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Title of Dissertation: Behavior Change Processes of Partner Violent Men: An in-depth Analysis of Recidivist Events Following Abuser Intervention Program Completion

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ABSTRACT

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Despite substantial gains made over the last four decades, intimate partner violence (IPV) remains a significant public health concern. While research has shown that abuser intervention program treatment completion decreases men's risk for recidivism, a clinically significant proportion of partner-violent men re-offend subsequent to completing treatment. A critical next step in enhancing treatment for IPV perpetration is to understand re-offense among the subsample of men who recidivate following treatment. The present study explored behavior change processes and factors for recidivism among partner-violent men who were arrested for IPV offenses following the completion of a cognitive behavioral IPV treatment program. In-depth interviews were conducted with former clients following their treatment completion in order to explore perceptions of treatment, experiences and change processes after treatment, contextual factors salient to their lives, and obstacles to staying nonviolent. A constructivist grounded theory approach was used in order to generate theory regarding behavior change and recidivist processes among men who experience difficulty staying nonviolent. Emergent qualitative themes revealed intrapersonal, interpersonal, group-level, and community-level factors for behavior change and recidivism.

# BEHAVIOR CHANGE PROCESSES OF PARTNER VIOLENT MEN: AN IN-DEPTH ANALYSIS OF RECIDIVIST EVENTS FOLLOWING ABUSER INTERVENTION PROGRAM COMPLETION

By

Galina Alexandra Portnoy

Dissertation submitted to the Faculty of the Graduate School of the
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# Dedication

For my daughter, Sasha Yael, who teaches me far more than I teach her,
who enables me to find strength where I think there is none.
It is for you, my dear girl, that I strive to make the world a better place.
This effort is dedicated to you.

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Thank you to the *undergraduate research assistants* who spent countless hours digging through criminal recidivism databases, helping me to track down participants, and later transcribing hours and hours of interviews. This work quite literally would not have been possible without you.

My gratitude to the men who participated in this study: may your stories help to advance much needed understanding and knowledge; thank you for your openness and willingness to share.

I am deeply indebted to the friends and family who cared for Sasha while I worked. It truly takes a village, and you were mine.

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## Chapter 1: Introduction

Intimate partner violence (IPV) continues to remain a significant public health problem despite women's rights activists and public health advocacy groups making substantial gains in raising consciousness regarding IPV over the last four decades. IPV is defined by the Centers for Disease Control and Prevention (CDC) as, "physical, sexual, or psychological harm by a current or former partner or spouse" (CDC, 2012). Partner violence occurs in both heterosexual and same-sex relationships and includes the act of, or threat of, abuse. While men and women can both be victims and perpetrators of IPV, some research has shown that women experience physical abuse at a higher rate than men and women are more likely than men to be injured during a violent assault (NIJCDC, 2000). According to findings from the 2000 National Violence Against Women Survey, 22.1% of women and 7.4% of men report being physically assaulted by a current partner, former partner, or date during their lifetime (NIJCDC, 2000). The majority of IPV homicide victims are women. In fact, in a 2004 study conducted by Fox and Zawitz, the authors reported that 76% of IPV homicide victims in 2002 were women.

Male-perpetrated intimate partner violence against women (MP-IPV)[1] is a far-reaching problem that can have significant short and long-term deleterious effects on victims and families (Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000). According to a meta-analysis that reviews mental and physical consequences of MP-IPV, effects can include serious physical injuries (e.g. broken bones, chronic

[1] "MP-IPV" will be used here to represent intimate partner violence that men commit against their women partners.

headaches from head injuries, and stress related diseases such as irritable bowel syndrome), psychological injuries (e.g. trauma related symptoms and depression), and consequences that extend to others in the family, such as children (Campbell and Lewandowski, 1997). For example, the rates of child abuse in homes with MP-IPV ranges from 40-70% and research has found that observing violence towards a parent can result in detrimental psychological effects on children including posttraumatic stress disorder (PTSD) and behavioral problems such as difficulty concentrating, aggression, and hyperactivity (Campbell and Lewandowski, 1997).

The multilevel factors contributing to men's violence against women can best be captured through an ecological model. The following chapter includes a description of multilevel causes for men's violence against women as well as a history and development of Abuser Intervention Programs (AIPs), which emerged alongside increased support services for victims of IPV and enhanced social consciousness regarding IPV. Also reviewed below is the research on AIP treatment effectiveness in light of the complicated and somewhat inconclusive findings, the assessment of AIP treatment through victim partner report and/or offender self-report of violence and abusive behavior, and criminal justice recidivism. Subsequently, further consideration is given to research studies that explore specific ingredients (e.g. components of the treatment or characteristics of the clients) that may produce greater behavior change as compared with other treatment or client ingredients.

While decades of research have helped to answer many questions regarding MP-IPV and treatment for partner-violent men, many more questions remain unanswered. For example, specific change processes and predictors for recidivism

among partner-violent men are not yet well understood. While program dropout is a robust predictor for recidivism – and there is certainly a distinction between program completers and non-completers in the sustainability of treatment outcomes – a subset of partner-violent men who complete AIPs subsequently re-offend following treatment completion. An important next step in AIP effectiveness research is to examine recidivist and change processes in this subsample of men who complete treatment but continue to assault their partners.

The present study examines behavior change processes and factors for recidivism among partner-violent men who recidivate following the completion of an AIP. Specifically, in-depth interviews were conducted with partner-violent men who were arrested for IPV offenses following treatment in order to explore their perceptions of treatment, experiences and change processes after treatment, contextual factors salient to their lives, and obstacles to staying nonviolent. Using a constructivist grounded theory approach, the present study aimed to generate theory that would frame and enhance our understanding of how intrapersonal, interpersonal, group-level, and community-level factors may influence the change and recidivist processes among this specific subset of partner-violent men. The present study is described in detail below following a review of MP-IPV literature relevant to the history and multilevel causes of MP-IPV, a brief overview of approaches to treatment, general AIP treatment effectiveness, IPV recidivism, and a detailed analysis of qualitative research exploring change processes among partner-violent men.

## Literature Review

### Causes of Men's Violence against Women

Numerous sociological and psychological theories exist regarding the causes of IPV perpetrated by men against women. The complexity of MP-IPV etiology and maintenance underscore the difficulties that men can face when attempting to change their abusive behavior. Various factors operating at multiple levels contribute to the etiology and maintenance of MP-IPV, thus MP-IPV should be considered within a multilevel framework. In his ecological theory, Bronfenbrenner (1979) emphasized that individuals' psychological processes are not the result of solely individual factors but rather function as interactions of person and environment. Bronfenbrenner's ecological model attended to the importance of an individual's immediate (called "proximal") environments (e.g. their relationships with others or their home environment), indirect but influential (called "distal") environments (e.g. society), and the interaction of the two. This framework is useful to the study of MP-IPV as it provides a multifaceted conceptualization that includes the contribution of multiple levels of influence such as an individual's psychological factors, relationship and family dynamics, societal and cultural norms, and even the global climate regarding violence against women. Bronfenbrenner's framework defined complex layers of influence, each of which has an effect on the individual embedded in the center. Forces at the various levels of influence interact to create an atmosphere in which MP-IPV takes place. Risk factors for MP-IPV can include proximal variables (e.g. intrapersonal and interpersonal variables) and distal variables (e.g. family history, community, and societal variables). In fact, in 1999, Harway

and O'Neil present a multilevel ecological framework for understanding MP-IPV. The authors emphasized the intersection and cumulative effects of multivariate factors, including both proximal and distal factors.

Proximal risk factors for MP-IPV include intrapersonal variables such as biological factors, personality factors, psychopathology, substance use, and cognitive factors. Research has shown that personality disorders, as well as some forms of Axis I psychopathology, are robust predictors of MP-IPV (Ehrensaft, Cohen, & Johnson, 2006). Ehrensaft and colleagues (2006) found that all three Axis II clusters, pertaining to unique and non-overlapping symptomology, were uniquely correlated with the perpetration of partner violence. Furthermore, rates of personality disorders among court-ordered and self-referred men who are seeking treatment for MP-IPV has been reported between 50%-90% (Dixon & Browne, 2003; Dutton & Starzomski, 1994). Antisocial and borderline features are the most common personality disorder traits found in samples of partner-violent men. Other forms of psychopathology including depression (Hamberger & Hastings, 1991) and substance abuse (Taft, O'Farrell, Doron-LaMarca, et al., 2010) have been shown to correlate with MP-IPV as well. In fact, strong empirical evidence exists supporting the relation between alcohol abuse and MP-IPV such that in clinical studies of men with alcoholism, MP-IPV is 4-6 times higher than in demographically similar men without alcohol problems (Quigley & Leonard, 2000; O'Farrell & Murphy, 1995).

Finally, cognitive factors such as hostile or biased information processing, negative attributions regarding the partner's behavior, and negative beliefs about relationships, contribute to the potential for men to become partner-violent (see

Murphy & Eckhardt, 2005). For example, hostile attributions can be reflective of other characteristics and beliefs, such as threat sensitivity associated with traumatic stress exposure, heightened sensitivity to abandonment, or generalized hostility that occurs both within and outside intimate relationships. Additionally, the cognitive process during an interaction with a relationship partner may involve biased (*i.e.* selective) attention to cues that confirm pre-existing attitudes including negative interpretation of the partner's intentions and actions. These biased attributions may be based on attitudes and beliefs that justify MP-IPV, including a belief in the utility of violence, and patriarchal beliefs relating to gender roles, power, and adversarial views of male-female relationships. For example, Sugarman and Frankel's (1996) meta-analysis reviewing the role of patriarchal attitudes and MP-IPV demonstrated a moderate effect of gender-role attitudes on MP-IPV. Notably, cognitive factors such as hostile attributions, adversarial beliefs about gender, and biased information processing serve as potential goals for treatment in cognitive-behaviorally based AIPs.

Distal risk factors for MP-IPV include interpersonal and societal variables such as factors related to the intimate relationship dyad, family history variables, and social norms. The literature on bi-directional violence (*i.e.* aggression towards a relationship partner by both partners in the dyad) demonstrates that the bi-directional patterns of physical aggression are relatively common in heterosexual couples. According to Cascardi, Langhinrichsen, and Vivian's (1992) research examining 93 heterosexual couples seeking couples therapy, 86% of partner-violent couples reported reciprocal violence; however, women reported more physical injury than

men as a result of violence. Archer's (2000) meta-analysis reviewing sex differences among partner-violent couples established similar findings, indicating that while women were slightly more likely to engage in physical relationship violence, women also sustained more physical injury as a result of their male partner's perpetration of IPV. It is important to note that Archer's review has been highly criticized, specifically for being skewed towards a younger age sample and a sample in which partners are not cohabiting (Brown, 2012). Additionally, while Archer (2000) reported few gender differences regarding forms of violence, other sources highlight the nuances of male and female perpetrated physical violence, emphasizing that women are more likely to push or throw things at their partners whereas men are more likely to hit (Bowen, 2008). Quality of violence notwithstanding, the pattern of bi-directional violence that can develop within a relationship dyad cultivates an interaction and conflict management style that likely heightens the risk of ongoing partner violence.

Family history, a further distal factor, can interact with interpersonal factors to produce an environment in which MP-IPV takes place. One theory that accounts for family history variables is the social-learning perspective (Bandura, 1973). Social learning theory indicates that being raised in a violent or abusive family-of-origin models to children that the use of violence and aggression as a conflict management tactic is acceptable and, as a result, increased the child's risk of using violence and aggression to deal with interpersonal conflict in the future. Current research regarding family-of-origin exposure to partner-violence suggests that such exposure does in fact influence later relationships; for example, violent conflict in the family-

of-origin and "harsh parenting" uniquely predicted higher levels of dating violence in Jouriles, Mueller, Rosenfield, and colleagues' recent research (2012). Additionally, in a sample of 453 heterosexual couples, exposure to partner violence in one's family-of-origin was found to significantly increase the risk of physical violence in future relationships (Fritz, Slep, & O'Leary, 2012). Another prominent theory relying on family history factors to predict MP-IPV is the intergenerational transmission of aggression theory (Widom, 1989). In her intergeneration transmission of aggression theory, Widom posited that witnessing or experiencing violence in one's family-of-origin increased the risk of experiencing or perpetuating violence in future relationships. These are just two of many studies that provide empirical support for the intergenerational transmission of aggression and social learning theories of IPV.

Finally, even more distal social factors contribute to MP-IPV. Feminist researchers, such as Rebecca Emerson Dobash and Russell Dobash have identified patriarchy as the major source of men's violence against women (e.g. Dobash & Dobash, 1992). Researchers from the feminist perspective posit that violence against women is accepted in societies that are structured in gendered and unequal ways in which men are dominant and therefore women are oppressed socially, politically, and/or economically. Feminist researchers theorize that this institutionalized power imbalance stemming from a society built on male dominance and men's power and control over women is the key factor in MP-IPV (Pence & Paymar, 1993). Due to system-level power differences between men and women, and social norms that dictate men and women's status in society, MP-IPV (including physical, emotional, financial, and sexual abuse) occurs in this context of men's power and control over

women. The feminist explanation for MP-IPV establishes that men's use of power and control within their intimate relationships is reinforced by societal level male privilege.

While much of the research on the social influences contributing to MP-IPV is conceptual and theoretical, Levinson (1989), a cultural anthropologist, presented cross-cultural findings from a worldwide comparative study of family violence. In his study, Levinson sought out to discuss family violence from three perspectives: cross-cultural forms and frequencies, psychosocial explanations, and prevention and intervention strategies (for which he drew from cultures with low or no family violence). Family violence was problematic in 75 of the 90 cultures Levinson examined. His findings indicated that cultures with low or no family violence also demonstrated greater gender equality (*i.e.* financial and social gender equality). Other factors that predicted low or no family violence in these societies included monogamy, economic gender equality, gender equality in access to divorce, and norms for nonviolent conflict resolution. Additionally, Else-Quest and Grabe (2012) reviewed a growing field of international research that demonstrates women's ownership of assets, such as land, is associated with decreased rates of IPV. The authors noted that property ownership serves as a proxy for power and enhances women's ability to provide input and negotiate in intimate relationships. Despite limitations and challenges in conceptualizing and evaluating gender dynamics and power in distinct cultural contexts, cross-cultural research has substantially enriched feminist theoretical models of the social contributors to MP-IPV.

Distinct intrapersonal, interpersonal, and systems-level factors do not alone predict partner violence; rather, an interaction of variables is likely to be predictive of MP-IPV. Harway and O'Neil's (1999) multivariate model established a framework comprising seven categories of risk factors: macrosocietal, relational, psychological, psychosocial, socialization, biological, and an interaction of the multiple risk factors. According to Harway and O'Neil, existing models that focused solely on one level of risk factors failed to capture the complexity and interaction of factors that contribute to MP-IPV because "no single theory adequately explains such complex phenomenon as men's violence against women. A multiplicity of risk factors that are complexly interrelated represent the greatest explanatory power…" (1999, p. 210).

Similar to Bronfenbrenner's (1979) model, Harway and O'Neil (1999) emphasized that individuals exist in the center of multiple levels of influence and thus should be considered in a multilevel framework. One specific influencing factor alone does not likely cause a man to become partner-violent; however, a combination of factors, operating at multiple levels, paint a more comprehensive causal picture. Harway and O'Neil (1999) further distinguished risk factors into two categories: predisposing risk factors and triggering risk factors. Being predisposed to violence through macrosocietal, relational, psychological, psychosocial, socialization, and biological factors increases the probability that an individual will use violence when triggered. Triggering risk factors are events and situations that can cue a violent incident. Harway and O'Neil emphasized that, "violence against women is contextual, idiosyncratic, and highly situational…men's risk for violence against

women is activated by a host of societal, individual, psychological, biological, psychosocial, and relational contexts" (1999, p. 212).

## History of Abuser Intervention Programs

Under 753 B.C. Roman "Laws of Chastisement," husbands had absolute rights to physically discipline their wives (Lemon, 1996). According to Lemon, because wives were considered their husbands' property, husbands were responsible for their wives' wrongdoings and in order to discipline their wives, husbands were permitted to beat their wives with an object that was no greater than the thickness of a man's thumb. While the historical accuracy regarding the origination of this "Rule of Thumb" is controversial, this sanction later became English Common Law. Until the late 19th century, husbands were permitted to discipline their wives for corrective purposes using physical punishment as long as it did not inflict permanent damage.

Two historic rulings transformed husbands' physical violence against their wives from "discipline" to "abuse." In 1824, the Bradley v. State decision by the Mississippi Supreme Court was the first legal ruling to modify the existing laws in order to permit husbands to administer only "moderate chastisement in cases of emergency" and (almost 50 years later) in 1871 under the Fulgrahm v. State case, Alabama became the first state to revoke the legal rights of husbands to beat their wives (Schechter, 1982). As domestic violence awareness and policy began to evolve, states began to pass laws criminalizing men's violence against their female intimate partners. These legislative sanctions increased protection for victimized women and increased public consciousness of intimate partner violence as a public health concern (Price & Rosenbaum, 2009).

With the aid of the burgeoning second wave feminist movement, resources for women victims of MP-IPV began to emerge by the late-1960s. While victimized women received various services, including shelter, mental health access, and legal resources, early interventions for partner-violent men only included contingencies such as legal consequences (Lemon, 1996). Services such as safe houses and shelters were offered to victims of IPV and thus enhanced women's ability to leave their abusive partners. While these types of resources may have increased safety and decreased risk for the specific women being victimized, it was soon discovered that the ending of an abusive relationship did not necessarily translate into decreased rates of partner violence on the whole (LaViolette, 2001).

From a prevention perspective, providing both resources for victims/survivors alongside rehabilitation and/or intervention services for offenders promotes a more comprehensive approach to IPV. During the 1970s, victim advocates noticed two phenomena that generated questions regarding the provision of services solely for victims of abuse while ignoring perpetrators. First, service providers began to better understand the complexities of women's processes of leaving their partners. For example, women tended to be at a higher risk of victimization during the leaving process and victimized women often returned to their violent partners several times, even after seeking shelter services (LaViolette, 2001). At the California shelter where LaViolette worked during the 1970s, over 80% of women who received housing through the shelter returned to their abusive partners. LaViolette noted that basic financial needs, fear, and attachment to their partners and family structure were the primary reasons women returned. Second, providers began seeing multiple victims

from the same offender. Advocates began to recognize that women's success in leaving their abusive relationships did not necessarily imply that partner-violent men would discontinue to abuse future female partners (Geffner & Rosenbaum, 2001). These two observations were key in advocating for rehabilitative services for partner-violent men. By the late 1970s, Abuser Intervention Programs (AIPs), also referred to as Batterer Intervention Programs (BIPs), began to emerge (Edleson, 2012).

According to LaViolette (2001), in 1979 only four programs, including her own entitled Alternatives to Violence (ATV), existed to intervene with partner-violent men. These early programs were based on a feminist educational framework. EMERGE in Quincy, Massachusetts, the Domestic Abuse Intervention Project (DAIP) in Duluth, Minnesota, and AMEND in Cincinnati, Ohio were prominent early programs on which many others across the country were based (Rosenbaum & Leisring, 2001). The programs consisted of 24-48 two-hour group sessions led by opposite gender co-facilitators who addressed issues of power and control in relationships. The programs were considered educational rather than therapeutic and therefore, as noted in the EMERGE program manual, unlike in typical therapeutic treatment programs, confidentiality was not offered to participants (Rosenbaum & Leisring, 2001). Despite partner-violent men's diverse needs, these early programs were primarily focused on providing psychoeducation regarding patriarchial social arrangements and attitudes as key factors in men's violence against women. The goal was to end violence through consciousness raising and personal transformation of beliefs and behaviors related to gender. However, victimized women described various additional needs that their partners had including substance abuse problems,

parenting issues, impulsivity, and generalized violence, suggesting that "the 'one size fits all' approach of a one-bullet patriarchal process theory seemed inadequate to address the issues brought to the table" (LaViolette, 2001, p. 47).

The emphasis on "teaching" versus "treating" partner-violent men arose due to concerns over conceptualizing partner violence as psychopathology. Because psychopathology is theorized to originate *within* the individual, victim advocates raised concerns regarding men's willingness to take responsibility for their behavior if violence was deemed to result from a mental (or medical) disorder outside of their control. Feminist advocates criticized treatment models for "failing to hold batterers responsible for their behavior," yet proponents of treatment models criticized educational approaches as ineffective in "deterring or rehabilitating batterers because they are too short and superficial and do not address the needs of batterers with severe mental illness, who may comprise up to 25% of all batterers" Healey et al., 1998, p. 26). Victim advocates were cautious not to reinforce the perception that partner-violent men were not responsible for their behavior thus many programs emphasized accountability, a framework that continues to exist today in many AIPs.

In order to accommodate the varying needs that existed among the diverse population of partner-violent men, more specialized approaches were developed. According to Healey and colleagues (1998), these approaches included interventions that were designed to address specific types of partner-violent men based on emergent theories regarding psychological risk factors and substance use, as well as interventions with unique focus on client retention, specifically within those populations that demonstrated high attrition rates (e.g. men of color, men with more

socioeconomic needs, and men who are unemployed). While victim-safety and the ceasing of men's use of violence were the goals across interventions, the widely divergent AIPs that emerged varied broadly in approach, staff qualifications, and techniques used to serve partner-violent men.

In an attempt to enhance the understanding and coordination among AIPs and the criminal justice system, by 1997, 40 States and the District of Columbia had mandated, supported, or were in the process of developing state-level standards or guidelines for AIPs (Healey et al., 1998). These standards for partner-violent men evolved alongside the criminal justice responses to MP-IVP cases. While nearly all states currently have standards or guidelines, the standards are often controversial. Although empirical support for specific requirements is lacking, some state guidelines may mandate specific approaches or may preclude specific interventions and strategies. Notably, approximately 75% of partner-violent men enrolled in AIPs are referred by the criminal justice system (Gondolf, 2002). As the quantity of AIPs increased, so did the diversity of approaches used within the treatment of partner-violent men. The best known AIP treatment approaches include feminist approaches, social learning and cognitive-behavioral approaches, family and relationship systems approaches, psychopathology approaches, and combined approaches.

**Brief Overview of Approaches to Treatment**

While a combination of proximal and distal risk factors contribute to MP-IPV, intervention models have struggled to incorporate the various levels of factors associated with MP-IPV into the treatment of partner-violent men. Treatment models have emerged from singular theories, yielding discrete treatment approaches for

offenders. Some of the prominent intervention models focus on distal contributors to MP-IPV. For example, the Duluth Model emphasizes the social context in which MP-IPV occurs and utilizes a didactic, consciousness raising, approach encouraging partner-violent men to acknowledge their male privilege and accept responsibility for their behavior (Pence & Paymar, 1993). The family and relationship systems approach focuses on the relationship dyad (rather than solely on the identified perpetrator) and promotes joint treatment of the relationship partners in order to enhance relationship skills and conflict resolution in the dyad.

Other prominent treatment models focus on more proximal factors or an interaction of contributors to MP-IPV. For example, social learning and cognitive-behavioral approaches underscore the importance of learning new, healthy, relationship skills in order to replace abusive behavior. The goal of social learning and cognitive-behavioral approaches are to help, partner-violent men learn to identify and challenge attitudes, cognitions, and beliefs that promote and maintain abusive behavior and replace these abusive behaviors with new effective interpersonal skills and emotion regulation skills. Finally, the psychopathology approach recognizes that intrapersonal problems such as personality disorders, trauma symptoms, and/or substance abuse can increase individuals' vulnerability to becoming violent; thus being abusive is considered a symptom of, or strongly influenced by, underlying psychopathological problems (Healey, Smith, & O'Sullivan, 1998). AIPs based on the psychopathology theory can include psychodynamic or cognitive-behavioral interventions, among others, and have the general goal of reducing abusive behavior through improving or altering associated conditions (e.g., substance use disorders) or

facilitating intrapersonal change such as the resolution of traumatic stress symptoms (Healey et al., 1998).

As diverse models of AIPs emerged, efforts to increase support and services for victims, mandate treatment for offenders, and develop effective abuser-intervention approaches increased. Providing psychosocial rehabilitation to partner-violent men became a major factor in the collaborative efforts to decrease the risk of violence. While referral to treatment for partner-violent men has increased over the last several decades, the research exploring effectiveness of AIPs remains largely inconclusive.

**Treatment Effectiveness**

Abuser intervention program treatment effectiveness is most commonly measured by victimized partner report, offender self-report of violence and abusive behavior, and rates of recidivism (Babcock, Green, & Robie, 2004). Overall, the findings of treatment effectiveness have been inconsistent due to a number of factors. Factors that contribute to mixed finding include methodological shortcomings, limited follow-up data, and the diversity of models included in analysis (Healey et al., 1998 & Gondolf, 2004). Reviews of AIP program effectiveness offer limited and conflicting conclusions of extant research. Existing research on AIPs has demonstrated low to moderate impact of programs on reducing MP-IPV beyond the effect of being arrested alone (Babcock, et al., 2004; Hamberger & Hastings, 1993, Gondolf & Jones, 2001). The most recent reviews of AIP treatment effectiveness include meta-analyses (Feder & Wilson, 2005; Babcock et al., 2004), methodologically focused reviews (Eckhardt et al., 2006; 2013), and overviews of recent research trends (Murphy & Ting, 2010). These reviews include both

traditional randomized experiments and quasi-experiments that either focus on treatment dropouts as the control or utilize some form of matching or statistical controls to estimate treatment effects.

Feder and Wilson's (2005) meta-analytic review used highly stringent criteria for study inclusion: studies had to have been completed in or after 1986; intervention must have been court-ordered post-arrest; participants must have been referred for opposite gender IPV; studies must have obtained an outcome measure of repeat IPV at a minimum of 6 months post-treatment; studies must have measured IPV in at least one method other than offender self-report; and studies report enough data to generate an effect size. Based on these criteria, 4 experimental studies and 6 quasi-experimental studies were included in Feder and Wilson's meta-analytic review of court-mandated AIPs. All 10 studies evaluated programs that were based on psychoeducational, feminist, and/or cognitive behavioral therapy (CBT) frameworks and all based treatment outcomes on victim report and offender self-report. The authors found mixed results. The experimental studies included in the review demonstrated modest mean self-report effects but no effects from victim reports. The quasi-experimental studies included in the review demonstrated inconsistent findings, including small harmful effects. Finally, studies that compared participants who completed the program with those who dropped out, demonstrated large positive effects; however, the authors discuss that this type of study design is quite problematic. The authors conclude that their review "does not offer strong support that court-mandated treatment to misdemeanor domestic violence offenders reduces the likelihood of further reassault" (Feder & Wilson, 2005, p. 257).

However, Babcock and colleagues' (2004) meta-analytic review revealed somewhat different findings. In their meta-analysis, the authors included 22 quasi-experimental and experimental studies that evaluated programs based on the feminist and psychoeducational model, CBT, and "other" treatment (i.e. couples therapy, supportive therapy, relationship enhancement, a mixture of interventions, and an unspecified therapy). Their inclusion criteria were much less stringent than Feder and Wilson (2005); authors required included studies to have a comparison group, a follow-up data point, and treatment effectiveness data collection beyond batterers' self-report alone. In Babcock and colleagues' (2004) review, reporting method (i.e. self-report or partner-report), study design, nor type of treatment elevated the effect size beyond the small range. Based on victimized partner report of offenders' behavior, the review demonstrated a 5% improvement attributable to AIP intervention. While "small" effects may appear minimal, Babcock and colleagues emphasize that a 5% improvement translates into, "batterers treatment in all reported cases of domestic violence in the United States would equate to approximately 42,000 women per year no longer being battered" (2004, p. 1044).

More recently, Eckhardt and colleagues (2013) provided a unique synthesis of treatment effectiveness research that included both AIP treatment effectiveness and the effectiveness of interventions for victim-survivors of IPV. Authors provided descriptive details for the studies included in their review in order to enhance understanding of not only research findings, but also methodological limitations to the AIP treatment effectiveness research to date. A two-stage process including a search of electronic databases and manual review of article references was utilized in

order to determine articles included for the review. A total of 30 AIP treatment effectiveness studies were included based on their ability to meet the following inclusion criteria: the inclusion of one or more treatment condition; at least one measure of violence recidivism; a publication date of 1990 or later (with some exceptions); if experimental or quasi-experimental designs, they must have had one or more comparison group; and if single-group, pre-post designs, they must have used multivariate statistical methods. Of the 30 studies included, 20 examined AIPs with "traditional" content and format, and 10 examined "alternative" AIPs. In addition to results regarding AIP treatment effectiveness, the review revealed interesting methodological flaws in the existing AIP treatment effectiveness research. Nine of the 20 studies utilizing traditional AIP treatment demonstrated statistically significant differences in recidivism reduction (either as self/partner-reported or as revealed by criminal justice records) between the treatment groups and no-treatment control groups or matched dropout comparisons. Only four of the 10 alternative treatment studies examined AIP treatment effectiveness; of these four, three reported significant differences in recidivism rates (either as self/partner-reported or as revealed by criminal justice records) between the treatment groups and no-treatment control groups at follow-up. In addition to reviewing AIP treatment outcomes, Eckhardt and colleagues discussed interesting and important methodological caveats that "prohibit unequivocal interpretation of results" (2013, p. 22). In the 30 studies reviewed, methodological flaws included the potential of selection bias producing non-equivalence between experimental and control groups, limited information regarding follow-up data collection procedures, large variations in follow-up criteria, the use of

existing records rather than self- or partner reports as follow-up data, low rates of partner-based recidivism information, random treatment assignment overrides by judges, concerns regarding sample generalizability, and the possibility of undocumented confounding variables. These methodological challenges enhance the difficulty of data interpretation and uncertainty concerning the status of AIP treatment effectiveness.

Also of note is Gondolf's multi-site evaluation of AIP treatment effectiveness (Gondolf & Jones, 2001; and Gondolf, 2004). Gondolf and Jones (2001) reported moderate effects in their multi-site evaluation of AIP treatment effectiveness. Gondolf and Jones considered each of the three sites included in their evaluation "well-established AIPs" emphasizing that each program met five selection criteria. Each AIP 1) complied with AIP state standards; 2) collaborated with victim services programs; 3) utilized a CBT approach gender psychoeducational components; 4) was least 5 years old and received a minimum of 40-50 monthly referrals; and 5) provided training and supervision for programming. The three sites included in Gondolf and Jones' evaluation were in major cities: Denver, Dallas, and Houston. Program completion was found to significantly effect reassault in the three AIP sites, reducing the likelihood of reassault by 44-64%. Furthermore, Gondolf's (2004) longitudinal 4-year follow-up evaluation continued to demonstrate moderate program effect and provides additional support for the CBT approaches used at these program sites. Gondolf reported that the majority of clients did not reassault in the year before each follow-up; approximately 20% of participants re-assaulted between 18 and 30 months after treatment and only about 10% between 36 and 48 months after treatment. He

also emphasized that the majority of women reported improvement in their quality of life and 85% reported feeling "very safe" at both 30-month and 48-month follow up time points. It is important to note, however, that this study did not have a traditional control group and treatment effects were estimated using complex data analysis of treatment completers versus treatment dropouts.

Overall, AIP treatment effectiveness research aims to answer two main questions: 1) Are AIPs effective (as compared to a control group)? And, 2) what specific ingredients (e.g. components of the treatment or characteristics of the clients) are more beneficial for AIPs than other ingredients. Some examples of the latter question include: do outcomes vary by client demographics, therapeutic approach, program retention, assessment strategies, treatment length, integration of services for co-occurring disorders, etc.? In response to the first question, research suggests that AIPs demonstrate small to modest positive effects, specifically for those who complete treatment (e.g. Gondolf & Jones, 2001; Gondolf, 2004). Answering the second question, however, has been more challenging for the IPV field.

Bennett & Williams (2001) outlined key findings related to potential characteristics and ingredients of benefit. The authors reported that AIP effectiveness may vary based on the following elements: offender's demographics (e.g. education, employment, relationship status, engagement in his community, etc), mental health (e.g. axis I and II psychopathology, particularly substance use disorder), and the "cultural congruity" between the group therapists and the client (p. 8). While little evidence has emphasized one particular AIP treatment approach over another, a meta-analytic review of program attrition revealed that theoretical orientation appears to be

a key moderating variable; the authors found that clients were less likely to drop-out of CBT AIPs as compared with strictly psycho-educational AIPs (Jewell & Wormith, 2010). Jewell and Wormith's meta-analysis examined theoretical orientation's relation to *program retention* rather than treatment effectiveness, however, other research has demonstrated that clients who complete treatment do better than those who drop out of treatment (e.g. Gondolf, 2004).

**Recidivism.** As reviewed above, recidivism rates are used as one measure of treatment program effectiveness. However, research on recidivism extends beyond program evaluation research alone. At least two types of IPV criminal recidivism are of potential interest for the Present investigation: Nonviolent Domestic Abuse (NVDA) recidivism (*i.e.,* an IPV incident without specific indication of physical violence; examples include charges such as harassment, issuance of a new protection order, or violation of an existing protection order) and Violent Domestic Abuse (DA) recidivism (*i.e.,* an IPV incident that results in charges such as assault, sexual assault, battery, attempted murder, etc. against an intimate partner). For the purposes of the present study, "recidivism" is used to describe one or more criminal IPV re-offenses against an intimate partner following the initiation of treatment. Several factors have been shown to increase the risk of IPV recidivism, including program dropout (Coulter & VandeWeerd, 2009), substance use (Mbilinyi, Neighbors, Walker, et al., 2011; Jones & Gondolf, 2001), criminal history (Kingsnorth, 2006) and specifically a longer IPV-related criminal history (Ventura & Davis, 2005), family-of-origin exposure to IPV (Fritz, Slep, & O'Leary, 2012), Antisocial Personality Disorder (ASPD) traits and Borderline Personality Disorder (BPD) traits (Dutton, Bodnarchuk,

Kropp, Hart, & Ogloff, 1997), and a low overall coordination of the community response involving criminal justice and counseling systems (Murphy, Musser, & Maton, 1998).

While many factors are associated with an increased risk of IPV recidivism, treatment dropout has been one of the most robust predictors. Coulter and VandeWeerd (2009) assessed the risk of re-arrests from 1995 to 2004 within a sample of 17,999 partner-violent offenders. The authors found significantly lower rates of criminal recidivism among study participants who completed treatment programs as compared to study participants who did not complete treatment programs. Specifically, their analysis of recidivism data revealed that those who completed treatment re-offended at a rate of 8.4% and those who did not complete the program re-offended at a rate of 21.2%. Coulter and VandeWeerde's research parallels Gondolf's (2004) 4-year follow-up multi-site evaluation in which Gondolf posited that those who dropped out of treatment had higher rates of future re-assault (as reported by partners) as compared to program completers. Gondolf also noted that comparing completers with non-completers is equivalent to comparing "'apples and oranges' since dropouts generally have different characteristics than the program completers" (p. 610). Clients become non-completers for various and diverse reasons, some include including non-engagement, transportation issues making it difficult getting to treatment, dismissal from treatment for noncompliance or behavioral issues, among others. While these reasons may be clinically relevant and can influence both treatment success and re-offense, it is also important to recognize

the potential differences in completers versus non-completers for the sake of designing rigorous methods of research for AIP studies.

**Assessing specific ingredients through qualitative research.** As stated above, AIP treatment effectiveness research seeks to answer whether AIPs are effective and what specific ingredients (*i.e.,* components of treatment or characteristics of clients) yield superior outcomes. Qualitative research in the AIP field has helped to provide nuanced information regarding some specific ingredients for treatment. In the early years of AIP research, Murphy and O'Leary (1994) proposed that:

> the use of qualitative strategies to supplement traditional quantitative hypothesis testing may help ground theories in the personal experiences of domestic violence victims and perpetrators, and may further understanding of the psychological, social, and historical conditions under which domestic violence occurs. (p. 208)

Since 1994, several researchers have responded to Murphy and O'Leary's call for qualitative research evaluating AIP treatment effectiveness. Most qualitative researchers have examined variables that contribute to behavior change among partner-violent men and/or variables that may act as barriers to program retention.

For example, Scott and Wolfe (2000) interviewed 9 partner-violent men who had successfully completed approximately 35 weeks of AIP group treatment. Successful behavior change was defined using a three-step process: 1) invitation into the AIP's advanced group; 2) primary clinician recommendation and judgment that these men made "significant and lasting changes (defined as a minimum 6 months) in their abusive behavior;" and 3) partner verification regarding "no incidents of physical violence or extreme psychological abuse (e.g., yelling names, extreme

jealousy) for at least 6 months" (pp. 830-831). Interviews with the nine men were conducted by a skilled clinical interviewer at varying points following the men's completion of the AIP's basic 20-week program; after which, the men were subsequently enrolled in the AIP's advanced group. Interviews were hour-long and semi-structured. Scott and Wolfe's analysis procedure followed pre-developed coding themes based on key constructs consistent with their literature review. Specifically, the authors began coding with 28 categories organized by 9 theories/models of behavior change among partner-violent men: "feminist, social-cognitive, personality, systems, attachment, deterrence, the health-belief model, the theory of reasoned action, and the information-motivation-behavior skills model" (p. 831). Data were analyzed by two independent coders who attended to how frequently a variable was noted during an interview: variables were categorized as "important" if they were mentioned two or more times during the interview and "not important" if they were mentioned one or no times. The authors found an interrater reliability of 80% between the two coders. Scott and Wolfe identified the following variables related to behavior change across the nine participants: increased responsibility for past abusive behavior, development of empathy for partners' victimization, reduced dependency on partners, and increased communication skills.

The following year, Wangsgaard's (2001) dissertation research revealed dyadic qualitative themes of AIP group treatment that appeared to facilitate behavior change among 23 partner-violent men. Wangsgaard employed a grounded theory approach in which he conducted 4 focus groups and follow-up phone interviews. Participants were recruited from three AIPs. The 4 focus groups ranged from 45

minutes to 1.5 hours depending on the amount of discussion that took place during the focus group. Wangsgaard followed up with each participant by phone in order to provide opportunities for participants to add to and/or clarify their responses. Consistent with analytic procedure for grounded theory, Wangsgaard identified codes based on the constructs that emerged from his interpretation of the data. Following data analysis, Wangsgaard developed an overarching theory in order to account for the themes that emerged from his data. Emergent themes for behavior change included a mutual respect between the clinician and group members that facilitated an emotionally safe space. When this safe space was not present, Wangsgaard found that clients were less likely to take responsibility for their abuse or work to change their behavior. Wangsgaard's research emphasized that the most important factors for behavior change were the emotionally safe treatment space or "asylum" developed between clients and facilitators and the common ground and support from the other group members.

Pandya and Gingerich (2002) conducted a microethnographic study of partner-violent men who did and did not demonstrate successful behavior change through Stonsny's (1993) Compassion Workshop. The Compassion Workshop AIP model is based on attachment theory and operates under the assumption that abuse and compassion are incompatible. One of the study authors was present at all 12 of the group sessions (but did not participate); both verbal and nonverbal behaviors were included in data collection. Extant data from agency files and clients' homework assignments were also included as data. Pandya and Gingerich employed a "two-tier analytic process" in which they first developed biographies for each participant and

then examined aspects of shared backgrounds and processes of change across the participants. The authors were able to develop biographies for 6 of the 8 group members, as 2 did not agree to participate in the study. Among the six participants who were included, 3 completed treatment and the other 3 dropped out at different stages of treatment. Emergent biographical and observational themes revealed the importance of overcoming the denial of violent behavior and practicing new ways of thinking and acting both in and outside of therapy.

Perhaps the most thorough qualitative study to date is Silvergleid and Mankowski's (2006) examination of change factors among partner-violent men, which was conducted in an effort to enhance effectiveness of AIPs. In their novel approach, the authors interviewed 9 clients and 10 group facilitators. The client participants were selected through purposeful sampling after being recommended by facilitators based on the client's near completion of the AIP and facilitators' perception that the client would be "…a good informant, articulate, reflective, and willing to share his experience" (p. 143). Interviews ranged from 60-90 minutes. Silvergleid and Mankowski also conducted semi-structured interviews with 10 group facilitators in order to gain a more comprehensive understanding of the client participants' change processes. The authors' data analysis approach was consistent with grounded theory efforts to develop a local theory or explanation of men's change processes. Data were organized into four levels of analysis. Silvergleid and Mankowski's organizational structure roughly paralleled Harway and O'Neil's (1999) multivariate model (reviewed above). Silvergleid and Mankowski's research revealed emergent themes of behavior change processes that were influenced by

community-level and extratherapeutic factors, organizational-level factors, group-level factors, and individual psychological development factors. Community-level and extratherapeutic influences included criminal justice intervention and the fear of losing their family. Organizational-level influences included mutual respect between the clients and facilitators and the facilitators' style. Specifically, data revealed that a balance of empathy and skillful confrontation was necessary to engage partner-violent men. Group-level processes included three interconnected influences: the balanced support and confrontation of the other clients, sharing and hearing others' stories, and the modeling that took place during group sessions. Notably, facilitators also identified "resocialization" into a new manhood as a key group-level factor of the behavior change processes, although clients did not identify this theme. Finally, individual psychological development factors included the acquisition of new skills, engagement in program activities, self-awareness, and the decision and/or motivation to change.

Subsequently, Sheehan, Thakor, and Stewart (2011) conducted a systematic review of the qualitative literature on the factors, situations, and attitudes that facilitate change among partner-violent men, calling these "turning points" for behavior change. Six qualitative or phenomenological studies were included in Sheehan and colleagues' review and were organized using Silvergleid and Mankowski's (2006) multilevel framework in order to arrange the turning points into individual, group, and community processes. The authors found that in four out of the six studies, specific incidents occurred that promoted men's participation in the AIP (*i.e.* some form of a community response such as criminal justice involvement or

an interpersonal process such as being motivated by family relationship). In two of the six studies, clients' relationships with others (including facilitators and other group members) also appeared to be critical. All six studies demonstrated the importance of taking responsibility for past abusive behavior and four out of six studies revealed the importance of participants feeling responsible for changing their own behavior. The development of new skills also emerged as a turning point for behavior change in five out of the six studies. Specifically noted skills included effective communication, assertiveness, emotional regulation, and distress tolerance. Sheehan and colleagues' (2011) review illustrates the various contextual, interpersonal, and individual factors that play a role in partner-violent men's behavior change processes.

The use of mixed methods research has also enhanced the understanding of AIP treatment effectiveness and behavior change processes among partner-violent men. Catlett, Toews, and Walilko's (2010) qualitative interviews and logistic regression with a subsample of participants helped the authors to examine how men make meaning of their violence and subsequent mandate to treatment, and the factors associated with some men's failure to complete AIP specific treatment. Slightly more than half (54.5%) of the study participants completed the AIP (84 of the 154 participants) and of the 34 men who consented to participate in the qualitative component of the study, 64.7% completed the AIP. It is of note that interviews for the qualitative portion of the study were conducted prior to participants' first treatment session in the AIP, thus qualitative results reflect pre-treatment beliefs. Regarding findings, the authors note the abundance of minimization that took place

stating, “all but one of the 34 men who were interviewed in-depth started their interviews by denying that they had done anything to give reason for their participation in the [AIP]… a few of these men denied outright committing any violent act” (p. 113). According to Catlett and colleagues’ qualitative results, minimization, denial of responsibility, and rationalization/justification of violent behavior emerged as themes in the sample. Although the authors posit that these factors explain the high attrition from treatment, this statement is difficult to support given that the resistance observed before treatment may have diminished over the course of treatment, especially among those who completed the AIP. Findings from Catlett and colleagues’ quantitative component revealed that men were more likely to drop out of the AIP if they had lower income, were no longer involved with the partner from the referring incident, and reported lower levels of physical violence and higher levels of hostility. While Catlett and colleagues’ study may not provide a thorough analysis of factors involved in behavior change or an adequate explanation of attrition, it *is* instrumental in providing a unique mixed method approach to AIP research as well as identifying useful starting points for treatment. Specifically, although it may not have been the authors’ intent, identifying themes consistent among partner violent men during treatment initiation (*i.e.* minimization, denial, and justification) demonstrates the pervasiveness of the initial resistance that exists. This initial treatment resistance is an important therapeutic goal during the early stages of treatment and corresponds to conclusions from Murphy and Ting’s (2010) review regarding the added benefit of intentionally targeting motivation and using strategies that serve to enhance readiness for change.

**Summary of AIP Research to Date & Future Directions**

The overall findings of research on AIP treatment effectiveness are complex and fairly inconclusive. Several meta-analytic reviews reveal very modest treatment effects, equating to a roughly 5 percentage point decrease in IPV re-offense associated with intervention (Babcock et al, 2004). Factors that contribute to mixed findings include methodological weaknesses, limited follow-up data, high levels of sample attrition, and the largely unstandardized AIP approaches that have been investigated. Whereas AIP treatment effectiveness is assessed through victimized partner report, offender self-report of violence and abusive behavior, and rates of criminal recidivism, the subject of re-offense (examined using criminal justice recidivism data or partner/self-report of re-assault) has been the most substantial point of focus. Treatment dropout has been emphasized as one of the most robust predictors of re-offense, thus those who complete treatment are expected to exhibit better treatment outcomes than those who do not complete treatment. In addition to examining the main effects of whether treatment works, AIP treatment effectiveness research also seeks to examine the specific ingredients (e.g. components of the treatment or characteristics of the clients) that may produce greater behavior change.

Qualitative research has made a valuable contribution to the IPV field in enhancing the understanding of specific components and characteristics essential to behavior change processes. Additionally, the use of qualitative methods aids in the exploration of contextual and interconnected levels of processes for which statistical analysis may be lacking. Harway and O'Neil's (1999) multivariate model describing the causes of MP-IPV and Silvergleid and Mankowski's multilevel organizational structure for men's behavior change processes emphasize the complexity and

interconnectedness of factors that contribute both to the perpetration of violence and to the processes of behavior change.

Many questions remain unanswered in the study of change and recidivist factors among partner-violent men. Future steps for AIP treatment effectiveness research include working toward a better understanding of re-offense, long-term effects of treatment, factors for enhancing victim safety, and coordinated interdisciplinary interventions. For example, Silvergleid and Mankowski (2006) noted that although they only included successful participants in their study (*i.e.* men who were nominated by facilitators based on specific criteria), some of the participants did not stop being partner-violent. While a major risk factor for re-offense is program attrition, research such as Silvergleid and Mankowski's, among others, demonstrates that some individuals deemed successful by facilitators nevertheless re-offend subsequent to treatment completion.

Other AIP treatment effectiveness researchers have sought to increase knowledge regarding factors that contribute to recidivism in partner-violent men who complete treatment (and may even be considered successful by facilitators during treatment) but subsequently reoffend. For example, Dutton and colleagues' (1997) study followed 156 participants post court-mandated AIP completion for an average of 5.2 years in order to assess long-term criminal recidivism. A comparison of program completers with those who dropped out of treatment indicated that those who completed the AIP committed fewer assaults than those who dropped out. However, the authors noted extremely skewed data, positing that while most of the participants committed either one or no criminal recidivist incidents of IPV, several

extreme outliers committed multiple re-offenses; in fact, one participant (from the AIP completer group) accrued six re-offenses, accounting for 1/5$^{th}$ of all the post-treatment criminal recidivism reported in the completer group. It is unclear why a subsample of partner-violent men do not stop being abusive, even post program completion. Other studies have reported similar findings, indicating that a large percentage of recidivist violent incidents are perpetrated by a small proportion of clients (e.g. Morrel, Elliott, Murphy, & Taft, 2003).

Similarly, Coulter and VandeWeerd (2009) found that 21.2% of those who dropped out of treatment were re-arrested for IPV-related crimes as compared to 8.4% of those who completed the AIP. While this decrease in IPV criminal recidivism is a significant finding as it demonstrates the added value of completing treatment through an AIP for many men, it is also important to note that 8.4% of Coulter and VandeWeerd's large sample (N=17,999) results in 1,512 men continuing to commit partner-violent crimes, even following program completion. Previously, Gondolf reported even higher rates of re-offense after program completion, demonstrating that re-assault of the original victim or of a new partner ranges from 20-30% among men who complete AIPs (Gondolf, 1997, 2003). So while there is certainly a distinction between program completers and non-completers, an important next step in AIP effectiveness research is examining recidivist and change processes in the subsample of men who complete treatment but continue to re-assault their partners.

**Present Study: Research Statement & Questions**

As noted above, although AIP treatment completion decreases men's risk for recidivism, a clinically significant percentage of partner-violent men recidivate after treatment completion. However, there is a dearth of research examining change and recidivist factors specific to this population of partner-violent men. The present study focuses on this subset of partner-violent men who recidivate post AIP completion in order to increase the knowledgebase of MP-IPV recidivism, long-term outcomes post treatment, and the gaps in understanding between IPV researchers/practitioners and partner-violent men's processes of change and stagnation. Implications for the enhanced understanding of post treatment recidivism are potential increases in victim safety, modifications to AIPs in order to enhance effectiveness for this subset of men, and an improved multilevel coordinated response to IPV. The present study aimed to explore change and recidivist factors among partner-violent men post AIP completion by examining the following research questions:

1) What factors are related to IPV recidivism following program completion?
    a. Why do partner-violent men who have reoffended perceive that they have reoffended?
2) What implications for treatment and research emerge from an exploration of reoffenders' beliefs and interpretation of recidivist events?
    a. What missing program factors would enhance program effectiveness among those who reoffend?

## Chapter 2: Methods

As noted in the review of literature, there is very little research that explores IPV recidivism among partner-violent men subsequent to AIP treatment completion. Partner-violent men's perceptions of treatment, experiences after treatment, and their post-treatment change processes, contextual variables, and obstacles to staying nonviolent remain largely unknown. Due to the limited knowledge base in this area, the present study necessitates a research design useful for rich description and theory generation. Consequently, the present study employs a qualitative research design based in constructivist grounded theory (Charmaz, 2002) in order to explore factors and processes that are related to IPV recidivism after program completion, and the influence that partner-violent men's participation in AIP treatment may have had before, during, and after their recidivist incident(s). Qualitative researchers select a grounded theory approach when the purpose of the research is to move beyond in-depth description (as in phenomenological research) to both description *and* theory development (Creswell, 2007). While qualitative and quantitative methods are complimentary approaches to understanding, qualitative inquiry, generally, and grounded theory, specifically, offer researchers the ability to gather information for descriptive purposes, explore diverse models and ideas, and develop a theory for a specific topic or process that is grounded in the data (Glaser & Strauss, 1967; Charmaz, 2006). The following chapter includes a review of this methodological approach, along with the present study's data collection method and procedures, strategies for validating the data, a data analysis plan, and a statement of reflexivity.

**Constructivist Grounded Theory**

Strauss and Glaser (1967) originated the grounded theory approach to "demonstrate relations between conceptual categories and to specify the conditions under which theoretical relationships emerge, change, or are maintained" (p. 675, Charmaz, 2002). Several decades later, Charmaz (2002) proposed modifications to the grounded theory approach. Both Strauss and Glaser's traditional grounded theory (also called "objectivist grounded theory") and Charmaz's constructivist grounded theory, at their core, aim to generate theories that are derived from descriptive data (Charmaz, 2002) but their epistemological approaches differ in several key ways. Through the lens of Glaser and Strauss' objectivist grounded theory, data are believed to be:

> "real in and of themselves… [and] represent objective facts about a knowable world. The data already exist in the world, and the researcher finds them. In this view, the conceptual sense the grounded theorist makes of the data derives from the data: meaning inheres in the data and the grounded theorist discovers it" (Charmaz, 2002, p. 677).

Another key epistemological aspect of traditional grounded theory is relevant for the present study: assumptions of insight and the capacity for accurate recounting of experience are inherent in the objectivist grounded theory approach. Within objectivist grounded theory, research participants are presumed to be able to accurately and willfully relay important, significant, and detailed information regarding their experiences and perceptions (Charmaz, 2002). However, partner-violent men's accounts of their violence, and their rationales for perpetration, may be reported in the context of limited insight and problematic beliefs, assumptions, and attributions.

Alternatively, Charmaz's constructivist grounded theory approach (2002) takes into account the experiences and perceptions of both the participants and the researcher. Through the lens of constructivist grounded theory, significance is placed on both the "phenomena of study" and the shared experiences, interpretations, and perceptions of the researcher and participants. "Constructivists also view data analysis as a construction that not only locates the data in time, place, culture, and context, but also reflects the researcher's thinking. Thus the sense that the researcher makes of the data does not inhere entirely within those data" (2002, p. 677). Charmaz's development of grounded theory offers a less positivist method for data collection and analysis than the traditional objectivist grounded theory approach as it "assumes the relativism of multiple social realities, recognizes the mutual creation of knowledge by the viewer and the viewed, and aims towards interpretive understanding of subjects' meanings" (Charmaz, 2003, p. 250). The present study will use Charmaz's constructivist grounded theory approach to explore and explain the statements and actions of partner-violent men who commit IPV subsequent to AIP treatment completion in order to learn about their lived experiences of AIP treatment participation and recidivism, and in order to develop theory regarding processes of change and re-offense in this population.

Constructivist grounded theory is an ideal approach for the present study based on its explicit emphasis on mutually constructed data generation and interpretation between study participants and the researcher. The researcher's perspective and the emphasized importance for the researcher to be part of the process are of benefit for the present study for two key reasons. First, the question of

insight emerges regarding partner-violent men's experiences of their recidivist events and their capacity to recount information that is self-aware and accurate. For example, partner-violent men may have limited insight about the sources of their violence. They may also have difficulty identifying the emotional cues that led to the recidivist incident and/or may downplay their role in the abuse. Thus, a constructivist grounded theory approach is particularly useful for the present study based on its emphasis on the interaction between researcher and participants at each point of the research process. For example, the researcher's knowledge of the literature base constructs a deeper understanding for, and ability to interpret, what participants report as significant and important in their experiences. This ability is in part due to a researcher's "theoretical sensitivity" that is developed through familiarity with existing literature and theory (Dey, 1993). Theoretical sensitivity and "sensitizing concepts" (Blumer, 1969) help researchers to generate interview questions, guide the interview process, analyze data, and develop interpretations that are grounded in sensitizing theory as well as the data themselves. The researcher's theoretical sensitivity can help mediate possible concerns regarding insight among participants. However, while prior knowledge and sensitizing theory can and should aid at each step of the research process, it is important that the knowledge is used to *inform* (rather than guide) the development of theory. Theory should be grounded in, and emergent from, the data and the researcher's interpretations of the data rather than made to fit into the preexisting theories; thus, researchers engaging in constructivist grounded theory should have "an open mind [but] not an empty head" (Dey, 1993, p. 229).

Second, the explicit emphasis of mutually constructed data generation and interpretation between study participants and the researcher in constructivist grounded theory is well suited for the present study based on the study's second research question. The present study aimed to understand whether (and how) partner-violent men's participation in the New Behaviors Program, an AIP located in Howard County, Maryland, informed their behavior during, and subsequent understanding of, their recidivist incident. In order to examine this topic, participants were asked about their perceptions and utilization of the skills covered in the AIP treatment. The data was reviewed with the purpose of identifying how consistently with the New Behaviors Program philosophy participants were interpreting their recidivist event. The New Behaviors Program philosophy incorporates cognitive behavioral therapy (CBT), motivational enhancement, and family/relationship systems approaches in order to enhance clients' self-regulation and relationship skills. These skills are designed to provide alternatives to conflict escalation and abusive behavior. The researcher's knowledge of the AIP model and her evaluation of participants' understanding of the program philosophy principles were used alongside participants' statements regarding their experiences and perceptions of recidivism. Ultimately, when aiming to identify skill deficits that may contribute to IPV recidivism, it is essential to understand what skills a "successful" (*i.e.,* non-recidivist) individual retains and is able to utilize following treatment as well as to recognize the expected change processes and challenges clients may face in using alternative strategies to prevent conflict escalation and abuse. Constructivist grounded theory allows for findings to be mutually grounded in both the data and the researcher's standpoint.

## Data Collection

**Qualitative interviews.** Various methods exist for qualitative data collection including content analysis of archival data, observation, focus groups, and interviews, among others. According to Charmaz (2002), "in-depth qualitative interviewing fits grounded theory methods particularly well" (p. 676). Interviews allow for the researcher to guide the study based on research questions. For example, through interviews, a researcher has increased control over the data gathered as compared to data gathered through ethnography or archival review. For the present study, data was collected through individual face-to-face, semi-structured interviews. Interviews were particularly useful for the purposes of both data collection and clarification. Specifically, during the interview, the researcher clarified participants' perceptions of their recidivist incidents and AIP treatment experiences and asked for clarification regarding interpretations provided by participants (Charmaz, 2002). Because interviews can flow like an active conversation, the interviewer was able to pursue topics or constructs that emerged during the interview itself and used these opportunities to engage in iteratively interviewing and theory development. The interview method for grounded theory, specifically, differs from the in-depth interviewing that is used in phenomenological research. In grounded theory, as more and more participants are interviewed, "theorists narrow the range of interview topics to gather specific data for their theoretical frameworks" (Charmaz, 2002, p. 676).

For the present study, participants were interviewed in a private room at the location of the AIP agency. Interviews were digitally audio-recorded and subsequently transcribed verbatim. Transcription was completed by an undergraduate

research assistant and an outside professional transcriber, aided and overseen by the study researcher. Transcript data was entered and analyzed in Microsoft Office Excel. Excel allows for manual manipulation of classification, sorting, coding, and exploration of trends in the data. Please see the "Analysis" section for more information regarding data analysis. Study participants received financial compensation ($50 cash) for their participation in the study interview. Several methods were used in order to protect participant confidentiality. Confidentiality was assured by keeping paper private information (*i.e.,* consent forms) secured in a locked filing cabinet and digital data (*i.e.,* audio-recordings) were electronically encrypted and password protected. Also, the names of the interviewees were not included in the audio-recordings themselves. Identifiable information was not shared with anyone outside the primary investigator's research team. Furthermore, no specific identifying information is included in the results of this study; as such, all data is disguised through the use of pseudonyms.

**Interview guide.** A start list of semi-structured questions helped to guide the initial interviews; these questions were further developed and narrowed through the iterative interviewing process (Charmaz, 2002). Consistent with grounded theory, the interview guide was developed based on relevant literature in the field and the researcher's experience working in an AIP. Throughout the course of the data collection, however, interviewee responses, coupled with the researcher's interpretations, guided subsequent interviews. Thus, the interview guide was further developed iteratively as the questions were refined throughout the interview process.

According to Kvale and Brinkmann (2009), there are nine possible types of interview questions to choose from when developing an interview guide: introductory, follow-up, probing, specifying, direct, indirect, structuring, silence (more of a technique than a type of question), and interpreting (p. 135). Charmaz (2006) recommends asking as few structured questions as possible, and instead, helping participants explore topics through follow-up, specifying, and probing questions as these allow for clarification, further exploration, and theory generation. The interview guide for the present study consisted of introductory, topic-related, and ending questions, with several follow-up questions and topics.

The interview questions aim at generating and exploring information regarding recidivism among partner-violent men who have committed IPV re-offenses subsequent to AIP program completion. An early question asks participants to recount their recidivist event in as much detail as possible. Following the retelling of their recidivist incident, questions explore the factors and/or processes that may have been related to participants' IPV recidivist event; participants' beliefs and

perceptions relating to the event; the amount to which participants believe that their participation in the AIP treatment group influenced their behavior leading up to, during, and after their recidivist incident and their subsequent understanding of the incident; and their perceptions of the skills covered in the AIP. These questions were designed to elicit information regarding factors related to participants' intrapersonal, interpersonal, group-level, community-level, and organizational-level experiences subsequent to AIP treatment completion. Questions were also intended to explore the consistency with which participants discuss their recidivist event as related to the New Behaviors AIP philosophy. The interview guide used in the present study was developed by examining relevant literature, reviewing the philosophy of the AIP that the participants attended, and consulting with a senior researcher to ensure that the questions were clear, not leading, and open-ended (please see Appendix A for a copy of the final interview guide).

**Participants and recruitment procedures.** A purposeful sampling recruitment method was used for the present study. Original study plan included selecting participants through the use of intensity-sampling, a technique that ensures the selection of participants who are accurate examples of the phenomena of interest and "intensely" exhibit the topic being studied (Patton, 2002). In the case of the present study, past AIP clients who have been charged with an IPV offense following treatment completion were contacted to participate in the study. Purposeful sampling methods (including intensity-sampling) require the researcher to determine inclusion criteria prior to study recruitment (Patton, 2002). Several steps were taken to select potentially appropriate study participants. First, data sets containing former clients

who completed the AIP between 1 and 6 years prior to the study were analyzed in order to select clients who completed "a credible dose of treatment" (*i.e.,* attended at least 15 group treatment sessions, or 75% of the program). Next, the list of cases was further narrowed down by selecting individuals who completed post-treatment self-report assessments. Post-treatment self-reports were analyzed in order to select clients who endorsed engaging in abusive behavior at the end of treatment (*i.e.,* responded positively to items regarding physical violence). Finally, a criminal case search was completed for the clients who self-reported engaging in abusive behavior during treatment in order to identify those who also committed IPV re-offenses subsequent to treatment. The original data recruitment plan included contacting the former clients who self-reported engaging in abusive behavior during treatment *and* committed a criminal IPV offense in order to ask them to participate in the study; this plan was carried out in the present study. However, additionally to identifying participants in this fashion, a broader review of treatment completers' criminal records was conducted in order to recruit participants who committed IPV re-offenses after completing the AIP but did not self-report abusive behavior during treatment. This second group was included in the study in order to strategically sample from former clients who may have made improvements in their abusive behavior and subsequently relapsed following program completion.

A recruitment concern emerged following setting the above criteria for participation. Although approximately 42 former AIP clients were eligible for study participation, only 8 participants could be reached. Of these, 7 agreed to participate in the study and were subsequently interviewed for the research project. The other

eligible former clients were unreachable, even following varied attempts at locating accurate contact information through all contact information previously provided by them to the clinic, and through thorough searches of public records. Interviews with the 7 participants who met the eligibility criteria presented above did not completely yield saturation of analytic themes in the interviews, and also created additional questions and areas for exploration. Thus, inclusion criteria were widened to include former AIP clients who completed a different treatment modality, individual treatment rather than group treatment. There were both practical and empirical rationales for including former individual therapy clients. Individual therapy clients were treated by the clinicians with the same level of experience, under the same supervision, and utilizing the same treatment philosophy. Additionally, several participants received both group and individual therapy. Including participants who completed both types of treatment provided a unique opportunity to contrast treatment modalities.

Expanding recruitment criteria to include clients who completed both group and individual treatment was consistent with emergent design logic inherent in qualitative methods as well. Specifically, many former group clients discussed the group process as a limitation to behavior change, noting that working with an individual therapist would have enhanced gains made in treatment. Widening inclusion criteria to allow for interviews with former individual therapy clients allowed the researcher to consider whether treatment modality plays a role in treatment outcomes and provided opportunities to compare treatment satisfaction and responsiveness. Therefore, expanding recruitment procedures was both practical (*i.e.,*

researcher exhausted all options for locating eligible participants within the narrow eligibility criteria) and data driven (*i.e.,* allowed for a broader framework within which to answer research questions based on initial interviews).

All study participants were contacted via phone and asked to participate in the present study. Procedures for recruitment included an initial phone conversation in which the researcher 1) explained the study, 2) answered questions that arose, and 3) conducted a screening of the former client's eligibility for participation. To screen for eligibility, the researcher inquired about the former client's recidivist incident in order to ensure the former client remembers the event and the event meets the study criteria (please see Appendix B for a copy of the study introduction and eligibility screening). If the former client was eligible for participation, a time and date for the study interview was arranged by phone. When participants arrived at the AIP for their interview session, they received a copy of the informed consent form and were given the opportunity to ask the researcher any questions they had about the study. Participants who provide informed consent completed the interview procedures. One eligible former client declined to participate following the consent process. Participant recruitment continued throughout data collection.

Qualitative researchers typically avoid pre-establishing a fixed sample size prior to study initiation. According to Kvale and Brinkmann (2009), the number of participants that should be included in a qualitative interview study depends on the purpose of the study. For example, if the purpose is to develop an in-depth, rich description of a subject (as in case studies or phenomenological research), a very small number of participants may be sufficient. However, if the purpose is to reach

"a point of saturation," (*i.e.,* a point in which no new themes emerge from the data and/or themes/trends begin to repeat), more participants are likely necessary; for this purpose, Kvale and Brinkmann (2009) recommend interviewing between 5 and 25 participants. For the present study, sample size was determined by an iterative analysis of data, assessing for a saturation of themes during data collection, rather than pre-determined. However, based on recommendations in methodological literature and past studies utilizing methods similar to the present study, the study sample size was anticipated to include approximately 10-15 participants.

**Field notes.** Field notes are used in qualitative research as a method for practicing reflexivity and initial data analysis early on during the research process (Patton, 2002). Field notes should include observations made during the interview, initial impressions of the experience itself and of the content of the interview, and/or reactions to the participant. Field notes should also be useful for developing themes and patterns early on in the interview process. In the present study, the researcher noted initial impressions, reflections, reactions, and observations regarding the interview, participant, and process immediately following each interview. It is crucial to write down field notes immediately following each interview in order to capture one's own experiences and perceptions as accurately as possible (Patton, 2002). Field notes are also useful in capturing participants' nonverbal communication, mood, and demeanor during the interview. For example, it may be noteworthy if a participant becomes anxious or upset during the interview; however, if his verbal replies do not demonstrate his mood accurately, his mood may be better accounted for by his nonverbal behavior such as his facial expressions, gestures, or posture. Finally, field

notes can also help to make the relationship between participants' stories and interviewer's subjectivity more explicit; engaging in this form on ongoing reflexivity is a useful practice in the meaning making process (Patton, 2002).

There are several strategies for maintaining field notes. These strategies range from broad, unstructured observations to highly systematic and comprehensive notes; both approaches aim to enable researchers to visualize the interaction later during coding and data analysis (Glesne, 2006). Spradley (1980) provided a guideline for field notes in which he instructed researchers to respond to prompts regarding: the physical environment of the setting (the space); the people involved in the interaction (the actors); what went on (the activity); the sequencing of events (the timeline); what the actors are striving to accomplish (the goals); and the emotions felt or expressed during the interaction (the feelings). In the present study, field notes also included statements regarding reflexivity in an effort to elucidate the origins and implications of how: 1) the researcher's reactions during the interview may have influenced the interviewer and the interview itself; 2) the researcher's standpoint may affect the way she understood and interpreted the participants' responses; and 3) the interview affected the researcher (please see Appendix C for a copy of the field notes guide.)

***Reflexivity Statement: Self of the Researcher***

*"You are so much more than the worst thing you've ever done." - Gregory Boyle*

In qualitative research, the verification (*i.e.,* trustworthiness and accuracy) of the research process and the confidence in its findings are grounded in the researcher's ability to honestly reflect on her experiences producing the research itself. This should be a transparent and ongoing process that includes accounts

regarding the development of the research (*e.g.,* research idea formulation, design, interview questions, findings, etc.), the researcher's interactions with participants, problems she may have faced, values and biases that arise, and any experiences that may necessitate further exploration (*e.g.,* reflections on gender dynamics). Documenting these elements of reflexivity throughout the research process creates a natural history of the research that serves to record the evolution of the study and enables others to verify that the research is reproducible, systematic, credible, and transparent (Glesne, 2006).

I am often struck by the questions of who produces "knowledge" and for whom knowledge is produced, questions that are well suited for the constructivist and critical theory paradigms, and consequently for qualitative research. Dillard (1988) wrote, "Our knowledge is contextual and only contextual. Ordering and invention coincide: we call their collaboration 'knowledge'" (p. 56). Dillard is describing the perspective that knowledge is subjective because it is created by people who bring with them histories, narratives, perspectives, values, and biases. Feminist researchers contend that reflexivity is especially meaningful in research as it allows researchers to clarify their own positionality through documenting their subjective experiences (*i.e.* their "standpoints") in the research process while recognizing and understanding the unique lenses through which they perceive the world and their research (Hartsock, 1983). Dillard's conceptualization of knowledge and Hartsock's emphasis on standpoints in feminist research are both quite relevant to the present study examining the recidivist experiences of partner-violent men, conducted by a feminist, qualitative researcher.

Gilgun (2008) notes that within the field of intimate partner violence, gender is a key aspect of identity and an important dimension of reflexivity, especially for feminist women. During the course of her decades of research within this field, she was very conscious of the fact that, "as a woman, [she] was a member of a class that was a target of male violence" (p. 184). I, on the other hand, have had a different experience throughout the course of my work within the field. Instead, I have grown to understand that in most cases, women are not the targets of men's violence just because they are *women;* it is simply more complicated than that. They are often the targets of men's violence because of learning histories that include using violence to resolve conflict, lack of skills inherent in the couple's dyad, and various multilevel factors (*e.g*., alcohol use and trauma history, among others). In few cases I have witnessed and experienced overt sexism and have worked with men who hold misogynistic beliefs; this, however, I have found to be the exception rather than the norm, and an exception that is often multifaceted with contextual factors (*e.g.,* cultural norms and/or learned behavior from men's histories).

Over the last four years, my personal and professional identities have been shaped considerably by my work with partner-violent men, partner-violent women, and victim/survivors of partner violence and sexual assault. As an avid feminist beginning her first clinical psychology practicum several years ago, I struggled. I was skeptical of partner-violent men's capacity to change and distrustful of what they might be like in therapy with a young woman. However, during my first two years providing individual and group therapy to men who were most often court-ordered to abuser intervention treatment, my personal and professional beliefs regarding myself

as a feminist, my future work as a psychologist, and the multilevel impact I can make through my work with partner-violent men, changed dramatically. Two long-term clients, who I treated for 2 years each, stand out. Upon termination with these clients, I remember hoping that I was able to successfully communicate to them as Gregory Boyle eloquently articulates, "you are so much more than the worst thing you've ever done." If I have learned anything from my work with these long-term clients, it is that people can and do change, and that their history is not necessarily the best predictor of their future. Professionally, I learned that I could validate people's suffering without approving their violent and abusive behaviors. This shift in my practice created the space for these clients to begin perceiving themselves as more than their worst action, and likely helped them take steps in their processes of behavior change. Getting in touch with the source of their pain and the shame regarding their behavior allowed them to move past their actions towards making changes in their intra and interpersonal lives.

Personally, I began to perceive my work with partner-violent men as the most feminist work that I had ever done; I was engaging in the prevention of future violence against women. My clinical work over the last five years has strongly shaped my feminist identity, an identity that previously meant working for the betterment of women and now means striving for true gender equality, an equality that recognizes the betterment of women means enabling men to communicate effectively, express emotions other than anger, participate fully in parenting, safely cope with their distress without using drugs and alcohol, and refrain from resorting to coercive and oppressive behaviors.

Reflecting back on my personal and professional growth over the last five years, I am struck by the relevance of myself as a woman gaining trust with men. Maybe these long-term clients stand out so much because of the rapport and trust gained over the course of the two years. Thinking back on my sessions with each of the men, I rarely remember struggles regarding power and control; I felt safe, respected, and therapeutic. However, in the same abuser intervention program where I continue to work, I lead orientation sessions three times a week and run a weekly group – I regularly experience gendered dynamics, often grounded in power struggles (or at least can be perceived and contextualized in such a way). Since dynamics of power and control may influence the interview process as well, it is crucial to gain trust and build rapport with study participants in order to decrease gendered power dynamics during the interviews as well as to reflect on possible perceptions of such experiences following interviews.

In terms of contextualizing life experiences, I am quite different from the participants in the present study in many ways. As such, it is important for me to recognize my positionality as a young, white, foreign-born, educated, Jewish, middle-class, woman who identifies as a feminist. A key part of reflexivity is reflecting on how these identities may influence the content and process of the research (Glesne, 2006). During the course of the present study I maintained a research journal for the purpose of reflecting on my experiences (in a style similar to what is written above) and processed my reactions and perspectives. This journal helped me to immerse myself in the data, recognize biases, and provide transparency. Additionally, in order to identify potential biases, I aimed to ask non-leading questions during interviews,

maintained field notes following interviews, engaged in reflexivity during analysis, and solicited feedback from others during theory development.

**Data Analysis**

Due to the iterative nature of qualitative research, data analysis occurs during several phases, including during the data collection, immediately following each interview, and after the transcription of data while engaging in the coding process. Qualitative data analysis exists on a spectrum from very structured, to systematic but flexible, to highly flexible forms of analysis; even within grounded theory itself, the system of analysis varies based on the grounded theory tradition. In the present study, data was analyzed according to Charmaz's (2006) recommendations for data analysis in the constructivist grounded theory practice, a systematic but flexible, structured approach to data analysis. During the study's interview phase, data analysis occurred simultaneously with data collection in two key ways. First, the researcher had an ability to clarify participants' responses to questions thus reducing the risk of misinterpreting meaning. Also, because interviewing is iterative, the ability to refine interview questions during interviews and between interview participants aids researchers in engaging in an analysis of the data throughout the interviewing process.

Field notes were maintained in a journal to keep track of the research and data collection process. Specifically, immediately following each interview, the researcher noted initial reactions, reflections, and observations in field notes. These notes were reviewed on a regular basis and contributed to the data analytic process in several ways. First, they enabled the researcher to reflect on her own potential biases

following interviews. Second, the researcher's comments in field notes were also substantive material for coding, especially as related to factors that may have been more difficult to identify through the audio recording and transcription process, such as capturing participants' nonverbal communication, mood, and demeanor during the interview. Field notes were also used as a place in which the researcher connected her previous experiences with some of the participants to their narratives during the interview; doing so provided an opportunity to reflect on participants' interview responses in context of the researcher's more in-depth knowledge of some of the participants' backgrounds and histories. Field notes followed Spradley's (1980) suggestion that researchers respond to prompts following each interview. Such prompts included, "what did the participant's goals appear to be?" and "what are the elements of my standpoint that may affect the way I understood and interpreted the participant's responses?" (please see Appendix C for the full list of field note questions). Finally, the field notes enabled the researcher to explore the symbolic interactionism that existed in the data (Charmaz, 2006). Charmaz describes the importance of researchers accepting that multiple realities exist and enacting constructivist grounded theory with the emphasis on mutually constructed data generation and interpretation between the participants and the researcher. Therefore, field notes were used to explore ways in which the data reflected both the researcher's and participants' constructions of the reality.

Following transcription of interviews, the data was coded by, "categorizing segments of data with a short name that simultaneously summarizes and accounts for each piece of data. Coding is the first step in moving beyond concrete statements in

the data to making analytic interpretations" (2006, p. 43). Coding enabled the process of categorizing, organizing, and sorting data in order to elucidate meaning and theory through emergent themes. Charmaz describes two phases of data coding in the practice of grounded theory data analysis: initial and focused (2006). During the initial coding phase, researchers identify lines and segments of data in order to "mine early data for analytic ideas to pursue in further data collection and analysis" (Charmaz, 2006; p. 46). Initial coding is similar to the "open coding" process described by Strauss (1987). The major analytic goal during this initial phase is to maintain an open mind to various theoretical directions and possibilities; the goal is not to focus in on one specific theory until the focused coding phase. However, a second goal of the initial coding phase is to use "'constant comparative methods' to establish analytic distinctions – and thus make comparisons at each level of analytic work" (Glaser & Strauss, 1967 in Charmaz, 2006; p. 54). Making comparisons of themes within the same interview and among previous interviews helps to clarify and revise codes to improve their fit. During the focused coding phase, researchers identify the most salient and/or frequently noted themes in order to "sort, synthesize, integrate, and organize large amounts of data" which will ultimately aid in the development of theory (p. 46). Focused coding is comparable to Strauss' (1987) "selective coding" process.

Additionally, axial coding helped to connect categories and themes to subcategories; this strategy was utilized in the present study in order to enhance data coherence and enable theory emergence. Axial coding was first introduced by Strauss (1987) as a way to construct "a dense texture of relationships around the

'axis' of a category" (p. 64) by linking codes together and adding structure to the data. Ultimately, while initial and focused coding serve to separate the data into distinct and meaningful categories, axial coding brings it back together thematically in order to provide structure, which generally aids in theory development.

Finally, examples of disconfirmation were also investigated. These examples were noted by intentionally seeking out negative evidence through asking "do any data oppose this conclusion or are any inconsistent with this conclusion?" Related to this strategy, 'if-then' codes were identified and analyzed. If-then codes are conditional statements of relation between variables (Miles & Guberman, 1994). Testing if-then codes requires researchers to generate and test other plausible competing explanations. If there are no examples of disconfirmation after looking for negative evidence, then the if-then expression is plausible.

**Data Verification: Trustworthiness & Accuracy**

The "reliability" and "validity" of qualitative research is sometimes called into question, especially within fields traditionally grounded in positivist and post-positivist paradigms that are highly prominent in modern American psychology. However, one can assert that this critique is not because qualitative research itself is inherently unreliable or lacks rigor, but rather because the constructs (reliability and validity) themselves are not well suited for qualitative research. While most psychology research is grounded in a hypothetico-deductive, post-positivist (or positivist) approach that requires the researcher to state a potentially falsifiable hypothesis in advance and use objective methods to test the hypothesis, qualitative research does not utilize hypothesis testing. Reliability and validity of measurement

and hypothesis testing operations are positivist and post-positivist constructs and thus incongruent with qualitative research, an approach that is more aligned with constructivist and critical theory paradigms. There are, however, other ways to ensure trustworthiness and accuracy (constructs comparable to reliability and validity) in qualitative research (Lincoln & Guba, 1985). Qualitative researchers must ensure that their research is reproducible, systematic, credible, and transparent. Lincoln and Guba (1985) describe c*redibility* as a construct used in place of internal validity to evaluate whether the research findings represent a "credible" conceptual interpretation drawn from the participants' original data. This is done, for example, by engaging in negative case analysis. *Transferability* takes the place of external validity and represents the extent to which knowledge obtained from the data is applicable to other contexts. *Dependability* takes the place of reliability, serving as an assessment of the quality of the research processes itself and is ensured by maintaining field notes, explaining the broader context, engaging in personal reflections, etc. Finally, *confirmability* reflects how neutral the study findings are and how much they are shaped by the respondents rather than the researcher's bias, motivation, or interest. Creswell (2007) recommends strategies for enhancing the trustworthiness and accuracy of qualitative research. In the present study, several of Creswell's recommended strategies for validation and evaluation of qualitative research were utilized.

According to Creswell (2007), "credibility," "authenticity," "transferability," "dependability," and "conformability" represent the internal validity of a study, or in qualitative terms, the study's *trustworthiness*. Creswell recommends two techniques

in order to establish trustworthiness: "prolonged engagement in the field and triangulation" (2007, p. 202). Additionally, Creswell (2007) describes eight verification strategies in order to enhance a qualitative study's *accuracy*; he recommends that researchers engage in at least two of these strategies. The eight strategies for verification include: prolonged engagement in the field of study and persistent interaction and observation with the population of interest; peer review; triangulation; external audit; negative case analysis where, "the researcher refines working hypotheses as the inquiry advances in light of negative or disconfirming evidence" (p. 208); ongoing reflexivity in order to explore and clarify researcher bias; conducting member checks to ensure the data is being understood correctly and interpreted appropriately; and rich description of data and context (Creswell, 2007). During the present study, six of the above strategies were utilized in order to enhance the trustworthiness and accuracy of data and findings. The primary researcher has provided clinical services to partner-violent men for approximately 5 years and continues to work within the field increasing her prolonged engagement in the field of study and persistent interaction and observation with the population of interest. Additionally, peer review and external audit with dissertation committee members and peer researchers took place over the course of various stages of research, including study design, data collection, data analysis, and interpretation of findings. Next, the primary researcher engaged in ongoing reflexivity as described above (in the field notes and reflexivity sections). Finally, the research document includes rich description in order to allow readers to understand the context and narrative of participants. Many of these strategies can also be categorized as triangulation

practices. Patton (2002) identifies four types of triangulation: methods, sources, analyst, and theory. In the present study, methods triangulation were conducted by using multiple data sources (*i.e.,* former clients' clinical charts, the Maryland Criminal Case Search Database, and interviews); analyst triangulation was done by working with others on the dissertation committee to review codes and analyze data; and theory triangulation was granted by maintaining multiple working theories regarding recidivism and change processes among partner-violent men during each phase of the research study.

## Chapter 3: Results

The results of the present study consist of findings from 11 qualitative interviews collected and analyzed in the manner described above. This dataset is comprised of approximately 580 pages of double-spaced, typed text, which was transcribed following data collection. The following chapter begins with a brief introduction to the participants, including participants' recidivist eligibility for participation. Next, a summary table illustrates participants' relevant biographical details and demographics. Finally, in depth description of the central themes is reviewed across the 11 qualitative interviews.

### Description of Participants

The 11 participants interviewed for the present study all met inclusion criteria based on criminal or civil charges related to domestic violence following treatment completion. Of the charges, 5 participants obtained new protective orders, 1 faced harassment charges specifically related to telephone misuse, 3 faced second degree criminal charges for assault, and 1 faced first degree criminal charges for assault. The

age of the participants ranged from 23 to 53 years old at the time of the interview, with an average age of 37.45 years. At the time of the interview, 6 participants were employed full-time, 1 was employed part-time, and 4 were unemployed. The racial and ethnic makeup of the group was diverse such that 4 participants identified as Black or African American, 5 as White or Caucasian, 1 as Indian, and 1 as Hispanic or Latino and White. Four participants reported completing high school, 5 stated they completed some college, 1 reported completing graduate school, and 1 completed the 11th grade and was studying for his GED at the time of research interview. Nine participants completed group treatment, and of those 9, 2 completed individual treatment following new charges and 4 completed group a second time following new charges. Two participants completed individual treatment only. At the time of treatment initiation, 8 participants reported being court-ordered to an abuser intervention program and 3 reported attending voluntarily. Please see Table 1 for an overview description of participants.

Table 1
*Description of Participants*

| Name[2] | Age | Race/ Ethnicity | Charge(s) Following Treatment Completion | Education | Employment | Treatment Modality |
|---|---|---|---|---|---|---|
| Andre | 41 | Black or African American | 2 protective orders | Some College | Unemployed | GRP |
| Darrell | 45 | Black or African American | 1 protective order | Graduate School | Full Time | IND |
| Carl | 42 | White or Caucasian | 1st degree assault of partner | 11th Grade | Full Time | GRP/IND |

[2] Participants' names were replaced with pseudonyms in order to maintain participant anonymity. These pseudonyms were generated with the intention of reflecting racial/ethnic characteristics of the participants' real names.

| | | | | | | |
|---|---|---|---|---|---|---|
| Glen | 38 | White or Caucasian | 2nd degree assault of partner; protective order two years later | High School | Unemployed | GRP |
| Gavin | 27 | White or Caucasian | 1 protective order; violation of protective order; willful motor vehicle tampering | Some College | Full Time | GRP/GRP |
| Javier | 44 | Hispanic or Latino/White or Caucasian | 2 protective orders; violation of protective order | Some college | Unemployed | GRP/GRP |
| Dominic | 29 | Black or African American | 2nd degree assault of partner; destruction of property | High School | Full Time | GRP/GRP |
| Dev | 37 | Indian | 2nd degree assault of partner | High School | Unemployed | GRP/GRP |
| Hank | 33 | White or Caucasian | 1 protective order; violation of protective order | Some college | Full time | GRP/IND |
| Dan | 53 | White or Caucasian | 2nd degree assault of partner; violation of protective order | Some College | Full time | GRP |
| Marcus | 23 | Black or African American | Telephone misuse (repeated calls/harassment) | High School | Part time | IND |

**Interview Findings: Analysis of Themes**

The findings below detail the themes that emerged from an in-depth analysis of the 11 interviews conducted. Line-by-line coding consistent with Charmaz's constructivist grounded theory qualitative research methodology was used to analyze the interview transcripts. The overarching objective for the present study was to gain understanding regarding behavior change processes and multilevel factors for recidivism among partner-violent men who commit IPV subsequent to AIP treatment completion, in order to develop theory regarding processes of change and re-offense in this population. Narratives presented below demonstrate the themes that emerged following data analysis. Findings were organized by research questions and axial codes, a coding system that helps to connect categories and themes to

subcategories. Consistent with Charmaz's (2006) coding recommendations, "axial" codes will be presented to enhance data coherence and enable theory emergence and "focused" codes will serve to separate the data into distinct and meaningful categories.

Research question one. What factors are related to IPV recidivism following program completion and what are participants' perceptions of their re-offense?

***Barriers (to staying nonviolent).*** *Skills deficit.* Participants identified various barriers to remaining nonviolent. All participants, regardless of treatment modality (*i.e.,* group, individual psychotherapy, or a combination of both) or type of recidivist incident (*i.e.,* criminal or civil charges), discussed skill deficits and/or lack of skill acquisition as barriers to staying nonviolent. Specific categories related to skills deficits included not gaining skills during treatment altogether (potentially due to participants' difficulty taking treatment seriously or engaging effectively), gaining skills but not using them following treatment, gaining only an abstract (and not a practical) understanding of skills, misapplication or misunderstanding of skills covered in treatment, and difficulty remembering to use skills when needed. The specific skills that may have been helpful in preventing ongoing violence in relationships following treatment that participants identified as lacking during their relationship conflicts, thus leading to interpersonal effectiveness, include strategies for emotion regulation, anger management, distress tolerance (especially regarding the perception of disrespect by partner), and effective communication (particularly related to use of assertive rather than avoidant/passive communication).

During the interviews, many participants struggled to identify specific examples of skills they gained following treatment completion. Once provided with examples of skills reviewed during the AIP treatment, most participants were able to at least vaguely describe their attempts at skills use. It should be mentioned that participants' vague recounting of skills may be attributable to their limited

understanding of the specific skills, but it is also possible that the interviewer misjudged participants' understanding of the skills based on the language used in their description of skills use. However, abstract understanding of skills seemed to be a barrier to successful skill implementation. Glen described how he "bobs and weaves" through obstacles, highlighting his potentially vague understanding of skills reviewed in group:

> When you wear your heart on your sleeve sometimes, just you're all over the place. You can't do that... Umm, you just think about things and you don't, you don't think 'em. But then again, I keep saying adjusting, adapting, and overcoming, I have to bob and weave through these obstacles and challenges.
>
> - Glen, group treatment

Glen's struggle to identify concrete skills for dealing with stressors, even following the interviewer's attempts at probing for specifics regarding just *how* he bobbed and weaved, emphasized the difficulty that many participants had at articulating the specific behavioral strategies that may have been helpful to them for managing distress. Hank similarly conveyed an abstract understanding of skills, as demonstrated here by his description of attempting to apply the "suppression" skill – it should be noted that no such strategy is taught during group treatment. A strategy most closely related to the one that Hank described is likely the "cooling down" skill involving a set of techniques recommended in response to intense anger and/or difficult situations (please see Appendix E for an overview of skills covered in the AIP):

> It's the strategies… I can only sum it up as when, uh, there was so much information. But again, learning what not to do. Suppression. Rather than getting in someone's face and freakin' them out. Because I know now that it, it's just not gonna work.
>
> - Hank, group and individual treatment

Hank was not alone in his misunderstanding and erroneous application of group content. For example, Dan described learning to be passive or avoidant as a strategy for conflict resolution. Not only was passivity *not* taught as a skill during the AIP, but the drawbacks of avoidance and passive communication and behavior are addressed in the content of treatment. However, Dan reported using passive communication as a relationship strategy, noting having learned it during group:

> Just walk away and take a couple deep breaths and, all right, shut your mouth, don't say anything whether you're right or you're wrong, just let it go and, you know, just somethin' like that is a strategy.
>
> - Dan, group

Dan's example demonstrates the combination of a potential cooling down strategy (at least in the way he understood it), coupled with avoidance behavior. As the interview progressed, Dan became frustrated at his difficulty remembering specific strategies that were covered during the group. He later exclaimed, "Um, uh, they, think back, the, um, (inhales) whew. I don't know. Christ! Um, I, and I, I can't give you specific examples." While Dan's frustration distinctly reveals his struggle to remember the lessons conveyed in the group, it also demonstrates an ongoing skill deficit related to distress tolerance. The agitation caused by his struggle to complete a task requested of him serves as an example of his difficulty managing emotions during moments of distress, a difficulty likely amplified when the distress occurs in the context of his romantic relationship that has a history of conflict.

Another way that the lack of skillful strategy application following treatment completion interfered with distress tolerance, and thus served as a barrier to staying nonviolent, was through difficulty remembering to use skills when needed. Many participants indicated that they acquired skills during treatment, but forgot to use the

strategies over time for several reasons, including too much time passing between needing the skills and completing treatment. For example, Dominic described having learned concrete skills during group, but forgetting to use them when he most needed them during future relationship conflicts:

> When you first get out of the program everything is so fresh (laughs) so you know everything is so new, so then you know when weeks and months go by, it's more like you forget about some certain things. It was like, take a step back, a breather, and some other things I can't remember all that.
>
> - Dominic, group 2x

Some participants, like Carl, demonstrated insight regarding their lack of skill acquisition during their program involvement. Carl described his awareness of the lack of gains made, alongside his regret regarding not taking treatment seriously his first time around:

> If I had been more involved then probably wouldn't be here [for the second time]… If I had really paid attention, you know what I mean, I could've, I could've got some behavior skills out of it...and, um, I didn't gain my behavior, right? That's for one thing. You know what I mean, I didn't learn nothing about controlling my anger like I should've. Cause I'm just, I'm just angry. I'm angry all the time. It's just the way I have been, just angry… I wish I would of learned something last time, you know what I mean. I wouldn't been this way with my wife, you know what I mean, and I wouldn't of put my hands on her, if I had really paid attention.
>
> - Carl, group and individual treatment

Carl was not alone in his openness regarding lack of skill acquisition. Gavin was completing the AIP group for the second time during the time of his interview. He described his lack of motivation the first time around and his willingness to engage differently in treatment when completing it for the second time:

> I mean I didn't really participate too much last time. Not really. I, uhh, sat there and didn't really say too much... Well, uhh, last time I didn't really participate when all the guys were crying about it. I was just kind of doing it just to do it. That was then, uhh, now I look to strategize better, and

> communicate better, and uhh, work with the program, and learn from the program, and not be stubborn.
>
> - Gavin, group 2x

Several participants who completed the AIP group more than once discussed motivation as a factor necessary for skill acquisition. Lack of motivation to engage in the AIP during time of treatment served as a barrier to skill acquisition for many participants (this theme will be described in more detail in the research question two section). A continued skills deficit following treatment completion may have led to participants reoffending and being ordered back into the AIP. Thus, not gaining skills during treatment emerged as a theme over the course of data collection. This theme is important to consider in the context of barriers to staying nonviolent as well as within treatment implications, which will be discussed more below. For example, Dev completed the AIP group twice and described engaging in treatment differently the second time around:

> If you're not interested in learning, nothing's going to be saved in your mind, you know? If you think like this is not going to help me, your brain's not going to process anything, you know? You got to want to know. You got to want to say 'hey, let me try this, try this for shits and giggles', you know? 'Cause you're in here for- you have to be here. And if you have to be here, just go ahead and try it. And that's what I did, you know and I tried some of the situations. I worked with my partner. You know, we did stuff together, filling out forms and everything 'cause just wanted to get this over with. And I helped us out because I knew how she felt too. You know.
>
> - Dev, group 2x

*Lack of support.* Participants' difficulty accessing support during times of conflict or distress also emerged as a theme for barriers to staying nonviolent. Participants described a strong desire for additional resources, but expressed various factors that interfered with their ability or willingness to access extra support.

Specific support that participants identified as resources that would have been useful included individual therapy, couples therapy, employment support, legal assistance, and the help of their extended family. Shame and financial constraints were identified as the primary factors that interfered with participants' ability and willingness to access additional support. For example, Marcus described a desire for additional support, whether through social/familial connection or through more structured resources, such as clinical services:

> My family, [which] I don't have. That's one thing that I've had a struggle with, is support. I've never had support. ...It would've been helpful if I had some support. Someone to you know, be there by my side, you know someone that actually can talk to me and x,y,z, and give me the best advice possible. But I've never had that.
>
> -Marcus, individual

Similarly, Joe described difficulty asking others for help, indicating that "most of the people don't understand. Nah, I didn't reach out, I didn't. I don't go to anybody." When asked about whether more structured support in the way of therapy would have been helpful to Joe and could have aided in his efforts to remain nonviolent, Joe agreed that therapy would have been useful for him at the time, but stated that the cost of therapy was prohibitive for him:

> I'm a construction worker. I make, uh, I make, like, $800 a week so and then I got a $1,400 mortgage. And actually I'm not allowed to be at the house. So, so, I mean, payin' a mortgage and then tryin' to make ends meet with that, it's very difficult. *[deep sigh]* I don't know... Most the time I think if you go to therapy, it's money. I'm in a financial bind. So I mean, a few years ago I had, like, $20,000 in the bank when and if I ever wanted to do anything I just went and did it. And it's, like, now it feels like I owe everybody.
>
> - Joe, group

Another form of desired support that Joe and others mentioned was couples therapy. Some participants noted the potential benefit of participating in couples therapy

during times of conflict with their partners. These participants indicated that it would have served as a potential protective factor decreasing the chances of violence in the relationship and supporting the preservation of the relationship:

> At that time I wish I could have gotten couples counseling for me and her. Somebody that's striving for that goal of trying to work on whatever the fuck we are going through because of the kids we were supposed to be mom and dad. So, I guess I wish that happened because maybe it would have went a different way. I guess that wasn't an option here. If that was an addition to the New Behaviors program where that option was available to some of us that weren't that far gone yet in our relationship, might have helped us also. Because this is a one man band when you are coming here and getting help and they are not... So I wish that was an option... You know what? That was frustrating.
>
> - Chris, group

*Alcohol use.* The final barrier to staying nonviolent that emerged was the use of alcohol. In qualitative data analysis, "if-then" expressions are codes grounded in the conditional statements of relation between variables (Miles & Guberman, 1994). The use of alcohol as a barrier to nonviolence emerged as an if-then expression, such that all of the participants who discussed alcohol use during the interview indicated that the use of alcohol served as a significant barrier to remaining nonviolent. Alcohol use fits the model of an if-then expression because not all participants discussed alcohol during the interview, however, those who did, identified it as a significant barrier to staying nonviolent. Participants noted inhibited decision-making during intoxication and frustration regarding additional consequences, such as legal issues, led to the use of aggression and violence in relationships. Dev described his difficulties managing relationship conflict and strong emotions, such as anger, in the context of alcohol:

> I don't know. I guess alcohol amplifies the angry. I don't know 'cause when I'm not drunk I can control myself, you know? You can reason stuff out, you

> know? There's a lot more reasoning when you're not drunk. When you're drunk its whatever, you know? And the sad thing is I've never been a bad drunk. I've always been a good drunk, you know. I've always had fun times. I've never had a bad time. But when I'm around my wife, she takes me out of that fun place and puts me in a really shitty place, you know? So we don't drink around each other anymore. I think that's the number one reason I hit my wife, you know? And I know it is. I know it is. And if I wasn't drinking I'd probably be angry, but I wouldn't hit her.
>
> - Dev, group 2x

Similarly, Carl discussed how difficult it is to remember to use skills when drinking. He reported that although he and his wife regularly get along and effectively manage conflict, once alcohol is added to their dynamic, it becomes difficult to successfully apply strategies learned in the AIP, such as time outs:

> We had our problem with alcohol. It's just…we normally get along but it's just the alcohol was our problem. And it's…when it happens, it happens, you know what I mean? ...Cause you're not thinking about taking time out at that time. You're already past that point already. You're already ten beers into your, into your mood already.
>
> - Carl, group and individual

Notably, both Dev and Carl incurred legal consequences related to their alcohol use, as well as IPV, following their recidivist incident (i.e., both were court-ordered to a substance use treatment program in addition to AIP). While many participants lacked insight regarding the other barriers to remaining nonviolent (described above), those participants who used alcohol demonstrated an understanding of the ways in which alcohol got in the way of their interpersonal effectiveness with relationship partners, especially in times of conflict.

***Rationale (for using violence).*** In addition to emergent themes regarding barriers to staying nonviolent, themes emerged highlighting the affirmative rationales that participants provided for using violence. The denial of responsibility for the

violence and partner blame emerged as the predominant rationalizations that participants used to justify their behavior during the recidivist incidents.

*Denial of responsibility.* The denial of responsibility of violence took several forms, including denying the abusive behavior altogether, rationalizing and justifying the violent behavior, making excuses for the behavior, and minimizing the behavior. Andre provided an example of how participants tended to deny their responsibility in the incidents that caused recidivist charges:

> She said that she came in the house, I questioned her about her whereabouts, and that I snatched the phone from her, I assaulted her. Okay, now when she came into the house, there was no need for me to question her because she just called me on the telephone and told me she was at the supermarket. I just questioned her about her fly and then I told her, 'If you're in a relationship, if you having an affair, you got a week to get it straight.' And then she said to me, 'No, you're the one in the affair.' So I said, 'You heard what I said. You got a week to get it straight.' At that time, she goes to call the police. When she goes to call the police, her phone drops. When her phone drops, we simultaneously go down to pick up the phone. I get it first, so we bump shoulders. So when we bump shoulders, she loses balance, falls back onto the stairs.
>
> - Andre, group

Like Andre, participants often denied or minimized their violence when first describing the recidivist incidents. After denying their behavior as violent altogether, many went on to acknowledge the behavior but offer justification for it in the ways of minimization. For example, later in the interview, Andre went on to illustrate some acknowledgement of his behavior, but continued to justify it:

> And it's like, you know I'm crazy and you going to push my buttons anyway? You must be crazy too! You know, why would you push a person's button when you know they're right at the edge? I mean, damn, do it when they're a thousand feet away from the edge. You're going to do it while they're at the edge and in the heat of the moment?
>
> - Andre, group

When participants acknowledged their use of violence or control during the recidivist incidents, the behavior was typically minimized or justified. This use of justification and minimization for violent behavior was very common among participants. Darrell went as far as to use Martin Luther King Jr. to provide context to his behavior, indicating that it is important to understand why violence takes place rather than to solely place blame on the perpetrators of violence:

> I said, "get out of my face!" I said, "you know you owe me $150. That's what I want." She says, "you can't take nothin' from me." I, in that split second, snatched her pocketbook. If she's standin' here and I snatch her pocketbook, as small as she is, that means I'll pull her towards me. She threw herself over there on the floor ...I think one of the things that I oftentime wrestle with is somethin' that my mentor, Dr. King, would say. He used the example of a riot. He says oftentimes we ask ourselves why are they rioting? And he reversed the question and he said, what could go on that would make a person want to riot? And that's kinda what we don't pay attention [to] in domestic violence.
>
> - Darrell, individual

However, a few negative examples of the denial of responsibility emerged in the data, as well. For example, Dev expressed his regret regarding his use of violence in his recidivist incident. He demonstrated awareness related to his impulsivity and took responsibility for the consequences of his violent behavior:

> I regret it. Even till today, you know? I do apologize to her all the time, you know? I wish I'd handled it differently, you know? It was kind of like an impulse action, you know? I'm mad 'cause I did it. I resented it. I never thought I would have done it, you know? I still do and I tell her every day. It hurts me that that's what came out of it, you know? If I'd left it the way it was, if I'd reacted differently, my whole life would've been different, you know?
>
> - Dev, group x2

Another way in which the denial of responsibility through minimization emerged, was the minimization or denial of partners' experiences. Even though Javier described a longstanding history of conflict and bidirectional violence in his

relationship, he dismissed his partner's fear of him and rationalized his ineffective behavior that contributes to conflict and escalation in his relationship:

> There's just fear I think with me and her, you know? We're both afraid of each other. She's afraid of me, cuz she thinks I'm gonna try to kill her, or do something to her. She's always thinking of the worst. …and it's just so scary, it seems like I go for trying to calm things down, when that's doing the opposite... I mean if she's screaming like she's being murdered, and the kids are sleeping. It's very distressing, and like, it becomes almost like an obsession to like stop, to stop the, to make it stop. And that's what keeps it going.
>
> - Javier, group 2x

*Partner blame.* The most common rationale provided for abusive behavior was in the form of partner blame. Partners were blamed for the recidivist incidents in two main ways, by provoking the participant and by initiating violence/being violent themselves. Partner blame especially emerged as a theme when participants described rationales for escalation of conflict to physical violence. Dan described that his recidivist incident quickly escalated from a verbal conflict that was "no big deal" to a physical altercation between the couple. He indicated that once his wife became physically aggressive towards him, he reciprocated:

> I just think, it was, it was nothing. Absolutely nothing... (*inhales*). When I opened that door she said, "you motherfucker" and she grabbed me by the balls. And that's, like, when it started. …And, uh, I mean, I got aggressive that night. And I admitted it. I told the police, "yeah, I grabbed her." I threw her, I mean, but she was hurtin' me. She had me by the (laughs) you-know-whats and I, I got tired of it. And then it got to a point, like, that was it. And, and, and I got aggressive. And I'm a lot bigger'n her and I'm a lot stronger'n her ...and I pushed her and she, she went flyin' down and 'boom,' she hit the wall. She put a hole in the wall.
>
> - Dan, group

Javier endorsed similar rationalized perceptions of his recidivism. He both blamed his partner for their relationship conflict and denied the actual violence. He blamed his partner by describing an approach/avoid pattern of interaction that has contributed

to a history of conflict in their relationship. During the recidivist incident, he indicated that he was attempting to de-escalate following a verbal conflict, but his partner would not give him the space he desired; this seemed to cause Javier to feel helpless and frustrated, likely leading to the physical altercation:

> Um, um, (*sighs*) it usually starts with yelling, or accusations, or something like that. If I try to isolate myself, well it's changed over the time. I mean she's tried different things. She's tried being very aggressive with me or very passive with me. So say, if I try to isolate myself, it may be okay for a while, you know, to try to be calming myself down, you know, adrenaline? I know I shouldn't be in the conversation with anybody, cuz that's just not gonna work, and um…but you, know, like she'll be like banging on the door or something, trying to get in, I'll be just like "no, just get out," she'll be forcing her way in, I'll be pushing her out of the door. Just stupid crap like that, you know? She'll fall over and hurt her leg or something, and it would be my fault, and it's always like that. (*Sighs*) So, yeah, that's how it is.
>
> - Javier, group 2x

***Factors (for violence).*** Participants identified various factors that contributed to their recidivist incident following treatment completion. Specifically, two main themes related to factors contributing to IPV recidivism following program completion emerged: general factors (often multilevel factors) and dyadic factors (*i.e.,* interpersonal factors related to the couple).

*General/multilevel factors.* General and multilevel factors that participants attributed to their own use of violence included intrapersonal, interpersonal (outlined in the dyadic factors section), group-level, and community-level factors. Specific multilevel factors included the intergenerational cycle of violence, broader family dysfunction that created environmental instability, financial problems and financial stress, and unemployment. Intrapersonal factors that were either identified directly by participants or noted by the researcher included cognitive rigidity (such as over-

accommodated beliefs developed following previous relationship conflict with partner), inflexible gender-based beliefs related to masculinity, and difficulty tolerating distressing emotions such as feelings of sadness, hurt, or being misunderstood.

One example of multilevel factors contributing to relationship conflict is financial problems. Dev noted that financial stress contributed significantly to conflict in his relationship, and ultimate recidivist incident, as it was frequently a source of tension and conflict in the relationship:

> Maybe financial problems. I wouldn't say it was solely that. That had a lot to do with it. You know, she doesn't work. And I had like three jobs. I have two jobs and a small side business and it was good but then I lost the one job with that side business. And it was one job, you know? And I had to make ends meet. And I feel a lot of strain when I'm not comfortable enough to have extra money, you know? When I live from paycheck to paycheck it drives me nuts, you know? That was actually happening at the same time.
>
> - Dev, group 2x

Several participants, including Javier, discussed how their history of witnessing patterns of ineffective interaction between their parents likely contributed to their use of violence in relationships. The intergenerational cycle of violence was identified by several participants; these participants stated that their patterns of interaction in relationships were learned following exposure to conflictual or violent relationships during childhood. When witnessing violence in one's history was discussed, it was not used as a rationale for behavior, but rather emerged in the context of potential insight and awareness. Participants seemed to demonstrate an understanding of how their histories may have played a role in their own relationships:

> Oh I just learned about issues that came from my childhood, like things that I harbor about my father, and um… um false accusations, and um other things that happened to me and um… it's just the environment I grew up in with my parents and how they interact, and [*chuckles*] it's very similar.
>
> - Javier, group 2x

Broader family dysfunction, that fostered an environment of instability, was also identified as a general factor for violence. In several cases, efforts to help family by allowing a family member to stay in the home with the couple or by lending money, contributed to dysfunction and additional stress in the relationship. Glen described a perfect storm of stress, culminating in the recidivist event, due to broader family dysfunction and other multilevel factors. Glen reported that after helping his brother, by finding him a job and letting him stay in Glen's home, his brother and his partner had an affair. Glen's recidivist incident involved an escalating conflict between his partner and himself during a discussion of this situation. Following this conflict, Glen's partner obtained a protective order, necessitating Glen to move out of his home. Moving forced him to leave his children and job. Glen continued to violate the protective order whenever he made contact with his ex-partner, noting that the multilevel stressors in his life often felt too overwhelming to manage:

> So now I'm losing her, my kids, brother, you know, my home, a job. I'm lost in my head. I moved, moved back to [another state]. Got a job, um, living with a friend of mine and my parents kinda back and forth, looking for a place to stay. …Saving money, trying to get back on my feet. Just trying to get out of this cloud. Trying to understand things.
>
> - Glen, group

Intrapersonal considerations emerged within in the theme of multilevel factors; these included cognitive rigidity, inflexible gender-based beliefs, and difficulty tolerating distressing emotions (such as feelings of sadness, hurt, or being misunderstood). This subset of codes presented a challenging but important category

of data because participants themselves did not always have insight regarding their beliefs and cognitive schemas. The constructivist grounded theory approach used to analyze data in the present study allowed the researcher to use her content expertise to co-construct meaning by providing interpretation to participants' experiences. The researcher's theoretical sensitivity and knowledge base helped mediate possible concerns regarding insight among participants. This methodological approach was particularly useful as partner-violent men's accounts of their violence, and their rationales for perpetration, are at times reported in the context of limited insight and problematic beliefs, assumptions, and attributions. One such example was Hank's description of his belief system, a schema that very likely contributed to the ongoing abuse her perpetrated in his relationship. Based on previous clinical contact with Hank and expertise in the field of trauma, the researcher was able to contextualize Hank's narrative as, at least in part, related to his over-accommodated beliefs (*e.g.,* regarding mistrust, among others) developed following a history of childhood abuse:

> People think you're crazy [*kind of laughs*] and they don't want to be around you. You know, and it's like *[inhales and exhales]* at the root of us as a species, I think there is mostly bad traits. I think we are primitive. We are ignorant. We are unwilling to do anything as a whole, as a majority that is righteous or justified at all. And I feel like most of us work toward death, destruction, greed, and hate. Way too much to ever evolve to something better. And ultimately that, I don't think that will ever change. I don't think we're capable. I think we lack the intelligence.
>
> - Hank, group and individual

*Dyadic factors*. Enough relationship-specific codes surfaced during data collection and analysis that "dyadic factors" emerged as its own category, separate from multilevel factors. Dyadic factors were made up of relationship characteristics that were related to the recidivist incidents. Specific examples of relationship

characteristics, or dyadic factors, include infidelity, betrayal, mistrust, mutual violence, relationship conflict, power struggles in the relationship, difficulty backing down from conflict, ineffective communication (e.g., avoidance of conflict), history of relationship violence, relationship ambivalence or disengagement, resentment, and relationship insecurity.

The perception of lying and/or mistrust, especially in the context of infidelity, was a common relationship characteristic that contributed to violence between partners. For example, Dominic indicated that difficulty backing down from conflict and mistrust made it challenging for him to engage in effective communication with partners:

> If like somebody is constantly in your face going you know "blah blah blah!" it's very difficult for you to like, you know, understand and walk away and stuff like that. And then a lot of other different relationships you got people lying, and stuff like that. You catch them in a lie, and you know they're lying, but you know you don't have enough evidence, but they still don't want to tell the truth, they still lie.
>
> -Dominic, group 2x

Similarly, Dev described the significant difficulty and relationship ambivalence that a history of mistrust caused in his relationship. Dev completed the AIP group twice over the course of 4 years and discussed mistrust in his marriage, alongside relationship ambivalence, during both treatment episodes. During treatment, Dev explored how difficult effective communication and emotion regulation were for him in the context of feeling suspicious and betrayed. During the interview, Dev described how the ambivalence and history of mistrust contributed to relationship conflict:

> Like her lying to me. Telling me that it [infidelity] wasn't true. …And I used to always think that she would be my wife forever and I think that I was trying

> to argue and fight with her to do the right thing for our relationship and now that I see that it's slowly drifting apart...I've gone back a million times trying to make it work, you know? I'm still going back and forth. Sometimes I just want her to know how I feel. ...'cuz I'm angry and I'm hurt. And I want her to know how I feel, you know?
>
> - Dev, group 2x

Relationship ambivalence also emerged in the context of longstanding histories of violence and relationship conflict. Ambivalence as a relationship characteristic served as a factor for recidivism due to the ongoing uncertainty in the relationship. On one hand, participants expressed that they did not want to stay in violent, abusive, or conflictual relationships; on the other hand, they sometimes become accustomed to the dysfunctional dynamic and/or experienced periods of relationship satisfaction and nonviolence, reinforcing their motivation to stay with their partner. Dan described this dynamic, noting that his relationship escalates to a level with which he is not comfortable "probably at least once a month:"

> The worst one, probably about a month ago. [*inhales*] I can't even remember what it was about. But she's sittin' there and she's pissed. And she's runnin' up the stairs. ...It was, like, no, you're not gettin' my keys. And I'm chasin' her up the stairs and she turns around and clocks me in the face with the handful of keys. Cut me pretty good. I mean, you can see the scar. ...I always feel like I'm stupid for being there and everybody around me tell me, "just bail out, get away." These problems, you don't need these, it's her problems. And it's just like, but what do you do with somebody like that? I mean, there's so many hours in between that we have a great relationship, but then...
>
> - Dan, group

**Research question two.** What implications for treatment and research emerge from an exploration of reoffenders' beliefs and interpretation of recidivist events? This question includes inquiry regarding potential elements of treatment that may enhance program effectiveness among those who reoffend following treatment completion.

***Modality-specific variables.*** *Flexible treatment approach.* Participants discussed the importance of flexibility in AIP treatment, specifically indicating how helpful various treatment modalities could be. Participants described that having the option of group therapy, individual therapy, and/or couples therapy may enhance therapeutic gains related to relationship skills. Individual therapy was identified as especially helpful due to participants' willingness to be more open and forthcoming in individual therapy as compared to group, having sufficient time during individual sessions rather than having to share time with others in group, and the unique interpersonal dynamics of individual therapy (such as the relationship between client and therapist). Couples therapy was also identified as a potentially useful treatment modality, especially for those participants who noted their partners' skill deficit. Particularly those participants who endorsed dyadic factors related to recidivism – and those who engaged partner blame as a rationale for violence – indicated that they themselves were attempting to use the skills learned in treatment but their partners were maintaining the previously established ineffective dynamic. Glen expressed frustration that couples therapy was not an option for him and his partner during his treatment episode. He believed that couples therapy should be offered in some cases, such as his:

> At that time I wish I could have gotten couples counseling for me and her. Somebody that's striving for that goal of trying to work on whatever the fuck we are going through, because of the kids. I guess that wasn't an option here for a lot. If that was an addition to New Behaviors program, where that option was available to some of us that weren't that far gone yet in our relationship, might have helped us also. Because this is a one man band when you are coming here and getting help and they are not. So if you get the couples then you're both now, pretty much dealing with us, what we were doing in the group sessions, but now you're doing it with your partner. So I wish that was an option.
>
> - Glen, group

Each of the participants who completed individual treatment, along with several participants who only completed group treatment, discussed the benefits of individual therapy. Carl and Hank were the only two study participants who engaged in an episode of care through both treatment modalities: group and individual therapy. Both participants expressed their certainty regarding the benefits of individual therapy versus group, citing useful factors of individual therapy such as the opportunity for deeper exploration and increased comfort to disclose elements of personal history:

> I think everybody should do a one on one session...Cuz then they get more involved into their feelings, relationship, everything else, you know what I mean? Instead of just sitting there in the corner, you know, sitting by the little tree in there and just, "okay. It's okay." It's not okay! Um, I don't know, I really never liked the group, but the one on one, I think that's the best thing ever.
>
> - Carl, group and individual

> I had some really difficult *[inhales]* struggles with my mother 'cuz it was, you know, I was the only child and it was just her and I. And, you know, I spent most of my life trying to avoid her. And be away. And, you know, it's 'cuz she wasn't, she was pretty, you know, she was neurotic and constantly on medication for depression. And it made it very difficult. And [in individual therapy] I could be more unfiltered. Well, because you don't want to say certain things in front of other people. Because you might not want them to know that. You know? …I'm sure there was some embarrassing things [other group members] didn't bring up either because they were in a group…That's one thing I can definitely tell you from my group or one-on-one experience. The group was fine. I just feel like one on one was probably a better option.
>
> - Hank, group and individual

*Elements of group effectiveness*. During their discussion of group treatment, participants described their perceptions of the effective and ineffective elements of group. Characteristics of group that made treatment particularly useful or beneficial to participants, and thus likely facilitated the greatest chance of behavior change, included: perceiving the group as an emotionally safe space (a variable termed "asylum" in past qualitative studies describing group effectiveness (Wangsgaard, 2001), experiencing the group as normalizing, being able to relate to other group members by sharing and hearing their diverse experiences, learning from other group members and being open to feedback from other group members, and experiencing positive relationships with the other group members and with the facilitators. Andre indicated that he benefited from the different opinions of participants in group. These differences in opinions resulted from the diversity of the group itself. Andre perceived that the diversity of viewpoints was valuable for him in his change process:

> I wasn't any greater than them, I wasn't any less than them. We was all in the same situation and even though we came from different walks of life, we all had problems and it didn't mean that you had two problems and I had five. You had a problem....The thing that really caught my attention was everybody's different viewpoints and their opinions. And you really get to see a whole bunch of different spirits because you have people who have a different opinion than you and they think differently than you. And I think that, that was interesting, the diversity of that was interesting because I might be at a point where I think I'm right and everybody else wrong. And then hearing it from somebody else, is like, it gives you the ability to check yourself and say, "Hey, I might need to look in the mirror and really think about this"
>
> - Andre, group

Participants benefited both from hearing from others as well as sharing with others. Javier described that contributing to the diverse viewpoints in the group allowed him to offer support and to feel supported. Hearing from others enabled him to gain

insight regarding the similarities of experience among participants. Javier indicated experiencing the group as normalizing and being able to relate to others:

> I feel that I enjoy participating and trying to offer my viewpoint or suggestions to people, like you know, support...Group made me realize, it's like, it seems like everyone is dating the same girl. Which is kinda crazy, you know? I was in group, and certain people were talking like, "oh the person I'm dating does the same thing." It's like a serious relationship, and like my girlfriend does the same thing!…and the girl probably thinks the same thing, their boyfriend does the same thing, it's crazy!
>
> - Javier, group 2x

*Elements of group ineffectiveness*. Participants also described their perceptions of the *in*effective elements of group treatment. The characteristics of group that participants indicated as particularly ineffective, and thus likely interfered with behavior change, included: monopolization of conversation by certain group members leading to insufficient time for everyone, sessions that went off topic, group members that did not take treatment seriously, sessions in which participants seemed to collude with one another in the denial of responsibility, and facilitators' styles. Gavin participated in the research study interview during his second time through the AIP group following his recidivist incident. He discussed his lack of program engagement the first time through treatment, and described factors that he believed contributed to the ineffectiveness of group the first time around.

> It can be difficult because anytime [I] thought back to the class it was mostly men complaining, so it was hard to remember anything. Umm, it could have been in a better environment to do the program because people in that class, you couldn't really learn too much. I mean I didn't really participate too much last time. I, uhh, sat there and didn't really say too much...last time I didn't really participate when all the guys were crying about it. Crying, or uh, complaining about it. Having to do the program, well uh I mean, I knew I was in it, I mean that was my fault, I can't complain about what I did to be in it, so. But all the other guys were complaining about being in it, except for one...but all the other guys, they didn't seem that it was fair for them to do the program, but they didn't really tell the truth about why they were in

> here...Well then it wasn't really like a program then a complaining session. I didn't feel like complaining, I'm not one for complaining but I was in there so I did, and it went by.
>
> - Gavin, group 2x

Javier, who also completed the AIP group twice, perceived others' participation in group treatment in a way very similar to Gavin. Both participants, among others interviewed, indicated that some group members did not take treatment seriously nor engage in a useful way, leading to group ineffectiveness and difficulties with group cohesion:

> There was some people in there obviously they don't care or whatever. Because they just got stuck there, and they're complying. And they're not really there to participate. You know, we bring them around and try to get them to participate.
>
> - Javier, group x2

Facilitators' therapeutic style was also identified as an important element of group effectiveness. Specifically, several participants described that a therapeutic approach that balanced support and confrontation likely facilitates behavior change best. Perhaps unsurprisingly, participants who noted that some group members did not take treatment seriously, also indicated that group facilitators were not holding these group members accountable for their behavior. During their AIP group treatment, these participants shared that facilitators often "let people off the hook too easily" and were not challenging/confrontational enough:

> Some nights the group seemed like they would take over. Uh, a lotta times I'd just be disappointed because it seemed like these guys in here would just go off the wall to subjects that didn't even mean anything…And I just think your counselors in your group ought to break it down into as, you're here, you're here for a reason, I want to hear what it is. Really. And be hard on 'em. Make 'em really tell you why are you here. How many times have you hit this person? They all deny it. What can you do? I mean, just draw the hard line on 'em. Tell 'em, "you're here for a reason. What happened? The court didn't just

> throw you in this place." Make 'em tell you… You really need to be hard on 'em. Make them speak up. Make them say something.
>
> - Dan, group

***Content-specific variables.*** *Skill acquisition.* Throughout the exploration of reoffenders' beliefs and interpretation of their recidivist events, two themes related to content-specific variables emerged: challenges related to skill *acquisition* and challenges related to skill *application*. Addressing both of these themes in treatment and research efforts could serve to enhance program effectiveness among those who reoffend following treatment completion. Challenges with skill acquisition emerged in the data following the identification of specific skills deficits that existed within the sample of reoffenders. Skill deficits were particularly salient regarding interpersonal effectiveness, communication skills, emotion regulation, distress tolerance, anger management, cognitive restructuring, and substance use. Additionally, a drop-in group was identified by a few participants as a potentially useful method of maintaining skills-based gains from therapy.

Above, Carl described his regret following ineffective program engagement during his first time through the AIP. In addition to articulating his general frustration with lack of skill acquisition first time through, he described specific skills that were taught and may have been helpful for him, but he did not acquire these skills during his participation in the group:

> I was just there playing the game from last time. I really was. I was playing the game. Just cause I had to...I didn't even listen to the relaxation tape or nothing like that. I didn't even take the time outs or nothing like that until now...I should've paid attention, but I didn't.
>
> - Carl, group and individual

Dev addressed a similar issue of motivation related to skill acquisition as he described his lack of program engagement the first time through treatment:

> ...if you're not interested in learning, nothing's going to be saved in your mind, you know? If you think like this is not going to help me, your brain's not going to process anything, you know? You got to want to know, you know?
>
> - Dev, group 2x

While Both Carl and Dev demonstrated insight regarding their lack of skill acquisition, some participants exhibited less awareness of their skill deficits, and even describing skills incorrectly during the interview. Again, the use of the constructivist grounded theory approach allowed for the researcher to introduce interpretation into the data. Thus, the situations in which participants discussed skills in inaccurate or erroneous ways were important opportunities for the researcher to utilize her content expertise in order to co-construct meaning by introducing interpretation to these participants' experiences. Specifically, participants' lack of accurate skill recounting was interpreted by the researcher as a problem in skill acquisition, even though participants would likely not construe these experiences in the same way. For example, when asked about the specific skills learned in group that would help Glen during relationship conflict, he demonstrated a lack of accurate skill acquisition by describing a likely ineffective approach to communication. Glen stated that through treatment, he learned to communicate with his partner *during* times of intense emotional distress; however, the skills taught in group emphasize the importance of using cooling down strategies and emotion regulation prior to engaging in communication with a partner:

> You gotta communicate, and when you communicate, communicate when your emotions are running high.

- Glen, group

Also related to enhancing treatment in the area of skill acquisition, implementing a drop-in group was identified by 2 participants. Although not necessarily an idea that came up during a majority of interviews, it is one that provides interesting suggestions for treatment improvement. These participants believed that a drop-in group could help to maintain skills learned during AIP treatment:

> A drop-in group would be cool. Like drop in every once in a while… Cuz I mean, it's like sharpening a pencil, you know? If you just keep, you know, using it, using it, using it, and not sharpen it, it's going to be dull.
>
> - Dominic, group x2

*Skill application.* Barriers to skill application also emerged in the data. Not applying skills when they were needed and ineffective use of skills were common obstacles discussed during interviews. Offering specific skills practice during AIP treatment would likely serve to enhance program effectiveness among those who reoffend following treatment completion. Skills practice in and between sessions could enhance the likelihood of successful skill application during times of conflict. Specific opportunities for skills practice addressed by participants included self-monitoring, role-plays, and homework completion. In addition to a drop-in group being potentially helpful, Dominic reported that holding onto his homework assignments could be useful for him in the future:

> Maybe more stuff like, uh take some stuff, like if it was some homework, or something like that? So I could look over it in like a year or so, umm, I could still read over a couple things, like and you know? Go over a couple things myself.
>
> - Dominic, group 2x

Similarly, Gavin stated that he applied the skills learned in group directly following completing treatment, but it became increasingly difficult to use skills the further out he got from treatment:

> I used them [the skills learned from group] for like maybe four or five months after, I just really don't remember, it's been so long, and I just do so many things. Umm I used mostly communication and staying calm...Umm mostly just to stay calm.
>
> - Gavin, group 2x

Gavin noted that after the first few months following treatment, it become increasingly difficult to apply the skills he learned, which, in large part, lead to his recidivist incident. He described the events leading up to the recidivist incident stating, "well, I could have been calm and talked to her, but I mean, I ran into her car, and the cops were there. So that's kind of the oops factor on that one." While Gavin noted earlier that he specifically used skills to stay calm and communicate effectively, he had not been successful at applying these skills several years after treatment.

Study participants varied in their insight regarding their degree of successful skill application during times of conflict or emotional distress. While some participants explicitly noted that ineffective skill use, or lack of skill use altogether, were major factors contributing to partner violence, others had less awareness regarding ways that the use of skills could have benefited them in moments of conflict or distress. These examples were most prevalent and notable during interview discussions of emotional regulation. For example, Carl and Dev recognized that difficulty with emotion regulation contributed to negative consequences with their partners, while Hank seemed to have less insight regarding the ways in which

his emotional dysregulation interfered with him getting what he wanted out of the situation:

> Um, probably just take the time out that I should've...You know what I mean? Walked away from the whole situation, came back. I should've just took that time out. I wasn't thinking about it. No. Didn't even cross my mind. I don't know, I just probably so heated already. I was already at boiling point. I was already number ten before, you know, before I catch number one.
>
> - Carl, group and individual

> My emotion and my emotions take over me, you know. They always get the better of me, you know.
>
> - Dev, group 2x

> So I told a judge to go fuck himself. You want real, you're gonna get it. I told a judge, if he didn't give me 48 more hours a month with my son, even though I presented my evidence, he said, "this is not the day in court to do that. This is about something else."...So he puts me in cuffs and I get three days for the first time in my life.
>
> - Hank, group and individual

***Participant-specific variables.*** *Intrapersonal characteristics.* The final theme that emerged related to implications for treatment and research based on reoffenders' beliefs and interpretation of recidivist events is intrapersonal characteristics. Characteristics of the participants themselves surfaced as an important element of treatment, and thus potential consideration of program effectiveness, among those who reoffend following treatment completion. Specific factors related to participants themselves included ways that participants engaged in treatment, participants' decision and/or motivation for behavior change, participants' intentions to use skills, participants' expectations of treatment, and participants cognitive flexibility, particularly as related to gender-based beliefs and beliefs regarding masculinity. Finally, the emotions that participants identified as particularly difficult to tolerate included regret, guilt, shame, and feeling disrespected.

Darrel and Andre demonstrated awareness regarding disrespect as a trigger for their violence. While Darrel's perceptions of disrespect appeared to substantiate the use of violence as almost inevitable, thus not necessarily serving as motivation for treatment engagement, Andre's account of his recognition of triggers motivated his efforts to improve relationships:

> My ex-wife making me feel like, that I'm not respected, it was the biggest time bomb for me. That's what set me off. And, um, you know a man can respond one or two ways: he can say nothing, and if he says nothing those words are gonna cut sharper than a sword, and they're going to sit and it's gonna manifest, and it's gonna build resentment and the hostility is going to come out eventually. But then if you have the man who does say something, he gets to the point where he says too much, and through saying too much, violence come out of it.
>
> - Darrell, individual

> Before participating in New Behaviors, I had a problem but it was more where I could take a lot and then if I got full, and one particular day you just

> disrespected me, then that was time for me to explode. And so, that's why I try to learn how to communicate too because through communication, you can release a lot of that hostility, a lot of them small things that build up to make things bigger.
>
> - Andre, group

Participants' motivation for behavior change also often incorporated their children as motivating factors. Children as motivation emerged in two, quite different, ways. One way in which children were motivating participants' behavior change was through participants' recognition that exposing children to violence may have longstanding impact on their kids. This belief served to limit the amount of partner violence participants wanted their children to witness. The other way that children were motivating factors was through participants' descriptions of the types of role models they wanted to be to their kids. Hank described what kind of man he wants his son to see when he looks at his father:

> I still get into arguments with family members. But I don't do it around my son. And, uh, it's not nearly as explosive. And I just, you know, I focus on other things, or I go work out. And it's, it's showing, it's finally starting to, you know, show results. I had a lot of changing to do. I didn't want my son to see me as a slob...So that was one big thing is my son. And I want him to see that this is what a man should look like. And he should also have his stuff together. And I'm working on that. But that takes longer. But, uh, you know, he's the big, he's the main influence.
>
> - Hank, group and individual

Motivation for treatment played a key role in participants' program engagement, as did their perceptions of how relevant they experienced treatment to be for them personally. The relevance of treatment also shaped their perceptions of program effectiveness. The majority of participants experienced topics covered in treatment to be relevant and useful for them, but one negative example in the data demonstrates the importance of relevance as related to skill acquisition and

application. While most participants noted the relevance of treatment, particularly related to the skills covered in group, Dan discussed how unlikely he and others were to apply the relaxation techniques reviewed during treatment. Dan noted how "ridiculous" he found the relaxation training to be:

> Come on. These guys aren't gonna sit there and do some kinda CD with this *[deep breath to mimic the breathing exercise]*. [Interviewer: how about you? Did you ever do the relaxation?] Hell, no! *[laughs]* I mean, I sat there goin', like, *[breathing in and out]*, all right, breathe, Dan, just sit there *[laughs]* and breathe. *[laughs]* Don't lose it. You know? It just seemed ridiculous.
>
> - Dan, group

The final intrapersonal characteristic that related to implications for treatment and research based on reoffenders' beliefs and interpretation of recidivist events was participants' expectations of treatment itself. Grant described his expectations and perceptions of what AIP group would be like, and what other group members would be like, prior to beginning treatment. These perceptions were largely shaped by stereotypical beliefs regarding intimate partner violence. Once involved in the group, his perceptions changed, as did his engagement with the AIP treatment material:

> Initially I was scared to start in group. I didn't know what to expect, I didn't know what type of people were going to be in there. I had a very stereotypical view of batterers *[laughs]*…So I did a couple individual sessions and then I did go into group, and, umm I found that I liked it a lot more than I thought I would.

When Grant returned to treatment following his recidivist event, he was offered individual treatment but asserted the benefits of group. Regarding his participation in the group the second time around, he noted during the interview:

> I would hope to be more perfect *[laughs],* but you know, I have set high expectations on myself I think, and I would love to be cured, quote unquote, and never have another incident. That might happen now *[laughs]*.
>
> - Grant, group x2

Grant's experiences depict one way in which expectations of treatment were closely related to participants' motivation to change their behavior. Andre described a similar motivation for treatment linked to his expectations for participating. He also noted a very specific gain made following group engagement regarding his understanding of partner violence itself. When asked what he hoped to get out of the AIP group before starting treatment, Andre responded:

> Um, realizing the monster that I was. And fixing it...and so the only way to stay away from it is to change your behavior. I was surprised doing a lot of the stuff that was abuse that I didn't look at as being abusive.
>
> - Andre, group

**Summary of results.** Participants described a variety of factors related to their IPV recidivism following program completion. Barriers that emerged, related to remaining nonviolent included skills deficits, not accessing support, and alcohol use. Partner blame and the denial of responsibility for violence and were the major affirmative rationales that participants used to justify violence perpetration. Participants also described difficulties knowing how to cope with their partner's anger and/or aggression, which often led to problematic dynamics and partner blame. Finally, multilevel factors that participants attributed to recidivism events emerged, these were particularly salient related to dyadic factors (characteristics of their romantic relationship itself), as well as other distal and proximal factors. Implications for treatment and research also emerged from the exploration of reoffenders' beliefs and interpretation of their recidivist events. Potential elements of treatment that may enhance program effectiveness among those who reoffend following treatment completion include modality-specific variables, such as flexibility in treatment approach and elements of the group itself that serve to increase or decrease group

effectiveness. Content-specific and participant-specific variables also emerged, particularly related to skill acquisition, skill application, and intrapersonal characteristics of participants.

## Chapter 4: Discussion

The purpose of the present study was to examine change and recidivist factors specific to partner-violent men who reoffend following treatment completion. Study findings serve to increase our understanding of IPV recidivism, provide suggestions for improving long-term outcomes following IPV treatment, and reduce the gaps in understanding of change processes between IPV researchers/practitioners and partner-violent men. Specifically, the present study aimed to 1) explore change and recidivist factors among partner-violent men following AIP completion by exploring multi-level factors related to IPV recidivism, both as perceived by those who have reoffended and as assessed by the researcher; and 2) identify implications for treatment and research that emerge from an exploration of reoffenders' beliefs and interpretation of recidivist events such as specific factors that may enhance program effectiveness and ecological variables that serve as potential obstacles for non-violent relationships among men with a history of partner violence.

At the study's outset, an extensive review of the literature revealed that the overall findings of research on AIP treatment effectiveness are complex and inconclusive. Several meta-analytic reviews demonstrate modest AIP treatment effects, equating to a roughly 5% point decrease in IPV re-offense associated with intervention (Babcock et al, 2004). In addition to evaluating treatment outcomes by means of recidivism, AIP treatment effectiveness research also seeks to identify the

specific ingredients that enhance outcomes. Research in this category includes exploration of components of the treatment (e.g., therapeutic style; specific intervention components; key change targets) and characteristics of the participants (e.g. treatment motivation; personality characteristics; employment status). The present study responds to a two-decade old call for "the use of qualitative strategies to supplement traditional quantitative hypothesis testing [in order to] help ground theories in the personal experiences of domestic violence victims and perpetrators" (Murphy & O'Leary, 1994, p. 208). Recent research using qualitative methodologies has begun to enhance the understanding of specific components and characteristics essential to behavior change among partner-violent men. This study expands knowledge of this contextualized understanding of change and recidivist factors grounded in the experiences of men who perpetrate IPV. Findings from such exploration may increase our knowledge of what works best in treatment and for whom.

The present study findings highlight partner-violent men's own internal experiences of their abusive and recidivist behavior. This research sought to develop a deeper understanding of recidivist incidents, as articulated by perpetrators' 'emic' accounts (Padgett, 2008). Learning about recidivism through perpetrators' own points of view enabled the researcher to explore their change processes, use of violence, insight, and meaning making processes. The study also provided an opportunity to consider elements of treatment that perpetrators experienced as more or less beneficial. An enhanced understanding of reoffenders' emic experiences, beliefs, and interpretation of their own recidivist behavior generates potential

implications for treatment and research. As previously discussed, there exists little research exploring IPV recidivism among partner-violent men subsequent to AIP treatment completion. Therefore, findings from the present study offer rich description in an area where little has been previously known and theory generation that can guide treatment options for this unique population of offenders. The following chapter provides an interpretation of the participants' responses and includes discussion of the main study findings, implications for treatment, study limitations, and recommendations for future research.

**Discussion of Main Study Findings & Treatment Implications**

The present study utilized grounded theory in order to develop a conceptual model that is inductively derived from data rather than tested based on hypotheses from existing theories (Glaser & Strauss, 1967). A major goal of this study was to develop theory regarding IPV recidivism, behavior change processes among partner violent men, and AIP treatment effectiveness. Grounded theory lends itself to researchers generating theoretical ideas from the data about a particular topic, then gathering additional data to check and refine the emerging analytic categories (Charmaz, 2007). In the present study, many of the emergent themes reflected those identified in previous research conducted by Silvergleid and Mankowski (2006). Therefore, findings from this study build on Silvergleid and Mankowski's theory and offer valuable additions/modifications grounded in the data collected. In this section, the main study findings will be reviewed for the purposes of theory development, a major goal in grounded theory research. The findings will be discussed using a multilevel organizational structure of change processes and recidivism, with theory

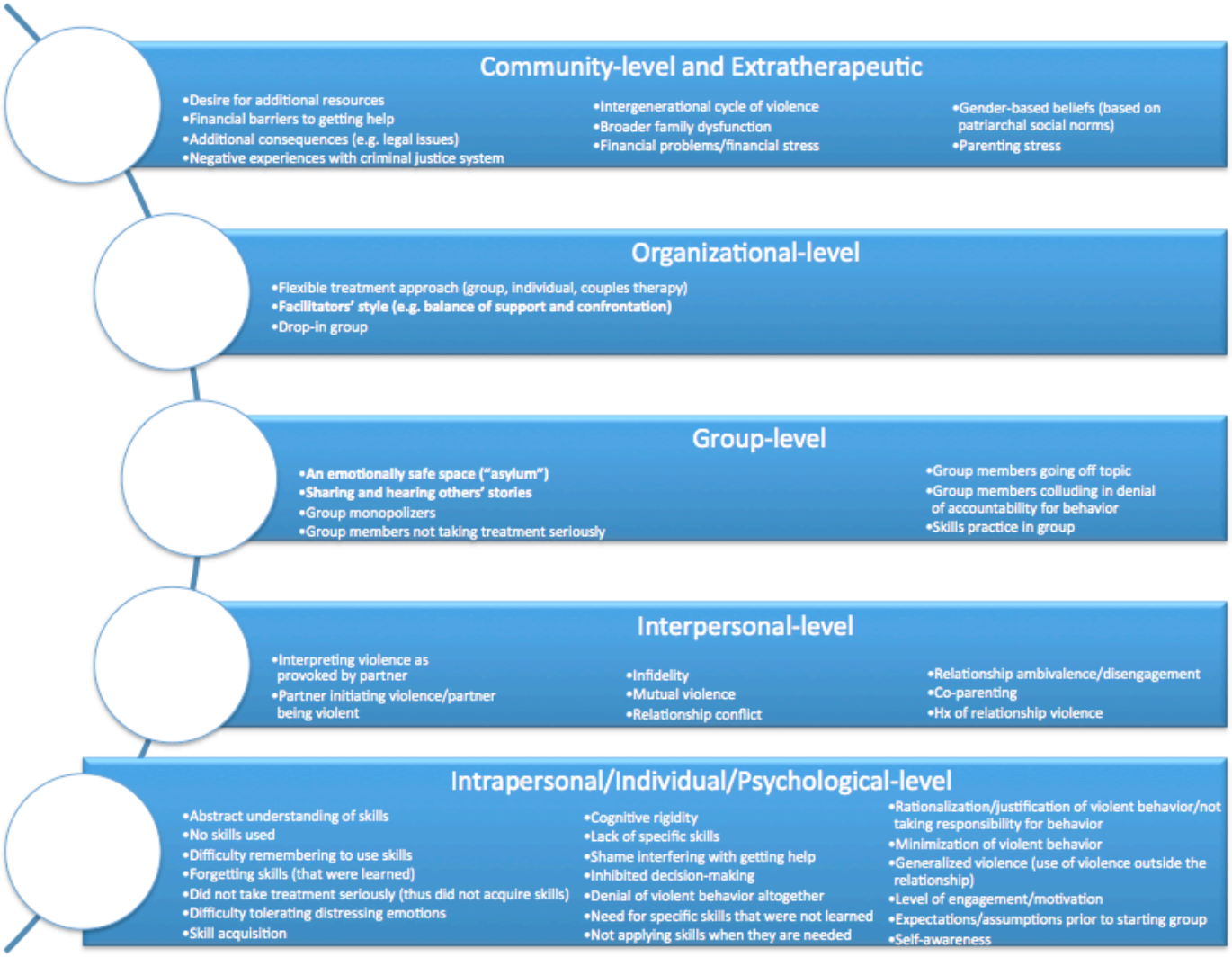
development suggestions grounded in the data. Implications for treatment will be considered alongside the review and discussion of study findings.

**Multilevel organizational structure**. Silvergleid and Mankowski's (2006) study examined processes of change among partner-violent men in order to enhance AIP effectiveness. They utilized an organizational structure to model behavior change processes as reported by facilitators and the participants themselves. Silvergleid and Mankowski organized ecological behavior change processes by community-level and extratherapeutic factors, organizational-level factors, group-level factors, and individual psychological development factors. Findings from the present study build on their ecological model by highlighting the addition of interpersonal-level factors to the organizational structure. Figure 1, below, presents a data display matrix of the modified ecological theory. The figure depicts the modified ecological organizational structure based on the current study's findings; the factors in bold font are highlighted because they have been identified as meaningful variables in past research in the fields of IPV recidivism, behavior change, and treatment effectiveness.

Factors at various levels of influence interact to create an atmosphere in which both behavior change and IPV recidivism occurs. Multilevel factors for behavior change and recidivism that emerged in the present study included both proximal variables (e.g. intrapersonal and interpersonal variables) and distal variables (e.g. family history, community, and societal variables). In-depth accounts from participants who completed treatment and subsequently reoffended demonstrated a range of recidivist factors across five levels of analysis. Four ecological levels mapped onto Silvergleid and Mankowski's organizational structure (*i.e.,* community-

level and extratherapeutic influences, organizational-level influences, group-level influences, and individual/psychological-level influences). A fifth level of analysis (*i.e.,* interpersonal-level influences) emerged in the present study. The addition of dyadic factors for behavior change and recidivism serves to further develop Silvergleid and Mankowski's organizational structure.

Figure 1. Data display matrix of modified ecological theory.




***Community-level and extratherapeutic influences.*** In the present study, community-level and extratherapeutic influences included participants' desire for

additional resources, participants' discussion of financial barriers to getting help (*e.g.,* the cost of therapy being prohibitive or prioritizing work over treatment due to financial constraints), participants' financial problems and financial stress, participants facing additional consequences (*e.g.,* legal issues), participants experiencing negative interactions with criminal justice system, the intergenerational cycle of violence, participants' broader family dysfunction (*e.g.,* conflict with other family members), participants holding strong gender-based beliefs (*e.g.,* based on patriarchal social norms), and participants experiencing parenting stress or challenges.

This study's findings are consistent with prior research that identifies similar community-level and extratherapeutic factors predicting increased risk of IPV recidivism. Prior research has shown that family-of-origin exposure to IPV (Fritz, Slep, & O'Leary, 2012) and low overall coordination of the community response (e.g., criminal justice and counseling systems) contribute to IPV recidivism within this population (Murphy et al., 1998). Assessing and processing family histories of IPV during treatment and increasing coordination with community resources for participants within AIP treatment may serve to enhance participants' engagement in treatment as well as their success following treatment completion.

***Organizational-level influences.*** Organizational-level factors reported by participants included requests for a flexible treatment approach (e.g., with options for group, individual, or couples therapy, focused treatment for substance use, and/or a drop-in group following treatment completion) and the significance of facilitators' style (specifically noting the importance of facilitators balancing support and

confrontation and facilitators holding group members accountable for their actions). Regarding facilitators' style, Silvergleid and Mankowski (2006) notably found similar evidence that a balanced supportive and confrontational facilitator style may be necessary for behavior change. The present study provides replication of these previous findings regarding implications for effective treatment.

The study's results suggest the potential benefit of a flexible treatment approach for partner-violent men who have previously completed treatment. However, this finding appears to be somewhat inconsistent with the latest research on the topic of treatment modality effectiveness. In a small randomized trial, Murphy, Eckhardt, Clifford, Lamotte, and Meis' found that group treatment for partner-violent men was generally more effective than individual treatment. In their comparison study, Murphy and colleagues examined whether a flexible, case-formulation based, individual treatment was more effective than a standardized, group CBT approach, and found that flexibility did not equate to effectiveness, but appeared to created challenges in agenda setting, homework implementation, and formal skill training. The present study's findings focused primarily on participants who completed both types of treatment, group first followed by individual therapy. Because they completed the AIP treatment twice, they may have had a different experience of individual therapy than participants who only completed individual treatment. Specifically, it is possible that participants were more motivated for behavior change and treatment engagement following their recidivist event and re-enrollment in the AIP, leading them to experience treatment differently the second time through. Also, these individuals represent a select group for whom group treatment was not

sufficient to prevent recidivist incidents. Potentially, a more flexible approach to AIP treatment is more effective the second time through treatment, or for those who do not respond well to group intervention, rather than being more effective at the outset for all participants.

The additional offering of couples therapy following AIP treatment completion may also be a treatment approach worth considering, especially in unique cases. Some researchers caution that couples therapy may inadvertently diffuse responsibility to both members of the couple, increasing risk for further manipulation or coercion of the victimized partner (Bograd & Mederos, 1999). However, therapists who emphasize the relational context or family system may consider a couples therapy approach, especially after determining the perpetrator's motivation for couples therapy. Also, screening strategies and treatment approaches designed to maintain the safety of victims in couples treatment have been developed and tested (e.g., O'Leary, Heyman, & Neidig, 1999). For example, such strategies include the assessment of IPV risk in order to determine whether the violence is so severe that it would preclude couples therapy.

Finally, one important implication for treatment related to the organization-level's flexible treatment approach finding is the necessity to focus on substance use treatment concurrently with, or sequentially to, participation in the AIP. All of the participants who reported alcohol use preceding their recidivist event noted that drinking inhibited their decision-making and made it more difficult to apply skills. Scholars have long identified the role of alcohol in partner violence. Strong empirical evidence exists supporting the relationship between alcohol use and IPV generally

(e.g., Quigley & Leonard, 2000; O'Farrell & Murphy, 1995), and alcohol use is an identified factor contributing to IPV recidivism specifically (e.g., Mbilinyi, Neighbors, Walker, et al., 2011; Jones & Gondolf, 2001). Therefore, substance abuse treatment, particularly alcohol use intervention, may be a valuable addition to treatment, especially for participants for whom alcohol use has been problematic in the past.

***Group-level influences.*** Participants from the present study noted positive and negative group-level variables. Positive factors reported by participants seemed to enhance their motivation for treatment while negative factors appeared to reduce their treatment engagement in group. Specifically, positive factors included an emotionally safe space (or as Wangsgaard, 2001, called it, an "asylum"), sharing and hearing others' stories, and getting the opportunity to practice skills in group. The present findings confirm previous results for this level of analysis as all three of these group level variables have been noted in other qualitative research examining group effectiveness (e.g., Wangsgaard, 2001; Silvergleid & Mankowski, 2006).

Study participants also noted negative group-level factors. These variables potentially decreased the effectiveness of AIP group treatment. Specific factors identified included groups containing participants who monopolized sessions, groups containing participants who did not take treatment seriously, groups containing participants who regularly went off topic, and groups in which participants would collude with one another in their denial of accountability for their behavior. None of these "ineffective group factors" appeared in previous qualitative research but are nonetheless notable due to their clinical implications for treatment. These findings

reveal the importance of therapists attending to group dynamics and intervening when noticing any of these ineffective group variables. Schopler and Galinsky (2005) suggested the use of open-ended groups to reduce the phenomenon of colluding described by the present study participants. In Schopler and Galinsky's study, open-ended AIP groups (in which participants enter and exist as they complete treatment rather than with a cohort of participants who start and end at the same time) enabled men further along in the change process to support others as they entered the program. The use of open-ended groups may significantly decrease participants' tendency to collude in the denial expressed regularly by those first entering treatment.

***Interpersonal-level influences.*** The interpersonal-level of analysis yielded a large number of factors related to IPV recidivism, behavior change, and group effectiveness therefore emerged as an important addition to Silvergleid and Mankowski's (2006) ecological organizational structure. This level included dyadic factors to which participants attributed their recidivism and/or difficulty maintaining behavior change. Interpersonal-level factors included interpreting violence as provoked by one's partner, reporting that the partner initiated violence, mutual violence during the recidivist incident, history of relationship violence, history of infidelity, ongoing relationship conflict, relationship ambivalence and/or disengagement, and co-parenting issues.

Dyadic factors have not been commonly discussed as variables that contribute to recidivism. However, interpersonal-level factors, such as mutual violence and partner-initiated violence, are essential elements to ongoing IPV in relationships. Research shows that 10–25% of physical violence in heterosexual relationships is

perpetrated by women (Hamby, 2014). Due to the frequency with which relationship factors play a role in the development and maintenance of violence in relationships, interpersonal-level variables present a unique and important opportunity for research consideration and intervention. Aside from the potential addition of couples therapy (as described above), treatment implications related to dyadic influences are unclear and warrant further research. Based on the present findings, potential treatment implications related to these dyadic factors may include treatment efforts to validate clients' difficulties managing bi-directional violence without colluding in the denial of their responsibility; provide greater outreach efforts and services for partners who may themselves struggle with anger and aggression; and consider innovative treatment strategies to engage partners in IPV services that may not involve a full course of couples therapy (e.g., occasional conjoint sessions).

***Intrapersonal/psychological-level influences.*** By far, intrapersonal/psychological-level variables were the most commonly identified factors for recidivism following treatment completion. Factors in this level of analysis could be grouped into three main categories: skills-related, accountability-related, and motivation-related. Skills-related variables included factors specific to skills use and skills deficit. These included an abstract or vague understanding of skills taught in group often leading to misapplication of the skill, not using skills during conflicts due to forgetting things that were learned or difficulty remembering to use the ones that were known, and lacking specific skills (particularly related to interpersonal effectiveness, communication skills, emotion regulation, distress tolerance, anger management, cognitive restructuring, and relapse prevention).

The individual/psychological level also included accountability-related variables, a finding consistent with previous research exploring behavior change among partner-violent men. For example, previously identified variables within the field of behavior change processes and AIP effectiveness include recognizing and taking responsibility for past abuse (Scott & Wolfe, 2000; Sheehan, Thakor, & Stewart, 2011) and overcoming denial (Pandya & Gingerich, 2002). Notably, Catlett, Toews, and Walilko's (2010) qualitative strand of their mixed-method study indicated that men make meaning of their violence through minimization, denial of responsibility, and rationalization/justification of violent behavior. Consistent with previous research, the present study found many participants recounted their recidivist events by denying their violent behavior altogether, rationalizing or justifying it, not taking responsibility for it, and/or minimizing it.

Finally, the individual/psychological level of analysis also included motivation-related variables, such as participants' self-awareness/insight of their problematic behavioral patterns, treatment engagement, and commitment to change. Consistent with previous findings demonstrating the importance of motivation-related variables, participants in the present study noted their level of engagement in treatment and motivation to change (Murphy & Ting, 2010). All 6 participants who returned to the AIP following treatment completion and subsequent re-offense, described that they did not take treatment seriously the first time through, and thus did not acquire skills during treatment. As they reflected on their level of engagement and motivation after having returned to treatment, most described the importance of having made the decision to take treatment seriously and engage in

behavior change upon re-enrollment. These participants appeared to discuss the type of self-awareness that Silvergleid and Mankowski (2006) emphasized was necessary when making the decision to change abusive patterns of behavior and thus become motivated to change.

Although arguably one of the most important factors for positive treatment outcomes, treatment engagement and motivation for change are difficult to identify clearly for AIP participation. Some AIPs (including the AIP in which participants in the present study participated) measure motivation through Prochaska and DiClemente's (1984) stages of change model. Another commonly used measure of treatment engagement is attendance. However, attendance may be a less accurate measure of engagement and motivation in the case of partner-violent men who are court-ordered to treatment due to their possible motivation being driven by external factors (e.g., avoiding legal consequences) rather than internal factors (e.g., desire and commitment to change). Measuring and enhancing engagement and motivation among partner-violent men in treatment is crucial for lasting change. Chovanec (2009) offers several recommendations for IPV treatment engagement and motivation including validation, addressing shame, supporting group leadership, and providing information to challenge previously held beliefs. Enhancing the use of these strategies would likely benefit partner-violent men and increase the effectiveness of AIP treatment.

**Treatment Implications**

The present study provided some useful takeaways for treatment enhancement. Based on study findings, recommendations for treatment include

considerations regarding treatment approach, modifications to program content, and group facilitation methods. Assessing and enhancing participants' motivation for treatment can increase program engagement. One method for enhancing motivation for treatment is by offering treatment options that clients perceive as relevant. For example, for some clients, offering a flexible treatment approach may be particularly useful. Many clients enter AIP treatment with co-occurring needs, thus the added options for group therapy, individual therapy, substance use treatment, and/or couples therapy can be beneficial in ensuring all of clients' mental health needs are met, especially when they are motivated to engage in these potentially complementary interventions. Additionally, enhancing skills training in specific content areas including distress tolerance, emotion regulation, interpersonal effectiveness, communication, anger management, and cognitive restructuring may be particularly useful for many partner violent men. Related to program content, addressing both skill acquisition and skill application is crucial; interventions should include a skills training component that enables clients to understand the skills taught as well as offer opportunities to practice applying skills both in session and for homework.

Other recommendations for treatment involved attending to variables in the facilitation of groups. For example, study findings emphasize the importance of training facilitators to attend to group dynamics and intervene when "elements of group ineffectiveness" arise. The participants in the present study described various factors that they perceived contributed to group treatment being ineffective, including participants monopolizing group, participants not taking responsibility, the sessions going off topic, and participants colluding with one another in their denial of

accountability. Training facilitators to respond to these group dynamics may enhance the treatment effectiveness and participant satisfaction with treatment. .

Finally, important conclusions related to participants' relationship with their partners emerged from the present study. One important focus of participants' narratives involved the interpersonal context of violence, and many provided explanations involving relationship dysfunction that included their partners. One important recommendation is that providers need training to validate clients' difficulties with bi-directional violence and the partner's contribution to relationship problems without colluding in the denial of their personal responsibility. Another potential treatment recommendation involves providing greater outreach efforts and services for partners who may themselves struggle with anger and aggression. Programs may also consider innovative treatment strategies to engage partners in IPV services that may not involve a full course of couples' therapy but involve partner participations, such as occasional conjoint sessions.

**Study Limitations**

This study was constrained by several limitations including transferability concerns and the potential for researcher and respondent bias. As noted in the Methods section, several strategies to enhance rigor were implemented to minimize these concerns. Nevertheless, caution should be exercised in generalizing research findings beyond those who participated in the present study. While qualitative research has many advantages, including the in-depth analysis and interpretive presentation of data, it also yields findings that are contextually situated representations of experiences, rather than a representation of the phenomena

themselves (Dyson & Genishi, 2005). The transferability of these findings may not be applicable in other contexts due to several factors.

First, the sample for this study involved partner-violent men who recidivated following treatment completion in a Maryland AIP. This AIP may be similar to or different from AIP treatment in other states, especially since there exists a wide range of policies regulating AIPs across the country. While some states mandate specific requirements of AIPs (e.g., length, content, court-system collaboration, etc.), others do not. Since other states may have different mandates for AIP treatment, replicating this study's findings may be difficult and/or may produce different results. However, many of the findings in the present study are supported by other research in the area of AIP effectiveness, IPV perpetration, behavior change processes among partner-violent men, and recidivism, which adds support to the results despite these limitations.

A second limitation related to transferability of findings is that of the sample used. First, the sample size in the present study is small relative to most studies in the field of psychology. However, standards and guidelines for quantitative research are different from those of qualitative studies, wherein appropriate sample size is determined by the identified purpose of the research (Kvale & Brinkmann, 2009). The purpose of the present grounded theory research was to reach a point of theme saturation. Therefore, sample size was determined by an iterative analysis of data, assessing for saturation of themes during data collection. The present study provided an in-depth exploration of individuals' narratives; these narratives were subjective and contextually-situated representations of partner-violent men's recidivist

experiences. Therefore the findings cannot be interpreted as generalizable representations of broader phenomena beyond the 11 men interviewed for the present study. A second sample consideration is related to the strategic sampling of participants with unfavorable outcomes. Since only those participants who re-offended were included in the study, results cannot be assumed to extend to partner violent men who do not recidivate. In addition, caution is needed in extending the resulting treatment recommendations to first time AIP participants whose experiences of treatment and perceptions of violence may be different from those who have re-offended.

An additionally limitation of the sampling strategy, as mentioned in the Methods section, was the trade-off conferred by expanding the study sampling criteria to include participants who completed individual treatment. At the study's outset, only those who completed group and went on to recidivate were determined to be included. However, due to recruitment challenges and emergent questions related to theory, the sample was expanded to include those who completed individual treatment as well. As it turned out, the final study sample included two participants who completed individual treatment only. Their inclusion provided a compromise to the competing interests of sameness in the sample and taking an iterative approach to methods based on study need and ongoing analysis; it also may have further diluted the transferability of study findings.

More generally, interviews themselves do not always generate the most accurate data. Patton (2002) notes that there are many possible limitations to data derived from interviews, including "distorted responses due to personal bias, anger,

anxiety, politics and simple lack of awareness…" (p. 306). Study participants may also be affected by an error in recall, lack of insight, a positive or negative reaction to the interviewer, and the desire to employ self-serving responses. Given the sensitive and often shame-inducing nature of IPV perpetration, the occurrence of any of the above is possible in the present study. Related to data verification, this study was additionally limited by the lack of inclusion of victims/survivors. Corroborating data from participants' partners regarding the IPV explored here could have enhanced the trustworthiness and accuracy of the findings. Especially given the significance of interpersonal-level factors that emerged as related to the IPV recidivist events, a better understanding of partners' experiences (e.g. through their accounts of the recidivist events) may have helped to contextualize the recidivism examined.

Another potential limitation of the study is instrumentation. In social science research, instrumentation refers to the use of various measurement instruments. In quantitative research, instruments refer most often to surveys or questionnaires, while in qualitative research, the "instrument" is the researcher herself. Therefore, potential sources of researcher bias and participant reactivity to the researcher are important areas of consideration (Creswell, 2008). The researcher's positioning as the interviewer *and* AIP director at the time of data collection, could have influenced participants' responses in unanticipated or unknown ways. For example, participants may have attempted to shape their responses, especially when describing perceived strengths and weaknesses of the AIP treatment itself. It is difficult to completely avoid instrumentation issues, as there always exists some level of risk that participants may be engaging in impression management, unwilling to answer

questions, or simply choose to be untruthful for any number of reasons. These concerns may be further elevated in a court-ordered population due to potential concerns regarding legal consequences.

Two major goals for researchers studying AIP effectiveness are reducing violence in current relationships and preventing violence in future relationships. A limitation of the present study is the lack of understanding regarding whether the relationship in which the recidivist event occurred was the same relationship as the original arrest incident or whether it took place with a new relationship partner. Future research should include the exploration of relationship status when considering IPV recidivism.

Finally, being a woman researcher may have had an effect on the data gathered as well. As a woman interviewer of men who have been abusive toward women, my gender may have biased the participants' responses by, for example, limiting the depth of the information obtained or decreasing the accuracy due to impression management. However, the partner-violent men participants in the present study appeared to feel comfortable and seemed to share their stories honestly, evidenced emotional expression across participants ranging from laughing to crying during the interview. Moreover, the data collection process in the present study, including communications with participants from time of contact to set up the interview and maintaining confidentiality, was exercised with care and consistency in order to minimize the likelihood of instrumentation problems. Participants appeared to willingly and voluntarily participate in their interviews, evidenced by their often choosing to extend their interview times, their openness about sensitive and personal

topics, and the seemingly strong rapport felt by the researcher during most of the interviews.

**Future Research**

Based on the findings of the present study, future research is needed to address the limitations of this research and to build upon the preliminary theory developments. There are four primary recommendations that require further consideration and exploration. First, the systematic exploration of men's ongoing violence against their women partners has only recently begun, and very little research focuses on recidivist violence after IPV treatment. Additional research is needed for the continued examination of what specific AIP treatment ingredients (i.e., components of treatment or characteristics of clients) are effective, and for whom. The present study explored the processes of treatment engagement, behavior change (or stagnation), and subsequent recidivism among partner-violent men through the emic perspectives of the participants themselves. Such research and findings increase our understanding of effective treatment ingredients, as perceived by those for whom the AIP treatments are being developed, and necessitate further exploration. Additionally, the use of self-report, partner-report, and criminal justice data (rather than participant report alone) would enhance the accuracy, trustworthiness, and rigor of these investigations; it would also be consistent with best practices for research in the field of IPV perpetration (Babcock, Green, & Robie, 2004).

Second, findings from the present study served to expand upon Silvergleid and Mankowski's (2006) organizational structure (i.e., community-level and extratherapeutic influences, organizational-level, group-level, and

individual/psychological-level), modeling behavior change processes among partner-violent men. The addition of a fifth level of analysis (i.e., interpersonal-level) emerged in the present study based on a significant number of dyadic factors noted to be involved in behavior change and recidivism. Mixed methods research would enhance evidence for this expanded model. For example, factor analysis may enable researchers to statistically model the various ecological levels of variables and identify the parameters of the model.

Third, treatment modality and flexibility of treatment may be an important area of further consideration among this population. Murphy and colleagues (under review) provide initial evidence that for cognitive-behavioral intervention, structured group AIP treatment is more effective than flexible individualized AIP treatment for partner-violent men. However, findings from the present study illustrate the potential value of a flexible treatment approach. Particularly, participants expressed interest in various treatment options, including group therapy, individual therapy, couples therapy, focused treatment for substance use, and/or a drop-in group following treatment completion. Offering a "menu of options" for those enrolled in AIP treatment may enhance treatment engagement and meet co-occurring needs that likely contribute to ongoing use of violence (e.g., substance abuse and mutual relationship abuse). Further consideration and investigation regarding complementary, sequential, and/or concurrent treatment options is warranted. For example, future research could target the identification of what type(s) of treatment(s) are best for which subsample of clients. It would be useful to develop methods for identifying which participants would benefit from individual treatment above and beyond group treatment, and for

whom additional services would be useful. In many AIPs, decisions such as these are made on a case-by-case basis, or are severely constrained by limited staffing resources; research that systematically examines for whom differentiated treatment is beneficial may help to create more effective treatment opportunities for partner violent men.

Finally, in the field of behavior change generally, and the efforts to end partner violent behavior specifically, it is difficult to discern between recidivism and relapse. Recidivism typically describes any new offense while relapse describes a return to the problematic behavior following a sustained period of change. In the field of IPV, the target behavior (violence) is intermittent and infrequent, making it quite difficult to determine whether individuals changed their behavior and then returned to previous patterns of behavior or never changed their behavior at all. Differentiating between partner-violent men who change their abusive behavior from those who continue to offend (recidivate) without any significant behavior change may be an important step in enhancing the effectiveness of treatment for each subsample of IPV perpetrators, as these two patterns suggest different intervention needs. For example, relapse may suggest a need for improved strategies to maintain change over time, whereas recidivism in the absence of behavior change indicates a need for different approaches to initiate change. Additionally, considerations for *how* relapse is discussed in treatment may be a useful area for future research. Unlike in substance abuse treatment, many AIPs do not explicitly address relapse-prevention. For example, in the AIP of focus in the present study, there is no standardized narrative presented in treatment about how and under what circumstances relapse

typically occurs. While the AIP content seeks to develop self-efficacy for coping with triggering events, it does not provide an explicit focus on relapse. Thus, identifying effective relapse-prevention skills for IPV, as well as effective strategies for how to incorporate these skills into AIP content, are important considerations for ongoing research.

**Concluding Remarks**

While this study is small in scale, it provides rich descriptions grounded in participants' voices of how partner-violent men perceive their behavior change processes and IPV recidivism following treatment completion. This study affirms Hearn's (1998) statement that, "in order to stop men's violence towards known women, it is probably useful to understand how men understand violence" (p. 60). By means of rigorous qualitative methods and systematic exploration of perceived behavior change and recidivism, the study contributes to a deeper understanding of what leads some men on a trajectory of continued IPV, despite intervention. The present study is just one contribution toward ongoing efforts to understand AIP treatment effectiveness and parse apart key ingredients in order to identify what works and for whom in treatment.

As the findings demonstrate, ongoing use of violence in relationships appears to be grounded in multilevel factors, including community-level and extratherapeutic influences, organizational-level influences, group-level influences, interpersonal-level influences, and intrapersonal/individual/psychological-level influences. The intersections and interactions of multilevel variables, including both proximal and distal factors, play an important role in men's ongoing use of violence against their

women partners. Findings emerged from an exploration of reoffenders' beliefs and interpretation of recidivist events. The study serves to confirm findings from previous research that have identified factors for behavior change and recidivism among partner-violent men. In addition, the current study generates new explanations for the ongoing use of violence at the interpersonal level. Several significant areas for future research have emerged from this inquiry, as well as recommendations for innovations in clinical practice.

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## Appendix A: Interview Guide

Thank you for agreeing to participate in this study. Today I would like to hear from you about your experiences in our program, your relationship with your partner *[or ex partner]* after completing the New Behaviors program, and the domestic violence incident that we talked about over the phone, along with potential others. I understand that it may be difficult to talk about some of these topics, please feel free to let me know if you need to take a break at any point during our interview. Do you have any questions before we begin?

**Introductory questions:**

I'd like to begin by talking about how you have been doing since completing the New Behaviors Program.

1. I would like to learn about any changes that have occurred in your life since you completed the New Behaviors Program. These changes can be small or large and can include things such as changes in your family, employment, health, hobbies, lifestyle, legal issues, attitudes, feelings about yourself, or practical things (e.g. new income or resources). What has changed in your life over the last ___ years?
   *Probe about a few different domains if necessary*

2. Are you currently in a relationship? *[If not, please think back to your most recent relationship.]* Every relationship has conflict; disagreements come up even in the healthiest relationships. How do you handle conflict or disagreements with your current partner *[or in your most recent relationship]*?
   a. Is this the same or different from the way you handled conflict or disagreement before participating in the New Behaviors Program? If so, how?

   *Probe if necessary:*
   b. *[if no specific skills/strategies mentioned]* What specific things do you do to manage conflict in your relationship now *[or in your most recent relationship]*?
   c. What problems have you encountered when trying to manage the conflict?

**Questions about recidivist event(s):**
I'd like to now talk about the incident that took place on __*date of DV arrest*__. Was this the most severe incident that you had with your partner since participating in the New Behaviors Program? *[If so, "Ok, I'd like to talk about this incident then…" If not: "I'd like to talk with you about the worst incident, can you tell me about the worst incident/conflict that you've experienced since participating in the program, starting with when it occurred?*

*If not: Can you tell me about any relationship incident/conflict that you've experienced since participating in the program, starting with when it occurred?]*

1. Can you describe the incident in as much detail as you can remember?
   *Probe if necessary for frequency:* How often did things escalate to this level of verbal or physical abuse?

2. What happened? Where? What did you do? What did your partner do?

3. Could you describe the events that led up to the incident? What was going on before the conflict began?
   a. Thinking back, what contributed to or influenced your actions during the incident? *[triggers]*
   b. Where drugs or alcohol involved?

4. What were you thinking and feeling before, during, and after the incident?
   Let's start with what you were thinking and feelings before the incident?
   During?
   How did you feel and what did you think immediately following the incident?
   *Probe if necessary: what stands out to you about the incident*

5. What was going on in your life during that time? *[multilevel factors and triggered displaced aggression?]*

6. What happened after the incident? *[immediately and as a result… consequences?]*
   *Probe if necessary:*
   a. Did the police get involved? How?
   b. Protective order? Jail time? Probation requirements? Reordered to an AIP?

7. How, if at all, did the incident affect your relationship?
   a. What other aspects of your life were affected by the incident? *[Children? Family? Friends? Work? Other areas of your life?]*

8. Has the way you manage relationships conflict and interact with your partner *[or ex, or new current partner]* changed since this incident? How?
   Was this change as a result of the incident?

9. Who or what was the most helpful to you during this time? How?
   *Probe if necessary:*
   a. What community resources did you use during this time? What resources would have been helpful? Why weren't they available? *[multilevel]*
   b. *[If difficulty understanding the question: Is there anything that you could have think of that would have helped you during that time? What was helpful to you?]*

10. What, if anything, did you learn from the incident? *[about yourself, your relationship, or anything else]*

11. Is there any anything else about the incident that you believe is important for me to know about this incident or other relationship conflicts that I have not asked you about?

**Questions about the New Behaviors Program:**
Now that we've talked about the incident from ___, I'd like to ask you some questions specific to your participation in the New Behaviors program and experiences after completing the program.

2. What was participating in the New Behaviors program like for you?
   *Probe if necessary:*
   *a.* What stands out to you when you think about your experiences in the program?
   b. How did you get along with and/or relate to other guys in the group?

3. How, if at all, did the group influence the way you think about relationships?

4. How often did you use skills or strategies gained in the program after you completed it?
   a. Which ones? [*Examples?]*

5. How did your experiences in the New Behaviors program affect how you handled the relationship conflict we talked about earlier?
   *[Were there skills you learned in group that were (or could have been) helpful for you during the situation?]*
   *Probe if necessary:*
   a. What was it like to try and use these strategies when you needed them most?
   b. What went well about using them?
   *c.* What made it difficult to remember/use the skills when you needed them? *[Obstacles or barriers to using the strategies/skills]*

6. What did you hope to get out of participating in the program?
   a. Did you achieve these things?
   b. What *did* you gain or learn?

7. What, if anything, was missing for you from the New Behaviors group?
   *Probe if necessary:*
   a. What did you not get out of the program that you wish you had?
   b. *[if no specific skills mentioned]* What topics, strategies, or skills would have been helpful for you to learn about in the group?

8. Is there anything else about the New Behaviors program that you believe is important for me to know that I have not asked you about?

**Ending questions:**

1. Was there anything that I didn't ask that I should have or anything that you didn't get to tell me that you would like to tell me?

2. Was there anything that you might not have thought about before that occurred to you during this interview?

3. Is there anything else you think I should know to better understand domestic violence in relationships?

4. What was it like for you to talk about these experiences?
    a. *[Provide AIP referral if applicable]* Are you interested in returning to the New Behaviors Program? *Tell participant about AIP services.*

5. Would it be ok for me to contact you again in a few months in order to make sure I understood your responses in the way you meant them and maybe even to tell you about my findings and ask whether you think I'm on the right track? *[permission for member-checking]*

## Appendix B: Study Introduction & Eligibility Screening

Study Introduction for Recruitment:

I am calling to follow up on your participation with the New Behaviors Program. I see that you completed the program in *month of year (e.g. September of 2009)*. We are conducting a study to help us further develop the New Behaviors Program and to better understand what is effective and helpful to program participants. I see that in *month of year* you were charged with a domestic violence offense and I was wondering whether you might be interested in coming in to talk with me about this incident and your experiences following participation in the New Behaviors Program. Because this is a research study, we are able to pay you $50 for your participation. I am calling to see whether you are interested in setting up a meeting with me to talk for 1-2 hours about the DV incident and your experiences after completing the New Behaviors Program with us. I will be audio-recording our conversation so that I can review it later for research purposes. However, all of your responses will be confidential. For more information regarding the study and confidentially, I can send you the study consent ahead of time so that you can review it before coming in to meet with me.

Are you interested in participating?

(If yes…)
Before we set up our meeting time, could you briefly tell me a bit about the DV incident from *month of year*?

Inquire about the following study criteria:

- At least one IPV incident must have taken place following treatment completion
- Incident must have involved a relationship partner or former relationship partner
- Incident must have taken place 5 or less years ago
- Participant must have adequate memory of the recidivist incident

## Appendix C: Field Notes Guide

Following each study interview, the researcher will reflect on the interview session using the following prompts, specifically noting anything atypical or out of the ordinary:

1. What was the physical environment of the setting?
2. Who were the people involved in the interaction?
3. What went on during the interview? What was the timeline?
4. What did the participant's goals appear to be?
5. What emotions were felt or expressed during the interview?
6. What were my reactions during the interview that may have influenced the participant and/or the interview?
7. What are the elements of my standpoint that may affect the way I understood and interpreted the participant's responses?
8. How did the interview affect me?

## Appendix D: Data Display Matrix of Codes

*Data display matrix of axial and focused coding*

| | | |
|---|---|---|
| Barriers (to staying nonviolent) | Skill deficit | Abstract understanding of skills |
| | | No skills used |
| | | Difficulty remembering to use skills |
| | | Forgot skills (that were learned) |
| | | Did not take treatment seriously (and thus did not acquire skills) |
| | | Lack of specific skills |
| | Not accessing support | Desire for additional resources |
| | | Shame interfered with getting help |
| | | Financial barriers to getting help |
| | Alcohol use | Inhibited decision-making |
| | | Additional consequences (e.g. legal issues) |
| Rationale (for using violence) | Denial of responsibility for violence | Denial of violent behavior altogether |
| | | Rationalization/justification of violent behavior |
| | | Minimization of violent behavior |
| | Partner blame | Interpreting violence as provoked by partner |
| | | Partner initiating violence/partner being violent |
| Factors (for violence) | General factors | Intergenerational cycle of violence |
| | | Generalized violence |
| | | Broader family dysfunction |
| | | Financial problems/financial stress |
| | | Cognitive rigidity |
| | | Gender-based beliefs |
| | | Difficulty tolerating distressing emotions |
| | Dyadic Factors (relationship characteristics related to violence) | Infidelity |
| | | Mutual violence |
| | | Relationship conflict |
| | | Hx of relationship violence |
| | | Relationship ambivalence/disengagement |
| Modality-specific variables | Flexible Treatment Approach | Group therapy |
| | | Individual therapy |
| | | Couples therapy |
| | Elements of Group Effectiveness | An emotionally safe space (“asylum”) |
| | | Sharing and hearing others’ stories |
| | Elements of Group Ineffectiveness | Group monopolizers |
| | | Group members not taking treatment seriously |
| | | Off topic |
| | | Colluding in denial of responsibility |
| | | Facilitators’ style |
| Content-specific variables | Skill Acquisition | Skills not acquired through treatment |
| | | Specific skills needed to address skill deficits |
| | | Drop-in group |
| | Skill Application | Not applying skills when they are needed |
| | | Skills practice |
| Participant-specific variables | Intrapersonal Characteristics | Engagement in program activities/method of program engagement |
| | | Expectations/assumptions prior to starting group |
| | | Tolerating difficult emotions |
| | | Cognitive rigidity |

## Appendix E: Overview of Abuser Intervention Program Skills

**Developing Nonabusive Relationships**

Session #1: Introduction of Program and Group Members
Session #2: Abuse and Its Consequences
Session #3: Healthy and Unhealthy Relationships

**Understanding and Managing Difficult Situations and Your Reactions to Them**

Session #4: Identifying and Describing Difficult Situations
Session #5: The Experience of Anger
Session #6: How to Cool Down
Session #7: Taking a Time-out
Session #8: Using Relaxation Techniques to Cool Down

**Communication and Conflict Resolution**

Session #9: Effective Communication
Session #10: Active Listening
Session #11: Expressing Anger and other emotions
Session #12: Assertiveness
Session #13: Negotiation and Compromise
Session #14: Problem-Solving

**Factors Contributing to Violence, Abuse, and Anger**

Session #15: Anger-Producing Thoughts/Anger Themes
Session #16: Effects of Stress on Relationships/Managing Stress
Session #17: Effects of Substance Use/Abuse of Relationships
Session #18: Effects of Childhood Experiences and Parenting on Relationships

**Tolerating Distress:**

Session #19: Potentially Triggering Situations
Session #20: Tolerating Difficult Situations