PATHS News

PATHS Bi-Monthly Newsletter

July 2011

Volume 1, Issue 6

PATHS Update

by Diane Delaney, Coordinator

Happy summer, everyone! Here is some good news I'd like to share with you.

PATHS has been funded by the Prairie Action Foundation for a project entitled *Origins of Violence and Strategies for Change* to take place in September and October of this year. There are 2 main components to this project. First, we will update our Fact Sheets (which can be found on our website) and produce 6 new pamphlets. These new pamphlets will be based on what we heard from the public and service providers in terms of areas where they felt they required more information. There will be pamphlets for people requiring Plain Language, information for Immigrant Women, and information for people in Same Sex Relationships. In addition we will produce pamphlets on Aboriginal Philosophies of Conflict Resolution, Conflict Resolution Strategies for Teen Girls, and Creating Non-Violent Communities.

The second part of the project will involve writing a paper entitled *Origins of Violence and Strategies for Change*. We will examine the roots of violence focusing on unequal power relations, oppressive social structures, and psychological dynamics all of which result in cultures of violence. In addition, we want to propose solutions that are grounded in a philosophical understanding of our values, ethics and what we are striving to become as individuals and communities.

All of what we produce in this project—the updated Fact Sheets, the new Pamphlets and the Research Document —will be used as groundwork for a proposed Campaign to Create Non-Violent Communities. We want to use these materials to reach out across the province to help us to produce communities that are safe for women and all people. We are grateful to the Prairie Action Foundation for giving us this opportunity to pursue this work. We look forward to sharing the results with all our mebers.

Working Together for Women who are Experiencing Mental Health, Addictions and Violence in their Lives

Tonya Verburg, from the Chatham Kent Women's Centre in Ontario, presented at the Second International Conference on Violence Against Women (CRI-VIFF) in Montréal on June 1st, 2011. The article below is an excerpt from her presentation.

According to a recent study by the Women's Mental Health and Addiction Action and Research Coalition, "85% of women with mental health or substance use problems had experienced physical, sexual or emotional abuse" (Buttery, 2003).

Verburg stated that women who use services are the reason for the service and must have a primary role in efforts to improve community coordination and integration and making services more helpful and effective. She says that collaboration is key— as service-providers, we know we are working with the same clients as other agencies, or clients with the same issues, so if we can come together with shared knowledge and resources, the outcomes will be better.

The system is often seen as a maze by clients. To a client, the mental health sector and services frame her problem as mental illness and the treatment approach is medication, coming to accept and live with one's symptoms, and accepting the diagnosis. The violence against women sector and services frame her problem as oppression and victimization through physical, emotional, sexual and financial forms of abuse. Interventions are based on a support and empowerment model where women are engaged in safety planning, choices and options, establishing independence from the abuser, and understanding the impact of the abuse. In the addictions sector there are services and self-help groups that frame her problem. They may frame her addiction as the disease of addiction, with the goal of sobriety or her addiction may be framed as a way of coping or self-medicating to deal her life situation. For a woman receiving services at a variety of agencies for all of the above problems, the system can be very confusing and difficult to navigate.

Verburg discussed the devastating impacts of violence on women and that many service providers may not recognize or understand the multiple, varied and complex impacts of violence. Symptoms may not be readily apparent or may be misunderstood when masked by seemingly unrelated behaviour. Standard approaches to mental health and substance abuse treatment and other human services may retraumatize women who have experienced violence, setting back their recovery or causing them to refuse care (Moses, D. et al 2003).

Women who are dealing with concurrent abuse, mental health and addiction issues need an approach to service delivery that integrates and coordinates services and sectors and makes the best use of limited resources. The service response needs to recognize and respond to the complexities and barriers facing vulnerable women with multiple issues.

Women who are dealing with concurrent abuse, mental health and addiction issues need an approach to service delivery that integrates and coordinates services and sectors and makes the best use of limited resources. The service response needs to recognize and respond to the complexities and barriers facing vulnerable women with multiple issues. Issues of violence and substance abuse are interconnected in complex ways. Stressors and determinants of health (e.g. legal issues, financial concerns, relationships, mental and physical health issues), as well as women's responsibilities (e.g., mothering, family duties, employment), and the availability of social and structural support are all factors affecting women's mental health, substance use and exposure to violence – and their ability to heal. In order to more adequately serve women experiencing substance use problems, woman abuse and related health and social problems that often accompany these problems – service providers, policy makers and researchers need to pull together and

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(continued from Page 1) link their work with a common goal of providing beneficial, integrated, holistic responses to women's needs. The connections provide a strong rationale for this collaborative work.

The Ontario Women Abuse Screening Project (womanabusescreening.ca) seeks to treat women's issues holistically and "make every door the right door". Now, in Chatham Kent women who come to mental health, addiction, domestic violence, or sexual assault services will complete a screening tool with a service provider. When women have completed the tool they talk about it with the provider who will use it to help the client identify and summarize priorities for action, next steps, and any immediate safety issues.

Domestic Violence Service staff can provide Mental Health-Informed and Addiction-Informed Services by: asking women about mental health and addiction issues; recognizing the signs of mental health and addiction issues; building rapport with a client so she feels comfortable disclosing regarding mental health and addiction issues; providing supports so that women with mental health or addiction issues can safely access shelter or counselling services; educating women about the connection between violence, sexual assault, abuse-related trauma, mental health, and substance use; providing information to normalize the responses to abuse and trauma; providing integrated/ intersectoral programs through collaboration with mental health and addiction services; acting as a professional support for women struggling to work through difficult circumstances related to mental health and addiction issues; and acting as a link or bridge to other community services and supports such as mental health and addiction agencies.

Distinguishing Among Types of Domestic Violence

Dr. Michael P. Johnson presented at the Second International Conference on Violence Against Women (CRI-VIFF) in Montréal on May 30th, 2011. The article below is an excerpt from his presentation.

Dr. Johnson spoke about the anti-feminist backlash, which seeks to deny the role of gender, attack feminist research, and attack programs that address violence against women. For example, in 2002, the Globe and Mail online ran the headline "Men as likely to suffer spousal abuse, Statscan says" and in 2009, the Pittsburgh Post Gazette stated that "feminist ideologues ignore research that shows domestic violence is just as often started by women as by men." So, what leads the media to develop these assumptions?

General surveys indicate that women are as violent as men, but agency studies indicate that men are the batterers. For example, the General Social Survey (GSS; 2009) showed that for "heterosexual intimate partner violence by gender", men were the perpetrators 51% of the time and women were at fault 49% of the time; while the Canadian Spousal Homicide survey (1995-2005) showed that " men were the perpetrators 82% of the time and women were guilty 18% of the time. Other general social surveys and agency surveys show similar results.

Dr. Johnson says that differentiating among types of intimate partner violence explains the contradictions. This is because there is more than one type of partner violence and one type is perpetrated mostly by men, another by both men and women. Agency studies are dominated by the male-perpetrated type, general surveys by the gender-symmetric type.

The three types are: Intimate Terrorism, which is characterized by violent coercive control; Violent Resistance, characterized by resisting the Intimate Terrorist; and Situational Couple Violence, which is situationally-provoked violence.

Intimate Terrorism is a pattern of violent coercive control. The basic pattern is the use of multiple control tactics (violent and non-violent) to attempt to take general control over one's partner. Specific control tactics vary from case to case, involving different combinations of economic control, isolation, emotional abuse, intimidation, use of children, and other control tactics. In heterosexual relationships, Intimate Terrorism is perpetrated primarily, but not exclusively, by men. Intimate Terrorism is generally rare, but common in agency settings.

Violent Resistance is when a victim responds with violence, though not necessarily in self-defence. In heterosexual relationships, most violent resistors desist and turn to other tactics to mitigate the violence or to escape the relationship.

Situational Couple Violence (SCV) is when conflicts turn into arguments that escalate. Both men and women engage in SCV, though men's violence is more likely to injure and frighten their partner. There is a huge variability in patterns and causes of SCV. In 40% of cases, there was only one violent incident, but SCV can also be chronic and violence can be severe. Variable causes of chronic SCV include substance abuse, anger issues, communication issues, etc. SCV is by far the most common type of violence.

A study done in Pittsburgh in the 1970s on gender symmetry/asymmetry by type of violence, showed that Intimate Terrorism was perpetrated 97% by men and only 3% by women, Violent Resistance was perpetrated 96% by women and only 4% by men, and SCV was perpetrated by both genders, with men at fault 56% of the time and women at fault 44% of the time. Other studies have shown that Intimate Terrorism takes place is 1/25 couples and is severe 76% of the time, with 60% of victims fearing for their lives; while SCV takes place is 1/8 couples and is severe 28% of the time, with 9% of victims fearing for their lives.

Knowledge of the different types of violence leads to implications for front-line staff during client intake sessions. Dr. Johnson recommends initially assuming the worst (i.e. that the woman is a victim of an intimate terrorist), and then assessing the woman's situation once safety has been established.

Survivors of different types of abuse need different types of interventions. Women who have survived Intimate Terrorism require long-term support, alternatives to violent resistance, empowerment to leave (or to not return to the relationship), transitional support. Clients who have experienced SCV need education and support (perhaps for both partners) surrounding sources of conflict, anger management, communication, and, perhaps, treatment for substance abuse.

In conclusion, general samples provide useful information about SCV, which is the most common type of intimate partner violence. It is gender symmetric in terms of perpetration, not in terms of impact. SCV is incredibly variable, with many different causes. Agency samples provide useful information about Intimate Terrorism and Violent Resistance. Intimate Terrorism is primarily male-perpetrated and gender inequality is central. Violent resistors are primarily female. Little is known about causes of violent resistance, other than the partner's behaviour. Dr. Johnson cautions those who work with victims of violence that different types of partner violence have different causes, different developmental trajectories, different effects, and different implications for policy and practice—failure to properly distinguish the type of violence being experienced can lead to mistakes in counselling and interventions.

About Michael P. Johnson

Dr. Michael P. Johnson is an Emeritus Professor of Sociology, Women's Studies, and African and African American Studies at Penn State University.

From the 1980s, until a few years ago, Michael Johnson volunteered at the Centre County Women's Resource Center in Pennsylvania. At first, answering phones, going out on night emergency calls, and assisting in the office. Then, he designed and facilitated support groups for partners, all male, of survivors of sexual assault (mostly childhood sexual assault). Later, he served on the Women's Resource Center Board. During four years as Chair of the Board, he achieved two goals: raising $1.5 million to expand the Center's facilities and giving the staff three years of 10% raises.

My Definition of Feminism

You're a feminist if you believe that:
(1) Men are privileged relative to women;
(2) That's not right; and
(3) You're going to do something about it, even if it's only in your personal life.

— Michael P. Johnson

Safe and Sustainable Housing
for Women and Children Leaving Domestic Violence Using a "Housing First" Approach

Brigitte Baradoy, Executive Director of Discovery House Family Violence Prevention Society in Calgary, presented at the Second International Conference on Violence Against Women (CRIVIFF) in Montréal on May 30th, 2011. The article below is an excerpt from her presentation.

The interconnectedness of domestic violence and homelessness was noticed by Discovery House, and a plan was made to create a program that would safely and permanently house women and children fleeing violence. The response was a program that is the first of its kind in Canada. Discovery and the Calgary Urban Project Society created the Community Housing program, which provides access to permanent housing for women with children who are fleeing family violence and facing homelessness.

The Community Housing program provides home-based case management that addresses the family's practical and emotional needs as well as offering financial support (rent subsidy, rent/utility arrears, groceries, transit, household start-up costs, etc.). The program guarantees the landlord that they will pay rent and damage deposits in the event that the woman is unable to.

The project works from a Housing First perspective, which says that people should be secure in housing *first,* before they can begin to work on issues such as substance abuse, mental health, or violence. It uses a rapid re-housing model of service delivery, which aims to move women into permanent housing as quickly as possible. The woman signs her own lease for her own rental in market housing, meaning she can stay as long as she chooses to. This is different than second stage or transitional housing.

Discovery House offers services to the woman for one year and ensures that a woman is living in a housing arrangement that she will be able to afford on her own once the one year program is completed. A major aspect of this program is an emphasis on client choice in service delivery. Sobriety is not a requirement to enter or stay in the program.

As of March 31st, 2011, the Community Housing program had received 390 Referrals—a 70% increase from year one to year two. The program had an intake rate of 156 families (156 women and 351 children)—a 40% overall acceptance rate. 137 families (88%) found housing through the Community Housing program and 127 (93%) of those went directly into market housing. There has been such a high demand, that the program has been unable to accept all referrals. The program only accepts women with children.

Client demographics reveal that the average age of program participants is 30; 52% are Aboriginal; 74% have less than a high school education; 85% are unemployed; 79% earn less than $1700 per month; 146 (94%) of the women came directly from domestic violence shelters; 75% had mental health concerns, 54% had substance abuse concerns, 49% had physical health issues, and 57% had two or more of these concerns.

During intake and assessment, alternative services are also offered. For example, 34 women who were referred to the program chose to go into second stage housing, as they found the level of support provided by that program more appropriate to their needs.

The Community Housing program uses a case management model. Case management includes: intense counselling for adult clients, safety planning, advocacy and assistance navigating different systems. Within the next year, additional counselling services will be provided for the children in the program.
Outcomes of the Community Housing program are health stability, increases in women voluntarily attending treatment, and housing stability. Twenty-four per cent (24%) of the participants were "re-housed" (the majority to upgraded housing, while some were re-housed due to safety concerns) and 86% retained their housing throughout their time in the program.

The Community Housing program has demonstrated that women and children who are fleeing violence can be housed safely in the community and that providing housing along with support creates much needed stability for women. This model allows women to make choices: where to live, how to live, and with whom to live.

Discovery House has learned that they can serve more clients. With a $1.2 million dollar per year budget, the Community Housing program can serve 100 families, while the Discovery House second stage shelter has a much larger budget and contains 19 apartments, where families may stay up to one year.

Baradoy explained that this model doesn't replace second stage shelters, as some women prefer the sense of community and support offered there, while others want to live independently in the community. The ideal model gives women choices. Women fleeing domestic violence are diverse, so housing options should be, as well.

PATHS is excited to announce… the launch of our **new and improved website**– Coming mid-July! www.abusehelplines.org

Mentor Recruitment

The PATHS & Regina Transition House *Modelling & Mentoring Pilot Project* is still recruiting mentors. If you, or someone you know, is a woman who has experienced intimate partner abuse, now lives a life free from violence, and is interested in spending time in a supportive relationship with a woman who has recently stayed at Regina Transition House, please contact Kim Fellner, Outreach Program Coordinator at Regina Transition House, at 757-2096 ext. 227 to get involved or to request more information.

Did You Know?

PATHS has **19** member agencies, which run **13** Emergency Shelters; **5** Second Stage Shelters; and **6** Counselling & Support Centres; in **15** communities across Saskatchewan. All together, these agencies have just under **300** staff!

Featured Member: Waskoosis Safe Shelter

by Melissa Vandale, Shelter Counsellor

Waskoosis Safe Shelter, meaning "Sky Woman", opened its doors to women and children fleeing violence in Meadow Lake in 1992. We are a non-profit shelter funded by INAC and community donations.

The shelter has 1 director, 3 fulltime and 4 casual staff members. Waskoosis has 7 rooms which can accommodate up to 21 people, this includes 1 emergency room. The shelter provides short term housing for up to 6 weeks and has emergency clothing on hand for women and children. We are available 24 hrs., 7 days a week for crisis counseling which can be accessed by telephone or walk-in.

The staff at Waskoosis Safe Shelter provide safe housing, support counseling, educational information and provide referrals to community and government agencies. In addition, the staff advocate on behalf of the women and children. We have also started to provide weekend emergency housing to Meadow Lake Tribal Council's Children and Family services children ranging from 5 to 12 years of age. Waskoosis Safe Shelter has just recently partnered with a local gym to provide our clients with gym access and access to a fitness instructor. The fitness instructor will also do shelter visits to work with our clients to provide alternatives for staying fit and leading a healthy lifestyle at home.

Counselling, Curiosity, and Unexpected Destinations:

Narrative Therapy with Women Who Have Been Victimized Through Intimate Partner Violence

Kirk Englot, a counsellor in Regina, facilitated a workshop on Narrative Therapy at the PATHS Conference, May 17-19th, 2011. The article below is an excerpt from his presentation, and is a follow up to the introduction to Narrative Therapy published in PATHS November 2010 Newsletter.

Narrative Therapy assists people in resolving problems by enabling them to separate their lives and relationships from those knowledges and stories that they judge to be impoverishing, assisting people to challenge the ways of life they find subjugating, and encouraging people to re-author their own lives according to alternative and preferred stories and identities. Narrative therapy is linked to the wider epistemology of Family Therapy and those therapies which have a common ethos of respect for the client, and an acknowledgement of the importance of context, interaction, and the social construction of meaning.

Narrative therapy suggests that people are born into stories and their social and historical contexts constantly invite them to tell and remember stories of certain events and not to tell and remember others. The creators of narrative therapy, White and Epston, created a therapy of literary merit drawing on timeless folk psychologies and oral tradition.

Narrative therapy recognizes that everyone's life contains two storylines, the dominant story line, which is informed by dominant discourses which are socially sanctioned and circulate unquestioned, and the subjugated story line – experiences, knowledges, skills, ideas and intentions that go unnoticed in the storyline of a person's experience. During therapy, the story is "re-authored" – the process of "excavating" subjugated knowledge and supporting this to be "written" into a person's "narrative".

The therapist must employ "double listening strategies", to listen and witness a client's account of experiences of problems, distress, pain, or fear while also listening to the skilful responses, resilient stances, values, and beliefs. Double listening supports the identification of "exceptions" to the problem. Narrative therapy practitioners must listen with curiosity or holding a position of not knowing. As well, practitioners of narrative therapy must recognize that "the person is not the problem, the problem is the problem", which is known as "externalizing the problem".

When responding to violence using narrative therapy, it is important to: name the effects and influences of the violence, externalize emerging problems (blame, guilt, shame), and help place these problems and the effects of violence in context through exploring an account of the politics of the person's experience.

Comments on the Newsletter? Suggestions? Want to submit an article for the next issue? Let Crystal know!
paths.services@sasktel.net

Elements of a Narrative/ Social Constructionist Stance

1. Am I asking for descriptions of more than one reality?
2. Am I listening so as to understand how this person's experiential reality has been socially constructed?
3. Whose language is being privileged here? Am I trying to accept and understand this person's linguistic descriptions? If I am offering a distinction or typification in *my* language, why am I doing that? What are the effects of the various linguistic distinctions that are coming forth in the therapeutic conversation?
4. What are the stories that support this person's problems? Are there dominant stories that are oppressing or limiting this person's life? What marginalized stories am I hearing? Are there clues to marginalized stories that have not yet been spoken? How might I invite this person to engage in an "insurrection of knowledge's" around those marginalized stories?
5. Am I focusing on meaning instead of "facts"?
6. Am I evaluating this person, or am I inviting her or him to evaluate a wide range of things (e.g., how therapy is going, preferred directions in life)?
7. Am I situating my opinions in my personal experience? Am I being transparent about my context, my values, and my intentions so that this person can evaluate the effects of my biases?
8. Am I getting caught up in pathologizing or normative thinking? Are we collaboratively defining problems based on what is problematic in this person's experience? Am I staying away from expert hypotheses or theories?

From: *Narrative Therapy: The social construction of preferred realities* (Freedman and Combs, 1996, p. 40)

The World's Most Dangerous Countries for Women

Reprinted from Reuters Online. Retrieved June 24 2011 from http://www.reuters.com/article/2011/06/15/us-women-danger-factbox-idUSTRE75E32A20110615.

Afghanistan, Congo and Pakistan are the world's most dangerous countries for women due to a barrage of threats ranging from violence and rape to dismal healthcare and "honor killings," a Thomson Reuters Foundation expert poll showed Wednesday. India and Somalia ranked fourth and fifth, respectively, in the global perceptions survey by TrustLaw (www.trust.org/trustlaw), the Foundation's legal news service.

TrustLaw asked 213 gender experts from five continents to rank countries by overall perceptions of danger as well as by six risks: health threats, sexual violence, non-sexual violence, cultural or religious factors, lack of access to resources and trafficking.

Following are key facts on each of the five countries, ranked in order of danger.

1. AFGHANISTAN
Beleaguered by insurgency, corruption and dire poverty, Afghanistan ranked as most dangerous to women overall and came out worst in three of the poll's key risk categories: health, non-sexual violence and economic discrimination.

- Women in Afghanistan have a one in 11 chance of dying in childbirth.
- Some 87% of women are illiterate.
- 70-80% of girls and women face forced marriages.

2. CONGO
Still reeling from a 1998-2003 war and accompanying humanitarian disaster that killed 5.4 million, Democratic Republic of Congo ranked second due mainly to staggering levels of sexual violence.

- About 1,150 women are raped every day, or some 420,000 a year, according to a recent report in the American Journal of Public Health.
- The Congolese Women's Campaign Against Sexual Violence puts the number of rapes at 40 women a day.
- 57 % of pregnant women are anemic.

3. PAKISTAN
Those polled cited cultural, tribal and religious practices harmful to women, including acid attacks, child and forced marriage and punishment or retribution by stoning or other physical abuse.

- More than 1,000 women and girls are victims of "honor killings" every year, according to Pakistan's Human Rights Commission.
- 90 % of women in Pakistan face domestic violence.

4. INDIA
Female feticide, child marriage and high levels of trafficking and domestic servitude make the world's largest democracy the fourth most dangerous place for women, the poll showed.

- 100 million people, mostly women and girls, are involved in trafficking in one way or another, according to former Indian Home Secretary Madhukar Gupta.
- Up to 50 million girls are "missing" over the past century due to female infanticide and feticide.
- 44.5 % of girls are married before the age of 18.

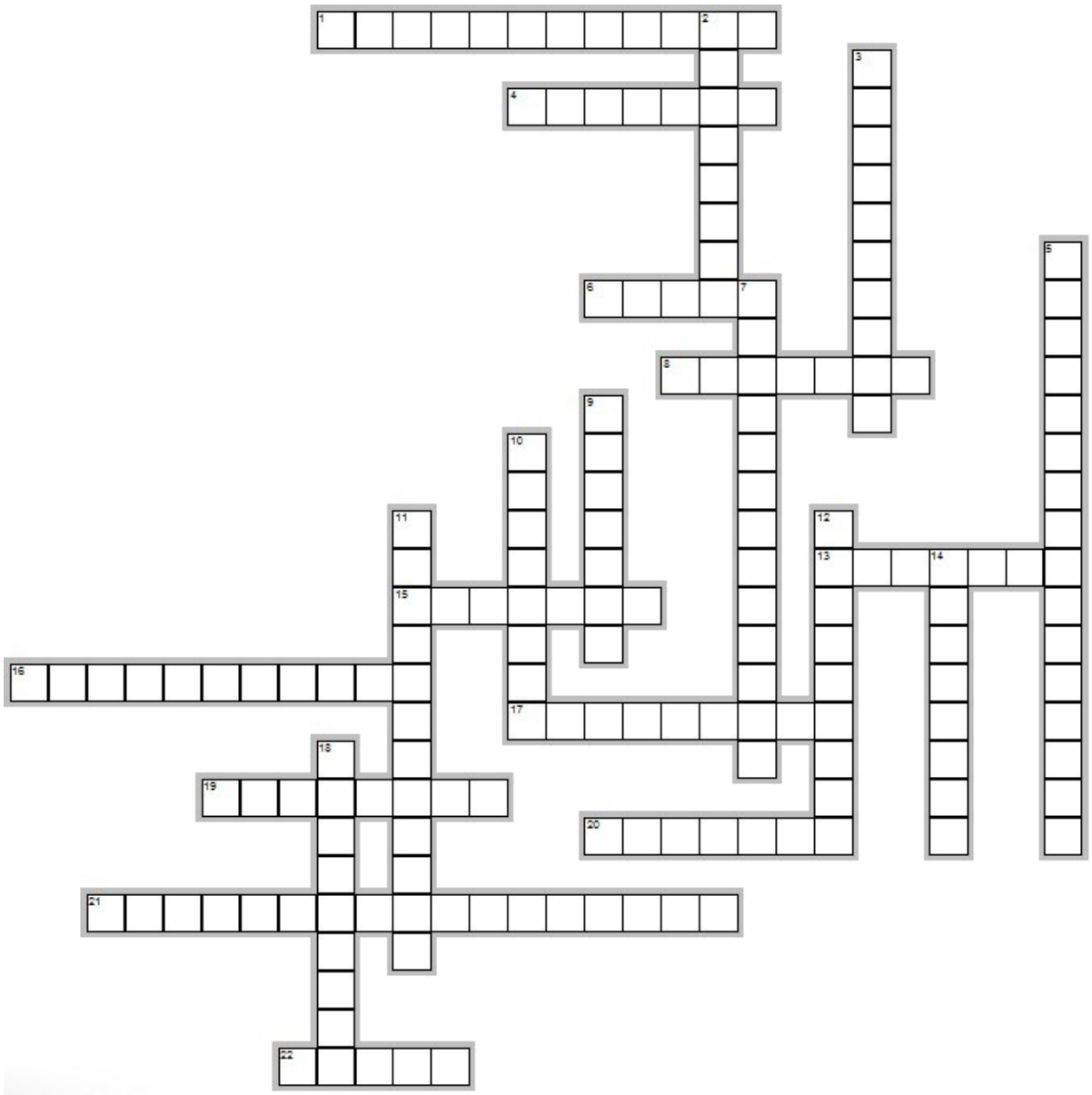
5. SOMALIA
One of the poorest, most violent and lawless countries, Somalia ranked fifth due to a catalog of dangers including high maternal mortality, rape, female genital mutilation (FGM) and child marriage.

- 95 % of women face FGM, mostly between the ages of 4 and 11.
- Only 9 % of women give birth at a health facility.
- Only 7.5 % of parliament seats are held by women.

Sources: AlertNet (www.trust.org/alertnet), U.N. agencies, IRIN News, American Journal of Public Health, World Bank, Gender Index, Human Rights Watch, International Center for Research on Women.

A woman walks past riot police outside a gathering in Kabul's stadium, 2007. Photo from Reuters Online (REUTERS/Ahmad Masood/Files)

July Interpersonal Violence Crossword



Across

1. The project featured on Page 3 uses a _____approach.
4. PATHS Member Agencies are in _____communities across Saskatchewan.
6. 85% of women with mental health or substance use problems have experienced _____.
8. The Meadow Lake Shelter has recently incorporated _____into the range of services that they provide for their clients.
13. The Responsible Choices for Women Group is aimed at assisting women who are _____in intimate relationships.
15. The Discovery House Community Housing program recognizes that women deserve _____when it comes to housing.
16. A country where 87% of women are illiterate.
17. According to Statistics Canada, this type of abuse is the most common reason for women to seek shelter.
19. Responses to women's needs should be _____.
20. PATHS new project is titled "_____of Violence and Strategies for Change".
21. When a victim responds with violence.
22. The second most dangerous country for women.

Down

2. In 2010, 593 _____offered services to abused women.
3. When both individuals involved in a domestic violence incident are arrested.
5. Requires the therapist to employ “double listening strategies".
7. _____the problem says that "the person is not the problem, the problem is the problem”.
9. For women with disabilities, the definition of domestic violence needs to be more widely _____.
10. Women with disabilities are at risk for abuse from _____abusers.
11. PATHS Member Agencies operate a total of five _____.
12. PATHS plans to produce six new _____.
14. The meaning of "Waskoosis".
18. The Canadian Spousal Homicide survey (1995-2005) showed that men were the perpetrators _____% of the time.

Abuse of Women with Disabilities Series:

Feature #1

by Allison Schmidt

Abuse of women with disabilities is a widespread problem. In Saskatchewan there are no formal measures to establish the rates of abuse of women with disabilities, however women with disabilities are abused at higher rates, on multiple occasions, by multiple abusers, and less than one third of women who have been abused seek help. Violence and abuse are widespread issues but they often go unrecognized by women with disabilities as well as service providers.

The disability community has ranked the elimination of violence against them as one of their most important priorities. Abuse against women with disabilities is a multi-faceted and complex problem which includes many types of abusive behaviours. For women with disabilities, the definition of domestic violence and abuse needs to be more widely defined, as existing definitions of abuse are far too narrow to describe the reality of women with disabilities. Women with disabilities can be subjected to abuses that women without disabilities are not—for example, disabling medical equipment, manipulating medications, or refusing to provide essential personal assistance. Abuse often occurs as a result of the type of personal contact that is required between a care provider and the individual with a disability.

Most women with disabilities are able to recognize more obvious types of abuse such as physical or sexual abuse— but the forms of subtle abuse are much harder for women with disabilities to identify. There are many reasons why women with disabilities are at increased risk for abuse. They are often dependent on others for care and support, they may have communication challenges, they often lack economic independence, and there is less risk of discovery perceived by the offender.

Over the next several months we will present a series of articles on abuse of women with disabilities. These articles will include the experiences of women with disabilities and abuse, the barriers that women with disabilities face when trying to escape from abuse, what are accessible programs and services, and what are effective prevention strategies to eliminate abuse of women with disabilities.

A Comparison of Women Who Were Mandated and Nonmandated to the "Responsible Choices for Women" Group

Leslie M. Tutty, from the University of Calgary, and Robbie Babins-Wagner, from the Calgary Counselling Centre, presented at the Second International Conference on Violence Against Women (CRI-VIFF) in Montréal on May 30th, 2011. The article below is a summary of their conference presentation and an article by the same name; by Tutty, Babins-Wagner, and Rothery; published in the Journal of Aggression, Maltreatment & Trauma, *Volume 18, 2009.*

Since 1995, the Calgary Counselling Centre has offered a group treatment program for women who behave abusively to intimate partners or children. The presentation by Tutty and Babins-Wagner described the group format, the demographic characteristics of the 293 women who attended the Responsible Choices for Women (RCW) program based on whether they were mandated to treatment or not, and discussed the treatment implications of their findings.

The presenters discussed how new criminal justice approaches to domestic violence aimed at taking these offenses more seriously, are resulting in a new population of women charged with domestic violence offenses. This has created the need to offer counselling for those mandated to treatment. RCW is a narrative-informed approach modeled after the men's program, began in 1995. RCW is unique compared to most other family violence treatment groups.

The primary goal of RCW is to assist women who are abusive in intimate relationships to become violence free. The major objectives include decreasing all forms of abusive behaviour, accepting responsibility for one's behaviour, increasing self-esteem, increasing assertive behaviour, improving family relations, decreasing stress, increasing empathy toward those who have been impacted by abusive behaviour, and assisting parents to cease physically abusing their children.

The Responsible Choices for Women groups are 30-hour groups conducted over 14 weeks. The groups typically comprise 6 to 12 women, both self- and court referred, and employ both an unstructured psychotherapeutic and a structured psychoeducational component. Covering the key themes is considered crucial; however, the facilitators have the flexibility to focus on an alternate issue should one emerge, allowing group members input into the agenda. The model adopts methods and techniques of social learning and cognitive behavioral theory, including cognitive restructuring, stress and relaxation techniques, communication skill building, and sex role socialization strategies.

The study done by Tutty, Babins-Wagner, and Rothery tested women who participated in RCW before and after. All research participants attended at least the first session of the RCW group between 1995 and 2008. The women were administered the instrument package, consisting on eleven standardized measures, in sessions 1 and 14 of the group.

Tutty and Babins-Wagner noted during their presentation that there were relatively few differences in demographic characteristics and scores on the standardized measures before participation in RCW of the women who were mandated to treatment by the courts or child welfare compared to those that were not. While the women who were mandated to treatment by the courts or child welfare self-reported using a few more physically and nonphysically abusive tactics and showed a different pattern of readiness for change, this factor did not differentiate treatment outcomes.

At the start of the program, the RCW group members reported clinically significant problems in a number of areas of their lives, including stress, depression, low self-esteem, mental health distress symptoms, and trauma. Additionally, the women reported violence being perpetrated by their partner and victimization by their partners. Four of these variables significantly improved after RCW. On average, the women self-reported less depression, clinical stress, partner physical abuse, and nonphysical abuse against their partner. Interestingly, the women's self-esteem scores worsened significantly on average.

Tutty and Babins-Wagner cautioned that many questions remain about abusive women and the programs developed to assist them. First, it can be difficult to distinguish women who behave aggressively in self-defense from those who act as the primary

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Please send your submissions for the September 2011 newsletter to Crystal (paths.services@sasktel.net) by **August 12th.**

PATHS Members

Battlefords Interval House	Regina YWCA Isabel Johnson Shelter
(306) 445-2742	(306) 525-2141
Envision Counselling and Support Centre	Saskatoon Interval House
Weyburn (306) 842-8821 Estevan 637-4004	(306) 244-0185
Hudson Bay Family and Support Centre	Saskatoon YWCA
(306) 865-3064	(306) 244-2844
Moose Jaw Transition House	Shelwin House
(306) 693-6511	(306) 783-7233
North East Outreach and Support Services	SOFIA House
(306) 752-9464	(306) 565-2537
Prince Albert Safe Shelter for Women	Southwest Crisis Services
(306) 764-7233	(306) 778-3692
Piwapan Women's Centre	Waskoosis Safe Shelter
(306) 425-3900	(306) 236-5570
Project Safe Haven	West Central Family Support Centre
(306) 782-0676	(306) 463-6655
Qu'Appelle Safe Haven Shelter	WISH Safe House
(306) 322-6881	(306) 543-0493
Regina Transition House	
(306) 757-2096	

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Status of Women Canada / Condition féminine Canada

PATHS
Provincial Association of Transition Houses and Services of Saskatchewan

Visit the PATHS website at
www.abusehelplines.org

Statistics Canada: Shelter Use in Canada

Reprinted from Statistics Canada. Retrieved June 29 2011 from http://www.statcan.gc.ca/daily-quotidien/110627/dq110627d-eng.htm

On April 15, 2010, there were 593 shelters offering services to abused women in Canada, up from 569 in 2008 when this information was last collected.

On that day, 4,645 women were residing in these shelters. More than one-third (36%) were staying at transition homes, followed by emergency shelters (21%), second-stage housing (20%) and women's emergency shelters (15%). The remaining 7% were staying in other types of shelters.

Nearly one-third (31%) of women in shelters on that day were repeat admissions, that is, it was not their first time at that facility. This compares with 25% two years earlier.

In addition, 426 women were turned away from facilities on April 15, 2010, most often because the facility had reached full capacity.
Emotional abuse (66%) and physical abuse (53%) were the most common reasons for women to seek shelter. Other reasons included the inability to find affordable housing (30%), issues related to mental health (23%) and drug and alcohol dependency (19%). On average, each woman reported five different reasons for seeking admission to a shelter.

Among those women in shelters for reasons of abuse, the majority (80%) reported that they had been abused by a current or former spouse or common-law partner.

Almost three-quarters of abused women with parental responsibilities brought their children to the shelter with them, an average of two children per woman.

About 6 in 10 abused women residing at the shelters on that day had not reported the most recent incident to police.

Responsible Choices for Women Group—continued

(continued from page 7) perpetrator in a couple. Some of the women in RCW clearly fit the former group rather than the latter. Second, most programs for women, including the current one, utilize models initially developed for men who abuse their intimate partners. One might question whether utilizing such models is the best fit for female aggressors. The authors noted that groups designed specifically for women may take women's prescribed roles and behaviours into consideration and how women's abuse of intimate partners likely differs from men's. As well, the impact of dual arrests and subsequent mandating of women to treatment needs to be monitored closely and evaluated to assess the extent to which women may be secondarily victimized by legal intervention when they were primarily defending themselves from harm.