Chapter V

DISCUSSION

Introduction

The purpose of this study was to examine the experiences of participants involved in an integrated couples treatment program for domestic violence where the male has been violent. Participants included seven therapists and five heterosexual couples, three of whom participated in the individual couple treatment modality and two of whom participated in a multi-couple group treatment. All of the men had had some kind of anger management training before beginning the couples work with their partners.

Before beginning treatment, participants filled out pre-tests that included three open-ended questions about their expectations for counseling. Once treatment began, participants were interviewed after their second and fifth therapy sessions of a 12-session treatment. Interviewers asked participants to share their experiences of what they found helpful about the therapy, the things they did not find helpful, and their advice to improve the treatment. Additionally, interviewers asked participants about the issue of racial difference in therapy (either between therapist and client or among clients in the multi-couple therapy group) and whether they felt it had made an impact. Finally, participants were asked to share their opinions about the controversy in the therapy field about the most appropriate and effective treatment to address domestic violence.

Phenomenology was the theoretical framework that guided the study. The written responses and interview responses were analyzed using the open coding procedure outlined by Strauss and Corbin (1990).

The purpose of this final chapter is to provide a summary and discussion of the results of this study, discuss the limitations of the study, discuss some of the clinical implications of the study, and outline potential areas of future research.

Summary and Discussion

Before beginning participation in couples counseling, participants were asked to record their answers to open-ended questions about their concerns about the counseling, the changes they hoped would be made, and their suggestions for what the therapists might do to be most helpful. In general, male clients tended to be concerned that their wives wouldn't change or that the therapists might be biased against them, while the female clients tended to be concerned that their partners might lie during the therapy. This finding makes sense, given the dynamics of a relationship in which the male abuses his partner. As this abuse was openly the presenting problem for these couples, some of the men may have felt that due to their violence, they were cast in the villain role from the outset. The women's concern about their partners being dishonest in session may have grown out of a context in which they had experienced their partners' minimization or outright denial of the violence they had inflicted.

As far as their expectations for therapy before treatment began, many of the clients expressed their desire to build healthier relationships through learning a variety of skills: anger-management, communication, and conflict-resolution. In general, therapists also believed focusing on these areas might be helpful to these couples. Many therapists also suggested that solution-focused techniques might be useful. In general, these same themes emerged when participants shared their experiences of therapy once it began.

Participants in this study, both clients and therapists, were asked to share their experiences of what was helpful during therapy during semi-structured qualitative interviews. All of the participants felt that numerous aspects of the therapy were helpful, including a number of therapist behaviors and qualities, the structure of the treatment, and some aspects of group treatment that were unique to having multiple couples go through the process together. Overall, there was a lot of agreement between clients and therapists about which aspects of therapy were perceived as helpful.

Regarding helpful therapist behaviors and qualities, clients generally emphasized those traits and actions that seemed to facilitate their engagement in the therapy process. Therefore, clients emphasized therapist qualities (e.g. caring, competent) and behaviors (e.g. listening, self-disclosing) that contributed to clients feeling “safe,” “heard,” “understood,” and “validated.” These findings are consistent with other research that suggests that clients often emphasize these elements of the therapeutic relationship as helpful to

them (Bischoff & McBride, 1996; Christensen et al., 1998; Gondolf & Hanneken, 1987; Kuehl et al.; Llewelyn, 1988; McCollum & Trepper, 1995; O'Dell et al, 1997; Sells et al.; Wark, 1994). Although some therapists mentioned some of these qualities and behaviors in their pre-tests, they did not mention them during the interviews. Rather, they tended to focus on specific techniques they employed to facilitate change in their clients (e.g. looking for exceptions, teaching time-out). This finding that therapists tend to emphasize formal techniques as helpful to their clients rather than their ability to engage the client in the therapeutic relationship is consistent with other research in the field that compares clients' views to those of their therapists (Miller, Duncan, & Hubble, 1997; Sells et al., 1996; Metcalf et al., 1996).

Many of the clients and therapists involved in the multi-couple group treatment mentioned some of the aspects described above. Additionally, they identified a number of aspects that were helpful about providing treatment in a group setting. Group members liked being able to share their stories and their strategies, and therapists described the benefits of these activities (such as the empowerment of the women in the group). Participants in the group treatment also tended to think that group members challenging each other to take accountability for their behavior was a positive benefit. Group participants also described the benefit of having a range of couples in the group at different stages of the change process, so that group members could observe a variety of couple behaviors and choose their paths accordingly. In

general, therapists and clients, both male and female, agreed on the helpful aspects that were unique to group treatment.

One of the most consistent findings that came out of the discussions on helpful aspects of the structure of therapy was the positive experience of having a male and a female co-therapist working with violent couples. Clients and therapists agreed that this set-up allowed therapists to provide a sense of balance to the sessions, such that each client (male and female) felt understood and validated. Additionally, numerous participants spoke favorably about the pre-session check-in, which was an opportunity for a therapist to meet individually with a client (or therapists to meet with a single-gender group, in the case of the multi-couple group treatment). Participants felt that this opportunity to meet with a therapist without their partners present allowed them to vent some of their experiences of the week and prepare for the conjoint session.

In general, aspects of therapy perceived as helpful seemed to contribute to clients feeling somewhat confident that therapy would ultimately help their relationship. Additionally, the fact that therapy was perceived as helpful seemed to contribute to clients' decisions to continue participating in the program. Finally, therapy was perceived by all of the couples as helping to change their relationships (from being able to use time-out successfully, to learning to communicate more effectively and problem-solve together).

Although the majority of the feedback about therapy was positive, some participants shared their opinions about aspects of therapy they thought

were not helpful. Many clients expressed frustration that their therapists were not trying to get to "the root of the problem." It seemed important to some of these clients to understand *why* they had violence in their relationships or why their partners were so angry. However, this deep exploration of the cause of a problem was not part of the integrated model which was largely based on solution-focused theory. Another strong finding in the not helpful category related to the structure of therapy. Many of the participants felt strongly that 12 weeks was not a sufficient treatment duration to address a problem as severe as domestic violence. This finding is consistent with the work of McCollum and Trepper (1995) who elicited feedback of women who had participated in a 12-week program for treatment of drug addiction. A majority of their participants, too, objected to the treatment duration and recommended that it be more intensive (either longer sessions or longer treatment duration). The mismatch between clients' beliefs about what was needed and what was actually provided seemed to contribute to a lack of confidence in the ultimate effectiveness of the treatment. Clients and therapists wondered whether they would "get to" everything they needed to in order to be successful. However, it should be noted that participants were only interviewed during the first half of treatment. Some of their concerns might have been addressed by the end of treatment.

Black clients (n=4) in the individual couple group treatment who were assigned to White therapists were asked about their perception of the racial

difference between themselves and their therapists, and what impact, if any, they felt that had on the treatment. Additionally, we asked clients in the multi-couple group treatment (n=4, all White) about their experience of a mixed-race group, as well as mixed-race therapists (one of the three therapists is an African-American woman), and what impact that had on the therapy group. The overwhelming response to this issue is that racial difference in this therapy had not been a factor. Most of the participants expressed the feeling that since all races share the common experience of relationship problems, this was an issue that could be well understood by therapists, regardless of their race. Only one Black male client felt that he might like to have two Black therapists, but he also stated that he felt the racial difference between himself and his therapists had not mattered in this therapy.

These findings conflict with other research which suggests that race does play an important role in the treatment for domestic violence (Saunders 1996, Williams, 1995). More specifically, Black men do not tend to complete traditional mixed-race batterers treatment groups (Saunders, 1996). Additionally, there seem to be more benefits for Black men who are in same-race treatment groups (Williams, 1995). However, the participants in this study shared a different experience. This begs the question of why?

First, it should be considered that participants were truthful in their responses. Perhaps their genuine experience was that they felt understood by their White therapists who they perceived to share common feelings and struggles about relationships. Perhaps race is not as significant in domestic

violence treatment when both members of the couple are being treated conjointly. Clients may feel more comfortable to have their same-race partner present, or perhaps having the balance of a male/female co-therapy team supersedes any discomfort that might be caused by racial difference.

Alternatively, there could be several possibilities for why the Black participants in this study did not say that having non-Black therapists had impacted their treatment, even if in truth, they believe it had. One possibility is that although we experimented with several different questions that attempted to "give permission" to Black clients to share their true feelings, we may not have asked the right questions. Another possibility is that due to the fact that all but one of the Black participants had White interviewers, the Black participants did not feel comfortable saying anything negative about their therapists--based on race--to White interviewers. This "hesitancy to say" any negative factors about racial differences may be part of a larger cultural context of a "politically-correct" society that prides itself on being colorblind. Due to the limited number of Black participants in the study, and the unavailability of Black researchers in our program, it is hard to know which of these possible explanations is accurate, or whether some combination is accurate.

Perhaps one of the most interesting areas of this study is the topic of appropriate treatments for domestic violence. Traditionally, batterers receive treatment in all-male anger management groups, while their partners receive no treatment or possibly participate in individual therapy or victims support

groups. The participants in this study received both anger management (for men only) and couples counseling. Treating couples in intact relationships where the male has been physically violent to the female is controversial in the domestic violence field (Saunders, 1996). Participants in this study shared their views of the traditional treatments and the idea of couples counseling for couples with violence in their relationships. Some of their ideas were elicited by a question about the controversy in the field, while some of their ideas (especially about the time-out technique that is traditionally taught in anger management programs) were offered unsolicited.

Time-out, a seemingly simple technique in which couples take a break from heated discussions that they feel might escalate to violence, is not simple at all from the perspective of participants. This technique seemed to be a major area of conflict for many of the participants. Partners had different views of the technique. For example, one female client did not like the technique at all, as she preferred to “have it out on the spot” rather than postpone the discussion for later. Her partner, however, felt the technique was very useful. More commonly, female clients felt their partners abused the tool by using it as a way to withdraw from intense or unwelcome conversations (and occasionally disappear from the room or the house for hours at a time). This abuse of time-out by the male generally happened when he had learned the technique in an anger management group, and his partner was not aware of how it should be properly used. Many couples expressed how helpful the couples counseling was in clarifying the time-out,

having both present to clear up any misunderstandings and come to an agreement on the use of the technique.

Clients expressed different views on the helpfulness of the anger management groups. Some of them felt that the anger management group had helped the male, but not helped the relationship. Others felt that the anger management group had either not helped the relationship, or had in fact made the relationship worse. For example, one woman talked about how her husband consistently returned from his group in a bad mood and took his feelings out on her and the children. Another woman talked about her perspective that she and her husband were working at cross-purposes in their separate groups (his anger management and her victims support group). She expressed the view that each of them got support for how difficult their relationship was, but they did not receive anything that would help them work out the problems in their marriage.

Most of the participants (seven out of 10) felt that couples counseling was their only hope for improving their relationships. Some of the clients expressed some of the positive things they got out of the couples counseling such as learning how to use time-out effectively and working on communication skills. Additionally, some of the women directly addressed the typical concerns about doing couples work when violence has occurred, which are concerns for the woman's safety and concerns that the woman may feel blamed as co-responsible for the violence if she is involved in treatment. Most of the women stated that they felt safe to talk about issues with the help

of their counselors. Only one woman expressed a concern about how her husband would react to some of the things she said in couples counseling, but she also felt that her therapists were able to keep the conversation productive and non-blaming. This woman did not report any physical abuse from her husband during the treatment. Regarding feeling blamed, none of the women expressed the idea that they felt co-responsible for the violence because they were in treatment with their partners. On the contrary, one woman stated that she felt exactly the opposite. Her experience in the couples counseling group helped her to stop feeling blamed, as she heard the experiences of the other women in the group and realized that she had not made her husband abuse her, as he had lead her to believe.

Certainly, the issue of couples counseling for violent couples remains controversial in the field. Due to the gravity of the presenting problem, couples counseling should not be entered into lightly. It should be noted here that this study only included couples who had reported mild to moderate violence. Those who reported severe violence were excluded from this study and referred elsewhere. Nevertheless, the female participants in this study overwhelmingly expressed their belief that they had been left out of other types of treatment, and they felt that couples counseling was their only hope to improve their relationships.

Limitations

There are several limitations to this study. First, the very small number of clients studied did not allow for theoretical saturation. Second,

the participants in this study are certainly not representative of all clients who present themselves for treatment of domestic violence. In order to participate in this study, clients could not have severe violence in their relationships, nor could they be addicted to drugs or alcohol, nor could they have weapons in their home. Both clients and therapists were chosen using convenience sampling. Although the clients chosen represent a broad diversity among the clients in our study (e.g. regarding race and socio-economic status), they are hardly representative of all couples who have violence in their relationships.

Additionally, the therapists in this study are not representative of all therapists who treat domestic violence. Therapists in this study were advanced interns or recent master's graduates who provided therapy following a treatment model in a university setting under strict supervision. In addition to the controlled circumstances they were working under, these therapists are all specially trained in marriage and family therapy, and treatment issues for domestic violence were emphasized in their program. Therefore, these therapists may have been more specially prepared to work with this population than therapists of other backgrounds.

Furthermore, results were based on interviews with participants during the first half of the 12-week therapy program. It is a possibility that participants' views of their therapy experience may have changed drastically by the end of their treatment program.

Another limitation applies to the findings regarding racial difference in therapy. Only four Black clients were interviewed about their views on this

issue. Additionally, three out of four of these Black clients were interviewed by White interviewers. It is quite likely that these participants did not feel comfortable sharing their "true feelings" about the impact of having White therapists while talking to a White researcher.

Finally, as with any qualitative study, there is potential for researcher bias to play into the way that data are interpreted and categorized. For example, one area that has potential for bias is in choosing which categories to include and which to dismiss. This is especially tricky when only one respondent discusses a specific idea. I chose to include some categories that had only one response. Generally, I chose those to include these categories of one response when the idea discussed was particularly interesting or well-stated, in my opinion. Obviously, my own bias played a role in which one-response categories I found interesting and relevant and which I did not. In addition to potential bias in selection of categories, it is also possible that the researcher can interpret meanings that are different than those that the participants intended. However, I was fortunate to have an experienced qualitative researcher who has published several qualitative studies as my able guide. Through frequent research meetings in which we discussed ideas, cross-coded interviews, and compared our thoughts on specific categories, hopefully any potential for researcher bias has been vastly reduced.

Despite the limitations of this study, I believe these participants have generously shared their experiences of having participated in an evolving couples treatment program for domestic violence. Much of what they

described has been supported by other general research on participants' experiences of the therapeutic process. Since the qualitative literature in the domestic violence field is very limited, I believe these participants can offer those of us who work with this population extremely valuable feedback and advice.

Clinical Implications

Despite the limitations of this study, there are several potential clinical implications to consider, based on the experiences of our participants. First, therapists should remember the old adage that little things mean a lot. Joining techniques that therapists may not consider to be very important are extremely important to these clients. Much of the therapy literature has shown the importance of listening to clients and helping them to feel respected, validated, and understood. However, it is possible that these things are even more important to this particular clinical population. Violent men who enter treatment are branded as "batterers." Physically abusing a loved one is viewed very negatively by much of the population who wonder how men could beat and batter their wives. Therefore, it is quite possible that these men feel a sense of shame and guilt when they walk in the therapy room, that makes it even more important for them to feel that their therapist can see good things in them. Similarly, women who stay in violent relationships are often disdained by other women who feel confident that they would leave a relationship or a marriage the second their husband or partner laid a hand on them. Unfortunately, these women have often been

blamed for their decision to stay in these relationships, sometimes by therapy professionals as well as their friends or families. Therefore, these women, like their male partners, quite possibly feel a sense of shame and embarrassment when they enter the therapy room that makes it even more important to them when someone can validate their experience and help them feel validated, despite the fact that they have chosen to stay with a man who hits them. Therefore, therapists should be mindful of really listening to these clients and complimenting their strengths. For these participants, these techniques seemed to create a context in which they felt comfortable and safe to begin working on their relationships and making meaningful changes in their lives.

The conflict that is sometimes apparent between what clients believe they need from therapists in order to be helped and what therapists believe they need to do to be helpful brings up another possible clinical implication. A number of clients in this study expressed their belief that they felt therapists should try to “get to the root of the problem.” Since this treatment was short-term (12 sessions) and heavily solution-oriented, spending time exploring the causes of anger and violence was not a focus of the treatment. Despite this mismatch in beliefs, most of the clients felt the treatment they received was quite helpful to them, and many responded positively to the solution-oriented techniques. However, their belief that they needed to understand the causes of problems and their feeling that this would not occur in therapy did seem to contribute to a lack of confidence that the treatment would

ultimately be effective. The question then is how should therapists deal with this mismatch of beliefs? There are a few options to consider. Perhaps therapists should discuss this conflict in beliefs directly with their clients and acknowledge their clients' viewpoint and explain their own. It seems possible that some open discussion of this mismatch might help calm some of the anxiety of clients wondering whether they are going to explore these causes in depth. Then, of course, the question becomes should therapists change their methods to facilitate this exploration with their clients? Therapists will need to consider whether or not they believe this would be helpful (or even possible if there is a time-constraint) and move forward accordingly. However, whatever they decide, this mismatch between therapist and client beliefs about the proper course of treatment needs to be considered.

Another potential clinical implication of this study is to re-think the treatment length for this program. Both clients and therapists overwhelmingly agreed that 12 weeks is simply not sufficient to adequately address the anger and pain in these couples, as well as to teach them new tools and ways to communicate and manage their conflict effectively. One client suggested that due to the fact that these are violent couples, problems are necessarily more complex, and dictate a longer treatment. How long is another question. Some therapists suggested 18 weeks to six months, while some clients suggested six months to a year. Obviously, there are several considerations involved in treatment length (e. g. managed care, financial

resources of the clients, availability of the therapists), but this seems to be an issue that warrants some consideration.

Another clinical implication of this study is that therapists should work in male/female co-therapy teams as much as possible with violent couples. Clients and therapists strongly voiced their view that this component had been essential to the treatment for a variety of reasons (e. g. including balance, opportunity to do individual check-ins and post-checks). In a non-research environment, this may be more practical in a group setting (where numerous clients can share the cost of having two therapists) than individual couple treatment.

A final implication for clinical work involves the use of the technique of time-out. As therapists (either for anger management groups or couples treatment) we need to be very thoughtful about how we present this tool. It is not a simple issue. These clients expressed the need for learning about the technique conjointly so that they could mutually agree on the "rules." Anger management facilitators may need to re-think how they present this technique. Is it presented in detail to the men? Do facilitators explain the "rules" clearly (i.e. you may not use this to withdraw from discussions entirely, you may not leave the house for hours at a time without telling your partner where you are, etc.). Is there some way to involve the female partners in the use of the technique, so that they are informed of its proper use, rather than being set up to be further victimized? For example, perhaps facilitators could give a home-work assignment in which the men take the thorough

explanation of time-outs home with them to discuss with their wives, and have her sign the homework. In any case, the experiences of these participants suggest that we cannot simply explain the technique to the men and assume that they are following it properly.

Future Research

There are a number of areas that need to be further researched. First of all, there needs to be more qualitative research that studies couples counseling for violence from both partners' perspectives. There is a lot we do not yet know about what is helpful to this particular population. Future research should attempt to study a wide range of clients, including clients from a variety of socio-economic backgrounds, with various relationship lengths, levels of violence, and couple dynamics. Additionally, further qualitative research should be combined with outcome measures to compare clients' and therapists' views on what is helpful to outcome measures that show the change (or lack thereof) in their relationship.

Additionally, more research should be done to obtain the feedback of minority clients in couples counseling for domestic violence. Although research on the experiences of Black clients in male-only treatment for violence suggests that racial difference is an important issue, this study did not find that difference. Future research in this area should attempt to use Black researchers, with the hope that Black participants will feel more comfortable sharing their true feelings with same-race researchers about having different-race therapists.

Personal Post-Script

This has been a very interesting experience to me as researcher and as a therapist. This was truly a growth experience as I struggled to learn how to manage each step of this research project from how to interview clients to how to code the data. Some days, I felt the growing pains more than others.

At the time I conducted this study, I was interning as a therapist in a university-clinic and in the family therapy program of a juvenile and domestic relations county court. In both settings, I sometimes worked with couples and families who had abuse in their relationships. During this time, I was also facilitating men's anger management groups. In all of these areas, I have been astonished by the complexity of the people and the relationships that are affected by violence. Working with men in anger management groups who have abused their partners helped me come to know some of these men who had behaved violently, but who also had the capacity for empathy, warmth, and sadness. Just as these men had disturbing pieces of themselves that co-existed with their strengths, I found that the participants in this study often described relationships that had violence co-existing with affection, humor, and love. There was nothing simple about their problems or their potential.

Interviewing participants, especially the clients, had its challenges. As clients told me about some of their struggles or even some of their successes, I struggled to stay in the neutral researcher role and not cross over to the supportive therapist role. Most times I successfully managed that struggle, I

believe. However, there were definitely times when I wandered slightly over the line, especially to offer compliments or "wows" when clients shared some of the changes they had made.

There is no doubt in my mind that I will think often of things participants shared with me as I continue in my clinical work. I feel fortunate to have had the opportunity to meet with so many of the participants who were willing to share freely of their time and their experiences, often touching on painful subjects. It is my hope that those of us who study and work with this population will hear their voices as we continually struggle to offer them the best treatment possible to end the violence in their relationships.

References

Adams, D. D. (1988). Treatment models of men who batter: A profeminist analysis. In K. Yllo & M. Bograd (Eds.), Feminist perspectives on wife abuse (pp. 176-199). Newbury Park, CA: Sage.

American Bar Association (1995). Report from the American Bar Association Commission on Domestic Violence.

Amir, D. (1993). Moments of insight in the music therapy experience. Music Therapy, 12 (1), 85-100.

Berg, I. K., & Miller, S. D. (1992). Working with the problem drinker: A solution-focused approach. New York: W. W. Norton.

Betz, N. E. & Fitzgerald, L. F. (1993). Individuality and diversity: Theory and research in counseling psychology. Annual Review of Psychology, 44, 343-381.

Bischoff, R. J., & McBride, A. (1996). Client perceptions of couples and family therapy. The American Journal of Family Therapy, 24 (2), 117-128.

Boss, P., Dahl, C., & Kaplan, L. (1996). The use of phenomenology for family therapy research: The search for meaning. In D.H. Sprenkle & S. M. Moon (Eds.), Research methods in family therapy (pp. 83-106). New York: Guilford.

Boyd-Franklin, N. (1989). Black families in therapy: A multisystems approach. New York: The Guilford Press.

Christensen, L. L., Russell, C. S., Miller, R. B., & Peterson, C. M. (1998). The process of change in couples therapy: A qualitative investigation. Journal of Marital and Family Therapy, 24 (2), 177-188.

Daly, K. (1992). The fit between qualitative research and characteristics of families. In J. F. Gilgun, K. Daly, and G. Handel (Eds.), Qualitative methods in family research(pp. 3-11). Newbury Park, CA: Sage.

De Shazer, S. (1985). Keys to solution in brief therapy. New York: W. W. Norton.

Elliott, R., Shapiro, D.A., Firth-Cozens, J., Stiles, W.B., Hardy, G.E., Llewelyn, S.P., & Margison, F.R. (1994). Comprehensive process analysis of insight events in cognitive-behavioral and psychodynamic-interpersonal psychotherapies. Journal of Counseling Psychology, 41 (4) 449-463.

Ferraro, K. & Johnson, J. (1983). How women experience battering: The process of victimization. Social Problems, 30, 325-339.

Franklin, A. J. (1992). Therapy with African American men. Families in Society: The Journal of Contemporary Human Services, 73 (6), 350-355.

Gelles, R. (1974). The violent home: A study of physical aggression between husbands and wives. Beverly Hills, CA: Sage.

Gelles, R. J., & Straus, M. A. (1990). The medical and psychological costs of family violence. In M.A. Straus & R.J. Gelles (Eds.), Physical violence in American families (pp. 425-430). New Brunswick, N.J.: Transaction Publishers.

Gilgun, J. F. (1992). Definitions, methodologies, and methods in qualitative family research. In J. F. Gilgun, K. Daly, and G. Handel (Eds.), Qualitative methods in family research (pp. 22-40). Newbury Park, CA: Sage.

Glaser, B. & Straus, A. (1967). The discovery of grounded theory. Chicago: Aldine.

Gondolf, E. (1995, March). Batterer intervention: What we know and need to know. Paper presented at Violence Against Women Research Strategic Planning Workshop, sponsored by the National Institute of Justice, Washington, D.C.

Gondolf, E. W., & Hanneken, J. (1987). The gender warrior: Reformed batterers on abuse, treatment, and change. Journal of Family Violence, 2 (2), 177-191.

Greene, B. (1997). Psychotherapy with African American women: Integrating feminist and psychodynamic models. Smith College Studies in Social Work, 67 (3), 299-322.

Gregory, M. A., & Leslie, L. A. (1996). Different lenses: Variations in clients' perception of family therapy by race and gender. Journal of Marital and Family Therapy, 22 (2), 239-251.

Hamberger, L. K., & Hastings, J. E. (1993). Court-mandated treatment of men who assault their partner: Issues, controversies, and outcomes. In N. Z. Hilton (Ed.), Legal responses to wife assault. Newbury Park, CA: Sage.

Heyman, R. E., & Neidig, P. H. (1997). Physical aggression couples treatment. In W.K. Halford and H. J. Markman (Eds.), Clinical handbook of

marriage and couples interventions (pp. 589-617). Chichester, UK: John Wiley & Sons, Ltd.

Kauffman, E., Dore, M. M., & Nelson-Zlupko, L. (1995). The role of women's therapy groups in treatment of chemical dependence. American Journal of Orthopsychiatry, 65 (3), 355-363.

Kuehl, B. P., Newfield, N. A., & Joanning, H. (1990). A client-based description of family therapy. Journal of Family Psychology, 3 (3), 310-321.

Lane, G., & Russell, T. (1989). Second-order systemic work with violent couples. In P. Caesar & L. Hamberger (Eds.), Treating men who batter: Theory, practice and programs. New York: Springer.

Levesque-Lopman, L. (1988). Claiming reality: Phenomenology and women's experience. Totowa, NJ: Rowman & Littlefield.

Liataer, G. (1992). Helping and hindering processes in client-centered/experiential psychotherapy. In S. Toukmanian & D. Rennie (Eds.), Psychotherapy process research: Paradigmatic and narrative approaches (pp. 134-162). London: Sage Publications.

Lindquist, C. U., Telch, C. F., & Taylor, J. (1983). Evaluation of a conjugal violence treatment program: A pilot study. Behavioral Counseling and Community Interventions, 3 (1), 76-90.

Llewelyn, S. P. (1988). Psychological therapy as viewed by clients and therapists. British Journal of Clinical Psychology, 27, 223-237.

McCollum, E.E., & Trepper, T.S. (1995). "Little by little, pulling me through"- Women's perceptions of successful drug treatment: A qualitative inquiry. Journal of Family Psychotherapy, 6 (1), 63-81.

McGoldrick, M. (1993). Ethnicity, cultural diversity, and normality. In F. Walsh (Ed.), Normal Family Processes (pp. 331-360). New York: The Guilford Press.

McNair, L. D. (1992). African American women in therapy: An Afrocentric and feminist synthesis. Women & Therapy, 12, 5-19.

Metcalf, L., Thomas, F. N., Duncan, B. L., Miller, S. D., & Hubble, M. A. (1996). What works in solution-focused brief therapy: A qualitative analysis of client and therapist perceptions. In S. D. Miller, M. A. Hubble, & B. L. Duncan (Eds.), Handbook of solution-focused brief therapy (pp. 335-349). San Francisco: Jossey-Bass.

Miller, S. D., Duncan, B. L., & Hubble, M. A. (1997). Escape from babel: Toward a unifying language for psychotherapy. New York: Norton.

Mishna, F. (1996). Finding their voice: Group therapy for adolescents with learning disabilities. Learning Disabilities Research and Practice, 11 (4), 249-258.

Murphy, S. O. (1992). Using multiple forms of family data: Identifying pattern and meaning in sibling-infant relationships. In J. F. Gilgun, K. Daly, & G. Handel (Eds.), Qualitative methods in family research (pp. 146-171). Newbury Park, CA: Sage.

Newfield, N. A., Joanning, H. P., Kuehl, B. P., & Quinn, W. H. (1991). We can tell you about "psychos" and "shrinks": An ethnography of the family therapy of adolescent drug abuse. In T. C. Todd & M. D. Selekman (Eds.), Family therapy approaches with adolescent substance abusers (pp. 277-310). Boston: Allyn and Bacon.

NUD*IST (1997). (Version 4.0): Qualitative Solutions & Research Party, Limited.

Odell, M., Butler, T. J., & Dielman, M. B. (1997). Client experiences of solution-focused couple therapy. Paper presented at the 55th Annual Conference of the American Association for Marriage and Family Therapy, Atlanta, GA.

O'Leary, K. D., & Rathus, J. H. (1993). Clients' perceptions of therapeutic helpfulness in cognitive and marital therapy for depression. Cognitive Therapy and Research, 17 (3), 225-233.

Pearlmutter, L. (1996). Using culture and the intersubjective perspective as a resource: A case study of an African-American couple. Clinical Social Work Journal, 24 (4), 389-401.

Peled, E. (1990). Research in progress: A qualitative evaluation of groups for children of women who have been battered. Qualitative family research, 4,(2), 3-4.

Peled, E., & Edleson, J. L. (1992). Multiple perspectives on groupwork with children of battered women. Violence and victims, 7 (4), 327-346.

Pfouts, C. (1978). Violent families: Coping responses of abused wives. Child Welfare, 57, 101-111.

Protinsky, H., & Marek, L. I. (1997). Insights into the treatment of eating disorders: A qualitative approach. Family Therapy, 24 (2), 63-69.

Riza, W., Stacey, W., & Shupe, A. (1985). An evaluation of the effect of the Family Preservation Program in Tyler, Texas (Vol. 35). Arlington, TX: University of Texas at Arlington Department of Sociology, Anthropology, and Social Work, Center of Social Research.

Saunders, D.G. (1996). Interventions for men who batter: Do we know what works? Psychotherapy in Practice, 2, (3), 81-93.

Sells, S. P., Smith, T. E., Coe, M. J., Yoshioka, M., & Robbins, J. (1994). An ethnography of couple and therapist experiences in reflecting team practice. Journal of Marital and Family Therapy, 20 (3), 247-266.

Sells, S. P., Smith, T. E., & Moon, S. (1996). An ethnographic study of client and therapist perceptions of therapy effectiveness in a university-based training clinic. Journal of Marital and Family Therapy, 22 (3), 321-342.

Smith, T., Sells, S., & Clevenger, T. (1994). Ethnographic content analysis of couple and therapist perceptions in a reflecting team setting. Journal of Marital and Family Therapy, 20, (3), 267-286.

Smith, T. E., Yoshioka, M., & Winton, M. (1993). A qualitative understanding of reflecting teams I: Client perspectives. Journal of Systemic Therapies, 12 (3), 28-43.

Snyder, D. & Fruchtman, L. (1981). Differential patterns of wife abuse: A data-based typology. Journal of Consulting and Clinical Psychology, 49, (6), 878-885.

Stevenson, H. C., & Renard, G. (1993). Trusting ole' wise owls: Therapeutic use of cultural strengths in African-American families. Professional Psychology: Research and Practice, 24 (4), 433-442.

Stith, S. M., Rosen, K. H., McCollum, E. E., Coleman, J. U., & Herman, S. A. (1996). The voices of children: Preadolescent children's experiences in family therapy. Journal of Marital and Family Therapy, 22 (1), 69-86.

Strauss, A., & Corbin, J. (1990). Basics of qualitative research. Newbury Park, CA: Sage Publications.

Taylor, J. W. (1984). Structured conjoint therapy for spouse abuse cases. Social Casework, 65, 11-18.

Timasheff, N. S., & Theodorson, G. H. (1976). Sociological theory: Its nature and growth (4th ed.). New York: Random House.

Tolman, R., & Edleson, J. L. (1989). Cognitive-behavioral intervention with men who batter. In B.A. Thyer (Ed.), Behavioral family therapy, (pp. 169-190). Springfield, IL: Charles C. Thomas.

Tolman, R. M. & Edleson, J. L. (1995). Intervention for men who batter: A review of research. In Understanding partner violence: Prevalence, causes, consequences, and solutions. Minneapolis, MN: National Council on Family Relations.

Tolman, R. M., & Saunders, D. (1988). The case for cautious use of anger control with men who batter. Response, 11, 15-20.

Walsh, M. S. (1997). "Looking at the picture by stepping outside": A qualitative study of parents' of adolescents experiences in family therapy. Unpublished Masters, Virginia Polytechnic Institute and State University, Blacksburg, VA.

Wark, L. (1994). Client voice: A study of client couples' and their therapists' perspectives on therapeutic change. Journal of Feminist Family Therapy, 6 (2), 21-39.

Weiss, R. (1994). Learning from strangers. New York: The Free Press.

Williams, O. (1995). Treatment for African American men who batter. CURA Reporter, 25, (3), 6-10.

Yin, Robert K. (1989). Case study research: Design and methods. Newbury Park, CA: Sage.

APPENDIX A

Guiding Interview Questions

<u>Questions for Clients:</u>

1) When you consider your most recent counseling session(s), what stands out in your mind?

2) What has been helpful?

3) What has not been helpful?

4) On a scale of 1-5 (1=completely misunderstood, and 5=completely understood), how understood do you feel by your therapists? **What does the therapist do that makes you feel (mis)understood?**

5) What advice would you give to your therapists to help them improve treatment?

6) ***For minority clients:*** One of the things we are trying to do is to reach minority clients and make the treatment relevant to them. How are we doing?

7) ***For minority clients:*** In general, how could we improve the treatment to be more useful to people of color?

8) You've had ___ sessions. What changes have you begun to notice as a result of your work in counseling?

9) How are you responding to these changes?

10) ***For group participants:*** You and your partner are receiving therapy with other couples in a group setting. How are you experiencing that?

11) ***For group participants:*** There is some controversy about the effectiveness of mixed racial/ethnic background groups vs. groups of clients who share the same race or ethnic background. Your group is mixed. How is that working for you? Your therapists are also diverse, how is that working?

12) ***For women:*** There is some disagreement about how women feel about their partner's participation in anger management groups. How do you feel about your partner's participation? How has his anger management group impacted your relationship?

13) What is your level of confidence that the counseling will be effective?(very confident, somewhat confident, not very confident, not at all confident)

14) How likely is it that you will complete the entire treatment program? (very likely, somewhat likely, not very likely, not at all likely)

15) What has influenced your decision to continue?

Questions for Therapists:

1) When you consider your most recent counseling session(s), what stands out in your mind?

2) What, if anything do you believe has been helpful to the clients?

3) What, if anything, do you believe has not been helpful?

4) ***For group participants:*** You are providing therapy to couples in a group setting. How are you experiencing that?

5) ***For group participants:*** There is some controversy about the effectiveness of mixed racial/ethnic background groups vs. groups of clients who share the same race or ethnic background. Your group is mixed. How is that working for you? As therapists, you are also of diverse genders/races. How do you believe the group is experiencing that?

6) ***for minority clients:*** One of the things we are trying to do is to reach minority clients and make the treatment relevant to them. How do you think you are doing?

7) You've had ___ sessions. What changes have you begun to notice in your clients as a result of your work in counseling?

8) What is your level of confidence that the counseling will be effective with these clients? (very confident, somewhat confident, not very confident, not at all confident) **Explain.**

9) How are you experiencing co-therapy? What do you believe are the pros and cons of co-therapy in this model?

10) What is it like for you to be a part of a research project? How does that impact on the therapy? How are you experiencing the use of a manual? (etc.)

11) What advice would you give to the researchers to help them improve the treatment model overall?

APPENDIX B

Client Informed Consent

VIRGINIA TECH COUPLES TREATMENT PROGRAM
INFORMED CONSENT

What is it?

- The Virginia Tech Couples Treatment program is a research project designed to see if adding couples treatment to a men's domestic violence program will be helpful to couples trying to end the violence in their relationships.

What Will I Have to Do?

- Fill out questionnaires before the beginning of treatment, at the end of treatment, and three months after that. Filling out the questionnaires should take about an hour.
- Attend all required sessions of an anger management program if you haven't already completed one (male partners only)
- Attend an additional 12 sessions of couples therapy (either in a group with other couples or you and your partner alone with a counselor) if you are randomly assigned to receive couples therapy
- Allow your couples therapy sessions (whether group or individual) to be videotaped for research purposes
- Complete a short questionnaire after each couples therapy session
- If asked, do a tape-recorded interview with a researcher about how the treatment has or has not been helpful

What are the Benefits and Risks?

- You will be helping us test a treatment that may help other people with some of the same problems you are having
- You will get additional therapy to help you work on problems in your own relationship
- Like any therapy, you may be asked to talk about upsetting or difficult issues
- It is possible that working on problems as a couple may lead to angry or violent feelings. You will be asked to sign an agreement to control these feelings. Your counselor will help you follow through with the agreement
- There is no guarantee that by participating in this project the violence in your relationship will end or that you will stay together.

Is it Private?

- All information you give in treatment is confidential, but there are times when your counselor may need to break that confidentiality.
    - If you threaten to hurt yourself or someone else, the counselor must take steps to protect you or others
    - If you reveal information that leads the counselor to think that a child or dependent adult has been abused, appropriate county officials must be notified

Will I get Paid?

- We will pay each of you $20 ($40 per couple) to complete the first set of questionnaires (before the beginning of treatment), and $25 each ($50 per couple) for the second and third sets of questionnaires (at the end of treatment and 3 months later). You will not be paid for any other activity that is part of the project.

Can I quit if I want to?

- The couples counseling project is voluntary. You may withdraw from it at any time.

Approval of Research

- This research project has been approved, as required, by the Institutional Review Board for projects involving human subjects at Virginia Polytechnic Institute and State University, and by the Department of Family and Child Development.

Participants' Agreement and Responsibilities

- I have read and understand what my participation in this project entails and I know of no reason that I cannot participate in this project. I have had all my questions answered and hereby give my voluntary consent for participation in this project.
- Should I have any questions about this project or its conduct, I can contact any of the following: Dr. Sandra Stith, Principal Investigator (703-538-8460); Ms. Claire Dunn, Coordinator, Alexandria Domestic Violence Program (703-838-4911); Dr. Gloria Bird, Department of Family and Child Development (540-231-4791) or Dr. H. T. Hurd, Chair of the Virginia Tech IRB (540-231-5281).

______________________________   ____________

Signature   Date

____

Printed Name

______________________________   ____________

Witness   Date

VIRGINIA TECH COUPLES COUNSELING PROJECT
INFORMED CONSENT
PARTICIPANT'S INFORMATION

Should you have any questions about this project or its conduct, you can contact any of the following people:

- Dr. Sandra Stith, Principal Investigator (703-538-8460);

- Ms. Claire Dunn, Coordinator, Alexandria Domestic Violence Program (703-838-4911);

- Dr. Gloria Bird, Department of Family and Child Development (540-231-4791)

- Dr. H. T. Hurd, Chair of the Virginia Tech IRB (540-231-5281).

APPENDIX C

Therapist Informed Consent

Title of the Project: Virginia Tech Couples Counseling Project

Principal Investigator: Sandra M. Stith

I. THE PURPOSE OF THIS PROJECT

You are invited to participate as a therapist in a research and development project to refine a manualized treatment model for couples who remain together despite the male partner's use of physical violence towards his partner.

II. PROCEDURES

The counseling model is 12 sessions and may be in the form of individual couple or couple group sessions. Each session will be videotaped. In addition to providing couples treatment with a co-therapist, we will ask you to attend group supervision twice per month and to provide feedback regularly about your ideas for improving the model and how you experience the process. This information will be collected after each session, during group supervision, and, for those selected, through qualitative interviews. We will also ask you to answer a few questions about your expectations prior to beginning your first session.

III. BENEFITS OF THIS PROJECT

Your participation in this project is critical to our ability to refine our treatment model for battering. You may benefit personally by learning more about the treatment of domestic violence through the experience of delivering treatment, receiving training and supervision, and exchanging ideas with your colleagues.

IV. EXTENT OF ANONYMITY AND CONFIDENTIALITY

Should we publish any data from this project, information that you supply will be presented in such a way that your identity is confidential.

V. FREEDOM TO WITHDRAW

Your participation in this project is strictly voluntary. You are free to withdraw from this project at any time without penalty.

VI. APPROVAL OF RESEARCH

This research project has been approved, as required, by the Institutional Review Board for projects involving human subjects at Virginia Polytechnic Institute and State University, by the Department of Family and Child Development.

VII. PARTICIPANT'S PERMISSION

I have read the informed consent and understand the conditions of this project. I hereby give my voluntary consent for participation in this project. If I participate, I may withdraw at any time without penalty.

____
Participant Signature