PREDICTORS OF DROPOUTS OF DOMESTIC VIOLENCE FOCUSED COUPLES

TREATMENT

by

Barry J. Alvarez

Master's Thesis submitted to the Faculty of the

Virginia Polytechnic Institute and State University

in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

in

Human Development

APPROVED:

Sandra Stith, Chairperson

Karen Rosen

Eric McCollum

June 12, 2003

Falls Church, Virginia

Key Words: domestic violence couples treatment programs, dropouts, stages of change

PREDICTORS OF DROPOUTS OF DOMESTIC VIOLENCE FOCUSED COUPLES
TREATMENT

by

Barry J. Alvarez

Sandra Stith, Chairperson

Department of Human Development

(ABSTRACT)

The purpose of this exploratory study was to examine differences between dropouts and completers in a domestic violence focused couples treatment (DVFCT) program. Fifty-eight men met the criteria of participating in at least one couples session for domestic violence. Data was analyzed with t-test and chi-squares. The dropout rate was 36 percent. Three variables – age, race, and marital status – were significant predictors of dropping out from the program. White men who were over 30 and married were found significantly more likely to complete treatment than were nonwhite single men younger than 30. Other variables that approached significance were employment, parental status, living arrangement and prior treatment. That is, employed men who lived with their partners, had children with their partners, and had prior treatment tended to stay in treatment. Stages of Change using the URICA and the URICA-DV measures and level of violence at intake using the Revised Conflict Tactics Scale were not found to differentiate between dropouts and completers in this sample. Other variables examined but not found as significant discriminators between completers and dropouts of DVFCT were education and referral source. A literature review of dropouts in therapy, marriage and family therapy, batterer programs and DVFCT; as well as literature on stages of change, is included. Further discussion and recommendations for further research and for improving domestic violence focused couples treatment is included.

ACKNOWLEDGMENT

TABLE OF CONTENT

CHAPTER 1
Introduction

The Problem and Setting

Domestic violence is a pervasive social problem in the United States today. The Bureau of Justice reports that although intimate violence has declined from 1993 to 1998, in 1998 an estimated 876,340 violent offenses against women were reportedly committed by their partner. In fact, twenty-two percent of all violent crimes against women were committed by their partner. In 1998, three out of four female murders were attributed to their partners (Bureau of Justice, May 2000). The First Comprehensive National Health Survey of American Women in 1993 found that close to 4 million women reported physical abuse from their spouse or partners (Women's Health, 1993).

The number of domestic violence treatment programs is apparently on the rise. On June 2, 2003, when the words "domestic violence treatment" were typed into the Google search engine of the World Wide Web, approximately 2,500 website references appeared. Most of the sites provide information about programs where perpetrators or victims of domestic violence can go to receive support. The overall goal of most of these programs seems to be stopping the violence. The "best" method to stop the violence for all men under all conditions has yet to be found (Stith, Locke, Rosen,& McCollum, 2001). Many questions still remain unanswered. Should the program be carried out in an individual or group setting? Do court mandated programs work better than self-referred programs? Does strict psychoeducation produce better results than a more therapeutic approach? Does graduation from a program mean that the individual will not become violent again?

Other important questions to consider are if and how the victims should be included in therapy (Brown, O'Leary, & Felbau, 1997; Gregory & Erez, 2002; Stith, Locke, Rosen, & McCollum, 2001). Many victims of domestic violence stay in the relationship with the partner that abused them (Lipchik, Sirles, & Kubicki, 1997). Most domestic violence programs work directly with the batterer with the overall goal of stopping the violence. However, the victim is usually not invited to participate and is often without information concerning the program and often receives little to no support.

Many believe that couple's treatment for domestic violence is unsafe for the victim. Even domestic violence programs that treat couples agree that couple's therapy is not appropriate for severely violent couples (Heyman, & Neidig, 1997; Stith,et al., 2001). However, for mild to moderate violence, studies have shown that working with couples can be as effective and safe as working with individual perpetrators (Brannen, & Rubin, 1996; O'Leary, Heyman, Neidig, 1999). The goal of these programs is not only to stop the violence but also to enhance the relationship (Heyman & Neidig, 1997; O'Leary, Heyman, Neidig, 1999; Stith et al., 2001).

One pressing issue for both individual and couple's domestic violence programs is reducing the dropout rate. O'Leary and colleagues stated that the dropout rate "represents a serious problem in domestic violence intervention programs" (O'Leary, Heyman, & Neidig, 1999). Gondolf, in his extensive review of domestic violence treatment attrition reported that an average attrition rate for batterers programs is approximately 50 percent (Gondolf, Feb. 1997). On the subject of attrition, Gondolf concludes, "In sum, two research questions need to be addressed with regard to the high dropout rates in batterer programs: Who drops out and why?" (p.90)

Studies of attrition in men's domestic violence programs have identified a variety of factors as predictors of drop out. Demographic factors such as race, sex, age, employment levels, and marital status have been seen as major contributors to attrition in domestic violence programs (Bennett & Williams, 2003; Coulter, et al 2002; Daly, Power, & Gondolf, 2001; DeMaris, 1989; Gerlock, 2001; Rondeau, et al, 2001). Other possible contributory factors of dropouts identified in the literature have been: referral source (Gondolf, 1997; Laing, 2002; Rosenbaum Gearan, & Ondovic, 2001), relationship variables such as stress and lower levels of mutuality (empathy, communication, understanding, and mutual respect) (Gerlock, 2001), alcohol use (Bennett & Williams, 2003; Daly, Power, Gondolf, 2001), and length of the program (Gondolf, 2001).

One men's domestic violence program found that some of their client's reported dropping out due to the lack of individual couple's issues being addressed (Brown, O'Leary, & Felbau, 1997). Domestic Violence Focused Couple Treatment (DVFCT), where both partners participate together, has not been around for as long as men's domestic violence programs, and research on dropouts of these programs is limited. Dr.

Sandi Stith and colleagues, who have worked on developing a DVFCT program for several years, indicated that little is known about what actually works for dropouts (Stith, Rosen, & McCollum, 2002). Only four articles (reporting on two different treatment approaches), have been located that studied dropouts in DVFCT programs (Brown, O'Leary & Feldbau, 1997; Harris, Savage, Jones, & Brooke, 1988 O'Leary, Heyman & Neidig, 1999; Heyman & Neidig, 1997). From the little research available, the attrition rate seems to be similar to the men's domestic violence programs, around 50 percent (Heyman & Neidig, 1997; O'Leary, Heyman & Neidig, 1999). From these studies, the reasons participants drop out are somewhat different from those reported in men's domestic violence programs. Brown and colleagues reported that, although demographics did not predict dropouts, a higher level of psychological aggression by the abuser, along with the inability to focus treatment on couple's issues, did (Brown, O'Leary & Feldbau, 1997). Investigating this study from a different view, Heyman and colleagues studied sixty couples. The sessions were videotaped and Heyman and colleagues found a relationship between communication variables, husband's hostility/non-hostility to wife's disclosure, and whether a couple completed or dropped out of treatment (Heyman, Brown, Feldbau, & O'Leary, 1999). Heyman and Neidig report that "the best predictors of drop-out are wives' higher use of humor and husbands' lack of empathy." The wives used humor to "placate the husband or defuse the conflict" (Heyman & Neidig, 1997). To date, none of the studies of dropouts in domestic violence therapy, whether men's group or DVFCT, have focused on Stages of Change (Prochaska & DiClemente, 1984) as a possible predictor.

The purpose of this exploratory study is to identify factors that discriminate between male clients who dropped out and those who completed DVFCT. Specific factors that were examined included: stages of change, demographic factors (race, age, employment, education, marital status, parenting status, and living arrangements), referral source (court referred versus other referrals), having been in prior treatment and the man's level of physical and psychological violence at intake.

<u>Rationale</u>

Statistics demonstrate that domestic violence is an important issue in the United States. The best treatment program for domestic violence has yet to be found. A perfect

program would assure that, after completing treatment, violence does not continue in any of the relationships of participants. A more rational and realizable goal for treatment programs would be to lower or stop the violence in a large percent of the couples who participate in treatment. Studies do show that perpetrators of domestic violence who complete domestic violence programs do better in society (employment) than those who drop out (Taft, 2001). Also, there is a relationship between staying in treatment and lower re-assault/re-arrest rates (Bennett & Williams, 2003; Gondolf, 1997). The rate of recidivism of domestic violence is higher among dropouts of these programs than it is for those that complete treatment (Gondolf, 1997; Gondolf, 2001; Hamberger & Hastings, 1989). Knowledge and understanding of the factors causing drop out are essential in programs to reduce drop out rates and therefore to stop the violence.

As stated previously, DVFCT is relativity new. Research has demonstrated that this treatment can be as effective as the individual men's treatment for selected clientele. DVFCT has the ability to focus not only on the perpetrator, but also assist the victim and may increase the effectiveness of stopping violence. Only two studies have focused on the subject of attrition in DVFCT. More are needed to understand the difference between the men who come to DVFCT and drop out and those that complete the program. With this information, the type of participant that is most likely to complete a program can be targeted for recruitment into these programs, and, this information can also be used to offer suggestions for lowering the dropout rate.

The VA Tech's DVFCT has been in existence since 1997. The program's focus is to be an "integrated solution-oriented program for treating couples who choose to remain together after experiencing mild to moderate relationship violence" (Stith, McCollum, Rosen, & Locke, 2001). The goal of this program is to end the violence in the relationship. The program provides individual couples domestic violence counseling as well as domestic violence focused multi-couple's groups. This study focuses on men who, together with their partner, participated in at least one of the individual couple's or multi-couple's group counseling session. Preliminary analysis of the program found the drop out rate in the VA Tech program to be approximately 29 percent of the couples that attended one session of the program (Stith, Locke, Rosen, & McCollum, 2001). Before

this study, no other study existed that identified factors that discriminate between male clients who drop out and those who complete this program.

Although there is some information available on predictors of attrition in domestic violence programs, the study of predictors of attrition in DVFCT is limited. The purpose of this exploratory study is to identify factors that discriminate between male clients who drop out and those who complete DVFCT. It is an exploratory study because of the lack of previous data to suggest a model.

<div align="center">Theoretical Framework</div>

The primary theoretical framework used to guide this study will be the Transtheoretical Model of Change or Stages of Change model (Prochaska & DiClemente, 1984). This model is based on the assumption that people come into a situation, such as therapy, at different levels of readiness to change. Begun and colleagues wrote that the model "offer[s] a promising perspective for understanding, preventing, and intervening with the problem of intimate partner violence" (Begun, Shelley, Strodthoff, & Short, 2001, p.106). The model suggests that there are six stages of change: Precontemplation, Contemplation, Preparation, Action, Maintenance, and Termination.

Individuals in the precontemplation stage are not ready to change at this time, nor do they have any plan to change in the future. They tend to minimize or deny their problems and usually blame others for their situation. In a domestic violence scenario, these clients could come to therapy because of a first time court order or a threat of divorce or separation from their partner. Therapy is not a high priority in their lives, and they tend to participate minimally.

Individuals in the contemplation stage perceive that there is a problem and intend to take action, but at this time they do not have a plan. These people are coming to a realization of their situation; however, they are still overwhelmed or struggle with identifying possible solutions. These clients come to therapy thinking that it might help to talk to someone; however they still doubt. These clients tend to be ambivalent, maybe a little negative, but willing to participate.

Individuals in the preparation stage are cognizant of their problems and intend to take action soon. These clients come to therapy with the desire to learn ways to solve

their issues and problems. These clients are the ones who seem to work hardest during therapy.

Individuals in the action stage have formulated plans and have recently been trying to solve their own issues/problems. These clients come to therapy hoping to add to the actions they have already taken.

Individuals in the maintenance stage have been working on their issue for a while. These clients come to therapy after a relapse.

Individuals in the termination stage are confident that the problem is no longer a threat or no longer present. These people often do not need therapy.

It is anticipated that when therapists are able to determine early in treatment where domestic violent clients are in the stage of change, they will be more able to tailor therapy to meet the clients needs. For example, clients in the precontemplation stage, in denial that their relationships have any real problems with violence will probably have a hard time understanding why they need a safety plan, timeout or many of the potential interventions in most domestic violence programs. These clients need help understanding the basics of domestic violence before they are able to recognize they have a problem.

Using the Stages of Change for domestic violence programs is a fairly recent concept. Two groups have recently published measurements for assessing a domestic violence perpetrator's Stage of Change (Begun, Murphy, Bolt, Weinstein, Strodthoff, Short, & Shelley, 2003; Levesque, Gelles & Velicer, 2000). Others have written articles about the importance of assessing domestic violence through the stages of change (Begun, Shelley, Strodthoff, & Short, 2001; Fraiser, Slatt, Kowlowitz & Glowa, 2000).

Stages of Change have been examined in a variety of mental health formats, for example: general psychotherapy (Brogan, Prochaska & Prochaska,1999; McConnaughy, DiClemente, Prochaska & Velicer, 1989); family therapy (Prochaska, 2000), nursing and mental health (Derisley & Reynolds, 2002; Haggerty & Goodman, 2002) and substance abuse (Belding, Iguchi, Iguchi, & Lamb, 1996; Easton, Swan & Sinha, 2000). Derisley and Reynolds (2002) state that the model "has been presented to psychotherapists as a simple way of understanding client reluctance to engage in therapeutic change and therapeutic failure" (p. 217).

The Transtheoretical Model of Change is used to facilitate a better understanding of the differences between those that complete DVFCT and those that drop out. Using the URICA-DV instrument that was given to each participant at intake, this study analyzed the scores to determine if there was a difference between the stage of change of those that completed treatment and those that dropped out.

Purpose for the Study

The purpose of this study was to identify factors that differentiate between male clients who drop out and those who complete DVFCT. A specific factor being examined is the Stages of Change of the participants based on the Transtheoretical Model of Change. The data provides an analysis of how the completers and the dropouts differ from stage to stage. In addition to using the Stages of Change variable based on the Transtheorectical Model, the study compares dropouts and completers' various demographic variables that have been used in many of the previous studies pertaining to drop out predictors. These factors include demographics (race, age, employment, education, marital status, parenting status, and living arrangements), referral source (court referred versus other referrals), prior treatment, and levels of physical and psychological violence.

This study assists in the understanding of difference between dropouts and completers in couple's domestic violence programs, as well as generates potential arenas for more research. It also tries to improve understanding of the male clients' readiness to change and how readiness relates to DVFCT completing.

Research Questions

1. How do those who drop out of Virginia Tech's Domestic Violence Focused Couples Treatment (DVFCT) differ from those who complete it, with regard to the stages of change?

2. How do those who drop out of DVFCT differ from those who complete in the following areas:
   - Demographics – (Age, Race, Employment, Education, Marital Status, Parenting Status, and Living Arrangement)
   - Referral Sources – (Court Referred or Other)
   - Prior Treatment – (Yes/No)

- Level of Physical Violence
- Level of Psychological Violence

Chapter II

Literature Review

The focus of the following literature review is research on domestic violence, dropouts in therapy and domestic violence programs, and the Transtheoritical Model, or Stages of Change. The domestic violence section is divided into an overview of domestic violence, research on male batterer programs, and research on domestic violence focused couple's treatment (DVFCT). The section of dropout literature includes research on dropouts in general therapy, marriage and family therapy, domestic violence treatments (men's batterer programs), and DVFCT. The literature reviewed focuses on the relationship between dropouts and completers for those variables researched in this study, namely: demographics (age, race, employment, education, marital status, parental status, and living arrangements), referral source, prior treatment and level of physical and psychological violence. In the stages of change section, an overview of the stages of change in therapy is followed by a review of literature studying stages of change in domestic violence, and predicting dropouts through stages of change. This section will conclude with a review of VA Tech's DFVCT.

Domestic Violence

The First Comprehensive National Health Survey of American Women in 1993 stated the in the United States a woman is beaten every 9 seconds by her husband, boyfriend or live-in partner (Women's Health, 1993). In 1992, 3.9 million American women were physically abused. An APA online article "Resolution on Male Violence Against Women" (2003) states that 20 percent of all adult women will experience physical assault by their partner. It also states that the assault level remains high even though there has been increased awareness and legislation over the last two decades; that victims of domestic violence also suffer from mental health problems such as depression, anxiety, and self-esteem issues. Safety measures are needed to assure that this trend does not continue. Couples need to be more educated and relationships need to be strengthened to curb this problem and lower these statistics.

Domestic Violence Treatment Programs

A variety of suggestions have been offered for treating male batterers. For example, Bryant (1994) suggested that an effective format for working with violent men

is in groups. Within groups, a man can feel he is a "human being whose abusive behavior must be confronted and stopped" (p.238). Bryant stated, "Many of the men involved in batterer programs tend not to be open or motivated to change their attitudes and behaviors" (p. 241). Bryant suggested that the therapist's job is to facilitate the men to deal with their violence on a situational, emotional, and cognitive level and that groups are the best forum in which to bring this about. Speaking on the need of also treating the victims, Bryant also states: "Existing programs would be more effective if agencies recognized the need to treat both the batterer and the abused woman. There also needs to be greater public awareness and understanding of the psychology in order for him [the batterer] to be treated, not persecuted" (p. 242). On the other hand, Stith and colleagues write, "while group treatment programs for male offenders are effective in eliminating physical violence for some men, there is no single approach that has been demonstrated to be the treatment of choice for all men under all circumstances" (Stith, Locke, Rosen, & McCollum, 2001).

The overall goal of most domestic violence programs is to stop physical violence in a relationship. Gondolf, in his 1997 article "Batterer Programs: What We Know and Need to Know" (1997a) provided an overview of the research on domestic violence programs. He reported that completers of domestic violence programs are less likely to reassault. He expressed concern that a gap exists in our knowledge about those that have completed and those that have dropped out of therapy. He proposed a more elaborate tracking plan for participants in these programs. He also proposed that in order to really demonstrate that these programs work, a "social impact assessment" needs to be implemented in the community to study whether or not the domestic violence program is having an impact on the community. In order to really assure that these programs are functioning, Gondolf indicated that more research is needed, especially in the understanding of those that batter. Programs need a better understanding of those that drop out of the programs, how the programs are helping or hurting the home and community, and how the victim is helped or hurt by the partner's participation in the programs.

What Stith, Gondolf, Bryant and many others are finding out is that it is virtually impossible to provide a program that will suit all types of batterers. What will work for

one type of batterer may not work for another. For instance, someone who frequently abuses and beats up his partner needs different interventions than someone who only pushes once in a while. A program that is serving court-ordered clients probably needs a different focus than a program treating a group of men who voluntarily entered treatment.

Domestic Violence Focused Couples Treatment (DVFCT)

In an article in the Journal of Marital and Family Therapy, Bograd and Mederos (1999) provided needed information to the marriage and family therapy (MFT) field as it pertains to working with domestic violent couples. With the primary issue being woman's safety, the article educates readers on not only assessing for domestic violence and the feasibility of couple's work with a domestic violent couple, but also on how to work with a couple when domestic violence is an issue. In their conclusion, the authors remind therapists that an assessment for domestic violence should be part of every intake interview. They state the need for every MFT "to develop a proficiency in this clinical specialty and to clarify one's ethical and clinical positions about the significant risks of couples work"(p. 309).

Gregory & Erez (2002) studied the importance of adding the woman's view into domestic violence therapy. They interviewed 33 domestic violence victims and found that many want teaching and training about violence. These women can provide a much truer picture of the violence in the home than the batterer, with his tendency to minimize the violence. Gregory and Erez recommend giving the women a "voice" and helping alleviate the fear, apprehension, victim blaming, and guilt women experience. The authors reported concern for the safety of those partners that give information to batterer programs. They are concerned that the information provided will expose them to "increased hostility and further abuse" (p. 229). They concluded that, "Ultimately, listening to and duly incorporating victim voices into social praxis will substantially increase our ability to reduce intimate violence and the related victimization of women and their families" (p. 230).

Not all couples go directly to domestic violence programs. So, O'Leary, Heyman and Neidig (1999) stress that most marital therapists are already seeing violent couples in their regular practice and need to understand how to treat couples who are violent in their relationship. Harris, Savage and Jones, (1988) state, "often, the occurrence of violence is

not identified as a presenting problem by either member of the couple. Most of the women are afraid of their partner" (p. 148). Harris' and colleagues responded by developing and evaluating a group program for abusive men and their partners. One of the reasons conjoint couple's treatment is beneficial is that a large percentage of couples who are violent remain in their relationships (Brannen & Rubin, 1996). Stith (2003), in The American Association for Marriage and Family Therapists (AAMFT) 2003 Consumer Update on domestic violence, wrote that physical violence occurs in approximately 20 percent of marriages and that emotional abuse is even more common. There is a need for therapists to understand that some of the couples that they see have domestic violence issues and may need a more focused treatment plan.

Gondolf (1997a), and also in his book Batterer Intervention Systems (Gondolf, 2001), questioned the use of couple's therapy for violent couples. Gondolf's concern is for the victim. Many of his studies concentrate on reassault and steps that need to be taken to lower the reassault rate. Most of the individuals in his studies are court-ordered and more violent individuals. This type of client would not fit the criteria of mild to moderate violence and would not fit into DVFCT. DVFCT programs would not be suitable for all couples, especially those with severe violence in their relationship, but they can work effectively for many couples with moderate to mild physical violence.

So, if couples are staying together and there is a need for the victim's voice in the treatment and the victim needs and wants to participate and learn and domestic violence is an issue, can DVFCT groups actually help stop the violence and help the couple? Brown, O'Leary and Feldbau (1997) stated, "there is strong suggestive evidence that treatment programs for intact couples seeking conjoint treatment can be effective in significantly reducing the level of aggression" (p. 366).

Looking at the same data set that Brown, O'Leary and Feldbau (1997) analyzed, O'Leary, Heyman and Neidig (1999) studied 75 couples that participated in either a gender specific or a couple's treatment group for domestic violence. The study's participants fit into the category of mild to moderate violence in the home. As stated in the Brown, O'Leary and Feldbau (1997) article, the researchers found no significant difference between the treatments in their effectiveness in reducing marital violence and improving marital satisfaction. The most frequently reported problems of those

participating in this study were commitment (43%), communication (42%), and sexuality (25%).   Regarding the safety of the women in the session, they found that the women were not fearful during the sessions; they did not feel blamed for the violence, nor did they feel put at risk, and the husbands were able to take responsibility for the abuse.

Heyman and Neidig (1997) also agree that marital therapists unknowingly treat violent couples. As they wrote about the study discussed above, their purpose was to evaluate a couple's treatment program that had the primary aim of violence abatement. Again they stressed safety and their findings that conjoint sessions are no riskier then the gender specific sessions. They also believed it was helpful for women to have the opportunity to recognize that the batterer is responsible for his actions. They found that the couple's group and the gender specific group both led to reduction in physical aggression, reduction in psychological aggression, and maladaptive beliefs, such as that a partner cannot change and that all disagreements are destructive. Both groups increased positive feelings and in taking responsibility. They also found that after participating in the 14-week gender specific treatment most of the participants wanted treatment for their couple's issues.

Brannen and Rubin (1996) studied 49 couples who were randomly assigned to participate in either a couples group or a gender-specific group dealing with domestic violence. The program consisted of 12-weekly sessions, lasting 1 1/2 hours. The study found that neither treatment group was more effective than the other. They also found that women were in no more danger in the couple's group than those receiving treatment in the gender specific. "However, for subjects with a history of alcohol abuse the couples group intervention appeared to be more effective than the gender-specific intervention in reducing the level of violence within the marital relationship" (p. 419).

Stith, Locke, Rosen, & McCollum (2001) state that although couple's treatment is controversial, there is not one domestic violence treatment program that fits all individuals.   The DVFCT at Virginia Tech is for "couples with low-level violence, who are not substance abusers, who choose to remain together, and who want to end the violence." The rationale for working with both partners is that women initiate physical assaults on their partners as often as men do, and marital discord is a leading predictor of physical aggression. The main goal of this program is the cessation all forms of violence;

the goal is not to preserve the relationship. Other goals are to increase the individual control and responsibility of each partner, to help participants understand that they are personally responsible for their actions and behaviors, and that their behavior affects the behavior of others. This program works on the premise, stated in another article by Stith (2003), that if both partners are violent, cessation in one partner is highly dependent on whether the other partner also stops. "Failure to address marital problems at some point in the treatment of men and/or women would make it likely that physical abuse would recur" (p.5).

The literature on DVFCT is limited. This literature review found few articles that discussed studies of couple's treatment for domestic violence. Perhaps DVFCT programs are few in number because of the safety issue for the victim, although safety has not been an issue for those programs reviewed. Those studies that look at both gender-specific and couple's treatment for domestic violence found that couple's treatment is just as effective in lowering the violence. More research is definitely needed on the subject.

<div align="center">Dropouts</div>

One of the major issues in therapy, whether in a general practice, in a marriage and family therapy arena, or with domestic violent clients, is the drop out rate. Therapists may perceive that when a client drops out of therapy prematurely, the client has not received the full treatment needed to help him/her deal with the issues that brought them in (Baekeland and Lundwall, 1975). As Bischoff and Sprenkle (1993) stated, "Our belief is that a greater understanding of the dropout phenomenon may lead to greater efficiency in [marriage and family] therapy treatment" (p. 366). This section analyzes the literature on the subject of dropouts in general therapy, marriage and family therapy, domestic violence programs, and DVFCT programs.

General Therapy

Dropping out of general psychotherapy has been an issue for many years. In 1965, Brandt conducted a literature review of 25 dropout studies and found no clear-cut way of identifying prospective dropouts. The purpose of his study was to serve as a basis for such future validation studies. Baekeland and Lundwall (1975) give a critical review of dropouts not only in psychotherapy, but also in medical treatment, alcohol treatment, and drug treatment. The authors stated that anyone who studies dropouts needs to answer

four questions, 1) Who is the dropout? 2) Why does the dropout leave treatment? 3) What are the implications of dropping out? And, 4) What can be done about dropping out? They discussed fifteen factors that predict dropping out in at least 60 percent of the relevant studies. Among those variables that were attributed to dropout were younger age, the female sex, lower socioeconomic status, higher level of depression, less needy, and poorly motivated.

Garfield (1994) also conducted an extensive literature review of research variables in psychotherapy. The study includes the research review of variables that seem to predict dropouts, such as lower socioeconomic status, lower education, younger age, and non-white race. Garfield states, "Where there are more rigorous standards for acceptance into treatment, the dropout rate tends to be less and the sample biased in favor of better educated clients" (p.196). He also warns that when research is involved, a clinical practice might make greater effort to retain the clients, thereby making the results biased and difficult to compare to common therapy practices. The study finds a relationship between social class and other variables, such as understanding of the therapeutic relationship, expectations of therapy, and lack of desire for therapy. The study also finds psychological tests unsuccessful in differentiating dropouts from completers; however, non-compliance with the request to complete questionnaires was found to be significantly related to dropouts. Garfield suggests that other related variables for distinguishing between dropouts and completers could be client/therapist relationship and therapist's view of client or vice-a-versa.

Another research study of therapy dropouts, by Berghofer, Schmidl, Rudas, Steiner, and Schmitz (2002), found that one-third of the 323 newly referred patients for psychiatric care dropped out prematurely. In this study, patients were considered dropouts if they participated in at least one therapy session but did not complete the four-month program. Among the variables found to have an association with dropping out of therapy were unemployment and previous psychiatric admissions. Patients living alone were found to be more likely to stay in treatment. The variables found not to be associated with premature termination included age, type of referral, marital status, and education (p.280).

A study by Edlund, Wang, Berglund, and Katz (2002) used secondary data from the National Comorbility Survey in the United States (830 participants) and the Ontario Health Survey (731 participants) to assess for potential dropout correlation/differences. The study was used "to examine patterns and predictors associated with dropping out of treatment" (p. 845). Drop out rates for this study were 19 percent in the United States and 17 percent in Ontario. The results demonstrated no difference between the United States and Ontario in the cumulative probability of treatment dropout. Dropouts were significantly higher among lower income and younger age participants. In the United States, those lacking insurance coverage were also shown to drop out prematurely. Participants who received medication as well as talk therapy from their mental health providers were less likely to drop out. The study also interviewed individuals who prematurely withdrew from services. Throughout the interview, the study suggests that dropouts felt the treatment was ineffective, or they were embarrassed about seeing a mental health provider.

Similar to the current study, Samstag, Batchelder, Muran, Safran, and Winston (1998) studied therapy dropouts and completers. They found no significant differences in demographic variables of age, race, marital status, gender, and education level. The study focused on the therapeutic alliance and found significant differences in how the therapists viewed their relationship with those clients who eventually dropped out versus those that completed, as well as how the clients viewed their relationship with the therapist. These variables of therapist attitude (Shapiro, 1974; Baekeland & Lundwall, 1975) and client's expectation (Baekeland & Lundwall, 1975; Horenstein & Houston, 1976) have previously been found as predictors for premature termination.

Wierzbicki and Pekarik (1993) provided a meta-analysis of 125 studies on psychotherapy dropout. The final study coded 32 variables including age, race, education, marital status, prior treatment, referral sources, and socioeconomic status. The mean dropout rate for all of the studies was 46.86 percent. Race other than white, low levels of education, and low socioeconomic status were show to significantly increase the risk of dropping out of therapy. In their section of future research, the authors write, "Studies that have investigated more complex variables, such as clients' intentions and

expectations and client-therapist interactions, have found them to be far more powerfully related to dropout than simple client and therapist variables" (p. 194).

In the area of group therapy and the subject of the differences between dropouts and completers, MacNair and Corazzini (1994) studied 155 university students in an open-ended therapy group. In this study, predictors of dropouts in a group therapy format included alcohol/drug problems, numerous somatic complaints at intake, and introversion. The study did not find significant differences between dropouts and completers in age, gender, or race. Previous individual counseling was show to have predicted program continuance. In conclusion the study stresses the importance of cohesive groups and possible ways of working with those clients that fall into the category of possible dropout.

Dropout in therapy, whether individual or group has been an issue for many years. Many of the variables examined in this study such as age, race, employment, education, marital status, prior treatment, and commitment, have been found as predictors of attrition in general psychotherapy.

Marriage and Family Therapy (MFT)

The MFT field is relatively young in comparison to general psychotherapy. Research on dropouts in the MFT field is lacking compared to research on dropouts in general therapy. It is important in studying dropouts to ensure that their researcher's definition of drop out matches the clients. For example, in a qualitative study of a couple who dropped out of therapy after three sessions, Helmeke, Bischof, and Sori (2002) found that although the therapist may have perceived failure, the couple found therapy to be the thing they needed so they could finally separate and move on with their lives. Although one of the partners came into therapy with strong intentions of leaving the relationship, therapy helped both of them make an amicable decision together. Therefore the clients were satisfied with treatment.

On the subject of dropouts in MFT, Bischoff and Sprenkle (1993) reviewed the "small body of research literature" (p.355) on the subject, prior to 1993. The researchers found four categories of variables affecting the drop out rate. The first category is called the "client variables", and the study reported that "lower socioeconomic status is the demographic variable most consistently found to be associated with premature

termination" (p.356). Race was another possible variable in this category but not significant when socioeconomic status and the race of the therapist were controlled. Some of the other client variables Bischoff and Sprenkle have found in association with dropping out of marriage and family therapy were having two children, only one spouse initiating treatment, initial treatment without the father, and relational therapy where the presenting complaint is towards one individual. Self-referral or referral by individual professionals (as opposed to being "referred by institutions such as schools or probation departments" (p. 357)) and having prior treatment were found to be associated with continuing therapy. Bischoff and Sprenkle's second category of variables affecting drop out is the "therapist variable". This study found that a mismatch in sex or race could predict drop out. Less experienced therapists or therapists with low "drive", warmth, and ability to join, were more likely to have clients terminate prematurely. The age of the therapist was not found to be significantly related to dropout. The third category is the "therapy process" itself. "The degree to which the therapist and client agree about the nature of the presenting problems will influence treatment attrition" (p. 362). The fourth category is the "interventions", or what the therapist did before the first session and between sessions to keep the family engaged in the therapeutic process.

In a more recent study, Masi, Miller and Olson (2003) compared dropout rates of individual, couples, and family therapy. The study consists of 463 participants. The data came from the archive records of a university-based marriage and family therapy clinic in the Midwest. The hypothesis was that couples and family therapy would have higher dropout rates due to more complex barriers of therapy, more difficulty in the therapeutic alliance with multiple clients, and misconception on part of the family and couples based on their therapeutic expectations. However, the findings of this study revealed no significant differences between the three types of therapy. The "no show" rate ranged from 14.7 and 16.7 percent. The dropout rate ranged from 17.1 to 25.4 percent. The study also reported that therapists felt that therapeutic goals were not completed in 31 percent of the individual cases, 30.1 percent of the couples' cases, and 39.8 percent of the family cases. Again, the differences were not significant.

In an article studying dropouts in family therapy, Le Fave (1980) examined a sample of 65 dropout families versus 65 completer families. A significant variable found

to predict dropouts was age of the identified patient. Families where an adolescent was the identified patient were more likely to drop out of therapy than families with younger or older children. Another variable found to predict dropouts was the number of children in the family. In this study, families with two children were more likely to drop out of therapy than families with more than or less than two children. Another significant variable was the attendance of the father. Families where the father did not attend the initial interview were more likely to drop out of therapy. Those families who had previous involvement with community agencies were also more likely to stay in therapy. Those variables that were not found significant were sex of the identified patient and the family structure. This study also found that the more dropout characteristics a family had, the more likely they were to dropout.

Davis and Dhillon (1989) studied 45 couples in couple's therapy. Twenty-one of the couples dropped out prematurely. The goal of this study was to find a quick way of assessing dropouts versus completers with initial first-session intake information. Two variables were found to predict dropping out of therapy: common-law relationship and low non-mortgage debt by the couple. The variables that did not significantly predict attrition were number of children, socioeconomic status, and previous therapy.

The subject of dropouts in marriage and family therapy has not been researched as thoroughly as dropouts in general psychotherapy. The findings in this area are similar to those in general psychotherapy. Couples and family dropouts tend to be lower socioeconomic status, less educated, not married, and younger. They also tend to have issues such as low levels of motivation and commitment.

DV Treatment

Literature concerning dropouts in domestic violence treatment programs is voluminous. Perhaps this is because of the importance and urgency of the work involved. If those that drop out are twice as likely to reassault, it is essential to understand dropouts and find ways to help them stay and finish therapy.

An article written by Bennett and Williams for the Applied Research Forum of the National Electronic Network on Violence Against Women (2003, online) questioned confidence in research on treatment outcome of batterer intervention programs (BIP). "We can have only limited confidence in these designs using program dropouts [as the

comparison group] because the characteristics of men who drop out of BIPs often differ from the characteristics of men who complete the program. In fact, dropout characteristics are similar to characteristics of those men most likely to re-offend: unemployed, young, substance abuser, and not in a stable relationship" (p. 4). Bennett and Williams' study found that BIPs have a small but significant effect; however, those that drop out are twice as likely to be re-arrested. The authors answer is stronger community coordination and batterers accountability.

Gondolf (1997, 1998, 2000, 2001) has reiterated in numerous research studies that dropouts are more likely to reassault their partner and are more likely to be rearrested than those participants that complete domestic violence programs. In his April 1997 study, Gondolf (1997) found that African American men were 13 percent more likely to drop out of the program than Caucasions. He also found non-significant difference between dropout and completers for those who were living together versus living apart. In his November 1997 study on reassault, Gondolf (Feb, 1997) stated that program dropouts are 13 percent more likely to reassault their partners. In his book, <u>Batterer Intervention Systems</u> (2001), he stated that the rate of reassault among completers was around 36 percent; however, the rate was 55 percent among dropouts. This rate was slightly skewed because many of the earlier dropouts did so because they no longer were with their partners and therefore did not reassault. Taking this information into account, Gondolf determined the rate for reassault for dropouts who remained together to be 67 percent.

In an apparent precurser to his studies on reassault, Gondolf (1995) tested a 10-item set of discharge criteria. This discharge criteria is a rating Likert scale that a counselor could use to make "clinical judgement about the patient's performance in the program and whether the patient should leave the program" (p. 3). The discharge criteria form rates the patients on attendance in the program, nonviolence in the relationship and with others, sobriety in the sessions, acceptance of violence, use of techniques taught in the sessions, help-seeking, respect of others in the group, engagement during the sessions, self-disclosure concerning their own struggles and feelings, and ability to show respect to their partner and women in general. The study found that, although no significant difference was evident between the pre-test scores of completers and dropouts, the final

rating was significant, with a 78 percent correct classification rating (n=164). The findings showed "preliminary evidence supports the utility of clinical judgments based on performance criteria" (p. 7).

In another study, Gondolf and Foster (1991) looked for predictors of pre-program attrition. Of the demographic variables studied, only marital status was significant. Those participants who were married to the victim were more likely to appear at the intake interview than those who were not married. The other demographics of age, income, and referral source were not found significantly associated with non-attendance. Limitation in this sample was its size, 27 participants. In the implications section, Goldolf and Foster mention that not attending the interview "may substantiate that the batterer is unwilling to change" (p. 347) suggesting a precomtemplation stage of change.

Daly, Power and Goldolf (2001) studied 220 men to see if demographics, violence-related, and psychological variables would predict the number of sessions the men attended. The demographic variables examined were age, race or ethnic origin, education, employment, and living situation. Marital status and occupation were eliminated because of their similarity to living situation and employment. The study considered referral source a violence-related variable, along with the level of violence score from the Conflict Tactics Scale (CTS). The psychological variables examined were alcohol use/abuse and the Millon Clinical Multiaxial Inventory-III. The study also asked the participant's spouses to predict the men's attendance. The bivariate hypothesis that fewer sessions would be attended by those who were younger, less educated, and more violent was not supported. The study did find that "men who report lower education, unemployment, and clinical levels of alcohol problems attend significantly fewer sessions" (p. 985). Court order was found to be a reliable predictor of attendance.

Gerlock (2001) studied 62 male batterers and 31 victims in a Washington State domestic violence rehabilitation program. The program was at the Department of Veterans' Affairs medical center. The focus of the study was on differentiating between dropouts and completers. The demographic variables that significantly predicted dropout were age and employment. However, unlike other studies where the older participants were more likely to complete treatment, completer's mean age in this study was 33.87 and the noncompleters was 42.16. Court monitored clients were also more likely to

complete the program. Those clients who had a higher level of relationship mutuality and fewer PTSD symptoms were also more likely to complete treatment. Part of this study's program curriculum was designed to build relationship equality and partnership. At the beginning of treatment, those that dropped out rated their level of mutuality in their relationship as lower than those who completed. The authors suggest that those who dropped out may have felt uncomfortable with the program's instruction on the subject of mutuality in couple's relationships. A limitation in this program was the fact that all of the participants were military personnel, either active duty or veterans.

An older study, quoted often by those who research dropouts in domestic violence, was presented by DeMaris (1989). DeMaris studied 227 court-ordered domestic violent men. The variables of this study included demographics of age, race, education, employment, and number of children; as well as social background variables such as prior violence, arrests, violence in the family of origin, drug and alcohol use, relationship to the victim, length of relationship involvement, and victim's age. DeMaris included a motivational variable, "How important is it to you to stop being violent with your partner?" This variable is similar to the Stages of Change questions with possible answers being "very", "fairly", "a little", and "not at all". DeMaris concluded that any answer other then "very" was an indicator of low motivation. The study found that participants who were younger, had lower incomes, and were unemployed were more likely to drop out. Alcohol use was also a predictor of dropout as well as a response anything other than "very" on the motivational question. DeMaris concluded that sociodemographic factors were not significantly useful when attempting to identify those who were high risk of dropping out of the program. He also questioned the participant's motivation to change based on the fact that all were court-ordered, and many felt that if they did not complete they could go to jail.

In another study of predictors of attrition in men's court mandated treatment programs, Buttell and Carney (2002) looked at demographic and psychological variables, and attempted to create a predictive model to identify those men who stand the greatest risk of dropping out of the program. This study was a secondary analysis of 137 men, 77 completers and 60 dropouts. Completers were identified as participants who completed the 16-week treatment program. The study found that completers were older and were

more often referred after arrest. No significant differences were found for education level, length of current relationship, income, employment, relationship status (married or not), race and other demographic factors. In their psychological profiles, completers were found to be less passive/aggressive, and they had a lower propensity for abusiveness at pretreatment assessments. The study failed to provide empirical support for their hypothesis, that is completers and dropouts could not be distinguished through demographics or psychological profiles. In the conclusion of this study, the authors state how important it is that batterer treatment programs keep these men in treatment long enough for them to learn to change their behavior.

In a similar study of men in a court-mandated treatment program, Buttell and Pike (2002) found no demographic or psychological variables to differentiate treatment completers and those which drop out. This study had 66 completers and 25 dropouts. As the previous study, this study also advocates for community or judicial support of domestic violence programs that will help keep violent men in treatment long enough for them to learn to change their behavior.

Cadsky, Hanson, Crawford and Lalonde (1996) stressed the importance of understanding why men fail to complete treatment. They felt that there are two common factors that explain dropout, according to their review of past drop out literature. The first factor is related to lifestyle instability, and the second factor is related to treatment incongruence, meaning the lack of similarity between the client's expectation and the program's interventions. The data analyzed came from a program with 526 men who were recommended to treatment. Of those recommended, only 218 attended at least one session and only 132 completed the program, leaving 86 that dropped out. Results supported the original hypothesis. The study found that those with lifestyle instability (those who were non-married, moved frequently, were less educated, of lower income, and with less consistent employment) tended to drop out. Congruence between the client's self-identification of their problem with spouse abuse and the treatment intervention provided by the program was also found as a predictor of completion. Completers had strong self-identification of problems with spouse abuse and admitted to spousal violence and aggression during the intake assessment. Only three of the thirty-

four men who denied any physical abuse of their partners (precontemplation) completed the treatment.

In another recent study, Chang & Saunders (2002) found that younger age and antisocial personality were significant predictors of attrition in men's domestic violence intervention programs. The study's sample was 134 men who completed treatment and 44 who dropped out. Variables studied included demographics such as age, income, education, and race. Other variables included living arrangement, referral source, witnessing abuse, victim of abuse, types of batterers (family-only or generally violent), alcohol use, anger level (Navaco Anger Index), depression level (Beck Depression Inventory), self-esteem (Rosenberg's Self-Esteem Scale), personality traits (Millon Clinical Multiaxial Inventory), and social desirability responding (Marlowe-Crowne Scale). The study found predictors of attrition in different types of group treatment. In cognitive behavioral groups, the younger participants, those that reported no childhood violence, and those with antisocial personalities were more likely to drop out. In process-psychodynamic groups, low income was related to attrition. There was no significant difference in variables such as living status or referral source in either group.

As this section demonstrates, research on the subject of dropouts in male batterer programs is voluminous. This literature review provides just a sample of the research studies that have been completed over the last twenty years concerning these domestic violence programs. This literature provides enough evidence that the variables in this study have been predictors of the differences between dropouts and completers in domestic violence programs. However, the review also demonstrates that the research is inconclusive and there is value in continuing research in this area.

<u>DVFCT</u>

In comparison to the amount of research available about men's batterer treatment programs and dropouts, there are very few research articles available examining DVFCT dropouts. Perhaps this is because of the controversy surrounding couple's therapy for violent couples. Brown, O'Leary and Feldbau (1997) conducted a study comparing gender-specific domestic violence treatment program with a DVFCT group. Their focus was on potential dropout predictors. They sought to determine if demographic variables of age, years of education and family income, as well as levels of psychological and

physical aggression, would predict dropping out. Seventy couples participated in the treatment, 37 completers (those with at least 70 percent attendance), and 33 dropouts. None of the demographic factors were found significantly associated with dropping out in this study. The predictors found associated with dropping out were the husbands' severe psychological aggression and the wives' mild psychological aggression. The authors also suggest that men who are "highly controlling psychologically abusive and physically abusive are not appropriate for couple's therapy" (p.382). One technique of this study was to contact as many of the dropouts as possible and interview them concerning their reason for dropping out. As with previous studies of therapy dropouts, client's expectation of treatment and their goals as they enter therapy not being addressed or met seemed to be the most frequent reasons offered by participants for dropping out.

Heyman, Brown, Feldbau-Kohn, and O'Leary (1999) continued studying the above group. Their purpose was to link pretreatment couples' communication to treatment dropout. They found that the "Husbands' pretreatment communication problems (specifically, husbands' distress-maintaining attributions, negative reciprocity, and nonhostile responses to wives' self-disclosures) were significant predictors of dropout" (p. 179). Heyman & Neidig's chapter in the Clinical Handbook of Marriage and Couples Interventions (1997), referring to the Heyman, Brown & O'Leary (1995) article, stated that other predictors of treatment dropouts are the wives' higher use of humor during the sessions and the husbands' lack of empathy and tendency to respond with hostility to their wives' self-disclosure. From the Brown and O'Leary (1995) article, Heyman and Neidig state that the "severity of psychological aggression and physical aggression would be associated with treatment completion" (p. 614). The findings were not expected: more severe the physical aggression was found to be a predictor of program completers, and more severe psychological aggression was determined to be a predictor of program dropouts.

Using the data from the study addressed above that compared gender-specific versus DVFCT, O'Leary, Heyman, & Neidig (1999) ran three logistic regression analyses to predict differential dropout between conjoint treatment and Gender Specific Treatment. The dropout rate of the study was 47 percent. The only significant variable was age. Younger couples were more likely to drop out of gender specific therapy. The

study suggested that most dropped out of treatment because it did not focus enough on marital problems.

Harris, Savage, Jones & Brooke (1988) also conducted a study comparing dropouts in both DFVCT groups and DVFCT. Like the Brown and colleagues study, they pre-screened out any couple that was too violent. The study consisted of 35 couples who were assigned couple's counseling, 23 that were assigned to the multi-couples group, and 10 couples on a waiting-list control group. Once the couples began receiving treatment, 67 percent dropped out before completion of the couple counseling, but only 16 percent dropped out of the multi-couples group program. The most important finding for this study was that participants recruited in the individual couple counseling were four times more likely to drop out of treatment than those in DFVCT group. One issue of controversy in this study was that the definition of "dropout" for individual couple's counseling was anyone that did not complete all of their goals. The average number of sessions of those that dropped out of the individual couple's counseling was 3.89. The study also found that when abusive men had a high level of social support at intake, they were more likely than others to drop out before treatment began. One explanation for this may be that outside support may have helped the men to minimize their violence or even place the blame on their partner. On the contrary, the women in the study without outside support were more likely to drop out. Both of these factors seem to add to the client's motivation for therapy or lack thereof.

The literature on the subject of dropouts in DFVCT is lacking. Other than the group of O'Leary and colleagues (1997, 1999(2), & 1995), and, Harris and colleagues (1988), not many other people have researched the subject. More information is needed from other groups who provide DFVCT, especially in the area of predicting dropouts.

<div align="center">Stages of Change</div>

McConnaughy, Prochaska and Velicer (1983) have established a five-stage model from the Transtheoretical Model of Change called the Stages of Change model. The stages are pre-contemplation, contemplation, decision making, action, and maintenance. As stated in the theoretical framework section of this study, the Stages of Change model is based on the assumption that people come into a situation, such as therapy, at different

levels of readiness to change. Their motivation to work on their problems is based on what stage they are and their readiness to change.

Stages of Change has also been used in many areas of study, such as therapy (McConnaughy, DiClemente, Prochaska & Velicer, 1989; Prochaska, 2000), methadone maintenance (Belding, Iguchi, & Lamb, 1996), obesity in Mexican American woman (Suris, Trapp, Diclement & Cousins, 1998), smoking (Prochaska & DiClemente, 1983), and panic disorders (Beitman, Beck, Deuser, Carter, Davidson, & Maddock, 1994) to name just a few. In fact, Vetere and Henley (2001) used the stages of change model for couples and family therapy work within a community alcohol service.

In working at hospital emergency rooms, Frasier, Slatt, Kowlowitz and Glowa (2001) developed a stage of change strategy for doctors who are seeing patients who have been victims of domestic violence. The purpose of their study is to educate doctors on potential interventions based on where the client is in their stage of change. The doctors can assess for the client's stage based two basic questions: (1) "Have you thought about making any changes in your current situation within the next 6 months?" and (2) "have you thought about making changes within the next 30 days?"

Overview of SOC in Therapy

Miller, Duncan and Hubble (1997), in their book Escape from Babel, which was written to give therapists different perspectives of the therapeutic process, discussed the importance of the stages of change. "Treatment programs sow the seeds of their own failure when, by design, they do not accommodate clients' readiness for change or motivational level"(p. 102). "In all, the stages-of-change model offers one way for therapists to think about the design and implementation of treatment that has been found to increase the client's participation in therapeutic relationship" (p. 104). "At the same time, the research shows that failure to accommodate the client's state of readiness can spell the failure of the most expensive, thoughtful, extensive treatment programs" (p. 104). The book breaks down the stages of change and provides some thoughts on how to work with clients in each of the stages. Although the book states that the preparation and action stages are the easiest to work with, its main focus is helping the reader understand that each client will be in a different stage, and interventions need to be different for each stage and within stages.

In their book The Transtheoretical Approach: Crossing the Traditional Boundaries of Therapy, Prochaska and DiClemente (1984) "demonstrate how this integrative model can serve as a systematic guide for eclectic therapists seeking to help clients with some of the most common yet complex clinical problems" (p. 2). They suggest that "for the most part, however, precontemplators are at high risk for dropping out of therapy"(p. 25). "Learning to work more effectively with precontemplators could make a considerable difference in the services that clinics provide to the public" (p.25).

In an article from the Cancer Prevention Research Center website, Velicer, Prochaska, Fava, Norman, and Redding (1998) stated, "The Transtheoretical Model has general implication for all aspects of intervention development and implementation" (p. 11). "The Transtheoretical Model is designed to develop interventions that are matched to the specific needs of the individual. Since the interventions are individualized to their needs, people much less frequently drop out because of inappropriate demand characteristics" (p. 11).

O'Hare (1996) used the stages of change instrument to differentiate between court referred and voluntary therapy clients working with social workers. He found that 33.3 percent of the 60 court-referred clients were in the precontemplator stage, compared to only 2.8 of the 215 voluntary clients. O'Hare warns against overgeneralizing or stereotyping groups. He also gives some implications and expectations for working with precontemplator clients. To social workers, he reminds, "it takes considerable patience and skill to cultivate a client's desire to change when it lies hidden beneath layers of anger, guilt, and humiliation" (p.421). This statement also seems appropriate for some of those clients coming to DVFCT. Some domestic violent clients who are court-ordered or made to come by their partner enter into therapy feeling angry, hurt, guilty, and humiliated.

As the above literature suggests, stages of change assists in the understanding of the clients that participate in therapy. By using the information provided according to the stage of change, therapists can better understand and tailor their interventions based on the readiness of their clientele.

Stages of Change in Domestic Violence

In two articles, Audrey Begun and colleagues discuss developing an approach to domestic violence using stages of change. In the book Domestic Violence Offenders, Begun, Shelley, Shrodthoff and Short (2001) discuss the importance of understanding the stages of change and the participant's readiness to change in the area of domestic violence. They suggest that a better understanding of what type of participants are in treatment could lead to modifications in the domestic violence interventions. As it pertains to domestic violence treatment, Began, Murphy, Bot, Weinstein, Strodhoff, Short, and Shelley (2003) believe that attrition occurs because of the mismatch of the participant's needs and abilities and the program's interventions.

In another study, Easton, Swan and Sinha (2000) researched stages of change/readiness to change as it pertains to both domestic violence and alcohol abuse. The study found that motivational enhancement interventions increased the "readiness to change substance use among domestic violence offenders" (pp.1). The study concluded that substance abuse may be an important indicator for higher dropout rates and re-assault, and the assessing for stage of change and treatment with enhancement interventions could lower these rates.

The ability to assess the client's stage of change in domestic violence provides the facilitators a benchmark to interventions in therapy. As those who provide treatment for domestic violence understand their client's stage and readiness to change, it is anticipated that they will also be able to provide the specific intervention that is best suited for that client.

Predicting dropouts through Stages of Change

One of the main purposes of the Stages of Change model is to better understand the clients that are served. As stated many times in this chapter, one of the main reasons that researchers study dropouts is to better understand the clients that leave service before completing treatment. In an article by Harris (1998) that discusses attrition from therapy, the author concludes that, although demographics are helpful in some studies, future research needs to focus on client's motivation.

In their 1982 article on Transtheoretical Therapy, Prochaska and DiClemente state, "If the client's expectations about how therapy will progress are not met, then the client is most likely to terminate therapy prematurely" (p. 277). The authors stress the

importance of evaluating and working within the stage the client is in. "One of the more common sources of resistance might well be when clients and therapists are working at two different stages of change" (p. 287). This process could be more complicated in couple's or in group work. The article warns the therapist to watch out for the bind of one partner who is farther along in the stages than the other. One will feel that the therapist is going too slow and the other feel that the therapist is going too fast.

In a more recent article, Prochaska and Norcross (2001) give an empirical research study of stages of change over the last 20 years. Their findings indicate that understanding stages of change can enhance the outcome of the therapy process. On the subject of dropouts they state that "research has identified stages-of –change-related variables as the best predictors of dropouts across a growing number of problems, such as heroin addiction, cocaine abuse, alcoholism, domestic violence, obesity, chronic mental illnesses and mental health diagnoses" (p. 445).

For example, the Brogan, Prochaska, and Prochaska (1999) article examined dropouts of therapy using the stage of change theoretical framework. Sixty clients were studied through four different questionnaires: the Stages of Change questionnaire (McConnaughy, Prochaska, & Velicer, 1983) which has 32 questions; the Processes of Change questionnaire (Prochaska, Velicer, DiClemente, & Fava, 1988) with 48 questions; the Levels of Attribution and Change (Norcross, Prochaska, Guadagnoli, & DiClemente, 1984) with 48 questions, and the psychotherapy decisional balance scale which is a scale with 63 questions. The study had three classification groups: pre-mature terminators, appropriate terminators and therapy continuers. Through t-scores and one way ANOVAs and chi-square for testing demographics, including sex, education level, income level, age, previous therapy experience, and marital status, no statistically significant differences were found. By using the stages of change, processes of change and decision-making variables, the study was able to predict, with a 92 percent probability, premature terminators from appropriate terminators and therapy continuers. A limitation to this study is that it did not represent a broad enough diversity in socioeconomic status, education and income levels. "Sixty percent of the clients were seen in university-based clinics by therapists who were in graduate training programs. Whether the results in this study would generalize to more experienced therapists in

private and public clinics can only be known for sure through future replications" (p. 111).

Brogan and colleagues (1999) found that premature terminators wanted to change their environment more than they wanted to change themselves. Appropriate terminators were mostly in the action stage. Therapy continuers were mostly in the contemplation stage, slow to take action but willing to learn from the program. The authors emphasized the "importance of matching therapy to client's stage of change in order to reduce the average rate of 40% of clients terminating therapy prematurely" (p. 105). Part of the conclusion of this article stated, "We can drive them away and then blame them for being resistant, not motivated, or not ready for therapy. Historically it has been us who were not ready for them" (p. 111).

Brogan and colleagues (1999) support the need for continued research on this subject. They state, "After 125 studies and 30 years of research all too little data are available for understanding why so many clients terminate therapy prematurely"; and, "Future studies should focus on dynamic variables of how people change and how therapy relates to peoples' readiness to change" (p. 106).

VA Tech's DFVCT – Stages of Change

According to the manual which guides the program, the program at VA Tech's DFVCT (2001) is designed to help participants move through stages. These stages are similar to the concept of Stages of Change. The first stage of therapy in this DFVCT is to establish the context of change, which could take from two to four sessions. During this stage, the therapist facilitators teach about violence; they communicate that change is possible; they work on the positive intentions of those that participate, and they provide a reachable vision for the participants. This is similar to helping a person move from the precontemplation to the contemplation stage in the Stages of Change, giving the participants something for which to hope and work. The second stage continues helping the participants through the contemplation stage, demonstrating their ability to change in their relationship. The hope is that the participants will begin to work on their relationship and move into the preparation and action stage of the Stages of Change. The focus of the third stage "is on consolidating, punctuating and planning for the

maintenance of change". This process is the similar to the action and maintenance stages in the Stage of Change (Stith, McCollum, Rosen, and Locke, 2001).

The present research focuses on individuals who drop out of the couple's treatment programs for domestic violence in the VA Tech's DVFCT program versus those that complete the program. The emphasis is on understanding how the dropout's readiness for change prior to therapy, as it pertains to domestic violence, differs from the readiness for change of those that complete the program. Using the URICA-DV measurement that each participant originally filled out at intake, an analysis of stage of change is made for both those participants who dropped out and those that completed. The URICA-DV measures which stage of change each individual is currently in and can help predict their readiness to end their violence (Levesque, Gelles, & Velicer, 2000).

Summary

In summary, as witnessed by these articles, domestic violence is an issue that needs to be understood and that needs good, safe programs in order to help those that batter and those that are battered. Domestic violence programs seem to serve a purpose in lowering reassault; however, many participants that start in domestic violent program do not finish. A larger percentage of the dropouts from these programs reassault than do those that remain for the entire treatment. Much research has already been gathered in attempting to understand dropouts within men's domestic violence programs. The subject that has not been researched as thoroughly is that of dropouts in the DVFCT groups. Through the use of secondary data analysis, the present study examines the men in one of these programs in order to explore significant differences between those that drop out and those that complete treatment.

Chapter III

Methods

The purpose of this study is to identify factors that differentiate between male clients who drop out and those that complete DVFCT. This section describes the research methods that are used in the study, including the procedures, participants, instruments, and method of data analysis.

Procedures

This study is a secondary data analysis of the National Institute of Mental Health funded research and developmental project at Virginia Polytechnic Institute and State University at Falls Church and the follow-on study provided by the Center for Family Services at the same university. The purpose of this larger study was to develop and pilot test a manualized couple's treatment model for both batterers and their partners.

Participants in the larger project were either self-referred or referred by courts. Participants were both individuals and couples who were interested in domestic violence treatment. This study focuses on the men who participated in at least one session of either the individual couple's treatment or the couple's group. Completers are those participants who successfully completed either the individual couple's counseling or the group counseling. Successful completion is based on finishing at least 80 percent of the sessions available. Dropouts are those participants who did not successfully complete 80 percent of the sessions. Participants were excluded from the study if there was severe abuse in the home, violence outside the home, ongoing substance abuse, weapons use or threats of weapon use in previous violence episodes, refusal to remove weapons from the home, or refusal to sign a no-violence contract. Participants were excluded from this analysis if the female partner was the only perpetrator of violence.

Potential participants phoned the Center for Family Services and spoke to a graduate assistant trained in screening prospective participants. If the caller was found to be a potential participant and was interested in the program, an intake interview was scheduled. During the intake interview, the participant provided demographic information and filled out questionnaires including a variety of quantitative research instruments, mainly dealing with relationships and domestic violence.

All participants signed an informed consent form identifying the purpose of the project, the risks and benefits, their right to drop out at any point, and the confidentiality of all the information they provided. A trained therapist intern interviewed the couples individually, filling out an intake form. The intake form consisted of questions regarding the individual, the couple, their relationship and the level of domestic violence in the home. For this study, two groups are analyzed, those men that completed the entire couple's program, and those men that started the couple's program but did not complete it.

<div align="center">Instruments</div>

Stages of Change

The original URICA (The University of Rhode Island Change Assessment) was developed to assess the client's readiness to work on the "problem" (unspecified) that brought them to treatment. The alphas were Precontemplation, .88; Contemplation, .88; Action, .89, and, Maintenance, .88 (McConnaughy, DiClemente, Prochaska, & Velicer, 1989; McConnaughy, Prochaska, & Velicer, 1983; Levesque et al., 2000). Using the data provided by this study, a reliability analysis was run and the resulting alphas for the URICA were precontemplation, .79, contemplation, .66, action, .65, and, maintenance, .71.

Sample questions from the URICA questionnaire are: Precontemplation, "As far as I'm concerned, I don't have any problems that need changing." Contemplation, "I have a problem and I really think I should work at it." Action, "At times my problem is difficult, but I'm working on it." And, maintenance, "I may need a boost right now to help me maintain the changes I've already made."

The URICA-Domestic Violence (URICA-DV) scale is used to assess the client's readiness to change with regards to domestic violence. The URICA-DV is a four-dimensional stage measure that assesses batterers' readiness to end their violence (Levesque, Gelles, & Velicer, 2000). URICA-DV is broken down into four dimensions representing Precontemplation, Contemplation, Action, and Maintenance. Preparation, one of the five stages of change identified in the Stages of Change, was not found to distinguish itself from the Contemplation and the Action stage in the URICA-DV tool and, thus, was excluded (Levesque et al., 2000). The URICA-DV is a smaller scale of the

URICA measurement. It is designed to assess batterers' readiness to end their use of violence in their relationship. Levesque found preliminary evidence of the construct validity of URICA-DV. The Coefficient Alphas ranged from .68 for the Maintenance scale to .81 for the Action (Levesque, Gelles, & Velicer, 2000). The alphas for the URICA-DV were precontemplation, .28, contemplation, .75, action .87, and, maintenance, .78.

Sample question from the URICA-DV are: Precontemplation, "There's nothing I can do to end the violence in my relationship." Contemplation, "More and more I'm seeing how my violence hurts my partner." Action, "I'm making important changes and ending the violence in my life." And, maintenance, "I've made some changes and ended the violence, but I'm afraid of going back to the way I was before."

Levels of Physical and Psychological Violence

The levels of physical and psychological violence variable were based on the participant's scores on the Revised Conflict Tactics Scale (CTS-2). The CTS-2 is a modified version of the CTS and was developed by Straus, Hamby, Boney-McCoy, and Sugarman in 1996. The CTS-2 consists of 78 questions that assess reasoning, psychological aggression, sexual coercion, physical assault, and injury of both the respondent and their partner. The scales that were examined in this study were the Respondent Psychological Aggression Subscale and the Respondent Physical Assault Subscale. The internal consistency of the CTS-2 ranges from an alpha coefficient of .79 to .95 (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). The instrument asks questions regarding frequency of abuse. If a particular item in the questionnaire did not happen in the last year, the respondent marks a 7, and if it never happened, the respondent marks a 0. The questions range from physical force (like hitting, holding down or using a weapon) to psychological abuse (insults, name calling, and shouting). There are 24 items to measure the level and frequency of physical violence, and, 14 items measure the level and frequency of psychological abuse. The average score of both the physical and psychological violence of the CTS-2 were analyzed for both dropouts and completers.

Additional Variables

In order to better understand how completers differ from dropouts in the current study, other variables are studied in addition to the stages of change.

Demographics

With the help of SPSS, this section used the data from the intake forms in both the NIMH and the VA Tech's couple's conflict group. Information was also provided by a review of the initial phone intake form, the partner's intake forms, and facilitators notes found in each participant's individual folders. Whenever it was available, the participant's self-report was used to obtain the data. When the participant omitted the question, other data sources (e.g. partner's report or facilitator' notes) were used. When needed, the data were collapsed into dichotomous categories to get rid of empty or low frequency cells.

The study used the mean age of those that dropped out of the program and those that completed.

The race variable was divided into two categories: "white" (Angloamericans) and "non-white" (i.e.- African American, Hispanic, Asian, etc.).

The employment variable was divided into two categories: full-time employment and those who were not (i.e.- part-time, student, retired, unemployed).

The education variable was divided into two categories: participants who had at least a college degree (bachelors and/or advanced degree) and those who had less than a college degree (did not finish High School, to High School graduate, GED, vocational training, and some college).

The marital status variable was divided into two categories: married or not married (engaged, boyfriend, living together, or partner).

The parental status variable was divided into two categories: children from the current relationship or not having children from this current relationship.

The living arrangement variable was divided into two categories were the couple living together at time of intake or separate at the time of intake.

The referral source variable was based on participant's self-report, partner's report, facilitator's report, or documents found in the file to specific organizations that were monitoring the progress of the participant or his spouse. The categories were either

court referred or self referred. A court referral came from the court, county agencies, police, social worker, or someone in authority that was, or could be, monitoring the participant's progress. A self-referral came from self, spouse, newspaper, friend, family member, church, or somewhere that did not have authority to check up on the participant.

The prior treatment variable was based on participant's self-report or partners report. Prior treatment included any mental health treatment, including batterer groups or men's domestic violence programs. This was a yes or no question.

<div align="center">Design and Data Analysis</div>

Research Question One –

How do those who drop out of couple's domestic violence treatment programs differ from those who complete, in relation to the stages of change?

In accumulating the research it was found that the URICA-DV had been added to the program after program inception. Of the 58 participants, only 37 had completed the URICA-DV. Before the implementation of the URICA-DV, the NIMH program used the 16 question shortened URICA measurement and 39 participants had completed this measurement including 24 that had used both the URICA and the URICA-DV. Only five of the participants had not completed either measurement.

Based on the URICA (McConnaughy, DiClemente, Prochaska, & Velicer, 1989; McConnaughy, Prochaska, & Velicer, 1983) and the URICA-DV (Levesque, Gelles, & Velicer, 2000), this study analyzed the data in three formats. The first method looked at the means of both the URICA and the URICA-DV in each of the 4 stages for both completers and dropouts. The second method looked at the differences between dropouts and completers in their predominant stage of change. Each individual participant's stage was identified based on that individual's highest category score. When two categories totaled the same amount, a judgement was made based on the totals of the other categories. For example, if a participant's highest score in any one category was 15 and he had 15's in both the Contemplator category and the Action category, the researcher would then look at the score of the Maintenance category to determine if the participant had the tendency more towards contemplator or action. An independent researcher later cross-checked this judgement for validity. The last analysis was an analysis based on the Levesque, Gelles, and Velicer (2000). Once again, the main researcher examined each

participant's score and placed the participant in one of six categories (pre-contemplation, contemplation, preparation, pseudo action, action and maintenance) based on a scoring method from the Levesque, Gelles, and Velicer (2000) article. A second researcher was used to validate the main researcher's findings.

Research Question Two –

How do those who drop out of couple's domestic violence treatment programs differ from those who complete in the following areas: Levels of Physical and Psychological Violence, Demographics – Age, Race, Employment, Education, Marital Status, Parental Status, and Living Status; Referral Source; Prior Treatment?

This study's analysis used chi-square and t-tests to determine the differences between the program dropouts and program completers. It used the variables of levels of violence (physical and psychological), demographics, referral source, and prior treatment.

CHAPTER IV

Results

In this chapter, the results from the data analyses are presented. First a description of the 58 men used in the analyses will be presented. Next, the potential variables are examined in relation to both completers and dropouts using paired t-tests and chi-squares based on the two research questions. Each analysis helped in gaining a better understanding of the differences between completers and dropouts.

Sample Description

First, an examination was completed of those male participants in both the NIMH study and the VA Tech's Couple's Conflict Group (CCG) that fit the criteria of having attended at least one couple's session of either program. Data from 45 men from the NIMH study and thirteen from the CCG fit the criteria and were further examined. Of the 58 participants, 64 percent (37) completed the program and 36 percent (21) dropped out. Most of the information provided by both studies was compatible. However, some of the information needed for this research was unavailable due to either program startup changes or modifications, and lack of information from participants self-report. The average age of the participants was around 37 years old; the average income was around $37,000; and, the average participant education level was some college. In the variable of race, the participants stated their race as the following, 3 Asian, 13 Black, 5 Hispanic, 34 White, 2 other, and one mixed race. Forty-one of the couples were married. Forty-nine of the couples were still living together at the time of intake.

Research Question One

How do those who drop out of couple's domestic violence treatment programs differ from those who complete, in relation to the stages of change?

It was found that the URICA-DV instrument had been added to the program after program inception. Of the 58 participants, only 37 had completed the URICA-DV. Before the implementation of the URICA-DV, the NIMH program used the 16 question shortened URICA measurement and thirty-nine participants had completed this measurement including 24 that had used both the URICA and the URICA-DV. Only five

of the participants had not completed either measurement. Therefore, both measures were used in this study.

Table 1 demonstrates the means of both the URICA and the URICA-DV in each of the 4 stages for both completers and dropouts. Neither the URICA nor URICA-DV scores significantly predict differences between completers and dropouts of therapy on any of the stages of change levels.

Table 1
T-Test Results for Stages of Change Measures

Stages of Change	Instrument	Dropouts	Completors	T-Test	p
Precontemplators	URICA	7.50	8.52	1.03	0.310
	sd	2.24	3.29		
	URICA-DV	8.42	7.56	-1.03	0.31
	sd	1.93	2.53		
Contemplators	URICA	17.14	17.00	-0.21	0.84
	sd	1.96	2.12		
	URICA-DV	19.25	18.84	-0.27	0.79
	sd	4.27	4.34		
Action	URICA	16.86	16.44	-0.56	0.58
	sd	1.88	2.38		
	URICA-DV	20.25	20.48	0.16	0.87
	sd	3.91	4.05		
Maintenance	URICA	15.43	14.04	-1.63	0.11
	sd	2.62	2.51		
	URICA-DV	15.75	15.36	-0.25	0.81
	sd	4.63	4.47		

Note: N for URICA and URICA-DV Completors = 25
     N for URICA Dropouts = 14
     N for URICA-DV Dropouts = 12

The next analysis of this data was to determine if there were differences between dropouts and completers in their predominant stage of change. Each individual participant's stage was identified based on that individual's highest category score. When two categories totaled the same amount, a judgement was made based on the totals of the other categories. For example, if a participant's highest score in any one category was 15 and he had 15's in both the Contemplator category and the Action category, the

researcher would then look at the score of the Maintenance category to determine if the participant had the tendency more towards contemplator or action. An independent researcher later cross-checked this judgement for validity. Table 2 and Table 3 provides the findings from a cross-tab analysis of differences between completers and dropouts in the predominant stage.

Table 2

Chi-Squared Analysis of Predominant Stage of Change Based on URICA Scores

Stage of Change	Completers		Dropouts		Chi Squared	p
Precontemplator	2	8.0%	0	0.0%	2.12	0.55
Contemplator	16	64.0%	9	64.3%		
Action	6	24.0%	5	35.7%		
Maintenance	1	4.0%	0	0.0%		
Total	25		14			

Table 3

Chi-Squared Analysis of Predominant Stage of Change Based on URICA-DV Scores

Stage of Change	Completers		Dropouts		Chi Squared	p
Precontemplator	2	8.0%	0	0.0%	2.91	0.23
Contemplator	9	36.0%	2	16.7%		
Action	14	56.0%	10	83.3%		
Total	25		12			

Most of the participants, from the URICA and the URICA-DV scores, were either in the contemplator or action stages. As Table 2 and 3 demonstrate, in comparing the individual stage categories, no significant differences were found between completers and dropouts.

In another analysis, each of the participants was placed into one of six categories based on a method in the Levesque, Gelles, and Velicer (2000) study. The main researcher examined each participant's scores of the URICA and the URICA-DV and placed the participant in one of the six categories (pre-contemplation, contemplation,

preparation, pseudo action, action and maintenance) based on a scoring method from the Levesque, Gelles, and Velicer (2000) article (see Attachment 3). A second researcher was used to validate the main researcher's findings. Table 4 and 5 present the analysis of these cluster scores. None of the participants fell into the sixth category of maintenance so it was not included in the Tables. Again, the analysis found no significant differences between dropouts and completers (chi-square = 5.57, p=.23) and (chi-square = 3.45, p=..49).

Table 4

Chi-Squared Analysis of Predominant Stage of Change Based on URICA Cluster Scores

Stage of Change	Completers		Dropouts		Chi Squared	p
Precontemplator	6	24.0%	3	21.4%	5.57	0.23
Contemplator	5	20.0%	3	21.4%		
Preparation	5	20.0%	1	7.1%		
Pseudo Action	7	28.0%	2	14.3%		
Action	2	8.0%	5	35.7%		
Total	25		14			

Table 5

Chi-Squared Analysis of Predominant Stage of Change Based on URICA-DV Cluster Scores

Stage of Change	Completers		Dropouts		Chi Squared	Sig.
Precontemplator	3	12.0%	1	8.3%	3.45	0.49
Contemplator	6	24.0%	5	41.7%		
Preparation	7	28.0%	1	8.3%		
Pseudo Action	6	24.0%	2	16.7%		
Action	3	12.0%	3	25.0%		
Total	25		12			

Research Question Two

How do those who drop out of couple's domestic violence treatment programs differ from those who complete in the following areas: Levels of Physical and Psychological Violence; Demographics – Age, Race, Employment and Education; Referral Process; and Prior Treatment?

This section reports results from data analyzed on each of these variables.

<u>Age</u>

As stated above, the average age of the 58 participants was over 37 years old. Table 6 illustrates t test results comparing the ages of dropouts and the completers. This analysis demonstrates a significant difference in age between the two groups, completers being significantly older than dropouts (t = 2.44, p=.02).

The ages among the completers was distributed with the youngest being 24, the oldest 73, 16 percent (6) in their twenties, 38 percent (14) in their thirties, and 46 percent (17) forty or over. The dropouts on the other hand were less evenly distributed, they ranged from 22 to 52, with 48 percent (10) in their twenties, 28 percent (6) in their thirties, and only 24 percent over 40.

Table 6

<u>T-test Results Comparing Age and Physical and Psychological Violence Scores (CTS2) between Completers and Dropouts</u>

Variable		Completers (n=37) Mean	Dropouts (n=21) Mean	df	T-Test	Sig.
Age		39.65	33.00	1/56	2.44	0.02
	sd	10.76	8.33			
CTS-Physical		16.70	14.14	1/56	1.15	0.26
	sd	9.25	5.66			
CTS-Psycholological		7.57	7.38	1/56	0.07	0.95
	sd	10.45	9.52			

<u>Levels of Physical and Psychological Violence</u>

Using the information from the CTS2, Table 6 illustrates the t test results comparing dropouts and completers on physical and psychological violence. The analysis does not demonstrate a significant difference in physical or psychological violence for dropouts and completers.

<u>Other Variables</u>

Table 7 breaks down the variables of race, employment, education, marital status, parental status, living arrangement, referral source, and prior treatment by completors and dropouts.

Table 7

Chi-square results for Other Variables of Differences between Dropouts and Completers

Variable	Completers Total	Percent	Dropouts Total	Percent	Chi Square	Sig.
Race						
White	27	73%	7	33%	8.68	0.003
Non-White	10	27%	14	67%		
Employment						
Full-time	31	84%	14	67%	2.26	0.133
Other	6	16%	7	33%		
Education						
> College Deg	15	45%	12	63%	1.51	0.219
College Deg(s)	18	55%	7	37%		
Marital Status						
Married	31	84%	10	48%	8.46	0.004
Not Married	6	16%	11	52%		
Parental Status						
W/Children	25	68%	10	48%	2.23	0.136
W/O Children	12	32%	11	52%		
Living Arrangement						
Living Together	33	89%	16	76%	1.73	0.189
Separated	4	11%	5	24%		
Referral Source						
Court	20	54%	12	57%	0.05	0.820
Self	17	46%	9	43%		
Prior Treatment						
Yes	30	81%	13	62%	2.57	0.109
No	7	19%	8	38%		

Race was broken down in either participants who were "white" (Angloamericans) and those who "non-white" (i.e.- African American, Hispanic, Asian, etc.). In this format, completors and dropouts differed significantly in self-reported race. The study shows that there a significantly larger percentage of the participants that completed the program were "white" (73%) (chi-square 8.68, p= .003). And a large percentage of the participants who dropped out of the program were "non-white" (67%).

Employment was broken down into those participants who had full-time employment at the time of intake and those who did not (i.e.- part-time, student, retired, unemployed). Employment was not found to be a significant variable, however, there is a tendency towards a higher percentage of completers who are employed full-time (84%) (chi-square 2.26, p=.13) versus only 67 percent of dropouts who were full-time employed.

Education was broken down into those participants who had at least a college degree (bachelors and/or advanced degree) and those who had less than a college degree (did not finish High School, to High School graduate, GED, vocational training, and some college). No significant difference was found for education levels between dropouts and completers (chi-square 1.51, p=.22).

Marital Status was broken down into either married at time of intake or not married (engaged, boyfriend, living together, or partner). A significantly higher percentage of those that completed the program were married (84%) (chi-square 8.46, p=.004). Only 48 percent of those who dropped out were married.

Parental Status was defined as either having children, or, not having children from the current relationship. Although there was no significant difference between completers and dropouts, there was a tendency for more completors to have children, 68 percent (chi-square 2.23, p=.14), versus 48 percent of the dropouts who had children.

Living Arrangement was defined as, at the time of intake, was the couple living together or separate. No significant difference was found (chi-square 1.73, p=.19).

Referral Source was broken into two categories, court and self. A court referral came from the court, county agencies, police, social worker, or someone in authority that was or could be monitoring the participant's progress. A self-referral came from self, spouse, newspaper, friend, family member, church, or somewhere that did not have

authority to check up on the participant. No significant difference was found between these two categories as it pertains to differences in dropouts and completers (chi-square .05, p=.82).

Prior Treatment was based on whether the participant had prior mental health or domestic violence treatment of any kind. Although the differences between dropouts and completers were not significant for prior treatment (chi-square 2.57, p=.109). There was a tendency for completors to have had prior treatment, 81 percent versus 62 percent of the dropouts with prior treatment.

CHAPTER V

Discussion

The main purpose of this study was to examine difference in men who drop out and men who complete domestic violence focused couples treatment (DVFCT). The variables that were anticipated to be related to dropouts were Stage of Change scores, demographics (age, race, employment, and education), marital and parental status, living arrangement, referral source, prior treatment and level of physical and psychological violence at intake.

Overall, of the 58 men who fit the criteria of having participated in at least one couple's session of either individual or multi-couple group DVFCT, 64 percent (37) completed the program and 36 percent (21) dropped out. The 36 percent dropout rate is lower than the 47 percent from both the O'Leary, Heyman, & Neidig (1999) and the Harris, Savage, Jones & Brooke (1988) couple's study.

Statistically Significant Variables

This study found significant difference between dropouts and completers for the variables of age, race and marital status. This section examines these variables.

Age

The study found that younger men were more likely to drop out than were older men. These findings are similar to many of the dropout studies found in the literature review for therapy (Brandt, 1965; Edlund, Wang, Berglund, & Katz, 2002; Garfield, 1994), and domestic violence programs (Bennett & Williams, 2003; Buttell & Carney, 2002; Daly, Power, & Gondolf, 2001; Demaris, 1989). Gerlock (2001) reported the opposite findings, his completers mean age was 33.87 and dropouts was 42.16. No DFVCT studies had found age to be significant for differentiating dropouts and completers.

So, does it make sense that age is a significant variable for this program? VA Tech's DFVCT program is centered eight miles from Washington, D.C. in Fairfax County in Northern Virginia. It is attached to the Center for Family Services at VA Tech, a clinic that serves people in the area. According to the U.S. Bureau of Census, in the

year 2000 the median age of Fairfax County is 35.9 years old but over 50 percent of the population is over the age of 35. The average age of those that participated in this project was a little over 37. Therefore the individuals in the program appear to represent the community. In addition, 62 percent of those men in their twenties dropped out of the program, 26 percent over 30, and, only 22 percent of those over forty. It is possible that older men are in more stable households or have more commitment in their relationships. Or, perhaps older men are more able to control their violence? Previous research on age stated that older clients are less likely to be violent (Howell & Pugliesi, 1988). As this study demonstrated, that older men stay in therapy. Perhaps older men are more willing to stay in therapy and work on their relationship.

Race

In the U.S. Census for 2001, Fairfax County had a population with 63.6 percent White and 36.4 percent Non-White. The program participants were 59 percent White and 41 percent Non-White. Therefore the race of the participants is fairly representative of the county in which the study was conducted. However, 67 percent of the dropouts are Non-White. Almost 80 percent of the Whites completed the program and only 42 percent of the Non-Whites completed the program.

While it is clear that more non-white than white participants dropped out from the program, it is unclear why this occurred. Literature on the subject demonstrates that race has been an issue in dropping out of therapy (Garfield, 1994; Wierzbicki & Pekarik, 1993); marriage and family therapy (Bischoff & Sprenkle, 1993); and, domestic violence programs (DeMaris, 1989; Sonkin, 1995). One of the issues raised in the literature is the inability of the program to match same race participants with the same race facilitators (Bischoff & Sprenkle, 1993). Most of the VA Tech's facilitators are master's and post-masters students in the Marriage and Family Therapy program. Although the program has a mixture of races, the majority of the facilitators in the DFVCT program have been white. However, in each of the last four groups, at least one of the facilitators was a minority and in one group, three of the four facilitators were minorities. In this area of Fairfax County, at this time, it would be almost impossible to provide a DFVCT for each minority class with the same minority facilitators.

Other issues concerning race and dropouts in this program have been language and culture. Four of the five Hispanic men that started the program dropped out. The main reason two of those participants dropped out was lack of ability to speak the English language. In both of those cases, the facilitators were able to find alternative counseling in another agency in the area. The differences between completers and dropouts in the area of race may also be explained by the interventions in the program. It may be true that the interventions fit the middle-class Anglo-American culture. According to Bischoff and Sprenkle (1993), Brown, O'Leary and Feldbau (1997), Edlund Wang, Berglund, and Katz (2002), and Garfield (1994), when interventions differ from a client's expectations, they are more likely to drop out.

Marital Status

Marital status has been used as a predictor of the differences between dropout and completor in therapy (Davis & Dhillon, 1989; Wierzbicki & Pekarik, 1993), and in domestic violence programs (Cadsky, Hanson, Crawford and Lalonde, 1996; DeMaris, 1989; Gondolf & Foster, 1991). However it has not been found as a predictor in the DVFCT. In this study married men were more likely to complete treatment. Eighty-six percent of completers were married whereas only 48 percent of the dropouts were married. Seventy percent of those men who were married at the time of intake stayed in the program. The same cannot be said of those that dropout. Sixty-five percent of those men who were not married dropped out of the program.

Marital status seems to demonstrate a commitment to working on the relationship. Three of the eleven couples that were not married dropped out because they separated. Four of the couples that were not married dropped out because they had scheduling problems and one did not like the procedures used in the treatment program (i.e. videotaping sessions).

Marital Status and Age

With both age and marital status being significant variables in determining dropouts, the next question would be the significance that marital status has on age as it relates to the differences between dropouts and completers. Two analyses were completed. As seen in Table 8, a significant relationship was found. Married men who were over the age of 29 were significantly more likely to complete treatment than were

married men under 29 years old (chi-square = 6.627, p= .036). Of the 10 dropouts who were married, five of them were under 30 and only one of the twelve married men who was between the ages of 30 and 39 dropped out of treatment. The category of not married, when broken down by age groups did not have demonstrate significant differences between completers and dropouts (chi-square=.345, p=.842).

Table 8

Chi-Squared Analysis of Age and Marital Status between Completers and Dropouts

Marital Status	Age by Group	Completers (n=37)	%	Dropouts (n=21)	%	Chi-Square	p
Married	20-29 Years Old	4	12.90%	5	50.00%	6.627	0.036
	30-39 Years Old	11	35.48%	1	10.00%		
	40+ Years Old	16	51.61%	4	40.00%		
	Total	31		10			
Not Married	20-29 Years Old	2	33.33%	5	45.45%	0.345	0.842
	30-39 Years Old	3	50.00%	5	45.45%		
	40+ Years Old	1	16.67%	1	9.09%		
	Total	6		11			

Other Variables

Some variables were not found significant but had the tendencies towards significance. This section discusses these variables (employment, parental status, living arrangement and prior treatment), as well as examines those variables that did not differentiate dropouts from completers. These variables are education, referral source, Stages of Change, and physical and psychological violence.

Employment

The employment variable was used with the belief that those that were full-time employed would be more stable and more committed to the relationship. Those who were still students, part-time employed, or unemployed would be less stable and less willing to commit to working on the relationship (Berghofer, Schmidl, Rudas, Steiner, & Schmitz (2002); Cadsky, Hanson, Crawford and Lalonde, 1996; DeMaris, 1989).

Although 84 percent of those men who completed treatment were full-time employed, this variable was not significantly related to dropouts. However, with almost 69 percent of full-time employed men completing the program, it is definitely a variable that should be considered. Of those who were either part-time employed, students, or unemployed, over half dropped out. A larger sample size and increased variance on this factor may have resulted in significant findings.

Parental Status

This variable was included in the analysis because it seemed likely that a more committed couple would be more likely to continue working on the relationship. When there is a child involved, it was assumed that more couples would look for ways to work on the relationship. Sixty-eight percent of those who completed the program had children from their current relationship. Seventy-one percent of those men with children from the current relationship completed the program. Of the men who did not have children from this current relationship only 52 percent completed the program. Although discrepancies exist between the group it did not reach the level of significance in this study; however, a tendency towards significance exists. A larger sample size and increased variance on this factor may have resulted in significant findings.

Living Arrangement

Although the literature review indicated that living arrangement was not predictive of dropping out (Buttell & Carney, 2002; Chang & Saunders, 2002), this variable was included in the study. It was expected that if a couple were living together they would be more committed to the relationship and more willing to work on their issues and complete treatment. Eight-nine percent of those who completed the program were living with their current partner at intake, whereas only 33 percent of those who dropped out were living together. Sixty-seven percent of those men who were living with their current partner completed the program. Although discrepancy exists between the group, it did not reach the level of significance in this study; however, a tendency towards significance exists. One of the reasons these numbers are not significant is the fact that such a high number of the total study were living together, both dropouts and completers. A larger sample size and increased variance on this factor may have resulted in significant findings.

Prior Treatment

Studies (Berghofer, Schmidl, Rudas, Stiener, & Schmitz, 2002; Davis & Dhillon, 1989; Edlund, Wang, Berglund, & Katz, 2002; MacNair & Corazzini, 1994) suggest that those participants who have had previous experience with mental health providers will have an easier time in treatment than those who are experiencing therapy for the first time. Eighty-one percent of those who completed the program had prior mental health treatment. Seventy percent of those who had prior mental health treatment finished the program. The variable did not reach the level of significance in this study; however, they do show a tendency towards significance. A larger sample size or increased variance on this factor may have resulted in significant findings.

Education

Studies (Cadsky, Hanson, Crawford and Lalonde, 1996; Daly, Power, & Goldolf, 2001; DeMaris, 1989; Garfield, 1994) suggest that the less educated client is more likely to drop out of therapy. Sixty three percent of those who dropped out of this program had less than a college degree. However, only 44 percent of all of those participants who had college degrees dropped out. The average participant in the study had some college education. The high level of education in the sample may have reduced variance in the sample. Another possible explanation would be the low sample size. A larger sample size or increased variance may have resulted in significant findings.

Referral Source

Studies (Bischoff and Sprenkle, 1993, Daly, Power, & Goldolf, 2001) suggest that court ordered clients are more likely than self-referred clients to complete treatment. This study did not support these findings, 57 percent of the dropouts were court referred and 54 percent of the completers were court referred. Because this program works with couples, most clients that are ordered by the court to a domestic violence program have demonstrated too high of a level of violence to participate in couple's treatment. Those participants who were referred to this program by the court, county, social worker, police or some other agency that was monitoring the participant's progress were generally not mandated to treatment. Even with this monitoring, these participants were not ordered to this treatment and could leave without feeling the repercussions of going to jail like some who are strictly "court ordered".

<u>Stages of Change</u>

The URICA and the URICA-DV are instruments to measure individual's readiness to change in therapy. The thought in the beginning of the study was that completers would be those who were more ready to change and dropouts would be more resistant to change. Using the URICA and the URICA-DV, this study looked at the men's pre-treatment stages of change scale in three different ways (mean score, individual category, and another category analysis based on the Levesque, Gelles, and Velicer (2000) article). The study found no significant differences between dropouts and completers in any of the analyses. The Levesque and colleagues (2000) analysis was another way of looking at the individual category and although it did not find any significant differences, it did provide some different ways of looking at the data. For instance, Table 2 of Chapter IV shows that most of the participants fell into the contemplation and action stages in both the URICA and the URICA-DV. The Levesque and colleagues (2000) analysis added the preparation stage back into the stages of change along with a new category called pseudo action. Bringing back the preparation stage helped better define the participant whose scores were similar for the contemplation and action categories. The addition of the pseudo action stage assists when a participant's scores are not consistent and as a participant seems to "experience pressure to participate in the change process when they are inadequately prepared to do so" (p.190). Although this analysis did not show any significance between dropouts and completers, further study using this analysis may provide some significant result. For instance, why are there more pseudo action men that completed the program than those that dropped out?

One potential reason for no significant difference in the scores of completers and dropouts on their stages of change has to do with the fact that the measure is an individual measurement and DFVCT is a couple's program. The reason to drop out of couple's therapy is not always based on the man's decision or the man's stage of change. What happens when each spouse is in a different stage? Do some wives come to these programs with "the-violence-better-stop-or-I'm-out-the-door" mentality? And what happens when you combine this expectation with a husband with a "sure-I-might-have-a-little-problem" mentality? How many of the men who dropped out of couple's program drop because their wife has left and they are no longer couples? The data in this research

project found that 6 of the 21 dropouts from this study dropped out because of separation prior to completion of the 12-week sessions.

Level of Violence at Intake

Studies (Brown, O'Leary & Feldbau, 1997; Cadsky, Hanson, Crawford and Lalonde, 1996; Daly, Power, & Goldolf, 2001) found that the variable of physical and psychological violence were significant predictors of dropouts and completers in therapy. In this study the Revised Conflict Tactic Scale (CTS-2) (Straus et al., 1996) score was used to assess the participants physical and psychological violence. The mean scores from each of the subscales were not significant in differentiating dropouts from completers. As in the discussion above, it is possible that couples factors or factors relating to the partner may be more important than the level of violence at intake.

<div align="center">Limitations</div>

One limitation of this study is the data itself. The data for this study had to be merged from two separate DVFCT programs. Although the program content and interventions are consistent, the data gathered was not always consistent. Some of the information was provided in full from one study but not complete in the other. The researcher had to build a separate database for this study's data.

Another limitation is the fact that all of the data, especially the URICA, URICA-DV, and the CTS scores, are provided by men's responses. Studies have shown that men are known to minimize or over-estimate their responses (Edleson & Brygger, 1986; Jouriles & O'Leary, 1985).

Another limitation is that this study examined many univariate variables. Correlation between variables was not tested. There is a possibility that random error could have led to significant findings that was not really significant.

Questions have been raised about the validity and reliability of The Stages of Change measurement. The URICA-DV is fairly new and has not been fully tested. Also, the subscale for precontemplation had a low alpha reliability (.28) in this sample. Although the idea of stages of change is an interesting concept, the test itself is geared for individuals. It may not fit well with assessing factors related to couples. Also, in using the stages of change as a predictor of dropout, researchers have to make sure that they do not see all dropouts as more likely to continue to be violent or in a lower stage of change.

As stated earlier, a couple could come to therapy to help make the decision to separate and once that decision is accomplished they no longer feel that they need therapy and they drop out. Thus, hopefully lowering the chance of reassault. This is similar to what Helmeke, Bischof, and Sori (2002) learned in their study.

Another limitation is the small sample size. Information concerning the 58 men who participated in this DVFCT program is far from being considered information that can be generalized to the larger population of violent men. The VA Tech program is not used as a mandatory court ordered program. Very few couples in this study were court-ordered to treatment. The study excluded men who were too violent in order to protect the partner. Few, if any, couples were forced to attend and the fear of repercussion from the courts for dropping out was not apparent as it was in some other studies (Buttell & Carney, 2002; Daly, Power, & Gondolf, 2001; Ferlock, 2001). However, this program does serve a metropolitan area and provides service to a wide range of couples.

Another limitation is the variables being examined. Variables were selected that looked at demographics, stages of change and violence. Many other potential variables were omitted, especially variables looking at the couple's relationship. Some of these other variables might have led to an increased understanding of dropouts.

<u>Research Implications</u>

This study is one of the pioneers in the examination the differences between dropouts and completers in DVFCT. Although the findings do not provide a clear picture of the characteristics of a dropout or a completer, it does provide a good starting point to work under. In VA Tech's program for working with couples who are violent, dropouts tended to be younger, not married and of a minority race. Completers had a tendency to be white, older, married, full-time employed, having children with the current partner, living together at the time of intake, and having had prior mental health treatment.

With the information provided by this study, VA Tech can now continue looking for differences between dropouts and completers with larger samples in the future. Many other scored instruments from the intake data are available to continue examining and finding out more about these men. Another area of study would be how partners' data predicts dropout. Many feel that the women will provide a more truthful and clear

picture of their partners. A researcher could start by looking at the same variables for the women and see if the same significant variables can be found.

As for the Transtheoritical Model, more research needs to be done on how to incorporate the ideas of the stages of change in working with couples with domestic violence. Similar to the CTS, where the partners are asked to rate themselves and their partner, maybe a stages of change model can be implemented that would score both the perpetrator and the victim's thoughts/feelings.

Bischoff and Sprenkle's (1993) review of the research on marriage and family therapy gave some recommendation that seemed appropriate for future studies similar to this one. Bishchoff and Sprenkle question the reliance on demographic variables as the primary source of data. They ask for more experimental studies, comparing different types of treatment programs and how they relate to dropouts and completers. They also ask for more studies that provide a look at other potential reasons clients dropout. Their idea is to study the potential identifiers from within the sessions. This would be an interesting research project in the VA Tech's DFVCT program. The data is now provided to know who the dropouts are and when they dropped out. With the use of videotapes, a researcher could look for potential variables from within the last sessions the clients attend.

Another idea of potential research with the current data would include looking at the program facilitators and how their characteristics may influence dropout. Answering questions such as, Who did the intake? How much training did that person receive? What year were they in the MFT program? Who facilitated the groups? Who took the lead? Finding potential variables concerning facilitator's age, race, and time in the program and comparing the rate of dropout and completion between subgroups of facilitators may provide some useful information for the future.

<u>Clinical Implications</u>

The information in this research project could have significant clinical implications for the VA Tech's DFVCT program as well as DFVCT programs in general. Through the information provided by this research study, the VA Tech DFVCT program has a better understanding of its clientele, both dropouts and completers.

From the findings, one can assume that this program is centered to meet the needs of those couples who are over 30 and married. The fact that the program is in Fairfax County and that description fits a good portion of the people in the county means that the program seems to be appropriate for the general population. However, if the program were to look at how it meets the needs of minority or younger couples, it would need to reevaluate its interventions. These finding could necessitate an assessment of group interventions. Question such as, "What would be needed for couples who are not as "mature" as the others?" and "Do we need more age appropriate interventions?"

At the time of intake, some changes could be helpful in better assessing clients and providing for their needs, especially those who are younger, not married, or not white. Bischoff and Sprenkle (1993) suggested that it would be important to know the client's expectations. Understanding what brought the client to therapy, what they expect the group to be like and what they expect from the group will give more information into who these clients are and what will keep them coming back. The program currently has questions on the intake form, "What do you hope will change about you, your partner, and your relationship as a result of your participation in the Couples Conflict Group?" These questions are very informative and could give good information concerning the participant's stage of change. However, it comes at the end of the intake when the client has answered many other questions already and may want to leave. What if the questions concerning what brought them to this program, what did they expect from a "Couple's Conflict Group", and question 50 were asked right at the beginning, when the participant was more fresh for "pondering" questions. Would that change the information received from the participant? Could that also open the communication channel even more for the rest of the intake?

As for better understanding dropouts and other information that this program could use, Bischoff and Sprenkle (1993) again provides some ideas that could help not only the VA Tech's DFVCT but also all therapists with dropouts. They suggested that the facilitator/therapist get in contact with the dropout as soon as possible and ask them two important questions. One, why they dropped out? And two, was therapy helpful and if so, to what degree. Many therapist assume that client drop out is a bad thing. The

answers of those two questions could provide the needed insight into the lives of the dropout and the needed information to help therapist with the next potential dropout.

Zweben, Pearlman, and Li (1983) studied potential conjoint therapy with alcoholic couples. They found that their program retention rate improved over time. The "initial 5 months had only 42% of the clients completed conjoint therapy, whereas in the last 3 months 83% completed treatment" (p. 328). This is a program that analyzed and learned from its past and continued to improve. This study hopefully will provide a little bit of information that will assist the VA Tech's DFVCT and other programs.

<div align="center">Conclusions</div>

The purpose of this study was to provide a piece of the puzzle in understanding the differences between dropouts and completers in DFVCT programs. The study finds that age, race and marital status were significant variables for differentiating dropouts and completers of the VA Techs DFVCT program. Employment, parental status, living arrangement and prior treatment also had tendencies towards significance. However, the Stages of Change model, the levels of violence, education, and referral source were not found significantly to differentiate dropouts and completers in this study.

References

Allgood, S., & Crane, D. (1991). Predicting Marital Therapy Dropouts. <u>Journal of Marital</u> <u>and Family Therapy, 17(1)</u>. 73-79.

American Psychological Association. (2003). <u>APA Online</u>. Public Interest: Resolution on male against women. [Online]. Available: http://www.apa.org/pi/wpo/maleviol.html.

Baekeland, F., & Lundwall, L. (1975). Dropping out of treatment: A critical review. <u>Journal of Family Violence, 82</u>. 738-783.

Begun, A., Murphy, C., Bolt, D., Weistein, B., Strodthoff, T., Short, T., & Shelley, G. (2003). Characteristics of the safe at home instrument for assessing readiness to change intimate partner violence. <u>Research on Social Work Practice, 13(1),</u> 80-107.

Begun,A., Shelley, G., Strodthoff, T., & Short, L. (2001). Adopting a stages of change approach for individuals who are violent with their intimate partners. Nonconventional approaches for intervention in cases of spouse/partner abuse. <u>Domestic Violence Offenders</u>. (pp. 105-127). The Haworth Press.

Beitman, B., Beck, N., Deuser, W., Carter, C., Davidson, J., & Maddock, R. (1994). Patient stage of change predicts outcome in a panic disorder medication trial. <u>Anxiety, 1.</u> 64-69.

Belding, M., Iguchi, M., Iguchi, R., & Lamb, R. (Sept 1996). Stages of change in methadone maintenance assessing the convergent validity of two measures. <u>Psychology of Addictive Behaviors, 10(3),</u> 157-166.

Bennett, L. & Williams, O. (2003). Controversies and recent studies of batterer intervention program effectiveness. In <u>Violence Against Women Online</u> <u>Resources</u>. [Online]. Available: http://www.vaw.umn.edu/documents/vawnet/ar_bip/ar_bip.html.

Berghofer, G., Schmidl, F., Rudas, S., Steiner, E., & Schmitz, M. (2002). Predictors of treatment discontinuity in outpatient mental health care. <u>Soc Psychiatry</u> <u>Psychiatry Epidermiol 37</u>. 276-282

Bischoff, R., & Sprenkle, D. (1993). Dropping out of marriage and family therapy: a critical review of research. <u>Family Process, 32</u>. 353-375.

Bograd, M., & Mederos, F. (1999). Battering and couples therapy: universal screening and selection of treatment modality. <u>Journal of Marital and Family Therapy, 25(3)</u>. 291-312.

Brandt, L. (1965). Studies of 'dropout' patients in psychotherapy: a review of findings. <u>Psychotherapy: Theory, Research, and Practice, 2</u>. 6-11.

Brannen, S., & Rubin, A. (Oct 1996). Comparing the effectiveness of gender-specific and couples groups in a court-mandated spouse abuse treatment program. <u>Research on Social Work Practices, 6(4),</u> 405-424.

Brogan, M., Prochaska, J., & Prochaska, J.M. (1999). Predicting termination and continuation status in psychotherapy using the transtheoretical model. <u>Psychotherapy, 36(2),</u> 105-113.

Brown, P.D, O'Leary, K.D., & Feldbau, S.R. (1997). Dropout in a treatment program for self-referring wife abusing men. <u>Journal of Family Violence, 12(4),</u> 365-387.

Bryant, N. (1994). Domestic violence and group treatment for male batterers. <u>GROUP, 18(4)</u>. 235-242.

Buttell, F., & Carney, M. (2002). Psychological and demographic predictors of attrition among batterers court ordered into treatment. <u>Social Work Research, 26(1).</u> 31-42.

Buttell, F., & Pike, C. (2002). Investigating predictors of treatment attrition among court-ordered batterers. <u>Journal of Social Service Research, 28(4).</u> 53-68.

Bureau of Justice. (May, 2000). Intimate partner violence. <u>Bureau of Justice Statistics Special Report.</u> [On-line]. Available: <u>http://www.ojp.usdoj.gov/bjs/pub/pdf/ipv.pdf</u>.

Cadsky, O., Hanson, R., Crawford, M., & Lalonde, C. (1996). Attrition from a male batterer treatment program: client-treatment congruence and lifestyle instability. <u>Violence and Victims, 11(1)</u>. 51-64.

Chang, H., & Saunders, D. (2002). Predictors of attrition in two types of group programs for men who batter. Journal of Family Violence, 17(3). 273-293.

Chisholm, S., Crowther, J., & Ben-Porath, Y. (1997). Selected MMPI-2 scales' abuility to predict premature termination and outcome from psychotherapy. <u>Journal of Personality Assessment, 69(1)</u>. 127-144.

Coulter, M; Byers, R; & Lipien, L. (2002). Absence of social supports predicts dropout from domestic violence intervention programs. <u>American Public Health Association Abstract, 46613</u>.

Daly, J., Power, T., & Gondolf, E. (2001). Predictors of batterer program attendance. <u>Journal of Interpersonal Violence, 16(10),</u> 971-991.

Davis, H., & Dhillon, A. (1989). Prediction of early attrition from couple therapy. <u>Psychological Reports, 65</u>. 899-902.

DeMaris, A. (1989 March). Attrition in batterers' counseling. <u>Social Services Review,</u> 142-154.

Derisley, J., & Reynolds, S. (2002). Evaluation of the stages of change scales to measure client readiness for treatment in a mental health sample. <u>Behavioral and Cognitive Psychotherapy, 30,</u> 217-222.

Easton, C., Swan, S, & Sinha, R. (July, 2000). Motivation to change substance use among offenders of domestic violence. <u>Journal of Substance Abuse Treatment, 19(1),</u> 1-5.

Edlund, M., Wang, P., Berglund, P., Katz, S., Lin, E., & Kessler, R. (2002). Dropping out of mental health treatment: patterns and predictors among epidemiological survey respondents in the United States and Ontario. <u>American Journal Psychiatry, 159</u>. 845-851.

Faulkner, K., Cogan, R., Nolder, M., & Shooter, G. (1991). Characteristics of men and women completing cognitive/behavioral spouse abuse treatment. <u>Journal of Family Violence, 6(3),</u> 243-253.

Fraiser, P., Slatt, L., Kowlowitz, V., & Glowa, P. (2001). Using the stages of change model to counsel victims of intimate partner violence. <u>Patient Education and Counseling. 43(2),</u> 211-217.

Garfield, S. (1994). Research on client variables in psychotherapy. In A.E. Bergin & S.L. Garfield (Eds.) <u>Handbook of psychotherapy and behavior change, 4th Ed.</u> (pp. 190-228). WileyEurope Publishers.

Geller, J., & Wasserstrom, J. (1984). Conjoint therapy for the treatment of domestic violence. In A.R. Roberts (Eds.) <u>Battered Women and their Families: Intervention</u>

Strategies and Treatment Programs. (pp. 33-48). Springer Publishing Company: New York.

Gerlock, A. (2001). Relationship mutuality: why is it important in batterers rehabilitation? Journal of Interpersonal Violence, 16(8). 768-783.

Gerlock, A. (2001). A profile of who completes and who drops out of domestic violence rehabilitation. Mental Health Nursing, 22, 379-400.

GMU Sexual Assault Services. (Aug 2001). Domestic violence national and Virginia statistics. [Online]. Available:

http://www.gmu.edu/facstaff/sexual/domviolnatl&vastats.htm

Gondolf, E. (2001). Limitations of experimental evaluation of batterer programs. Trauma, Violence, & Abuse, 2(1), 79-88.

Gondolf, E. (2001). Final report: an extended follow-up of batterers and their partners (1997-2001). In Report to the center of disease control and prevention from the Mid-Atlantic addiction training institute (MAATI). [On-line]. Available: http://www.iup.edu/maati/publications

Gondolf, E. (Nov. 2000). How batterer program participants avoid reassault. Violence Against Women, 6(11), 1204-1222.

Gondolf, E. (Apr. 2000). Mandatory court review and batterer program compliance. Journal of Interpersonal Violence, 15(4), 428-437.

Gondolf, E. (1999). An extended follow-up of batterers and their female partners. Center for Disease Control, National Center for Injury Prevention and Control, Violence Prevention Monitoring Session. [online] Available: http://www.iup.edu/maati/publications/CDCMonitoringSession.shtm

Gondolf, E. (1997). Multi-site evaluation of batterer intervention systems: summary of the 15-month follow-up. National Center for Injury Prevention, Centers for Disease Control and Prevention. U.S. Department of Health and Human Services. [online] Available: http://www.iup.edu/maati/publications/15MonthSummary.shtm

Gondolf, E. (Feb. 1997). Batterer programs: what we know and need to know. Journal of Interpersonal Violence, 12, 89-88.

Gondolf, E. (1996). Multi-site evaluation of batterer intervention systems: summary of the 12-month follow-up. National Center for Injury Prevention, Centers for Disease Control and Prevention. U.S. Department of Health and Human Services. [online] Available: http://www.iup.edu/maati/publications/12MonthSummary.shtm.

Gondolf, E. (1995). Discharge Criteria for Batterer Programs. Mid-Atlantic Addiction Training Institute. [online] Available: http://www.mincava.umn.edu/papers/gondolf/discharg.htm.

Gondolf, E., & Foster, R. (1991). Pre-program attrition in batterer programs. Journal of Family Violence, 6. 337-349.

Gregory, C.; Erez, E. (Feb. 2002). The effects of batterer intervention programs: the battered women's perspectives. Violence Against Women, 8(2), 206-232.

Haggerty, L. & Goodman, L. (2002). Stages of change-based nursing interventions for victims of interpersonal violence. JOGNN Principles and Practice, 32(1), 68-75.

Hamberger, K. & Hastings, J. (1989). Counseling male spouse abusers: characteristics of treatment completers and dropouts. Violence and Victims, 4(4), 275-286.

Harris, P. (1998). Attrition Revisited. American Journal of Evaluation, 19(3). 293-305.

Harris, R., Savage, S., Jones, T., & Brooke, W. (1988). A comparison of treatment for abusive men and their partners within a family-service agency. Canadian Journal of Community Mental Health, 7(2). 147-155.

Helmeke, K., Bischof, G., & Sori, C. (2002). Dropping out of couple therapy: a qualitative case study. Journal of Couple & Relationship Therapy 1(2). 51-73.

Heyman, R., Brown, P., Feldbau-Kohn S., & O'Leary, K.D. (1999). Couples' communication behaviors as predictors of dropout and treatment response in wife abuse treatment programs. Behavior Therapy 30, 165-189.

Heyman, R. E. & Neidig, P. H. (1997). Physical aggression couples treatment. In W. K. Halford & H. J. Markman (Eds.), Clinical handbook of marriage and couples intervention (pp. 589-617). New York: Wiley.

Horenstein, D., & Houston, B. (1976). The expectation-reality discrepancy and premature termination from psychotherapy. Journal of Clinical Psychology, 32. 373-378.

Howell, M., & Pugliesi, K. (1988). Husbands who harm: predicting spousal violence by men. Journal of Family Violence, 3(1). 15-27.

Laing, L. (2002). Responding to men who perpetrate domestic violence: controversies, interventions and challenges. Australian Domestic & Family Violence Clearinghouse, Issues Paper No. 7.

LeFave, M. (1980). Correlates of engagement in family therapy. Journal of Marital and Family Therapy, 6. 75-81.

Levesque, D., Gelles, R., & Velicer, W. (2000). Development and validation of a stages of change measure for men in batterer treatment. Cognitive Therapy and Research, 24(2), 175-199.

Lipchik, E., Sirles, E. A., & Kubicki, A. (1997). Multifaceted approach in spouse abuse treatment. In R. Geffner & S. B. Sorenson & P. K. Lunberg-Love (Eds.), Violence and sexual abuse at home: current issues in spousal battering and child maltreatment. (pp. 131-148). USA: The Haworth Press Inc.

MacNair, R., & Corazzini, J. (1994). Client factors influencing group therapy dropout. Psychotherapy, 31. 352-362.

Masi, M., Miller, R., & Olson, M. (2003). Differences in dropout rates among individual, couple, and family therapy clients. Contemporary Family Therapy, 25(1). 63-75.

McConnaughy, E., DiClemente, C., Prochaska. J., & Velicer, W. (1989). Stages of change in psychotherapy: a follow-up report. Psychotherapy, 26(4), 494-503.

McConnaughy, E., Prochaska, J., & Velicer, W. (1983). Stages of change in psychotherapy: measurement and sample profiles. Psychotherapy Theory, Research and Practice, 20(3), 368-375.

Miller, S., Duncan, B., & Hubble, M. (1997). Escape from Babel: toward a unifying language for psychotherapy practice. WW Norton: New York.

O'Hare, T. (1996). Court-ordered versus voluntary clients: problem differences and readiness for change. Social Work, 41. 417-422.

O'Leary, K., Heyman, R., & Neidig, P. (1999). Treatment of wife abuse: a comparison of gender-specific and conjoint approaches. Behavior Therapy. 30, 475-505.

Prochaska, J., & Norcross, J. (2001). Stages of Change. Psychotherapy, 38(4). 443-448.

Prochaska, J., Norcross, J., & DiClemente, C. (1994). Changing for Good. New York, NY: Quill.

Prochaska, J. (2000). A transtheoretical model for assessing organizational change: a study of family service agencies' movement to time-limited therapy. Families in Society, 81(1), 76-84.

Prochaska, J., & DiClemente, C. (1984). The transtheoretical approach: crossing traditional boundaries of therapy. Homewood, IL: Dow Jones, Irwin.

Prochaska, J., & DiClemente, C. (1983). Stages and processes of self-change of smoking: toward an integrative model of change. Journal of Consulting and Clinical Psychology, 51(3). 390-395.

Prochaska, J., & DiClemente, C. (1982). Transtheoretical therapy: toward a more integrative model of change. Psychotherapy: Theory, Research, and Practice, 19. 276-288.

Renk, K., Dinger, T., & Bjugstad, K. (2000). Predicting therapy duration from therapist experience and client psychopathology. Journal of Clinical Psychology, 56(12). 1609-1614.

Rondeau, Gilles, et al. (Apr 2001). Dropout and completion of treatment among spouse abusers. Violence and Victims 16(2), 127-143.

Rosenbaum, A., Gearan, P.J., & Ondovic, C. (2001). Completion and recidivism among court and self-referred batterers in a psychoeducational group treatment program: Implications for intervention and public policy. Journal of Aggression, Maltreatment and Trauma, 5(2), 199-220.

Samstag, L., Batchelder, S., Muran, C., Safran, J., & Winston, A. (1998). Early identification of treatment failures in short-term psychotherapy: an assessment of therapeutic alliance and interpersonal behavior. Journal of Psychotherapy Practice and Research, 7. 126-143.

Shapiro, R. (1974). Terapist attitudes and premature termination in family and individual therapy. Journal of Nervous and Mental Disease, 159. 101-107.

Sledge, W., Moras, K., Harley, D., & Levine, M. (1990). Effect of time-limited psychotherapy on patient dropout rates. The American Journal of Psychiatry, 147. 1341-1347.

Sonkin, D. (1995). Chapter nine: cross-cultural issues. In D. Sonkin, <u>A Counselor's</u>
<u>Guide to Learning to Live Without Violence</u>. Volcano Press.

Stanton, M., Steier, F., & Todd, T. (1982). Paying families for attending sessions:
counteracting the dropout problem. <u>Journal of Marital and Family Therapy, 8</u>.
371-373.

Stith, S. (2003). Domestic violence: prevalence and costs of domestic violence. <u>AAMFT</u>
<u>Clincial Update</u>. [online] Available:
http://www.aamft.org/members/familytherapyresources/articles/clup22000_3_5.ht
m.

Stith, S., Rosen, K., McCollum, E. (2002). Domestic violence. In D. Sprenkle, (Ed.).
<u>Effective research in marriage and family therapy.</u> (pp. 223-254). American
Association for Marriage and Family Therapy.

Stith, S., Locke, L., Rosen, K., McCollum, E. (2001). Domestic violence focused couples
treatment. <u>AAMFT Family Therapy News, Vol. 32, Num. 4.</u> 10-12.

Stith, S., McCollum, E., Rosen, K., & Locke, L. (2001). <u>Domestic violence focused</u>
<u>couples treatment handbook</u>. Virginia Polytechnic Institute and State University.
Unpublished document.

Suris, A., Trapp, M., DiClemente, C., & Cousins, J. (1998). Application of the
transtheoretical model of behavior change for obesity in mexican american
women. <u>Addictive Behaviors, 23(5).</u> 655-668.

Taft, D., Murphy, C., Elliott, J., & Morrel, T. (2001). Attendance-enhancing procedures
in group counseling for domestic abusers. <u>Journal of Counseling Psychology,</u>
<u>48(1),</u> 51-60.

<u>U.S. Bureau of the Census</u>, U.S. Census of Population, 1970 through 2000.

Velicer, W., Prochaska, J., Fava, J., Norman, G., & Redding, C. (1998). Transtheoretical
model: detailed overview of the transtheoretical model. <u>Cancer Prevention</u>
<u>Research Center</u>. [online] Available:
http://www.uri.edu/research/cprc/TTM/detailedoverview.htm

Vetere, A., & Henley, M. (2001). Integrating couples and family therapy into a
community alcohol service: a pantheoretical approach. <u>Journal of Family</u>
<u>Therapy, 23</u>. 85-101.

Walitzer, K., Dermen, K., & Connors, G. (1999). Strategies for preparing clients for treatment: a review. Behavior Modification, 23(1), 129-151.

Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. Professional Psychology, Research and Practice, 24(2). 190-195.

Women's Health. (1993). First comprehensive national health survey of American women finds them at significant risk. National Survey of Women's Health Press Release. [On-line]. Available: http://www.cmwf.org/programs/women/whpress.asp.

Zweben, A., Peralman, S., Li, S. (1983). Reducing attrition from conjoint therapy with alcoholic couples. Drug and Alcohol Dependence, 11. 321-331.

Data Location

Questions 1 Location

The URICA

- NIMH Intake Answer #39

The URICA-DV:

- "Attitudes and Behaviors Survey" – 20 questions (attached)

Question 2 Location

Age:

- NIMH Intake Answer #1
- Couples Conflict Group Intake Answer #1

Race:

NIMH Intake Answer #3

Couples Conflict Group Questionnaire Answer #3

Employment:

- NIMH Intake Answer #4
- Couples Conflict Group Questionnaire Answer #4

Education:

- NIMH Intake Answer #7
- Couples Conflict Group Questionnaire Answer #6

Marital Status:

- NIMH Intake Answer #Initial Phone Intake & Client Information
- Couples Conflict Group Questionnaire Answer #10

Parental Status:

- NIMH Intake Answer #Initial Phone Intake & Intake cover page & Client Information
- Couples Conflict Group Questionnaire Answer #14

Current Living Status:

- NIMH Intake Answer #8
- Couples Conflict Group Questionnaire Answer #11

Referral Process:

- NIMH Intake Answer #34
- Couples Conflict Group Questionnaire Answer #15

Prior Treatment:

- NIMH Intake Answer #15
- Couples Conflict Group Questionnaire Answer #37

Levels of Violence:

- CTS-2 Measurement

ATTACHMENT 2: URICA

This questionnaire is to help us better understand the way you feel about participating in counseling. Each statement describes how a person might feel when starting treatment or approaching problems in their life. Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel. For all the statements that refer to your "problem," answer in terms of physical violence in your relationship and "here" or "this place refers to Virginia Tech's counseling center.

1=Strongly Disagree
2=Disagree
3=Undecided
4=Agree
5=Strongly Agree

1. As far as I'm concerned, I don't have any problems that need changing
2. I'm not the problem one. It doesn't make much sense for me to be here.
3. I am finally doing some work on my problem.
4. I've been thinking that I might want to change something aobut myself.
5. I have been successful in working on my problem but I'm not sure I can keep up the effort on my own.
6. At times my problem is difficult, but I'm working on it.
7. Being here is pretty much a waste of time for me because the problem doesn't have to do with me.
8. I have a problem and I really think I should work at it.
9. Even though I'm not always successful in changing, I am at least working on my problem.
10. I thought once I had resolved my problem I would be free of it, but sometimes I still find myself struggling with it.
11. I have started working on my problems but I would like help.
12. Maybe this place will be able to help me.
13. I may need a boost right now to help me maintain the changes I've already made.
14. I may be part of the problem, but I don't really think I am.
15. I hope that someone here will have some good advice for me.
16. After all I had done to try to change my problem, every now and again it comes back to haunt me.

Attitudes and Behaviors Survey

> **Please indicate how much you disagree or agree with each of the following statements. Base your responses on you're feeling and acting NOW. Please answer using a 5-point scale with 1= Strongly disagree to 5= Strongly agree.**

1 = Strongly disagree
     2 = Disagree
          3 = No opinion
               4 = Agree
                    5 = Strongly agree

1. There's nothing I can do to end the violence in my relationship.   **1 2 3 4 5**

2. I'm beginning to see that the violence in my
    relationship is a problem.   **1 2 3 4 5**

3. Although I haven't been violent in a while, I know it's
    possible for me to be violent again.   **1 2 3 4 5**

4. I'm actively working on ending the violence in my relationship.   **1 2 3 4 5**

5. I wish I had more ideas about how to end the violence
    in my relationship.   **1 2 3 4 5**

6. I'm actually doing something to stop my violent behavior,
    not just thinking about it.   **1 2 3 4 5**

7. The violence in my relationship isn't a big deal.   **1 2 3 4 5**

8. I've ended the violence, but sometimes still struggle with the old
    urges that allowed the violence to happen in the first place.   **1 2 3 4 5**

9. It's OK to use violence as long as you don't hurt anyone.   **1 2 3 4 5**

10. I'm at a point in my life where I'm beginning to feel the
    harmful impact of my violent behavior.   **1 2 3 4 5**

11. I've made some changes and ended the violence, but I'm
    afraid of going back to the way I was before.   **1 2 3 4 5**

12. Although at times it's difficult, I'm working on ending my
    violent behavior in my relationship.   **1 2 3 4 5**

13. More and more I'm seeing how my violence hurts my partner.   **1 2 3 4 5**

14. I'm finally doing something to end the violence.   **1 2 3 4 5**

15. There's no way I can control my violent impulses.   **1 2 3 4 5**

16. I've been pretty successful in leading a violence-free life, but
    there are still times when I'm tempted to resort to violence.   **1 2 3 4 5**

17. I'm making important changes and ending the violence
    in my life.   **1 2 3 4 5**

18. More and more I'm realizing that my violence in wrong.   **1 2 3 4 5**

19. Although I've made the changes necessary to lead a violence-free
    life, there are still times when I'm tempted to use violence.   **1 2 3 4 5**

20. I don't see the point of focusing on the violence in
    my relationship.   **1 2 3 4 5**

Client intake number: _____

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences.

Please circle how many times you did each of the following things in the past year, and how many times your partner did them in the past year.

If you or your partner did not do one of these things in the past year, but it happened before, circle "7."

How often did this happen?

"0" = No, this has never happened

"1" = Once in the past year

"2" = Twice in the past year

"3" = 3 - 5 times in the past year

"4" = 6 - 10 times in the past year

"5" = 11 - 20 times in the past year

"6" = More than 20 times in the past year

"7" = Not in the past year, but it did happen before

1. I showed my partner I cared even though we disagreed	0	1	2	3	4	5	6	7
2. My partner showed care for me even though we disagreed	0	1	2	3	4	5	6	7
3. I explained my side of a disagreement to my partner	0	1	2	3	4	5	6	7
4. My partner explained his or her side of a disagreement to me	0	1	2	3	4	5	6	7
5. I insulted or swore at my partner	0	1	2	3	4	5	6	7
6. My partner did this to me	0	1	2	3	4	5	6	7
7. I threw something at my partner that could hurt	0	1	2	3	4	5	6	7
8. My partner did this to me	0	1	2	3	4	5	6	7
9. I twisted my partner's arm or hair	0	1	2	3	4	5	6	7
10. My partner did this to me	0	1	2	3	4	5	6	7
11. I had a sprain, bruise, or small cut because of a fight with my partner	0	1	2	3	4	5	6	7
12. My partner had a sprain, bruise, or small cut because of a fight with me	0	1	2	3	4	5	6	7
13. I showed respect for my partner's feelings about an issue	0	1	2	3	4	5	6	7
14. My partner showed respect for my feelings about an issue	0	1	2	3	4	5	6	7
15. I made my partner have sex without a condom	0	1	2	3	4	5	6	7
16. My partner did this to me	0	1	2	3	4	5	6	7
17. I pushed or shoved my partner	0	1	2	3	4	5	6	7
18. My partner pushed or shoved me	0	1	2	3	4	5	6	7
19. I used force (like hitting, holding down, using a weapon) to make my partner have oral or anal sex	0	1	2	3	4	5	6	7
20. My partner did this to me	0	1	2	3	4	5	6	7
21. I used a knife or a gun on my partner	0	1	2	3	4	5	6	7
22. My partner did this to me	0	1	2	3	4	5	6	7
23. I passed out from being hit on the head by my partner during a fight	0	1	2	3	4	5	6	7
24. My partner passed out from being hit on the head in a fight with me	0	1	2	3	4	5	6	7
25. I called my partner fat or ugly	0	1	2	3	4	5	6	7
26. My partner called me fat or ugly	0	1	2	3	4	5	6	7

27. I punched or hit my partner with something that could hurt	0	1	2	3	4	5	6	7
28. My partner did this to me	0	1	2	3	4	5	6	7
29. I destroyed something belonging to my partner	0	1	2	3	4	5	6	7
30. My partner did this to me	0	1	2	3	4	5	6	7
31. I went to a doctor because of a fight with my partner	0	1	2	3	4	5	6	7
32. My partner went to a doctor because of a fight with me	0	1	2	3	4	5	6	7
33. I choked my partner	0	1	2	3	4	5	6	7
34. My partner did this to me	0	1	2	3	4	5	6	7
35. I shouted or yelled at my partner	0	1	2	3	4	5	6	7
36. My partner did this to me	0	1	2	3	4	5	6	7
37. I slammed my partner against a wall	0	1	2	3	4	5	6	7
38. My partner did this to me	0	1	2	3	4	5	6	7
39. I said that I was sure we could work out a problem	0	1	2	3	4	5	6	7
40. My partner was sure that we could work it out	0	1	2	3	4	5	6	7
41. I needed to see a doctor because of a fight with my partner, but I didn't	0	1	2	3	4	5	6	7
42. My partner needed to see a doctor because of a fight with me, but didn't	0	1	2	3	4	5	6	7
43. I beat up my partner	0	1	2	3	4	5	6	7
44. My partner did this to me	0	1	2	3	4	5	6	7
45. I grabbed my partner	0	1	2	3	4	5	6	7
46. My partner did this to me	0	1	2	3	4	5	6	7
47. I used force (like hitting, holding down, or using a weapon) to make my partner have sex	0	1	2	3	4	5	6	7
48. My partner did this to me	0	1	2	3	4	5	6	7
49. I stomped out of the room or house or yard because of a disagreement with my partner	0	1	2	3	4	5	6	7
50. My partner did this to me	0	1	2	3	4	5	6	7
51. I insisted on sex when my partner did not want to (but did not use physical force)	0	1	2	3	4	5	6	7
52. My partner did this to me	0	1	2	3	4	5	6	7

53. I slapped my partner	0	1	2	3	4	5	6	7
54. My partner did this to me	0	1	2	3	4	5	6	7
55. I had a broken bone from a fight with my partner	0	1	2	3	4	5	6	7
56. My partner had a broken bone from a fight with me	0	1	2	3	4	5	6	7
57. I used threats to make my partner have oral or anal sex	0	1	2	3	4	5	6	7
58. My partner did this to me	0	1	2	3	4	5	6	7
59. I suggested a compromise to a disagreement	0	1	2	3	4	5	6	7
60. My partner suggested a compromise	0	1	2	3	4	5	6	7
61. I burned or scalded my partner on purpose	0	1	2	3	4	5	6	7
62. My partner did this to me	0	1	2	3	4	5	6	7
63. I insisted my partner have oral or anal sex (but did not use physical force)	0	1	2	3	4	5	6	7
64. My partner did this to me	0	1	2	3	4	5	6	7
65. I accused my partner of being a lousy lover	0	1	2	3	4	5	6	7
66. My partner accused me of this	0	1	2	3	4	5	6	7
67. I did something to spite my partner	0	1	2	3	4	5	6	7
68. My partner did this to me	0	1	2	3	4	5	6	7
69. I threatened to hit or throw something at my partner	0	1	2	3	4	5	6	7
70. My partner did this to me	0	1	2	3	4	5	6	7
71. I felt physical pain that still hurt the next day because of fight we had	0	1	2	3	4	5	6	7
72. My partner still felt physical pain the next day because of a fight we had	0	1	2	3	4	5	6	7
73. I kicked my partner	0	1	2	3	4	5	6	7
74. My partner did this to me	0	1	2	3	4	5	6	7
75. I used threats to make my partner have sex	0	1	2	3	4	5	6	7
76. My partner did this to me	0	1	2	3	4	5	6	7
77. I agreed to try a solution to a disagreement my partner suggested	0	1	2	3	4	5	6	7
78. My partner agreed to try a solution I suggested	0	1	2	3	4	5	6	7

6855 Grande Lane   Phone 703-509-2217
Falls Church, VA 22043-1630   E-mail Adeana@cox.net

Barry J. Alvarez

Academic **experience**	2000- 2003 **Masters, Marriage and Family Therapy**	Virginia Tech	Falls Church, VA
	1983 – 1987 **BS, Accounting**	Brigham Young University	Provo, UT

Professional experience

May, 2002-May, 2003   Inova Kellar Center   Fairfax, VA

Therapist Intern – Abused Children's Treatment Services

- Provide individual, group, and family therapy for sexually abused children and adolescents who have been referred by Inova Fairfax Hospitals' F.A.C.T. (Forensic Assessment and Consultation Teams) program or Child Protective Services. Develop goal oriented treatment plans and case coordination. Actively work with FACT program and other community agencies to identify and meet community needs and service gaps. Supervisor: Dr. Eliana Gil, Ph.D – 703-218-8537

October, 2000 – January, 2003   Center for Family Services, VA Tech

Therapist Intern

- Provide individual, group, and family therapy. Therapy included verbal and psycho-educational therapy as well as play therapy.
- Facilitate Couple's Conflict Groups. Eighteen-week Domestic Violence couple's groups that included domestic violence education as well as couple's therapy.
- Director: Dr. Eric McCollum - 703-538-4871

Languages

English and Spanish

Community activities

1987 – 2002, Leadership positions in the Church of Jesus Christ of Latter-day Saints. Bishop of a Spanish Ward in the Northern Virginia area from 1989 – 1992.

1981-1983 – Missionary for the Church of Jesus Christ of Latter-day Saints in the Lima Peru South Mission

Personal

Married for 18 years, 5 children