PARTICIPATING IN A RESEARCH STUDY: A QUALITATIVE STUDY OF THE CLIENTS' AND THERAPISTS' EXPERIENCE

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(ABSTRACT)

This was an exploratory study of the experiences of 26 clients and 5 therapists participating in a research project testing a manualized multi-couple treatment program for domestic violence. The purpose of this study was to understand the experience of clients and therapists in participating in a research study with the hope of informing researchers who are seeking to make manualized treatment programs more effective.

Despite a low level of conscious awareness of the research project, clients and their therapists provided a rich set of data. From the clients, the themes revealed views on how little the research project seemed to affect their therapy, and how the research project reinforced their learning and changes and allowed them to feel they were making a contribution to others.

The therapists felt challenged to balance their roles with the research project's requirements. Theoretical fit was not an issue, but their comments inform the body of research on research participation. The therapists reported the model worked well, but early on they had to struggle with components.

The study found that clients appreciate being asked their views through the treatment. Both therapists and clients recommend using a thorough check-in/check-out process with domestic violence. Therapists recommended that any fielded programs should include an ongoing evaluation process. Also, when clients and therapists believe that participating in a research project may help others and that they are participating together in something special, the therapeutic process may be enhanced. These elements appear to be easily incorporated into conventional therapy and may generate the same beneficial effect observed in this project.

DEDICATION

I dedicate this last requirement of my Marriage and Family Degree to my beloved wife, Kathleen. I would have never considered entering this field before meeting your kind and generous spirit. You supported me with patience and love as I struggled to bring this degree to completion. Thank you.

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I want to acknowledge the courage and commitment of the women and men who gave of their time, energy, and wisdom to further research in the field of domestic violence. Change is difficult, but you gave important insights into what works and what doesn't in the hope of helping other couples struggling with domestic violence. I wish you success in your continuing efforts to achieve the health you are striving so hard to achieve. I want to acknowledge the therapists participating in this study, you were superb and I sincerely appreciate the help you gave me in completing this.

I wish to thank my chairperson, Sandra Stith, whose encouragement and faith that I would complete this project was critical to my bringing this paper to a finish. Your optimism and patience guided my study through the long months of research and writing. Your dedication to your students, your research and to the field of relationship violence is worthy of great respect. Thank you for being there throughout my studies.

Thanks to Karen Rosen for patiently helping a disbelieving student see value to qualitative research. I know you still find it humorous that your most disbelieving student did a pure qualitative study, but you are directly responsible for motivating me to consider the qualitative approach.

My thanks also to Eric McCollum for your encouragement and your many research ideas. I am glad that I finally found one that could become a completed thesis.

I wish to thank my volunteer expert focus group facilitator, Jenny Matheson. I sincerely appreciate all of your help in making this process work.

I also wish to thank my fellow students for your support throughout my course of study. I especially want to thank Kim, Rona, Betty, Lisa, Doug, and the many others whose lives intersected with mine. I have never met such a talented group of individuals so full of life.

I have dedicated this thesis to my wife, Kathleen. Her support and unwavering belief in me was critical to my completing this task. I want to thank my children, Carey, Alan, Chris, Jason, Ryan, and their spouses and children. I am motivated by my love of them to help many families make the changes they need. The work we do in this field does make a difference.

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CHAPTER I: INTRODUCTION

The Problem and its Setting

The landmark October 1995 issue of the Journal of Marital and Family Therapy was a major undertaking to establish the state of research in the field and more specifically to present a body of research that demonstrates that family therapy is effective for many types of psychological disorders. Family therapists have traditionally relied on clinical observations, circular systemic process theories, and epistemological debates to guide the development of their work. Many family therapists have been reluctant to use the tools of empirical research to refine the process and outcome of their work. However, there is now a requirement for “hard evidence” about the effectiveness of marital and family therapy that can be presented to third-party payers, legislative bodies, and other professionals (Pinsof, 1995).

Family therapists need to know what works to compete with other mental health professionals and to insure they are using the most effective treatments possible with their clients. There is no substitute for applying modern research methods to develop and field more effective treatments. To secure funding for these studies, marriage and family researchers are required to develop treatment manuals (Wilson, 1996).

Effective treatment manuals are a desired product of developmental studies sponsored by the National Institute of Mental Health. The development of a treatment manual by researchers is an effort to standardize treatment so researchers can make conclusions about effectiveness. Using treatment manuals for controlled treatment studies offers advantages to researchers. They can operationalize the independent variable in treatment outcome studies, making it easier to train therapists to a particular level of technical and clinical competence, making psychological therapy, whatever its form, more disseminable (Wilson, 1996). Manualized treatment programs appear to offer some solutions to the question of how to translate research into effective field programs.

However, manualized treatment programs often don’t get used after fielding. For reasons poorly understood, there are few manualized treatment programs being used as designed. We need studies that help us understand which components of treatment manuals assist or get in the way of clinicians using them in the field. This study seeks to identify factors that may be required for successful implementation of manualized treatment.

A better understanding of how the research process itself influences treatment outcome from the perspective of clients and their therapists may help us more effectively translate manualized treatment programs developed from research into the “real world”. Largely absent from the discussion related to research projects is the impact of the research process on the clients and their therapists. In this study, clients and therapists were asked to guide us in better understanding the complex interaction between the structure of the research project and the therapy.

Perhaps there is no more urgent area for researchers to focus on than the area of domestic violence. Domestic violence is a pervasive social problem that has devastating affects on 8.7 million American families (Straus, 1999). Although domestic violence is a pervasive issue, it is often hidden from therapists. In one study only 12 percent of 262 families initially reported domestic violence as the presenting problem. Yet, domestic violence was occurring in at least 40 percent of the families (Stith, Rosen, McCollum 1991). Unfortunately, treatment programs for domestic violence offenders experience high dropout rates (50 percent) and while many of the men who complete these programs cease using physical abuse, controlling behaviors and emotional abuse are likely to continue (Stith, 2000).

I am drawn to this topic by my experiences as a military officer, marriage and family therapy student, and therapist. As a commander, I was often confronted with domestic issues including domestic violence. Young and midgrade soldiers and their families were often involved in violent incidents that required my attention. At the time I saw domestic violence as an unfortunate part of life. Soldiers were disciplined, but there were no treatment programs offering alternatives to violent behavior to resolve disputes. Today, there are.

My military training provided me with many examples of the benefits of the applying the results of effectiveness research to field use through the mechanism of manuals. Manuals should be an effective way of communicating well-documented methods to address specific problems to therapists practicing in clinical settings. As a therapist I have noticed that when I follow a coherent, well-designed treatment plan my tasks as a therapist are easier. My clients also appear to benefit if I draw strength from a theoretical framework in which I have confidence. Conversely, if I am unsure of where I am going, my clients appear to pay a price. As a facilitator of anger management programs, a therapist working with batterers and their partners, and as a psychoeducational couples group facilitator, I have found treatment manuals useful and effective.

In my training, I have found it truer than not that effective therapy requires a high degree of artistry. But, I can't help but wonder about the many clients that drop out of treatment, or become discouraged after trying many possible solutions without the results they need. Why should they pay the price of my inexperience when there are methods and data available that will allow researchers to draw important lessons about the most successful ways of treating specific issues?

When I learned that few of the fielded manuals developed from research are being used, I began to wonder what was missing from these manuals that clinicians needed. Why did clinicians avoid using them? Why was the research not being applied? Are there pieces of research studies that need to be in the clinician's hands?

A study by Weisz, Weiss and Donenberg (1992) suggested that most tests of the effects of child and adolescent psychotherapy were done with research psychotherapy in laboratory settings rather than in common clinical settings. They distinguished research from clinic therapy on six dimensions: (a) in research therapy, subjects were recruited by the researcher, in clinic therapy, subjects are self-referred or referred by others; (b) in research therapy subjects are more likely to be homogeneous in their personal characteristics compared to clinic therapy clients; (c) in research therapy, treatment is often focused on one focal problem compared to the range of problems typically encountered in a clinic setting; (d) in research therapy, therapists are trained before the study begins in using the technique to be studied, this is not the case in clinic therapy; (e) in research therapy, the therapist is usually instructed to use only the technique under study, in clinic therapy the therapist does not rely on one technique; and (f) in research therapy, often a treatment manual is used and its implementation is monitored, this does not happen in clinic therapy. Perhaps some of these elements of research need to be applied to clinic therapy to increase clinical effectiveness. As a therapist participating in a major research project on treatment of domestic violence, I often wondered what the clients thought about the research. What were the potential contributions of the research process to the client's experience? This project gave me the chance to ask them.

Of course, research is difficult and complex. In previous work I tried to identify extratherapeutic factors that the domestic violence client brought into their therapeutic experience (Hubble, 1999). I began to notice that for many clients it appeared the research project and their therapy experiences were one and the same. It is often difficult to separate the components of the research project from therapy in the client's mind. From the client's perspective, the therapy and

the research appear to be of one whole. McCollum et al. (1996), in a study of participants' views of participating in a research project found that clients conceptualize their therapy experience and participating in a research project as participating in "therapy within a research project." This leads to the conclusion: "It is possible that the outcomes we find in outcome studies are, themselves, affected by the context of the study, and that the therapy being tested might produce different outcomes under non-research conditions (p. 615)."

Rationale for the Study

The overall purpose of this study is to understand the experience of clients and therapists in participating in a research study. There are two aspects to this issue. The first has to do with the client's perception of how being in a research study has impacted on their treatment and the client's belief about whether the treatment can be reproduced without the research program components of the total project; and the second has to do with the therapist's perception of how their clinical work was affected by following a manualized treatment protocol. Understanding the effects of the research program on the client and therapist appears to have significance, both for the purposes of fielding an effective program to clinicians, but also for determining, what, if any, research program components contribute to the client's perception of the effectiveness of the treatment. The hope is to inform researchers who are seeking to make manualized treatment programs more effective.

Many clinicians see research as distracting at best, or irrelevant to their work. Is it? Do the requirements for research have to detract from the clinicians work, or can they enhance the work? Is it possible for therapists to apply their skills creatively, despite the manualized nature of the treatment? It is hoped this study will identify the constraints or advantages therapists experience when following the manualized treatment protocols of the larger study. In addition, understanding the client's perspective on removing the research piece from a manualized treatment program could significantly inform researchers as they strive to develop effective clinical treatment programs for the treatment of domestic violence offenders. It is my hope that this study will inform the larger project from which this study draws its data, and other manualized treatment protocols on some of the aspects researchers must consider in developing effective, and used, clinical treatment manuals.

Conceptual Framework

The theoretical framework of phenomenology informs this study. Phenomenology is based on the assumption that knowledge is socially constructed (Boss, Dahl, & Kaplan, 1996). "Truth" is an evasive concept because knowledge is socially constructed. Therefore, 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 & Theodorson, 1976). The goal of phenomenological research is to understand the experience of the participant rather than to seek to discover some objective truth (Murphy, 1992).

Phenomenologists use qualitative methods that yield descriptive data such as in-depth interviewing, participant observation, and analysis of written materials in an effort to gain an understanding of other people's experiences (Boss et al., 1996). The phenomenological researcher does not define categories and events for the research participant. Rather, the researcher asks questions that 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).

This study does not seek to find the "truth" of what occurred in this research project. Nor, does it strive to definitively state how participating in a research project was helpful for all clients in couples treatment of domestic violence. Instead, the researcher attempts to understand the "truth" for some of the participants in the research study. How do individuals experience this process? In addition to studying the experiences of the individuals involved in this research project, broad patterns across individuals are examined, seeking similarities and differences in their experiences.

Research questions

1. How was the client's perception of the effectiveness and constraints of treatment affected by his/her participation in a research project? This question includes how their perceptions changed over the course of the treatment.
2. In what ways did therapists feel that following a manualized treatment protocol constrained/enhanced their ability to meet the needs of their clients?

3. According to both therapists and clients are there elements of the research project that are inseparable or get in the way of producing an effective fielded clinical program? If so, what are they?

CHAPTER II: LITERATURE REVIEW

Introduction

This study uses qualitative interviews with clients and therapists to obtain their perceptions of how participating in a research study affected treatment provided to clients. The integrated therapy model is based on family systems theory. The literature was first reviewed to understand the environment of domestic violence and the limitations and problems of conducting treatment and research in this critical area. The literature reflects the problems of translating efficacy research into effective clinical programs. A significant effort is ongoing to address the shortcomings of efficacy research by developing treatment programs based on treatment manuals. The advantages and limitations of treatment manuals were also reviewed to inform this study. Previous qualitative research has focused primarily on the therapists' perceptions of treatment and its outcome. The literature was reviewed for understanding of the client's perspective of participating in a research project and how the clients' and therapists' views of therapeutic change differ.

Domestic Violence

Prevalence

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). Victims of domestic violence, mostly women, may end up in the emergency room for severe injuries, and suffer longer-term physical and psychological illnesses (Gelles & Straus, 1990). Despite the severe negative consequences to these women, the majority remains with their abusive mates. Approximately 50 to 80 percent of domestic violence victims stay with their abusive partners (Ferraro & Johnson, 1983; Gelles, 1974; Pfouts, 1978; Snyder & Furchtman, 1981). Surveys in the early 1990's revealed that one out of eight husbands have committed an average of one violent act per year towards their spouses (Straus & Gelles, as cited in Barnett, 1997). The public's growing awareness of domestic violence and the urgent work of victim advocates during the past two decades has led to the review and augmentation of theories on why domestic violence occurs.

Theoretical Perspectives

Domestic violence theorists sharply disagree about the reasons behind the perpetuation of domestic violence. Feminist theorists consider power and control in male/female relationships to be a major contributing factor to the occurrence of abuse. Jory, Anderson and Greer (1997) have found many batterers have a hierarchical view of relationships between men and women. They equate "respect with submission, obedience, and deference rather than intrinsic human worth" (p.410). Feminists suggest men batter women because they can get away with the violence. In the past there were few consequences for a violent act towards a family member.

Critics of systems theory maintain that systems theory assumes that problems within the family are mutually created and maintained. Consequently, the victim may get the message that she is partly responsible for the violence (Hansen, 1993). Feminist theorists have long been critical of the family systems approach. They charge that the systems approach perpetuates the victimization of the female, or at least contributes to her assuming partial blame for the violence (Barnett, 1997; Goldner, 1998; Holtzworth-Munroe, 1995).

Jennings et al. (1991) expressed concern that systemic approaches imply that battering is seen as reactive rather than purposefully initiated by the abuser. They cite Bogard and Walker's opinion that the therapist needs to be an empowering advocate rather than neutral to help the battered woman heal. Walker maintained that the conjoint systematic treatment approach should only be used if it acknowledges the power differential between men and women. Goldner (1998) notes the challenge for many therapists when violent couples seek therapy as a couple. Therapists must "capitalize on the strengths of the systemic approach while minimizing its dangers" (p. 265). The feminist perspective can offer a "fundamental, ethical, and political framework with which to view abuse and victimization."

Treatment Methods

Several methods of treatment have attempted to end violence in these abusive relationships. The majority of these methods have treated the batterers as the sole unit of treatment, although many batterers are part of intact relationships. Treatment models have been based on feminist theory, skills training, psychodynamic theory, cognitive restructuring, and awareness of sex role socialization (Adams, 1988; Saunders, 1996; Tolman & Edelson, 1989; Tolman & Saunders,

1988). Most treatment programs currently involve psychoeducation with small groups of batterers (Tolman & Edelson, 1995).

Conjoint Therapy and Controversy

In addition to treatment programs for individual batterers, some persons have begun treating batterers together with their partners. Treating both members of the couple has been a controversial practice (Saunders, 1996). Critique of couples treatment of violence includes the potential that conjoint treatment implies blaming the victim and that revelations in the therapy session may trigger violence. However, Saunders also writes of the potential advantages of couples treatment. Participants are able to put new relationships skills immediately into practice during the session and the woman has the opportunity to "witness the ways in which the therapist holds her partner solely responsible for the violence" (p.84), thereby decreasing her self-blame.

There has been little research on the effectiveness of conjoint treatment for domestic violence. However, there are several excellent reviews of couples therapy outcome (e.g. Jacobson, 1993, Lebow, 1995) including a comprehensive evaluation of therapy efficacy published by Shadish, Ragsdale, Glaser, & Montgomery (1995). The Shadish et al. meta-analysis of published and unpublished family and couple therapy outcome studies suggests that couples therapy is an effective treatment for relationship dissatisfaction and, to a slightly lesser extent, specific presenting problems. However, the finding that nearly one-third of couples do not improve with treatment suggests the continued need for more research into effective couple therapies (Whisman, 1997).

What little research that has been done on conjoint domestic violence treatment has focused upon the effectiveness of the treatment. The literature shows mixed results. Some studies have shown successful outcomes from a conjoint approach (Lane & Russell, 1989; Riza, Stacey, & Shupe, 1985), while other studies have shown less favorable results (Lindquist, Telch, & Taylor, 1983; Taylor, 1984). In the absence of conclusive research on the usefulness of conjoint treatment of violence, there is a need for further research.

Multicouple Groups

Couples group therapy has been used for relational issues, but not often applied to the treatment of domestic violence. (Greenspun, 2000) believes the "couples group format enlarges upon the benefits of both individual couple sessions and group therapies, providing a unique arena

in which to address the complexities of violence within relationships" (p. 171). Each partner's perspective can be represented and addressed in a manner not possible in other formats. The couples group reduces social isolation, provides ongoing accountability, cross-coupling (the ability of a member of one couple to conform the opposite-gendered member of another couple in a meaningful way), and allowing the participants to experience a community of non-violence.

Solution Focused Approach to Domestic Violence

This study draws its data from a larger grant project developing a manualized treatment program based on a "strength-based" or "solution-focused" approach. Both terms are interchangeable and refer to a therapeutic approach of building on the positive attributes of clients. In the search for treatment models to address intimate relationship violence, it has been noted that couples experiencing domestic violence tend to stay together (Campbell, 1994). With the dropout rate for mandated clients remaining high (Gelles, 1997), researchers continue to test new treatment approaches. One approach that shows promise is solution-oriented or solution-focused approach.

The solution-focused model makes assumptions that (1) the couple has already begun to move toward the solution for their problem, (2) therapist's beliefs greatly influence their work, (3) people change faster when therapy focuses on how things will be different when the problem is solved and (4) change is inevitable and ongoing. The therapist's role is to find examples of the client's internal strengths and to amplify the changes they are already making (O'Hanlon, 1989). This approach helps couples caught in a violent cycle to refocus the relationship in new directions by building on their relationship strengths.

Sirles, Lipchik and Kowalski (1993) studied the effectiveness of solution-focused brief therapy. Their model focuses treatment on creating a violence-free future to move clients away from the dangerous present. The therapists, usually working in teams of two, emphasize the strengths of each client and respect their individual needs and goals. Sirles, et al, conclude that this type of treatment "is individually empowering and conducive to the acceptance of responsibility for behavior" (p. 270). The researchers reported the majority of their clients (84%) stated that they had benefited from their treatment in client surveys. In a population of mostly court ordered cases, the clients reported they thought they had learned new ways to respond to their conflict and they were planning to remain together.

As researchers struggle to determine the value versus the risks of treating batterers with conjoint treatment, it is important to recognize the artificialities and limitations of the research

process itself on the outcomes. A research environment, with its structure, controls, intensive data collection, ongoing evaluation, and resources is a highly artificial one. Research focused on the effectiveness of conjoint domestic violence treatment generally has an objective to produce effective treatment methods that can be replicated by practitioners in the field separated from a research process.

Outcome Research

The editors of the JMFT special issue on marital and family therapy effectiveness noted the need for more emphasis on studies of effectiveness, "whether a treatment works under 'normal therapy' field conditions" (Pinsof & Wynne, 1995, p.342). Efficacy studies, by far the most prevalent, are controlled clinical trials with well-defined protocols, treatment manuals, and specialized training for the therapists applying the treatment. These studies lend themselves to clarifying the components of therapy that promote specified aspects of outcome under controlled conditions. But, the results of efficacy studies are often difficult to translate into recommendations for therapy in the "field".

Translating the results of research, particularly efficacy research to the field has been a persistent shortcoming bedeviling researchers. Critics have noted the underacknowledgement of the practical utility of efficacy research (Francis & Aronson, 1990). In an extensive meta-analysis, Shadish et al., (1995) found that behavioral treatments done in a university setting, yielded very large effects even with small populations. Yet, both behavioral and non-behavioral studies done outside of the university yielded small to medium effects no matter where they were done. Their finding was "how a treatment is studied may be as important to determining the effect size as what the treatment is (p.351)."

Mental health efficacy research has been handicapped by the many differences between the studied populations and those seeking treatments, by wide differences among clients from where they are treated to how they found treatment, by differences in how clinicians apply even detailed treatments, and by the complexity of the problems for which diagnostically similar people seek help. It has been stated "it is virtually impossible to apply psychosocial treatments in the same way to all people, independent of the therapist's peculiar history and perspective."

Therefore, researchers continue to struggle with the requirements for sound research and the often-conflicting requirements for effective clinical practice. As a result, researchers have turned to developing treatment manuals as a way of operationalizing clinical findings.

Client and Therapist Views of Therapeutic Change

The therapist's view or model of therapy has a strong influence on how therapy proceeds. The therapist's view of the nature of change and the process of changing directly influences what the therapist does clinically. Erickson has said in this regard, "Each person is a unique individual. Hence, psychotherapy should be formulated to meet the uniqueness of the individual's needs , rather than tailoring the person to fit the Procrustean bed of a hypothetical theory of human behavior" (Zieg, 1982, p. viii in (O'Hanlon, 1989) p. 44). Training programs and professional publications often provide the concepts which therapists practice, and trainees are rarely trained to think from the perspectives of their clients. Thus, client's views of these events may be only rarely considered in therapy.

Two studies specifically focused on gaining clients' perspectives of the therapy they received. Wark (1994) used qualitative methods to examine the perspectives of client couples and their therapists on therapeutic change. She found that clients and therapists considered vastly different aspects of the therapy as important for therapeutic change. In addition, the clients found a part of the research process, the research interviews, helpful to their therapeutic experience.

Metcalf (1994) used qualitative methods to explore the experience of therapy as perceived by six couples and their therapists in an investigative study at the Brief Family Therapy Center. The qualitative method focused on the discovery of meaning of clients' experience through interviews.

Treatment Manuals

Early in the investigation of the effectiveness of psychotherapy, it became apparent that global descriptions of psychotherapeutic techniques were insufficient. Studies by Strupp and Bergin and Bergin and Strupp (as cited in Butler and Strupp, 1993)showed more specific descriptions of treatment modalities reflected a need for disciplined scientific study of psychotherapy. To answer the call for greater specificity by insurance companies and governmental agencies, psychotherapy researchers have developed treatment manuals.

Kernberg and Clarkin (1993) report effective treatment of borderline character disorder by means of a treatment manual. Manuals have been developed for “every properly equipped therapy”(p. 211). Manuals have three characteristics: (1) a presentation of the main principles of the techniques, (2) concrete examples of each technical principle, and (3) scales to guide judges in evaluating samples of sessions to determine the degree of conformity to the manual.

Luborsky and Barber (1993) found that conformity to the manual rewarded the therapist by better outcomes for the patient. They found that therapists who adhered to the manual were the ones who had the capacity to carry out the recommended therapy. The therapists who did not adhere were less able to perform the therapy.

Treatment manuals offer several advantages to researchers conducting controlled treatment studies, including allowing the researchers to operationalize the independent variable in treatment outcome studies, making it easier to train therapists to a defined level of technical and clinical competence, and making therapy more disseminable. Manual-based treatments are often empirically validated, more focused, and more disseminable. Manual-based treatment demands therapist skill in its implementation. In suitably chosen therapists these skills are more a function of training than amount of clinical experience. Treatment manuals are likely to encourage a pragmatic approach to therapy and should not discourage clinical innovations. They are useful in the training and supervision of therapists (Wilson, 1996).

Therapy in experiments often appears to have shown larger effect sizes than therapy in clinics. The beneficial therapy effects are associated with three factors which are more common in research therapy than in clinic therapy: (a) the use of behavioral (including cognitive-behavioral) methods, (b) reliance on specific, focused therapy methods rather than mixed and eclectic approaches, and (c) provision of structure (e.g., through treatment manuals) and monitoring (e.g., through review of therapy tapes) to foster adherence to treatment plans. These three factors all involve dimensions along which clinic procedures could be altered (Weisz, Donenberg, Han, & Kauneckis, 1995).

Critics of treatment manuals note although outcome research is important to improving psychotherapeutic procedures, and empirical evaluation of manualized clinical procedures (both broad and narrow) is a valuable current research trend, the conditions of such research are far removed from the conditions that exist in everyday clinical practice. Practitioners have long urged

psychotherapy research to focus on commonly used forms of treatment and more typical patient populations so as to produce more clinically useful research (Havik & VandenBos, 1996).

Criticisms of manual-based treatments center on five main themes: they are conceptually at odds with fundamental principles of cognitive-behavioral therapy; they preclude idiographic case formulation; they undermine therapists' clinical artistry; they apply primarily to research samples which differ from the patients practitioners treat; and they promote particular 'schools' of psychological therapy (Wilson, 1996). Clinicians have reported feeling limited by manuals. This is a question of whether a therapy is an art or a craft. But some manuals get around this problem by providing enough flexibility to allow the clinician to apply creativity while adhering to the model (Anderson, Reiss, & Hogarty, 1986; Miklowitz & Goldstein, 1997).

An important concern about manualized treatment studies is the question of how generalizable the treatment is to the larger population. Havik and VandenBos (1996) have expressed concerns that participants in psychotherapy research projects are highly selected due to the rigorous requirements of conducting valid and funded research. They observe that less than 10% of all unselected participants, and perhaps less than 5 % would qualify for inclusion in the research studies of most of the existing forms of validated treatment.

Lebow, (2001), in his recent discussion of empirically supported treatments (EST), reports on the difficulty of bridging research and clinical practice. He suggests that this EST effort is the most ambitious effort thus far to define treatment procedures that are scientifically proven to be effective with specific psychological conditions. A task force sponsored by the American Psychological Association has been the issuing and updating a list of ESTs. To be designated an EST, the treatment method must meet 3 criteria: 1) two independent studies must show the treatment to be more effective than no treatment, a placebo, or an alternative treatment; 2) the method must be guided by a specific treatment manual; and 3) all the clients being studied must be suffering from the same psychological disorder. Lebow reports that despite more than 20 therapies being designated as EST's, most clinicians are not using them. He lists four reasons: 1) EST's ignore the importance of the therapist; 2) EST's limit the focus of therapy and hamper creativity; 3) EST's favor therapies that are easily researched rather than those most deserving; and 4) EST's potentially narrow the field of reimbursable treatments and represent a threat to therapist's freedom of choice.

A concern of the researchers in the larger Multicouple Group Treatment for Domestic Violence project was the degree with which the therapists would comply with the treatment manual. This was a major concern because the primary purpose of the larger study was to produce a manualized treatment program. The therapists of the program had never followed a manualized treatment approach. This is not unusual because only a fraction of clinical psychology program graduate students are trained in the use of manual-based treatments ("Task Force on Promotion and Dissemination of Psychological Procedures." 1995). Students training in Marriage and Family Therapy graduate programs are probably even less likely to be trained to use treatment manuals. The therapists in the parent project expressed concerns about following a manualized treatment protocol including possible limitations on their flexibility, decreased effectiveness, and doubts about their ability to follow a manual (Stith, Rosen & McCollum, 1999).

For the purposes of this smaller study, participants were selected from the clients that were treated with batterer's group treatment plus a multi-couple therapy group. These clients were a well-defined group, engaged in a less common treatment modality, that of multi-couple group therapy, and were thought by the author to possibly be more sensitive to the contributions and restraints of the research project to their therapeutic experience due to the multi client and multi therapist treatment modality.

Participating in a Study

Researchers must be aware of the impact of their research on the study participants. Some survey researchers, outcome researchers, and quantitative researchers have reported the research methods themselves influenced their research participants' experience. Given the intimate relationship of qualitative researchers and their methods to the experience of their participants, it seems reasonable to postulate a significant influence of qualitative research methods on their participants' experience.

Versof & Hatchett (1992) in an investigation of the effects of survey research methods on participants in a longitudinal study of marriage found "being part of an intensive, longitudinal study focused on feelings one has about his or her marriage, and perceptions of the feelings of one's spouse, may result in both attitudinal and behavioral changes among newlywed couples (p.326)." The researchers recommend that survey researchers asking respondents complex

questions about significant people should be aware that the topics they probe may linger as issues in the respondent's lives.

It is not common for outcome researchers to ask their subjects about the impact of their participating in outcome research. Some clients report that interviews about their experience have had a therapeutic impact in and of themselves (Gale, 1993; McCollum & Beer, 1995). There have been relatively few studies that explore what subjects experience as part of quantitative studies. Veroff, Hatchett, and Douvan (1992)found that couples who participated in a longitudinal study of marriage were better adjusted on measures of marital quality at the end of four years than couples who did not participate in the assessments. Bradbury (1994) found participants reported positive outcomes from their participation in a laboratory and mail survey study of marriage. Bussell, Matsey, Reiss, and Hetherington (1995) solicited feedback in the form of questionnaires from participants in a longitudinal study of family process and adolescent development. Despite the researchers assumption that the research project would have little effect on the participants, almost half of the respondents to the questionnaire reported negative or positive changes in their families.

McCollum, et al (1996) studied the participants' experiences while taking part in a therapy outcome study, a qualitative study of drug-abusing women and their partners who had completed an integrated drug treatment program, based on integrated systemic couples treatment. Six women and their partners who had finished the couples therapy component of a drug treatment program for women were interviewed for their perspectives on the treatment they received. Research and treatment were not separated in the minds of some participants, as they had in the minds of the researchers. Some of the participants reported using end of session assessments to gauge their therapeutic progress. Many of the participants were quite aware that the structure of the research project made the treatment they were receiving different than it probably would have been if it occurred in a non-research setting. They also realized that the project may have affected their therapists' behaviors. The monetary reimbursement the participants received for their participation had a positive influence on their participation in the therapy. Another major theme was the idea of the clients' participating in "Part of Something Important" (p.614).

Related Studies Using the Data

In a study conducted with data from the research study's first year, Middleton (1998) looked at the client's experience specifically through a qualitative approach in a 7 therapist and 5

heterosexual couple qualitative study. Her study explored the client's experience in the research project and how the research affected the client's experience and outcome. Her findings informed the researchers in an ongoing program including emphasizing the teaching of the use of time outs and gender based anger management training for both partners.

The study identified client and therapist expectations of therapy prior to treatment and their experiences of therapy during the first half of treatment. Participants discussed which aspects of therapy were helpful and unhelpful. Therapists focused on specific techniques they used and clients emphasized therapist behaviors and qualities that facilitated their engagement in the therapy process. Participants most often criticized the treatment length as insufficient. A major part of the study, most participants believed that racial difference had no impact on their treatment. Finally, participants shared their thoughts on the value of couples treatment of violence versus traditional domestic violence treatment. Middleton's study was conducted in the first year of the research project. Her findings about the use of time outs and anger management training were incorporated into several of the later couples treatment groups with good results.

Anderson (2000) using data from 11 women participating in the same research project as Middleton, but in the fourth year of the project, had two findings related to this project. The findings of this study addressed the feminist's concerns about conjoint therapy for domestic violence. Anderson's subjects noted that the pre and post check-ins of the research project enhanced their sense of safety. Upon entering treatment, most of the women were focused on accommodating their mates. A few women also mentioned initially that they felt partially to blame for the violence. However, as therapy progressed, most of the women who completed treatment stated that they knew they did not deserve violent treatment. Many of the women in this study found a way to speak up for themselves. They felt heard and appreciated by others. As the women became more empowered, they were able to move from their prior victimized position to a more equitable position that afforded them more options in their relationship. Analysis of the data gathered from individual women over time demonstrated how some women's views of therapy and their relationships changed. Women talked about their concerns about safety when entering treatment, but indicated in subsequent reports that they felt more comfortable sharing in session. Some women in later stages of treatment said that they could confront their mates during the session due to their trust in therapists to intervene if needed.

Many women expressed concern initially about the positive emphasis of the strength-based approach. They stated in early interviews that the men should be lectured or confronted about their violent behavior. However, in subsequent interviews, women noted that the positive focus encouraged their husbands to continue in treatment. By the end of therapy, many of these women noted a change in their husbands in how they were about to accept more responsibility and make other accommodating changes in the relationship.

The one area of concern to women in the study that did not appear to change was the controlling behavior of the men. Many women mentioned in early interviews that their partners were using the tools learned in the men's anger management group to control them at home. For many of the women, the controlling behavior of their mates did not change over time. Many women who completed treatment reported in follow-up interviews that the physical violence had ceased and that the emotional abuse was diminished; however, their mates still attempted to control them.

This thesis builds on the work of Middleton and Anderson by examining results over 5 years of the domestic violence research project. The focus of this study, participating in a research project, is different, but the subjects of this study include several from the first two studies.

Summary

The research project itself appears to have an important influence on outcome that must be considered when attempting to design an effective treatment program. Although treatment manuals do have disadvantages, they offer possibilities for designing research supported effective clinical practice. This study will explore one application of a treatment manual based study in a solution-oriented therapeutic model. The focus is on a research treatment program that created and tested a manualized treatment program. Under a NIMH grant, that research program is designed to develop and pilot test a culturally sensitive, manualized couple's treatment model for treating violent men and their partners. The larger treatment program is testing two treatment conditions: batterers group treatment plus individual couple therapy, and batterers group treatment plus a multi-couple therapy group.

The two earlier studies (Middleton and Anderson) did not ask therapists and clients about how the client's experience as part of a research project may have changed over time. Nor, has there been an effort to distinguish the effects of the various components of the research model from

the treatment itself to attempt to understand what parts of the research project contributed to the effects of the treatment. This knowledge appears to be important in that the purpose of the program is to produce a manualized treatment protocol that can be applied successfully in the field. This study will attempt to fill this gap.

CHAPTER III: METHODS

Procedures and Design of the Study

This study is designed to explore the experience of clients and therapists 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, as cited in Smith, Sells & Clevenger, 1994). Also, qualitative designs focused on the participant's beliefs about their experiences (Strauss & Corbin, 1990). The qualitative design aided me in my attempt to understand how participants interpret the impact of the research project on their experiences. This design is compatible with the phenomenological theoretical framework of this study.

This qualitative study was designed to be an exploratory study of the experiences of the members of 26 clients and 5 therapists in 31 individual units participating in couples treatment of domestic violence. An exploratory study is appropriate when the researcher is studying what makes a program effective (Yin, 1989).

The unit of analysis for this study is each individual in the therapeutic unit involved in multi-couples treatment of domestic violence. Each of these participants was interviewed and /or responded to open-ended questions This study is looking at themes and patterns of individual participation in four multi-couple groups. Participants are twenty-six clients and five therapists.

Participants

This study uses data collected from a larger NIMH-funded, Phase I study designed to develop and pilot test a systemic domestic-violence focused treatment program for male batterers and their partners. A description of the larger study is presented first and the description of the subgroup of participants and procedures of this study follow.

The Larger Study

The Virginia Tech Domestic Violence Focused Couples Treatment Program began its fourth and final year in January 2001 with funding from the National Institute of Mental Health (NIMH). The goal of the project was to develop and test a manualized treatment program for

couples who choose to remain together after experiencing mild to moderate violence in their relationship. The couples treatment program is a 12-session add-on to a traditional men's treatment program.

Couples were recruited via county domestic violence programs in the Northern Virginia suburbs of Washington, DC, as well as through newspaper advertisements targeting men who have anger problems. To be eligible for inclusion in the research project, men must be at least 18 years old, a perpetrator of relational abuse, in an ongoing relationship with the woman he physically abused, willing to participate in a men's' treatment program if he has not already done so, and willing to participate in 12 sessions of couple therapy or multi-couple therapy with a partner who is also willing to participate in such therapy.

Not all men who meet these criteria were included in the study. There were eight criteria that we used to exclude couples from the project. We wanted to insure that the couples therapy was only provided to appropriate clients. These exclusionary criteria include the use of severe violence, a history of the male's violence outside the home, current alcohol or drug abuse, threat of use of weapons in violent events, possession of guns in the home (and refusal to relinquish these guns), and refusal to sign a no violence contract.

During intake appointments prior to beginning treatment, participants provide demographic information, complete a battery of quantitative instruments and answer several open-ended qualitative questions. Eligible men are assigned to one of three treatment conditions: men's group treatment plus individual couple therapy, men's group treatment plus a multi-couple therapy group, or the control group which includes the men's group treatment only. For those assigned to the individual couple therapy modality, two therapists provide therapy. For those assigned to the multi-couple therapy group modality, two or three therapists serve as group leaders. Conjoint treatment began after the men attend a minimum of six men's group treatment sessions. Therapists are either graduates of, or advanced interns in, the Virginia Tech master's-level COAMFTE-accredited marriage and family therapy training program.

All therapists and clients completed post-session evaluation questionnaires at the end of each session to provide feedback on what was and was not helpful about each session. Selected clients and their therapists also completed tape-recorded, qualitative interviews at intervals throughout the 12 weeks of treatment to let the project know what has and has not been effective and helpful.

The thirty couples who completed treatment came from a wide range of socio-economic backgrounds ranging from working class to upper-middle class and have ranged from 24 to 54. Twenty-one of the eligible couples were Caucasian; four were African American, and five were interracial. Most couples have been married, but a significant minority were cohabiting and a few were dating. One couple was in the process of separating. Most couples had children. Eleven of the men were court ordered to batterer's treatment. Of a total of 42 couples who were eligible and actually began treatment, 30 completed the program. This compares to an average drop out rate from traditional men's domestic violence treatment programs of about 50%, even when men are court mandated to treatment (Edelson, 1992). Twenty-seven of the thirty couples who completed treatment were married and twenty-eight had children together. Only four of the twelve couples who dropped out were married. Twenty-one different therapists have provided the treatment; 18 are Caucasian, 2 are African-American and one is Hispanic. Seven therapists are graduates of the Virginia Tech marriage and family program and thirteen were advanced marriage and family therapist interns (Stith, Rosen & McCollum, 1999).

Participants of this study's subgroup

This study uses data collected from twenty-six clients, participating as 13 committed heterosexual couples, and 5 therapists. The 26 client participants were selected from the above described larger NIMH-funded, Phase I study designed to develop and pilot test a systemic domestic-violence focused treatment program for male batterers and their partners. For the purposes of this smaller study, participants were selected from the subjects that were treated with batterers group treatment plus a multi-couple therapy group. These clients were a well-defined group, engaged in a less common treatment modality, that of multi-couple group therapy, and were thought by the author to possibly be more sensitive to the contributions and restraints of the research project to their therapeutic experience due to the unusual treatment modality.

The participants all have completed a 12-week treatment multi-couple therapy group and were members of one of three groups. Ten clients participated in the first group from April to June 1998. Eight clients participated in the second group July 1999 to January 2000. The final group of eight clients participated in a multi-couple group August to November 2000. The five therapists came from the three multi-couple therapy groups. Three therapists were assigned to the first group,

two to the second group, and two to the third. One of the therapists participated in all groups. Two therapists were graduates and three were advanced interns.

Client's ages ranged from the early twenties to fifty-four. All clients were in counseling as a couple. They represented a variety of socio-economic backgrounds ranging from not working, to working class to upper-middle class. Educational levels ranged from two client's completed GEDs, one was a high school graduate, one completed some vocational/technical training, nine completed some college, four had Bachelor's degrees, six had Master's degrees, and one held a Doctoral degree. Two did not state what their educational level was.

Due to the nature of the larger study, it would be clearest to describe the participants by their qualities as a couple. Two couples were Black; eight couples were White; three couples were from differing racial-ethnic heritages (Asian-White, Middle Eastern-Black, Black-White). Eleven couples were married; two were cohabitating or dating. Twelve couples were raising or had raised (the children are now adults) children together. Six couples were court ordered to batterers' treatment; two partners were also ordered.

Pseudonym	Age	Race	Marital Status	Years	Children	Court ordered	Previous counseling	Education
Adam	34	White	M	7	2	Y	Y	Some Col
Annette	34	White	M	7	2	N	Y	Voc/Tech
Bart	54	Black	M	27	4	Y	N	HS Dipl
Brenda	46	Black	M	27	4	N	N	HS Dipl
Candice	36	Native American	M	5	1	N	N	Some Col
Charlie	34	Mid East	M	5	1	Y	N	Bach Deg
Donna	54	White	M	10	1	N		Mast Deg
Don	50	White	M	10	1	Y		Doc Deg
Ed	44	White	M	12	2	Y	Y	Some Col
Edna	35	White	M	12	2	N	Y	Mast Deg
Frank	36	White	M	5	2	Y	N	Mast Deg
Francine	40	Mixed Filipino	M	5	2	N	N	Bach Deg
Gretta	24	White	Co-habit		1	N	Y	Some Col
Grant	33	Black	Co-habit		1	Y	Y	GED
Harry	27	White	M	10	0	N	Y	Some Col
Hannah	25	White	M	10	0	N	N	Bach Deg
Irene	42	White	M		2	N	Y	Some Col
Ivan	40	White	M		2	Y	Y	Bach Deg
James	31	Black	Co-habit		1	Y	N	Some Col
Jenny	28	Black	Co-habit		1	N	Y	Some Col
Karen	32	White	M	1	1	N	Y	HS Dipl
Kyle	36	White	M	1	0	Y	Y	Some Col
Lewis	44	White	M	10	1	Y	Y	GED
Linda	36	White	M	10	1	N	Y	Mast Deg
Mike	53	White	M	35	2	N	Y	Mast Deg
Michelle	52	White	M	35	2	N	Y	Mast Deg

Figure 3.1 Client Demographic Data

Five different therapists delivered the treatment; four are White, one is Black. Two therapists were masters or post masters level marriage and family therapists in private practice; three were advanced marriage and family therapist interns.

Data Collection and Analysis

Information in this study was obtained through three mechanisms: written responses to open-ended questions, responses to questions asked during interviews, and verbal responses to questions asked in a focus group. The data for clients and therapists was collected by separate, but closely related processes. Analysis methods was very similar.

Client Data Collection

Four hundred twenty separate data collection points were examined for applicability to the research questions concerning participating in a research project. Client pre and post tests and 3 months follow-ups were examined. As part of the larger study, clients were given a battery of

assessments before beginning treatment, at the end of the 12th and final session, and again 3 months following treatment. Open-ended questions about their expectations for therapy were included in that assessment. These questions were examined to gather any comments about the clients' experiences in being in a research project. Additionally, each after session questionnaire was examined for applicable comments.

Following the analysis of the data received from the clients, I conducted focus group sessions and telephone interviews to better answer the research questions using the questions at Appendix A. The focus group allowed for reflection by the participants after the therapy was completed and focused on the effects of participating in a research project. Seven of the clients participated in an hour and a half session with a trained moderator. I observed and took notes. Twenty-four participants (of a possible twenty-six) were contacted by letter or in person with follow-up telephone calls to invite them to participate. One couple had moved to another part of the country and current contact information was not available. A focus group report was compiled at the completion of the focus group. The report includes a transcript that I transcribed. I then open-coded the transcripts.

An additional seven telephone interviews were conducted with clients who could not attend the focus group, but were available for a 20-minute interview. Interviews were conducted by first ascertaining whether or not the participant was in a safe place to answer questions. Resources for additional assistance were prepared to be offered if ongoing violence was revealed. Although not recorded, I transcribed my detailed notes upon completion of the interview. The interviews were then open-coded.

A total of 38 qualitative interviews were collected from the Multicouple group participants. Sixteen clients participated in qualitative interviews as their therapy progressed. Four clients from the first group completed four interviews after the second, fifth, eighth, and twelfth sessions each for a total of 16 interviews. Another two clients in the first group completed one interview each. The project could not sustain conducting four interviews for each selected participant so the interviewing goal was reduced to two qualitative interviews following the sixth and twelfth sessions in subsequent groups. The below figure shows in detail the sources of data for each client. All interviews were tape-recorded and transcribed.

Pseudonym	Group	Pre-test	Post-test	3 mos	Qualitative Interviews	End of Session	Telephone Interview	Focus Group	Totals
Adam	1	1	1	1	4	12	0	0	19
Annette	1	1	1	1	4	12	1	0	20
Bart	1	1	1	0	1	11	0	0	14
Brenda	1	1	1	0	1	11	0	0	14
Candice	1	1	1	1	0	11	0	0	14
Charlie	1	1	1	1	0	11	0	0	14
Donna	1	1	1	1	0	11	0	0	14
Don	1	1	1	1	0	11	0	0	14
Ed	1	1	1	1	4	12	0	1	20
Edna	1	1	1	1	4	12	0	1	20
Frank	2	1	1	1	2	12	1	0	18
Francine	2	1	1	1	2	12	1	0	18
Gretta	2	1	1	1	0	12	0	1	16
Grant	2	1	1	1	0	12	0	0	15
Harry	2	1	1	1	2	10	0	0	15
Hannah	2	1	1	1	2	10	0	0	15
Irene	2	1	1	1	2	10	1	0	16
Ivan	2	1	1	1	2	10	1	0	16
John	4	1	1	1	2	12	0	1	18
Jenny	4	1	1	1	2	12	0	1	18
Karen	4	1	1	1	0	11	0	0	14
Kyle	4	1	1	1	0	11	0	0	14
Lewis	4	1	1	1	0	12	0	1	16
Linda	4	1	1	1	0	12	0	1	16
Mike	4	1	1	1	2	10	1	0	16
Michelle	4	1	1	1	2	10	1	0	16
Totals		26	26	24	38	292	7	7	420

Figure 3.2 Client Data Collection

For all client participants, a minimum of 14 data points were collected including a pre-test with written responses to open-ended questions regarding expectations for therapy. The other data points included the 12 post-session questionnaires following each session, and post-test responses to open-ended questions regarding their experience. Fourteen clients agreed to participate in the focus group or telephone interviews. They were recruited to participate through letters and personal appeals from myself.

Therapists Data Collection

All five therapists participating in leading the multi-couple groups were interviewed. For each of the five therapists, a minimum of 13 data points were collected: 12 post-session questions asked after each session, and an interview about their experiences with being in a research project. Six therapist qualitative interviews were available for my analysis as well. 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.

I had originally intended to conduct a focus group with the therapists. However, it proved too difficult to meet with everyone at one time. Instead, I met with each therapist in an hour-long interview (see Appendix B). The interview was recorded and then transcribed. I had experienced transcriptionists do the transcribing to expedite the process. I then open-coded the transcripts.

Analysis

In addition to the open coding procedures, I kept coding notes and memos divided into theoretical memos and personal memos. Some memos were written during the coding of transcripts, others were written anytime I had ideas that needed to be recorded. The theoretical memos included my thoughts about possible categories, future questions to be asked, and emerging themes. My personal memos were used to record my personal reactions to the data, the participants, or the project.

The pre, post, and 3 months follow-up tests and post session questionnaires were examined for possible themes and data that might be useful for this study. Given the small amount of data directly applicable to the research questions, the data was combined with data from the available qualitative interviews. The qualitative interviews were analyzed using the open-coding procedure outlined by Strauss and Corbin (1990). I read each data source and picked out any responses that address the impact of being in a research study. I then organized by week and gender the results of the questionnaires to discern patterns and to capture key quotes.

The responses from the pre and post tests, the end of session questionnaires, and the interviews were used to further refine the focus group questions and interview questions at Appendix A and B. I used 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.

I used software especially designed for qualitative coding (NUD*IST, 1997) to facilitate the coding process of the interviews from the NIMH process. For the majority of interviews I used open coding. My research advisor also read most of the client interviews. I provided her with my thematic analysis for all interviews and data. We met to discuss emerging categories and to discuss

the results of the interviews and the focus group. Using her experience, categories were refined or adjusted.

Confidentiality

Client confidentiality was protected by several measures. Participants were assigned a code number by the larger project. This was the only identifier on the tapes and written materials gathered from them. The corresponding names to the code numbers were kept locked. Information from the participants were 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 to inform the project. Names and identifying information in any written report adequately disguise the identity of participants involved to protect their privacy. New data collected for this thesis was transcribed and then destroyed following the completion of this thesis.

Instruments

Data were gathered from written responses to the pre, post, and 3 months follow-up tests, qualitative interviews, and a focus group. The questions for the focus group were derived from responses received in the data collection by the larger project. As the interviewer, I 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 talking about one's self or interrupting the participant. In accordance with the guidance of the experienced moderator, a detailed focus group moderator guide was developed. Questions for the clients and therapists were vetted with the NIMH investigators to take advantage of their interviewing experience. The entire moderator guide is at Appendix A.

Client focus group

Examples of the questions used by the focus group moderator in the facilitator guide were:

1. First, how aware were you that the counseling program you were being invited to join was a research project?
2. What did it mean to you that you were participating in a research project?

3. How did the fact that you were in a research project influence your decision to complete the program?
4. Think about the day you came in for the screening and the pre-tests. What was the effect of the screening process and battery of pretests on your thinking about your relationship?
5. How did the video cameras affect your treatment?
6. Are there ways that the interviews affected your thinking about your treatment?
7. Are there ways that the posttests affected your thinking about your treatment? How did your thinking about the research project change from beginning to end?
8. Before each session, you participated in male and female check-in groups. What was the impact of the check-in process on your therapy?
9. What are your thoughts about using this model without the research pieces (pretests, interviews, questionnaires)?
10. How did the cameras, questionnaires, pretests, and posttests affect your perceptions of safety for you and other participants?

<u>Client telephone interviews</u>

The questions for the telephone interviews with clients were similar, but abbreviated:

1. Looking back at the period of time you were considering participating in our couples treatment program, what was the effect of the screening process and the battery of tests on your thinking about your relationship? (If necessary probe with questions like, "Did you find the tests helpful or a waste of your time".)
2. Several aspects of your experience were a part of the research project (for example, you were asked to complete pretests and posttests, your therapy was videotaped, you were asked to complete questions at the end of each therapy session and you may have been interviewed). Are there ways that the data collection affected your belief about how the treatment was going?
3. Did you think these things made the treatment you received better in any way, worse or did not effect treatment?

4. How would the treatment have been different for you without the research pieces of pre and posttests, cameras, questions at the end of each therapy session, and interviews?
5. Would you have any concerns if we continued to offer this treatment but did not include these things?
6. Next, I would like to get an update of your experience in the project. Please think back on your entire experience. How useful was it to you?
7. What are your thoughts in general about the project?
8. Do you have any final advice for us?
9. Next, I have a few questions about you.
   Are you still with _________?
   If yes, Is your relationship better than before you entered the program?
10. If yes, Did anything you learned in the program play a part in improving your relationship?
11. Has there been any physical incidents from ______ to you since you completed the program?
12. Has there been any physical incidents from you to _______ since you completed the program?
13. If there have been incidents, is there any difference in the level of violence in your relationship since you left the program?
14. If she/he is not with partner in program, explore. Was violence a part of decision?
15. Did anything he/she learned in the program influence decision to leave?
16. If she/he is not with partner, ask if there have been other partners since the program?
17. If so was violence a part of these relationships?

If so, did anything you learned in the program affect that violence?

Therapist Interview

The questions used in the interviews with the therapists were:

1. What training did you receive relating to your participation as a therapist in this project?
2. How did you use the manual for therapists? How often did you refer to it? Did your supervisor refer to the manual in supervision? Did your supervisor use the manual when working with you?
3. Think back to when you were first beginning with your role as a couples group therapist. How did the following parts of the research project hinder/help you in your efforts as a therapist?
    a. Screening/pre-testing
    b. Check-in session
    c. Check-out session and questionnaires (client and therapist)
    d. Interviews (therapist and client)
    e. Post tests
4. What did it mean to you that you were participating in a research project?
5. In what ways were you able or not able to listen to the clients about what they wanted within the constraints of the model? Did you ever do something or not do something because of the manualized treatment model?
6. Safety was clearly a major responsibility for you in this research project. How did the research pieces of this study contribute to/degrade your knowledge of your clients' safety? As a result of the research pieces, was the treatment safer or not affected? More dangerous?
7. What were the client's concerns about data collection? What was the impact of those concerns on their experience over time?
8. Consider for a moment, the possibility of your using this program or any therapist using this program in an ordinary clinical setting. What, if any, parts of the research project would be required in the field for an effective clinical program?
9. Information about the imbalance in information between the men and women about anger management in the early project was a recurring theme. How did the model help you or hinder you in working through the imbalance?

10. This may have been the first time you have been asked to use a manualized protocol. If in the future your agency or you were asked to use another manualized protocol, how would your experience using this one affect your decision?
11. If you were affected by the fit between your theoretical orientation and the theoretical framework of a new proposed treatment manual, what would be the factors that would enter into your decision to participate or not?

Researcher as an Instrument

In addition to the written instruments, qualitative interviews, focus group, and telephone interviews, I as researcher also served as an instrument of data collection. As recommended by Weiss (1994), I kept notes and memos about my observations and reactions to the data, interviews I conducted, focus groups, and the process as a whole. Some of the content of these memos helped me as I analyzed the data for trends and similarities between participants' responses that might be emerging categories. Other content included my personal reactions to the people I interviewed and the qualitative research process as a whole.

Summary

In summary, 31 individuals were included as participants in this exploratory multiple case study. For each unit, at least 14 data points were collected: pre and post tests, the end of session questionnaires, and the interviews. For 14 clients, focus group results or telephone interviews were collected. The five therapists each provided an additional interview. All interviews and the focus group, except for the telephone interviews, were tape-recorded and transcribed. Detailed notes were kept on the telephone interviews. Data were analyzed using the open-coding procedure outlined by Strauss and Corbin (1990). In addition to eliciting the experiences of clients and their therapists, I also recorded my own experiences and ideas in notes and memos.

CHAPTER IV: RESULTS

As might be expected, perspectives on being involved in a research project were different for clients and therapists. There were some common themes however. In this chapter, I first explore the themes that developed from the data about the client's views of participating in a research study. Then, I explore the therapists' experiences. Finally, I summarize the results.

Clients' Perspectives

A number of major themes emerged from analysis of client data. In this chapter the themes will be organized into eight sections: the general experience of being in a research project, the length of the program, end of session questionnaires, the check-in/check-out process for each session, cameras, the pre and post tests, participating in interviews, and other emerging themes. Analysis in this client-oriented section of the chapter will follow these eight sections. In order to give a sense of continuity to the reader, the clients are assigned pseudonyms. See Figure 1 for their demographic data. Partner's assigned names share the same first alphabet letter with their partner's first names.

Participating in a Research Project

Despite 12-24 weeks of participation (including time in anger management prior to beginning the multi-couple groups), there were few client comments in the data about being in the research project. It was only after we asked clients direct questions about participating in a research project that comments about the project were made. Out of a total of 368 opportunities to comment, express concerns, or ask questions about being in a research project on the pre-test, post-test, end of session questionnaires and interviews, 273 were without comment (See Table1). Of the comments made, fifty-two comments could be considered negative with 72% being related to the comment that 12 sessions were not enough. Forty-three could be considered positive in nature. Only 19 of the total comments directly addressed being in a research project and they were of a general nature. The remainder of the comments were liberally inferred by myself as relating to the client's experience in the research project.

For example, this woman at the end of her tenth session in response to the question "How helpful was this session?" wrote: "Your research shows how 12 weeks is not enough when you open a can of worms like abuse." Another woman at the end of session eight in response to the

same question wrote: " The 'positive' at times seemed artificially contrived." I counted both comments as negative about their experiences in the research project.

It was not until clients were asked directly in qualitative interviews, telephone interviews, and the focus group that answers relating to their experience in a research project began to emerge. Even when later versions of the post-test asked the question directly about how their experience of being in a research project affected their therapeutic experience, the clients, almost without exception, commented on their therapy. It was clear that the client's initially equated their therapy experience as the same as participating in the project. Here is a quote from Lewis (pseudonyms were assigned for each client, partners share the same first letter in their assigned names, see Chart 2) at the beginning of the focus group:

> *I have a question. You* [the moderator] *distinguished between the couples therapy and the research project. I am not sure what the difference was.*

Several themes emerged about the clients' participation in the project: a minimal effect on their treatment, noticing the project is using an experimental intervention, hope that their participation will help others, and that the research reinforced their therapy.

<u>A minimal effect on their treatment</u>

Many times in the post-tests, clients said participating in the research project had little to no effect on their experience in therapy. In response to the question, only six clients made more comprehensive answers. Bart, in his second interview, made comments similar in nature to several others:

> *I don't even think of it. I don't even see it as a research project. All I see is people that need help, people that want to talk, people that want to communicate and get things out on the table with their spouses. And they want to be able to interact with other people so that their spouses can see how these people are dealing with it. They can also get ideas from other people. So, I don't see it as a research project.*

Linda, in the focus group, spoke for several others who remembered at the beginning of the project being somewhat concerned with the cameras and other components of the research project but as their therapy progressed:

The research component kind of fell away for me, I didn't really think too much about it. I have been through a lot of therapy. [She laughs.] *Umm, the therapy part seemed good, the videotapes and the questions were not relevant…I didn't think about* [videotaping and the questionnaires], *they weren't in my consciousness. I guess the problems were so overwhelming, that I didn't…*

Experimenting

The research project made it very clear in screening interviews, releases, and in the statements of the therapists that the program was testing a relatively uncommon treatment for domestic violence. Yet, only a few participants commented on the program being experimental, and only with specific prompting in qualitative interviews or the focus group. The consensus was that most of the participants did not feel as if they were participating in an experiment.

Several of the participants' comments indicated they were aware they were participating in an experiment. In her first interview Brenda observed: *They're just experimenting, so they're not really sure. But we told them exactly what we think.* Ed, in his third interview said: *it's sort of an experimental thing but I guess sometimes I do question what-what's the direction...* His wife, Edna, in her second interview noticed some resentment she was feeling:

> *I feel like, well, I'm a little bit of a guinea pig. They're not sure what they're doing, so let's open all this stuff up, and the experiment is over, and they can go and deal with their lives. So, part of that, I think I feel a little resentment. On the other hand, I feel good about being able to talk.*

By her fourth interview, Edna's resentment seemed to have dissipated and she offered:

> *It was good, it really did not seem like we were in, except for the questionnaire at the end of the session… I never really felt like there was that much experimentation going on other than the use of the time out, for instance it came up a lot at the beginning of the sessions, other than that it really did not feel like it was any kind of experimentation, although we did have a lot of emotional kind of stuff coming up in the middle of the session…but I don't know that it was experimental, we were just going over some things I guess, the turbulence of our marriage and kind of bringing up some of those things that … have forced*

emotions inside for a while, but other than the questionnaire at the end of each session it did not really feel like an experiment.

In the focus group, a spirited discussion began when the group was asked about their reactions to being in a research project. Lewis raised a unique question, the only time it had appeared anywhere in the data from this project:

I have one more concern… Is this a placebo group or were we getting the real medication? In other words…was there anything different because it was research? Is something being done that maybe the therapist would not want to do, but because it is research that they would say something one way that in any other situation the frame of the therapist would be different? I was wondering in my mind…was this about being a placebo? Because in a double blind study one group gets nothing and the other group gets the real medication. I don't know if this was a double blind study or not.

The other focus group members disagreed strongly with the idea that their therapy may have been seriously affected by the research design. Edna stated it best:

I guess I haven't thought that because…we are dealing with something very, very serious. I think, I always thought that probably what would happen in this program they were trying to see how different types of therapy can be used to benefit some couples. Some couples it doesn't benefit…But then there's others who stay on track. I think that it is very similar in the management. I hope that it takes. The therapists that I dealt with I felt like it was taken very seriously so I didn't feel like a placebo.

<u>Helping others</u>

Several participants expressed the hope that their experiences in the project would be helpful to others struggling with domestic violence in their relationships. Francine in her last interview said there were some uncomfortable aspects about the research project, particularly the cameras, but:

…when you think of what you can give or what you can share with other people in the future that need help… I would like to help because I have the same

experience that might be of help - - my experience or my input might be of help to other couples so I agree with the research one hundred percent.

Clients were clear that their primary motivation in their participation in the project was to improve their relationship. But, the idea of being helpful to others was an added benefit to them. Lewis noted that he was in the project for his self-interest but *"Also, in addition to being selfish, I had thoughts of benefiting others."*

Frank in his last interview said: *Although, since it was a research project I think that hopefully what we were able to give information to the counselors will help other couples also in the future.*

He then went on to say candidly:

…well, to tell the truth, it didn't really make a whole lot of difference because we're there for one reason. And that reason was to improve our relationship. So, if of course we can benefit other people by that, that's a side effect for us.

Reinforcing their therapy.

Three clients mentioned that participating in the research project helped them in either reinforcing the changes they were making or noticing what they needed to work on. Annette, in a telephone interview about her experience of being in a research project, noticed that she participated more as a result of the tests, end of session questionnaires and interviews:

I would have just listened, instead I participated in the therapy. The questions and stuff encouraged me to participate.

Francine found:

the check-out and end of session questionnaires helped us think of what went right and were a general reminder of what we needed to concentrate on.

The themes that emerged about the clients' participation in the project are noteworthy in that only a minority of clients had anything to say on the topics of: a minimal effect on their treatment, noticing the project is using an experimental intervention, hope that their participation will help others, and the research reinforcing their therapy. The theme most frequently commented on, beyond their general experience of being in a research program, was the issue of the length of the program.

Length of Program

The issue of time, or the number and length of sessions, was one aspect of the research project most commented on. Clients frequently commented on their end of session questionnaires on their concerns about the 12-session format of the therapy. Less frequently, some of the clients expressed concern or frustration about the 2-hour session length.

Several clients voiced concerns about "What comes next after the twelve sessions?" Annette in her first qualitative interview asked: *"I'm fearful for when the 18 weeks is over* [this group combined a 6 weeks anger management program with the 12 week couples treatment], *how do we cope?"*

Candice expressed her fears in her second of four interviews:

> *I need this group. But what's scaring me, and maybe this is why I'm starting to clam up a little, is I don't think 12 weeks is long enough with a group. I think that this group setting is really good and I think that you get to know all these people, it takes a while to open up, and then when you open up, to the counselors as well, all of a sudden it's over when you could start making some changes. Twelve weeks isn't enough time for people to change and to work. I feel like the 12 weeks are going to happen and all of a sudden it's going to be over and we're going to be like, well, now what do we do? All these worms will be open, cans will be open and all, what's going to happen is we're going to go back and it's going to be the same roller coaster. So, I'm really getting upset about that part.*

Later in the same interview, Candice expanded on her concerns:

> *Yeah, we're getting to that. But, see, I don't think you can do this whole thing in 12 weeks. And I've said that in all of my evaluations, I've been putting that, and other people too. I feel that its great that you all are running this program, but it's not only an experiment, you know. You're dealing with human beings who have problems. I feel like there needs to be a response to maybe they can extend the program a little bit. I really--if it was--if I was asked to sign up for this program again, I wouldn't do it, if it was just 12 weeks.*

Some of the men expressed their concerns along the same lines. The fear seems to be connected to concerns about how to make any changes they are making permanent. Frank in his first interview:

Yeah, once we've completed this, we kind of have to assess where we are because my fear is, just like I've said in anger management, is once it ends there has to be a way to be able to reinforce or continue this. Of course the reinforcement for myself and some of the other men is the one-year probation at this point. But when that ends there has to be motivation not to have an unhealthy relationship. So I think that occasionally whether one needs it or not but I think it's helpful to have this reoccurring group. Also to gauge how things are going. I told anger management just like this one here. 12-weeks isn't really long. I mean I would have had it for a whole year. Or at least in sessions to see you know what real progress…because in 12 weeks you really can't you cannot gauge what type of progress has been made in real time.

By the end of the 12-week treatment, clients were being thoughtful about their progress, both for themselves and their partners. Again, frustrations with the 12-week limitation on their formal treatment came to the fore when considering their experience in the research project. Ed in his last interview speaks of the changes his wife and he made:

…the number one thing that stands out… people were afraid to open up and when they finally did, they got to the point, that is exactly where we are leading to now, they got to the point where the sessions were not long enough. … the eleventh session, all the females and all the men really started getting going, and …when everybody realized, hey, this is, we are just starting to make a difference here and we need to continue on. And I was one of those people because on that eleventh session, that is when I find out that my wife…was really starting to open up, and for somebody, I have known Edna for over fifteen years, since she was a kid, and just when you think you know somebody, we have been to marriage counseling, we have been to other forms of counseling, this is the first time she has ever opened up so, deep impact…I went through ten sessions of listening to people and my wife and all throughout those ten sessions I did not see something, and the eleventh session I did.

Bart in the same couples treatment groups also notices major changes in himself and his wife, Brenda in his last interview:

And I have been with her in adulthood since August of 1991, I am very impressed that this, Virginia Tech institute got her to open up, I have not been able to get a single human being to do that… I also attended the anger management and I really believe in my heart and soul that it did me a great justice, but I did not perceive her feelings the way that she did and that is why I am specifying it is her specific feelings, you just, I don't know how to explain this, but you just can't see or feel another person until you really start letting them talk about their lives, that is the main reason why we want to continue the sessions.

Annette in her last interview had this very descriptive statement about her experience in time-limited therapy in a research project:

…the only time I ever thought of it as research is when we went OK the twelve weeks is up guys, you know we only have four more weeks so we got to really get into this…Where if you were paying for sessions or whatever they would just keep going 'til you ran out of money or you just didn't want to go anymore…so they say OK this is week eleven and we are going [panting sound] *one more week, one more week can we just stay after another half an hour, we got to really finish this off we only have one more week.*

Bart in his second interview of four complained that the sessions were not long enough. Perhaps surprisingly, this did not come up often:

For me personally, there's a feeling of dissatisfaction. Hey, come on, we're really getting going here, let's not stop…So, whenever we fill out the form at the end, the questionnaire, I fill out dissatisfaction, and I put down why. Because we really started getting into the talking, and boom, the conversation is cut!

In response to client concerns in the first multi-couple group, the project offered an ongoing alumni group to this and all subsequent groups. Several of the clients remarked on their plans to continue, describing how they believed they needed more than the 12 weeks allocated. An example of their thinking were the words of Frank in his last interview:

…So, I think the biggest benefit is my wife was exposed to a lot of techniques including timeout that has really helped, you know, us. We still have a ways to go, I mean we can't correct our relationship in just 12 sessions ... In fact that is why we're going to join alumni group also…A twelve-week session doesn't correct

or erase, it's just the tip of the iceberg. There's still the other three quarters under the water, so…

In the focus group we were able to raise the subject again. The clients recognized that their therapy was limited by the financial constraints of the larger project. This is what two of the women participants had to say:

> Gretta: *For me, I think it was too short. We were really starting to make some headway in there.*
>
> Edna: *We were cut off. … Financially we could not afford counseling. I really felt that we had made progress here. We had no progress in a year of counseling. We had just started getting into all that and then it was just like, the end. Good luck.*
>
> Gretta: *…What changed for me was that we could come to therapy because it was funded…first of all, some of the things that went through my head as time went on about research was… because it was a research project, we could afford to come to therapy. Because research usually means it gets funded. …one thing that I kept saying very loudly was that it wasn't long enough and that things…cycles can re-happen again if we don't stay in touch with what we have to do within ourselves and how we can learn to be…just continue to learn how to grow in our relationship. And make sure that the anger or violence doesn't happen in the home… Our group* [the Alumni Group] *was extended. And I don't think that if it wasn't a research project that it wouldn't be. Probably we wouldn't be as far along. We did continue and we still continue.*

End of Session Questionnaires

The end of session questionnaires were a very visible part of the participants' experience of the project. At the end of every session they were asked to fill out two forms (Appendix C). The session rating form was not seen by the therapists to encourage candid responses. The therapists used the safety rating scale as an additional check on the status of clients before they left the session. There were nineteen comments about that experience. The themes of the comments included the burden of filling them out, suggestions for alternative administrations, safety, and how they gave the participants varying beneficial results.

Filling them out

Several comments spoke to the repetitive nature of the comments and how they were burdensome. Ed in his last interview noticed that participants in his group were ready to leave and not very interested in filling out the questionnaires:

> *…sometimes the reviews that we do at the end of the class they are always the same questions and … by the end of the session, I think everybody just wanted to go home. You know, they were worn out…it seems like every question wanted an explanation and it was kind of hard to really sit there and write out a lot of things because class seemed to run a little late and we were trying to get out of there…*

Candice in her telephone interview too had a negative reaction to the questionnaires:

> *It became* [the end of session questions] *a pain in the rear. The others were giving it short shrift, and I felt awkward as I tried to fill it out thoughtfully. Less times would be more helpful.*

Linda in the focus group spoke for several others: *I wasn't at my best to give reflective comments. It was at the end of a long day of work and a long night of really intense…so; sometimes I wasn't feeling like I was at my best.*

Irene in her last interview noticed that she was in the minority in trying to fill out the questionnaires thoughtfully especially in later sessions:

> *… what was hard for me because I would try to fill things and all…everybody else they gave the paper to they were out of the class in one minute. And I'm thinking, 'what am I doing wrong? Am I just slow?' So I felt awkward because I'm thinking 'Well I'm just slow.' And then come to find out most of them aren't even answering the questions and are just going yes, no, and out the door. And so …I felt awkward filling things out because I mean, I'm thinking, 'God I'm stupid.' And actually I was the only one filling things out.*

Making questionnaires more useful

Several participants offered up suggestions to make the questionnaires more useful. Grant in his third interview offered:

…they're always the same. If they could just change 'em just a little bit one week or something because you know this is a lot of weeks, and it's the same form to fill out every night, I mean every Tuesday night....

Frank in his telephone interview suggested:

If done again, the questionnaires should not be done at the end, but ahead of the next session. I would like to think about them before filling them out.

Surprising results

Despite the routine many of the participants complained of, several had some surprising experiences related to the questionnaire process. Bart in his first interview reported that he had written that he expected his wife, Brenda, was going to be verbally abusive to him. But:

She wasn't. That's why I was surprised. I was really shocked. Every time [before these sessions] *she and I get to really intense arguments, she always brings up that she wants a divorce. And we come out of this class, she's laughing and she's giggling and she's happy. We go home and she's happier than a pig in slop. So that must be something good.*

Client's opinions

Brenda in her first interview reported she was pleased at being asked for her input. She likes participating in therapy where she is asked for her opinion. She also feels all the participants have something of value to offer:

You write it down on a little questionnaire at the end of the session. Just write it down… apparently everybody there has been to some form of marriage counseling, some form of therapy…So, we've all been through all this one on one stuff.

And along the same lines Linda in the focus group felt she was making a contribution:

This was different from other forms of therapy, I think it mattered what I thought. In regular therapy there is not an opportunity to give feedback. This kind of feedback is rare.

By her second interview Edna noticed she was increasingly thoughtful as she filled out her questionnaire.

…well that's like on the sheet it says are you totally certain that your partner will not physically abuse you this week… and then it says totally certain, certain-and it gives you the same thing--I can always say fairly certain because you know I only can control myself. I can't control my partner so when it comes to other people I can't…

<u>Client feedback</u>

In the focus group a thoughtful discussion about the impact of the questionnaires occurred. Gretta and Ed assumed that their feedback was going directly to the therapists (it wasn't). Ed saw a value in the questionnaires helping the therapists keep current on safety issues:

Ed: *I think that the how certain, the how uncertain you feel about safety, I think that is a little bit important because whoever is in charge of the program can pick those up and know that they should be focusing on that. Maybe a check up phone call.*

Interviewer: *You see a value to an actual written check?*

Ed: *Yeah, that part being something that can bring out a lot of heated feelings. We went real heated sometimes in our group. We got calmed down. It might be a good idea to have that so you can share it.*

Gretta thought the therapists were reacting to the participants' comments in the questionnaires:

As much as, you know, sometimes the writing was difficult, I guess I am sort of being a hypocrite I guess. But, part of it is important because you can mold…Your therapist then has an opportunity to go away with something saying 'Oh, that didn't work, or that was really helpful.' Then they can come back and utilize that. That makes them only a better therapist I feel. You know. I know that I have experienced a lot of therapy in my days before Virginia Tech. But some of the therapists here are extraordinary… maybe some of that had to do with the input we gave...I think that somewhat of what the beauty of this program for me has been is the flexibility in the therapists. At times in our group we had, we were very forceful. We didn't like the way certain sessions were going, the therapists were

dealing with certain issues and so we verbalized. This is what we need and this is where we should go.

Check-in/Check-out

On this element of the program, two interesting themes emerged. There appeared to be a gender-based difference in the way the check-ins/check-outs were viewed. The women assigned more value to this part of the process. A few of the participants, both men and women, expressed concerns that the check-ins/check-outs took away from work on their relationships.

Men's views

A number of the men commented on how the men's sessions were not very interesting. Ivan said it well in his first interview:

It's more interesting when there's couples in there, I'll say that, it keeps it a little more interesting and keeps you more awake, so you know, kinda boring with these guys with the same issues…

Charlie in his telephone interview said much the same thing: *Too much time was wasted. The 10 min at the end was ok. The guys spent time staring at each other.*

Women's views

The women were more enthusiastic about the contributions of the gender-separate sessions to their therapeutic experience. Edna in her second interview said:

I don't know what happens in the men's group, the women focused a lot on their issues in the women's group. So, we check in and see how everyone's doing, but then we go out and we deal with the issues in that setting, as long as it's comfortable for the people who are having a difficult time.

Linda in the focus group noted*: I don't think it would have been the same without gender-based groups. Because when we first met, it created a safe environment. But, I still think it was helpful to separate and talk, each side to talk.*

Edna in the focus group expanded on her thoughts:

…Sometimes I think women and men can relate in different ways to each other. In our group, there were women helping each other out…I thought that was a really good time…it looked like the therapists started formulating how they were going

to take the group…Everyone was made sure to be ok. That was a unique and special part of the program. There were actually three groups, a men's group, a women's group, and couples. So, it is almost like there are three groups.

<u>Taking away from relationship work</u>

In the early sessions of the program, several persons expressed concerns about devoting a large amount of time to gender-based groups. Edna in her first interview expressed her frustration:

> *…it feels like two groups, instead of that my husband and I are a team and we're trying to work together…* [It is frustrating] *Because we're here to try to sort out some of how we can work through some of the anger where we have to, which is at our home. And we're being separated.*

Ed in his third interview noticed:

> *I don't know all the theories, but I think having the couples together seemed to get a lot more, well I get a lot more out of that part of it. So, like around a discussion group. I think the perspective changes a lot when the couples are together. It seems like it's more of a real atmosphere as to what's going on, the problem areas....*

Adam in his second interview expressed the strong feelings he had about the effect of separating from his wife:

> *I'll be honest with you, I feel a little bit like I'm betraying my wife, when I talk to the men…Here we are in the beginning, and here's the women. That gives them a chance to privately say, 'hey, this is how I really feel.' O.K. that's good, I agree with that. Because you gotta get it out on the table, and the women may not feel comfortable in the beginning talking in the interactive group. So, it's great they talk to the therapists, I see that, it's good... But, then, to talk about it afterwards, for me, is like a betrayal…To me you're supposed to be honest in the beginning talking because you're not, because there's that lack of… courage, to speak in the beginning…Then we interact, but then that's where it should be. I just don't agree with discussing it afterwards. Every single time that we sit down afterwards, I really don't have anything to say… Don't come back afterwards and say*

> *something that you don't want the wife to hear. Because then that takes away from the honesty of the group.*

<u>Cameras</u>

The therapists videotaped each session. Cameras were set up in the larger group room for each session. Most participants initially commented on the presence of the cameras when asked about participating in a research project. The cameras appeared to be the most visible part of the research project and the part the clients were most aware of. Early in the therapy, many clients said the cameras made them feel uncomfortable or self-conscious. In her last interview, Francine reflected back on her experience: *Especially if there is a camera I would say at the beginning, I was not comfortable.* Candice in her telephone interview noticed that she got used to the cameras as time went on: *I didn't realize the cameras were on after a while, even though they made me very nervous at first.*

On the other hand, Gretta and Ed in the focus group noticed they had forgotten about the taping: *The videotaping didn't bother me. I don't even remember it, truthfully.*

Two clients noticed that their groups adapted to the presence of the cameras by avoiding them or changing their seating while in the cameras' presence. Irene in her first interview noticed that the women in the check-in would be careful to share about physical incidents outside the room with the cameras:

> *…some of these women when their husbands are physical, they need to talk about it. And with the husbands, as a couple of them said, he said don't you dare say anything, don't you dare. So far they haven't or they won't allow it*. [They share that:] *Usually when, well we all forget the camera's going but it's either before the class or during you know the break.*

Jenny in her last interview noted that she did not mind that the videotaping was being made but that her group members:

> *…we made jokes about the camera. We tried to sit with our backs to the camera. As long it is being used in an appropriate manner. As long as it is being used to educate, to motivate, to help encourage, that's fine. I don't mind at all.*

Pre and Post Tests

Reactions to the pre and post tests ranged from there was no impact at all on the clients' experience (this was true for the majority of clients asked) to irritation, to increased levels of self-awareness. Several clients reported feeling irritated at the repetition and length of the pre and post test instruments. Ed and Edna in the focus group agreed that the questions felt repetitive and irritating, Edna said:

> *Yeah…from the first week where you got paid to fill it out. It felt like you were in that room forever, you were by yourself. That was…because…at first I didn't even really want to do it, the whole thing. On Saturday morning, so it was my last straw* [this opportunity for therapy] *but to fill all that out was like really grueling…the repetitive questions? Irritating. Didn't I answer this on page one? I mean…it was long; we were able to take ours home after the session ended…and I did mine at work. And it still took me a long time!*

At least three participants wondered if they belonged in the group because the questions did not seem to apply to them. Francine in her telephone interview wondered:

> *I thought they were more dramatic than where we were at. The scenarios were very severe. I was not certain if we were appropriate for this group given the kinds of things the questions were asking about. But, many things were applicable for me. I wasn't sure we would be chosen given that the scenarios were speaking about such severe situations.*

For Jenny in the focus group she felt validated in her experience as she filled out the test instruments:

> *It confirmed everything for me. How I felt…I thought like wow. Somebody knows!*
>
> But, on the other hand, she was surprised at the degree of severity of violence asked about by the questions. *Some of the questions were strange… I thought wow, people go through these things? And on the way home, from filling the questionnaire out, the booklet out, we talked about did this really happen? ... I was amazed at some of things they were asking about.*

Others noticed they felt discouraged as they filled out the questionnaires. Gretta in the focus group:

It was a little discouraging…You don't realize that you don't think how often or how bad they were. You are sitting there and it is all right there in front of you. Yes, this actually happened. I didn't want to think about how often or how severe it was. Even though it happened.

Still others found the tests helpful. Frank in his telephone interview noticed that through his answers on the test batteries he became more aware of his issues:

They opened up a lot of things I wasn't aware of. The questions were so detailed; it helped me focus on my problems… it [the tests] *made me aware of where I was. The questions helped me know the stage of where I was. It also helped me be aware of areas I need to strengthen and work on.*

Francine in her telephone interview also noticed:

The questions were eye openers for me. They helped me think through my problems…The tests were helpful in that they showed us ways we can improve.

Annette in her telephone interview became more realistic about her situation after completing the pre-tests:

It caused me to evaluate the situation a little bit more than I would have otherwise. It was upsetting to do the questionnaire as I had to answer yes to questions about broken bones and bruises.

Like Annette, Gretta also became more realistic about her situation and increased her determination to make changes:

I drew the line. This was it. I knew I was not going to live like this when I saw it laid out. For both of our health, it wasn't just for me it was for him too. We need to work at this, you know. Especially after seeing it in black and white. Knowing this was it.

Several women expressed the thought that this participation in the research project to get therapy for them was a last attempt. Edna expressed it:

I guess I felt like there was some hope. It was the last straw and we are either going to get help from this or we've done everything we can. And …I was embarrassed but …I knew that this would be better.

Interviews

The participants indicated three themes as they considered the impact of participating in the qualitative interview process. Some were pleased to be asked for their input into the research, others used the interviews as a review of their progress, and still others felt they were gladly giving something back for their free therapy by participating in the interviews.

Linda believed that not only was her experience helpful to the project, but that her answers to the interview questions were being used by the therapists to guide subsequent sessions. In the focus group she said:

> *I feel like they were used. I felt like they were read. The next group I would notice the feedback had been considered.*

Ed in the focus group used the interview as a review:

> *I thought it was hard, but it was a good review. You know, because it made you think about what went on that night…it was more for myself than for the counselors as I tried to remember what was described.*

Several of the focus group members made the point that they participated in the interviews as a way of repaying the program for their therapy. In addition to using the interview sessions as a review Ed in the focus group said:

> *I don't think it affected the talking portion of the therapy. We were getting a pretty good deal on the therapy, we had been going to other therapists for our relationship, but it was getting pretty expensive. So I was willing to do anything it took…Just like coming tonight* [to the focus group], *we felt that this was important.*

His wife Edna added: *I think I felt the same way. I felt like anything I can do to help Virginia Tech, they helped us out. And, maybe to continue to help them and they can continue to help us.*

Jenny also added: *I think we got here 30 minutes early* [for each interview session]. *It didn't make a difference for me. Because of the quality of help and me being able to participate in the sessions it made it all worthwhile.*

Other Issues

As I processed the data identifying themes I came across several issues individual clients raised that are worthy of consideration. They follow in no particular order.

Babysitting

It was clear that logistics played a major role in determining for some clients whether or not they could participate in the research project. Two clients noted that quality babysitting was very important to them. Frank in his first interview said: *Yeah, we're lucky this group here that they offer babysitting.* Irene in her first interview added:

> *Another wonderful thing you guys have a baby sitter. If you didn't I don't think a lot of people with kids would come...That's a key issue. That was wonderful. And I appreciate it, my kids love it, and they love…the gal who does the babysitting.*

Safety

Issues of safety came up throughout the project. Generally, most clients bringing up issues of safety were concerned for others in the early stages of the project and became increasingly comfortable that safety was being adequately addressed as their participation progressed. Edna in her first interview was concerned for others:

> *So, I understand therapy a lot. But, I'm questioning some of this program... we're dealing with people who have some--like everyone says safety is the most important thing. And I think because of that that there needs to be some other issues addressed. O.K. If safety is the most important, yes, time-out is one way. But when is the point where someone else maybe needs to step in and say, O.K. you've been abused so much, are you sure you're making the right decision? Are you safe enough to be going home with your partner or whatever?*

Candice in her telephone interview was critical of the inexperience of the therapists and had a suggestion to offer:

> *The counselors were good, but they had no experience with kids or long-term marriages. There needs to be a veteran counselor to guide couples. We were at our wits end, we needed a veteran and structure…One week, there were horrific events that occurred for 2 couples. They were raised in the check-in, but not*

addressed in the group. I was worried because the counselors left them hanging. There is a need for someone to handle the aftermath.

In the focus group this discussion took place between Linda and Gretta: *Linda: This point may have already been made, but filling out the safety questionnaires, sometimes I would feel less safe because it was raising my awareness, Like the safety plan. But it makes me focus on that more.*

Gretta: *The safety plan, they kept emphasizing that everyone had to have one. Every week…but he* [her husband], *was not very talkative and they would automatically think that he was angry and then they* [the therapists] *would be really on me, '…are you sure you are ok?' Yes he is ok. So, that is true, I felt more aware of* [my safety].

Linda: *Yeah...it was a way for me to cope as well. It made me think of things I wouldn't do this week.*

<u>Skills</u>

There were many comments about learning skills for making their relationships work better. The program changed its approach in later groups to include teaching communications skills, but even those participants wanted more. In the focus group Ed observed: *I think some of the tools or methods they taught us to use for communication, we can at least get them home and start using them. They get you on the road.* Candice in her telephone interview wanted:

Teach us how to go from here…We need ways to do things to help ourselves… More role playing could have been helpful…Give the couples something to go with. We need to know what we can do.

Frank in his telephone interview suggested: *I thought it was overall, helpful. I wish we had done a lot more practical kinds of things. We did some at the end, but overall we did not practice them. Maybe more role playing would be helpful. I think the counselors should bring out the emotions. Perhaps more emotions of the males would be helpful. The males were more guarded because they are males and sometimes for cultural reasons…The wives might better appreciate their husbands point of view if they knew their husband's emotions more.*

Research components and therapy

In the focus group, participants were asked if their therapy would have been as effective if the research components were not present. Participants generally believed their therapy would have been as effective without the research components. Ed answered:

> *I think it would still be effective. I think for me those research things I used as a review. But you can review by taking notes or having some kind of written…I think it is important to have some information with you…its very hard to remember* [everything]...
>
> Jenny responded: *I don't think it would be less effective. I think as far as safety is concerned, someone needs to make sure that you are ok. That aspect of it I think is important, but the other ones it wouldn't make the therapy less effective.*
>
> In contrast, Lewis thought: *I think it would be slightly more effective. Because along the same lines…it would be somewhat more effective in the sense that the therapists involved would be totally focused on what was beneficial for the individuals. So there would be no distraction about booklets, videotape or focus or evaluations.*

Therapists' Perspectives

The five therapists involved in the four couples groups in this project were available through the data collection process and in person for interviews. Five major themes emerged from my analysis of their discussion of the research process. They candidly shared their experiences in participating in a research project, how they addressed issues of theoretical fit, applied the model to the groups, experienced the components of the research project and their views on the clients' experiences. This section follows these topics in order.

Participating in a Research Project

This section addresses the therapists general experience of participating in the project. It also examines the themes of training, using a manual, and balancing the therapist role with the requirements of a research project.

The therapists were very clear they enjoyed participating in a high profile research project and that they felt challenged. Tom in his research qualitative interview (RQI) (each

therapist participated in one interview, Mary and Nick were interviewed together) saw his participation as a culmination of his training at Virginia Tech:

> *I liked the fact that it felt sort of like cutting edge kind of stuff. I loved the preparation that I got at Virginia Tech and I loved the involvement of the Staff there too. It really sort of reinforced everything that I'd been pointing towards so it was a validation of the time and effort that I put into the program, and it was nice to be working on something that could have some really positive, long lasting effects depending upon the outcomes.*

The theme of helping others and participating in a project with larger effects was universal. Sandra, in her RQI, spoke of the importance of the somewhat controversial project:

> *It meant that I was helping to come up with a new therapeutic technique intervention, a way of helping. I know it was controversial going in because not many people--the bulk of the feminist movement felt …that you shouldn't see couples together that have been abusive in relationships, that it is best to see them as individuals. That never made sense to me from a systemic standpoint. I understand the reasoning for that and that was really grilled into us, that you really do not want to blame the women for the abuse that she is receiving. However, it is a systemic dynamic …and everybody has a part and a role in it, and unless everyone addresses that, you're not going to bring about change in the system. And the women were real keen. I mean they were just thrilled to be a part.*

Pat, in her RQI, too felt she was making a difference:

> *I think therapy tends to be more specific, like you can change lives of those people you're working with and this in a theoretical sense, the work that we all did, is going to go to many more lives than you as a therapist.*

Sandra commented further about how being part of the research project challenged her as a therapist and helped her developed even stronger skills:

> Sandra: *I felt, I don't know, pride or I felt good in being a part of a developing technique. At the same time I was scared, I was nervous.*
>
> Interviewer: *How so?*

Sandra: *I'm a grad student. … I am working with two very skilled therapists. Their style was very didactic, very confrontive, very different from me… So being in that environment felt like 'Oh, my God! My skills are not finished ....' but you know, they were also good with me and Tom in particular helped bring me along and helped me to see my own skills and my own gifts and it was a good thing that I was different because I had a different perspective …and that gave balance for the group and I had a role in it. But that was good for me because it helped me to grow in that kind of supportive, nurturing environment which was a subset of the larger group because that was what we were trying to teach them as well in a supportive, nurturing, safe environment.*

Training

The therapists were very positive about the training they received and as the above section makes clear, very pleased to be selected to participate. This section discusses the positives and shortfalls the therapists' experienced in their preparation to lead the couples therapy groups.

Nick saw the training as very much a continuation of his earlier family therapist training, but he saw in gap in leading group therapy:

It [the training] *was helpful, I don't think what we're doing strayed very much from the things we were already used to doing, so it wasn't that big a stretch… The guest speakers were interesting because they provided us with different view points on things, but the one place that I would say would be deficient would be the one thing that we never really get, and you don't get in this program is training on doing group therapy, and of course that is what we were doing."*

For Pat, the training was problematical in that the formal training took place two years before she was a facilitator. She felt:

I think the training was too long ago, I think, two years ago, it's been awhile. So that wasn't helpful in the way that if I needed to go back and review a lot of it myself because I couldn't remember specifics, so the length between the training and when I did the group was not helpful…

Using the Manual

The therapists were fully aware a major goal of the research project was to develop an effective manualized treatment for domestic violence. The three themes that emerged from their experiences were general comments about using the manual itself, how the therapists used the manual, and what the therapists would consider before agreeing to use another manualized treatment program based on their experience with this one.

The therapists agreed that the manual had all the flexibility they needed to facilitate effective therapy. The manual was very usable and the theoretical framework was clear. Mary in her RQI commented:

> *The manual is very open so you can fit what you want to into it. I think we used the basic model that the manual provided, in terms of structuring the sessions…developing a vision, yet violence-free, and then there's a big chunk of middle where you can do what you want to and the end being termination…The other thing from the manual I think we knew once we read it was the theoretical framework, I think that's the other piece that brings in a balanced perspective when we talked about family and solution focused.*

Tom participated in the development of the manual and felt prepared for his therapist experience:

> *I think it was really helpful because they were looking at using a manualized approach, and so I think that the initial drafts were pretty thorough in terms of the theoretical model that was gonna be used, the techniques that were going to be used, and the actually steps in the process. So I think I went in to the experience having a real clear understanding of what was expected.*

Sandra in her RQI noted that she had some concerns about following the treatment manual in the early sessions affected one participant:

> *You know, you've got pre-session check-in, you've got post-session check-in, and I think you've got 45 minutes for the session. …so if we did not stay on target, if we allow one person to go off, where as if you were just individual couples not on a manual you might actual stop and say 'ok, story telling seems to be really important to you.' You might do a whole session or two sessions on that, and how do we interrupt that and how does that serve you and is there another way...We*

didn't get to deal with that and so consequently we left him. He didn't finish the group, as I recall. …we were not able to stick with his way of processing… if you didn't have a manual, you might have. You might have stopped and said 'Ok, does anybody else talk this way where it is important for you to tell the story'.

Mary, when asked about using this manual in an agency was concerned about the flip side of a flexible approach for new or inexperienced therapists:

…I think that's the one downside of this model is that its so flexible that people who get it might go, 'you're not telling me what to do' and get anxious about it. I know I did. I was like, 'what do I do with this. You just tell me the middle of therapy from 3 to 10 sessions, ok what am I supposed to do?' And as I grew as a therapist and I was thankful that it had that kind of flexibility and we could address what the group wanted to go to but I think if I was a new therapist getting this model at this age I'd go, 'what the heck am I supposed to do here? It's not telling me what to do.' And that would be a downfall.

The therapists reported they used the manual extensively, as did their supervisors. Each had a different style, but soon realized the manual offered resources to help them lead the group through the various issues that came up. Sandra used the manual to determine what themes they should address in the upcoming session:

I personally used the manual to see what was supposed to be dealt with in what session. 'What are we going to address now?' And for me, it was helpful to review that like the night before that session was coming so it would be set, I'd know where we were going, what the goal was…So for me it was more a living supportive document …it wasn't just a 'how-to.'

Each therapist was asked the question: If in the future your agency or you were asked to use another manualized protocol, how would your experience using this one affect your decision? The major themes that emerged were of theoretical fit and flexibility. Mary comments:

I would want to read it and make sure it was something I could buy into before I did it. I wouldn't go into it blindly. … let me see if I agree with what this is saying. I'd probably ask questions…'Is it the style of therapy I could do, is it the theoretical framework, if its another domestic violence, does it address safety?' What are the precautions that are built in? Do they do anger management? Are

they just leading people in blindly? I wouldn't, if this model said no anger management beforehand, then I wouldn't do it because it would be too much risk for me as a therapist.'

Sandra and Pat put flexibility first, Pat said: *I think that I would honestly need to know how flexible it was because I think to me at least that was a very important piece that, it wasn't like ok you turn to page so-and-so and you will do this for the first session, no deviations, no exceptions. I guess my experience with a manualized treatment is that it can be flexible and that most importantly it's the clients needs first, not the model first. I think that's where supervision comes in, I mean having somebody who knows the model, knows the clinical work, help you stick to the model, but be able to deviate when something else can be more helpful or something...*

Balancing the Therapist Role with Research Requirements

Therapists in a research project, no matter how well designed, appear to face an inevitable conflict over their dual roles of therapist and research administrator. Mary in her first qualitative interview had early concerns:

For me, it just last week brought up that dilemma of being a therapist and being a researcher, and where you draw the line, and accepting some of the things that happen as good data for the research. It might not be great therapy, and as long as it's not doing any harm. I mean, we don't, obviously, want to keep doing bad therapy, [laughs]. *It's not bad therapy, but not the best therapy. To accept, O.K., that was data, it's great data for the research, and coupling that with how am I going to be able to get the best therapy to these couples? And so that dilemma is really hard for me…Having to maintain that balance, but know my role. I am part of a research team, but my role is therapist here, and looking out for the best interest of the clients.*

She spoke of the effort she made in leading the first couples group, essentially a pilot group:

Now if you're talking about the research then there wasn't as much flexibility, I think, being in the first group we had to really fight for that flexibility from our

researchers. But with the model you have the flexibility to do… I think it's a hard conflict for a therapist. It's a very difficult conflict. Do you honor the research or do you honor the client?

When asked how she solved her dilemma, she said forcefully: *I honored the client. We basically told the researchers 'I'm sorry, this is the way it is going to happen', Nick and I both took a stand other times with our supervisors and we had great supervisors who realized we were on the front lines and maybe they needed to adjust it.*

And Nick added: *Supervision, that's something that's vital and because that's how you resolve those issues, you come back and tell your supervisor that you're having a problem so they can help you. That's something that has to be part of it.*

Theoretical Fit

In the research qualitative interviews, the therapists were asked several questions that related to theoretical fit. Additionally, they were asked this direct question: If you were affected by the fit between your theoretical orientation and the theoretical framework of a new proposed treatment manual, what would be the factors that would enter into your decision to participate or not? The therapists' responses all referred to strong bottom lines on what they could work with and what they could not. Nick spoke to the necessity of the therapist feeling comfortable with the model and its theoretical underpinnings:

I think its pretty important in this model, especially when you go into a group and you're supposed to be asking solution focus questions and the group, that's the conflict again, the group wanted to go and talk about all the bad things that happened. You really have to be able to sell your position, so it's not a time to feel really uncomfortable with what you're doing.

Sandra answered the question with a strong statement about the requirement for her for the model to have a strength-based approach:

It has to empower the client, I'm very much positive focus, strength-oriented theoretical base …you could say, Bowen doesn't really fit with that but it is empowering in the sense that if you understand the family patterns in relationships and interactions then you are empowered to bring about change. So

it is an empowering theoretical base. If you are supposed to be too critical, I would not be willing to compromise…That's just not who I am.

Tom, too, had a bottom line in what he required to work within a framework. He, like the others, was willing to be open to new possibilities and frameworks:

I'd want to have a clear understanding as to whether the manual was a framework or a bible in terms of what was to be done. I liked the fact that it was a framework. That it permitted us to use our own personal talents and skills…I liked the fact that you had guidelines, but it wasn't so rigid…I'd take a real hard look at goals, I'd take a real hard look at outcomes, and if they were not ...if they were just totally off...out of my own frame of reference... or if they just were… bizarre to the point of me not really being able to understand what the purpose was I certainly wouldn't want to do that. I'm willing as an individual and therapist to use different techniques and to explore different theoretical frameworks.

Applying the Model

The themes that emerged from the therapists describing their experiences of applying the model were:

Their struggles of working within the model;

several interesting model qualities;

the challenge of working through the imbalance that emerged in the early groups between the men who had been together in the anger management class and the women who had not;

and, safety issues.

Working Within the Model

In the early therapist interviews, the therapists were candid in their struggle to adapt the manual to the requirements of the group members. As they gained experience with the model, their focus shifted to decision-making in the room. The therapists generally described that they reached a point where they were not thinking about the model in room, they appeared to have comfortably adapted to the framework and the group process. In the first group, Nick and Mary made some critical additions to the manual that may have helped minimize conflicts with the model for the therapists working with later groups.

Mary in her first qualitative interview after two sessions: *That seems, it's tricky, as how much do you adhere to the model, how much do these women need a place to talk about these things? It brings up issues of should we have a women's support group running along with this. It's research. It's finding out what's the best therapy for couples experiencing domestic violence.*

Tom at the same point, in the same group, was experiencing similar sentiments, but expressing faith in the model counseled: *Just that I feel like we should--we've had so much stuff happen in the first couple of session--but should trust the model until we see that it's not working, because we haven't had a chance yet to really see.*

Mary, in her RQI, reflected back on her struggles with the model: *I think in terms of what it meant for me was I was a little more structured than I probably would have been in terms of making sure I was following what the model wanted, so it didn't always guide me but I would think 'Oh I've got to ask a foolish focus question' or 'we've got to fit this genogram in, how are we going to fit this in? So I would be thinking of the aspects of the model and how I was going to make sure I was doing the model, as well as doing my own things that weren't maybe in the model but I think as we're going to go on and talk about what should be in the model and shouldn't… Sometimes it was helpful and sometimes it hindered. But most of the time it didn't hinder because I would ignore the model if I felt like I needed to go in a certain direction, I would just abandon the model for that session and maybe get in some solution focus questions, which were helpful, but if it wasn't going to work today, I went with what the client needed.*

Nick's experience was a little different. He felt more comfortable with the model from the beginning: *When I was actually in the room doing the therapy, I don't think I thought too much about the model or the fact it was a research project. I never felt a lot of pressure around the research project. There were some nice things about it. You were getting a lot of feedback and supervision that you wouldn't normally get. There were other people working on it so you were getting feedback from people who were doing the exact same type of work and that's not*

something you would normally get. It's nice to know that your input is going into something, that hopefully, is going to make something, that's going to be helpful. Both Nick and Mary agreed that they were never deterred from doing something they felt therapeutically necessary. Mary, in her RQI: I think that if it came in conflict with the model we went with what the client wanted and I think that's the flexibility of the model too. I think that's one of the strengths of the model, that it says, this is not a cookbook. But I think, I was lucky to work with other therapists who felt the same that I did that you had to look into what the client needed at that time and forget okay today was going to be the genogram session, you know, just forget about that and just go with what the clients came in with.

Nick agreed with Mary and went on to say the model provided him even more options: *Yeah, I agree with that. I don't think we ever didn't ever do anything because of the model. Some of the visioning stuff; I think that's pretty heavily influenced by the model. So that's one of the things that we do do that if I'd never seen that model I might not have done it quite that way.*

Tom, in his RQI, noticed that even for a solution-focus therapist, he was thoughtful about keeping to the model: *I tend to be a solution-focused thinker anyway, in terms of that was sort of a model that I had ended up sort of hitting upon for myself. So then I found it to be a real natural fit between the model and my own personal theoretical background and framework. There were times, though… when we would talk about 'Gee I really would like to ask a question here that might be more strategic,' … so there were some, quote-un-quote restraints, but I didn't feel really confined by it. …we always knew that we wanted to stay within the model.*

Tom went on to say: *in some ways, it sort holds your feet to the fire a little bit, but in another sense it is really comforting if you weren't really comfortable or really skilled that it would provide you with a good framework to use.*

All of the therapists spoke of the necessity of multiple co-therapists when using this model. All also spoke of the enjoyment and support they felt working with other co-therapists in working with a couples group. Mary spoke of the balance between her and her co-therapists in two different groups:

…luckily I was paired with someone in the first session who was very solution-focused, so we did a nice balance, because I was more process oriented and he was more solution-focused and from that experience I was able to bring in a little bit more the next time, more solution-focused. The next time when I wasn't with someone that was solution-focused and [we were] *more alike… in our … theoretical framework, so it was a struggle to put it into solution-focus but we would both do that.*

As Mary and Nick worked with the first couples' group, they refined and added to the model guiding the therapists. Mary described how they:

…came up with something that was definitely necessary for couples who were going through this to deal with and that was accountability, listening, understanding the other persons perspective, making a plan to change and then implementing it and those were the four we talked about. Taking accountability for the violent, listening to the past hurts, making a plan to change and then implementing that plan. Getting over it.

<u>Model Qualities</u>

As the therapists described their experiences in the project, various unique qualities about the model emerged.

<u>Things that worked well</u>

The therapists described many times how they enjoyed working with the solution-focused model. Mary in her fourth and last qualitative interview at the end of the first couples group noted the strength of that approach:

I think focusing solutions, what works, in this group setting was very powerful because for people whose things weren't going well and they listened to someone [who told them that some things]... *are going well, on how do they do that…I think we, as therapists, did … a good job, that when they felt there was no hope or we had a couple 'oh things are bad' … we were able to pick out something that was working, 'how did you get that to do?' I think that gave* [them] *the confidence … to pose things 'oh, there is, even if it was only for an hour, that things were calm, how did that happen?' 'Yeah, we did it for an hour, how did we do that?'*

Mary went on to describe how genogram work supported the progress of the clients: *I think the intergenerational piece, bringing that out…I thought that was helpful to get some understanding of where this might have come from, the models that people grew up and identifying couples within their own family who do things well, to kind of point them in a direction 'hey, maybe you can talk to your aunt Tia,' I thought that went well.*

She again spoke of the strength of the flexibility of the model: *I think that flexibility that Sandra was talking about that this model is an evolution that they're hearing what works for these couples and taking that into account and changing the model as needed. I think that's great because we're not stuck with you have to do A, B, and C and when B is not working, well. I thought that was very respectful, not only of the therapists, but of the clients. That this is more than just a research project; we're working with real people here with real problems and they need the help as much as* [others] *down the line or in the field when maybe we have this great model, framework setup after three years of research.*

<u>Telling you where you are going, then molding it</u>

Mary described a term the therapists had coined about the power of the group: *The group had the power, and they're going to tell you where you're going to go, and you're kind of molding it from then, when there's just two in the room it's a lot easier to stay more structured than when there's ten people in the room because they're going to tell you what they want to go. You might be trying to go to a vision but they're stuck on this thing over here and two women or a couple of men keep bringing it up and you can't ignore it, you have to go* [there].

<u>Empowers women</u>

Nick, in his RQI, noticed how the group process was uniquely helpful to the women in groups: *when you get all the women together you have an empowering effect that you don't have in the individual therapy, which empowers them to react to some of the past violence in a different way… one of the things that happened was the groups wanted to go to the stuff that happened. …'I'm feeling a little safer, more empowered, I want to talk about the things you did to me.'*

The group paradox

Nick and Mary identified a paradox in group work in the RQI. Nick noticed: *There's kind of a paradox in the group. The group wants you to be in charge, at least the couple of groups I've done, they want you to be in charge and when you, if you, hand them the reins of leadership and say 'what do you want to do' they don't know. But when you are in charge, the group definitely, once it gets rolling, it's rolling in a direction that is sort of unique to the group, so it ebbs and it flows.*

Mary added: *I think that the therapists are the leaders of the group, you have to be respectful to what the group wants and you have to know when to take charge and know when to sit back and just let it go, and …just let it roll.*

Differences from individual therapy

Several times the therapists commented on the differences between group and individual therapy. In individual therapy, the therapists were of course very aware they could adapt their approach to the needs of one client. Sandra commented on one client who did not respond well to the model and the constraints she felt:

I'm thinking about another male member …We totally confronted him as much as we could, but maybe there was probably more we could do. We had some one who was seriously into control. …We probably could have done more with family of origin, but in the group setting, I think in the individual couples, they were able to go more into individual family history and how that impacted the marriage. In the group we talked about it in terms of a culture. You know you were raised in a certain culture and that culture impacts your marriage in what way …we significantly impacted some of the couples …So we were constrained not so much by the manual but by the group setting.

Struggling with an Imbalance

One of the themes that emerged from the earlier data to include Middleton's study was the imbalance that was created in the early part of the program by treating only the men in anger management. The women were at a disadvantage because the men had received training in anger

management techniques, knew a common set of language and skills, and had bonded around the experience. The program adapted in later groups to correct the imbalance.

Clearly a challenging issue for the therapists to deal with, I asked this question to each therapist: The information imbalance between the men and women about anger management in the early project was a recurring theme. How did the model help you or hinder you in working through that imbalance?

The answers shed further light on the therapists' challenge of working within a research project. Mary commented in detail on how the therapists worked through the dilemma with the support of their supervisors:

> *On the research end of it, we were supposed to keep going on, but on the therapists level, these women were crying out... 'We need some help, or we need some more information, we need accountability, we need this.' So the dilemma for the therapists doing the research projects was, do you go with the research or go do you go with the client? Now in the beginning our supervisors and the researchers were like, 'we've got to keep with this model' and the therapists kept coming back saying 'no we can't just go with this model. We have to address this.' So one of the things, especially the women, they didn't have information, they didn't know what was going on, they felt that the men were abusing time-out, things that they had learned in anger management... I had women come up to me and say, 'Well you told me this, and Nick told my husband this', and we said, 'No, we're teaching the same thing. So we'll get you back together.' ...there was one case where I think I said something different than Nick, but we were able to address it because we were working together, but they were getting the same exact information... It might have caused a few more conflicts when the woman said,' wait, that's not the way to use time-out,' but I think it helped them overall to be able to work together, learn to do a time-out plan, work together to say, 'hey, we're not communicating well here, we need some more communication skills.'*

Safety

Safety was a major responsibility for the therapists and it came up often in their comments. When asked about how the research components of the study contributed or degraded

the clients' safety two differing views emerged. Four therapists were certain that the research components added to the sense of safety, one was uncertain. Upon further reflection, two therapists gave the specific example of reducing the length of the anger management training in later couples groups:

> Mary: *I think that research made it paramount. That was the most important thing and we told the group 'this is the most important thing, that you feel safe when you walk out of here, when you're in your relationships at home,' so even if one couple had an incident and the other four, or three, or however many were in there did not, that couple superceded anything else that we were doing and we would focus on the safety. …we're constantly checking and editing the check-ins in the beginning and the end is there for safety. The therapist check-in is there for safety: 'Are we all on the same page?' I think sometimes maybe the clients would have been frustrated because we made that the most important thing and would go back to it as necessary, but we had incidents happen in group and we had to address them. To ignore them would have been just repeating that same pattern that they do at home, or that society does and we said that we're not doing that.*
>
> Tom too, saw the research project contributed to the sense of safety: *…that was the hard line that we took. That we were not going to monkey around with safety here. That is something that is going to be a priority for us. And I think that any of the safe guards that were built in just enhanced that message that safety was going to be of supreme importance.*
>
> Tom went on to say: *I mean, obviously, we're getting into … pretty difficult and touchy topics any of which could have led to volatility. But I think when you look at all the different safe guards that were put into place with the contract that people signed, the information that they knew was going to be shared, I think that just gave it all a new seriousness that lent itself to better security. I think that the sense that I had was that the people… felt that the issue of safety was being more than adequately addressed. Whether they personally felt safer or not anecdotally I'd say that I sensed that most of the clients did feel safer; but certainly that they knew that safety was a primary issue for us.*

Pat liked the strict structure of the model around safety. She found it reassuring that she was not missing anything:

> *I think it was safer because there was such an emphasis on safety, like you couldn't forget safety. You had safety check-ins before, you had safety check-ins afterward, and since it was brought into the model you couldn't forget it. …hopefully I wouldn't anyway, but as a therapist you get involved with stuff, especially when you've gone a little bit over* [time], *I can see me, I shouldn't admit that, but I can see me forgetting to say, separate and say, ' are you guys feeling safe going home?'* [My] *making the assumption that since the session went well, or that we don't need to do that. Like… if you have a client who is suicidal and has contracted with you and has been safe for a real long time…generally you don't* [check about it] *every session…I think it was helpful for me… to have that structure because … it was always front and foremost in my mind because you had to fill out the paperwork and do all the things that it would never be able to be forgotten. But yes, for me it was helpful to focus on that.*

Nick was not as sure. He described a feeling that the requirements of the project to get, keep and move clients through the program detracted from some of the safety of the clients:

> *I do think the fact that there is a research project may have compromised, not comprising safety, but there were times when some decisions were made I think that might not have held safety foremost. …its more like a feeling, but there was certainly a push to get enough clients through and there were some decisions made about how anger management was done before hand that I think may not have been the ideal situation…safety was always put forward, but I think it was more of, call it a structural pressure because of the research project,* [that is not] *reflected in the model itself… It's the fact that there's a pressure to get a certain number of people through, and in this case there was some concern about that because they weren't getting as many people as they had hoped.*

After experiencing groups with a 12-week anger management program prelude before beginning therapy and a 6-week program, Mary and Nick were firm on the requirement for the longer anger management program before beginning couples therapy. Mary said:

…the last two groups, they went from a twelve week anger management to a fifth week couple anger management, which does not necessarily delve in enough to the individual need for accountability and control. … Nick and I have both taught a twelve week and Nick beyond eighteen week [program], *and seeing the benefit of having longer anger management versus the six week that we did in order to get couples in for the group and that was a concern that Nick and I both voiced when they started talking about it. But that was part of the research, to get couples here.*

<u>Components of the Research Project</u>

When asked about how the components of the research project affected the therapeutic process, themes emerged from the therapists comments about the pretests/screening, check-in/check-out, videotaping, questionnaires, interviews, and their thoughts on which components of the research project should be fielded as a part of the manual.

<u>Pre-tests/Screening</u>

Mary thought the screening process helped the therapy in an indirect way:

we didn't feel the impact of it in therapy but I think what it did was get us couples that would match the group therapy process. …I think it's a behind-the-scenes thing that helped get a group together that was similar in maybe mild domestic violence versus a severe domestic violent couple…

Pat thought the screening process was helpful for the information that it provided to her as a therapist beginning to work with the couples:

That was helpful because coming into the group you have an idea what the couples' issues were, because when it comes to the domestic violence they're not always forthcoming, not knowing you, not knowing other group members. So it was helpful because …they would give us the questionnaires about violence and history of violence so that was helpful to know, cause sometimes you'd think, "oh, he's an abuser," and it gave you a really clear look at what exactly their domestic violence looked like and … they couldn't mask any of their violence that had happened as a couple…

Check-in/Check-out

All the therapists considered the check-in/out process as an important part of the therapy. It appeared especially valuable to the women clients. However, it was a challenging process for the therapists to manage, especially in the early stages of the group.

> Michele, in her first qualitative interview, about the check-ins: *Yeah, the check in... I think the fact that issues have come up that we don't quite know how to go forward with. How do we manage it and what is our role. I think that's O.K. because that moves it to us. But I think it speaks to the fact that the women, especially listening to what they say, that it was very important to find out that others were having similar experiences to theirs. I think that was real critical, a validating piece to them. And it was good that they no longer had to keep this quiet, hidden, and they had people that they could trust and share and learn from.*

> Tom commented on the process: *I think that was kind of good to get some feedback from each member of the couple that was really useful in working with them during the session. So both checking in and checking out was really almost like a reality check.*

> Pat, in her RQI commented on the dilemmas she found herself facing: *Helpful because people would share information they wouldn't share in the groups…Unhelpful in the same token, that sometimes these couples* [had information] *that needed to come out in group, but there was more to tell you. And that was a challenge, 'but I don't really want this brought out in group.' So it was helpful to have that information as a safety issue but sometimes it was a hindrance as far as we needed to work on this as a group issue with their partner and …we had some couples that weren't very comfortable sharing in the group format, personal business.*

> Nick, in his RQI shared his thoughts on the check-out: *I think the end-of-session check-in was really useful and necessary in that kind of work because it allows to do the assessment and time to process what happened in the session separately. The sheet itself* [safety questionnaire], *we would look at that, and then if someone had marked off things that concerned us in terms of their safety then we could go*

back in and address it. It was definitely helpful. I would say the fact of doing the session was more helpful than the actual sheet, but they were both positive things.

Videotaping

The therapists commented very little on the videotaping. However, Pat did have an observation and a suggestion:

It was interesting because you have to videotape it and you'd have couples ask if they would ever be able to see them, I think that's an interesting piece that could be used therapeutically to show change. I don't know that I would include it but I think that's an interesting piece that could possibly be used not only for us but a teaching perspective for the model but almost as a teaching tool for them to see. … we really did have some people say 'I would have loved to have seen what I showed'. I guess I have to kind of edit it and show some pieces that were interesting.

Questionnaires

Questionnaires were administered to both the therapists and the clients at the end of each session. The therapists were asked for their evaluation of the session and for information about the interventions they used. Clients were asked to rate their safety and for their evaluation of the session. Their evaluation of the research was kept confidential from the therapists to promote candid responses.

The therapists, when asked about the impact of the questionnaires on both their work and their clients, initially responded about the redundancy of the questions. Tom in his second qualitative interview reacted:

Oh, yeah! I don't like the evaluation form, the therapist feedback form. It's like redundant in places, and worded ambiguously. It's a frustrating form to fill out at the end of an evening, even after a good session.

Nick had a suggestion about better using the client evaluations of the session: *One thing that you might be able to do, because the clients filled out the evaluations, we didn't see them but our supervisors did, and so the supervision could reflect things that were going on in the evaluations, which could be incorporated if someone was using this model that would be helpful.*

On the client safety questionnaires, Sandra noticed that only once did a client identify herself at risk and for Sandra that validated the process: in one of the post tests, someone was identified as one at risk. Just once. So that significantly impacted the therapeutic intervention that took place at the end of the evening. So that was extremely valuable, very, very helpful.

Pat appreciated the ability to distinguish between the various forms of abuse on the client safety questionnaire in addition to physical abuse: The client questionnaires, I think it was good because it gave us a real tangible judge at how safe they felt, of course you always asked. They generally say yes, we feel safe but then sometimes you look at the questionnaire and they say like… three [on the scale], emotional abuse. Yes, they felt safe, I guess from a physical sense, but that gave me a better way to judge of whether they had concerns, so that was helpful in that sense.

Pat also commented on Nick's suggestion above being implemented in a later group: [our supervisor] *would give us feedback about the questionnaires, she would review how they thought the sessions were going and give us feedback like we know if the group wants more of this or less of this and that was very helpful so that I as a facilitator of the group could tailor the groups to their needs.*

<u>Interviews</u>

Therapists were asked about their comments on the qualitative interviews conducted for both the therapists and the clients. Nick reported on the impact on his personal thinking:

I've done interviews from the individual and I thought that the impact that they had for me was that it makes you stop and really think about what you're doing, which is a good thing, by really examining. It's kind of like a different form of supervision, that you go in there and they ask you questions and it makes you think about what exactly you're doing in the group and you see things you could change.

In the same interview, Nick commented on his impressions of the clients' responses to the interviews: *We did get feedback from group members about interviews they were doing. We didn't encourage them to talk about the interviews*

because they weren't supposed to, but I did get the impression that they liked doing them. They liked having that feedback and knowing their input was counting for something.

Sandra commented on her perceptions of the impact of the interview process on client's: *I think the interview process helped individuals go even deeper on a personal level with the information and gain even more insight and they would share that. I don't think they would share that in the group; but I can recall at least two instances, so it was probably more than that—where in the women's group it was shared, 'you know in the interview I was talking about...'*

Components of the Research for the Field

The therapists were asked to consider the possibility of their using this program or any therapist using this program in an ordinary clinical setting. Then they were asked what, if any, parts of the research project would be required in the field for an effective clinical program? The response from all was that a screening process and a pre and post-session check-in were needed. Sandra thought the client written questionnaires were important.

What was interesting was that even after an extensive discussion of the components of the research project, even the therapists blended the model components with the research project components. Mary's comments are an illustration:

I think a pre-screening, you have to do, and I know agencies have the clients pay for the pre-screening, so that's a way you can tell their commitment and things like that. You know, can you have three therapists, you know if they're all private practice, its probably not gonna work but if you have four community agencies, I think it would work. If there were only two therapists in the private practice, but they're probably going to have to take a pay cut... I think we have to keep the anger management requirement beforehand. I think the structure of the sessions is good... Therapists check in between, the whole idea of the model, I think, you would have to keep.

Mary also offered that the pre and post testing for effectiveness could be important to an agency: *if you have the pre and the post then you can see the effectiveness of that treatment…why do this model if its not working, if its not*

providing better treatment and better outcomes? So I think by the community agencies, especially if they're going to be getting funding for that program, you're going to have to sell this to your supervisors or whomever at the county agency …and they're going to want to see some data from you. It also helps the clients to really think about 'oh, how have I changed'…

Sandra offers these words of advice: *thinking about implementing that model in the field, the pre-session, and the post session, and the written and addressing—being able to provide that on the spot individual therapy…should a client feel out of control—being able to help the other client implement the safety plan—ensuring that the safety plan had been implemented. I think in that context, it would be critical. None of those components would I lose.*

Clients' Experience Through the Therapists' Eyes

When asked about what were the views or concerns their clients held about being in a research project, few examples came to the therapists' minds. There were some concerns about the confidentiality of the data being collected and the videotaping.

Sandra note that there were some people who may have dropped out of the project due to confidentiality concerns: *Yeah, there were some people who dropped out because of 'how long were you going to keep the records, who would subpoena the records, who could possibly have them.' So there was concern about it impacting their job. But that wasn't anyone in the group.*

Tom observed no major reactions from his clients to the project: *I don't think they had any. I think…the main thing…that people always are concerned about is confidentiality. But once they were sort of assured that that was, based on the information they had, that their information would be kept confidential. I didn't hear any other concerns expressed. They wanted it to be helpful. The clients that I talked to that were being interviewed really felt that they were giving/providing useful information and they wanted it to be helpful.*

Pat's observations were along the same lines, but her clients did express some concerns, especially early on: *Some of them wouldn't like the taping and they expressed sometimes what would exactly be done …they said, they were*

> *concerned that maybe we were lying to them* [or] *that we would forget and maybe use it in more ways than we said we wouldn't'… I also had clients that were concerned about how people would view them on tape like would they think they were mean or stupid…But yeah, the taping was generally, I would say, the biggest concern.*

Summary

In this chapter, I have presented the themes that emerged from two major groups of participants in the research project, the clients and the therapists. Despite a generally low level of conscious awareness of the research project, these clients and their therapists revealed a rich set of data that helps us understand the impact of their participating in a research project.

From the clients, the themes revealed views on how little the research project seemed to affect their therapy, to how the research project reinforced their learning and changes and allowed them to feel they were making a contribution to others while wrestling with important and often frightening issues. The clients provided data on the end of session questionnaires, the check-in/check-out process, the impact of the cameras, pre and post-tests, and the interview process.

The therapists too, were highly focused on the therapeutic process. They felt privileged to have the opportunity to participate and to be challenged professionally. They were challenged in learning how to balance their roles with the research project's requirements. Theoretical fit was not an issue, but their comments inform the body of research on research participation. The therapists reported the model worked well, but they had to struggle with components, especially in the beginning. The therapists also had important comments and suggestions on the components of the research.

CHAPTER V: SUMMARY AND DISCUSSION

This study was designed to describe the impact on 26 clients and 5 therapists of participating in a research project testing a manualized multi-couple treatment program for domestic violence. The clients and therapists were participating in one of four multi-couple treatment groups.

Phenomenological theory guided me in designing the study and in evaluating the responses of the clients and therapists. The interview comments, focus group results and written answers were analyzed using constant comparative analysis (Strauss and Corbin, 1990).

It is difficult to separate out the differences between the research structure and the therapy. I was challenged to find ways to extract the information needed to answer the research questions. I had expected the volumes of data collected by the larger parent project, both qualitative and quantitative, to be rich in data that could be used to answer these questions. The questions were much more subtle than I anticipated.

Three research questions guided this study. This section will begin by presenting data informing the research questions. The first question asked how the client's perception of the effectiveness and constraints of treatment was affected by his/her participation in a research project. This question includes how their perceptions changed over the course of the treatment.

Clients In a Research Project

The data from this study supports McCollum et al.(1996) findings that clients conceptualize their therapy experience and participating in a research project as participating in "therapy within a research project." Clients were very much aware that their therapy was being delivered to them in a research project, but from their perspective there was little impact. Bart spoke for most of the participants: "I don't even think of it. I don't even see it as a research project."

As I approached this project, it seemed that the research components of the project were very different from the therapy model. But, the data clearly supports McCollum and his colleagues' findings that research and treatment were not separated in the minds of some participants. There were few references in the data to anything that could be construed as a perception of separateness. The questionnaires and cameras were referred to by several clients as being manifestations of the research project, but they seemed to have little effect on their

therapy experience. Any feelings of being treated differently in the research project from "normal" therapy appeared to dissipate by the mid-way point as the therapy sessions continued.

McCollum and his colleagues also reported that some of the participants reported using end of session assessments to gauge their therapeutic progress. For a few participants in this study, the end of session questionnaires were helpful in prompting reflection and gauging their progress. But, most participants mainly complained about the repetitiousness of the questionnaires.

Other components of the research project prompted deeper reflection and changes in client thinking about their situation. Gale (1993) and McCollum & Beer (1995) noted that some clients report that interviews about their experience have had a therapeutic impact in and of themselves. Wark (1994) reported that the clients found a part of the research process, the research interviews, helpful to their therapeutic experience. Results from this project supported their findings. Several clients experienced major changes in their thinking as they filled out pre tests. For example one man said: "The questions were eye openers for me. They helped me think through my problems…" Another woman found herself making a major decision about her and her husband's future together: "I drew the line. This was it. I knew I was not going to live like this when I saw it laid out." For some participants, the interviews were a useful review: "I thought it was hard, but it was a good review. You know, because it made you think about what went on that night…" But, on the whole, the interview process did not seem to make a major difference to the clients.

Like the clients in McCollum, et al. (1996), many of the participants were quite aware that the structure of the research project made the treatment they were receiving different than it probably would have been if it occurred in a non-research setting. Baby sitting, payments for completing testing and the free therapy sessions had a positive influence on their participation in the therapy. A woman participant remarked: "What changed for me was that we could come to therapy because it was funded…"

The clients in the study conducted by McCollum and his colleagues found participating in "Part of Something Important" (p.614). as an energizing component of their therapy. Clients in this project also spoke of helping others. "…I think that hopefully what we were able to give information to the counselors will help other couples also in the future." Therapists too, were honored and professionally challenged to be selected to participate in the research project.

Some of the clients in McCollum and his colleagues' study thought that the project may have affected their therapists' behaviors. For all but a small minority of clients in this project, most were certain that their therapists' behaviors were not influenced by the project. A woman in the focus group spoke for several other participants: "The therapists that I dealt with I felt like it was taken very seriously so I didn't feel like a placebo."

The results of this study were consistent with Middleton's (1998) findings that participants most often criticized the treatment length as insufficient. Given that Middleton's participants and the early participants of this study were in many cases the same participants, this is not surprising. What is notable is that this criticism became less of an issue for later multi couple groups after the alumni group was initiated one respondent indicated that: "In fact that is why we're going to join alumni group also…A twelve-week session doesn't correct or erase, it's just the tip of the iceberg. There's still the other three quarters under the water, so…"

Anderson's (2000) subjects noted that the pre and post check-ins of the research project enhanced their sense of safety. Her participants were drawn from the females, several of whom also participated in this study. Other female and male participants in this study noted that the check-ins were a helpful part of the project. One participant indicated that: "Everyone was made sure to be ok. That was a unique and special part of the program. There were actually three groups, a men's group, a women's group, and couples. So, it is almost like there are three groups."

Therapists and Treatment Manuals

The second research question asked therapists consider ways that following a manualized treatment protocol constrained/enhanced their ability to meet the needs of their clients. The data supports Wilson's (1996) findings that manual-based treatment demands therapist skill in its implementation. And that well written treatment manuals are likely to encourage a pragmatic approach to therapy and should not discourage clinical innovations. The data also supports Anderson, Reiss, & Hogarty (1986) and Miklowitz & Goldstein (1997) reports that researchers get around the problem of therapists feeling limited by manuals by providing enough flexibility to allow the clinician to apply creativity while adhering to the model.

The therapists were unanimous in their views that they had the flexibility they needed to deliver appropriate therapy consistent with their client's needs and within the guidelines of the

model. One therapist said: “The manual is very open so you can fit what you want to into it. I think we used the basic model that the manual provided, in terms of structuring the sessions…” This was in direct contrast to the concerns they had expressed at the beginning of the project (Stith, Rosen and McCollum, 1999).

Research Project and the Clinical Effectiveness

The third research question was to determine if there elements of the research project that are inseparable or get in the way of producing an effective fielded clinical program. Both therapists and clients were asked about what elements of the research project needed to be fielded for a treatment that works under “normal therapy” field conditions (Pinsof & Wynne, 1995).

The therapists felt that the pre-tests provided them with two important components of information. First, the participants had been screened for meeting the criteria of participants in this research design. Second, they were provided with important background information relating to each couple’s history and issues before beginning treatment. One therapist noted: “That was helpful because coming into the group you have an idea what the couples’ issues were, because when it comes to the domestic violence they're not always forthcoming…”

The therapists were also certain the check-in/out sessions were critical requirements to this work. The check-ins were very useful for the women to create a feeling of a safe environment and for the therapists to plan their couples’ session with current client-provided data. A therapist commented: “I think that was kind of good to get some feedback from each member of the couple that was really useful in working with them during the session.”

The clients too, thought the check-ins were important. Although some of the men did not find them as useful for themselves, the women did find them important. A woman participant commented: “…Sometimes I think women and men can relate in different ways to each other. In our group, there were women helping each other out…it looked like the therapists started formulating how they were going to take the group…”

The check-outs with their questionnaires were very important as well. The structure of the post-session check-out was helpful in insuring they were not missing a major safety issue. One therapist said: “I think the end-of-session check-in was really useful and necessary in that

kind of work because it allows us to do the assessment and time to process what happened in the session separately."

The clients recognized that their safety was a priority of the process and the end of session check-out was part of the overall safety structure. One woman client said: "…we are dealing with something very, very serious…I felt like it was taken very seriously…"

The therapists were insistent that a batterer's treatment before the couples treatment began was essential. Two of the most experienced therapists argued for a minimum of twelve weeks of treatment. One therapist asserted: "…they went from a twelve week anger management to a fifth week couple anger management, which does not necessarily delve in enough to the individual need for accountability and control…"

The therapist data also agreed with Pinsof's (1995) assertion of a requirement for hard evidence about the effectiveness of marital and family therapy. Pre and post test data would provide important data about the effectiveness of the therapy. A therapist commented: " So I think…community agencies, especially if they're going to be getting funding for that program, you're going to have to sell this to your supervisors…and they're going to want to see some data from you."

Limitations

This research was limited by the experiences of a small number of participants in the multi-couple groups. Approximately 50% of the participants were interviewed, the others were not available. Only those participants who completed therapy were interviewed. Those who were not available or who had dropped out may have very different perspectives of the project.

Additionally, the period of time between completion of the 12 weeks of multi couples therapy and their interviews varied from one week to two years. A more uniform time period for the qualitative interviews may have produced different results.

The treatment manual was written for clinicians trained by a specific Marriage and Family Therapist training program. The results may differ if different clinicians applied this manual.

Another limitation was the effect of the pre-existing relationships of the therapists with the researchers. All of the therapists had strong bonds with the researchers from their family therapy training. The therapists were predisposed to trust the researchers and accept the

manualized treatment program with perhaps fewer reservations. This trust between the therapists and the researchers may have had significant influence on the ready acceptance of the manualized treatment program by the therapists.

Clinical Implications

Clinicians either using a manualized treatment program in a research project or in the field must be comfortable with the theoretical fit. It is also important to recognize that the data collection components of the research may have a beneficial effect on the manualized therapy and may need to be included.

In a well designed research project, both clients and therapists may not be aware they are being affected by the research. The clients and therapists are not very aware of the impact the research components are having on their therapeutic experience, but there does seem to be an effect. The better the effect is understood, the more successfully the program can be fielded.

The manual was originally designed for therapists working with individual couples and adapted to the multi-couple work. The manual should be revised to reflect the differing requirements of group work. In addition, specific training is required for the therapists leading groups.

If a research program or clinical program uses questionnaires as an instrument to monitor effectiveness and solicit feedback there are some suggestions from the participants of this study that should applied. The first requirement is that the participants must feel the instrument is being used to provide feedback and impacting their therapy or project experience. The clients spoke of the positive effect of having their input honored. Second, the instrument must not be seen as repetitious, but germane to the therapy and/ or project.

A major benefit for both clients and therapists appears to be the feeling of being involved in something that may make a difference. The participants consider their participation as an opportunity to give something back to an institution that they have derived some personal benefit from. This is a dynamic that should be included in both research and clinical programs.

Another element that appears to be influencing the positive outcomes in this project is the effect of clients and therapists being in the same situation together. Both groups referred indirectly to feeling of doing something important together. This may have positively influenced

the clients' views of their therapists and helped them be more accepting of the therapists suggestions.

Just as the clients enjoyed discussing their experiences in the project with interviewers, the therapists in the early part of the research project thought getting together with their peers, supervisors, and researchers an important benefit of participating in the research project. This should be an ongoing component of a research project.

Creating the perception that their experience may help others and the feeling that clients and therapists are in the same situation together may prove to be powerful therapeutic factors. These elements appear to be easily incorporated into conventional therapy and may generate the same beneficial effect observed in this project. Regular therapy may be improved by incorporating the elements of client questionnaires following the session, stressing to therapists and clients alike that their suggestions about therapy may be incorporated into future client work, and regular feedback between data collectors/supervisors and the therapists about what is working.

Future Research

I am curious about the possibility that the impact of participating in a research project is greater than the participants realize. To them, the research project appeared to be woven into the fabric of the therapeutic experience. Yet, to me, their experience was fundamentally different from what they would have experienced in a normal clinical setting.

It is also possible that the positive effects of participating in a research project could be easily incorporated into conventional therapy. Research into this possibility may lead to an easy way to increase clinical effectiveness.

Future research into producing more effective manuals may be assisted by better understanding the factors causing clients to minimize the impact of participating in a research project. It may be the difficulty I experienced in extracting the data I was seeking helps to explain the paradox between the results produced by research developed programs and fielded programs. The paradox is therapy in experiments often appears to have shown larger effect sizes than therapy in clinics (Weisz et al., 1995). I believe that this is an important issue to explore as researchers continue to try to answer the questions asked by the editors of JMFT (Pinsof &

Wynne, 1995), about how to make research developed treatments work under ‘normal therapy’ field conditions.

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APPENDIX

Appendix A: Questions for the Clients

1. When you first heard about the project, how significant for your decision to participate that the study was it that this was a research project?
2. How significant to your decision to participate was it that this research project was federally funded?
3. What did it mean to you that you were participating in a research project?
4. What was the influence of being in a research project on your commitment to stay with the program until completion?
5. Several interviews, pre and posttests, cameras, and questions at the end of each therapy session, all were part of the research. Are there ways that the data collection and interviews affected your belief about how the treatment was going?
6. Looking back at when the period of time when you were considering your possible participation in the research project, what was the effect of the screening process and the battery of pretests on your thinking?
7. After therapy was completed, you were asked to complete a battery of tests. What was the effect of completing those tests?
8. The pre-session gender group check in was a major component of the research project. What was the impact of the check in process on your therapy? How did the impact change over the course of treatment?
9. How would the treatment have been different for you without the research pieces of several interviews, pre and posttests, cameras, and questions at the end of each therapy? Would you have had any concerns?
10. What would be your thoughts about putting this model out into the world without the research pieces? Would it improve the process? Take away from it? Improve next group? What concerns would you have?
11. How did the research affect your perceptions of safety for you and other participants?
12. How did the therapist not seeing your responses to the post-session questionnaires affect your answers?

13. If you had reservations about the influence of the research project on your therapy, what did the therapist do to facilitate the changes in your attitudes towards the research project?

Appendix B. Questions for the Therapists

Instructions	Mins.	Questions and Probes
	5	What training did you receive relating to your participation as a therapist in this project? PROBES: How was the training helpful or deficient for you?
	5	How did you use the manual for therapists? PROBES: How often did you refer to it? Did your supervisor refer to the manual in supervision? Did your supervisor use the manual when working with you?
	10	Think back to when you were first beginning with your role as a couples group therapist. How did the following parts of the research project hinder/help you in your efforts as a therapist? Screening/pre-testing Check-in session Check-out session and questionnaires (client and therapist) Interviews (therapist and client) Post tests PROBES: What did your clients say about what they were doing? Did it seem helpful to them or not?
	5	What did it mean to you that you were participating in a research project?
	10	In what ways were you able or not able to listen to the clients about what they wanted within the constraints of the model?

		PROBES: Did you ever do something or not do something because of the manualized treatment model?
	5	Safety was clearly a major responsibility for you in this research project. How did the research pieces of this study contribute to/degrade your knowledge of your clients' safety? PROBES: As a result of the research pieces, was the treatment safer or not affected? More dangerous?
	5	What were the client's concerns about data collection? PROBES: What was the impact of those concerns on their experience over time? Changes over time?
	10	Consider for a moment, the possibility of your using this program or any therapist using this program in an ordinary clinical setting. What, if any, parts of the research project would be required in the field for an effective clinical program? PROBES:
	5	Information about the imbalance in information between the men and women about anger management in the early project was a recurring theme. How did the model help you or

		hinder you in working through the imbalance? PROBES:
	10	This may have been the first time you have been asked to use a manualized protocol. If in the future your agency or you were asked to use another manualized protocol, how would your experience using this one affect your decision? PROBES: Did your reservations in the beginning change?
	10	If you were affected by the fit between your theoretical orientation and the theoretical framework of a new proposed treatment manual, what would be the factors that would enter into your decision to participate or not?

Appendix C: Client Questionnaires

Session Evaluation - Client

1. How helpful was this session? (Circle the number below that best describes the degree to which this session was helpful to you "1" meaning not helpful at all; "6" meaning extremely helpful; 2-5 ranging in between those extremes)

NOT HELPFUL AT ALL 1 2 3 4 5 6 EXTREMELY HELPFUL

2. What happened during the session that was not very helpful?

____

____

3. What happened that was helpful?

____

____

4. Circle all the things below that the <u>counselors</u> could have done differently to improve the usefulness of this session for you:

Talk less   Talk more   Be more supportive of me   Be less supportive of me

Be more supportive of my partner   Be less supportive of my partner

Be more assertive   Be less assertive   Nothing   Something but I don't know what

Other ____

5. Circle all the things that <u>you</u> could have done differently to make this session more useful for you:

Talk less   Talk more   Listen more attentively   Be less defensive

Get more involved   Trust more   Keep my sense of humor   Think more

Be more honest about things   Other ____________________________________

6. Circle <u>all</u> the words that best describe how you felt during today's session:

Anxious   Depressed   Involved   Bored   Angry   Content   Safe

Tense   Understood   Pleased   Detached   Worthless   Comfortable

Important   Scared   Other _______________________________________

7. Circle your gender:

MALE   FEMALE

Thank You!

Post Session Safety Questionnaire

Date: ________ Client # _______ Session # _____ Client gender: Male Female

Please circle the most appropriate response to each of the questions below.

1) How certain are you that YOUR PARTNER will not be physically violent toward you between now and the next time we meet?

1	2	3	4
Very certain	Fairly certain	Somewhat uncertain	Very uncertain

2) How certain are you that YOUR PARTNER will not be psychologically abusive toward you between now and the next time we meet?

1	2	3	4
Very certain	Fairly certain	Somewhat uncertain	Very uncertain

3) How certain are you that YOU will not be physically violent toward your partner between now and the next time we meet?

1	2	3	4
Very certain	Fairly certain	Somewhat uncertain	Very uncertain

4) How certain are you that YOU will not be psychologically abusive toward your partner between now and the next time we meet?

1	2	3	4
Very certain	Fairly certain	Somewhat uncertain	Very uncertain

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Summary of qualifications

Masters in Marriage and Family Therapy. Supervised clinical experience since 1997. Extensive training in strength-based brief family systems therapy. 3 years experience facilitating psychoeducational programs for families, couples, singles, business, and military. Over 25 years of hands-on experience in performance oriented leadership and management positions. Strong analytical skills and proven ability to implement effective and cost-efficient solutions. Excellent verbal and written communications skills. Competent in use of a broad spectrum of computer applications.

Education

Master of Science, Marriage and Family Therapy, Virginia Tech

Master of Arts in Asian Studies, Cornell University, Ithaca, New York

Bachelor of Arts in History, Loyola University of Chicago

Senior International Strategic Studies, Carlyle, Pennsylvania

Midlevel Management and Strategic Planning, Leavenworth, Kansas

Professional experience

Psychoeducational presenter

1998 – Present GreatPairs Burke, Virginia

Psychoeducational programs for public, churches, non-profits, and military

1998 – Present Northern Virginia Family Services

Divorce Education presenter and trainer of Transparenting

1999-2001 PAIRS, International

Board member and Corporate Treasurer

Family Therapist

1998 – 2000 Prince William Community Services Board

Therapist

1997 – 2000 Center for Family Services, Virginia Tech

Therapist Intern

1998 – 1999 Family Life Center, Fort Belvoir

Therapist Intern

Cross-cultural Specialist

1983 – 1998 US Army

Asian affairs advisor, US State Department

Asian affairs senior analyst

3 years working and living in Southeast Asia and Korea

Executive with Progressive, People-oriented Skills

1973-1998 US Army

Manager and staff officer to senior managers overseeing administrative functions including training, morale, problem solving and quality of life issues. Consistently recognized as an outstanding manager of people and coordinator of services. Advised employees on relationships, careers, and substance abuse issues.