Couples' Perceptions of a Brief Intimate Partner Violence Intervention: A Qualitative Analysis.

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TABLE OF CONTENTS

ABSTRACT

Conjoint treatment for couples experiencing intimate partner violence has been found to be effective; however, there are still many concerns around the safety it provides for the victims. This study looked at the experiences of adult couples who disclosed the existence of physical or severe psychological abuse and then completed one or more sessions of a brief-intimate partner violence intervention. These couples were interviewed about their perceptions and experiences of the intervention using a semi-structured interview format. Constructivist grounded theory methodology was used to collect and analyze the data. A model was constructed that portrays the overall experiences participants had during the intervention sessions. This model contains useful information on the effectiveness of conjoint interventions for couples experiencing intimate partner violence and on their perceptions of safety in their relationships. Results indicated all components of the intervention were influential in the development of awareness.

Keywords: intimate partner violence, perspectives, conjoint treatment

CHAPTER I

INTRODUCTION

Conjoint couple's therapy for intimate partner violence (IPV) has been gaining acceptance in the field of marriage and family therapy. However, many have expressed concerns around the safety and effectiveness of these treatment protocols (Harris, 2006; LaTaillade, Epstein, & Werlinich, 2006; Stith, Rosen, McCollum, & Thomsen, 2004). A handful of clinical trials have concluded that conjoint couples' treatment for intimate partner violence is safe when used with couples participating in non-controlling violence. Additionally, it has been found to be at least as effective as conventional, gender-specific batterer intervention programs, yet very few researchers have explored couples' perspectives on receiving conjoint treatment (Todahl, Linville, Tuttle-Shamblin, & Ball, 2012). Previous studies examining IPV have suggested that researchers should investigate clients' perceptions of violence-focused conjoint treatment because little is known about how clients experience this treatment modality (Stith, Rosen, & McCollum, 2003).

The aim of this study was to understand clients' experiences of a brief intervention for couples presenting with a current or past history of violence. While much literature has focused on understanding risk factors for perpetrators of IPV, understanding client's perspectives of an IPV intervention is equally important, but understudied (Scott-Tilly & Brackley, 2005). Understanding both the clients' perceptions of what was helpful and not helpful, as well as the safety aspects of the intervention can help researchers and clinicians develop more effective conjoint IPV treatment programs, ultimately decreasing intimate violence.

Study Importance

Intimate partner violence is a nationwide issue affecting many individuals and families. In a survey conducted on national violence, it was found that in the United States, 25% of women surveyed and 7.6% of men surveyed had been either physically or sexually assaulted, or both, as adults. Of those who indicated a history of assault, 75%

were assaulted by a current or former spouse, cohabitating partner, or date at some point in their life (Tjaden & Thoennes, 2000). The same study found that one in six couples experience IPV each year (Tjaden & Thoennes, 2000). Prior research documents higher IPV rates among young women and women of lower socio-economic status (Coker, Smith, McKeown, & King, 2000; Thompson, Bonomi, Anderson, Reid, Dimer, Carrell, et al., 2006; Vest, Catlin, Chen, & Brownson, 2002; Wilt & Olson, 1996), as well as college-aged students, and married couples with children. IPV has many negative outcomes including poor physical health, injuries, depression and anxiety, posttraumatic stress, substance abuse, and decreased relationship satisfaction (Caldwell, Swan, & Woodbrown, 2012).

Abuse is often chronic and recurrent, increasing the negative outcomes. It is estimated that 21% to 80% of battered African American women remain with their abusive partners or return to them after leaving a women's shelter, even when severe violence has occurred (Sullivan & Rumptz, 1994). The continued involvement of men and women in violent relationships and the commonality of IPV among couples seeking therapeutic services (Bradford, 2010; Simpson, Doss, Wheeler, & Christensen, 2007; Todahl, Linville, Chou, & Maher-Cosenza, 2008) makes it vitally important that clinicians understand the implications of IPV and how to change the patterns exhibited by these couples. Studies have shown that between 36% and 58% of couples who seek regular outpatient services have experienced male-to-female or female-to-male physical assault (Jose & O'Leary, 2009). It has been suggested by Johnson (2008) that a portion of IPV found in clinical couples is situational and is owed to interactional factors between partners. Also, it has been hypothesized that situational violence is the most prevalent type of relationship violence (Simpson, et al., 2007). Situational couple violence is one of the four types of violence experienced by heterosexual couples noted by Johnson (2006). The other three types noted by Johnson (2006) include mutual violent control, violent resistance, and intimate terrorism. Situational couple violence is non-controlling, more likely to be bilateral, and conflict usually surrounds a particular issue (Johnson, 2006; Johnson & Ferraro, 2000). In a study by Straus and Gelles (1986), it was found that

50% of physically aggressive couples exhibit low-levels of mutual violence that is situational in nature. Another study noted a prevalence of mutually violence experiences with the majority of participants experiencing at least one event of mutual aggression. Participants described both offensive and defensive violence (Scott-Tilly & Brackley, 2005). Reciprocity of verbal aggression and other forms of psychological abuse between partners is a hallmark of distressed couple relationships (Epstein & Baucom, 2002; Epstein, Baucom, & Rankin, 1993; Weiss & Heyman, 1997). If therapists fail to see the problem IPV causes in clinical couples, they are likely to struggle with the permanency of long-term client goals.

Many marriage and family therapists fail to adequately assess for partner violence among couples presenting for relational therapy, often missing an important safety and relational issue (Stith, McCollum, & Rosen, 2011; Straus & Gelles, 1986). Schacht, Dimidjian, George and Berns (2009), found that among a random selection of AAMFT practicing marriage and family therapists, there was limited adherence to universal violence screening guidelines. This could be attributed to the fact that new clinicians learning to become competent therapists often do not receive adequate training. Current education programs fail to teach the tools necessary to inquire about, and deal with this pervasive and difficult issue (Stith, et al., 2011; Straus & Corbin, 1998). A lack of knowledge around the possible consequences for inquiry about victims' safety leads therapists to fear about asking. The therapists believe these questions will put victims at further risk or re-traumatize them (Stith, McCollum, Amanor-Baodu, & Smith, 2012), and so do not ask at all. Due to this lack of training, there is an increased risk that couples may not get the help they need and that some may be put at a greater risk of harm. Speaking of risk, couples' are also put at a greater risk when the type of treatment is not suitable for their relationship. Clinicians who are inadequately trained in violence assessment may also be inadequately trained in providing other forms of therapy for violent couples.

Conjoint couple's treatment is an appropriate treatment for working with situationally violent couples (Stith, et al., 2011; Stith, et al., 2012). However, in

developing effective conjoint treatment programs, it is also important to consider those factors that may increase the risk for IPV (LaTaillade et al., 2006). One risk of conjoint treatment is the possibility that a victim might be intimidated or fearful of retribution violence and not be comfortable sharing concerns in a room with his or her partner (Stith, et al., 2012). Due to this fear, conjoint therapy may perpetuate an environment where victims minimize the problems and suppress their needs (Todahl, et al., 2012). Other potential risks include a lack of responsibility taken by the perpetrator or an over involvement in taking responsibility by the victim. Although these risks are important, studies have shown that conjoint couple's treatment has been safely and effectively implemented with situationally violent couples without increasing levels of violence (Simpson, Atkins, Gattis, & Christensen, 2008; Stith, et al., 2004).

Although several conjoint treatment approaches have been developed and found to have successful results, very few of them have been empirically tested (Babcock & LaTaillade, 2000; Stith, et al., 2003), and little is known about the success and failure predictors of these treatment models (Stith & McCollum, 2009). This suggests an increased need for research to measure the effectiveness of conjoint treatment approaches for couples experiencing IPV. Measuring the perspectives of the client participants could provide additional information about predictors of effective violence-focused conjoint couple's treatment.

Only a small number of studies to date have looked at client participant perceptions of an IPV intervention program (Harris, 2006). The couples are the reason for IPV intervention programs and yet researchers have not attempted to understand these programs through the couple's perspective. Clients who participate in these emerging treatment protocols can offer important insights. They can articulate the elements of the model they find useful, their perceptions of change, the factors that led to changes that may have occurred, and whether or not they felt safe (Todahl, et al., 2012). There is a clear and urgent need to continue to improve our understanding of safe and effective interventions for interpersonal violence (Todahl, et al., 2012). This study will contribute

new information obtained directly from clients in order to help therapists better detect and implement effective IPV intervention programs.

Theoretical Framework

This study was conducted using constructivist grounded theory methodology. The theoretical basis guiding the study was a combination of feminist influences about relationship violence, human ecology theory, and constructionism. Each perspective offers insight into theoretical issues and components addressed throughout this study. The theories are discussed from general to specific, and the grounded theory methodology will be discussed further in Chapter 3.

Early feminist critiques around relationship violence placed the majority of the blame on the male aggressor ultimately leading to the creation of batterer intervention programs (BIPs). Yet, due to the high number of couples experiencing situational couple violence and still wanting to remain in their relationships, this was not every couple's preference. BIPs address the male's role in the violence, yet fail to address the female's role in the violence, and any underlying relational issues that may cause or perpetuate the violence (Stith, et al., 2003). If reciprocal violence is occurring, treating one partner without the other is not likely to be effective in reducing the relationship violence (Stith, et al., 2003). These ideas suggested that conjoint treatment is an alternative for couples experiencing situational violence.

Human ecological analysis of social or relational institutions look at the inner workings of a system (e.g., the ways in which organizational policies govern service options and quality or the ways that family rules govern input and output of the family) (Chung, Oswald, & Hardetsy, 2009). According to this theory, individuals constantly interact with their surrounding physical and social–cultural environments. Individual behavior is shaped by the way they perceive, interpret, and experience their surrounding environments (Chung, et al., 2009). As a result, researchers must understand the meaning of the environment from the perspective of the individual (Bubolz & Sontag, 1993). This study sought to understand the inner workings of an IPV intervention for situationally

violent couples. Human ecology guided the study by examining the effects of an intervention on a small system [the couple relationship] that was interacting with a larger sociocultural system [which includes the intervention].

Additional theoretical insight came from the constructionist theory. Constructionism is based on the foundation that people construct their own perceptions of the world. Constructionists believe that reality is subjective and unique to each individual and place emphasis on context and meaning (Efran, Lukens, & Lukens, 1988). This study was aimed at gaining the clients' perspectives which are based on the context in which they experience the intervention and the meaning that they apply to what they experience.

This study also included contextual issues that contributed to the theoretical framework, including the clients' experience of safety in their relationship. These issues were discussed by the participants during the semi-structured interview process, and are important topics regarding the effectiveness of conjoint couple IPV interventions. Client safety has been found to be a key clinical issue in treating violence (Whiting, Smith, Oka, & Karakurt, 2012a), and in how a partner perceives safety and its impact on what happens in the relationship (Whiting, et al., 2012a). This perception can influence the way a client experiences an intervention that leaves them vulnerable to a lack of safety. One study found that therapeutic safety helped partners feel open, or vulnerable with each other, citing one client that said: "You don't feel afraid to share your thoughts or your feelings" (Whiting, et al., 2012a). The component of safety in treating IPV should guide how interventions are developed and implemented and gain clients' perspectives around relationship safety that may increase the effectiveness of future interventions.

Study Boundaries

Study boundaries are presuppositions assumed by the researchers and limitations narrowing the focus of the study. Some assumptions that were present within this study included (a) the importance of assessing relationship safety, (b) the clients' desire to increase their relational satisfaction by attending conjoint couple's treatment, (c) the idea

that clients develop their own constructs about the intervention and that those constructs help clinicians determine what is and is not useful in treating IPV. Other assumptions included (d) client congruency when speaking about intervention perceptions, and (e) the idea that all clients interact within their environment influencing their perceptions of that environment. Each of these assumptions points to the idea of interpretation as a means of data collection.

At the core of the constructivist grounded theory is the idea of interpretation. Interpretation is the means by which researchers construct and understand theories about how humans interact and see the world. Interpretation was a characteristic of this study as the perspective of the researcher was present in both clinical and research settings and shaped the study and impact of the results. The participants had their own interpretation of the intervention. The researcher used her interpretation of the client perspectives to develop theories about the effectiveness of conjoint couple's treatment. The process of interpretive theorizing covers overt processes, but also delves into implicit meanings and processes (Charmaz, 2006). It pieces together and interprets implicit meanings that constitute the category, thereby showing how a mundane statement alludes to an array of meanings and experiences (Charmaz, 2006). The array of meanings that followed the interpretation was then co-constructed between the researcher and participants. The interpretation developed the theory, but was also a possible limitation of the study through researcher biases.

Other study limitations included the target population, self-report measures of data collection, and lack of follow-up data. This study was completed with participants presenting at an on-campus clinic for problems with their relationship and/or family system. To be admitted into the study the clients had to meet the intervention criteria, which will be further explained below, and had to have completed at least half of one session of the intervention program. This intervention protocol was the participating clinic's policy and if clients were unwilling to participate in the intervention, they were referred to an outside facility to receive treatment. When clients were accepted and then participated in the intervention, they were then allowed the opportunity to give feedback

on their experiences during the intervention process. The feedback was received via a self-report measures and a semi-structured interview process. One problem with self-report measures is a lack of understanding about the client's accuracy of his or her perceptions. Researchers struggle with whether the participants in a study are "(a) expressing hopefulness for change over actual and lasting change, (b) reporting actual change in their relationship, or (c) protecting or concealing more accurate information (e.g. violence was occurring, although it was not being disclosed for fear of repercussion)", either way, this is an important question and common criticism of IPV research validity (Todahl, et al., 2012, pp.163).

A final limitation was that this study did not collect follow-up data for additional information purposes. With follow-up data, researchers could monitor what aspects of these treatment programs created lasting change and limited short-term change. If changes were tracked, the impact may decrease prevalence rates of couples experiencing IPV.

Purpose of Study

The research questions developed for this qualitative study of client perspectives of an IPV conjoint couple's treatment intervention include:

1. How do male and female clients in a brief violence-focused individual couple intervention experience the intervention?
2. What aspects of this intervention are most helpful to the clients? Which aspects of the intervention are least helpful?
3. How does this intervention affect the couple's perception or experience of safety in their relationship?

CHAPTER II

LITERATURE REVIEW

Awareness of intimate partner violence (IPV) has been in existence since at least the mid-1800s (Barner & Carney, 2011), and IPV is present among most populations and cultures. Garcia-Munroe, Jansen, Ellsberg, Heise, and Watts (2006) found that partner abuse occurs internationally in 29% to 63% of couples of varying races, sexual orientations, relationship configurations, and socio-economic statuses. Another analysis conducted by Whitaker, Laileyesus, Swahn and Saltzman (2007) examined data on adults aged 18 to 28 from the 2001 National Longitudinal Study of Adolescent Health and found that almost 24% of all relationships had violence. Findings show that 50% of those relationships had violence that was reciprocal. In a meta-analysis conducted by Tjaden & Thoennes (2000) it was found that, in reciprocally violent relationships, 26.4% of male IPV victims and 32.6% of female victims report that their partner threatened to harm them. Researchers have estimated that between two and four million women suffer at the hands of their domestic partner each year (Centers for Disease Control & Prevention, 2000). This is an international problem that can have lasting effects on many people.

In an attempt to reduce this global problem, laws and interventions have been developed and implemented. First, law makers developed punishment for violent crimes against partners while advocates built shelters for victims to use when their relationships became violent. This increased the societal awareness of the issue and there then became a shift towards offender-based criminal justice interventions, a paradigm characterized by increased prosecutions and mandatory arrests for IPV. It became clear that simply providing a safe-haven to victims was not enough, and there needed to be some accountability to guilty men and women for their behavior (Johnson, 1995). With this new movement underway, treatment approaches began to surface. Various approaches were developed including the psycho-educational treatment approach developed by the Duluth Domestic Abuse Intervention Project (DAIP) (Pence & Paymar, 1993), and the multiple cognitive-behavioral interventions for IPV perpetrators (Dutton & Corvo, 2007). Following the emergence of the cognitive-behavioral approach came various other

interventions and techniques for working with victims and perpetrators of IPV. These interventions will be discussed later in more detail.

Intimate Partner Violence

Intimate partner violence, also known as domestic abuse or relationship violence, has generated a large amount of research literature during the last half-century, particularly in the areas of criminal justice, psychology, and the social sciences (Barner & Carney, 2011). It is characterized by physical and sexual violence, emotional abuse, and controlling behavior by a current or former partner (Spangaro, Zwi, & Poulos, 2011). The most common forms of physical violence include grabbing, slapping, pushing, and throwing things at one another (O'Leary & Murphy, 1999). Many different views of this type of violence exist and each view influences the specific course of treatment for these relationships.

The conceptualization of IPV varies based on the theoretical assumptions driving the research. Feminist researchers believe IPV is primarily perpetrated by males as a means to maintain power and control, which is supported by a patriarchal culture. The responsibility is seen as unilaterally male's and the punishment or emotional costs are unilaterally female's (Stith et al., 2012). Family conflict researchers however, conclude that some violence is controlling and battering while some may be the result of individual, relational, and societal variables that tend to be more gender neutral (Greene & Bogo, 2002).These researchers hypothesize that the acceptance of using violence to address conflict is entrenched at all levels of our society and thereby, permeates our family systems. Therefore, according to this perspective, all family members are susceptible to this socialization of violence (Graham-Kevan 2006; Hamel & Nicholls 2006; LaRoche 2005; Straus and Gelles 1990). This type of violence is centered on the interplay of the couple, but is influenced by outside forces (Giles-Sims, 1983). It does not have a specific target population, but does exist in certain populations more frequently.

Specific populations most often affected are young women, parents, and college-aged students. A prevalence study of 1,138 women enrolled in a health maintenance

organization demonstrated that women with children had annual IPV prevalence rates over twice that of women without children (Jones, Gielen, Campbell, Dienemann, Kub, O'Campo, et al., 1999). Child rearing increases stress (relational and financial), which can potentially lead to dissatisfaction within the intimate relationship (Twenge, Campbell, & Foster, 2003). Parenting issues did cause minor disagreements but often precipitated violent episodes (Scott-Tilly, & Brackley, 2005). IPV also continues to occur in much larger frequencies among the older high school and college-aged populations than any other age group (Rennison, 2001). Despite greater awareness about violence on college campuses within the last decade, IPV, which includes sexual assault, relationship violence, and stalking, has remained a substantial problem among college students (Baum, 2005; Rennison, 2001; 2003). Although these populations most notable for participating in relationships with violence, other populations can and are affected.

Domestic violence is not a singular phenomenon; rather research conducted by Johnson and Ferraro (2000; Johnson, 2006), and consistent with previously cited research, has identified four types of violent heterosexual couples: "violent resistance," "mutual violent control" "intimate terrorism," and "situational couple violence," (Johnson, 2006; Johnson & Ferraro, 2000), now referred to as situational couple violence. Violent resistance is exhibited when both partners are violent, but only one partner is controlling. And mutually violent control involves two partners both of which are violent and controlling. Intimate terrorism is defined as one partner being violent and controlling while the other partner is non-violent and non-controlling. It represents a pattern in which systemic use of both violent and nonviolent actions are used to achieve control over one's partner (Greene & Bogo, 2002). This type of violence is more likely to escalate over time, cause serious injury, have a higher frequency of violent incidents, and involve the unilateral use of violence by one perpetrator (Greene & Bogo, 2002). Unlike intimate terrorism, situational couple violence is an intermittent response to a specific argument or conflict, and control is limited to specific situations (Johnson, 2006; Johnson & Ferraro, 2000). It is relationship violence where both partners are non-controlling and yet are violent toward one another in times of conflict. The violence is bilateral between partners

and is hypothesized to be the most prevalent type of relationships violence (Johnson, 2006; Johnson & Ferraro, 2000). In the majority of relationships exhibiting any of the violence listed above there is the possibility of physical aggression being committed against a partner.

Along with physical IPV there has been research conducted around four types of non-physical abuse. These types include emotional, psychological, social, and economic (Denzin & Lincoln, 2005). Emotional abuse is intended to undermine the victim's self-respect and sense of worth and often involves embarrassment, name-calling, insults, complaints, and accusations. An example of this would be when a parent insults a child's lack of success making the child view his or herself as worthless. Psychological abuse is used to undermine the security of the victim's logic and reasoning, an example of this being where a person is told they are stupid so many times that they then start to question their own thoughts. Social abuse involves forced isolation where victims are cut off from their friends and family. Economic abuse involves imposed economic dependence (Miller, 1995). Emotional abuse is the most widely recognized and researched of the four types and is a consistent risk factor for physical violence (Coker et al., 2000). Regardless of the type of violence occurring in relationships there are detrimental outcomes.

Risk factors associated with IPV have been widely studied and exist at every ecological level (e.g., individual, relational, and community levels) (Stith, Green, Smith, & Ward, 2008). Also being studied are the negative personal and societal outcomes. One outcome involves the decrease in marital satisfaction. As a result of a meta-analysis, it was shown that decreased martial satisfaction and increased martial conflict are positively associated with physical IPV aggression (Stith et al., 2008). In addition, psychological aggression has been found to be a stronger predictor of marital dissolution than physical aggression (Jacobson, Gottman, Gortner, Berns, & Shortt, 1996). Researchers are beginning to understand that violence often co-occurs with other significant problems including substance abuse and mental health disorders (Stith et al., 2012). Other negative outcomes include increased injuries, poor general health and functioning, disability, and frequent medical treatment needed (Campbell, 2002).

Intimate partner violence also has both costly and debilitating social and health concerns for families, communities, mental health and physical health practitioners, the criminal justice system, policymakers, and the society at large (Caldwell et al., 2012).

Situational Couple Violence

Situational violence is thought to be the most prevalent type of relationship violence when looking at samples from the general population and in couples seeking conjoint therapy (Simpson et al., 2007). This is mutual, low-level violence (i.e., pushing or grabbing) perpetrated by both partners as a means of conflict management (Friend, Cleary-Bradley, Thatcher, & Gottman, 2011). It is also known as common couple violence where both partners are engaging in mild to moderate physical aggression and where it occurs more commonly in distressed couples (Holtzworth-Munroe, Meehan, Rehman, & Marshall, 2002). Situational violence is more likely to be bilateral and involves conflict over a particular issue (Johnson & Ferrero, 2000). It is a couple dynamic in which conflicts may unintentionally escalate to minor violence (Satir, Banmen, Gerber, & Gomori, 1991). This type of violence found in couples also tends to be more reciprocal and symmetrical (there is not a clear perpetrator and victim), tends to be limited to the family, is followed by remorse from both partners, and does not involve a context of control and fear (Stith, McCollum, & Rosen, 2012a). The core problem of situational couple violence appears to be communication skill deficiencies for which an individual compensates with verbal aggression that then escalates into violence (Johnson, 2006; Dutton & Corvo, 2007).

Situational perpetrators, usually both partners, tend to be in relationships where there is a higher likelihood to be reciprocal violence and where violence serves to exert control over specific interactions rather than as part of an overarching pattern of domination (Jose & O'Leary, 2009). Situational violence is likely to be part of a coercive family cycle that contains the characteristics of negative reciprocity, rapid escalation, and lack of withdrawal rituals from the escalating arguments. These rituals are habitual

patterns of conflict that these couples do not know how to break (Jacobson & Gottman, 1998). As with any type of violence there are both positive and negative outcomes.

Within the realm of situational couple violence there are multiple clinical and social outcomes that can be detected. First, this type of violence corresponds well with the family violence perspective (Straus & Gelles, 1990), as escalation of family conflict in stressful situations may lead up to partner violence (from both males and females) (Straus & Gelles, 1990). When families are interacting with one another, there is always chance for injury both physical and emotional within the family system. Secondly, Whitaker et al. (2007) found that reciprocal IPV was associated with greater injury than was nonreciprocal IPV, regardless of the gender of the perpetrator (Whitaker et al., 2007). Finally, men and women are equally likely to initiate violent conflicts with women more likely to report those patterns of mutual violence and retaliation (Satir et al., 1991).

Couples who experience this type of violence are less likely to seek assistance from shelters, file for divorce, seek medical attention, or report incidents to police (Satir et al., 1991). Those couples that seek treatment often do so together and are otherwise unwilling if gender-specific treatment is the only option. For this reason, researchers and clinicians developed conjoint couple's treatment used for working together with partners to address the violence and conflict present in their relationships.

Conjoint Couples' Therapy

Conjoint couple's treatment is treatment that consists of seeing partners who exhibit some form of relational violence within their relationship rather than individually in gender-specific groups. Intimate partners work together directly after an individual assessment and safety protocol are completed (Todahl et al., 2012). For couples who report low to moderate levels of violence, tend to be in stable relationships, and do not fear each other, a conjoint approach that addresses systemic as well as individual cognitive and behavioral risk factors for IPV may be the most appropriate and effective treatment (LaTaillade et al., 2006). Other criteria include couples who acknowledge that abuse is a problem, are willing to work toward having an abuse-free relationship, and are

committed to staying together. In addition, the partner, seen more as the victim by the therapists, must feel safe living with the other partner participating in conjoint treatment as well as comfortable being honest in the presence of that other partner (LaTaillade et al., 2006). With couples experiencing reciprocal violence, both partners need to feel safe participating in this form of treatment.

For conjoint couple's treatment approaches to be safe and effective there are four different concepts that must be addressed: (a) therapeutic goals, (b) gender differences, both in perceptive norms and couple roles, (c) equality in contribution of violence, and (d) psychological abuse in non-violent couples. Conjoint treatment approaches should include the key goals of reducing risk factors for aggressive behavior, as well as enhancing protective factors against relationship violence (Coie, Watt, West, Hawkins, Asarnow, Markman, et al., 1993). Researchers found that it is important that gender differences in aggressive behavior (i.e., aggressor, victim, roles, and assumptions) be taken into account when clients are participating in conjoint approaches to IPV treatment (LaTaillade et al., 2006). It is a common assumption that the male is the perpetrator and the female is the victim in heterogeneous couples; however, that is not always the case and treatment modalities need to address how this impacts each individual couple relationship. The quality in contribution to atmosphere of aggression, meaning how extensively one partner participates and perpetuates the violent communication, is also an important concept needing to be addressed. Although identification of female aggression in no way holds women responsible for males' abuse, researchers and clinicians need to attend to ways in which both partners contribute to an atmosphere of aggression and should design interventions that reduce all sources of violence in relationships (LaTaillade et al., 2006). The final concept surrounds the fact that many couples whose relationships are not characterized by battering, but may be at risk for future violence would not be appropriate for existing gender-specific treatment programs. Therefore, it seems crucial to develop conjoint treatment programs designed to reduce prevalent psychological and physical aggression between partners (LaTaillade et al., 2006).

Couple treatment of IPV has increased in recent years, but is still considered controversial by many (Stith & McCollum, 2009). There have been studies showing the positive outcomes of conjoint couple's treatment, however, the skepticism is present for both clients and clinicians. This study decreased the skepticism about conjoint therapy by allowing clinicians and other clients to explore the benefits through the current therapy clients' perspectives. Current findings suggest that cognitive-behavioral interventions, as well as other systemically oriented forms of couple therapy can be effective in decreasing negative communication behaviors associated with IPV, decreasing psychological and physical aggression, and increasing relationship satisfaction (LaTaillade et al., 2006). Conjoint treatment also is associated with reducing subsequent partner violence (Stith et al., 2012a). Conjoint treatment not only reduces negative relational outcomes as a result of IPV, but also gives opportunities to the couples in conjoint sessions that would not be possible in gender-specific groups. These sessions allow for the correction of conflict management issues, support for each partner in learning problem-solving techniques, and therapy plans that can be tailored to meet the needs of these individual couples (Harris, 2006).

Safety in Conjoint Couples' Treatment

The concept of safety in relation to human interactions is one that must not be overlooked. Safety is understood traditionally as being free from danger, and is a basic life requirement for happiness and thriving (Everly & Lasting, 2004). The idea of relational safety helps individuals to feel comfortable being themselves with their partner and discussing difficult issues without fear of punishment for not following their partner's viewpoints. From an IPV treatment perspective, safety is defined as the absence of, or ability to avoid violence (Stith et al., 2004). The absence of safety in relationships can create fear, jealousy, anger, or other violence-provoking emotions and so, it must be considered when dealing with violent partners seeking conjoint treatment.

There are several concerns coming from both clinicians and researchers about the impact that conjoint couples' therapy has on each individual, especially the primary

victim, as defined by the therapist. One concern that has been expressed about conjoint treatment includes the possibility that a victim might be intimidated or fearful and not be comfortable sharing concerns in a room with a partner (Stith et al., 2012a). During most therapeutic treatments between couples, sensitive conversations may readily lead to physical and emotional violence thereafter (Todahl et al., 2012). Another concern arises with the fear of retribution. This fear can at times create an environment where the victims of the violence suppress their needs and do not disclose their true feelings (Todahl et al., 2012). If the victim is unable to express his or her needs, then treatment will not be effective and the cycle of violence could continue.

Safety is a critical consideration within relationships and while couples are in treatment. The assumption that intimate partners can be the primary source for safety or the lack of it, make it is important that clinicians assess for safety regularly and allow ample time for clients to feel safe before pursuing other topic areas (Whiting et al., 2012a). Times have occurred where clinicians have sometimes neglected the construct of safety, and instead focused on discrete acts (e.g., of aggression), or on more evident treatment issues like adjustment, stability, or communication (Goldner, 1999). If clinicians had a better awareness of their clients sense of safety, treatment outcomes could improve and prevalence rates for violence in couples seeking treatment may increase, which could be perceived as a negative but will ultimately decrease the overall prevalence of violence between intimate partners.

Intimate Partner Violence Interventions

IPV interventions have changed over the past 200 years; they have changed in methodology, typology, and overall assumptions, and vary across theoretical perspectives and governmental laws. For instance, cognitive-behavioral interventions are predominately focused on changes within the individual (Beck, 1976; Ellis, 1962), systemically-based treatments attempt to alter interactional patterns (Cottone, 1991; Cottone & Greenwell, 1992), and feminist theory challenges the effects of a patriarchal society on women (Holtzworth-Munroe & Stuart, 1994). Stith et al. (2004) argued that,

due to the heterogeneity of IPV; multiple treatment options are needed that address the type of IPV exhibited by the couple. Most standard IPV treatments are designed to treat male perpetrators (Pence & Paymar, 1993).

Interventions became known in 1981 when the psycho-educational treatment approach for perpetrators, commonly referred to as the Duluth model, was developed (Pence & Paymar, 1993). Within this model great importance is placed on punitive responses to the violent actions of the perpetrator, in particular the judicial and legal consequences (Pence & Paymar, 1993). Tools are offered presumed to perpetrators as a means to assuage the issues of power and control at the heart of violence and replace existing behaviors (Barner & Carney, 2011).

Intervention programs patterned from the Duluth model are referred to as Batterer Intervention Programs (BIPs). They were designed to teach new ways of relating and to challenge men's use of male power (Stith et al., 2012a). BIPs are perpetrator programs based in a psychoeducational framework and are widely available and serve a predominantly court-mandated male clientele. Most of these treatment programs operate on cognitive and behavior change strategies within a feminist framework (Musser & Murphy, 2009). The goal of these gender-specific treatments is to vigorously confront male efforts to accept anything less than total responsibility for their violent actions. It also attempts to attack their often presumed unconscious use of male privilege while separately empowering female victims to protect themselves and, leave the abusive relationship (Stith et al., 2011).

Although Dutton and Corvo (2007) suggested that the Duluth model and others like it are by design are not therapeutic even though they claim they are initiating psychotherapeutic and behavioral changes in IPV perpetrators, gender-specific batterer intervention program continue to be the main treatment methodology used by the United States of America. It is hoped by many that there will be a decrease in the number of IPV related crimes. However, approaches that rely heavily on an individual deficit model are typically regarded as lacking sufficient psycho-educational content to be effective with domestically violent men (Day, Chung, O'Leary, & Carson, 2009). Research studies

examining these perpetrator-centered programs have been shown to have limited effectiveness in reducing violence, and a high percentage of male participants reoffended after treatment ends (Babcock & LaTaillade, 2000; Murphy & Eckhardt, 2005). Additionally, multiple studies have demonstrated that traditional psychoeducational programs are not effective for all forms of partner violence (Babcock, Greene, & Robie, 2004; Stith et al., 2004; Stith et al., 2003). Systemic interventions were developed as an alternative to perpetrator-focused methods.

Systemic Interventions

Systemic interventions for violence were once regarded as ineffective and even illegal due to the possible safety risks that could occur during treatment. Attitudes have slowly changed, and now researchers are supporting systems theory. Wileman and Wileman (1995) "found that reductions in violence were associated with both the man assuming responsibility for his own violence and with the woman decreasing her vulnerability and taking an active role in balancing power in the relationship." (p.171). Through the changes in perceptions and roles of each partner, the entire couple unit can be successful in creating positive and lasting change.

Systemic approaches to IPV intervention theorize that all members of the system are part of the presenting problem and through the understanding of the system in its entirety couples can learn to interact and communicate with one another in a non-aggressive or violent manner. With many couples choosing to remain together after experiencing violence, the need for therapeutic violence treatment will increase (Stith et al., 2012). Various treatment methods are based in systems theory and have provided strong support for systemic interventions (Stith et al., 2012).

Treatment methods currently in practice include behavioral couple's treatment (BCT), couples abuse prevention programs (CAPP), and domestic violence-focused couples treatment (DVFCT). BCT was developed to work with adult couples with substance abuse disorders. In addition to sobriety support, it includes skill training that increases positive interactions and teaches communication skills to help manage conflict

better (Stith et al., 2012). There is strong evidence to support the efficacy of BCT in reducing IPV (Fals-Stewart, Kashdan, O'Farrell, & Birchler, 2002).

CAPP is a cognitive-behavioral couple treatment seeking to address IPV risk factors for couples with a history of minor to moderate physical and/or psychological aggression (LaTaillade et al., 2006). The aim of this program is to improve relationship satisfaction and lower the risk for future episodes of violence (LaTaillade et al., 2006). Outcomes of the CAPP treatment model include an increase in relationship satisfaction and a decrease in psychological aggression. The program also produced less negative communication for both men and women (Stith et al., 2012).

Lastly, DVFCT is a treatment model that works with couples directly on their violence through the use of solution-focused brief therapy (Stith et al., 2011). The goal of DVFCT is to eliminate all forms of partner violence, promote self-responsibility, and enhance the couple's relationship (Stith et al., 2012). Participants learn safety skills, including education about IPV, how to develop a safety plan and implement it, and a violence reduction tool called a negotiated time-out (Stith et al., 2012).

Results of a study examining conjoint couple's treatment factors concluded that for men and women, the program, either single couple or multicouple, led to significant reductions in physical violence towards partners (Stith et al., 2012). Each of these treatment programs has substantiated positive outcomes, but there are also limitations that future research should address.

Current Research Limitations

Systems-based IPV interventions have recently produced encouraging results supporting their effectiveness in reducing the prevalence and recidivism of partner violence. However, multiple limitations still exists. First, there has not been a study where the researcher addresses the processes involved in changing violent relationships making it difficult to know which specific aspects of the intervention are unnecessary and which produce change. There is a lack of research around the cost effectiveness of systemic treatment models. Researchers have little information regarding which

population of people these interventions can and will be effective with and which populations may be dangerous to treat using this model (Stith et al., 2012). There is a lack of diversity around the types of violence, an example being that many studies are conducted using gender-specific group interventions and the populations used to evaluate the programs (i.e., community, clinical). Last, research has failed to examine systemic interventions in "real-world settings" nor have they evaluated treatment approaches with varying client cultural backgrounds (Stith et al., 2012).

Although this study did not address all of these limitations, it developed a better understanding of client perceptions who are participating in these interventions, which has been a limitation to many researchers in the past, helping researchers and clinicians gain valuable insight into developing more effective treatments.

Participant Perspective

The entire basis for data collection within this study was client perspectives. Harris (2006) addressed the lack of research surrounding how conjoint therapy is perceived by the participants themselves. Stith et al., (2003) urged researchers to investigate client perceptions, citing the lack of knowledge around how women experience DVFCT, and various other studies have mentioned this increased desire to investigate client perceptions and the positive outcomes that are received through these perceptions.

Clients are the reason for the interventions, have firsthand experience within the interventions, and thus are the most educated to help clinicians understand the workings of family system change. Clients who participate in these emerging conjoint couple therapy models can offer important insights. They can articulate their feelings about safety in the therapy room, the elements of the intervention found useful, the factors that led to changes, and the client's perception of change (Todahl et al., 2012). Through client perspective analysis, clinicians and researchers can understand how to better serve their clinical population base. In two studies examining client perspectives of what was helpful within an intervention, one study found that participants viewed being treated with

respect as the most important characteristic of the provider (Todahl et al., 2012), while the other study, a meta-analysis of clients' perceptions of conjoint therapy, found that client reports of a "safe haven of comfort and hope" was associated with their overall experiences in therapy (Chenail, St. George, Wulff, Duffy, Scott, & Tomm, in press).

CHAPTER III

METHODS

This study used constructivist grounded theory, a branch of grounded theory methodology, to address the research questions.

Grounded theory is a general methodology in which data are systematically gathered and analyzed (Strauss & Corbin, 1998). The data come from the lived experiences of the participants, and are used to develop theoretical constructs (Corbin & Strauss, 2008). The grounded theory approach begins with a question rather than a hypothesis and allows the theory to develop from the data collected (Randell, Bledsoe, Shroff, & Clyde-Pierce, 2012). Grounded theorists believe that both the problem and the solution can be found in the data, and they analyze that data in order to help explain the various relationships between constructs presented and discovered. These theorists take an inductive approach, in which there are few preconceived ideas about what to prove or disprove (Morse, 2001). Grounded theory methodology is more than a description of important societal concepts; it explains and articulates the relationships between those concepts (LaRossa, 2005) and gives a conceptual understanding of social behavior.

One type of grounded theory is constructivist grounded theory. The philosophy of this approach asserts that knowledge claims are interpretive, and are generated through linguistic interactions and a meaning-negotiating process between the participants and researcher (Gergen, 2008). Constructivists have developed epistemological assumptions based on social constructionism. There are two basic assumptions. The first is the idea that the truth of an object is partially a product of the individual who experienced it. The second assumption is that the knowledge around that object is always changing simply by the comprehension of new information (Pawlicki & Larson, 2011). Other assumptions include that knowledge is constructed by both the participant and the researchers, and that the way in which the data is presented is merely a reconstruction of the experience (Charmaz, 2005; 2006). When using a constructivist approach, researchers are not simply presenting how participants view their situations. Instead, researchers co-create and interpret the participants' experiences and acknowledge the resulting theory as an

interpretation (Charmaz, 2000; 2006). For this study constructivist grounded theory methods were used to piece together and interpret the implicit meanings that constituted the couples' perceptions of the IPV intervention.

Sample

The research participants for this study were part of an intervention study that administered a brief-IPV intervention to couples experiencing relational conflict (See Appendix F). The intervention was developed from theories such as Solution-Focused Brief Therapy (Stith et al., 2010) and Narrative Therapy. Intervention participants were adult couples seeking therapeutic services as the Texas Tech University Family Therapy Clinic in which one or both partners reported perpetrating or being the victim of severe psychological violence or any physical violence in the current relationship. These intervention couples were not allowed to participate in other therapeutic sessions at this clinic before the intervention was complete, unless a couple did not accurately disclose the relational violence until after the original therapy had begun. Specific intervention inclusion criteria were, (a) both partners are at least 18 years old, (b) a least one member of the couple reported, as defined, severe psychological violence or any physical violence in the current relationship, (c) both partners reported that they felt safe discussing the violence in a conjoint session with their partner, (d) both partners agree to add the discussion of any psychological or physical violence to their treatment plan at the Family Therapy Clinic, and (e) both partners agreed to sign a no-violence contract. Clients were excluded from participation for the following reasons, (a) only one partner in the couple reported the existence of severe psychological or any physical violence, (b) either partner indicated that they do not feel safe discussing the violence in a conjoint session with their partner, and (c) either partner was unwilling to add the discussion of the violence to their overall therapeutic treatment goals. The couples that participated in the perceptions study had to have completed at least half of one or more of the required intervention sessions and volunteered for participation in the perspectives study.

Research participants for this perspective study were recruited from the brief-IPV intervention study currently being administered at the Texas Tech Family Therapy Clinic. Standard procedures at the clinic require an individual violence assessment to be conducted on each partner of a couple coming in to receive therapeutic services. Based on inclusion criteria gained during these assessments, couples were then assigned to complete the intervention procedures, and at that time, were invited to participate in the perspectives study research interviews. All intervention clients that met the inclusion criteria were offered the chance to participate in the study. A recruitment script was read to each member of the couple separately at the beginning of the standardized intervention which informed them of the research assessments they had the choice of completing. The interviews were completed only if the couple chose to do so, which made the recruitment of participants based solely on those couples admitted to complete the standardized intervention. An incentive was offered, to each partner in a couple, of $20 for the completion of the interview. The interviews were conducted individually with each partner, which meant that one partner was able to participate in the research interview without his or her partner also having to complete an interview.

The final sample included 15 intervention participants (7 males, 8 females; 7 couples, 1 individual). They ranged in age from 21 to 53. There were five married couples and two dating couples, three were separated and four were living together, ten individuals were Caucasian and five were Hispanic, twelve individuals were employed or students and the remaining three were unemployed, and their financial status ranged from poverty to middle class as defined by the participants. In qualitative research methodology, the sample size is smaller than in quantitative methodology. The focus is on saturation rather than representation. Researchers simply need to have enough information to gain an adequate understanding of the categories that are being developed in the emerging theory (Hodges, 2011). The characteristics of this sample were narrowed to a specific topic area, thus developing an appropriate context for gaining multiple perspectives.

Procedures

To assess the couple's perception and experience of the brief-IPV intervention, the researcher collected data using a semi-structured interview procedure. Various studies using similar methodology also used a one-on-one interview method and yielded adequate results (Doig, McLennenn, & Urichuck, 2009; Whiting et al., 2012). Upon completion or termination of the couple from the standardized intervention, a graduate research assistant contacted the couple by phone to schedule a time to complete the qualitative interview. Before contacting the couple, the graduate student revisited the IPV intervention consent form to double-check that this couple had given written consent to participate in these interviews.

Interviews took place at the Texas Tech University Family Therapy Clinic and were conducted with individual research participants by a graduate research assistant. The interviews were semi-structured, audio-taped for transcription, and lasted approximately fifteen to thirty minutes. The interview guide (See Appendix A) was composed of questions that asked research participants to reflect on their experiences during the standardized intervention. Participants were asked about what they believed to be the advantages and disadvantages of the intervention, what benefits they felt the intervention brought to their relationship, and the impact the intervention had on each partner's perception of safety as related to the topic of violence in the relationship. After the completion of the interview, the graduate research assistant paid the participant their incentive of $20.00. The recorders that contain the interview data were stored in a locked file cabinet in the primary investigator's office. The graduate research assistant transcribed each interview using transcription software and then erased the data from the recorder. The transcriptions were identified by a case number only, and all other identifying information was removed from the transcription sheets.

Constructivism requires researchers to be collaborative and transparent, so when interviewing the participants the graduate research assistant emphasized a sense of curiosity and attempted to maintain the most respectful and ethical stance. When asking participants to reflect on their own experiences in both the intervention and in their

personal relationships, the interviewer also attempted to convey a nonjudgmental stance and help the client to feel safe to say any and all comments.

Analysis

The analysis of this interview data was conducted using a constructivist grounded theory approach. After the first seven to ten interviews were transcribed the researcher began analyzing the data using open coding (See Appendix B). Open coding, or the development of codes, is the initial step to understanding the research data. It is the analytic process by which concepts are identified and their properties and dimensions discovered in the data (Strauss & Corbin, 1998). It is intended to identify the large concepts in the data along with their properties and dimensions (Scott-Tilly & Brackley, 2005). It "leads to refining and specifying any borrowed extant concepts" (Charmaz 2000, p. 515), and begins the process of theory-building through organizing themes into categories of tentative conceptions. The process of open coding ends when the researcher has developed one or more core categories for further analysis.

As interviews were transcribed and coded, groupings of codes become tentative categories through the use of axial coding (See Appendix C). This type of coding includes reconfiguring the fractured data into categories indicating relationships (Charmaz, 2005). During this process, researchers will write memos (See Appendix D) to track their analytic decisions and textual indicators that add description to the concepts at hand (Charmaz, 2006). The categories then are developed further using the grounded theory procedures of dimensionalizing which involve dividing properties into dimensions along a continuum (Charmaz, 2000; La Rossa, 2005). These dimensions are noted as common themes and help researchers develop new theoretical assumptions about the participant's perspectives of the brief-IPV intervention which could influence the interview protocol for future research studies using semi-structured interviews to gather feedback. The final step of analysis included the creation of a model that paved the experiences held by participants during the intervention (See Appendix E).

Implications and Risk

Within this study there were ethical implications and participant risks that needed to be addressed. Some of these implications were within the realm of confidentiality. Confidentiality is an important aspect of research to look at when addressing serious issues such as IPV. Confidentiality and an informed consent are necessary to conduct a safe and ethically-based research study. In dealing with high risk couple clients who both participate in the consent of services, many ethical issues can arise. Also, there is a level of emotional distress that comes from working through issues around safety and abuse. Clinicians must be aware of the participant's view of safety in order to effectively deliver treatment.

For this study, the risks to participants were minimal in the discussion of their perceptions of the intervention. The brief-IPV intervention was approved by the IRB and the researchers were given permission to conduct all sections of the intervention and data collection. To minimize risk, participants were interviewed independently of one another and by someone other than the therapist who administered the intervention.

CHAPTER IV

RESULTS

A key theme that developed in the analysis of the participant's interviews was *awareness,* defined as an increase in knowledge about their relationship in connection to the violence presented. Through continued analysis it became clear that both the *therapists* and the *intervention components* helped to create awareness for the participants. These were the major subthemes of the final model. Additional subthemes included the *client context* and *safety*. Most of the participants discussed the concept of *honesty* and its necessity in all relationships looking to change and improve. When the participants felt safe they were more *open and honest* about their experiences. The therapists played an important role in the experiences of these participants. Subthemes of the therapist were the *role* and *personality* of the therapist, and these were mentioned by many as increasing their safety during the intervention. Subthemes related to the intervention components included *tools and techniques* and *barriers.* These influenced the amount of awareness gained by the participants. The barriers discussed by participants seemed to interfere with the incompletion of the intervention by one couple and the termination of therapeutic services by several other couples. The intervention components interacted with the therapists' attributes in generating both safety and awareness. The components of awareness that emerged from the analysis included *communication cues,* violent *interactions* with their partner, and how to *create change* in the future. The categories are presented in an interactive form where one category influences the following category. All of these categories and subcategories are presented in a process model. These will be discussed and quotes from the participants will be given that illustrate these subcategories. This model (See Appendix E) shows the interactive pattern and relationships between the categories that represent the experience that the participants had during the intervention.

Client Context

The participants presented similar experiences in terms of the experience of the intervention, but attributed those experiences to a variety of different intervention components. Each participant began the intervention in roughly the same way with little to no current or ongoing therapeutic relationships with other therapists at the clinic or additional therapy setting. Also, the intervention was administered in nearly the same way and each participant received the same intervention tools. However, some participants achieved a greater understanding of their situation regarding violence and experience of the intervention than others. It was important to be conscious of each participant's context when analyzing the data due to the vast array of life experiences each brought to this study.

Intervention Therapist

As the participants began the intervention, procedures they were introduced to and influenced by the therapists conducting the intervention and the variety of the intervention components. Each component interacted with other components to help participants see and understand the violence within their relationship. The therapists conducting the intervention interacted with those components and with the participants themselves which added to the awareness obtained. The *role* and *personality* of the therapists were listed as major subthemes contributing to the experiences of the participants.

Therapist Role

The role of the therapist is influential based on the perception a participant had of what purpose a therapist serves to a client within a therapeutic setting. Within this study, participants noted three distinct categories related to the role of the therapist. These included being *safe* to talk to, being *aware* of what was occurring in session, and they created a *therapeutic environment*. One client noted: "It was somebody to talk with you that was safe." Another said: "It is just who they are and knowing that is what they are

here for." The feeling of safety came also from a sense of equality. One participant stated: "I liked that there were both male and female counselors because it felt like nobody was on anyone's side." Another participant noted the tracking done by a therapist by giving this example: "[The therapist] noticed and pointed out an issue by checking in on the participants' thoughts and feelings at a single moment during the session." The therapists were aware and acted in specific, high-intensity situations to help participants better communicate. This was noted by one male participant: "To have someone trying to direct the conversation and provide the environment in which good communication can happen was helpful." Another noted: "I think it is just the virtue of having another person there kind of mediating."

Another aspect found in conjunction with the role of the therapist was the therapeutic environment created by the therapists. This environment was vital to the successfulness of the intervention by allowing participants to feel safe enough to express their thoughts within session. This was stated by one who said: "It has given us a safe environment where we can actually talk." Another said: "I felt like it provided a safe atmosphere to discuss some things that would normally get us into an argument." A third pointed out: "The environment is conducive to actually coming to some solution." This environment allowed for participants to feel safe in an unpleasant and vulnerable situation.

Therapist Personality

For the role to be accurately portrayed, a therapist also needed the personality traits to back up the role. These traits are attributes of the therapist that are not forced but are natural and are seen by participants as a part of who that therapist is as a person and not just as part of their job requirements. Participants noted several different personality traits presented by the therapists that added to their feelings of safety and increased their willingness to participate in the intervention. These included categories of *openness*, *honesty*, and being a good *listener*. Participants noted various traits through comments such as, "Both of the counselors were very personable, encouraging, and thankful for our

participation," and "their attitude; they were very unassuming and very accepting." Another common thought among participants was the authenticity and openness shown by the therapists. One participant stated, "They were just them. There was no faux to anything, it was just that they were out there." A second noted how a therapist's honest feelings increased her experience, "She, [the therapist], told him "I was moved by what you just said," and that was deep." Another noted the usefulness and appreciation for the honest self-disclosure by the therapists by saying: "I like how, without being inappropriate, [the therapists] have kind of lended themselves to us by saying they are not afraid to say I can relate to you in this way; it makes them seem more human."

Another personality trait noted by many was the skill of active listening. One participant noted this positive trait and said, "He [the therapist] would patiently sit with me and listen to what I had to say." Another discussed the patience that her therapist had with her and how that was helpful in making her feel comfortable and safe. The therapists were responsible for the safety felt by each of the participants during the intervention. This ultimately led to the disclosure of information, and the awareness of negative communication and violent interactions that inhibit positive relational change.

Safety

As noted previously the therapists conducting the intervention and the client's perception, of both the therapist and the concept of safety, all contributed to the safety felt by the participants throughout the intervention. Safety is noted as the idea that a participant can speak freely within session without fear of retribution or negative blowback. This idea of safety was seen through the *comfort* shown by participants to communicate in session and the *openness* that was felt in the therapy room during the session. One participant noted how she was able to achieve a level of comfort within the intervention sessions and with her therapists. She said, "It made it a lot more comfortable because we got to know them; it gave us time to get to know them. I am not a very trusting person and so, it gave me time to read them and watch how they interact with each other." Another noted, "They made me feel really comfortable about opening up."

The intervention not only helped the participants to feel comfortable within the intervention session, but also with their individual therapist and moving back into their regular therapy sessions. A female participant noted, "I definitely think these past couple of weeks have helped me to feel more comfortable with [my therapist]." It was also noted by one individual that "It is very likely [the participant] will be uncomfortable at times," which makes that safety factor even more important.

Along with the feeling of comfort and safety, participants also discussed their beliefs about *honesty* and how it played a role in their experiences of the intervention. A majority of the participants who discussed honesty did so in terms of honesty being the key to change. One noted, "Therapy is only as good as the effort you put in. If you do not talk, then nothing is going to happen." Another stated, "You are only able to get better when you face the truth." They believed that without full honesty, change would not be possible. One noted, "If you are not honest with each other you are never going to be able to uproot and dig out those issues you have that so deeply affect both of you in your relationship." If participants are unwilling or unable to be honest within the intervention, their chances for change, based on their perceptions, will diminish.

The role of the therapist and the environment, the personality of the therapist, and the safety created by the therapist all played a role in the awareness developed from this intervention experience. In addition, it was believed by the researcher that the concept of honesty, which was so pronounced in many of the participants' ideals, also contributed to the sense of safety experienced by the participants.

Intervention Components

There were specific components of the intervention that participants mentioned that emerged as relevant to their experience. The main categories that emerged were a) *tools and techniques*, and b) *barriers*. The tools included specific actions that could be done by the participants and assessment documents used by the therapists, while the techniques were therapeutic skills utilized by the therapists to deliver specific concepts or understandings to participants, and overall therapy techniques. Because the tools and

techniques were delivered to the participant by the therapist there was a constant interaction between the intervention and therapist that combined to influence the overall key theme of awareness.

Tools and Techniques

The intervention included a multitude of therapeutic tools and techniques which were ultimately responsible for the awareness developed by the participants. The influential tools included the negotiated time-out and the safety plan, while the techniques included conjoint therapy and modeling, multiple therapist perspectives, and continuity of care.

Tools. The intervention included three different tools to be used with the participating clients to help discontinue or limit the amount of violence occurring in the relationship. Of the three tools utilized the negotiated time-out and the safety plan were seen as positive influences in helping participants become more aware of their relationship and communication. One participant noted, "We came up with some kind of sign for when the argument gets heated and some kind of word, for us it was a symbol, which basically just means time-out." Another participant said, "We were given a code word, so when one of us feels that [the argument] is not going in a good direction we can use that code word to take a time-out." The negotiated time-out tool was noted by almost every participant as being an influential aspect of the intervention. It helped participants become more aware of boiling points for both themselves and their partners. One participant said, "To learn that when we get to a certain point and we know that, If I don’t stop at this point there is not going back." The safety plan, which was used by therapists to help participants understand the cycle of violence and how to recognize times when violence is out of control, was less recognized by participants as being helpful, but for some it was a great for helping them become more aware of what happens violently within their relationship. One female participant stated, "When they asked how I felt [about the violence] before it happened and what I felt during it; it was things I had never thought about before." These tools are necessary and utilized by participants during and

after the intervention sessions are complete. One participant noted, "We went home after the first session and started using it right away; it helped."

Techniques. The tools used in this intervention were noteworthy but did not stand alone. The use of various techniques also influenced the awareness gained by participants. The intervention utilized the technique of *conjoint couples' therapy*, or having the partners meet together, to discuss therapeutic topics with violent couples. This form of therapy helped clients gain a better understanding of their partner. One participant said, "Paying attention to what your partner has to say and paying attention to the signs your partner is giving you is helpful." Another noted, "Just being able to get everything out there with both of you together." Another reported, "When [my partner and I] were together it seemed like I was able to speak more freely." This was information and experiences they would not have been able to have in a gender specific therapy group.

This intervention also utilized the technique of *modeling*. This is a technique used by the therapist to show clients how to properly communicate with one another. This was noted by one participant, "Some of the different scenarios they discussed and how to talk through those in different ways." Another participant stated, "[The therapists] would talk to each other [in more positive ways] and that made it a little bit easier to calm things down." One participant said, "It is nice to see a different structure. It was like throughout the years we had handled things this way and [my husband] had never seen it handled any other way, but [with the therapists] he could see it differently." This noted that as a couple he and his partners' ability to see anything different or do anything different was lacking and the therapist showing them helped them better understand and utilize that skill. An additional sign of success from this technique was stated best by one participant who said, "It kind of helps you to stop before it gets to the extreme it has gotten to in the past."

A third technique was having *multiple therapists* administer the curriculum. This occurred by having two trained therapist administer the intervention together to the couple while a third, non-trained therapist that would take over the couple's case after the

intervention was complete, sat and simply observed. One participant noted, "I really liked having the three therapists; I liked having the three different lifestyles which makes a difference because I am from one background, they are from another background, and my husband is from a different background." This discussed the positive aspects of having multiple therapists involved in treatment. Other participants addressed this issue as well, making statements such as, "It helps out because we had three counselors in there and they all put their opinions in and that was helpful.", and "They all had different views, different ways of looking at things, and they worked well together."

Along with the multiple perspectives being helpful, participants also noted the positive aspect of having their original therapist present for the intervention in its entirety. This was viewed as *continuity of care*. One participant said, "I thought [having my regular therapist present] was good because she got kind of an idea about what she has got to deal with.", while another noted, "She is well aware of a lot of our history and even our personalities; she has gotten to see a lot of that." Having the original therapist observe the interactions during the intervention increases the participant's knowledge about how to create change later on in therapy. This was noted in regards to having the original therapist present by one statement, "It would positively influence [our relationship] because our therapist actually sat in on the sessions with us and said she had new ground on what to work on with us."

Barriers

Although the intervention possessed many awareness producing factors, not all participants gained the awareness found by some. These differences in awareness disclosed by participants can be attributed to certain barriers noted by participants. The barriers discussed included the *flow* of the sessions, the intervention *curriculum*, and *participant perspectives* of violence. The barriers could have contributed to a lack of awareness by a participant or to the discontinuation of therapeutic services by one or both of the relational partners. An additional note should be made about the nature of the

intervention itself being a barrier. This is a required intervention which forces the discussion of topics not always desired by clients.

The first barrier noted was the overall *flow* of the intervention, meaning the way in which the intervention was administered. For the flow of the intervention, participants noted problems with the lack of training given to the therapists and the organization of the intervention procedures. One participant said, "If it could have been a little clearer to the clients that would be better for everyone involved." One female participant noted, "It felt a little rehearsed because she was just reading off a piece of paper." Another stated: "I could tell it was new to both of them." Participants also were distracted with the lack of organization presented throughout the intervention. One male participant said, "[The therapists] could not figure out what room to go to and kept leaving to try and figure out what they were supposed to do next." Another stated, "It just seemed really unorganized and made it difficult to want to participate." Many participants felt cheated out of adequate service, as suggested by the following: "It was really disorganized and I really felt like I wanted to come in and work on my relationship, not come in and work on the organization of the session."

Along with the flow of the intervention, the *curriculum* also was seen as a barrier to awareness. The curriculum required specific tools to be administered to participants during the intervention as well as specific topics to be discussed. The no violence contract was a specific tool that was found to be unhelpful. This contract was perceived as a restraint to defending oneself as opposed to being a tool for the prevention of further violence while seeking treatment. This was noted by one female participant, "The contract kind of prevents you from [defending yourself] and I think that is not right. It takes that away from you." Additionally, the extreme focus and rigidity of the curriculum was difficult for some clients. One participant noted, "The curriculum was very rigid, and yet the training given to the therapists were not sufficient enough for the rigidity presented by the therapists." This rigidity, or lack of give-and-take between the intervention curriculum and client needs, caused negative feelings in participants and the feeling that they were being forced into a discussion they were not prepared for. A male

participant stated, "I wanted to move forward from it. I didn't want to talk about it," while a female participant also said, "We don't want to bring up the past." Other participants made similar statements which included, "We don't want to bring it up now just because it makes the other person feel bad or feel guilty," and "I wanted to move forward with it; I wanted to get past it and just do our regular therapy."

A final barrier that can be looked at to determine why a participant may not have receive the same amount of awareness as another is the *participant's perspective* of their own relational violence. One participant noted this idea by stating, "I don't know if they actually thought this through, but I felt as if there were this assumption that there is a lot of conflict, but there is not." This showed how one participant was making a case for how they did not need to be addressing these violent issues because of the lack of violence within their own relationship. Another noted, "I think maybe our case isn't as severe as what they are expecting people to be."

These barriers were not attributed to a lack of awareness by the participants because everyone gained some form of awareness, but they were connected to a decrease in awareness gained and the discontinuation of services. It was observed by the researcher that these intervention components produced a barrier against gaining awareness. This potentially occurred due to a decrease in focus on the intervention tools and techniques and an increase in focus on the lack of training and organization produced by the therapists leading the sessions. A small portion of the participants who discussed these negative barriers dropped out of therapy either during the intervention or directly after the intervention. The barriers affected some participants much more than others and it is hypothesized that if participants were able to fight against or ignore those barriers that their awareness was increased more than those participants who struggled to keep their focus on the intervention topics.

Awareness

Each of the above parts of the model of experience contributed to the overall theme of *awareness* that emerged. Both the tools and techniques utilized within the

intervention, along with the therapists' role and personality that developed the safety combined to develop the awareness that was received through the intervention. Through the couple's participation in the intervention, three areas of awareness were found; communication cues, violent interaction process, and how to create relational change.

Communication Cues

In looking at the way in which these couples communicate with one another it can easily be seen that there are problems. In order to fix problems a person must first see and understand that a problem exists. This intervention allowed partners to become aware of the *triggers* and *boiling points* that cause violence to occur. One noted, "Identifying what things were precursors leading up to it so that it could be used preventatively." Another said, "It gave me an idea about what to look for with her so we don't have to go to battle all the time." A third participant stated, "It helped to become more aware of "Oh wait if I don't stop now this will happen." Or "If I stop now maybe we can talk later." The triggers provide awareness to participants about how they escalate their communication.

Becoming aware of violent triggers is extremely important. What is also important is having an understanding of, and being able to recognize theirs and their partner's boiling points or "points of no return" as mentioned by one participant. One partner noted, "I know Okay when I get to this point this is where I need to stop because if I don't it's going to lead to this and then at the end it's just dangerous." Another female partner noted, "I now know that I push him to that point sometimes and I don't get physical with him, but he knows that pushing me to a certain point just completely ticks me off and I want nothing to do with him." As participants became more aware of their triggers and boiling points they also become more understanding of each person's role within those violent interactions.

Violent Interaction Process

Through this intervention participants became more aware of their own thoughts and actions, as well as the actions and perceptions of their partner. They also become

aware of the pattern of interaction that leads to violent conflicts. One female participant stated this well by saying:

> "There were a lot of things he said that I did not realize and I hope there were things I said that he didn't realize. You don't realize what the other is thinking. You don't know how they feel. And like he said he was really hurt when he would see me cry from doing it and I didn't realize that he was actually hurt I just thought all of the apologies were excuses that he would never follow through with, but he was sincere."

Understanding themselves and their own thoughts, and their reactions to their partners was seen by several participants. One stated, "I now know when I get to that point that I cannot talk anymore." A male participant said, "I first came here thinking that I had a problem with my relationship and then about when I started talking to [the therapist] it was more or less opening up that there were other things that were wrong which pushed me with how I deal with things mentally." This helped him to change his perception about what was going on in his relationship. This intervention also helped participants gain a better understanding of their partner and change their perceptions. One participant noted a change in perception when discussing her partner's feelings. She stated, "Though I am feeling pain in the relationship, I know that he is feeling it too." Another female participant stated, "I've learned a little more about myself." She also said, "We expect the other to read our mind and if you really step back and think about it that is just not possible." Participants came to better understand how their actions influence their partner and vice versa. They also better understood what their communication pattern looks like when escalation is about to occur. This was noted by one participant who said, "It helped us get to a point where we know we can't continue doing this."

Many participants were asked questions they had never thought about before which added to the increased awareness. One participant noted on two different occasions, "It made me think about things I had never thought about." Another noted, "I guess the questions make you really think about [your relationship]." When participants

think about their relationship they are not only thinking about the role they play but also the role of their partner.

Creating Change

The final area of awareness that was developed through this intervention was the idea and path for creating changes both individually and conjointly. This change can be seen through the *goals* developed and the *head start* given when resuming normal therapy. Participants gained an understanding of future goals that would help them change their pattern of violent interaction. One participant said, "We developed goals, both individual and relational, for our relationship. This triggered some discussion around current issues in the relationship that we hadn't dealt with yet." Another said, "I definitely think talking about goals was helpful."

Another area was the head start, or plan of action, given to participants. Participants gained awareness about how to change their interactions through the development of treatment-like plans for participation in therapy after the completion of the intervention. One participant noted, "Instead of spending weeks or months trying to uncover or isolate what is causing the problems, we will be starting off our sessions with [our therapist] already knowing what is really going on." Another realized, "I know we are nowhere near cured, but at least we've got something to work on." A third participant noted, "It laid the foundation work. It gave us some techniques to get us by and through some tough times until maybe we can get more in depth into it."

Being prepared for therapy after the intervention is over is important for the continuation of the positive changes that occurred during the intervention. For some participants, small changes occurred both during and after the intervention, through the use of the newly witnessed tools and techniques. Some of the small changes developed around the safety felt within the relationship and the escalation of violent communication. One participant discussed her increase in safety with this statement, "I was feeling distant and trying to push away from him and now we can talk and I feel closer to him." The intervention not only brought participants closer together in their communication, but it

also increased the safety some participants felt, allowing them to disclose non-socially-acceptable feelings. One participant stated, "I have always felt really ashamed of myself when I did those things."

More changes were seen in participants around the escalation of their violent communication. One participant noted, "It stopped things before they intensified quite a bit," and another noted, "Our fighting does not escalate really badly anymore. We are able to actually talk, but it is not getting out-of-hand anymore." A third participant described how he and his partner still argue about a lot of issues, but now "know where to stop." These changes that have begun as a result of the intervention provide an additional sense of awareness for the participants as to how their relationship can look when changes occur and the benefits that result from those changes. As participants became more aware of their conflictual interactions with their partner they were more able to accept and utilize other techniques given and could develop a plan for the continuation of the changes they are currently working toward.

CHAPTER V
DISCUSSION

This constructivist grounded theory analysis examined the experiences of couples who participated in an IPV intervention. A model was developed which provided researchers and clinicians a path of the experiences had by participants. This model can be used to help professionals understand the impact that IPV interventions can have on a clinical population. The model addresses various components of the intervention and how each is related to the others. It also supports the idea that conjoint couple violence-focused interventions are helpful in working with situationally violent couples.

Participants were overall positive about their experiences with the IPV intervention. They felt safe and found various tools and techniques of the intervention useful. These findings are consistent with the small body of IPV conjoint outcome literature (Stith & McCollum, 2009). The safety felt by the clients was attributed to the therapist role and personality, and the therapeutic environment in which the intervention was delivered. One study's findings, conducted by Beck, Friedlander, and Escudero (2006), support this connection between the therapist and the sense of safety felt by the client. This study found complex relationships between a family member's personal relationship with the therapist and a sense of safety during therapy. Additionally, the participants of the current study included discussions about honesty and its impact on the process of the relationship and the intervention. It was believed by many that honesty was directly related to a couple's ability to make positive changes to their relationship. Research has shown that "safety may be compromised by a lack of honesty" (Knutton & Pover, 2004). This then became a focal point and it is believed to be connected with the safety the participants felt and their ability to be honest with the therapist and their partner.

In combination with the sense of safety felt by participants, created by honesty and the therapist role and personality, the tools and techniques of the intervention were influential in helping participants develop a better awareness of their issues around violence. It may be that the safety felt by the participants decreased their fears and

anxieties which allowed for the tools and techniques to be better understood and utilized. These intervention components increased participants' awareness, an outcome consistent in other studies looking at the impact of IPV interventions on participants (Schwartz, Magee, Griffin, & Dupuis, 2004; Hamilton, 2000; Schwartz, Griffin, Russell, & Frontaura-Duck, 2006). Although participants described the tools and techniques as major factors in the development of their awareness, some participants struggled with and disliked the tools and techniques that positively influenced others.

The struggles and negative components experienced by participants acted in some ways as barriers to awareness. Barriers have been identified in a multitude of intervention studies and have been attributed to an inability to or a lack of screening, disclosure, and awareness (Elliott, Nerney, Jones, & Friedman, 2002; Schwartz et al., 2010; Kulkarni, Lewis, & Rhodes, 2011). The participants who focused on the barriers of the intervention over the benefits still achieved some level of awareness; however, because of their intensified focus on the barriers the participants may have missed specific intervention techniques or ideas which reduced the awareness gained. The impact of the barriers on the awareness gained by participants also may be attributed to the population of participants. There were inconsistent impacts found between the participants, an example of this being the implemented safety planning tool and the usefulness found by one female partner, but a feeling of non-necessity expressed by the male partner. Each participant came from their own background with their own set of ideals making it more reasonable that impacts would differ. It has been shown that inconsistent impacts found in IPV interventions provide a possible explanation for the difficulties encountered in achieving lasting change (Spangaro et al., 2011). Regardless of the inconsistencies among the impact of the intervention, each participant was still able to achieve some level of awareness.

It has been shown that the victims of IPV need help understanding their current relational violence because of the vast array of negative physical and emotional consequences (Whiting, Oka, & Fife, 2012). This intervention allowed for awareness and understanding to develop for these participants, which then made it possible for them to

reduce or combat those negative consequences. The awareness that developed during participation in the intervention was categorized into three major categories. These categories developed around communication, the violent interaction process, and how to create change among those patterns. Participants disclosed that they could better understand their own and their partner's aggression triggers and communication patterns. This then allowed the couple to reduce or prevent the escalation of violence. They also discussed the development of a plan of action for the continuation of therapy following the intervention. These plans acted as a head start for the study participants by allowing participants to become comfortable with their original therapist and to have their violent communication under control. Similar plans created during interventions have been attributed to decreasing recidivism rates during the therapeutic relationship (Todhal et al. 2012).

Last, the intervention has shown a positive connection between conjoint couples' treatment and IPV interventions. Many clinicians and researchers have long believed that systemic interventions for couples experiencing violence were unsafe, however that has been disproven when working with couples presenting with bidirectional, non-controlling violence (Stith et al., 2012; Todhal et al., 2012). The results of this study were consistent with those findings and gave evidence that couples experiencing IPV can develop successful awareness and begin making changes while participating in conjoint therapy. This study increased awareness for the participating clients while also creating implications for clinicians and researchers working with this specific population.

Clinical and Training Implications

It has been asserted that couples therapy grounded in concerns for safety should be a credible treatment option when IPV is the presenting problem (Goldner, 1998). It has also been argued, as mentioned previously, that conjoint couples' treatment possess multiple risks to the victim partner and he or she should not be participating in conjoint therapy with the perpetrator (Stith & McCollum, 2009). Although it is likely true that this form of therapy is safe and useful for couples experiencing IPV, it is still important to

recognize that violence-focused conjoint couples' treatment models are different than standard couples' therapy and the safety of participants needs to be monitored closely (Stith & McCollum, 2009). Safety must be the primary consideration with any intervention for IPV, which makes this study no different (Stith et al., 2012). This study presented valuable information about the mechanism safety plays in working with situationally violent couples.

Despite the evidence presented which validates the effectiveness of conjoint couples' therapy, there is growing evidence that supports the notion that effective conjoint treatment for IPV needs to be administered by clinicians who are knowledgeable of IPV (Todahl et al., 2012). Research findings have shown that clinicians can help couples recognize their actions which contribute to their aggression (Whiting et al., 2012a), however, if therapists are not knowledgeable of the interactions produced by aggressive couples they may not be successful in delivering a safe and effective intervention. As new treatments and interventions are developed it becomes vital that clinicians are competently trained to assess for and recognize interpersonal violence and implement evidence-based interventions. When clinicians are inadequately trained to deliver interventions, especially when working with violent couples conjointly, there are safety and ethical risks that may occur to the therapist as well as consequences for the clients (Stith et al., 2006). In the case of this intervention, the lack of training and preparation created a barrier which prevented some participants from obtaining an increase in awareness.

The therapists conducting the intervention study struggled to present the material accurately because of a lack of training and practice. They reduced the awareness gained by some clients, but increased the awareness felt by others. A sense of safety was created by the therapists which led to the openness and achievement of awareness. An additional training piece that can be improved from this study is joining, building report, and building the therapeutic alliance. As new clinicians learn to build appropriate and lasting therapeutic relationships with their clients, they gain the ability to be seen as someone safe and trustworthy.

A third and final implication is the number of therapists presenting the intervention materials. Much of the awareness gained by participants came through the interaction between multiple therapists (i.e., modeling, multiple perspectives, disclosure, safety, etc.). However, not all clinical settings have access to multiple therapists. The model of participant experiences will change with a reduction in the number of therapists presenting the material. Also the curriculum is written to be implemented using multiple therapist so that would need to be adjusted as well. As each piece of the intervention changes the curriculum, implementation, and model experience will also change.

Research Implications

Along with clinical and training implications, this study has several implications for future research. First, the sample size and population utilized for this study were small and concise, which created inquiry into who is best served by violence-focused conjoint treatment. The impact of this intervention varied for participants and yet they came from similar backgrounds in regards to socioeconomic status, race, and class. This reinforces the idea that inclusion and exclusion criteria for conjoint IPV interventions are not well understood or developed (Todahl et al., 2012). There are varying views on who is most suitable for IPV conjoint couples' treatment. While some researchers believe that gender-specific treatment needs to occur before couples work can begin (Hamel, 2009; Babcock & LaTaillade, 2000) and that conjoint services may not be suitable for "characterological" violence (Stith & McCollum, 2009), others, such as Bograd and Mederos (1999), argue that conjoint couples' treatment may be acceptable if the violence is bidirectional and non-controlling. The criteria for including or excluding participants from the study could be changed to look at how awareness or changes occur with varying populations of violent couples.

Awareness may also have been affected by the therapeutic constellation of the intervention. Clients completed the majority of the intervention as a couple, but were interviewed separately. If they had participated in the intervention and been interviewed as a couple, or if they participated and interviewed as individuals the experiences may

have looked different. There were concerns about safety and the truthfulness of disclosure which is why the interviews were conducted individually; however, the couple dynamic together may have given a greater amount of insight into how the intervention affected the couple as a whole.

It has been shown that there are differences in perceptions when participants enter relationships with different histories (Whiting et al., 2012a). Researchers could compare the differences between a participant's background and their perceptions to see how a client's history impacts their perception of a specific IPV intervention. Also, because of the extensive similarities between the study participants, researchers may consider predictor variables such as demographics, relationship factors, and contextual issues.

Many concerns about conjoint couples' therapy surround the topic of safety and increasing the need to understand the pertinent elements of safety to accurately assign clients to a specified treatment model (Todahl et al., 2012). In conjunction with the concept of safety in assigning a therapeutic setting, safety must also be addressed around the accuracy of participant disclosure. Many aggressive or conflictual couples request conjoint therapy and are unwilling to participate if individual, gender-neutral classes are the only option (Jory, 2004). A partner must feel safe in order to speak openly about ongoing physical violence (Todahl & Walters, 2010) and if they are only willing to participate in conjoint therapy the need for safety is imminent. Without a sense of safety in the therapy room, a participant may not fully or honestly disclose his or her emotions and needs during the therapy session. To the extent that this does occur it is difficult to know if participants are accurately reporting change and awareness. This is a common criticism of IPV research making it an important question in research looking at this population (Todahl et al., 2012). An additional area to be considered in addressing this topic further is the researcher and participant's perceptions of safety.

When developing a constructivist grounded theory model, it is important to remember that the research is an interactive process which is co-constructed and influenced by the assumptions of the researchers involved (Whiting et al., 2012). When ideas are co-created by a participant and a therapist, their perspectives and perceptions

influence how the ideas are defined. It may be beneficial to complete the study using a different or additional researcher, or to have the researcher participate in transcription auditing. These techniques will address any potential researcher bias that might have skewed the data. Additionally, the overall context of the research can influence the responses of the participants. Although some participants may have recognized the influential techniques, others may not have noticed due to other aspects that had a larger influence on their perceptions and responses.

Cautions and Limitations

Despite the encouraging findings and potential for further research to be completed from this project there are several limitations that must be addressed. First is the sampling bias. The researcher cannot be certain of the extent to which the study participants represent the average population. They can also not be certain of the extent to which study participants represent other IPV intervention participants (Todahl et al., 2012). In accordance with this, it is important to understand the homogeneous nature of the participants. The majority of all participants identified themselves as Caucasian, heterosexual, and earning low to middle income. The study may be missing some crucial information on other ethnic and cultural groups that also experience interpersonal violence.

A second limitation surrounds the method of data collection. For the collection of the participant experiences, the researcher utilized an interview which gives information based only on what the participant chose to disclose. The results were based on self-report alone and were not verified using any other data collection strategy. However, it has been shown that changing the data collection mechanism may influence the types of experiences (Spangaro et al., 2011). When reports are made from self-report only, without an additional assessment or interview to validate the statements, it becomes more difficult to ensure the accuracy of the results because the truth of both the experience of the intervention and the feelings of safety are unknown. Just as the participants

disclosure of change about their partner cannot be verified, the experience of the intervention components are also unverifiable.

A third is the co-constructed meanings that were developed through the interactions between the participant and the researcher. The researchers of this study was also a therapist working in conjunction with the therapists presenting the intervention material. The bias nature of the researcher being in close connection to the therapists had an impact on the positive attributes of the therapists as presented by the participants. It is important to recognize the unavoidable influence of the researcher on the process of model development and that the choices made by the researcher during the interview and the study components influenced and shaped the resulting model (Whiting et al., 2012a). The researcher influences the final model of experience, but the overall concept comes from the co-creation, developed by the interaction between the participants and the researchers. These meanings are socially constructed and influenced by society's view of violence interventions and conflictual interpersonal relationships.

The fourth and final limitation of this study is the training and experience of the therapists delivering the intervention. Many participants discussed negative thoughts about the training given to the therapists. The therapists were working at the collegiate campus clinic as part of their training to become licensed therapists. However, because of their lack of adequate training on both the intervention and the topic of intimate partner violence, these therapists may have limited the experiences for participants. If therapists were picked specifically for this intervention and were given adequate training on IPV couples, safety in these relationship, and were given weekly or bi-weekly supervision, outcomes may have changed slightly.

The awareness gained by clients developed from the interaction between safety, the therapists' roles and personalities, and the tools and techniques utilized in the intervention. This awareness is applicable and influential to both conflictual couples and IPV therapists. Each can use the understandings gained about conflictual communication and interactions to further their progression from violent escalation to calm and controlled conversations. The participants interviewed in this study provided valuable

insights into their experiences and awareness. These insights will contribute greatly to clinicians and researchers as the topic of safety continues to be at the forefront of conjoint couples' treatment for IPV.

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APPENDIX A

SEMI-STRUCTURED INTERVIEW QUESTIONS

1. You and your partner recently participated in two therapy sessions focused on relationship violence. Please tell us about your experience of the sessions.
   a. What aspects of the sessions were helpful?
   b. What aspects of the sessions were unhelpful?

2. How do you think participation in the sessions has influenced your relationship?

3. How do you think participation in the sessions will influence your experience in therapy?

4. What advice can you offer about how to change the sessions so they would be the most helpful to future clients?

5. Can you describe your thoughts on the safety that you felt during the intervention? Did the therapists do anything that made you feel more or less safe? Did you feel as if you could say what you wanted to without fear?

6. Sometimes when we are hurt or abused in a relationship, it is easier to "forget" the incident or deny its occurrence. Our partner may also insist that we keep the abuse "secret" or attempt to convince us that we were not abused.

7. Or, sometimes when we hurt others in a relationship, we may try to deny our part in it or even deny that our behavior is abusive. We may also try to force our partners to deny the abuse or convince them that our behavior isn't abusive at all.

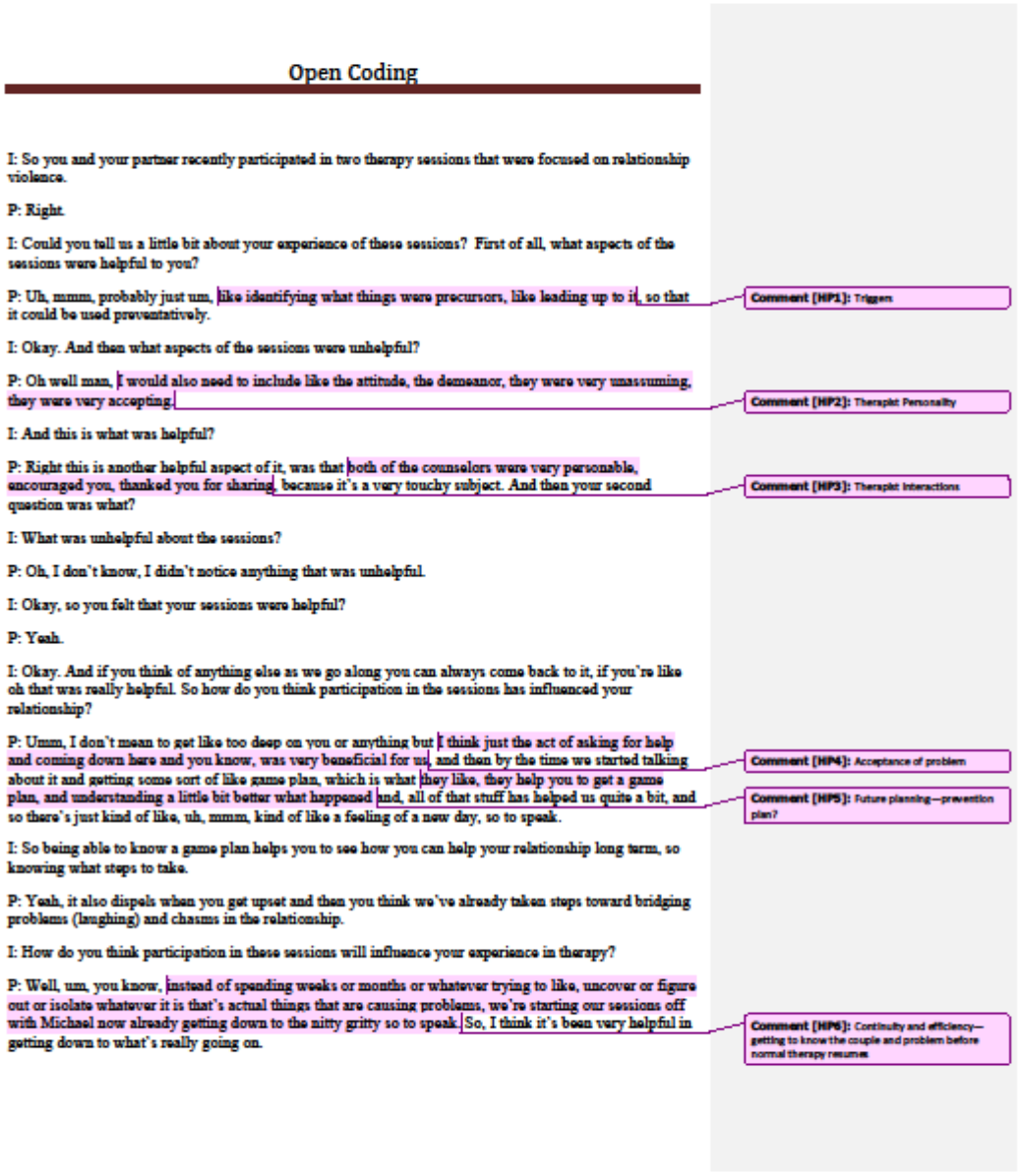
   a. Can you describe times when you may have denied to yourself that behavior was abusive even though you know it was hurtful? Did you ever feel two ways about the abuse? On one hand you knew it was wrong, but on the other hand you thought it really wasn't that bad or even maybe deserved.

8. Sometimes when we are violent or abusive towards our partner, we may try to make our own behavior seem better than it really was and make our partner's behavior seem worse to excuse our behavior. We may also tend to minimize the severity of the incident to ourselves and to our partner.

   a. Can you think of examples when you may have tried to make yourself sound more innocent than you really were?

APPENDIX B

OPEN CODING



Open Coding

I: So you and your partner recently participated in two therapy sessions that were focused on relationship violence.

P: Right.

I: Could you tell us a little bit about your experience of these sessions? First of all, what aspects of the sessions were helpful to you?

P: Uh, mmm, probably just um, like identifying what things were precursors, like leading up to it, so that it could be used preventatively.

Comment [HP1]: Triggers

I: Okay. And then what aspects of the sessions were unhelpful?

P: Oh well man, I would also need to include like the attitude, the demeanor, they were very unassuming, they were very accepting.

Comment [HP2]: Therapist Personality

I: And this is what was helpful?

P: Right this is another helpful aspect of it, was that both of the counselors were very personable, encouraged you, thanked you for sharing, because it's a very touchy subject. And then your second question was what?

Comment [HP3]: Therapist Interactions

I: What was unhelpful about the sessions?

P: Oh, I don't know, I didn't notice anything that was unhelpful.

I: Okay, so you felt that your sessions were helpful?

P: Yeah.

I: Okay. And if you think of anything else as we go along you can always come back to it, if you're like oh that was really helpful. So how do you think participation in the sessions has influenced your relationship?

P: Umm, I don't mean to get like too deep on you or anything but I think just the act of asking for help and coming down here and you know, was very beneficial for us, and then by the time we started talking about it and getting some sort of like game plan, which is what they like, they help you to get a game plan, and understanding a little bit better what happened and, all of that stuff has helped us quite a bit, and so there's just kind of like, uh, mmm, kind of like a feeling of a new day, so to speak.

Comment [HP4]: Acceptance of problem

Comment [HP5]: Future planning—prevention plan?

I: So being able to know a game plan helps you to see how you can help your relationship long term, so knowing what steps to take.

P: Yeah, it also dispels when you get upset and then you think we've already taken steps toward bridging problems (laughing) and chasms in the relationship.

I: How do you think participation in these sessions will influence your experience in therapy?

P: Well, um, you know, instead of spending weeks or months or whatever trying to like, uncover or figure out or isolate whatever it is that's actual things that are causing problems, we're starting our sessions off with Michael now already getting down to the nitty gritty so to speak. So, I think it's been very helpful in getting down to what's really going on.

Comment [HP6]: Continuity and efficiency—getting to know the couple and problem before normal therapy resumes

APPENDIX C

AXIAL CODING

Axial Coding

Prevention
Triggers (T)
Prevention (P)
Plan of Action (PA)
Addressing Abuse (AA)
Goals (G)

Tools
Negotiated Time-Out (NTO)
Removing Self (RS)
Conjoint Couple Therapy (CCT)
Individual vs. Couple Sessions (IC)
Violence Contract (VC)
Modeling (Mo)
Safety Plan (SFP)

Therapist
Therapy Environment (TE)
Therapist Personality (tp)
New Therapist (NT)
Patience (p)
Therapist Role (TR)

Understanding
Acceptance (A)
Understanding (U)
Behavior/Reaction (BR)
Acknowledge (AK)
Practice (pr)
Perspective (sp)
Awareness (AW)

Safety
Feeling Safe (FS)
Comfortable (Co)
Honesty (H)

Feelings
Remorse (Re)
Optimistic about Change (OC)
Nervousness (N)
Motivation for Change (M)
Fear (fe)
Willingness (W)

Negatives
Session Flow (Fl)
Training Needed (TN)
Previous Therapy (PRE)
Rushing Process (R)
Initial Assessments (IA)
Prevented Communication (PC)
Lengthen Sessions (L)
Redundancy (RY)

Communication
Communication (C)
Partner Talking about Partner (PTP)
Enhanced Relationship (ER)

APPENDIX D

MEMO EXAMPLE

May 09, 2013

Memo-Case #7767.3 (Male Client)

This interview was the first to be completed and was done so by another co-worker. The man was very appreciative and positive about the intervention. He understood his own role in the relationship violence and enjoyed both what he learned and his experiences with the IPV therapists. He believed that learning triggers for the prevention of future violence was helpful but also enjoyed how each therapist was empathetic and encouraging. I wonder if he has ever had someone in his life that possessed those same or similar attributes. Along with understanding the triggers to aggression, he also enjoyed the overall goal of creating a game plan for dealing with or reducing the incidence of violence occurring in the relationship. Along with this was included the idea of the original therapist being present. Continuity of care creates a sense of safety that allows clients to feel more open in discussion and as if they are being heard.

I am curious about how this client perceives himself—he talks about perpetrators being nervous when separated from their victim partner but them at the same time mentions the great communication he has with his wife that allows him to no be nervous…is he covering up something or making a connection between his old and new behaviors? He does mention in the second half of the interview that honesty or truth is the only way to feel better and I am curious about his thoughts around that.

This man has been incarcerated before and comes from a lower socioeconomic status. He describes his appreciation for the affordability of the program and I wonder if that is only due to the nature of his financial situation. He ends with a reiteration on his like for the therapists and their empathetic drive to be helpful.

Triggers

Game Plan

Therapists—continuity, empathy, encouragement

Communication/safety—perpetrator?

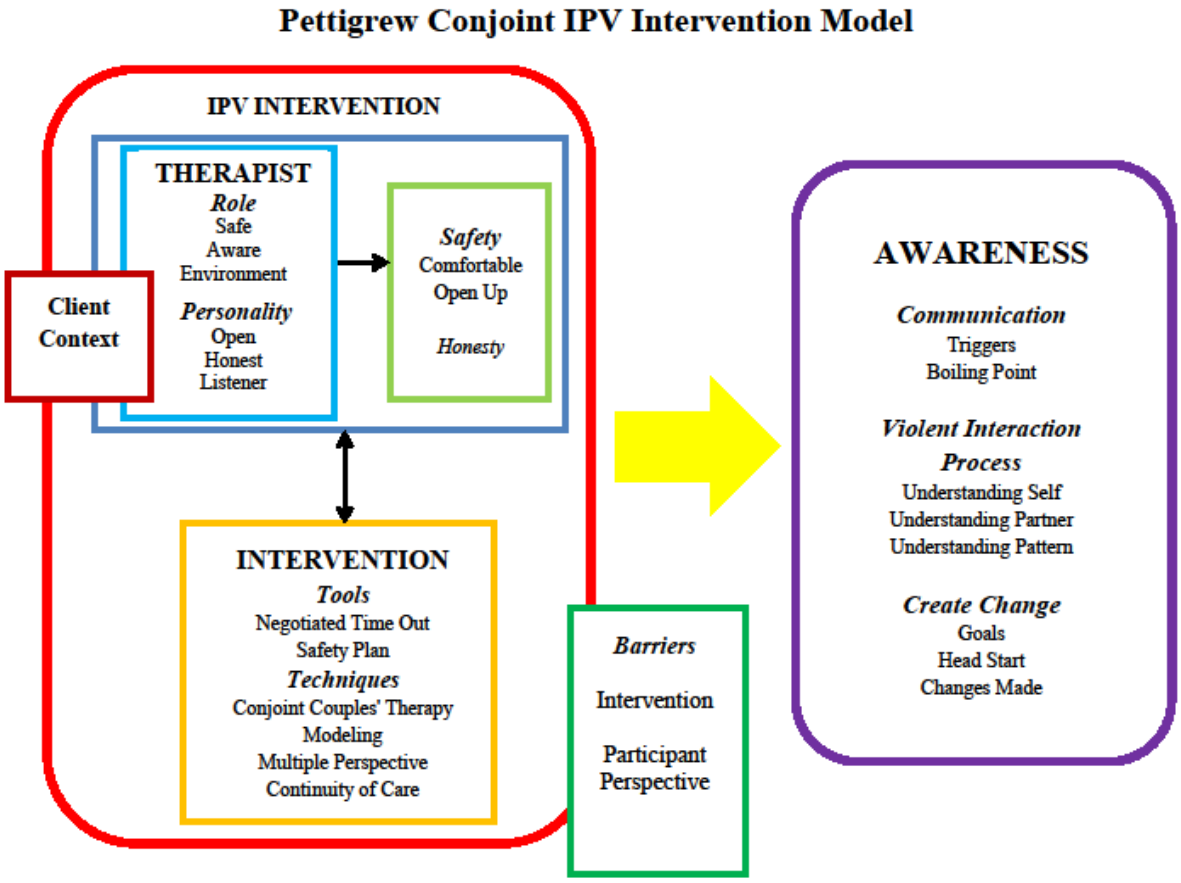
Honesty

Appreciation—low SES

Justification/Minimization

APPENDIX E

PETTIGREW CONJOINT IPV INTERVENTION MODEL



APPENDIX F

IPV INTERVENTION MANUAL

Intimate Partner Violence Intervention Manual

TTU Family Therapy Clinic

Douglas B. Smith

Table of Contents

K. Constellation Schedule

Introduction

Intimate Partner Violence (IPV) is a serious problem that affects both men and women on global, national, and local levels. The World Health Organization reported a lifetime prevalence rate of IPV across 15 countries which ranged from 15% to 71% (Bracken, 2010). In the United States alone, 25% of women have reported being victims of IPV at some point during their lives (Tjaden, 1998). Eighty-five percent of all IPV is directed toward a female partner and is perpetrated by a male partner; however, numerous studies have shown that men are also victims of IPV (Roark, 2010; Hines, 2009; Holtzworth-Munroe, 2005). According to the U.S. Bureau of Justice Statistics in 2005, 1 in 320 households was affected by IPV (Roark, 2010). IPV results in two million injuries and thirteen-hundred deaths annually (Karch, 2005).

Intimate Partner Violence is particularly salient in the clinical population within the United States. In a clinical study, 33 out of 262 families who entered treatment programs initially reported IPV as the presenting problem; however, IPV was actually occurring in at least 40 % of the families (Todahl, 2011).

In populations not seeking clinical services, IPV affects both married and committed couples. One study showed that within a group of married couples, at least one type of aggression was reported by 90% of the couples; over 40% of the couples reported that physical aggression had occurred in the past year (Slep, 2005). In a study following married Christian couples, 46% reported common couple violence, 29% reported sexual victimization, and 10% reported severe physical abuse (Drumm, 2006).

Undergraduates from a small, Midwestern university completed an internet survey regarding their current committed relationship, and 35% reported at least one episode of physical violence (Fass, 2008). Of 149 Mexican-American college women who are currently in dating relationships, 43% experienced some type of partner violence, 12% experienced physical violence, and 5% experienced sexual violence (Coker, 2008). Intimate partner violence occurs in an extensive number of couples regardless of their location, age, ethnicity, relationship type, or sexual orientation (Breiding, 2009; Sormanti, 2008; West, 2002). In fact, between 12 % and 54 % of homosexual men report experiencing some form of violence in their relationship (Ramachandran, 2010). One-quarter of gay and lesbian participants in a study reported being victims of same-sex IPV, about 10 % reported perpetrating IPV, and most notably, nearly all of the perpetrators endorsed being victims. An equal number of gay men and lesbians reported IPV (Carvalho et al., 2011).

Problems with Reporting

While intimate partner violence is predominant in our society, only a minority of cases are actually reported (Towns & Adams, 2009). Men are likely to underreport instances of IPV because they blame their partner for provoking them, they use violence to express perceived unmet needs, and they fear legal repercussions. Similarly, women are likely to underreport IPV; they make excuses for why the violence is occurring, they use love to disregard IPV, they are financially dependent on the perpetrator, they blame themselves for the violence, they fear increased violence and retaliation and the possibility of losing rights to their children, and they worry that community resource

personnel will not respond to their reports (Ko Ling, 2011; Curry, 2011; Towns, 2009). Social desirability, shame, and guilt influence underreporting rates for both men and women (Ko Ling, 2011). Some couples view violent behaviors as normal and unproblematic, and so they do not report them (Curry, 2011). Even in the cases that are reported, couples do not agree on the occurrence and/or frequency of IPV.

In addition to gender norms, cultural factors also influence the reporting of IPV. Chinese couples are less likely to report IPV for fear of bringing disrespect to the family (Ko Ling, 2011). For Latin cultures, the concept of machismo, which values masculinity and excuses aggressive behavior, IPV goes underreported (Ko Ling, 2011). A non-English speaking woman may not leave her abuser because of the cultural consequences (Sugg, 2006). Other marginalized populations often underreport because they do not want to further stigmatize their image (Curry, 2011).

Clinicians can unwittingly influence reporting rates by using assessment measures that contain a generalized or vague question about violence rather than specific behavioral questions (Curry, 2011). Clients may also perceive that health and social services professionals will not ensure their privacy or believe their report of IPV (Curry, 2011). As privacy is an important factor that may lead to disclosure, reports of IPV are more likely to occur if the client is alone with the clinician, and if the clinician is a woman (Ko Ling, 2011).

Clinical Assessment

The goal of assessing for Intimate Partner Violence (IPV) is to promote safety and improve the relationship between partners (Hoyle, 2007). An effective IPV assessment

should include a structured screening process, inquiry about type and level of violence, and methods to determine appropriate therapeutic setting for treatment (Bieschke, 2007; Schacht, 2009). The screening process should include both a written assessment and a face-to-face interview, in order to increase the likelihood of violence disclosure (Stith, 2011). To conduct an effective violence assessment, a clinician should receive specialized training, understand types and levels of violence, and always ensure client confidentiality (Hetling, 2011).

Without specialized training, clinicians can easily overlook IPV. For example, clinicians may instantly begin treatment for the presenting problem without ever inquiring about violence (Elbogen, 2010). Additionally, clinicians' gender bias toward IPV could prevent them from fully understanding each partner's role in violent interactions (Bieschke, 2007). An assumption that only males perpetrate violence might cause clinicians to overlook female-perpetrated violence. When assessing for IPV in same-sex couples, clinicians often have difficulty determining who the main perpetrator of violence is (Bieschke, 2007). This can become an issue when deciding which partner to assess and interview first. For heterosexual couples, the clinician generally assesses for violence with the female partner first in order to minimize the risk of the male partner becoming angry and behaving violently toward his partner after the session. When faced with a same-sex couple, the clinician must use his or her intuition and clinical judgment to determine who to interview first.

Some commonly used risk assessment tools include the Spousal Assault Risk Assessment (SARA), the Domestic Violence Screening Instrument- Revised (DVSI-R),

and the Domestic Violence Risk Appraisal Guide (DVRAG) (Connor-Smith, 2010). The above assessments measure risk factors for IPV, which include history of violence, recent violent episodes, substance use, and employment problems (Connor-Smith, 2010). In the current study, we will be using our own assessment, the Clinical IPV Assessment.

Conjoint Treatment

After determining that IPV exists in a relationship, the next decision the clinician must make is whether to engage in individual or conjoint treatment of the couple. The benefits of conjoint treatment include being able to reduce violent behavior, relieve relationship distress, and enhance protective relational factors, while lessening the likelihood that male partners will reoffend (LaTaillade, 2006; McCollum & Stith, 2008; Stith, 2008). One predictor of re-offense is normalization of violence, which male-only treatment may encourage (Stith, 2011). Because 50 to 70 % of violent couples choose to stay together, conjoint treatment is useful in alleviating relationship problems that often lead to IPV (McCollum & Stith, 2008).

To determine whether conjoint treatment is appropriate, the assessment process should include an individual interview with each partner (Holtzworth-Munroe, 2002). To participate in conjoint therapy both partners should be willing to participate, the level of violence should be low to moderate, the female partner should not fear retaliation, the perpetrator should accept responsibility for the violence, and the primary goal of treatment should be to stop violence completely (Bradford, 2010). Only clients who entered therapy voluntarily should be recommended for conjoint treatment, which

excludes court mandated clients and clients involved with Child Protective Services (Bradford, 2010).

Clinicians must carefully differentiate between couples who are appropriate for conjoint treatment and those who are not. For instance, conjoint treatment can worsen the abuse in couples experiencing moderate to severe violence (Bradford, 2010; McCollum & Stith, 2008). It is important for a clinician to be aware of the problems with conjoint treatment, such as: women feeling compelled to control their partner's violence, fear of retaliation because of honest disclosure, false sense of security because of partner's agreement to treatment, and male's lack of responsibility toward his violent behavior (McCollum & Stith, 2008; Stith, 2008; Stuart, 2009). Despite these problems, it is our view that with careful and separate screening of each partner, this intervention can be effectively employed.

Best Practices

When a couple begins conjoint IPV treatment, it is important for the clinician to define IPV, so that the couple is aware that their behaviors constitute violence. The clinician should allow for processing of emotions regarding the therapy process and how that process may affect the relationship. The clinician should carefully observe the couple's interaction in order to validate their experiences (Stith, 2011). Throughout treatment, the clinician should conduct ongoing safety assessments to determine reoccurrence of violence (McCollum & Stith, 2008).

For conjoint treatment to be effective, the clinician should ensure that there are a variety of safeguards in place. Specific safeguards include validating a victim's voice

even if he or she chooses to stay in the violent relationship, helping the couple identify an outside support system, such as church, community groups, or non-violent accountability partners, and teaching couples how to use negotiated time-out and mindfulness practices (Stith, 2011). Clinicians should also encourage victims to follow their instincts in order to de-escalate dangerous situations (Kress, 2008).

Developing a safety plan is another beneficial practice. A safety plan helps the victim to prepare in advance for conflictual situations and choose how to best respond (Kress, 2008; Bradford, 2010). Safety plans should include gathering essential items for a quick escape (keys, money, medications, documents, etc.), having a safe place to go, asking friends for help when violence arises, discussing the plan with children, and developing and practicing escape routes (Kress, 2008).

Some of the IPV intervention programs currently in place are: Boss's contextual model of family stress, the Duluth model, the Physical Aggression Couples Treatment (PACT) program, Domestic Violence Focused Couples Treatment (DVFCT), The Domestic Conflict Containment Program (DCCP), and Behavioral Couples Therapy (Rolling, 2010; Stover, 2009; LaTaillade, 2006; Stith et al., 2004; McCollum & Stith, 2008; Stuart, 2009).

The current IPV intervention is broken down into two, two-hour sessions. The first hour addresses safety plans, and is conducted individually. The second hour focuses on negotiated time-out, and is done conjointly. The last two hours, examination of how violence supports the presenting problem and goals for a violence free relationship, are done conjointly.

Safety Considerations

It cannot be stressed enough, that the overriding principle in the IPV Assessment and Intervention is safety. Safety should inform every decision made concerning the appropriateness of treatment and intervention. If at any time during the assessment or intervention safety seems questionable, it is essential that the therapist consult his or her supervisor and proceed in a manner that reduces the potential for harm, even if that means diverging from the steps outlined in the manual. This manual attempts to highlight times when the therapist should assess and consider the safety of participants; however, there may be other times in which the therapist's intuition leads to doubt about the safety of participants. If this occurs, the therapist(s) can split the couple and ask them individually about their safety concerns and consult with their supervisor, Doug, or Jason, if needed.

Initial Assessment

Complete the Clinical Intimate Partner Violence (IPV) Assessment for any couple presenting for services, this include couples presenting for family therapy even when a child is the Identified Patient. After the couple completes the clinic intake packet (see Appendices A, B, C, and D for Clinic Assessments at Intake, Session 5, Session 10, and Termination, respectively) and has signed consents, explain that it is clinic policy to see couples individually for the first session. For a heterosexual couple, complete the IPV Assessment on the female partner first, while the male partner waits in the waiting room. For a homosexual couple, use your own clinical judgment to decide which partner to question first. Assign each partner a number to be used for the IPV assessment (i.e. Male 1 and Male 2, Female 1 and Female 2, or Male and Female) and write this at the top of the clinic intake packet and the Clinical IPV Assessment.

Begin the individual session by asking about goals, reason for seeking therapy, or whatever fits your style of therapy. At some point, if the client does not introduce the topic of conflict, ask about how conflict is handled in their relationship. Use the Clinical IPV Assessment (see Appendix E) as a script to ask questions about conflict or assess using your own questions. To proceed safely, all questions on the assessment must be answered. Even if you use your own questions, fill out the assessment with the client present.

Before ending the first individual session, ask the client if he/she is comfortable with you asking their partner these same questions (Questions 14 and 15 on the IPV Assessment). If the answer is NO, then do not initiate a conversation about conflict or

violence during the individual session with the second partner. Focus on goals, expectations of therapy, or whatever fits your model of therapy. Once the session is over, speak to your supervisor, Doug, or Jason about what steps to take next. Generally, in the next session, you will meet with the partners individually, beginning with the person who is less violent. Explain to the first partner that it is the clinic's policy to see members of a couple separately until they feel safe and are ready to address the violence.

If the first partner answers YES to questions 14 and 15 on the IPV Assessment, complete the IPV Assessment with the second partner, following the same procedure. Use the instructions at the end of the IPV Assessment to make a decision regarding inclusion in the IPV Intervention and the safety of conjoint therapy. Inclusion criteria for the IPV Intervention include:

1) Report of PHYSICAL or VERBAL violence within the last year OR ongoing CONCERN of PHYSICAL or VERBAL violence if violence occurred over a year ago.
2) Partners acknowledge and report similar levels of violence (Questions 6-12).
3) Violent partner(s) is able to take some responsibility for their role in the violence (Question 13).
4) Both partners feel comfortable and safe discussing the violence (answers to Questions 14 & 15 are YES for BOTH partners).
5) Both partners agree to sign a No Violence Contract (Question 16).

If inclusion criteria are met, meet with the couple together and read or paraphrase the script at the end of the Clinical IPV Assessment. Also have the partners sign the Contract

of Violence Prevention attached to the IPV Assessment. Then schedule a 2-hour appointment with the IPV Intervention Team using the scheduler posted in the main clinic hallway. When writing the receipt, in the "Next Appointment" box, check IPV Session 1. Put the receipt in the IPV mailbox in the Clinic Office (not the student room safe).

If the couple does not meet the inclusion criteria, follow the instructions at the end of the Clinical IPV Assessment. Exclusion criteria include:

- Neither partner reporting physical or verbal violence within the last year or ongoing concern of physical or verbal violence. In this case, proceed with therapy as normal.
- Either partner feeling unsafe to discuss violence (answer to question 14 or 15 is NO).
- Either partner refusing to sign a No Violence Contract (answer to question 16 is NO).
- Partners reporting dissimilar levels of violence or are unable to take responsibility for their role in the violence (Questions 6-13).

For the latter three scenarios, consult with your supervisor, Doug, or Jason before the next session. Conjoint therapy cannot proceed if one partner does not feel safe. If either partner refuses to participate in the IPV Intervention or individual therapy as recommended, then they may have to seek therapy elsewhere.

Session I/Unit I—Safety Planning

Unit I of Session I is a 50-minute individual session. Begin the session by introducing yourself and the IPV Intervention. Read the Recruiting Script and the Purpose Script (Appendix F), answer any questions, and have the client sign the Consent Form (Appendix G). Then begin Safety Planning.

Rationale

When working with couples with IPV, safety is of the utmost importance. As such, the first step in the IPV intervention is to raise awareness of safety and escalation patterns, and to create a plan to prevent and manage violence—a safety plan. Unfortunately, research into the effectiveness and essential components of safety plans is virtually nonexistent. However, common components of safety plans include protection strategies, staying strategies, leaving strategies, and time frames (Davies, Lyon & Monti-Catania, 1998). Safety planning should be ongoing, dynamic, and individualized, especially in consideration of special populations and their needs (Merchant, Leckie, & Atchley, 2012). Clinicians should be familiar with available resources, as well as thorough in assessing each client's specific circumstances. Davies, Lyon, and Monti-Catania (1998) endorse a woman-defined model of advocacy that centers on the exploration of options for the victim, as well as the analysis of the availability, relevance, and usefulness of each option, in order to determine the best strategy for safety. The key to remember is that no 'one size fits all' safety plan exists that meets every client's needs. Clinicians must consider safety planning as an ongoing process that requires information-gathering about the client and the options available, as well as collaborative planning and

routine re-assessing of the usability and comprehensiveness of the safety plan (Merchant, Leckie, Atchley, 2012).

Goals

1) Identify patterns of escalation that lead to violence.
2) Identify strategies to reduce tension and prevent escalation.
3) Identify strategies for recovering safety if violence occurs or becomes imminent.

Procedures

Being that many couples report mutual violence, the therapist must first identify a primary victim and primary perpetrator. The primary victim is the person most likely to be injured if violence occurs, i.e. the person most in need of an escape plan. Safety planning procedures are the same for both victims and perpetrators, except with primary victims there is the added goal of identifying strategies for recovering safety if violence occurs or becomes imminent. Therapists will also give victims the "Helpful Numbers" card that is attached to the Safety Plan Worksheet.

Because safety planning should be conversational, the Safety Plan Worksheet should only be used as a guide. Therapists should not read directly from the worksheet, or ask only the questions on the worksheet. The authors believe that for safety planning to be effective, therapists must gather a rich description of escalation and a thoughtfully consider de-escalation techniques. Therapists can write on the worksheet as they explore conflict with clients or at the end of the session.

Goal One: Identify patterns of escalation that lead to violence.

Developing a clear picture serves three purposes: 1) it raises clients' awareness of interactional patters and internal reactions that escalate conflict; 2) it raises clients' awareness of safety risks; 3) it provides a timeline of escalation from which you can develop a plan to stop escalation. Therapists may want to begin with an open-ended grand tour question, like "What does it look like when you two argue?" Then gather more details by asking questions to develop the timeline: What happens next? What happened before that? What is your partner doing while you are _____? What is happening when you start feeling concerned? How can you tell when your partner is about to lose it? If the client begins their description of conflict at the point of violence, back them away from the violence. If they begin in the early stages of tension-building, walk them toward the violence.

Goal Two: Identify strategies to reduce tension and prevent escalation.

Once the therapist and client develop a timeline, they can begin identifying strategies for reducing tension and preventing escalation. Client may have more than one pattern of conflict, many of which may not escalate to violence. What is different about the times when conflict does not escalate to violence? What has worked in the past to reduce tension? What activities help the client feel calmer? Many clients will know how to calm themselves, while others may have difficulty identifying calming activities or suggest activities that could be dangerous. Driving, having a beer, punching a bag and other similar activities may increase the risk of violence and should be avoided.

Goal Three: Identify strategies for recovering safety if violence occurs or becomes imminent.

This step pertains to the primary victim only. Here, therapists develop a plan for escaping if violence happens or if the client expects that violence will happen. Therapists can help clients decide how they will escape, where will they go, who they can call, and what they need to take. Therapists need to encourage victims to call 911 in case of an emergency, as well.

Concluding Safety Planning

Fill in the Safety Plan Worksheet and have the client sign the bottom of the form. The worksheet will go in the couple's chart. If the client is a primary victim, fill out the Helpful Numbers card attached to the worksheet with the therapist's extension and the name and number of a safe person to contact in an emergency. The primary victim takes the Helpful Numbers card with them.

Session I/Unit II—Negotiated Time Out

Take a break between Unit I and Unit II of Session I to discuss with the other therapist if safety concerns prevent conjoint therapy. Unit II is a 50-minute conjoint session, unless otherwise instructed by your supervisor.

Rationale

Self-report data has found that negotiated time-outs (NTO) taught in the context of male-only batterer programs are ineffective at best and abusive as worst (Rosen, Matheson, Stith, McCollum, & Locke, 2003). Batterers may use the time-out to control interaction by leaving for an undetermined length of time or by prematurely ending a discussion when his partner challenges him (Rosen, et al., 2006; Gondolf & Russell, 1986). Victims report being confused by the time-out or, even worse, demeaned when the batterer tries to put them in time-out (Stith & McCollum, 2011). Likewise, batterers report that time-outs are ineffective. When they want to take a break, their partner, who has no knowledge of the time out process, continues to pursue the argument (Rosen, et al., 2003). Or when the batterer returns from the timeout, their partner is either angry or feels abandoned due to the departure (Rosen, et al., 2003; Stith & McCollum, 2011). Negotiated time outs include both partners in the time-out process, teaching partners to recognize signs of anger and escalation and helping them reach an agreement about how to prevent escalation. Partners learn and develop the technique together, avoiding confusion and misuse and increasing its effectiveness and their problem-solving abilities.

Goals

1) Teach each partner to recognize signs of anger, when anger is escalating, and when arguments are becoming unproductive and unsafe.

2) To teach each partner how to disengage from an argument before it leads to violence.

3) To teach each partner how to return safely to the discussion.

4) To create a plan agreed upon by both partners that addresses these goals.

Procedure

Introduction

Couples may have already tried time-outs, either successfully or unsuccessfully. As such, the first task is to find out if they have used time-outs and if so, how well the time-outs worked. What does it look like when they take a time-out? Who decides when to take a break? How do they let each other know they need a break? What do they do during the time out? Where do they go? What happens afterwards? Does the conflict get resolved? Are time-outs helpful? Are they happy with the process? What problems have occurred when they take a time out? What concerns do they have about using time outs?

Listening to the concerns of couples who have tried time-outs unsuccessfully may help soften their resistance. Couples who have doubts are asked to set aside their concerns and try it. NTO can help couples reach their goal of having a violent-free relationship. Moreover, many couples have found NTO helpful in both reducing violence and resolving problems.

Introduce the Negotiated Time Out technique, which is similar to taking a break, except that both partners agree on the terms of the time-out. Instead of partners using the timeout to prematurely end an argument or to have an excuse to walk-out, partners are taught to recognize signs of anger, take steps to disengage and calm down, and then return and resolve the conflict. Moreover, the NTO can be renegotiated as needed until both partners are satisfied with how it is used.

The NTO has seven steps: awareness of anger and escalation; staying within the safety zone; signaling the need for a break; acknowledging the need for a break; disengaging; cooling off; and returning. At this point, the therapist can give the NTO Worksheet to each partner with a pen and clipboard. See Appendix I for NTO Worksheet and Contract.

Step One: Awareness

Descriptor. The purpose of awareness is to learn to recognize internal cues that anger is escalating.

Questions. Have partners fill out the worksheet as you ask them the following questions: How can you tell when you are getting angry? What are you doing, thinking, or feeling? How can you tell when your anger is getting out-of-control? How can you tell when you're the argument is becoming unproductive or unsafe? Continue to ask for details on their escalation patterns to determine specifics on verbal or physical behaviors that may be abusive.

Considerations. Partners may have different comfort levels with intense emotion; one may be ready for a time-out before the other has reached his or her warning level.

The therapist may need to make this overt. It is also important that both partners take ownership for their responses and agree to act in a way that maintains safety. Partners may try to blame one another for their responses.

Step Two: Stay in the Safety Zone

Descriptor. To stay in the Safety Zone, we have to know where the "point of no return" is and when it is time to call a time out. Either partner can call a time out based on what they are feeling, thinking, or doing. So, one partner may want to call a time out when he feels his face turn red or his heart race, or she may want to call a time out if she feels unsafe or intimidated.

Questions. Where is the point of no return? How will you know based on what you are feeling, thinking, or doing that it is time for a break?

Considerations. The victim may feel more in control and empowered knowing that she can initiate a timeout should her own or her partner's anger escalate.

Step Three: Signaling

Descriptor. Next partners have to decide on a signal that indicates it is time for a break. Some couples make a "T" with their hands. Others may simply say, "I need a break." The signal needs to be clear, non-threatening, and something both partners can agree to.

Questions. What signal can you use to indicate that you need a break? Will that escalate the conflict? How will that be received by your partner? Can you say that in a calm voice?

Considerations. Let the couple negotiate and mutually agree to the signal.

Step Four: Acknowledging

Descriptor. It can be tempting to continue the argument when one partner initiates a timeout. Partners must learn how to prevent themselves from continuing the argument. Deciding how to respond to a time-out signal can help prevent pursing the argument.

Questions. How do you think you will respond when your partner calls a time out? How can you prevent yourself from pursuing the argument? How will you acknowledge that your partner has called a timeout?

Considerations. Some partners may feel abandoned when their partner initiates a time out. If that seems to be a concern for your couple, you may need to explore what would help the "abandoned" partner feel more secure before they disengage.

Step Five: Disengagement

Descriptor. Once the time out has been called, partners must decide how to disengage and for how long to disengage. For example, one partner may want to go to another room, outside, or to the garage. Time outs need to be sufficiently long enough for each partner to calm down, but not so long that issues do not get resolved.

Questions. Where will you each go? How long will the time out last? What will you do with the children? Negotiate which places are off limits for a time-out, such as a bar.

Considerations. One partner may suggest leaving the house or being gone for several hours. This may be how they are used to managing conflict. While these

behaviors may help prevent violence, they may also prevent the couple from resolving conflict. Fifteen minutes to one hour is the general recommendation.

Step Six: Calming

Description. During the timeout, it is important that partners calm themselves. NTO isn't about just avoiding violence, but also about facilitating conflict resolution.

Questions. How do you normally calm yourself down when you are angry? What have you found helpful for calming yourself? What will you do during the break?

Considerations. Couples may suggest activities such as having a beer or hitting a punching bag as options for calming down. However, both drinking and "blowing off steam" violence have been found to escalate violence. Neither is conducive to conflict resolution. Likewise, avoidance activities, such as watching TV may also prohibit conflict resolution. Couples may need education about both helpful and unhelpful calming behaviors. Suggestions for calming include mindfulness, meditation, breathing, prayer, exercise, a brisk walk, etc.

Step Seven: Returning

Description. As stated, NTO isn't just about avoiding violence; it is also about resolving conflict. As such, to prevent issues from being continually swept under the rug, partners need to return, reconnect, and decide what to do about their conflict. When partners return, they have four options: take another timeout, continue to discuss the conflict calmly, table the issue for another time, or drop the discussion altogether.

Questions. How will you know if you ready to discuss an issue? Take another time out? Table the issue? Drop it altogether? How are you going to check-in with one another? What are you going to say?

Review

Transfer their answers from the worksheet to the contract, reviewing the agreement. If time permits, have the couple practice the timeout in session. Remind the couple that the timeout can be revised as needed until all the kinks are worked out and both partners are satisfied with the results.

Session I Conclusion

At the conclusion of Session I, schedule Session II, which is also a 2-hour appointment. Then divide the couple, meeting with them individually for a few minutes to determine if they feel safe leaving with their partner. Ask clients about their experience of the intervention and if they felt comfortable negotiating for time-outs. If one partner expresses concerns about leaving, explore those concerns then consult with your supervisor, Doug, or Jason concerning what to do next.

Session II/Unit III—Examination of How Violence Supports the Presenting Problem(s)

Prior to beginning Unit III, meet with each partner individually to learn if violence has occurred, if they had opportunity to practice the Negotiated Time Out (NTO), and if they are still interested in and comfortable with conjoint therapy. If violence has occurred, do not proceed with conjoint therapy. Instead meet with partners individually to determine the extent and effects of the violence. Then consult with your supervisor, Doug, or Jason before proceeding. If the couple has used the NTO, explore how it worked. If it did not work well, spend part of the session revising the NTO. Finally, assess whether their commitment to creating a violence-free relationship is still a priority and whether they continue to feel safe discussing the violence. If either their commitment or safety has been negated, meet with client's individually and consult with supervisor before proceeding. If violence has not occurred and both partners continue to feel safe and invested, then continue with Unit III, which is a 50 to 75 minute conjoint session. It is less structured than Session I. It may be helpful to recall the goals of this session, listed below, to help stay on track.

Rationale

Externalization of a problem in therapy helps make the problem easier to investigate and discuss the influences the problem has on the clients' lives. The application of this stage of the intimate partner violence couples intervention is to help the clients connect the relationship between their presenting problem(s) and IPV. This connection should help solidify the importance of working on intimate partner violence

not only for safety reasons, but to help them better work towards their goals. However, special care should be taken to avoid allowing perpetrators of violence to use externalization to minimize their responsibility for their decision(s) to engage in violent behavior. Specifically, during this phase of treatment, therapists should balance the use of externalizing questions about violence with clear statements that the decision to behave violently is solely the responsibility of the perpetrator of violence.

Intimate partner violence carries with it a profound stigma and fear of legal ramifications. Shame can have an immobilizing effect on the clients and prevent them from talking about intimate partner violence. Through the process of externalization, discourse separates the person/couple from the problem, making space for difficult conversations to occur. White (1988) stated that externalization "frees persons to take a lighter, more effective, and less stressed approach to 'deadly serious' problems" (p.6). Anytime that intimate partner violence is present in a relationship it should be cautioned that perpetrators of violence cannot excuse the role they play in violence and that externalization is not a means to remove fault or take away responsibility. Externalizing questions should help each member of the couple understand their relationship with the problem and their role in sustaining it. Questions should be used to invite partners to become more responsible in understanding how they do or don't let the violence influence their own actions.

Goals

- To develop an understanding of how the violence in the relationship is related to other problems in the relationship and how it prevents resolution of problems.

- To recognize the effects of violence on family relationships other than the intimate partnership and on non-familial relationships.
- To examine minimization, distortions, and attributions that interfere with the development of violence free relationships.
- To foster partner understanding of the hurt and pain caused by relationship violence.

Procedure

Begin the conjoint session by informing the clients of the goals for the session. For example, you might say, "In this session, we are going to explore how violence impacts your relationship and develop goals for a violence-free relationship." If the couple objects to the word "violence" you might ask what they call it when things "get out of hand" or when "someone gets hurt." Using their preferred terminology, be it abuse, aggression, conflict, escalation, fighting, etc., is acceptable as long as it does not minimize the abuse. If it seems as though the couple is using a word that minimizes the violence, you may want to have a conversation about their reluctance to call it violence. What does violence or abuse imply? How does that fit/not fit their situation? This can then segue into discussing the effects of violence on their relationship.

Course of questions to help externalize Intimate Partner Violence

- **The Miracle Question** – Imagine that while you are sleeping tonight miracle happens and the threat of (physical/psychological) violence is completely

removed from your relationship. However, because you were sleeping when the miracle occurred you are not aware that it happened when you first wake.

- **What will be the first clue that the miracle has happened**?
- **Who will be the first person in your family to notice that violence is gone from the relationship**?
    - **What will they notice**?
    - **What difference will this change make (on your relationship, family, etc)**?
- **Who will notice first, you or your partner?**
- **When do you think your children will notice and what will give it away?**
- **Who outside of your immediate family will notice?**
- **Supplemental Questions to be asked as follow-up when appropriate:**
    - **How will your relationship change as a result?**
    - **What will you be able to do/accomplish now that this change has occurred?**
    - **What will you and/or your partner start doing because of this change?**
    - **What affect will the change have on the reasons you came to therapy?**
    - **How will you and your partner handle conflict differently now that violence is gone from the relationship?**

- **How will the way you and your partner interact/communicate change now that violence is gone?**
- **What will you do that you were afraid to do before, now that violence is gone?**
- **What will you be able to tell your partner about how the violence affected you?**

In general this line of questioning should help the couple more clearly understand the effects that the violence has on their individual and relational well-being. They also should come away better able to identify the choices each of them make that may enable or disable the violence.

Violence and Distortion

When conflict occurs in a relationship, people distort what happens. Typically they minimize their own contributions and blame their partner for the problems. This always occurs in violent relationships, with denial, minimization, and rationalization being common. When violence is situational or bi-directional the types of distortion used by each partner may be similar. For example, individuals are likely to exaggerate how hard they are trying to make things work and they will ascribe negative motives to their partner's behaviors ("she is just trying to annoy me by not making the bed"). However, when violence has a terroristic or controlling component, the distortions are more extreme from the perpetrator (Goldner, 1999). This type of blame and threat from a violent and controlling male is likely to cause self-doubt and self-blame with his partner (Whiting, Oka & Fife, 2012). In other words, if the violence is intimate terrorism, then

the power of the perpetrator will invite the victim to doubt her own perceptions. Early approaches to violence treatment suggested that this type of minimizing, denying and rationalizing was one of the many control strategies used by a perpetrator (Paymar & Pence, 199X). In general, it is important to explore and understand the role of distortion in highly conflictual and abusive relationships. The following vignettes and questions can be used to do this.

Explain to each member of the couple that the goal for this section will be to discuss how distortion is a part of the conflict that occurs in their relationship. Remind them that most people have an easy time of seeing their partner's faults and distortions, but that we will ask them to focus on their own distortions during these questions. Work from the following script:

- Sometimes when we hurt our partner we may try to deny our part in it or deny that our behavior is hurtful or abusive.
    - Can you describe times when you may have denied that your behavior was abusive even though you know it was? Can you think of times when you have tried to convince your partner that he/she was not being hurt?
- Sometimes when we are abusive towards our partner, we may try to excuse our behavior by saying that our partner (or something else) made us do it. We may also tend to minimize the severity of the incident. I will read a short example.
    - *[Vignette] Chuck and Mary are fighting because Mary came home late from work and Chuck is suspicious. Although Mary previously had been involved emotionally with a co-worker, she denies that she has done*

anything wrong which frustrates Chuck further. She tells him he is stupid and stomps off to another room. Chuck follows her accusing her of cheating, and she pushes past him and he slaps her and shoves her to the couch. After the incident, Chuck is angry and Mary is crying. He tells her that if she wouldn't have called him a name and pushed him he wouldn't have hit her. He also tells her that it wasn't that bad. It's not like he punched her face. He tells Mary that he is sorry, but that she is overreacting. She accuses him of jealousy and says that she called him names because of his suspicions.

- Where do you see either of these individuals excusing their behavior?
- Where do you see blame or accusation?
- What about minimizing or denying?
- Can you share examples when you have blamed your partner for your own hurtful choices? [You may have to remind partners to only discuss their distortions, not their partner's]
- What about times you may have tried to make yourself sound more innocent than you really were?
- Can you share times that you may have excused or minimized your partner's behavior?
- Can you describe times that you tried to control your partner's actions or feelings?

- Are there other ways that you have tried to make yourself out to be the victim, when you were also contributing to the problem?
- Are there any other ways you see denial, blame, or minimization happening in your actions?

Session II/Unit IV—Goals for a Violence Free Relationship

Take a break between Unit III and Unit IV if needed. Unit IV is a 25 to 50 minute conjoint session. At the conclusion of Session II, meet with the couple individually as at the end of Session I to ensure that the partners feel safe leaving with one another.

Rational

In the domain of intimate partner violence, goals are often imposed on perpetrators and victims alike without their collaboration. This makes it difficult for the clients to be truly invested in taking steps toward a violence free relationship. Therefore, it is extremely important to keep the client's personal goals at the forefront of the therapy sessions (Stith, McCollum, & Rosen, 2012).

When the clients' visions of a healthy relationship are asked about and included, research has shown that they are more likely to develop clear, concrete, and achievable goals. Another method that has been shown to be useful in developing goals is to explore parts of the clients' vision that are already occurring in their relationship. This process should inspire them to imagine the possibility of a better relationship (Stith, McCollum, & Rosen, 2012).

Procedure

First, collaboration between the clients and the therapist should take place in order to develop goals. If the client states vague goals, such as "we would like to be happy," the next step is to ask what that means for them, and to ask for specific behaviors. We want to give the clients a concrete picture of the goal and to encourage them to envision the steps needed to reach a violence free relationship. This process will help to instill hope, help the therapist join with both clients, allow all participating members of the session to give feedback, and to assist the therapist in focusing on goals actually desired by the clients.

Questions surrounding broad goals

- When Violence is gone, what do you think it will take to create a healthy relationship?
- What steps can you take to keep Violence away?
- What kind of relationship do you want to have?
- If I was there and Violence had left, what would I see you doing that showed me you were satisfied with your relationship?
- What are the signs that you have overcome Violence and are moving towards a healthy relationship?

Questions surrounding specific goals

- What is the first step you should take in order to move toward a healthy relationship?

- After you notice that your relationship is getting healthier, what would you do next?
- What will be the signs that your partner is confident that Violence has left your relationship?
- What signs will tell you that Fear is gone?
- How will you know when Safety has come to stay?

If clients have trouble developing goals, or leave an important goal out of their plan, the therapist can introduce these goals to the clients and have a discussion around their importance:

- Be able to recognize all forms of abuse, and that they occur on a continuum (physical, emotional, sexual, verbal, intimidation, male privilege, social isolation, religious, and child abuse).
- Be able to recognize triggers
- Be able to follow safety plan
- Use negotiated time out effectively
- Practice healthy coping without Violence
- Be able to resolve conflicts without inviting Violence back
- Recognizing how you invite in Violence
- Learning to use relaxation and mindfulness techniques if Violence is knocking at the door

Termination

After the conclusion of the Session II, a Graduate Assistant should be present to administer the assessments and schedule the interview for couples participating in the research. Assessments are in Appendix D and the Interview Schedule is in Appendix J. The Graduate Assistant will pay the couple for the assessments at that time and will pay for the interview at the time of the interview.

Future therapy sessions will be schedule through the primary therapist. The primary therapist should regularly meet with partners individually to assess for violence. If violence should occur, the primary therapist should consult with his or her supervisor. The primary therapist should also regularly assess the utility of the Negotiated Time Out and re-negotiate with the couple as necessary.

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Stith, S. M., & McCollum, E. E. (2011). Conjoint treatment of couples who have experienced intimate partner violence. Aggression And Violent Behavior, 16(4), 312-318. doi:10.1016/j.avb.2011.04.012

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Appendix A: Clinic Assessment Packet

IPV Assessment

CASE #:_____ ROLE:_____ TODAY'S DATE:

____/____/_____

What is your gender? ❑ 1. Male ❑ 2. Female ❑ 3. Other

What is your date of birth? ___/___/_____ (mm/dd/yyyy)

INSTRUCTIONS: In the past 7 days, how much have you been bothered or distressed by any of these?
Your first reaction should be your answer:

BSI	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1. Faintness or dizziness	0	1	2	3	4
2. Feeling no interest in things	0	1	2	3	4
3. Nervousness or shakiness inside	0	1	2	3	4
4. Pains in heart or chest	0	1	2	3	4
5. Feeling lonely	0	1	2	3	4
6. Feeling tense or keyed up	0	1	2	3	4
7. Nausea or upset stomach	0	1	2	3	4
8. Feeling blue	0	1	2	3	4
9. Suddenly scared for no reason	0	1	2	3	4
10. Trouble getting your breath	0	1	2	3	4
11. Feelings of worthlessness	0	1	2	3	4
12. Spells of terror or panic	0	1	2	3	4
13. Numbness or tingling in parts of your body	0	1	2	3	4
14. Feeling hopeless about the future	0	1	2	3	4
15. Feeling so restless you couldn't sit still	0	1	2	3	4
16. Feeling weak in parts of your body	0	1	2	3	4
17. Thoughts of ending your life	0	1	2	3	4
18. Feeling fearful	0	1	2	3	4

INSTRUCTIONS: Looking back over the last week, including today, help us understand how you have been feeling.
Read each item carefully and circle the number under the category which best describes your current situation.
For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.

OQ - 45.2	**Almost always**	**Frequently**	**Sometimes**	**Rarely**	**Never**
1. I get along well with others.	5	4	3	2	1
2. I tire quickly.	5	4	3	2	1
3. I feel no interest in things.	5	4	3	2	1
4. I feel stressed at work/school.	5	4	3	2	1
5. I blame myself for things.	5	4	3	2	1
OQ - 45.2	**Almost always**	**Frequently**	**Sometimes**	**Rarely**	**Never**
6. I feel irritated.	5	4	3	2	1
7. I feel unhappy in my marriage/significant relationship.	5	4	3	2	1
8. I have thought of ending my life.	5	4	3	2	1
9. I feel weak.	5	4	3	2	1
10. I feel fearful.	5	4	3	2	1
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	5	4	3	2	1
12. I find my work/school satisfying.	5	4	3	2	1
13. I am a happy person.	5	4	3	2	1
14. I work/study too much.	5	4	3	2	1
15. I feel worthless.	5	4	3	2	1
16. I am concerned about family troubles.	5	4	3	2	1
17. I have an unfulfilling sex life.	5	4	3	2	1
18. I feel lonely.	5	4	3	2	1
19. I have frequent arguments.	5	4	3	2	1
20. I feel loved and wanted.	5	4	3	2	1
21. I enjoy my spare time.	5	4	3	2	1
22. I have difficulty concentrating.	5	4	3	2	1
23. I feel hopeless about the future.	5	4	3	2	1
24. I like myself.	5	4	3	2	1

25. Disturbing thoughts come into my mind that I cannot get rid of.	5	4	3	2	1
26. I feel annoyed by people who criticize my drinking (or drug use).	5	4	3	2	1
27. I have an upset stomach.	5	4	3	2	1
28. I am not working/studying as well as I used to.	5	4	3	2	1
29. My heart pounds too much.	5	4	3	2	1
30. I have trouble getting along with friends and close acquaintances.	5	4	3	2	1
31. I am satisfied with my life.	5	4	3	2	1
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never")	5	4	3	2	1
33. I feel that something bad is going to happen.	5	4	3	2	1
34. I have sore muscles	5	4	3	2	1
35. I feel afraid of open spaces, of driving, or being on buses subways, and so forth.	5	4	3	2	1
36. I feel nervous.	5	4	3	2	1
OQ - 45.2	**Almost always**	**Frequently**	**Sometimes**	**Rarely**	**Never**
37. I feel my love relationships are full and complete.	5	4	3	2	1
38. I feel that I am not doing well at work/school.	5	4	3	2	1
39. I have too many disagreements at work/school.	5	4	3	2	1
40. I feel something is wrong with my mind.	5	4	3	2	1
41. I have trouble falling asleep or staying asleep.	5	4	3	2	1
42. I feel blue.	5	4	3	2	1
43. I am satisfied with my relationships with others.	5	4	3	2	1
44. I feel angry enough at work/school to do something I might regret.	5	4	3	2	1
45. I have headaches.	5	4	3	2	1

INSTRUCTIONS: Please carefully read each of the following statements. Each statement describes an event that could possibly occur in your relationship. Using the scale described below, indicate how likely it is that the described event will occur in your current relationship with your partner. Remember that we are not asking whether the described event has actually occurred in your current relationship. Instead, indicate your belief about the likelihood that the event could occur in the near future.

S. A. F. E.	**Extremely Unlikely**	**Very Unlikely**	**Somewhat Unlikely**	**Somewhat Likely**	**Very Likely**	**Extremely Likely**
1. My partner will refuse to talk to me.	1	2	3	4	5	6
2. My partner will allow me to come and go as I please.	1	2	3	4	5	6
3. My partner will threaten to harm me.	1	2	3	4	5	6
4. My partner will deny that my thoughts or feelings are valid.	1	2	3	4	5	6
5. My partner will encourage me to have my own friends.	1	2	3	4	5	6
6. My partner will physically restrain me.	1	2	3	4	5	6
7. My partner will say things to make me feel stupid.	1	2	3	4	5	6
8. My partner will restrict my communication with other people.	1	2	3	4	5	6
9. My partner will be physically aggressive toward me.	1	2	3	4	5	6
10. My partner will curse at me or call me unkind names.	1	2	3	4	5	6
11. My partner will be jealous.	1	2	3	4	5	6
12. My partner will physically hurt me.	1	2	3	4	5	6
13. My partner will yell at me.	1	2	3	4	5	6
14. My partner will prevent me from having relationships with other people.	1	2	3	4	5	6
15. My partner will use a weapon to hurt me.	1	2	3	4	5	6

INSTRUCTIONS: Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. (Circle one answer for each question).

RDAS	Always agree	Almost always agree	Occasionally disagree	Frequently disagree	Almost always disagree	Always disagree
1. Religious matters	5	4	3	2	1	0
2. Demonstrations of affection	5	4	3	2	1	0
3. Making major decisions	5	4	3	2	1	0
4. Sex relations	5	4	3	2	1	0
5. Conventionality (correct or proper [illegible])	5	4	3	2	1	0
6. Career decisions	5	4	3	2	1	0

INSTRUCTIONS: Please indicate the best answer to each of the following questions using the scale below. (Circle one answer for each question).

	All the time	Most of the time	More often than not	Occasionally	Rarely	Never
7. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	5	4	3	2	1	0
8. How often do you and your partner quarrel?	5	4	3	2	1	0
9. Do you ever regret that you married (or lived together)?	5	4	3	2	1	0
10. How often do you and your partner "get on each other's nerves"?	5	4	3	2	1	0

INSTRUCTIONS: How often would you say the following events occur between you and your partner?

	More than once a day	Once a day	Once or twice a week	Once or twice a month	Less than once a month	Never
11. Have a stimulating exchange of ideas?	5	4	3	2	1	0
12. Work together on a project?	5	4	3	2	1	0
13. Calmly discuss something?	5	4	3	2	1	0

INSTRUCTIONS: Please indicate the best answer to the following question using the scale below. (Circle one answer).

	Every day	Almost every day	Occasionally	Rarely	Never
14. How often do you and your partner engage in outside interests together?	5	4	3	2	1

INSTRUCTIONS: No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired or for some other reason, couples may also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please mark whether you did each of these things since the last time you completed this survey, and whether your partner did them since the last time you completed the survey.

CTS2S	**YES**	**NO**
3. I insulted or swore or shouted or yelled at my partner.	Y	N
4. *My partner insulted or swore or shouted or yelled at me.*	Y	N
5. I had a sprain, bruise, or small cut, or felt pain the next day because of a fight with my partner.	Y	N
6. *My partner had a sprain, bruise, or small cut, or felt pain the next day because of a fight with me.*	Y	N
9. I pushed, shoved or slapped my partner.	Y	N
CTS2S	**YES**	**NO**
10. *My partner pushed, shoved or slapped me.*	Y	N
11. I punched or kicked or beat-up my partner.	Y	N
12. *My partner punched or kicked or beat-me-up.*	Y	N
13. I destroyed something belonging to my partner or threatened to hit my partner.	Y	N
14. *My partner destroyed something belonging to me or threatened to hit me.*	Y	N
15. I went to see a doctor (M.D.) or needed to see a doctor because of a fight with my partner.	Y	N
16. *My partner went to see a doctor (M.D.) or needed to see a doctor because of a fight with me.*	Y	N
17. I used force (like hitting, holding down, or using a weapon) to make my partner have sex.	Y	N
18. *My partner used force (like hitting, holding down, or using a weapon) to make me have sex.*	Y	N
19. I insisted on sex when my partner did not want to or insisted on sex without a condom (but did not use physical force).	Y	N
20. *My partner insisted on sex when I did not want to or insisted on sex without a condom (but did not use physical force).*	Y	N

Appendix B: Session Five Follow up Assessment

Session 5 Assessment Packet

CASE #:_____ ROLE:_____ TODAY'S DATE:

____/____/_____

What is your gender? ❑ 1. Male ❑ 2. Female ❑ 3. Other

What is your date of birth? ___/___/_____ (mm/dd/yyyy)

INSTRUCTIONS: In the past 7 days, how much have you been bothered or distressed by any of these?
Your first reaction should be your answer:

BSI	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1. Faintness or dizziness	0	1	2	3	4
2. Feeling no interest in things	0	1	2	3	4
3. Nervousness or shakiness inside	0	1	2	3	4
4. Pains in heart or chest	0	1	2	3	4
5. Feeling lonely	0	1	2	3	4
6. Feeling tense or keyed up	0	1	2	3	4
7. Nausea or upset stomach	0	1	2	3	4
8. Feeling blue	0	1	2	3	4
9. Suddenly scared for no reason	0	1	2	3	4
10. Trouble getting your breath	0	1	2	3	4
11. Feelings of worthlessness	0	1	2	3	4
12. Spells of terror or panic	0	1	2	3	4
13. Numbness or tingling in parts of your body	0	1	2	3	4
14. Feeling hopeless about the future	0	1	2	3	4
15. Feeling so restless you couldn't sit still	0	1	2	3	4
16. Feeling weak in parts of your body	0	1	2	3	4
17. Thoughts of ending your life	0	1	2	3	4
18. Feeling fearful	0	1	2	3	4

INSTRUCTIONS: Looking back over the last week, including today, help us understand how you have been feeling.
Read each item carefully and circle the number under the category which best describes your current situation.
For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.

OQ - 45.2	**Almost always**	**Frequently**	**Sometimes**	**Rarely**	**Never**
1. I get along well with others.	5	4	3	2	1
2. I tire quickly.	5	4	3	2	1
3. I feel no interest in things.	5	4	3	2	1
4. I feel stressed at work/school.	5	4	3	2	1
5. I blame myself for things.	5	4	3	2	1
OQ - 45.2	**Almost always**	**Frequently**	**Sometimes**	**Rarely**	**Never**
6. I feel irritated.	5	4	3	2	1
7. I feel unhappy in my marriage/significant relationship.	5	4	3	2	1
8. I have thought of ending my life.	5	4	3	2	1
9. I feel weak.	5	4	3	2	1
10. I feel fearful.	5	4	3	2	1
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	5	4	3	2	1
12. I find my work/school satisfying.	5	4	3	2	1
13. I am a happy person.	5	4	3	2	1
14. I work/study too much.	5	4	3	2	1
15. I feel worthless.	5	4	3	2	1
16. I am concerned about family troubles.	5	4	3	2	1
17. I have an unfulfilling sex life.	5	4	3	2	1
18. I feel lonely.	5	4	3	2	1
19. I have frequent arguments.	5	4	3	2	1
20. I feel loved and wanted.	5	4	3	2	1
21. I enjoy my spare time.	5	4	3	2	1
22. I have difficulty concentrating.	5	4	3	2	1
23. I feel hopeless about the future.	5	4	3	2	1
24. I like myself.	5	4	3	2	1

25. Disturbing thoughts come into my mind that I cannot get rid of.	5	4	3	2	1
26. I feel annoyed by people who criticize my drinking (or drug use).	5	4	3	2	1
27. I have an upset stomach.	5	4	3	2	1
28. I am not working/studying as well as I used to.	5	4	3	2	1
29. My heart pounds too much.	5	4	3	2	1
30. I have trouble getting along with friends and close acquaintances.	5	4	3	2	1
31. I am satisfied with my life.	5	4	3	2	1
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never")	5	4	3	2	1
33. I feel that something bad is going to happen.	5	4	3	2	1
34. I have sore muscles	5	4	3	2	1
35. I feel afraid of open spaces, of driving, or being on buses subways, and so forth.	5	4	3	2	1
36. I feel nervous.	5	4	3	2	1
OQ - 45.2	**Almost always**	**Frequently**	**Sometimes**	**Rarely**	**Never**
37. I feel my love relationships are full and complete.	5	4	3	2	1
38. I feel that I am not doing well at work/school.	5	4	3	2	1
39. I have too many disagreements at work/school.	5	4	3	2	1
40. I feel something is wrong with my mind.	5	4	3	2	1
41. I have trouble falling asleep or staying asleep.	5	4	3	2	1
42. I feel blue.	5	4	3	2	1
43. I am satisfied with my relationships with others.	5	4	3	2	1
44. I feel angry enough at work/school to do something I might regret.	5	4	3	2	1
45. I have headaches.	5	4	3	2	1

If you are currently in a relationship (married, dating, cohabiting), please continue to the next page and answer the remaining questions. If not, please stop here.

INSTRUCTIONS: Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. (Circle one answer for each question).

RDAS	Always agree	Almost always agree	Occasionally disagree	Frequently disagree	Almost always disagree	Always disagree
1. Religious matters	5	4	3	2	1	0
2. Demonstrations of affection	5	4	3	2	1	0
3. Making major decisions	5	4	3	2	1	0
4. Sex relations	5	4	3	2	1	0
5. Conventionality (correct or proper [illegible])	5	4	3	2	1	0
6. Career decisions	5	4	3	2	1	0

INSTRUCTIONS: Please indicate the best answer to each of the following questions using the scale below. (Circle one answer for each question).

	All the time	Most of the time	More often than not	Occasionally	Rarely	Never
7. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	5	4	3	2	1	0
8. How often do you and your partner quarrel?	5	4	3	2	1	0
9. Do you ever regret that you married (or lived together)?	5	4	3	2	1	0
10. How often do you and your partner "get on each other's nerves"?	5	4	3	2	1	0

INSTRUCTIONS: How often would you say the following events occur between you and your partner?

	More than once a day	Once a day	Once or twice a week	Once or twice a month	Less than once a month	Never
11. Have a stimulating exchange of ideas?	5	4	3	2	1	0
12. Work together on a project?	5	4	3	2	1	0
13. Calmly discuss something?	5	4	3	2	1	0

INSTRUCTIONS: Please indicate the best answer to the following question using the scale below. (Circle one answer).

	Every day	Almost every day	Occasionally	Rarely	Never
14. How often do you and your partner engage in outside interests together?	5	4	3	2	1

INSTRUCTIONS: Please carefully read each of the following statements. Each statement describes an event that could possibly occur in your relationship. Using the scale described below, indicate how likely it is that the described event will occur in your current relationship with your partner. Remember that we are not asking whether the described event has actually occurred in your current relationship. Instead, indicate your belief about the likelihood that the event could occur in the near future.

S. A. F. E.	**Extremely Unlikely**	**Very Unlikely**	**Somewhat Unlikely**	**Somewhat Likely**	**Very Likely**	**Extremely Likely**
1. My partner will refuse to talk to me.	1	2	3	4	5	6
2. My partner will allow me to come and go as I please.	1	2	3	4	5	6
3. My partner will threaten to harm me.	1	2	3	4	5	6
4. My partner will deny that my thoughts or feelings are valid.	1	2	3	4	5	6
5. My partner will encourage me to have my own friends.	1	2	3	4	5	6
6. My partner will physically restrain me.	1	2	3	4	5	6
7. My partner will say things to make me feel stupid.	1	2	3	4	5	6
8. My partner will restrict my communication with other people.	1	2	3	4	5	6
9. My partner will be physically aggressive toward me.	1	2	3	4	5	6
10. My partner will curse at me or call me unkind names.	1	2	3	4	5	6
11. My partner will be jealous.	1	2	3	4	5	6
12. My partner will physically hurt me.	1	2	3	4	5	6
13. My partner will yell at me.	1	2	3	4	5	6
14. My partner will prevent me from having relationships with other people.	1	2	3	4	5	6
15. My partner will use a weapon to hurt me.	1	2	3	4	5	6

INSTRUCTIONS: No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired or for some other reason, couples may also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please mark whether you did each of these things since the last time you completed this survey, and whether your partner did them since the last time you completed the survey.

CTS2S	**YES**	**NO**

3. I insulted or swore or shouted or yelled at my partner.	Y	N
4. *My partner insulted or swore or shouted or yelled at me.*	Y	N
5. I had a sprain, bruise, or small cut, or felt pain the next day because of a fight with my partner.	Y	N
6. *My partner had a sprain, bruise, or small cut, or felt pain the next day because of a fight with me.*	Y	N
9. I pushed, shoved or slapped my partner.	Y	N
CTS2S	**YES**	**NO**
10. *My partner pushed, shoved or slapped me.*	Y	N
11. I punched or kicked or beat-up my partner.	Y	N
12. *My partner punched or kicked or beat-me-up.*	Y	N
13. I destroyed something belonging to my partner or threatened to hit my partner.	Y	N
14. *My partner destroyed something belonging to me or threatened to hit me.*	Y	N
15. I went to see a doctor (M.D.) or needed to see a doctor because of a fight with my partner.	Y	N
16. *My partner went to see a doctor (M.D.) or needed to see a doctor because of a fight with me.*	Y	N
17. I used force (like hitting, holding down, or using a weapon) to make my partner have sex.	Y	N
18. *My partner used force (like hitting, holding down, or using a weapon) to make me have sex.*	Y	N
19. I insisted on sex when my partner did not want to or insisted on sex without a condom (but did not use physical force).	Y	N
20. *My partner insisted on sex when I did not want to or insisted on sex without a condom (but did not use physical force).*	Y	N

Appendix C: Session 10 Follow Up Assessment

Session 10 Assessments

CASE #:_____ ROLE:_____ TODAY'S DATE:

____/____/_____

What is your gender? ❑ 1. Male ❑ 2. Female ❑ 3. Other

What is your date of birth? ___/___/_____ (mm/dd/yyyy)

INSTRUCTIONS: In the past 7 days, how much have you been bothered or distressed by any of these?
Your first reaction should be your answer:

BSI	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1. Faintness or dizziness	0	1	2	3	4
2. Feeling no interest in things	0	1	2	3	4
3. Nervousness or shakiness inside	0	1	2	3	4
4. Pains in heart or chest	0	1	2	3	4
5. Feeling lonely	0	1	2	3	4
6. Feeling tense or keyed up	0	1	2	3	4
7. Nausea or upset stomach	0	1	2	3	4
8. Feeling blue	0	1	2	3	4
9. Suddenly scared for no reason	0	1	2	3	4
10. Trouble getting your breath	0	1	2	3	4
11. Feelings of worthlessness	0	1	2	3	4
12. Spells of terror or panic	0	1	2	3	4
13. Numbness or tingling in parts of your body	0	1	2	3	4
14. Feeling hopeless about the future	0	1	2	3	4
15. Feeling so restless you couldn't sit still	0	1	2	3	4
16. Feeling weak in parts of your body	0	1	2	3	4
17. Thoughts of ending your life	0	1	2	3	4
18. Feeling fearful	0	1	2	3	4

INSTRUCTIONS: Looking back over the last week, including today, help us understand how you have been feeling.
Read each item carefully and circle the number under the category which best describes your current situation.
For this questionnaire, work is defined as employment, school, housework, volunteer work, and

so forth.					
OQ - 45.2	**Almost always**	**Frequently**	**Sometimes**	**Rarely**	**Never**
1. I get along well with others.	5	4	3	2	1
2. I tire quickly.	5	4	3	2	1
3. I feel no interest in things.	5	4	3	2	1
4. I feel stressed at work/school.	5	4	3	2	1
5. I blame myself for things.	5	4	3	2	1
OQ - 45.2	**Almost always**	**Frequently**	**Sometimes**	**Rarely**	**Never**
6. I feel irritated.	5	4	3	2	1
7. I feel unhappy in my marriage/significant relationship.	5	4	3	2	1
8. I have thought of ending my life.	5	4	3	2	1
9. I feel weak.	5	4	3	2	1
10. I feel fearful.	5	4	3	2	1
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	5	4	3	2	1
12. I find my work/school satisfying.	5	4	3	2	1
13. I am a happy person.	5	4	3	2	1
14. I work/study too much.	5	4	3	2	1
15. I feel worthless.	5	4	3	2	1
16. I am concerned about family troubles.	5	4	3	2	1
17. I have an unfulfilling sex life.	5	4	3	2	1
18. I feel lonely.	5	4	3	2	1
19. I have frequent arguments.	5	4	3	2	1
20. I feel loved and wanted.	5	4	3	2	1
21. I enjoy my spare time.	5	4	3	2	1
22. I have difficulty concentrating.	5	4	3	2	1
23. I feel hopeless about the future.	5	4	3	2	1
24. I like myself.	5	4	3	2	1
25. Disturbing thoughts come into my mind that I cannot get rid of.	5	4	3	2	1
26. I feel annoyed by people who criticize my drinking (or drug use).	5	4	3	2	1
27. I have an upset stomach.	5	4	3	2	1

28. I am not working/studying as well as I used to.	5	4	3	2	1
29. My heart pounds too much.	5	4	3	2	1
30. I have trouble getting along with friends and close acquaintances.	5	4	3	2	1
31. I am satisfied with my life.	5	4	3	2	1
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never")	5	4	3	2	1
33. I feel that something bad is going to happen.	5	4	3	2	1
34. I have sore muscles	5	4	3	2	1
35. I feel afraid of open spaces, of driving, or being on buses subways, and so forth.	5	4	3	2	1
36. I feel nervous.	5	4	3	2	1

OQ - 45.2	Almost always	Frequently	Sometimes	Rarely	Never
37. I feel my love relationships are full and complete.	5	4	3	2	1
38. I feel that I am not doing well at work/school.	5	4	3	2	1
39. I have too many disagreements at work/school.	5	4	3	2	1
40. I feel something is wrong with my mind.	5	4	3	2	1
41. I have trouble falling asleep or staying asleep.	5	4	3	2	1
42. I feel blue.	5	4	3	2	1
43. I am satisfied with my relationships with others.	5	4	3	2	1
44. I feel angry enough at work/school to do something I might regret.	5	4	3	2	1
45. I have headaches.	5	4	3	2	1

If you are currently in a relationship (married, dating, cohabiting), please continue to the next page and answer the remaining questions. If not, please stop here.

INSTRUCTIONS: Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. (Circle one answer for each question).

RDAS	Always agree	Almost always agree	Occasionally disagree	Frequently disagree	Almost always disagree	Always disagree
1. Religious matters	5	4	3	2	1	0
2. Demonstrations of affection	5	4	3	2	1	0
3. Making major decisions	5	4	3	2	1	0
4. Sex relations	5	4	3	2	1	0
5. Conventionality (correct or proper [illegible])	5	4	3	2	1	0
6. Career decisions	5	4	3	2	1	0

INSTRUCTIONS: Please indicate the best answer to each of the following questions using the scale below. (Circle one answer for each question).

	All the time	Most of the time	More often than not	Occasionally	Rarely	Never
7. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	5	4	3	2	1	0
8. How often do you and your partner quarrel?	5	4	3	2	1	0
9. Do you ever regret that you married (or lived together)?	5	4	3	2	1	0
10. How often do you and your partner "get on each other's nerves"?	5	4	3	2	1	0

INSTRUCTIONS: How often would you say the following events occur between you and your partner?

	More than once a day	Once a day	Once or twice a week	Once or twice a month	Less than once a month	Never
11. Have a stimulating exchange of ideas?	5	4	3	2	1	0
12. Work together on a project?	5	4	3	2	1	0
13. Calmly discuss something?	5	4	3	2	1	0

INSTRUCTIONS: Please indicate the best answer to the following question using the scale below. (Circle one answer).

	Every day	Almost every day	Occasionally	Rarely	Never
14. How often do you and your partner engage in outside interests together?	5	4	3	2	1

INSTRUCTIONS: Please carefully read each of the following statements. Each statement describes an event that could possibly occur in your relationship. Using the scale described below, indicate how likely it is that the described event will occur in your current relationship with your partner. Remember that we are not asking whether the described event has actually occurred in your current relationship. Instead, indicate your belief about the likelihood that the event could occur in the near future.

S. A. F. E.	**Extremely Unlikely**	**Very Unlikely**	**Somewhat Unlikely**	**Somewhat Likely**	**Very Likely**	**Extremely Likely**
1. My partner will refuse to talk to me.	1	2	3	4	5	6
2. My partner will allow me to come and go as I please.	1	2	3	4	5	6
3. My partner will threaten to harm me.	1	2	3	4	5	6
4. My partner will deny that my thoughts or feelings are valid.	1	2	3	4	5	6
5. My partner will encourage me to have my own friends.	1	2	3	4	5	6
6. My partner will physically restrain me.	1	2	3	4	5	6
7. My partner will say things to make me feel stupid.	1	2	3	4	5	6
8. My partner will restrict my communication with other people.	1	2	3	4	5	6
9. My partner will be physically aggressive toward me.	1	2	3	4	5	6
10. My partner will curse at me or call me unkind names.	1	2	3	4	5	6
11. My partner will be jealous.	1	2	3	4	5	6
12. My partner will physically hurt me.	1	2	3	4	5	6
13. My partner will yell at me.	1	2	3	4	5	6
14. My partner will prevent me from having relationships with other people.	1	2	3	4	5	6
15. My partner will use a weapon to hurt me.	1	2	3	4	5	6

INSTRUCTIONS: No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired or for some other reason, couples may also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please mark whether you did each of these things since the last time you completed this survey, and whether your partner did them since the last time you completed the survey.

CTS2S	**YES**	**NO**
3. I insulted or swore or shouted or yelled at my partner.	Y	N
4. *My partner insulted or swore or shouted or yelled at me.*	Y	N
5. I had a sprain, bruise, or small cut, or felt pain the next day because of a fight with my partner.	Y	N
6. *My partner had a sprain, bruise, or small cut, or felt pain the next day because of a fight with me.*	Y	N
9. I pushed, shoved or slapped my partner.	Y	N
CTS2S	**YES**	**NO**
10. *My partner pushed, shoved or slapped me.*	Y	N
11. I punched or kicked or beat-up my partner.	Y	N
12. *My partner punched or kicked or beat-me-up.*	Y	N
13. I destroyed something belonging to my partner or threatened to hit my partner.	Y	N
14. *My partner destroyed something belonging to me or threatened to hit me.*	Y	N
15. I went to see a doctor (M.D.) or needed to see a doctor because of a fight with my partner.	Y	N
16. *My partner went to see a doctor (M.D.) or needed to see a doctor because of a fight with me.*	Y	N
17. I used force (like hitting, holding down, or using a weapon) to make my partner have sex.	Y	N
18. *My partner used force (like hitting, holding down, or using a weapon) to make me have sex.*	Y	N
19. I insisted on sex when my partner did not want to or insisted on sex without a condom (but did not use physical force).	Y	N
20. *My partner insisted on sex when I did not want to or insisted on sex without a condom (but did not use physical force).*	Y	N

Appendix D: Final Session Assessment

Termination Assessments

CASE #:_____ ROLE:_____ TODAY'S DATE:

____/____/_____

What is your gender? ❑ 1. Male ❑ 2. Female ❑ 3. Other

What is your date of birth? ___/___/_____ (mm/dd/yyyy)

INSTRUCTIONS: In the past 2 weeks, how much have you been bothered or distressed by any of these?
Your first reaction should be your answer:

BSI	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1. Nervousness or shakiness inside	0	1	2	3	4
2. Faintness or dizziness	0	1	2	3	4
3. The idea that someone else can control your thoughts	0	1	2	3	4
4. Feeling others are to blame for most of your troubles	0	1	2	3	4
5. Trouble remembering things	0	1	2	3	4
6. Feeling easily annoyed or irritated	0	1	2	3	4
7. Pains in heart or chest	0	1	2	3	4
8. Feeling afraid in open spaces or on the streets	0	1	2	3	4
9. Thoughts of ending your life	0	1	2	3	4
10. Feeling that most people cannot be trusted	0	1	2	3	4
11. Poor appetite	0	1	2	3	4
12. Suddenly scared for no reason	0	1	2	3	4
13. Temper outbursts that you could not control	0	1	2	3	4
14. Feeling lonely even when you are with people	0	1	2	3	4
15. Feeling blocked in getting things done	0	1	2	3	4
16. Feeling lonely	0	1	2	3	4
17. Feeling blue	0	1	2	3	4
18. Feeling no interest in things	0	1	2	3	4
19. Feeling fearful	0	1	2	3	4
20. Your feelings being easily hurt	0	1	2	3	4
21. Feeling that people are unfriendly or dislike you	0	1	2	3	4
22. Feeling inferior to others	0	1	2	3	4
23. Nausea or upset stomach	0	1	2	3	4

24. Feeling that you are watched or talked about by others	0	1	2	3	4
25. Trouble falling asleep	0	1	2	3	4
26. Having to check and double-check what you do	0	1	2	3	4
27. Difficulty making decisions	0	1	2	3	4
28. Feeling afraid to travel on buses, subways, or trains	0	1	2	3	4
29. Trouble getting your breath	0	1	2	3	4
30. Hot or cold spells	0	1	2	3	4
BSI	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
31. Having to avoid certain things, places, or activities because they frighten you	0	1	2	3	4
32. Your mind going blank	0	1	2	3	4
33. Numbness or tingling in parts of your body	0	1	2	3	4
34. The idea that you should be punished for your sins	0	1	2	3	4
35. Feeling hopeless about the future	0	1	2	3	4
36. Trouble concentrating	0	1	2	3	4
37. Feeling weak in parts of your body	0	1	2	3	4
38. Feeling tense or keyed up	0	1	2	3	4
39. Thoughts of death or dying	0	1	2	3	4
40. Having urges to beat, injure, or harm someone	0	1	2	3	4
41. Having urges to break or smash things	0	1	2	3	4
42. Feeling very self conscious with others	0	1	2	3	4
43. Feeling uneasy in crowds, such as shopping or at a movie	0	1	2	3	4
44. Never feeling close to another person	0	1	2	3	4
45. Spells of terror or panic	0	1	2	3	4
46. Getting into frequent arguments	0	1	2	3	4
47. Feeling nervous when you are left alone	0	1	2	3	4
48. Others not giving you proper credit for your achievements	0	1	2	3	4
49. Feeling so restless you couldn't sit still	0	1	2	3	4
50. Feelings of worthlessness	0	1	2	3	4
51. Feeling people will take advantage of you if you let them	0	1	2	3	4
52. Feelings of guilt	0	1	2	3	4
53. The idea that something is wrong with your mind	0	1	2	3	4

INSTRUCTIONS: Looking back over the last week, including today, help us understand how you have been feeling.
Read each item carefully and circle the number under the category which best describes your current situation.
For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.

OQ - 45.2	**Almost always**	**Frequently**	**Sometimes**	**Rarely**	**Never**
1. I get along well with others.	5	4	3	2	1
2. I tire quickly.	5	4	3	2	1
3. I feel no interest in things.	5	4	3	2	1
4. I feel stressed at work/school.	5	4	3	2	1
5. I blame myself for things.	5	4	3	2	1
OQ - 45.2	**Almost always**	**Frequently**	**Sometimes**	**Rarely**	**Never**
6. I feel irritated.	5	4	3	2	1
7. I feel unhappy in my marriage/significant relationship.	5	4	3	2	1
8. I have thought of ending my life.	5	4	3	2	1
9. I feel weak.	5	4	3	2	1
10. I feel fearful.	5	4	3	2	1
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	5	4	3	2	1
12. I find my work/school satisfying.	5	4	3	2	1
13. I am a happy person.	5	4	3	2	1
14. I work/study too much.	5	4	3	2	1
15. I feel worthless.	5	4	3	2	1
16. I am concerned about family troubles.	5	4	3	2	1
17. I have an unfulfilling sex life.	5	4	3	2	1
18. I feel lonely.	5	4	3	2	1
19. I have frequent arguments.	5	4	3	2	1
20. I feel loved and wanted.	5	4	3	2	1
21. I enjoy my spare time.	5	4	3	2	1
22. I have difficulty concentrating.	5	4	3	2	1
23. I feel hopeless about the future.	5	4	3	2	1

24. I like myself.	5	4	3	2	1
25. Disturbing thoughts come into my mind that I cannot get rid of.	5	4	3	2	1
26. I feel annoyed by people who criticize my drinking (or drug use).	5	4	3	2	1
27. I have an upset stomach.	5	4	3	2	1
28. I am not working/studying as well as I used to.	5	4	3	2	1
29. My heart pounds too much.	5	4	3	2	1
30. I have trouble getting along with friends and close acquaintances.	5	4	3	2	1
31. I am satisfied with my life.	5	4	3	2	1
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never")	5	4	3	2	1
33. I feel that something bad is going to happen.	5	4	3	2	1
34. I have sore muscles	5	4	3	2	1
35. I feel afraid of open spaces, of driving, or being on buses subways, and so forth.	5	4	3	2	1
36. I feel nervous.	5	4	3	2	1

OQ - 45.2	**Almost always**	**Frequently**	**Sometimes**	**Rarely**	**Never**
37. I feel my love relationships are full and complete.	5	4	3	2	1
38. I feel that I am not doing well at work/school.	5	4	3	2	1
39. I have too many disagreements at work/school.	5	4	3	2	1
40. I feel something is wrong with my mind.	5	4	3	2	1
41. I have trouble falling asleep or staying asleep.	5	4	3	2	1
42. I feel blue.	5	4	3	2	1
43. I am satisfied with my relationships with others.	5	4	3	2	1
44. I feel angry enough at work/school to do something I might regret.	5	4	3	2	1
45. I have headaches.	5	4	3	2	1

INSTRUCTIONS: The purpose of this scale is to measure the frequency and severity of symptoms that you may have been experiencing in the <u>past two weeks</u> in reaction to a stressful event or events that occurred any time in your life. Please indicate the frequency (how often you have the symptom in the past two weeks) to the left of each question. Then indicate the severity (how upsetting the symptom is) by circling the letter that fits best on the right side.

FREQUENCY				MPSS-SR	**SEVERITY**				
Not at All	**Once a Week or Less**	**2 to 4 Times a Week**	**5 Or More Times A Week**		**Not At All Disturbing**	**A Little Bit Disturbing**	**Moderately Distressing**	**Quite A Bit Distressing**	**Extremely Distressing**
0	1	2	3	1. Have you had repeated or intrusive upsetting thoughts or recollections of the event(s)?	A	B	C	D	E
0	1	2	3	2. Have you been having repeated bad dreams or nightmares about the event(s)?	A	B	C	D	E
0	1	2	3	3. Have you had the experience of suddenly reliving the event(s), flashbacks of it or acting or feeling as if the event(s) were happening again?	A	B	C	D	E
0	1	2	3	4. Have you been intensely EMOTIONALLY upset when reminded of the event(s), including	A	B	C	D	E

				anniversaries of when it happened?					
0	1	2	3	5. Do you often make efforts to avoid thoughts or feelings associated with the event(s)?	A	B	C	D	E
0	1	2	3	6. Do you often make efforts to avoid activities, situations, or places that remind you of the event(s)?	A	B	C	D	E
0	1	2	3	7. Are there any important aspects about the event(s) that you still cannot recall?	A	B	C	D	E

FREQUENCY				MPSS-SR	**SEVERITY**				
Not at All	**Once a Week or Less**	**2 to 4 Times a Week**	**5 Or More Times A Week**		**Not At All Disturbing**	**A Little Bit Disturbing**	**Moderately Distressing**	**Quite A Bit Distressing**	**Extremely Distressing**
0	1	2	3	8. Have you markedly lost interest in free time activities that used to be important to you?	A	B	C	D	E
0	1	2	3	9. Have you felt detached or cut off from others around you since the event?	A	B	C	D	E
0	1	2	3	10. Have you felt that your ability to experience emotions is less (unable to have loving feelings, feel numb, or can't cry when sad)?	A	B	C	D	E
0	1	2	3	11. Have you felt that any future plans or hopes have changed because of the event(s) (for example: no career, committed relationship, marriage, children, or long life)?	A	B	C	D	E
0	1	2	3	12. Have you been having a lot of difficulty falling or staying asleep?	A	B	C	D	E
0	1	2	3	13. Have you been continuously irritable or having outbursts of anger?	A	B	C	D	E
0	1	2	3	14. Have you been having persistent difficulty concentrating?	A	B	C	D	E
0	1	2	3	15. Are you overtly alert (checking to see who is around you) since the event(s)?	A	B	C	D	E
0	1	2	3	16. Have you been jumpier, more easily startled, since the event(s)?	A	B	C	D	E

0	1	2	3	17. Have you been having intense PHYSICAL reactions (for example: sweating, heart beating fast) when reminded of the event(s)?	A	B	C	D	E

If you are currently in a relationship (married, dating, cohabiting), please continue to the next page and answer the remaining questions. If not, please stop here.

INSTRUCTIONS: Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. (Circle one answer for each question).

RDAS	Always agree	Almost always agree	Occasionally disagree	Frequently disagree	Almost always disagree	Always disagree
1. Religious matters	5	4	3	2	1	0
2. Demonstrations of affection	5	4	3	2	1	0
3. Making major decisions	5	4	3	2	1	0
4. Sex relations	5	4	3	2	1	0
5. Conventionality (correct or proper [illegible])	5	4	3	2	1	0
6. Career decisions	5	4	3	2	1	0

INSTRUCTIONS: Please indicate the best answer to each of the following questions using the scale below. (Circle one answer for each question).

	All the time	Most of the time	More often than not	Occasionally	Rarely	Never
7. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	5	4	3	2	1	0
8. How often do you and your partner quarrel?	5	4	3	2	1	0
9. Do you ever regret that you married (or lived together)?	5	4	3	2	1	0
10. How often do you and your partner "get on each other's nerves"?	5	4	3	2	1	0

INSTRUCTIONS: How often would you say the following events occur between you and your partner?

	More than once a day	Once a day	Once or twice a week	Once or twice a month	Less than once a month	Never
11. Have a stimulating exchange of ideas?	5	4	3	2	1	0
12. Work together on a project?	5	4	3	2	1	0
13. Calmly discuss something?	5	4	3	2	1	0

INSTRUCTIONS: Please indicate the best answer to the following question using the scale below. (Circle one answer).

	Every day	Almost every day	Occasionally	Rarely	Never
14. How often do you and your partner engage in outside interests together?	5	4	3	2	1

INSTRUCTIONS: Please carefully read each of the following statements. Each statement describes an event that could possibly occur in your relationship. Using the scale described below, indicate how likely it is that the described event will occur in your current relationship with your partner. Remember that we are not asking whether the described event has actually occurred in your current relationship. Instead, indicate your belief about the likelihood that the event could occur in the near future.

S. A. F. E.	**Extremely Unlikely**	**Very Unlikely**	**Somewhat Unlikely**	**Somewhat Likely**	**Very Likely**	**Extremely Likely**
1. My partner will refuse to talk to me.	1	2	3	4	5	6
2. My partner will allow me to come and go as I please.	1	2	3	4	5	6
3. My partner will threaten to harm me.	1	2	3	4	5	6
4. My partner will deny that my thoughts or feelings are valid.	1	2	3	4	5	6
5. My partner will encourage me to have my own friends.	1	2	3	4	5	6
6. My partner will physically restrain me.	1	2	3	4	5	6
7. My partner will say things to make me feel stupid.	1	2	3	4	5	6
8. My partner will restrict my communication with other people.	1	2	3	4	5	6
9. My partner will be physically aggressive toward me.	1	2	3	4	5	6
10. My partner will curse at me or call me unkind names.	1	2	3	4	5	6
11. My partner will be jealous.	1	2	3	4	5	6
12. My partner will physically hurt me.	1	2	3	4	5	6
13. My partner will yell at me.	1	2	3	4	5	6
14. My partner will prevent me from having relationships with other people.	1	2	3	4	5	6
15. My partner will use a weapon to hurt me.	1	2	3	4	5	6

INSTRUCTIONS: No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired or for some other reason, couples may also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please mark whether you did each of these things since the last time you completed this survey, and whether your partner did them since the last time you completed the survey.

CTS2S	**YES**	**NO**
3. I insulted or swore or shouted or yelled at my partner.	Y	N
4. *My partner insulted or swore or shouted or yelled at me.*	Y	N
5. I had a sprain, bruise, or small cut, or felt pain the next day because of a fight with my partner.	Y	N
6. *My partner had a sprain, bruise, or small cut, or felt pain the next day because of a fight with me.*	Y	N
9. I pushed, shoved or slapped my partner.	Y	N
CTS2S	**YES**	**NO**
10. *My partner pushed, shoved or slapped me.*	Y	N
11. I punched or kicked or beat-up my partner.	Y	N
12. *My partner punched or kicked or beat-me-up.*	Y	N
13. I destroyed something belonging to my partner or threatened to hit my partner.	Y	N
14. *My partner destroyed something belonging to me or threatened to hit me.*	Y	N
15. I went to see a doctor (M.D.) or needed to see a doctor because of a fight with my partner.	Y	N
16. *My partner went to see a doctor (M.D.) or needed to see a doctor because of a fight with me.*	Y	N
17. I used force (like hitting, holding down, or using a weapon) to make my partner have sex.	Y	N
18. *My partner used force (like hitting, holding down, or using a weapon) to make me have sex.*	Y	N
19. I insisted on sex when my partner did not want to or insisted on sex without a condom (but did not use physical force).	Y	N
20. *My partner insisted on sex when I did not want to or insisted on sex without a condom (but did not use physical force).*	Y	N

Thank-you for taking the time to accurately complete this intake information packet!

Appendix E: Clinical IPV Assessment

Clinical IPV Assessment

"Because participation in therapy has the potential to raise sensitive or difficult subjects, when working with couples or families, it is helpful for us to have a clear picture of what conflict looks like in your relationship. What does it look like or what happens when there is conflict between you and your partner?"

"When the conflict is at its worst, has there ever been a time when one of you raised your voice or became aggressive?

"Have you or your partner ever resorted to physical means to stop an argument, get your way, or prevent your partner from doing something?"

1. "Have you ever been physically violent toward your partner? For example, have you ever grabbed, pushed, slapped, hit, physically restrained or prevented your partner from leaving a space? Have you ever done anything else that might make your partner feel physically threatened?"

❑**Yes** ❑**No**

2. "Has your partner ever been physically violent toward you? For example, has your partner ever grabbed, pushed, slapped, hit, physically restrained or prevented you from leaving a space? Has your partner ever done anything else that made you feel physically threatened?"

❑**Yes** ❑**No**

IF THE ANSWER TO **EITHER** QUESTION 2 OR QUESTION 3 WAS **YES**, **SKIP TO 5**

3. "Have you ever been verbally aggressive toward your partner? For example, have you ever yelled at your partner, called them names, said things to make them feel stupid, or tried to control them?"

❑**No** ❑**Yes**

4. "Has your partner ever been verbally aggressive toward you? For example, have they ever yelled at you, called you names, said things to make you feel stupid, or tried to control you?"

❑**No** ❑**Yes**

IF THE ANSWER TO **BOTH** QUESTION 3 AND QUESTION 4 WAS **NO**, **STOP HERE**

5. "Would you describe for me exactly what has happened when (you and/or your partner) is (physically violent/verbally aggressive)? If I were there watching, what would I have seen?"

Provide a behavioral description of the violence: _____

_____

_____

PERPETRATOR

6a. How often do you get physically violent/verbally aggressive toward your partner?

_____

7a. When was the last time you were physically violent/verbally aggressive toward your partner?

_____

For Physical Violence Only

8a. Have you ever used a weapon or threatened to use a weapon against your partner?

❑Yes **❑No**

9a. Has your partner ever been injured as a result of violence in your relationship? For example, have they ever had bruises, cuts, sprains, or broken bones?

❑Yes **❑No**

10a. What was the injury(s)?_____

_____

11a. Has your partner ever had to seek medical attention as a result of violence in your relationship?

❑Yes **❑No**

VICTIM

6b. How often does your partner get physically violent/verbally aggressive toward you?

_____

7b. When was the last time your partner was physically violent/verbally aggressive toward you?

_____

For Physical Violence Only

8b. Has your partner ever used a weapon or threatened to use a weapon against you?

❑Yes **❑No**

9b. Have you ever been injured as a result of violence in your relationship? For example, have you ever had bruises, cuts, sprains, or broken bones?

❑Yes **❑No**

10b. What was the injury(s)?_____

_____

11b. Have you ever had to seek medical attention as a result of violence in your relationship?

❑Yes **❑No**

12. What is the worst episode of violence that has ever happened between you and your partner? ____

_____

_____

_____

_____

_____

_____

13. Who do you think is most responsible for the violence that has occurs in your relationship?

❑Self **❑Partner** **❑Both**

14. I was planning on asking your partner the same set of questions I just asked you. It is likely they will guess that I asked you these questions. Do you feel safe if I ask your partner the same questions?

    ❑**Yes** ❑**No** ⟶ **DO NOT** CONDUCT ASSESSMENT WITH PARTNER

15. Do you feel safe if we discuss the violence you reported with your partner as part of therapy?

    ❑**Yes** ❑**No** ⟶ **DO NOT** CONDUCT CONJOINT THERAPY

16. Are you willing to sign an agreement to not engage in physical violence?

    ❑**Yes** ❑**No** ⟶ **DO NOT** CONDUCT CONJOINT THERAPY

"Thank you for your willingness to discuss what can often be a difficult subject. Your open and honest answers will help us to provide you with the best clinical services possible. When we work with couples that have reported violence in their relationship, it is our standard practice to schedule two, two hour sessions to address safety in the relationship. We know this may not be the reason you sought out therapy, but our experience tells us that addressing safety in your relationship will improve the usefulness of therapy and we believe it will also improve your chances of successfully achieving the goals for therapy that originally brought you to see us. While the next couple of sessions will focus on violence, please be assured that we take your presenting concerns seriously and will work with you to achieve the goals you define."

*****INCLUSION CRITERIA FOR IPV INTERVENTIONS*****

6) Report of PHYSICAL or VERBAL violence within the last year OR ongoing CONCERN of PHYSICAL or VERBAL violence if violence occurred over a year ago.
7) Answers to Questions 14, 15, & 16 are YES for BOTH partners.
8) Partners report similar levels of violence (Questions 6-12).
9) Violent partner(s) is able to take some responsibility for their role in the violence (Question 13).

*****EXCUSION CRITERIA FOR CONJOINT IPV INTERVENTION*****

- If neither partner reports physical or verbal violence within the last year or ongoing concern of physical or verbal violence, then proceed with therapy as normal.
- If the answer to **QUESTION 14 or 15 is NO**, conduct a goal-setting session with the violent partner and then talk to your supervisor after the session about how to proceed. Conjoint therapy is not recommended for violent couples who feel unsafe talking about the violence.
- If the answer to **QUESTION 16 is NO**, talk to your supervisor after the session about how to proceed. Therapy will not be effective if there is not safety.
- If partners meet all other criteria for inclusion, but report dissimilar levels of violence or are unable to take responsibility for their role in the violence (**Questions 6-13**), talk to

your supervisor about how to proceed. Conjoint therapy is not recommend when these criteria are not met.

If you have questions or concerns about scheduling an IPV Intervention, you may call Doug at ###-#### or Jason at ###-####.

Texas Tech University Family Therapy Clinic
Contract of Violence Prevention

I agree that I will not use any form of physical aggression toward my partner. I will not hit, slap, push, kick, restrain, block my partner's movements, put my hand on my partner during conflict, or attempt to control my partner's actions.

If I believe that there is a risk for physical aggression, because either myself or my partner is losing control of their behavior, I will call a time-out for myself, enact my safety plan, leave the area, or call 911 as needed.

_____ _____

Signature of Client Date

_____

Signature of Therapist

Appendix F: Recruiting and Purpose Scripts

Recruitment Script

The TTU Family Therapy Clinic is currently researching how well we work with couples who have a history of violence. This violence could be physical or verbal. We are asking couples that complete the Violence Intervention to participate in the research. You can choose to participate in this research or you can choose not to participate. If you participate in the research, you will fill out another assessment packet, for which you will receive $15.00. You will also complete a one hour interview with a graduate student here at the clinic and will be paid $20.00 for the interview. You do not have to do both parts and you can stop participating at any time during the assessment or interview if you feel uncomfortable. Not participating in the research will not affect the services you receive here. We will use this information to better serve future clients. The information collected is confidential and we will not use your name to identify the data. Data will be identified using a case number and will be linked to the assessment packet you completed at Intake. If you have questions, you can address them to Douglas Smith in the Department of Marriage and Family Therapy here at Texas Tech.

Purpose Script

When there has been violence, be it physical or verbal, it can make partners feel unsafe to address other issues in their relationship. As such, these sessions have three goals:

1) To help partners feel more safe from verbal or physical violence.
2) To help partners know what to do when they begin to feel unsafe.
3) To provide you with tools for resolving conflict.

We will accomplish these goals by examining what conflict looks like in your relationship, how conflict escalates, and the effects of violence on the relationship. We will develop a plan for maintaining safety when conflict does escalate. We believe that by helping you create a sense of safety in your relationship, it will better enable you to resolve the issues for which you came to therapy.

The session today is divided into two parts. During the first hour, we are going to meet with you individually to talk about what conflict looks like in your relationship and how it escalates. We'll also talk about how to stay safe during an argument. During the second hour, if it is appropriate, we will meet with you both together to talk about how to stop conflict from escalating into violence.

What questions to you have so far?

Appendix G: Informed Consent

Informed Consent Form

We would like your help with a research study. What we learn will help us work with couples and families like yours.

In this study, you will be asked to complete one survey in addition to the surveys you complete as part of your regular services at the clinic. The surveys will ask about your relationship, your concerns, and your general well-being. The survey will take about 30 minutes. Your answers will be kept without any information that would identify you. You will receive $15 for completing the survey.

In this study, you will also be asked to be interviewed by a research assistant about your experiences in therapy and your thoughts about how to improve the work we do. The interview will be audio recorded so it can be transcribed. The recording will be destroyed once the transcription is complete and the written transcript will be kept without any information that would identify you. You will receive $20 for completing the interview.

We think you can answer the questions safely. You can stop answering questions any time you wish. You can still come to the Texas Tech Family Therapy Clinic whether or not you are in the research.

- The study is being run by Douglas B. Smith and Jason B. Whiting. They are from the Marriage and Family Department at Texas Tech University. You can call them at (806-742-3060). You can write to them at Box 41162, Texas Tech University, Lubbock, TX 79409-1162.

- TTU also has a Board that protects the rights of people who participate in research. You can call them at 806-742-2064. You can write to them at the Human Research Protection Program, Office of the Vice President for Research, Texas Tech University, Lubbock, TX 79409.

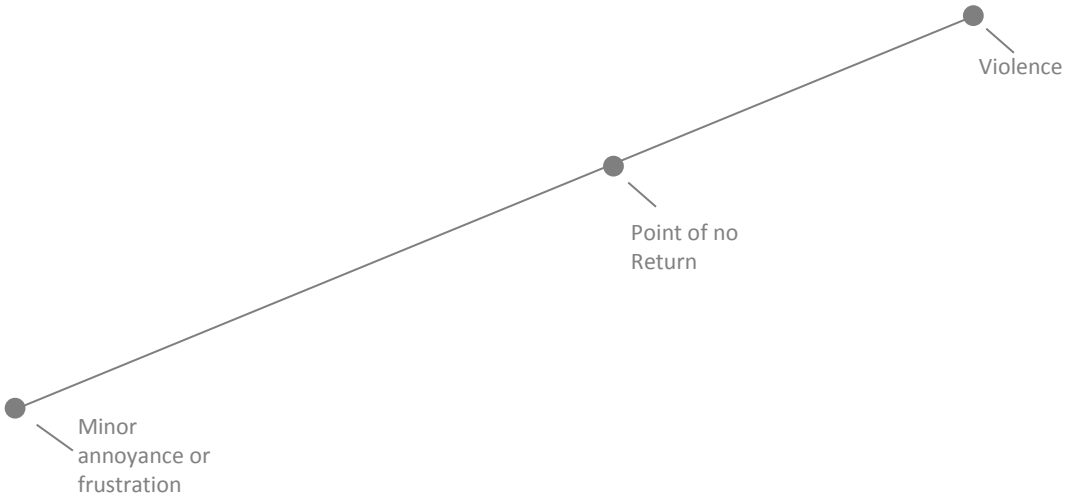
_____	_____	_____
Participant Name (Print)	Signature	Date

This consent form expires on May 31, 2013.

Appendix H: Safety Plans for Session I/Unit

Safety Worksheet
Primary Victim

Goal One: Identify pattern of escalation that lead to violence. What does conflict look like in this relationship? What behaviors, thoughts, sensations, and feelings indicate escalation? What is the "point of no return" indicating that violence is likely?



Goal Two: Identify strategies to reduce tension and prevent escalation. What is different about the conflicts that don't escalate to violence? What has worked in the past to reduce tension? Examples: journaling, walking the dog, cleaning the kitchen, being agreeable, smoking a cigarette, etc.

Goal Three: Identify strategies for recovering safety if violence occurs or becomes imminent. If you begin to feel unsafe or scared, what will you do? Where will you go? Who can you call? Are there things you need to have ready, such as a cell phone, bag, or credit cards, in case you need to leave?

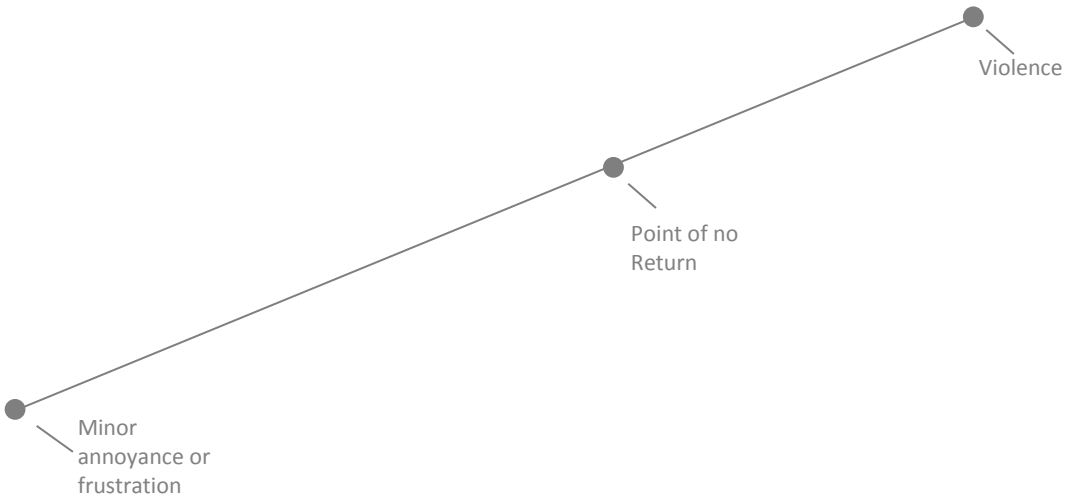
I agree to follow the plan outlined above for preventing escalation and maintaining safety. If I feel unsafe or am concerned that violence will occur, I will call 911.

_____ _____

Client Signature & Date Therapist Signature & Date

Safety Worksheet
Primary Perpetrator

Goal One: Identify pattern of escalation that lead to violence. What does conflict look like in this relationship? What behaviors, thoughts, sensations, and feelings indicate escalation? What is the "point of no return" indicating that violence is likely?



Goal Two: Identify strategies to reduce tension and prevent escalation. What is different about the conflicts that don't escalate to violence? What has worked in the past to reduce tension? Examples: journaling, walking the dog, cleaning the kitchen, smoking a cigarette, practicing mindfulness, etc.

I agree to follow the plan outlined above for preventing escalation and maintaining safety.

_____ _____

Client Signature & Date Therapist Signature & Date

Appendix I: Session I/Unit II NTO Worksheet and Contract

Negotiated Time Out Contract

I, _____ and I, _____ voluntarily enter into the following agreement for the purpose of creating safety in our relationship:

We agree that either of us may call a time-out for ***OURSELVES*** if either of us is feeling unsafe because of our partner's behavior or because we are concerned about our ability to control our own behavior.

We agree to respect our partner's time-out when they call for one no matter what.

Time-Out Signal

We agree to use the following signal to call a time-out for ourselves: _____

Time-Out Location

I, _____, will go to the following location when I call a time-out for myself: _____.

I, _____, will go to the following location when I call a time-out for myself: _____.

Length of Time-Out

I, _____, will remain in my time-out location for _____ when I call a time-out for myself. If I need additional time, I will let my partner know that I need an additional time-out.

I, _____, will remain in my time-out location for _____ when I call a time-out for myself. If I need additional time, I will let my partner know that I need an additional time-out.

Returning

We agree that after the time indicated above, we will reconnect with our partner, unless we have reason to believe doing so is not safe, and together we will decide whether to:

1) Continue the activities or discussion that were interrupted by the time-out
2) Postpone the activities or discussion
3) Drop the activities or discussion.

Client Signature	Date
Client Signature	Date

Negotiated Time Out Worksheet

This worksheet is designed to help couples make a plan for remaining calm when it seems like anger is escalating. Put your names in the columns below and then answer the questions for both you and your partner. Then, copy your answers into the contract.

Don't forget to practice time-outs while you're calm and that time-outs can be renegotiated as needed.

Name:
Step One: Awareness. How do you know when your anger or your partner's is escalating? List below some cues that will help you know that a time out is needed.
Step Two: Staying in the Safety Zone. What is the point of no return? How will you know based on what you are thinking, feeling, or doing that it is time for a break?
Step Three: Signaling. How will you let each other know that you need a time out? List some ideas.
Step Four: Acknowledging. How can you prevent yourself from pursuing the argument? How will you acknowledge that your partner has called a timeout?
Step Five: Disengaging. Where will you go when a time out is called? Who will take care of the kids? How long will it last? List your ideas below.

Step Six: Cooling Off. How will you calm down during the time out? List your ideas below.
Step Seven: Return. How will you know you are ready to reconnect? Take another break? Table the issue? Drop it altogether? How will you check-in with one another? What will you say?

Appendix J: Semi-Structured Sample Interview Questions

Interview Questions

1. You and your partner recently participated in two therapy sessions focused on relationship violence. Please tell us about your experience of the sessions.
    a. What aspects of the sessions were helpful?
    b. What aspects of the sessions were unhelpful?
2. How do you think participation in the sessions has influenced your relationship?
3. How do you think participation in the sessions will influence your experience in therapy?
4. What advice can you offer about how to change the sessions so they would be the most helpful to future clients?
5. Sometimes when we are hurt or abused in a relationship, it is easier to "forget" the incident or deny its occurrence. Our partner may also insist that we keep the abuse "secret" or attempt to convince us that we were not abused.
6. Or, sometimes when we hurt others in a relationship, we may try to deny our part in it or even deny that our behavior is abusive. We may also try to force our partners to deny the abuse or convince them that our behavior isn't abusive at all.
    a. Can you describe times when you may have denied to yourself that behavior was abusive even though you know it was hurtful? Did you ever feel two ways about the abuse? On one hand you knew it was wrong, but on the other hand you thought it really wasn't that bad or even maybe deserved.

7. Sometimes when we are violent or abusive towards our partner, we may try to make our own behavior seem better than it really was and make our partner's behavior seem worse to excuse our behavior. We may also tend to minimize the severity of the incident to ourselves and to our partner.
    a. Can you think of examples when you may have tried to make yourself sound more innocent than you really were?
    b. Can you think of times when you may have downplayed what happened to your partner or other? Have you felt that your behavior was being blown out of proportion or you were being shown in a bad light (e.g. during an fight)?

Appendix K: Constellation Schedule

Constellation Schedule

Session	Procedure	Conjoint	Individual	Discuss with Supervisor
Intake Assessment	Clinical IPV Assessment		X	
	If inclusion criteria is met, refer client to IPV assessment	X		
	If excluded with no safety concerns	X		
	If excluded due to safety concerns		X	X
Session I	Unit I: Recruitment & Purpose Script, Safety Planning		X	
	--Break to discuss concerns with other therapist--			
	If safety is not a concern, Unit II:NTO	X		
	If safety is a concern, Until II: NTO		X	X
	Post-session check-in to discuss feelings of safety		X	
Session II	Pre-session check-in to determine if violence has occurred		X	
	--Break to discuss any concerns with other therapist--			
	If safety is not a concern, Unit III & Unit IV	X		
	If safety is a concern, Unit III & Unit IV		X	X
	Post-session check-in to discuss safety		X	
Post-Sessions	If safety is not a concern	X		
	If safety is a concern		X	X
	Periodically to check safety, even in conjoint couples		X	