Chapter I

INTRODUCTION

The Problem and its Setting

Domestic violence is recognized as a major problem in American society today. Every year, two to four million women are battered by their partners (American Bar Association, 1995). These beatings have severe consequences for the women who experience them. Victims of domestic violence may end up in the emergency room for severe injuries, and suffer physical and psychological illnesses (Gelles & Straus, 1990). In spite of the negative consequences to these women, many remain with their abusive mates. Approximately 50 to 80% of domestic violence victims stay with their abusive partners (Ferraro & Johnson, 1983; Gelles, 1974; Pfouts, 1978; Snyder & Fruchtman, 1981).

Although many batterers are part of intact relationships, the batterer is typically the sole unit of treatment. Several methods of treatment have been attempted to end violence in these abusive relationships. Treatment models have been based on feminist theory, psychodynamic theory, skills training, cognitive restructuring, and awareness of sex role socialization (Adams, 1988; Saunders, 1996; Tolman & Edleson, 1989; Tolman & Saunders, 1988). Currently, most treatment programs involve psychoeducation with small groups of batterers (Tolman & Edleson, 1995).

In addition to treatment programs for individual batterers, some people have begun treating batterers together with their partners. The

practice of treating both members of the couple has been controversial (Saunders, 1996). Critique of couples treatment of violence includes the notions that such conjoint treatment implies blame of the victim and that revelations in the therapy session may trigger violence. However, Saunders also writes about some of the potential advantages of couples treatment, including the ability to put new skills immediately into practice during the session, and the opportunity for the woman to "witness the ways in which the therapist holds her partner solely responsible for the violence" (p.84), thereby decreasing her self-blame.

To date, what scant research that has been done on conjoint domestic violence treatment has focused on the effectiveness of such treatment. Some studies have shown successful outcomes from a conjoint approach (Lane and Russell, 1989; Riza, Stacey, and Shupe, 1985), while others have shown less favorable results (Lindquist, Telch, & Taylor, 1983; Taylor 1984). With no conclusive research on the usefulness of couples treatment of violence, there is a need for further research on the conjoint treatment of domestic violence.

Rationale for the Study

This study qualitatively investigates how batterers, their partners, and their co-therapists experience the initial stages of conjoint treatment as part of a research and development project for couples treatment of domestic violence. This research and development program, funded by the National Institute of Mental Health (NIMH) is designed to develop and pilot test a culturally sensitive, manualized couples' treatment model for dealing with

violent men and their partners. The couples and therapists involved in this project were interviewed to better inform the development of the treatment model, and to help fill in some of the gaps in our knowledge about couple therapy programs for domestic violence.

This study is a qualitative endeavor, since it allows the researcher to gain an in-depth understanding of the therapeutic process from the unique perspective of each of its participants. "Qualitative methods are suited to understanding the meanings, interpretations, and subjective experiences" of people (Daly, 1992). By using a qualitative design, experiences are explored that would be difficult to assess quantitatively such as salient moments during the therapy session, which discussions are perceived as useful to the clients and therapists, and which interactions are experienced as culturally respectful versus culturally insensitive. Peled (1990) discusses the appropriateness of qualitative study for gaining understanding of a program, and stresses the importance of interviews that yield descriptions from various points of view. Further, a qualitative design allows room to explore in-depth how participants experience the evolution of the therapy process by asking further questions for clarification and elaboration.

Since this study is part of a larger research and development project, the exploration of participants' experiences informed the development of that project. The perceptions of clients and therapists involved in the program provided essential information to improve and evaluate the developing treatment model. "Familiarity with change processes and interpersonal

dynamics taking place in a program is crucial in understanding its outcomes and judging its merit" (Peled, 1990).

Researchers have recognized the importance of obtaining different viewpoints of the same therapy session (Llewelyn, 1988; Peled, 1990). Both therapists and clients were interviewed to further a thorough understanding of the most salient events that occur during the treatment process, and how they are experienced by each member of the therapeutic unit. Since such events can be interpreted differently by different people, it is essential to obtain multiple perceptions of the same event (Boss, Dahl, & Kaplan, 1996). Similarly, because the therapeutic process evolves differently for each of the participants, it is important to gain an understanding of each participant's experiences.

The focus of this study is on the early sessions of therapy, since these sessions tend to be crucial in clients' decisions to continue therapy. A study by Gregory and Leslie (1996) emphasized the significance of the early sessions of therapy when they found that clients' feelings about therapy changed substantially between the first and fourth therapy sessions. Other researchers also focus on the potential impact of the beginning stages of therapy. For example, research conducted by Kuehl, Newfield, and Joanning (1990) suggests that there are key elements of therapy that are deemed important by clients in the first phase of therapy. Additionally, Heyman and Neidig (1997) stress the importance of addressing possible causes of dropout at the earliest stages of couple treatment for domestic violence.

Another focus of this study is to enhance our understanding of how to improve the effectiveness of treatment programs for African-American participants. African-Americans are often reluctant to participate in the therapy process, as they may "view therapy within the context of other traditional dealings with white institutions, which have basically never served their needs" (McGoldrick, 1993, p. 356). For domestic violence treatment specifically, there may be a continuation of not meeting the needs of African-American clients. The research on batterers' treatment programs suggests that such programs are less effective for Black men than for their White counterparts (Williams, 1995). This is an important problem, since Black men are typically over-represented in batterers' treatment programs. We do not seem to know what works for African-Americans dealing with domestic violence. More generally, there is a scarcity of research on Black couples in therapy (Boyd-Franklin, 1989). Furthermore, "empirical work on the impact of race and gender on the process and outcome of family therapy is virtually nonexistent" (Gregory & Leslie, 1996, p. 240). This study seeks to fill in some of the gaps in our knowledge by exploring the experiences of Black men and women in the couples treatment program, to help improve the cultural sensitivity of the final treatment model developed.

Finally, a major problem in the treatment of domestic violence is an extremely high attrition rate among batterers. In their examination of 28 treatment outcome studies, Hamberger and Hastings (1993) found dropout rates ranging from 0 to 83%, with an average of 43.7%. Another researcher

reported that batterers' treatment programs experience a "40% to 60% dropout within 3 months" (Gondolf, 1995, p. 5). As these statistics predict, we experienced some attrition from our couples treatment project. Couples who dropped out of the program were contacted for interviews so that we could begin to understand the decision-making process that led to their choice to drop out.

Theoretical Framework

Phenomenology is the theoretical framework that informs this study. Phenomenology is based on the assumption that knowledge is socially constructed (Boss et al., 1996, p. 86). Since knowledge is socially constructed, "truth" is an evasive concept. Thus, phenomenology can be viewed as a repudiation of positivism (Levesque-Lopman, 1988). Phenomenology challenges "the underlying assumption that scientists through their five senses can simply and directly investigate the world about them, record their findings, and in time build up a body of knowledge that accurately reflects the realities of the objective outside world" (Timasheff and Theodorson, 1976, p. 291-292). Rather than seeking to discover some objective truth, the goal of phenomenological research is to understand the experience of the participant (Murphy, 1992).

In an effort to gain understanding of another's experience, phenomenologists use qualitative methods that yield descriptive data such as in-depth interviewing, analysis of written materials, and participant observation (Boss et al., 1996). The phenomenological researcher does not

define categories and events for the research participant, but asks questions that will draw out the meaning of a phenomenon from the participant's point of view. "Phenomenological research questions are questions of meaning designed to help the researcher understand the lived experience of the participant" (Boss et al., 1996, p. 92).

This study does not seek to find the "truth" of what occurred in any one therapeutic session, nor does it strive to definitively state what is helpful for *all* clients in couples treatment of domestic violence. Instead, the researcher attempts to understand the "truth" for each participant in the therapeutic experience. How does one unique individual experience this process? What does this unique person find helpful or not useful in the treatment? In addition to studying the experiences of the individuals involved in the treatment, broad patterns across individuals are examined, seeking the similarities and differences in their experiences.

Using phenomenology as a guide, this study strives to understand the meaning of participants' experiences within a therapeutic unit by allowing them to express this meaning in their own language. Therefore, qualitative interviewing is used to allow the clients and therapists to use their own words to describe the significant events they experience. Researchers ask clarifying questions to try to obtain a deep understanding of each person's experience.

Finally, a phenomenological framework suggests that each person's experience of a situation or event is important in understanding that event

(Boss et al., 1996). Therefore, each member of an individual therapeutic unit, comprised of a batterer, his partner, and their therapists were interviewed. The purpose of multiple sources of data is not to pose them against each other to find the single truth of the experience. Instead, interviewing each person paints a picture of the experience with multiple shades and forms, furthering a unique understanding of each individual's experience and the process as a whole.

Purpose of the Study

The purpose of this study is to explore the experience of batterers, their partners, and their therapists involved in couples treatment of domestic violence. Participants were asked to describe what is most salient to them about the therapy process. Clients and therapists were asked about their perceptions of what is helpful or not helpful in therapy, what changes they notice, and their feelings about the evolving therapy process. Information obtained from this study informed the development of the treatment model in the larger study. It is also hoped that this information will help determine possible prevention of attrition in future programs by outlining a model that addresses the concerns of the participants. This study also explores the experiences of Black clients, to determine their perceptions of the cultural sensitivity of the program. Their responses helped to inform the researchers about how to improve the treatment in order to be more effective for Black participants.

Research Topics

Questions in this study attempted to tap into the experience of each of the participants in the therapeutic unit (therapists, batterers, and their partners). I sought to understand the expectations, hopes, and concerns of each of these individuals before beginning the treatment program. Once the treatment began, participants were asked about the effectiveness of the therapy (specifically what interventions or conversations seemed helpful, and which were perceived as not useful). Minority clients were asked about their perception of the cultural sensitivity of the program, and their ideas for improving this sensitivity. Their therapists were also asked about their efforts to be culturally sensitive, and how effective they feel these efforts have been. All of the participants were asked about their experience of the evolving therapeutic process and relationship (See Appendix A for a list of guiding interview questions).

The study also examines the similarities and differences between participants' experiences. For example, do husbands and wives find the same interventions helpful? Are the techniques that therapists assume to be most effective perceived effective by their clients? Does each therapist of the co-therapy team perceive the same interventions as most useful? Finally, for those couples that decided to discontinue treatment, the researcher interviewed them to understand their decision to drop out, and what might have prevented their attrition from the project.

Chapter II

LITERATURE REVIEW

Introduction

The current study uses qualitative interviews with client systems (clients and therapists) to obtain their perceptions of an integrated model for couples treatment of domestic violence. The integrated therapy model is based on family systems theory. Specifically, it has a heavy emphasis on solution-focused theory, with structural and Bowen concepts included. Clients and therapists are asked about their perceptions of helpful or not helpful aspects of the therapy, changes that have resulted from the therapy, and advice to improve the therapy.

Previous qualitative research has focused primarily on therapists' perceptions of treatment and treatment outcome. Recently, there has been a significant interest in studying clients' perceptions of their treatment as well using qualitative methods. Qualitative methods have been used to study clients and therapy from numerous angles. For example, researchers have examined the views of clients presenting with a variety of problems such as chemical dependence, depression and eating disorders (Kauffman, Dore, & Nelson-Zlupko, 1995; O'Leary & Rathus, 1993; Protinsky & Marek, 1997). Qualitative methods have also been used to elicit the views of clients involved in a variety of treatment methods including psychodynamic and behavioral therapies, experiential therapy, and family therapy (Elliott et al., 1994; Liataer, 1992; Newfield, Joanning, Kuehl, & Quinn, 1991; Walsh, 1997).

Researchers have used qualitative methods to not only study adult clients, but child and adolescent clients as well (Mishna, 1996; Newfield et al., 1991; Peled & Edleson, 1992; Stith, Rosen, McCollum, Coleman, & Herman, 1996; Walsh, 1997). Finally, qualitative methods have even been used to obtain clients' opinions about specific treatment interventions (e.g. reflecting teams) employed in their treatment (Sells, Smith, Coe, Yoshioka, & Robbins, 1994; Smith, Yoshioka, & Winton, 1993). Clearly, a number of researchers have discovered the versatile uses of qualitative methods for studying the perspectives of diverse clients and their therapists involved in a variety of treatments.

The current study uses qualitative interviewing to obtain feedback from both clients and therapists involved in an integrated couples treatment program for domestic violence. This literature review thoroughly examines studies that share a similar focus to this study. For example, this literature review discusses studies that measured one or more of the following: clients' and/or therapists' views of helpful and not helpful events in therapy, clients' and/or therapists' experiences of solution-focused therapy; and clients' views of domestic violence treatment.

The current study also examines the experiences of African-American clients in therapy. Therefore, this literature review includes papers from the clinical literature addressing treatment issues for African-American clients. Studies that have obtained feedback directly from African-American clients are also discussed.

Clients' and Therapists' Perceptions of Therapy

The following sections describe, in detail, qualitative studies of clients' or clients' and therapists' experiences of therapy, similar to the current study. Studies that illicit feedback from clients or clients and therapists about helpful aspects of therapy are discussed (Bischoff & McBride, 1996; Christensen Russell, Miller, & Peterson, 1998; Kuehl et al., 1990; Llewelyn, 1988; O'Leary & Rathus, 1993; Sells, Smith, & Moon, 1996). As the current paper examines participants' views of a primarily solution-focused model, this review also describes three qualitative studies that examined clients' experiences of solution-focused therapy (McCollum and Trepper, 1995; Metcalf, Thomas, Duncan, Miller, & Hubble, 1996; Odell, Butler, & Dielman, 1997). Finally, this review examines qualitative studies that have obtained clients' and therapists' experiences of treatment for domestic violence (Gondolf & Hanneken, 1987; Wark, 1994; Williams, 1995).

Clients and Therapists Perceptions of Helpful/Unhelpful Aspects of Therapy

O'Leary and Rathus (1993) studied women presenting with depression and marital discord. They studied 20 women who received marital therapy for these problems and 11 women who received cognitive therapy and compared the results. Female clients were asked to write their responses to an open-ended question upon completion of therapy: "In a few words, what would you say has been most central in helping you feel better over the course of therapy?" (p. 228). Their responses were coded into 12 response categories and compared to discover the similarities and differences in their

responses based on treatment type. The authors noted the lack of overlap in responses: "clients who received marital therapy reported that the most helpful aspects of therapy were relationship-focused or interpersonal, while clients who received cognitive therapy reported that the most helpful elements were intrapersonal" (p. 225). For example, women in the couples treatment tended to report benefits such as seeing positive changes in their spouses and improved communication. Alternatively, women who had completed cognitive therapy mentioned different helpful aspects of therapy such as gaining insight into their own problems, having the support of the therapist, and feeling better about themselves. The authors note that responses might have been different had they been obtained periodically throughout the therapy. They conclude by stating their belief about the importance of gaining clients' perspectives of therapy in order to better understand therapy.

Llewelyn (1988) studied 40 clinical psychologists, psychiatrists, psychiatric nurses, and social workers and 40 of their clients during treatment and after the end of treatment. The clients studied were between the ages of 15 and 60 and presented with a variety of problems including phobias, sexual difficulties, depression, and interpersonal problems. These therapist-client pairs were asked to write their views concerning helpful and unhelpful events after each session and upon termination of treatment. The Therapeutic Impact Content Analysis System (TICAS) was used to analyze the events reported by participants.

The results of the study found that clients and therapists valued different aspects of therapy as helpful (Llewelyn, 1988). "During therapy, these clients valued most the reassurance and relief provided by therapy and, in retrospect, valued most the problem-solving aspects of therapy" (p. 233). The therapists, however, felt both during and after treatment that the cognitive and affective insight they perceived their clients to have gained was the most helpful aspect of the treatment.

Kuehl et al. (1990) conducted ethnographic interviews with clients about their experiences in family therapy where the presenting problem was adolescent drug use. The client sample consisted of 12 families, comprised of 37 individuals (mothers, fathers, adolescent identified patients, and siblings). The researchers conducted 27 interviews, ranging from 1 to 6 interviews per family. All interviews were conducted after treatment had ended. Interviewers used a combination of open-ended questions (e.g., "If someone said they were going to that place to do what you did, and they wanted you to tell them what it was like, what would you tell them?" p. 312) and semi-structured questions to expand understanding of the informants' perceptions of therapy. Data were analyzed using domain analysis.

Several themes emerged from the study (Kuehl et al., 1990). For example, researchers found that most family members did not know what to expect of the therapy process. In addition, clients tended to prefer therapists who offered suggestions rather than telling clients exactly what they should do. The authors also discovered that two therapist characteristics seemed

important to clients: "(a) caring and understanding and (b) able to generate relevant suggestions" (p. 318). Furthermore, the presence of these characteristics seemed to be related to outcome. Those clients who felt their therapists possessed these traits were more likely to be satisfied with the therapeutic experience than those clients who did not see their therapists in this light.

The family therapy literature provides another example of clients' perceptions of their treatment. Christensen et al. (1998) studied the experiences of 24 couples involved in therapy at a university-based family therapy clinic for treatment of marital distress. Interviews were conducted separately with each partner of couples who were either currently in treatment for marital distress, or had recently completed such treatment (within 2 weeks). The interviews were semi-structured and in general, "participants were asked to tell the interviewer about what the therapist did to help facilitate change and what was happening at the time they thought the most was being accomplished" (p. 180). Data were analyzed using the constant comparative method.

Clients identified three major areas of change in their relationships as a result of couples counseling (Christensen et al., 1998). Clients identified changes in affect (e.g. "I don't feel as discouraged about the relationship," p. 181), communication, and cognition (e.g., "I've changed my idea about my responsibility in our problems," p. 182). Clients also identified several helpful qualities and techniques employed by therapists that served as necessary

preconditions to change. First, clients stated that their therapists provided a safe atmosphere to discuss problems. Clients also noted the importance of being fair and unbiased as a therapist. When therapists normalized clients' problems, clients were able to progress with the assurance that their problems were not abnormal. Clients also revealed the importance of feeling hopeful about change, which was often brought about by a therapeutic focus on strengths. Finally, clients found it helpful when therapists slowed the pace of in-session discussions to ensure that both partners heard and understood one another.

Bischoff and McBride (1996) also qualitatively studied clients attending marital or family therapy. A total of 18 client systems, consisting of families, couples, or individual clients, were interviewed about their experiences with therapy at a family therapy clinic staffed by doctoral students in marriage and family therapy. A total of 28 interviews, conducted by trained doctoral students, were analyzed using the constant comparative method of data analysis (Glaser & Strauss, 1967). Three themes emerged: "1) the hierarchy within the therapist-client relationship, 2) therapist empathy and other ingredients of good therapy, and 3) family therapy techniques" (p. 119). First, clients felt that a hierarchical relationship between therapist and clients, with the therapist taking control of the therapy, was helpful. Clients who did not see their therapists as directing the course of therapy expressed frustration with the process. However, clients reported that the therapist must possess certain qualities to be helpful, such as empathy, understanding, and respect

for clients. Second, the results of this study suggest some differences in clients' perceptions of the usefulness of out-of-session tasks. These researchers found that some clients found homework assignments helpful and completed the homework assignments, while other clients still found the homework suggestions helpful even though they did not complete them. There were some clients who neither completed out-of-session tasks, nor found the suggestion of them to be helpful. Finally, the study validates the use of experiential exercises (such as sculpting or empty chair techniques) in therapy. "Both parents and children explained that they felt children were able to participate more appropriately in treatment through these exercises" (p. 125). Authors conclude by suggesting that future research should obtain clients' expectations of the therapist and the impact of client and therapist factors on the therapy process and its outcome.

Sells et al. (1996) studied the perceptions of clients and their therapists about therapy conducted at a university marriage and family therapy clinic. Fourteen client systems (families, couples, or individuals) were interviewed after therapy sessions twice over a four-month period using open-ended and specific questions. One example of an open-ended question used was "If a friend came to you and said, 'We are going to counseling to do what you did, could you please give a step-by-step description of what happened?" (p. 325). One example of a more structured question was "What are all the important qualities that your counselor should posses?" (p. 325). Data from therapists were collected in three ways: audio-taped therapist field notes, individual

interviews with therapists, and focus group interviews with therapists. Domain analysis was used to analyze the data.

A total of five categories related to therapy emerged from the analysis of clients and therapists: "(a) changes associated with counseling, (b) important therapist qualities, (c) effective interventions or techniques, (d) ineffective interventions or techniques," and "(e) recommendations for future sessions" (Sells et al., 1996, p. 327). Two categories of changes were reported by clients and therapists: "specific areas of improvement (e.g. being able to set rules at home, better communication)" and "changes or adjustments made by therapists between sessions that led to positive changes" (p. 329).

Both clients and therapists identified certain therapist qualities as helpful for the therapy process, such as having a sense of humor and being understanding (Sells et al., 1996). However, clients and therapists differed somewhat on their perceptions of effective moments in counseling. Clients tended to identify interventions such as homework, providing focus on a specific goal for treatment, and providing support as helpful therapist actions. Clients also identified the importance of a safe place to talk about their problems. Therapists, alternatively, tended to emphasize formal interventions such as joining, unbalancing, reframing, and looking for exceptions to the problem.

Regarding ineffective actions of the therapist, clients noted instances when therapists either did not directly address the problem or failed to

understand it (Sells et al., 1996). Clients also expressed that therapists were ineffective when they seemed unclear on the treatment goals and direction for therapy. Therapists interviewed also identified a lack of clarity on goals as a problem. Furthermore, therapists added that not giving equal speaking time to family members was not helpful, although this was not noted as a problem by clients.

Both clients and therapists were interviewed about their recommendations for future counseling sessions (Sells et al., 1996). Clients suggested that therapists should "focus on specific problem areas and establish clear goals" and "offer specific suggestions to solve a particular problem" (p. 333). Therapists also noted the former of these two suggestions. Additionally, they felt that reviewing clients' goals and progress midway through the counseling process might be useful.

The authors (Sells et al., 1996) noted potential clinical implications of the study. For example, they discussed the differences in what is perceived as important to clients (rapport and therapist qualities such as warmth, humor and sincerity) versus what is perceived important to therapists (formalized techniques such as joining, unbalancing, or reframing). The authors suggested that more research with therapists and clients should be conducted to determine the importance of gaining multiple perspectives of family therapy.

In summary, when asked about helpful aspects of therapy, clients often mentioned therapists' qualities (e.g., caring, understanding, unbiased, and

having a sense of humor). Helpful therapist behaviors were also discussed such as normalizing, focusing on clients' strengths, giving suggestions, and giving homework. Some studies found that therapists and clients tended to mention different aspects of therapy as helpful (e.g. clients tend to focus on relationship qualities, while therapists sometimes focus on formal interventions). Changes that seemed most salient to clients included improved communication and problem-solving skills.

Clients' and Therapists' Experiences of Solution-Focused Therapy

A few studies examined clients' and/or therapists' perceptions of solution-focused therapy, specifically. For example, O'Dell et al. (1997) used a combination of qualitative and quantitative methods to obtain clients' experiences of solution-focused couple therapy. In addition to using quantitative measures (e.g. Couple Therapy Alliance Scale), the authors used semi-structured ethnographic interviews to interview eight White married couples. Couples were interviewed together after termination of therapy (mean length of time since therapy ended = 8.7 months). Data were analyzed using content analysis and grounded theory.

Clients reported both positive and negative experiences of therapy, but the authors found that "negative comments were more common, and were usually focused on a 'lack of connection' with the therapist" (O'Dell et al., 1997, p. 3). The authors also noted that more of the negative comments came from women than men. Very few of the clients interviewed mentioned specific techniques employed by the therapist as they recalled their treatment

experiences. Several of the clients, however, did share positive views of the therapist's qualities (e.g. he was "cool" or non-biased). The authors concluded that although a client may feel positively towards the therapist, this does not mean a positive therapeutic alliance has been built. They also suggested that future research should be conducted more immediately following the therapy.

The current study focuses on the experiences of participants involved in a manualized integrated family therapy treatment program for domestic violence, which draws heavily from solution-focused theory. McCollum and Trepper (1995) qualitatively studied drug-abusing women and their partners who had completed an integrated drug treatment program that was based, in large part, on solution-focused theory. This manualized treatment program provided 12 one-hour couples counseling sessions for the women and their partners, provided by female therapists. In their study, six women and their partners who had finished the couples therapy component of a drug treatment program for women were interviewed about their perspectives on the treatment they received. Additionally, three women who received systemic counseling without their partners in an individual treatment modality were also interviewed. The interviewers used three questions to guide their interviews:

> (1) What did these women, and their partners, feel had been helpful to them during couples therapy? (2) What barriers did they feel existed that make it hard for women to enter or remain in drug treatment?

and (3) What advice would they offer therapists about improving treatment for women? (p. 63-64)

Data from the interviews were transcribed and coded using the method outlined by Strauss and Corbin (1990). Several themes emerged.

In response to the question about what was helpful in therapy, participants talked about therapist qualities, such as being supportive, caring, and non-judgmental, as being helpful to them (McCollum & Trepper, 1995). Participants also appreciated the therapists' abilities to manage conflict in the session and provide direction. Another theme that emerged as helpful to clients was termed "new realizations." These included receiving new information about addiction, new awareness about self and relationship, and making a connection between past and present behavior. Some clients specifically mentioned the use of a genogram (allowing them to view their problems in a multi-generational family context) as helpful. Finally, clients also said that therapy helped them take new actions in their lives, such as expressing their feelings, communicating with their partners, and changing their behavior.

McCollum and Trepper (1995) also asked clients about their views of what barriers stand in the way of beginning or completing drug treatment. The women mentioned several barriers, including finding child care, paying for treatment, resistant partners, and fear of being labeled as an addicted woman by a society that sees such women in a harsh light. Finally, participants were asked about their advice for improving treatment.

Participants suggested that treatment be more intensive (either longer sessions, or longer treatment period), and that therapists should understand the addiction process and traditional ways of treating chemical addictions. Furthermore, two out of the three women who participated in treatment without their partners thought that their partners should have been included in treatment.

In a qualitative study focused on solution-focused brief therapy, Metcalf et al. (1996) used ethnography to study the experiences of participants who had completed successful therapy. Six cohabiting couples and their therapists were interviewed about their experiences in therapy that was described as successful from the perspectives of both couples and therapists. Couples were interviewed separately from their therapists. The primary question asked of couples was "What was it that occurred in the therapy process that you found the most helpful?" (p. 337), while the main question asked of therapists was, "What did you do in the therapy process that seemed to help change occur?" (p. 337). Data were analyzed using the constant comparative approach.

Metcalf et al. (1996) found that four of the six couples interviewed held different perceptions than their therapists about the change process. Specifically, therapists mentioned distinct techniques such as positive blame and scaling questions, while clients mentioned therapeutic relationship factors, such as allowing them to "dump" their problems, the therapist's self disclosure, and affirmation. Despite these differences, several similarities existed. Both couples and their therapists stated the usefulness of "amplifying

strengths, praising, noticing differences, and focusing on what worked" (p. 345). The authors concluded by recommending that future research should include more studies of solution-focused therapy from the perspective of both the client and the therapist.

In summary, these studies of solution-focused therapy shared many similar findings to the studies on other types of therapy discussed in the previous section. Specifically, clients emphasized certain therapist qualities as helpful, such as being supportive and non-judgmental. Clients also felt that certain therapist behaviors were helpful, and specifically mentioned techniques that are associated with solution-focused therapy (such as focusing on what works and complimenting). One study that compared clients' feedback to therapists' feedback found the similar difference that clients tend to mention therapists' positive qualities and relationship-building techniques (such as self-disclosure) while therapists mentioned formal techniques (e.g. scaling). One study found that although clients mentioned positive qualities of the therapist, they often reported a lack of connection to their therapists, which was perceived negatively.

Clients' and Therapists' Experiences of Domestic Violence Treatment

Clients who have participated in treatment for domestic violence have been asked about their perceptions of the treatment, using qualitative methods. For example, Gondolf and Hanneken (1987) interviewed 12 men who had successfully completed a counseling group for violent men such that all 12 were non-violent after 10 months post-termination according to

their wives. The counseling group was a 24-week program that included several topics such as “stopping the violence, dealing with anger, communicating feelings, relationships with one’s father, [and] attitudes toward women” (p. 180). Interviews included 115 open-ended questions on various topics, including questions to elicit the men’s perceptions of the counseling program in which they had participated. All of the men spoke very highly of their experiences in the group. Specifically, they noted “the non-judgmental approach of the staff and the sense of support that grew out of the group” (p. 185). In an atmosphere of acceptance, the men felt they had received firm direction and correction that enabled them to make changes in their behavior. The men highly valued the discussions they had with the other group members, which fostered a feeling of closeness. Many men named the emotional education they received as a catalyst for change. They described discovering their feelings, which enabled them to reevaluate their relationships with women and redefine their ideas of manhood.

Wark (1994) qualitatively studied the experiences of five heterosexual couples and their therapists of the therapy provided at a university-based clinic. Although the therapy program was not focused on the treatment of violence, all of the couples were experiencing conflict, and two had experienced violence in their relationships. The therapists were doctoral students with a variety of therapeutic approaches. Two used experiential approaches, two defined themselves as solution-focused, and one therapist identified as a structural family therapist. The couples and therapists were

interviewed separately after each of six therapy sessions and for a wrap-up interview one month after the sixth interview. Data were analyzed using analytic induction and constant comparative analysis. The guiding questions for the interviews focused on areas of therapy that were helpful or not helpful, and aspects of therapy that brought about change.

Wark (1994) found that therapists' perceptions of what lead to change in therapy were different than the perceptions of the couples with whom they worked. When asked to share their ideas about their helpful contributions to change, therapists noted several themes. For example, therapists mentioned their efforts to draw attention to relationship patterns and their focus on the clients' commitment to therapy. Therapists also felt their ability to relate well to clients and to provide an environment for change were helpful to their clients. Additionally, therapists mentioned their use of in-session and out-of-session interventions, such as blocking and homework assignments to practice new skills. The couples discussed different ideas about what was helpful in therapy. They discussed important personal characteristics of the therapist (such as being friendly or easy to talk to) and the fact that the therapists had given their own opinions. The couples also discussed the importance of their therapists providing equal time to each partner, thus keeping the sessions balanced. Finally, clients liked the therapists' efforts to enhance the positives (e.g. validating progress).

The therapists and couples also expressed their ideas about what was not helpful in therapy sessions (Wark, 1994). Therapists mentioned not

following through with important issues and making mistakes (e.g. bringing up the couple's sexual relationship while their child was in the room). Couples mentioned frustration with a lack of resolution in a session (e.g. when a solution was not immediate) and feeling misunderstood by the therapist (e.g. the therapist categorizing the couple in a way that did not fit for them). Although the author concluded that these views are very different, there appears to be some similarity between clients' and therapists' views (i.e. not following through seems similar to lack of resolution).

Williams (1995) used qualitative interviews to interview 41 African-American men about their experiences in men's groups designed to treat batterers. Williams found that, in general, the men felt that learning how to control their behavior, learning to express their feelings and getting feedback from other group members were beneficial (for a more thorough description of this study, see next section: African-American Clients in Therapy).

In summary, men in group treatment for domestic violence felt that learning to regulate their emotions and express their feelings was helpful, as was the supportive feedback of group members. Some men also mentioned the non-judgmental attitude of the facilitators as helpful. In the one study that focused on couples therapy for conflictual couples (including violent ones), clients spoke favorably about therapists' qualities (such as being friendly) and behaviors (such as giving equal time to partners and complimenting strengths). In addition to mentioning their ability to relate well to clients, therapists, however, focused on helpful formal interventions

such as blocking and assigning homework. It should be noted that although this study of couples treatment included some couples who had had violence in their relationships, the study did not exclusively focus on a couples treatment program that is designed for the purpose of eliminating violence. A comprehensive literature search did not locate any studies that qualitatively measure clients or therapists reactions to such a program.

African-American Clients in Therapy

The current study obtains feedback from Black clients about their experiences in couples therapy for domestic violence. Several authors have written about special guidelines for working with African-American clients in therapy (e.g. Franklin, 1992; Greene, 1997; McNair, 1992; Stevenson & Renard, 1993). These clinical writers have offered guidelines for clinicians working with African-American clients. For example, Franklin (1992) offers suggestions to clinicians on how they "may bridge the gap of distrust between patient and therapist" when working with Black men (p. 350). Alternatively, in her article entitled "Psychotherapy with African-American Women: Integrating Feminist and Psychodynamic Models," Beverly Greene (1997) writes about the needs of Black women in treatment. Her article discusses factors clinicians should consider in order to deliver culturally literate psychological services to African-American female clients, such as validating the client's perceptions of discrimination and the impact of that bias on her life. Similarly, McNair (1992) offers guidelines for treating African-American women based on an integration of feminist and afrocentric

theories. For example, she suggests that therapists should be aware of their "own values regarding race and gender issues as they influence one's assessment and evaluation of a client's behavior" (p. 16). McNair also recommends that therapists utilize and recommend community supports to their African-American clients. Finally, the work of Stevenson and Renard (1993) offers an example of clinical guidelines for working with African-American families in therapy. In their article, entitled "Trusting Ole' Wise Owls: Therapeutic Use of Cultural Strengths in African-American Families," the authors advise clinicians to "appreciate and mobilize the oppression-survival strategies of many African-American families" (p. 433).

Although numerous authors have communicated their ideas for working with African-American clients, very few researchers have formally studied this population to obtain their feedback about the treatment they have received. The current study obtains such feedback from Black clients participating in couples treatment for domestic violence. Saunders (1996) notes that African-American men are significantly more likely than their White counterparts to drop out of their batterers treatment groups. This suggests that current treatment for Black batterers does not adequately meet their needs. Therefore, it seems logical to interview these men to discover their perspectives of domestic violence treatment. However, an expansive search of the recent literature revealed only one qualitative study of Black clients' perspectives of domestic violence treatment (Williams, 1995). One literature review (Betz and Fitzgerald, 1993) and two studies that obtained the

feedback of African-American couples in treatment for other presenting problems were located (Gregory & Leslie, 1996; Pearlmutter, 1996). One of these studies is a clinical case study in which the author interviewed an African-American couple about their experiences of couples therapy in which she used culture as a resource for change (Pearlmutter, 1996). The other study discussed research performed at a university-based clinic to study the effects of clients' race and gender and therapists' race and gender on the clients' evaluation of treatment (Gregory & Leslie, 1996). The one study that obtained feedback specifically from African-American men in treatment for domestic violence elicited their perspectives of batterers treatment groups (Williams, 1995). No studies that obtained Black clients' perceptions of couples treatment for domestic violence were located.

In their review of literature on counseling and diversity, Betz and Fitzgerald (1993) examined the research on the match between counselor and client. The authors cited Stanley Sue's review of research concluding that most treatment studies have failed to show any differential outcome based on ethnic matching of clients and therapists. Sue (as cited in Betz & Fitzgerald, 1993) hypothesized that ethnicity, per se, is less important to study than the cultural match between therapist and clients (e.g. the fit between each person's views of the client's problems, ways of solving those problems, and treatment goals). Furthermore, Betz and Fitzgerald point out that much of the research on ethnic and cultural diversity as they relate to counseling has been done with college students, "examining questions such as willingness to

participate in counseling and for what problems" (Ponterotto & Casa, 1991, as cited in Betz and Fitzgerald, 1993, p. 365). The authors conclude that further research should focus on naturalistic settings, in order to gain the perspectives of actual clients of their actual therapists.

Pearlmutter (1996) wrote about her clinical experience working with an African-American couple in 8 sessions of couples therapy. The couple came to therapy to improve their marital satisfaction. During the first session, the author laid the groundwork for discussing race in therapy when she asked the couple if they had been disappointed to realize that their previous therapist, a Black female, was no longer with the clinic, and they had been assigned to a White therapist. The female client did admit that she had been disappointed that their previous therapist was no longer living in their city. The couples work ensued, and the discussions revolved around the wife's dissatisfaction with the passivity of her husband. Gradually, over the first four weeks of therapy, the author noticed that the wife was becoming increasingly more dissatisfied, and the author felt they had reached a stuck point. She decided it was time to introduce a cognitive re-frame to get the wife to see the marital relationship differently. The author decided to use the couple's cultural background for this purpose. Through the use of a genogram, the author explored the themes of active/passive men in the couple's families. Pearlmutter (1996) then added the further lens of African-American history over the past two hundred years, that left Black women often emerging as the stronger partner in a couple. Finally, she framed the wife's efforts to change

her husband as “trying, in only one generation, to reverse the pattern developed in several generations of family process and in over two hundred years of African-American history” (p. 393). The author noticed a strong reaction to her reframe, and the couples therapy concluded after eight weeks with both clients feeling satisfied that they had met their original goal.

The author contacted this couple twenty-eight months after the conclusion of therapy for a follow-up interview. During the interview, the couple, without prompting, told the author “how they remembered and used the genogram and African-American history discussion” (Pearlmutter, 1996, p. 394). The woman’s tone was light and she chuckled as she reported to the author how often she thinks of the author’s suggestion that she is trying to change the course of the Black male in one generation. The wife stated that she often laughs with her friends about her attempts, and laughs at herself when she catches herself trying to change the actions of her husband, going against two-hundred years of history. In the discussion section, the author states that she believes re-introducing the topic of race at a stuck point of the therapy was the turning point for successful work with this couple. From her interviews with the couple, she confirmed her feeling that the use of culture in therapy was a powerful resource for change.

In an article published in the Journal of Marital and Family Therapy, Gregory and Leslie (1996) reported the results of an empirical study on the effects of clients’ and therapists’ race and gender on clients’ evaluations of therapy sessions. The authors studied 63 families who presented for

treatment at a university-based clinic. A total of 27 of the couples were Black, and the other 36 couples were White. Black and White clients shared similar educational and occupational levels and were similar in age (average age for men and women was 33). All of the families were assigned to one of eight therapists: two Black male therapists, two Black female therapists, and four White therapists who were matched for gender and similar age, marital status, and parental status. All eight therapists were interns in the final year of their graduate work. After each session, as a regular clinic practice, all clients were asked to fill out the Session Evaluation Questionnaire developed by Stiles (1980, as cited in Gregory and Leslie, 1996). The questionnaire includes scales measuring the client's positivity towards the session and his/her perception of smoothness. Data collected after the first and fourth sessions were examined for the study.

The authors (Gregory & Leslie, 1996) found that the race was a significant factor in the clients' rating of the session. Black female clients assigned to White therapists rated the initial session significantly more negatively than their White female counterparts. Alternatively, Black female clients working with Black therapists had higher scores for positivity and perceived smoothness of the initial session. The findings for male clients suggest different results. Black men had more positive responses to the first session than their White male counterparts, "regardless of the race of the therapist" (p. 239). Additionally, the authors found that all of these differences decreased over time. Therefore, as therapy continued, Black

female clients with Black therapists rated ongoing sessions as less smooth than the first session. Alternatively, the responses of Black female clients with White therapists showed an increase in smoothness over time. The authors hypothesize that it may take Black women more time to get comfortable with their White therapists, given their experiences with racism and sexism. They do note that according to their study, this increased comfort level seems to be achievable in a relatively short period of time. All other gender and race combinations showed a decrease in session smoothness over time. The authors hypothesize that this finding suggests that "the work of therapy gets tougher regardless of client and therapist characteristics" (p. 247).

Williams (1995) used qualitative interviews to study the experiences of African-American men in treatment groups for batterers. In total, 41 Black men were interviewed about their experiences in batterers treatment groups. Slightly over half of the sample (24 men) had participated in racially-mixed groups, while the remainder of the sample (17 men) had participated in a group of African-Americans only. Interviews were conducted by two graduate students, one of whom was African-American and the other of whom was White. The interviews, which were conducted by phone or in person, consisted of a thirty-seven item semi-structured questionnaire to gather the men's perspectives of their group experiences. For example, the men were asked what they found most useful about their counseling group, how they felt about having mixed race or same race group members, and how

they felt about their counselors. Data were analyzed using the constant comparative method.

Williams (1995) found that men in both types of groups (mixed race or same race) felt that learning how to control their behavior had been beneficial. Men in both groups also spoke favorably about learning to express their feelings and getting feedback from other group members. Men in the all Black groups, however, seemed to gain the additional benefit of breaking the isolation they had felt, and getting the understanding that many Black men share their problem. By contrast, some of the Black men in the racially-mixed groups were uncomfortable participating early on if there were no other Black members. "In the racially-mixed groups, some men disliked the lack of cultural sensitivity, particularly by the counselors" (p. 8). The lack of cultural sensitivity caused drop-outs and reduced trust in some cases. Men in the all African-American groups had mixed feelings about their fellow group members challenging their behavior. These men expressed the difficulty of these confrontations, but also the benefit of learning about themselves. Williams suggests that the "level of confrontation is greater in same race groups and that the confrontation comes out of given cultural understandings" (p. 8). The author concludes that same-race batterer groups do have added benefits, and that counselors of mixed-race groups need to work harder to deliver culturally sensitive treatment (e.g. by making special efforts to include African-American group members and possibly co-facilitating with an African-American counselor). Williams suggests that

programs need to be culturally sensitive rather than using a “one size fits all” approach.

In summary, much of the literature that exists about delivering culturally competent treatment to Black clients is clinical literature, from the perspective of the therapists. Very few studies directly obtain feedback from Black clients about their perceptions of therapy. One study that did obtain this feedback focused on therapist/client racial matches. This study noted that Black women seem to have the hardest time adjusting to White therapists, but that their perceptions of the therapy improved over time. Another study that obtained feedback directly from African-American men focused on their experiences of racially-mixed groups versus same-race groups. This study found benefits for both groups, but some increased benefits for the same-race group. It is important to note that a search of the literature located no studies that obtained the feedback of Black clients of couples therapy for domestic violence.

Conclusion

Qualitative studies of therapy experiences are being used with increasing frequency for a variety of clients and treatments. Qualitative methods are particularly useful when trying to understand the unique perspective of clients and/or therapists about the usefulness of treatment. The studies discussed illustrate that clients and therapists point to a variety of aspects of therapy they find useful, and that their perceptions often differ. A few authors have studied the use of solution-focused techniques specifically,

while very few researchers have used qualitative methods to study the experiences of participants involved in therapy for domestic violence. Similarly, qualitative studies that elicit the perspectives of minority clients about the treatment they receive are quite rare. An expansive literature review failed to locate any studies that qualitatively explored the experiences of clients in a couples treatment program for domestic violence.

The current study seeks to build on the research that obtains clients' and therapists' perspectives about the perceived usefulness of their treatment. Additionally, this study explores the experiences of participants involved in couples treatment for violence, including the exploration of Black clients' views of the racial sensitivity of the program.

Chapter III

METHODS

Introduction

The purpose of this study is to examine the experiences of participants involved in an integrated couples treatment program for domestic violence. This chapter describes the research methods used for the study. Specifically, the participants and the process by which they were selected are described. I also explain the procedures used in the study, including the instruments used to gather data, the design of the study, and the method of analysis.

Participants and Selection Process

I studied five therapeutic units for this thesis, comprised of therapists and their clients (heterosexual couples). Participants were part of the larger NIMH-funded study of a research and development program designed to develop and pilot test a manaulized couples' treatment model for dealing with violent men and their partners. It should be emphasized that this couples' treatment program is specifically focused on the treatment of domestic violence, and all therapists who participated were especially trained in such treatment. The larger study included batterers in treatment with County domestic violence programs in the Northern Virginia area, as well as couples who responded to a newspaper ad placed by the project targeting men who have anger problems.

In order to be eligible for inclusion in this research project, the batterers had to be at least 18 years old, identified as a perpetrator of relational abuse, involved in a serious ongoing relationship with the woman he has physically abused, willing to participate in a men's anger management program if he had not already done so, and willing to participate in 12 sessions of conjoint couple therapy or multi-couple group therapy with a partner who is also

willing to participate in such therapy. Not all men who met these criteria were included in this NIMH-funded study. In addition to the inclusionary criteria, there are eight exclusionary criteria that were used to exclude couples from the project in order to provide an optimum context for the development and pilot testing of the therapy model, and to better ensure the safety of the men's partners. These exclusionary criteria include the use of severe violence, a history of the male's violence outside the home, anti-social personality disorder, alcohol or drug use, threat or use of weapons in violent events, possession of guns in the home (and refusal to relinquish these guns), and the refusal to sign a no violence contract.

Therapists for this study came from a marriage and family therapy program at an accredited university. The couples who were chosen to participate in the individual couple treatment modality had two therapists, one male and one female. Those couples who were part of the multi-couple therapy group had three therapists, two females and one male. Therapists were either advanced masters' or post-masters' certificate students, or practicing professionals with degrees in marriage and family therapy. All of the therapists were chosen for convenience based on their availability.

From this larger study, an opportunistic sample was chosen of couples who were willing to be interviewed about their experience. Additionally, since one of the research questions focused on the experiences of African-American clients in domestic violence treatment, two Black couples were asked to participate. In total, five couples and their therapists were chosen to participate. Three couples were chosen from those couples participating in individual couple therapy and two couples were chosen from those participants involved in the multi-couple therapy group. Four out of five of these couples were married and had children. One couple had been dating for

two years and described themselves as being part of a "committed relationship." Clients ranged in age from being in their early twenties to their mid-forties. The couples represented a variety of socio-economic backgrounds ranging from working class to upper-middle class.

Procedures

Participants were referred to the Couples Counseling Project in one of two ways: by a county employee at a domestic violence treatment program or through self-referral after seeing a newspaper advertisement for the program. Upon calling our program, participants were asked to come in for an intake appointment. Participants who were referred through the Alexandria Domestic Violence Program met with an employee of that program to complete the intake. Other participants met with a university researcher to complete the intake.

Each participant in the larger study read and signed an informed consent form given to them by the intake administrators. During the intake appointments, participants provided demographic information and answered several research scales which included measurements of their violence, views on relationships, and relationship satisfaction. At times, men were referred to the program and came in first to complete the intake. During the intake process with the men, intake administrators sought out men who would not be excluded by the criteria outlined above. They informed the men about the larger NIMH study and asked if they were interested in participating, and if they believed their wives or partners would also be interested. If so, an intake administrator called the woman to ask her if she was indeed interested in coming in for an intake interview to start the process. During the intake appointment, the intake administrator met with

her to explain the program and asked her to read and sign an informed consent form. At other times, the female partners knew about the program from their husbands or partners, and arranged to come in for the intake at the same time as their partners to meet separately with two intake administrators. For male and female participants, the informed consent included a brief description of the research study, and the client's right to end participation at any time (see Appendix B).

Therapists were also asked to read and sign an informed consent form before they began participating in the research (see Appendix C). These consents were in place as part of the NIMH study, and covered the participation in this study.

Once participants gave their informed consent, the batterers were assigned to one of two treatment conditions: batterers group treatment plus individual couple therapy, and batterers' group treatment plus a multi-couple therapy group. For the individual couple therapy, the therapy was provided by two therapists, one male and one female. For the multi-couple therapy group, therapy was provided by three therapists (one White female, one Black female, and one White male). Analysis was done on each therapy unit (couple and two or three co-therapists), and across units.

Information in this study was obtained through two mechanisms: written responses to open-ended questions and interviews. As part of the larger study, clients were given a battery of assessments before beginning treatment. For this study, open-ended questions about their expectations for therapy were included in that assessment. The therapists were also asked to give written assessments of their expectations about providing couples treatment to violent couples before the treatment began. These written

assessments were administered at the beginning of the first training session for participating therapists.

The conjoint treatment began after the batterers attended a minimum of six anger management sessions. Once conjoint treatment began, interviews were conducted with each client and their therapists. Interviews averaged about 30 minutes in length. I conducted many of the interviews, and others were given by one of five other members of the interviewing team. Interviewers were all graduate students in marriage and family therapy. The interviewing team met monthly to refine techniques, revise the questionnaire, and troubleshoot any common difficulties. These meetings were supervised by my research advisor, who was also a co-author of the NIMH-sponsored project.

Clients and therapists were interviewed following the second session and the fifth session. These interviews were completed either directly following the therapy session, or as soon as possible thereafter. In some cases, for the sake of convenience, clients were interviewed just prior to their next therapy session. Clients were interviewed individually, while therapists were interviewed together, except in a few cases when scheduling made this impossible. In those cases, they were interviewed separately.

One couple decided to terminate therapy after the first interview had been completed. I contacted them to do a second interview about their decision to drop out, and they agreed to do so. Thus, for all participants, there were three data points collected (written record before treatment begins, interview after second session, and interview after fifth session or decision to drop out). All interviews were tape-recorded with the permission of participants, so that they could be later transcribed. I transcribed all but one of the interviews myself, to become better acquainted with the data. However,

one interview was particularly difficult to hear and understand, and was therefore transcribed by the interviewer who had conducted it, since she had a better sense of what the participant had said.

Several efforts were made to protect the confidentiality of the participants. Participants were assigned a code number, which was the only identifier on the tapes and written material gathered from them. The corresponding names to the code numbers were kept in a file in a locked area. Information obtained from the participants was also kept confidential from other participants (i.e., spouses were not told of each other's responses, and therapists were not told the responses of their clients). The information provided by the participants was shared with the investigators of the larger NIMH study, in order to inform the development of the treatment manual. Names and identifying information in any written report of preliminary findings or results, including this report, adequately disguise the identity of the participants involved to protect their privacy.

Instruments

Data were gathered via the written responses and via qualitative interviews. The written questions were standardized with all clients receiving three open-ended questions prior to the beginning of therapy:

1) What do you hope will change about you, your partner, and your relationship as a result of your participation in therapy?

2) What are your concerns or fears about beginning couples therapy?

3) If you could give your therapist advice on how he/she could be most helpful to you, what would you tell your therapist to do?

The therapists also filled out a standard questionnaire containing open-ended questions about their expectations of the therapy process. This

questionnaire was given to therapists at the beginning of their first training session, and included the following questions:

1) What changes do you hope the couples will make as a result of your work with them? In addition to stopping the violence, what will be your signs of success?

2) What concerns do you have about providing treatment to batterers and their partners?

3) What concerns do you have about your involvement in the research project in general? Do you have any concerns about doing co-therapy?

4) Of the qualities you possess as a therapists, which qualities do you believe these couples will find most helpful? Which qualities do you think will be least helpful?

5) Which therapeutic techniques/interventions do you think will be most helpful with these couples?

6) How confident are you that batterers and their spouses can be successfully treated? (1=very confident, 2=somewhat confident, 3=not very confident, 4=not at all confident).

In addition to written assessments, the clients and therapists participated in qualitative interviews with a researcher. The interviewers followed the guidelines outlined by Weiss (1994). Weiss offers ideas on how to develop a partnership between participant and researcher, how to phrase questions, and how to help the respondents develop information. Weiss also identifies some things to avoid when interviewing, such as interrupting the participant, and talking about one's self.

Before interviewing the study participants, I conducted a pilot test of the research questions with a client at the on-site clinic of the university

where the research was conducted. The client's therapist asked her if she was willing to be interviewed by a researcher from the university. The client agreed to the request, and I interviewed her about her experiences in therapy at the university clinic. All of her answers were kept confidential from her therapist. This pilot interview allowed me to practice asking questions related to clients' experiences with therapy in order to estimate the amount of time each interview would take, clarify any confusing questions, and become comfortable with the interview process. The other members of the interview team also had the opportunity to practice interviewing. Since some of the members of the interviewing team were advanced students in the therapy program, they had already practiced "interviewing" clients. However, there were two students on the interviewing team who had not yet begun their clinical practice. These students conducted mock interviews with each other to practice asking the questions and probing for follow-up explanations.

Some structured questions were asked of all participants (regarding feelings about the counseling process, helpful aspects of therapy, not helpful aspects). We also asked questions about how the therapeutic process was evolving, and what changes clients and therapists were experiencing. Additionally, we allowed for extra time to be used for elaboration and further exploration to outline new themes. To expedite elaboration, clients were asked to provide their own definitions of their experiences, rather than relying on the researcher's interpretations (Searight, & Young, 1994). To provide space for the development of new themes, we asked one very open-ended question: "When you think about your therapy session, what comes to mind?" (Amir, 1993). The following are some sample questions that guided the interviews:

1) How comfortable did you feel in the therapy session?

2) Did you feel that the therapist understood you? Why or why not?

3) What, if anything, has been helpful in therapy so far?

4) What, if anything, has not been helpful in therapy so far?

5) What changes, if any, are you seeing in your relationship as a result of the therapy? How are you responding to these changes?

6) What is your level of confidence that the counseling will be effective?

(very confident, somewhat confident, not very confident, not at all confident)

7) How likely is it that you will complete the entire treatment program?

(very likely, somewhat likely, not very likely, not at all likely)

Black clients and their therapists in the individual couple treatment modality were asked to share their perceptions of the racial difference between them and how it impacted therapy, if at all. We tried to get at this concept using a variety of questions. For example, we asked participants "One of the things we are trying to do with this project is to reach minority clients and make it relevant to them. How is that going for you?" We followed up that question with this one: "How could we improve the treatment to be more effective to people of color?" For the second Black couple we interviewed, we revised the questions further to give them "permission" to share criticism or compliments: "Some people think that therapy is most effective when therapists and clients are the same color, while other people think that doesn't matter. What are your thoughts on this?" We also asked their therapists in each interview about their efforts to make the treatment culturally relevant to their clients: "One of the things that we are trying to do is to reach minority clients and make the treatment relevant to them. How

do you think you are doing?" We followed up that question with these questions: "Any specific things that have come up? Anything you have tried?" Although none of the clients we interviewed from the multi-couple therapy group are Black, we decided to ask the White participants their feelings about being in a mixed-race therapy group with mixed-race therapists: "There is some controversy about the effectiveness of mixed racial/ethnic background groups versus groups of clients who share the same race or ethnic background. Your group is mixed. How is that working for you? Your therapists also diverse, how is that working?" We asked the same question to the therapists for the multi-couple group to elicit their perspectives of how racial difference was affecting group, if at all. (For a sample of a complete interview questionnaire, see Appendix D).

Finally, in addition to the written instruments and the qualitative interviews, the researcher also served as an instrument of data collection. As recommended by Gilgun (1992), I kept notes and memos about my observations and reactions to the data I collected, the interviews I conducted, and the process as a whole. Some of the content of these memos helped me as I analyzed the data (such as observations of similarities between participants' responses that might outline emerging categories). Other content included my personal reactions to the people I interviewed, the stories I heard, and the qualitative research process as a whole.

Design and Analysis

This qualitative study was designed to be an exploratory multiple case study of the experience of the members of five therapeutic units in couples treatment of domestic violence. I chose to use qualitative methods for the study, as they are appropriate when there is very little known about a particular area, and they are "an optimal beginning to discover theory and

generate hypotheses that can be tested empirically" (Moon, Dillon, & Sprenkle, 1990; Strauss, 1987, as cited in Smith, Sells, & Clevenger, 1994). An exploratory case study, specifically, is appropriate when one is studying how and why a program works (Yin, 1989). A case study has been defined as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context . . . in which multiple sources of evidence are used," (Yin, 1989, p. 23). The unit of analysis for this study is each individual in the therapeutic unit involved in couples treatment of domestic violence. The therapeutic unit consists of two co-therapists for the individual couple treatment modality (a male and a female), or three co-therapists in the case of the multi-couple group (two females and a male), a batterer and his partner. Each of these participants was interviewed. Since more than one case was studied, it was necessary to use a multiple case study design (Yin, 1989).

The written responses and interview responses were analyzed using the constant comparative method of data analysis outlined by Strauss and Corbin (1990). The first step in this method is breaking down sentences and phrases and giving names to concepts and phenomena. Once these conceptual labels are devised, they are grouped into categories. Then the researcher names the categories using logical and graphic words that will easily connote their referents (p. 67). For example, in this study, some categories included actions (of the therapist or client), and changes made by the clients.

In order to facilitate the coding process, I used software especially designed for qualitative coding (NUD*IST, 1997). Additionally, my research advisor also coded several of the interviews. We met weekly to discuss emerging categories and to discuss the results of our cross-coding of interviews. In most cases, we were in agreement about the themes and

categories we were coding. When there was disagreement, we discussed the ideas, clarified our definitions of categories, and re-coded accordingly.

In addition to the open coding procedures, I kept coding notes, or memos. These memos were loosely divided into two sections: theoretical memos and personal memos. Some memos were written during coding of an interview, others were written anytime I had ideas that needed to be recorded. Theoretical memos include thoughts about possible categories, future questions to ask, and articulations of emerging themes. The personal memos were used to record my personal reactions to the data, the participants, or the project.

In summary, five therapeutic units (comprised of a couple and their therapists) were included as participants in this exploratory multiple case study. For each unit, three data points were collected: written responses to open-ended questions regarding expectations for therapy, one qualitative interview conducted after the second session of therapy, and one qualitative interview conducted after the fifth session of therapy. All interviews were tape-recorded and transcribed. Data were analyzed using the open-coding procedure outlined by Strauss and Corbin (1990) with the help of computer software designed for qualitative coding (NUD*IST, 1997). In addition to eliciting the experiences of clients and their therapists, I also recorded my own experiences and ideas in notes and memos.