

Domestic violence: solution-focused practice with men and women who are violent

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This article reviews the progress of sixty-eight adults (fifty-two men and sixteen women) on a solution-focused programme aimed at reducing domestic violence. The practice principles are described, using examples of participants' experiences. The outcomes over a three-and-a-half-year period are presented and difficulties in assessing effectiveness of outcomes are discussed.

The programme

The Domestic Violence Programme was originally established in 2001 as a pilot scheme, in conjunction with Kirklees Domestic Violence Forum [now mainstreamed into Kirklees Metropolitan Council Adults and Communities Service and known as the Domestic Violence Team (DVT)]. DVT has well-developed services for women experiencing violence at the hands of male partners but had identified gaps in service provision. There was no specialized refuge provision or therapeutic intervention for gay and lesbian people experiencing violence, no therapeutic provision for women who were violent to their male partners, and no provision for men who had not been through the court process. In addition, a significant number of the women receiving support from DVT expressed dissatisfaction with existing group work programmes for their male partners, most particularly their exclusion from the therapeutic programme and, because of the focus in these groups of men taking full responsibility for their violence, what they perceived as the minimization and denial of their attempts to accept that their behaviour played some part in the violence. The pilot scheme aimed to provide a more flexible

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response to domestic violence based on what the people involved said they wanted, thus accessing traditionally hard-to-reach populations. Early results of the pilot project are reported elsewhere (Milner and Jessop, 2003) and the service is now established with therapeutic services provided by Resolutions (Yorkshire) in conjunction with DVT as part of Kirklees Safer Communities Partnership. Sixty-eight participants who worked with the authors were tracked between 2001 and 2004 and are reported on here. A solution-focused approach was used, as it has been found to be effective with this client group (Essex *et al.*, 1996; Lee *et al.*, 2003, 2007; Milner and Jessop, 2003; Milner, 2004; Myers, 2005; Turnell and Essex, 2006; Milner and Myers, 2007).

Solution-focused explanations of violent behaviour

Solution-focused brief therapy does not have an explanation for violent behaviour, nor does it attempt to predict risk. This is in part because it considers that diagnoses provide extremely limited perspectives of individuals' capacities for change. The approach is particularly concerned with the negative effects of labelling; for example, Turnell and Edwards (1999) argue that violence in families usually accounts for no more than 5 per cent of the family's behaviour and that focusing solely on this ignores 95 per cent of family competence. Concentrating solely on the signs of danger not only gives an unbalanced picture but engaging with risk leads to defensiveness, engendering an adversarial and hostile relationship (Berg, 1994; Lipchik and Kubicki, 1996).

By not imposing explanations for violent behaviour, the solution-focused practitioner is acknowledging that, despite a strong interest in assessment, accurate prediction of violent behaviour is out of our reach. Lee *et al.* (2003) review the research into domestic violence, illustrating the incomplete and contradictory findings. For example, although research has identified links between violent behaviour and psychopathy (Royal College of Psychiatrists, 1996), Gondolf and White's (2001) study of 840 male participants in batterer programmes in the USA found that the evidence of psychopathic disorder was relatively low, particularly in 'repeat assaulters', of whom 60 per cent showed no serious personality dysfunction or psychopathology. In addition, while the 'repeat assaulters' were likely to be younger, have substance abuse problems and to have been arrested for other criminal offences, the extent of difference in these problems was

small and not clinically significant. The differences between the re-offenders and other participants in the Gondolf and White study are not substantial enough to help professionals predict or identify high-risk offenders. Similarly a meta-study of the sex offender research (Hanson, 2004) shows there to be no single factor sufficient to determine whether offenders will or will not re-offend. Interestingly, Rutter *et al.* (2004) found that the most violent inmates of high-security psychiatric hospitals were young women with learning needs, although the Department of Health Guidance on women's services (Department of Health, 2003) has very little to say on women who are violent, considering them less of a risk than men (for a fuller discussion of women's violence see Milner (2004) and Milner and Myers (2007)). Any assumption that people who are violent are similar to each other and different from non-violent people seems likely, therefore, to be fatally flawed. In addition, negative assumptions about the meaning of offenders' behaviours mean that situational and complex variables that might be significant are ignored (Lee *et al.*, 2003, 2007).

This is not to say that accountability is either denied or minimized in a solution-focused approach to the assessment of, and intervention in, violent behaviour; what is avoided is blame and confrontation: 'acknowledgement, whilst preferable, is neither a sufficient nor a necessary condition of safety' (Turnell and Edwards, 1999, p. 140; see also Hollin, 2004). We all know of a heavy drinker who acknowledges the mantra: 'I am an alcoholic' but carries on drinking, or the serial sex offender who acknowledges his crimes during a prison sentence but re-offends on release. The motivation of a violent offender to acknowledge culpability and guilt may be to avoid a long prison sentence or obtain parole, while denial may be due to shame, the desire to maintain an interpersonal relationship, or a way of avoiding humiliation. Many violent offenders are not able to discuss their violence in detail until they have gained some confidence in their ability to change and develop, and can trust the person they are admitting to, usually initially a professional and lastly their family (Lord and Willmott, 2004). Equally, the idea that confrontation will help offenders see the error of their ways, and that accepting responsibility for past behaviour is the first step before they can move forward, is not particularly effective. It takes considerable effort and usually results in the creation of significant resistance. This has the potential to turn the therapeutic relationship into an adversarial one and, perhaps, explains the increased use of motivational interviewing in the Probation Service as a means of preparing offenders for

programmes in which they will be challenged and confronted (see e.g. Fuller and Taylor, n.d.). Here there is an assumption that violent offenders are in denial (Teft, 1999), or ambivalent about making changes in their lives (Miller and Rollnick, 2002). Demonstrating accountability and taking responsibility for past behaviour does not necessarily help offenders work out what they need to do differently in the future.

The solution-focused practitioner holds violent offenders responsible for finding their own solutions to their behaviour, particularly what their futures will be like when they are violence-free. However, there is no assumption made that this will be easy; a solution-building process requires discipline and effort (De Jong and Berg, 2002). The role of the solution-focused practitioner is, therefore, one of helping offenders define a goal that is achievable, measurable and ethical (i.e. within pragmatic and safe limits); helping them find exceptions to their violent behaviour, and solution behaviours; and then amplify, support and reinforce these behaviours (Lee *at al.*, 2007). Exceptions are not discovered simply to be praised, nor are solution behaviours regarded as 'positives'; rather they are examined as possible competencies that the offender can use in the search for a satisfactory and enduring solution. For example, if offenders can give an example of a time when they were calm in a situation that has led to violence previously, they are asked where and how they did this, and whether they can do it again. Unlike cognitive behavioural work, the practitioner does not take a position of having the ability to work out what is wrong and know what needs to be done to put it right; rather a position of uncertainty with respect to solutions is adopted to encourage people to discover their own way forward (Vivian-Byrne, 2002).

As can be seen from this brief outline, assessment and intervention intertwine in a solution-focused approach which is most commonly referred to in working with violence as a *signs of safety approach*.

The signs of safety approach

This approach accepts that risk assessment defies accurate quantification. Telling offenders that they must stop being violent leaves the problem of how to be sure that the behaviour has ceased. Neither does it help offenders to work out what they will be doing differently when they are non-violent. Instead, a 'signs of safety approach' helps offenders identify any existing signs of safety which are measurable, and to develop these signs and expand them so that a safe care plan can

be put in place. Offenders are helped to do this but are held accountable for their behaviour in the future. The six practice principles developed by Turnell and Edwards (1999) are outlined below.

Understanding the position of each family member

A welcome effect of the growth of services for women experiencing domestic violence from their male partners has been the more sympathetic and comprehensive delineation of their victimhood (see e.g. Department of Health, 2003) but this has also had the effect of treating men's accounts of their violence as attempts to deny or minimize their behaviour. A signs of safety approach accepts violent people as people worth doing business with, aiming to understand rather than confront. Jenkins (1996) comments that we often treat those who are violent towards others with considerable disrespect at the same time as we expect them to learn how to show respect to others.

Understanding offenders does not involve colluding with mitigating accounts of the violence; rather it means listening respectfully to accounts of perceived unfairness, encouraging them to explore the meaning of their behaviour to them and the underpinning beliefs. Cavanagh and Lewis (1996) found that this helps offenders to move beyond superficial responses. Respectfulness also involves not reframing people's concerns as poor motivation, denial, victim blaming or resistance to change. A central feature of solution-focused practice is seeking the person's unique way of cooperating. Listening carefully to their accounts of their lives avoids a sullen stand-off which is often initiated by confrontation.

Practitioners often have firm hypotheses about violence and its causes which make those who have already been humiliated by the circumstances of arrest only too aware that the damage they have done is disproportionate to the satisfaction or tension release the violence provided in the first place. It is much easier for individuals to begin accepting responsibility for changing their behaviour in the future when they have been listened to and permitted to explore their own beliefs and meanings.

Finding exceptions to the violence

The occasions when the person was frustrated and angry but was not violent are examined in great detail – when, where and how – so that these abilities can be used in other situations – ‘can you do this again?’

Asking a person to tell you about a time when they could have been violent but were not helps those who talk about being overwhelmed by violent feelings which 'just explode' to recognize that they do have some control over their behaviour. This control may not be directly linked to the violent context which led to the referral, and it may be a very small exception, but it can be used in solution-building. Where exceptions exist and the person can recognize how they came about, they are developed by setting homework tasks that involve 'doing more of them'. For example, one man, who was violent to his partner and her family at home and on social outings, found it difficult to think of a situation in which he was not violent, as he worked mainly alone. Very occasionally, he worked as part of a team and was non-violent in this context. When asked how he 'did that', he replied that he treated his colleagues with respect. When asked how he 'did' respect, he replied that he was polite and sociable. He was then asked if he could be more polite and sociable towards his family and this was a task well within his capability. At his second session, he recounted in great detail, and with considerable pleasure, successful outings with his family that included shopping, swimming and a trip to the park where he had been in complete control of his temper.

Sometimes exceptions are discounted as chance events (I don't know, it just happened) or the result of other people's efforts (if she doesn't wind me up, I don't get mad), and then a prediction task is given. When individuals get a high proportion of their predictions correct about the days when they are going to be non-violent, they are asked if the exceptions are really spontaneous or if they have some control over their behaviour. This control is again analysed in great detail so that they can increase their chances of 'doing it again'. Exceptions are the first signs of safety, although it is not always easy to confirm that they are present. While it is simple to check with other family members that physical violence has decreased, this confirmation is harder to come by when the victims are not known or when a person is reporting exceptions to sexual urges. Here, a tangential approach is needed, checking for allied behaviours which are measurable – such as increased respectfulness towards others, responsibility taking over a wide range of situations, truthfulness, and so on. Where there is a total lack of exceptions, the person can be given a pretend homework task: pretending not to be angry or frustrated one half of the week and noticing what is different or what other people see is different. This helps to identify possible exceptions. Where there are no signs of safety at all, dangerousness is increased.

Discover strengths and resources that can be used in the problem situation

A focus on deficits discourages people; violent offenders are rarely told what they are doing well, so they begin to believe that there is nothing good about themselves – especially when it is written down in psychopathological terms. For example, a man was initially devastated when he read the results of a psychological assessment, which concluded: ‘Given his personality difficulties and the long standing nature of his interpersonal problems, change is likely to be difficult to achieve ... the prognosis is poor.’ Such comments do not aid engagement in the therapeutic process, as recipients tend to resist hearing bad things about themselves or become depressed. Looking at existing strengths validates the totality of offenders’ experiences, places current problems in context (few people are completely evil), and makes contact with professionals less threatening. More importantly, it helps the offender develop a more competent self – it is easier to do more of something that is working than to stop doing something that is problematic. For example, the man referred to above was set a homework task to ask his family what things they liked about him. His son surprised him by saying that he liked his dad’s resilience (the boy’s actual term), his explanations, and playing football with him. This not only reminded him that he had fathering skills that could be built on but it also allowed his son to comment on his fathering – the boy was soon feeling confident enough to say what behaviours made him feel unsafe too.

Focus on the goals of all involved people to ensure the safety of those most vulnerable

The setting of goals is vital to the process of assessment, as this enables clarity about the nature of the problem and what can be done about it. In solution-focused practice, goals must be measurable, achievable and ethical. These goals are set through negotiation with all parties with an emphasis on the safety of vulnerable family members. Rather than accepting a blanket goal of the violence stopping, what will be happening differently when all parties consider that safety is present is identified. For example, one man had ceased physical violence and developed ways of ‘being calm’ after five sessions but returned for more work after three episodes where he had been verbally abusive to his partner, resulting in his youngest son copying the behaviour and his autistic stepson becoming fearful of him. The man’s goal was ‘to be a better husband and father, one who

thinks about other people, thinks what he says before he says it, and remembers what he has said'. His partner's goal was for him to listen to her when she was explaining her son's special needs. Specifically, she wanted him to handle his tiredness better (he was working very long hours). When he was doing this, she said, he would be going to bed at 10 p.m., getting up at normal times, eating proper food, and having no coffee after teatime. He chose to start meeting her goal by eating properly, something he thought would be easier if he cooked. This resulted in the two of them eating and talking together and, subsequently, in enjoyable and peaceful family mealtimes.

Where there are child protection issues, it can be difficult for an offender to develop a realistic goal because other professionals may have predetermined goals which preclude other goals. For example, Scourfield (2003) noted that social workers tended to expect women to separate from abusive husbands in the interests of the children's emotional well-being. As most women and children prefer the violence to stop rather than the family to be split (Lipchik and Kubicki, 1996; Milner, 2004), there are often conflicting goals which hinder the therapeutic process. To reduce potential conflict over goals, child protection social workers are asked what offenders will be doing differently that would make them confident enough to close the case; victims are asked what they will notice differently about the offender when they feel safe; and offenders are asked what they need to be doing differently to ensure the safety of others, and their own safety from accusations.

The solution-focused practitioner is not surprised if offenders find it difficult to describe a clear goal in the early stages, not least because they would not have been likely to resort to violence had they already achieved a well-developed repertoire of solutions. People are helped to develop goals but it remains the offenders' responsibility to work on this for themselves. Goal-setting of this kind removes responsibility for monitoring dangerousness and assessing risk from the practitioner, placing the responsibility for developing safety on to the offender. For example, a sex offender may well undertake a variety of courses in prison (e.g. victim empathy, alcohol control) and the probation officer may have put in place a number of monitoring devices in the community but, unless offenders can say what they will be doing differently when released from prison that will ensure the safety of others, and how this will be measured, then there are no signs of safety.

Scaling safety and progress

It is difficult to estimate the extent to which risk has reduced. Solution-focused practice avoids this dilemma. Quite simply, offenders are asked how safe they rate their partners on a scale of 1–10 and this rating is then compared to the partner's rating. Offenders are then asked what they need to do differently for partners to feel safe, who are then given the opportunity to talk about their safety without the offender being present and provided with ways of communicating any unsafe feelings by means of the provision of stamped, addressed 'help' postcards. Children can be involved in this scaling process too, but simpler ladder scales or smiley and sad face charts are used. For example, after the partner of one man joined sessions, the four children came too. They mostly played during these sessions but happily joined in with their parents' scaling questions on the flip chart, devising their own scales once they got the hang of the process ('dad's grumpiness' scale was particularly useful, although mum was less pleased when they drew a 'mum's grumpiness' scale too). Similarly the child protection agency can be asked to scale safety and progress. All parties are asked for detailed, measurable evidence of any changes.

Using scales enables people to acknowledge when they are not achieving sufficient progress without making them feel like complete failures. The range of points on a scale means that they are rarely condemned and recognizes their aspirations to 'do better'. The scales can be constructed to make it easier for families to discuss what offenders need to be doing differently even when the subject is emotionally charged. The violent person's rating is used to identify what they need to be doing differently to move up the scale. For example, 'you rate your partner's safety at 5 but your probation officer only rates it at 2. What do you think you will be doing differently when you can agree?' Where there are child protection issues, agency ratings are also assessed. For example, a woman had ceased being violent towards her partner and hoped to be reunited with her baby son, so she was asked where she rated her mothering on a 1–10 scale (she said 5), where she thought the social worker would rate her (she thought 0), and what she would be doing differently if the social worker could agree with her rating of 5. In complex situations where an offender is separated from partner and children and the courts are involved, questions can be asked such as: 'When you are asking the judge for contact with your children, what will you say that will convince him/her that your child is safe with you?' Again

this places the responsibility for developing a safety plan, and putting it into effect, on the person whose violence led to safety concerns in the first place.

As scales can be devised for any issue that arises during therapy, this gives the offender the opportunity to discuss strong emotions which would otherwise be difficult to express constructively. For example, we have devised scales which permit safe discussion of murderous feelings, i.e. 'If 1 is you feel very tender and loving towards your partner and 10 is you really could murder him/her, where are you on this scale today?' or 'If 1 is you know your jealous thoughts are not true and 10 is you are absolutely convinced that your jealous thoughts are true, where are you on this scale today?' Even if offenders rate themselves highly on these scales, they can still talk about how they have managed to exercise some control, and how they can do more of this. It is also important to establish the extent of murderous feelings in devising safety plans for partners, and for deciding when to seek additional psychiatric support; one man emerged as so dangerous that he was asked to leave the programme while he received psychiatric help, and his partner was assisted to leave the home.

Assessing willingness, confidence and capacity to change

Although it is important for offenders to take responsibility for their behaviour in the future, Turnell and Edwards (1999) make the point that practitioners have a responsibility for setting the scene so that motivation can be improved. Adversarial relationships with professionals reduce the possibility of this, causing unnecessary frustration and increasing feelings of powerlessness at the same time as the offender is expected to exercise self-control. Willingness to change can be increased by assessing whether the person needs help with motivation or ability to change. This is done by creating separate scales for each behaviour: for example, 'If 1 means you can't be bothered and 10 means you will do anything it takes, where are you on this scale?' And 'If 1 means you have no confidence in your ability to change and 10 means you have complete confidence, where are you on this scale?' The lower of the two scores becomes the focus of the work. For example, one sex offender only rated himself at 6 on the motivation scale because 'I'll do anything it takes but when I get depressed I sneak about, and avoid situations'. Helping him identify exceptions to times when depression incapacitated him enabled him to handle his depression better and increase his motivation.

It is also important to ask 'If 1 means you haven't a clue about what to do differently and 10 means you know exactly what to do to change, where are you on this scale?' Offenders may be determined to change their behaviour but lack the knowledge or confidence to make the necessary changes, so solution-focused practitioners assume nothing, ask questions to which they genuinely don't know the answer and are keen to discover so that they can remain flexible and creative to opportunities for change.

The programme

The referrals

Over the first three and a half years of the DVT programme for adults wanting to change their violent behaviour, sixty-eight adults (fifty-two men and sixteen women, including four couples where both were involved in the violence) began a solution-focused programme. The majority were white and heterosexual, there being only three black men, one Asian man and one black woman. There were three women in lesbian relationships (all white), but no gay men. They were predominantly working class, although approximately a quarter were well qualified and held down professional posts. All but one of those involved with social services child protection workers were unemployed. The ages of the participants ranged from 18–59, with an average age of approximately 37 years. On the whole the men were slightly older than the women, the exceptions being the lesbian women who were on average three years older than the heterosexual women. Thirty men completed the programme (all male on female violence), as did the four men who attended with their partners as couples. All have been violence-free. Four men were asked to leave the programme and fourteen dropped out. All sixteen women, including the women from four couples, completed the programme and are violence-free. The men who dropped out of the programme tended to be slightly younger than the men who completed, while the men who were asked to leave the programme were significantly older. Eight of the dropouts are known to have continued to be violent, involving between one and nine episodes, three are non-violent, and the outcome is not known in the remaining three. Of the four who were asked to leave, three continued to be violent.

The degree of violence involved was mostly severe: broken bones, black eyes, knifings and so on, with just one man using only emotional

violence. All made verbal threats as well as causing physical damage, which their partners described as equally frightening, although only the men were described as using facial expressions, hitting walls and walking out as means of intimidating their partners. A significant number of the participants admitted to entertaining murderous thoughts and their violent assaults were actually life-threatening: attempted strangling and drowning; knifing, and pouring lighter fuel over the partner's body.

There were no gender differences in the severity of the violence; for example, one woman attempted to cut off her partner's testicles with a carving knife; another attacked her partner with a baseball bat; and a third threw her partner down a flight of stairs. Although established research constructs women's violence as 'fighting back', resorting to the use of weapons to compensate for physical differences (Pagelow, 1985; Daly and Wilson, 1988; McGibbon *et al.*, 1989; Counts *et al.*, 1992), we did not find this to be the case. The women not only initiated the violence but, as with the men, they also attempted initially to blame their partners for their own loss of temper control; for example, one woman said: 'When he nags me about not helping enough in the house, it winds me up. I get madder and madder and then I explode . . . like the Incredible Hulk . . . only not green.' This accords with the growing research into female on female violence (Renzetti, 1992; Leventhal and Lundy, 1999) and female on male violence (Mirrlees-Black, 1999; Fitzroy, 2002; McKeowan *et al.*, 2001). Where police apply zero tolerance to both male and female domestic violence, it is clear that women's violence is not necessarily defensive. Muptic *et al.* (2007) found women using violence offensively and repeatedly.

The female partners of violent men were more likely than the male partners of violent women to contribute to the violence by following partners who were attempting to remove themselves from situations where arguments were escalating to the point of violence. For example, when one man got out of bed to sleep on the sofa as a way of avoiding violence, his partner followed him with a bucket of water which she then poured over him. Both male and female participants reported partners 'putting them down' but, as noted above, only the male participants used non-verbal means of intimidation. The other main gender difference was that women were more likely to complete the programme than men, although this has not remained the case with later referrals. Although three-quarters of the participants reported on here were male, subsequent referral rates

show the ratio to be shifting, with more women and the victims of men on men violence being referred, although their violent partners are not yet accessing the programme. There is also emerging evidence of women using non-verbal means of intimidation.

The violence was mostly directed against partners, although a small number of men were also violent towards other adult relatives and strangers, and a small number of both the men and women had been violent towards their children. As both social services and the police in Kirklees treat domestic violence as a child protection issue, regardless of whether or not the children were present at the time, social services were actively involved in the lives of seventeen of the participants (eight of the men and three of the women who completed the programme and six of the men who dropped out). One man who completed the programme had previously had his son adopted following a child protection investigation.

The majority of men and women who completed the programme talked of emotionally violent partners who instigated as well as responded to physical fights. This was confirmed by partners later in the therapy; for example, the partner of one man asked for therapy for herself to deal with her sexual jealousy which led her to ring her partner on his mobile constantly when he was visiting his children by an earlier relationship, keeping him awake when he returned from these visits, and hitting him. The extent of emotional violence among the partners of the men who dropped out of the programme is not known, although three of the men who were asked to leave the programme did not have emotionally violent partners. The most frequently cited reason for emotional violence by partners was sexual jealousy.

Other than fourteen of the participants subject to child protection investigations who attended the programme at the 'suggestion' of their social workers, all participants actively volunteered to attend after finding out about the programme from various professionals involved in their lives – health visitors, the police, GPs and DVT. DVT was the main source of information for participants due to their involvement with partners, who were also referred when they needed help to make decisions about whether or not to separate from violent partners, regardless of whether the partner wished to attend the programme. This agency also provided continuing support to either or both parties during and after they had left the programme. Working in cooperation with DVT to ensure the safety of the non-violent partner is a central principle of the programme.

Organisation of sessions

The types of sessions offered reflected the participants' preferences, being individual, couple or family sessions. At the pilot scheme stage, the intention was to offer the violent person individual sessions, with the partner offered the opportunity to join sessions later if they so wished, and only after the physical violence had ceased. There were three reasons for this; first, to emphasize that responsibility for becoming non-violent lies solely with the violent person; second, to facilitate discussion of any possible substitution of physical violence with emotional violence; and third, to guard against any possible dangers which couples' work might create. Arrangements were made to see partners separately and, if necessary, secretly, to discuss their safety needs. All partners were informed about the support available from DVT, and they were also invited to correspond with us about any issues – be these concerns about safety or reports of progress/lack of progress. This focus on safety meant that any fears that couples' work could be dangerous were not realized. Partners not only availed themselves of the support offered outside their partners' sessions but, all too often, they also simply turned up at sessions earlier than we planned. Mostly they were curious about what was happening in sessions: for example, did their partner tell the truth about what had happened?; and, in most cases, they were anxious to express their support for their partner's endeavour to change. After being 'heard', they would then dip in and out of sessions, depending on whether or not they had a contribution they wanted to make, or ask for an individual session for themselves – not always directly concerned with the violence. They would also drop in and out of DVT.

Holding a couples' session was not necessarily indicative that the couple were actually living together; some women were living in refuges, some men were at their parents' home – although all but one of these people expressed hopes that they would eventually be reunited. In one instance where a woman was living in the marital home and her husband was living with a friend some distance away (to comply with a non-molestation order), she attended a session with him to say how afraid she was of living alone in their large home. As someone had to live there to care for the pets, they agreed that the man move back home and she move in with her parents for a further three weeks. It was by listening to couples negotiating together in the security of a session that we learned to appreciate the complexities of participants' relationships; that much tied them together and that

separation was rarely an option without far-reaching consequences for all parties.

Neither did holding individual sessions necessarily indicate that the couple were separated or that the partner had refused to attend; some participants preferred to 'do it on my own, prove that I mean it'. Where appropriate, individual and couples' sessions were also used to make constructive parting arrangements, some relationships proving unsustainable when the violence ceased. Where children were involved in sessions this tended to be requested after the cessation of physical and emotional violence had led to the couple reuniting but where the children were still feeling insecure about the stability of the newly non-violent nature of their parents' relationship.

The number and spacing of sessions held varied according to participants' needs and the complexity of homework tasks set. Therapy ceased when all parties were confident that not only had violence ceased but the participant had also developed more satisfactory ways of being as a person, and could evidence this. Participants were, however, offered an open-ended invitation to return should they require further sessions. This conforms with solution-focused practice which regards people as experts in their own lives and aims to provide a tailor-made service in which participants can develop their own solutions to their problems. There is no notion of a set number of educational sessions; indeed, we wonder how programmes that insist on a set number of sessions arrive at a figure – where is the evidence that twelve or twenty-four sessions, say, are necessary for change or that, as the psychologist wrote about one man, 'therapy would be at least twelve months in duration'? The research actually points to the reverse; Orlinsky *et al.* (2004) found that more therapy sessions are not always associated with better outcome, and Lambert and Ogles (2004) that outcome actually decelerates as the number of sessions increase. Of the fifty participants (forty-six cases) who successfully completed the programme, the average number of sessions needed was 4.3, lasting approximately an hour each (excluding follow-up sessions as only one was concerned with issues of violence). Eighteen people who completed the programme successfully needed only one to three sessions. In these cases there had been significant change before starting the work so the person had clear goals and was able to talk about the violence in detail. In solution-focused approaches, pre-session change is always assumed and discussed at the first appointment. This gives a success rate of 73.5 per cent (78 per cent discounting the men who were asked to leave the programme).

Assessing outcomes*Satisfactory programme completion*

Programmes which involve a set number of sessions are simpler to evaluate than the individualized programmes described here where the number of sessions required for each person to meet their goals varies considerably. With regard to the former, 'completion' is easily established by attendance, although what constitutes a satisfactory completion is somewhat more problematic: how successfully has the person engaged with the programme, how long must violence have ceased before we can be confident that the partner is safe; how is emotional violence measured; and what influence might other life events have had on the outcomes?

We found it difficult to establish accurate baseline data, since offenders tended to disclose more details of their violence gradually during therapy as they gained trust in the therapeutic process and began to take responsibility for their present actions. We do have data about the violence from the referrers but we often find during later disclosures that this underestimates both the severity and extent of the violence; particularly in respect of the holding of truly murderous feelings. Equally, the use of emotional violence, both verbal and non-verbal expressions of intimidation, is difficult to detail in the early stages of therapy. These data emerge in two ways; the offender begins to disclose more fully and the partner begins to describe emotional violence more clearly as they talk about exactly what their partner will be doing differently when they feel safe. Frequently partners talk about being able to express their opinions without fear of 'being put down', sarcastic remarks made, or threatening facial expressions – these being common early warning signs of imminent physical violence. 'Being listened to' is a frequent goal for partners, so 'listening' is an equally frequent goal for offenders. Thus 'completion' of this programme is as likely to consist of success in 'listening' as well as it is of physical violence ceasing. Satisfactory completion is, then, the successful achievement of solution-building and safety goals established through negotiation with all concerned parties. We measure this in several ways.

Self-reports

Mullender and Burton (2001) caution against 'over-stated, impressionistic claims for success' in practitioner reports on the grounds that participants' self-reports are unreliable. However, we find that it is

possible to increase the reliability of these reports. As the role of the solution-focused practitioner is to help offenders find exceptions to their violent behaviour, develop solutions to such behaviours and amplify these, the offender is asked to describe these in minute detail – the how, where and when questions. When individuals report being violence-free but cannot describe exactly what they did differently, the self-report is not only suspect but of little use in the development of solution behaviours. For example, one man who dropped out had persisted with a poorly defined goal – he wanted to be violence- and alcohol-free so that social services would return his child but had no idea of what he would be doing instead. He reported that he had become violence- and alcohol-free but was unable to describe any ways in which he had been different with his partner. Further sessions were unsuccessful in helping him develop a goal that consisted of his doing something differently. His partner was supported in leaving him. Those who successfully met well-defined goals were able to provide much more detail about the differences they had made in their lives. Three brief extracts from videoed subsequent sessions evidencing these differences are presented below.

This man reported no physical or emotional violence since the last session (confirmed by his partner) and had been able to explain exactly what he had been doing differently (respecting her opinions) and how he had overcome depression. He was a little more vague about how he had ‘done’ the latter (‘I think I just grew up a bit’), so he was asked about other situations in which he had been a ‘bit more grown up’, to which he replied:

‘I’ve had a few problems at home, people breaking windows. Kids on the street, putting windows in. A few years ago I’d have just gone out with a piece of wood. They’re not little kids, 17, they’re old enough to know better. But I try to do things in the proper way now. [How do you do things in the proper way?] First I tried talking, telling them they were out of order and I didn’t want anyone getting in trouble with the police. I said if it carries on, I’ll phone the police, so I phoned them and then got in touch with the council and they came and saw them at the house and said if they carried on they were jeopardizing their tenancy. So I don’t need this happening but I’ve got it happening anyway. It’s been making me that angry. I do feel like losing it but I stop and think. Think, if I do it, what’s going to happen? Get in trouble with police, and social services, I think about the consequences of my actions. So, make the choice that I want my son back and I don’t want to go back to gaol no more. I just want to be right. I won’t say a more peaceful life, just one without trouble. I’ve had enough of it.’

A woman deferred her second session for two months as she was busy working on one of her goals – making her house habitable. On arrival she reported using the time when she was painting to reflect on her life and the changes she had made: sorting out her business, enjoying her daughter (previously she had palmed this child off on her ex-husband), completed half the house repairs and decorated, and weaned herself off antidepressant medication. She was then asked about her violence:

‘It’s gone. [How did you do that?] You know I said I’d been doing drugs, I don’t know, it’s just gone. Drugs were part of it, not all of it, I haven’t been right for years, but that was clouding everything. That was the main thing. I walk away now. Too many times I’ve done sorry in the past. I don’t want to be saying sorry the next day or an hour later. Like he was scared of me. He’s not scared of me anymore. He said the other day, “you’ve hurt me. When I said, it’s either me or drugs, you sat there ten minutes. You’ve hurt me.” He knows now I’ll, I’ll still argue . . . but I won’t be violent anymore. There’s something wrong with you if you are. [What are you doing differently that makes him feel safe now?] Before, I’d ring six, seven times a day. Like that obsessive thing. Now, I might ring him once. Might not ring him at all. I’m much more chilled. More, like I said, there’s always tomorrow. Before, it had to be now, everything, I used to have to have everything now. I couldn’t wait a minute. Now I can wait.’

Another man attended alone, as his wife had sustained a broken arm in their last drunken fight (she fell over). Previously they had both inflicted injuries on each other following heavy drinking either together when they went to the pub to watch football matches, or at home where he drank morosely in front of the television in the sitting room and she drank with girlfriends in the kitchen. His goals were ‘to disconnect myself from the television and get off my arse more’ and enjoy outings with his wife ‘like, we used to talk a lot, have a laugh. It were good.’ Two extracts from his third session are detailed here:

‘A lot hasn’t happened since a fortnight ago (his last appointment). I did do one thing she liked. I stripped the wall paper off the kitchen for the job the council’s doing . . . We went out for dinner yesterday. To White Horse ’cos they do food. We went yesterday. I had four pints and she had five lagers. Then I said “come on, we’ve got to get home now” and she was quite all right about it. Not her usual So that were all right. I had scampi and chips and she had beef, Yorkshire pudding, it were this big (indicating), with beef. It’s only three ninety nine. [what did you do

differently that made her willing to stop drinking and come home with you?] I talked with one of lads who's talking about taking me shooting Sunday morning. He's going to show me how, with an air rifle. He said he'll take me. So, I had a word with him for ten minutes and then I talked with her . . . about everyone in the village. Who's died and boring stuff like that. Not boring but morbid. And our lass 'as calmed down . . . *(His contribution to the change in his daughter's behaviour is explored in detail and then he returns to talking about himself and his wife).*

There 'asn't been any fighting. [Not any?] No. [How long is now since you had a fight?] You mean actually come to blows? [Yes] Oh, flipping heck, must be nearly two months. [What are you doing differently?] Maybe, maybe I've just calmed down. We had an argument the other morning. That was about, she's quite volatile, our lass had left a cup out and it had gone all, it smelled. She got a right telling off. She likes t' house to be clean. Me, first thing in morning, I get stuck into washing up. I got vac out and moved t' cup and cleaned round . . . it's a bit more tense now we're all in t' room *(the kitchen is being done up by the council)*. I haven't, I haven't got upset about it. [how have you done that?] Think, no. No. No. Don't kick off. I might say "come on, we're supposed to be watching this film, not arguing". Or whatever. [does that work?] Yes. And 'cos our little 'un says "shut up dad", I realise I might have said something. [Are you having the same number of arguments, less or more?] Oh, so, last time we'd had none. In last two weeks, we've only had two. This one was over, what was it over? This kitchen thing. I said "never mind t'cupboards. Council's going to do it anyway". She said, "you're always sat on your arse". So that was one. *(he talks about cleaning out the shed as a result)*. Other one was last week but it was about something and nothing. Just shouting a bit 'cos she raises her voice and then I raise my voice. I just have to agree with her. I let her have her say . . . and then I retaliate with my mouth and then I realize this is stupid and I just shut up. Disappear upstairs and listen to my stereo for ten minutes and then come back down and it's all forgotten. [Is she happy about this? Some people tell me they don't like it when their partners walk out on an argument.] Before, when t' police used to come to house, they used to say "just go upstairs out of way" but there has been occasions when she's followed me and carried it on. But that hasn't happened this time. She's been all right about it.'

Partner reports

Partner reports are considered the most reliable check on the validity of self-reports (Mullender and Burton, 2001), and we access these in a number of ways. Each offender is provided with written feedback

notes detailing their progress (what they did) and their solutions (how they did it). Where the offender is still in a relationship, they share these notes with their partner and they can compare these with *overcoming violence checklist* scores at regular intervals. These checklists are completed by the offender and by the partner reporting on the offender, who then compares his or her rating with the offender's for discrepancies. The partner is then asked to choose one or more items where a change in behaviour would not only lead to a higher score but also make a big difference. This provides a simple way of negotiating goals and a regular progress check.

Where partners do not wish to attend joint sessions, they are invited to correspond with us by letter or telephone, or make an appointment on their own. Most readily avail themselves of one method of communication, but there remain some offenders whose relationships have broken down and further checks are needed (we have no partner reports for six instances). This is also important in cases where couples are hoping to have children returned from care, as there is always the possibility that a relapse may not be reported by either offender or partner. Here we also cross-check with the police and other professionals.

Police checks

These have some potential limitations as re-offending may have been under-reported, particularly female on male violence (Grady, 2002). Mullender and Burton (2001) suggest that official data are likely to miss re-offending (reconviction figures suffer the worst attrition rate and not all women report abuse). In West Yorkshire there is zero tolerance of domestic violence so this is not likely to be the case, especially as the domestic violence section of the police has been involved in the programme from the outset, referring offenders and providing us with detailed reports of every incident in which the name of a participant figures. This level of detail sometimes highlights successes too; for example, one man figured in a police check but only because he was trying to stop his brother's domestic violence.

Professionals' reports

We routinely check with referring professionals, particularly where they have good access to information, such as health visitors, but our main source of longer term follow-up is through our close links with

DVT. Gondolf's (1997) two-and-half-year follow-up study showed that men who have ceased violence for six months after completing a programme have a good chance of sustaining this behaviour pattern but we wished to ensure that this endured over a longer period of time. DVT is trusted by its service users, and has excellent links with a very wide range of professionals, so we have a great deal of qualitative data on the lives of people who have participated in the programme. This also meant that we discovered successes which we would not have known about otherwise; for example, DVT reported that the partner of one of the men who was asked to leave the programme is 'a new person', and that a man who dropped out is out of prison and living peacefully with his partner.

DVT also provides useful checks during therapy. For example, a female partner was living in a refuge and we were made aware of an incident during therapy; subsequently her safety needs were reassessed. DVT also supports partners who wish to attend sessions separately so that they can report on their safety concerns without risk to themselves. This also led DVT to develop refuge facilities for victims of lesbian violence, and began a mapping exercise to assess the need for similar accommodation for gay men. As noted earlier, gay and lesbian victims of violence come forward once services are explicitly tailored to their needs.

Non-completion

Of the participants who did not complete therapy, four were asked to leave and fourteen dropped out. This gives a dropout rate of almost 26.5 per cent (22 per cent discounting the men who were asked to leave), which compares favourably with other programmes (Mullender and Burton estimate the dropout rate in UK programmes to be between 30 and 90 per cent, with self-referred men being the least likely to complete). The re-offending rate of the people who dropped out of the programme is in line with national re-offending rates. Of the participants who were asked to leave the programme, two were unable to hold logical conversations and we arranged for them to receive psychiatric help. As one man was separated from his partner the police were informed of the danger he posed to her; the other was still married and DVT provided her with long-term support after she made the decision to leave her husband. The other two men were asked to leave because they wanted their partners to change rather than themselves. Their partners attended sessions and made the

decision to leave these two men during this period. They both requested, and received, individual support.

Of the men who dropped out of the programme we have limited information, other than that the majority have remained violent. Where the reasons for dropping out were known, these varied from being withdrawn by a partner, disappearing on a drinking spree, beginning attendance on another programme, and being imprisoned for burglary. Three men were already the subject of child protection intervention and had been referred to the programme by their social worker. As it became clear to them that this was a token gesture and that they were likely to lose contact with their children in any event, they were not motivated to continue on the programme. However, of the men who successfully completed the programme and were also involved with social services, all but one subsequently satisfied the courts that they had changed sufficiently to be reunited with their families, and the other (who was separated from his wife) was granted contact with his children. These men were younger than average with younger children and their social workers were planning for both rehabilitation and adoption (parallel planning). The complexities and difficulties this created for these young fathers are discussed in detail elsewhere (Milner and Myers, 2007).

Caveats

Although as far as we have been able to ascertain via the various checks outlined above, none of the people who completed the programme have re-offended, we must offer certain caveats. This account is a practitioner report and is, therefore, subject to bias – we want to believe that the programme works – and much of the data we offer in support of the programme working are ‘soft’ data that depend upon informal information from DVT. We have not undertaken an independent evaluation, largely on the grounds that, because we wish to maintain the client-centredness of the programme, we do not attempt to establish rigorous baseline data at the onset of the therapy. To do so would, we think, be unnecessarily distressing to participants who are very nervous on first contact and who tend to disclose more details about their violence after they have come to trust the therapeutic process. Equally it might be that our ‘successes’ were actually self-selecting. They may have been well-motivated people who would have changed their behaviour anyway; they all developed clear goals and worked assiduously to meet them. The concomitant provision of

specialized refuge provision for gay and lesbian victims of violence enabled more people to access the programme but we failed to reach gay men who are violent towards their partners. This may well be because it is more difficult to readily identify a 'victim' where violence involves two men of about the same physical size and thus is neither reported nor necessarily acted upon by police. Equally there could be other biases about gay lifestyles operating.

We do, however, feel sufficiently encouraged by our results to invite you to join with us in using a *signs of safety* approach in working with people who are violent, and to further test the effectiveness of the approach.

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