

Recent Trends in Evaluating Programs for Men Who Batter

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As programs for men who batter continue to develop, attempts to evaluate the success of these programs have not kept pace (Saunders & Azar, 1989). Serious ethical and practical challenges confronting the program evaluator help to explain the lack of sound evaluation studies. However, lessons and innovations from existing studies can help us to meet these challenges. The purpose of this paper is to review recent trends in evaluation efforts, including design, implementation, and measurement issues. The overall goals of treatment also need to be reviewed. I will begin with a discussion of the goals of intervention.

Goals of Intervention

There seems to be growing consensus that we need to go beyond the measurement of physical abuse when judging success. In correctional settings, because of the legal definitions of assault, the focus seems to be on the cessation of physical abuse when measuring outcome. Many of us in the field are recognizing the need to focus on psychological abuse because of its dire effects (e.g., Tolman, 1989). I think we can also look beyond the areas of physical and psychological abuse to some broader areas for evaluation.

First, because of the links between patriarchal structure and family violence (Yllö & Straus, 1984), long-lasting change requires attention to increasing equality in the men's relationships. Movement in this direction is illustrated by the addition of an Equality Wheel by the Domestic Abuse Project in Duluth. It complements their Power and Control Wheel that focuses on the negative tactics of men who batter. The Equality Wheel helps to point the men in a new direction so that they are not simply told, "You have to give up your power."¹ Equality is at the core of various methods of mutual decision-making and responsible assertiveness training. The men seem to understand equality when it is described as mutual respect - giving the same respect and rights to others that they want for themselves.

¹ [Editorial note: Copies of the Power and Control Wheel and the Equality Wheel are reproduced on pp.35-36.]

Second, I would also like us to look beyond the goal of equality in the men's relationships with their partners. We know that in working with men who batter we are only reaching a very small percentage. Perhaps we can look at the treatment of these individuals as a beginning point for social change. For example, Gondolf (1987) describes a final stage of treatment: the ways in which these men can help with social change. They can do this by speaking out in public, but they can also do it by affecting those around them - their children, friends and co-workers.

In the film *Shifting Gears* (O.D.N. Productions, 1981), there is a scene near the end where two friends confront each other. Both are men who batter, but one has been through treatment. The man who has been through treatment is able to restrain himself when hit by his friend. He is also able to confront the possessiveness of his friend and point out his need for help. Thus, treatment may be like throwing a stone into a pond - the ripples can spread to men other than those receiving treatment. As an empirical example, there is evidence that treating the men also has positive effects on the children by reducing abuse toward them (Stacey & Shupe, 1984). Without intervention, there is good evidence that the sons of these men will grow up to be the next generation of wife abusers, child abusers, and criminals outside the home (Hotelling & Straus, 1989). One way to view much of the corrections work in this area, then, is to view it as crime prevention.

In summary, it seems desirable and possible to see the goals of treatment as broader than stopping the violence of individual men in treatment. In our evaluations, we can include measures of change in the men's children and the men's social networks.

Formulating Interventions

Risk Factor Research

Current findings from risk factor research can help guide our interventions. I will briefly review recent findings on risk factors, which are not necessarily causal factors. More research in this area is certainly needed; in particular, longitudinal studies. However, interventions cannot wait until all the research is complete.

In my review, I rely heavily on the work of Tolman and Bennett (1990) and Dutton (1988), with other studies integrated with their reviews. Table 1 shows a classification of risk factors according to their consistency across studies. Those marked "prominent" are found consistently across all or almost all studies. The most consistent risk markers are childhood violence, alcohol abuse, and low income and education.

I have also reviewed risk factors for severe violence and these are shown in Table 1. These factors are derived from studies on abuser typologies. Those at risk for the most severe assault were the most victimized in childhood, they abuse alcohol the most, and they are violent outside the home as well as inside (Saunders, in press). We

may need to take the greatest ethical precautions with these men when evaluating programs. We may find through experimentation that they need the longest and most varied treatment.

A second point I want to make about formulating interventions is that we should try to base them on theoretically distinct models. If the theoretical underpinnings of an intervention are clearly defined, then the consistent success of one treatment over another may inform our causal theories. In a study that we are completing at the Alternatives to Aggression Program in Madison, Wisconsin, we have made clear our assumptions and methods for the experimental comparison. The comparison is between behavioral-feminist and psychodynamic approaches.

Design Issues

In designing evaluation studies, there are complex practical and ethical problems in trying to conduct a true experiment.

Control Groups

If we want to have a no-treatment control group or a wait-list control group, there is an ethical problem in denying treatment to a dangerous population. A dilemma is created because it is through experimentation that we will find effective treatments. There is the practical problem of control group participants turning to other sources of help in a haphazard fashion. A form of minimal treatment control group is probably the best solution. This control group would be akin to very strict monitoring by a probation officer, i.e., weekly visits that would not involve treatment. The monitoring would help detect the escalation of violence in case a person has to be withdrawn from the control condition and placed in a separate "crisis" condition. The monitoring might also be found to be an inexpensive form of treatment with a good rate of success for some types of abusers.

Differential Effects by Abuser Type

A relatively undeveloped area of research is one that would answer the question: "What type of abuser responds best to what type of treatment?" Debates about what type of treatment is most effective may be resolved through research that shows we need different treatments for different abusers. The length of treatment may also need to differ based on different abusers. For the severe abuser described above, we may need one to two years of treatment, rather than the five or six months that is typically given. We can also try to uncover the abuser types that consistently fail to benefit from treatment. Preliminary, cross-sectional studies give some evidence of those most likely to re-offend: the alcoholic batterer, the narcissist, those with longer histories of abuse, and those who witnessed parental abuse (Hamberger & Hastings, 1990). Some would argue that these men are untreatable. I tend to be optimistic and argue that we may need to

TABLE 1: Risk Factors for Wife Assault (Saunders, in press)

Risk Factor	Degree of Risk		Comments
	Any Assault	Severe Assault	
Violence in family of origin	***	***	More risk if both saw abuse and was abused
Low education and income of man	***		More risk if woman higher status
Alcohol	***	***	Chronic abuse may be key factor
Behavioral deficits	**		Especially if combined with the need for power
Psychopathology	**		Mostly if defined as personality disorder
Child abuse	**	*	Half of violent husbands severely abuse a child
Anger	**		Especially for marital situations
Stress	*		"Stressors" may be the result of violence
Depression	*		Low self-esteem may be better risk marker
Generalized aggression		***	Violent inside and outside the home
Anti-social traits		*	Criminal lifestyle & no remorse for violence
*** prominent risk	** probable risk	* possible risk	

give them more treatment and a greater variety of it. The men who were severely abused in childhood probably suffer from Post-Traumatic Stress Disorder and may not even be aware of it. They probably turn to alcohol to cover the pain and do not show remorse because they cannot empathize with their victims (Saunders, 1992). Rather than using post hoc designs for analyzing the match between abusers and treatment, we can also have studies that match clients to particular types of treatment in advance.

Differential Attrition

A potentially serious problem in comparing treatments is differential attrition. For example, one treatment or a particular leader may be very confronting with the men. Consequently, there may be a higher attrition rate for this treatment. The treatment may have a higher success rate only because it finishes with the most self-motivated men or those who are least violent. If differential attrition occurs, the randomization of the experiment is jeopardized. We must turn to statistical adjustments for solutions.

Control Variables

There are also some important control variables to consider when interviewing the women. As a simple example, we need to find out how much of the time after treatment they are together. If they are separated, are they still having contact? We can adjust our rates of violence by the length of time for which there has been no contact. Contact during separation is more difficult to handle as a variable. Does the risk of violence increase or decrease during this time? We know that many women are threatened, harassed or are direct targets of violence during this time.

Actions by the woman during this time can have effects greater than the effects of his treatment. Has she threatened to arrest him? Has she threatened to divorce him? It is not only the fear of arrest, but the fear of losing one's partner and one's self-respect that may deter these men from further violence (Dutton, Hart, Kennedy, & Williams, 1990). Thus, a variety of forms of potential deterrence should be included as control variables.

Statistical Power

A final point I will make on the topic of study design is that if the above recommendations are taken, then samples will need to be quite large. Use of different treatments, control groups, typology analysis and control variables means that large numbers of research participants are needed. A multivariate, statistical power analysis must be conducted long before the implementation of the study. An implication is that one or two large evaluation sites are preferable to numerous smaller ones.

Implementation

Treatments must be implemented according to pre-set goals. Otherwise, the internal validity of the study can be called into question. The recently completely National Institute of Mental Health's collaborative study on depression can be used as model of treatment implementation (Elkin, Parloff, Hadley, & Autry, 1985; Elkin, Pilkonis, Docherty & Sotsky, 1988). The cost of the study was substantial and I doubt that the methodology can be replicated by most researchers. However, many of its methodological principles can be applied.

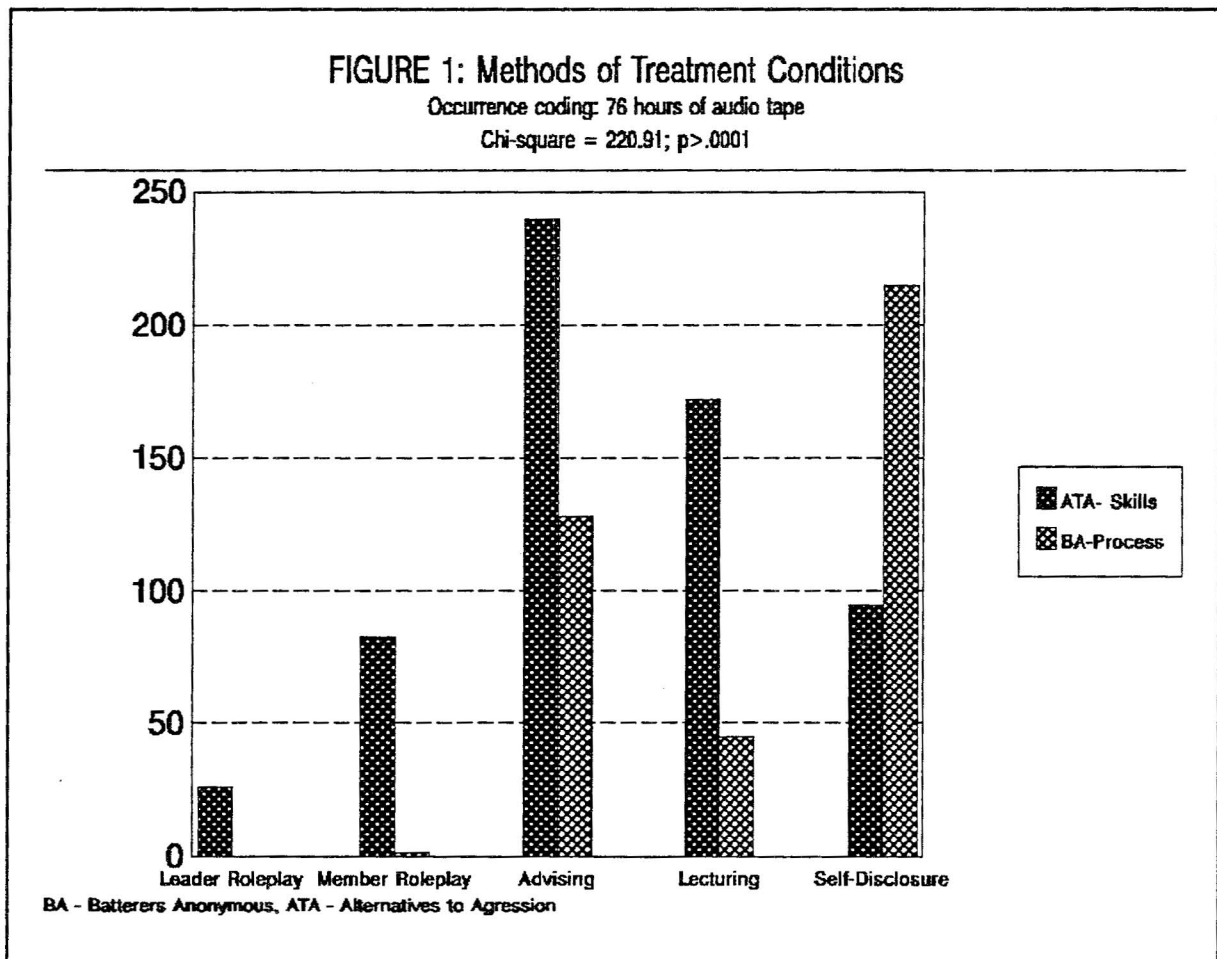
First, we need to specify the treatment clearly. One of the most effective ways of doing this is to provide treatment manuals for the leaders. The NIMH depression study was able to develop manuals even for the interpersonal approach to treatment. Compared with behavioral approaches, this approach is usually difficult to specify. Therefore, treatments for batterers that are non-behavioral (e.g., existential, insight-oriented, interpersonal) can probably be specified in leader manuals.

Second, we need to make sure that the leaders are competent. Competency involves both background knowledge and therapy skills. Background knowledge must include a high level of awareness of the causes of domestic violence and the impact that it has on the victim. Knowledge of the many ways that offenders minimize and rationalize their behaviour is crucial. The more experience the leaders have in treating offenders and working with populations in crisis the better. The importance of training is exemplified in the research of others. Deffenbacher and his associates at Colorado State University had a reversal of findings that was probably due to different training and experience levels of group leaders (Deffenbacher, McNamara, Stark, & Sabadell, 1990). They compared process groups with cognitive-behavioral groups for college students who had anger problems, some who were severely aggressive. Therapist training, however, can be a major investment. The NIMH depression study spent many thousand dollars per therapist in the training.

A final point I would like to make on implementation is that we need to make sure treatment is applied according to the treatment goals. In a study that I am now completing at the Alternatives to Aggression Program in Madison, Wisconsin, we tape-recorded every session. We sampled and coded segments of the tapes to ensure treatment integrity. Testing the validity of treatment application is especially important if two or more treatments are being compared. We are comparing an unstructured, psychodynamic group with a structured, feminist-behavioral group. To give you a few examples of our coding results, Figure 1 shows the level of self-disclosure over 76 hours of audiotape recording per type of treatment (based on counts of the occurrences, not the duration). The self-disclosure was twice as high in the psychodynamic group, as we expected. In the process group role playing did not occur, also as predicted.

There were some forms of leader intervention that were equal and were expected to be equal. For example, praise and support did not differ in the two treatments. One analysis we will conduct collapses both forms of treatment together to see if the process variables are more powerful in predicting outcome than either of the two treatments.

Again, testing treatment integrity is a major research investment: a coding scheme must be developed, coders need to be trained to reliability, and the coding itself is time-consuming. A more economical but less valid way to assess treatment process is to ask group members to give ratings at the end of each session. For example, we use a simple rating of helpfulness for each session. There was no difference on this variable when we compared the two treatment conditions. However, within each treatment condition,



there was a fair amount of variability. This was also true for measures of cohesion: how close they felt to other group members and how much support they received from other members. We will be able to correlate these member evaluation variables with outcome measures. As with the tape codings, we may find more of an impact for the atmosphere in the group - the level of cohesion - than for a particular kind of treatment.

Measurement

There are some major problems in measuring what most regard as the ultimate outcome - victim reports of the offender's behaviour. Often the reports are not relevant because the couple is divorced and having no contact. Many cases are lost because of this simple fact. If they are separated or divorced and having contact, we need measures of the threats, harassment and emotional abuse that often occur during this time.

Considering the number of couples who do not have contact with each other after treatment or who cannot be located, we need better post-treatment measures. Measures based on the men's role-playing or physiological responses are likely to be more valid

than their self-report measures. Some researchers have developed video and audio-taped vignettes that assess behavioral, verbal and physiological responses in the men (Dutton, 1988; Holtzworth-Munroe & Anglin, 1990). These measures have been used in descriptive research but they can be adapted for program evaluation. The measures appear to be much more difficult to fake than most self-report measures. They use themes that have been found to differentiate men who batter from control groups.

The men's attributions for their partners' behaviour can also be captured with these measures. For example, after either role-playing or presenting a vignette to a man, he can be asked what his thoughts are. Thus, besides measuring behavioral tendencies, we can attempt to measure thought patterns. In this way we can possibly become less dependent on victim reports. This will be especially true if the vignette and role-playing measures have external validity - if they correlate highly with victim reports.

Finally, we need to improve our methods for locating and staying in touch with victims. Christine Sullivan has had a high rate of success in maintaining follow-up contacts with victims after an experiment (Rumptz, Sullivan, Davidson, & Basta, 1991). The experiment is testing the effects of advocacy following shelter. During the follow-up phase, she has been able to find and interview over 90% of the women in both the experimental and control groups. Among the innovative strategies for locating women, she receives permission at the beginning of the study for locating women through their friends and relatives.

Related to the topic of respondent cooperation, we need to do more work assessing the impact of interviewer traits, affiliation and methods. Should the interviewer be affiliated with the treatment centre or a separate research centre? Should interviews be conducted in person or by telephone? There seems to be agreement that women should be interviewed by women, but we probably need to be matching interviewer and interviewee by race as well.

SUMMARY

In summary, program evaluators need to consider carefully the goals of treatment. Perhaps goals need to be broadened beyond the cessation of physical and emotional abuse to include the social networks of these men. Crime prevention as well as crime cessation are embodied in these goals. If we are to conduct evaluations with conclusive results, we must have well-trained leaders, the valid application of treatment, and adequate methods for locating and gaining the cooperation of victims.

DISCUSSION

1. **Question:** You suggested that men who are alcoholics or whose family of origin is violent may often fail to respond to treatment. Does this group actually fail to respond or are alcoholism and a violent family of origin just risk factors for recidivism? In other words, have researchers conducted studies monitoring the decrease in violence among high risk men who receive treatment or do high risk men simply fail to respond to treatment more often?

Response (Saunders): This comes from studies of typical programs and, in particular, the program follow-ups. I am thinking of Kevin Hamberger's work (Hamberger & Hastings, 1990).

2. **Question:** These studies do not have a control group of high-risk men?

Response (Saunders): Right. These studies include the men who complete treatment. The ones who are likely to recidivate have these characteristics.

3. **Question:** So these characteristics are risk factors for recidivism; they do not necessarily indicate responsivity to treatment for this group? The men with these characteristics may be at even higher risk to recidivate prior to treatment while afterwards they are at lower risk? For example, they may go from a 100% chance to an 80% chance of recidivating?

Response (Saunders): Exactly. So treatment may still have had a good impact on them. That is why we need to find out what the level of violence is before treatment. In our program, we do that with a retrospective baseline measure for two years prior to treatment. This has many methodological problems, but that is what we are attempting.

4. **Question:** I have heard from Ed Gondolf that they are now doing experimental groups in Ann Arbor which deal with addictions to alcohol with violent men. Have you had any contact with those groups and do you know what is happening there?

Response (Saunders): Yes. I consult with Catholic Social Services in Ann Arbor which offers a specialized program for alcoholic men who batter. These men go to treatment two nights a week, once for the physical abuse and another night for the alcohol abuse, with special attention to the connections with violence. We have not begun any kind of outcome work with that program so I cannot say how it is working. There are, however, some other programs around the country that are combining the two.

I think there are some advantages to this approach. We know, for example, that many alcoholism counsellors minimize the unique role of violence in the relationship.

They may also attribute the violence to the alcohol only.

5. Question: Your list of risk factors does not include either pro-violence sexist attitudes or social support for violence among the peers and associates of the men. Is this because the evidence is not there for those risk factors or is it because they have not been explored?

Response (Saunders): Walter Dekeseredy (1988) has done some work on social support which I think is confirming of that risk factor. However, I may have been looking for more than one study in order to include it on the list.

In terms of sexist attitudes, we need to turn to the typology literature. Studies are consistent in not finding a difference between batterers and non-batterers on certain measures, such as the Attitudes Towards Women Scale (Spence, Helmreich, & Stapp, 1973). When we look at different types of abusers, however, there are some types that are higher on sexist attitudes than others.

6. Comment: Mike Smith (1990) has done some interesting research in this area. In his Toronto survey, he looked at the adherence to the ideology of familial patriarchy. He found that there is a difference: people who abuse their wives are more likely to adhere to that particular ideology. I think the data is quite good.

7. Comment: On general measures of sexist attitudes, researchers do not find any difference between batterers and non-batterers. The Attitude Towards Women Scale, for example, washes out completely. There have been a number of studies conducted in this manner, including a couple of studies on patriarchy (see the review by Hotaling & Sugarman, 1986). Most of them do not hold, although Smith's (1990) study is reasonably good and does. I think the jury is still out on attitudes to women as a risk factor.

If, however, researchers ask specific questions about how much violence is acceptable in relationships, they get effects (e.g., Dibble & Straus, 1980). Therefore, exploring attitudes which are specifically conducive to violence in relationships looks promising.

Response (Saunders): I think we may have a ceiling effect in our cultures. If you look at Kristi Yllö's (Yllö & Straus, 1984) state-by-state comparisons or David Levinson's (1989) wonderful cross-cultural work you find very strong effects, depending on the culture. We may have a ceiling effect. In a patriarchal culture, you may not get much variation.

8. Comment: This may also reflect how we have to improve our instruments. Social desirability is a factor. Also, people just know how to give the right answers to psychological questions. This may be especially true if you have been caught doing

something you should not be doing.

Response (Saunders): We are making adjustments statistically for response bias in our self-report measures (Saunders & Hanusa, 1986).

9. Question: How did you define the differences between the group modalities? You mentioned that one group was psycho-dynamic and the other was cognitive-behaviourist. What is the parameter of each of these concepts?

Response (Saunders): Is the question about the assumptions and the methods used in each of the groups?

10. Question: Yes. If you are looking at these two groups as distinct, what makes them distinct? Do you know how the content of the concepts was constructed?

Response (Saunders): We started with certain assumptions which we listed. We then listed the methods that would be used. For example, in the cognitive-behavioural group we knew there would be more lecturing and role-playing, as well as work on sexist attitudes and cultural norms. We had agendas for each session and it was quite structured. We supported this structure by using ratings of the tape recordings.

For the psychodynamic group, we had to hire supervisors and leaders to come in from the outside because we had never done these groups before. The supervisors convinced us that they could not develop a manual (which is what I am recommending that you do). Although there were certain treatment phases that they went through and some structured exercises, they provided more of a general orientation to their group leaders.

The supervisors for both treatment groups also listened to the tapes and used that in their supervision. Basically, we laid out some general goals and then we developed ways of operationalizing the goals and measuring the treatment integrity.

11. Question: There is so much eclecticism in the practice. One person calls their program "psychodynamic." Another one is "pro-feminist." Another is "cognitive-behaviourist." How can you tell them apart?

Response (Saunders): It would take me quite a while to go into the details. For the psychodynamic group, we relied on the work of Alice Miller (1983) and some of the work that comes out of the Healing the Wounded Child movement. In addition, Charles Whitfield's book (1987) was used with the group leaders. Handouts from his book were used with the men in the group.

The first phase of the psychodynamic work was to build cohesion and trust. In the first four to six sessions, leaders used dyadic exercises to build enough trust in the

group so that the men felt safe enough to open up about their traumas from childhood. Jerry Jennings has written the most about this approach. It involves using process groups to train in a naturalistic style what a structured, behavioural group would teach in a very matter-of-fact, lock-step fashion.

5. Question: In the groups you are evaluating, what proportion are court-mandated?

Response (Saunders): When we started our program in 1978, it was approximately 30%. Now we have approximately 80% who are criminal justice-mandated. This figure includes those who are court-mandated as well as first offenders who have signed a contract with the prosecutor's office under a special program.

6. Comment: It is useful to be reminded about the implementation problems and the issues related to treatment integrity. In corrections, we have an incredibly rich history of implementation failure. Although our rhetoric is sometimes terrific, what happens on the ground frequently falls far short of that, for a whole set of reasons. We will have to be careful about that.

It is also extremely interesting to learn about the attempts you are making to find out exactly what is going on in these groups, i.e., the specific content of the therapy. Most studies do not provide this information. One sometimes wonders if anything was ever implemented at all or whether or not the program was one night out a week for the men to talk to their friends. I really applaud your efforts. I think this is a lesson that we will have to keep hold of.

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