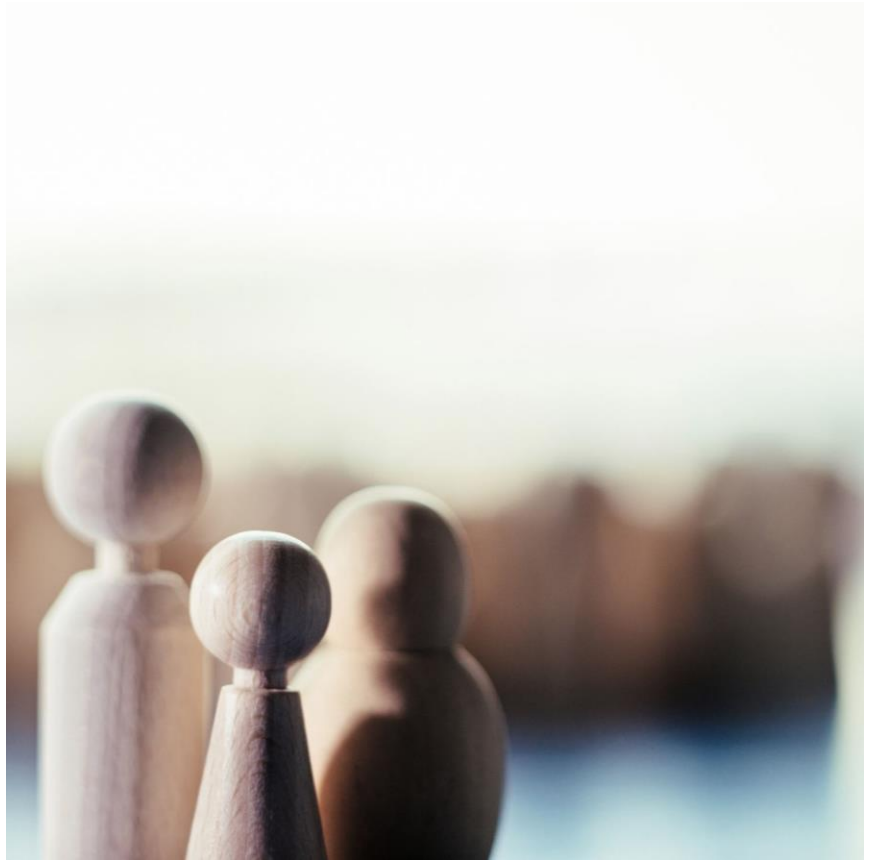
Advanced practice for engaging individuals who cause harm in their intimate relationships using Gender Based Violence



Partner Assault Response Conference

Ottawa May 2025

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CREVAWC • The Children's Aid Society of Oxford County

Learning Objectives

By the end of this workshop, you will be able to:

- Connect change theory to GBV intervention work
- Understand the Duluth Model as a GBV accountability framework.
- Use Motivational Interviewing (MI) to engage resistant or mandated clients.
- Apply CBT, ACT, and Narrative Therapy as flexible change-focused tools.
- Integrate trauma- and violence-informed practice (TVIP) across all approaches.
- Recognize how DEI, culture, and systemic harm shape interventions.

Workshop Agenda

- Change Theory in GBV Counselling
- Duluth Model – Foundations of Accountability
- Trauma- and Violence-Informed Practice (TVIP)
- Motivational Interviewing (MI)
- CBT, ACT, and Narrative Therapy
- Case Scenarios + Breakout
- Group Debrief + Takeaways
- Closing Reflection + Resources

What’s running in the background.

When we work with men who use gender-based violence we should keep somethings as our foundational platform.

Change Theory in GBV Counselling

DV work is unique:

Rooted in power, control, and entitlement

High levels of resistance, minimisation, and shame

Requires balance of accountability and compassion

Progress is relational and identity-based

Stages of change model (Transtheoretical Model)

The Stages of Change model describes how people move through different phases when changing a behavior:

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse (sometimes included)

- Key idea:
- Change is a process, not a one-time event. People move back and forth between stages

Change Theories

Stages of Change – Meet clients where they are (Precontemplation → Action)

CBT – Challenge distorted thinking and build emotional regulation

Motivational Interviewing – Work with ambivalence, not against it

Narrative Therapy – Reframe identity and separate person from behaviour

Trauma-Informed Lens – Recognize survival responses without excusing harm

Applying Theory in Practice

Blending Models Effectively:

Use MI to engage → CBT and ACT to challenge → Duluth for accountability → Narrative for identity

Match the model to the moment

Progress isn't linear — expect relapse, shutdowns, and resistance

Handling Stuck Points

Explore	Minimisation: Explore impact, not just facts
Blame	Blame: Separate feelings from behaviour
Shame	Shame: Reframe without rescuing
Tick box	Compliance: Bring it back to personal meaning
Setbacks	Treat as learning, not failure

Key Reminder

You’re not just changing behaviour. You’re helping shift identity, belief systems, and generational patterns.

Duluth Model

A Foundational Framework

What is the Duluth Model?

Developed in Duluth, Minnesota by Ellen Pense and Michael Paymar (1980s).

Positions violence as a choice used to exert power and control.

Rooted in feminist theory; not “anger management”.

Framework for accountability, not traditional therapy.

Power and Control Wheel

What patterns do you see here in your own work?

Duluth in Practice

Individual Work:

- Identify belief systems that justify harm.
- Explore personal responsibility and choice.

Group Work:

- Peer accountability through facilitated dialogue.
- Explore gender norms and power collectively.

Embedding Diversity Equity and Inclusion

Adapt	Adapt content to reflect race, class, trauma, and colonial harm.
Honour	Honour intersectional identities.
Use	Use a Trauma and Violence Informed Practice lens to promote safety without compromising accountability.

Trauma- and Violence-Informed Practice (TVIP)

TVIP shifts our approach from:

"What's wrong with them?" to "What's happened to them?"

Principles:

Cultural, emotional, and relational safety

Trust, transparency, and collaboration

Non-pathologising, strengths-based lens

Structural violence is acknowledged, not ignored

Examining 4 modalities when working with those who use GBV

Engagement:

- Motivational Interviewing

Behaviour Change:

- Cognitive Behavioural Therapy (CBT)
- Acceptance and Commitment Therapy (ACT)
- Narrative Therapy (NT)

Using MI for Engagement and CBT, ACT, and Narrative Therapy for Behavioural Change in GBV Work

- **Group vs. Individual Settings – Key Differences with Modalities**

Element	Individual Work (MI, CBT, ACT, Narrative)	Group Work (MI, CBT, ACT, Narrative)
Pacing & Depth	Allows in-depth exploration using Narrative re-authoring, CBT thought records, and ACT defusion; MI used to reduce defensiveness and explore readiness.	Uses shorter, shared reflections and group pacing; combines MI check-ins, CBT skill-building, ACT metaphors, and shared narrative exercises.
Focus	Client-specific, addressing personal triggers, relational patterns, and internalized narratives using all four modalities.	Addresses common themes like justification, entitlement, and emotional regulation through structured modality-based activities.
Modality Integration	Flexible integration tailored to session goals: e.g., MI to explore ambivalence, CBT for distorted thinking, ACT for values, Narrative for identity.	Planned integration: MI for check-in, CBT for skills, ACT for metaphor, Narrative for reflection and accountability in a structured group format.
Facilitator Role	Therapeutic guide—uses MI for engagement, Narrative for witnessing change, ACT for reflection, CBT for structured interventions.	Group leader—sets norms, prevents collusion, facilitates shared learning using scripted MI, CBT-based exercises, ACT values discussions, and group narrative practices.
Common Challenges	Resistance, shame, over-identification with victim role—requires MI for motivation, ACT for defusion, and Narrative to shift stories.	Collusion, posturing, minimization—addressed through CBT group challenges, ACT acceptance of discomfort, and Narrative group reflections.

Motivational Interviewing (MI)

A powerful approach for engagement when applied in GBV group work

Why engagement matters

Key Points:

- Most clients are mandated and enter with resistance or minimization.
- Traditional confrontation can entrench defensiveness.
- MI offers a respectful path to explore change.
- Engagement ≠ agreement — it’s about building safety and trust.
- TVIP tells us: resistance may be protection, not denial.

Motivational Interviewing

A collaborative approach to strengthen internal motivation for engagement and change.

Spirit of Motivational Interviewing

Partnership

Acceptance

Compassion

Evocation

Trauma and Violence Informed Practice Link: Creates relational safety and avoids re-traumatization

Four Core MI Processes

- Express Empathy
- Develop Discrepancy
- Roll with Resistance
- Planning – Support aligned action

Motivatinal Interviewing Core Skills

OARS

Open Questions

Affirmations

Reflections

Summaries

TVIP Add-on: Reflect not just words, but emotions and survival strategies.

MI in Individual vs. Group

- Individual:
- Slower pacing
- Deep exploration of ambivalence
- Private shame work
- Group:
- Normalise doubt and resistance
- Peer support
- Watch for posturing

Culturally & Trauma-Informed MI

Ask	Ask permission before offering tools.
Honour	Honour mistrust of systems.
Stay	Stay curious about silence or avoidance.

Motivational Interviewing (MI) for Engagement

MI is an essential starting point in GBV work to establish rapport, reduce resistance, and enhance intrinsic motivation. Practitioners use open-ended questions, reflective listening, and affirmations to draw out ambivalence and help clients identify their own reasons for change without defensiveness or shame.

In Practice:
- Individual: Explore personal costs of behaviour, identity contradictions, or moments of discrepancy (e.g., “How does that fit with the kind of father you want to be?”).
- Group: Use shared reflections or scaling questions (e.g., “On a scale from 1–10, how ready are you to change this behaviour?”) to spark discussion while avoiding confrontation.

Supporting change

Cognitive Behavioural Therapy

Acceptance and Commitment Therapy

Narrative Therapy

Why Multiple Change Models?

One model doesn’t fit all.

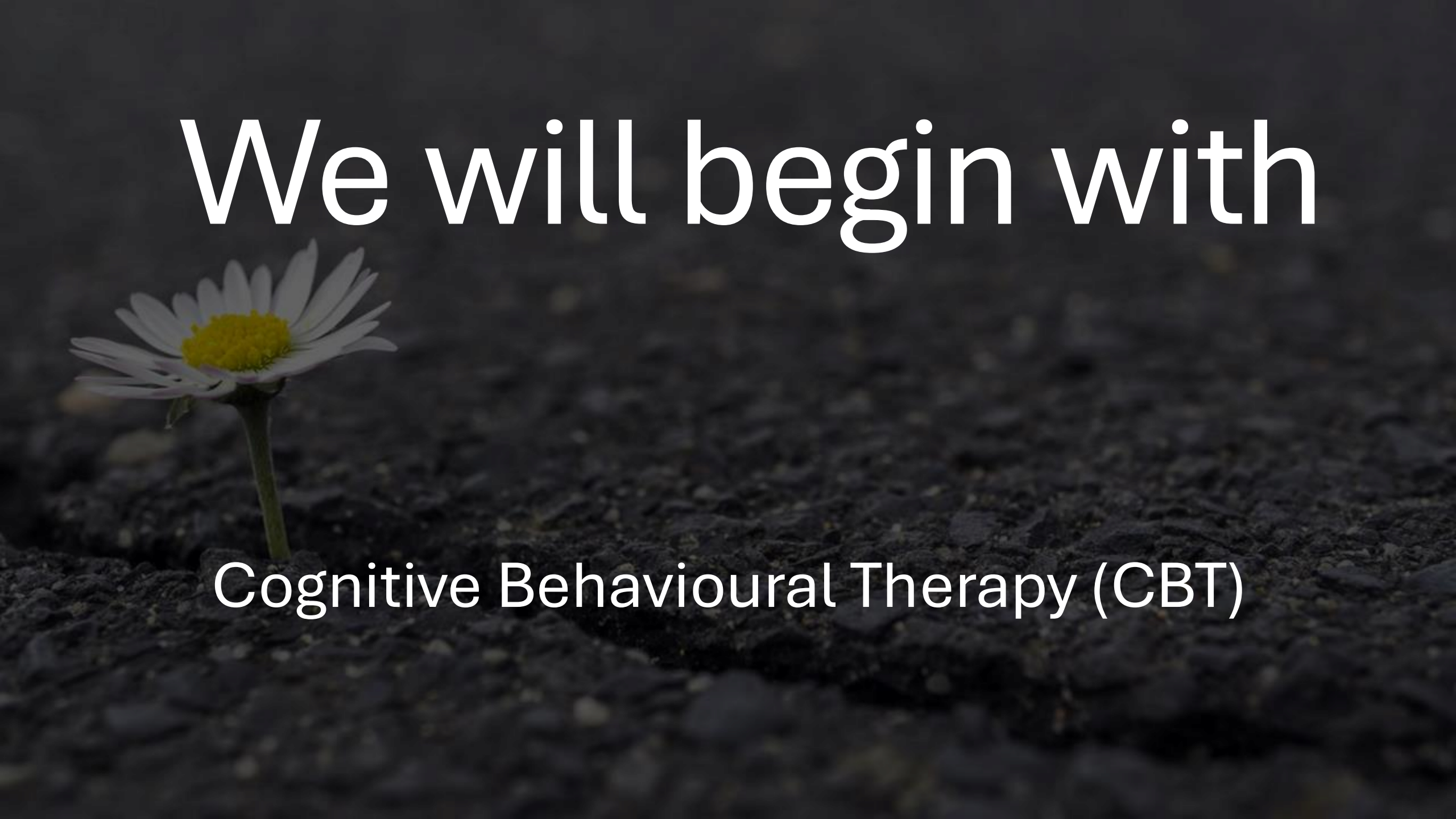
Clients bring diverse traumas, identities, and defenses.

CBT, ACT, and Narrative approaches allow tailored, safe intervention.

Common Ground Across the Approaches

- All three approaches promote personal responsibility, self-awareness, and values-based change, which are essential in GBV offender work.
- They can complement the Duluth Model, shifting from confrontation to collaboration without minimizing harm or accountability.

We will begin with



Cognitive Behavioural Therapy (CBT)

Cognitive Behavioural Therapy (CBT) for Skill-Building and Accountability

- CBT helps clients recognize distorted thinking, challenge cognitive distortions (e.g., justification, minimization, blame), and learn new emotional regulation and conflict resolution strategies.

  In Practice:
  - Individual: Thought records, ABC (Activating Event–Belief–Consequence) charts to unpack moments of anger or control.
  - Group: Role plays or structured group discussions to explore “thinking traps” and rehearse alternative responses to triggers.

CBT: Challenging Thought Patterns and Behaviors

- Focus: Identifying and restructuring distorted beliefs (e.g., entitlement, minimization, externalization of blame).
- Tools: Cognitive distortions, ABC model (Activating Event–Belief–Consequence), behavior tracking.
- In GBV work: Helps service users examine beliefs about control, jealousy, and masculinity, and how those link to abusive actions.

Key concepts include

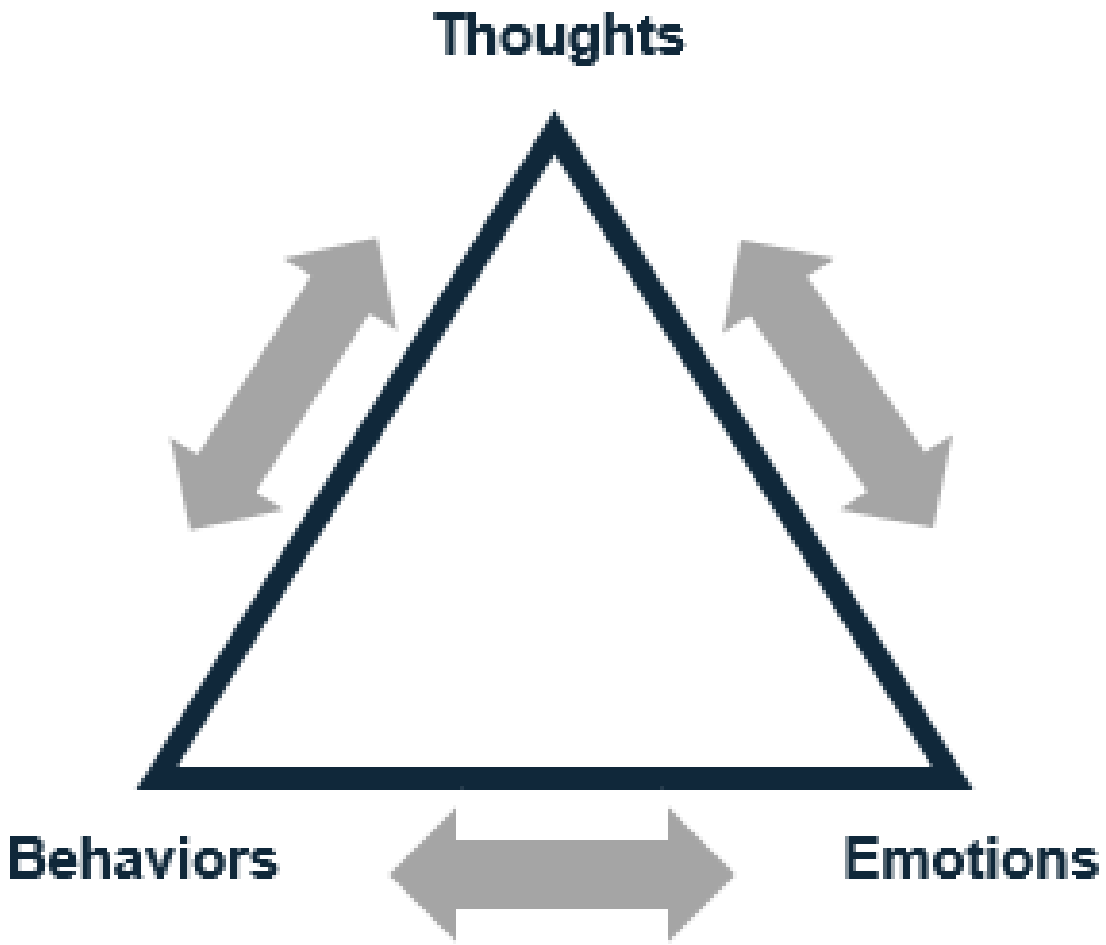
- Cognitive distortions (e.g., blaming, minimizing, justifying)
- Core beliefs and assumptions
- Skill-building for emotional regulation and problem-solving
- Behavioral change through structured practice and homework

Core Goals When Working With GBV Offenders Using CBT

Challenge	Challenge justifications and minimization of abuse.
Identify	Identify harmful beliefs about gender, power, and entitlement.
Teach	Teach emotional regulation skills (e.g., anger management).
Develop	Develop empathy and perspective-taking.
Promote	Promote accountability and recognition of harm.

Cognitive Behavioural Therapy (CBT)

- Focus: Thoughts → Feelings → Behaviours
- Disrupt distorted beliefs (“I had no choice”)
- Skill-based, structured, and practical



CBT In Practice

- Individual: Thought records, ABC (Activating Event–Belief–Consequence) charts to unpack moments of anger or control.
- Group: Role plays or structured group discussions to explore “thinking traps” and rehearse alternative responses to triggers.

Acceptance and Commitment Therapy (ACT)

Acceptance and Commitment Therapy Overview (ACT)

Focus: Accept difficult thoughts + Commit to values-aligned action

Reduce reactivity by increasing flexibility

Ideal for clients overwhelmed by shame

Acceptance and Commitment Therapy (ACT)

- Is form of behavioural therapy that helps individuals develop psychological flexibility—the ability to be present with difficult thoughts and emotions without being controlled by them, and to take meaningful action aligned with personal values.

ACT uses six core processes

1. Cognitive Defusion – creating distance from unhelpful thoughts
2. Acceptance – making space for difficult emotions
3. Contact with the Present Moment – increasing awareness of here-and-now experience
4. Self-as-Context – viewing oneself as more than one's experiences
5. Values – identifying what truly matters
6. Committed Action – taking steps guided by values, not urges or old patterns

Applying ACT to GBV Offenders

- ACT helps GBV offenders by addressing avoidance, rigidity in thinking, and habitual behaviour patterns that contribute to harm. It encourages accountability through self-awareness and value-driven change rather than shame or coercion.

Key Applications and Examples

- Cognitive Defusion
  - Example: A man may think, “She disrespected me, so I had to show her who’s in charge.”
  - ACT invites him to notice “I’m having the thought that I need to be in control” rather than acting on it. This creates space to choose a non-violent response.
- Acceptance
  - Example: Instead of avoiding feelings of shame, ACT teaches him to acknowledge and sit with uncomfortable emotions without acting them out through aggression or withdrawal.
- Values Clarification
  - Example: He might identify that being a loving, present father is important. When conflict arises, he can be guided by this value rather than reacting from anger.
- Committed Action
  - Example: Taking responsibility for past harm and choosing to act differently—even when it’s hard—because it aligns with who he wants to be.
- Self-as-Context
  - Example: ACT helps clients separate their identity from their past actions (“I’m not just a violent man—I’m a person who has done harm and wants to change”).

ACT – Individual vs. Group

Individual:

- Values clarification and self-as-context
- Mindfulness for trauma activation

Group:

- Shared values exploration
- Normalizing struggle without collapse

Narrative Therapy

Narrative Therapy with GBV Offenders

In the context of GBV, Narrative Therapy offers a way to engage men in meaningful conversations about power, control, identity, and harm—without collusion or shame-based confrontation. It allows space for reflection while still emphasizing accountability and repair.

Core Goals

- Separate the man from the abusive behavior to reduce shame and allow for change.
- Expose and question harmful narratives about gender, entitlement, and relationships.
- Explore the impact of violence on partners, children, and the self.
- Support the development of a preferred story rooted in accountability, safety, and respect.

Narrative Therapy Overview

Story shape's identity

Externalize problems (“violence” vs. “violent man”)

Re-author stories based on dignity, growth, and accountability

Narrative – Individual vs. Group

Individual:

Letters, metaphors, timelines

Honour family and cultural stories

Group:

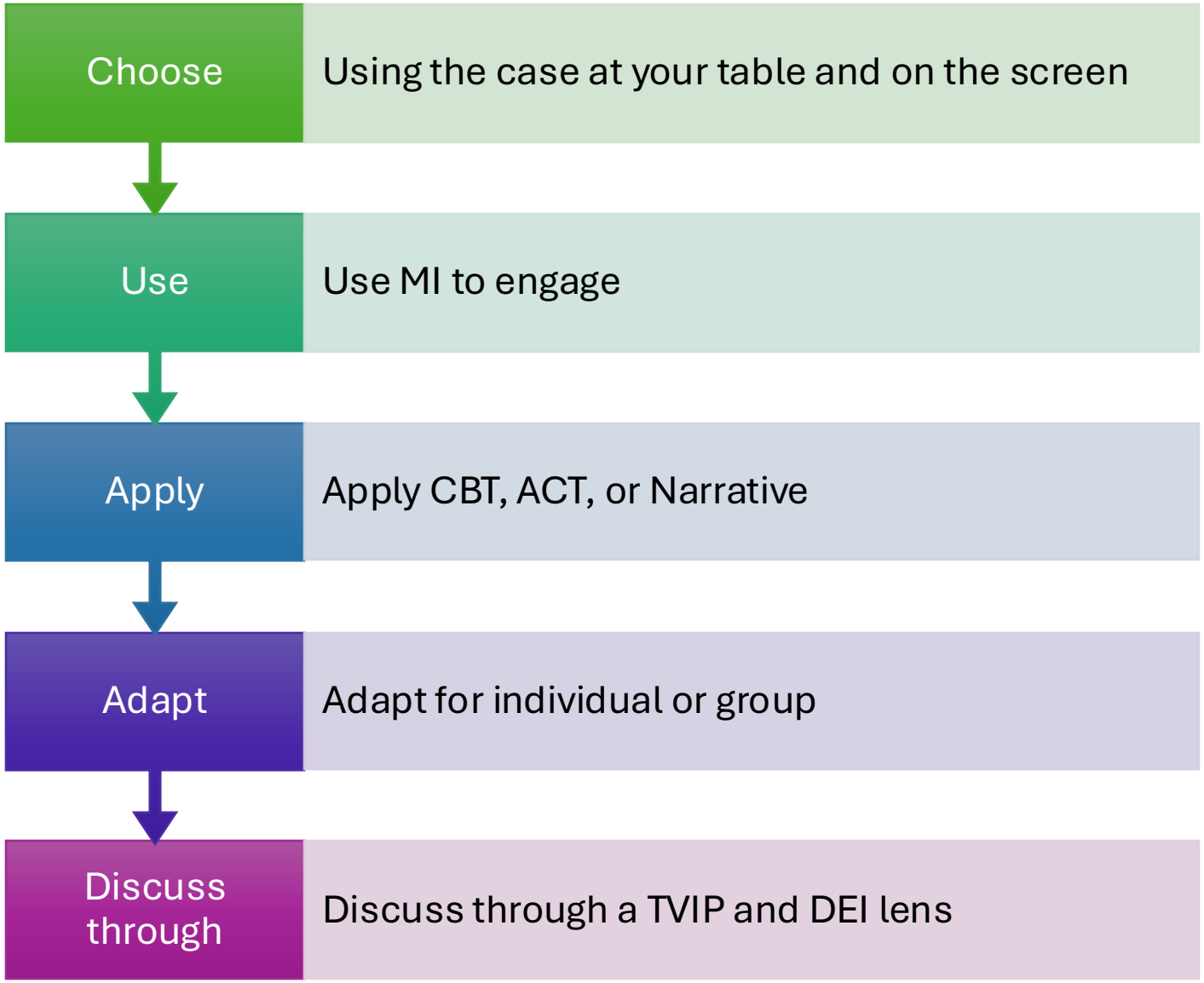
Challenge dominant masculinity

Witness each other’s re-authoring

Group vs. Individual Settings – Key Differences with Modalities

Element	Individual Work	Group Work
Pacing & Depth	Allows deeper exploration of trauma, shame, or resistance	Emphasizes peer accountability, normalization, and practice
Focus	Tailored to personal experiences, triggers, and relationships	Shared themes, collaborative learning, role plays
Modality Integration	Sequential or fluid use of models based on readiness	Structured sessions mixing modalities (e.g., MI check-in + CBT skill + ACT metaphor)
Facilitator Role	Reflective, exploratory, therapeutic	Directive, boundary-setting, facilitator of group safety
Common Challenges	Resistance, denial, over-identification with victimhood	Collusion, comparison, performative compliance

Breakout Instructions



Case Scenario 1: James
Age: 36
Referral: Court-mandated
Presentation:
James feels misunderstood and victimized by the system. He resents being forced into group counselling and presents with defensiveness, especially when his actions are described as abusive. He often speaks about stress at work, financial pressures, and feeling like no one listens to him.

Therapeutic Approach Suggestions:
•**Motivational Interviewing (MI):** Use reflective listening to explore ambivalence. Affirm his values as a father and man, and link these to change talk.
•**Narrative Therapy:** Externalize the stress (e.g., “The Pressure”) and explore how it influences his actions. Invite James to re-author a story of responsibility and respect.
•**Cognitive Behavioral Therapy (CBT):** identify and challenge cognitive distortions like entitlement or minimization. Help James connect thoughts to behaviors.
•**Acceptance and Commitment Therapy (ACT**): Introduce values clarification and help James tolerate discomfort in group work.

Group Reflection Prompts:
•How can we balance empathy and accountability with James?
•Where might we notice collusion or over-validation?
•What would a values-based intervention look like here?

Debrief Questions

How did TVIP shape your plan?

What resistance or insight emerged in your discussions?

What would you try in real life?

Integrating MI, CBT, ACT, Narrative Therapy with TVIP & DEI in GBV Intervention

Summary

Engagement and Readiness (MI & TVIP)

- Fostering trust through empathy and cultural safety
- Motivational Interviewing (MI) enhances engagement by meeting clients with empathy and collaboration. When combined with Trauma- and Violence-Informed Practice (TVIP), it acknowledges the impact of past trauma and systemic violence, creating a safe space for clients to explore change.

Cognitive Restructuring and Behavioural Change (CBT & DEI)

- Addressing harmful beliefs within a culturally responsive framework
- Cognitive Behavioural Therapy (CBT) targets distorted thinking and behaviours. Integrating Diversity, Equity, and Inclusion (DEI) principles ensures that interventions are culturally sensitive and address systemic factors contributing to GBV.

Emotional Regulation and Values Alignment (ACT & TVIP)

- Building resilience through acceptance and commitment
- Acceptance and Commitment Therapy (ACT) helps clients tolerate difficult emotions and commit to value-driven actions. TVIP complements this by recognizing the role of trauma and violence in emotional responses, promoting safety and empowerment.

Identity Reconstruction and Empowerment (Narrative Therapy & DEI)

- Rewriting personal narratives to support non-violent identities
- Narrative Therapy enables clients to separate themselves from violent identities and construct empowering life stories. Incorporating DEI ensures that these narratives are inclusive and acknowledge the client's cultural and social contexts.

Key Takeaways

- Engagement comes before insight.
- Models are flexible — people are complex.
- Accountability can be non-shaming.
- Trauma lives in the room — don’t ignore it.

Closing Reflection

TVIP encourages us to approach individuals with a dual mindset — one focused on accountability and the other on compassion. Remain engaged in your efforts, maintain a sense of curiosity, and continue to move ahead.

Questions or comments?