple in a counselling context. Second, some couples stay together despite the abuse (Heyman & Neidig, 1997). Thus, failing to provide services that address violence with these couples may inadvertently disadvantage the female partner in a relationship where the violence and abuse is continuing covertly. This chapter provides an overview of IPV among Aboriginal couples. In addition, consequences of IPV, treatments as well as support for and against the use of conjoint therapy are discussed.

Intimate Partner Violence

IPV constitutes one in four violent crimes in Canada (Statistics Canada, 2013). IPV often involves physical abuse. Based on Statistics Canada, in 2010, three of every four people who experienced IPV reported physical abuse. Most of the physical abuse committed consisted of common assaults (81%) causing injuries. After physical abuse, the next most common offences against intimate partners involved making threatening statements (9%) as well as criminal harassment (7%). Although both men and women are victims of IPV, women are three times more likely to suffer from severe violence including being beaten, choked or sexually abused compared to males (Statistics Canada, 2009). Sexual abuse and criminal harassment also occurred more frequently for females than males.

Aboriginal women are three times more likely to be victims of IPV than non-Aboriginal women (Statistics Canada, 2009). Aboriginal women also tend to experience more severe violence. Spousal homicide rates of Aboriginal women in Canada are eight times higher than non-Aboriginal women (Trainor & Mihorean, 2001). The overrepresentation of Aboriginal peoples in Canada's correctional institutions suggests that violence is a significant concern (Weinrath, 2000). While Aboriginal peoples make up only 3% of Canada's population, they constitute 27% provincial and 20% of federal inmate population (Statistics Canada, 2012a). Furthermore, Aboriginal peoples account for 23% of incarcerated violent offenders (Public Safety Canada, 2007).

Colonial Legacy

Family violence in Aboriginal communities is rooted in the experience of intergenerational trauma (Brownridge, 2003). Following the arrival of European settlers

there were large-scale losses of life from disease from which Aboriginal peoples had no immunity. Furthermore, the passing of the Indian Act (Stevenson, 1999) resulted in many negative consequences for Aboriginal peoples. Relationship with the land was threatened through the imposition of reserves that resulted in confinement and led to starvation (Oetzel & Duran, 2004; McEachern, Van Winkle & Steiner, 1998). The banning of cultural practices drove cultural knowledge underground. Children were forced to attend residential schools for indoctrination into European values, language and culture (Richardson, & Nelson, 2007). Some were also removed from communities for adoptions into non-Aboriginal families (Wesley-Esquimaux & Smolewski, 2004).

These efforts to colonize Aboriginal peoples left many negative effects on the subsequent generations of children, families and communities. Many children experienced harsh punishments, were denied parental contact and sexually abused in the schools (Barlow, 2009). The loss of intergenerational opportunities for sharing cultural knowledge and caregiving experiences has led to feelings of grief. Recurrent thoughts of these losses and abuses continue to be associated with anxiety and depression (Whitbeck, Chen, Hoyt, & Adams, 2004) as well as substance misuse (Robin, Chester & Goldman, 1996). Violence within Aboriginal communities and families can be seen as rooted in these losses resulting from colonial efforts to commit cultural genocide (Brownridge, 2003).

IPV: A Heterogeneous Problem

Intimate Partner Violence can take many forms including physical, emotional as well as sexual. IPV can also differ with respect to severity, directionality and generality. Mild-to-moderate violence may involve pushing, slapping and grabbing while severe

violence involves choking, kicking and using a weapon (Horwitz, Santiago, Pearson, & LaRussa-Trott, 2009). Researchers have also made a distinction between symmetrical versus asymmetrical violence. In symmetrical violence, both partners engage in violence. Thus, each partner can be simultaneously a victim and a perpetrator. In asymmetrical violence however, violence is committed by a single partner and a clear distinction can be drawn between the perpetrator and the victim (Capaldi & Clark 1998; Tolan, Gorman-Smith, & Henry, 2006). It has been suggested that 59% to 71% couples with any history of violence experience symmetrical violence (Capaldi & Clark, 1998). Lastly, differentiation has been made based on the generality of violence: whether it is directed by a man toward his female partner versus other individuals within the larger social context.

Based on these distinctions two types of IPV can be identified: characterological and situational (Madsen, Stith, Thomsen & McCollum, 2010). In characterological IPV, the perpetrator likely has a diagnosable mental illness (e.g. personality disorder), violence tends to be severe and used as a means of domination and control. In situational violence however, violence is triggered and maintained by dysfunctional relationship dynamics, rapid escalation and a lack of procedures to escape from escalating arguments. Situational violence is symmetrical, tends to be mild-to-moderate and may not be used as a means of domination and control. Given the heterogeneity and complexity of the problem, treatments for IPV need to be tailored to the particular perpetrator type along with the type of violence involved.

Treatments

The standard treatment for men who engage in IPV has consisted of gender-specific (i.e. all male) group treatments. These programs are rooted in the feminist theory which asserts that violence is used by men as a means for control and domination of women (Mitchell, 2009). From a feminist perspective the responsibility for violence is placed solely on male partners. As such, the goal of these programs is to help male perpetrators accept responsibility for violence, reduce interpersonal controlling behaviour, raise their awareness about issues such as male privilege and gender-based power dynamics as well as help them develop strategies for facilitating a safe, egalitarian relationship (Pence & Paymar, 1993).

Family Systems theory places the problem of IPV in the context of family, community relationships and patterns of behaviours (Erdman & Caffery, 2013). From this perspective, it is important to understand the impact of the larger context on abusers, the impact of abuse on other members within the system as well as on the system as a whole. Conjoint therapy is considered a system-based approach to IPV. It has been suggested that partners who experience IPV are often locked into a pattern of dysfunctional relationship dynamics and a vicious cycle that maintains violence. Therefore, being in therapy together in conjoint sessions they can learn to manage unhealthy relationship dynamics that lead to violence (Madsen, Stith, Thomsen & McCollum, 2010). Conjoint treatment can be an effective treatment for situational violence, where there is mild-to-moderate violence and both partners want to remain together (Stith, Rosen, McCollum & Thomsen, 2004).

Arguments against Conjoint Treatment

Conjoint therapy for IPV is a controversial choice, particularly from a feminist perspective (Stith, McCollum, Rosen, & Locke, 2002). Indeed, having the couple in a conjoint setting may imply that the woman is also responsible for the violence and thereby decreases responsibility from abusive men (Bograd, 1984). It potentially allows men to not be held accountable for their behaviours, leading women to blame themselves for their partners' abusive behaviours (Thome-Finch, 1992).

Furthermore, in conjoint sessions, women's safety is a concern. As the couple discusses relationship problems there is an increased risk for conflict. In this context, if the woman expresses negative attitudes towards her husband or discloses information disapproved by him, she may suffer further violence (Trute, 1998). This may make the woman feel isolated and further hesitant to disclose incidents of violence in therapy out of fear of her abusive partner (Trute, 1998). Lastly, as the woman becomes more vulnerable in therapy, the abusive male may take advantage of these vulnerabilities to engage in new abusive behaviours while avoiding legal responsibility by claiming that he is working on his problems in therapy (Jory, Anderson, & Greer, 1997).

Arguments in Support of Conjoint Treatment

Although gender-specific programs have been widely used to address IPV with mandated male clients, research indicates that they have some limitations (Feder & Wilson, 2005; Babcock, Green, & Robie, 2004). In some studies, men who complete programs show a modest reduction in violence perpetration (Babcock et al., 2004). In addition, couples may decide to stay together after violence, and when they do, there are unhealthy relationship dynamics that trigger and maintain the violence. As such, gender-

specific treatment groups may be limited in their effectiveness because they only address men's role in the violence and fail to address the underlying relationship dynamics. If situational violence is occurring in these relationships then treating men without treating the couple is not likely to stop the violence. Also, failing to provide services to both parties in an on-going relationship may inadvertently disadvantage the female partner who chooses to stay (Heyman & Neidig, 1997).

Upon successful completion of gender specific treatment, conjoint treatment can be used as an additional component to monitor the couple's relationship as well as to provide support to both parties while safeguarding women's safety. Conjoint therapy has the potential to be an effective treatment for IPV with Aboriginal couples because of its holistic, contextualized approach and focus on family relationships. However, components of conjoint treatment need to be modified in order to become culturally sensitive.

Need for a Culturally-Sensitive Model

There is a general consensus that effective interventions for Aboriginal peoples should have a restorative approach (e.g. Heilbron & Guttman, 2000; Alaggia & Vine, 2006). Interventions for family violence in Aboriginal communities should be culturally responsive and involve healing for the family (Alaggia & Vine, 2006). Effective counselling with Aboriginal clients depends on how well the counselor understands the culture and how well she or he operates from within that culture by attending to the relational as well as traditional and spiritual aspects of healing (Heilbron & Guttman, 2000).

A strong connection to traditional culture has been found to act as a protective factor against the negative effects of colonization (Zubrick & Silburn, 2006). Indeed, Aboriginal communities that have taken measures to maintain their cultural ways and collective cultural identity experience significantly better mental health than other communities (Chandler & Lalonde, 1998).

Despite the need for a culturally sensitive treatment model, there is a lack of such model for effective IPV treatment with Aboriginal couples (Willmon-Haque & Bigfoot, 2008). Treatments for IPV with Aboriginal clients need to address unique factors, such as intergenerational trauma, systemic oppression and discrimination which have contributed to existing violence. Many times the only route available to Aboriginal men who engage in IPV is incarceration. When these men are released, they are mandated to attend Western-based counselling programs that may not be appropriate to their needs.

Continuing to charge and incarcerate Aboriginal men is extremely expensive (Aboriginal Justice Implementation Commission, 1999). If IPV is not adequately addressed, it will continue to bear significant costs to policing resources, social services and medical treatments. Developing a counselling model for IPV with Aboriginal couples can educate clinicians about the history, ongoing consequences of colonization as well as the contemporary problems Aboriginal couples face. This knowledge can help clinicians provide effective services that meet their clients' needs.

Beyond its economic costs, the negative effects of IPV on victims' health further highlight the importance of developing a culturally-responsive intervention that can effectively address violence with Aboriginal couples. IPV can negatively impact the victim's health. IPV is associated with significantly more depression and substance abuse

for women (Bonomi, Thompson, Anderson, Reid, Carrell, Dimer, & Rivara, 2006). Female victims of IPV are more likely than female partners in nonviolent relationships to suffer from physical injuries, mortality and experience anxiety disorders, suicidal ideation, chronic physical disorders and sexual health complaints (Briere & Jordan, 2004; Golding, 1999; Hathaway, Mucci, Silverman, Brooks, Mathews & Pavlos, 2000).

In addition, the presence of IPV negatively impacts other members in the family, particularly children. Children in violent families may be physically harmed themselves (Jaffe, Wolfe & Wilson, 1990). Also, children witnessing IPV tend to experience vicarious trauma (Stith & Farley, 1993). They are also more likely to assault siblings and parents as well as potentially partners, later in life compared to children who have not witnessed violence (Edleson, 1999; Jaffe & Sudderman, 1995).

Structure of the Thesis

The presence of IPV among Aboriginal couples stems from the abuse and loss associated with colonization (Kirmayer, Brass, & Tait, 2000; Nuttgens & Campbell, 2010; Yellow Horse Brave Heart & DeBruyn, 1998). Although therapeutic interventions are available for IPV, they tend to consist of Western-based interventions. The present study can help with the development of a contextualized counselling model for effective conjoint treatment intervention of IPV with Aboriginal couples.

A review of the research literature in Chapter 2 focuses on the history of oppression and its relation to IPV among Aboriginal couples, an overview of current theoretical approaches to IPV and a description of evaluated conjoint therapy programs as well as important content and activities features of these programs as identified in the literature for IPV intervention. Chapter 3 provides a description of the Concept Mapping

methodology and its procedures that were employed in this study. Chapter 4 includes a presentation of the study results and in Chapter 5 the results are compared and contrasted with the literature reviewed in Chapter 2.

Chapter 2: Literature Review

This chapter includes an overview of colonization and its implications for IPV treatment with Aboriginal clients as well as theoretical approaches to IPV and conjoint therapy as a potential treatment for IPV with Aboriginal couples. Additionally, four evaluated conjoint therapy treatment programs, their underlying concepts and activities are reviewed.

Colonial Effects

Oppression is the effect of unjust use of force and authority on a social group. Systematic oppression occurs when oppression is institutionalized and reinforced through laws and practices that lead to inequities based on one's social group membership. In Canada, Aboriginal peoples have been subjected to colonial control and the effects of oppression. Research indicates the rates of mental health and social problems that exist among Aboriginal peoples are attributable to oppression as a result of assimilation efforts that were made (Armitage, 1998; Kirmayer, Simpson & Cargo, 2003; Robin, Chester, & Goldman, 1996). At the centre of these assimilation efforts were the Indian Act, residential schools, the reserve system and the 60's Scoop (Wotherspoon & Satzewich, 2000).

The Canadian government along with Christian ministries established residential schools for the purposes of assimilating Aboriginal children (Armitage, 1998). In these schools children were taught European values and language. Their traditional ways were shamed and use of first language punished (Armitage, 1998; Morrissette & Naden, 1998). As a result, children attending the schools began to lose their languages and cultures. Many survivors lost closeness, connection and sometimes contact with family members

and others in their communities (Wotherspoon & Satzewich, 1993). They were also subjected to poor role models for caregiving, which negatively affected their wellbeing as well as the wellbeing of subsequent generations (Tafoya & Del Vecchio, 1996). These negative effects involve feelings of alienation and meaninglessness (Brave Heart, 2003; Brave Heart & DeBruyn, 1998), disassociation and memory gaps with respect to experiences at the schools (Duran et al., 1998), problems with sadness and confusion as well as doubts about parenting skills (Brave Heart, 2003).

Aboriginal peoples have faced oppression as a result of the Indian Act which is still an active legislation (Stevenson, 1999). Although this legislation has been modified through the years, its ramifications continue to negatively impact Aboriginal peoples to this day. In the past, the Indian Act overtly controlled the movement of individuals from reserves and prohibited their participation in cultural activities, driving traditional knowledge and practices underground. The Indian Act also took away women's right to vote in community elections, prohibiting them to run for political power (Stevenson, 1999). Through the establishment of oppressive laws, particularly for women, European colonizers introduced their patriarchal notion of male domination (Kirmayer et al., 2003). By the time Aboriginal women regained their legal rights, patriarchal values and practices had been internalized by many Aboriginal men in communities and began to undermine traditional ways of functioning (Stevenson, 1999).

Furthermore, continued oppression led to the overrepresentation of problems including high rates of involvement with the children's services and justice system in Aboriginal communities (Royal Commission on Aboriginal People, 1996). The accumulation of such losses over multiple generations contributed to the breakdown of

family and community structures (Brave Heart, 2003; Kirmayer et al., 2003). In response, “child welfare” efforts focused primarily on the removal of children from families and communities. Widespread poverty compounded by the lack of preventive and responsive local services for Aboriginal families contributed to sharp rises of adoptions and out of community placements into foster care (Kirmayer, et al., 2000). By the 1970s, one in four Aboriginal children was in foster care (Kirmayer et al., 2003).

All of these efforts made to assimilate were not successful, but have challenged communities, strained intergenerational relationships, separated children from their families, disrupted the transmission of cultural knowledge and left gaps in understanding and knowledge among adults parenting their own children. The multiple losses and abuses, the influence of patriarchal attitudes and subsequent disruptions to family and community functioning have contributed to violence in Aboriginal communities. The psychological and political weight of these experiences has manifested in family violence and IPV.

As such, effective treatment of IPV with Aboriginal couples necessitates a contextualized model of counselling that takes into account colonization and intergenerational trauma, and requires the infusion of Aboriginal culture (Brave Heart, 2003). However, contemporary Western-based treatment approaches to IPV widely used with Aboriginal clients tend to lack such cultural sensitivity.

Theoretical Approaches to IPV

Two main theoretical perspectives have been used to explain underlying causes of IPV: feminist and family systems theories. The feminist theory argues that the culturally-based systems of male privilege, domination and control, referred to as patriarchy,

sanction women's oppression and subjugation by men and give rise to violence (Stordeur & Stille, 1989). From this view, violence is viewed as a control tactic. Feminists are also critical of the system-based approach to IPV which distributes responsibility across both genders, potentially reducing responsibility on the man for the violence. They suggest that using systemic therapy for IPV implies that women are also to blame for their partners' abusive behaviours, thus making women more vulnerable to further abuse.

From a Family Systems approach couples who experience IPV are viewed as locked into a pattern of dysfunctional relationship dynamics and a vicious cycle that maintains the violence and abuse (Wood & Kiyoshk, 1994). This approach locates IPV in the context of family and community relationships as well as broader social and political systems. From this perspective, it is important to understand the impact of the larger social context on perpetrators, the impact of abuse on other members within the system as well as on the system as a whole. By paying attention to the social context within which IPV occurs, the family systems model can provide a framework in which factors such as oppression, intergenerational trauma and culture are taken into account. Conjoint therapy is derived from a system-based approach to IPV. Although conjoint therapy programs for IPV so far consist of solely Western-based components, they can be modified to become culturally responsive.

The preferred approach integrates feminist and systemic principles, in an emphasis on male responsibility for violence as well as tactics of power and control in the relationship, the utilization of strengths that both partners have, as well as recognition of the relationship within which the problems occur. It should be noted that each of the four

evaluated programs presented herein reflect this integration. The next challenge is to identify culturally-appropriate contents and processes for these programs.

Conjoint Therapy & IPV

There are four treatment programs in North America that use conjoint therapy for IPV (O'Farrell & Fals-Stewart, 2002; O'Leary, Neidig, Heyman, & Brannen, 1999; Stith, McCollum, Rosen & Locke, 2002; Dunford, 2000). The Behaviour Couple Therapy program (O'Farrell & Fals-Stewart, 2002) is a treatment for substance abuse problems among couples who have also experienced IPV. The goals of the program include male partners abstinence from alcohol and drugs as well as improving couples' relationship functioning. Only male partners, who meet DSM substance abuse disorder criteria, agree to stop using drugs during treatment, and give verbal agreement to disengage from angry touching are eligible to participate in this program. The program consists of 12, 60-minute weekly conjoint sessions, as well as 20, 60-minute individual sessions. Interventions for substance abuse are used throughout BCT to promote abstinence. When abstinence and attendance have been attained, relationship-focused interventions such as increasing positive activities and teaching effective communication skills are used to improve relationship functioning (O'Farrell & Schein, 2011).

The Physical Aggression Couples Treatment program (PACT) (O'Leary, Neidig, & Heyman, 1999) aims to reduce anger and improve relationship skills among couples in order to prevent violence. The program consists of groups of 6-8 couples and it is facilitated by male and female co-therapists. Couples who acknowledge aggression is a problem and indicate violence is not severe enough to elicit substantial fear or serious injury to the female partner are eligible to participate. The first half of PACT is focused

on improving intrapersonal skills such as anger management skills, increasing awareness of violence, accepting responsibility for aggression, as well as learning to challenge anger-engendering cognitions. The focus on the second half is to improve interpersonal skills such as communication skills, to promote fair-fighting as well as effective conflict resolution skills (Heyman & Schlee, 2003).

The Domestic Violence–Focused Couples Therapy program (DVFCT) (Stith et al., 2002) has been adapted from Solution-Focused Brief Therapy (SFBT) (De Shazer & Dolan, 2007) to address IPV with couples. This program focuses on the strengths and capacities of clients. It helps them develop a picture of a future without the problem and asks questions in a way that elicit self-generated solutions to client’s own issues. The goals of the program include ending all forms of violence between partners, increasing positive affect in relationship, as well as increasing each partner’s responsibility for violent behaviour. The first half of the treatment is conducted in gender-specific groups or with individual partners in order to address coping skills, increase awareness of violence and create hope for change. The second half consists of 12, 2-hour conjoint sessions with separate meetings with partners before and after the sessions. During the conjoint phase, couples address issues that cause conflict in their relationship in order to prevent violence.

Dunford (2000) developed a program for US Navy couples where husbands had engaged in physical abuse against their partners. This program consisted of 26 weekly sessions as well as 6 monthly sessions (1.5 hours each), co-facilitated by a male and a female therapist. The goals of the program include ending abusive behaviour towards

women, personalizing violence and increasing empathy and respect for the female partner.

Content in Conjoint Therapy

The evaluated conjoint therapy programs consist of mostly Western-based therapeutic concepts and components. In these programs clients learn about effective anger management skills, negotiated time-outs, as well as communication and conflict resolution skills. In addition, these programs utilize a solution-focused approach and positive reinforcements, as well address substance abuse problems in order to address IPV.

Anger Management Training. Anger is associated with different forms of aggression including IPV and child abuse. It has been found that arguments precede physical aggression in couples much of the time (e.g., O’Leary, Smith, & O’Leary, 2007). Nearly all husbands and two-thirds of wives who commit mild-to-moderate forms of physical aggression report that it takes place in the context of an argument (Cascardi, Vivian, & Meyer, 1991). Research suggests (O’Leary, Smith, & O’Leary, 2007) that when arguments escalate to physical aggression, anger is usually present. Given the importance of anger in relation to aggression; conjoint treatments for IPV aim to address anger management issues and other control tactics.

A key component of the anger management training involves learning how to monitor signs of escalating anger. The couple learns to identify physical and emotional signals, thoughts and verbal cues that indicate to them their anger is escalating (Heyman & Schlee, 2003). Mindfulness meditation is used to help clients relax, take a step back and become aware of their physical, emotional and cognitive experiences. Rooted in

Eastern meditation practices, mindfulness-based techniques enable clients to effectively regulate their attention and be open and aware of their internal experiences (Baer, 2003). Being much more in tune with their internal experiences, clients gain the enhanced ability to recognize anger signals before escalation to violence.

Lastly, a cognitively oriented approach enables couples to become active observers and evaluate their own cognitions. The cognitive-behavioral (ABC) model of anger is used to highlight the role of hot thoughts in triggering anger. Clients learn to identify and challenge their cognitive distortions, replace hot thoughts with alternative cool thoughts and to finally replace maladaptive responses arising from anger with more adaptive responses (Epstein & Baucom, 2002). By learning to identify when anger is intensifying, partners are better able to step back and manage their anger effectively.

Negotiated Time-outs. Once clients can identify signs of escalation, they learn about effective time-out strategies. When properly used, time outs allow partners to disengage from an escalating conversation for a time period, calm down and be able to use more effective strategies to manage and resolve the conflict (Epstein & Baucom, 2002; Holtzworth-Munroe et al., 2003). The process of developing a time-out procedure for the couple is interactive and collaborative. Both partners have to find a mutually acceptable way to call a timeout and determine a specific length of time for the break (Gurman, 2008). This way the couple will be more inclined to follow the plan they develop. Having a specific time-out plan in place is useful during the conjoint phase of the treatment when clients address more challenging issues that are interpersonal in nature.

Communication & Conflict Resolution Skills. Lack of effective communication and conflict resolution skills often leads to relationship discord (Clements, Stanley & Markman, 2004; Gottman & Notarius, 2000). Once a couple learns to use the time-out strategy appropriately to deescalate conflicts, it is important to work with them to help them effectively resolve conflicts. Conflict resolution skills training (e.g., Stanley, Amato, Johnson, & Markman, 2006) helps couples learn effective strategies for resolving conflict in ways that are productive and safe. Couples learn to take a mutual, constructive, problem-solving approach to conflicts that arise between them and to avoid negative strategies such as blaming or sarcasm (Silliman, Stanley, Coffin, Markham, & Jordan, 2001). In order to improve relationship functioning, couples also complete communication skills training. Concepts that are covered in communication skills training include sending clear I-messages, empathic listening and responding in a way that shows the speaker was heard and understood (O'Farrell & Schein, 2011).

Solution-Focused. In conjoint therapy, therapists also help the couple develop a clear vision of a healthy, violent free relationship (Lebow, 2005). This solution-focused approach helps clients identify the particular changes they want to see in their relationship. This approach is future-oriented and focuses on possibilities instead of past mistakes and blaming (De Shazer & Dolan, 2007). By using a solution-focused language, the therapist helps clients identify signs that inform them when they are moving toward achieving a healthy relationship. This will also help keep the couple motivated during the therapeutic work.

Positive reinforcement. Another strategy used to keep couples motivated involves enhancing relationship satisfaction and increasing positive behavioral exchanges

between partners. This is done by helping the couple increase caring and mutually pleasurable activities in their relationship such as acknowledging pleasing behaviors in one another or engaging in shared recreational activities. Furthermore, substance abuse and intimate partner violence often co-occur (O'Farrell & Schein, 2011). Many substance abusers' families disengage from shared activities due to strained relationships and embarrassing substance-related incidents. It is important to reverse this trend by increasing pleasurable activities and exchanges between the partners (Moos, Finney, & Cronkite, 1990).

Abstinence from substances. In cases where substance abuse problems are contributing to relationship functioning, motivational interviewing around substance abuse is conducted to increase the client's awareness of the potential problems caused as a result of the substance abuse. The goal is to motivate the client to achieve sobriety by making him/her aware that substance abuse is not consistent with a client's personal values and goals. In cases where substance abuse problems are severe, clients are required to abstain from using drugs while in treatment. They also have to attend Individual Drug Counselling and AA support groups.

Activities in Conjoint Therapy

Clients learn about the essential content, including concepts and skills reviewed herein, through different activities. These activities can be either didactic or experiential. Didactic activities involve teaching clients relevant concepts and skills through lectures, collaborative discussions, books, movies or pen-paper exercises. Experiential activities involve role-playing and behaviour rehearsals for the purposes of practicing the specific skills learned.

Didactic. In the context of conjoint therapy couples are taught how to recognize initial anger cues and engage in self-soothing methods, as well as how to use effective communication and conflict resolution skills to prevent violence. In order to learn to identify anger cues, a solution-focused language is used to discuss the topic of escalation signals with partners. Each partner is asked to think about the specific signs or cues that would indicate anger is escalating. Instead of being taught a list of common signals, each partner is invited to identify anger signs that are specific to him or her (Stith, McCollum, & Rosen, 2011). With some guidance from the therapist, partners identify physical signals, emotional signals, thoughts, words or phrases that may serve as signals that their anger is escalating. To solidify this learning, for homework, partners are asked to document the emotional, behavioral and cognitive changes that occur as their anger escalates (Heyman & Schlee, 2003).

Another technique that is taught to help partners become more aware of their escalation signs is mindfulness meditation. Clients are taught to meditate using a “mantra”, which is a verbal cue that clients repeat silently in order to become more focused. Partners are provided with handouts explaining the purpose of this concentration-based meditation, the rationale behind it and steps outlining its procedures. The procedures outlined have been adapted from Carrington’s (1998) clinically standardized meditation manual that is widely used.

Couples also learn about anger control techniques and how to challenge hot thoughts. Using cognitive-behavioral (ABCD) model of anger they learn about types of cognitive distortions, how to identify them and challenge them. Four steps are presented: (a) differentiating anger cues (b) pausing (i.e., deep breathing or thought stopping); (c)

deciding on action; and (d) control thinking. When “deciding on action”, couples discuss the function of anger and violence, whether they are adaptive or maladaptive and learn about adaptive behaviours in response to anger. The last step, “controlling thinking,” involves having each partner provide examples of her and his hot thoughts and then replace these thoughts with alternative cool thoughts.

When partners learn to recognize their own anger cues (i.e. physical, emotional, thoughts), they learn about the first anger management strategy: timeout. The six steps of timeout strategies including self-watching, signalling for time out, recognizing the partner’s signal, separating, cooling off and returning are presented to partners and discussed (Heyman & Schlee, 2003; Stith, McCollum, & Rosen, 2011).

Couples are provided with handouts to help them develop the timeout procedures that work for them. Each couple works collaboratively to negotiate the details of a time-out plan including identifying signs that would inform them their resolution efforts are becoming ineffective, mutually agreeing to the signal selected for time-out, the length of time-out as well as the activities that will take place during the time-out. The therapist guides the couple through this negotiation process, ensuring that both partners have contributed to the decision making and are satisfied with the plan.

In addition, couples are taught effective conflict resolution skills. Partners are introduced to the concepts of harsh versus gentle start-ups. They are taught to: (a) avoid blaming the other in their initial start-ups, (b) start with something positive, (c) describe what is happening instead of judging the other, (d) be respectful, (e) express appreciation, and (f) express their feelings in terms of vulnerable emotions (Gottman & Silver, 1999).

Couples are presented with examples of effective and ineffective conflict resolution

scenarios. Another way couples learn about ineffective conflict resolution strategies is through humorous workbook exercises such as “Dirty Fighting Techniques” (O’Leary, Neidig, & Heyman, 1999). These exercises require the couple to read about ineffective ways of handling conflict (i.e. blaming or sarcasm) and identify ineffective ways they have used in the past to resolve conflicts.

Couples also learn general communication skills such as learning to express feelings directly, owning one’s feelings and expressing feelings using I-statements. They also learn about gender differences in communication styles because it was found that aggressive men have difficulty recognizing and expressing their feelings (Heyman & Schlee, 2003). Finally, couples learn to distinguish between primary emotions such as sadness and secondary emotions (i.e. anger) (Greenberg & Johnson, 1988) as well as their impact on conflict management.

The therapist helps the couple build a clear vision of a healthy, violence free relationship using the solution-focused technique of the miracle question (de Shazer & Dolan, 2007). By asking questions such as, “What kind of marriage you want to have with your partner?”, or “When you think about a healthy relationship, what are its building blocks?” the therapist orients the couple toward their preferred future and possibilities for change instead of focusing on past mistakes. The couple is asked to provide specific, concrete descriptions of their vision for their relationship and describe steps they would take to achieve this vision. The couple is asked to recall the miracle question throughout the program as a source of motivation.

Lastly, to increase pleasurable exchanges, couples are asked to list pleasing behaviours they notice in one another outside of session, for example, listing items such

as “my partner told me he/she loved me”. Couples are also invited to acknowledge caring behaviours in one another and list them. This could include listing something positive about what one’s partner said and how he or she said it. Finally, to support abstinence from substances, partners engage in a discussion with therapist about the personal use of substances with the therapist.

Experiential. The experiential activities in conjoint therapy consist of live practice of the conflict resolution and communication skills learned in the session, in the presence of the therapist. Other experiential activities consist of behavioural changes that the couple is invited to make in the relationship outside of sessions.

To practice conflict resolution skills, each partner practices calling a time out when neither one of them is angry (O’Farrell & Schein, 2011). Practicing the procedure in a calm state allows partners to assess the effectiveness and appropriateness of their time-out plan in real life. As the couple becomes more comfortable with the procedure, they practice calling a time out to de-escalate conflict in a real life situation. Time-out plans are revisited and revised throughout the program.

Partners also practice their conflict resolution skills during the session. After they are provided with examples of harsh versus soft start-ups, each partner practices a softened start-up during a conversation and receives feedback from the therapist as to how she or he can improve this skill. In addition, sometimes when partners return from a time-out, they may still experience some negative feelings and tension. Partners need to learn how to repair these negative feelings. They are encouraged to use “I” statements to softly begin the conversation and repair the negativity first. Each partner is invited to share a feeling about what happened and take responsibility for his and her actions. If the

conflict escalated before the time out, one or both partners may need to apologize. The other partner is encouraged to provide positive feedback to the partner attempting to repair the negativity. This is done to ensure that the partner repairing the negativity feels accepted and appreciated for his or her efforts. The therapist is active during this practice, ensuring that partners use a non-blaming and non-judgmental language.

In another exercise, partners learn to “accept influence”. This means they learn that sharing power and compromising can positively impact their relationship. In this exercise, partners collaboratively work to establish a common solution to a problem by compromising when possible. Each partner uses a positive, non-blaming language to discuss his or her viewpoint on the issue. They are then encouraged to reach a mutually agreed decision with respect to the issue. Each partner is encouraged to openly listen to the other’s point of view and identify opportunities to compromise. These skills allow couples to discuss issues calmly and reach mutually-agreed decisions.

To practice their previously learned communication skills such as paraphrasing, empathizing and validating, partners discuss an issue during planned structured discussions. Each partner takes turn speaking without interrupting the other using listener and speaker skills learned. Couples are also instructed to engage in 15-20 minutes of “listening with understanding” sessions where they discuss daily problems as well as charged issues using the new skills learned.

As well, couples are invited to engage in mutually rewarding activities. Each partner lists possible pleasurable activities, plans one activity each week (i.e. a date night). During the session, the therapist models planning an activity, to illustrate solutions

to common problems couples may face when planning activities (O'Farrell & Schein, 2011). Couples are instructed to avoid discussing problems during these activities.

To reinforce and support a partner's abstinence from drugs and alcohol, the couple learns to engage in daily trust discussions at home. During these discussions, the substance-abusing partner expresses his or her intention not to use drugs that day while the other partner verbalizes support for the efforts to stay abstinent. For clients who are on medication, daily medication ingestion is verbally reinforced by their partner. Both partners agree not to discuss past drinking or fears about future drinking at home to prevent conflicts and a subsequent relapse. To improve their skills partners also practice trust discussions in the session. The substance-abusing partner is also encouraged to attend 12-step or other support group meetings.

Summary and Rationale for Present Study

Given the colonial history and oppression of Aboriginal peoples as the contributor to IPV, the existence of couples choosing to remain together following violence and the need for culturally appropriate interventions, the present study can add to what is known about the possibility of conjoint therapy. Current theoretical approaches to IPV treatment are Western-based as is the practice of conjoint therapy. The main concepts and activities of evaluated conjoint therapy treatment programs offer techniques that could be considered for use with Aboriginal couples. However, the history and context of colonization and oppression with effects on families and communities suggest that the ideas and practices within existing models of conjoint therapy need to be explored for their relevance and utility for working with Aboriginal couples.

It is suggested that because the current conjoint therapy programs have been developed solely based on Western values, they fail to take into account the culture and unique circumstances of Aboriginal peoples. Thus, effective treatment of IPV with Aboriginal couples requires a contextualized model of counselling that takes into account the oppression, and intergenerational trauma as well as the existing cultural diversity among Aboriginal clients. Thus, the aim of the study was to identify salient features of conjoint therapy for working with Aboriginal couples following IPV.

Chapter 3: Method

The purpose of the study was to identify characteristics of a conjoint therapy program for IPV with Aboriginal couples. The focus was on service providers' perspectives of the content and activities for such a program. This thesis utilized existing data previously collected as part of a large-scale study of family violence professionals in 2012. The approved ethics protocol for the complete study is included in the appendix. The author performed the interpretation of multidimensional scaling and cluster analysis results in the concept maps.

As part of the larger study, telephone interviews of experts who provided safety and therapeutic services to Aboriginal couples experiencing IPV were conducted. Participants answered several questions including the two questions which are the focus of this thesis: 1) "How would you address content with Aboriginal men in couple counselling who use abusive behaviour toward their intimate partner?" and 2) "How would you address activities with Aboriginal men in couple counselling who use abusive behaviour toward their intimate partner?". Results were analyzed using Concept Mapping (Trochim, 1989). In this chapter a brief overview of Concept Mapping and the procedures followed are provided.

Concept Mapping

Concept Mapping is a method used to analyze and interpret qualitative data (Chambers, 1992). Developed by Bill Trochim (1989), Concept Mapping is a structured conceptualization process, which provides a visual representation of individuals' views on a particular research topic and their conceptual relationships to one another. This method applies a uniform structure to the analysis of qualitative data. Concept Mapping

has been used for program planning and evaluation (Trochim, Stillman, Clark & Schmitt, 2003), to develop conceptual frameworks (Cousineau, Houle, Bromberg, Fernandez & Kling, 2008) as well as theories of change (Petrucci & Quinlan, 2007).

Procedure

The Concept Mapping process includes six steps: 1) Preparation, 2) Generation, 3) Structuring, 4) Representation, 5) Interpretation and 6) Utilization (Trochim, 1989). The steps for concept mapping were followed in the present study, beginning with the collection of responses to a focal question. Next, participants' responses were edited and redundant responses were excluded. Individual responses were printed on cards. Participants were asked to sort the responses into groups. Two statistical procedures were used to analyze the sort data. Multidimensional scaling was used to represent the responses as points on a point map while cluster analysis combined responses to form concepts. The Concept System (Trochim, 1987) was utilized to perform the analyses. The writer and her advisor determined an appropriate number of concepts and assigned a label to each for the two questions described in this thesis.

Preparation. Individuals were invited to participate in the study if they had expertise in either of the following areas: 1) service provider in safety area (e.g. shelter, law enforcement), or 2) professional providing treatment for IPV (e.g. group facilitator, support services worker). Participants were recruited through advertisement to staff working within justice, family services and health departments in a Canadian province. Interested participants were invited to contact the researchers to arrange for individual telephone interviews.

During the telephone interview participants' responses to demographic questions as well as to several open-ended questions were noted by researchers. No audio recording was done. The present study focused on two of the open-ended questions: 1) "How would you address content with Aboriginal men in couple counselling who use abusive behavior with their intimate partner?" and 2) "How would you address activities with Aboriginal men in couple counselling who use abusive behavior with their intimate partner?" These research questions were part of the larger study which had received ethics approval from the "Sub Research Ethics Board" within the Education Department at Western University.

Generation. At the time of interview each was informed that Western University's institutional ethics board had approved the study and that participation was voluntary, confidential and each had the right to withdraw at any time without consequence. All individuals who were contacted agreed to participate. At the end of the interview each was asked if she or he was interested in participating in the sorting task at a later time. A list of interested individuals was kept.

Participants included 26 individuals who provided services, including both safety and therapeutic, for IPV to Aboriginal couples. They were between 29 to 64 years of age (average age = 49). The sample consisted of mainly female participants, with male participants constituting ¼ of the sample. Participants had from 3 to 40 (average = 22) years of experience working in the area of IPV. At the time of interview participants were employed as front line law enforcement and corrections as well as women's shelter staff, senior administrators in family violence programming as well as experienced therapists providing treatment.

Structuring. All responses provided to each question by participants were separately examined. Unique responses to each question were identified by having three researchers flag responses that were redundant. Any response identified as redundant by at least two researchers was excluded and any responses identified as ambiguous by at least one, was edited. This process resulted in 74 unique responses to question one and 44 unique responses to question two.

Participants who agreed to participate in the sorting task were contacted by telephone to confirm their interest in the sorting task and mailed out packages containing copies of all responses by question, printed on separate cards. Consistent with the instructions provided by Trochim (p. 5, 1989) on how to complete the sorting task, participants were given the following instructions: a) “a response card cannot be placed in two piles simultaneously”; b) “all responses cannot be placed in a single pile”, and c) “all responses cannot be put into their own piles (although some items may be sorted by themselves)”. Each participant was asked to sort the cards together in a way that she or he found most meaningful (Trochim, 1989).

Representation. The sort data was analyzed using multidimensional scaling and cluster analysis with the Concept System (Trochim, 1987). Multidimensional scaling organized responses as points on a map. Responses that were sorted together more frequently by participants were closer to one another on the map. Responses that were rarely sorted together were further apart on the map. Multidimensional scaling results were used for the cluster analysis of responses which grouped responses into concepts.

Multidimensional scaling. A similarity matrix was constructed based on the sorting results. The matrix indicated the frequency with which any one response was

sorted with every other response (Kane & Trochim, 2007). A similarity matrix was calculated for each individual participant and a combined matrix value was calculated on across all participants (Kane & Trochim, 2007). Using a multidimensional scaling of the similarity matrix on a two-dimensional plot (X-Y graph), responses were placed as points on a map. The point map visually represented the frequency with which each response was sorted with the other responses (Kane & Trochim, 2007).

Cluster analysis. Cluster analysis was used to identify the conceptual structure underlying the responses on the map (Everett, 1980). Ward's technique was used to determine the conceptual clusters on the map. The technique began with each response as its own concept and at each stage two concepts were combined until all responses were in one concept. Ward's method provided solutions that were more meaningful and interpretable than other cluster analysis techniques (Trochim, 2015).

The bridging index. A bridging index was calculated for each response. The bridging index is a statistical value ranging from 0 to 1. A bridging index value is used to describe the relationship between each response with the other responses near it on the map. A low bridging index (between 0-.25) indicated that the response was sorted with other responses in its close proximity. A high bridging index (between 0.75-1) indicated that the response was frequently sorted with responses in areas farther from it on the map. An average bridging index value was also calculated for each concept. Smaller average bridging index values were indicative of highly cohesive concepts.

Interpretation. Researcher judgment was used to determine the most appropriate number of concepts. In general, maps with fewer concepts provided a broad visual representation of the most important ideas, while maps with greater numbers of concepts

provided a more detailed view (Kane & Trochim, 2007). In selecting the most appropriate number of concepts as few concepts as possible should be chosen (Trochim, 1989). The writer and her advisor reviewed maps for each question and made the decision about the most appropriate number of concepts to be included in each map. These decisions were made based on conceptual similarity between responses in the same concept as well as conceptual differences between responses in different concepts. Each concept was then assigned a label to reflect its contents (Trochim, 1989).

Utilization. Concept mapping provided a visual representation of the participants' main ideas as well as their conceptual structure (Trochim, 1989). In Chapter Four, the maps are presented along with a description of the responses in each map. In Chapter Five the results of the concept maps are compared and contrasted with the current literature.

Chapter 4: Results

The purpose of the study was to identify characteristics of a conjoint therapy program for IPV with Aboriginal couples. The focus was on service providers' perspectives of the content and activities for such a program. The responses were collected through telephone interviews with professionals who provided either a safety or therapeutic service for IPV to Aboriginal couples. Responses to two questions were the focus of the present study: "How would you address content with Aboriginal men in couple counselling who use abusive behavior with their intimate partner?" and "How would you address activities with Aboriginal men in couple counselling who use abusive behavior with their intimate partner?" Responses to these questions were then sorted into groups by participants. The sort data was analyzed using multidimensional scaling and cluster analysis. A concept map was created for each question. This chapter presents the results of the concept maps for each question.

Content

The question, "How would you address content with Aboriginal men in couple counselling who use abusive behavior with their intimate partner?" elicited 74 unique responses. Six participants sorted the responses. Multidimensional scaling as well as cluster analysis were used to analyze the sort data. According to Trochim (1989), for 100 unique responses or less, concept maps with 3 to 20 concepts should be examined. This ensures that the final number of concepts in a map accurately capture the most meaningful themes underlying the data.

For the first question, concept maps reflecting a range of possible solutions were reviewed. Maps containing 20 and 15 concepts showed a significant amount of scatter.

Concept maps with 10 to 4 concepts were then reviewed and assessed for the best data interpretability. The concept map containing ten concepts did not produce clusters that were significantly differentiated. As the number of concepts decreased from nine to five, the map showed greater differentiation between concepts. The concept map containing four concepts did not capture the complexity of the data. The concept map which most accurately represented the data contained six concepts (see Figure 1).

Individual responses along with their corresponding bridging index values are shown in Table 1. The bridging indices helped determine the most important responses belonging to each concept. They were also used to help label concepts. Each bridging index took a value between 0 and 1. A value of 0.0 to 0.25 was considered to be in the low range. Any response with a low bridging value implied that it was frequently grouped only with responses in the same concept. A bridging index value of 0.75 to 1.00 was considered to be in the high range. A response with a high bridging index value implied that the response was also frequently grouped with responses in other concepts. Trochim (1989) suggests that responses with high bridging index values do not conceptually fit solely with responses in their immediate surroundings. As such, these responses may be less representative of the general theme of the concept they belong to.

An average bridging value was calculated for each concept. Concepts containing responses that were more consistent with one another had a lower average value. Higher average bridging values indicated that responses in the concept were sorted with responses in other concepts on the map.

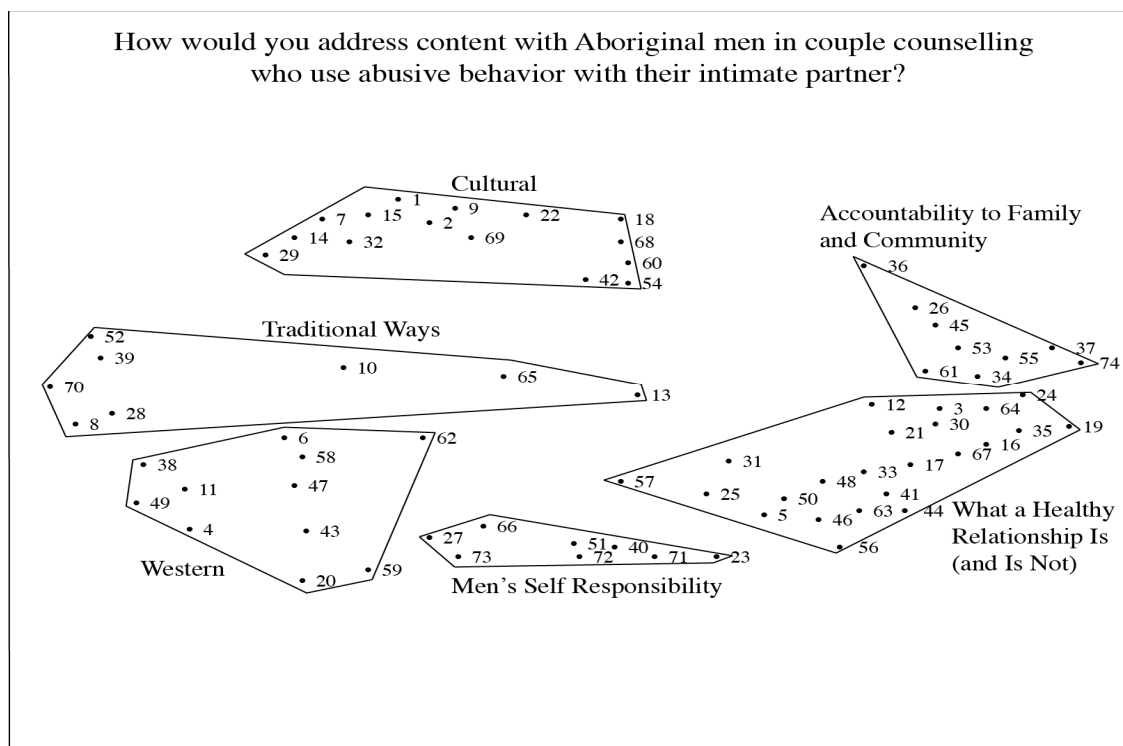


Figure 1. Concept Map for Question One.

Table 1

Concept Items and Bridging Values for Concept Map for Question One

Concept and Response	Bridging Index
Cultural	0.32
1. Aboriginal healing approaches	0.00
2. Aboriginal spirituality	0.00
9. ceremonies	0.00
15. cultural practices	0.13
68. traditional approaches	0.13
7. blend of western and traditional concepts	0.17

69. traditional values	0.24
14. cultural context	0.30
22. Elders involved	0.32
32. historically this is what the family looked like	0.36
29. healing circles	0.53
18. different beliefs and tribes	0.59
42. language specific	0.61
60. skills based in the process of a circle	0.66
54. ritual	0.70
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Western	0.67
4. addictions	0.52
47. pride	0.57
62. strength	0.63
11. Cognitive behavioral therapy	0.63
58. self-esteem	0.64
49. psychological/psychiatric concepts	0.69
20. drugs and alcohol	0.70
6. belonging	0.71
43. mental health	0.74
59. sexism	0.76
38. intergenerational cycle of abuse	0.76

Traditional Ways	0.80
13. couples needs	0.55
65. talking and sharing	0.70
70. trauma	0.74
52. residential schools	0.76
39. intergenerational trauma	0.84
28. ground therapy in holistic way	0.88
10. children	0.97
8. broad focus	1.00

What a Healthy Relationship Is (and Is Not)	0.33
67. time-outs	0.22
30. healthy relationships	0.26
16. cycle of violence	0.26
41. knowing what their risk factors are	0.27
46. power and control	0.28
17. dealing with conflict	0.29
21. dynamics of relationship	0.29
63. taking responsibility	0.29
44. ownership of behavior	0.29
48. problem solving	0.31

33. how his abuse impacts the relationship	0.31
3. accountability	0.32
5. anger	0.34
50. public ownership by him of his abusive behaviour towards her	0.34
12. communication skills	0.35
35. impact of abuse on themselves, partner, and children	0.35
64. talk about forms of abuse	0.37
25. express needs in healthy ways	0.37
31. help them identify abusive behavior	0.38
19. discipline with children	0.39
24. equality	0.39
57. safety	0.49
56. role of male	0.50
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Men's Self Responsibility	0.44
40. jealousy	0.36
71. trust	0.36
72. understand triggers	0.37
23. emotion management	0.43
51. regulate anger	0.47
27. feelings and expectations	0.49
66. thoughts and behaviors	0.49

73. violence	0.56
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Accountability to Family and Community	0.58
61. stop violence from happening with their children	0.40
34. how to live as a family	0.42
74. what does a healthy community and household look like	0.42
53. respect for women	0.48
45. parenting	0.55
37. incorporate local resources in the community	0.66
55. role modeling	0.71
26. extended families and closeness of families	0.73
36. importance of family	0.82
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Cultural. This concept emphasized the importance of integrating elements of Aboriginal culture and practices into IPV treatment. Responses in this concept included: “Aboriginal healing approaches”, “Aboriginal spirituality” as well as getting “Elders involved”, “ceremonies”, “cultural practices”, “skills based in the process of a circle”, “ritual” and “healing circles”. Other responses in this concept included: “traditional approaches”, “blend of western and traditional concepts”, “traditional values” and “cultural context”. Responses such as “different beliefs and tribes” and “language specific” indicated that Aboriginal communities are culturally diverse and that IPV treatment for Aboriginal couples needs to be sensitive to such diversity. The response

“historically this is what the family looked like” suggested that teaching clients about what constituted a normal structure of family within Aboriginal culture (e.g. extended family) should also be addressed with Aboriginal couples.

Western. In this concept, participants provided a number of responses that reflected a Western-based approach to IPV treatment. From a Western perspective “addictions”, “drugs and alcohol” are often predictive of violence and need to be addressed in IPV treatment. Responses such as “psychological/psychiatric concepts” and “mental health” indicated that from a Western perspective, an effective IPV treatment needs to address the couple’s mental health problems as well. Other responses including “pride”, “strength”, “self-esteem” and “belonging” referred to traits and tendencies that when exaggerated (e.g. narcissistic tendencies) from a Western perspective, they can turn pathological and potentially lead to violence. “Intergenerational cycle of abuse” and “sexism” referred to other risk factors for female partner abuse. Lastly, professionals indicated “cognitive behavioral therapy” which is a Western-based therapeutic approach, can be used to address IPV with Aboriginal men.

Traditional Ways. This concept emphasized the importance of taking a traditional approach to address violence with Aboriginal men. The responses such as “ground therapy in holistic way” and “broad focus” suggested that the treatment of IPV with Aboriginal couples needs to be contextualized and conducted in a holistic manner consistent with Aboriginal traditional ways of healing. The response “couples’ needs” suggested that the treatment sessions need to be structured and guided based on the couple’s needs. The response “talking and sharing”, highlighted the importance of silence and the manner with which the couple and the therapist communicate with one another,

with respect and without interruption. The response “children” indicated that not only the couple, but also the children need to be involved and focused on in the therapeutic work. Other responses in this concept included “trauma”, “residential schools”, and “intergenerational trauma” which are all factors that uniquely contribute to violence among Aboriginal clients and need to be considered in therapeutic work with these clients.

What a Healthy Relationship Is (and Is Not). This concept highlighted the importance of teaching couples about the characteristics of a healthy and safe relationship as well as the ways of building such a relationship. Participants in this study suggested that violence can be prevented by teaching couples about various concepts such as the “cycle of violence”, “anger”, “dynamics of relationship”, “dealing with conflict”, “power and control”, “equality”, “role of male”. and “knowing what their risk factors are” for violence. To maintain a healthy relationship couples also need to learn about what constitutes “healthy relationships” and learn about specific strategies including “time-outs”, “communication skills”, “problem solving” and learning to “express needs in healthy ways”. Other responses including “ownership of behaviour”, “accountability”, “taking responsibility”, “public ownership by him of his abusive behaviour towards her” highlighted the importance of having men take responsibility for the violence as well as the changes they want to make congruent with a healthy relationship. Responses such as “talk about forms of abuse”, “help them identify abusive behaviour”, “how his abuse impacts the relationship” and “impact of abuse on themselves, partner, and children” suggested that learning about the negative consequences of abusive behaviour can lead to the motivation to end abusive behaviours, thereby facilitating a healthy relationship.

Other signs of a healthy relationship included how safe children and female partners felt in the relationship. Responses such as “discipline with children” and “safety” represented appropriate safe behaviours toward children and female partners that were indicative of healthy relationships among family members.

Men’s Self-Responsibility. This concept highlighted the importance of men’s personal responsibility for violent behaviour, as well as feelings and thoughts that can potentially lead to violence. Responses such as “understand triggers”, “emotion management” and “regulate anger” implied that men needed to take ownership for their abusive behaviours and the positive change they want to create. Other responses including “feelings and expectations”, “thoughts and behaviors”, “violence”, “jealousy” and “trust” indicated that men need to take charge of their individual thoughts and feelings that can potentially trigger violence.

Accountability to Family and Community. This concept implied that violence can be addressed with Aboriginal men by increasing the sense of accountability they feel toward their families and communities. Responses including “importance of family”, “what does a healthy community and household look like”, “how to live as a family”, “extended families and closeness of families”, “respect for women” and “incorporate local resources in the community” reflected the importance of holding men accountable to their female partners, family and influential community members. Other responses highlighted the importance of holding men accountable to their children in order to prevent violence. These responses included “parenting”, “role modeling” and “stop violence from happening with their children”.

Activities

The question “How would you address activities with Aboriginal men in couple counselling who use abusive behavior with their intimate partner?” elicited 44 unique responses. Seven participants sorted these responses. Multidimensional scaling as well as cluster analysis were used to analyze the sort data. Trochim (1989) suggested that when seeking to determine the right number of concepts in a concept map, visual maps containing 3 to 20 concepts should be considered when there are a 100 responses or less. Concept maps involving different number of concepts were visually examined. This was done to determine the extent to which responses within each concept were consistent with each other and inconsistent with the responses in the other concepts.

For this question, concept maps containing 20 and 15 concepts were reviewed and they showed significant scatter. Maps with 10 to 3 concepts were then assessed. The concept map with 10 concepts did not produce clusters that were conceptually differentiated. Furthermore, reducing the concepts to eight, seven, six, five, four concepts did not lead to significant changes, while the concept map with two concepts overgeneralized the underlying clusters. Finally, the map containing 3 concepts provided the best fit with clear meaningful differentiation between concepts (see Figure 2).

Bridging indices were used to determine which responses were most central to each concept and to guide with appropriate labelling of the concepts. A bridging index value can range from 0 to 1. Responses with low bridging indices (0.0 to 0.25) were considered to be more frequently sorted with responses in the same concept. Responses with high bridging indices (0.75 to 1.00) were considered to be more frequently sorted with the responses in the same concept as well as the responses in other concepts. A high

bridging value indicated that the response may not be conceptually consistent with the responses in its close proximity and thus less likely to reflect the underlying theme of the concept to which it belonged to (Trochim, 1989).

Each concept had an average bridging index. Concepts with low average values included responses that were more often sorted together with one another than with the responses in other concepts. High average values indicated that responses in the concept were grouped with responses in the other concepts as well as the responses in their own concept.

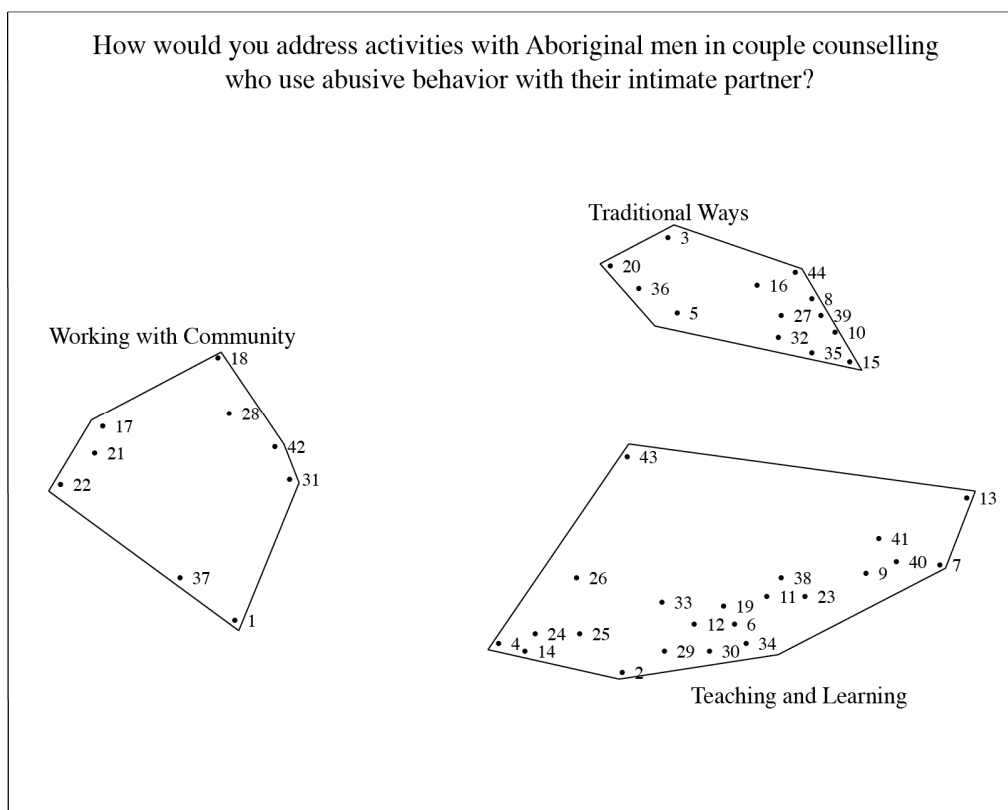


Figure 2. Concept Map for Question Two.

Table 2

Concept Items and Bridging Values for Concept Map for Question Two

Concept and Response	Bridging Index
Working with Community	0.66
17. healthy active lifestyle	0.45
21. inclusive of family	0.45
22. involve others in the community	0.63
18. healthy connections beyond group	0.63
31. practice skills at home together	0.67
28. outreach	0.68
42. time alone	0.68
1. balance	0.76
37. stuff you can measure to see if it is working	1.00
Teaching and Learning	0.27
30. practice in session	0.17
6. demonstrative hands-on work	0.18
34. role playing	0.18
12. give facts	0.18
29. pencil and paper exercises	0.18
38. support each other by sharing	0.20

2.	brainstorming	0.21
14.	guest speakers	0.22
33.	problem solving	0.22
19.	homework assignments	0.22
23.	keeping it simple	0.24
9.	educational videos	0.25
25.	lists	0.27
4.	check-in in group	0.27
24.	letters to each other	0.31
40.	teaching by counselors	0.31
41.	teaching each other	0.31
7.	different forms of media to teach	0.32
26.	male and female counselor interaction	0.35
11.	experience in moment	0.36
43.	use their stories	0.48
13.	give them tools	0.48
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	Traditional Ways	0.12
8.	drumming	0.00
39.	sweats	0.00
3.	ceremonial	0.05
16.	healing circle	0.07

35. smudging	0.07
44. visits by the Elder	0.07
27. Medicine Wheel	0.07
32. prayer	0.07
20. in contact with their culture	0.19
5. culturally relevant activities	0.22
36. spiritual needs are met	0.22
10. Elders open and close sessions	0.23
15. healing approaches	0.32

Working with Community. The concept highlighted the importance of engaging family and community members as well as appropriate community agencies in IPV treatment of Aboriginal couples. Responses in this concept were: “healthy active lifestyle”, “inclusive of family”, “practice skills at home together”, “involve others in the community”, “healthy connections beyond group” and “outreach”. The responses “time alone” and “balance” suggested that there needs to be a balance between outreach activities in the community and time spent independently by clients to extend the knowledge and awareness needed to prevent violence. “Stuff you can measure to see if it is working” had a high bridging index value (1.0) suggesting this response was also frequently sorted with responses in other concepts.

Teaching and Learning. The concept of teaching and learning was reflected by responses including “pencil and paper exercises”, “homework assignments”, “educational

videos”, “different forms of media to teach”, “teaching by counsellors”, “guest speakers”, “give facts” and “teaching each other”. Other responses within this concept focused on experiential learning through “role playing”, “experience in moment”, observing “male and female counselor interaction”, “demonstrative hands-on work” and “practice in session”. Additionally, responses including “support each other by sharing”, “lists”, “letters to each other”, “brainstorming”, “use their stories”, “problem solving”, “give them tools”, “check-in in group” and “keeping it simple” were also included in this concept.

Traditional Ways. This concept highlighted the importance of including traditional cultural practices and ceremonies in IPV treatment. Culturally relevant activities including “drumming”, “sweats”, “healing circles”, “smudging” and “prayer” reflected this concept. “Visits by the Elder” and “Elders open and close sessions” indicated that it is important to involve traditional knowledge holders and those who have the expertise to perform such ceremonies in the treatment program. The importance of having culturally relevant activities to address violence with Aboriginal men was further highlighted through responses including: “Medicine Wheel”, “ceremonial”, “in contact with their culture”, “culturally relevant activities”, “spiritual needs are met” and “healing approaches”.

Results Summary

Six service providers participated in the sorting of 74 responses to the research question, "How would you address content with Aboriginal men in couple counselling who use abusive behaviour toward their intimate partner?" Through multidimensional scaling and cluster analysis of the sorted responses six concepts emerged: 1) Cultural, 2)

Western, 3) Traditional Ways, 4) What a Healthy Relationship Is (and Is Not), 5) Men's Self Responsibility, and 6) Accountability to Family and Community.

The "Cultural" concept emphasized the importance of integrating elements of Aboriginal culture and practices into the treatment of IPV with Aboriginal couples. This concept included responses such as "Aboriginal healing approaches" and "Aboriginal spirituality". The "Western" concept emphasized a Western-based approach to IPV treatment and it included responses such as "psychological/psychiatric concepts" and "cognitive behavioral therapy". The concept of "Traditional Ways" emphasized the importance of taking a holistic approach consistent with Aboriginal cultural teachings to address violence with Aboriginal men. This concept included responses such as "ground therapy in holistic way" and "intergenerational trauma". The concept of "What a Healthy Relationship Is (and Is Not)" highlighted the importance of teaching couples the knowledge and skills needed to build a healthy safe relationship. This concept included responses such as "healthy relationships" and "express needs in healthy ways".

The concept of "Men's Self Responsibility" highlighted the importance of having men take responsibility for their violent behaviours as well as feelings and thoughts that can potentially lead to violence. This concept included responses such as "understand triggers" and "emotion management". The concept of "Accountability to Family and Community", suggested that violence can be prevented by holding men accountable to their families as well as communities members. This concept included responses such as "importance of family" and "extended families and closeness of families".

For the research question, "How would you address activities with Aboriginal men in couple counselling who use abusive behaviour toward their intimate partner?"

forty-four responses were sorted by 7 service providers. Three main concepts emerged from data analyses: 1) Working with Community, 2) Teaching and Learning and 3) Traditional Ways.

The concept of “Working with Community” highlighted the importance of engaging families, community members and community agencies in order to address IPV. Some responses representing this concept were “involve others in the community” and “healthy connections beyond group”. The concept of “Teaching and Learning” highlighted the importance of teaching activities conducive to learning and involved responses such as “homework assignments” and “educational videos”. The concept of “Traditional Ways” highlighted the importance of having traditional practices and activities to address violence with Aboriginal men. Some responses representing this concept were “visits by the Elder” and “culturally relevant activities”.

Chapter 5: Discussion

The purpose of the study was to identify characteristics of a conjoint therapy program for IPV with Aboriginal couples. Service providers were asked about the necessary content and activities for such a program. The responses were collected through telephone interviews with professionals who provided either a safety or therapeutic service for IPV to Aboriginal couples. Participants sorted responses to the research questions into groups. The sort data was analyzed with multidimensional scaling and cluster analysis. A concept map was constructed for each question. This chapter compares the results of this study with the available literature.

Content

Six concepts emerged from responses to the question: "How would you address content with Aboriginal men in couple counselling who use abusive behaviour toward their intimate partner?" The concepts included: Cultural, Western, Traditional Ways, What a Healthy Relationship Is (and Is Not), Men's Self Responsibility as well as Accountability to Family and Community. Cultural referred to the importance of incorporating cultures and traditional practices into IPV treatment with Aboriginal couples. Western referred to a Western-based approach to IPV treatment. Traditional Ways referred to the use of culturally-based ways of healing in order to address IPV. What a Healthy Relationship Is (and Is Not) suggested that IPV can be addressed by improving relationship functioning. Men's Self Responsibility referred to having male partners take responsibility for the violence as well as the feelings and thoughts that trigger violence. Accountability to Family and Community, suggested that increasing the male partner's sense of accountability toward their families and communities may help address IPV.

Cultural. Participants in this study suggested that traditional healing approaches, values, spirituality, as well as specific cultural practices should be integrated into IPV treatment for Aboriginal couples. Suggested practices included invitations to Elders to be involved and participation in ceremonies. Additionally, the response, “historically this is what the family looked like” suggested the importance of educating clients on traditional family structure and values (e.g. women-led communities) before the introduction of patriarchal values by European colonizers. Of note, by offering responses such as “different beliefs and tribes” and “language specific”, participants suggested that a culturally sensitive conjoint treatment program for Aboriginal couples who experience IPV needs to also be sensitive to the cultural and language diversity which exists among Aboriginal communities.

The responses provided in this concept were not present in the existing literature. Although research on therapeutic treatments for Aboriginal peoples has emphasized developing culturally appropriate interventions, no existing research on conjoint therapy for IPV has specified the nature of such interventions. Based on the responses in this concept, engaging traditional knowledge holders, leaders and healers in the work can be a very powerful experience for clients.

Western. Consistent with the existing literature, a Western-based approach to IPV treatment with Aboriginal couples was advocated by the participants in this study. Responses such as “addictions” and “drugs and alcohol” suggested that participants believed addiction problems need to be addressed in IPV treatment with Aboriginal couples. This is consistent with O'Farrell's and Fals-Stewart's Behaviour Couple Therapy program for IPV, where substance and alcohol abuse problems are addressed in order to

reduce violence among couples who experience IPV (O'Farrell, Kashdan, & Fals-Stewart, 2002).

Research (e.g. Fals-Stewart, 2003; O'Leary and Schumacher, 2003) suggests that the occurrence of IPV is significantly high among couples who abuse drugs and alcohol. Studies indicate that 40–60% of couples participating in substance abuse treatment programs reported at least one occurrence of IPV in the previous year (e.g., O'Farrell & Murphy, 1995; Fals-Stewart, Golden, & Schumacher, 2003). Substance abuse problems have also been found to negatively impact relationship functioning, thus increasing the chance of escalating conflicts (e.g. Leonard, 2005; Jacob, Leonard, & Haber, 2001; Jacob & Leonard, 1988). In these cases, therapists often use motivational interviewing or invite clients to participate in Individual Drug Counselling in order to help them eliminate substance use behaviours, thus reducing the risk that conflicts escalate to violence.

Responses such as “mental health”, “psychological/psychiatric concepts”, “self-esteem”, “pride”, highlighted the importance of taking into account the male partner’s mental health status and its role in the perpetration of violence. Research (Hamberger & Hastings, 1991), indicates that mental health problems can increase the risk of violence in relationships. For example, antisocial and narcissistic predispositions are more likely to occur in men who use abusive behaviours with their female partners (Hamberger & Hastings, 1991).

Participants also suggested that other Western-based concepts such as “sexism” need to be integrated into IPV treatment programs for Aboriginal couples. Sexism is discussed in therapy sessions in order to help clients become more aware of the link between holding negative attitudes about women and the perpetration of violence.

Furthermore, the response “cognitive behavioral therapy” suggested that participants in this study consider this Western-based therapeutic approach to be effective at helping clients monitor their maladaptive cognitions that can potentially trigger violent behaviour. This response is also consistent with the existing literature on conjoint treatment of IPV. For example, O'Leary's, Neidig's, and Heyman's Physical Aggression Couples Treatment program (PACT) (1999) incorporates anger management skills and Cognitive Behavioural strategies to challenge anger-engendering cognitions which can potentially trigger violence.

Furthermore, participants suggested that the pattern of “Intergenerational cycle of abuse” should also be addressed with Aboriginal couples who engage in IPV. This is consistent with research that suggests childhood abuse is associated with the perpetration of violence later in life in the context intimate relationships (Swogger, Walsh, Kosson, Cashman-Brown, & Caine, 2012). All the responses in this concept were consistent with existing literature emphasizing the use of Western-based concepts and approaches for effective conjoint treatment of IPV with Aboriginal couples.

Traditional ways. Participants highlighted the importance of incorporating traditional ways as well as historic links and context to present experiences. None of the responses provided by participants in this concept were present in the existing literature. Responses such as “ground therapy in holistic way” and “broad focus” suggested using a holistic approach consistent with Aboriginal cultural teachings. For some communities, this may involve using a Medicine Wheel that can include physical, mental, spiritual and emotional dimensions of well-being. A holistic approach can also involve the integration

of a client's family and community members in his or her healing (Oulanova & Moodley, 2010).

Furthermore, responses such as “trauma”, “residential schools”, and “intergenerational trauma”, suggest that a conjoint treatment of IPV for Aboriginal couples needs to address and consider the consequences of the systemic oppression and collective intergenerational trauma which many couples may have experienced. In this context, providing psycho-education on the impact of the oppression and traumatic experiences can be therapeutic for couples (Oulanova & Moodley, 2010).

What a healthy relationship is (and is not). Participants in this study noted that couples need to learn about what constitutes a healthy relationship and the strategies they can use to build such a relationship. Responses including “time-outs”, “communication skills”, “problem solving”, “express needs in healthy ways”, and “dealing with conflict” suggested that couples need to enhance various interpersonal skills in order to create and maintain healthy violent-free relationships. Other responses such as “ownership of behaviour”, “accountability”, “taking responsibility”, “public ownership by him of his abusive behaviour towards her” suggested that effective conjoint treatment of IPV needs to help abusive partners take responsibility and be accountable for their behaviours.

These responses are consistent with existing literature on conjoint therapy for IPV which highlights the important role of accountability and effective interpersonal skills in IPV treatment. For example, in the Physical Aggression Couples Treatment program (PACT) (O'Leary, Neidig, & Heyman, 1999), the goal is to improve relationship skills such as communication skills and to promote fair-fighting among couples in order to prevent future physical violence. In addition, in the Domestic Violence–Focused Couples

Therapy (DVFCT) (Stith, McCollum, Rosen, & Locke, 2002) program, IPV is addressed by increasing each partner's awareness of violence as well as their individual sense of accountability for the violence committed.

Furthermore, to maintain healthy relationships participants suggested it is important to raise awareness about forms of abuse and risk factors that can make the occurrence of abuse more likely. Responses such as "power and control", "equality", "talk about forms of abuse" and others represent this finding. These responses are consistent with Dunford's conjoint therapy program (2000) for US Navy couples which aimed to eliminate violence by educating clients on gender inequality, verbal bashing of women, as well as personalizing the violence.

Some responses in this concept however were not represented in the existing literature. Responses such as "how his abuse impacts the relationship", "impact of abuse on themselves, partner, and children" suggest that educating abusive men about the negative consequences of their behaviours on their families can motivate them to eliminate such behaviours, thus promoting healthier relationships. Another finding which was not represented in exiting literature included teaching male clients about safe behaviours toward family members including children that are conducive to healthy family relationships. Responses such as "discipline with children" and "safety" represented this finding.

Men's self-responsibility. This concept refers to having men take responsibility for the perpetration of violence as well as feelings and thoughts that can potentially trigger such violence. Responses such as "understand triggers", "emotion management", and "regulate anger", "jealousy" and "trust" suggest that male clients need to take

responsibility for managing thoughts and emotions that can contribute to their violent behaviors.

All of these responses in this concept were consistent with the existing literature on conjoint therapy for IPV. For example, in the Physical Aggression Couples Treatment program (PACT) of O’Leary, Neidig, & Heyman’s (1999), a major component of therapy consists of learning how to manage angry feelings, take responsibility for aggressive behaviours, as well as learning how to counteract dysfunctional thoughts that may produce anger and potentially subsequent violence.

Similarly, the Domestic Violence–Focused Couples Therapy program (DVFCT) (Stith, McCollum, Rosen, & Locke, 2002) is also partly focused on addressing IPV by increasing individual’s sense of responsibility for violent behaviours. Taking full responsibility for any violent act is often established through psycho-education and discussion in therapy sessions. For example, clients are taught that their partners cannot make them angry, but the meanings they attach to their partners’ behaviors shape their angry responses. Clients are then invited to think about occasions where they were able to control their aggression and identify factors that helped them exercise such control. Lastly, clients are taught to increase their awareness of the physical, cognitive, behavioural anger cues in order to stop anger from escalating to violence.

Accountability to family and community. Participants in this study suggested that promoting a sense of accountability to family and community in clients can make the occurrence of violence less likely. This finding is not represented in the existing research on conjoint therapy for IPV. Responses included “importance of family”, “what does a

healthy community and household look like”, “extended families and closeness of families”, “respect for women” and “incorporate local resources in the community”.

A collectivist orientation to wellness operates in many communities. Despite many colonial challenges, this sense of mutual responsibility and accountability remains. Connectedness and belonging to family and community are highly valued. Extended family and other community members are family (McCormick, 1995). When one member of a community is hurt, in a collectivist culture, all members are hurt. Accountability to one’s partner as well as others in the community, and especially to highly influential people in the community, can play an important role in controlling violence by Aboriginal men.

Activities

Three concepts emerged from responses to the question: "How would you address activities with Aboriginal men in couple counselling who use abusive behaviour toward their intimate partner?" The concepts included: Working with Community, Teaching and Learning and Traditional Ways. Working with Community referred to the involvement and participation of family and community members in IPV treatment with Aboriginal couples . The concept of Teaching and Learning referred to helping men learn about abusive behaviour and ways of preventing it through psychoeducational and experiential learning activities. The concept of Traditional Ways referred to the infusion of Aboriginal traditional knowledge and healing ceremonies to address the violence.

Working with community. This concept highlights the importance of involving families and community members to address abusive behaviour by Aboriginal men. This finding is not represented in the existing research. The responses in this concept included

“healthy active lifestyle”, “inclusive of family”, “involve others in the community”, “healthy connections beyond group”, and “outreach”.

This concept also refers to integrating IPV treatment with a broader community healing. Beyond family members, it is important to engage Elders, other community leaders as well as potentially other families (Oulanova & Moodley, 2010). Partnering with community organizations and social groups in order to educate the community about violence is important (Oetzel & Duran, 2004). Having knowledgeable others in the community who speak openly about non-violence can extend this awareness and practice with other men in other settings, so that dynamics of control in any interpersonal relationship are seen to be something that can and should change.

Furthermore, counsellors can assess dysfunctional patterns of communication and problems that contribute to violence. Interventions that are inclusive of other family and community members may produce results that are observable and make the partners accountable to others, not just each other, for improving their relationship. Community-based treatment programs have been previously used with justice-involved populations (Mills, Grauwiler & Pezold, 2006; Grauwiler & Mills, 2004). Some of these programs are implemented by involving a person outside of the family known as the “stable third” in the therapeutic process. This person is someone who the couple and counsellors know and trust. This person visits the family and checks in on the children, as well as provides an account from a third person perspective about any violence that is occurring at home (Vetere & Cooper, 2007, p.383). There are weekly meetings with the stable third, the couple, and counsellors where therapeutic progress is assessed.

Teaching and learning. The concept of teaching and learning referred to various didactic and experiential learning activities that can be utilized in IPV treatment with Aboriginal couples. Didactic learning was reflected by responses such as “pencil and paper exercises”, “brainstorming”, “homework assignments”, “different forms of media to teach”, “teaching by counsellors”, and “give facts”. Other responses within this concept focused on experiential learning through “role playing”, observing “male and female counselor interaction”, “demonstrative hands-on work”, and “practice in session”.

The responses in this concept were consistent with existing literature on conjoint therapy for IPV. Didactic activities are central to the existing conjoint treatment programs of IPV. For example, in Stith, McCollum, & Rosen’s conjoint therapy program (2011), counsellors teach couples about anger control techniques and how to challenge hot thoughts that may potentially lead to violence using cognitive-behavioral (ABCD) model of anger. Using handouts and discussions couples also learn about types of cognitive distortions, as well as how to identify and challenge them in order to prevent escalation to violence. The last step, “controlling thinking,” involves having partners brainstorming examples of their hot thoughts and then replacing these thoughts with alternative cool thoughts.

Also, couples are taught to replace ineffective conflict resolution skills with those that are effective. For example, counsellors use humorous workbook exercises (O’Leary, Neidig, & Heyman, 1999) to teach couples about ineffective ways of handling conflicts. In each exercise, couples read about ineffective conflict resolution strategies such as blaming or sarcasm. They then identify the ineffective strategies they consistently use for conflict resolution.

There was also a consistency between existing literature and this study regarding the experiential activities that may be used to address IPV. For example, in O'Farrell & Schein's conjoint therapy program (2011) couples practice conflict resolution skills and communication skills both in session and outside of the sessions using role plays. For example, partners may engage in role plays where they practice effective communication techniques, with the therapist giving them immediate feedback about how effective they are using these techniques. The consistency between the existing literature and this concept indicates that similar experiential activities can also be used to address IPV with Aboriginal couples.

Traditional ways. This concept refers to integrating cultural and traditional practices into IPV treatment with Aboriginal couples. Participants described the importance of including a "Medicine Wheel", "culturally relevant activities", "Drumming", "smudging", "sweats", "healing circles", "sweat lodge" and "prayer" in IPV treatment. The inclusion of ceremonies is a major difference from the existing literature. Although culturally sensitive activities and interventions have been emphasized in the existing literature, the specific forms of such activities have not been identified (Gone, 2010). Traditional ways also reinforce sense of identity and relationships (Duran, 2006). This is something that Western-based psychotherapy may not be able to do, but through connections to those who have the expertise and authority to perform ceremonies couples may be able to integrate Western and Indigenous ways of healing.

Furthermore, other responses in this concept including "Visits by the Elder" and "Elders open and close sessions" suggest that engaging community leaders and traditional knowledge holders is essential. An Elder is someone who is accepted by the

community as a wise individual who has knowledge of the cultural values and teachings, as well is committed to living in a way that is consistent with these values and teachings (Waldram, 1997). Waldram (1997) further suggests that learning about history; culture and values are healing experiences in and of themselves.

Summary

Participants' responses to the research question, "How would you address content with Aboriginal men in couple counselling who use abusive behaviour toward their intimate partner?" formed 6 concepts including: Cultural, Western, Traditional Ways, What a Healthy Relationship Is (and Is Not), Men's Self Responsibility and Accountability to Family and Community.

There were a number of similarities between the findings of this study with respect to therapeutic content and previous literature. Firstly, a Western-based approach to conjoint therapy for IPV with Aboriginal couples was emphasized. This involved addressing men's mental health problems as well as addiction issues using Western-based therapeutic approaches such as CBT or individual addiction counselling. Secondly, both findings emphasized the importance of educating couples about the dynamics of a healthy versus an unhealthy relationship as well as the skills and strategies needed for building such a relationship. For example, effective problem solving and communication skills were some of the strategies discussed. Lastly, it was highlighted that it is important for men who engaged in abusive behaviours to take responsibility for their violent behaviours as well as the positive changes they want to create in their relationships.

Participants in this study, however, emphasized two additional factors to be considered for conjoint therapy with Aboriginal couples experiencing IPV. Firstly, they

highlighted the importance of integrating Aboriginal culture and traditions for effective treatment of IPV with Aboriginal couples. Secondly, involving Aboriginal family and community members in the therapeutic process and activities was deemed as helpful in addressing IPV with Aboriginal couples.

Participants' responses to the research question "How would you address activities with Aboriginal men in couple counselling who use abusive behaviour toward their intimate partner?" formed three concepts including: Working with Community, Teaching and Learning, and Traditional Ways. With respect to activities of a conjoint therapy, the literature and the findings of this study were similar in that they both emphasized utilizing different methods of learning including both experiential and didactic methods to address IPV with Aboriginal couples.

Participants in the study suggested that it is also important to incorporate traditional knowledge and practices, including teachings and ceremonies by qualified people in the community. Furthermore, they suggested engaging family members, as well as Elders and community leaders to promote healthy relationships in general, in all relationships, not just intimate relationships.

Implications

This study identified some features of therapeutic content and activities for conjoint treatment of IPV with Aboriginal couples. The findings of this study emphasized the importance of integrating culturally appropriate content and activities into existing conjoint therapy programs in order to appropriately address Aboriginal clients' needs.

The findings in the study highlighted many therapeutic content and activities features that are already part of existing conjoint therapy programs. Such consistency

indicates that these features can also be useful in addressing IPV with Aboriginal clients. There were however some additional factors for conjoint treatment of IPV with Aboriginal couples which were highlighted by participants in the study. These factors included the integration of cultural knowledge and healing, addressing IPV in the context of families and communities, as well as involving family and community members in the therapeutic process.

The findings have a number of implications for counsellors who work with Aboriginal clients who experience IPV. Counsellors need to recognize the importance of cultural identity and ways of facilitating such identity in their therapeutic work. Counsellors also need to have partnerships within and between well-respected organizations and agencies in the communities within which they work. Through these connections they can engage with local leaders, Elders, knowledge holders to be included, as appropriate, in the counselling work itself as well as the community work that the service provider should be doing to be credible and respected in that community.

It is essential that a culturally sensitive conjoint treatment program fits with the community it serves. This is because of diversities in geography, language, worldview, values and traditions as well as different levels of awareness and sensitivity to IPV issues which exist among Aboriginal communities. In addition, it is important that there is an interest in moving forward with an intervention program for community members.

For future research, these consideration of therapeutic content and activities need to be further explored to facilitate a more contextualized and comprehensive knowledge of a culturally appropriate conjoint therapy program. Other important factors that need to be considered and further explored for a contextualized model of conjoint therapy for

IPV include assessing risk and safety factors during the treatment process as well as monitoring and following-up with Aboriginal couples who complete their conjoint treatment.

Limitations

The results of the study were based on the opinions of a limited number of experts who provide therapeutic and safety services in a Canadian province to Aboriginal clients experiencing IPV. As a result, future research on therapeutic content and activities needs to involve experts from different geographic areas who work with Aboriginal couples experiencing IPV. Given the cultural diversity among communities, one needs to investigate whether the findings from this study can be replicated among experts who work with different Aboriginal communities.

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Supporting the family circle: Couple counselling and family violence

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

We are conducting telephone interviews with staff in the areas of children's services, justice and health who are working in the area of safety and protection for intimate partner violence.

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

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

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

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

Jason Brown, University of Western Ontario,

Sue Languedoc, Aboriginal Consulting Services,

XXXXX XXXXXX, Research Assistant(s)

xxx@uwo.ca

xxx@uwo.ca

Supporting the family circle: Couple counselling and family violence

LETTER OF INFORMATION* (Phase 1)

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

Introduction

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

Purpose of the study

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

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

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

Confidentiality

Direct quotes from the first telephone interview will be used in the second part of the study, but WILL NOT include identifying (i.e. names or locations) information. The information collected will be used for research purposes only, and neither your name nor information which could identify you will be used in any publication or presentation of the

study results. All information collected for the study will be kept confidential. No names will be used in the report.

Risks & Benefits

There are no known risks to participating in this study.

Voluntary Participation

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

Questions

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

Supporting the family circle: Couple counselling and family violence

CONSENT* (Phase 1)

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

Has the nature of the study been explained to you?

Have all questions have been answered to your satisfaction?

Do you agree to participate?

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

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

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

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

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

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

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

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

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

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

Demographics:

Sex (circle one): Female, Male

Age: _____

Years of Experience _____

Current Position _____

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

Can we contact you to help us with the second part of the study (group the statements)?

Yes / No

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

All contact information is to be recorded on a separate sheet.

-----DETATCH-----

Sorter Information

Name: _____

Telephone Number: _____

Mailing Instructions

Address: _____

Supporting the family circle: Couple counselling and family violence

LETTER OF INFORMATION* (Phase 2)

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

Introduction

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

Purpose of the study

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

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

Confidentiality

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

Risks & Benefits

There are no known risks to participating in this part of the study.

Voluntary Participation

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

Questions

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

Supporting the family circle: Couple counselling and family violence

CONSENT* (Phase 2)

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

Has the nature of the study been explained to you?

Have all questions have been answered to your satisfaction?

Do you agree to participate?

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

Grouping Task Instructions (Phase 2)

UWO Letterhead

Date _____

Dear Participant,

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

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

For example:

Pile 1 included responses 23, 45, 73, 12 & 24, and was called “understand each other”

Pile 2 included responses 3, 2, 67, 56 & 35, and was called “difficulty following rules”

....and so on, until you have used up all of the responses

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

Sincerely,

Jason Brown,

Associate Professor

Pile	Label (optional)	Statement Numbers
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

*please use back of sheet if necessary

Parisa Ghanbari

CURRICULUM VITAE

EDUCATION:

Master of Arts Degree in Counselling Psychology 2013-2015

Western University - London, ON

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

Bachelor of Science Degree in Psychology (Honours with Distinction) 2006-2011

University of Toronto - Toronto, ON

ACADEMIC AWARDS:

- Western Graduate Entrance Scholarship (WGRS) valued at 5,000 (Sep2013-Apr 2014)
- Western Graduate Research Scholarship (WGRS) valued at 5,000 (Sep2014-Apr 2015)
- C.L. Burton Scholarships for Modern Languages valued at 300- University of Toronto (2011)

Poster Presentation

Ghanbari, P. (2013). Acculturative stress, self-efficacy, and depressive symptoms among Iranian-Canadians. Poster presented at CPA, Quebec City.

RESEARCH EXPERIENCE:

Research Assistant 2010 – April 2012

Dr. Tracey Skilling- CAMH - Youth and Adolescent Services

Experimenter January 2011 - May 2011

Dr. Penelope Lockwood (Psychology Department) - University of Toronto

CLINICAL EXPERIENCE:

Personal Counselling Services Sept 2014-Present

York University, Toronto, ON

Group Counsellor/Co-facilitator Sep 2014-Present

PCS- York University, Toronto, ON

Group Counsellor/Co-facilitator Sept 2014-Present

Shoniker Clinic, Toronto, ON

RELATED PROFESSIONAL EXPERIENCE:

Interviewer/ Research Assistant March 2012-Dec 2013

St. Michael's Hospital - Centre for Research on Inner City Health

Distress Line Counsellor Feb 2012-Nov 2012

Distress Centres, Toronto, ON