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## Voices of family- and partner-violent adults in treatment : participants' experience of therapy

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Justin Butler  
Voices of Family- and  
Partner-Violent Adults in  
Treatment: Participants'  
Experiences of Therapy

## ABSTRACT

This study examines the preferences and opinions of partner- or family-violent adults in rehabilitative therapy and counseling. With the goal of informing and improving treatment approaches for this population, the study seeks to augment the current field of research, based primarily on external measures, with the voices and opinions of participants themselves. A convenience sample of 80 male and female participants at an urban social service agency in the U.S. was selected to complete the mixed-methods (qualitative and quantitative) survey. The survey consists of 5 demographic elements, and 38 questions (33 rating-scale and 5 short-answer). The survey explored participants' opinions about: overall satisfaction, styles of therapeutic engagement, types of therapeutic interventions (directive, nondirective, psychodynamic, cognitive-behavioral, etc.), aspects of the helping alliance, moments of change/growth, and other elements. Quantitative data was analyzed for trends within and across various survey items, and qualitative data was transcribed and coded to examine trends and themes therein. Findings indicated a strong correlation between satisfaction and the working alliance between participant and counselor, a slight preference for CBT and skills-based interventions, a preference for some psychodynamic and non-directive styles, higher satisfaction with longer-term participation, and no significant differences in satisfaction between mandated and non-mandated participants, among other insights into participants' experiences.

VOICES OF FAMILY- AND PARTNER-VIOLENT ADULTS IN TREATMENT:  
PARTICIPANTS' EXPERIENCES OF THERAPY

A project based upon an independent investigation, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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2015

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## **CHAPTER I**

### **Introduction**

The prevalence of interpersonal violence in the U.S. is staggering. An estimated one in four women, and one in seven men, have experienced severe physical violence from an intimate partner, with significantly higher rates of severity and sexual violence among women (Black et al., 2011; Breiding, Black & Ryan, 2008). While both men and women are arrested for domestic violence offenses in the U.S., female offenders are considerably more likely than men—about 40%—to have been recent victims of domestic violence themselves (Kernsmith and Kernsmith, 2009). The majority of violence against women—an estimated 75%—is perpetrated by their male intimate partners (Garcia-Moreno, Jansen, Ellsberg, Heise & Watts, 2005). On a global scale, the World Health Organization calculates that the international prevalence of physical and sexual intimate partner violence (IPV) among partnered women is 30.0%, ranging from 23.2% to 37.7% in different global regions (World Health Organization, 2013).

Statistics from the justice system in the U.S. offer information on the reported cases of IPV. In 2008, there were approximately 652,700 nonfatal intimate partner victimizations committed by current or former partners, including same sex relationships; 551,600 of these were against females and 101,100 were against males (Catalano et al., 2009). Also in 2008, IPV made up 23% of nonfatal violence against females and 3% of nonfatal violence against males (Rand, 2009). In 2007, there were 1,640 women and 700 men murdered by an intimate partner in the United States (Catalano et al., 2009). In a social climate that is largely pro-arrest and pro-prosecution, there are extremely high rates of criminal charges for these offenses, many of which

lead to mandated treatment in counseling programs (Mills, Barocas & Ariel, 2013). There are currently about 2,000 batterer treatment programs in the United States, and hundreds of thousands of convicted offenders are mandated by local courts to participate in these programs every year (Labriola et al., 2007).

This study seeks to contribute to the research on partner- or family-violent adults and the treatment methods used in rehabilitative therapy and counseling. It examined the experiences and preferences of participants in such therapy, such as: which types of therapeutic interactions participants preferred; which qualities they most appreciated in a therapist; their perceptions of themselves before and after therapy; and when and why moments of change occurred during therapy. The goal of this researcher was to gain greater insight about the therapeutic preferences of family-violent and partner violent adults and what they find to be helpful in their treatment. Therefore, the study asks: *What types of therapeutic interventions for partner-violent and family-violent adults are considered helpful, in the eyes of the participants?*

This study, instead of focusing on concrete, pre-determined outcomes, asks people about their experiences in group and individual treatment, in order to gain a more nuanced, complete and client-centered perspective on treatments. In this way, this study addresses an apparent gap in the field of research on this important topic: a more thorough documentation of participants' experiences and opinions, in order to better understand what practices are most effective in addressing family violence. It is an attempt to assess how clients feel during treatment, and what *they* perceive as the most helpful elements of that treatment. Such a perspective is valuable to the fields of psychology and social work, because it directly addresses the needs of the clients being served, with the hopes of making more impactful interventions. Social work—which prides itself in meeting the client where he or she is, in serving the needs of the client, and in



working to improve the lives of clients—should find this study particularly relevant. Hopefully, some of the knowledge that was gathered might be used to inform practitioners’ practices in working with partner- and family-violent adults. Thus, the intended audience for this study is practitioners—therapists, psychologists, psychiatrists, social workers, counselors, case workers, and other mental health professionals; as well as researchers, managers, supervisors, directors, funders, and policy-makers in the field. This study could also be beneficial for both survivors and perpetrators of family violence to read.

The limits of this study are many. Data could only be gathered within the span of four months. Data collection was limited to one program at a family-counseling agency in the United States. It is also significant to note that, for the sake of brevity and both accessibility for and respect of participants, extensive histories were not gathered on study participants—therefore, certain correlative connections may not be able to be made.

For the purpose of this study, *partner-violent adults* will refer to people who have committed acts of physical violence against their romantic partners, whether married or not. *Family-violent adults* refers to those who have committed acts of physical violence against other family members, including children. *Interpersonal violence, intimate partner violence (or IPV)* will be used to describe the same phenomena of relationship violence. *Participants* may refer to either participants in the treatment programs or in this survey, and the distinction will be made each time. *Therapy* and *treatment* will be used interchangeably, to refer to any intervention process that involves a client speaking with a mental health professional, or with other clients in a clinical setting. *Breakthrough* refers to a perceived moment of change during treatment.

## **CHAPTER II**

### **Literature Review**

#### **Impacts of IPV**

As indicated previously, the prevalence of IPV is an insidious issue in the United States (Black et al., 2011; Breiding, Black & Ryan, 2008; Catalano et al., 2009; Rand, 2009). Not surprisingly, many studies have found linkages between negative health outcomes—such as mental disorders, gene expression, depression, smoking, binge drinking, substance abuse, suicide attempts, likelihood of incarceration, etc.—and exposure to violence (Cerulli, Bossarte & Dichter, 2013; Cicchetti & Moffitt, 2013; Iverson et al., 2013; Lynch, Fritch & Heath, 2012). People who are partner-violent often face similar concurrent issues, such as economic stress, threats to identity (e.g., masculinity, femininity, role as caregiver, etc.), substance abuse, past trauma, military trauma, and psychological diagnoses (Caetano, Vaeth & Ramisetty-Mikler, 2008; Chen, Jacobs & Rovi, 2013; Peralta & Tuttle, 2013; Williston, Taft & VanHaasteren, 2015). Though, some findings suggest that those involved in violent relationships do not appear to be very different from those not involved in violent relationships” (Caetano, Vaeth & Ramisetty-Mikler, 2008). Many studies of IPV perpetrators also discuss the prevalence of the role of dominance and control in all of their interpersonal relationships (Peralta & Tuttle, 2013).

A troubling problem in families and relationships, family violence and the patterns and precipitating histories of such violence have been extensively researched (Straus, Gelles, &

Steinmetz, 1980). Straus et al. (1980) developed the now widely accepted theory that perpetrators of abuse were typically victims of abuse as children (Davies & Frawley, 1994; Grand, 2002; Straus et al., 1980). In fact, victims of child abuse and neglect have been found more likely, compared to a control group, to perpetrate criminal violence, child abuse, and interpersonal violence as adults (Milaniak & Widom, 2014). Child abuse victims are also more likely to experience *victimization* as adults (Widom, Czaja & Dutton, 2014). This work, of course, builds on the theoretical work of Melanie Klein (1952), D. W. Winnicott (1975; 1977), and others, who posited that we establish relational patterns early in life, and repeat the patterns throughout our lives in attempt to soothe, correct, feel whole, and connect to our ever-elusive attachment figures (Juni, 2009; Miller, 1990). In this vein, studies have shown that new, supportive relationships can help break this cycle of intergenerational violence (Jaffe et al., 2013). More recently, valuable studies have been conducted to explore the strategies of therapeutic interventions for partner- and family-violent people, with a particular focus on male perpetrators (Lawson et al., 2006; Murphy et al., 2005). There is a substantial body of research that analyzes the correlation between client traits, such as self-esteem and attachment styles, and violence in interpersonal relationships—as well as the way these participants respond to treatments aimed at building skills for compassion and self-regulation (Lawson & Brossart, 2009; Murphy, Stosny & Morrel, 2005).

### **Attachment Styles and Self-Esteem**

Research on attachment styles and treatment, as well as predictive factors of attachment and self-esteem among men who have committed violence, have been conducted in the literature (Lawson et al., 2006; Lawson & Brossart, 2009; Murphy et al., 2005). For instance, one study, based on observations of participants in group treatment, reported that the most statistically

significant changes that occurred in attachment styles (measured using the Adult Attachment Scale) during the course of treatment were among those who transitioned to a more secure attachment style (with greater comfort with closeness and dependence on others), while a large number of men also remained in a more avoidant attachment style (Lawson et al., 2006). This suggests that a substantial internal shift, such as in attachment styles, can occur positively during treatment, but that certain men are still not affected in this dramatic way. Further research on attachment has explored predictive qualities of abusers, using the Adult Attachment Scale to measure participants' attachment style, in order to correlate them to the types of abuse committed. They found that there was a relatively strong correlation between: attachment anxiety and mild physical abuse, intrusive attachment problems and psychological abuse, and avoidant attachment and severe violent abuse (Lawson and Brossart, 2009). Both of these studies point to a crucial significance of addressing dismissive attachment styles in the efforts to end partner violence. Researchers have suggested that it would be particularly valuable to identify reasons why certain men exhibited dismissive attachment styles prior to therapy (Lawson et al., 2006; Lawson & Brossart, 2009), suggesting that extensive research into clients' histories could be advantageous in shaping therapeutic strategies. While the study reported in this paper does not assess attachment styles in this formal way, it is helpful to understand how therapeutic change is linked to certain factors like attachment styles, and how this evidence has been used to legitimize certain therapeutic modalities. The study presented here augments these external measures of change with the participants' own internal measures of satisfaction.

Self-esteem is another widely researched quality among male abusers. Increases in self-esteem have been found to decrease recurrences of violence, improve the likelihood of a collaborative therapeutic working alliance, and correlate to a readiness to change (Murphy et al.,

2005; Semiatin, Murphy and Elliott, 2013; Taft, Murphy, Musser and Remington, 2004). Not only does this data on self-esteem invalidate the myth that higher self-esteem leads to greater violence (Murphy et al., 2005), but it also suggests that higher self-esteem increases one's ability to be self-reflective, a crucial aspect of therapy. Reflection could also include critique, and incorporating the perspectives of others—a true challenge for someone with low self-esteem. In fact, ego defenses that are reflective of relatively low self-esteem, such as minimization and denial, which often manifest as partner-blaming behaviors, have been shown to correlate with higher levels of partner violence among men (Scott & Strauss, 2007).

## **Treatment**

Cognitive-behavioral therapy (CBT) and variants of CBT have been widely studied in work with family-violent and partner-violent men (Lawson, 2010; Taft, Murphy, King, Musser & DeDeyn, 2003; Taft et al., 2004). CBT, when integrated with psychodynamic therapy (CBT/PT) in a 45-person study, has been shown to produce more lasting improvements in partner violence, relationship problems, and attachment issues, than CBT alone—which has been shown to decrease general symptoms—such as interpersonal problems and life dissatisfaction, and maladaptive behaviors like aggression, insulting and cursing (Lawson, 2010). Of course, because of the small size of this study, widespread conclusions cannot be drawn. Recognizing that multiple factors contribute to the effectiveness of CBT interventions, two studies focused on the more predictive qualities of CBT participant traits and their influence on therapeutic success. For instance, they found that “motivational readiness to change” and self-referred status (i.e., client-chosen participation) increase the chances of a productive working alliance with a clinician, while psychopathological and borderline traits, as well as low age and income, decrease the chances of such a relationship (Taft, Murphy, King, Musser & DeDeyn, 2003; Taft

et al., 2004). This seems to reveal a conundrum: clients more inclined to change will change, but what about clients who are not motivated in this way? Motivational Interviewing has been found to have some better outcomes for clients with reluctance to change, though more extensive research is needed (Murphy, Linehan, Reyner, Musser and Taft, 2012).

There also seem to be recurring findings that the therapeutic/working alliance is a crucial factor in, and a somewhat reliable predictor of, success in the treatment of partner-violent men, and in a reduction in violence in their relationships (Taft et al., 2003; Taft et al., 2004; Lawson, 2010; Semiatin et al., 2013). While this may seem like a fairly logical finding, it is important to emphasize, especially in a field in which stigma is often attached to the clients and their past offenses: the relationship between therapist and client is one of the most powerful factors in bringing about meaningful change (Semiatin et al., 2013). In an observational study of partner-violent men in treatment, working alliance and compliance with CBT homework assignments was correlated with “pro-therapeutic client attitudes,” which was positively correlated with lower recidivism rates after treatment (Semiatin et al., 2013). It therefore appears that it would be useful to study further exactly what brings about such a fruitful relationship, and what preferences clients express about therapy.

These above findings, addressing the significance of the therapeutic relationship, as well as the demonstrated effectiveness of both concrete, skill-based interventions and more involved, emotional-processing interventions (e.g., CBT/PT), perhaps point to the value of a varied, multifaceted approach with clients, and one which consistently values the working alliance between client and therapist. As discussed below, this conclusion forms the basis of the hypothesis for this study.

Surveys of IPV program participants' actual therapeutic preferences—whether they are perpetrators or victims—are less common than the external measures in the above studies, but seem to be quite useful toward the goal of understanding clients, and building an effective treatment. One study of men and women in court-ordered batterer programs concluded that participants prefer a type of treatment that provides them with some increased self-awareness and useful coping skills, as well as those treatments which accommodate participants' unique cultural experiences (Benki, 2013; Daniels, 2001). Moreover, studies of female victims of assault, have found a preference for psychotherapy versus medication (Cochran, Pruitt, Fukuda, Zoellner & Feeny, 2008). There have also been findings of perpetrator participants confirming, via surveys, their behavioral cycles of rejection—threat to self—defense of self—abuse (Brown, James & Taylor, 2010). Such studies of treatment participants are useful in understanding one's experience in treatment. For instance, research from surveys of women who disclose their experience of abuse to a health care provider, demonstrated that the preferred type of response is one that is immediate, respectful, empowering, informative, and connected to action (Dienemann, Glass & Hyman, 2005). In the same way that this study was invaluable in informing clinical approaches with a specific population, surveys of perpetrators of violence could inform our therapeutic work with them.

In a study of consumers of substance abuse treatment in Delaware state-run mental health programs, client satisfaction surveys proved to be quite useful, highlighting trends in service delivery, outcomes of treatment, and ideas for “provider monitoring processes,” among other factors (DSAMH, 2010). This access to clients' perception allowed the evaluators to assess the program's effectiveness, as well as client's experience of the program. The demographic data further elucidated discrepancies in care across race, age and gender (DSAMH, 2010). All non-

demographic questions asked participants to rate statements on a scale of one (strongly agree) to five (strongly disagree), in the categories of: “Access,” “Quality and Appropriateness of Services,” “Outcomes,” “Consumer Participation in Treatment Planning,” “Overall Satisfaction,” “Functioning,” and “Social Connectedness” (DSAMH, 2010). This survey, and other similar surveys of client satisfaction, are evidence of the value of such assessments, and the insight they provide into client experience (Day et al., 2012; Deering, Horn & Frampton, 2012; Kelly, O’Grady, Brown, Mitchell, & Schwartz, 2010). For example, one survey of opioid treatment clients helped to identify client’s definitions of progress and success, as well as trends in preferences for the staffing structure of the clinic itself (Day et al., 2012). Such a study could be similarly useful to the field of treatment of interpersonal violence offenders.

Studies of incarcerated and formerly incarcerated sex offenders have also demonstrated the usefulness of client satisfaction surveys. One study of sex offenders who were incarcerated at the time of data collection found that counselors who focused on empathy for victims, as well as concrete skills, like methods of controlling sexual arousal, were rated the highest (Levenson, Prescott & Jumper, 2014). Another study, which mostly focuses on the efficacy of treatment with sex offenders, showed that the perceived working alliance between therapist and client was central to therapeutic success, and correlates positively with symptom reduction (Fenske, 2008). Interestingly, the study demonstrated, using pre- and post-tests, that the working alliance improved over time, whether or not client feedback regarding therapists’ empathy was shared with therapists (Fenske, 2008). This survey also used the Helping Alliance Questionnaire (HAQ-II), a vetted consumer survey tool that inspired two of the questions included in this researcher’s study (Luborsky et al., 1996).



As illustrated above, the potential for this study to augment the existing research with subjective responses from participants is clear. There are many empirical studies of recidivism rates, attachment styles and client traits, and quantitative outcomes of certain therapeutic techniques (Stover, Meadows & Kaufman, 2009). However, the studies allow for very little agency on the part of the participants, and do not directly ask them about their account of their own experience. Instead, outcomes such as “readiness to change” and “accepting responsibility” are studied (Taft et al., 2004). These foci suggest some level of bias and blame from practitioners and researchers. Larger and more diverse samples were also called for across the board, as well as more varied methods, such as full-length interviews (Lawson et al., 2006).

## CHAPTER III

### **Methodology**

This study uses self-reported preferences of treatment style among 80 partner-violent adults in treatment for interpersonal violence, in order to understand better what types of therapeutic interventions for partner-violent and family-violent adult are considered helpful, in the eyes of participants. In an attempt to answer this question, this study focuses on: the types of therapeutic modalities, styles and interventions that participants believe work best and worst; participants' perceptions of any change they experienced during therapy; and when and why had breakthroughs or moments of change occurred during therapy. Based on the above research, a general hypothesis is that, in the eyes of participants, a more client-centered and empathic approach, and one which addresses current and past traumas, will be the most preferred type of treatment, as well as those that provide concrete skills (Day et al., 2012; Levenson, Prescott & Jumper, 2014).

### **Sample Selection**

Data collection followed approval from Smith College Human Subjects Review Board, as well as the required agency review processes. Due to access to the population, respect for participants, and time and resource constraints, a non-probability convenience sample was used. Whichever participants volunteer to answer the surveys were the included data sources. The process also required an element of voluntary buy-in from program staff and leadership. I

contacted multiple agencies across the U.S. that run programs explicitly dedicated to providing counseling to people who have been accused of interpersonal violence. I exclusively contacted agencies that seemed to value therapy/counseling, and that described clear goals of healing, rehabilitation, or positive change for clients in their websites. Of these, one agency located in the U.S., which treats interpersonal violence, responded to my inquiries in a timely manner, and demonstrated the most amount of interest. They therefore became the focus agency for my study. While the agency does not have a formal Human Subjects Review Board, they do allow this level of client access, with the proper protections in place. Individual respondents (a convenience sample) were screened by agency staff for their perceived ability to complete the survey without experiencing distress. Agency staff identified participants, based on the agency's record-keeping and staff knowledge of participants' experience in a specific program at the agency that addresses past abusive behavior. Staff were identified by the Program Director; this selection was based on their typical responsibilities in the program.

Inclusion criteria included: participants must be adults (18 or over) who have participated in the specific interpersonal violence treatment program at the participating agency. All participants must have either completed the counseling program, or have participated for a minimum of 3 weeks, so that they are able to reflect on a substantial period of therapeutic experiences. Because the agency serves both male and female offenders of IPV, both male and female respondents were able to participate. Because there was a range of English fluency and literacy among participants, survey questions were read aloud, verbatim, to all groups of participants; staff were specifically instructed to only read the words of the survey, and not answer any other clarifying questions. This was a change to original study design, and a Protocol Change Approval form was received by Smith College Human Subjects Review Board

(see APPENDIX H). Participants were also identified by program staff as able to complete the survey without experiencing distress.

As mentioned above, participation in the study was voluntary. Informed consent documentation preceded all survey materials. Other ethical issues taken into consideration included participants' personal information: participants' names were only included on the Informed Consent forms, which were kept separate from the surveys. Participants were fully informed about the nature of the research and the purpose of the study; and participants were told that they could opt out of participation at any time. The experience of participants while completing the survey was taken into account; while it was not possible to predict what content may have been triggering for participants, they were not asked directly about their pasts or the nature of the abuse they have experienced or perpetrated. In fact, it is the hope of this researcher that the experience of completing the survey was a positive one, and maybe even allow for some beneficial reflection and validation.

### **Data Collection**

In an effort to receive such personal, subjective and varied responses, as well as some analyzable data, a mixed-methods approach was used. Paper surveys were sent to participating agency staff, who then offered the surveys to participants of their counseling programs. Again, completion of the surveys was voluntary. The survey consisted of 5 demographic elements, and 38 questions (33 rating-scale and 5 short-answer). Two of these questions (#s 30 and 32) were based on questions from the Helping Alliance questionnaire - II (HAq-II) (Luborsky et al., 1996). All other questions were designed by the author. Survey questions were both quantitative and qualitative—asking participants to rate certain factors (e.g., “It was helpful when my facilitators reflected my feelings back to me,” and “It was helpful when my facilitators

and I thought of new, positive thoughts”), and answer open-ended questions with brief, narrative responses (e.g., “What advice would you like to give to the facilitators of this program?”). The rating scale used for quantitative questions ranges from 1 to 5, with each integer having a corresponding value—‘strongly disagree,’ ‘disagree,’ ‘somewhat agree,’ ‘agree,’ ‘strongly agree,’ and ‘N/A—this did not occur.’ In this way, the data lends itself to both statistical analysis, and to a more nuanced, detailed analysis. Therefore, this study is both descriptive and exploratory. Please see Appendix F for all survey questions.

The procedure was as follows. Participants completed the survey on-site, in an agency office, and placed their completed survey into individual sealed envelopes, which were collected by agency staff. These envelopes (provided to agency staff by the researcher prior to the survey) were stamped and addressed to the researcher only (provided via mail by researcher). Then, agency staff returned the completed surveys via mail. Agency staff provided participants with writing utensils, and with private space to sit and write. This survey was offered in tandem with the agency’s own brief post-participation evaluation, which was one page long and assesses concrete skills and concepts gleaned during the program, using a rating scale and three short-answer questions.

Participants were provided with the researcher’s email address, to ask questions about the study and the use of data, or to withdraw their particular survey. Participants were also able to communicate through agency staff, who were able to relay questions to the researcher. Moreover, agency staff was instructed in how to identify and assist participants who appear distressed, as well as provide them with additional resources (see Appendix C). These resources were also provided directly to participants (see Appendix B).

## Data Analysis

The main question in this study is: What types of therapeutic styles and interventions do IPV offenders prefer? In order to answer this question, several additional questions were asked, including: How satisfied were participants?; What was most and least helpful during treatment?; How does the perceived helpfulness of certain modalities and approaches compare to others?; and, How does satisfaction relate to demographic and other factors? From the paper surveys, all data was manually transcribed into an electronic spreadsheet. Quantitative data was organized by question category, and included all scale values, and qualitative data was fully transcribed and thematically coded. The sub-questions are outlined below.

As mentioned above, literature suggests that participants will express a preference for both cognitive-behavioral (CBT) interventions *and* psychodynamic ones (Lawson, 2010; Taft et al., 2004). To study this, questions 7, 23, 25, and 28 have been coded as relating to psychodynamic interventions, and questions 11, 12, 14, and 24 have been coded as relating to CBT interventions. The mean response values for these grouped questions were compared.

This study also sought to analyze the comparative preference for humanistic, client-centered (non-directive) treatment, versus directive and opinion-giving treatment (including normalizing statements). To do this, questions 5, 17, 18 were coded as *non-directive*, and questions 10, 15 and 16 were coded as *directive*. The mean response values for these grouped questions were compared to each other. Because of the range of clinical styles when employing CBT or psychodynamic techniques, these stylistic question-groups are distinct from the above modality-specific questions.

This study also examined the relationships between questions evaluating aspects of the established helping alliance (questions 30 and 32), participant satisfaction (questions 29 and 31),

and each of the four above groups of directive, non-directive, CBT, and psychodynamic questions. A six-variable correlation was run to examine the associations between these scales. The range of each of these summative scales was also calculated, in addition to Cronbach Alphas to measure internal consistency.

Also, to examine the impact that specific variables had on overall satisfaction (questions 29 and 31), a regression was run. The regression measured satisfaction against: the reason for joining the program (e.g., mandated versus non-mandated) (question 3), African-American identifying or not, the helping alliance, CBT, psychodynamic, directive and nondirective scales.

An ANOVA was calculated to study the relationship between satisfaction and time spent in the program, for which there were five possible responses. T-tests were run in order to determine if differences in satisfaction existed by race/ethnicity, gender, or whether or not a client was mandated into treatment.

Qualitative data were read, fully transcribed, and general types of responses were coded, with as much specificity as possible, to allow for outlier expression. Thematic analysis of this kind allows for a representative, data-driven set of themes and patterns—i.e., the coded themes were determined organically, during the process of reading all responses, and were continued to be refined, to ensure that existing codes fully captured the multitude of responses (Vaismoradi, Turunen & Bondas, 2013). For instance, a paragraph-long response was attributed as many different descriptive traits as necessary, such as: “desire to talk more about personal experiences,” “feelings of shame in therapy,” “preference for cognitive-behavioral interventions,” “dislike for talking about childhood,” etc. These summarized codes allowed for data to be better compared, and for trends in qualitative responses to emerge. Then, possible inferential statements could be made, which spoke to trends and correlations among these vastly

varied data.

## **Limitations**

Because of the way in which the convenience sample was selected, the sample is not representative of the larger population. It was also not able to include individuals who are incarcerated. For all the reasons above, the sampling technique is biased towards programs with cooperative program staff, program staff who value research and evaluation, men and women who are interested in sharing their experiences (and maybe who have therefore had more positive therapy experiences), and participants with more extra time to fill out a survey. Disconfirming data was sought out through various open-ended narrative questions, allowing participants to give a truly subjective response, and opening the data up to an infinite range of possible responses.

In order to track data and monitor diversity, as well as possible trends across demographic traits, the survey begins with questions about participants' age, gender, race, ethnicity, and level of schooling completed. It is this study's concern that any other detailed demographic data—such as class, career, family situation, etc.—would be a nuisance to participants because of the extra time required, and may contribute to the feeling of being scrutinized, and therefore discourage honest responses.

One weakness of this qualitative aspect of the survey is that deeper, more elaborate responses were not possible. A one-on-one interview would be required to gather such detailed responses. Moreover, it was likely that many of these short-answer questions would be left blank (Dillman, 2009). This study's responses were expected to be brief, and to be constrained by the topics of each open-ended question. However, to this end, a final question, such as “is



there anything else you'd like to share?" was included to invite more unique responses; though, it is possible that such a question would be deemed more optional than the others, and would therefore be skipped entirely.

The surveys also require time for participants to complete—this may be difficult because of their schedules, and may limit participation. Another major logistical hurdle is the returning of the surveys. There was a chance of surveys being lost in the mail. It is also possible that participants would be reluctant to fill out the surveys if they have to hand them back to their counselors or therapists, thereby jeopardizing confidentiality—this has hopefully been addressed by the requirement of placing them in individual envelopes, then sealed, and the explanation that they were only read by the researcher.

One possible source of bias is that I, the researcher, am inclined to feel that perpetrators of family-violence can be rehabilitated; it is likely that this is reflected in my survey questions, and in my analysis of the responses. My previous experience working in IPV treatment settings has impacted me and my thoughts on IPV treatment. I have worked to limit this bias by heavily editing the survey to remove such biases, and by using colleagues as previewers/editors of the survey. It also seems likely that participants' responses could be biased towards describing their therapy experiences in a positive light, especially if they feel their therapists may read their responses, and if their participation in treatment is court-mandated. Regarding the diversity of subjects surveyed, they were self-selected and therefore unpredictable in their diversity. Moreover, this study does not include adults who have been referred to private clinicians.

## CHAPTER IV

### **Findings**

The goal of this survey was to examine the types of therapy that participants found most effective, and then to note any correlations between different elements of the survey, as well as themes across responses. The initial hypothesis was that clients would express some preference for non-directive and psychodynamic approaches, as well as value concrete skills (such as in CBT), and emphasize the importance of the working alliance.

#### **Demographics**

There were a total of 80 participants in this sample. Just over 76% (n=61) were male, and 23.75% (n=19) were female. Regarding race and ethnicity, which was an open-ended fill-in question, 40.8% (n=31) participants identified as Black or African-American; 35.5% (n=27) identified as White or Caucasian; 10.5% (n=8) identified as Hispanic or Latino; 4% (n=3) identified as multiracial; and 9.2% (n=7) identified as either Native American, Asian, Middle Eastern, or Indian. Participant ages ranged from 19 years old to 68 years old, with the mean age being 34.9 years old (SD=11.0). Just over 42% (n=32) of participants graduated high school, 23% (n=18) had completed “some college credit, 9.2% (n=7) had completed technical/trade school, and 9.2% (n=7) had received an Associate’s degree. Refer to Table 1 for the full data on participants’ education level.

Table 1

Participants' Education Levels

<u>Highest Grade Completed</u>	<u>Frequency</u>	<u>Percentage (%)</u>
Elementary School (5 <sup>th</sup> grade)/ Middle School (8 <sup>th</sup> grade)	6	7.90
High School (12 <sup>th</sup> grade)	32	42.11
Technical/trade school	7	9.21
Some college Credit	18	23.68
Associate's Degree	7	9.21
Bachelor's Degree	3	3.95
Master's Degree/ Doctorate or other terminal degree	3	3.95

**Treatment**

The majority of respondents, 92.5% (n=74), were mandated to attend counseling. 87.3% (n=69) of respondents attended solely group counseling, and 12.7% (n=10) attended both group and individual counseling. No participants attended solely individual treatment.

Regarding time spent in the counseling program, 30.0% (n=24) participated for 16 weeks or longer; 27.5% (n=22) participated for 12-15 weeks; 18.75% (n=15) participated for 8-11 weeks; 16.25% (n=13) participated for 4-7 weeks; and 7.5% (n=6) participated for 3 weeks or less.

As mentioned in the Methodology chapter, there were six groupings of questions that were used to analyze the data. The two-question "Satisfaction" scale had a lowest possible score of 2, and a highest possible score of 10; participants scored between 3 and 10, with an average

score of 8.6 (SD=1.50). The two-question “Helping Alliance” scale had a lowest possible score of 2, and a highest possible score of 10; participants scored between 2 and 10, with an average score of 8.49 (SD=1.58). The four-question “CBT” scale had a lowest possible score of 4, and a highest possible score of 20; participants scored between 7 and 20, with an average score of 17.24 (SD=2.94). The four-question “Psychodynamic” scale had a lowest possible score of 4, and a highest possible score of 20; participants scored between 8 and 20, with an average score of 16.02 (SD=3.21). The three-question “Directive” scale had a lowest possible score of 3, and a highest possible score of 15; participants scored between 6 and 15, with an average score of 12.60 (SD=2.08). The three-question “Non-directive” scale had a lowest possible score of 3, and a highest possible score of 15; participants scored between 7 and 15, with an average score of 11.97 (SD=2.25).

For the four survey questions comprising the psychodynamic construct used in the data analysis, each of the items making up the scale (asking about “past experiences,” “talking about my childhood,” discussing “past relationships,” and talking “about ways that my childhood and current life are similar”), had a higher percentage of “my counselor didn’t do this” responses than the questions comprising the CBT construct (suggesting “new, positive thoughts,” suggesting “new, positive behaviors,” teaching “ways to relax and lower my stress,” and discussing “the differences between emotions, thoughts and actions”). Just over 24% of respondents (n=19) indicated that their counselors did not make “connections between current life and childhood,” and 17.7% (n=14) of respondents indicated that their counselors did not “discuss [their] childhood[s].” These two techniques also included a slightly higher incidence of “disagree” or “strongly disagree” responses, 7.6% (n=6), and 10.1% (n=8), respectively. Comparatively, all four CBT questions combined had a mean of 4.7% (n=3.75) of “my counselor

didn't do this," and a mean of 3.75% (n=3) of "disagree" or "strongly disagree." Moreover, in the psychodynamic cluster of questions, the highest scoring technique was "talking about my past relationships," wherein 68.4% (n=54) of participants agreed or strongly agreed that it was helpful. In the CBT cluster of questions, the highest scoring technique of developing "new, positive behaviors," wherein 90.0% (n=72) of participants agreed or strongly agreed that it was helpful.

Of the questions that comprise the non-directive construct (asking about feelings, asking for more details of a story, and giving reflecting responses), asking about feelings scored slightly higher, with 72.5% (n=58) of participants circling "agree" or "strongly agree" that these items were helpful. Of the questions that comprise the directive construct (explaining that "emotions are normal responses," giving "solutions to problems," "suggesting new ways to think about something" ), "suggesting to new ways to think about something" scored highest, with 85.0% (n=68) of participants marking "agree" or "strongly agree."

Of these six summative scales described above, internal consistency was measured for each. See Table 2 for all items in each scale. Cronbach's Alphas were .85 for CBT, .84 for psychodynamic, .69 Nondirective, .68 Directive, .86 satisfaction and .73 Helping alliance (Booxbaum, 2015). With the exception of the Non-directive and Directive scales – the Cronbach Alpha's were all quite good. The non-directive and directive summative scales were just under the generally accepted .70 for satisfactory internal consistency ratings (Booxbaum, 2015).

Table 2

Contents of Summative Scales

<u>Scale</u>	<u>Survey Questions</u>
CBT	7, 23, 25, 28
Psychodynamic	11, 12, 14, 24
Directive	10, 15, 16
Non-directive	5, 17, 18
Helping Alliance	30, 32
Satisfaction	29, 31

Correlations were run between all of the summative scales (CBT, psychodynamic, directive, non-directive, satisfaction, and helping alliance) in order to examine the relationships between the scales. Each scale was positively significantly correlated with the other, with the highest correlation values being between helping alliance and satisfaction (.82) and directive and CBT (.83) and non-directive and psychodynamic (.76) (Booxbaum, 2015). See Table 3 for more information on correlations. This indicates that: as helping alliance increased – so too did satisfaction; as perceived helpfulness of directive techniques increased, so too did perceived helpfulness of CBT techniques; and as perceived helpfulness of nondirective techniques increased, so too did perceived helpfulness of psychodynamic techniques (Booxbaum 2015).

Table 3

Correlations of All Summative Scales

	<u>Satisfaction</u>	<u>CBT</u>	<u>-dynamic</u>	<u>Directive</u>	<u>Nondirective</u>	<u>Help. Alliance</u>
<u>Satisfaction</u>	1					
<u>CBT</u>	0.59***	1				
<u>Psychodynamic</u>	0.53***	0.62***	1			
<u>Directive</u>	0.57***	0.83***	0.56***	1		
<u>Nondirective</u>	0.54***	0.64***	0.76***	0.47***	1	
<u>Helping Alliance</u>	0.82***	0.64***	0.50***	0.62***	0.60***	1

*Note: Regarding significance (p), \*=0.5 or less, \*\*=0.01 or less, \*\*\*=0.001 or less.*

In order to determine if differences in satisfaction existed by race/ethnicity, gender or whether or not a client was mandated into treatment, t-tests were calculated. Due to the very limited number of individuals in each racial/ethnic sub-group in this sample, the race/ethnicity variable used was Black/African American versus non-Black/African American (Booxbaum, 2015). The variable was constructed this way because participants who identified as Black/African American were the largest racial/ethnic group in this dataset. There were significant differences found with African American participants on average scoring .68 points higher on satisfaction than non-African American participants:  $t(72)=-1.97, p=0.0525$  (Booxbaum, 2015). On average, African American respondents scored a 9.00 on the satisfaction scale and non-African American respondents scored an 8.32.

With regards to gender, females scored on average very slightly higher (8.63) on satisfaction than males (8.59), but these differences were not significant:  $t(76)=-0.10, p=0.92$  (Booxbaum, 2015). Moreover, mandated clients scored slightly higher (8.65) than non-mandated clients (8.00) on satisfaction, but these differences were not significant:  $t(76)=-1.03, p=0.31$ .

To determine if there was a relationship between satisfaction and the time participants spent in the program, an ANOVA was calculated. The five categories included in this analysis were: 1) individuals who spent 3 weeks or less in the program, 2) individuals who spent 4-7 weeks in the program, 3) individuals who spent 8-11 weeks in the program, 4) individuals who spent 12-15 weeks in the program and 5) individuals who spent 16 or more weeks in the program. The calculation determined that there was a significant relationship between time spent in the program and satisfaction [ $F(4, 73)=4.61, p=0.00$ ]. Significant differences existed between individuals who had spent between 12-15 weeks in the program and 4-7 weeks, with those who were in the program for 12-15 weeks scoring on average 1.64 ( $p=0.02$ ) points higher on satisfaction than those in the program for 4-7 weeks (Booxbaum, 2015). Additionally, individuals who had spent 16 or more weeks in the program scored on average 1.67 ( $p=0.01$ ) points higher on satisfaction than individuals in the 4-7 week group. Among all the groups of individuals, the lowest scoring were those in the 4-7 week group (on average scoring 7.50) and the highest scoring were those in the 12-15 week (on average scoring 9.14) and 16 plus week (on average 9.17) groups (Booxbaum, 2015).

A multivariate regression was run to further examine the relationship between different types of treatment and participant satisfaction. In addition to the abovementioned summative scales, and satisfaction, the regression included the African-American/non-African American



variable, the mandated/non-mandated variable, as well as the Helping Alliance summative scale. Findings included that helping alliance had a positive and significant impact on participant's overall satisfaction, indicating that a one unit increase in the helping alliance scale yielded a .53 increase in satisfaction when holding all other variables constant (Booxbaum, 2015). Regarding treatment preference, CBT and psychodynamic were both positive and significant when controlling for all other factors, indicating that, as perceived helpfulness of CBT and psychodynamic treatment increased, satisfaction also increased (Booxbaum, 2015). Interestingly, participant's perceptions of therapists that used a directive style was significant and negative, indicating that as perceived helpfulness of directive treatment increased, satisfaction decreased when controlling for helping alliance, other treatment type, race/ethnicity and whether or not a client was mandated (Booxbaum, 2015). No other variables in the regression were significant, including non-directive approaches, whether or not a client was mandated, and race/ethnicity. The Beta values, which allow for more accurate comparison of the strength of the independent variables on participant satisfaction, showed that participants' perceived helpfulness of CBT had the strongest effect on participant satisfaction ( $\beta=.64$ ) (Booxbaum, 2015). The  $R^2$  value, used to measure how the model fits the data, was 0.63 – indicating that roughly 63% of the variation in participants' satisfaction was explained by the model. The model was also tested for heteroscedasticity (a test to check for whether or not the error terms are constant) and multicollinearity (a test to see how correlated the independent variables are) and no heteroscedasticity was found; the highest Variance Inflation Factor score was 4.40 (Booxbaum, 2015). See Table 4.

Table 4

Regression: Participant Satisfaction and Multiple Variables (n=48)

Satisfaction	Coefficient	Standard Error	Beta
Helping Alliance	0.532	0.144	0.546
CBT	0.265*	0.084	0.636
Psychodynamic	0.128*	0.053	0.374
Directive	-0.286*	0.108	-0.493
Non-directive	-0.156*	0.089	-0.318
Mandated	0.123*	0.460	0.028
African-American	0.378*	0.224	0.174

*Note: Regarding significance (p), \*=0.5 or less, \*\*=0.01 or less, \*\*\*=0.001 or less.*

**Qualitative Data**

As mentioned in the Data Analysis section, qualitative data was analyzed thematically, using themes that were developed and refined based on the text of the responses, to allow for maximum representation of common responses (Vaismoradi, Turunen & Bondas, 2013). Certain thematic categories, such as “skill” taught in therapy were given subcategories, such as “communication” and “anger-management.” Categories were made as specific as possible while still allowing for commonality, and responses that were particularly representative of certain themes were noted during the coding process.

In response to the qualitative question, “What was the most helpful thing your facilitators did? Why was it helpful?,” which 77 of 80 participants completed, the most common

responses addressed the skills that counselors helped participants acquire (n = 16), with 9 respondents specifying communication skills and 5 respondents specifying anger-management related skills (e.g., “He/she help me with the communication part of my relationship. It was helpful because now me and my fiance communicate better and more.”). Seven participants wrote that it was most helpful that their counselors ‘listened’ to them, one of which added the element of feeling like their counselor ‘cared’ (e.g., “They listened to my story. It seemed like they cared.”). Six respondents addressed the value of their counselors probing with useful questions (e.g., “They were always asking why,” and “...never leaving any stone unturned.”). Five respondents expressed that it was most helpful to be able to vent during sessions: “Just giving me a chance to get things off my chest. It's good to have someone to talk to.” Five participants stated that the sessions helped them understand abuse, and its patterns and effects, more thoroughly (e.g., “Taught me about different types of abuse, because I never knew their[sic] were so many wrongs I have done.”). Five respondents also expressed that the counselors helped them gain empathy for others’ experiences. Other repeated, but less common responses included themes of: making connections between past and present experiences; exploring the participants’ patterns; being given the chance to express their feelings; being encouraged to change; being helped to accept responsibility for their actions; relaxation techniques; behavioral substitution; being helped to understand themselves better; and being given advice.

In response to the question, “What was the least helpful thing your facilitators did? Why wasn’t it helpful?,” which 71 of 80 participants completed, the most common responses (n = 35) expressed the sentiment that the counselors did nothing that was “least helpful” (e.g., “Nothing” and “There was never a least helpful thing.”). A similar idea, but with a more positive

bent, 10 participants wrote that everything the counselors did was useful (e.g., “Everything they show and teach is helpful.”). Five participants stated that a particular activity was not useful (e.g., “had us act out a scene of a dispute, I think we could have just read it.”). And 2 respondents gave the specific critique that the check-in activity during sessions was a poor use of time (e.g., “Take an hour for long winded check-ins, - waste of class time.”). Other repeated, but less common (2 participants or fewer) responses included themes of: too much discussion about the past; not enough conversation about the past; being asked to share too much; the counselors did not share enough of their own experiences; and the cost of the program was too high.

In response to the question, “What advice would you like to give to the facilitators in this program?,” which 74 of 80 participants completed, 37 responses included the theme of continuing the treatment as is (e.g., “keep it up,” “keep doing what you’re doing,” and “keep up the positivity and the ‘tough love.’”). Similarly, 6 respondents wrote “N/A.” 4 participants suggested that it would be better if there were more individual time offered to participants (e.g., “They need more one-on-one with clients. Weekly.”). Three participants wrote that the program would be improved with smaller class sizes, and 3 wrote that the program would be improved with more efficient session management (e.g., “Be more concise and not waste time over small organizational issues.”). Two participants stated that counselors should “relax” more. Other themes addressed, but which were not repeated, included: being more on time; being more organized; and telling more stories.

In response to the question, “What advice would you like to give to future participants in this program?,” which 72 of 80 participants completed, the most common response (n = 19) was that participants should keep an open mind during the program (e.g., “Please, please take all into consideration & advantage of this program,” and “You may go into the program not wanting

to be there, but if you go in w/ an open mind, you will learn a lot.”). Fifteen respondents stated that future participants should listen while in the program (e.g., “just listen more talk less!” and “sitting here and listening to each other's story[sic]of why there[sic] in the class will help you understand more.”). Nine responses included the theme of it being worthwhile, or ultimately beneficial to be in the program (e.g., “It’s well worth it,” and “Great program!!! It helps you become a better you!”). Seven responses suggested that future participants keep coming, and stay in the program (e.g., “Keep coming back. It works.”). Seven participants wrote that future participants should actively participate in the sessions (e.g., “just really participate.”). Five participants suggested that people be respectful during sessions. Three respondents wrote that future participants should actively apply the tools learned in the class in their real lives (e.g., “use what you’ve learned.”). Three participants wrote that future participants should be “honest” during the sessions. One notable response, the themes of which were not repeated across responses, addressed themes of asking and sharing: “Don’t be afraid to ask any questions you have or what comes to mind for you. Don’t afraid to share your feelings to facilitators or group.”

In response to the final question, “Please share any other thoughts you have about this program and your experience in it,” which 68 of 80 participants completed, there were not many repeated themes across surveys. However, 8 respondents addressed the ways in which the group process was helpful for them (e.g., “nice to know I’m not the only one,” and “I think the group process helps a lot because you here[sic] stories and situations from your peers which helps you deal wit your situation.”). And 6 respondents addressed the theme of the program being “eye-opening” or providing insight (e.g., “Well I know my thought have change from what I thought the class would be it's been a great learning experience,” and “It has truly been an eye opening experience and has given me more traits to help make my life better in so many ways, not just in

relationships but in day to day life.”). A few examples of other responses, which address themes of self-awareness, reflection, and skills gained, include: “I see my faults and flaws more clear and I accept the fact that I can’t change other people;” “Great time just looking over my life. Not blaming;” “I believe in this group to help me manage my emotions, and to help with not being abusive in any way towards anyone;” and “I like it. I will say I had my moments not using the advice but the more I take time out to use their advice it works very well.”).

## CHAPTER V

### **Discussion**

Using quantitative scales, qualitative questions, and demographic questions, this study attempted to add participants' voices to the existing literature on family- and partner-violent adults in treatment, with the goal of gaining more insight about the therapeutic elements and approaches that participants find most helpful. Findings were somewhat supported by the initial hypothesis, which predicted a preference for treatment that is both non-directive and skills-based, and that the working alliance between client and therapist would be an important factor in client satisfaction. Other additional insights, such as the relationship between different treatment approaches, and the relationship between descriptive data and satisfaction, are discussed below.

Regarding the descriptive data on this sample, it is notable that the vast majority of participants identified as Black/African American or White; previous studies of IPV treatment programs have ranged from a concentrated focus on one ethnic group, such as Navajo men (Daniels, 2001), to deliberately and more broadly diverse samples (Dienemann, Glass & Hyman, 2005; Levenson, Prescott & Jumper, 2014). The racial or ethnic identities of the program facilitators were unknown. While the majority of participants were either high school graduates or completed "some college credit," the socioeconomic class of participants was unknown. Moreover, it is notable that the vast majority of respondents were mandated for treatment, and that none of them received solely individual counseling.

### **Quantitative Data**

Regarding the summative scales, it seems worth noting that psychodynamic treatment elements contained the most “n/a” responses. Clearly, counselors did not use these techniques as much as CBT techniques, which is reflective of the published literature for the program (found on its website). This could also have been an intentional strategy by counselors—to avoid bringing up specific past traumas, as they could potentially trigger or re-traumatize other participants. Specifically, discussing the past had the lowest scores within the psychodynamic scale, which possibly points to the inherent difficulty or discomfort of such conversations. Of course, at face value, this trend in responses may simply suggest that these approaches were perceived by participants to be less useful than other approaches. Contrastingly, the concrete skills within the CBT scale scored the highest; and the directive (versus non-directive) techniques scored slightly higher as well. This could suggest a greater perceived value of tangible tools, such as alternative behaviors—tools that participants feel like they can immediately implement in their daily lives. This differs from the hypothesis that nondirective techniques would be most favored. This finding also somewhat reflects the conclusions in previous literature that CBT and Motivational Interviewing are some of the most effective treatments for IPV (Semiatin et al., 2013; Stover, Meadows & Kaufman, 2009). This study, however, compliments those previous objective measures with participants’ subjective experience. The discrepancy between the perceived helpfulness of CBT and psychodynamic treatment may also speak to the slower process and sometimes-intangible value of psychodynamic change (Davies & Frawley, 1994), particularly among a cohort with many participants receiving treatment for less than 8 weeks.

The finding that all summative scales (CBT, psychodynamic, directive, nondirective, helping alliance, satisfaction) were positively correlated perhaps suggests the importance of the



helping alliance on the entire experience of the treatment: the stronger their working alliance with their facilitator is, the more satisfied they will be overall, and will be more likely to find *all* techniques more helpful. This importance of the helping alliance has been well-documented in previous literature (Fenske, 2008; Lawson, 2010; Taft et al., 2004). This finding could also reflect an occurrence of respondents within the sample who are simply more open to therapy. Moreover, the positive correlations between directive approaches and CBT, and nondirective approaches and psychodynamic treatment, affirm the distinct relationships between these couplings. However, nondirective and directive treatments were also correlated, which may relate to the occurrence of respondents who might be more open to therapy, as stated above.

While it is intriguing T-tests showed that respondents who identify as Black/African American had very slightly higher satisfaction rates, it is too small of a sample, with too limited of a variable, to draw any significant conclusions. Previous studies of IPV treatment programs have not closely examined the difference in satisfaction rates across race or ethnicity, although some have documented the demographic makeup of the sample (Meis, 2009; Stover, Meadows & Kaufman, 2009)—this is an important area for future research. There were also no significant differences in satisfaction rates between mandated respondents and non-mandated respondents, possibly suggesting that certain conditions of mandated participation (coercion, repercussions, etc.) do not impact participant satisfaction. This finding is supported by previous literature about the comparable success rates of mandated and non-mandated participation (Taft, Murphy, Musser & Remington, 2004). It is also interesting that the findings revealed no differences by gender. The majority of previous studies have focused on only male IPV perpetrators (Cerulli, Bossarte & Dichter, 2014; Meis, 2009; Murphy, Stosny & Morrel, 2005; Peralta & Tuttle, 2013), and more mixed-gender studies could be a useful focus for future research.

According to the ANOVA that was run, it appears that longer time in the program generally correlates with greater participant satisfaction in this sample. This could be because, as participants experience more treatment, they are exposed to more and more skills and processing that feel helpful; it could also be because some concepts and skills covered in the sessions require multiple sessions to be fully covered, and for their impacts to be felt. This trend could also be reflective of early resistance to treatment and change, which some studies have shown erodes over time, and can be closely tied to initial expectations about treatment (Meis, Murphy, & Winters, 2010; Murphy & Maiuro, 2009). It is also maybe reflective of the differences between counselors and their styles, who teach different cohorts, and who remain with one class for the whole program (i.e., a 4-week participant would likely have a different counselor than the 12-week participant, and maybe the 12-week group had higher satisfaction rates overall).

The findings from the regression again reaffirm the relationship between helping alliance and satisfaction, and the importance for clinicians to focus on this therapist-client rapport; this will be discussed further below. The regression also revealed that, as perceived helpfulness of CBT and psychodynamic techniques each increased (separately), overall satisfaction increased; however, this is essentially a tautological conclusion, in that greater satisfaction with each technique would correspond with greater satisfaction overall. Furthermore, perceived helpfulness of CBT had a stronger bearing on satisfaction than did perceived helpfulness of psychodynamic treatment—an expected result in a program that explicitly emphasizes CBT treatment. Perhaps, however, it would be useful to compare a group of participants who received no CBT or psychodynamic treatment (those who responded with “n/a” to those elements) to those who did receive such treatment. This could be a useful future study.

### **Qualitative Data**

Through the thematic coding of the qualitative survey questions (Vaismoradi, Turunen & Bondas, 2013), the most common response to the question about “the most helpful thing your facilitator did” related somehow to skills—concrete skills (for communication, anger management, etc.) that they can use immediately. Participants seemed to enjoy such tangible tools, and this is reinforced by the quantitative data. The next three most common responses to this question addressed the notions that therapists “listened,” asked probing questions, and provided the ability to “vent.” These answers point to a different priority among participants, which focuses on the value of processing and expressing emotions. This not only is a useful compliment to skills-based work, but is reflected in some previous literature, about the value of psychodynamic CBT (Lawson, 2010), and is in-line with the initial hypothesis. These emotional processing techniques also seem to relate to the participants’ comfort and rapport with the facilitator—or, the helping/working alliance. Listening, asking probing questions, and allowing participants to vent may be understood as the elements of an active, engaged therapist, and one who creates a nonjudgmental space. In this way, these themes seem to point to a preference for non-directive treatment—yet, not all responses clearly expressed this, and being listened to or being allowed to vent can be central elements of some directive approaches, too, such as when discussing the stages of change in Motivational Interviewing or CBT (Murphy & Maiuro, 2009). The two next most common responses to this question, understanding abuse and gaining empathy for others, seem quite related, in that a greater knowledge of the cycle of abuse would lead to greater understanding of others’ experiences. In fact, 2 participants’ responses explicitly linked both of these concepts. This trend perhaps points to the novelty of such ideas, like ‘the cycle of abuse,’ and the importance of introducing it to participants in IPV programs; this type of psycho-education has been discussed in previous studies (Brown, James & Taylor, 2010;

Lawson, 2010).

Regarding the question about the “least helpful thing your facilitator did,” it is intriguing that so many had no critique to offer. Because many of these responses are quite brief, it begs the questions: Were they truly completely satisfied? Were they possibly intimidated or indirectly coerced by their counselors being in the room? Or maybe they were skeptical about the confidentiality of the survey? Did any fondness for their counselor make them less inclined to offer a critique? The wording of the question possibly lends itself to a feeling of negativity, which they could have felt uncomfortable with; perhaps wording it as ‘what could they have done better’ would have been more useful. It is also possible that participants were reluctant to express dissatisfaction because they want to believe the treatment is working, especially because of the time, money, and expectations invested in it thus far. For the few critiques about specific activities (films, check-ins, etc.), it would be valuable for the actual program staff to incorporate this feedback into their own planning and evaluations.

It is very important to note that the 80 voluntary survey participants constitute only 56% of the total program participants (total=144) at the studied agency. This could have led to a self-selection for those who were already satisfied with the program, or already actively engaged, or invested in improving it for the future. Though, of course, it is a possibility that the forum of the survey attracted those with more critiques of the program. Either way, the 80 respondents are not fully representative of the entire program, and a larger percentage of respondents would increase the applicability of the results—for the agency, and for researchers.

For the question regarding advice for facilitators, there was again, a lack of actual suggestions. However, the most commonly repeated answers, about more one-on-one work and smaller class sizes, point to a preference for greater individual treatment, versus solely group

treatment. A number of other responses for this question addressed improved class management and organization, which, again, would be useful for the actual program staff to take into account.

When participants were asked to offer advice for future participants, the most common suggestion was to keep ‘open mind,’ which suggests that many participants enter the program with a pessimistic or distrustful mindset, and that this is a considerable barrier for clinicians to keep in mind, especially in early sessions. Also, in light of the data on the significance of the helping alliance, perhaps this further emphasizes the importance of building rapport between therapist and client early on—perhaps especially in a widely mandated program, and within a social context of punitive and judgmental connotations. A subtle connotation in the tone of some of these comments, encouraging others to “keep coming” or to keep an “open mind” also seems to be one of high self-esteem, which has been discussed in previous literature as one determining factor in recidivism of IPV offenses (Taft, Murphy, Musser & Remington, 2004).

The next most repeated response—advising future participants to listen, apply skills, and participate—suggests that participation is a significant factor in determining a participant’s success in the program, and any effort to actively engage participants (especially those who are more difficult to engage) is well worth it. The next most common responses, which relate to having an ‘open mind,’ advise future participants to stick with it, and the ultimate benefits of the program; this perhaps suggests that participants need encouragement during the whole course of the program. This is somewhat in-line with previous literature about the value of utilizing Motivational Interviewing with people in IPV treatment (Taft, Murphy, King, Musser & DeDeyn, 2003).

### **Limitations**

This study has a relatively small sample size, is a convenience sample, and only includes

participants from one program, which limits the generalizability of the data. Importantly, only 56% of program participants within the one program completed the survey – thus the sample may not be representative of all participants in the program. There is some lack of precision in the summative scales, due to the difficulty of clearly delineating between CBT and psychodynamic treatment, and between directive and non-directive treatment. This posed a problem in the phrasing of the survey questions, and in the analysis of the data, because of the many shared qualities across modalities, and because many clinicians flow so easily between different styles. Perhaps a study with more strictly controlled treatment modalities would allow for a more meaningful comparison.

The high scores for CBT could also be explained by the fact that the language of the survey questions for those elements used language that was very similar to the language the program uses, and likely the language used by facilitators during sessions—this sort of repetition and subtle programming could have increased participants’ recognition of such concepts. CBT also contains inherently more concrete and simple concepts, and ones which are easier to encapsulate in brief survey questions—e.g., it is perhaps easier to identify and name “alternative behaviors” than the concept of talking about and processing one’s past.

And, as mentioned above, the accuracy of the responses could have been impacted by an element of coercion, because of the facilitators presence in the room during survey completion, and because of participants’ potential concern that the survey will have a bearing on their court-mandated progress (despite it being stated on research materials and consent forms that this would not be the case).

Future research would be well served by larger sample sizes, for more generalizable data. It would also be valuable to control more strictly for specific treatment modalities, such as CBT,

Motivational Interviewing, psychodynamic, etc., to allow for a more valid comparison.

Questions that probe more extensively into client experiences in treatment may be helpful to provide researchers with more nuanced answers about participants' experiences. Also, a more detailed study of the operational particulars of certain participant preferences (e.g., “venting” or “making connections to childhood”) could be helpful; for, the question remains of exactly *how* to achieve these therapeutic elements—e.g., how exactly does one *create* a nonjudgmental space?

### **Implications for Social Work**

Hopefully this study will be of some use to practitioners and to the field of social work. These findings certainly serve to reemphasize the value of focusing a great deal of resources and clinical energy on forging a strong helping/working alliance between clinicians and clients, and have provided some details of the content of such relationships. While a number of previous studies, including this one, sought to establish a hierarchy of effectiveness among treatment modalities, perhaps greater attention should be placed on exactly *how* to create such a productive therapist-client relationship. In these results, we have some hints: creating a nonjudgmental space, providing clients with tangible skills, and inviting clients to process their emotions.

The data from this sample also points to a preference for a combination of psychodynamic and CBT treatment, as well both directive and non-directive styles, which has been found in previous studies (Benki, 2013; Daniels, 2001; Levenson, Prescott & Jumper, 2014). Participants appreciate tangible skills and well as insight into their pasts and inner worlds. In this way, this study provides a very multifaceted view of “what works” in terms of satisfaction for participants in such programs, and perhaps suggests that a more eclectic approach is the most valuable—one that may impact the greatest number of participants, with all of their unique preferences. And still, there were enough significant themes throughout the data—

regarding the helping alliance, the value of teaching skills, and processing emotions, etc.—to offer a very early idea of what could be tested in future studies on such an eclectic approach.

These findings also support the notion that perpetrators of violence find it helpful to learn about abuse, its cycles, and the experiences of victims. Participants expressed their appreciation for these parts of the program in both the quantitative and qualitative responses. In a field with much focus on getting participants to “accept responsibility” or to increase people’s capacity for empathy, perhaps these results can offer a slight reframe: that participants are desiring of such information and perspectives, and are not reluctant subjects who must be molded with external measures, or forced to receive certain information.

Another finding, albeit simple, has important implications for future research: that mandated therapy may not necessarily lead to lower satisfaction rates. This seems to be especially important to consider when working with perpetrators of violence who are mandated to therapy—that the essentially punitive nature of the treatment does not preclude it from being useful and meaningful for participants. It also seems relevant to program directors and clinicians that longer-term therapy, in this study, was deemed more valuable by participants. In a judicial and medical system which is ever favoring cost-cutting and rapid results, we should note any reminder that change takes time, and that participants themselves feel that the treatment is more “helpful” the longer they are in it.

## **Conclusion**

The aim of this study was to gain greater insight about the therapeutic preferences of family-violent and partner violent adults and what they find to be helpful in their treatment. By administering a mixed-methods (quantitative and qualitative) survey at an interpersonal violence counseling program in the United States, findings were gathered which indicated: a strong



correlation between satisfaction and the working alliance between participant and counselor, a slight preference for CBT and skills-based interventions, a preference for some psychodynamic and non-directive styles, higher satisfaction with longer-term participation, and no significant differences in satisfaction between mandated and non-mandated participants, among other insights into participants' experiences.

These findings provide a helpful preliminary look at the experiences of adults in IPV treatment programs, and offer many possibilities for potentially valuable future research. It was the intention of this study to augment the existing literature with the actual words and opinions of participants in such counseling programs, and the field could benefit from further commitment to client-centered research designs—particularly those which ask participants for their own definitions of success, and which prioritize empowerment and dignity over pre-determined measures for change. There is certainly more to learn from people who have victimized others, and who are actively engaged in treatment programs to improve their lives and the lives of those close to them.

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## APPENDIX A

\*Note: any identifying information of the agency, program and/or location were removed from all materials.

### Recruitment Flyer

#### **PARTICIPATE IN A RESEARCH STUDY ABOUT PARTICIPANT EXPERIENCES!**

*Are you a current or former participant in the [PROGRAM NAME] program at [AGENCY NAME]?  
Please offer your opinions, in order to improve the services provided at [PROGRAM NAME]*

#### **You can participate if:**

- You have completed, or are currently in, the [TREATMENT PROGRAM NAME]
  - You feel comfortable completing a survey that will ask questions about the programming you have received. While no questions directly ask about trauma, or upsetting experiences, possible answers may bring up memories of past experiences.
  - You are an adult 18 or over.
  - You can read and write basic English fluently.
- \* If you agree to be in this study, you will be asked to do the following things: complete a paper survey of 38 questions (33 multiple choice & 5 short answer), place your survey in an envelope, seal it, and hand it to agency staff. The survey may take 10-30 minutes, and all of the questions are related to your experience in the program. Completion of the survey is voluntary.
  - \*\*This is a research study of participants' experiences in and opinions about interpersonal violence programming. The goal of this survey is to get better insight about the types of programming that participants prefer. The results of this survey will be used in a study that focuses on the opinions and experiences of participants in programs like [PROGRAM NAME]. This study is part of a student thesis, toward the completion of a Master of Social Work degree at Smith College School for Social Work.

**CONTACT ANY [PROGRAM NAME] STAFF TO REQUEST MORE INFORMATION ABOUT THE SURVEY!!**

APPENDIX B

Informed Consent

Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA

.....

Title of Study: Voices of Participants in Interpersonal Violence Treatment: Clients' Experience of Programming
[AGENCY NAME; PROGRAM NAME]

Investigator(s):

Justin Butler, MSW candidate, Smith College School for Social Work XXX-XXX-XXXX, jbutler@smith.edu

.....

Introduction

- You are being asked to be in a research study of participants' experiences in and opinions about interpersonal violence programming. The goal of this survey is to gain insight about the types of programming that participants prefer. The results of this survey will be used in a study that focuses on the opinions and experiences of participants in programs like [PROGRAM NAME]. This study is part of a student thesis, toward the completion of a Master of Social Work degree at Smith College School for Social Work.
You were selected as a possible participant because: you have completed or are currently participating in [PROGRAM NAME], you are 18 years or older, and you have been identified by agency staff.
We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to learn what types of programming people prefer who are participating in interpersonal violence programs, like [PROGRAM NAME].
This study is being conducted as a research requirement for my master's in social work degree.
Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: complete a paper survey of 38 questions (33 multiple-choice & 5 short-answer), place your survey in an envelope, seal it, and hand it to agency staff. The survey may take 10-30 minutes, and all of the questions are related to your experience in the program. Completion of the survey is voluntary.

Risks/Discomforts of Being in this Study

- The study has the following risks. First, when answering some of the questions about the program, you may be reminded of some past experiences, some of which might be upsetting. The study has been designed to avoid such direct associations, because it is the goal of the researcher to not cause distress to participants. Therefore, the researcher expects that there is a low likelihood of such



upsetting memories arising. However, there is a possibility that these memories and feelings will arise during the survey. Second, although your data will remain anonymous, and stored separately from this piece of paper with your signature, your participation in the survey will be known to agency staff that are present. However, they do *not* have access to your responses.

- If you feel emotional distress during the survey, please stop at any time, and refer to these resources:
  1. *Find a staff person and tell them you are feeling upset, and need help.*
  2. *A list of local counseling services and contact numbers*
    - i. [COUNSELING SERVICES 1]
      1. [CONTACT INFORMATION]
    - ii. [COUNSELING SERVICES 2]
      1. [CONTACT INFORMATION]
    - iii. [COUNSELING SERVICES 3]
      1. [CONTACT INFORMATION]
  3. *A list of crisis hotline numbers to call*
    - i. Crisis Call Center – “Call. Anytime. 24/7/365.”
      1. 1-800-273-8255 (TALK) or 775-784-8090
      2. www.crisiscallcenter.org
    - ii. National Domestic Violence Hotline
      1. 1-800-799-SAFE (7233)
      2. www.thehotline.org

### **Benefits of Being in the Study**

- The benefits of participation are: an opportunity to get a better understanding of your feelings about your experience in the program, an opportunity to talk about issues that are important to you.
- The potential benefits to social work/society are: increasing an understanding about the types of programs, and group techniques that people in interpersonal violence programs prefer; having a greater representation of the experiences of participants in such programs; provide insight for the design of existing and future programs at this agency.

### **Confidentiality**

- Your participation will be kept confidential. Your responses will be stored separately from your name and signature below, and stored in a locked file cabinet. Agency staff and other participants will have knowledge of your participation, but will not have access to your survey responses. The records of this study will be kept strictly confidential.
- All information, including consent/assent documents, will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

### **Payments/gift**

- You will not receive any financial payment for your participation.

### **Right to Refuse or Withdraw**

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to

withdraw completely. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by April 1, 2015. After that date, your information will be part of the thesis, dissertation or final report.

**Right to Ask Questions and Report Concerns**

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. Feel free to contact me, Justin Butler, at [jbutler@smith.edu](mailto:jbutler@smith.edu) or by telephone at XXX-XXX-XXXX. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

**Consent**

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep. You will also be given a list of referrals and access information if you experience emotional issues related to your participation in this study.

.....

Name of Participant (print): \_\_\_\_\_

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Researcher(s): \_\_\_\_\_ Date: \_\_\_\_\_

## APPENDIX C

### Instructions for Agency Staff to Identify and Attend to Distressed Participants

1. **IDENTIFY DISTRESS:** Throughout the survey-completion process, please be alert (look and listen) to signs that participants are distressed, such as:
  - a. Crying
  - b. Shaking
  - c. Putting their head down on the table
  - d. Excessively fidgety
  - e. Leave multiple times to go to the bathroom
  - f. Tense muscles or clenched jaw
  - g. Any vocal distress cues (yelling, moaning, heavy breathing)
2. **PROVIDE SUPPORT:** If participants exhibit any of the above symptoms, please gently offer support in the following ways:
  - a. Quietly approach them and ask them if they are okay, and if they would like to talk
  - b. Remind them that the survey is voluntary and that they can stop at any time
  - c. If they would like to talk, or simply be sat with, offer to escort them to a private room, for a one-on-one support session (wherein empathic listening, safety planning, and/or relaxation exercises may be employed).
  - d. If necessary, conduct a suicide/risk assessment.
  - e. If necessary, develop a safety plan.
  - f. Ask your supervisor, or other trained mental health clinician, for support.
  - g. Direct participants to the below list of local and national counseling services:
    - *A list of local counseling services and contact numbers*
      - [COUNSELING SERVICES 1]
        - [CONTACT INFORMATION]
      - [COUNSELING SERVICES 2]
        - [CONTACT INFORMATION]
      - [COUNSELING SERVICES 3]
        - [CONTACT INFORMATION]
    - *A list of crisis hotline numbers to call*
      - Crisis Call Center – “Call. Anytime. 24/7/365.”
        - 1-800-273-8255 (TALK) or 775-784-8090
        - www.crisiscallcenter.org
      - National Domestic Violence Hotline
        - 1-800-799-SAFE (7233)
        - www.thehotline.org

## APPENDIX D

### Screening of Participants

#### **Eligibility:**

1. **Is 18 years old or older**
2. Must have completed or be enrolled in [PROGRAM NAME]
3. Must be able to read basic English fluently
4. Must be able to write in English
5. Is perceived by staff to be able to complete a 27-question survey that asks questions about their experience in the program, and which indirectly references their experiences of violence, without becoming excessively distressed.
  - a. \* “excessive distress” may include any of the below behaviors:
    - i. Crying
    - ii. Shaking
    - iii. Putting their head down on the table
    - iv. Excessively fidgety
    - v. Leave multiple times to go to the bathroom
    - vi. Tense muscles or clenched jaw
    - vii. Any vocal distress cues (yelling, moaning, heavy breathing)

APPENDIX E

**Agency Approval Letter**

2/2/15

Smith College  
School for Social Work  
Lilly Hall  
Northampton, MA 01063

To Whom It May Concern:

[AGENCY NAME] gives permission for Justin Butler to locate his research in this agency. We do not have a Human Subjects Review Board and, therefore, request that Smith College School for Social Work's (SSW) Human Subject Review Committee (HSR) performs a review of the research proposed by Justin Butler. [AGENCY NAME] will abide by the standards related to the protection of all participants in the research approved by SSW HSR Committee.

Sincerely,

Signature & Title  
**(Agency or Institution Director)**  
**(Name of program)**

APPENDIX F

Survey Questions

SURVEY

**Voices of Participants in Interpersonal Violence Treatment:**

**Clients' Experience of Therapy**

Researcher: Justin Butler, Smith College School for Social Work

Contact: jbutler@smith.edu

About this survey: *The goal of this survey is to get better insight about the types of that participants prefer. The results of this survey will be used in a study that focuses on the opinions and experiences of participants in programs like [PROGRAM NAME]. This study is part of a student thesis, toward the completion of a Master of Social Work degree at Smith College School for Social Work.*

**Instructions:**

This survey is voluntary.

This survey is nameless and your responses will remain confidential.

This survey has no impact on any evaluation of your success in the program.

Please read each question carefully.

Please answer every question honestly, and to the best of your ability.

Please do not include any names, locations, or personal details in your responses.

If you feel distressed or uncomfortable during the survey, please stop and refer to the list of available resources, or seek out agency staff for any necessary support.

**Thank you so much for your completion of this survey.**

**QUESTIONS ABOUT YOU**

Age: \_\_\_\_\_

Male \_\_\_; Female \_\_\_; Transgender Male to Female \_\_\_; Transgender Female to Male \_\_\_; Other \_\_\_;  
Refuse \_\_\_

Race: \_\_\_\_\_

Ethnicity: \_\_\_\_\_

What is the highest grade/level of schooling you completed?

Elementary School (5<sup>th</sup> grade)

Middle School (8<sup>th</sup> grade)

High School (12<sup>th</sup> grade)

Technical/trade school

Some college credit

Associate's Degree

Bachelor's Degree

- Master's Degree
- Doctorate or other terminal degree

**QUESTIONS ABOUT YOUR EXPERIENCE IN THE PROGRAM**

1) How long have you been in the [PROGRAM NAME] program?

- Three weeks or less
- 4-7 weeks
- 8-11 weeks
- 12-15 weeks
- 16+ weeks

2) What types of programming have you participated in? (Check all that apply)

- Individual (one-on-one)
- Group

3) I am in [PROGRAM NAME]: (Check one)

- The court or other agency said I needed to be
- Someone I care about told me I should
- I decided on my own

4a) I will know I have changed when there is less or no violence in my relationships. (Circle one)

- |                   |          |                |       |                |
|-------------------|----------|----------------|-------|----------------|
| 1                 | 2        | 3              | 4     | 5              |
| Strongly Disagree | Disagree | Somewhat Agree | Agree | Strongly Agree |

4b) I'll know I have changed when my relationships get better. (Circle one)

- |                   |          |                |       |                |
|-------------------|----------|----------------|-------|----------------|
| 1                 | 2        | 3              | 4     | 5              |
| Strongly Disagree | Disagree | Somewhat Agree | Agree | Strongly Agree |

4c) I'll know I have changed when I feel better about myself. (Circle one)

- |                   |          |                |       |                |
|-------------------|----------|----------------|-------|----------------|
| 1                 | 2        | 3              | 4     | 5              |
| Strongly Disagree | Disagree | Somewhat Agree | Agree | Strongly Agree |

4d) I'll know I have changed when I feel less stressed. (circle one)

- |                   |          |                |       |                |
|-------------------|----------|----------------|-------|----------------|
| 1                 | 2        | 3              | 4     | 5              |
| Strongly Disagree | Disagree | Somewhat Agree | Agree | Strongly Agree |

5) It was helpful when my facilitators asked me about my feelings. (Circle one)

- |                   |          |                |       |                |                                 |
|-------------------|----------|----------------|-------|----------------|---------------------------------|
| 1                 | 2        | 3              | 4     | 5              | N/A                             |
| Strongly Disagree | Disagree | Somewhat Agree | Agree | Strongly Agree | My facilitators did not do this |

6) It was helpful when my facilitators asked me to think about other people's feelings, (Circle one)

- |                   |          |                |       |                |                                 |
|-------------------|----------|----------------|-------|----------------|---------------------------------|
| 1                 | 2        | 3              | 4     | 5              | N/A                             |
| Strongly Disagree | Disagree | Somewhat Agree | Agree | Strongly Agree | My facilitators did not do this |

7) It was helpful when my facilitators asked me about my childhood and past experiences. (Circle one)

- |   |   |   |   |   |     |
|---|---|---|---|---|-----|
| 1 | 2 | 3 | 4 | 5 | N/A |
|---|---|---|---|---|-----|

- |                   |          |                |       |                |                                 |
|-------------------|----------|----------------|-------|----------------|---------------------------------|
| Strongly Disagree | Disagree | Somewhat Agree | Agree | Strongly Agree | My facilitators did not do this |
|-------------------|----------|----------------|-------|----------------|---------------------------------|
- 8) It was helpful when my facilitators and I talked about ways to avoid destructive and controlling behavior (such as hitting or setting strict rules). (Circle one)
- |                   |          |                |       |                |                                 |
|-------------------|----------|----------------|-------|----------------|---------------------------------|
| 1                 | 2        | 3              | 4     | 5              | N/A                             |
| Strongly Disagree | Disagree | Somewhat Agree | Agree | Strongly Agree | My facilitators did not do this |
- 9) It was helpful when my facilitators helped me understand my emotions (sadness, shame, anger, etc.). (Circle one)
- |                   |          |                |       |                |                                 |
|-------------------|----------|----------------|-------|----------------|---------------------------------|
| 1                 | 2        | 3              | 4     | 5              | N/A                             |
| Strongly Disagree | Disagree | Somewhat Agree | Agree | Strongly Agree | My facilitators did not do this |
- 10) It was helpful when my facilitators told me that my emotions are normal responses. (Circle one)
- |                   |          |                |       |                |                                 |
|-------------------|----------|----------------|-------|----------------|---------------------------------|
| 1                 | 2        | 3              | 4     | 5              | N/A                             |
| Strongly Disagree | Disagree | Somewhat Agree | Agree | Strongly Agree | My facilitators did not do this |
- 11) It was helpful when my facilitators and I thought of new, positive thoughts (such as “I deserve to be loved”). (Circle one)
- |                   |          |                |       |                |                                 |
|-------------------|----------|----------------|-------|----------------|---------------------------------|
| 1                 | 2        | 3              | 4     | 5              | N/A                             |
| Strongly Disagree | Disagree | Somewhat Agree | Agree | Strongly Agree | My facilitators did not do this |
- 12) It was helpful when my facilitators and I thought of new, positive behaviors (such as making time for myself, or planning quality time with others). (Circle one)
- |                   |          |                |       |                |                                 |
|-------------------|----------|----------------|-------|----------------|---------------------------------|
| 1                 | 2        | 3              | 4     | 5              | N/A                             |
| Strongly Disagree | Disagree | Somewhat Agree | Agree | Strongly Agree | My facilitators did not do this |
- 13) It was helpful when my facilitators and I talked about better ways to communicate (such as using “I statements” or stating my needs clearly). (Circle one)
- |                   |          |                |       |                |                                 |
|-------------------|----------|----------------|-------|----------------|---------------------------------|
| 1                 | 2        | 3              | 4     | 5              | N/A                             |
| Strongly Disagree | Disagree | Somewhat Agree | Agree | Strongly Agree | My facilitators did not do this |
- 14) It was helpful when my facilitators taught me ways to relax, and lower my stress. (Circle one)
- |                   |          |                |       |                |                                 |
|-------------------|----------|----------------|-------|----------------|---------------------------------|
| 1                 | 2        | 3              | 4     | 5              | N/A                             |
| Strongly Disagree | Disagree | Somewhat Agree | Agree | Strongly Agree | My facilitators did not do this |
- 15) It was helpful when my facilitators gave me solutions to problems. (Circle one)
- |                   |          |                |       |                |                                 |
|-------------------|----------|----------------|-------|----------------|---------------------------------|
| 1                 | 2        | 3              | 4     | 5              | N/A                             |
| Strongly Disagree | Disagree | Somewhat Agree | Agree | Strongly Agree | My facilitators did not do this |
- 16) It was helpful when my facilitators suggested new ways to think about something. (Circle one)
- |                   |          |                |       |                |                                 |
|-------------------|----------|----------------|-------|----------------|---------------------------------|
| 1                 | 2        | 3              | 4     | 5              | N/A                             |
| Strongly Disagree | Disagree | Somewhat Agree | Agree | Strongly Agree | My facilitators did not do this |
- 17) It was helpful when my facilitators asked for more details about a story. (Circle one)
- |                   |          |                |       |                |                                 |
|-------------------|----------|----------------|-------|----------------|---------------------------------|
| 1                 | 2        | 3              | 4     | 5              | N/A                             |
| Strongly Disagree | Disagree | Somewhat Agree | Agree | Strongly Agree | My facilitators did not do this |
- 18) It was helpful when my facilitators repeated my thoughts and feelings back to me. (Circle one)
- |                   |          |                |       |                |                                 |
|-------------------|----------|----------------|-------|----------------|---------------------------------|
| 1                 | 2        | 3              | 4     | 5              | N/A                             |
| Strongly Disagree | Disagree | Somewhat Agree | Agree | Strongly Agree | My facilitators did not do this |
- 19) It was helpful when my facilitators said words of encouragement. (Circle one)



1	2	3	4	5	N/A
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree	My facilitators did not do this

20) It was helpful when my facilitators used silent pauses. (Circle one)

1	2	3	4	5	N/A
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree	My facilitators did not do this

21) I benefited from talking about a specific conflict/fight. (Circle one)

1	2	3	4	5	N/A
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree	This did not happen

22) I benefited from talking about my emotional responses during conflicts. (Circle one)

1	2	3	4	5	N/A
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree	This did not happen

23) I benefited from talking about my childhood. (Circle one)

1	2	3	4	5	N/A
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree	This did not occur

24) I benefited from talking about the differences between emotions, thoughts, and actions. (Circle one)

1	2	3	4	5	N/A
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree	This did not occur

25) I benefited from talking about my past relationships. (Circle one)

1	2	3	4	5	N/A
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree	This did not occur

26) I benefited from listening to other participants talk about their experiences. (Circle one)

1	2	3	4	5	N/A
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree	This did not occur

27) It was helpful when my facilitators shared stories from his/her life. (Circle one)

1	2	3	4	5	N/A
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree	This did not occur

28) It was helpful when my facilitators talked about ways that my childhood and current life are similar? (Circle one)

1	2	3	4	5	N/A
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree	This did not occur

29) My facilitators in the program were very helpful. (Circle one)

1	2	3	4	5
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree

30) My facilitators understood me.

1	2	3	4	5
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree

31) My facilitators helped me change for the better? (Circle one)

1	2	3	4	5
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree

32) I feel the facilitators want me to achieve my goals. (Circle one)

1	2	3	4	5
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree

33) The group helped me change for the better. (Circle one)

1	2	3	4	5
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree

34) What was the **most** helpful thing your facilitators did? Why was it helpful?

35) What was the **least** helpful thing your facilitators did? Why wasn't it helpful?

36) What advice would you like to give to the facilitators in this program?

37) What advice would you like to give to future participants in this program?

38) Please share any other thoughts you have about this program and your experience in it.

**THANK YOU SO MUCH FOR YOUR RESPONSES!!!!**

APPENDIX G

**Smith HSRB Approval**



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**School for Social Work**  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

January 21, 2015

Justin Butler

Dear Justin,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.  
Co-Chair, Human Subjects Review Committee

CC: Amy Booxbaum, Research Advisor

APPENDIX H

**Protocol Change Approval**



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**School for Social Work**  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

March 18, 2015

Justin Butler

Dear Justin,

I have reviewed your amendments and they look fine. These amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.  
Co-Chair, Human Subjects Review Committee

CC: Amy Booxbaum, Research Advisor