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Engaging Men: Optimum Transformation Conditions for Domestic Violence Offenders

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Engaging Men: Optimum Transformation Conditions for Domestic Violence Offenders

by

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Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Marital and Family Therapy.

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"I believe restorative justice is a way of returning men to society in a meaningful way. I've heard it said that one of the ways of looking at restorative justice is taking soil and turning it over to restore that soil so that something can grow."

– Deacon George Salinger

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"I suppose that since most of our hurts come through relationships so will our healing, and I know that grace rarely makes sense for those looking in from the outside."

– William P. Young, *The Shack*

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Engaging Men: Optimum Transformation Conditions For Domestic Violence Offenders

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This study explored which conditions are optimal for supporting domestic violence offenders in reducing recidivism thereby enabling long-term sustainability of healthy relationships. This study's objectives were to identify the role of current interventions in creating optimal conditions for change in domestic violence offenders, determining what motivational strategies are effective in producing meaningful engagement in treatment, identifying relational treatment methods and processes that are (are not) effective in reducing domestic violence recidivism, and what is needed programmatically to be effective in decreasing recidivism. Qualitative data from semi-structured interviews were analyzed using the methodology of grounded theory. Collection and analysis of the data included 18 interviews and a focus group of domestic violence offenders that were mandated to treatment. This study identified four necessary factors in treatment to effectively help domestic violence offenders not recidivate: First, a domestic violence program that includes the partner in treatment to strengthen relationships. Second, the inclusion of one-to-one facilitator meetings. Third, the development of personalized relational goals to focus treatment. Fourth, address the

influence of substance abuse on domestic violence. This study has useful implications for mental health professionals interested in utilizing sustaining evidence based interventions that address deeper systemic issues of domestic violence and reducing recidivism

CHAPTER 1

INTRODUCTION

Domestic violence is a serious epidemic both globally and nationally. Domestic violence program completion and recidivism rates demonstrate that current interventions are not effectively preventing the persistence of violence (Babcock, Green, & Robie, 2004; Corvo, Dutton, & Chen, 2008; Dalton, 2009; Feder & Wilson 2005; Stuart, Temple, & Moore, 2007). Attrition from domestic violence programs is as high as 62% - 75% and is a significant challenge to treatment effectiveness (Chang & Saunders, 2002; Edleson, 2008; Lee, Uken, & Sebold, 2007). Partner reports used as an outcome measure and largely found to be a more reliable estimate of violent behavior, indicate that 40% of offenders who complete treatment do not recidivate compared to 35% of offenders who remain non-violent without treatment (Babcock, Green, & Robie, 2004; Lee, Uken, & Sebold, 2007). Researchers found no significant benefit of domestic violence programs (Babcock, Green, & Robie, 2004). The current study will examine the conditions that are necessary for optimum effectiveness in the treatment of domestic violence offenders. The results of this study may provide needed information about effective treatment methods that could be used to reduce the incidence and prevalence of domestic violence.

Domestic violence is characterized as any abusive physical, emotional and/or sexual behavior that occurs between former or current partners in an intimate relationship (Roth, 1997). However, much of the research on domestic violent offenders expressly directs attention to physical violence between conjugate or cohabiting intimate partners (Sartin, Hansen, & Huss, 2006). Emotional abuse, while important however, receives less attention despite its debilitating effects (Sartin, Hansen, & Huss, 2006). In this study the

mention of domestic violence unless indicated otherwise will refer to that of physical violence directed toward an intimate partner. The World Health Organization's 2005 study on partner violence against women surveyed 24,000 women from 10 different countries and revealed that up to 71% of women in developing countries have been physically and or sexually assaulted by their partners at some time in their lives.

Scope of the Problem

Domestic violence is one of the most severe societal, psychological, and criminal problems in the United States. More than 4.8 million domestic violence incidents occur each year against current or former partners (CDC, 2009). The National Institute of Justice (2000) estimated 25% of all intimate partners become involved in domestic violence at some phase in their relationship. Yet only about half of those that enter into therapy reveal experiences of domestic violence to their therapist (Brosi & Carolan, 2006; Cascardi, Langhinrichsen, & Vivian, 1992; O'Leary, Vivian, & Malone, 1992). In 2006, 176,299 calls linked to domestic violence were received by law enforcement officials in California; 80,946 of the calls received involved weapons such as knives and guns (Crime in California, 2006). Although police reports in subsequent years in California show a slight decrease in the incidents of domestic violence and sexual assault, (Preliminary Report Crime in California, 2009), given the relatively high incidence of this kind of assault, it remains necessary need to be addressed.

Human costs in terms of physical, emotional, and psychological turmoil and damage from domestic violence can be debilitating and may even be lethal to an intimate partner. Greenfield et al. (1998) reports that nationally there are nearly 2,000 murders per

year are ascribed to an intimate assailant in the United States. The Attorney General's office reported 134 intimate partner homicides in California with 110 of the victims female and 24 male in 2006 (Crime in California, 2006). Since that time there has been a 7.3% decrease in aggravated assault and a 2.9% decrease sexual assault (Preliminary Report Crime in California, 2010). In spite of the decrease, these numbers demonstrate the danger of intimate partner violence in California and the need to improve domestic violence treatment. The FBI (2001) asserts that police records show that nearly one-third of victims in female homicides were murdered by a romantic partner.

While not all intimate partner violence ends in death, it can lead to severe injury of the partner. Many of the injury related visits to the emergency department are results of violent altercations from intimate partners (Greenfield et al., 1998; Huss, Covell, & Langhinrichsen-Rohling, 2006). The pervasiveness of domestic violence among women treated in a primary health care clinic is estimated to range between 7% and 29% (Coker, Smith, McKeown, & King, 2000). Women who experience intimate partner violence access a disproportionate portion of health care services, increased visits to mental health agencies, emergency departments, and primary care facilities in comparison to women who are not abused (Coker, Smith, McKeown, & King, 2000). Only one third of women whom are experiencing partner violence voluntarily discuss their problem when visiting their health provider and most health providers do not regularly monitor for abuse (Coker, Smith, McKeown, & King, 2000). This represents an area where an improvement in domestic violence identification must be made. Screening for battery and other forms of domestic violence is important not only for the victim of domestic violence but also

getting help in the form of treatment for the offender especially when relationships have become physically violent and can lead to a severe injury or fatality.

Battering is another form of violence and is often defined as chronic patterns of these abusive behaviors toward an intimate partner and is typically defended by recourse to culture or religion (Coker, Smith, McKeown, & King, 2000). The impact of domestic violence has social and psychological implications for the intimate partner by which he or she may experience psychological helplessness and a loss of agency and power. The following section will expand this understanding by marking out how domestic violence has been viewed and addressed within the extant literature.

Problems with Addressing Domestic Violence

Offenders who have been arrested and convicted of intimate partner violence assaults are often mandated to attend a Batterer Intervention Program to fulfill the conditions of probation, with more than 1/3 of first-time offenders required to attend (Daly et al., 2001). However, completion of this program is a significant factor in achieving successful treatment. A significant number of men (40–60%) drop out, are terminated, or never attend the batterer intervention programs regardless of the judicial order to do so (Chang & Saunders, 2002; Daly & Pelowski, 2000; Healey et al., 1998; Rosenfeld, 1992). In addition, research reveals that a significant percentage of men ordered to treatment persist in attacking their female partners (Gondolf, 1997), showing only minimal clinical improvement linked to these treatment programs when compared to interventions of the criminal justice system (Babcock et al., 2004; Dunford 2000; Eckhardt & Utschig, 2007). There is also a disparity in length of batterer intervention

programs ranging from 12 to 52 weeks (Adams, 2003). These programs also vary widely by state by state (Adams, 2003; BISCMI, 2008).

Research analysis of various domestic violence treatment programs' effectiveness showed recidivism of battering ranging from 20% to 50% a year following the program completion (e.g., Edleson, 1996; Feder & Wilson 2005; Rosenfeld, 1992; Tolman & Edleson, 1995). Even the Duluth Model which serves as the foundation for the Duluth Domestic Abuse Intervention Program, a duration of 52 weeks and standard model for most batterer interventions programs, has a recidivism rate of 40% (Shepard, 1992; Lee, Uken, & Sebold, 2007).

Standard domestic violence treatment models have not been shown to be more effective than incarceration. A meta-analysis study conducted by Feder and Wilson (2005) using 10 rigorous controlled studies of randomized participants found recidivism decreased only 7% beyond interventions of probation and community service used by the criminal justice system. However, no benefit of batter treatment programs was found when partner outcome measure reports were included (Feder & Wilson 2005; Stuart, Temple, & Moore, 2007). These reports often reflect a more accurate estimate of domestic violence occurrences than police reports (Stuart, Temple, & Moore, 2007). In another meta-analysis study of batterer treatment programs conducted by Babcock et al. (2004) it was found that there was only a 5% decrease in the likelihood that a woman would be re-assaulted by the offender who was previously arrested, charged and mandated to attend a batterers program than the offender who was only arrested and charged but not ordered in to treatment.

Clearly domestic violence is a significant problem and health hazard for individuals, couples, families, and communities. A lack of effective treatment fails to equip offenders to successfully practice non-violence and to adopt a stance of nonviolence in the family, intimate relationships and community. These outcomes do not bode well for many batterer intervention programs and reflect a need for evaluation of treatment protocols that may serve to improve program completion and decrease recidivism. This study seeks to provide needed information that may be useful in the development of effective interventions for domestic violence treatment programs.

Some work in this regard has already been done. A study by Lee, Uken, and Sebold (2007) investigated the components that may be important to increase program completion and decreasing recidivism of domestic violence. Using data from 88 court-ordered offenders who attended the solution-focused goal directed treatment program, they report that, a) well-defined self-determined goals, b) enhanced client commitment to goals, c) therapist agreement with goals, and d) increased program completion, negatively predicted recidivism. In this study their program accounted for 58% of variance explained and an overall recidivism rate of 10.2% (Lee, Uken, & Sebold, 2007). Change occurs in the context of motivation that is personalized to the individual. Lee, Uken, and Sebold (2007) posit that for lasting change to occur in human behavior towards adopting a stance of non-violence, it is necessary to create a context for change. This framework helps individuals recognize, become aware of, revisit and re-embrace their inner strengths and resources and link them to their goals. Change is influenced by doable, observable, behavioral, and relationship-based goals that are open to feedback that identifies, boosts,

and consolidates behavioral change according to those goals (Lee, Uken, & Sebold, 2007).

This approach to domestic violence treatment represents a shift from traditional assumptions and strategies of punishment to include rehabilitation/safety evidenced based methods that achieve behavioral transformation. Domestic violence offenders are expected to take ownership for the solutions instead of focused responsibility on the problems (Lee, Uken, & Sebold, 2007).

The next section will address the research questions this study seeks to answer. Many batters programs have been launched to address the problem of domestic violence. Of these programs the Duluth model is one of the most common. Historical assumptions and strategies have had a strong influence in the societal approach, development of treatment programs for batterers, and shaping laws and policy regarding domestic violence.

Research Questions

The questions this research study seeks to answer are as follows:

1. What interventions are most helpful/ not helpful in producing behavioral change in domestic violence offenders?
2. What motivational strategies are effective/ not effective in producing meaningful engagement in treatment?
3. What relational goals would be effective /not effective in reducing domestic violence recidivism?

4. What is needed in a domestic violence treatment program to be effective in reducing the likelihood of recidivism?

Historical Assumptions and Strategies

Historically domestic violence was assumed to be a private matter within the family that did not necessarily require the intervention criminal justice system (Fagan, 1995). In spite of an emerging range of community services available, this perception has not been adequately addressed (Kelly, 2003). Entrenched and idealized assumptions about privacy that perpetuate domestic violence have very often not been challenged (Kelly, 2003). Domestic violence is often addressed through batter intervention programs, law enforcement, or the criminal justice system.

Public action to address domestic violence and provide batter intervention treatment began in early 1970's in the form of psycho-education and therapy groups for men who were physically and emotionally abusive to their female partners (Catlett, Toews, & Walilko, 2010). It was the goal of these groups to use methods and interventions from behavioral and cognitive modalities that reinforced an anti-misogynistic view (Catlett, Toews, & Walilko, 2010). As the public response progressed, in the middle of the 1980s batterer groups turned to clinical psychologists and social workers to learn techniques in brief therapies and to further develop clinical skills to address this social problem that did not seem adequately addressed by law enforcement (Gondolf, 1997). In addition this also gave emergence to a political preference for feminist based treatment approaches such as the Duluth Model. The impact of this

emergence on enacting comprehensive legislation informing domestic violence treatment will be address later.

Previously, law enforcement was often not inclined to intercede through apprehension of the offender, but often gave the couple a stern talking to; then proceed to ask one of the partners to vacate the premises for a certain time period (Maxwell, Garner, & Fagan, 2001). However, the Minneapolis Domestic violence Experiment demonstrated that making an arrest was the most effective police response (Buzawa & Buzawa, 1990; Buzawa & Buzawa, 2005; Sherman & Berk, 1984).

Mandatory or pro-apprehension laws that either encourage or mandated or arrest of men who are the focus of reports to law enforcement regarding intimate partner violence, grew considerably during the 80's, which also created a need for more improved and expand batterer intervention programs (e.g., Ganley 1987; Gondolf 1991). These batterer intervention programs also gained more traction especially with signing of Violence Against Women Act, 1994, which sought to enhance the actions of the justice system response to domestic violence offenders and victims of the abuse, provide group batterer intervention programs that reduce recidivism of violence, and help them choose non-violent ways of relating to their female partners (Catlett, Toews, & Walilko, 2010).

The feminist view point of intimate partner violence especially against women that emerged in the 70's saw this type of violence as being issues of power and control, grounded in patriarchal customs of masculine rule in mixed gendered relationships (Johnson & Leone, 2005; Straus, Gelles, & Steinmetz, 1980; Walker, 1979). This feminist movement's perspective of intimate partner violence has had a significant role in advising social and legal policy as along with becoming quite influential within the

education system (Carlson & Jones, 2010). This perspective has been effective in shaping clinical treatment, giving way to the pervasive acceptance of batterer treatment programs such as the prominently used Duluth Model that are grounded in feminist principles. Such programs attempt to re-socialize men in alternatives to authoritarian control and power over women (Carlson & Jones, 2010; Young, Cook, Smith, Turteltaub, & Hazelwood, 2007).

Many domestic violence programs were held as the effective response to treat domestic violence offenders however, meta-analysis and research evaluations (e.g. Babcock et al., 2004; Dunford 2000; Eckhardt & Utschig, 2007; Edleson, 1996; Feder & Wilson 2005; Rosenfeld, 1992; Tolman & Edleson, 1995) have found few programs that produced consistent and effective evidence based results. Most programs showed no difference or minimal outcome on reducing domestic violence recidivism among offenders (Catlett, Toews, & Walilko, 2010).

Empirical evidence has shown that the majority of domestic violence offenders are not being effectively reformed through batter intervention programs as they are presently designed (Babcock et al., 2004; Dunford 2000; Eckhardt & Utschig, 2007; Hanna, 1998). Instead the criminal justice system's reliance on batterer intervention programs is politically and not scientifically driven. This is often reflective of a discussion among scholars and clinicians as to the response why abuse is perpetrated by men against women and how best legally to address it (Hanna, 1998).

At the criminal justice level, most sentencing uses batterer treatment as a stipulation of probation (Hanna, 1998) in regards to offenders convicted of domestic violence. However, given the weak outcomes of most domestic violence programs others

have suggested that efficacy of treatment has been overstated and imprisonment and punishment have not been given enough consideration (Hanna, 1998). Hence a call for a clearer coordination of law enforcement and stiffer criminal justice sentencing to adequately decrease intimate partner violence (Catlett, Toews, & Walilko, 2010; Hanna, 1998; Weisz, 2001).

The criminal justice system has sought to reduce the epidemic of domestic violence and has used multiple methods to reduce recidivism including stiffer sentencing. The severity of punishment (i.e. the length of sentence and incarceration) by the criminal justice system amongst general offenders has been shown to have no significant association to domestic violence recidivism (Davis et al., 1998; Gendreau et al., 1999; Hanson & Wallace-Capretta, 2004). In a study by Thistlewaite et al. (1998) there is an exception in which severity of sentencing resulted in a decrease in recidivism. Tolman et al. (1996) revealed that offenders' expectations of future punishment with known consequences had no affect on their persistent domestic violence abuse recidivism towards their partner. It is suggested that some men may not re-engage in actions of domestic violence for fear that a court mandated consequence (e.g. prison) may result in the social consequence of their partner leaving them (Hanson & Wallace-Capretta, 2004).

As previously in the beginning stated there has been a 7.3% decrease in aggravated assault and a 2.9% decrease sexual assault (Preliminary Report Crime in California, 2010). Despite these efforts by the courts and the recent decline in domestic violence incidents there is still a high prevalence of domestic violence incidents which is evidenced by substantial number of reports and arrests in the State of California (Armstrong, 2006; Preliminary Report Crime in California, 2010). While this decrease

may be in part due to an elevated awareness regarding domestic violence, the bottom line is that research indicates that the current methods used by the criminal justice system to reduce domestic violence are not as effective as commonly promulgated.

In his early studies Foucault (1977) suggests that mere punishment is not an effective method of producing change and rehabilitation and upon release the offenders are likely to re-offend. McLaren (2002) in her analysis of Foucault writings, she purports that if an offender is viewed as capable of reform, the application of punishment should focus on rehabilitation, on altering the actions and attitude of the offender, instead of reprisal.

Foucault (1977) purports in *Discipline and Punish*, that modification in delivery of punishment, for example, the move from capital punishment to imprisonment, does not automatically signify that outside power now does not affect the individual. Power is merely enforced in a different manner (McLaren, 2002). Foucault (1977) suggests that outside forces or power can have a profound effect on the soul of the individual. These outside forces such as the criminal justice system, family history, and the dominant discourse of society that sets expectations of what it means to be a successful man or woman have an impact on an individual's behaviors and attitudes.

Law enforcement and activist groups have sought to implement effective laws and programs to address the problem of partner abuse. However, some of the laws and domestic violence programs that have been enacted have not produced outcomes that support effectiveness of treatment or decreasing recidivism of domestic violence (Buzawa & Buzawa, 2005; Johnson, Luna, & Stein, 2003).

As previously mentioned the Minneapolis Domestic Violence Experiment was a catalyst for much of the approaches that are used today in policy making, law enforcement protocols, and criminal justice sentencing. The study reported recidivism of domestic violence incidences had decreased by half in the following six months against the partner of the offender and presented better outcomes than counseling (Sherman & Berk, 1984). The research study of Sherman and Berk (1984) had a significant impact on the shifting strategies and policies of law enforcement in handling domestic violence. Several law enforcement agencies as well as states adopted policies that mandated arrest without a warrant for domestic violence incidents if the law enforcement official responding to the call determined that a crime had transpired (Johnson, Luna, & Stein, 2003). Nevertheless, the study faced criticism in regards to its methodology, lack of significant results, and conclusions that repeatedly could not be reproduced (Buzawa & Buzawa, 1990; Johnson, Luna, & Stein, 2003).

The majority of states mandate participation in a batter treatment program for men who have been arrested for intimate partner violence against their significant other as a prerequisite of probation (Daly et al., 2001; Stuart, Temple, & Moore, 2007). In these programs they are trained how to handle anger, communicate more effectively, resolve relational issues, and educated on the exploitation of control and dominance over their significant others (Stuart, Temple, & Moore, 2007).

Nevertheless these programs have yielded outcomes that do not effectively decreases in recidivism (Stuart, Temple, & Moore, 2007). There are many research studies with varying methodologies that have arrived at similar conclusions; that is, batter treatment programs have not shown significant clinical effectiveness at reducing

domestic violence recidivism especially when compared to batterers who were arrested but not referred to a treatment program (Feder & Wilson 2005; Stuart, Temple, & Moore, 2007).

Despite these evaluation outcomes, the standard that domestic violence intervention model used to treat partner violence offenders in the United States has not undergone rigorous vetting like other therapeutic behavior programs (Corvo, Dutton, & Chen, 2008). Instead, the content of the model and interventions are formed and guided by predetermined standards created and distributed by state level or government certifying agencies which determine approved interventions that are to be used by local programs (Corvo, Dutton, & Chen, 2009; Feder & Wilson, 2005; National Institute of Justice, 2003; 1998). Stith, Rosen, McCollum and Thomsen (2004) underline this point suggesting that state standards often block or discourage funding alternative domestic violence treatment programs that include couples. This makes it difficult for programs that offer treatment alternatives to gain credibility despite the evidence. The feminist position has been a powerful force in guiding legislation that approves batterer treatment programs. This driving influence is connected to the fact that program standards and state sanctioned certifications are informed by the feminist based Duluth Model which is concerned with the rehabilitation of domestic violence offenders focuses on feminist based address of power and control as a framework for psycho-educational instruction of the cycle of violence, giving tools to men to better manage anger and conflict and also taking responsibility of their actions of violence (Dutton & Corvo, 2006). These batterers programs are usually made up of men only, and provide cognitive behavioral therapy or psychoeducational group treatment that ranges from 6 to 52 weeks. Consistent with the

tradition described above, the programming is often focused on emphasizing emotional regulation, accountability, power and control (Corvo & Johnson, 2003; Edleson, 1996; Eisikovits & Edleson, 1989; Feder & Wilson, 2005).

The lack of rigorous empirical accountability in designing domestic violence treatment programs sets a low bar for intervention outcomes. In addition, Corvo and Johnson (2003) suggest that trainers are not motivated to implement new evidence-based practices given that state certifying agencies' interventions are strictly predetermined. State policy protects state certified batters programs from scrutiny and disincentivizes conformity to empirically verified outcomes and safety measures that challenge certified models. Corvo, Dutton, and Chen, (2008) reveal an example of this in the New York Office for Prevention of Domestic Violence where all forms of family therapy, mediation and conjoint counseling is prohibited in cases of domestic violence even when the victim requests it.

The office's rationale is that it is unfair, unsafe, and ineffective (Corvo & Johnson, 2003) despite research pointing to safe, effective conjoint, and family methods that were more effectual than traditional intervention programs (Stith, Rosen, McCollum, & Thomsen, 2004). Here again, this is largely due to the fact that policy decisions and structure are linked to the feminist based Duluth Model that seeks punishment rather than striking a balance with rehabilitation of offenders (Dutton & Corvo, 2006). It is informative to note that an evaluation study of participants that completed the Duluth based domestic violence program revealed that after five years the intervention ceased to have an effect on recidivism (Shepard, 1990). Clearly, state laws could be updated based on the best current empirical information that is available.

In another study of thirteen domestic violence programs from five different regions, findings revealed that some state standards like those in Iowa mandate that the curriculum of the Duluth model be used in all batterer interventions related to treatment. In fact, in Des Moines batterer intervention program services are administered through a single approach, the Duluth model.(Babcock, Green, & Robie, 2004). Unlike Iowa, the states of Florida, Colorado and Washington permit providers to put into practice various treatment methods, providing they hold to particular protocols associated with frequency of victim contacts, client assessment and intake, and extent of participation in treatment (Babcock, Green, & Robie, 2004; Healey, Smith, & O'Sullivan, 1998). These states allow domestic violence programs that differ in theoretical views and size the flexibility to provide services that best fit their diverse population of clients (i.e. recent immigrants, Native Americans Asians, gays and lesbians veterans, Latinos) in cities like Denver and Seattle (Babcock, Green, & Robie, 2004; Healey, Smith, & O'Sullivan, 1998).

Presently there has been a tendency for the range of domestic violence treatment guidelines to become more encompassing and detailed in determining the principles, mandate a theoretical approach, and to require adoption of a recognized treatment curriculum such as the Duluth model (Maiuro & Eberle, 2008; Murphy, 2001). This tendency has caused disagreement among those in the field regarding whether such requirements are untimely and devoid of valid empirical evidence (Maiuro & Eberle, 2008).

While research has established that current approaches produce less than desired outcomes of recidivism and program dropouts, State-mandated domestic violence programs have not focused on evidence based research that targets amenability to

treatment methods that enhance outcomes. Most practitioners would agree, based on current evidence, that there is no one single method that solves the problems associated with domestic violence. They acknowledge that more research is warranted to improve interventions of domestic violence programs (Maiuro & Eberle, 2008). In light of this, one might question whether the dominant model for partner violence treatment is adequately developed to justify detailed dictates concerning chosen method of treatment at the exclusion of other more promising methods (Maiuro & Eberle, 2008). While practitioners are comfortable with the advantages that the group modality provides it should not overlook the integration of evidenced based approaches of individual therapy and conditions-based couple therapy in addressing change in the family system (Maiuro & Eberle, 2008). Evidence based practices as demonstrated by the Plumas project that uses specific well defined partner relational goals to orient participants' actions to non-violence utilizing the power of the self-determined, goal facilitator and the group have shown to be effective in treating intimate partner violence. Taft et al. (2001) focuses on increasing motivation to encourage participant interaction and buy-in such as tracking attendance, positive encouragement, client reflection, feedback, in connection to their goals of reform. Flexibility is needed in developing programming that allows for the ability to integrate evidence-based practices to meet not just the needs of clients (Maiuro & Eberle, 2008) but effectively treat the family system factors that contribute to domestic violence.

In this regard, domestic violence programs need to be guided by evidence based methods that increase program completion and reduce recidivism. Earlier, Healy, Smith, and Sullivan (1998) postulate that poor partner violence treatment outcomes reveal

greater need for evaluations to examine the effect of systemic factors such as arrest and guidelines of prosecution, court procedures, and monitoring of parolees on intervention effectiveness, in addition to elucidation of the goals of Duluth-based programming. They further suggest that if prevention and recidivism are not meaningfully addressed such as including evidence based intervention outcomes, goals that promote behavioral change, and engaging joint cooperation of community and municipal partnerships, domestic violence programs will continue to employ mediocre methods of addressing partner violence that do not effectively protect the victim or reform the batter. The outcomes in the literature suggest that domestic violence programs have already reached this point.

There are definite questions to be asked about why these programs are continued to be mandated as a condition of parole given these treatment outcomes instead of evidence based programs that produced significant outcomes. However, this is not the only problem with which states must grapple. Most batterers programs are under-funded, under-resourced and are usually staffed by individuals who have basic clinical skills but do not have advanced educational training (Holtzworth-Munroe 2001; Stuart, 2005). Mental health problems and substance abuse problems have been found to be contributing factors to inter-partner violence therefore it is necessary that staff be adequately trained to work with clients who suffer such problems (Holtzworth-Munroe 2001; Stuart, 2005). Furthermore Stuart, Temple, & Moore (2007) argue that that batterer programs should customize treatment to address vital areas of need clients may have, such as, mental health problems and/or substance abuse.

In this regard, Stuart, Temple, and Moore (2007) make the point that for treatment to be effective it is important to consider the context of the client that affects his/her

motivation and to recognize that there is no one size fits all approach. For example, a client with a significant substance abuse problem along with diagnosed psychopathology may necessitate a different treatment plan than a first time offender who has no co-morbidity but was convicted of low-level situational partner-violence.

A contextual tailored approach in working with domestic violence offenders not only addresses their needs but helps provide a pathway to engage and motivate them in treatment. This is particularly important when program completion is tied to the identification of client level of motivation through use of the transtheoretical model of behavior change (Brogan, Prochaska, & Prochaska, 1999, Murphy & Baxeter 1997; Prochaska & Diclemente, 1983) and specific personal goal, hopes and dreams (Lee, Uken, & Sebold, 2007). Such an approach promotes a supportive therapeutic relationship with offenders that will diminish defensiveness and enhance willingness to engage in behavioral reform over other methods that are more confrontational (Stuart, Temple, & Moore, 2007).

Many of the batterer treatment programs developed according to Stuart, Temple, and Moore, (2007) suggests a great need and demand for domestic violence treatment programs expressed by activist groups and local municipalities. However, there has been a rapid growth and implementation of these programs before they were thoroughly evaluated for their effectiveness (Stuart, Temple, & Moore, 2007). One of these programs that have rapidly expanded is the Duluth Model.

Ascendancy of the Duluth Model

The feminist-based Domestic Abuse Intervention Project out of Duluth, Minnesota commonly known as the Duluth Model was developed in the 1980's after particularly atrocious domestic violence related murder and set out to address the problem of domestic violence (Pence & Paymar, 1993). The Duluth model accentuates the significance of a well orchestrated community response (i.e. the criminal justice system, human service providers, law enforcement agencies) to partner violence and sets battering within an more expansive contextual array of controlling behaviors depicted in by the well known Power and Control Wheel diagram (Pence & Paymar, 2002).

The diagram illustrates how partner violence is tied to patriarchal power and control through different methods such as: threats, intimidation, emotional and economic abuse, isolation, children, denial, male privilege, blaming, and minimization of partner (Pence & Paymar, 2002; Haley, Smith, & Sullivan, 1998). The Duluth model holds that the batterer retains control of his partner through regular forceful behaviors, isolation and intimidation, and interposed by intermittent violent behaviors (Dutton & Corvo, 2007; Gondolf, 2007; Pence & Paymar, 2002).

The model's objective is to specifically address men's misguided notions of women and the masculine belief that they have the right to dictate what their partner does and where they go (Pence & Paymar, 2002; Stuart, Temple, & Moore, 2007). The clinical didactics are intended to encourage men to closely study their patriarchal attitudes and chauvinist views and about how they act in relationships (Gondolf, 2007; Stuart, Temple, & Moore, 2007). In treatment men are requested to seriously look at the diverse tactics they employ to control their intimate partners as well as how the community might

approve of such actions and how to create and develop a plan to stop violent behavior (Gondolf, 2007; Stuart, Temple, & Moore, 2007).

The Duluth model has had a key role in guiding not only social and legal policy but also clinical interventions. In fact it has been commonly attributed as the standard blueprint for batterer treatment programs within the country (Van Wormer & Bednar, 2002). States often adhere to the standards set by the Duluth Model when granting certification to batterer treatment program providers. Although the model receives persistent recognition and is nationally used as the model approach to treating partner violence, research and evaluation of Duluth Model based programs have not produced significant results.

Critique on Duluth Model Transition to Other Studies

Traditional, Duluth Model and feminist-based batterer programs play an important in furthering treatment for partner violence offenders. Nevertheless, research and evaluation studies have given pause and more scrutiny to the efficacy of these batterer programs from a clinical and outcome point of view (Lee, Uken, & Sebold, 2007). Current evaluations of domestic violence treatment programs typically use an input-output methodology to determine levels of program effectiveness (Gondolf, 1997). These evaluations focus on change in level of violent activity of offenders from the beginning to end of treatment (Tolman & Bennett, 1990). Although this methodology is practical, basic, and convenient, it does not take into account other contributing variables or dynamics integral to discerning program effectiveness (Lee, Uken, & Sebold, 2007).

Various limitations of the input-output methodology is that it does not assess for key factors within treatment protocols that potentially affect desired outcomes (Babcock, Green, & Robie, 2004; Fagan, 1989; Valliant, 1982) such as motivation, techniques for enhancing relational dynamics, and substance abuse. The literature suggests these are necessary components in domestic violence treatments to effectively increase program completion and decrease recidivism (Babcock, Green, & Robie, 2004). Current programs need to improve by implementing these components rather than maintaining status quo because the results indicate a lack of clear benefit between batterers who received treatment versus none at all.

Meta-analysis studies of the Duluth model program reveal an effectiveness outcome that shows 40% of offenders who go through treatment do not recidivate in comparison to 35% of offenders who remain non-violent without treatment (Babcock, Green, & Robie, 2004).

To better understand the significance of effect size of domestic violence treatments, it is important to compare it to treatment outcome effect sizes of other clinical studies (Babcock, Green, & Robie, 2004). Davis and Taylor (1999) juxtapose the Duluth model treatment outcome effect size of 0.41 to a pharmacological study with an effect size of 0.068 in an initial clinical trial on the ramification of aspirin on heart attacks. This effect size shows a 4% decrease in risk of having a heart attack (Rosnow & Rosenthal, 1988). Davis and Taylor (1999) concluded that the batterer treatment outcomes are quite significant when compared to the effect sizes of the heart attack study. In contrast, the batterer treatment effect size was not as significant when compared to the average effect size of 0.85 in evaluation studies of psychotherapy. Psychotherapy also received a 70%

reported therapeutic benefit in assessed cases (Rosenthal, 1995; Smith, Glass, & Miller, 1980). In comparing the effectiveness of batterer treatment therapy to psychotherapy, there is considerable need for improvements to batterer treatment intervention methods (Babcock, Green, & Robie, 2004).

Babcock, Green, and Robie, (2004) suggest that this juxtaposition of batterer treatment programs with the outcomes of psychotherapy may not be entirely equitable because psychotherapy addresses internal problems (i.e. anxiety, depression) instead of externalized problems (i.e. violence, aggression). However, the choice to respond with aggression is linked to patients' internal beliefs about relationships, their mental state of being (i.e. low self-esteem, depression, anxiety) and batterer typology (Chang & Saunders, 2002; Holtzworth-Munroe & Meehan, 2004; Holtzworth-Munroe & Stuart, 1994; Stoops, Bennett, & Vincent, 2010). In addition, therapists often address those internal issues of anger or aggression which are most likely externalized towards others (i.e. family, spouse, co-workers). Studies can therefore make legitimate comparisons between effect sizes from psychotherapy and current batterer treatment models. Although comparing various treatment methods indicate need for improvement to current methods, techniques within current methods also indicate the same need.

Studies show that one expects smaller effect sizes in treating aggression in batterers especially when they are mandated to participate in treatment (Gondolf, 2001). This calls for focus on interventions that can effectively engage these offenders in adopting non-violent ways of interacting in their significant relationships. Three studies with significant effect sizes and treatment outcomes have shown particular promise in domestic violence treatment. In the initial research study by Taft et al. (2001) male

offenders were randomly selected to attend the Cognitive Behavioral Therapy group or a supportive therapy group, both of which were enhanced by interventions intended to decrease attrition in treatment through motivational interviewing techniques (Miller & Rollnick, 1991).

Some of the motivational interviewing techniques included use of encouraging notes written by the therapist and phone calls to remind clients of appointments. After the intake session and sessions missed, hand written notes engaged the clients in reflection and feedback, and provided positive encouragement to pursue their goals of reform. These techniques helped contribute to some the highest rates of treatment retention seen in literature (Babcock, Green, & Robie, 2004). Although both therapies are different in orientation, i.e. structured vs. nondescript, both purported robust effect sizes particularly when outcomes were based on law enforcement reports (Babcock, Green, & Robie, 2004; Taft et al., 2001). The outcomes of this study purports that there is a strong link between a client's motivation and treatment attrition in domestic violence programs (Babcock, Green, & Robie, 2004).

These straightforward interventions send a strong message to clients that program facilitators are invested and aware of their participation in treatment (Babcock, Green, & Robie, 2004). Offenders are more likely to be motivated to seriously participate and complete treatment in order to ultimately gain the ability to pursue and engage in meaningful, non-violent relationships.

A second study by Waldo (1988) which produced significant outcomes was based on a relationship enhancement intervention (Accordino & Guerney, 2003; Guerney, 1977) which also showed success in improving marital relationships between

incarcerated men and their wives. This 12-week skills training relationship enhancement group (Waldo, 1988) focused on objectives of relationship enhancement in relation to partner violence. These interventions aimed to assist and encourage male offenders to adopt practical interpersonal skills to improve relationships and end their violent behavioral patterns (Waldo, 1988).

This study's success purports an emotion-focused approach rather than a cognitive-behavioral approach. It uses interventions such as role-plays and homework assignments to help offenders identify and handle their emotions, enhance empathy, improve communication skills and abilities to express themselves appropriately (Accordino & Guerney, 1998; Babcock, Green, & Robie, 2004; Waldo, 1985). The outcomes of this program suggest that this approach holds promise for effectively altering relational misperceptions and enhancing relational dynamics. While further research is warranted for both of these programs, these results encourage domestic violence research and programs to explore more effective treatment methods outside of traditional, Duluth-based models.

In another study by Lee, Uken, and Sebold, (2007) they predicted a decrease of domestic violence recidivism in court mandated batterers through using self-determined goals. Based on a goal-directed, solution-focused treatment program they suggested that establishing specific simple detailed goals and goal commitments are key factors in determining recidivism rates (Lee, Uken, & Sebold, 2007). If offenders can be engaged in a manner that increases motivation, self-confidence, and commitment to relational goals, they are less likely to recidivate. According to this model the rate of recidivism for participants in treatment was 10.2% along with final program outcomes accounted for

58% of recidivism variance (Lee, Uken, & Sebold, 2007). This outcome is a significant improvement from the recidivism rate reported by evaluation studies of Duluth Model based batterer treatment programs.

This study holds that the best orientation to effectively treat the problem of domestic violence – specifically participation, motivation, recidivism – is essentially the post-modern paradigm. This approach helps orient the researcher to information provided by participants and acts as a theoretical lens in selecting clinical relevant information. This theoretical lens is discussed further in the next chapter.

CHAPTER 2

THEORETICAL APPROACHES AND EMERGING VIEWS AND DIRECTIONS FOR BATTERER TREATMENT

Areas of motivation, relational dynamics, substance abuse, and tailored treatment have been shown to be vital components that should be addressed in domestic violence programs and can significantly improve treatment outcomes. Theoretical approaches of Solution Focused Theory, Goal-Setting Theory, and the Transtheoretical Model have been shown to be effective in domestic violence treatment by using tailored programs to enhance motivation, improve relational dynamics and decrease substance abuse to better address the clinical needs of each participant.

Solution-Focused Theory

Solution Focused Theory is grounded in social constructionism and is also a post-modern philosophical stance. This postmodern theoretical approach has been used in many various treatment frameworks with diverse populations such as victims of severe abuse (Dolan, 1994), juvenile delinquency (Clark, 1996), domestic violence offenders (Lipchik & Kubicki, 1996; Lee, Uken, & Sebold, 2007), and substance abuse (Osbourn, 1997). It has also been incorporated with several therapeutic modalities such as Experiential Therapy (Bischof, 1993; Lee, Uken, & Sebold, 2007) and Bowen Family Therapy. It also presents a stable structure in which clients can attain practical achievable goals within a brief period of time.

Solution-Focused Brief Therapy incorporates the client's positive strengths to help them successfully form specific goals which promote effective self-generated

solutions to solve life challenges. This theoretical approach alleges that when clients focus and act on their positive strengths and solutions to achieving future goals, this mobilizes desired meaningful behavioral changes (de Shazer, 1990).

This theory focuses on finding exceptions and solutions to the presented problems or reflecting on moments when the problem is not present. Solutions to the problem are developed and based on the exceptions that are presented (de Shazer, 1990). It is important to highlight these exceptions because it identifies times when the goals of therapeutic treatment are being achieved or have occurred in the past.

The objective of Solution Focused Therapy is to encourage clients to engage in actions that best represent the goal-behavior they would like to achieve rather than focus energy on what actions they want to avoid. The principle here is an inverse relationship, as positive behaviors increase the negative behaviors decrease. Therefore it makes sense to focus energy on what positive behaviors you want to see displayed. For example if a client states that he wants to stop physically abusing his wife, the therapist would encourage him to focus on the types of interactions and communication he would like to have with his wife rather than focusing on actions he wants to avoid. As the client implements the interactions that he wants with his wife, the actions of domestic violence will go away.

Some clients may have difficultly readily thinking of an exception to the current presenting problem or forming goals that are positively based. The therapist can help the client to frame a hypothetical solution that encourages alternative ways of perceiving problems and developing effective solutions. Rather than clients maintaining a problem saturated approach they are liberated to explore and implement goals and solutions that

match and are reinforced by their strengths. A common Solution Focused intervention to open exploration of goals and solution is exemplified in the Miracle Question (de Shazer, 1990). For example "if tonight a miracle occurred and you woke up and you were no longer acting abusively towards your spouse but communicating and interacting in a way you have always wanted, what would you be doing differently?"

Here the therapist has an opportunity to spur deep reflection of thought through follow-up questions that challenge clients to think differently, consider how they would feel, the impact of their new behaviors on significant people in their lives, how would those people recognize that a change had transpired, and how might they behave differently in response to these changes (de, Shazer, 1990; Walter, 1996; Yee, Uken, & Sebold, 2007).

Clients then are able to link the hypothetical to identified exceptions that are in contrast to their current problem and replicate/build on positive behaviors that reflect their desired reality (de, Shazer, 1990; Walter, 1996; Yee, Uken, & Sebold, 2007). A Solution-Focused methodology holds offenders of partner violence responsible for constructing solutions instead of concentrating on their weakness and a problem saturated narrative. Group treatment that utilizes a Solution Focused model does not deny or minimize aggressive or violent behaviors.

The deliberate attention given to the emphasis of offenders' strengths, skills, and solutions must never be likened to the minimizing of disparaging and vicious effect of their violent actions (Yee, Uken, & Sebold, 2007). Like other domestic violence treatment programs it recognizes the part of offenders in perpetrating violence against

victims and acknowledges that intervention programs are a component of a larger synchronized social response to partner violence (Yee, Sebold & Uken, 2003).

Moreover the efficacy of a domestic violence program based on Solution Focused methodology is dependent on the justice system's support, which levies strong enforceable consequences against actions that are violent and abusive (Yee, Sebold & Uken, 2003). Like other domestic programs that have used a solution-focused methodology this proposed program is not meant to be view as cure-all but a part of a multifaceted in coordination with the community to utilize practical evidenced based methods to address more pressing, observable and systemic patterns that contribute to domestic violence and substance abuse in intimate and family relationships. This requires concerted effort especially for clients that often are not motivated to engage in treatment.

One of the difficulties that batter treatment programs often face is the lack of motivation on behalf of the men to change (DeJong & Berg, 1999). This is not a surprise since the men convicted of partner violence are usually required by the criminal justice system (Healey, Smith, & O'Sullivan, 1998) to participate and may not be motivated or reluctant to admit responsibility for their violence actions (Stuart, Temple, & Moore, 2007).

The perception often held by the men participating in these treatment programs is that they are being coerced into unjustifiable treatment because their intimate partner was not truthful to law enforcement officials about their participation in the violence, initiating violence, about the violence altogether (Stuart, Temple, & Moore, 2007). It is not uncommon that partner violence offenders minimize the brutality of their

maltreatment and frequently deny it entirely (Pence & Paymar, 1993; Murphy & Baxter, 1997; Stuart, Temple, & Moore, 2007).

The engagement of male violence offenders in the process of treatment that is mandated is challenging, especially when they are in the company of other male offenders who view that it is the criminal justice system and or their partner who is out to make them look bad and that they are not to blame (Stuart, Temple, & Moore, 2007).

Many clinicians that treat partner violence offenders who are court-mandated know well the defensiveness that is frequently visible in bogus agreements, continual ambiguity, refusal to speak, and vehement rebuttals when offenders are asked to take responsibility for their violent actions (Murphy & Baxter, 1997). Many even thought they are court mandated chose to stop coming to treatment altogether (Lee, Uken, & Sebold, 2007). A study of attrition rates by Gondolf and Foster (1991) in a 32 session batterer treatment program revealed that 7.4% of participants out 27 completed the whole program. Another study of batterer treatment programs for men in Canada reported a noncompletion rate of 75% for participants that attended (Cadsky, Hanson, Crawford, & Lalonde, 1996).

This perception decreases the probability of meaningful transformation away from violence (Stuart, Temple, & Moore, 2007). Therefore to ensure meaningful change identifying and encourage motivation to change that is participant generated and driven is important. Self-determined goals have been shown to be effective in enhancing intrinsic motivation and promoting behavioral change.

Goal Setting Theory

The science behind the use of self-determined goals is developed by Edwin A. Locke and Gary P. Latham (1990, 2002) from the field of organizational psychology and is the foremost extensively researched evidence based theory on Goal-setting. Backed by nearly forty years of empirical research Locke and Latham (1990, 2002) along with Ryan (1970) purported that there is an association between self-determined goals and job performance. This to say that an individual's self-determined goals will affect their behaviors.

Goal setting is common place to designing treatment plans and therapist/practitioners often work with their clients to establish what these goals will be. However this approach is not usually evident in domestic violence treatment. In domestic violence treatment the goal "seems" obvious to the practitioner and participant. Nevertheless the goal (i.e. education on the misuse of power and control, stopping violent behavior) while important does not inherently promote the buy-in in the offender to change as evidence by previously mentioned outcomes of Duluth Model based programs.

The goal is the expected event that directs behavior and purpose for action to be taken. Lock and Bryan (1969) purport four means by which goals influence action. First, goals function as a behavioral guide in that they focus thought and endeavor toward pertinent actions that help bring about goal achievement and away from unrelated behaviors that would sabotage the goal (Locke & Latham, 2002). For example an offender who often gets angry and physically abusive towards his wife when she "constantly" interrupts his work calls before dinner shares his wife "pissess him off" by saying he never listens and is always to busy. He states he would like to have better

communication/listen to his wife without getting abusive before dinner (goal). He intends to show her by turning off his work phone and sitting down listening to her talk about her day before dinner.

Second goals awaken inspiration in an individual and energize them towards achieving new opportunities (Locke & Latham, 2002). In addition greater discipline and or determination are given towards higher goals rather than semi-complex, effortless, or ambiguous goals (Locke & Latham, 2002). Third, goals have an influence on persistence (Locke & Latham, 2002). When individuals are permitted to manage the time they expend on a job, more discipline is given towards goals that are harder (LaPorte & Nath, 1976). It should be noted that fixed impending deadlines create a sense of urgency to achieve a goal rather than deadlines that are not clear and variable (Bryan & Locke, 1967). Fourth, goals indirectly influence action by awakening awareness, development, and or implementation of task-applicable strategy and motivation to gain new knowledge (Wood & Locke, 1990).

Locke and Latham (2002) explain that an individual's relationship to goal–achievement is the most robust when they are committed to their goals. Moderators such as the goal-importance and self-efficacy are major factors in eliciting goal commitment (Locke & Latham 2002). Furthermore, the ability to set a goal and achieve it is mediated by variables such as self-efficacy, goal-commitment, and feedback (Locke & Latham, 2002).

When an individual takes part in setting self-determined goals that are important to them they are more effective in staying committed to their goal especially when they believe that the goal is attainable (Bandura, 1986; Latham, Winters, & Locke, 1994).

Individuals experience more success in setting goals when they are given feedback that highlights progress that is goal related (Locke, 1996). Moreover, individuals employ goal-performance more effectively, when they receive feedback as a method of tracking or measuring progress toward their goal (Locke & Latham 2002).

The academic research related to goal theory has shown this theory to be applicable in the treatment process. Gordon (1996) and Maple, (1998) purports there is a relationship between individuals who participate in developing self-determined goals and positive treatment outcomes. Therefore goals should originate and be determined by the participant to be therapeutically effective (Lee, Uken, & Sebold, 2007).

Clients are more likely to take ownership and buy in to a goal if they know it theirs, it is personal and important to them rather than having it told to them what their goal should be. Bohm and Peat (2000) reveal externally and involuntarily imposed goals that seek to change behavioral patterns without a individual understanding or buying into its purpose only generates inflexible mental constructs that do not allow for creative thought and development of mindfulness and responsiveness that are essential for inspiration to used.

Positive outcomes are likely when goals are specific (O'Hearn & Gatz, 2002; Weissberg, Barton, & Shriver, 1997) and stated optimistically (Lee, Uken, & Sebold, 2007). Instead of an offender negatively stating his goal "I am not going to yell at my wife when I get home" he would stated his goal positively "I am going to complement and kiss my wife when I get home". Negative outcomes are associated with goals that are defined by behaviors an individual wants to evade rather than what they positive actions they want to implement (Lee, Uken, & Sebold, 2007).

According to the literature there are additional factors that assist positive outcomes in achieving goal. One such factor is that of goal agreement. For treatment to be successful it is important that client and therapist reach an agreement on what the goal is going to be (Busseri & Tyler, 2004; Long, 2001). Goal incongruity between participant and therapist is often linked to poor treatment outcomes: participant dissatisfaction, non-compliance in treatment, and increased drop-outs (Goin, Yamamoto, & Silverman, 1965).

These negative outcomes also manifest themselves when a therapist does not attune to the needs of a participant or disregards their input in setting their own goals (Lazare, Eisenthal, & Wasserman, 1975). Therefore it is important that therapist seek to include as much of the participants input in crafting of the goal which produce the necessary buy-in, self-efficacy, motivation, and responsiveness. This provides the therapist an avenue to provide helpful feedback and guide goal specificity that can be agreed upon to ensure positive treatment outcomes.

Lee, Uken, and Sebold, (2007) convey that since the experience of domestic violence is interpersonal it is necessary and valuable for the offender to cultivate a goal that can be interpersonally implemented. It is important that the goal is not just a mental experiment but rather an action that can be observed by another person. This is confirmation to not just the offender that he or she is undergoing specific areas of change but others are able to observe and experience interpersonally.

Therefore in addition to Goal-setting theory and the influence of Solution Focused theory Lee, Uken, and Sebold (2007) have added that goals should be interpersonal, different, and new. Goals that are different and new are recommend that they be small and do able as to enhance self-efficacy (Lee, Uken, & Sebold, 2007). Goal behavior that

is doable, different and new, impacts and changes the relationships and patterns of relating, the system is no longer the same (Bateson, 1979). The systems based perspective suggests that domestic violence offenders have used futile, repetitive coping methods to address their problems which have only served as a means of feedback that continues the problem of abusive and violent partner behavior (Lee, Uken, & Sebold, 2007).

Treatment should be intended to develop different, new, alternative ways of relating that are most likely to foster helpful means of feedback that can be used to uphold new behavioral patterns that are solution oriented (de Shazer, 1991). Goals that are based on old behavioral patterns can disillusion an offender from expecting positive outcomes because he or she has previously "tried that before and it did not work" and doubts that there will be much difference this time around. Sensing the strong pull of the engrained pattern they feel that they are set-up to fail.

Attempting goal related actions that are new gives offenders an opportunity to adopt a path of non-violence and have a new more positive reinforcing experience of themselves. Berg and Kelly (2000) assert that goal related actions that different and new will enhance the chances that participant will employ behaviors that are useful, appropriate solution driven actions instead of replicating patterns of behavior that are harmful and unproductive.

For change to be effective participants should be able to completely visualize the positive outcomes of the goal related actions, try out their goal related actions, and discern the difference between prior actions and their new goal related actions (Lee, Uken, & Sebold, 2007). It is important that they develop the capability to examine and

assess the positive effect of their goal related actions have had (Lee, Uken, & Sebold, 2007).

Hence participants need appropriate feedback that identifies progress and encourages them to continual to improve new skills and actions as they implement their goal (Locke & Latham, 1990; Lee, Uken, & Sebold, 2007). The therapist therefore would want to facilitate therapeutic conversation that offers feedback to participants about their goal performance using evaluative questions (Lee, Uken, & Sebold, 2007). Through these questions therapists can help participants self-assess practicality, effect, care, and challenges of their goal related actions on other individuals (Lee, Uken, & Sebold, 2007).

Feedback is more effective when an individual is able to thoughtfully evaluate his or her actions and internally develop adjustments and ideas to make their goal related actions more effective and helpful (Lee, Uken, & Sebold, 2007). As stated earlier with Goals setting theory increased buy-in to one's goal contributes to a greater likelihood of a positive outcome. Similarly when participants take ownership in assessing their progress and their ideas to improve task performance the greater chance these adjustments will prove to be successful. Externally imposed feedback is less likely to produce a positive outcome and may in fact not be what is needed in the participant's context (Lee, Uken, & Sebold, 2007).

Lee, Uken, and Sebold (2007) go a step further to consolidating change in domestic program participants. Based on solution focused theory, they make use of the new perspective, meaningful goals, increased self-confidence and self esteem, to describe themselves in the likeness of their action-related goal instead of maintaining the label of "domestic violence offender" or "batterer" (Lee, Uken, & Sebold, 2007). For example if

a participant's goal is to show compassion and love to his wife by helping her with the house after work, he may describe himself as helpful caring husband. This falls in line with the person he wants his actions to reflect. This is far more effective in reinforcing behaviors that break away from old patterns and enhance new interpersonal ways of relating. Lee et al. (2003) purports that it also helps the participant developed a dialogue defined by success rather than problem laden, moreover it unites participants' goal tasks to the future by cultivating a path that marks signs of progress. Identifying the participants' motivation and readiness to change can help professional select necessary treatment interventions to improve outcomes.

Transtheoretical Model and Motivational Strategies

Murphy and Baxter (1997) purport that using the transtheoretical model of behavior change as is effective in decreasing violent behavior especially in the context of motivational interviewing interventions. The transtheoretical model holds that in the progression of change there are 5 stages: precontemplation (individual sees no need to change), contemplation (individual is considering change), preparation (individual takes necessary actions to make change), action (individual is actively involved in thoughts and behavioral change), and maintenance, that is identifying ways to prevent relapse (Brogan, Prochaska, & Prochaska, 1999; Prochaska & Diclemente 1983; Stuart, Temple, & Moore, 2007).

The transtheoretical model of change postulates that matching interventions with a client's readiness to change can increase program treatment outcomes (Brogan, Prochaska, & Prochaska, 1999; Hellman, Johnson, & Dobson, 2010). The cross-sectional

correlational study by (Hellman, Johnson, & Dobson, 2010) of a 52-week batterer treatment program observed characteristics that influenced self-reported willingness to change domestically abusive actions among a sample of 109 men.

Participants completed measures of parental manipulation, anger/hostility, willingness to change, and self-worth (Hellman, Johnson, & Dobson, 2010). Results indicated that reflection on the effect of maltreatment was highly correlated with participant stated change in actively employing behaviors end domestic abuse (Hellman, Johnson, & Dobson, 2010).

Motivational interviewing interventions can also be effective as evidence by the work of Stuart, Moore, Kahler, and Ramsey (2003) in treating substance abuse. Like the Solution focused model Motivational interviewing seeks to intervene in clients lives no matter their present state of readiness and utilizes non-confrontational methods to aid clients in drawing out their own motives and rationale for making a change (Miller & Rollnick, 2002)

Motivational interviewing postulates that developing a constructive and supportive therapeutic nonjudgmental relationship with clients will decrease resistance and increase readiness to adopt a path of transformation rather than using more confrontational methodologies (Stuart, Temple, & Moore, 2007). This approach has shown to be an effective addition to current batterer treatment programs that characteristically do not address substance abuse and use interventions that are confrontational to promote behavioral change in offenders (Stuart, Temple, & Moore, 2007).

Research studies have found that the majority of men starting a batterer treatment program are in the precontemplation and contemplation stages of change (Eckhardt, Holtzworth-Munroe, Norlander, Sibley, & Cahill, 2008) and that the use motivational interviewing improved attendance and reduced partner violence recidivism (Taft, Murphy, Musser, & Remington, 2004). It is held that this intervention can be adapted into batterer treatment programs fairly effortlessly and may be chiefly significant in that this methodology often postulates that the individuals starting the program are open to explore change that improves their current circumstances (Eckhardt, Holtzworth-Munroe, Norlander, Sibley, & Cahill, 2008).

It is expected that as participants work towards their goal, their interpersonal dynamics of relating will also improve. To help better frame goals that can be useful to help break old patterns and develop new ways of relating it is important domestic treatment programs understand how men and women interact and perceive and use relational aggression.

CHAPTER 3

REVIEW OF LITERATURE

Men and Women and Aggression

How men and women interact and perceive aggression is influenced by normative societal expectations of gender and expected roles (Almeida & Durkin, 1999; Bettencourt & Miller, 1996; Eagly & Steffen, 1986). Prevalent in the social discourse are many norms of male gender roles that that promote various types of aggression (Eagly & Steffen, 1986). It is further suggested that men usually display more aggressive behavior than women unless particular aspects of a circumstance make the role of gender less relevant (Eagly & Steffen, 1986; Murray-Close, Ostrov, Nelson, Crick, & Coccaro, 2010).

Data from North American police and medical sources reveal that females comprise 85-90% of partner violence victims (Tjaden & Thoennes 2000a, Bunge & Locke 2000; Barnish, 2004). Among victims who had terminated their relationship with the assailant after the most horrible episode at the administration of the survey, the violence stopped entirely after separation for 63%, but in various forms was ongoing for the other 37% (Barnish, 2004). In response to the need to prevent domestic violence, many programs have been developed for individuals who batter, of which men comprise the majority. In California Male offenders comprised the majority (80%) of the 43,911 people were arrested for domestic violence crimes compared to 20% by females (Crime in California, 2006).

The use of provocation to elicit an aggressive response plays a significant role in gender (Berkowitz, 1989; Carlson & Miller, 1988; Miller, Gregory, & Ivonni, 2005). A common social norm in interaction is reciprocity also known as tit-for-tat which wields

potent results (Gouldner, 1960) and frequently the escalation of aggression and conflict are the result (Axelrod, 1984; Dodge & Coie, 1987). Here provocation is usually cited as the justification for an aggressive response (Bettancourt & Miller, 1996; Dutton & Corvo, 2007). Bettencourt and Miller (1996) purport that this telling aspect of justified aggressive behavior may be especially consequential for women because it allows them to break free from stereotypical norms that constrain gender roles.

Experimental research paradigms that included an incident of provocation before aggressive behaviors were reciprocated, found no significant difference between genders (Ahmed, 1982; Dor-Shav & Dolgin, 1981; Frodi, 1978; Golin & Romanowski, 1977). When both genders interaction to varying levels of provocation in several studies were examined, men displayed more aggressiveness then women in neutral circumstances, however women slightly exhibited an increased level of aggression than men when they were provoked (Anderson, 1993; Dutton & Corvo, 2007; Fischer, Kelm, & Rose, 1969; Schuck, Schuck, Hallam, Mancini, & Wells, 1971).

Researchers found that women may be less willing to act aggressive for fear that acting aggressively will escalate retaliation violence (Berkowitz, 1988; Bettancourt & Miller, 1996). Eagly and Steffen (1986) argue that anticipation of retaliation affects the magnitude of aggressive behavior and is a telling difference between genders. In addition the different aggressive responses that were available to study participants seem to suggest the degree of divergence between genders (Eagly & Steffen, 1986; White, 1983).

Socially certain behaviors considered more suitable for one gender to exhibit than the other (Bettancourt & Miller, 1996). For example its usually considered more socially appropriate for men to display physical aggression and females verbal aggression

(Bettancourt & Miller, 1996). Although the literature reveals in meta-analysis studies that there is no significant difference but rather the magnitiude of the difference increased when physical aggression was used (Bailey and Ostrov, 2008; Basow et al., 2007; Burton et al., 2007; Bettancourt & Miller, 1996; Eagly & Steffen, 1986; Loudin et al., 2003).

Men and women however react differently to various types of provocations. Women are more reactive more when provoked verbally than physically (Frodi et al., 1977; Murray-Close, Ostrov, Nelson, Crick, & Coccaro, 2010; White, 1983) whereas men perceived physical aggression as to be more provoking than verbal insults (Harris, 1993; Murray-Close, Ostrov, Nelson, Crick, & Coccaro, 2010). In a study by Murray-Close, Ostrov et al. (2010) based in PENN Twins study found that in the general levels of relational aggression there were no significant differences in gender observed; however in sub-types of relational aggression women were more probable to employ relational aggression with a romantic partner while men were more probable to engage in peer-directed proactive and rash relational aggression.

The differences that are manifest in this study are slight which is supportive of earlier studies there is little difference between gender in use of relational aggression (Bailey & Ostrov, 2008; Basow et al., 2007; Burton et al., 2007; Loudin et al., 2003) except in subtypes of relational aggression. These studies also suggest that men and women may be socialized early in life through inter-gender interaction, romantic partners how to effectively use relational aggressive tactics (Bailey & Ostrov, 2008; Basow et al., 2007; Burton et al., 2007; Loudin et al., 2003). Moreover women as they age are more likely to transfer relationally aggressive actions learned in the context of their peer interactions to their romantic partner relationships (Murray-Close, Ostrov, et al. 2010).

Relational Dynamics

While poor relational dynamics are a contributing factor in domestically violent relationships, traditional Duluth model programs often do not attend to the primary relationship dynamics that influence a partner's choice to stay in spite of the abuse, or that may contribute to sustaining the abusive relationship (Stith, Rosen, McCollum, & Thomsen, 2004). Partner violence in not always one-sided but includes both men and women. Although the chances of physical harm resulting from assaults by women occur with lower probability, a meta-analytic examination of 82 studies established that women were to some extent more prone than men to reveal engaging in physical violence while in a romantic relationship (Archer, 2000). Regardless of who perpetrated the violence both are serious (Straus, 1993).

This is not to blame women or to lessen responsibility of men but rather to state that significant relationship dynamics are contributing to the abuse. In a study of randomly chosen military personnel by Pan, Neidig, and O'Leary (1994) that sought to predict mild and harsh aggression in romantic relationships between men and women, it was discovered that discord in relationship was the most significant predictor of partner violence.

Pan, Neidig, and O'Leary (1994) also report that for each 20% relational discord goes up, the probability of mild aggression towards the partner went up by 102% and the probability of harsh aggression went up 183%. Therefore it would suggest that because discord in relationship is significant predictor of physical partner violence there is a need to present treatment alternatives that allows for these couples to address their relational dynamics (Stith, Rosen, McCollum, & Thomsen, 2004). Disregarding the partner

dynamics in an abusive relationship is imprudent especially when addressing it would decrease the probability of partner violence from recurring.

A study by Herbert, Silver, and Ellard (1991) revealed that nearly 66% of 132 battered women at the time of assessment did not return to their partners; however 34% still stayed with their partners after the violence had occurred. In a research by Gondolf (2000) it is purported that 40% victims of batterers return to their partner who had first accosted them. Hence not making available services that address the relational needs of both partners that intend to continue the relationship may unintentionally disadvantage the women who decide to stay (Stith, Rosen, McCollum, & Thomsen, 2004). Strategies to properly address relationship issues often used in couples therapy have shown promise in reducing partner violence especially for those participants that do not present an imminent danger to their partners.

Couples Treatment

What many current batter treatment programs overlook is the fact that many romantic partners do not intend to progress towards dissolution of the relationship in spite of the existing poor relational dynamics that lead to concurrent violent behaviors (Stith, Rosen, McCollum, & Thomsen, 2004). As previously mentioned, 34% to 40% of partners decide to continue the relationship. Hence this suggest that this lays bare an obtrusive oversight; for, if the couple chooses not to separate or reunify later on, the curriculum for batterer's might not have addressed the key relational dynamics necessary for a successful long-term relationship (Stith, Rosen, McCollum, & Thomsen, 2004).

Couple dyad interventions while understandably controversial, have demonstrated new evidenced based approaches to domestic violence treatment (Stith, Rosen, McCollum, & Thomsen, 2004; O'Farrell & Fals-Stewart, 2006). This has been evidenced by an experimental study by Stith et al. (2004) treating couples who had experienced mild to moderate violence. It was found that violence recidivism rates six months after treatment were significantly lower for the multi-couple group than the comparison group or individual couples therapy group. Couples reported a significant increased marital satisfaction and a decrease in aggression especially towards the wife.

Stith, McCollum, and Rosen (2002) developed a solution-focused model Couple's treatment that addresses domestic violence (Stith & McCollum, 2009; Stith, McCollum, Rosen, Locke, & Goldberg, 2005; Stith, Rosen, McCollum, & Thomsen, 2004). The primary objective of their couples domestic violence treatment program is to stop partner violence with the supplementary objective of assisting couples in improve the quality of their relationships. The 18 week program can be administered in both multi-couple group and individual design. The first 6 weeks of the program involve gender-separate treatment during which assessment for the appropriateness of the couple to engage in conjoint treatment and then continues with psychoeducational interventions and information presented to both individuals (Stith, McCollum, & Rosen, 2002).

At the start of conjoint meetings and throughout treatment there is ongoing safety assessment built into the framework treatment (Stith, McCollum, & Rosen, 2002). Every couple session commences with an inquiry about abuse or violence since the last meeting (Stith, McCollum, & Rosen, 2002). Towards the end of the session separate meetings are

used to reflect on the session and assess if there is enough safety present for the couple to leave session together (McCollum & Stith, 2007; Stith, McCollum, & Rosen, 2002).

With these safety procedures in place the program uses a solution-focused methodology (i.e., Pichot & Dolan, 2003) as it would be utilized with other intimate partners. Nevertheless, if the hazard of violence should be present, the therapists depart from the solution focused structure to prioritize and assure safety, only returning to a solution-focused approach when, and if, both individuals are again safe from acts of abuse and violence (McCollum & Stith, 2007).

Granted this type of treatment approach requires that the appropriate safety measures and assessments be taken to prevent an escalation of violence. It would not be appropriate for couples who have a history of high levels of violent interaction with each other. It may be considered for partners who have demonstrated low or moderated aggression, the woman separately chooses to be involved in treatment and does not feel at risk of repercussive aggressive action as result of talking about violent interactions and the relationship, and both partners commit to stopping further physical violence (O'Farrell & Fals-Stewart, 2006).

This method may not be appropriate unless there is a history of low or moderate levels of violence, the woman independently agrees to participate and does not express fear of negative consequences for discussing the relationship and violence, and both partners commit to avoiding additional physical aggression (O'Farrell & Fals-Stewart, 2006). With these established contingencies and if the couple chooses to continue their relationship, couple treatment presents benefits that are not available with methods used in standard domestic violence programs.

Most domestic violence that occurs in relationships includes mutual partner participation in aggressive behaviors towards each other (Archer, 2000). Although women are more often the recipients of violence that is more severe and injurious, and more likely to access mental health services as result of domestic violence, aggression stokes more aggression, therefore to stop violence within the relationship it is necessary to address it at the level of the couple dyad (Stith, Rosen, McCollum, & Thomsen, 2004). It is important to examine what are the underlying factors that contribute to the breakdown of relationship dynamics that lead to domestic violence. Substance abuse has been identified as one such factor.

Substance Abuse

Substance abuse has been cited as a significant factor that contributes to a break down in partner relationship dynamics that leads to domestic violence (Dalton, 2001; Dalton, 2009; Dutton, Nicholls, & Spidel, 2005; Stuart, Temple, & Moore, 2007). Dalton (2001) purports that despite the promise of court sanctions; substance abuse is stronger predictor failure in a batterer treatment program. The probability of violence increased eleven fold on days that the batterer had been drinking alcohol (Fals-Stewart, 2003).

Amongst partner violence offenders, addictive behaviors are overrepresented (Stuart, Temple, & Moore, 2007). Stuart, Moore, Kahler, & Ramsey (2003) reveal in their study that 68% of men that participate in domestic violence treatment met criteria for alcohol abuse, 53% had a likely diagnosis of alcoholism, and 42% had a dependency on alcohol. Furthermore, those that were participating in treatment 54% in the past year had used illegal drugs (Moore, & Stuart, 2004; Stuart, Temple, et al., 2008) and of those

31% it was discovered that some had a possible drug use problem (Stuart, Temple, & Moore, 2007).

A research study of offenders in domestic violence treatment revealed that abuse of their partner was 20 times more probable on days of heavy alcohol consumption compared to days offenders did not drink (Fals-Stewart, 2003). Regardless of the research that demonstrates offenders in domestic violence treatment programs have considerably poorer outcomes compared to those who don't have substance abuse problems (Jones, & Gondolf , 2001; Stuart, Temple, & Moore, 2007) merely 3% of men arrested for domestic violence were mandated by the court to attended a treatment program for substance abuse (Goldkamp, Weiland, Collins, & White, 1996).

This is not to say that substance abuse problems relinquish the batterer from responsibility but rather to recognize the serious issues that exacerbate partner violence and that it is necessary to be included along with domestic violence treatment. Some offenders' substance abuse problems upon assessment may require more extensive treatment then can be provided in batterers program.

Stuart, Temple, and Moore (2007) suggest that, it is less probable that a treatment participant with an current substance abuse disorder will successfully apprehend and implement the techniques taught in a domestic violence program. In certain cases the substance abuse disorder may have precipitated relational discord and may interfere with an individual's capacity to thoughtfully examine and implement the techniques taught in the program, which can enhance possibility of aggression recidivism (Stuart, Temple, & Moore, 2007).

Participants that receive substance abuse treatment are most likely to significantly reduce violent behavior towards their partner (O'Farrell, Fals-Stewart, Murphy, & Murphy, 2004; Stuart, Ramsey, Moore, et al. 2003) This evidence of the increased comorbidity in domestic violence offenders suggest that those who are mandated to treatment would benefit from substance abuse treatment that is tailored to clients needs and incorporated into current batterer treatment programs (Stuart, Temple, & Moore, 2007).

Tailored Treatment

The etiology domestic violence is not necessarily the same for each offender that is in treatment. Research suggests that batterers are not a homogenous group and that the etiologies and subtypes of domestic violence offenders vary (Stuart, 2005; Holtzworth-Munroe, & Stuart, 1994; Holtzworth-Munroe, & Meehan, 2008). Researchers reveals that partner violence is influenced cultural and social variables, it is more thoroughly understood up further assessment of purposes and contexts of behavior, and characteristics of the individual (Smith, 2003). Research is starting note contributing factors such as history of trauma, substance abuse, individual stressors, shame, and characteristics of personality as chief factors that lead to intimate partner violence (Brown, 2004; Goldner, 1998, Gilligan, 1997).

Both males and females whom were arrested for partner violence scored higher personality characteristics such as avoidant, schizoid, antisocial, aggressive-sadistic, one factor loading on scales of narcissism, and second factor loading on self-defeating scales (Ley, 2001). Narcissism was discovered to be associated to a greater degree of minor and

major psychological aggression (Blanchard, 2001). External displays of anger revealed for narcissism a main effect for and an interaction effect for self-esteem and narcissism (Blanchard, 2001).

Although outcome research is still emerging it is purported that treatment that is tailored to the typologies of domestic violence offenders can improve outcomes and reduce recidivism (Holtzworth-Munroe 2001; Stuart, Moore, Kahler, & Ramsey 2003). Detailed assessments of batterer needs would help improve not only the outcomes of domestic violence treatment programs but it would help guide referrals for offenders that need more intensive treatment (i.e. Substance abuse treatment center, Psychiatric needs, Counseling) and identify the best skills to ensure favorable outcomes (Stuart, 2005).

While most batterer treatment programs may not have access to resources to utilize all these methods it is possible to perform assessments that track the needs of program participants throughout treatment, make appropriate collateral care referrals, and support participants to follow through with treatment referrals (Stuart, Temple, & Moore, 2007).

Goal-setting theory can also be useful in tailoring treatment interventions to offenders' needs to produce successful outcomes. The offender who sets a goal behavior that is relational based can help focus treatment outcomes. For example the participant shares that he gets in physical fights with his wife because he always has a few beers after work and watches television instead of spending time with her. He decides that he would not be violent if he did not drink and spent time with his wife helping her around the house. Another individual may share his goal to spending time patiently and lovingly

listening his wife, or going home and helping kids with homework instead of going to the bar his colleagues

These participants along with therapeutic collaboration and goal agreement from the therapist can tailor his treatment to energize him to act on his goal. If an individual has difficult relational issues with his father that he often takes out on his wife. The therapist could make an appropriate referral to counseling. Therefore in a domestic treatment program based on the group design there maybe 8-10 different goals but all tailored interventions that have the support of the therapist plus the encouragement and accountability of the group. Every participant is motivated to reach their goal because it is personal and the interventions to experience a successful outcome are tailored to them in steps that are manageable. This will improve treatment outcomes.

CHAPTER 4

METHODS

This chapter details the methods of research that has been utilized to identify key program components and interventions in domestic violence treatment programs that offenders find helpful in reducing reoffending. It also describes the process by which participants were selected, in order to show the extent to which offenders experience is consistent with the generalized typologies described in the research. The objective was to uncover the significant experiences of offenders in order to improve domestic violence treatment. This research yielded an outcome that will improve their relationships with their significant others.

This research study used grounded theory to analyze the data gained through qualitative interviews (Glaser & Strauss, 1967; Strauss & Corbin, 1998). This qualitative methodology was chosen because of its effectiveness in highlighting theoretical themes within the descriptive experiences of the participant and connects these themes to more encompassing relational premises. This qualitative design is a scientific approach that is commonly utilized in describing the processes by which actions linked to specific relational experiences, such as partner violence and treatment materialize (Charmaz, 2006; Morse, 2003).

Grounded Theory qualitative methodology also elicits the discovering foundational descriptive themes while assessing for unique differences in individual experiences within the identified paradigm of that which is being studied (Barbour & Barbour, 2003; Charmaz, 2006; Strauss & Corbin, 1998). For this study the qualitative grounded-theory design uncovered and elicited crucial themes related to offender's

experience of domestic violence treatment and what they feel is necessary to help them be successful in adopting a life of non-violence. Coding was used to (articulate these themes/concepts and to highlight significant experiences (Corbin & Strauss, 2008) and components of treatment that are crucial to partner violence offenders to the researcher. As it relates to this study those themes/experience common to domestic offenders in treatment were explored. As these themes developed it was able connect them to salient tenets that are represented in current scientific research (Charmaz, 2006; Strauss & Corbin, 1998; Thorne, 2001). Here the researcher sought to identify how closely the concepts fit with the experiences that are being studied through constant comparison (Corbin & Strauss, 2008). Moreover, because this qualitative approach yielded informed participant information it can be useful in formulating more effective clinical methods.

The researcher has developed a workable theoretical and clinical framework that best explains the phenomenon being studied (McCaslin & Scott, 2003; Corbin & Strauss, 2008). This methodology has moved scientific gains of the study past traditional practices used in current domestic violence treatment programs and towards intervention that address nonviolence and substance abuse in the context of relational values. The theoretical description of what interventions offenders would find helpful in adopting a relational life of non-violence will have useful and systemic implications for treatment.

Philosophical Paradigm

The qualitative method of grounded theory is grounded in phenomenology. It uses a systematic approach to develop an inductively generated theory about a phenomenon (Corbin & Strauss, 2008). The focal point is informed research regarding the experience

of the offender and what they feel is necessary and helpful in a domestic violence program to adopt life of non-violence. The principal goal is to expand upon the detailed experience of the phenomenon by recognizing and highlighting the significant rudiments of that phenomenon, and then coding the associations of those rudiments to background and process in which the experience is grounded (Corbin & Strauss, 2008).

Theoretical Sampling

One approach to make certain that the detailed personalized experiences of participants sufficiently revealed the dimensions of domestic violence coping was to employ theoretical sampling. Theoretical sampling will help the research achieve a depth and richness of the complex phenomena reflected in the experience of the participant as opposed to a general broad surface sweep of the experience (Johnson & Waterfield, 2004). This allowed the study to achieve balance between experiential and the theoretical (Swanson, 2001). In qualitative research it is possible to obtain attain this balance with fewer rather than large numbers of subjects as seen in a quantitative study.

What is important is that a multiplicity of experiences be included that represents a variety of perceptions of the phenomena described in order to provide a conceptual context of collective participant experience (Corbin & Strauss, 2008). To develop a theoretical understanding of the subjective needs of domestic violence offenders and their treatment needs this study recruited participants to be interviewed while implementing constant comparison to achieve saturation.

In the process of selective coding if it was deemed by the researcher that further clarification or information was needed regarding the interview, the researcher would

follow-up with the participant to make sure their experience is correctly represented. The researcher would contact the participant to set up a follow-up meeting within two months if it had been necessary (See appendix B). The researcher would have gone back and again to interview the participants and compare, validate, and refine the nuances of the theory as based on the feedback. This process was be repeated until saturation was reached (Charmaz, 2006; Corbin & Strauss, 2008; Thomas & Chambers, 1989).

Qualitative researchers who use a grounded theory approach commonly use theoretical sampling (Thorne, 2001). In this study, this procedure was used to develop an emergent theory that reflects the coded categories borne out through constant comparison and a fitting descriptive explanation of the phenomena has reached saturation (Glaser, 2002; Corbin & Strauss, 2008). It was the researcher that determined when there has been sufficient clarification of the phenomena has been achieved (Glaser, 2002) given that this process could continue to produce relevancy in infinite measure. This study proposed that a suitable degree of theoretical relevancy would be developed by the researcher once saturation of the participants' interviews had been reached.

Participants

The participants in this qualitative study were composed of male offenders over 18 years of age, recruited from clients at day treatment centers, law enforcement, anger management programs, and possibly the courts. Participants must have been arrested at least once for a domestic violence event. In order to enroll in the study participants called the available number on the handout/poster provided to them. This study presented measures that were be taken to address and preserve the safety, wellbeing, and

relationships of the future participants as discussed in greater detail in section participant safeguards.

Emphasis on Men's Subjective Domestic Violence Treatment Needs

Currently domestic violence services and public policy reflect an emphasis focused on the protection of women who are most affected by domestic violence (i.e. arrest/punishment of the offender, Shelters and support groups for women) but not as much emphasis on treatment interventions that would decrease recidivism of offenders who are male (Edleson, 2008; Stuart, Temple, & Moore, 2007). Many meta-analyses, qualitative research studies have shown that current traditional methods of treating domestic violence especially in men are not effective in decreasing recidivism (Stuart, Temple, Moore, 2007). Nevertheless many agencies still employ these ineffective methods despite the clear need for implementation of evidence based treatment programming. The lack of emphasis on evidenced based treatment that could effectively decrease recidivism is a disservice not only to the offender but to the victims of domestic violence. Therefore the focus of this study guided by research is to ask men who have been involved/charged with domestic violence to enter in to a hypothetical experience and share their ideas of treatment methods that would most help them to not recidivate.

Inclusion Criteria

Participants must be men over the age of 18 and had at least one arrest regarding domestic violence and be able to speak English. Research participants in this study included adult men because evidence reveals that the majority charged with partner

violence and are in domestic violence treatment programs are men (Bureau of Justice Statistics Crime Data Brief, 2003; Cadsky, Hanson, Crawford, & Lalonde, 1996; Murphy & Baxter, 1997).

Exclusion Criteria

In this study females were included in addition men who exhibit severe mental illness or current intoxication were excluded.

Diversity in Research

It is important to this study that the research done reflect a balance of diversity that includes minority groups. Research should reflect diversity in cultural representation, which contextualizes it within a larger ethnographic structure (Atkinson, 2005). Diversity in grounded theory enhances triangulation of data, deepens and enriches descriptions (Atkinson, 2005). Therefore minority groups such as African American, Mexican American, Asian-American and Native American, may be included however they were required to be able to speak English for this study. While for this particular study men were being studied it was important that men of other minority group be included.

In San Bernardino, California there is a sizeable population of Mexican-American, African American, and Native Americans. This study included minorities in its recruiting practices from clinics, churches, and centers in which these populations were present.

Screening Procedures

Referrals were made ready to participants that might need of additional services such as counseling, inpatient drug or psychiatric treatment, and danger to self or others. A phone number to contact the researcher was made available to the participants to address further questions or concerns regarding research, screening procedures or referrals (Cloitre, Koenen, Cohen, & Han, 2002). During the first contact the criteria for inclusion to the study was explained (See Appendix A). Of the participants who match the inclusion criteria and wish to volunteer the researcher will supply general information where they can be contacted and a scheduled time for the initial interview.

While it was possible that the screening procedure will produce sensitive information of prospective participants, special care was be taken to ensure privacy and confidentiality. Thus the important consideration of participant safety comes into focus. The next section of this proposal will address participant safety and ethical considerations that was pertinent to conducting research with domestic violence offenders.

Participant Safety and Ethical Considerations

Cowburn (2005) purports research that includes individuals that have committed abusive or violent acts requires careful attention to methodology given that participants are often concerned about self incrimination and being stigmatized. Cowburn (2005) goes on to assert that participants maybe resistant to cooperate with researchers if safety privacy conditions are not in place. The indictment of domestic violence not only has a societal stigma and but brings criminal/legal consequences. Participants may be skeptical about sharing in any information for fear that it may be used against them or that it may

reveal who they are and jeopardize any restitution, economic opportunities or, worsen punishment. Therefore it was necessary that data and the participants be handled with care, privacy, and sensitivity (see Appendix B).

Importance of domestic violence treatment research. Domestic violence is a serious societal problem that disrupts the lives of individuals, couples, and families and has a severe negative impact on physical and psychological wellbeing (Campbell, 2002; Dorahy et al., 2007; Tjaden & Thoennes, 1998; 2000). Hence adequate informed treatment research was necessary to address this societal crisis that reduces recidivism of violence and in relationships.

Research should deliver ethically sound essential, far-reaching, and applicable results that enhance how individuals interact in their world (King & Churchill, 2000; Kvale, 1996). It is believed this research will significantly contribute useful scientific knowledge to how practitioners develop and implement treatment for domestic violence offenders and their families.

The researcher is a trained therapist, and has the joining skills that were necessary to facilitate participant safety. This study's qualitative design specified that participants must be informed of the research process. Participants were encouraged to take a collaborative part of the research process through validating coded categories as well as providing insights into phenomena that enhanced and accurately reflected the final presentation of the developed theory.

It was the hope of the researcher, that through the joint involvement of the participants, they would find their collective contribution meaningful should they participate in a treatment program based on results of the study. It was this joint

involvement that this researcher holds to be crucial implication for effective domestic violence treatment programs.

Recruiting of participants. The Primary Investigator (PI) attended one the regular meetings at local clinics and Day Treatment Center and made a brief speech about the study (See Appendix G). After the speech the PI stated that he would stay during and after the meeting to meet with those that were interested and would like to participate in the study. For those that choose to volunteer an informed consent form that outlines the benefits and risks of participation in the study were presented to each prospective participant that qualified for the study as specified in the inclusion and exclusion criteria. The informed consent was reviewed with the participant at the scheduled time of the interview.

Participant screening. The student researcher in this study made the preliminary contact in person or by telephone in response to participants that requested to join the study. The initial conversation procedures that serve as inclusion/exclusion criteria were used to screen out prospective participants that do not fit the criteria necessary for the study. The research solely focused on the necessary information to determine eligibility for the study. All information was treated with sensitivity and confidentiality. If a participant had revealed a danger to self, others, or child abuse the guidelines of AAMFT and Board of Behavioral Sciences would have been followed. There was no such revelation in this study. Those that did not speak any English, Minors, severely mental ill, and those with sever criminally behaviors other that domestic violence, were excluded. If a participant or the research had question regarding the suitability of participation a mental health professional was available to answer questions.

Informed consent. An informed consent form that outlines the benefits and risks of participation in the study was presented to each participant (Collogan, Tuma, Dolan-Sewell, Borja, & Fleischman, 2004), This consent form also included instructions on what the participant should do if anxiety and feelings of anger or violence worsen (see Appendix B). The researcher presented to chosen participants during the review of the informed consent for three mental health professionals that have been previously contacted by the researcher and have agreed make their services available to participants. If participants had experienced adverse effect of the study, they were instructed to call any of the mental health professionals presented on the list.

The student researcher presented a contact number to participants if they have any questions or concerns about the study. If a participant started to experience feelings of anxiety and anger during intake/interview the researcher would have stayed in contact with the participant to ensure he gets the appropriate professional assistance needed (Cone & Foster, 2002; Heppner, Kivlighan, & Wampold, 1999).

Tenets of volunteering. In this qualitative research study there are three important ethical tenets that are necessary to be addressed; the mental ability of the participant to make an informed decision to consent, participant did not feel pressured or coerced, and participants' autonomy was maintained and respected. It is crucial that the prospective participants have the mental stability and awareness to make an informed decision regarding their participation in the study. Participants should be presented with ample accurate information to make to make an informed decision to participate or not to participate. If at any time the participants in this study had behaved or revealed that their

agency in decision making had been compromised the individual would have not be included in the study.

Non-participant coercion. This study held that participants should not feel implicit or overt pressure or coercesion into volunteering for the study. Heppner, Kivlighan, and Wampold (1999) state that researchers should also respect a volunteer's right to decline participation by not repeatedly contacting them even after they have refused participation. This matter is significant because the researcher is affiliated with the clinic that was conducting the study. In addition, Hammersley and Atkinson (1995) have purported that therapist conversation with the prospective participant may have a persuasive influence and may be construed as coercision despite the good intentions of therapist. Therefore the research did not use participants that are seeing therapist at the clinic. Information was given to clients that inform participants that they must not feel pressure to continue with study if they sought out the therapist provided to them. Their decision to not participate in the study would affect the services that could have been potentially provided to them. However in this study no requests to terminate or to seek out a therapist were requested by participants.

The researcher was attentive to any effort by the participants to withdraw from the study given that participants are less likely to be assertive in advocating for their well being once they have consented to participate especially in clinical populations (Griffin, Resick, Waldrop, & Mechanic, 2003). It has been stated the importance of informed consent and the need to protect and honor the rights of the volunteer. In consideration of this it was essential to address beneficial and risk factors that may possibly impact participation.

Beneficent & nonmaleficence. To ensure that there was appropriate allocation of risks and benefits, this research was ethically guided by the principles of beneficence and nonmaleficence (Fontes, 2004; King & Churchill, 2000). Research studies ought to be designed to acquire knowledge that benefits the particular individuals of society which the participants of the study represent (CIOMS, 1991; Fontes, 2004). The section of society represented in the study as well as the participants that bare the weight should receive a suitable benefit, and the class principally proposed to benefit ought to shoulder reasonable share of studies risks and challenges (CIOMS, 1991, Fontes, 2004).

Nonmaleficence holds that there is a duty to do no harm and is recognized as the first condition that must be met (Fontes, 2004; King & Churchill 2000). Beneficence holds that there is a duty to actively to do good for the benefit of others. This study in regards to the principals of beneficence and nonmaleficence sought to consciously reduce the amount of risks and maximize the benefits (Fontes, 1998; Loue, 1999).

Beneficence focuses on the stipulation of benefits and seeks to achieve an appropriate balance of the benefits versus the risks of volunteering (Fontes, 2004). The discussion section of scientific studies usually suggests areas of additional research regarding implementation or study by professionals but presents not much of direct benefit to the participants (Fontes, 2004). The concept of catalytic validity is useful here (Lather, 1991). The model of catalytic validity as presented by Lather (1991) is applies here. The extent research transforms the participants it studies to comprehend a world view how it is developed and ability to shape it (Fontes, 2004).

Much of the domestic research on domestic violence does not usually directly improve the ability of the participants to get the treatment to live a life of nonviolence or

disentangle themselves from domestically violent circumstances, neither does it enhance their understanding of the toll abuse systemically has in their lives (Fontes, 2004). The purpose was not to see participants as a means to an end or leave the participant as equally vulnerable after participation as they were before but to provide a benefit that will improve their lives. While the role of research was not necessarily mandated to administer therapeutic treatment, researchers are charged with providing for the safety of the participants (Collogan, Tuma, Dolan-Sewell, Borja, & Fleischman, 2004). Therefore an assessment of risks was implemented to reduce traumatization or increasing feelings of anger or violence.

Risks of triggering anger and violence. It is important to realize that talking about treatment that would be helpful to reduce violence with offenders raises the potential to awaken vulnerable feelings of emotional distress, guilt, regret, insecurity, remorse, and anger towards themselves and even victim. Cowburn (2005) points out that the type of interview, its focus, duration and intensity / unavoidably brings up past situations that are personal and hurtful, that even talking about it can be exceptionally traumatic both to the participant and researcher. This can be invasive and could, in some scenarios, present as a risk to the participants' emotional and mental health Cowburn (2005). Therefore it is essential to assess and be aware of the volatility of the participant to reduce the risk of emotional distress.

However if the research study process is controlled and the participant knows what to expect, participation in the study may bring up difficult feelings but will not cause emotional distress (Collogan, Tuma, Dolan-Sewell, Borja, & Fleischman, 2004).

In-depth interviews conducted by researchers also can have a therapeutic effect on participants and that the transformation that may occur may be welcomed by the participants (Boss, 1987; Sprenkle and Moon, 1996; Sprenkle & Piercy, 2005). Cutcliffe and Ramcharan (2002) purport that participants involved in research express personal benefit of knowing that their contribution will help others, and hope that other will avoid or learn from painful circumstances. In addition participants reflect positively rather than negatively and see their personal involvement as having helped them make progress in key areas of their lives and see it as a way to repay goodwill or resolve past emotional situations (Cutcliffe and Ramcharan 2002; Newman & Kaloupek, 2004).

This research study will as suggested by Hammersley and Atkinson (2007) let the power stay will the participant to reveal what they want in the interview, to provide a benefit that can be useful in the form of a referral or information, and empower the participant that their involvement in this research study is a significant contribution to science.

Legal Challenges. Maintaining confidentiality can pose serious legal challenges, particularly when the researcher has built a relationship of trust along with the promised of confidentiality and has received information of child abuse, malpractice, violent criminal behavior by the participant in the study (Cowburn, 2005). It was not the aim of the study to seek information from participants that may in some way incriminate themselves. In fact no information about their case or substantial facts was required of them. They were only be asked to comment on the perceived efficacy of treatment alternatives for domestic violence offenders. However it was possible that a participant may unintentionally disclose personal information. Therefore to address this possibility

from the outset, the informed consent clearly addressed the limitations of confidentiality and the researcher reviewed it with the participants prior to the interview. The form also disclosed that mental health professionals, as well as researchers of the study are mandated to report child abuse or harm to others. This duty to report also included statements made by the participant that would have given the researcher or mental health professional a reasonable suspicion of child abuse, harm to self or others.

Maintaining privacy. Maintaining privacy of participant identify is a key concern at all stages of the research process. This is not limited to only data collection but it also includes the location where contact with the participants is made and risk their identity being discovered. It is necessary regarding research that a plan be in place that ensures the protection of privacy of the participants (Collogan, Tuma, Dolan-Sewell, Borja, & Fleischman, 2004; Cowburn, 2005). A setting was selected that offered the participant privacy particularly during data collection and interviews. Given the possibility that some of the interviews may be given at a clinic Morse (2006) states that researchers should make the distinction between what is research and what is therapy. Morse (2006) also goes on to say those participants should be clear about the expectations of research and that records linked to research are separate from clinical documents. Another concern to privacy is that of data collecting and ensuring that documents and published material does not identify the participant

Sprenkle and Moon (1996) stress the importance being vigilant in changing demographic information or names that might specifically identify the participant. This is especially relevant to the qualitative interviews that will be conducted. The researcher that conducts the interviews was committed to the proper handling of information and

maintenance of confidentiality of the participants as previously stated. The transcript of the interviews was given numbers that will correspond to each participant to ensure protection of privacy. This practice was used with all documentation relevant to the participant except the document of informed consent. All documentation, transcripts, media and audio files pertaining to the research study was kept in a secure place under lock and key. After the study is completed all material was archived in a secure location (American Psychological Association, 2010).

This research was conducted in an ethical and professional manner that minimizes risks, maximizes benefits in a way that honors a confidential relationship and adheres to legal standards without compromising participant privacy. The researcher thoughtfully considered every phase of this research design to ensure all APA guidelines are followed.

Training of the Interviewer

The interviewer was prepared ahead of time for expected uncomfortable feelings that may arise in regards to revelations of past abusive altercations. The interviewer was equipped to effectively conduct the interviews in a way that produced the data necessary to sufficiently answer the questions. In qualitative research, the researcher serves as the human instrument by which data is collected. Furthermore, Maykut and Morehouse (1994) purport researchers as human instruments sensitive enough to capture the multifaceted rudiments of an individual's experience. The phenomenological experience is a human experience and only human beings can give voice to the nuance of those participants that they have interviewed. In effect, it is the qualitative researchers' ability to be and interact in human experience that sets them apart from other research

instruments (Maykut & Morehouse, 1994). When an individual is emotionally open to another's circumstances that individual is in a state of being with him or her (Maykut & Morehouse, 1994).

Emotional awareness can be an asset to the qualitative researcher for it encourages the researcher to listen more carefully to experiences presented, and think carefully about how to accurately present the data (Wincup, 2001). Rager (2005) suggests researchers can be affected by the emotionally laden content of the interview which can improperly impact presentation of the data. Rager (2005) states qualitative researchers should be trained to engage in self-care to ensure accurate data collection.

When interviewing participants they maybe sensitive and resistant to answering questions because they expect to be asked about past acts of violence. The researcher made clear to participants that he is only interested in asking questions about their perception of interventions that are helpful to partner violence offenders in a treatment program. Researchers should establish a collaborative relationship with the participants and be familiar with the research process and interview questions (Cowburn, 2005; Shaw, 2005). This helped the participants to feeling at ease and feel confident in the researcher's competency to conduct the study.

It is imperative that the researcher be prepared to address and dispel myths participants might have about research and correctly share how the research process works (Shaw, 2005). During the research process it is not uncommon that the participant may experience shame, fear, or suspicion (Cowburn, 2005; Shaw, 2005). The research should reassure the participant with expression of empathy and non-judgment (Cowburn, 2005; Shaw, 2005).

The interviewer identified and was aware of their personal feelings regarding domestic violence offenders. First strong feelings of dislike of the participant by the researcher may prevent good information being gained and even terminate the interview. Second the researcher's awareness of his or her feelings can prompt natural conversational responses which will elicit good data.

Shaw (2005) purports researchers should be mindful of the participants' verbal and non-verbal responses and manage the interview in a manner that does not overwhelm the participant. This might mean the interviewer selects questions of less intensity or the taking of a 5-10 minute break.

The perceived power differential between the researcher and participant can serve as a barrier to obtaining necessary data. Researcher adopted an open, one-down position, which is respectful and curious. As the researcher honed his interviewing skills and the participant feels more comfortable in the interview much of these anxieties decreased. Although guided by an interview format, researchers sought to make the interview more conversational in nature as to promote open less guarded responses from the participants.

Orientation, interview and debriefing. There is much useful information that can be gained by understanding what domestic violence offenders believe to be helpful to them in treatment. Therefore to reflect an accurate portrayal of the study the researcher interacted with the participant as part of the research team (see Appendix C for interview format). This method of working was beneficial in helping reduce anxiety with an emotionally laden topic, provides support, and helps refine and produce accurate of research findings (Cowburn, 2005; Goodwin & O'Connor, 2006; Perry, Thurston, & Green, 2004).

Orientation. The researcher discussed and reviewed the research process and informed consent form with each participant before the interview. After the participant had demonstrated that they fully comprehend the form (Heppner, Kivlighan, & Wampold, 1999; King & Churchill, 2000) they signed and dated it (see Appendix B). Demographic data was collected on a separate form (see Appendix D). After the form had been completed the researcher turned on equipment to recorded the interview. In addition, researchers provided participants with a list of at least three mental health professionals (i.e. Marriage and Family Therapists, and Psychologists) they could contact if in any case they experience trauma or adverse effects related to their participation in research. If additional referrals (i.e. psychiatry, 5150) were need those would have been provided. However in this study no additional referrals were requested or needed.

Interview. The standard open ended interview approach was used to interview participants. The researcher also used interview guide. This ensured that all participants were asked the same questions while allowing flexibility for the researcher to ask follow up questions to gain the information necessary. The goal of the qualitative researcher as a human instrument was to ask questions in a manner that elicit the richness of the participant's experience (Denzin & Lincoln, 2005; Kvale, 1996; Patton, 1990). The influence power and gender can be a barrier or impede the interview process even if the participant and researcher are of the same gender (Schwalbe & Wolkomir, 2001).

The interaction of power according to Nunkoosing (2005) is a constant in the dialogue of an interview, as reflected in all human communications. In research, power is also present during the interview process and constantly moves in between the interviewer and interviewee (Nunkoosing, 2005). The qualitative researcher uses the

power of education in scientific method to elicit experiential knowledge from the interviewee and the interviewee has the power to be the giver of that knowledge (Nunkoosing, 2005). In addition this relationship is made more complex if the interviewee is seen as a social outcast for breaking societal mores (Cowburn, 2005; Shaw, 2005). At the same time the interviewee seeks to communicate his or her perspective and preserve dignity (Shaw, 2005).

Gender also influences the interview process. In this study the researcher is male. Schwalbe and Wolkomir purport that a male interview may pose a threat to a male interviewee because it may put his portrayal of self in doubt. Cowburn (2005) suggests that male interviewers may overlook certain male mind-sets, or expressions of emotions. Therefore in this study the researcher was mindful of the gender and power interaction and reflected on each interview as to what follow questions may be necessary to elicit deep rich experiences.

Goodwin and O'Connor (2006) recommend researchers highlight the following areas regarding a qualitative interview: a) ambiance/environment of the interview, b) How is the attitude of the participant, c) the emotional response of the participant to questions asked, d) the opinions, experience, and reflection of the researcher. This helped the researcher clarify his thoughts and decide if follow-up questions/interviews were needed.

Debriefing. The researcher spent few moments at the end of the interview to debrief the participant and evaluate for any feelings of emotional discomfort or concern (Cutcliffe & Ramcharan, 2002). The researcher also allowed time for the participant to share what benefits they may have gained from their involvement. It is important the

participant experienced their involvement not as a means to an end but as a benefit that will enhance their lives (Fontes, 2004). Debriefing post-interview with the participants also helps reduce the chance of the participant feeling of abandoned especially after sharing their perspective (Cutcliffe & Ramcharan, 2002; Shaw, 2005). The participants were given the information on how to contact the researchers and other clinical personnel if adverse effects related to involvement with research surface.

Interview site and recording device used. The researchers conducted the interviews in a controlled safe environment that allowed for privacy and free of outside distractions (Collogan, Tuma, Dolan-Sewell, Borja, & Fleischman, 2004). Research interviews are typically documented using an audio recorder as to provide an enduring record of the interview with which to work. Interviews are transcribed into text for intent analyzing the data and the assessment and method of transcription is contingent on the type of hypothesis and methodology (Halcomb & Davidson, 2006). A Hewlett Packard laptop computer was used to record and transcribe/code the interviews. In addition a data recorder was used as back-up to capture audio if other equipment fails. The researcher was involved at every step of the research process to maintain fidelity to the data.

Interview Questions

In qualitative research there are many approaches towards conducting an interview (i.e. informal conversation interview, general interview guide approach, standard open interview). This study utilizing a grounded theory approach sought to enter the participants' world and understand through thick deep rich descriptions the perspective and meaning of their experience (Denzin & Lincoln, 2005; Patton, 1990).

Through a standardized open interview every participant was asked the same questions about what experience in a domestic violence program would present the most effective treatment. However the research was also free to probe with follow up questions that best elucidated the richness of the participant's experience.

How interview questions are written can inhibit or help participants to clearly express their perspective. The interview questions were designed without academic jargon as to be easily read and understood by the participant (Kvale 1996; Patton, 1990). This best helped the participant to articulate their experience at a deeper detailed experiential level. It also enabled researchers to better collect and clarify data at a depth of inquiry that contributes new knowledge to science (Andersen, 1992; Denzin & Lincoln, 2005; Patton, 1990). To provide a comfortable interview atmosphere the research spent five minutes joining with the participant before commencing with the interview (see Appendix C interview procedures). If future interviews were deemed necessary follow up questions would have been used based off the interview questions previously asked.

Coding Validity and Reliability

First phase: Open coding. Open coding in grounded theory involves the utilization of the comparative method. This approach asks questions and employs comparisons of the data that get labeled and categorized into concepts (Charmaz, 2006). Labeling and categorizing is the product of analysis that fleshes out the data to better understand the questions of who, how, where, when, what in the experience of the participant (Charmaz, 2006; Pandit, 1995). The researcher's line by line coding of the

transcript produces meaningful distinct themes that are contextually imbedded in the participant's experience.

As ideas and themes from the data start to emerge they are grouped into a category together (Charmaz, 2006; Pandit, 1995). The researcher then begins rigorously comparing and scrutinizing each category for variance in aspects of the experience (Charmaz, 2006; Strauss & Corbin, 1998). Memos were written directly after categorizing data as a means of noting the impressions of the researcher and characterizing the experience. The use of descriptive, active language the codes have the ability to elicit an authenticity of participants experience (Charmaz, 2003). These are essential as they offer a collection of perspectives which can be referenced to formulate a theory. This allows the researcher to thoughtfully systemically analyze and constantly compare the offender's experiences without losing focus of the theory.

Second phase: Axel coding. Axel coding seeks to understand not just what is occurring in the data but how identified concepts interrelate (Glaser & Strauss, 1967). The purpose is to find the connections between meaningful complex relationships of the identified subcategories (Charmaz, 2003; Strauss & Corbin, 1998). The discursive purpose of axel coding is to engage inductive and deductive analysis that goes beyond the data in formulating a core category (Charmaz, 2006; Coffey & Atkinson, 1996). The researcher also engaged in constant comparison with established research as orientation guide in theoretical development (Strauss & Corbin, 1998).

Third phase: Selective coding. The selective coding process integrates categories into a theory through the present inferred and deducted relationships (Stamp, 1999). Strauss and Corbin (1998) suggest analyzing the relationship between categories

at a macro and micro level in a manner that weaves a conceptual narrative. Categories can be sequenced that can address the various conditions and consequences, providing specificity and accuracy to the emerging narrative (Brown, Stevenson, Troiano & Schneider, 2002). However researchers must ensure that selective coding is not disjointed and random but stays thematically focused (Strauss & Corbin, 1998).

The core category should best reflect and articulate the multiplicity of nuance dimensions that thematically emerge from coding. Hence the data can be assessed how, its rationale, and from where the themes and categories were conceptualized (Goulding, 1999). Reciprocally the theory can be evaluated in terms of how it connects to the data (Goulding, 1999). Therefore, it is crucial that evidence be provided that maps out these relationships between themes, categories, and theory (Charmaz, 2003; Strauss & Corbin, 1998).

Theoretical construction of model. The concluding phase of qualitative research should reveal a theory that draws themes together and integrates them into core categories that have descriptive ability within the framework of the researched theory (Charmaz, 2006; Moghaddam, 2006; Strauss & Corbin, 1998). The theoretical narrative should capture the context of the experience and articulate it in a manner that is understandable and meaningful (Barbour & Barbour, 2003; Meadows & Morse, 2001). What should be present is a clear articulation of the concepts that links the experiential to the abstract and vice versa (Barbour & Barbour, 2003). The research results should be set in context of current research and assessed for how it contributes to the discipline (Gilgun 2005; Morse, 2003). The researcher's ability to articulate the interrelatedness of the

emergent theory into present scientific discipline provides a value to future research (Morse, 2003).

While some research phenomena may yield results that are not easily integrated into present (Shamai & Levin-Megged, 2006) both divergent and convergent findings should be recognized as significant knowledge that is critical to the discipline (Morse, 2003; Strauss & Corbin, 1998). This qualitative study utilized an interview process. The approach yielded a unique rich understanding of the treatment needs of domestic violence offenders. It captured a variety of data that could be utilized to inform clinical practice and programming (Sandelowski & Barroso, 2003) in domestic violence treatment programs.

Internal validity. Internal validity, often associated with quantitative research, verifies whether the research has indeed measured what it intended to measure and how accurate the results of the study are (Joop, 2000). This involves the disqualification of alternative hypotheses (i.e. selection of subjects, maturation, instrumentation, effects of testing) that pose a threat to validity (Lincoln & Guba, 1985). In qualitative research the internal validity is addressed through the pursuit of "trustworthiness and credibility" (Flick, 2006). The researcher sought truthfulness in the collection and presented outcomes of the data to ensure reliability and validity. While the researcher pursued the facts to ensure truthfulness it also included the honest perspective and experience of the participant (Wolcott, 2001).

External validity. In quantitative research the ability of a theory/model to be generalized across different domains is referred to as external validity (Guba & Lincoln, 2004; Lincoln & Guba, 1985; Morse, 2006). Qualitative research exercises external

validity through transferability, which is the extent the results can be generalized to different contexts (Guba & Lincoln, 2004; Lincoln & Guba, 1985). Transferability is enhanced through the researcher's detailed rich descriptions of the participant's experience, context, and the assumptions that guided the research (Fereday & Muir-Cochrane, 2006; Morse, 2006). Transferability can also be assisted by the study's explanation of how its results move forward theoretical knowledge that is applicable to multiple contexts (Kuper, Lingard, & Levinson, 2008). For example, a study of partner violence offenders' preferences in domestic violence treatment programs may contribute to theories of typology, engagement of offenders into treatment, and development of effective clinical protocols.

Reliability. A key point of reliability is demonstrating a consistency of the study's findings that that can be substantiated by other scientists (Lincoln & Guba, 1985; Pandit, 1996). This is demonstrated through comparing the study with other similar research findings in the field (Flick, 2006). Therefore in this study research scientist compared the treatment needs of domestic violence offenders to those in other study in a different part of the country. In qualitative research reliability is enhanced when the researcher describes the methodology, data collection, and process of research including the use of field notes (Flick, 2006). While the researcher is not a completely objective observer the written process allows other scientists to follow the author's inductive and deductive analysis (Flick 2006; Thomas & Chambers, 1989). In this study documenting the research process not only helped ensure reliability but aided the researcher in accurately and comprehensively representing the perspectives of domestic violence offenders that would produce effective treatment.

CHAPTER 5

RESULTS

This study sought to explore which domestic violence program interventions and conditions are optimal in helping domestic violence offenders to have a successful treatment experience and effectively reduce recidivism. Four research questions were addressed in this study and are presented in this chapter: (1) What interventions are helpful/ not helpful in producing behavioral change in domestic violence offenders? (2) What engagement strategies are effective/ not effective in producing meaningful motivation in treatment? (3) What relational goals would be effective /not effective in reducing domestic violence recidivism? (4) What is needed in a domestic violence treatment program to be effective in reducing the likelihood of recidivism? To address these questions using grounded theory, semi-structure interviews were conducted. 18 offenders who were mandated to treatment in addition, a focus group of 10 mandated offenders was also conducted to explicate more completely, the richness and intricacy of offenders needs to be successful in treatment and not recidivate. Of all the participants involved in the study 15 were Hispanic, 2 were African-American, and 1 was Caucasian. All 10 of the participants in the focus group were Hispanic.

Helpful Interventions

Four major themes that emerged in the interviews regarding interventions that participants believed to be helpful were interventions focused on understanding the different types of domestic violence, anger management, conflict management, and communication skills development. Interventions that were thought to be helpful were

breaking down a situation, taking an hour break or time-out, letting go of the past, venting to the group. Interventions that were viewed as not helpful were few in comparison to those that were perceived as helpful and will be address in this study.

Understanding types of domestic violence. Not all domestic violence offenders are always arrested for physical altercations with their partners. Some participants reported being arrested after a neighbor called the police because of loud heated arguments in which things were being thrown. In the beginning of treatment not all participants understood that there are different forms of domestic violence. One participant was surprised to learn that he was being arrested after he threw an object at her in a heated argument even though he didn't touch her. Learning about other forms of domestic violence such as verbal abuse, financial abuse, sexual abuse, as well physical violence helped participants to feel less confused as to why there were mandated to treatment when they "only" grabbed, held or threatened their partner.

> So if I would have had some kind of education or something about learning about domestic violence…I had never heard about it or ever thought that you could just get a case by just, you know, arguing or her putting her hands on you and you're trying…what are we supposed to do? I tried to run, she followed me out the house. She threw a knife at me, I threw a phone at her. And that's it. I caught a case.

Many participants found it useful when interventions aided them in "*breaking down*" their situation in which the incidents of domestic violence occurred and to look at how and why it occurred. As stated by one participant:

> "It's just like…I feel like it's broad. Just domestic violence and that's it. There's no gray area… Can we just break it down somehow."

Participants shared that receiving handouts on the cycle of violence and interventions breaking down the forms of domestic violence "was really good." Reflecting the sentiment of the group one participant shared how breaking down a situation in a movie with domestic violence helped him to identify the forms of partner abuse and take responsibility for his own actions.

> Well, like, okay, like, for example, I know that domestic violence, when we go to that class, it's supposed to be discussions about certain things. But a couple of times he says, hey, you know what, we're going to watch a movie. And we're like, oh, what movie are we going to watch? And he's like, oh, we're going to watch La Mission. Some movie where, you know, where everybody's thinking to themselves, what does this have to do with it? But as the movie goes on, he's like, hey, see what you're seeing here, this is a form of domestic violence. He starts breaking it down into the class period instead of just movie time. Because the first thing we think about, you know, watching a movie in that class is, oh I got a 2 hour break. I'm going to watch a good movie and relax. But at the end of the movie, he does tell you, okay now, I want you to write something about it. I want you to write something about what you saw as domestic violence. What went on about domestic violence, you know. By the time you're done with it, you're writing this little page, and you're like, wow, he got me, you know. We watched a good movie and he got me to talk about domestic violence and what we saw in that movie. He's able to do it that way. That was good. I like that…

This indicates that offenders desire to both understand how their actions are domestically violent and learn better ways of communicating by being able to take a-part a situation and look how words and actions feed into partner violence. Another participant found understanding the cycle of violence and the different forms of domestic violence including verbal abuse "very helpful". "So now I understand that you can't even yell at a girl nowadays." When asked what are you learning that is helpful? One participant replied:

> "I don't know. Like, when I read that paperwork that he tells us…when he gives us paperwork and there are things that tell us of why domestic violence happens…I notice I relate to it a lot. It does happen to me. I don't talk to them about it but I'm kinda distinguishing why it's happening to me.

Another participant shared how breaking down the situation helped him to identify the motives behind his actions of violence, of trying to get love and respect was working against him:

> He broke it down to us in so many ways and gave us some work on it to where you were able to see the difference, as far as fear and respect… He showed us the difference because when you fear somebody, obviously you fear them because you think they're going to hurt you, whatever. And you respect somebody, maybe the same reason…out of fear. So like, you try to it break down… and there's no love in fearing somebody. There's no respect when you fear somebody. There's no…different ways, I guess. Right now, I can't specifically think about it, but he did break it down to where I had never looked at it like that. Like, my dad, I don't love him and I don't respect him. All I do is fear him, you know, because of the way he raised me…And that was something that I had never looked at it that way. And after coming here, it was like I had a different perspective of words. Respect and fear…

Participants shared that this exercise helped them take responsibility for their actions and to look at how they could have avoided the situation altogether. This was evidence by one participant who shared the following:

> Yes. Because I believe, you know, now that I've been going to class over a year, I do believe that there are a lot of different forms of domestic violence. There's not just physical violence. There's verbal violence, mental violence that can be put on a victim. It made me feel a bit responsible…for my actions, when I did it.

This participant went on to share that he was able to apply the interventions to areas in his life that he needed to change:

> Well, other than the domestic violence situation its learning about the different forms of it. I learned a lot about myself, you know. We're able to learn a lot. Take a lot of that situation that we're talking about and take it back and relate it to our real life situations. You learn a lot about how, you know, hey, I didn't know I was doing that with my verbal…you learn a lot, you know. You're able…I think I've learned something from there is to…to how would I say it…to evaluate myself and say, hey, you know, watch what you're doing, you know, so you won't go back. Because that's one thing I don't want to ever do.

Another participant was made aware through discussion of domestic violence as to why he acted violently and the influence the cycle of violence has had on his family history stated it this way:

> Like, why I do things or why I bottle things up. And I think it's part of my family history of why I'm doing what I'm doing. And I'm interested in learning how to break that cycle but I just haven't gotten to that point yet or I don't know. I'll have to learn a bit more.

Similar thoughts were also expressed by another participant, who shared it was helpful to slow down the situation to see his actions and reflect how he could have behaved differently.

> Well I didn't actually think about how we got to that position that got me in here. You know, think about …it makes you think about, like, really what you could have done different in the relationship to actually make it work and not be in that situation you got into.

One participant upon reflecting on his actions felt overwhelmed with responsibility of his actions:

> It was everything I was feeling every emotion. You know, I was sad because of what I did. I was mad at myself. I was mad at the situation because of how it went down. I was, you know, I felt like, you know, I shouldn't be in here. But then I felt like I didn't want to deal with my problem. I didn't wanna…I don't want to use the word problem because that's so big. I didn't want to deal with that issue. You know, by nature, I'm not a violent person, you know. I've always been one to, like, be like,

> you can walk away, you can talk to somebody. And so just seeing me hit somebody, especially somebody that I love and is close to me, was just like…wow. You know, it's like, who is that person in the mirror… It's hard to be….first of all, it's hard to be honest with yourself, admitting that you're wrong…especially men, its like, dude, no… I'm never wrong, you know. And the ways we go about saying, switching the blame or denying things. Just our last class we were talking about that. You know, and how we say it. If she didn't get me upset I wouldn't hit. You know, or… Or, she ran into my fist. And it's just like…it's all these things of not being honest with yourself. You know a lot of things we're basically taught is…it starts with us first. Then work on…then work it on the outwards. A lot of people want to be, it's not me, it's you. But that person didn't' cause you to get here, man. You know, man up to your own things. As men, we say we're men but sometimes when it comes down to it, you know, in this situation, a man doesn't want to be a man. They want to point the fingers and blame. And it's like, dude, that doesn't do anything at all. You're not acknowledging the problem. You know, you're just putting a band aid over a gash of wounds that needs to be seriously treated.

Interventions that broke down situations and different forms of domestic violence were central to helping participants identify and understand and take responsibility for similar behaviors in their own life.

Anger and Conflict Management. Emotional regulation of intense emotions such as anger was a challenge that participants expressed as a personal challenge to control. Interventions of "time out" and "taking an hour break" provided them with better emotional control were found to be useful. It was found that participants in the beginning of treatment were not necessarily aware that they had a problem managing their anger or knowledge how to appropriately channel it.

> They also talk anger management, too, which is really good because being a male, I know me and a lot of other gentlemen in the class, we struggle with that. Because we're not really taught to have an outlet, and this is a chance for an outlet, you know. We can just get things off our chest, which is really good, you know.

It was not until after the facilitator was able to highlight the problematic areas of poorly

managed anger and its consequences, through discussion and interventions that the offenders began to see their role.

> But I did take in a lot of the anger things… domestic violence and anger management…and I found out that, man, I got a lot of these anger issues.

Analogous thoughts were also expressed by another participant who shared how he learned how to use a "time out" to deal with emotions of anger affect family life and how to put those feelings in their proper context.

> So they reminded me that it's the best thing to do. Take your time out so you don't get into that kind of violence or problems with your partner. In this case, my partner, you know. Some people, they are here because of their brothers or sisters. And I think it's because we were under a lot of stress because of my little son. We didn't know how to deal with the situation.

Participants shared interventions helped them learn a lot about how they deal with their anger and what happens when it gets out of control. Participants spoke of the need to not be so quick to get angry and think before acting as a necessary to initially not letting their anger get out of control. Some of the chief interventions that participants shared that helped them to manage anger and conflict them were: to take a step back to reassess the situation, take an hour break to cool off, letting go of the past, and thinking before acting. A participant talking about how these interventions aided had this to say:

> I've learned a lot. But, yeah, it's just, you know, letting go of your past, that's a big one. A lot of people didn't know that but I realized a lot of guys, you know, we're just holding on to so much. And to say, you know, its okay what happened in the past, you know. Like, if it was traumatic, its okay. You know, don't hold on to pain because you're not being able to grow. It's just holding you down. It's just weighing on you. So that was a big one. And then that hour break was a really good one. And just being able to really talk. That's a big one.

Sharing a similar thought one participant who expressed how letting go of the past frustrations was useful for him put it this way:

> She talked about letting go of the past, which is really big. I think it's really big for a lot of people because we want to hold on to that. We want to fixate on it so much that, you know, it's kind of walking forward, looking back. You know, you're so fixated on what happened that you're not ready for what's going on next. And that was a big thing to, like, you know what, let it go. Just let it go. Because you can't change it. You know, keep talking about it over and over. It's not going to do anything. You know, it's like, you know, realize, look, I messed up.

A participant, speaking on how writing a letter to himself helped him confront his own anger issues, said this:

> Because there was a… not this group, but in my 3rd group there was an activity to where we had to, more or less, write a letter to ourselves, explaining to ourselves what we thought our faults were and why we didn't want to change them. Like our anger issues. Or it was too hurtful to go back and try to change what happened in the past that made us up front, you know. Up front as not wanting to be furious with that person. And I made a list of a couple items and I actually looked at them in a different perspective because I was doing it to myself. I was basically criticizing myself. And that kind of helped me out.

One participant shared why taking a time out and checking his first thoughts is effective in helping him manage his anger and even change his perspective on a tense situation this way:

> Uhhh and the reason why it struck a chord with me is because I uhhh got some paper work similar to that in rehab it's like your train of thought that leads to actions or something like that A, B, and C. Your first thought leads to an emotion which leads to an action so if can change your first thought you can change the emotion and change your action…I was an angry person for a long time. Still a little bit but not to over the top I don't think any more. But my first thought was just a negative one so like if a situation would arise and say in the paperwork they use the example of an uh flat tire. And so your first thought would be ok OH I'm gonna be so

> late for work or something like that and your emotion would be anger or uh…anxiety or something like and your so your action would be to start yelling or something at somebody getting on the phone and yelling at people. So if you change your first thought was uh… oh now I have a chance to get some coffee or something like that. It's like changing your perspective and then your first emotion will be a calm relaxed emotion. And your action would be just as…calm. You know so … I really like because usually my first thought is negative one… if we're in an argument or whatever and I don't get a chance to step back because she is angry too. So it's like an instant time out for me. Uhmm I know going to say that sit here and tell you that I am perfect or anything like that…and I don't argue back. But for the most part I am able to kinda take a step back in my head. A mental step back you know…like a mental time out and figure out what's going on with the situation. I still am able to check that first thought and you know the arguments that we get into don't even escalate to where they used to…especially when I was drinking. SO uh Its not necessarily like a 10 second like 10 deep breath thing…you know maybe just a quick mental...wait a minute where's this going? So I have to check that.

Along with managing anger, participants talked about the challenges of managing conflict, how to avoid it, and being able to recognize behavioral patterns that escalate an already intense situation or even create one. One participant speaking on the usefulness the intervention of breaking down patterns of behavior as a way to avoid conflict put it this way:

> Because you can see…sometimes you'll go through a dialogue between two people that are certain…this type, so you can see the pattern… I think that's helpful. So you know…so when you see it or you hear it, you'll know it. You'll know what it is…if you recognize that behavioral pattern, you know what that is. It also gives you suggestions on how to deal with it.

Before a conflict gets too heated another participant shared how he uses the "time out" to calm down this way:

> So I think about all that before I even get to that point where I'm going to start arguing, start being uncontrollable. I think about it before I get to that

> point. I just calm myself down. Either I take a deep breath or a little walk to calm myself down and after that it's all good.

Many of the participants described their conflicts in a way that seemed to happen out of the blue and responding to it without thinking. When participants reflected on their actions differently, participants revealed that had used the time-out intervention to think they may have avoided the situation. Consider what this participant shared when reflecting on managing conflict:

> Well I didn't actually think about how we got to that position that got me in here. You know, think about …it makes you think about, like, really what you could have done different in the relationship to actually make it work and not be in that situation you got into…

A participant expressing a similar thought of how taking a time-out calms him down and aids him in controlling himself and choosing an appropriate response stated it this way:

> Control myself. Like, run things through my head, you know what I'm saying…calmer things. Like, two years, I'd just get pissed off… you know what I'm saying… I don't have a short fuse no more. I know how to take it in and respond it back out in a calm way, you know.

In situations where domestic violence occurs, circumstances are often described as spinning out of control or erupting out of nothing. Rather than choosing what concerns are worth challenging, every situation becomes a heated big deal without proper emotional regulation and physical restraint. Interventions that teach offenders to slow the building of conflict by taking a time out, or taking hour break to checking their first thoughts, and breaking down the situation were thought to be helpful. One participant who shared how taking a time-out to checking his first thoughts helped him slow the escalation of conflict put it this way:

> Checking ourselves and just, you know, before it gets out of hand, think about it. You think about it, you cool yourself down, you know. That's something that I've learned there. That it's like, don't get mad over certain things, you know. Sometimes you tend to blow up for the smallest things, you know, and that can lead into something bigger. That's one thing you want to avoid. Any form of conflict or anything with anybody, you know. So if it's not a big deal, let's not make it a big deal, you know…
>
> You know, like I said, everything there was helpful for me…all the little exercises that we do, the quizzes that we do. I try to keep as much as I can. There is one that I really like. It was this one where he just broke down the situation on paper, you know. What happened? And seeing it on paper and seeing it the way it is. It's like, wow, to go that far. I could've done things a lot different when I'm looking at it on paper, you know. But like I said, it is hard when you're in the heat of the moment. But if I know, if I would've known all this before, it would have been totally different situation. I would've walked away from the house. I would've not even confronted her about it. I already knew what happened, you know. I already had the evidence.
>
> There was no need for me to go in there and try to make it a worse issue or a worse problem than it already was. I just needed to be the bigger man and just step back and say, you know what, let's just get a divorce. And that's it. There's no need for name calling. There's no need for anything, you know. And if I would have known that then, I probably wouldn't of even been in this situation.

Here, the participant, like many participants, expresses how taking a time out and checking his thoughts would have given him the time to cool down and take a different course of action. Being able to identify conflict creates enough mental space that enables them to slow down, step back, and assess the situation enough to make thoughtful choices as to how they should respond rather than a knee jerk violent reaction.

Communications Skills Development. As participants talked of their experiences, each of them spoke of the necessity of developing better communication skills that helped them communicate their feelings without verbal abuse or violence, and

to effectively manage conflict. A participant conveyed the value of learning to better communicate this way:

> Communication, honesty, loyalty, you know, a lot of things that we were taught as children and never really applied…and realizing those things are really important. You know, not just for your spousal relationships but even friendship relationships. I've learned…how to communicate a lot better. You know I thought I was great at it. I've, you know, I've taken speech classes. I'm not afraid to get up there and talk to people. But to actually talk about a situation like domestic violence, it's kinda scary, but I'm willing to. And I want to I want to talk about it… I don't want to miss anything. I don't want to be naive or anything and be like, oh, I don't need this, you know, because, you know, what's that gonna do. Like, this isn't here to hurt us or anything. It's here to help us. If someone wants to help me, he, I will take all the help I can, you know.

At the same time, data revealed that participants seemed troubled by their lack of tools to effectively communicate without using violence. It is not that participants do not sometimes sense there is a better way to express themselves, but not knowing how, can make it hard to break the vicious cycle of violence. One conveyed it this way:

> The communication skills... Well, I've only been there for about, maybe like a month. Just a month… But I mean, like the way he's helping me communicate with, you know, my peers. I think that's helping me because I do have a communication problem…And I think to myself about how to solve the current situation with my problems. So, it's kinda learning how to communicate a little bit better. I know I do have communication skills but I don't know how to express them when it comes to someone else or to a crowd. I have a little bit of stage fright so when I do talk I get nervous…I don't know how to express how I feel. I've never actually done that before. I have always, like, kept it in and just take it and take it… like I know my parents when they tell me something I just don't say nothing back because that's what I was taught…I didn't know, like, the cycle of communicating… I'm learning about myself as far as something that I never actually learned about…Why did I get to that point? You know, like, instead of exploding physically I should have…communicated verbally to say, you know what, this is enough.

Participants spoke of their difficulties with communicating their feelings and it was as if they saw themselves as having only two emotions, angry and not angry. Emerging from the data were struggles on how to effectively identify and communicate the other basic emotions (i.e. sadness, disappointment, hurt/pain, stress, frustration, joy, happiness) that are also within them. This created a great sense of frustration for many participants, because some felt they were fighting against traditional culture and gender views that limited them from truly communicating the nuances of their emotional range. Many conveyed a desire and need to gain more communication tools to effectively express themselves without violence. Another participant opened up about his experience this way:

> I think that's really important because awhile back, he was giving us certain things as far as communication goes. A lot of times, if I say something it might be really misinterpreted by the other person, depending on how I say it, depending on my emotions or actions. If I don't try to explain myself or try to communicate in a better way, then that plays a major role. But he was teaching us certain ways as far as giving us papers and reading on it…allowing us to think before we speak…or try to communicate in a way where it might not affect the other person to cause an altercation.
>
> So I think it does have a lot to do with it because we always try to be, like, the macho Hispanic or macho person or man. But I think that it does because it really helps out…if I don't know any better, or I don't want to know any better, or it's my own personal ignorance. If someone shows me something or tires to explain it to me or tries to tell me about it, then it gives me a second way of trying new things…

After an argument has started down a bad path a participant shares how a time out for him could stop poor communication from escalating this way:

> As soon as that first F word comes out or that first punch comes out, something right there, I think she just stops. And you have the opportunity to walk away at that point. I think that would be the better thing. It would

> be a better thing because if it keeps happening, you keep going back to the same thing.

Expressing a similar thought another participant who shared how taking his time-out helps him manage his stress and prepare himself to communicate better with his family in this manner:

> Well, communication because I was working all day, almost all day. So when I got home I have to, you know, still working, you know, do some paperwork on the computer and I was talking to her, just talking. But not communicating with her, you know... And I was under a lot of stress because of the work, you know. So they're teaching me still how to deal with my stress, you know. And that's helped me a lot with my problem. I still work a lot but I have my time. I take my time out every time that I feel, you know, under stress. I sit down for awhile and talk to myself and try to see what's going on. If I'm tired or angry about something…so I try to, you know, talk to myself a little bit more and get calm a little bit more, for like one or two minutes. And then think about it more, first.

Venting to the group. Many participants expressed that one of the most helpful things about treatment that is helping them was expressing their feelings in the group and talking about what is going on in their personal lives.

> It's just a place to go to bounce what was going on with myself, you know, bounce that off of other people and get some opinions back as to what to do in any given situation. Having that place to go …it's a good thing. Especially when we're all kind of united in this common thing of domestic violence, you know, there's like a stigma attached to that, you know what I mean, so when you go in there and people are going through the same thing as you are, it's kind of like camaraderie going on, like okay, well this guy gets me, you know… I think it's just that the process works well. Stat feeling more comfortable, opening up. You start opening up and I think the process is a process, you know.

Expressing similar thoughts another participant shared how venting to the group has helped him not catch another case.

> Yeah, because, you know, I'm opening up and it's like a relief off my back. It's like an anchor off my back. Telling my problems and I just feel like a lighter man, you know. I feel like I have a less baggage on my back because I'm opening up and I'm telling people that are listening to me what I have to say. They're giving me advice, too. They're giving me advice about what I should do, what I should say away from. And if it keeps progressing, you have to end the relationship because you can't keep going on and on like that because sooner or later you are going to catch another case. So if it's not working out, you know, then you have to leave that relationship. But since I have a kid with her and it's been good. Before I caught the case we were happily together for two years, you know. We never argued. We'd argue a little bit but it never escalated to this point where I've been thrown in jail for domestic violence. So I think this program is helping me a lot. I just want to wait to finish the program and see where I'm headed from there.

Non-helpful Interventions.

Of the interventions experienced in treatment, most of the participants found them to be helpful. However, emerging from the data were a few interventions that some participants felt were not as helpful and could be critiqued. One such intervention was walking away to manage a conflict. Some participants felt it overly simplified a solution to a complex problem. While it may momentarily solve the problem, it can also make the problem worse. One participant articulated it this way:

> Because, I mean, he taught us to walk away…sometimes it doesn't work because they're going to follow you. Take off. Sometimes it works, but you come back and it's even a bigger problem now because you walked out.

The intense emotional situations that offenders and their partners find themselves in are at times complex and filled with years of unaddressed hurt and pain. The data revealed that interventions that do not properly balance the reality of these situations can serve more as a disservice rather than an aid. This is also reflected in the way an intervention is delivered. How interventions are presented to the group matters, especially if they are

relevant to the group. It can help encourage the offender to be receptive to learning or can it can be a complete turn off. One of the participants spoke of his experience this way:

> Well, we did have one situation where, you know, I don't know… I guess they gotta look at the forms of domestic violence more clearly because we did watch a movie one that really bothered a lot of us in the class. It was about child abuse. You know, I understand that that's some kind of form of violence there, but if we're there for domestic violence against another adult, let's try to keep it that way, you know. Let's talk about the partner. Let's not talk bout kids being abused or anything like that because, you know, that's a whole different subject. That's a whole different form of violence there. And if you're not there for that, you don't want to hear it because a lot of us don't believe in that.
>
> That made a lot of us upset in the class, when we started watching the movie about, you know…and they're talking about little kids being abused, you know. A lot of us there are parents and a lot of us there understand our problems. We don't want to hear that kind of stuff because that kind of stuff just ticks you off, you know. Beating a parent, beating anything is just so wrong.
>
> Let's keep it to the domestic violence talk, you know. Certain topics let's not go into it if it's not involved in the group. If it's not part of the group, you know what I mean. That one was really rough on us, you know. And they did take it off, you know. We started…everybody was like, oh, no, no, no. This is not us. We're not here for that. Don't show me that kind of stuff because it just gets me pissed off, you know. And they're like, well, you guys all feel that way? Yes. Okay. Let's take it off.

An intervention was perceived at times not helpful because it was not presented in a way that offenders could make relevant to their experience. For example one participant in discussing the need for more attention to developing communication skills besides written information stated it this way:

> I think I received one four page paper on communication or I think it was communication. That's the only thing I've seen since I've been there.

The data reflects that interventions that promote the development of emotional intelligence and communication skills to manage anger and conflict as conveyed by the

participants are necessary to help instill confidence in offenders to be able to express their needs without reliance on threats and hostility. Mastery of these skills, along with an understanding of the different forms of domestic violence, can not only improve emotional intelligence, but reduce recidivism.

Effective Engagement and Motivation Strategies from the Facilitator

Participants express that feeling motivated in treatment helps them want to participate. The two major themes that emerged from the analyses of the interviews regarding effective/not effective motivation in treatment were motivation derived from facilitator, and motivation from dynamics of the group. The data from the interviews showed that the frustration/anger at the "system" (i.e. judge, police, district attorney, etc…) and baggage of the participants' relationships gets attached to the negativity, resistance, and denial that they bring into a mandated to treatment program. Participants shared that they often feel the stigma that is attached to domestic violence and that it can affect their motivation in treatment. One participant who shared how being labeled with the stigma can decrease participation described it this way:

> So I definitely think there's a stigma attached…when somebody hears domestic violence, you automatically think their first thought goes to somewhere that's pretty bad, you know, and kind of paint the person involved with the stigma, you know…and in all reality, they may not be a bad person. But they're playing the part as like they're really bad….because they've already been judged and stuff like that, you know. So I think that that has and plays a big role in that, you know.

It revealed the task to effectively engage these men to participate successfully in treatment is not only important, but also imperative. As one participant bluntly put it

> I think that probably the initial thing is somehow convincing me to want to be here and to want to participate and to want to get something from you.

The tone/attitude, relationship, and professionalism of the facilitator to the group were important factors that emerged from the data for engaging the participants in treatment. A participant speaking on the tone and attitude of the facilitator put it this way:

> I think it's pretty important. See I think the facilitator needs to set the tone and you know…She would be like hey guys how are you doing and you know tell us what was the topic for the day or we'd start off and say our like in a typical group we'd check in and say how was your week and how are you feeling to day and stuff like that and you know she'd chime in with questions and stuff and I noticed that in the end I started kind of looking around and trying to see what was going on a lot and I noticed that a lot of the guys would talk directly to her as and I think that's just a comfort like a comfortableness that comes from just the nature of the person you know the type of questions that are asked and stuff like that you know…She's kinda got that grandma feel to her.
>
> But I've been in groups also where we had some pretty like tough counselors where they're on you about things and but just the way she is helps set the tone and all that. It's a very comfortable environment and yeah, she doesn't come off as overpowering or anything like that.

Another key component of motivation from the facilitator, as described by the participants, was the quality of their relationship to him or her. Participants shared that the relationship should be caring, meaningful, positive and personable. When describing what type of relationship would motivate him to change, a participant described it this way:

> I think my counselor from my DUI class would do great as a domestic violence counselor…because he's able to talk to us like a person. He tells us it real. No sugarcoating, nothing… He's like, I've been through stuff just like you guys, probably even worse. And if I can come out of it and be who I am today, so can you guys. Now let's work on that together, you know. We're all in here together, you know. Some are in here for four months and in that four months, take what you can, you know, and grow. Some of you in here for 18 months, so me and you, we gonna have a lot of

> time together…You know, show people… I mean, that's what I really like about this school is that I feel like they're here to help us with our life. You know, not just that DUI school and this is it. I really feel like, everybody here, I mean, I can go and talk to any counselor and I feel like they're willing to help me for my life. You know, they want to see us succeed. They don't want to just be, like, you know what, use whatever, another case, another case. They're really like family, you know. Looking out for us…

Here another participant similarly describes how a caring relationship with the facilitator motivates him be less resistant and more receptive to learning about himself, accepting responsibility for his actions.

> For instance, the counselor now, he actually shares a little bit about how he got to where he's at and it make us realize that we can all make mistakes. But we can escape a lot of things. And he helps us. He's somebody that me, personally, I feel that he has actually taken a lot of things real serious. He's not just here to waste our time or pass the two hours that we're here for…But he seems to be more personal about it instead of just a teacher, a student relationship, you know…
>
> Like, what I really enjoy is that he…off a long weekend, once we go back to class; he's like, how was your weekend? How is everything? How are you doing? That makes you feel good, you know. Makes you feel good when someone is, how are you doing? How are your kids? He gets down like that and he makes you feel like he is a friend there for you. And I guess when he does that, it does make other people feel better, that they feel more open about it and they start discussing things more. And once you start discussing things you start accepting things more.
>
> You're like, you know what, and maybe he is right. Maybe I was at fault in this. But that's on a friendly basis. That's how he approaches things. That's good to know, that's good to see. That he's….it seems like you're talking to a friend instead of just an instructor that's there to get paid and there just to sign you in and out.

This participant talks about another perspective on why a caring relationship with the facilitator can be a powerful motivator and even give hope that life can be better.

> It helps you. It lets you know people care. When you know people care and people have genuine interest in them, it helps out. They're not just

> playing a part for everybody else. They're not just doing it so that…to meet a quota or for whatever reason, you know. It's because people care. And I've seen that…one of the things that really helped me out in my depression is when I broke this other leg here. I was in a hospital for a month. And you know, yeah, the nurses are there to do their job and everything and the doctors are there to do their job and everything. And you could tell that some people do care about you getting better. About you going through it, you know. And it really made me start wanting, there are people out there who care. There are people who care. And it's like, it's a little bit of hope but it's enough hope to just hang in there a little bit, you know.

Some participants stated that having relatable facilitator that can give then hope about turning their life around helps motivate them to do the same. Another participant expressed a similar thought about why it is important for him to be connected to a caring personable facilitator.

> It makes me feel that I'm not the only one and therefore, you know, it can't be because I'm crazy or something's wrong with me in my brain. But if someone else has lived a very similar life like myself… and they've been able to turn it around, you know, why was it that we lived that particular lifestyle and what was it that turned this person around? That's why it's important for me to feel that connection versus when I don't… it's almost like I see it as when people tell you do as I say, but not as I do kinda deal.

Another key motivation point that participants shared was the professionalism of the facilitator. Participants shared that they look to their facilitators for credible knowledge, ability to practically relate knowledge to their situations, and effectively and professionally manage the group. A participant, reflecting the thoughts of other participants, shared his thoughts on what would motivate him and to get past his resistance this way:

> I mean, I just want the facilitator to be honest. And the facilitator would have to be knowledgeable. I mean, first of all, you're not going to … I'm not going to have any confidence in anybody that I don't think knows crap and I'm not going to have any confidence in anybody that is bullshitting me because they're not being honest. So you're going to have a pretty well rounded person that's pretty experienced in matters of this sort. And how do you get that, I don't know. And you have to have a person that's honest, not just sitting there paying a lot of lip service or following some script. Those are probably the biggest two…because otherwise I'm not going to trust them, and I'm not going to get crap from them.

Data from the interview revealed that it was also a combination of the facilitator's ability to listen and engage the group in discussion that motivated them in treatment. A participant reflects many of the views of those interviewed here:

> He's a good listener and he asks us a lot of questions…and also actually talking about different situations. Also hearing other people talk about what they went through, that's very helpful. To actually, you know, get out of that bubble that you're in and actually speak about it and it makes you think about how you got into the situation that brought you here…He gives us the opportunity to actually speak what's on our mind and then what's going on in your life, you know, that actually attends to your domestic violence…because most of the guys there, they're like trying to make it work.

Akin ideas were voiced by another participant who stated it this way, regarding how a facilitator engaged his group in deep discussion:

> It allows us to think, rather than saying, you do this, this, and this... He allows us to really think about things. To say, you know, you guys are all going to have different views on this, but actually think about it, you know. Take some time to actually process these answers that you're giving me. You know, don't just blurt something out.

Similar thoughts were expressed by a participant who stated his expectations this way:

> What makes it helpful is that I want to learn something new… I know he gives us the paperwork for us to read and I have been reading it but I do want to see what the teacher has to say about it. What kind of examples, or…what is his insight on it. I want to know that. And maybe it's because I've gone to school and I think that way. Like, I want to see what he's saying… I mean, like a teacher, he'll tell you how to solve this problem and explain to you…he doesn't give you the details of how to figure it out but he gets you on the right path… He needs to get you the best feedback for the situations that we're in. Nobody else that I go out for advice is going to give me what he already knows because he's already been trained. And I think that's what's important…I think as long as he gives you the right tools and the right mindsets then he's doing his job.

Non-effective Engagement and Motivation Strategies from the Facilitator

Data from the interviews showed that just as a positive, professional, and a personable relationship with the facilitator can be a powerful motivator in treatment, participants were equally vocal on what would be a non-motivating experience with the facilitator. Participants expressed that they are aware of the unsavory stigma and mental picture of "wife beater" that is associated with domestic violence offenders. Participants expressed it's hard to feel motivated in treatment if you're being taught by someone that thinks the worst of you. A participant directly put it this way:

> You don't want them to look at you as a woman beater. That's where that stigma comes in. Because it's tough, man.

Another participant who shared his views on why it matters how the facilitator views him described it this way:

> Because of the way they view you, is the way they're going to treat you. If they view you as a criminal, as a wife beater, as a girl beater, you're going to get treated like one. And, you know, that's not good because every situation is different, you know. Some people are there for getting out of control and doing that, but there's others of us that are not, you know.

One participant passionately communicated how an experience like this would affect him:

> Coming here and just being….this is what you're going to do…sit down and shut up. And just, feeling of oh, you're just an asshole; you're a fuckin spousal or woman abuser or batterer, before they even knew me…I mean, that's just the assumption…

A similar idea is shared by another participant who voiced a parallel sentiment:

> Like, sometimes it feels like we're pushed to think that we're violent men and we might not be. That this one act doesn't define us and sometimes I feel like it might be what defines us to her… You already did something wrong, so you already feel ashamed. And now I gotta come to class so somebody can kinda belittle me.
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> That's not gonna work with me… It's like, yes, I know I have more power and that I have hit a woman and all that, but don't make me feel worse. I already felt worse that I hit a woman, you know what I'm saying. I already felt bad about that. Don't dig the knife in deeper…We all have anger issues. We all need to learn how to control it better.

Data also showed that many participants shared that if they are going to be mandated to treatment, they expect to learn and develop tools that would improve their lives and avoid experiences of domestic violence in the future. However, if the class was not run professionally, and they felt that facilitator did not value them, it was a big turn off. One such participant conveyed it this way.

> My first time that I went to my first group was a waste of times… To me, it would feel like…I'm just here because I have to be here. And he's here because he has to put up with our crap. And when he's done talking on the phone, drinking his coffee, whatever it is he does, and then we can all go home. Just letting us sit there and wasting the 2 hours. Or letting like 2 or 3 people and not allowing everybody to participate…
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> And the person behind the desk really didn't care if you made it there to class or not as long as you signed in two or three days after, made the payment. It's just a facility that's bypassing everybody that goes through

> there. Just to get their certificate and that's it. I think that's the worst place I've ever been to in my life, you know. Because they just let us slide.
>
> They just get us get through the system and I think that's the worst place. It was basically, you know, pay your money, sit there, and wait. You know what I mean…it didn't make you feel…anything other than, you know, a paycheck for them, you know. You're there to pay your $40 and that's all they really care about, you know. They will slap on a movie and that's it period. Fill this out. You know it was never, fill this out and let's talk about it. Let's talk about why you put this answer. If it was more personal, I think people would relate to it a bit better, you know, and think about the problem a bit better.

When speaking on why a lack of professionalism in the facilitator running the class is a turn off, a participant shared his thoughts this way:

> Yeah, just floating away on different subjects, you know. Like, we could be talking serious and all of a sudden the teacher, one of the students, or one of the persons just comes up with some kind of card thing or news event that's happening at the time and boom, it just floats out and there goes about an hour of, you know, talking on it, you know. Instead of just keeping it, okay, like I said, like an outline of each day, you know. We need an outline of the whole course, you know. Like, I mean, right now is there any books or anything on that? Like a class that they're teaching out of …?

From the interviews emerged a clear picture of motivation driven expectations that offenders have of their facilitators. Treatment programs that hire facilitators should have well trained facilitators who are positive, professional and a personable. These qualities in a facilitator have a better chance of engaging and motivating offenders in treatment and improving treatment outcomes.

Effective Engagement and Motivational Strategies from Group Dynamics

Participants shared how important is was to them to have a place where they do not feel judged, where they can open up about vulnerable feelings and get solutions to

personal problems were important motivational dynamics of the group to reduce recidivism. Participants openly shared that feelings of resentment and perceptions of being further stigmatized are initial barriers to participating in treatment. It is almost certain that if these feelings and perceptions are not overcome, offenders will be less likely to participate in treatment, thereby jeopardizing the chances of a successful outcome. A participant stated it this way:

> The process of warming up, the process of getting through all the feelings that you have of the anger sand stuff like that, the resentment of the court system, because you're there from the court system. So you have to get through all that, feel comfortable with the group…

The data showed that the feeling of safety and acceptance, rather than judgment, was one of the key motivators in treatment. In additional to the stigma of being an offender, interviews revealed that traditional gender views of men also played a role in not feeling judged. Men shared that they did not want to be judged as emotional or soft if they took a risk to share their feelings. However, the data revealed that if the men found that the group was not going to judge them for sharing their feelings, they experience the group as a safe haven. One participant conveyed it this way:

> Most men will say talking about your feelings is just something, you know, you talk down to you because it's not good to be sensitive and all that. But this is serious thing to look at, you know. So here's the chance to finally be able to talk about it. You know, whatever it may be that's upsetting you, and nobody's going to judge you. And that's very important, to not feel like somebody's going to judge you.

A related thought is expressed by another participant who shared why being able to have a safe place without judgment to open up and share his feelings of vulnerability is a powerful motivator in treatment.

> It's just the way that the facilitator was able to make it feel like nothing's going to leave this room. You guys are all okay here. This is not something that we're not going to go around blabbing to everybody, you know. But talk about your situations. Everything that's being said here is going to stay here. And that makes everybody else feel a bit comfortable. Because I did notice a couple of guys that came in, you know, fresh out of jail. Doing 5 months for whatever… Hard, you know.
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> And you give them two, three weeks and just by making them feel comfortable because of the way that everybody else is reacting to the class, make them want to open up. When any instructor reaches at least one person to be able to open up, I feel it can cause a snowball effect, you know. Once a group…seven guys, one of them is like, you know what man, it's like this, you know. Someone else there, sitting there, wow, look at how he's able to express himself or open up. And that makes this guy say, you know what, this situation…he opens up and a snowball effect happens.
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> And before you know it, the hardest guy that came in there is talking about what he misses about his girlfriend or what he misses about, you know ….what his situation is, what happened, you know. It's just real interesting how it opens up like that, like I said. It only takes one person to open up and just say, hey, I too feel this way. And before you know it, another guy is like, hey, I do too.

The data revealed that creating a new therapeutic experience for offenders in treatment is an important part of the group dynamic of sharing feelings of vulnerability. For many participants this was the first time that they had ever opened up about their intertwined feelings of love, softness, frustration, hurt, pain, guilt and regret to anyone, let alone a group of men. Moreover, it was revealed that many found the experience of sharing their feelings to be a powerful tool for generating support for each other and getting helpful solutions with their personal situations and managing anger. One such participant conveyed his experience this way:

> Well, when we're able to talk openly and freely amongst other men that they can also pick up ideas. Maybe they don't know how to express themselves or deal with issues. Maybe they learn…if I give an example of

> how I would try to do it, maybe for them it might be helpful. Or maybe I might be helpful as far as what they're saying and I might pick it up and do it myself… I think you walk away a different person because of the burden of that anger inside you is kind of like, taking off the jacket because you know that person's listening and you're not alone and you're able to share and get it out of you. Maybe you're able to go home feeling just a little bit different. And then working on that I think helps out more because you're able to accept it and get over it.

A congruent thought is voiced by another participant who revealed why hearing other guys share their experiences is meaningful in helping him not return to domestic violence:

> Yeah, it is very important, yes. Because you think you are the only one with this problem and when you hear other problems it's like, oh man, that problem is worse than my problem, you know what I mean. Because they're probably fighting or the kids are involved. So sometimes their situation is worse, you know what I mean. So you learn from them, to listen to them, and try not to do the same thing, you know.

The new experience of addressing personal issues related to domestic violence and the vulnerable feelings that often go unaddressed in the group, emerged from that data as a beneficial experience. One such participant stated it this way:

> They're giving out their feedback to me. And I think that's what I like about it. I feel like somebody's listening and we're starting to have a conversation about something…that probably never gets touched.

Data from the interviews shows that the dynamics of the group that advocates an environment that is safe, and allows participants to share vulnerable feelings without judgment, can be a powerful motivator in helping offenders gain practical solutions to leading lives of non violence.

Non-effective Engagement and Motivational Strategies from Group Dynamics

Participants' interviews also pointed out that if groups were perceived to be judgmental, and sharing dominated by few members, they would not feel motivated to participate in treatment. One participant, speaking of a prior negative experience in a group, described how feeling judged affected him this way:

> I was in a group where I was a lot younger and the people around me were of older age. And I couldn't really cry or emotionally break or emotionally say something because they would judge me or mock me or make me less of a person. Because of the fact that, me, at a younger age, I'm trying to say how I love my mom or I miss my wife or I wish I wouldn't of done that to her. Or I shouldn't have done this. And to them it's a form of mockery, or kind of like, putting them down. For me, I didn't want them to put me down. I wouldn't want to cry, I wouldn't want to break. I'd have to swallow it and not say anything. But that would make me more of like an aggressive person because I wasn't able to get it out…

The data is clear to show that participants appreciate being able to communicate their feelings and using the power of the group to find solutions and support. This serves as a motivator to practice what is learned in the group. However, the opposite also holds true. If equal participation in the group is not encouraged, but discussion is dominated by a few, members are less motivated to take part in treatment. One participant stated it this way:

> I think, yeah, sometimes there's people in there that communicate way too much…but it kinda takes up time sometimes. And, you know you do want to hear what he has to say but they do take a long time to come out with what they have to say. And I think that's the times where, you know, it's time for us to learn something new. So I think… maybe, like, reversing it.

Data shows that offenders view sharing their emotions and getting help as a risk, but a risk worth taking if they perceive there will be acceptance. If this dynamic is not present in treatment, data shows that offender do not ask or pursue the help that they need and are

more than likely to become disengaged in treatment. In addition, the facilitator has to be a good manager of the group in creating safety and allowing equal time for each member to share, ask questions, and get the help that they need. If the group is dominated by a few, other members began to checkout instead of using the entire group to leverage new learning experiences.

Effective Relational Goals in Reducing Domestic Violence

The impact of domestic violence is not limited to the victim, but extends to the whole family, work, and other social systems. This awareness is reflected in many of the participants' interviews, and recognition of a need for a focused tool to help them. Participants shared that having a relational goal would be helpful to them in not reoffending. One participant, reflecting on the pain his domestic violence had cost his family, stated his thoughts on having a relational goal this way:

> Yeah I wouldn't want to reoffend…to have my family deal with this crap after going through the system. Obviously it impacts a family. My kids, my mom, friends, socially it's a stigma, it's terrible. Going to jail and all this bullshit and then you talk about after it comes up and invariably. So yeah, I wouldn't want to have my people I care about subjected to this crap…it would be a good reinforcer. It would be a reason for people who were inclined to participate in this stuff not to and reinforce the impact it has on the other…the other social impact it has on your family and friends… And just so it's not just you, but it affects them, too.

Personalized relational goals have been shown to be effective in reducing recidivism in domestic violence offenders (Lee, Uken, Sebold, 2007). Data from the interviews identified communication, listening, and taking others into consideration, as the most important relational goals that would help offenders improve their relationship with their spouses, children and colleagues at work. One participant put it like this:

> Listening skills… Communication and listening, you need to be able to talk to understand the other person. Listen to where they're really coming from. Because, I mean, sometimes we listen but it just goes right in and out the other ear, you know. And that's when you start fighting, you know.

A similar thought was expressed by another participant who related how relationship goals of communication, listening and consideration of others would be helpful in making him a more attentive husband and father:

> That's a big goal for me to keep my family together and raise my son the way I…with a dad, the way I wasn't raised. That's how I want to raise him. I want to be different… And that's what really motivates me is just my son. Just to stay with him, just to see him grow up. That's really what motivates me the most.

The same theme was echoed by another participant who described how the impact goals has on him and how he relates to his family share this:

> I'd say it's exactly that because she has two kids and then we just had one. So I think parenting has a lot to do with it. And obviously communication…when you're able to communicate and keep that communication open then it's just very helpful. Obviously I don't want to be that macho Mexican no more. I don't want to be that person who's always right… I always lashed out and never really sat and listened to what the hell she was saying. It's more like, I don't care what you're saying… I'm able to talk more with her instead of just yelling, screaming, and talk shit and cuss basically… When we're in a relationship, it takes two to be in a relationship. And I can't just be worrying about my own feelings and worrying about my own things when there's someone else there. We're a team. We gotta worry about us, you know. Just like in any sport or anything like that, you have your teammates. You're going watch out for your teammates. You're going to understand your teammates. You want to learn from them… Sometimes you gotta be able to step back and take everybody else that's involved feelings into consideration instead of just thinking about ourselves. That would keep people from going back. From, you know…I think so. I think it'll help people form ever going back to that place, you know.

Speaking more specifically on how communication would help him at work, and be a better parent to his daughter, a participant conveyed this thought:

> And I think once I learned the skill of how to communicate then I think that would actually help me own my own business because I'd know how to talk to other people. And not only that, it would also help my relationship, or any relationship. Even with my kid, my daughter…she's not…I think I teach her how to be a good person and I know that when it comes to the age where she's going to be a young adult… I know that she'll go through the process of rebelling and I don't know if I was sure I'd be able to handle that with my past communication. And I think if I learn assertive communication then that will be very helpful for me to be able to raise her…Like, I was just thinking to myself, like, if you don't have the tools to be able to move then you can't really move forward.

Many of the participants still maintain romantic relationships with their partners. Relational goals have the potential to help offenders who, mutually with their partners, plan on staying together, improve the satisfaction of their relationship. Even for offenders who plan on not returning to their past relationships, these goals have the potential to help them live healthier relational lives in their familial, work and social systems.

Needed Factors in Domestic Violence Treatment to Reduce Recidivism

Three factors main factors were identified by participants as needed in treatment to effectively help them not recidivate: First, a domestic violence program that would included their partners in treatment in order to help strengthen their relationships. Second, the inclusion of one on one meetings along with the development of personalized relational goals with the facilitator to focus treatment. Third, address the influence of substance abuse on domestic violence.

Couples treatment program. Many of the participants interviewed still continue a romantic relationship with their partner. Research suggests that not making available

services that address the relational needs of both partners that are determined to stay together can disadvantage the health of the relationship (Stith, Rosen, McCollum, & Thomsen, 2004). These participants shared they want to make their relationships work and that including their partner would help them to successfully do that and decrease the likelihood of recidivism. However, many expressed that even though they are making progress, it feels they are alone in utilizing the interventions learned in treatment, and more gains could be made if their partner could learn and practice with them some of the same things they are learning. Participants spoke of the back and forth physical and verbal conflicts that often go unseen. While there is no justification for violence, it does indicate that both partners could benefit from treatment that would enhance their relationship if they choose to remain together. One participant stated his reasons this way as to why including the partner in treatment would be beneficial:

> I'm not saying it's right to put your hands on your spouse but a lot of times it's both ways, you know. I know in arguments with her, I've been hit with things and stuff like that, especially when before, like now, I've been sober for about a year and three months…first of all, both sides, a group for both sides. I think that it's imperative because a lot of times I feel like I'm the only one who's working on myself, and it's on me to stop these things from happening when in reality, it needs to be on both people. Because I myself have gone through this therapy and stuff and group sessions and group therapy and stuff and she hasn't, so she's not educated as to what's going on. So in a perfect world or a perfect program, I'd have a group for the other person involved… I think a perfect treatment program would have that. That's huge… And I know that it all costs more money, but I think that would be very beneficial for especially for the people returning into the family dynamic. Everybody needs to be on the same page, you know…at least have the spouse educated in what the offender is going through, what he's trying to accomplish, what he's trying to do. When he's trying to take a time out, to let him, you know. Stuff like that. I think it's just recognition okay, this is what he's trying to do so okay, and I'm going to let him. Let's try that.

Some participants shared that is often difficult to get their partner who feels resentful to read the program materials with them. It seems that the responsibility of fixing the relationship is often solely the responsibility of the offender. And offenders do have a duty to stop acts of physical and emotional violence. Moreover, to rebuild a relationship, it will take the cooperation of both sides. If both partners agree to stay together, a program for both of them could help decrease resentment and promote healthy relational skills. One participant reflecting on the difficulty of trying to including his partner in treatment conveyed it this way:

> I mean, how is just one person going to take all this information? He's not the professional to be able to teach this person. Like, and I can take all this information home but I don't have the communication skills. It's not my profession. It is not something I do every day. So how can I take that to her, talk about it, and then practice it and everything goes down and happy. It's not going to happen. My partner said, you're the one that needs this. You're the one that hit me in the first place. So then what am I going to do with it? So I think that's why I think it's important to have both of them in there, assessing both. They both have to have the group sessions. They both have to have the individual. And then they both have the partner one, to be able to assess what they learned, the experiences to communicate to each other and then put it together as a team. It's like basketball. They get taught individually. They practice in a group. And then they play together. It's the same thing with work. They get trained individually. They put it into practice together, and then they work as a team.

An equivalent idea is expressed by another participant who shared how potentially frustrated he would be trying to practice the skills he learned in class alone, without involvement from his partner:

> It would be helpful if she was in the program…Her to come. Because you know where you have mediation or stuff like that, or parenting…obviously they always have two parts. But if I'm the only one, getting all this knowledge and stuff, learning all these new ways and all this stuff…but I go home and try to do it and she shuts me down, I feel

> like it's pointless. It's like why the hell did I even go to class today? I'm not going to be able to provide that in my relationship. I thank God that she's actually opened minded and we read the stuff together. But she's even said, you know, can I go to class, but I said, it's only guys. Where both people are on the same page…you're able have a better relationships, I think so. But that would only work if you are staying with your person.

Even participants who dissolved their partnership shared that if they were to continue their relationship, they would find such a program useful in helping them have a better relationship and not recidivate. One such participant stating the positive benefits of such a program put it like this:

> Yeah, I mean, I think that would be helpful…especially in situations where there are kids involved and this relationship is not going to be the end of this…you still gotta deal with that person in the future.

As reflected by the data, a domestic violence program that includes partners in treatment can be an effective way of decreasing recidivism in relationships of couples that agree to stay together. Even if the relationship does eventual dissolve, both partners will have gained skills that can limit occurrences of violence in future relationships.

One-to-ones and personalized relational goals. Data from the interviews revealed the desire for one to one meetings along with the development of personalized relational goals with the facilitator to focus treatment and tailor it to individual needs. Some participants, despite the level of comfort in the group, expressed that they do not feel comfortable sharing certain vulnerable issues in the group. The one to one time with the facilitator enables the offender to have time to share deeper personal issues regarding his situation. One participant put it this way:

> In front of other men, I have not gotten into that comfort zone. So I wish that we would have part of our sessions as a one on one with our counselor, you know…

The facilitator can use this time to help the offender set specific relational goals he wants to achieve in treatment. The development of self-determined relational goals by the participant has been shown to be therapeutically effective in reducing recidivism (Lee, Uken, & Sebold, 2007). Participants expressed that a personalized relational goal would focus on a treatment outcome that would positively benefit them rather than just showing up to group. A participant discussing why the development of relational goals would be helpful stated it this way:

> I think that it would have given me a little more confidence. I think you get a heads up, would have given me a head start… rather than just…you sit there and you listen to what people say… I would tell you that it would be helpful. I think that makes sense to me…if you made it a little more personal.

The quality relationship between facilitator and offender as described earlier, is an essential part of treatment. The one to one meetings have the potential to further enhance a positive personable and professional relationship between facilitator and offender. If the members experience their facilitator as caring, they will be more motivated in treatment. Moreover, the combination of the one-to-ones and personalized relational goals with the facilitator can provide a motivating force in treatment because offenders are able to track their progress and gain feedback from the group as well as from the facilitator. Here is what one participant had to say:

> Have group and have one-on-one. If it was a year like that, yeah, that would be a lot easier to take in. I get the feedback and the intensity from my counselor, and now I have the feedback from the group.

In considering the beneficial combination of one-to-one meetings and setting tailored relational goals, a participant detailed his thoughts this way:

> That one-to-one basis does come in handy. That would be a good thing where, in the beginning, you first go to your first meeting. Maybe they have a one on one session, basically get to know you. Set goals for yourself. Maybe half way through the program, maybe call you in again, hey, how are things going? How was what we discussed at the beginning going for you? Oh, it's going good. Progress report or something… A lot of people I know get excited when they are meeting their goals. When they are…oh, my goal is not to get upset at my wife for dumb reasons. And then at the middle of the day, you know what, hey, I haven't been getting mad and our relationship is great, you know. That kind of stuff right there really helps. Because we want goals and we need to set ourselves up to do certain things so we can feel good about ourselves, you know. When you meet those goals, whether it is school, work, or anything, you know. You apply yourself to something and once you meet it, it makes you feel good. Even if it's as insignificant as not arguing, you know, it still makes you feel good because you did it…Not because of what it is but what you did. You did it. Hey, I didn't argue. Makes you feel good. And that helps you in the relationship wise, you know. Something like that, a one-to-one basis, just a little something to see how you're going personally. That would be great. Something like that would be great in the program.

Offenders in treatment need to know that there is something in the treatment program for them. A tailored treatment program to the offenders' needs can create the engagement and motivation to see their treatment in the context of their relationships and personal development. Furthermore, as reflected in the data, it seems that the incorporation of one-to-one meetings and relational goals would not only provide motivation for successful program completion, but also decrease domestic violence recidivism.

Addressing substance abuse. The data shows there is a need to more directly address the influence of substance abuse on domestic violence. Almost all of the participants interviewed had domestic violence cases that involved substance abuse. The data shows that participants recognize this to be a significant problem that has caused distress in their lives and relationships. Moreover, they shared this is a vital area that needs to be addressed more in treatment in order to help them not recidivate. Substance

abuse is a strong predictor of failure in a batterer treatment program and a major contributor to a dynamics that give rise to domestic violence (Dalton, 2001; Dalton, 2009; Dutton, Nicholls, & Spidel, 2005; Stuart, Temple, Moore, 2007). One participant reflecting on the damage of substance abuse and domestic violence can have on the family, put it this way:

> I think you use alcohol or drugs and stuff… it blows up for everybody.

When openly sharing how substance abuse affects his judgment in handling conflict with his spouse the participant, shared this:

> Oh absolutely. When I was drinking I was just angry, fly off the handle no thought. It was all running on just basically just running off instinct, and my first instinct was anger. And now I'm thinking with a clear head, able to hear what's going on with the other person, and take their feelings and stuff into account as well you know and rather than just flying off the handle and you know stuff like that.

A similar thought was expressed by another participant who discussed the need to address substance abuse and domestic violence in treatment:

> Anger, drugs, alcohol, you know. We are not just here because we fight with our girlfriends, you know. Some of them are…we fight, we drink, you know. It has to be both. The two are connected. Most cases, I think it's connected. Sometimes its alcohol involved and you know that helps a lot with violence, you know. You're already violent but the alcohol helps a lot, you know what I mean, so that's our problem. So even if it's not a DUI class, they have to talk about that situation, too, you know… Teachers need to talk about violence, anger, and you know, substance, like alcohol and drugs, too.

The data suggests that participants sometimes self medicate with drugs and alcohol to cope with feelings of anger. This would not only exacerbate the problems within couples' relationships, but also serve as a significant barrier to solving relational problems in a

healthy way. A participant sharing the impact of substance abuse and anger and the need for it to be addressed in treatment conveyed his experience this way:

> Because I just know, I mean, just talking to guys just in general, even people that haven't hit somebody, they hold a lot of the anger in and they don't know what to do. I also found out a lot of times it has to do with alcohol and for my case that was it. And I think if you don't get to the root of that, of, you know why you drinking and all that, this might happen… I don't know what the probabilities are, you know, on domestic violence, you know… and then it happening again and again. If its alcohol or drug related, you gotta bring that into it. You know, and just bringing it in anyways.

One participant spoke about how conflicts are exacerbated with substance abuse and that addressing this in treatment plus utilizing the power of the group for support as well as mentorship would help offenders not recidivate:

> I think it would make them understand, too, you know, why things happen. I mean, because in my situation, it was just…pretty much every time I would get in trouble by the law, it was because I was drunk or something…pretty much drunk. And, I mean, I think it would help them, too. In all my situations…if it wasn't for alcoholism I'd have a clean record, pretty much, you know… I know they don't pay them in AA. If they were to do something like that, too, you know…that you can call somebody like a sponsor… Like if you get in a big argument with your spouse or somebody else, your significant other…instead of beating them up or whatever, they walk away to go straight to a bar. Go straight to go do drugs and then they come back and the situation's gotten worse. So instead just have somebody to call and go, hey, you know, can we go talk? Let's go for a cup of coffee somewhere, you know. Let's go to Starbucks. Sit down, talk, whatever. Like me, I have friends at church, hey, can we talk? Can we go meet somewhere? Can we hang out? Stuff like that. I mean…

Participants that struggle with substance abuse may benefit having this area addressed along with domestic violence treatment. This could help participants better search for healthier ways to improve communication, cope and manage feelings of anger that include practical answer adapted to their needs. It is necessary to recognize the grave

issues that intensify partner violence. Moreover, as suggest in the data, by addressing substance abuse as a part of treatment, domestic violence recidivism can be reduced.

CHAPTER 6

DISCUSSION

This research study explored the treatment needs of male domestic violence offenders that would successfully enable them to not recidivate. This study sought to explicate variables that are pertinent in transforming behavior to decrease in emotional and physical abuse from the perspective of domestic violence offenders mandated to treatment. This study was guided by four major research questions to understand the needs of domestic violence offenders in treatment. (1) What interventions are most helpful/ not helpful in producing behavioral change in domestic violence offenders? (2) What engagement strategies are effective/ not effective in producing meaningful motivation in treatment? (3) What relational goals would be effective /not effective in reducing domestic violence recidivism? (4) What is needed in a domestic violence treatment program to be effective in reducing the likelihood of recidivism?

Helpful/Not Helpful Interventions

In response to the first question, interventions that were thought to be helpful were breaking down a situation, taking an hour break or time-out, letting go of the past, venting to the group. While many different interventions are covered in treatment these were the most consistently mentioned by the participants as useful tools in helping them not recidivate. Findings show two main areas where these program intervention skills were often used: understanding the different types of domestic violence and the management of anger, conflict, and communication.

Understanding the different forms of domestic violence. Data from the interviews revealed that many participants did not understand that domestic violence is not limited to physical abuse but also includes emotional and verbal abuse, sexual abuse and intimidation/terrorization of a partner. Participants in the beginning of their treatment saw domestic violence only as a physical act of aggression. A possible reason for this as stated in the views of the participants was that many of the participants grew up in environments where they were exposed to forms domestic violence by parents or other family members. While this in no way excuses the behavior of the offender, it does warrant consideration of how their attitudes towards domestic violence developed. It is conceivable that verbal abuse, intimidation, and some forms of physical force were not perceived as rising to the level of domestic violence. Hence some participants feeling confused as to why there were mandated to treatment when they "only" threw an object at their partner.

However while in treatment participants shared that "breaking down" the many forms of domestic violence was helpful to them in identifying and taking responsibility for their behavior that led them to be arrested. This means that participants were able to discover and examine in detail the many parts of domestic violence (i.e. physical, sexual, verbal abuse, threats/terrorization, etc…) rather than viewing it as "punching their partner". Some participants stated that the paperwork that detailed the cycle of violence was useful. Reason as stated by the participants suggests that it gives them a context and rationale as to why this repetitive pattern occurs. Once participants discovered how the pattern displays its self in their life they were interested in learning on how to break the cycle.

This intervention seemed to really connect with participants when they were required to "break down" a scenario either personal, hypothetical, or movie shown in class and write out the different forms of domestic violence present in the situation and discuss it in the group. Watching a film clip that contained domestic violence and breaking it down seemed especially effective because it allowed enough emotional distance for the participant to vicariously live the experience from the view point of the offender, victim, and third party observer. As participants took a-part the scenario, compared it to their own situations, and discussed it in the group they were able to identify their own abusive actions and take responsibility.

Participants mentioned that they often did not realize the extent of their actions until they took a step back to break down their behavior and see through new eyes how they had perpetuated it in their relationships. Participants shared that this intervention was useful because they could take the didactic material and readily see how it applies to their personal situation. This intervention also seems to be effective in generating awareness, understanding and responsibility. However it suggests that the facilitator must be able to take didactic material and help offenders meaningfully link it to their real life situations.

Managing anger, conflict, and communication. The most frequently stated useful intervention to manage anger, conflict, and communication was the "time-out" or "taking an hour break" followed by "letting go of the past". This skill was found to be useful by participants in managing emotionally heated situations. Poor emotional regulation of anger and lack of communication skills is where most participants shared their personal struggles were in managing conflict. Hence it often created the perfect

circumstances for conflict to erupt into domestic violence. During the interviews participants shared that arguments with their romantic partner frequently spun out of control. It would happen so fast that in retrospect they did not realize how their conflict had reach that one point. As participant shared “once you are in the heat of the moment it is hard to stop”.

Participants described the “time-out” or “taking an hour break” as a way of slowing themselves and the other person down, away of diffusing the situation before it gets out of control. This gives both parties an opportunity to exercise restraint before explosive rage and assess what they are feeling. Do I feel angry, frustrated, hurt, disappointed, betrayed or misunderstood etc…? What is this person trying to communicate to me? Is this situation worth me getting angry over? What is it that I want to communicate to them? They now have given themselves time to reframe the situation and options to consider as to how they want to respond.

This allows participants to step out of the learned limited emotional response of “angry” and “not angry” and embrace a fuller, less volatile and more communicative way of expressing themselves. It also empowers the participant with tools to take responsibility for their feelings and actions rather than feeling helplessly bound to a destructive response. Many participants described how they used the “time-out” or taking an hour break” to stop themselves from physically or verbally abusing their partners by remaining calm, thinking before they speak, or letting go of a petty issue. One drawback to this intervention is that not every situation permits one person to physically leave and “take an hour break” however participants have learned that even a quick ten second time out can keep a conflict from escalating.

Letting go of the past was an intervention also seen as useful because it allowed the participants to move on rather stay emotionally stuck in on an issue. Some participants shared how holding onto certain issue can quickly grow into an unnecessary unmanageable conflict. Letting go of such issues provides freedom to choose to steer the conversation with their partner, family member down a more positive path of communication.

Venting to the group. An unexpected result in this study was that the group its self served as an intervention for the participants. Participants routinely expressed how sharing in the group allowed those to open up about their anger and improve their communication by "getting things of their chest". Traditional and cultural assumptions of masculinity were reasons participants gave as to why anger was the emotion of first response to a conflict rather than an embrace by participants of more vulnerable but equally expressive emotions such as sadness, hurt, and disappointment. This limiting social discourse for many was how they survived on the streets, or in the work place, and related to those in their family. It is no surprise that many of the participants went through much of their lives with bottled up anger. Even more challenging for them was not knowing how to communicate their feelings effectively and be heard without it exploding into violence or being judged as less of man.

Initially members of the group were reluctant to open up about their personal situations. However, as group cohesion developed and the therapeutic relationship with the facilitator strengthened members were willing to trust each other with their vulnerable feelings and obtaining feedback for their problems. "Hard men" had a chance to observe other "hard men" express vulnerable emotions of sadness and regret in their personal

relationships and it was “ok”. Here they had a safe place to openly express their feelings. Participants expressed that it is a relief to come to group and let out their feelings without fear of judgment. This intervention also helped men better practice the art of expressing their feelings which helped them begin to improve their communication with their families, intimate partners and co-workers. It started to give them a language of how to express the nuances of their feelings beyond a restrictive anger on/off switch.

Feeling safe in a relationship is a significant issue for couples both emotionally and physically. What is interesting here is that for those participants who want to remain in relationship with their spouse Instead of creating that safe place in their relationship together, they are on their own. Most participants who expressed they wished their partners could learn with them how to use these new skills to manage anger, conflict, and communication to improve their relationship. The power of discussing venting to the group serves as a tool to help men develop communication skills and manage anger and conflict. This suggests that the therapeutic relationship between members and facilitator and between members has significant role in the success of treatment.

Only a few participants identified an intervention that was perceived as not helpful. First it was mentioned that sometimes “walking away” from the conflict can sometimes make things worse especially if the man copes with his anger through alcohol or drugs use before returning home. Second, showing a film that addressed child abuse was difficult for some participants because it was too emotional for them to watch and they felt it was not the reason why they were in treatment.

Engagement and Motivational Strategies

It is said that client engagement is a formidable nonetheless vital element in producing effectual treatment (Thompson, Bender, Lantry, & Flynn, 2007). As reflected in the data, motivation is a key factor in engaging offenders in treatment and can be a significant factor in reducing recidivism. The two major themes that emerged from the analyses of the interviews regarding effective/not effective motivation in treatment were motivation derived from facilitator, and motivation from dynamics of the group. Finding showed first, facilitator tone/attitude, quality of relationship and professionalism to the group were important factors for motivating participants in treatment. Second, group dynamic of cohesions, acceptance, trust and personableness are essential to treatment motivation.

Engagement and motivation from the facilitator. The stigma of domestic violence, and anger related to their arrest fueled initial feelings of resistance to treatment among many participants. Participants shared they are aware that the attached label of domestic violence offender causes people to automatically assume the worst things in them. The label illicits powerful negative images of a man "that just beat the shit out of your spouse". Socially, this crime draws broad, passionate, and clear disapproval. Participants shared the feeling of disapproval and disdain for them is evident as work their way through the "system" of the police, jail, district attorney, and judges. By the time participants arrive at treatment they are prepared to be encountered by someone who will judge and also see the worst in them. Usually one of the first persons they will encounter in treatment is the facilitator. This suggests that compelling engagement is needed in order for a participant to feel motivated in treatment.

Results show participants who encountered a facilitator who demonstrated a nonjudgmental positive attitude, and a caring relationship towards them were more likely to be motivated to participate in treatment and eager to learn. This parallel to research on clients' views of talk-therapy that purports a therapists' bond, personableness, hopefulness, commitment, and wit are essential characteristic of effectual treatment (Beck, Friedlander, & Escudero, 2006). If the participants feel the facilitators genuine acceptance of them in the beginning of treatment it gives them feelings of value. It gives them a feeling of "comfort" in the group. Moreover it shows it that facilitator believes domestic violence does not have to "define" them. This is first step in the therapeutic relationship between facilitator and client is important because it sets the motivational prospects and success for treatment. Clients that are engaged in treatment are more likely to bond with facilitator and therapists, approve goals for treatment, be motivated to participate, less likely to drop-out of treatment longer, and feel their needs are being met (Thompson, Bender, Lantry, & Flynn, 2007).

Another important component that emerged from the data was that of quality of the therapeutic relationship between facilitator and client. A quality therapeutic relationship was thought to be a caring relationship between client and facilitator. Participants defined it as a facilitator who listens, is personable, knows their name, and checks with group members as to how they are doing. It confirmed for many their facilitator as someone who cared about them personally and wants to listen to them share about their deepest personal problems. The sense that there was someone who cares enough to empower them to become a "better person" without "judging" was meaningful to them.

It sent participants the message that here is someone who is committed to me getting my life back together. For participants they expressed this as “hope”. That there is someone who can really help them finally learn how to manage anger, conflicts, and communicate better in their relationships. Hope is transformative and a necessary element for a positive treatment outcome. This engaging experience really seems to help break down the resistance that the majority of participants initially carry into treatment. Several participants shared that this quality in their facilitator helped them to be “open” to treatment.

This willingness to learn is significant because it shifts the view of the facilitator from agent of the “system” to “mentor” or “teacher”. This also reveals that participants are not just showing up to meetings to fulfill the terms of punishment but expect to learn something that will aid them in not recidivating.

The times participants did not feel engaged or motivated to take part in treatment was when the facilitator viewed them as only “offenders” or a “pay check” instead of people. In places like this it was said that the facilitator would often let them slide through the program as long as they paid their money. This approach seems destructive to motivation and probably would do almost nothing to reduce repeat offense of domestic violence. Important to cultivate are the vital ingredients of effectual treatment which demonstrates the quality of the intercommunication, the joint method of developing tasks and goals of treatment, and client and therapist rapport (Digiuseppe et al., 1996; Horvath & Symonds, 1991; Thompson, Bender, Lantry, & Flynn, 2007).

Another key motivation point for participants was the professionalism of the facilitator. Even though participants are mandated to treatment they still expect to learn

skills that will help improve their lives. Participants shared that they are motivated in part by facilitators' demonstration of credibility, capability to sensibly relate didactic material to their personal situations, and effectively and professionally manage the group. Findings reveal that facilitators were expected to have proper training so that they could credibly teach the material. Participants stated that credibility was important because they expect the facilitator to be able to give them practical knowledge on how not to return to domestic violence.

More importantly facilitators are expected to be able to take the knowledge from the book and make it relevant in the personal lives of the clients. When a facilitator is able to help participants successfully link learning to personal experiences they are able to make it real to themselves. This aids them in identifying, take responsibility, and changing their domestically violent behavior. Participants also appreciated facilitators who ran the class with a purpose because the members also took it seriously. This also includes managing groups from being dominated by few and keeping the group on topic so that every can get the help that need. Data from the interviews showed that a positive, professional, and a personable relationship with the facilitator can be a powerful motivator in treatment.

Engagement and motivation from the group. Some participants initially felt that they did not need to be in group because their personal situation not as serious when compared to other group. In the beginning stage of the group men many were "slow to warm up" to share or even talk in group. Others described themselves as "reluctant" to share their feelings in front of men. The fear of being seen or judge as less than man for sharing their feelings was a greater worry for many towards the beginning of their

experience in group. At that point participants are less concerned about what the facilitator thinks, “it’s more about the people that are your peers”. It is almost certain that if these feelings and perceptions are not overcome, clients will be less likely to participate in treatment, thereby jeopardizing the chances of a successful outcome.

Data from the interviews revealed that being able to share vulnerable feelings without judgment and get meaningful help with personal problems were important motivational dynamics of the group to reduce recidivism. Many of the participants who struggled with communicating with their partners would bring this issue up in the group. They would explore with other members what communication techniques were and were not working. The feedback from the group as many participants stated helped them to think about and implement non-violent and non-abusive language with their partner. Some participants shared that it also allowed them to ask other men on how they best could repair their relationships such spending time with their partners and improving their family lives. Many participants shared that it also helped them with managing legal issues, getting jobs, and their communication with their co-workers and bosses. Instead of losing their temper at work they could talk about they could practice the advice from the group of calmly resolving disputes. This study as reflected by the participants, suggest that the development of nonjudgmental supportive relationships is essential to successful domestic violence treatment outcomes.

The data revealed that creating a new therapeutic experience for offenders in treatment that centers on acceptance, trust, personableness is an important part of the group dynamic of sharing feelings of vulnerability. As participants experienced acceptance, trust, and the level openness in the group deepen so did the “camaraderie”

and cohesion of the group. Participants at this point were more likely to share their "vulnerable" feelings. They describe it as a "snowball effect" that kept on building on each other as members of the group began to open up. It at this point the participants describe the group "going deep" and talking about real issues (i.e. struggles with parenting and relationships) and feelings (i.e. missing their partner and dealing with guilt for their actions) they struggle with.

Participants began to look forward to the groups realizing they were "not the only ones" with challenging problems. There were others that have and understand the vulnerable feelings they had been bottling up. For many participants this was the first time they had ever opened up about their intertwined softer more vulnerable feelings of love, frustration, hurt, pain, guilt and regret to anyone, let alone a group of men. Moreover, it was revealed that many found the experience of expressing their feelings to be a powerful tool for generating support for each other and getting helpful solutions with their personal situations and managing anger.

What is evident here is motivational and therapeutic growth occurring in the context of relationships. This suggests the development of strong group cohesion is necessary for participants to feel motivated in treatment. More importantly participants expressed feeling "different" like they had "learned something" when they left group that could improve personal situations. This observation is significant because participants had discovered a significant motivational factor in effective treatment, there is something in this for them (i.e. how to communicate better with their partner). Discovering that there is something in treatment for them orients a client towards a self determined goal of what they want to get out of treatment. This observation is underscored by Lee, Uken,

and Sebold's, (2007) outcome research which showed domestic violence offenders treatment goals must be self-determined to be therapeutically effective.

Relational Goals

When asked if having a relational goal would be effective in helping participants not recidivate, all responded with a "yes". Relational goals put forth by participants that were thought to be effective in reducing domestic violence were based on communication in relationships without violence and being a better partner and father. Participants especially those that were trying to make their relationship work were focused on how they could not only be better communicators of their vulnerable feelings but also be better listeners to their partners/family members and meaningfully take into consideration the perspective of that individual.

Participants defined being a partner and father was defined as being more emotionally present and spending more quality time with their partner/family and or children. Some participants shared that they wanted to be able set a better example for their kids and not subject them to the same domestic violence they experience growing up. The drawback that many participants had was that they were working on these goals without their partner and loosing the potential benefit that goal collaboration could have.

Many of the participants still maintain romantic relationships with their partners. Relational goals have the potential to help offenders who, mutually with their partners, plan on staying together, improve the satisfaction of their relationship. Even for offenders who have dissolved their past relationship, these goals have the potential to help them live healthier relational lives in their familial, work and social systems.

Most participants initially did not have any goals set for themselves and had gradually or inadvertently discovered them in treatment. It was expressed by many that had they had personalized relational goals in the beginning it would have encouraged them to changes earlier and help them "not become a repeat offender". Self-determined goals that encourage change can have a significant all-encompassing influence on the effectiveness of treatment (Elliot & Church, 2002; Foster & Mash, 1999; Lee, Uken, Sebold, 2007). Findings showed that as participant began to focus on a relational goal (i.e. improve communication with partner) as an outcome for treatment they started align their behaviors to meet that goal. Participants stated their desire for personalized goals because it gives them "something to achieve" and focus on what they want to get out of treatment. Personalized relational goals have the ability channel the meaningful experience gained in the group into focused behavior that is relationally transformative.

Future Program Needs

Participants consistently identified three needed factors in treatment that would effectively help them not recidivate: First, a domestic violence program that includes their partner in treatment in order to help strengthen their relationships. Second, a program that includes one-to-one meetings along with the development of personalized relational goals with the facilitator to focus treatment. Third, address the influence of substance abuse on domestic violence.

Couples treatment program. Between 34-40% of offenders maintain a romantic relationship even after the domestic violence has occurred (Gondolf, 2000). Findings in this study show many of the participants interviewed still continue a romantic

relationship with their partner. Participants described they need a program "for both sides" to help them effectively make their relationship but currently have nothing to help them. These participants stated as they went through treatment they had gained new emotional "tools" to manage anger, conflict, and communication and their partner had not. The drawback expressed by the participants was lack of including the partner limited the progress the couple could make together in how the communicate and solve problems. Participants reveal that sometimes resentment and misunderstandings can get in the way of progress when they are working the program by themselves. Research suggests that not making available services that address the relational needs of both partners that are determined to stay together can disadvantage the health of the relationship (Stith, Rosen, McCollum, & Thomsen, 2004). If the partner is not included in treatment it suggest that fixing the relationship is solely the responsibility of the offender. And while offenders do have a duty to stop acts of physical and emotional violence, it will take the cooperation of both sides to rebuild a relationship, If both partners agree to stay together, a program for both of them could help decrease negativity and resentment and promote healthy relational skills. There is no doubt that the wounds, disappointments, and hurts of domestic violence in the context of an intimate relationship can push resiliency to its breaking point. However it is in the context of relationship couples can rebuild and find relational healing.

One to ones and personalized relational goals. The quality relationship between facilitator and offender as described earlier, is an essential part of treatment. The one to one meetings have the potential to further enhance a positive personable and professional relationship between facilitator and offender. If the members experience their facilitator

as caring, they will be more motivated in treatment and less likely to recidivate. Moreover, the combination of the one-to-ones and personalized relational goals with the facilitator can provide a motivating force in treatment because offenders are able to track their progress and gain feedback from the group as well as from the facilitator.

Research findings show the desire for one to one meetings along with the development of personalized relational goals with the facilitator are needed to help reduce domestic violence recidivism. Some participants, despite the level of group cohesion, do not feel comfortable sharing certain vulnerable issues in the group. The one to one time with the facilitator enables the offender to have time to share deeper personal issues regarding his situation. Participants who experienced these one to one meetings in their DUI class shared that it helped them to bond, feel understood by the facilitator, and help focus and tailor treatment to their individual needs. The facilitator can use this time to collaborative work with the offender set specific relational goals to be achieved in treatment. This suggests that participants are looking for accountability, support, and encouragement in the context of a therapeutic relationship to motivate them to meet their goals for treatment. Offenders in treatment need to know that there is something in the treatment program for them. Participants feel that one to one meets can help them better identify these goals. Furthermore, as reflected in the data, it seems that the incorporation of one-to-one meetings and relational goals would not only provide motivation for successful program completion, but also decrease domestic violence recidivism.

Addressing Substance abuse. The data show there is a need to more directly address the influence of substance abuse on domestic violence recidivism. Many of the participants interviewed for this study had domestic violence cases that involved

substance abuse. The data shows that participants recognize this to be a significant problem that has cause distress in their lives and relationships. Moreover, they shared this is a vital area that needs to be addressed more in treatment in order to help them not recidivate. Substance abuse is a strong predictor of failure in a batterer treatment program and a major contributor to a dynamics that give rise to domestic violence (Dalton, 2001; Dalton, 2009; Dutton, Nicholls, & Spidel, 2005; Stuart, Temple, Moore, 2007). Given the confluence of domestic violence and substance abuse it would seem natural to include both as a part of treatment. The data suggests that participants sometimes self medicate with drugs and alcohol to cope with feelings of anger. This would not only exacerbate the problems within couples' relationships, but also serve as a significant barrier to productively solving relational problems.

Batterer treatment programs are not substance abuse programs and offenders should be given the necessary referrals for intensive treatment as needed. However, the data suggests batterer treatment programs need to address the problem of substance abuse and its inappropriate use as a coping tool for anger. Participants with substance abuse issues are in need of relying on healthy effective ways to communicate, cope and manage feelings of anger that include useful solutions tailored to their needs. These solutions could be addressed through utilizing the support of the group, one-to-ones with the facilitator, and in the treatment program lessons. While substance abuse problems do not relinquish the batterer from responsibility of his action, it is necessary to recognize the grave issues that intensify partner violence. Moreover, as suggest in the data, by addressing substance abuse as a part of treatment, domestic violence recidivism can be reduced.

Limitations

There are some limitations of this study that merit consideration. First, this study sought out to have a cultural diverse but representative sample. However 15 out of 18 of the men in this study were Hispanic English speaking males. In the focus group all 10 of the participants were Hispanic English speaking males. This was due in part to the location of the clinics in Southern California where there is a high population of Hispanics. Another factor was that the majority of men at the clinics who interested in participating in the study were also Hispanic. The same is also true for those that participated in the focus group. Second, although important, using recidivism as the singular outcome variable in this study could conceivable cause the inquiry to overlook other possible factors that are representative of successful completion of a domestic violence treatment program. Third there may be other interventions that are far more effective that participants could not remember them right off hand. A more thorough review of the interventions would probably require that the researcher have a complete list that is used to ensure that all interventions have had chance to be vetted by the participant**.** Fourth, this study did not explore all the cultural differences of the participants because the majority of them were Hispanic. This did not provide the study the opportunity to explore if there were differences between cultural groups as it relates to treatment needs. However, within group cultural differences within Hispanics participants (i.e. differences between Mexicans and Costa Ricans) were not explored and therefore differences within groups may have been overlooked. It is recognized that there are differences both between and within groups and that further exploration of these differences in regards to domestic violence offenders needs in treatment should be

studied. Fifth, this study only interviewed the offender about their needs not the victim's. In the future a study should next time look at what the needs of the victim are as it relates to treatment.

Despite these limitations, the current study adds to qualitative literature on needs of domestic violence offenders in treatment to effectively reduce recidivism. This research also looked at current treatment interventions, engagement strategies, relationship goals, and program needs from the view point of the offender. This fills a void in research by highlighting the voices and rich experiences of men who desire to both improve their relationship and not recidivate. While this study was not as culturally diverse as intended the sample size and triangulation enabled the study to obtain saturated rich data detailing the needs of domestic violence offenders.

Implications

This study in response to calls from the literature for more evidence based approaches to domestic violence treatment(Babcock et al., 2004; Catlett, Toews, & Walilko, 2010; Feder & Wilson 2005; Lee, Uken, & Sebold, 2007; Stuart, Temple, & Moore, 2007; Stith, Rosen, McCollum, & Thomsen, 2004) chose theoretical approaches that have proven to be effective in addressing the necessary components that contribute to domestic violence recidivism (i.e. program attrition/completion, relational conflict, and substance abuse).

Solution focused theory as theoretical model has proven to be effective in treating diverse populations such as victims of severe abuse (Dolan, 1994), juvenile delinquency (Clark, 1996), domestic violence offenders (Lipchik & Kubicki, 1996; Lee, Uken, &

Sebold, 2007), and substance abuse (Osbourn, 1997). This theory is also flexible to be incorporated with other therapeutic modalities such as Goal theory and the Transtheoretical model and Motivational Interviewing.

This theory utilizes the client's strengths to overcome personal challenges. Rooted in a relational goal, Solution focused interventions are based in relational activities that can be noticed by significant others in the client's family system. Group treatment that utilizes a Solution Focused model does not deny or minimize aggressive or violent behaviors. Moreover, Solution-Focused methodology holds offenders of partner violence responsible for constructing solutions instead of concentrating on their weakness and a problem saturated narrative. The therapist can help the client to frame a hypothetical solution that encourages relational alternative ways of perceiving problems, spur deep reflection, and developing effective solutions. Outcomes reveal improved relationships that are connected to their goal and a decrease in recidivism (Lee, Uken, & Sebold, 2007). A benefit of this theory is that it gives a stable structure in which clients can achieve practical achievable goals within a brief period of time.

Goal theory was chosen because it is effective addressing the absence of motivation domestic violence offenders have towards treatment and initiating relational goal developement. One of the challenges that batter treatment programs often face is the lack of motivation on behalf of the men to change and a factor that encourages attrition (DeJong & Berg, 1999; Lee, Uken, & Sebold, 2007; Stuart, Temple, & Moore, 2007). The absence of motivation decreases the probability of meaningful transformation away from violence (Stuart, Temple, & Moore, 2007). Therefore to ensure meaningful change identifying and encourage motivation to change that is participant generated and driven is

important. Goal theory utilizes specific self-determined relational goals have been shown to be effective in enhancing intrinsic motivation and promoting behavioral change.

Goal theory helps individuals set self-determined relational goals that are effective in generating motivation to stay committed to their goal especially when they believe that the goal is attainable (Bandura, 1986; Latham, Winters, & Locke, 1994). Individuals experience more success in setting goals when they are given feedback from therapists, group members, and significant others that highlights progress that is goal related (Lee, Uken, & Sebold, 2007; Locke, 1996). Moreover, individuals employ goal-performance more effectively, when they receive feedback as a method of tracking or measuring progress toward their goal (Locke & Latham 2002).

The Transtheoretical model and Motivational Interviewing was chose because of its effectiveness in working with substance abusers and domestic violence offenders (Hellman, Johnson, & Dobson, 2010; Stuart, Temple, & Moore, 2007). Current batterer treatment programs often do not address this frequent co-morbidty which has been identified as factor that contributes to recidivism (Hellman, Johnson, & Dobson, 2010; Stuart, Temple, & Moore, 2007). The Transtheoretical Model of Change postulates that matching interventions with a client's readiness to change can increase program treatment outcomes (Hellman, Johnson, & Dobson, 2010). This helps the therapist best tailor interventions to the clients' needs especially in the area of substance abuse. The Transtheoretical Model along with motivational interviewing has shown to be an effective addition to current batterer treatment programs that characteristically do not address substance abuse and use interventions that are confrontational to promote behavioral change in offenders (Stuart, Temple, & Moore, 2007). Murphy and Baxter

(1997) purport that using the transtheoretical model of behavior change as is effective in decreasing violent behavior especially in the context of motivational interviewing interventions.

Given the similarities between motivational interviewing and solution focused theory the use of solution focused theory interventions can also be effective as evidence by the work of Stuart, Moore, Kahler, & Ramsey (2003) in treating substance abuse and domestic violence (Eckhardt, Holtzworth-Munroe, Norlander, Sibley, & Cahill, 2008). Both theories postulate that developing a constructive and supportive therapeutic nonjudgmental relationship with clients will decrease resistance and increase readiness to adopt a path of transformation rather than using more confrontational methodologies (Stuart, Temple, & Moore, 2007).

This theoretical approach has shown that the use motivational interviewing improved attendance and reduced partner violence recidivism (Taft, Murphy, Musser, & Remington, 2004). It is held that this methodology can be adapted into batterer treatment programs fairly effortlessly and may be chiefly significant in that this methodology often postulates that the individuals starting the program are open to explore change that improves their current circumstances (Eckhardt, Holtzworth-Munroe, Norlander, Sibley, & Cahill, 2008).

It is expected that these theoretical approaches will help enhance batterer treatment methods that promote motivation to help break old patterns and develop new ways of relating and reduce recidivism. Moreover, that as participants work towards their relational goal, their interpersonal dynamics of relating will give way to healthier ways of being.

New Directions: The Foundations of Intervention

The following are proposed criteria that could be used to evaluate different programmatic approaches. This is not designed to replace either batterer intervention programs or domestic violence shelters but rather to expand the community's resources in addressing family violence in a way that renders existing programs significantly more effective. It is proposed that assessment tools be used to determine the best utilization of resources for each program participant. Participant assessments not only help us best target how to awaken the individual to the destructive nature of domestic violence but also help the individual form goals that improve relationships within the family and community. As this happens the burden of family violence will be lessened on civic institutions such as law enforcement, the courts, and even first-line medical emergency responders and hospitals. Evaluation of safety, program completion, and recidivism will be used to measure improvements in outcomes.

It is proposed that, by involving both victims and offenders in interventions that run concurrently with existing programs, important factors contributing to current outcome deficits can be effectively neutralized. The following five proposed components are designed to address the previously identified factors in a synergistic way: First, recruiting men into setting self-determined goals has been found to be effective in increasing participant motivation which in turn fosters program commitment/completion. This approach is also consistent with a strength-based perspective. Second, by making participants more aware of relational behavior patterns that precipitate violence and how to effectively modify them, the likelihood of re-offending is decreased.

Third, by involving positive mentors, extended family, and community partners in this experience, new patterns of interaction are reinforced and more deeply established. This enables people to reunify their families (if they so choose) without being drawn back into previously-established patterns of violence. Fourth, by exploring the role of substance abuse in affecting progress toward self-identified goals, participants become aware of how alcohol and drugs may be contributing to the maintenance of violent behavior patterns and inhibiting success with regard to relational goals.

Fifth, support from community stakeholders reinforces the value of relationships that are non-violent. This increases participant commitment to a non-violent lifestyle. The combined use of these strategies contributes to increasing broader engagement with already existing community resources. These proposed components could be used to contribute to a measurable improvement in the effectiveness and efficiency of the community's overall response to family violence.

Sixth this study has produced an in-depth needs assessment that will inform evidence based practice in domestic violence programs. Based on the research produce by this study it has caused the author to reflect on an idea of how a program influenced by this study would be proposed. The following is an idea of how a program like this might be conceived:

- First, this domestic violence program would have 6 phases and would run over 4 months. In phase 1 there would be two separate individual treatment groups one for the men and one for the women (partners of the offenders). At the beginning of the group each participant will meet one on one with the facilitators to develop relational goals for treatment and begin to work on those goals as well as

identifying forms of domestic violence, managing anger, conflict, and communication, and addressing substance over a few weeks.

- In phase 2 both participant and victim continue in groups but began to meet individually with a therapist to work on personal emotional and relational issues and to decide if they still want to continue in the relationship with their partner.
- In phase 3 if the couples decide to stay and continue their relationship then couple therapy begins to work on rebuilding the relationship together. Both men and women still continue on in their separate groups.
- In phase 4 couples therapy with conjoint group in parallel with groups to further build support for couples who are continuing their relationships.
- In phase 5 the extended family will be invited to family groups to deepen supportive relationship and to help them also learn how they can be supportive to each other. This is also influence from the research because offenders stated support from their families helps them to make better choices to be non-violent.
- In phase 6 the program involves community activism, mentorship training, and graduation to help serve as support to help them maintain lives of non-violence and to decrease the stigma as they return to the rebuilding their lives in the community.

Participants shared that if the community is supportive through acknowledging their efforts to live a non-violent life the feel more motivated to shared the persona of domestic violence offender and adopt the personal peaceful contributing member to the community. While this program is not perfect in does hold promise in incorporating a systemic approach to domestic violence programming that is based on research and

incorporates the interventions of other effective group interventions and process to help reduce domestic violence recidivism.

CHAPTER 7

CONCLUSIONS

This research study has further expanded the field of Marriage and family therapy in several ways. The main purpose of this study is to uncover and advance treatment interventions and programs that are effective in helping clients be successful in domestic violence treatment. Given the significant in-depth outcome research on current domestic violence treatment programs the need for evidence based approaches is long past due. In a time where funding for social programs is competitive and evidence based practices are paramount; researchers, clinicians, and academics in our field have an opportunity to directly bring our knowledge to bear on developing and improving social programs that are underperforming (i.e. domestic violence treatment programs). Working in tandem with other larger systems (i.e. justice, law enforcement, and community) we can drastically reduce recidivism and promote relational healing in an area that is in much need of professional evidence based interventions.

This study that is in response to the call for research to go beyond the status quo and explore methodologies of domestic violence treatment is most effective in reducing recidivism (Corvo, Dutton, & Wan-Yi, 2008; Feder & Wilson, 2005). It is believed this study will contribute to the field of Marriage and Family Therapy by helping inform clinicians of evidence based methodologies that work best in treating domestic violence offenders and provide solid outcomes. The research on offender typologies suggests there is a need to carefully assess and direct offenders towards treatment that appropriately best addresses their issues (Corvo, Dutton, & Wan-Yi, 2008).

This study also responds to calls for a thorough assessment of the individual needs of offenders that promotes engagement in treatment, the inclusion of the couple/family, and the influence of substance abuse in domestic violence treatment (Corvo, Dutton, & Wan-Yi, 2008; Dalton, 2009; Feder & Wilson, 2005). First, this study contributes to the field knowledge on how individualized assessment and tailored treatment approaches hold potential for more effective treatment and program outcomes. Research reveals that domestic violence offenders are more likely to return to their significant other/family after incarceration or treatment. In recognition of this fact, this study also contributes a methodology that addresses the behavioral and emotional pathology linked to disrupted attachment and to set implementable goals that promote as appropriate, connection, affection, and safe membership. Presently many current domestic violence programs do not address the influence of substance abuse (Stuart, Temple, & Moore, 2007). Third, this study as called for by Saunders (2002) and Stuart, Temple, & Moore (2007) puts forth an integrated treatment approach for clinicians that holds promise in addressing the influence between substance abuse and domestic violence.

Fourth this study has implications for the field of medical family therapy. Medical family therapists have an expertise in management of chronic illness, multifaceted health issues and social stressors that affect an individual's health and family system (McDaniel, Campbell, Hepworth, & Lorenz, 2005; McDaniel, Hepworth, & Doherty, 1992; McDaniel & le Roux, 2007). Patients rarely present to healthcare providers with a singular issue to which one type of intervention can be applied, this does not reflect the majority of the patient population that health care providers treat every day (McDaniel,

Campbell, Hepworth, & Lorenz, 2005; McDaniel & le Roux, 2007; Campbell, 1997). One such under reported compounding health issue is that of domestic violence (Perciaccante, Carey, Susarla, & Dodson, 2010).

A number of patients whom are victims of domestic violence present to the emergency department or primary care each year without openly acknowledging they are victims of partner violence (Perciaccante, Carey, Susarla, & Dodson, 2010). This can present a serious challenge to health care providers to collaborate with patients, give necessary referrals, effective interventions (Perciaccante, Carey, Susarla, & Dodson, 2010; Campbell, 1997). This goes beyond diagnosing mental, emotional, relational problems but rather helping the patient in resolving and managing the circumstances that brought about the crisis (Lechnyr, & Lechnyr, 2010). Healthcare providers may recognize domestic violence but that does not always mean that he or she will intercede, and interceding may not produce outcomes that are effective (Campbell, 1997).

Calls from the field of medical family therapy have requested interventions that go beyond crisis management and provide for long-term management techniques that address the deeper systemic issues of the patient and their family system. Such an effective intervention can help reduce overutilization of the medical system and provide for greater collaboration between patient and healthcare team (Campbell, 1997; Lechnyr, & Lechnyr, 2010; Ruddy & McDaniel, 1995). This study answers that call and provides healthcare providers with essential research to better understand domestic violence offenders and what prompts and maintains the cycle of physical violence. Moreover, it helps provide medical family therapists and other healthcare providers with stated

descriptive needs from the offenders as to what domestic violence programs could include to effectively treat victims and perpetrators.

Domestic violence is an ugly expression of pain and brokenness. For couples/families that are seeking restoration and healing, this study provides a promising pathway towards non-violent interrelationships.

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Appendix A

Participant Selection Script

Thank you for your interest in our study. Your experience and knowledge of what would best meet your needs in an effective domestic violence treatment program is very important to us. It is our desire to design a program that would help individuals experience and maintain non-violent lives and relationships.

We are looking for participants who are currently or have recently been in a domestic violence program, who are 18 years of age or older, and who have at least one arrest associated with domestic violence. If you meet these criteria, we would like to invite you to participate in a short interview. The interview will last approximately 60 minutes, and will ask you questions about the domestic violence program you attended. We are specifically interested to know what you found to be helpful and what you found to be less than helpful. This interview will be analyzed to provide information about the development of domestic violence treatment programs. After a participant has completed their initial interview we may contact that participant to ask follow up questions. These post interview contacts will happen within two months of the initial interview.

If you are interested in participating in the interview please see me after the meeting or you may contact me by phone. Interviews will be conducted at the, local clinics, Day Treatment Center or the Offices of C.A.R.E Counselors. Thank you for your interest in our study.

Appendix B

Informed Consent Form

Loma Linda University
Department of Counseling and Family Sciences

INFORMED CONSENT

Informed Domestic Violence Treatment Study

Purpose

You are invited to participate in this research study on Domestic Violence Treatment. The purpose of this study is to gain information from men who have been arrested for domestic violence and have been in domestic abuse treatment, to develop an effective domestic violence treatment program that decreases risk of relapse and improves relationships. I would like to ask you to share your ideas of treatment methods that are effective. This is a doctoral student project that is supervised by Dr. Colwick Wilson Ph.D, Chair of the Department of Counseling and Family Science Faculty at Loma Linda University.

Procedures

In this study you will be asked to participate in an interview in which you share your ideas about what will improve domestic violence treatment methods. The duration of this interview is estimated to last around 60 minutes. In addition some participants may be asked to participate in a follow-up interview that asks additional questions that emerge from the analysis process. It is important to this study that your experience is correctly represented in the research. If it is deemed by the researcher that further clarification or information is needed regarding your interview, the researcher would like your permission to follow-up with you to make sure that your experience is correctly represented. The researcher would contact you by phone to set up a follow-up meeting within two months if necessary. This follow-up interview is estimated to last about 30 minutes. If you are willing to participate in the follow-up interview please let us know at the end of the first interview.

While we appreciate your willingness to participate in this study, you are not obligated to answer every question in either interview. If you feel uncomfortable you may simply choose not to comment. You are free to terminate your participation at any point in the study.

Initial here to indicate that you have read
the contents of this page.

_____ Initials _____ Date

Risks

The committee at Loma Linda University that reviews human studies (Institutional Review Board) has determined that participating in this study exposes you to minimal risk. However there are some risks that you should be aware of.

Risks to Privacy and Confidentiality

During the interview process, the researchers will audio record your interview. Following this interview, the researcher will transcribe the audio tape. A temporary key will be created that links a participant i.d. code to your contact information. The key will be kept in a lock box separate from the data and may only be accessed by the student researcher and the supervisor of this study. After all interviews have been completed within the two months time frame, the key will be destroyed. The purpose of the key is so that we may follow up with you if necessary. The transcription will not contain any identifying information about you and once the audio tape has been transcribed, it will be destroyed. The transcript, as well as additional information obtained from you, will be kept confidential and under lock and key in the student researcher's office. Only the researcher and the faculty supervisor of this study will have access to these documents. No information that identifies you will be used or published in the final write up of the research. In addition, no one from the Day Treatment Center or Batter Treatment groups will be told who does or does not participate in this study or what anyone says about the treatment center. Audio recordings will be destroyed after the interviews have been transcribed. Audio recordings will be held no longer than three months.

Legal Risks

This study does not seek to assess whether or not the individual/s responsible for the domestic violence have committed abusive acts towards minors and vulnerable populations. However, some participants may inadvertently reveal this type of information. You should be aware that mental health professionals associated with this research are required by California state law (Penal Code 11165-11174) to report child abuse whenever there is reasonable suspicion that abuse is taking place.

Benefits

There are no monetary benefits to the individual for participating in this study. The benefit to humanity is that this study will help provide research that helps inform treatment methods for addressing the problem of domestic violence recidivism. This study can also help domestic violence offenders in treatment to be able to live a life of non-violence in their families and community relationships.

Participant Rights

Your participation in this study is completely voluntary. You have the right to withdraw from the study and stop the interview at any time without consequence or hard feelings. If you decide to withdraw from the study, it will not affect your participation in your current treatment program.

Initial here to indicate that you have read the contents of this page.

_____ Initials _____ Date

Reimbursement

You will not be paid for participation. We hope you take pride in your participation.

Informed Consent Statement

By signing this consent form, I acknowledge that I have read its contents or have had the contents read to me. I have had all my questions related to the study answered to my satisfaction. I acknowledge that the researcher has discussed my rights with me. I understand that I may contact the student researcher Pierre Scott by telephone at (909) 771-7726 or LLU Faculty Dr. Colwick Wilson Ph.D. (909) 558-4547 at any time if I have additional questions or concerns.

I have received a copy of this consent form. I understand that I may contact an impartial third party not associated with this study regarding any question or complaint I may have about the study by contacting the Office of Patient Relations, Loma Linda University Medical Center, Loma Linda, California 92354, phone (909) 558-4000, or Email: patientrelations@llu.edu for information and assistance.

_____ _____

Participant Signature Date

_____

Primary Telephone Number

I have reviewed the consent form with the individual signing above. I have adequately explained each section, including the risks of participation in this study, and answered any questions or concerns that are relevant to the study.

_____ _____

Researcher Signature Date

Appendix C

Interview Guide

Welcoming of Participant

- Initial meeting of the participant, thanking him for his willingness to participate in the study, introducing of the research will then follow and commence with about three minutes of small talk.
- The researcher will closely observe non-verbal cues regarding the participant's level of anxiety and comfort. The researcher will address any lingering questions the participant may have to put participant at ease.
- The researcher will then invite the participant to be seated and make himself comfortable.
- The participant will be handed a copy of the Informed Consent Form (see Appendix B). The researcher will review the informed consent document with participant and obtain consent.

Obtaining Informed Consent

- The researcher then will collect the Participant Information (See Appendix D). The researcher will assure the participant that the information will kept confidential and no information identifying them will be published.
- The researcher will commence with the interview.

Debriefing

The last part of the interview is designed to aid the participant in coming to a degree of closure regarding their participation in the research. The researcher will express gratitude for the participant's willingness to share their experience and be a part

of the study that will help individuals that are in need of domestic violence treatment. The researcher will also ask the participants about their openness to additional participation such as a follow-up interview if needed.

Appendix D

Participant Information

Information to be collected at the time of the first interview:

1. Patient Number _____
2. How many times were you exposed domestic violence? Single or Repeatedly. If repeatedly, how many times?
3. Previously or currently participated in domestic treatment program
4. Level of involvement in program (scaled on a 10 point scale).

Lowest 1 2 3 4 5 6 7 8 9 10 Highest (circle one)

5. How much did the program help you? (scaled on a 10 point scale).

Lowest 1 2 3 4 5 6 7 8 9 10 Highest (circle one)

6. The relationship of the domestic violence victim to you?
7. Has the participant ever been treated for a mental health disorder? If yes what kind of mental health disorder?

   _____

8. Is the participant currently being treated for a mental health disorder? If yes what kind of mental health disorder?

   _____

9. Is the participant on any psychiatric medication? _____If Yes what kind?_____
10. Is the participant being treated for any substance abuse problems? If Yes what kind?_____ What kind of treatment is the participant receiving?_____

Participant Information Form

1. Participant Number: _____

2. Age: _____

3. Have you been arrested for domestic violence? Y or N. Number of times? _____

4. Are you currently on Probation, Parole, or Neither (circle one) : _____

5. Ethnicity: (circle one)

African-American, Asian-American, Hispanic or Latino, Native American, Caucasian,

Non-Hispanic, Other: _____

6. Describe your level or likely level of involvement in domestic violence treatment program:

Lowest 1 2 3 4 5 6 7 8 9 10 Highest (circle one)

7. Describe how much the domestic violence treatment program helped you:

Lowest Threat 1 2 3 4 5 6 7 8 9 10 Highest Threat (circle one)

8. Have you ever been treated for a mental health disorder? (Circle Yes or No). If yes what kind of mental health disorder?_____

9. Are you currently being treated for a mental health disorder? (Circle Yes or No) If yes what kind of mental health disorder?_____

10. Are you taking any psychiatric medication? If Yes what kind?

Is the participant being treated for any substance abuse problems? If Yes what kind?_____ What kind of treatment is the participant receiving?_____

Appendix E

Referral

Although unlikely, if in the case you experience emotional distress related to your participation in the program, we would provide the following references to mental health services in this community. You may access these services at your own expense.

CARE Counselors
1881 Commercenter E., Suite 232
San Bernardino, CA 92408
(909) 890-0525

Behavioral Health Institute
Loma Linda University
1686 Barton Road
Redlands, CA 92373
(909) 558-9500

California State University
San Bernardino Day Reporting Center
1465 S. D st. Suite. 100
San Bernardino, CA 92408-3217
(909) 327-2981

Appendix F

Interview Questions

1. **What is the role of the chosen theoretical methodology in creating the optimal conditions for change in domestic violence offenders?**
   (What is the best way to produce change in behavior for domestic violence offenders.)

- What do you remember from you program that was particularly helpful for you?

2. **What motivational strategies are effective/ not effective in producing meaningful engagement in treatment?**
   (What would be helpful and not helpful in motivating offenders in treatment?)

- What would have motivated you to participate and in your program?
- What did not motivate you in your program?

- Given the range of people that you interact with in the program how do you think the group could help motivate you in the program?
- What did the therapist or group facilitators do that motivated you in your program? Why was this helpful to you?
- What did you see the therapist or facilitator do that was not helpful for you?
- Why do you think this was not helpful for you?

3. **What relational treatment methods and processes are effective/not effective in reducing domestic violence recidivism?**
   (What relationships goals would help you not want to re-offend?)

- What did you learn from the program that helped you from engaging in Domestic violence?
- Why was this helpful?
- What did you learn in the program that was not helpful?
- Why do you think this was not helpful?
- What skills did you learn that to helped you have better relationship?
- Have you used any of these skills before?
- How have these skills helped you before?
- What skills would you want to learn in order communicate with your significant other without violence and abuse?

4. **How does the research generated from domestic violence offenders' suggestions for producing optimal conditions for change minimize the likelihood of recidivism?**

(What do you think would make a domestic violence program effective for someone like you?)

- If you could imagine the perfect treatment program to show you a better way to communicate with your partner without being violent what would make you want to participate in this program?
- With what you are going through now what do you not like about the domestic violence treatment program? Why? What would be better? How would that be better?
- What do you like about the current domestic violence treatment programs? Why? Would you want those same things to continue? Would you change them in any way? How and Why?
- How would you like to be treated in such a program?
- How would this be helpful to you in stopping violent behavior?
- What would you want to experience from you therapist/facilitator in a domestic violence treatment program?
- How would this be helpful to you in stopping violent behavior?
- What would you want fixed about the system that is currently in place?
- How would fixing this be helpful to you in stopping violent behavior?

- If you are not happy with your life and the way things are going now and you wanted to have a better romantic relationship what type of treatment would you find helpful in a domestic violence treatment program?
- How would this be helpful to you in stopping violent behavior?
- If you had a specific relational goal that you focused on in treatment would that be helpful to you? Why? Why not?
- How would focus of a specific relational goal be/not be helpful?

Appendix G

Recruiting Speech to be given

Thank you so much for the privilege to address you. My name is Pierre Scott and I am a doctoral student from Loma Linda University and interested in understanding how to best minimize repeat offenses of domestic violence occurrences after treatment. Domestic Violence is a significant challenge that affects the lives of many individuals. As some of you who have encountered this challenge in your personal experience you understand all too well the painful difficulties and consequences that arise out of it despite your best efforts to not reoffend. I am here to invite you to participate in a study to help me understand what is most needed in a domestic violence program. I want you to tell me what you think would help you be successful in not reoffending. This would involve you participating in an hour long interview. It is important to this study that your experience is correctly represented in the research. If the researcher needs further clarification or information regarding your interview, the researcher would like your permission to follow-up with you to make sure that your experience is correctly represented. The researcher would contact you by phone to set up a follow-up meeting if necessary. The follow-up interview would last around 30 minutes. If you would like to participate in the follow-up interview please let us know at the end of the first interview. Your input into this study will help design a treatment program that is not only helping those be successful in not reoffending but also what would help them develop tools that will lead to healthier lives and relationships. While your participation in this program will not change or have any effect on you legal situation we appreciate your contribution to this study. The new program that eventually may come of this information is not a study

benefit. However, it may or may not be something you could eventually participate in. I will stay during and after the meeting to meet with those of you who are interested in participating in this study. Thank you for your time.