AN EXPLORATION OF THE STAGES OF CHANGE MODEL IN A GROUP TREATMENT PROGRAM FOR MALE BATTERERS

A Dissertation

by

ROBERT DAVIS WELLS

Submitted to the Office of Graduate Studies of
Texas A&M University
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

December 2004

Major Subject: Counseling Psychology

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ABSTRACT

An Exploration of the Stages of Change Model
in a Group Treatment Program for
Male Batterers. (December 2004)

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The purpose of this study was to investigate the adequacy of the Stages of Change model in a group therapy treatment program for male batterers. The sample consisted of three groups with a total sample size of 22 participants. Data for this study were obtained by administering the Safe at Home Instrument and the Group Climate Questionnaire – Short Form. Results indicated the Safe at Home Instrument had limited clinical utility with involuntary male batterers. Independent of scoring method used, the majority of participants reached the action stage early in group treatment. Because the action stage is the highest stage attainable in this study, further growth was not measurable. The lack of variability in participants' scores on the Safe at Home Instrument limits its clinical

usefulness. Results from the Group Climate Questionnaire – Short Form indicate the groups did not progress according to a popular group development theory (MacKenzie & Livesley, 1983). The groups appear to enter the differentiation stage but do not successfully master the developmental issues needed to progress through the subsequent stages. The results from both instruments indicate that treatment groups with involuntary, male batterers did not progress as expected.

Recommendations for future research and clinical practice are discussed.

DEDICATION

This dissertation is dedicated to my wife, Karen, my daughter Tori, my son Joey, and to my family, Henry, Gayle, Sean, Karen and Cindy, who told me I could accomplish anything I wanted as long as I tried hard enough. Their ever-present faith and support would never let me give up on my dreams.

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To my wife and best friend Karen; my daughter Tori; my son Joey; my parents Henry and Gayle; my siblings Sean, Karen and Cindy; my in-laws; and my life long friends – Thanks to all of you for many years of love, patience, and encouragement.

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Throughout my life hundreds of people have touched my life, most without knowing it, to develop the strength within myself to be able to accomplish this task. I thank you all.

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CHAPTER I

INTRODUCTION

Intimate partner abuse (also referred to as domestic violence, interpersonal abuse, spouse abuse, partner abuse, courtship violence, battering, marital rape, and date rape) is actual or threatened physical, sexual, or emotional abuse directed toward a spouse, ex-spouse, current or former boyfriend or girlfriend, or current or former dating partner whether the individuals are cohabitating or not. Intimate partners may be heterosexual or homosexual. Intimate partner violence (IPV) is defined as the physical or sexual abuse (i.e., murder, rape, physical assault, sexual assault) of a current or former spouse, partner, girlfriend, or boyfriend. The perpetrator of intimate partner violence or abuse is referred to as an abuser or, more commonly, a batterer. Intimate partner violence and abuse are recognized globally as critical public health concerns and human rights violations that affect children and adults worldwide. Emotional abuse of an intimate partner often results in as severe emotional consequences to an individual as physical abuse (O'Leary, 1999). Due to

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This dissertation follows the style and format of the *Journal of Counseling Psychology*.

the majority of batterers in treatment being court ordered to group treatment as a result of their physical violence and not their emotional abuse, this research study focuses on intimate partner violence (IPV) and not intimate partner abuse.

Prevalence of Intimate Partner Violence (IPV)

According to Tjaden and Thoennes (2000), approximately 1.5 million women and 834,700 men are raped and/or physically assaulted by an intimate partner each year in the United States. They found almost two-thirds of women who reported being physically assaulted, raped, or stalked since age 18 were victimized by a current or former boyfriend, date, cohabiting partner, or husband. Although strangers or acquaintances commit the majority of the assaults perpetrated against men, women are much more likely to be assaulted, raped, or murdered by an intimate partner (Mahoney, Williams, & West, 2001). Walker (1999) depicted "the single most powerful risk marker for becoming a victim of violence is to be a woman" (p. 23). Campbell (2001) found the number of yearly cases of IPV reported in past years ranged from 4% to 14% in population-based studies and up to 44% in health care settings. Campbell's review of the literature found lifetime estimates to vary

from 5% to 51%. As daunting as these high figures are, it is commonly accepted that these crime data statistics represent underestimates of the actual incidence and prevalence of intimate partner violence.

Consequences of IPV

Among women who are raped or physically assaulted by an intimate partner, one-third are injured (Tjaden & Thoennes, 2000). Tjaden and Thoennes found that each year, over 500,000 women injured as a result of IPV require medical attention and as many as 324,000 women each year experience IPV during their pregnancy. IPV is most often not a single violent assault. Rather IPV is a cyclic, progressive process in which violence is used to control or manipulate another person. Grynbaum, Biderman, Levy and Petasne-Weinstock (2001) found 8-14% of female victims reported abuse in the previous year. Dutton (1988) estimated that severe and repeated IPV occurs in nearly 7% of all marriages, whereas Strauss and Gelles (1990) found IPV occurs in 17% of American couples. The American Psychological Association (1996) reported that nearly one-third of adult women experience at least one physical assault by a partner during adulthood. Estimates as high as 72% indicate that men who assault their partners are likely

to perpetrate IPV again unless an intervention is utilized (O'Leary, Barling, Arias, Rosenbaum, Malone, & Tyree, 1989). This repeated victimization has been described as a "battering syndrome", in which a physical assault is followed by an increase in medical and psychological problems (Grynbaum, Biderman, Levy & Petasne-Weinstock, 2001). According to the National Research Council (1996), IPV is associated with both short- and long-term problems, including physical injury and illness, psychological symptoms, economic costs, and death. As a direct consequence of severe IPV, female victims are more likely than male victims to need medical attention and take time from work; they also spend more time in bed and suffer more mental health problems. Wisner, Gilmer, Saltzman, & Zink (1999) estimated the yearly direct medical cost of caring for battered women to be $1.8 billion.

The negative effects of IPV on society are also substantial. IPV is a widespread problem that affects families of all races, ethnicities, ages, sexual orientations, and socioeconomic levels (Rynerson & Fishel, 1993). Results of the National Crime Victimization Survey (Rennison & Welchans, 2000) showed approximately 45% of female IPV victims live in a home with children under

twelve years old. Children living in abusive homes have been shown to exhibit a variety of behavioral, physical, and psychological problems (Wolak & Finkelhor, 1998). Researchers agree that witnessing IPV as a child is a more consistent risk marker for battering as an adult than is being physically abused as a child (Hotaling & Sugarman, 1986). Other societal ills created by IPV include increased health care cost (Brannen et al., 1999), increased unemployment rates (Byrne, Resnick, Kilpatrick, Best, & Saunders, 1999), homelessness (Khanna, Singh, Nemil, & Best, 1992), financial strain on the criminal justice system (Buzawa & Buzawa, 1996), and increased need for mental health and social services (Healey, Smith, & O'Sullivan, 1998).

Treatment of IPV

Although IPV has been prevalent in the United States since the birth of the nation, it has only been within the last 30 years that it has been recognized as a societal problem (Landes, Siegel, & Foster, 1993). In the early 1970s the focus of attention was on providing shelter and treatment for the female victims rather than treatment for the perpetrators (Hamby, 1998). However, over the last 30 years there has been a shift of focus

from the victim to the perpetrator. The establishment of treatment programs for IPV perpetrators began in Boston in 1977. Since this time the number of treatment programs has increased to several thousand programs (Carden, 1994; Hamby, 1998; Rosenfeld, 1992). Male perpetrators of IPV are frequently treated by group counseling (Lundberg, 1990). Group treatment for IPV males is favored over individual, marital, or family treatments (Cook & Frantz-Cook, 1984; Feldman & Ridley, 1995). The advantages of group treatment for domestic violence perpetrators include: a) ability to serve a large number of clients with limited resources; b) ability to offer low cost treatment to low-income clients who may not otherwise receive services; c) ability to utilize peer support and confrontation to challenge traditional ways of thinking; and d) ability of group members to bond with one another resulting in continued contact and support outside of the group experiences (Daniels & Murphy, 1997; Elliott & Blair, 1994). Lindsey, McBride, and Pratt (1993) purport that another important advantage of group treatment for IPV perpetrators is the opportunity for them to develop social skills through practicing, role playing, receiving feedback, and modeling. Daniels and Murphy (1997) purport

that movement toward active behavioral change for male IPV perpetrators happens much faster in group treatment than it does in individual treatment. They state that group members are more likely to make decisions and a commitment to change if they see other group members doing so and are being reinforced for nonabusive behaviors.

Statement of the Problem

As group treatment for male batterers rises in popularity, probation departments and other state agencies continue to push for the acceptance of this format as a standardized and required group treatment (Healey, Smith & O'Sullivan, 1998). Even with this emphasis, research on batterer treatment groups is sparse. Feldman and Ridley (1995) estimate that over 30 empirically based outcome studies have been published evaluating various group treatment formats for male perpetrators of IPV. However, none of these studies addressed processes of change. Begun, Shelley, Strodthoff, and Short (2001) state that these studies provide important information about intervention outcomes, but they do not provide information about the actual process of change experienced by participants who attempt cessation of their abusive behaviors. They

advocated using the stages of change (SOC) approach developed by Prochaska and DiClemente (1984) that offers an opportunity to enhance current program evaluation practices by generating information about the change process itself. Begun et al. (2003) suggested that implementing process focused research eventually would allow treatment programs to become more responsive to the diverse change experiences of the participants enrolled and may lead to a higher proportion of successful outcomes. It is important to note that, to the author's knowledge, to date no group process research has been published on male batterer treatment.

Purpose of the Study

The purpose of this exploratory investigation was to gather empirical evidence demonstrating the effectiveness of utilizing the Stages of Change principles for group treatment of male IPV perpetrators. By developing a thorough understanding of the utility of the Stages of Change approach in male batterers' groups, we may be able to increase the effectiveness of these groups. For example, if at the end of the 24-week group treatment a large percentage of participants were in the precontemplation or contemplation stage, it would be argued that the length of treatment should be increased to facilitate more positive

behavior changes. On the other hand, if a majority of participants achieve the action stage earlier than predicted an argument could be made to decrease the length of treatment. Because previous research has mixed results on these issues, it is hoped that a greater understanding will emerge.

Research Questions

The following research questions were investigated:

1. Upon completion of the 24-week group treatment, to what stage of the Transtheoretical Model (TTM; i.e., precontemplation, contemplation, preparation, or action) do the participants achieve?
2. At what length of treatment would 75% of the members be predicted to reach the action stage?
3. Are the treatment interventions stage appropriate?

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

This literature review will focus on treatment for intimate partner violence (IPV) and group processes of change. It will provide a description of group treatment programs for IPV and an overview of outcome research on these programs. According to Healey, Smith, and O'Sullivan (1998), approximately 80% of IPV perpetrators undergoing group treatment programs are court-ordered to attend and 85-90% of batterers arrested are heterosexual males. They purport that most IPV treatment groups have been developed for heterosexual men. Therefore, this review will address court-mandated group treatment programs for heterosexual male IPV perpetrators. Additionally, Prochaska and DiClemente's Transtheoretical Model of Behavior Change will be the primary focus for the group process discussion.

Intimate Partner Violence (IPV)

The criminalization of intimate partner violence (IPV) began in the United States in the 1970s (Zorza, 1992). Since this time attention to IPV issues has risen dramatically. It is estimated that 2 million women are abused and 1,400 killed by their partners per year

(Goodwin, 1997). The following statistics illustrate the severity of IPV in the United States (Flowers, 2000):

> Every 9 seconds a woman is battered by her spouse. Four million spouses are battered each year. Two million women are victims of severe intimate abuse annually. One-third of female homicide victims are killed by an intimate. Ninety-five percent of assaults on spouses or ex-spouses are perpetrated by men against women. One in 5 battered women were victims of at least 3 assaults in the last 6 months. (p. 15)

Increased public awareness of the magnitude of IPV has led to important societal and legal changes. Today, shelters for abused women that provide legal services, advocacy, social services, and therapy can be found in most metropolitan cities (Rosenbaum & Maiuro, 1990). Rosenbaum and Maiuro (1990) report services for batterers are less common, less well organized, and inadequately supported and they refute the belief that money spent treating the batterers is money that is unavailable to help the victims. Fortunately, the increased awareness of IPV issues has led to a growing belief that treatment for batterers is necessary as well. From this viewpoint, the

plight of battered women can only be improved by treating IPV perpetrators (Rosenbaum & Maiuro, 1990).

Within the growing field of IPV research, the study and treatment of battering men is an open frontier, which had remained unexplored until the late 1970s (Jennings, 1987). Edleson (1990) stated that the problem of IPV has been recorded throughout history, but research on intervention, especially with male batterers, is in its infancy. Although there is some debate about the treatment of choice for IPV, many specialists are claiming that group therapy is most effective (Rosenbaum & Maiuro, 1990; Bennett & Williams, 1999; Jennings, 1987). However, researchers do not agree on length of group treatment required to treat IVP. There is considerable variation in the length of group treatment with the number of sessions ranging from as few as 5 or 6 to as many as 50 or more (Rosenbaum & Maiuro, 1990). The length of batterer counseling group treatment has been found to vary from one month to a year (Gondolf, 1990; Gregory & Erez, 2002). Sonkin (1988) set a minimum length of treatment at 6 months, but allowed for more extended treatment as deemed necessary. Rosenbaum and Maiuro (1990), found that group treatment is usually structured

and time-limited, ranging from 8 to 32 meetings of 2 to 3 hours each, but some programs are as long as 52 meetings. They found treatment programs determine successful completion by participants' attendance during the required time. Thus, the batterers may "successfully" complete the program just by showing up. Edleson (1996) argues against this definition of success. This study examines the question of completion defined by behavioral changes (i.e., stage of change achieved) as discussed later.

Session Impact Variables in Group Counseling

The use of "session impact variables" is an attempt to uncover or measure processes that arise during group counseling (Brossart, 1997). Some researchers refer to session impact variables as process variables (Phipps & Zastowny, 1988); however, "session impact" seems more appropriate as the time of measurement usually occurs immediately after the group session (Brossart, 1997). Two session impact measures will be reviewed, the Safe at Home Instrument (SAHI; Begun et al., 2003) and the Group Climate Questionnaire- Short form (GCQ-S; MacKenzie, 1983). The SAHI instrument is designed to assess readiness to change for men who are perpetrators of IPV.

The instrument was adapted from Prochaska and DiClemente’s transtheoretical model of behavior change (TTM or TMBC; 1982, 1986). Both the TTM and the GCQ-S have enjoyed widespread use in research.

Safe at Home Instrument (SAHI)

This review of the stages of change will begin first with an overview of the transtheoretical model of change (TTM), which offers a framework for the stages of change approach. Second, studies that have used the TTM will be reviewed to present an overarching picture of how researchers have construed the stages of change. The concept of stages of change has been used to identify the processes by which individuals are able to effect changes in health related behaviors, and to determine the effects of interventions to predict outcome.

In their seminal article Prochaska and DiClemente (1982) described the concept of the stages of change that individuals utilize to alter their troubled behavior. Their model is described as transtheoretical because it incorporates psychodynamic, existential, reality, client-centered, gestalt, cognitive, motivational, and social learning theories (Prochaska, 1979). The key feature of TTM states that health behavior change progresses through

a series of steps or stages (Morera et al., 1998). Prochaska and DiClemente (1982) differentiated four stages of change: a) thinking about stopping; b) becoming determined to stop; c) actively modifying their habits and/or environment; and d) maintaining their new habit. From the outset they realized that these stages are not linear but cyclical. "For addictive problems, such as smoking, a revolving-door schema is a more accurate representation of the sequence that smokers pass through in their efforts to become non-smokers." (Prochaska & DiClemente, 1982, p. 283). In this article they reported that smokers remain in the contemplation stage from two weeks to twelve months and the determination stage ranges from two hours to two months.

Since then a fifth stage, preparation, has been empirically supported and added to their model. The five stages have been shown to occur in both self-mediated and treatment-facilitated modification of problematic behaviors (Prochaska, DiClemente & Norcross, 1992). The five stages of change, which reflect the temporal and motivational aspects of change include: precontemplation, contemplation, preparation, action, and maintenance (Prochaska & DiClemente, 1992). The following

descriptions of the five stages are adapted from Daniels and Murphy (1997).

Precontemplation. Persons in the earliest stage of change, precontemplation, are unaware that they have a problem, are unwilling to change, or are even discouraged in their attempts to change. During treatment, these persons minimize the negative consequences of the problem behavior and the benefits of change, and they frequently exaggerate the difficulty of making changes or the negative consequences of making the changes. These individuals are not currently engaging in any change activity and are unlikely to respond well to active behavioral change strategies.

In the case of IPV, especially with court-ordered perpetrators, many individuals arrive for treatment in the precontemplation stage. These persons deny any problems exist, minimize any problem, or report their problem has already been changed, yet are unable to support this claim.

Contemplation. In this next stage, persons ponder the possibility of change and weigh the pros and cons of change. Individuals in this stage are open to receiving information and are beginning the process of self-

evaluation. Begun et al. (2003) described individuals in the contemplation stage as thinking about changing, but having no specific plans. Contemplators are cognizant of a distressing life situation and are interested in deciding whether the problems are resolvable (McConnaughy, DiClemente, Prochaska & Velicer, 1989). Individuals in the contemplation stage are struggling to understand the problem (i.e., cause, solution) and are seeking information, but have not made a commitment to change (McConnaughy, Prochaska & Velicer, 1983). Progression out of the contemplation stage requires a firm commitment to take action.

Preparation. This stage has also been named “decision making” (McConnaughy, DiClemente, Prochaska & Velicer, 1989; McConnaughy, Prochaska & Velicer, 1983). Individuals enter the preparation stage when they made a commitment to take action in changing their problematic behavior. Persons in this stage may have already begun to change their behavior. McConnaughy, Prochaska and Velicer (1983) describe individuals in the decision making stage as having made a decision to change; are willing to pay the price (i.e., time, effort, financial); have begun to

accept responsibility; but have not started working on the behavior.

Action. Individuals in the action stage are actively modifying their problem behavior. These persons have actively started to change their behavior or their environment, are struggling to change, or have not been very successful on their own and need help (McConnaughy, Prochaska & Velicer, 1983). These individuals have not attained the desired change. Relapse, temporary setbacks, and disappointment may occur during this stage.

Maintenance. The maintenance stage is entered when individuals consistently use their new behaviors and refrain from violence. Daniels and Murphy (1997) suggest that a 3- to 6-month period of active behavior change with no physical violence is usually sufficient to deem someone in the maintenance stage. Although an individual is in the maintenance stage, the prior problematic behavior is not necessarily completely extinguished, nor are the new adaptive behaviors firmly established. “Maintenance requires sustained behavioral change activity for a period of time after initial action… relapse is very common, and often several attempts to modify problem behavior are made on the way to successful

maintenance of behavior change.” (Murphy & Daniels, 1997, p. 139)

The stages of change characterize the dynamic and motivational aspects of change over time (DiClemente & Prochaska, 1998). They described the stages of change as a way of partitioning the process into meaningful steps consisting of specific tasks required to achieve successful, sustained behavior change.

Processes of Change

“The processes of change are the engines that facilitate movement through the stages of change. These principles of change have been derived from many diverse theories of behavior change and are at the heart of the transtheoretical model.” (DiClemente & Prochaska, 1998, p. 4) DiClemente & Prochaska identified ten reliable, separate, and distinct processes of change: consciousness raising, dramatic relief, environmental reevaluation, self-reevaluation, self-liberation, social-liberation, counterconditioning, stimulus control, contingency management, and helping relationships. These ten processes represent change principles identified by the various cognitive, behavioral, experiential, and humanistic existential theories of psychotherapy

(DiClemente & Prochaska, 1998). According to their model, these 10 processes employed at particular stages are responsible for movement through the five stages of change. Prochaska and DiClemente (1992) wrote:

> The integration of stages and processes of change can serve as an important guide for therapists. Once a client's stage of change is clear, the therapist knows which processes to apply in order to help the client progress to the next stage of change. Rather than apply change processes in a haphazard or trial-and-error approach, integrative therapists can begin to use change processes much more systematically." (p. 303)

Consciousness raising, dramatic relief and environmental reevaluation are the processes employed to facilitate movement from the precontemplation stage to the contemplation stage. Consciousness raising helps clients become increasingly aware of the causes, consequences, and cures of their problematic behaviors. Consciousness raising techniques include observations, confrontations, and interpretations shared with the client or group. Dramatic relief affords clients helpful affective experiences that can raise emotions related to their

problems. Discussing the abusive situation or legal difficulties is one way to accomplish this process. Environmental reevaluation begins when clients view their situation as different from how they would like it to be. For IPV perpetrators, it occurs when they view their abuse as creating problems in their or their significant other’s physical environment.

In the contemplation stage the goal is for individuals to consider the pros and cons of changing their problematic behaviors. The process of change that facilitates this movement is self-reevaluation. Self-reevaluation occurs when the group member assesses himself in relation to the problematic behavior or abuse. When in group treatment, this process can occur through comparing himself with other group members, identifying with other group members and receiving feedback from the group regarding his abusiveness.

Self-liberation is the vital process in moving from the preparation to the action stage. Self-liberation is committing internally to the new, non-abusive, behavior, believing in one’s ability to enact the new behavior, and encouraging one’s self to do so (Daniels & Murphy, 1997).

The action stage is when an individual is actively modifying one's problematic behavior. The processes of change integral towards movement to the maintenance stage are contingency management, stimulus control, counterconditioning, and helping relationships. Within the group milieu, contingency management can take the form of positive feedback from the group leader or other group members. The individual can develop ideas that are self-rewarding as well. Stimulus control techniques involve removing reminders of unwanted behaviors and keeping or adding reminders to perform alternative/non-abusive behaviors (Daniels & Murphy, 1997). There are many techniques employed for counterconditioning. For example, group members can imagine an anger producing circumstance while in a relaxed state. In this relaxed state, he can imagine non-abusive behaviors.

Finally, group leaders can serve as helping relationships for the group members. Prochaska & DiClemente (1992) discussed group leaders' beneficial role:

> Since action is a particularly stressful stage of change that involves considerable opportunities for experiencing coercion, guilt, failure, rejection, and

> the limits of personal freedom, clients are also particularly in need of support and understanding. Knowing that there is at least one person who cares and is committed to helping serves to ease some of the distress and dread of taking life-changing risks. (p. 306)

Success in the maintenance stage requires a continuation of the processes that came before, as well as, an awareness of conditions in which the individual is likely to be coerced into relapsing. Individuals need to assess the alternatives they possess for coping with antagonistic conditions without resorting to self-defeating defenses and pathological responses (Prochaska & DiClemente, 1992).

Further research has shown that the processes of change can be categorized into two factors (Greene et al., 1999). They found *experiential* processes focus on thoughts, experiences, and feelings. The experiential processes were found to occur more in the earlier stages of change. The experiential processes include: consciousness raising, dramatic relief, self-reevaluation, self-liberation, social liberation, and environmental reevaluation. The *behavioral* processes

focus on behaviors and reinforcement. The behavioral processes were found to occur in the action and maintenance stages of change. The behavioral processes include: helping relationships, reinforcement management, counterconditioning, and stimulus control.

Empirical Efforts Utilizing the Stages and Processes of Change

The transtheoretical model of change (TTM), and its associated stages of change and processes of change, has enjoyed much research in health promotion. One of the first measures developed according to the TTM was the Stages-of-Change Questionnaire (McConnaughy, Prochaska, & Velicer, 1983). The development of this questionnaire resulted in a brief yet highly reliable instrument for measuring change. Their results indicated a clear structure yielding four well-defined stages. Decision-making (later named preparation) was dropped as a separate stage of change due to high loadings on contemplation and action stages. McConnaughy et al. explained this result:

> It is possible that decision-making is such a transitory phenomenon that people cannot be assessed when making important but quick commitments. An

> alternative explanation is that decision-making involves both contemplation and commitment to action. (p. 374)

This explanation would seem more plausible if they had collected data at more than one point in time to test the transitory nature of decision-making. However, the development of the stages-of-change questionnaire led to a burgeoning of research based upon the TTM.

In a recent review of the stages of change literature, Whitelaw et al. (2000) identified over 1000 publications between 1985-1998. They narrowed this search to include 239 empirical studies with an associated data set. They categorized these studies according to whether they were primarily about *structure* (tests of the fabric or framework of the model/theory), *process* (tests of the ingredients, mechanisms, or procedures of the model/theory), or *outcome* [end-point assessment or measurement after delivery of scientific health intervention(s)]. Of the empirical studies, they reported 178 (74.48%) were classified as concerned with structure, 50 (20.92%) with process, and 11 (4.6%) with outcome. They found no outcome studies appeared in the literature

until 1994. Their interpretation for the paucity of outcome research stated:

> …the complex and interactive nature of stage allocation, transtheoretical processes and intervention makes the precise structuring and isolation of independent and dependent variables problematic. Therefore, it may be inherently difficult to isolate the generalized effects of an intervention from the specific influence of Stages of Change. (p. 712)

Distilling the hundreds of articles based upon TTM theory necessitates that not every study can be presented and critiqued, nor what has been written in previous reviews be repeated. Thus, a sample of studies that specifically conceptualize the TTM from a stages and/or processes of change perspective will be reviewed.

As previously mentioned, the stages of change is the key aspect of TTM theory. Therefore, the stages of change component has been the most widely researched. In a replication study, McConnaughy, DiClemente, Prochaska and Velicer (1989) found similar results to their original study. This study confirmed their hypothesis of an invariant stage model that characterized the stages of

change. The invariant stage model suggests that the stages are additive and that adjacent stages are more highly correlated than nonadjacent stages. In their concluding remarks they suggested future research could explore clients' stages of change during the treatment process to determine whether predominant stages change as a result of treatment. Again, in their study they employed one data point; thus, stage of change development over time could not be studied.

In an earlier study, DiClemente (1981) found that persons with higher self-efficacy in the maintenance stage are more likely to maintain their smoking cessation. Those with lower self-efficacy were more likely to relapse. This study used two data points that were 5-months apart. Therefore, stage development over time could not be assessed.

In a similar study, Prochaska, Crimi, Lapanski, Martel, and Reid (1982) found both higher self-efficacy and reliance on more inner-directed, experiential processes of change led to higher levels of smoking cessation. This study included one data point, thus stage development over time was not a focus.

In an early study focused upon the processes of change, Prochaska and DiClemente (1983) found that self-changers implement the fewest processes of change during the precontemplation stage; emphasize consciousness raising during the contemplation stage; emphasize self-reevaluation in both the contemplation and action stages; emphasize self-liberation, a helping relationship, and reinforcement management during the action stage; and use counterconditioning and stimulus control the most in the action and maintenance stages. They gathered their data every six months for two years for a total of five data points. This study is one of only a few that focused on stage development over time. However, they did not report how stages progress or relapse.

DiClemente et al. (1991) found that an individual's stage of change can be used to predict smoking cessation. Those who entered treatment in the preparation stage had a greater percentage of smoking cessation than compared to those in the contemplation stage, who in turn, had greater smoking cessation than those in the precontemplation stage. Prochaska, DiClemente, Velicer, Ginpil, and Norcross (1985) found certain processes of change might be used to predict change in smoking status

as well. They reported the change processes of self-reevaluation and the helping relationship were the most efficacious predictor variables. They also found the process of change more oriented toward environmental events (i.e., dramatic relief and social liberation) tended to predict failure or no progress whereas more experientially oriented processes predicted progress. Wilcox, Prochaska, Velicer, and DiClemente (1985) found similar results. They found the 10 processes of change were able to make more accurate predictions of smoking cessation after six months than static variables (i.e., age, socioeconomic status, educational level). Both studies utilized two data points; therefore stage development over time was not addressed.

Prochaska, Velicer, DiClemente, and Fava (1988) developed the Processes of Change Questionnaire, which is a 40-item instrument that measures the 10 important processes of change in a statistically well-defined and highly reliable manner. The Processes of Change Questionnaire continues to enjoy widespread use in transtheoretical model of behavior change research. Prochaska, Velicer, Guadagnoli, Rossi, and DiClemente (1991b) utilized the Processes of Change Questionnaire in

a longitudinal study. They gathered data every six months for five rounds. They found the basic pattern of change processes could best be represented by a "mountain metaphor". In their study, the change processes followed a general pattern of increasing from precontemplation to contemplation, peaking at a particular stage of change, then declining either to precontemplation levels or to slightly higher levels if used as relapse prevention strategies. This study is a rarity in that it addressed processes of change development over time. Similar to the stages of change research, there is a paucity of empirical findings addressing process of change development over time.

Only one study was found that looked at both stages and processes of change development over time. Prochaska, Rossi, and Wilcox (1991a) conducted a naturalistic and longitudinal study using three clients who entered therapy. The processes of change were assessed after every session, while the stages of change were assessed every fifth session. Their results were congruent with TTM theory. They found clients progress from one stage to the next by shifting their reliance from one set of change processes to the set that is most effective for

the next stage of change. They found this progression held true for clients entering therapy not just for smoking cessation. They suggested future research be conducted with other mental health issues to determine if the TTM and its measures are applicable to a much broader range of clients and their issues.

Although smoking cessation continues to be widely researched from TTM theory, other health related problems are beginning to be addressed. Empirical studies utilizing either the stages or processes of change have been conducted with dietary interventions (Greene et al., 1999; Kristal, Glanz, Curry & Patterson, 1999; Ounpuu, Woolcott, & Rossi, 1999; Van Duyn et al., 1998); bulimia nervosa (Treasure et al., 1999); condom and contraceptive use (Grimley & Lee, 1997; O'Campo et al., 1999); obesity (Suris, Trapp, DiClemente, & Cousins, 1998); physical exercise (Cardinal, 1997; Cole, Hammond, Leonard, & Fridinger, 1998; Gorely & Gordon, 1995; Turjanica, 1996); abuse survivors (Burke, Gielen, McDonnell, O'Campo, & Maman, 2001; Koraleski & Larson, 1997); HIV (Patten, Vollman, & Thurston, 2000; Riley, Toth, & Fava, 2000); adolescent offenders (Hemphill & Howell, 2000); and diabetic control (Edwards, Jones, & Belton, 1999).

Incorporating TTM theory for the treatment of IPV is in its infancy. Daniels and Murphy (1997) and Murphy and Baxter (1997) proposed utilizing TTM theory with IPV perpetrators. Daniels and Murphy stated that batterers' treatment programs could benefit from integrating TTM theory; most specifically they supported matching interventions depending on stage of change. They preferred group treatment for IPV perpetrators because of the power of peer modeling and other social influence processes. They reported a perpetrator may be more likely to make a decision and commitment to personal change if he sees other clients doing so, and especially if he sees that others are experiencing reinforcement from nonabusive behavior. They felt that a greater understanding and appreciation of the stages and processes of change would help behavior therapists to better assess IPV perpetrators and to provide stage-appropriate interventions.

Murphy and Baxter (1997) reported similar ideas. They reported that other IPV treatment strategies (i.e., confrontational or anger control models) are limited by their emphasis on only one stage of change. They felt TTM offers a more integrative approach that relies on

supportive, relationship enhancing strategies to help batterers move through all stages of change.

Levesque (1999) was the first to study empirically the transtheoretical model with IPV perpetrators. Her results provided strong evidence of the applicability of the TTM with this population, as well as, external validity of the stages of change measures. She reported that longitudinal research is needed to gain a better understanding of the stages and processes of change as they relate to IPV treatment.

Levesque, Gelles and Velicer (2000) developed the University of Rhode Island Change Assessment- Domestic Violence measure (URICA-DV) that assesses batterers' readiness to end their violence. Their data provided preliminary evidence of validity for the URICA-DV. They reported the need to develop an instrument specific to IPV treatment:

> Psychometrically sound and valid measures of stages of change…and processes of change are critical initially in testing to examine how well the Transtheoretical Model constructs, and the established relationships between them, characterize the process of change among assaultive men. Measures

> also provide the tools for assessing change over time and provide the data that guide client-treatment matching to increase the impact of interventions. (p. 178)

They found that stages of change could be assessed using continuous measures that represent each of the different stages. Although persons progress from one stage to another, they can possess attitudes and exhibit behaviors that characterize more than one stage at the same time. Therefore, they used clustering techniques to provide profiles or patterns of scores that characterize readiness to change. Their results did not discriminate a separate preparation stage. They suggested that individuals did not discriminate between preparation and adjacent stages. They stated that future research is needed, especially longitudinal research assessing the progression, regression and/or lack of movement among men in the various stages.

Begun et al. (2003) developed a similar instrument to assess individuals' readiness to change their intimate partner violence behaviors. The development of the Safe At Home Instrument (SAHI) resulted in identification of three scales that are consistent with the

Precontemplation, Contemplation, and Preparation/Action stages outlined in the Transtheoretical Model. They offered several reasons as to why Preparation and Maintenance failed to result in distinct stages: a) preparation is an amalgam of elements from both contemplation and action stages; b) few clients being treated for intimate partner violence are involved in the maintenance of long-term behavior changes, so the failure to identify this stage may reflect an inherent characteristic of the target population; and c) future analyses may need to explore more complex scoring systems (i.e., allowing for overlaps and blending across stages, cluster analysis of cases).

Begun et al. (2003) also offered another explanation for why their results were not more favorable. They collected their data at pre- and post-intervention sessions. They suggested that intervention time frames of 16 weeks might be too limited in comparison to the time required for sustained progression through all five stages. Another plausible explanation stated their instrument would be useful in evaluating intervention impact on attitudes and beliefs, but may not be directly

relevant in evaluating behavior change associated with the actual cessation of intimate partner violence.

Readiness-to-Change (RTC)

Bandura (1997) and Sutton (2001) have criticized the Stages of Change model. Sutton (2001) purports that readiness to change a particular problematic behavior occurs on a continuum of readiness to change (RTC) rather than through a series of stages. He argues that data using the quick and refined scoring methods, according to the stages of change theory, do not support the proposition that discrete and identifiable stages exist.

Instead, Sutton (2001) and Budd and Rollnick (1996) suggest the existence of a second-order factor that reflects readiness to change. A readiness to change score can be calculated by reverse scoring the precontemplation score and adding it to the contemplation and action scores. According to the RTC scoring method, higher scores correspond to greater readiness to change. The RTC scoring method has the advantage of one score to determine stage allocation. Whereas, with the quick or refined scoring method, respondents often endorse various stages simultaneously, rendering stage allocation arbitrary and confusing.

Summary

Begun et al. (2003) concluded that their instrument needs to be administered to a greater number of individuals. Also, the instrument needs to be analyzed for its application to individuals' stage development over time. Prochaska (1994) stated in order to help entire populations of clients at risk, more research and greater understanding of how people progress from precontemplation to action is needed. Perusing the literature on TTM theory, one finds a huge piece of this puzzle is missing. How can progress from one stage to the other be understood when the typical study employs only one or two data points? This is especially true considering TTM theory states stage progression is cyclical. It is surprising to find the lack of longitudinal research in this area. This study is an attempt to address these important issues.

CHAPTER III

METHOD

The purpose of this study was to gather empirical evidence demonstrating the effectiveness of utilizing the Stages of Change theory for group treatment of male batterers. By developing a thorough understanding of the utility of the Stages of Change approach for intimate partner violence perpetrators, it is hoped that more efficient and effective treatment groups will be developed. The current study was an expansion of a project that currently exists between the Brazos County Community Supervision and Corrections Department and the Texas A&M Educational Psychology Department. For the past eight years, doctoral students from Texas A&M University have conducted research and delivered services (assessments and group therapy) to men who are on probation for crimes related to intimate partner violence. Each Anger Management- Intimate Partner Violence Treatment group met two hours weekly for six months. Doctoral students in a male and female co-therapist format facilitated the groups. The groups met at the Brazos County Community Supervision and Corrections Department. New groups began approximately every four to six months throughout the year.

Group Leaders

Doctoral graduate students in counseling psychology at a large midwestern state university facilitated all groups. The graduate students were enrolled in a yearlong group counseling practicum. All three groups were co-led by a Caucasian male (ages 29, 31 and 28) and a Caucasian female (ages 26, 31 and 30) doctoral counseling psychology student. All group leaders had a minimum of two semesters of group practicum. In general, the experience of the group leaders was at the novice/intermediate level because they had led or co-led from one to seven short-term groups. As part of their training in this practicum experience, the leaders received group supervision by their instructor for 1.5 hours per week.

Participants

The participants consisted of group members from three Anger Management/Intimate Partner Violence Treatment groups. Although the participants were required to attend the group by the Community Supervision and Corrections Department, their participation in this research project was completely voluntary and there was no deception used in the study. Group members were all males over the age of 18.

Instrumentation

Demographic Information Form. At the first group session, all group participants completed a demographic information form (see Appendix A). This form was utilized to obtain the following information: group member's name, age, educational level, occupation, and racial/ethnic origin.

Safe at Home Instrument (SAHI). Begun et al.'s (2003) 35-item SAHI (see Appendix B) is a self-report measure designed to assess individuals' readiness to change intimate partner violence behaviors. The SAHI asks respondents to rate their level of agreement with each statement, utilizing a 5-point Likert-type scale, ranging from "I strongly agree" to "I strongly disagree" (coding-adjusted so that higher values indicate greater advocacy of the statement). While the stage of change theory suggests five stages in the change process, Begun et al. found the SAHI to be adequate only as a measure of three phases: Precontemplation, Contemplation, and Preparation/Action. They found the factor structure of the SAHI to be consistent across samples and across times (intake to post-intervention). They report the reliability for these three phases to be "reasonably good" with Precontemplation being

the least reliable. Predictive validity of the SAHI was reported to be lacking. They hypothesized one possible explanation is the possibly insufficient time frame for changes in behaviors to occur and that intervention time frames (16 weeks in their study) may be much too short for sustained progression through the Stages of Change. They suggest that the SAHI needs to be administered to a greater number of individuals who are likely to reflect the Maintenance stage, in order to permit development of a computable Maintenance scale from the current items. The present study differs from Begun et al.'s study in two major areas. First, the number of sessions was increased from 16 to 24. With increased length of treatment it is hoped four Stages of Change may become computable. The Maintenance stage will not be scored, as the length of treatment was too short. Second, the SAHI instrument was administered after every session compared to Begun et al.'s (2003) pre- and post-intervention. The Stages of Change theory suggests the change process is not linear; therefore, this study analyzed the stages of change over time measured at each session.

Group Climate Questionnaire-Short Form. This instrument was used to measure the group atmosphere as

perceived by each participant. The Group Climate Questionnaire- Short Form (GCQ-S; MacKenzie, 1983; see Appendix C) contains 12 items in a 7-point Likert-type scale, ranging from “not at all” to “extremely”. The GCQ-S is also self-reported and yields scores on three scales: Engagement (cohesion, self-disclosure, willingness to confront), Avoiding (conformity, superficiality, and denial of responsibility) and Conflict (friction, distrust, mutual withdrawal). One item is used to represent a measure of participant’s anxiety. Researchers have found the GCQ-S to be easily understood and scored by participants, and that it reflects meaningful clinical phenomena (Kahn, Sturke, and Schaeffer, 1992). Hurley and Brooks (1987) reported that because MacKenzie (1983) gave means and standard deviations only for miniscales and not on individual items, intersample comparisons are limited. Brossart (1997) reported that studies utilizing the GCQ-S to assess differences across groups have provided evidence for the construct validity of the instrument by showing that in more successful groups, participants score higher on the engagement scale (Kanas & Barr, 1986; MacKenzie et al., 1987). In addition, Brossart (1997) reported these more successful groups have higher scores on the conflict and

anxiety scales and lower scores on the avoiding scale. Additionally, Kivlighan and Goldfine (1991) examined student perceptions in personal growth groups and reported coefficient alphas for the Avoidance, Conflict, and Engagement GCQ-S subscales ranging from .88 to .94.

Procedure

All research participants completed the Anger Management/Intimate Partner Violence Treatment group. The format for the treatment groups was based in part on the *Men's Education for Non-Violence: A Treatment Manual* (Elliot & Blair, 1994), a cognitive-behavioral psychoeducational curriculum developed specifically for persons facilitating small group counseling sessions with male batterers. The group treatment format also contained an interpersonal/dynamic component. All three groups followed the same curriculum format, i.e. same lessons given in the same order (see Appendix D). Typically, each group session included an educational component on a specific topic, accompanied by in-session activities and homework assignments.

At the first group session the research study was explained to the group members and those who agreed to participate signed a research consent form (see Appendix

E). All group members consented to participate in the study.

The research instruments were administered in the following order: At the first group session each member completed a Demographic Information Form. At the end of every group session, including the first session, the participants completed the Safe at Home Instrument (SAHI) and the Group Climate Questionnaire-Short Form (GCQ-S).

CHAPTER IV

RESULTS

Demographic Analyses

Participants successfully completed the group if they attended a minimum of 22 of the 24 sessions. They were dropped if they missed 3 sessions or missed either of the last two sessions. The attrition rate for all three groups was 24.14% (i.e., 22 of 29 members finished the group program). Only participants who successfully completed the program were included in this research. For demographic comparison of members who completed the group (completers) versus those who did not complete the group (non-completers) see Table 1. There were no statistically significant differences between completers and non-completers on age, education, or ethnicity Wilks $F(3,26) = 2.61$, $p = .073$. Of the 22 group members included in the study, eight classified themselves as African-American, nine as Caucasian, and five as Hispanic. The age of the participants ranged from 20 to 44 years, with an average age of 27.9 years. Only 13.6% of the participants had received more than a high school education and 40.9% neither graduated from high school nor earned a GED.

Table 1

Demographics of Completers Versus Non-completers

n	*M* age	Ethnicity		Education	
Completers					
22	27.9	African-American	36.4%	< High school	40.9%
		Caucasian	40.9%	High school	45.5%
		Hispanic	22.7%	Jr. College	9.1%
				College	4.5%
Non-completers					
7	27.4	African-American	62.5%	< High school	50.0%
		Caucasian	12.5%	High school	37.5%
		Hispanic	25.0%	Jr. College	0.0%
				College	12.5%

Reliability Analyses

Reliability analyses were calculated using four stages of the Safe at Home Instrument (i.e., Precontemplation, Contemplation, Preparation and Action) as items. The alpha coefficients for the individual scales were as follows: .592 for precontemplation, .928 for contemplation, .816 for preparation and .867 for action. Each scale consisted of seven items.

Williamson et al. (2003) developed a Readiness-to-Change scale specific to anger management. The Readiness-

to-Change scale (RTC-S) creates a continuous measure rather than classifying participants’ responses into the categorical stages of change specified in the transtheoretical model. The RTC-S is computed by adding the participant’s score of the items for the contemplation and action scales and subtracting the score of the items for the precontemplation scale. The mean of the RTC-S (n = 469) was 4.67 (SD = 1.35, range .86 – 8.43). The alpha coefficient for the RTC-S was .555. It is important to note that if the items from the precontemplation scale were not included in the RTC-S the alpha coefficient would increase to .902. As these results indicate the precontemplation scale items were more internally inconsistent than is typically desired. Table 2 shows that the precontemplation scale, as predicted, is either negatively or minimally correlated with the other scales. Again showing that precontemplation is unlike the other three scales.

Table 2

Correlation Matrix for the Four Stages of the Safe at Home Instrument

	PRECON	CONT	PREP	ACT
PRECON	1.00	-.14	-.03	.04
CONT	-.14	1.00	.85	.23
PREP	-.03	.85	1.00	.43
ACT	.04	.23	.43	1.00

Research Question One

The first research question was: What stage do the participants achieve?

Using data obtained from the Safe at Home Instrument, descriptive statistics were calculated to determine what percentage of participants obtained each stage. Three commonly used scoring methods (Quick; Refined; Readiness-to-Change Scoring Method (RTC-SM)) were compared.

The quick scoring method is the easiest to compute and the most widely used. The quick scoring method classifies participants into the stage in which they scored the highest. In the case of tie scores, the highest-ranked stage is chosen. Figures 1-3 display all 22 group members' stage achieved across time according to the quick scoring method. The figures are displayed according to group membership.

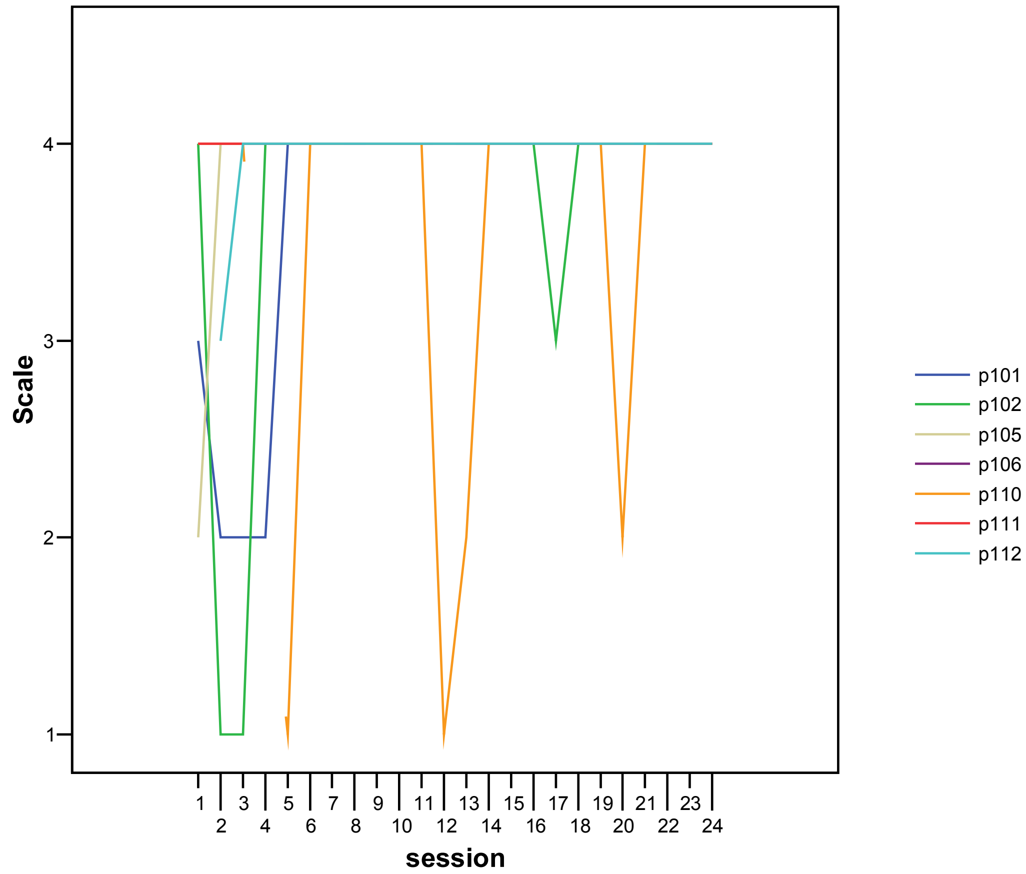

Figure 1. Quick Scoring Method Group One. Note: 1 = precontemplation; 2 = contemplation; 3 = preparation; 4 = action; n = 7.

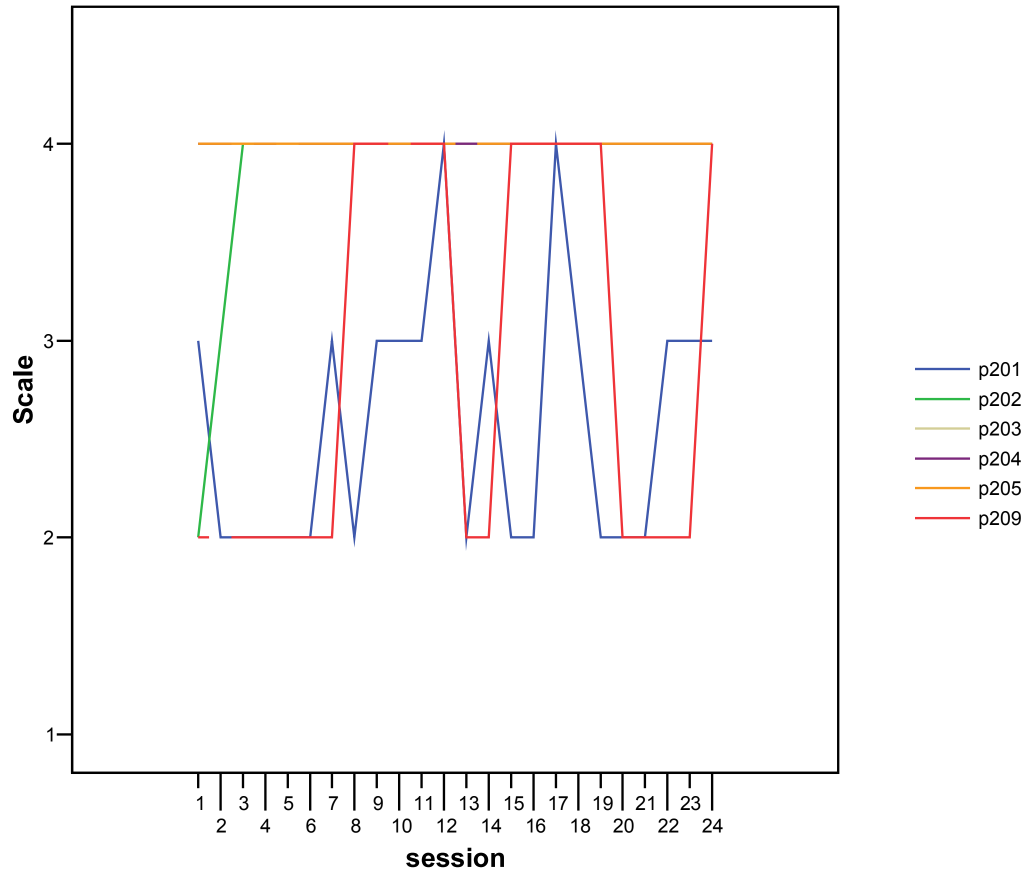

Figure 2. Quick Scoring Method Group Two.
Note: 1 = precontemplation; 2 = contemplation;
3 = preparation; 4 = action; n = 6.

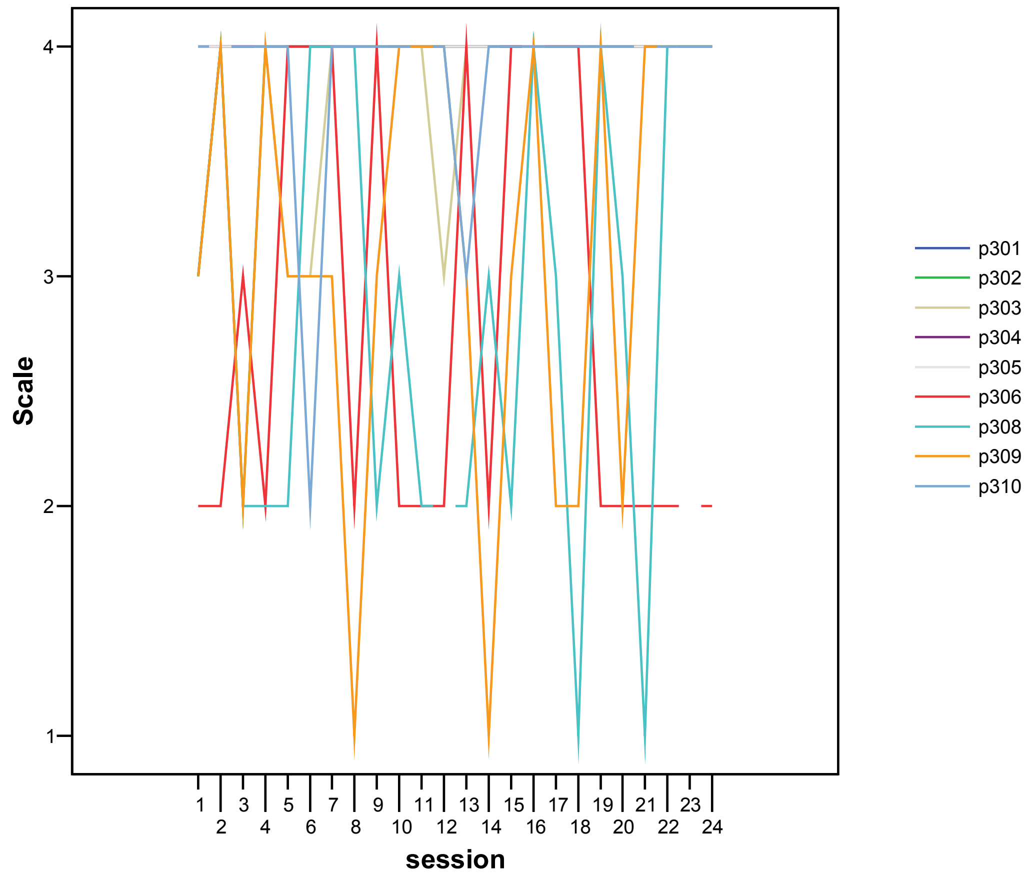

Figure 3. Quick Scoring Method Group Three.
Note: 1 = precontemplation; 2 = contemplation;
3 = preparation; 4 = action; n = 9.

The refined scoring method is unique in that it classifies participants only with meaningful patterns of scores. A classification to the precontemplation stage occurs when a participant scores a positive score on the precontemplation stage, but a negative or zero score on both the contemplation and action stages. A classification to either the preparation or action stages occurs when scores are negative or zero on the precontemplation stage and positive on both the contemplation and action stages. The decision to classify to either the preparation or action stage is based upon which stage scores higher. Patterns showing high or low scores on all three scales (precontemplation, contemplation and action) represent non-meaningful patterns. A non-meaningful pattern also occurs for high scores on both precontemplation and action but a low score on contemplation. When non-meaningful patterns occur the participant is classified as "undefined". Figures 4-6 depict stage allocation across time according to the refined method. The figures are displayed according to group membership.

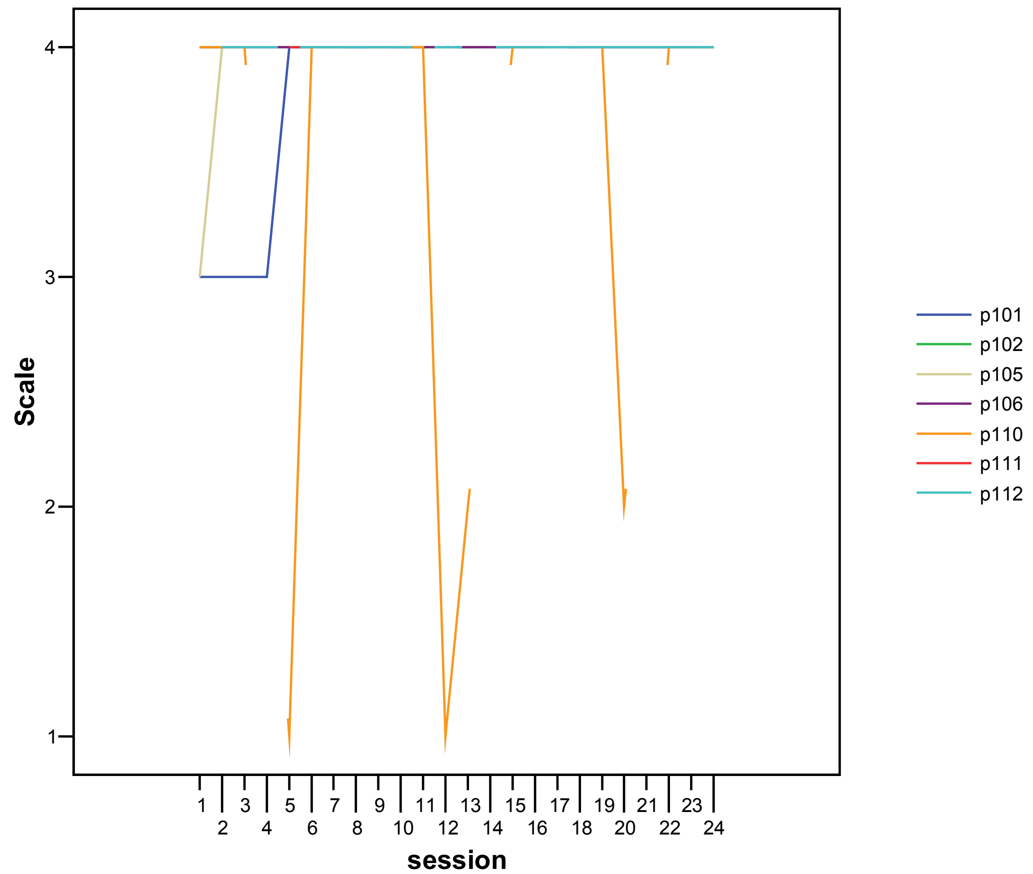

Figure 4. Refined Scoring Method Group One.
Note: 1 = precontemplation; 2 = contemplation; 3 = preparation; 4 = action; n = 7; broken lines indicate either missing data or undefined classifications.

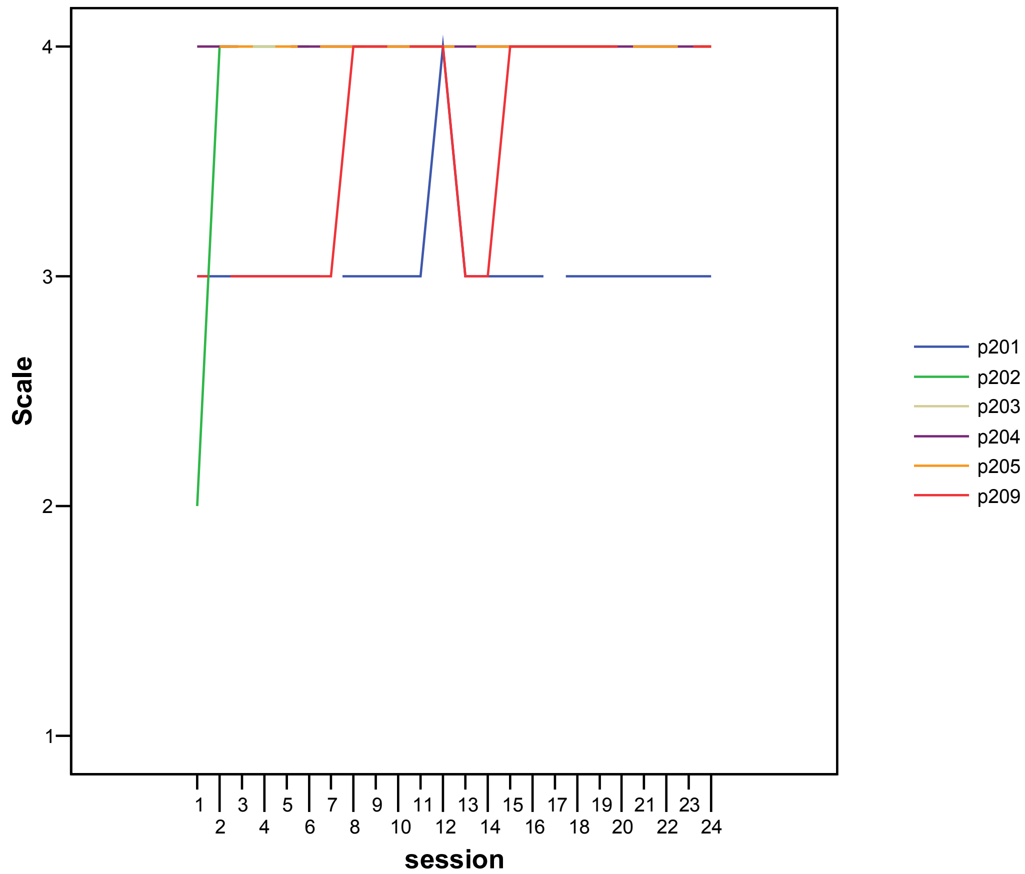

Figure 5. Refined Scoring Method Group Two.
Note: 1 = precontemplation; 2 = contemplation; 3 = preparation; 4 = action; n = 6; broken lines indicate either missing data or undefined classifications.

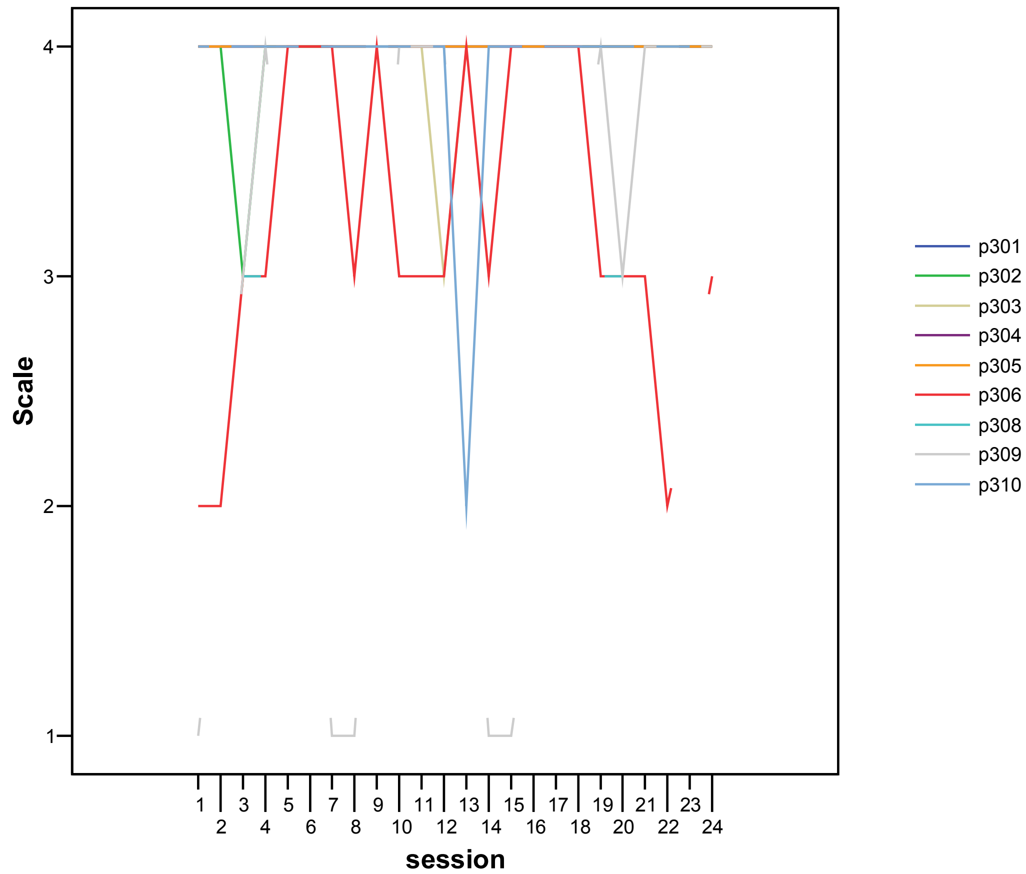

Figure 6. Refined Scoring Method Group Three. Note: 1 = precontemplation; 2 = contemplation; 3 = preparation; 4 = action; n = 9; broken lines indicate either missing data or undefined classifications.

The Readiness-to-Change Scoring Method (RTC-SM) classifies participants along its continuous score. The RTC-SM scores range between –24 and +24, with higher scores indicating a greater readiness to change. The range of scores is divided by four to correspond to each stage. Thus, the precontemplation stage is classified for scores between –24 and –12; contemplation is –12 to 0; preparation is 0 to 12; and action is 12 to 24. A major disadvantage to this scoring method is the extreme participant’s responses needed to score in either the precontemplation or action stage. The RTC-SM tends to classify participants into the middle two stages (see Figures 7-9). The figures are displayed according to group membership.

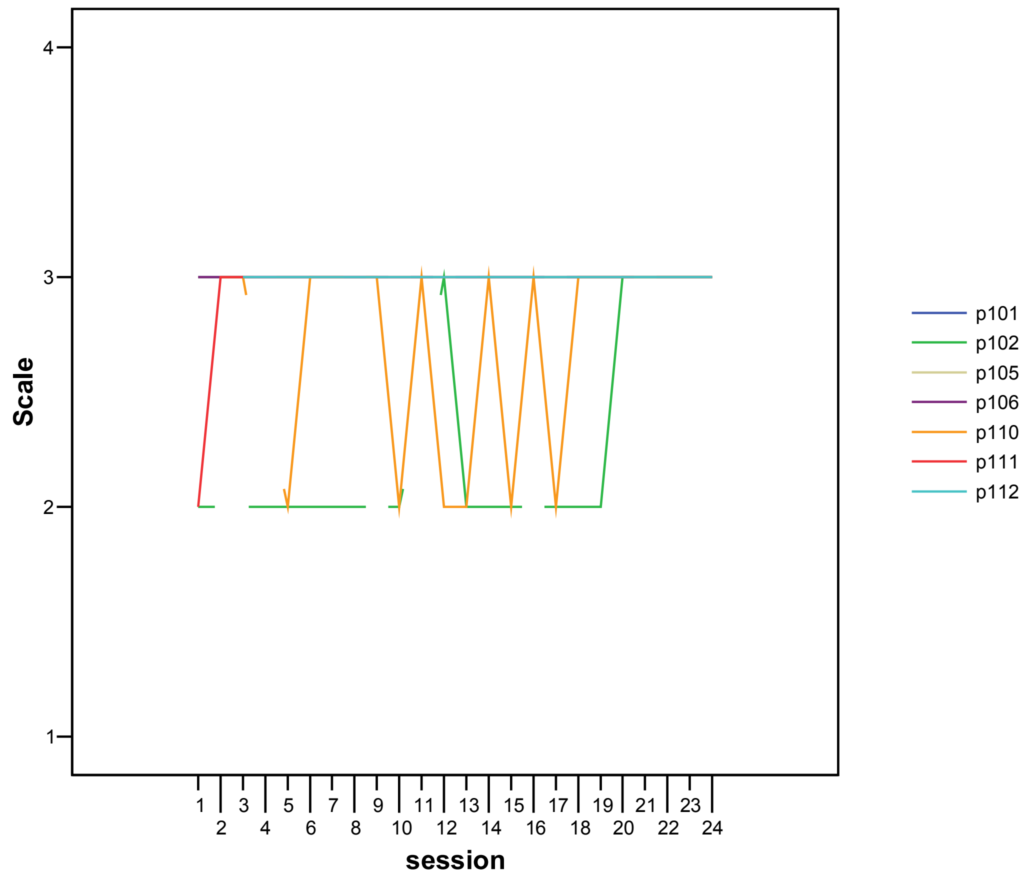

Figure 7. RTC Scoring Method (RTC-SM) Group One. Note: 1 = precontemplation; 2 = contemplation; 3 = preparation; 4 = action; n = 7; broken lines indicate missing data.

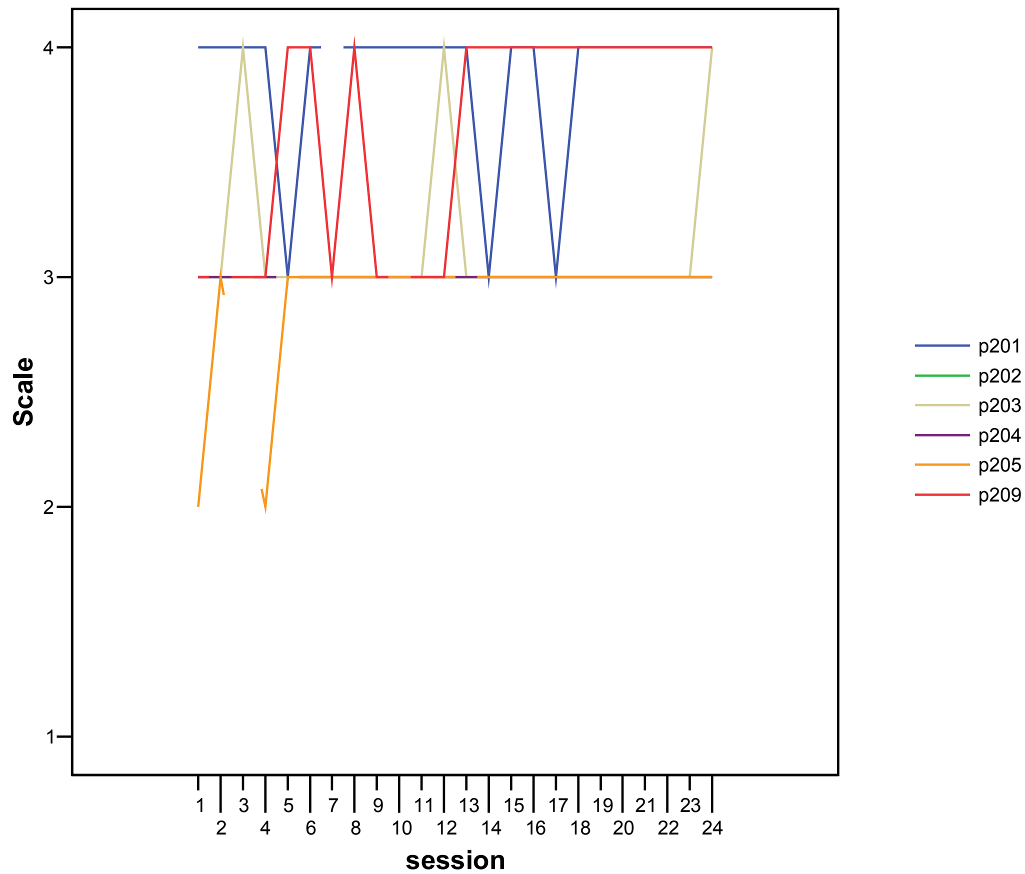

Figure 8. RTC Scoring Method (RTC-SM) Group Two. Note: 1 = precontemplation; 2 = contemplation; 3 = preparation; 4 = action; n = 6; broken lines indicate missing data.

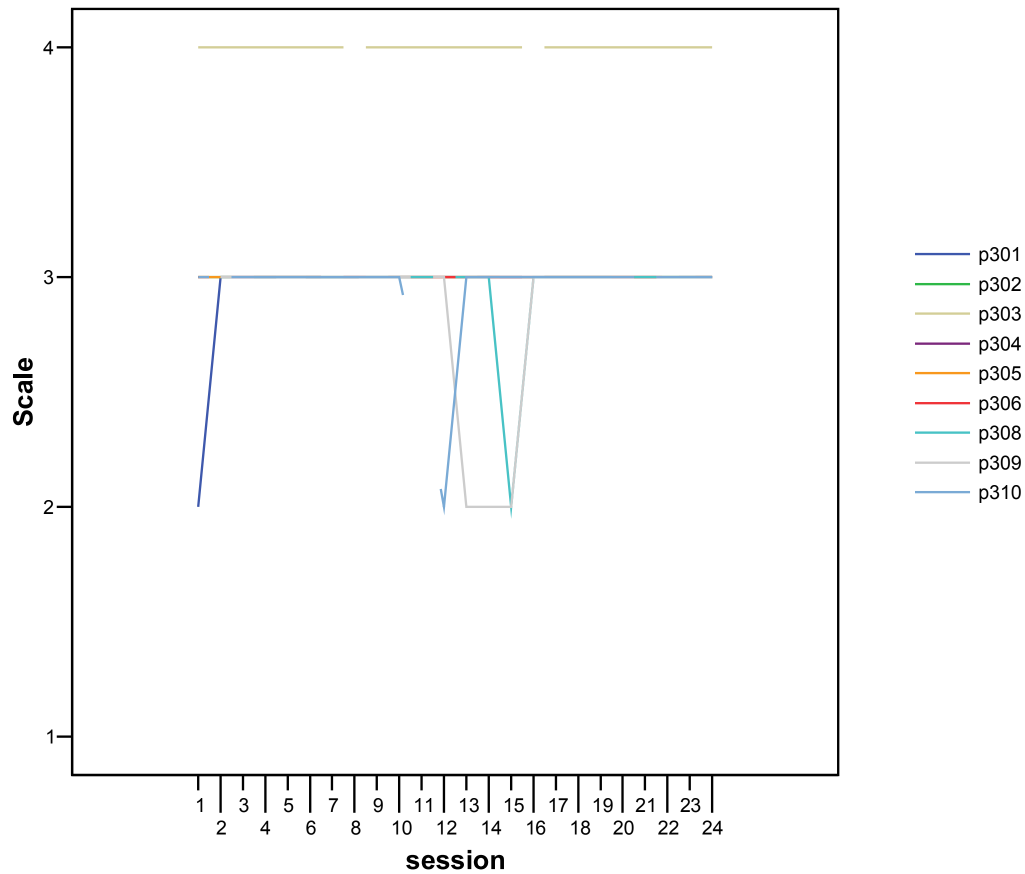

Figure 9. RTC Scoring Method (RTC-SM) Group Three.
Note: 1 = precontemplation; 2 = contemplation;
3 = preparation; 4 = action; n = 9; broken lines
indicate missing data.

These three scoring methods are different ways to interpret the RTC-S scores. Although using the exact same scores on the RTC-S, the different scoring methods often assign participants to different stages; see Table 3. It is important to pay close attention to the difference of the RTC-S, which is the scale, and the RTC-SM, which is one of three scoring methods used to interpret the RTC-S. As shown, the majority of participants indicate that they are either in the preparation or action stage by the first session. Because the action stage is the highest stage obtainable in this study, the majority of participants cannot obtain a higher stage after the first session. Therefore, growth, in terms of stage, cannot be measured beyond the action stage unless an individual regressed to

an earlier stage then cycled to a higher stage. With very few exceptions, regressions to a previous stage did not emerge from the data, thus growth was not seen. The pattern that did emerge most frequently (n = 16) was a “flat-line” where individuals began in the highest stage, the action stage, and remained in this stage for the duration of the group treatment. The “flat-line” pattern was especially true with the quick and refined scoring methods. A fluctuating pattern emerged less frequently (n = 6). This pattern is characterized by five or more stage changes during the course of treatment. Figures 10-13 use the quick scoring method to illustrate the differences between the “flat-line” respondents and the fluctuating respondents.

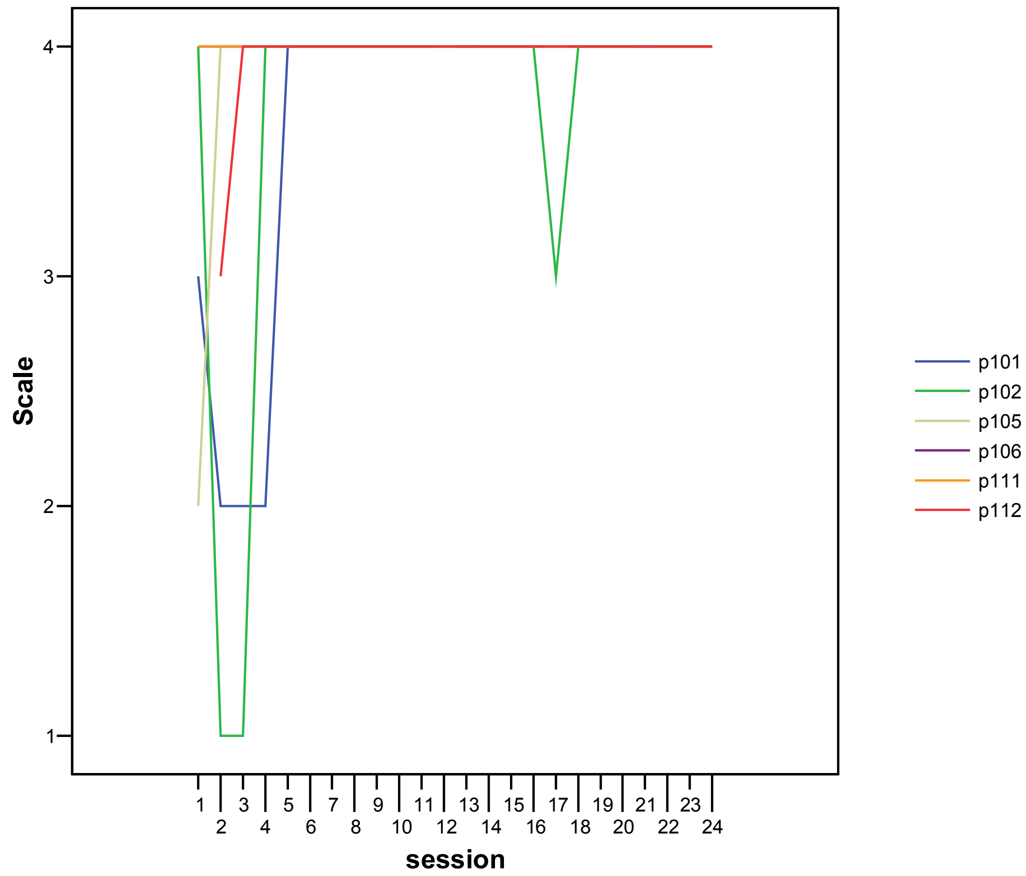

Figure 10. Flat-Line Respondents Group One.
Note: 1 = precontemplation; 2 = contemplation;
3 = preparation; 4 = action; _n_ = 6.

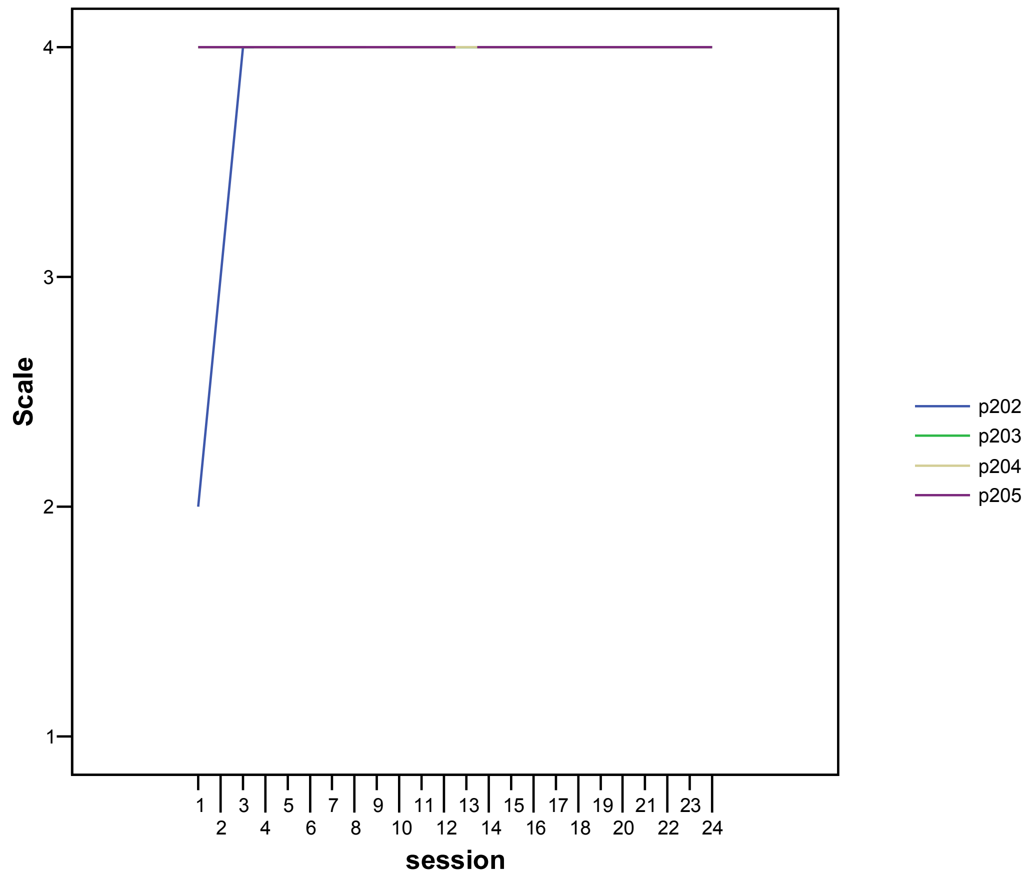

Figure 11. Flat-Line Respondents Group Two.
Note: 1 = precontemplation; 2 = contemplation;
3 = preparation; 4 = action; n = 4.

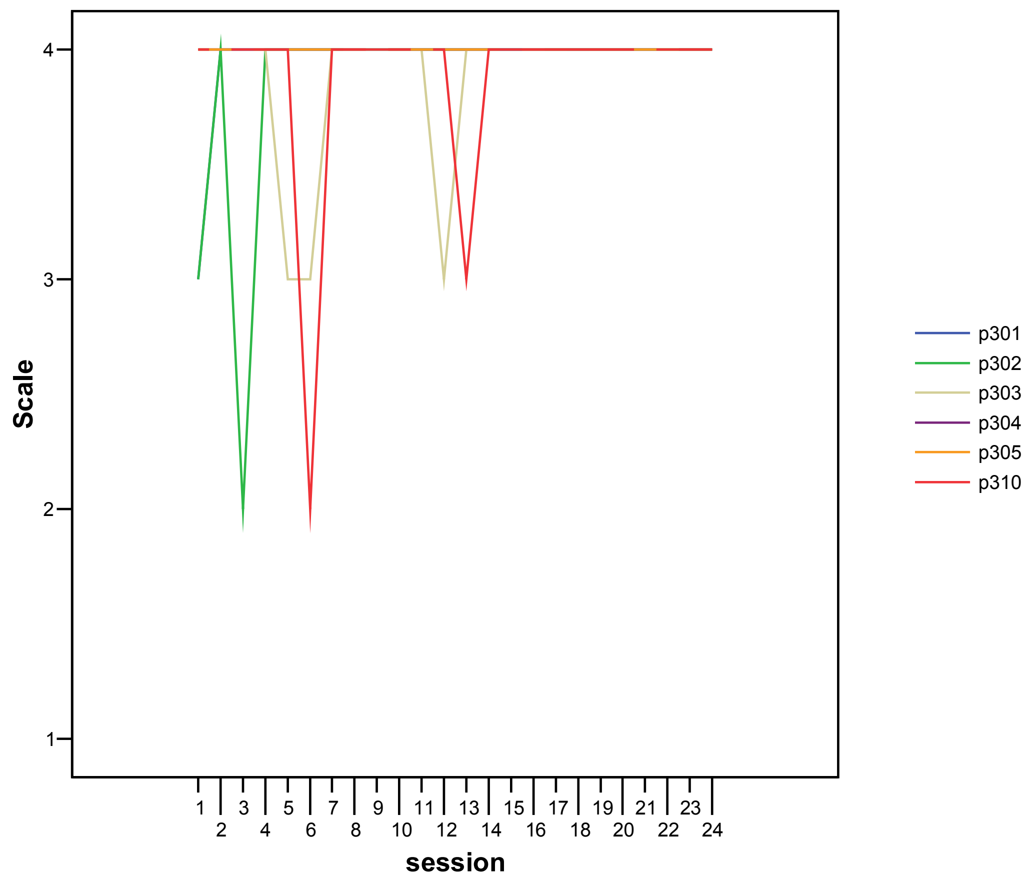

Figure 12. Flat-Line Respondents Group Three.
Note: 1 = precontemplation; 2 = contemplation;
3 = preparation; 4 = action; n = 6.

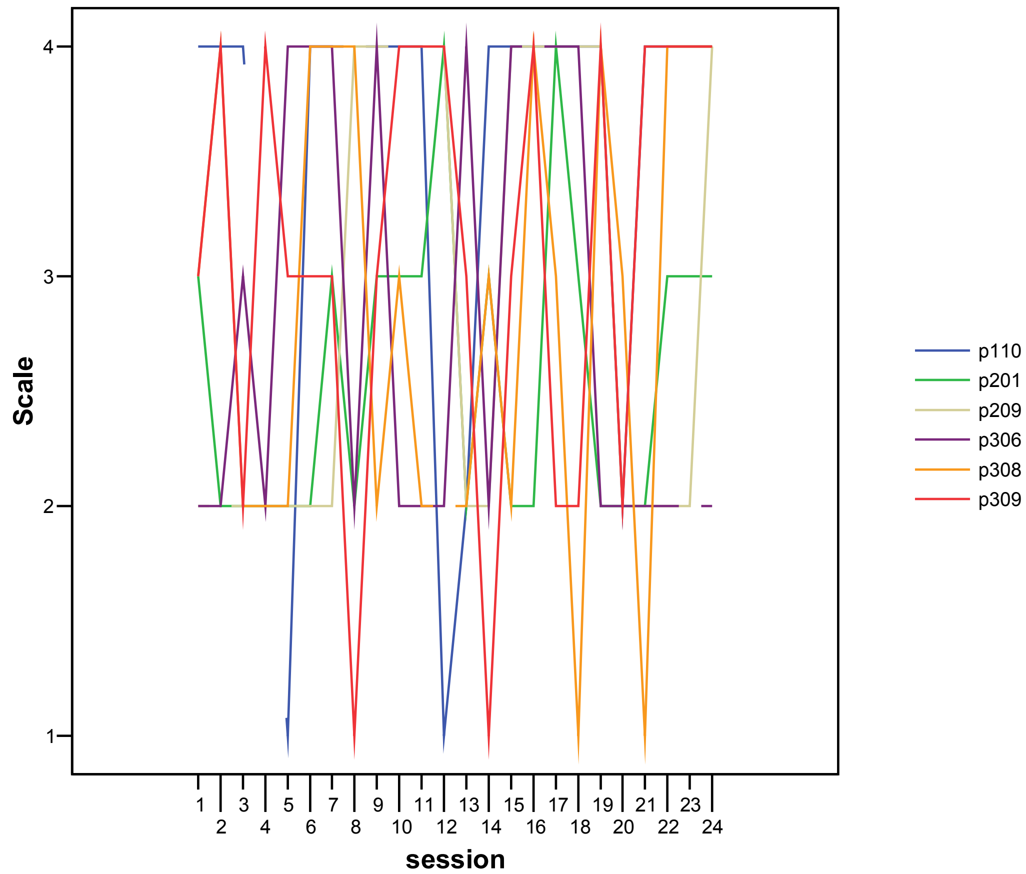

Figure 13. Fluctuating Respondents. Note: 1 = precontemplation; 2 = contemplation; 3 = preparation; 4 = action; n = 6.

Table 3

Stage Achieved by Scoring Methods

Session	PC	CONT	PREP	ACT	Undefined	Missing Data
			Quick Scoring Method			
1	0.0%	18.2%	27.3%	50.0%	--	4.5%
8	4.5%	9.1%	0.0%	77.3%	--	9.1%
16	0.0%	4.5%	0.0%	86.4%	--	9.1%
24	0.0%	4.5%	4.5%	90.1%	--	0.0%
			Refined Scoring Method			
1	4.5%	9.1%	18.2%	40.9%	22.7%	4.5%
8	4.5%	0.0%	9.1%	50.0%	27.3%	9.1%
16	0.0%	0.0%	4.5%	59.1%	27.3%	9.1%
24	0.0%	0.0%	9.1%	68.2%	22.7%	0.0%
			Readiness-to-Change (RTC) Scoring Method			
1	0.0%	18.2%	45.5%	9.1%	--	27.3%
8	0.0%	4.5%	68.2%	13.6%	--	13.6%
16	0.0%	0.0%	72.7%	13.6%	--	13.6%
24	0.0%	0.0%	81.1%	18.2%	--	0.0%

Note: PC = precontemplation; CONT = contemplation; PREP = preparation; ACT = action; n = 22; missing data occurs when a participant does not respond to an item or missed that session.

Not relying upon scoring methods, residualized gain scores is another method to determine growth over time (see Table 4). Residualized gain scores are calculated by computing a gain score, which is the RTC-S post-test score minus the RTC-S pre-test score. A regression is then run using the gain score as the dependent variable and the pre-test score as the independent variable. The residuals are saved from this regression, and these are the residualized gain scores.

Gain scores do not indicate which stage an individual attained; instead they reflect the difference in an individual's post-test minus his pre-test scores. The residualized gain scores are similar to the gain scores except they take the initial score level (pre-test score) into account. Contrary to expectation, the gain scores and residualized gain scores in this study indicate minimal gains or very slight reductions over time. Nine of the twenty-two group members showed decreases in RTC scores from pre- to post-test.

It should be noted that the minimal decreases in these scores do not necessarily reflect a regression from a higher stage to a lower stage. For example, person 4 in Table 4 shows a negative residualized gain score of -2.69 from his pre- to post-test. However, person 4 obtained the action stage at session one (pre-test) and at session 24 (post-test), thus showing that a negative gain score does not necessarily result in a relapse to a lower stage. The same holds true for positive gain scores.

In conclusion, neither the results of the scoring methods nor the results of the gain scores support a pattern suggestive of growth over time. It was predicted that group members would begin in the precontemplation or

contemplation stage then progress to higher stages with the possibility of cycling through the stages. However, the participants' scores indicated that they achieved the action stage very quickly and remained in this highest stage for the duration of treatment (quick and refined methods). The implications of this finding for both research and practice will be discussed further in the conclusion section.

Table 4

Gain Scores and Adjusted Gain Scores by Person

Person	Gain score	Residualized Gain Score
1	.86	.54
2	.72	.76
3	-1.00	-.79
4	-2.53	-2.69
5	.14	-.36
6	.57	-.73
7	.17	-.31
8	-.29	.41
9	.72	.25
10	1.38	1.42
11	1.14	.33
12	1.43	.51
13	.72	.82
14	.43	-.15
15	-.43	-.52
16	-.29	.23
17	1.76	1.09
18	.86	.51
19	1.14	.64
20	-1.57	-1.62
21	.57	.44
22	-.29	-.91

Research Question Two

The second research question was: At what length of treatment do seventy-five percent of the group members reach the action stage?

Using data obtained from the Safe at Home Instrument, three commonly used scoring methods were analyzed. As shown in Table 5, the quick scoring method indicates that 75% or more of the group members reached the action stage by session number four. The refined scoring method does not indicate that 75% or more of the participants reach the action stage at any session. However, by session 5 the refined method indicates 60% of the group members have reached and remain in the action stage, except for sessions 13 and 14. Using the RTC scoring method (RTC-SM) not even by the twenty-fourth session do 75% of the group members reach the action stage. Although the three scoring methods produced varied results, they all scored participants in the action or preparation stages much sooner than expected. The implications of these large discrepancies for both research and practice will be discussed further in the conclusion section.

Table 5

Participants Reaching Action Stage by Session

Session Number	Scoring Method		
	Quick	Refined	RTC
1	52.4%	42.9%	12.5%
2	70.0%	65.0%	12.5%
3	60.0%	50.0%	11.8%
4	75.0%	55.0%	10.5%
5	70.0%	60.0%	10.5%
6	77.3%	68.2%	10.0%
7	86.4%	63.6%	0.6%
8	85.0%	60.0%	15.8%
9	84.2%	68.4%	11.1%
10	85.7%	66.7%	10.0%
11	90.0%	66.7%	11.1%
12	85.7%	70.0%	10.0%
13	75.0%	50.0%	15.8%
14	77.3%	50.0%	9.1%
15	85.7%	66.7%	14.3%
16	95.0%	73.7%	15.8%
17	85.7%	61.9%	9.5%
18	85.7%	61.9%	9.5%
19	90.9%	72.7%	13.6%
20	77.3%	59.1%	14.3%
21	85.0%	75.0%	15.8%
22	85.7%	66.7%	15.0%
23	90.5%	66.7%	14.3%
24	90.9%	72.7%	18.2%

Research Question Three

The third research question was: Are the treatment interventions stage appropriate?

The anger management groups in this study were modeled after Elliott and Blair's (1994) treatment manual for male batterers. The stage of change theory postulates that

accountability will be lowest in the precontemplation stage and increase through the subsequent stages. Accordingly, the treatment intervention focusing on accountability was addressed near the end of treatment. This research question attempted to discover whether the session placement of the treatment interventions were stage appropriate. The RTC-S scores were used for these analyses.

The treatment intervention addressing accountability during session number 15 will be used for illustrative purposes. For session number 15, it was hypothesized that group members in the preparation or action stage would score higher on the engaged scale and lower on the conflict and avoidance scales, whereas participants in the precontemplation or contemplation stage were hypothesized to score lower on the engaged scale and higher on the conflict and avoidance scales.

According to the transtheoretical model, individuals are in the precontemplation or contemplation stage when they have not begun working, or acknowledging, their behavioral problem. If the group session is addressing accountability issues, but the individual is denying a problem exists, this would create conflict and avoidance within that individual. In this situation, the individual

would be predicted to score high on the precontemplation stage of the SAHI, and low on the engaged scale, high on the conflict scale, and high on the avoidance scale of the GCQ-S.

To analyze this prediction, longitudinal K-means analyses were conducted with two-cluster solutions producing the most explicable results. The advantage of using longitudinal K-means analysis is that it accounts for individual variability across the entire group experience when attempting to cluster individuals. The two-cluster solution depicted high and low achievers on the readiness-to-change (RTC-S) score and the engaged, conflict, and avoidance scales. Again, it is important to note that when conducting longitudinal K-means analyses only one variable is analyzed at a time.

Session 15 was briefly discussed above to aid in conceptualizing the hypothesis. For the next analyses all 24 sessions were included. Attempts were made to compare the predicted outcomes (i.e., persons in the high RTC-S cluster would cluster high on engaged and low on both conflict and avoidance). Repeated measures analyses were utilized to compare the high versus the low clusters on the RTC-S (between-subjects factors) on the engaged, conflict,

and avoidance scales (dependent variables). The results showed no statistical significance between the high and low RTC-S clusters on the engaged, conflict, and avoidance scales.

This result is believed to have occurred due to the invariance of participants' responses (i.e., regardless of the scoring method used to interpret the RTC-S, all three scoring methods classified a majority of the participants in the preparation or action stages at an early session). With a small sample size it is difficult to find statistically significant differences between high and low achievers when almost all participants' scores are so high from the beginning of the group treatment. The invariance in participants' scores is again a result of problems stemming from the Safe at Home Instrument.

A different approach to determining if the treatment interventions were stage appropriate was made by analyzing the group process data. Process variables (Avoiding, Conflict, Engaged) were collected after every session using the Group Climate Questionnaire – Short Form (MacKenzie, 1983).

MacKenzie and Livesley (1983) presented a popular model of group development basing each of their six stages

in terms of avoiding, conflict, and engaged. They describe how avoidance, conflict, and engagement fluctuate as the group develops. In the first stage, labeled engagement, avoidance will be high, conflict will be low, and engagement will begin low but increase. In the second stage, differentiation, avoidance slowly decreases whereas conflict increases. Individuation, stage three, is distinguished by a drop in conflict, a marked increase in engagement, and avoidance declining. The fourth stage, intimacy, is depicted by high levels of engagement, low conflict, and moderate to low levels of avoidance (MacKenzie and Livesley, 1983). The fifth stage, mutuality, involves high levels of engagement, a possible increase in conflict, and low avoidance. The final stage is called termination; MacKenzie and Livesley (1983) did not report levels of avoidance, conflict, and engagement for this stage.

Using MacKenzie and Livesley’s model, a visual analysis of this study’s group development was used to determine if these groups developed as this model predicts. Simply put, if the group process data match the developmental model put forward by MacKenzie and Livesley (1983) it would suggest that the group members were

successfully working through each developmental stage and that the experience was beneficial.

The stages of change theory is a process of making positive behavioral changes facilitating movement into healthier living, whereas MacKenzie and Livesley's model of group development is seen as a process of how healthy working groups function over their lifespan. This descriptive analysis was conducted to determine if the process variables help explain the lack of variance found in the RTC-S results.

Figure 14 graphs the mean scores of all 22 participants on the GCQ-S process variables at each session. As can be seen, the groups did not develop through all six stages according to MacKenzie and Livesley's model. The most striking departure from their model is how conflict and engagement developed. As predicted, the level of engagement began low and increased by the second session. However, this growth was not maintained, but decreased much lower than the model predicts in subsequent sessions. The levels of conflict began low and increased as expected. However, the multiple peaks in conflict with gradual declines did not match the theory.

According to MacKenzie and Livesley's model, a key indicator of the second stage, differentiation, is a rapid increase in conflict and a sudden decrease in engagement. The groups appear to enter this stage by session 8. During sessions 9 to 12 the groups appear to be working towards the individuation stage, but then appear to relapse back to the differentiation stage at session 13. The results suggest that the groups never successfully mastered the developmental issues of the differentiation stage. According to Saravay (1978), as group members resolve transferences among members, cliques, and the group leaders, the group advances in its development. As a result, a revisiting of a stage-specific conflict may be necessary before the group can advance to the next stage. By sessions 23 and 24 it appears that the groups did make some movement into the individuation stage before the group had to end.

The implications of these two approaches for both research and practice will be discussed further in the conclusion section.

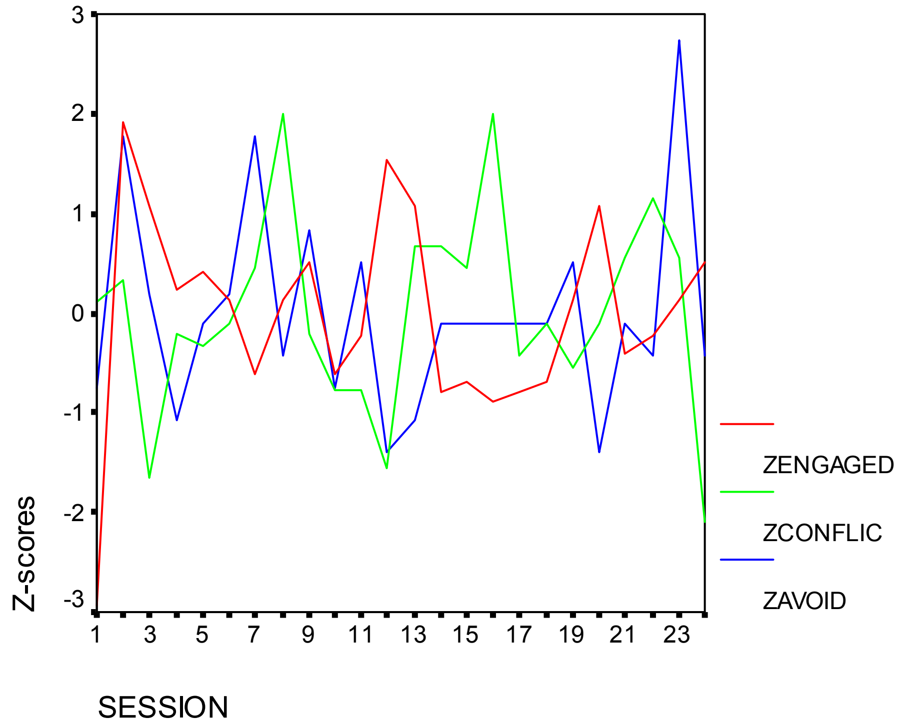

Figure 14. Group Development on the GCQ-S Process Variables.

CHAPTER V

CONCLUSION

This chapter addresses the results, clinical implications, research generalizability and limitations for each of the three research questions. Suggestions for further research are also discussed.

Research Question One

The first research question was: What stage do the participants achieve?

The transtheoretical model of behavior change hypothesizes that individuals progress through a sequence of stages. Individuals who are successful in changing their behaviors enter the maintenance stage which focuses on attempts to prevent relapse. However, if individuals fail at either the action or maintenance stage then they typically recycle through the stages, sometimes several times, before achieving long-term maintenance (Budd & Rollnick, 1996). Prochaska, DiClemente and Norcross (1992) likened this model to a spiral, with individuals moving round this spiral, through the different stages of change, until achieving maintenance.

To answer this first research question, participants were scored on the Readiness-to-Change scale (RTC-S) for

all 24 sessions. A review of the literature resulted in no longitudinal research depicting how individuals progress through the stages. Pre-post tests were utilized most frequently, stating the participants began at a particular stage and ended at a particular stage. This methodology could not demonstrate the spiral cycle hypothesis. As noted above, the Quick scoring method, the Refined scoring method, and the RTC-SM were all calculated to answer this research question.

These data neither supported a progression through the stages nor a spiraling effect through the stages. The quick and refined scoring methods resulted in the majority of individuals scoring in the action stage at the first session and remaining in the action stage throughout the entire course of the group. The RTC-SM resulted in the majority of individuals scoring in the preparation stage at the first session and remaining in the preparation stage throughout the course of the group. By definition, the maintenance stage is achieved when behavior change has lasted for six months or longer. As the group treatment was 24 weeks, the maintenance stage was not achievable, thus this stage was not included in the current study.

It is important to consider the remarkably stable results of the stage achieved by the participants. Although the participants were assured anonymity and that their answers would be confidential and never reported to the probation department, it is quite possible that they may have felt a need to present themselves as being very motivated towards treatment (Williamson, et al., 2003). The participants were all required to attend the group according to their probation status, thus they may have perceived benefits from answering the questionnaires in the most positive light. For example, if a participant's responses placed him in the precontemplation stage he would be denying that he has an anger management problem. He might not be willing to admit this if he feared the group leaders would report his lack of accountability to the probation department. Thus, a participant may have answered the questionnaire in a way to score in the action stage, admitting he had a problem and is working on positive behavior changes, although he may not have actually felt that way. Williamson, et al. (2003) noted that the original Stages of Change model was developed to focus on intentional change, as opposed to societal, developmental, or imposed change. Tutty, et al. (2001) wrote that

batterers on probation have been found to give answers on self-reports that they think will be in their best interest. Therefore, social desirability may have influenced their responses, resulting in an over-inflation of action stage scores.

Another problem using the Safe at Home Instrument with probation populations is a contradiction that may arise according to the scoring methods. Many individuals report they do not perceive a problem with their anger management. This type of attitude would normally classify one in the precontemplation stage. However, because these individuals are involuntarily being treated they may answer, honestly, that they are working to change their behavior. The contradiction here is they state they are working on changing their behaviors, yet simultaneously deny problematic behaviors exist. This contradiction could be remedied with several of the items being reworded or changed altogether.

When using the quick scoring method, this contradiction may lead to a score that places the person in the action stage. The refined scoring method would result in an “undefined” score, meaning the answer pattern does not result in a theoretically meaningful picture. The RTC-

SM would most likely result in a preparation or action stage score. The quick scoring method is the fastest and simplest to use. For this reason it may enjoy the most clinical use. However, as shown above, it may lead to misleading results. The same is true for the RTC-SM. The RTC-SM also appears to place individuals in the middle stages (contemplation and preparation), as extreme scores are needed to score in the precontemplation or action stages. The refined scoring method, although the most time-consuming and complex, demonstrated the most clinically sound results.

The refined scoring method produced scores that were the most clinically meaningful. For example, a participant may deny having a problem with how he deals with anger, yet respond to answers that he is working towards changing his anger management behaviors. On both the quick scoring method and the RTC-SM, this person would be scored in the action stage. This does not make theoretical sense. However, with the refined scoring method this person would be undefined. The undefined category is scored for participant responses that do not make theoretical sense. From the Transtheoretical Model of Behavior Change perspective, it reflects better clinical judgment to score

this response type as undefined rather than incorrectly scoring it as the action stage.

A limitation of this study was that it did not include any means to measure external validation for the Safe at Home Instrument, the Group Climate Questionnaire – Short Form, or the three scoring methods. External validation measures could have included a checklist of more frequently occurring or more behaviorally specific behaviors related to interpersonal violence (i.e., occurrences of negative thoughts the past week, number of verbally abusive arguments the past week), completion of homework assignments, or clinicians' assessments of individual's stage of change. If external validation measures had been included, stronger support or clearer reasons to not implement these instruments may have been possible.

It is also important to analyze the meaning of the negative gain scores. One explanation is the nine participants with negative gain scores were cycling through the stages, or spiraled. However, this does not hold true for any of the scoring methods. The participants were found to have remained steady from their initial stage to the final stage. No scoring method showed any individual beginning at a higher stage than where he scored at the

final session. Thus, these nine participants may have shown a small decrease in their behavior change, but not enough to regress to a lower stage.

Another explanation would be that these nine group members initially responded in a socially desirable manner to present themselves the most positively. Then, as the group progressed and the individuals realized their answers were confidential and they became more comfortable with the group leaders and members, they gave more honest answers. At this point their answers would indicate more problems with how they handle their anger, resulting in lower scores, but not necessarily at a lower stage. These answers would appear to indicate a spiral downwards. However, from a clinical viewpoint this could indicate a participant becoming more honest and accountable for his anger management problems. It is recommended that the Safe at Home Instrument's wording of items be rephrased more clearly. Also, future research should include a measure of social desirability.

Research Question Two

The second research question was: At what length of treatment do seventy-five percent of the group members reach the action stage?

The action stage was chosen to determine if participants are making positive behavior changes during the 24-week group treatment, and if so, for how many sessions. It was hypothesized that the 24-week group treatment would end before many group members had reached the action stage. Accordingly, it was thought the length of treatment would need to be increased to allow positive changes to occur. However, using any of the three scoring methods, a majority of participants were classified in the preparation or action stage early in the group treatment. For the methodological reasons discussed above, it would be premature to conclude that the length of treatment should be decreased according to these results.

Using the quick scoring method as an example, two types of responders were discovered from these data, stable (n = 16) and fluctuating (n = 6). The stable responders either began in the action stage or entered the action stage early in treatment and remained in the action stage throughout the course of treatment. The fluctuating responders moved up or down stages from session to session. These responders were defined by five or more stage changes during the course of treatment.

Both of these responder types show that individuals on probation do not seem to follow a smooth progression from precontemplation to contemplation to preparation and finally to action. These respondents either start high and stay high (stable) or cycle from stage to stage (fluctuating).

In summary, clinicians should be aware that due to social desirability issues, an over inflation of preparation or action stage scores may result with involuntary participants. Clinicians should also be mindful of group members who fluctuate from stage to stage. With both of these issues the clinicians may need to focus more attention on group process and group developmental issues. Researchers should also plan to address these issues by including social desirability scales and rewording the Safe at Home Instrument more clearly and more specific to male batterers. Once the measurement issues are addressed, more research using the stages of change model with involuntary participants needs to be conducted, as this population has not been the focus of much research. Involuntary populations may not follow the stages of change in the same patterns as voluntary populations.

Research Question Three

The third research question was: Are the treatment interventions stage appropriate?

Due to the lack of variance in participants' stage scores on the RTC-S, this question was unable to be addressed in a meaningful manner. For example, it is clinically difficult to conceptualize a group member to be classified as a low RTC achiever, based on that individual's RTC-S scores, when he scores in the preparation or action stage at all 24 sessions (according to all three scoring methods).

Due to the inability to answer this question in a meaningful manner, the following conclusions are offered tentatively. The groups in this study did not progress on the process variables as predicted. Possible explanations could be the interventions were not well matched with participants' stage of change level or that these groups did not progress normally as MacKenzie and Livesley (1983) suggest. Another possible explanation is the groups need more focused help mastering the developmental issues in the differentiation stage. For domestic abuse perpetrators this may include working through reactions to authority figures.

More time may have been needed addressing the role of the group facilitators and how the groups will be run.

Early conflict issues appear to result in the participants' scores. On the Safe at Home Instrument they respond they are in the action stage, "I'm okay". However, on the GCQ-S their responses indicate that the group is in conflict. Since the GCQ-S is not related to their anger management problem but on group dynamics, the social desirability demands would be less for the participants when completing the GCQ-S. In essence, it appears that the group members felt significant conflict in the group and likely did not progress to a therapeutic working stage (mutuality or intimacy in MacKenzie and Livesley's 1983 model), yet they respond that they have made positive behavioral changes early in treatment.

In conclusion, this study highlights the usefulness of examining change on multiple levels. This study used both the stages of change model (Prochaska & DiClemente, 1983) and a group developmental model (MacKenzie and Livesley, 1983). Using both simultaneously allows one to explore the group members' experiences from several angles and aids the investigator in understanding any growth (or lack there of) that occurs.

Limitations and Recommendations for Future Research

A major limitation of this study is highlighted by the invariance of participants' scores on the Safe at Home Instrument. Several possibilities for the invariances of scores have been mentioned, including confusing language on the Safe at Home Instrument, issues of social desirability, and imperfect scoring methods. At session number four, using the quick scoring method, 75% of the participants produced a score in the highest stage possible, the action stage. Similarly, high scores occurred with the refined scoring method and the RTC-SM. Although the group members were assured anonymity and that their answers would be confidential and never reported to the probation department, it is quite possible that they may have felt a need to present themselves as being more motivated towards treatment (Williamson, et al., 2003). The participants were all required to attend the group according to their probation status, thus they may have perceived benefits from answering the questionnaires in the most positive light. For example, a participant may have answered in a manner to score in the action stage, although he may not feel he has an anger management problem (precontemplation). A perceived benefit would be this individual appears to be

making positive changes to his anger control, thus the group leaders would not recommend further treatment to his probation officer. Thus, he may have answered the questionnaire in a way to score in the action stage, although he may not have actually felt that way.

This limitation may have been exacerbated by the group sessions being held within the probation department building. A group member may have feared the group leaders would disclose his denial of anger control to a probation officer who happened to be in the building. Also, one of the co-facilitators had conducted all the evaluations that recommended group treatment for these individuals. Thus, conflict and transference issues may have been exacerbated because the group leader was the evaluator who placed him into group treatment against his liking. Future research should try to minimize these limitations. One recommendation would be to conduct the group sessions in a setting outside of the probation department. A second recommendation would be to have all group facilitators remain independent of the evaluations for group treatment.

Tutty, et al. (2001) wrote that batterers on probation have been found to give answers on self-reports that they think will be in their best interest. Therefore, social

desirability may have influenced their responses, resulting in an over-inflation of action stage scores. Scott and Wolfe (2003) purport that because of the confound of self-reporting biases, change over time may reflect changes in openness and honesty as much as it does changes in abusive behavior, thus any pattern of progress is potentially indicative of positive change. This may be what was reflected in the negative gain scores in the data – that the participants were becoming more open and honest with their responses versus obtaining lower scores based on increased abusive behaviors. Future research would benefit from an inclusion of a social desirability scale to measure the effects this may have on respondents' answers to the self-report measures. Although often difficult to obtain, phone interviews with the victim regarding the weekly level of violence, would be a type of verification of the actual amount of violence in the home.

Williamson, et al. (2003) noted that the original Stages of Change model was developed to focus on intentional change, as opposed to societal, developmental, or imposed change. McMurran et al. (1998) argued that poor statistical outcomes have resulted because the category of intimate partner violence was too general and represented

too infrequent a behavior to be meaningfully rated. Future researchers may want to include measures that are not self-report and are behaviorally specific, that is, more objective than subjective.

It is recommended that replication studies be conducted to investigate further the clinical appropriateness of self-report measures evaluating the stage of change model with involuntary participants. Because the Stages of Change Model postulates that progress may be cyclical, it is recommended that data collection occur at every session instead of pre- and post-test data collection that typifies much of the past research.

This study was conducted on males who had been domestically violent against females. Future research is needed that addresses treatment for perpetrators who are homosexual, female, or of other ethnicities than those conducted in this study. As domestic violence continues to be a concern these issues need to be researched.

Finally, it is recommended that future research be conducted on the Safe at Home Instrument's clinical utility with this population. This study highlighted some problems in the wording and scoring of the instrument, as illustrated by the lack of variability in the participants'

stage of change or RTC-S. Until future research provides an improved instrument, it is recommended that clinicians use the refined scoring method versus the quick scoring method or the RTC-SM. The refined scoring method appears to be the most clinically sound and meaningful. Use of the Safe at Home Instrument (SAHI) or any of the three scoring methods (Quick, Refined, RTC-SM) for predicting stage level is not recommended at this time. Future research would benefit by including some external criteria to validate or refute continued use of the SAHI and the three scoring methods.

Future research would also benefit from larger sample sizes and longer group treatment to evaluate the effectiveness of the SAHI and the three scoring methods. The maintenance stage of the Stage of Change model can not be meaningfully analyzed with group treatment of less than six months. That is assuming the participants started out in the maintenance stage. As discussed above, most participants do not enter group treatment at this advanced of a stage. This would seem even more true of involuntary populations.

Research with men who have been violent with their partners is still in its infancy. Although there are difficulties associated with studying this population, the

benefits seem worth the effort required to overcome the current methodological deficits facing investigators. It is hoped that this study provided some useful insights into both using the stages of change model as well as how that model interfaces with a model of group development. It is also hoped that this study highlighted areas needing increased attention in future research.

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APPENDIX A

DEMOGRAPHIC INFORMATION FORM

Name: ____

Phone Number Home: ___________________ Work: ________________________

Cell phone, pager, or other: ______________________________________

Address:____

Age:____

Occupation: ____

Highest Grade Level Completed:____________________________________

Ethnicity: (Check one)
___ Asian-American
___ African-American
___ Hispanic
___ Caucasian
___ Other:____________________

Do you have children? _____ If yes, how many?_____

Relationship Information:
___ Married
___ Living with someone
___ Dating someone
___ Not currently in a relationship

Partner information:

Name:____

Phone Number Home: ___________________ Work: ________________________

Cell phone, pager, or other: ______________________________________

Address:____

Age:________

Does this person know that you are attending this group? Yes____ No_____

Check one of the following:

_____ I am attending this group because of an incident involving the partner above.

_____ I am attending this group because of an incident involving an ex-partner not listed above.

_____ Other: (If checked please explain below)

APPENDIX B

SAFE AT HOME INSTRUMENT

ID: ______________________

QUESTIONNAIRE FOR GROUP MEMBERS

Instructions: Please check the box (X) that best describes how much you agree or disagree with each statement in the list below.

Num	ITEM STATEMENT:	I Strongly Agree	I agree	I don't agree or disagree	I disagree	I Strongly disagree
1	The last time I lost control, I realized that I have a problem.	1	2	3	4	5
2	If it was up to me, I wouldn't be here.	1	2	3	4	5
3	I try to listen carefully to others so that I don't get into conflicts anymore.	1	2	3	4	5
4	It feels good to finally face how I've been messing up my life.	1	2	3	4	5
5	It's no big deal if I lose my temper from time to time.	1	2	3	4	5
6	In the future, I know I will get some help before I hurt myself or others.	1	2	3	4	5
7	No one "makes" me act the way I do.	1	2	3	4	5
8	I have a problem with losing control.	1	2	3	4	5
9	I want to do something about my problem with conflict.	1	2	3	4	5
10	I want help with my temper.	1	2	3	4	5
11	I'll come to groups, but I won't talk.	1	2	3	4	5
12	I believe that others can learn from my past mistakes.	1	2	3	4	5
13	I need to change before it's too late.	1	2	3	4	5
14	There's nothing wrong with the way I handle situations, but I get into trouble for it anyway.	1	2	3	4	5
15	Even though I get angry, I know ways to keep from losing control.	1	2	3	4	5
16	I really am different now than I was when conflicts were a problem for me.	1	2	3	4	5
17	I guess I need help with the way I handle things.	1	2	3	4	5
18	It'll cost me plenty to get help.	1	2	3	4	5

Num	ITEM STATEMENT:	I Strongly Agree	I agree	I don't agree or disagree	I disagree	I Strongly disagree
19	It's important for me to keep practicing what I've learned about controlling myself.	1	2	3	4	5
20	If my partner doesn't like the way I act, she can leave.	1	2	3	4	5
21	Some of what I see and hear about people being abusive seems to apply to me.	1	2	3	4	5
22	When I feel myself getting upset, I have ways to keep myself from getting into trouble.	1	2	3	4	5
23	I'm sick of screwing up my life.	1	2	3	4	5
24	I try to talk things out with others so that I don't get into conflicts anymore	1	2	3	4	5
25	There may be some things I need to change about myself.	1	2	3	4	5
26	It's her fault I act this way when we disagree.	1	2	3	4	5
27	It's okay that I got into trouble because it means that now I'm getting help.	1	2	3	4	5
28	It's becoming more natural for me to be in control of myself.	1	2	3	4	5
29	I'd get help if I had more free time.	1	2	3	4	5
30	I have to plan for what to do when I feel upset.	1	2	3	4	5
31	There's nothing wrong with me.	1	2	3	4	5
32	It's time for me to listen to the people telling me I need help.	1	2	3	4	5
33	I know the early cues for when I'm losing control.	1	2	3	4	5
34	Getting help would be a waste of my time.	1	2	3	4	5
35	I've been thinking a lot about how to change the way I act.	1	2	3	4	5

APPENDIX C

GROUP CLIMATE QUESTIONNAIRE – SHORT FORM

GROUP CLIMATE QUESTIONNAIRE

Instructions: Read each statement carefully and try to think of the group as a whole. Using the Rating Scale as a guide, circle the number of each statement which best describes the group during today's session.

RATING SCALE

0 not at all
1 a little bit
2 somewhat
3 moderately
4 quite a bit
5 a great deal
6 extremely

PLEASE MARK ONLY ONE ANSWER FOR EACH STATEMENT.

Statement	Rating
1. The members liked and cared about each other.	0 1 2 3 4 5 6
2. The members tried to understand why they do the things they do, tried to reason it out.	0 1 2 3 4 5 6
3. The members avoided looking at important issues going on between themselves.	0 1 2 3 4 5 6
4. The members felt what was happening was important and there was a sense of participation.	0 1 2 3 4 5 6
5. The members depended upon the group leader (s) for direction.	0 1 2 3 4 5 6
6. There was friction and anger between the members.	0 1 2 3 4 5 6
7. The members were distant and withdrawn from each other.	0 1 2 3 4 5 6
8. The members challenged and confronted each other in their efforts to sort things out.	0 1 2 3 4 5 6

RATING SCALE
0 not at all 1 a little bit 2 somewhat 3 moderately 4 quite a bit 5 a great deal 6 extremely

PLEASE MARK ONLY ONE ANSWER FOR EACH STATEMENT.

Statement	Rating
9. The members appeared to do things the way they thought would be acceptable to the group.	0 1 2 3 4 5 6
10. The members distrusted and rejected each other.	0 1 2 3 4 5 6
11. The members revealed sensitive personal information or feelings.	0 1 2 3 4 5 6
12. The members appeared tense and anxious.	0 1 2 3 4 5 6

APPENDIX D

ANGER MANAGEMENT/INTIMATE PARTNER VIOLENCE GROUP

CURRICULUM OUTLINE

Session	Activities
Session 1. Introduce Program: Nonviolence	Activities: Complete Non-violence contract, rules, guidelines, homework, participation; each member relate their offence
Session 2. Avoidance of Abuse	Activities: Group participation information; Awareness of physical cues of anger handout, Guidelines for time-outs
Session 3. Avoidance of Abuse II	Activities: Handout on ways to avoid abuse;
Session 4. Defining Abuse	Activities: Handout defining abuse: physical, psychological, and sexual; Power & control handout
Session 5. Basic Anger Management	Activities: Anger as emotion, abusive anger, non-abusive anger; awareness of anger producing situations during week
Session 6. Cycle of Violence	Activities: Handout on cycle of abuse, explain, discussion, assuming personal responsibility
Session 7. Support Systems	Activities: Go over written prevention plans; need for support systems-examples; complete support systems handout
Session 8. Dealing with Emotions	Activities: Handout on emotions; Discuss example emotions/thoughts from previous week
Session 9. Communication: Negative Self-talk 1	Activities: Discuss relationship between thoughts, actions, feelings; handout on distorted thinking
Session 10. Communication: Negative Self-talk 2	Activities: Distinguish between self-defeating and self-enhancing thoughts; self-talk diary handout for homework
Session 11. Interpersonal Style	Activities: Non-verbal behavior; handout on effective communication; practice active listening
Session 12. Assertiveness	Activities: Distinguish between assertive and aggressive behavior examples; handouts; practice
Session 13. Equal Man-Woman Relationships	Activities: Define; advantages vs. disadvantages; update prevention plan for next week
Session 14. Family of Origin	Activities: Discuss how families influence behavior; genograms
Session 15. Accountability	Activities: Discuss accountability handout
Session 16. Most Violent Behavior	Activities: Each member discusses ex. of their violent behavior, address any denial; discuss prevention plans
Session 17. Self-concept/esteem	Activities: Discuss how feelings about self affects behavior; discuss awareness wheel (known by self, known by others, known by self but not others, known by others but not self); do group self-awareness and feedback exercise

Session	Activities
Session 18. Prevention Plans	Activities: Each man present plan; feedback
Session 19. Prevention Plans	Activities: Each man present plan; feedback
Session 20. Self-awareness	Activities: Do and process group member feedback exercise.
Session 21. Review	Activities: Review past handouts, especially anger cues, violence cycle, timeouts, supports systems, assertiveness vs. aggressive communication, and accountability
Session 22. Personal Anger Inventory	Activities: Do and discuss anger inventory handout
Session 23. Process Review	Activities: Review group experience and how it relates to other roles in their life. Review prevention plans.
Session 24. Review and Evaluation	Activities: Review personal progress and future goal; and evaluate program.

APPENDIX E

STATEMENT OF CONSENT TO PARTICIPATE IN RESEARCH

(Group Member)

The Counseling Psychology program and the Department of Educational Psychology at Texas A&M University are committed to the protection of human subjects participating in research. Therefore, the following information is offered to assist you in deciding whether or not to participate in the present study.

I am aware that this study is being conducted to investigate the process and effectiveness of men's and women's group therapy and couples therapy in eliminating partner abuse and learning more effective skills for problem-solving, conflict-resolution, and positive relating with partners. I am also aware that it is anticipated that approximately 20 to 50 individuals may participate in the study.

I understand that my participation would require a maximum of 4 hours to complete several questionnaires concerning either the relationship with my partner or the group. I realize that my responses on the questionnaires will be coded in such a manner that my name will not be attached physically to the information I contribute. I am aware that information collected for this study will be kept strictly confidential unless there is immediate danger to someone. Also, this information will not be reported to the Brazos County Community Supervision and Corrections Department or in the treatment group. I understand that this project is intended to benefit me and my partner in achieving a more productive relationship.

Additionally, I am aware that David Lawson, LuAnn Helms, and Robert Wells (project investigators) will also request that my partner provide similar information about our relationship. I understand that if my partner's chooses to participate, his or her responses will not be made available to me, nor my responses to my partner unless we both agree by signing a consent to release information form.

I also realize that participation in this research project is strictly voluntary and that I may stop participating at any time. Choosing not to participate will not affect my involvement in the group or couple treatment. I can choose not to answer any questions and still participate in the research project.

I understand that if at any time I have questions about any procedures in this project, I am free to contact the investigators by mail or phone at:

David Lawson, Ph.D.
Department of Educational Psychology
Texas A&M University
College Station, TX 77843-4225
O-409-845-9250

This research study has been reviewed and approved by the Institutional Review Board-Human Subjects in Research, Texas A&M University. For research-related problems or questions regarding subjects' rights, the Institutional Review Board may be contacted through Dr. Richard E. Miller, IRB Coordinator, Office of Vice President for Research and Associate Provost for Graduate Studies at 409-845-1811.

I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study. I have been given a copy of this consent form.

Signature of Participant ____ Date __________________

Please print your name ____

Signature of Investigator ____ Date __________________

VITA

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EDUCATION

Ph.D., Counseling Psychology, Texas A&M University, 2004.

M.Ed., Educational and Counseling Psychology, University of Louisville, 1994.

B.A., Psychology, Miami University, 1992.

COUNSELING RELATED WORK EXPERIENCE

2001-present: *Counselor*, Health, Counseling and Prevention Services, Northern Kentucky University, Highland Heights, KY.

2000-2001: *Psychology Intern*, Counseling and Consultation Service, The Ohio State University, Columbus, OH.

1997-2000: *Graduate Assistant*, Texas A&M University, College Station, TX.

1994-1997: *Counselor*, Children's Home of Northern Kentucky, Covington, KY.

SELECTED DOCTORAL PRACTICA EXPERIENCE

Practicum in Group Treatment for Male Batterers, Brazos County Probation Department. (Spring 1998 to Summer 2000)

Practicum in Counselor Supervision, Counseling and Assessment Clinic, Texas A&M University. (Fall 1999)

Field Practicum in Psychotherapy with College Students, Student Counseling Service, Texas A&M University. (Spring 1998 and Fall 1999)