Evaluation of a Community Based Programme for Male Perpetrators of Intimate Partner Violence.

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ABSTRACT

Treatment for perpetrators of Intimate partner violence (IPV) is most often provided by community based IPV perpetrator programmes. These programmes have become an integral part of the response to IPV despite the fact that they are plagued by high rates of attrition and researchers suggest their effectiveness may be limited. It has been suggested that the retention rates and effectiveness of the programmes may be improved by tailoring treatment to specific subgroups of IPV perpetrators. This study was an evaluation of a community based IPV perpetrator programme. Participants were twenty two male IPV perpetrators who were court and not court ordered to treatment for violence towards a female intimate partner. Only seven participants completed the programme. Their self reported incidents of violence, alcohol consumption, change readiness and levels of working alliance were measured up to four times during the 18 week programme. Results indicated that participants who completed the programme or the majority of it significantly reduced their violence towards intimate partners and their levels of alcohol consumption. Higher levels of violence were associated with alcohol abuse and non court ordered status. As expected, court ordered participants reported lower levels of readiness to change and working alliance, and higher levels of alcohol abuse. However they were more likely to complete the programme compared with non court ordered participants. Implications of these findings are discussed.

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CHAPTER ONE

Introduction

Intimate partner violence (IPV) is a serious and widespread problem. Traditionally, IPV was perpetrated, hidden and suffered behind closed doors. Police involvement was rare, as was support for victims. While we have come a long way in our response to IPV, the impact on victims has not changed. They experience varied, often serious and sometimes fatal consequences.

For victims, physical health consequences include injuries such as fractures, cuts and bruising, reduced physical functioning and lifelong damage from traumatic brain injuries (Fanslow, 2005). Psychological effects manifest in many ways such as poor self-esteem, depression, anxiety disorders, alcohol and drug use and suicidal or self-harming behaviours (Fergusson, Horwood, & Ridder, 2005). In female victims, sexual and reproductive health consequences are also common. Bladder infections, abdominal cramping, miscarriage, sexually transmitted infections, and bleeding are examples (E. K. Martin, Taft, & Resick, 2006).

Other effects can include loss of friends, employment and independence. Family functioning is often compromised with the impact especially damaging on children who witness the abuse. These children also become victims and can experience a host of difficulties including developmental delays, aggression, low self-esteem and depression (Fanslow, 2005).

For convicted perpetrators, depending on the severity and recidivist nature of their actions, consequences range from community service to prison. It has also become common practice for IPV perpetrators to attend community based IPV treatment

programmes - either voluntarily or by court direction. These programmes have been "scrutinised more closely than any other treatment form" (Dutton & Sonkin, 2003, p. 3) and results suggest their effectiveness is limited (Babcock, Greena, & Robie, 2004; Feder & Wison, 2005). Furthermore group programmes are plagued by high rates of attrition (Bowen & Gilchrist, 2006; Buttell & Carney, 2008). Despite these findings, IPV programmes continue to offer treatment and are seen by the justice system as a useful sentencing option (Dutton, 2003). Researchers must therefore continue to evaluate IPV programmes and investigate and establish ways of improving their effectiveness.

Although researchers suggest that IPV perpetrators are a heterogeneous group, there are still relatively few treatment options (Holtzworth-Munroe & Meehan, 2004; Holtzworth-Munroe & Stuart, 1994; Lohr, Bonge, Witte, Hamberger, & Langhinrichsen-Rohling, 2005). The general consensus is that improvements might be made by moving away from a one size fits all approach and examining how treatment can be tailored to specific groups, such as perpetrators with alcohol and drug problems and those perpetrators who are at different stages of treatment readiness (Dutton, 2003; Eckhardt, Murphy, Black, & Suhr, 2006; Stuart, Temple, & Moore, 2007).

The majority of research on IPV treatment programmes has been carried out with American populations. This study focuses on the effectiveness of a New Zealand stopping violence programme. Chapter two begins by defining IPV and reporting on worldwide and New Zealand estimates of prevalence. Following that, the major theoretical approaches to IPV are outlined along with a summary of the perpetrator risk factors.

Chapter three is devoted to treatment. It begins by describing the most common types and modes of treatment for IPV perpetrators. The overall research on treatment effectiveness is reviewed, along with the rates and characteristics of participants who drop out. The last section of the chapter is focused on IPV perpetrators with alcohol problems, the impact of the working alliance, the participants stage of change and how that impacts on treatment retention and effectiveness.

Chapter four outlines the aims and hypotheses of the study. Chapter five, the methodology, outlines the procedure, discusses the measures used, and describes the participants of the study. The results are reported in Chapter six. Chapter seven discusses these results, draws conclusions and ends with recommendations.

CHAPTER TWO

An Overview of Intimate Partner Violence

Many different disciplines contribute to the research base on IPV and as such the definition of IPV can vary widely. This chapter will begin by defining the key terms used in this study. It will be followed by estimates of incidence and prevalence of IPV, a description of the main theoretical approaches, and concludes with a review of perpetrator risk factors.

Definitions

Family Violence

The term, *family violence* is used to describe "a broad range of controlling behaviours, commonly of a physical, sexual, and/or psychological nature which typically involve fear, intimidation and emotional deprivation" that occur within close interpersonal relationships (Family Violence Focus Group, 2002, p. 8). Child, sibling, elder, parental and intimate partner abuse are all encompassed by this term (Family Violence Focus Group, 2002).

Intimate Partner Violence (IPV)

IPV is a pattern of abuse, violence, intimidation and/or controlling behaviours perpetrated by one partner towards the other (Family Violence Focus Group, 2002). Many different terms have been and are used to describe abuse between partners. Currently there is no universal terminology. *Wife abuse* and *domestic violence* were early terms used when researchers and common public perceptions viewed violence as occurring in heterosexual married relationships (McHugh & Frieze, 2006; Murphy & Eckhardt, 2005). These terms are common terms still used to refer to IPV as well

as others such as *women battering*, *interpersonal violence*, *wife abuse* and *violence against women*.

Some of the disagreement on appropriate terminology stems from differences in the conceptualisation of IPV (McHugh & Frieze, 2006). For example, *women battering* is a term favoured by some feminist researchers, as it makes clear the role that gender plays in the feminist conceptualisation of IPV (McHugh & Frieze, 2006). IPV is a term also commonly used by researchers. It is congruent with research findings showing that violence between intimate partners occurs not only in heterosexual cohabiting relationships, but where partners live apart, are dating, are in same gender relationships, and are divorced or separated (Fanslow, 2005; Murphy & Eckhardt, 2005; Saltzman, Fanslow, McMahon, & Shelley, 2002). Although violence includes physical, sexual, psychological and emotional abuse, it is common for research to focus only on physical violence (Fanslow, 2005).

While there has been some reluctance to acknowledge and address the problem of female IPV perpetrators, research has shown that women can also be perpetrators of IPV (Frieze, 2005; Morris, Reilly, Berry, & Ransom, 2003; Robertson & Murachaver, 2007). Some studies have reported that the occurrence of female IPV perpetrators is similar to, or even greater than that of males (Magdol, Moffitt, Caspi, Newman, & Fagan, 1997; Robertson & Murachaver, 2007). However, female violence against male victims is less likely to result in serious injury or to create fear in the victim (Fanslow, 2005; Frieze, 2005; Morris et al., 2003).

The research on same gender IPV is limited, but indicates that the issues and dynamics of IPV perpetration are similar to those faced by heterosexual couples

(Coleman, 2007; Kulkin, Williams, Borne, De la Bretonne, & Laurendine, 2007; McClennen, 2005). Research reports that victims are subjected to physical, psychological and sexual abuse, with psychological abuse the most common (Coleman, 2007; Kulkin et al., 2007). While IPV is traditionally a hidden crime, for same gender couples this issue is compounded by society's negative view of homosexuality (Coleman, 2007). Therefore, victims must also contend with issues around disclosure of the nature of their relationship and discrimination from the justice system (Kulkin et al., 2007). There is also some reluctance to disclose incidents of same gender violence as same gender couples feel it may contribute to the negative perception of homosexuality as a whole (Kulkin et al., 2007).

This study is an evaluation of a male perpetrator stopping violence programme and therefore the focus is on Intimate Partner Violence (IPV) as perpetrated by males in married, de facto and dating relationships. Neither the programme nor this study excluded participants based on sexual orientation. However the literature review and the subsequent study are based on intimate partners engaged in heterosexual relationships. Therefore the focus of this study is on IPV as perpetrated by males against females and will follow the description that includes physical, psychological, and sexual abuse. Each variant of abuse is defined as follows.

Physical abuse

Acts of physical abuse include punching, kicking, strangling, biting, pushing, and generally behaviours that cause pain and injury to another person (Saltzman et al., 2002). The use of weapons and objects is common and injuries can result in lifelong damage or death, especially if medical treatment is unavailable or denied (Murphy & Eckhardt, 2005).

Sexual abuse

This includes threatened, pressured and forced non-consensual sexual contact of any kind (Murphy & Eckhardt, 2005). For example, rape, forcing a partner to view pornography, take part in humiliating sexual behaviour or withholding sex as a punishment. The lack of control over the sexual activity in the relationship will often extend to the denial of contraception so that victims are at risk of sexually transmitted infections and unwanted pregnancy (M. P. Johnson, 2008).

Psychological abuse

Of the IPV subtypes, psychological abuse is the most common (Löbmann, Greve, Wetzels, & Bosold, 2003). There are a wide range of behaviours that make up psychological abuse. They all usually involve behaviours designed to increase dependence on the perpetrator, increase vulnerability of the victim, and instil fear (Jackson, 2007).

Murphy and Eckhardt (2005) describe four specific types of psychological abuse that have emerged from the literature. *Dominance and intimidation* includes behaviours that try to produce fear or submission. Examples include violence towards objects and pets, intimidating looks and threats to hurt or kill. *Denigration* includes behaviours aimed at belittling, humiliating and breaking down a person's self-esteem. *Restrictive engulfment* is the third type of psychological abuse and involves isolating, monitoring, spying and going through personal belongings. In one study 96% of perpetrators reported that they usually or always knew where their partner was when they were apart (M. P. Johnson, 2008). Lastly, *hostile withdrawal*, and as name implies this involves the withdrawal of attention and affection (Murphy & Eckhardt, 2005).

Incidence and Prevalence of IPV

Research on the incidence and prevalence of IPV are important indicators of whether community initiatives, justice systems, treatment programmes and women's advocacy centres are reducing the rates of perpetration and recidivism. Depending on exactly what factors are measured, these studies can also indicate risk factors and identify trends. While the studies may differ on the figures they report, there is agreement that IPV is under-reported.

Worldwide Estimates

IPV prevalence rates from a number of countries were obtained from a large study carried out by the World Health Organisation (WHO) (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). Participants were 24,097 women from 10 different countries who answered questions about physical, sexual and controlling behaviours. Results showed that between 15% and 71% of women reported physical and/or sexual violence by an intimate partner at some point in their lives. Twelve-month prevalence ranged from 3.7% to 53.7%. Japanese women (n = 1276) reported the least IPV (15.4%) while Ethiopian women (n = 2261) reported the most.

Another large study was recently carried out in 18 states within America looking at instances of physical and sexual violence from over 70,000 respondents (Breiding, Black, & Ryan, 2008). Just over a quarter of women reported experiencing some form of threatened, attempted or actual physical violence and/or unwanted sex in their lives, with 1.4% reporting this occurred within the last 12 months.

New Zealand

Police statistics reported for 2005 and 2006 indicated there were 32,108 family violence related offences in New Zealand over that period. However Police estimate that they are only involved in 18% of actual family violence incidents (New Zealand Family Violence Clearinghouse, 2007). Of this figure, 8437 were male assaults female offences; the highest number recorded in the last ten years (New Zealand Family Violence Clearinghouse, 2007).

The New Zealand National Survey of Crime Victims provides estimates of incidence and prevalence of IPV (Morris et al., 2003). The survey found 26.4% of women surveyed (N=2526) had been victims of IPV in their lifetime and 3% (N=1606) were victims during 2000 (12-month period) (Morris et al., 2003). In a later study Fanslow and Robinson (2004) found even higher lifetime prevalence rates of 33% from Auckland women and 38% from Waikato women.

Twelve-month prevalence of IPV was examined as part of the Pacific Islands Families: First Two Years of Life (PIF) study (Paterson, Feehan, Butler, Williams, & Cowley-Malcolm, 2007). The PIF study is a longitudinal study of 1398 infants born during 2000 and their parents. As part of their first interview, 1096 of the mothers completed the Conflict Tactics Scale (CTS) and reported on incidents of abuse occurring during the past twelve months. Results indicated 11.0% of mothers were victims of severe violence, 21% reported minor physical violence, and 77% reported verbal aggression.

Prevalence rates for Māori have been found to be significantly higher than for non-Māori (Marie, Fergusson, & Boden, 2008; Morris et al., 2003). Results gathered from

research on a longitudinal birth cohort suggest the differences between Māori and non- Māori may be due to the generally higher exposure of Māori to social, economic and family disadvantage (Marie et al., 2008).

Overall, the studies indicate a lifetime prevalence of 17% to 38%. According to police reports these figures are rising (New Zealand Family Violence Clearinghouse, 2007). As a result of government initiatives family violence has recently been receiving a great deal of media attention. It is possible the increase in the police statistics is because of a better understanding of IPV and a perceived increase in support for victims.

Theoretical approaches to IPV

Social Learning theory

This approach is based on Bandura's model of social learning which suggests that abusive behaviours are learnt in childhood (Bell & Naugle, 2008; Murphy & Eckhardt, 2005). Children who witness and/or experience abuse develop a tolerance for violence, fail to learn acceptable conflict resolution skills and often go on to perpetrate IPV as adults - a process known as the intergenerational transmission of violence (Bell & Naugle, 2008; Stith et al., 2000). Social learning theory suggests that IPV perpetrators often lack basic relationship skills and have a tendency to positively interpret the outcomes of their violence while negatively interpreting others behaviours (Gorenstein, Tager, Shapiro, Monk, & Sloan, 2007; Murphy & Eckhardt, 2005).

Support for social learning theory has come from the large amount of research supporting the intergenerational transmission of violence (Gil-Gonzalez, Vives-

Cases, Ruiz, Carrasco-Portino, & Alvarez-Dardet, 2007; Hill & Nathan, 2008; Kwong, Bartholomew, Henderson, & Trinke, 2003; Murrell, Christoff, & Henning, 2007). However, the social learning model has been unable to account for the fact that not all children who grow up in violent homes become IPV perpetrators and many perpetrators deny witnessing or experiencing abuse as children (Bell & Naugle, 2008). It has also been suggested that this model does not explain the interpersonal and situational nature of the abuse (Murphy & Eckhardt, 2005).

Psychopathology approach

This approach attempts to explain IPV by focusing on a person's psychopathology and personality characteristics (Bell & Naugle, 2008; Murphy & Eckhardt, 2005). Explanations for IPV perpetration usually involve insecure attachment, personality disorder, unresolved trauma, and mood disorders (Dutton, 2007a; Feldman & Ridley, 1995; Murray & Graybeal, 2007).

Explanations also involve identifying and describing different types of perpetrators. Holtzworth-Munroe and Stuart (1994) report that at least 15 different IPV perpetrator typologies have been proposed. They found that they generally fell into 3 subgroups *Family only, Dysphoric/borderline* and *Generally violent/antisocial.* Family only perpetrators are categorised by low levels of; violence, personality disorders, alcohol use and depression. They suggest family only perpetrators make up around 50% of identified IPV perpetrators. The dysphoric/borderline subgroup are said to be perpetrators who engage in moderate to high levels of intimate violence, low to moderate general violence, and often display personality disordered features. They have also been found to have higher levels of alcohol and drug abuse, depression and anger than the family only group and are said to make up around 25% of

identified perpetrators. The third group generally violent/antisocial are also expected to have similar patterns of violence and abuse as the dysphoric/borderline group although use more violence outside the home. The generally violent/antisocial group is also more likely to have a criminal record and exhibit antisocial personality disorder features. They are said to make up 25% of IPV perpetrators.

Critics of this approach point out that many perpetrators do not have personality disorders, traumatic childhoods or insecure attachment (Murphy & Eckhardt, 2005). Difficulties in the practical application of IPV perpetrator typologies has also been highlighted (Capaldi & Kim, 2007). Research has shown that when clinicians have attempted to sort IPV perpetrators into their correct subgroup large numbers are allocated incorrectly (Langhinrichsen-Rohling, Huss, & Ramsey, 2000; Lohr et al., 2005). The use of the typologies is further limited by the fact that most research has been undertaken predominantly in the United States. This, as Dixon and Brown (2003) point out limits the generalisation of the typologies.

Feminist theory

Feminist theory views sexist and patriarchal societies as the cause of IPV (Bell & Naugle, 2008; Bograd, 1988). According to this perspective, men live, are socialised and grow up in a culture "rooted in the assumption that, based on differences, some people have the legitimate right to master others" (Pence & Paymar, 1993). This position is reinforced by structures such as the law, religion, education and the media (Dasgupta, 1999). According to Bograd (1988), violence and abuse is one way men establish power and control and retain their dominant position. From this perspective violence is a rational choice, is always intentional (Mankowski, Haaken, & Silvergleid, 2002) and according to Lehrner and Allen (2008, p.221) "best

understood as an act of universal male gender privilege rather than as an aberrant instance of individual psychopathology".

The theory is generally criticized for being a narrow view of a complicated problem that lacks empirical support (Dutton & Corvo, 2006). Critics point out that if our patriarchal society supports and maintains men's violence against their intimate partners then how can men be held individually accountable? (Dutton, 2006). The theory has also been criticised for being unable to explain the existence of same-gender partner abuse as well as violence by women against men (Bell & Naugle, 2008; McClennen, 2005).

Social learning, psychopathology and feminist approaches all guide our research and understanding of IPV. They have however been seen largely as competing theories with minimal or mixed empirical support (Bell & Naugle, 2008; Mauricio & Gormley, 2001). There is also some concern that the theories are focused on factors that are difficult to treat such as personality disorders, childhood experiences and cultural beliefs (Bell & Naugle, 2008; R. B. Stuart, 2005). As will be seen in the following review of risk factors each model alone is limited in its ability to fully explain IPV.

Perpetrator Risk Factors

Risk factors are characteristics that are found to be predictors of particular problem behaviours. A number of factors have been proposed as being IPV perpetrator risk factors and are subsequently reviewed.

As previously mentioned, a number of researchers have investigated the intergenerational transmission of violence and subsequently found evidence to support it as a risk factor for IPV perpetrators (Delsol & Margolin, 2004; Gil-Gonzalez et al., 2007; Hill & Nathan, 2008; Kwong et al., 2003; Murrell et al., 2007). However, findings from a study by Fergusson, Boden and Horwood (2006) did not indicate that being a victim of violence during childhood was a risk factor for IPV. They suggest the major limitations of the current research is the use of retrospective data and the "failure to control for the psychosocial context within which inter-parental violence occurred" (Fergusson et al., 2006, p. 103). Their study used data from the Christchurch Health and Development Study and controlled for the effects of confounding variables such as parental bonding and family living standards. Results revealed childhood exposure to IPV was significantly associated to psychological aggression but not significantly associated with increased rates of physical partner violence. Further analysis of confounding variables revealed statistically non significant results for both physical and psychological abuse.

Other proposed risk factors include marital satisfaction, employment status and economic hardship. While it seems likely that a lack of finances and unemployment would place both individuals and families under stress and possibly increase the risk of IPV, research findings have not been particularly supportive of the associations. In the meta analysis by Stith, Smith et al.(2004) 23 studies were used to explore an association between income levels and the perpetration of physical violence in relationships. Individual effect sizes from those studies ranged from r = -.03 to -.40 with a composite effect size of -.08 signalling a weak correlation. Unemployment was also found to be a weak correlate at r = -.10. Stronger support has been found for

decreased marital satisfaction as a risk factor for IPV perpetration (Stith, Green, Smith, & Ward, 2008; Stith, Smith et al., 2004). Two meta analyses with large samples (N=3,896 and N=4,112) found effect sizes of r=-.30 and r=-.27 showing a small to moderate correlation between decreased marital satisfaction and aggression in intimate relationships (Stith et al., 2008; Stith, Smith et al., 2004).

There is widespread agreement that there is an association between alcohol and IPV perpetration (Fals-Stewart, Golden, & Schumacher, 2003; Foran & O'Leary, 2008; H. Johnson, 2001; Murphy, Winters, O'Farrell, Fals-Stewart, & Murphy, 2005; Stith, Smith et al., 2004). Research has found that alcohol abusing IPV perpetrators perpetrate the highest rates and most severe violence when compared with those IPV perpetrators who don't drink (H. Johnson, 2001). In another study researchers found that in more than half of the violent episodes that occurred, the male partner drank or used drugs before the violent incident (Fals-Stewart et al., 2003).

A number of proposed risk factors are linked to feminist theory which suggests men are socialised within a patriarchal society that condones and supports violence towards women. Accordingly we would expect research to find a relationship between IPV perpetrators, positive attitudes towards aggressive behaviour, and friends who condone and support violence. Sugarman and Frankel (1996) reviewed results from five studies and found violent husbands did have more positive attitudes towards violence than non violent husbands (d=.71). Furthermore Smith (1991) found that husbands whose friends would condone violence towards a partner were more likely to have assaulted their own partners than husbands whose friends would not approve of violence towards women. Worth noting is that the opinions on whether or not a partners friends would support violence towards women came from

the women (N=508) and depending on how well they knew their husbands friends could be an under or over estimation of their attitudes towards violence against women. Another study also supported peer support for violence against women as a risk factor but at a group level (Rosen, Kaminski, Parmley, Knudson, & Fancher, 2003). Research with American soldiers found that men who were part of a group characterised by rude and sexualised language, violent behaviour, and the use of pornography perpetrated more violence against partners than those men involved with a group that did not share this hyper masculine culture.

A number of studies have reported results supporting the association of male dominance and IPV. Straus (2008) suggests the results indicate that within relationships where one partner is dominant, the risk of IPV is increased as violence can be used to maintain that dominant position. A study by Mauricicio and Gormley (2001) supports this view with findings from their research indicating a positive relationship between men who reported a high need for dominance in their relationship and higher levels of perpetrated physical violence. Furthermore another study found a greater risk of violence for women who earned the same as or more than their husbands and also made decisions in the home, than for women who earned less (Chung, Tucker, & Takeuchi, 2008). However when those women whose earnings equalled or exceeded their partners made less household decisions the risk of violence was reduced suggesting that dominating decision making and possibly deciding on what to spend money on is more important than who makes that money.

In summary, most of the widely used treatment programmes have been developed according to the theories previously mentioned. A number of researchers have suggested that a better conceptualisation can be formed by drawing from multiple

theoretical perspectives and integrating individual and environmental factors (DeKeseredy & Draigiewicz, 2007; Heise, 1998; Margolin, John, & Foo, 1998; Mauricio & Gormley, 2001; McHugh & Frieze, 2006; Stith, Smith et al., 2004). The literature on risk factors demonstrates support for such an integrated theory of IPV.

Any enquiry on IPV must make clear what is being discussed, measured and researched. The use of varied definitions has implications for all facets of IPV research and weakens the ability to generalise findings. Much research includes only physical violence and could be due to difficulty measuring other aspects of IPV or because physical violence is seen as most harmful. Most of the prevalence surveys also only collect information of incidents of physical and sexual violence while neglecting psychological abuse. Prevalence rates would be different if a more complete definition of IPV was used consistently.

CHAPTER THREE

Treatment for intimate partner violence

This chapter focuses on treating IPV perpetrators and begins with a review of some of the different treatment approaches. One particular treatment approach, the Duluth model is covered in more detail as it is the treatment programme evaluated in this study. This chapter will also review the effectiveness of treatment programmes and concludes by presenting three factors; alcohol, the working alliance and the stages of change. Researchers have suggested the application of these factors in IPV programmes may be important in increasing attendance and effectiveness of the programmes.

Treatment approaches

Treatment for IPV perpetrators can be delivered individually, for couples and in a group format. Group treatment is by far the most popular format for IPV perpetrator treatment (Babcock et al., 2004).

Couples Counselling

Couples counselling advocates suggest that techniques work better when both parties are learning them together and each know exactly what is being discussed (Gondolf, 2002). The couple attend counselling either alone or in a group with other couples. Couples counselling is not recommended for couples when there is severe violence in the relationship (O'Leary, Heyman, & Neidig, 1999; Stith, Rosen, McCollum, & Thomson, 2004) or when there is a history of violence within prior relationships (Dutton, 2007b).

One example of couples counselling is Physical Aggression Couples Treatment (PACT) (Heyman & Schlee, 2003; O'Leary et al., 1999). This is an integrative approach based on Solution Focused, Narrative, Bowen and CBT therapies with an overarching feminist perspective (O'Leary et al., 1999). The first half of the fourteen session programme consists mainly of education on anger, introducing the cognitive model of anger, and teaching timeout and anger control methods (Heyman & Schlee, 2003). The second half focuses mostly on communication skills and gender differences such as *equality in decision making* and *assertion versus aggression* (Heyman & Schlee, 2003).

Most of the criticism of couples counselling centres on the perspective that if both parties are attending counselling then both parties are seen as responsible for the conflict (Murphy & Eckhardt, 2005). This is an assumption that some would argue removes responsibility from the perpetrator and partially blames the victim (Gondolf, 2002; Murphy & Eckhardt, 2005). Another concern is that the woman's self-disclosed anxieties and vulnerabilities can be used by the perpetrator as fuel for a more damaging psychological abuse (Jory, Anderson, & Greer, 1997).

Cognitive Behaviour Therapy

Cognitive Behaviour Therapy (CBT) is a psychotherapy based on the idea that a person's mood and behaviour can be improved by changing dysfunctional thinking (Beck, 1995). CBT is generally a structured short-term psychotherapy that concentrates on present difficulties. CBT for IPV perpetrators can be conducted individually, with couples, or in a group programme, with the latter being more common (Babcock et al., 2004; Smedslund, Dalsbo, Steiro, Winsvold, & Clench-Aas, 2007).

IPV perpetrators are often thought to lack basic relationship skills and treatment is therefore aimed at bringing about changes in the way abusive men think about violence (Hamberger, 1997; Murphy & Eckhardt, 2005). By using the theory and techniques of CBT those patterns of abusive behaviours can be unlearnt and replaced with better ways of relating (Murphy & Eckhardt, 2005). CBT interventions commonly used in IPV perpetrator programmes include social skills training, anger management techniques such as learning about timeout, relaxation training, cognitive restructuring techniques and relapse prevention (Babcock et al., 2004; Hamberger, 1997; Murphy & Eckhardt, 2005).

A number of the interventions used in this approach focus on the reduction of anger and anger enhancing thoughts (Murphy & Eckhardt, 2005). Feminist researchers have criticised the use of these interventions maintaining that perpetrators can use anger as an excuse for their violent behaviour (Murphy & Eckhardt, 2005). It has also been suggested that when the focus is on interventions such as communication skills and stress reduction or relaxation training then issues of power and control can be neglected (Adams, 1988).

The Duluth Model

The Duluth model refers to a community wide response to family violence that began in the early eighties in Duluth, Minnesota (Mederos, 1999). In an attempt to address the escalation of family violence in their community, changes were made to the way the justice system responded to family violence such as prosecution for perpetrators and mandated participation in IPV programmes (Shephard, 2005).

Another part of the community wide response was the development of a group programme for IPV perpetrators. Witten by Pence and Paymer (1993) and called *Education Groups for Men who Batter*, the programme has become the most widely used manual for IPV treatment programmes (Babcock et al., 2004; Feder & Wison, 2005; Gondolf, 2001; Mederos, 1999). The term *The Duluth model* is often used to refer to that curriculum as it does from here on in this study.

The Duluth model (Pence & Paymar, 1993) is underpinned by feminist theory outlined earlier. Self described as an educational model, the groups are focused on educating participants about male privilege and non violent ways of relating to women rather than conducting group therapy. Groups are co-facilitated by a male and female so that both genders can bring their perspectives to the group, support one another and model an egalitarian relationship. The Duluth model has five main objectives:

- To help participants recognize and understand that their anger and violence is a means of controlling their partner.
- To examine and increase understanding of the cultural and social contexts in which violence is used.
- To promote a willingness to change by examining the negative effects of their actions on themselves and their family and friends.
- To provide information on non-violent ways of relating to women.
- To encourage participant accountability and responsibly towards those who have been hurt by violence and abuse.

The Duluth model was originally introduced to New Zealand through the National Collective of Women's Refuge (NCWR) (Balzar, 1999). The appropriateness of the model for New Zealand populations was investigated and evaluated by both Pakeha and Māori groups (Balzar, 1999). Both groups felt the model explained the culturally supported suppression of women and Māori in New Zealand and it went on to be implemented in Hamilton (Balzar, 1999).

The Power and Control wheel as shown in Figure 1 is an integral part of the programme. The wheel was developed by more than 200 victims of IPV who attended sessions sponsored by the women's shelter in Duluth (Pence & Paymar, 1993). The 26 sessions are based around the eight themes contained in the wheel with interventions focusing on the effects and consequences of using violence. A comparison is made by discussing the alternative use of behaviours on the Equality wheel, shown in Figure 2.

Group interventions include, role-plays, discussing vignettes and control logs (Pence & Paymar, 1993). A control log exercise involves looking at an abusive incident; either from a participant's disclosure or one of the vignettes is used. The incident is then deconstructed so that participants can learn to identify the actions, intentions and beliefs, feelings, effects, and past violence that underlie the violence. The exercise ends with the group producing alternative behaviours to those abusive ones discussed in the exercise.

Figure 1.Power and Control wheel.

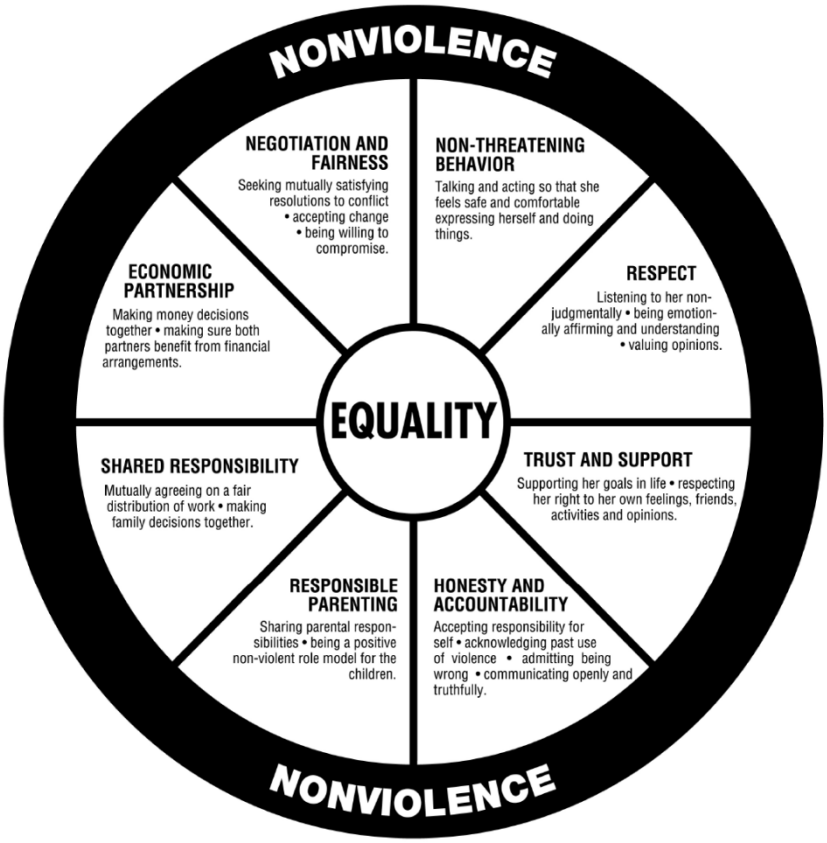

Figure 2. Equality Wheel.

While the Duluth model has remained the most widely used IPV perpetrator programme it is not without critics. A common criticism is the use of confrontation (Dutton, 2007b; Mankowski et al., 2002). Confronting participants about sexist and abusive language use, minimisation of violence and victim blaming are required elements of this intervention (Pence & Paymar, 1993). Potentially this can lead to participants feeling singled out, picked on and can impact on establishing a therapeutic alliance (Murphy & Eckhardt, 2005). Mankowski et al. (2002) suggest that depending on the skill of the facilitator the groups can parallel the same power and control dynamics that characterise abusive relationships.

A further criticism is the models narrow view and determination to distance itself from all psychological and individual factors relevant to IPV (Dutton, 2007b). As earlier mentioned, the Duluth model is self described as an educational model rather than a therapeutic model (Dutton & Corvo, 2006). The violence of the group participants is seen as a "socialised option for men" rather than coming from "personal or family dysfunction" (Pence & Paymar, 1993, p. 23). Therefore factors that could possibly impact on or help improve treatment effectiveness are ignored. So while research has shown that compared with nonviolent men IPV perpetrators have consistently indicated higher levels of anger and hostility across a variety of measures, anger is seen by the Duluth model as an inappropriate focus for intervention (Norlander & Eckhardt, 2005).

Research on the effectiveness of IPV treatment programmes

Evaluations of IPV perpetrator programmes in New Zealand

The few programme evaluations carried out with New Zealand IPV programmes have all reported that the programmes have been successful in reducing violence

(Dominick, 1995; McMaster, Maxwell, & Anderson, 2000; Morgan & O'Neill, 2001; Ratima et al., 1995). Interviews reveal that most participants self report positive changes in attitude and behaviour (McMaster et al., 2000; Ratima et al., 1995).

In one study 92% self reported that they were less violent and 73% self reported a positive change in attitude (Ratima et al., 1995). In another evaluation 88% of participants reported that they were motivated to change their behaviour and 54% of victims felt that the programme had contributed to a reduction in their partner's violence (Dominick, 1995).

In a qualitative study pre-treatment interviews revealed that the participants explained their violence in two predominate ways, as "expressive tension" or as "pathology" (Morgan & O'Neill, 2001, p. 282). Most participants talked of being overwhelmed by tension and consequently becoming temporarily abnormal. However, post treatment interviews revealed increased accountability for the violence, with participants seeing themselves as "rational agents with choices" (Morgan & O'Neill, 2001, p. 284).

While the New Zealand studies all reported favourable outcomes, it is important to note the limitations of the studies as they are common limitations of research with IPV programmes in general. Recidivism rates and reductions of violence reported in research are based on three types of reports; self, victim and police reports. Some of the studies relied entirely on self reports which are subject to dishonest reporting by perpetrators wanting to make themselves look better (Helfritz et al., 2006; Murray & Graybeal, 2007). Although a mix of both self and partner reports was used by two of

the studies, victim reports while seen as providing the most accurate information, are still subject to underreporting (Heckert & Gondolf, 2000).

Furthermore, it is important to note, none of the studies used control groups. This is mainly due to the ethical ramifications of delaying treatment in that it could expose victims to undue risk and further abuse (Dobash, Dobash, Cavanaugh, & Lewis, 1999; Sartin, Hanson, & Huss, 2006). As an alternative studies will often use treatment drop-outs as a control group. This is also problematic as recidivism rates from participants who complete treatment may look better because the participants who are more prone to reoffending have dropped out (Gondolf, 2001).

Worldwide studies

The Babcock et al. (2004) study was the first meta analysis conducted on IPV programmes. Twenty two studies, five experimental and seventeen quasi-experimental designs formed the data for the review. Results showed that for quasi-experimental designs based on partner report, a small to medium effect size of d = 0.34 was found. When only the experimental designs (based on partner and police reports) are evaluated a much smaller effect size of d=0.12 is found.

In a later meta analysis, Feder and Wilson (2005) limited their review to studies that showed pre- treatment equivalence between groups, either with matched groups or by using multivariate statistical methods. A minimum follow up period of six months was required as well as the use of one or more objective measure of repeat violence, such as victim or police report. The purpose of the meta analysis was to discover the effectiveness of IPV programmes for court-ordered participants on the rates of recidivism compared with routine legal interventions. Results for the seven

randomized studies that relied on police or court reports was a small effect size of d= .26. However, when the six randomised studies that relied on victim report were analysed a non-significant effect size of d=.01 was produced.

Results from both studies support the claim made by Weisburd, Lum and Petrosino (2001) that quasi-experimental designs are weaker and lead to a greater likelihood of researchers concluding that the treatment has been successful. Furthermore, both studies suggest that current treatment programmes have only a small effect on reducing recidivism. They also recommend that programme providers move away from “rigidly adhering to any one curriculum” and that improvements to programmes could be made by tailoring treatment to specific client groups, and developing pilot studies of alternative programmes (Babcock et al., 2004, p. 1048; Feder & Wison, 2005).

Both of these meta analyses found that no particular treatment programme was more effective than another (Babcock et al., 2004; Feder & Wison, 2005). In the Babcock et al. (2004) study the overall effect size for the five CBT quasi-experimental designs was d=.12. No significant difference in effect sizes was found between CBT and Duluth programmes. The researchers suggest that the reason for this is that over the years the content of the two groups has become very similar (Babcock et al., 2004). However, other comparison studies have found similar results. Morrell, Elliot, Murphy and Taft (2003) found that Supportive and CBT therapies were both successful in reducing intimate violence but neither programme was found to be superior. No difference was found between recidivism rates for those attending either group treatment compared to couples counselling (O'Leary et al., 1999). Similarly, recidivism rates were examined for two groups of IPV

perpetrators, one who attended a Duluth based treatment programme and one who did not attend treatment (Gordon & Moriarty, 2003). Results showed that those who attended the programme did not have a significantly lower likelihood of re-arrest when compared to those who did not attend the programme.

Improving Programme Retention and Effectiveness

One of the biggest problems facing those researching and providing IPV treatment programmes is the high rate of attrition, sometimes over 60% of participants (Scott, 2004). Characteristics of programme drop-outs suggest they are usually younger (Bowen & Gilchrist, 2006; Buttell & Carney, 2008; Morrell et al., 2003; Rooney & Hanson, 2001), unemployed or lower wage-earners (Bennett, Stoops, Call, & Flett, 2007; Buttell & Carney, 2008; Rooney & Hanson, 2001; Stalans & Seng, 2007; Yarbrough & Blanton, 2000), have problems with alcohol (Rooney & Hanson, 2001; Yarbrough & Blanton, 2000) and have a more extensive criminal history (Rooney & Hanson, 2001) than those who complete programmes. Many people believe self referred IPV perpetrators are more motivated to attend programmes due to their voluntary engagement. However, analysis by referral source has shown self referred participants attend significantly fewer sessions than participants court ordered to attend (Daly, Power, & Gondolf, 2001; Jones & Gondolf, 2002; Morrell et al., 2003).

Many IPV programme participants fail to attend any sessions. Drop out rates following the initial assessment has been documented at between 24% (Daly et al., 2001) and 46% (Rooney & Hanson, 2001). In 2005 5254 New Zealand men were referred to IPV programmes (New Zealand Family Violence Clearinghouse, 2007). While only 31% attended the assessment just 20% completed the programme.

Failure to attend programmes has wide-ranging implications for victims, researchers and programme providers. For victims, their partner's attendance and completion of a programme can help prevent further violence. The completion of a greater number of sessions has been shown to reduce the likelihood of re-arrest (Gordon & Moriarty, 2003; Shephard, Falk, & Elliot, 2002). Perpetrators who complete treatment have been shown to be less than half as likely to be arrested for IPV following treatment when compared to perpetrators who drop out (Bennett et al., 2007). Furthermore, those who drop out have been shown to have the highest levels of violent behaviour compared with those remaining in treatment (Rooney & Hanson, 2001). For researchers, studies with high drop outs become based on only a few people who complete the programmes (Hamberger, Lohr, & Gottlieb, 2000). For programme providers, participants who don't attend create more work as programmes need to report court ordered absentees.

Research has informed our understanding about what is not going well with IPV programmes, and consequently, studies have begun to focus on how to make improvements. It has been suggested that in order to advance the effectiveness of programmes and retain participants in groups, program developers and providers need to move towards an evidence based practice rather than an ideologically driven one (Babcock, Canady, Graham, & Schart, 2007). The next section discusses three current areas of investigation. The impact of alcohol, perpetrator readiness to change, and the working alliance.

IPV treatment with alcohol abusing perpetrators

The association between alcohol and IPV is well documented (Fals-Stewart & Kennedy, 2005; Foran & O'Leary, 2008; A. R. Klein & Tobin, 2008; Murphy et al.,

2005). Studies have reported that up to 60% of people entering substance abuse treatment have been violent towards a partner (O'Farrell, Murphy, Stephan, Fals-Stewart, & Murphy, 2004; Schumacher, Fals-Stewart, & Leonard, 2003). It has also been shown that in perpetrators entering IPV treatment, 41% of participants (N=41) met the criteria for substance dependency and 67% reported that they abused substances (Easton, Swan, & Sinha, 2000).

More concerning is the finding that alcohol use can impact on the severity of IPV. Based on both self and partner reports, one study found that more aggressive acts by husbands occurred when alcohol was involved than in episodes where it wasn't (Testa, Quigley, & Leonard, 2003). Similarly, in another study alcohol was consumed (by either partner) before most of the violent and nonviolent incidents reported by both partner and self reports (Murphy et al., 2005). The quantity of alcohol consumed by the husband as measured in standard drinks was significantly higher before the violent incidents than the non violent incidents.

Treatment combining alcohol abuse and IPV is rare, however evidence does suggest programmes are beginning to provide information about the impact alcohol and drugs can have on mood and the capacity for violence (Rothman, Butchart, & Cerda, 2003). An integrative approach was developed and compared with treatment focusing solely on alcohol dependence (Easton et al., 2007). Results showed those in the integrated treatment showed a higher decrease in alcohol consumption but not in incidents of violence. The researchers did however note that most of the participants in the alcohol only treatment group were living alone and therefore the likelihood of IPV occurring was limited.

The inclusion of interventions or information on alcohol abuse in IPV treatment programmes could improve treatment outcomes and retention (G. L. Stuart, 2005). It has been suggested that substance abuse screening of participants be included in the initial assessment process within agencies as well as developing policy and protocols around dual problem clients (Carter, 2003). According to Rothman et al. (2003), many IPV agency's actually decline treatment to those with substance abuse issues

Working Alliance

The working alliance (also called the therapeutic alliance) is recognised to be a collaborative, emotional relationship between the therapist and the client who agree about the tasks and goals of therapy (Tryon, Blackwell, & Hammel, 2007). Psychotherapy research has consistently demonstrated that the quality of the working alliance significantly correlates with therapy outcome (Castonguay, Constantino, & Holtforth, 2006; Crits-Christoph, Connelly Gibbons, & Hearon, 2006; Horvath, 2006; D. J. Martin, Garske, & Davis, 2000). Researchers suggest IPV programmes could be improved through a greater emphasis on the working alliance (Taft & Murphy, 2007).

The most popular working alliance conceptualisation is the theoretically neutral one developed by Bordin (1994). The working alliance referred to in this and following sections will refer to this conceptualisation. According to Bordin (1994) there are three components to the working alliance; *goals, tasks and bond*. He suggested that goal development is a key part of alliance building and best developed by negotiation between the client and therapist. The task aspect refers to the actual interventions and activities to be used within the therapy to achieve the goals. If the client and

therapist agree on the goals for therapy and methods to be used, this collaboration should help to foster the bond aspect of the alliance which is characterised as a warm, trusting and respectful connection (Bordin, 1994).

Horvath (2000) maintains that the alliance has been shown not to improve as treatment progresses and suggests that a good alliance needs to be developed by the fifth session. In one study working alliance was measured up to eight times during weekly (up to 52 sessions) CBT (Strauss et al., 2006). Results showed stronger early alliance was connected to completing more sessions and with earlier improvement of depression. Although only a small sample (N=30) the results support those from a larger (N=367) previous study that also showed early alliance to significantly predict change in depressive symptoms (D. N. Klein et al., 2003).

Taft and Murphy (2007) acknowledge that the development of a good working alliance with IPV perpetrators can be difficult but maintain that it is vital for behaviour change. They also maintain that forming a working alliance is especially difficult in programmes that use confrontation where perpetrators may find their disclosures of emotional problems or substance use are not met with empathy but are challenged as excuses and blaming.

Furthermore, the way staff see their programme, as treatment or as punishment can impact on the formation of the working alliance (Taft & Murphy, 2007). Many group participants are court ordered and participant attendance is noted and reported by facilitators. It is understandable that the purpose of the programme can sometimes become blurred for staff. In fact Silvergleid and Mankowski (2006) carried out in-

depth interviews with ten facilitators who revealed feelings of “walking the fine line” in balancing positive regard and support with confrontation

Currently, specific research on the working alliance in IPV programmes is limited. In a study of seventy self-referred violent couples, the Working Alliance Inventory (WAI) observer version was used as an alliance measure. Results showed alliance for both husbands and wives to be unrelated to treatment completion (Brown & O'Leary, 2000). Alliance measured at session one did however significantly predict decreased mild and severe psychological and physical aggression of husbands (Brown & O'Leary, 2000).

In a later study, Taft, Murphy, King, Musser and DeDeyn (2003) hypothesised that working alliance would be associated with lower physical and psychological abuse at follow up 6 months post group CBT for partner violent men. Working alliance was assessed by self report and therapist report using the WAI. One hundred and seven court ordered participants were measured early, at sessions three and five, and then late, at sessions 11 and 13. Both early and late therapist reports correlated with partner reports of physical and psychological abuse at the follow up although client rated alliance was not significant.

Stages of Change

The Transtheoretical Model (TTM) is a widely used behaviour change model used to help understand and explain the course of intentional change (Derisley & Reynolds, 2000). The model has been used to predict progress and attrition of clients in psychotherapy, addictions treatment and most recently has been used in IPV research (Derisley & Reynolds, 2000).

The TTM stages of change describes the different stages an individual experiences and moves through when they try to change some problem behaviour (DiClemente, 2003). Each stage is characterised by specific thoughts, beliefs, attitudes and behaviours.

- Stage 1: *Precontemplation* represents the earliest stage in the change process (DiClemente, 2003). Individuals in this stage are not considering change. Precontemplation is characterised by a lack of awareness of the problem or feeling that others are to blame (Murphy & Eckhardt, 2005).
- Stage 2: *Contemplation.* In this stage the individual is thinking about change by weighing up the pros and cons but no firm decisions about changing have been made (Begun, Shelley, Strodthoff, & Short, 2001).
- Stage 3: *Preparation* involves the individual deciding and committing to change and devising a plan of how they will do that (DiClemente, 2003).
- Stage 4: The *action* stage is characterised by carrying out what was planned in the previous stage (DiClemente, 2003).
- Stage 5: *Maintenance* involves the continued effort to sustain the changes made in the action stage and prevent relapse (Prochaska & Norcross, 2007). A person is said to be in the maintenance stage when they have successfully changed the behaviour for at least six months (Prochaska & Norcross, 2007).
- The final stage, *Termination* is reached when a person no longer fears a relapse and is confident in their ability to handle triggers and temptation to engage in old behaviours (Prochaska & Norcross, 2007).

Certain tasks and goals are also associated with each stage and need to be achieved in order for the participant to progress in the change process (DiClemente, 2003). For example, the main task in the precontemplation stage is to become aware of the behaviour and the goal is to consider change (DiClemente, 2003).

The TTM proposes that movement through the stages is helped by matching the correct processes to the correct stage (DiClemente, 2003). Researchers have pointed out that most IPV perpetrator programmes are designed as *one size fits all* programmes (Stuart et al., 2007) with only a small choice of different programmes available (Day, Bryan, Davey, & Casey, 2006). A good majority of participants in IPV programmes are mandated and often lack motivation for treatment and are unwilling or not ready to change (Daniels & Murphy, 1997; Eckhardt & Utschig, 2007; Murphy & Eckhardt, 2005). Research with both court and not court ordered substance abuse clients found that those court ordered to treatment reported lower levels of motivation to change (O'Hare, 1996). Similarly Bowen and Gilchrist (2004) found that court ordered IPV perpetrators displayed lower levels of motivation to change when compared with non court ordered IPV perpetrators.

Prior to beginning programmes the majority of IPV perpetrators have been found to be in the precontemplation or contemplation stage (Babcock, Canady, Senior, & Eckhardt, 2005). They often are then confronted by “action oriented interventions” a mismatch that likely contributes to the high drop out rates (Babcock et al., 2005, p. 238). In fact, smoking cessation studies show that treatment was most successful when the clients stage of change and the relevant process of change was tailored to the individual (Prochaska & Norcross, 2007). It has also been shown that those with

low contemplation scores attended fewer sessions and were more likely to withdraw prematurely from psychotherapy (Derisley & Reynolds, 2000).

The impact of change readiness on IPV programmes and participants attrition was examined by Scott (2004). Three hundred and eight men attending an IPV programme had their stage of change assessed by self report and counsellor ratings. While self reported stage of change was found not to be associated with drop out, counsellor ratings were. Those results showed precontemplative men to be more than twice as likely as men in contemplation to drop out and nearly nine times more likely than men in the action stage to drop out.

In another study participants who began the programme in the precontemplation stage showed little change in self and partner reported violent behaviour when measured towards the end of a programme. However those men who began the programme in the contemplation stage showed a substantial reduction in self reported violence and those in the action stage showed a substantial reduction in violence as reported by partners.

The assessment of change readiness of IPV perpetrators could indicate the appropriateness of group interventions or point to the need for techniques aimed at improving motivation to attend treatment (Eckhardt & Utschig, 2007). Interventions that meet participants at their particular stage of change readiness, motivational interviewing and motivational enhancements have been suggested (Babcock et al., 2005). In a study of participants mandated to attend substance abuse counselling those who attended a motivation group prior to the standard group treatment missed

fewer sessions, were significantly more likely to complete their treatment goals and to complete the programme (Lincourt, Kuettel, & Bombardier, 2002).

The aim of this chapter was to provide a review of IPV treatment, effectiveness and future directions. Although several treatment types are discussed, superiority of one type over another has not been shown and overall treatment effectiveness appears limited (Babcock et al., 2004). Researchers suggests the most effective treatments are those delivered to "motivated neurotics" with the least effective treatment delivered to criminals, particularly sex offenders (Dutton & Sonkin, 2003, p. 3). They suggest IPV treatment falls somewhere in-between. However, while programme participants may be only 5% less likely to reoffend than those who do not receive treatment, in the United States this would equate to approximately 42,000 women per year free from abuse (Babcock et al., 2004).

The high rate of attrition from IPV programmes makes keeping participants a fundamental goal of anyone working to stop violence against women and children. According to Stuart (2005, p. 254) failing to complete a programme may be more harmful than not attending at all "because treatment creates a false sense of security that exposes abuse victims to continued risk".

While not all treatment providers will have the staff, resources or will to integrate alcohol treatment into IPV treatment, research clearly supports the association between the two. It is important that we remember the safety of women and children is paramount and follow recommendations from an evidence base as opposed to a political and ideological one (McMurran & Gilchrist, 2008).

The working alliance and the stages of change are relatively new areas of enquiry for IPV treatment programme research. Both concepts are well researched with other populations, the working alliance with psychotherapy groups and the stages of change largely in the addictions field. As such both have amassed a large body of literature on practical interventions, strategies and applications. In the Babcock et al. (2004) meta analysis the treatment programmes showing the largest effect sizes were those which used retention techniques. In one of those studies participants were phoned, and sent handwritten notes following an absence from the group (Taft, Murphy, Elliot, & Morrell, 2001). These straightforward and easily carried out motivational enhancing techniques resulted in a significant increase in session attendance and a significant decrease in programme attrition.

CHAPTER FOUR

The present study

This study is an evaluation of a community based programme for male IPV perpetrators. The aims of this study are to:

- Evaluate the effectiveness of a community based programme for male IPV perpetrators.
- Contribute to the research literature on IPV perpetrator programmes in New Zealand.
- Provide the participating agency with a comprehensive evaluation of their programme.
- Explore the impact of variables that have been proposed as important in improving retention and outcome.
- Obtain and report participant feedback.

Hypotheses

1. Participants who complete the IPV perpetrator programme will show reductions in self reported violence towards intimate partners. In addition,
    a. Participants who self report pre-treatment levels of “hazardous” drinking as defined by the AUDIT will self report higher levels of violence towards intimate partners than those who self reported non hazardous levels of pre-treatment drinking.
    b. Participants who complete the programme will show significant reductions in the level of alcohol abuse as measured by the AUDIT.
2. Drop out rates from the programme will be higher for those who are not court ordered to attend.

3. Participants who complete the programme or attend most of the sessions (13-18) will have:

a. Higher Readiness to change scores as measured by the URICA than those participants who attend fewer sessions.

b. Higher self reported levels of working alliance than those participants who attend fewer sessions.

c. Higher levels of facilitator working alliance as reported by the facilitators of the programme than those participants who attend fewer sessions.

d. Lower levels of pre treatment alcohol abuse than those who attend fewer sessions.

4. Court ordered participants will:

a. Self report higher levels of pre-treatment violence towards intimate partners than not court ordered participants

b. Report lower readiness to changes scores prior to treatment than those not court ordered to attend.

c. Report lower levels of working alliance than those not court ordered to attend.

d. Facilitators will report lower levels of working alliance for those participants court ordered to attend compared to those not court ordered to attend.

e. More court ordered participants will self report hazardous drinking levels as defined by the AUDIT than those not court ordered to attend

5. Levels of working alliance measured in the early stages of treatment (following completion of session 4) will not significantly increase when measured later during the programme (following completion of session 12).

CHAPTER FIVE

Method

Research Setting

This study was conducted at a community based stopping violence agency in the North Island of New Zealand. The agency provides programmes for perpetrators and victims of family violence. It runs four women's groups and seven men's groups per week from various venues. The women's groups are generally attended by female victims of IPV. The men's groups are generally attended by men who have perpetrated IPV. Although IPV is the main reason people attend the agency, other reasons include violence towards other family members such as children, siblings or parents, and on occasion violence in the community.

The agency has three full-time staff members; a men's group coordinator, a women's group coordinator and a business manager. The agency has 13 paid facilitators and currently has one unpaid trainee. Services available include advocacy, individual counselling and group programmes.

Description of the men's programme

The men's programme is based on the Duluth model (Pence & Paymar, 1993) previously described in Chapter three. While most of the original elements from the Duluth model remain, additions and changes to the programme have been made. For example, a session has been included that specifically focuses on the impact of IPV on children. Additionally, all videos and DVD's used are produced in New Zealand.

The programme is 18 weeks long with each group meeting for one, two hour session per week. Groups are co-facilitated by a male and a female and each group generally contains up to 14 participants. Participants may enter the groups at any stage as the programme runs continuously. The programme is open to both homo and heterosexual males.

The programme contains six themes that each represents an aspect of non-violent and respectful relationships. The themes; non-violence, respect, non-threatening behaviour, trust and accountability, partnership and sexual respect are each examined for three weeks. Activities undertaken during the sessions include discussions and brainstorming topics, control logs, viewing relevant DVDs and videos and learning techniques such as time out, self-talk and communication skills such as negotiation. Participants are not assigned homework however they are regularly provided with handouts to take home and refer to or share with family.

Participants attend the programme through self referral, referral from another community agency, by order from the Criminal and Family Courts, or statutory agency's such as Child Youth and Family. There is no charge for participants with an order to attend, for self referred participants there is a ten dollar per session charge. However for those unwaged or in financial difficulty the charge is usually waived.

All potential participants attend an hour-long initial interview with the men's group coordinator. During the interview the programme is described to them, their circumstances are documented and they are assigned to the group most suitable to their location, work and family commitments. At this time the participants enter into a contract with the agency which outlines expectations, and rights and policy

surrounding attendance. Self referred men are told at their initial interview that failure to contact or attend the programme for three consecutive session's results in termination of the contract. For those mandated to attend their attendance is regularly reported to the appropriate authority. As such, those participants are not automatically removed from the groups for absence.

Participants

All men who attended an initial interview at the community based stopping violence agency between June 3rd 2008 and 31 July 2008 were approached by the researcher to participate voluntarily in an evaluation of the men's programme. Eligibility to take part in the research was based on the following criteria;

- The violence had been perpetrated against an intimate partner, as opposed to another family member, child or stranger.
- Participants described themselves as either Māori or NZ European/Pakeha.
- Participants were currently in a relationship. To evaluate changes in behaviour it was vital that participants had contact with an intimate partner. Relationship status was self-determined and it was not necessary for partners to be living together.

Seventy men were scheduled for initial interviews. Forty men attended their initial interviews. Of the 40 who attended, 15 did not meet the criteria of the study and three declined to participate. A total of 22 men agreed to participate in the study. Demographic information collected at the first meeting is presented in Table 1. Although one of the criteria for participation in the study was that the men were currently in a relationship there was no requirement that the relationship be with the partner they had perpetrated violence against. However, all men were still with their

original partners and the majority were living together. The mean age of participants was 31.5 years.

Table 1

Demographic characteristics of participants (N=22)

Participants	*n*	%
Age		
16-20	6	27
21-30	5	23
31-40	6	27
41-50	5	23
Ethnicity		
Māori	8	36
New Zealand European	12	55
Both	2	9
Attendance via		
Self referral	10	45
Referred by other agency	3	14
Court ordered	8	36
Referred by partner	1	5
Protection order		
No	21	95
Yes	1	5
Relationship status		
Original partner	22	100
New partner	0	0
Living arrangements		
Living with partner	15	68
Living apart	6	27
Both	1	5

Facilitators

Six IPV programme facilitators were initially approached and subsequently agreed to take part in the research. One facilitator went on leave for three months at the beginning of the study. A newly trained facilitator was employed to cover the position and also agreed to be part of the study. Towards the end of the study one facilitator resigned from the agency. An existing facilitator who was already part of the study, took over the facilitation of that group. The mean length of time working in the men's programme was 6.2 years. Three facilitators identified their ethnicity as Māori, three as Pakeha, and one as New Zealander. All facilitators had formal qualifications in the social science or health areas ranging from Certificate to Masters Level.

Research Design

This study used a repeated measure within and between subjects design. The between-group factors were court ordered and not court ordered and low, medium and high session attendance. The within group factors were pre-treatment, during treatment, and post treatment measures.

Measures

Demographic questionnaire

A self report demographic questionnaire was developed for this study. Questions on this form asked for the participant's name, date of birth, ethnicity, referral source and type, whether they had a protection order against them, their relationship status and living situation. A copy of this questionnaire can be found in Appendix A.

Session attendance or dropout

Attendance is recorded on an attendance roll by group facilitators. Attendance was

checked by viewing and recording information from the attendance roll. Completion of the programme was defined as attendance at one initial interview and 18 group sessions. For self referred men, including those referred by police, partners and other agencies, drop out was defined as no contact with or attendance at the programme for three consecutive weeks.

Socially desirable responding

A common issue when using self report measures is the tendency for participants to respond in a socially acceptable manner. This is particularly relevant when participants are being asked about their own unacceptable behaviour. The Balanced Inventory of Desirable Responding (BIDR) was designed to measure the tendency to give socially desirable responses on self reports (Paulhus, 1991). Several versions of the BIDR are available. This study used the BIDR version 6.

The BIDR is a 40-item self report measure that takes about 7-10 minutes to complete (Paulhus, 1991). Each item is a proposition, for example: My first impressions of people usually turn out to be right. Respondents are asked to indicate their agreement with each proposition by selecting a score from 1-Not true to 7-very true on a likert scale. The inventory is comprised of two 20-item subscales. Self-Deception (SD): the tendency to give honest but positively biased self descriptions and Impression Management (IM): the tendency to give a distorted representation of the self to be seen favourably by others (Paulhus, 1991). To score the inventory, the negatively keyed items are firstly reversed. Items that have responses of 6 or 7 are scored a 1 with responses from 1 to 5 scoring 0. Therefore the maximum score from each subscale is 20 with a minimum of 0.

Li and Bagger (2007) assessed the reliability of the BIDR by conducting a reliability generalization study. One hundred and ten articles that reported reliability coefficients of test scores were included. A reliability coefficient of .74 was found for the IM scale, .68 for the SD scale and .80 for the total scale. Similar coefficient scores of .72 for both subscales were found in another study (Holden, Starzyk, McLeod, & Edwards, 2000).

Both the SD and IM subscales have been shown to have good concurrent validity. The SD scale correlated positively with several measures of defence and coping and the IM scale with measures formally used to detect lies (Paulhus, 1991). Correlations between the SD and IM have been found to range from .04 to.40 providing support for the discriminant validity of the scale (Paulhus, 1991). Test-retest analysis carried out with five weeks between testing showed correlations of .69 for the SD scale and .65 for the IM scale (Paulhus, 1991).

Abusive Behaviour

The Abusive Behaviour Inventory (ABI) is drawn from a feminist perspective, and was designed by Shepard and Campbell (1992) originally as a means for evaluating a Duluth model domestic violence programme. The 29 items in the scale are based on the Power and Control wheel used in the Duluth model (Zink, Klesges, Levin, & Putnam, 2007). Within the scale there are two subscales measuring physical and psychological abuse. Respondents indicate on a five point likert scale how often the described type of abuse has occurred within a determined time period.

Two studies have shown that the ABI has demonstrated good reliability, ranging from .70 to .92 (Shephard & Campbell, 1992; Zink et al., 2007). The studies also found

that the ABI had good construct validity, correlating well with measures related to abusive behaviours. Furthermore, the ABI is easy to use (Shephard & Campbell, 1992; Zink et al., 2007) and is drawn from a philosophy congruent to the current programme being evaluated.

Alcohol use

The Alcohol Use Disorders Identification Test (AUDIT) was developed to screen for excessive drinking (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). It has been used in various settings with varied populations and ethnic groups (Reinert & Allen, 2007).

The AUDIT contains ten questions and takes about five minutes to complete. Scores on the AUDIT range from 0 to 40. The first three questions represent hazardous alcohol use, the second three dependence symptoms, and the last four, harmful alcohol use (Babor et al., 2001). To answer two of the questions, participants need to understand what a standard drink is. A list of common drinks and their standard drink equivalence was created for participants in this study (see Appendix A).

Total scores of 8 or more are “recommended as indicators of hazardous and harmful alcohol use, as well as possible alcohol dependence” (Babor et al., 2001, p. 19). The examination of answers to specific questions is also suggested. A score of 1 or more on question 2 or question 3 indicates alcohol consumption at a hazardous level while scores above 0 on questions 4, 5,and 6 imply the presence of alcohol dependence (Babor et al., 2001).

Reinert and Allen (2007) reviewed 18 studies carried out between 2002 and 2005 that used the AUDIT and found a reliability coefficient range of .75 to .97. Test-retest

correlations range from .87 with a one week interval between testing (Rubin et al., 2006) and .93 when a 3-4 week interval was used (Bergman & Kallmen, 2002).

Change readiness

The University of Rhode Island Change Assessment (URICA) (McConnaughy, DiClemente, Prochaska, & Velicer, 1989) scale is the most commonly used measure of readiness for change (Dozois, Westra, Collins, Fung, & Garry, 2003). It is based on the Transtheoretical model previously discussed in Chapter three.

The URICA contains 32 statements and takes about 10-15 minutes to complete. The scale is made up of four subscales, each consisting of eight items and representing four stages from the stages of change model; precontemplation, contemplation, action and maintenance. Participants respond to the statements on a 5-point Likert scale ranging from 1 (strong disagreement) to 5 (strong agreement). Scores from each subscale can be summed providing an indication of agreement with the behaviours and attitudes of that stage. It is recommended that scores be evaluated through cluster analysis rather than determining the participants stage based on the one with the highest score (Amodei & Lamb, 2004). Another way of scoring the URICA is to calculate a composite *Readiness* score (Amodei & Lamb, 2004). The readiness score is obtained by adding the contemplation, action, and maintenance scores and subtracting the precontemplation score (Amodei & Lamb, 2004).

Internal reliability of the subscales has been shown to range from .77 to .84 with a total scale score of .79 (Dozois, Westra, Collins, Fung, & Garry, 2004; McConnaughy et al., 1989). Previous research has found that the contemplation, action and maintenance subscales correlate positively with each other, whereas the

precontemplation subscale correlates negatively with the other subscales (Amodei & Lamb, 2004; Dozois et al., 2004).

Working Alliance

The Working Alliance Inventory (WAI) has been developed from a "transtheoretical perspective" and therefore is suitable for use with any form of therapy (Castonguay et al., 2006, p. 273). A number of versions are available. The full length version (36 items) comes in client, therapist and observer forms. The short version (WAI-S) contains 12 items. It comes in two forms, client and therapist. This study used the client and therapist short form version of the WAI based on the study by Tracey and Kokotovich (1989).

The WAI-S is a brief questionnaire that contains three subscales, bond (e.g., "I feel comfortable with_____"), task (e.g., "We agree on what is important for me to work on"), and goal (e.g., "We have established a good understanding of the kind of changes that would be good for me). It takes between 5-10 minutes to complete. Items are rated on a 7-point scale, ranging from 1 (*never*) to 7 (*always*). Two changes were made to the original wording of the WAI-S for this study. *Therapist* was replaced with the term f*acilitator* and *therapy* was replaced with *group sessions*.

The internal consistency estimate of the total score for the client form was .98 and .95 for the therapist form (Tracey & Kokotovic, 1989). In a later study examining the reliability generalization of all the WAI versions and forms, results for the short version indicated a mean of .95 for the client form and .93 for the therapist form (Hanson, Curry, & Bandalos, 2002).

Procedure

Consent was granted by the Massey University Human Ethics Committee. Consent was also sought and granted by the Board of Trustees of the community agency where the research was located.

Data was collected from the 3rd of June 2008 to the 17th of December 2008. Initial meetings with potential participants occurred following their initial interview and agreement to engage in the programme. When possible all men were assigned to their preferred group. One group runs on Monday night, two on Tuesday night, two on Wednesday night and one during Thursday morning. The seventh group is held out of town and was not part of this study. The Monday night group was made unavailable to participants due to the researcher facilitating this group. Participants were spread over four different groups.

All potential participants were fully informed about the research and requirements as a participant both verbally and through a written information sheet (see Appendix B). After completing the consent form (see appendix B) most participants (n = 19) went on to complete the measures immediately. The other three participants completed the measures with the researcher at a later time. For all participants this involved reading or being read a questionnaire and answering the questions by indicating an answer from a scale or set of possible answers. Participants completed the demographic, URICA, AUDIT, ABI and BIDR questionnaires. After participants had completed these measures they were reminded the researcher would meet with them again after they had completed their fourth group session. All participants agreed this meeting would take place immediately following completion of their fourth session.

Following their fourth session participants completed the ABI and WAI-S for both facilitators. The timeframe for the ABI was altered to the time it had taken for each participant to complete four sessions. Group facilitators also completed the therapist version of the WAI-S. Although all participants had initially agreed to complete the measures immediately after the session, one meeting was conducted the following day due to the fact that the researcher was required in two different places on the same night.

The same procedure was undertaken for the next meeting with participants following completion of their 12th session. The timeframe for the ABI was altered to the time taken between completing session four to the completion of session 12. Again, group facilitators completed the therapist version of the WAI-S. A discussion was also had regarding the time and place of the final meeting.

At the conclusion of the programme (18th session) participants were met at a time and place most convenient for them. Two meetings took place at participant's homes with their partners present. All other interviews occurred immediately following the session at the venue the group had been held in. Participants completed the ABI, URICA, and AUDIT. The timeframe of the AUDIT was altered to represent the time it had taken to complete the whole programme e.g., five months.

Following the completion of the questionnaires, the researcher asked the participant a number of questions about the programme (see Appendix A). This was an opportunity for the participants to discuss and comment on the programme.

Questionnaires were mailed to those participants who did not complete the programme (n=13) along with a pre-paid return envelope. A follow up phone call or text message was also made to remind participants to return the questionnaires. Two completed sets of questionnaires were returned.

CHAPTER SIX

Results

The data was analysed using SPSS 16.0 (SPSS Inc, 2007) and was first examined for accuracy of data entry, missing values and normality. One AUDIT questionnaire contained missing data. Item 2 was not answered as the participant reported that he had stopped drinking and did not want to answer this question. Missing data from this questionnaire was replaced with a 0 as this did not alter the total score of the scale.

Missing data from the BIDR questionnaire was confined to two questions. “The reason I vote is because my vote can make a difference” (2 missing) and “I always declare everything at customs” (3 missing). It was decided not to replace any missing data.

As shown in Table 2 a large amount of data was missing from the facilitators WAI-S. Due to the fact that during the study one female facilitator went on leave and one male facilitator resigned, there were five instances where the researcher did not deem it appropriate for the WAI-S facilitator form to be completed. There was also a further large amount of unanswered items on the facilitator WAI-S, an issue that will be discussed in the next chapter. It was decided not to replace any of this data.

Table 2

WAI-S Facilitator missing data

	n=Total facilitator questionnaires	n= WAI-S facilitator questionnaires distributed to facilitators	n= actual completed WAI-S facilitator questionnaires
Male facilitators 4th session	17	16	14
Male facilitators 12th session	13	11	11
Female facilitators 4th session	17	16	9
Female facilitators 12th session	13	12	9

As shown in Table 3 the distribution was found to be normal and no problematic outliers were found. The 0 standard deviation skew and kurtosis results reported for the ABI physical subscale measured at time 4 (programme competition) are the result of all participants reporting nil physical violence.

Table 3 *Assessment of Normality*

Scale	*N*	*M*	*SD*	Skew	Kurtosis	Min-max
AUDIT:1	22	15.04	9.37	-.13	-1.36	0-29
AUDIT:4	7	9.4	7.02	.28	1.59	1-20
ABI Total scale:1	22	47.90	8.16	.66	-.47	37-64
ABI Total scale:2	17	38.58	6.99	.90	.36	29-54
ABI Total scale:3	13	35.84	4.09	.02	.10	29-44
ABI Total scale:4	7	32.28	2.69	.29	-1.81	29-36
ABI Total Psych:1	22	30.63	6.15	.54	-.32	21-44
ABI Total Psych:2	17	25.82	6.29	.90	.31	17-39
ABI Total Psych:3	13	23.23	3.83	.24	.14	17-31
ABI Total Psych:4	7	20.28	1.01	.29	-1.8	17-24
ABI Total Physical:1	22	17.27	3.26	.61	-.02	12-24
ABI Total Physical:2	17	12.76	1.39	1.73	1.85	12-16
ABI Total Physical:3	13	12.61	.96	1.6	2.0	12-15
ABI Total Physical:4	7	12.00	0	0	0	12
URICA Pre contemplation	22	15.86	5.09	.18	-.69	8-26
URICA Contemplation	22	35.59	3.80	-1.01	1.26	25-40
URICA Action	22	33.90	3.74	-.89	2.40	23-40
URICA Maintenance	22	30.86	4.85	-.48	.47	19-40
BDR Total	22	9.81	4.69	.97	.97	3-22
BIDR SD	22	5.04	2.83	.38	-1.07	0-13
BIDR IM	22	4.77	2.99	.94	1.73	0-10
WAI-S Client male Total:2	17	67.88	11.02	-.11	-.89	48-84
WAI-S Client male Total:3	13	68.76	11.48	-.74	1.34	42-84
WAI-S Client female Total:2	17	65.82	10.29	.039	-.36	46-84
WAI-S Client female Total:3	13	66.30	7.69	.46	.73	55-83
WAI-S Facilitator male Total:2	14	55.07	7.44	-.58	-.11	39-65
WAI-S Facilitator male Total:3	11	56.63	6.37	-2.40	6.78	39-62
WAI-S Facilitator female Total:2	9	53.66	10.19	.73	.88	40-74
WAI-S Facilitator female Total:3	9	64.77	7.29	-2.22	5.07	47-70

1= pre-treatment 2=after the 4th session 3= after the 12th session 4=programme completion

Scale Reliability

In the current study the Cronbach alpha coefficient for the URICA total scale score was .82, slightly higher than that found by other researchers (Dozois et al., 2004; McConnaughy et al., 1989). The reliabilities for the four subscales were also found to be higher than those reported elsewhere with a Precontemplation Cronbach Coefficient alpha of .85, Contemplation of .83, Action of .86 and Maintenance of .80 (Dozois et al., 2004; McConnaughy et al., 1989).

According to the review carried out by Reinert and Allen (2007) the AUDIT had good internal consistency and a reported reliability coefficient range of .75 to .97. The Cronbach alpha coefficient for this study was within this range at .85.

Past research had also reported good reliability for the ABI (Shephard & Campbell, 1992; Zink et al., 2007) findings which were replicated by this study. A Cronbach alpha coefficient of .88 was found for the total scale with the psychological subscale reported at .84 and the physical subscale at .79.

Total scale scores for the WAI-S client version were .81 (reporting on female facilitators) and .92 (reporting on male facilitators). For the WAI-S facilitator version completed by female facilitators the coefficient was .89 and for the male facilitators .88.

Total scale reliability for the BIDR was .62, .57 for the SD and .62 for the IM. These results are slightly lower than coefficients reported elsewhere (Li & Bagger, 2007). The finding of a higher reliability estimate for the IM scale compared with the SD scale is consistent with previous research (Li & Bagger, 2007; Paulhus, 1991)

Table 4

Correlations between the pre-treatment measures and their subscales (N=22)

Scale	1	2	3	4	5	6	7	8	9	10	11
1 BIDR		.79**	.82**	-.12	-.49*	-.44*	-.38	.06	-.39	-.14	.18
2 SD			.30	.20	-.34	-.25	-.38	-.06	-.37	-.20	.12
3 IM				-.38	-.44*	-.46*	-.24	.14	-.26	-.03	.18
4 AUDIT					.50*	.48*	.36	-.05	-.05	-.10	.03
5 ABI						.93**	.74**	.00	.35	.08	.13
6 Psych							.45*	-.03	.32	.06	.13
7 Phys								.07	.28	.10	.19
8 Precon									-.53*	-.43*	.05
9 Con										.86**	.51*
10 Action											.63**
11 Maint											

*p<0.05 (2 tailed) **p<0.01 (2 tailed)
BIDR=Balanced Inventory of Desirable Responding, SD=BIDR Self Deception subscale, IM=BIDR Impression Management subscale, AUDIT=Alcohol Use Disorders Identification Test, ABI=Abusive Behaviour Inventory, Psych=ABI Psychological abuse subscale, Psys=ABI Physical abuse subscale, Precon=URICA Precontemplation subscale, Con=URICA Contemplation subscale, Action=URICA Action subscale, Maint=URICA Maintenance subscale

The relationships between the pre-treatment measures used in the study were investigated by calculating Pearson product-moment correlation coefficients. The WAI-S was not included as it was only measured from the fourth session onwards. As shown in Table 4 significant correlations were found between the BIDR total scale and both its subscales. Previous research has found correlations between the IM and SD scales to range from .04 to .40 (Paulhus, 1991). Consistent with those results a coefficient of .30 was found in this study. The ABI total scale was significantly correlated with its two subscales. Consistent with previous research the contemplation, action and maintenance subscales were all significantly correlated with each other and the precontemplation subscale was negatively correlated with contemplation and action (Amodei & Lamb, 2004; Dozois et al., 2004). However, according to these results, precontemplation was not negatively correlated with maintenance.

Socially desirable responding

Participants completed the Balanced Inventory of Desirable Responding (BIDR) as one of the pre-treatment measures. Paulhus (1991) reported results from studies carried out with religious groups and college students showing mean scores for males of 7.5-7.6 for the self deception (SD) scale and 4.3-7.3 for the impression management (IM) scale. Previous research with IPV perpetrators reported IM mean scores of 4.19 for participants who did not complete treatment and 4.70 for those who did complete treatment (Bowen & Gilchrist, 2006). SD mean scores for participants who did not complete treatment were 5.72 and 4.71 for those who did (Bowen & Gilchrist, 2006). The results from this study are similar to those reported by Bowen and Gilchrist (2006) and are below or equal to results found within other

populations (Paulhus, 1991). In this study a mean score of 5.0 was found for the SD. This was slightly lower than the mean scores published by Paulhus (1991) and indicates participants in this research did not give positively biased answers. A mean score of 4.7 was found for the IM indicating that participants did not tend to intentionally misrepresent themselves in order to be seen favourably.

Hypothesis 1: Participants who complete the IPV perpetrator programme will show reductions in self reported violence towards intimate partners. Those that completed the programme took on average 21 weeks to complete, with the quickest completing in 18 weeks and the longest in 26 weeks. Two participants were still completing the programme when the time frame for data collection was finished. One was not court ordered and at the last session of the year had taken 19 weeks to complete 16 sessions. The other participant was court ordered and at the last session of the year had taken 22 weeks to complete 15 sessions. Figure 3 shows the mean scores for the ABI for all participants.

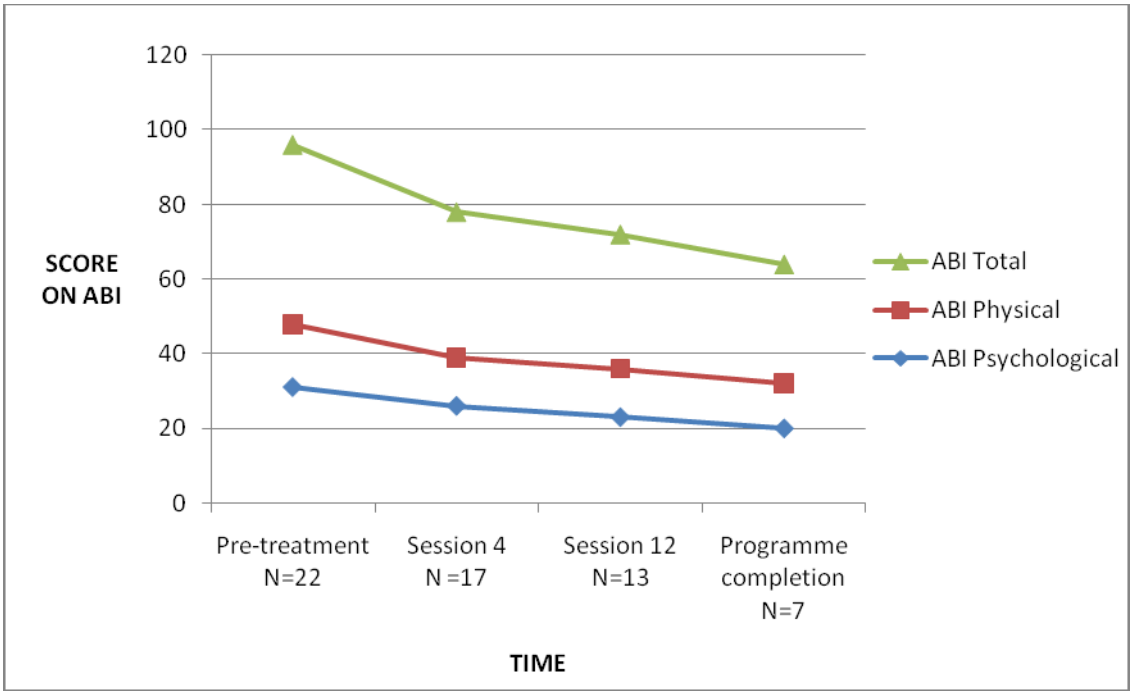

Figure 3. ABI total and subscale scores measured over time.

A one way repeated measures ANOVA was carried out to compare scores on the ABI measured at Time 1(pre-treatment), at Time 2 (following the fourth session), at Time 3 (following the 12th session) and at Time 4 (programme completion) for those participants that completed the programme. The means and standard deviations are presented in Table 5. There was no significant change in scores on the ABI over the four time periods measured, Wilks Lambda=.31, $F(3,4)=2.89$, $p=.16$.

Table 5

ABI scores for programme completers

	N	*M*	*SD*
Time 1	7	46.71	10.82
Time 2	7	39.57	9.50
Time 3	7	35.42	4.85
Time 4	7	32.28	2.69

It is possible that due to the small sample size the non significant result from the one way repeated measures ANOVA occurred due to type II error (Levy & Steelman, 1996). As shown in Table 6 pre-treatment scores were paired with time 2, 3 and with programme completion scores. Paired-sample t-tests were carried out in order to further clarify whether any significant differences in mean scores existed. Significant differences were found in all pairings. The eta squared statistics indicated large effect sizes for all the paired samples with .53 for pre-treatment and time 2, .72 for pre-treatment and time 3 and .66 for pre-treatment and programme completion (Pallant, 2001).

Table 6

Paired sample t-test results for the ABI

	M	*N*	*SD*	*(df)t*	*p*
ABI pre-treatment	47.64	17	8.60	(16)	.00
ABI time 2	38.58	17	6.99	4.31	
ABI pre-treatment	47.23	13	8.38	(12)	.00
ABI time 3	35.84	13	4.09	5.66	
ABI pre-treatment	46.71	7	10.82	(6)	.01
ABI programme completion	32.28	7	2.69	3.43	

Hypothesis 1a: Participants who self report pre-treatment levels of "hazardous" drinking as defined by the AUDIT will self report higher levels of violence towards intimate partners than those who self reported non hazardous levels of pre-treatment drinking. According to the AUDIT developers total scores of 8 or more indicate hazardous and harmful alcohol use, as well as possible alcohol dependence (Babor et al., 2001). Those with hazardous drinking as defined by the AUDIT were overrepresented in the sample. As seen in Table 7, 16 out of 22 (73%) participants self reported hazardous alcohol use.

Table 7.

Distribution of AUDIT scores measured at pre-treatment

Assessment AUDIT Score	*N*	%	*M*	*SD*
Below 8	6	27	2.83	1.60
8 -20	9	41	14.88	3.75
21-30	7	32	25.71	2.21
31-40	0	0	0	0

Examination of the AUDIT questions 2 and 3 indicated 77% of participants scored 1 or more on either of these questions further indicating alcohol consumption at a hazardous level (Babor et al., 2001). It was also found that 59% of participants scored above 0 on questions 4, 5, or 6, an indication of alcohol dependence (Babor et al., 2001).

An independent samples t-test was carried out to discover if those classified as engaging in hazardous drinking prior to commencing the programme self reported higher levels of violence towards intimate partners than those defined as engaging in non hazardous pre-treatment drinking. There was a significant difference in ABI scores for hazardous drinkers (M=49.62, SD=8.95) and non hazardous drinkers (M=43.33, SD=2.25; t(20)=2.60, p=.02. The eta squared statistic .25 indicated a large effect size (Pallant, 2001).

Hypothesis 1b: Participants who complete the programme will show significant reduction in the level of alcohol abuse as measured by the AUDIT. A paired-samples t-test was conducted to evaluate the impact of the programme on the self reported scores on the AUDIT for the seven participants who completed the programme. There was a significant decrease in AUDIT scores from pre-treatment (*M*=17.85, *SD*=9.99) to completion of the programme (*M*=9.00, *SD*=6.32), *t*(6)=2.56, *p=.04.* The eta squared statistic .52 indicated a large effect size (Pallant, 2001).

Hypothesis 2: Drop out rates from the programme will be higher for those who are not court ordered to attend. Of the 22 participants 8 were court ordered to attend and 14 were not court ordered. Court ordered participants attended on average 16.88 (*SD*=2.2) sessions while those not court ordered attended on average 8.36 (*SD*= 6.3) sessions. More court ordered participants (N=6) completed the programme than those not court (N=1) ordered to attend. A chi-square test of independence showed that the difference between drop out rates of court ordered and not court ordered was significant, $X^2(1, N = 22) = 11.28$, *p*=.00.

Hypothesis 3: Participants who complete the programme or attend most of the sessions (13-18) will have (a): Higher Readiness to change scores as measured by the URICA compared to those participants who attend fewer sessions. Participants were grouped by the number of sessions they had completed. Low was defined as completing 0-4 sessions, medium was defined as completing 5-12 sessions and high was defined as completing 13-18 sessions. A one way between groups ANOVA was conducted to investigate the association between readiness to change as measured by the URICA and sessions completed. There was no significant difference found on the readiness to change score between

participants in these three groups [$F(2,19)=.33$, $p=.72$]. In fact, as can be seen in Figure 4 the group who attended the least number of sessions reported the highest levels of readiness to change.

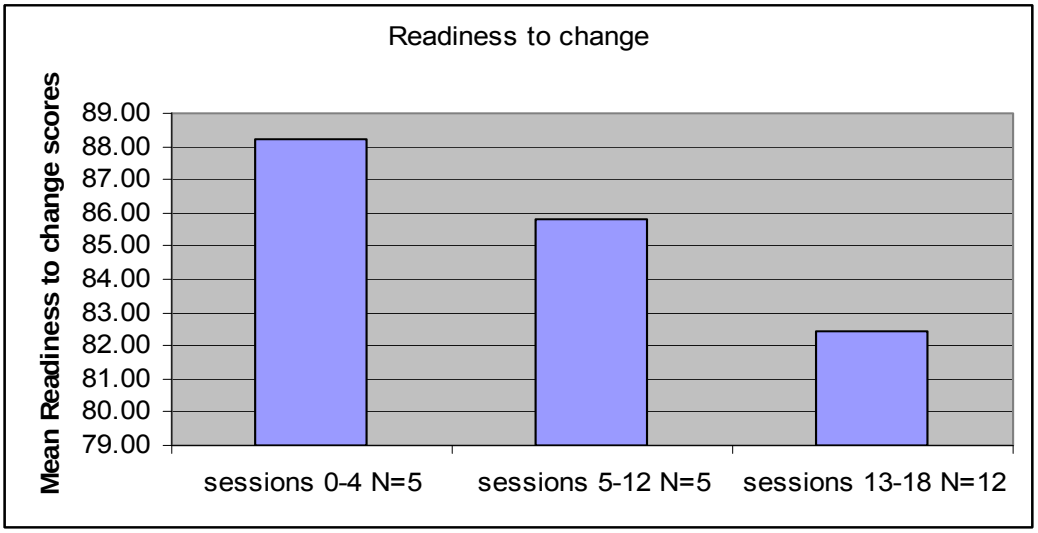

Figure 4. Comparison of readiness to change by session attendance groups.

Hypothesis 3b: Participants who complete the programme or attend most of the sessions (13-18) will have higher self reported levels of working alliance than those participants who attend fewer sessions and 3c: Higher levels of facilitator working alliance as reported by the facilitators of the programme than those participants who attend fewer sessions. Working alliance was first measured following session 4. Therefore only two groups, medium (5-12 sessions) and high session (13-18 sessions) attendance could be tested. As shown in Table 8 higher levels of working alliance were reported by participants in the high session attendance group and by facilitators towards participants in the high session attendance group. However, the difference was not significant.

Table 8.

WAI-S scores for medium and high attendance groups

	Group	*N*	*M*	*SD*	*(df)t*	*p*
WAI-S Client	Medium session attendance	5	64.20	14.08	(15) -.67	.51
	High session attendance	12	67.95	8.93		
WAI-S Facilitator	Medium session attendance	6	51.75	3.48	(12) -1.3	.22
	High session attendance	8	56.06	8.46		

Hypothesis 3d: Participants who complete the programme or attend most of the sessions (13-18) will have lower levels of pre treatment alcohol abuse than those who attend fewer sessions. A one way between groups analysis of variance was conducted to explore the impact of pre-treatment alcohol intake as measured by the AUDIT on programme attendance using the three session attendance groups of low 0-4, med 5-12, and high 13-18. The low session attendance group had a mean AUDIT score of 15.6 (*SD*=11.4), the medium group 13.6 (*SD*=3.04) and the high group 15.4 (*SD*=10.75). Results showed no significant difference $F(2,19)=.07$, $p=.93$, however results of the levene test of homogeneity of variances showed this assumption had been violated. Due to the small sample size and the violation found by the levene test futher analysis was performed using the non parametric alternative, the Kruskal-Wallis test. The results of this analysis were also not significant $H(2, N = 22) = .20$, $p = .90$.

Hypothesis 4: Court ordered participants will (a) Self report higher levels of pre treatment violence towards intimate partners than those not court ordered to attend. An independent t-test did not find that court ordered participants reported higher levels of pre treatment violence towards intimate partners than non court ordered participants. There was no significant difference between court ordered (*M*=46.87, *SD*=10.32) and not court ordered (*M*=48.50, *SD*=7.01) participants on levels of pre-treatment violence towards intimate partners, *t*(20)=-.44, *p*=.66.

Hypothesis 4b: Court ordered participants will report lower readiness to changes scores prior to treatment than those not court ordered to attend. As predicted court ordered participants were found to self report lower levels of readiness to change as measured by the URICA than those participants not court ordered to attend. An independent samples t-test revealed a mean score of 74.12 (*SD*= 12.75) for court ordered participants while not court ordered participants mean score was 90.42 (*SD*=9.86). This difference was significant at *t*(20)=-3.35, *p*=.00 with the eta squared statistic .33 indicating this was a large effect size (Pallant, 2001).

Hypothesis 4c: Court ordered participants will report lower levels of working alliance than those not court ordered to attend and 4d: Facilitators will report lower levels of working alliance for those participants court ordered to attend compared to those not court ordered to attend. Both scores from the participants WAI-S (working alliance for male and female facilitators) were added and then averaged to give one total client score. When complete data sets were available for both male and female facilitator's scores they were also added and averaged. If only one facilitator score was available then that score was used to give the total facilitator score. As Table 9 shows court ordered participants reported lower levels of

working alliance although this difference was not significant. Facilitators reported higher levels of working alliance for court ordered participants although again this difference was not significant.

Table 9.

WAI-S score for court and not court ordered participants

		N	*M*	*SD*	*(df) t*	*p*
WAI-S client	Court ordered	8	63.56	10.62	(15) -1.27	.22
	Not court ordered	8	70.25	10.36		
WAI-S facilitator	Court ordered	7	57.57	7.89	(11) 1.76	.11
	Not court ordered	6	51.75	3.48		

Hypothesis 4e: More court ordered participants will self report hazardous drinking levels as defined by the AUDIT than those not court ordered to attend.

An independent samples t-test was conducted to compare the AUDIT scores for court and not court ordered participants. Court ordered participants did report higher levels of hazardous drinking (*M*=17.75, *SD*=8.41) then not court ordered participants (*M*=13.50, *SD*=9.84) however this difference was not significant *t*(20)=1.02, *p*=.32.

Hypothesis 5: Levels of working alliance measured in the early phase of treatment will not significantly increase when measured later during the programme. As seen in Table 10, for participant's there was no significant increase or decrease in the level of working alliance from session 4 to 12. However, for facilitators there was a significant increase in WAI-S scores from session 4 *M*=54.45, *SD*=8.21) to session 12 (*M*=60.20, *SD*=7.00), *t*(9)=-2.42, *p=.03.* The eta squared statistic .39 indicated a large effect size (Pallant, 2001).

Table 10

Working alliance paired sample statistics

	M	*N*	*SD*	(df) *t*	*p*
Client WAI-S male session 4	67.15	13	11.05	(12)	
Client WAI-S male session 12	68.76	13	11.48	-.38	.71
Client WAI-S female session 4	67.00	13	10.56	(12)	
Client WAI-S female session 12	66.30	13	7.69	.24	.82
Facilitator WAI-S session 4	54.45	10	8.21	(9)	.03
Facilitator WAI-S session 12	60.20	10	7.00	-2.42	

Participant Feedback

Participants who completed the programme were asked to provide feedback on their experience of the programme. Overwhelmingly, the aspect of the programme that participants found most beneficial was the support of the other participants, with many making comments such as, “You’re with other guys who don’t pre-judge and you hear your story from them*”.* Participants also talked about being on common ground with the other group members and the value they placed on hearing others stories. They also found other group members were helpful in alleviating feelings of apprehension and nervousness when they first began attending. One participant commenting that,

> ”At the start I was nervous about opening up about yourself. This changed because of the guys being open and it became easier to relate to others. I became more relaxed and could relate to the group. We are all different but the same”.

Participants reported a number of specific interventions and exercises that they had found particularly helpful. These were, learning about Time Out, Control Logs, and identifying

warning signs. Two participants commented on the videos with one saying they were "truthful". When asked about what parts of the programme participants found the least helpful, all said they had found it all helpful. One person found brainstorming on the whiteboard difficult saying, "it becomes hard to take it all in" and another felt he was not always heard saying, "I got frustrated when I and other men were unable to discuss partner's violence".

All participants said they felt the programme had helped them, with most feeling like they had new tools to help them deal with situations differently. A number of men also talked about knowing themselves better,

> "knowing how to identify things before they happen, the body stuff; knowing your limits and triggers and knowing that anger and violence is not acceptable".

CHAPTER SEVEN

Discussion

This chapter will begin by firstly discussing the results of each hypothesis and then providing an overall discussion. This will be followed by the limitations of the study, conclusions and recommendations.

Hypothesis 1:Participants who complete the IPV perpetrator programme will show reductions in self reported violence towards intimate partners.

There was support found for the hypothesis that participants who completed the IPV perpetrator programme would show reductions in their self reported violence towards intimate partners. Analysis carried out with the seven participants who completed treatment revealed that the reductions in self reported violence were not significant. Further tests which included all available participants' scores, revealed significant reductions in violence between pre-treatment and session 4, pre-treatment and session 12 and pre-treatment and treatment completion (18 weeks). This result indicates that reductions in violence can occur after only four sessions of the programme. The difference in reduction of incidents in self reported violence measured at session 12 and at treatment completion was quite small. This would suggest that keeping participants in treatment for at least 12 sessions can help them reduce violence towards partners, almost as much as those who complete the whole programme. While these results are based on self reported incidents of violence by the IPV perpetrators themselves, results from the BIDR did not indicate that participants were providing positively biased answers or interested in being seen favourably by the researcher. Furthermore, incidents of self reported violence in this study were similar to those reported in another study using the ABI (Bowen &

Gilchrist, 2006). Other evaluations carried out with New Zealand IPV perpetrator programmes have also found participants reported reductions in violent behaviour (Dominick, 1995; McMaster et al., 2000; Ratima et al., 1995). However in this study, the sample size of participants who completed treatment was very small and as such the results should be viewed with caution. Furthermore, as no follow-up was conducted it is impossible to know if the reductions in violent behaviour were maintained.

Hypothesis 1a: Participants who self report pre treatment levels of "hazardous" drinking as defined by the AUDIT will self report higher levels of violence towards intimate partners than those who self reported non hazardous levels of pre-treatment drinking.

Participants with hazardous drinking levels were overrepresented in the sample with 73% indicating levels of hazardous drinking. An examination of the levels of self reported violence towards partners showed that as predicted, participants who were identified as hazardous drinkers self reported significantly higher levels of violence towards their partners than non hazardous drinkers. Further analysis revealed a large effect size. Past research has found that levels of alcohol consumption prior to acts of violence impact on the severity of the perpetrated violence (Murphy et al., 2005; Testa et al., 2003). In fact, Murphy et al. (2005) found that the topic that started the majority of conflicts was the husbands drinking. Although this study did not examine whether alcohol was consumed before or during particular incidents of violence, the results support a more general conclusion that perpetrators who drink more tend to be more violent.

Hypothesis 1b: Participants who complete the programme will show significant reduction in the level of alcohol abuse as measured by the AUDIT.

Results indicated that participants who completed treatment significantly reduced their levels of alcohol consumption, with mean scores reducing by nearly half. It seems that although alcohol abuse is not specifically addressed in the programme there appears to be a flow on effect into substance abuse. It is possible that some participants identified that alcohol could be connected to, or be a trigger for, violent behaviour and have adjusted their consumption accordingly.

Previous research has also found reductions in both violence and substance abuse following treatment for only one of these problems. McMaster et al. (2000) found that IPV perpetrators engaged in treatment programmes reported less problem drinking behaviour than prior to attending the programme. Similarly, O'Farrell et al.(2004) found significant reductions in IPV for participants who completed behaviour couples treatment for alcoholism. They suggested that participating in the treatment programme influenced relationship functioning which in turn, had a positive impact on both problems.

Hypothesis 2: Drop out rates from the programme will be higher for those who are not court ordered to attend.

According to these results, drop out rates were significantly higher for those participants not court ordered to attend the programme. These findings are consistent with previous research indicating that when participants are mandated or monitored by an authority, they are more likely to complete treatment programmes (Daly et al., 2001; DeHart, Kennerly, Burke, & Follingstad, 1999; Jones & Gondolf,

2002). Court ordered treatment can therefore be viewed as a useful external motivator (Hamberger & Hastings, 1986) and possibly a vital element of effective treatment for IPV perpetrators. The high rate of attrition of non court ordered participants would suggest the programmes may only be useful for a few participants who are highly motivated (Dobash et al., 1999). The one non court ordered participant who completed the programme had previously had a positive experience attending substance abuse counselling. He had been successfully abstaining from substances for some time and it is possible that his own experience of committing to make a change and living with the benefits of that change was a contributing factor in his motivation and continued attendance in the programme.

Hypothesis 3: Participants who complete the programme or attend most of the sessions (13-18) will have (a): Higher Readiness to change scores as measured by the URICA compared with those participants who attend fewer sessions.

The results found in this study did not indicate any significant differences between the low (0-4), medium (5-12), and high (13-18), session attendance groups. In fact those participants with the highest levels of readiness to change attended the least number of sessions (0-4 sessions). While the differences were small these results are contrary to other studies that have found that the stages of change model successfully predicted treatment completion (Derisley & Reynolds, 2000; Scott, 2004). It is possible that the lack of movement through the stages occurred due to a mismatch between the level of readiness to change and the processes of change (DiClemente, 2003). DiClemente (2003) suggests that during the early stages of the change process individuals are in a period of instability, and that if change is going to occur, the reasons for change need to be important enough for the individual to

decide to make the effort to change. Further evaluation of the treatment programme curriculum would be useful in order to ascertain how well the programme interventions are aimed at provoking and tipping the decisional balance towards change.

An alternative explanation for this finding is that without adequate attendance at group sessions participants do not develop the feeling of being a group member and a useful process of change is lost. Silvergleid and Mankowski (2006) suggest that IPV perpetrators treated in group programmes use the group dynamics as one of the main processes of change. In their study participants talked with enthusiasm about the other men in the group and how they had played a major part in their own process of change. Similarly, in interviews conducted with participants who completed the programme in this study they also talked about the benefits from the group especially in terms of helping alleviate their anxiety about attending.

Hypothesis 3b: Participants who complete the programme or attend most of the sessions (13-18) will have higher self reported levels of working alliance than those participants who attend fewer sessions and Hypothesis 3c: Higher levels of facilitator working alliance as reported by the facilitators of the programme than participants who attend fewer sessions.

Results indicated that those participants who completed a medium number of sessions (5-12) did report lower levels of working alliance than those who completed a high number of sessions (13-18) although the difference was not significant. Facilitators also indicated higher levels of working alliance for those participants who completed more sessions although again this difference was not significant. While research has often found a significant relationship between working alliance and

attendance in therapy, these results are similar to studies undertaken with IPV perpetrators that have not found a significant association between self reported working alliance and the completion of more sessions (Brown & O'Leary, 2000; Taft et al., 2003). Brown and O'leary (2000) suggested that the reason no significant association was found in their study was not connected to lack of working alliance, and that participants who dropped out had other reasons for not completing treatment. It was not possible to compare the mean working alliance scores from that study with those reported in this study as different measures were used. Inspection of the mean scores of this study did not reveal particularly low indications of working alliance, so it is plausible that participants dropped out for other reasons. The researcher did discuss reasons for dropping out with two participants. One participant reported dropping out due to work commitments. A second participant said he had dropped out because during the programme he had missed some sessions and as the programme revolves continuously, that meant towards the end of the programme he had started to repeat previously completed sessions. Most participants in this study who dropped out were not available for follow up and so it is not possible to make a statement such as that by Brown and Leary (2000). Taft et al.(2003) suggested in their study the lack of a significant relationship between the two factors was likely to be due to the high number of court ordered participants (88%) and the lack of variability in attendance. This was not a problem in this study as more participants were not court ordered and the opportunity for variability was present. The present study did however have a small sample and it is possible that with more participants a significant difference may have been found. Furthermore working alliance was not measured until after the fourth session missing out on two participants who had already dropped out.

Hypothesis 3d: Participants who complete the programme or attend most of the sessions (13-18) will have lower levels of pre treatment alcohol abuse than those who attend fewer sessions.

Surprisingly the results of this study found no significant difference between the mean scores of the three session attendance groups. Past research has found that participants who were classified as having high levels of alcohol problems completed significantly fewer sessions (Daly et al., 2001; Rooney & Hanson, 2001). It is possible this finding was not replicated in this study because the majority of participants (73%) were classified as hazardous alcohol users.

Hypothesis 4: Court-ordered participants will (a) Self report higher levels of pre treatment violence towards intimate partners compared with non court ordered participants.

Group means showed that the group not court-ordered self reported more violence than the court ordered group, however this difference was not statistically significant. Bowen and Gilchrist (2004) suggest that not court-ordered perpetrators are also more likely to underreport violence than court ordered perpetrators. They believe this is due to not court-ordered perpetrators not having an 'offender' label and having more to lose in terms of their identity. Although the BIDR did not indicate high levels of social desirability from the participants it is possible that in reality, not court ordered perpetrators are significantly more violent than court ordered perpetrators. Regardless of the statistical significance this finding is somewhat alarming given that not court ordered participants were also found to attend fewer sessions and drop out of treatment in greater numbers than court ordered participants. The finding is also in

line with previous research that has found that treatment drop outs exhibit the highest rates of violence (Rooney & Hanson, 2001).

Hypothesis 4b: Court ordered participants will report lower readiness to change scores prior to treatment than those not court ordered to attend.

Results supported this prediction with significantly higher readiness to change scores found for not court ordered participants. The difference found between readiness to change scores was the largest difference in measures found between court and not court ordered perpetrators. The eta squared statistic indicated a large effect size. These results are consistent with the literature on motivation to change. It is possible that the high levels of readiness to change reported by the not court ordered participants, are actually the by product of panic or concern to save their relationships. Once the issue has subsided there is little reason to continue in the programme (Bowen & Gilchrist, 2004).

Hypothesis 4c: Court ordered participants will report lower levels of working alliance than those not court ordered to attend and Hypothesis 4d: Facilitators will report lower levels of working alliance for those participants court ordered to attend compared to those not court ordered to attend.

Support was found for the hypothesis that court ordered participants would report lower levels of working alliance when compared to those participants not court ordered. The difference was however not statistically significant. Similarly, it was expected that facilitators would also report lower levels of working alliance in regards to court ordered participants when compared to not court ordered participants. Facilitators however reported higher levels of working alliance for court ordered men.

These results are not surprising when viewed in conjunction with the other results from facilitators regarding working alliance. Facilitator's reports of working alliance were higher for those participants who completed more sessions and those participants who completed more sessions were court ordered. Furthermore in the results of hypothesis 5 facilitators reported a significant increase in levels of working alliance when measured at session 4 and then again at session 12. The levels of working alliance were therefore higher for court ordered participants who made up the majority of participants still in the programme in the later sessions. The results suggest that unlike participants, working alliance for facilitators improves with increased contact. In the researchers experience facilitators may have indicated higher levels of working alliance with court ordered participants because often court ordered participants are more real about their situation. As earlier discussed not court ordered perpetrators are often interested in preserving their personal identity which as yet does not involve a criminal conviction (Bowen & Gilchrist, 2004). This can lead to them presenting at treatment with vague issues, minimised violence and also a determination to differentiate themselves from court ordered participants.

Hypothesis 4e: More court ordered participants will self report hazardous drinking levels as defined by the AUDIT than those not court ordered to attend.

There was no significant difference found between the two groups although the court ordered participants mean AUDIT score was higher than that of the not court ordered participants. Again the lack of difference between the groups could be due to the fact that 73% of participants were hazardous drinkers.

Hypothesis 5: Levels of working alliance measured in the early phase of treatment will not significantly increase when measured later during the programme.

It had been predicted that levels of working alliance measured following the fourth session would not show a significant increase when measured again after the twelfth session. Results for participants supported this prediction and confirm the importance of establishing a working alliance early in treatment. For facilitators however working alliance scores were significantly higher when measured later in the programme. One explanation for this finding could be that within a group situation it might take longer for facilitators to get a sense of participants. Another explanation could be related to the measure used to assess working alliance. A large amount of data was missing from the WAI-S therapist version. Horvath (1994) suggests that the WAI-S therapist version is simply a reworded version of the WAI-S for clients and as such is based on two assumptions. Firstly, what constitutes a "positive environment" is the same for both the therapist and the client and (p. 266), secondly, that the therapist can judge the clients "inner experience" (p. 266). The therapist version asks therapists to report on what they think the client thinks and was identified by facilitators as a problem during this study. It was, as one facilitator commented, extremely difficult to complete the measure when participants had not engaged in the group process yet. It was also brought to the researcher's attention that facilitators found it difficult to answer questions that related to goal setting. While the goals of the programme were explicit, 'stopping violence', facilitators did not discuss personal goals or carry out goal setting with participants. They assumed this had been done during the initial interview. However, goal setting was not observed by the researcher during any of the initial interviews of participants for this study.

Overall Discussion

Although this study was carried out with a small sample and the results should be treated with caution, the findings support previous findings from the research literature on IPV perpetrator programmes. It would appear that while significant reductions in violence can be made by those who complete all or part of the programme, the more violent perpetrators dropped out of treatment. Even though the difference between self reported violence by court and not court ordered participants was not significant it suggests that particular attention needs to be paid to not court ordered perpetrators in order to retain them in treatment. Given that they report higher levels of readiness to change and working alliance than court ordered participants, it is likely that some aspect of the programme is not meeting their needs. Furthermore, the finding that only small gains were found between those who completed 12 sessions and those who completed 18 sessions indicates that it may be worth trialling a shorter programme specifically for those participants not court ordered to treatment. A shorter programme could possibly seem more attainable, and when made up of only not court ordered participants, it would take away the need to differentiate themselves from court ordered participants and could possibly lead to greater group cohesion. Furthermore, separating court and not court ordered participants could have benefits for court ordered participants as group cohesion can be reduced by the high rates of attrition by not court ordered perpetrators (Bowen & Gilchrist, 2004). The other possibility is that retention of not court ordered perpetrators may be enhanced by simple motivating techniques such as phone calls after absences or hand written notes as used in the study by (Taft et al., 2001).

The finding that alcohol abusing perpetrators tend to perpetrate the most violent abuse towards their intimate partners provides further support for the introduction of programmes that cater better to perpetrators with the dual problems of alcohol and violence (Carter, 2003). The extent of their substance abuse problems will however never be recognised without a comprehensive assessment and a willingness to acknowledge the impact alcohol can have on violence towards intimate partners. Results showing that the level of alcohol abuse significantly declined for those who completed the programme are encouraging. Given that these reductions were made without targeted intervention it raises the question of how much reduction in alcohol abuse could be made when a small amount of education, discussion, and intervention is introduced to a programme curriculum.

The lack of firm support for the association between working alliance and treatment completion should not deter further investigation. Future research could benefit from earlier measurement of the alliance and possibly the use of an alternative working alliance measure better suited to group treatment.

Limitations of the study

This study relied almost exclusively on self reported information. As previously noted, self reports can be subject to dishonest reporting by perpetrators wanting to make themselves look better (Helfritz et al., 2006; Murray & Graybeal, 2007). Furthermore, often participants were asked to recall behaviours over an extended period of time, sometimes six months. It has been suggested that unless the behaviours in question are rare and significantly important, respondents will rely on an estimation strategy when reporting frequency (Schwarz, 1999). Future research should include corroborating reports from either police or participants partners.

Another limitation in the study was the small sample of participants. Adding to that, 59% of participants dropped out of the programme and most were then not prepared to engage in the research. Although the use of treatment dropouts as a control group is problematic, without the participation of these participants useful comparisons could not be completed. Furthermore, the results of this study are based only on pre and post measures with no follow-up. Future research should include follow-up with participants in order to see how long reductions in violence were maintained.

Although the measures used in this study were selected based on their widespread use and good reliability and validity, a number of problems were encountered. Problems with the WAI-S facilitator version have already been discussed. Issues were also found with two items on the BIDR that asked about customs and voting. A number of participants were unable to answer these items as they had not travelled overseas, and had not voted. Furthermore, on numerous occasions clarification and definitions were sought and given during completion of the BIDR.

Conclusions

Despite the limitations of the study, results of this research have revealed several important findings. Results indicate that completion of all or part of the IPV treatment programme was associated with reductions in violence towards intimate partners. The high drop out rate of not court ordered perpetrators is of particular concern given they reported the highest incidents of violence. Also concerning is the finding that alcohol abuse is linked to more incidents of violence. These findings support the claim that in order to increase the effectiveness and retention levels of perpetrator programmes, it is necessary to stop treating IPV perpetrators as if they are all the same.

Recommendations

- In order to understand the needs of each programme participant it is recommended that a comprehensive assessment process is introduced. This would include an assessment of the participant's typical alcohol consumption levels. It is also recommended that the agency develops good links with specialist substance abuse agencies in order to facilitate a referral process.
- In order to further enhance the working alliance, it is recommended that some form of goal development and goal setting be carried out with participants. This would be a good way to acknowledge and bring some individuality of participants into the group and also may help motivation levels.
- To increase the impact of the programme on the reduction of alcohol abuse it is recommended that the programme incorporates some alcohol education component into the curriculum.
- To address the high drop out rates of not court ordered participants, it is recommended that the agency investigate and adopt retention enhancing techniques and follow up with participants when sessions are missed. It is also recommended that the agency investigates the possibility of trialling a shorter, possibly closed group for self referred participants.
- To monitor and assess the effectiveness of the programme on an ongoing basis, it is recommended that the agency introduce outcome measures as part of the initial assessment and programme completion. The measure could also be sent to partners so that a fuller and possibly more accurate picture of the violent behaviour and any reductions can be gathered.

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Appendix A

Demographic Questionnaire

Balanced Inventory of Desirable Responding (BIDR)

Abusive Behaviour Inventory (ABI)

Alcohol Use Disorders Identification Test (AUDIT)

Standard drink information sheet

University of Rhode Island Change Assessment (URICA)

Working Alliance Inventory Short Client version

Working Alliance Inventory Short facilitator version

Interview schedule

Name:_____**Date of Birth**:_____

Which ethnic group do you belong to?

Please mark the space of the group you identify most strongly with.

☐ New Zealand European

☐ Maori

Please select the option that best describes how you have come to be at Tauranga Living Without Violence

☐ Self referred to this programme

☐ Advised by a Lawyer

☐ Ordered to attend by _____

☐ Other, please explain_____

Do you currently have a protection order against you? ☐ Yes ☐ No

Are you still with the partner you had relationship difficulties with and which resulted in you being here?

☐ Yes ☐ No Are you living together? ☐ Yes ☐ No

If you are no longer in that relationship, are you in a new relationship? ☐ Yes ☐ No

Are you living together? ☐ Yes No ☐

Thank you for your cooperation

PDS (BIDR Version 7)

	not true		neither		very true
My first impressions of people usually turn out to be right	1	2	3	4	5
It would be hard for me to break any of my bad habits	1	2	3	4	5
I don't care to know what other people really think of me	1	2	3	4	5
I have not always been honest with myself	1	2	3	4	5
I always know why I like things	1	2	3	4	5
When my emotions are aroused, it biases my thinking	1	2	3	4	5
Once I've made up my mind, other people cannot change my opinion	1	2	3	4	5
I am not a safe driver when I exceed the speed limit	1	2	3	4	5
I am fully in control of my own fate	1	2	3	4	5
It's hard for me to shut off a disturbing thought	1	2	3	4	5
I never regret my decisions	1	2	3	4	5
I sometimes lose out on things because I can't make up my mind soon enough	1	2	3	4	5
The reason I vote is because my vote makes a difference	1	2	3	4	5
People don't seem to notice me and my abilities	1	2	3	4	5
I am a completely rational person	1	2	3	4	5
I rarely appreciate criticism	1	2	3	4	5
I am very confident of my judgements	1	2	3	4	5
I have sometimes doubted my ability as a lover	1	2	3	4	5
It's alright with me if some people happen to dislike me	1	2	3	4	5
I'm just an average person	1	2	3	4	5

	not true		neither		very true
I sometimes tell lies if I have to	1	2	3	4	5
I never cover up my mistakes	1	2	3	4	5
There have been occasions when I have taken advantage of someone	1	2	3	4	5
I never swear	1	2	3	4	5
I sometimes try to get even rather than forgive and forget	1	2	3	4	5
I always obey laws, even if I'm unlikely to get caught	1	2	3	4	5
I have said something bad about a friend behind his or her back	1	2	3	4	5
When I hear people talking privately, I avoid listening	1	2	3	4	5
I have received too much change from a salesperson without telling him or her	1	2	3	4	5
I always declare everything at customs	1	2	3	4	5
When I was young, I sometimes stole things	1	2	3	4	5
I have never dropped litter in the street	1	2	3	4	5
I sometimes drive faster than the speed limit	1	2	3	4	5
I never read sexy books or magazines	1	2	3	4	5
I have done things that I don't tell other people about	1	2	3	4	5
I never take things that don't belong to me	1	2	3	4	5
I have taken sick-leave from work or school even though I wasn't really sick	1	2	3	4	5
I have never damaged a library book or store merchandise without reporting it	1	2	3	4	5
I have some pretty awful habits	1	2	3	4	5
I don't gossip about other people's business	1	2	3	4	5

ABI

Here is a list of behaviours that many women report have been used by their partners or former partners. I would like you to estimate how often you have used these behaviours during the past six months.
CIRCLE a number for each of the items listed below to show your closest estimate of **how often** it happened in your relationship with your partner or former partner during the past **six months**.

1 = Never 2 = Rarely 3 = Occasionally 4 = Frequently 5 = Very frequently

1. Called her names and/or criticized her	1	2	3	4	5
2. Tried to keep her from doing something she wanted to do (example: going out with friends, going to meetings)	1	2	3	4	5
3. Gave her angry stares or looks	1	2	3	4	5
4. Prevented her from having money for her own use	1	2	3	4	5
5. Ended a discussion with her and made the decision yourself	1	2	3	4	5
6. Threatened to hit or throw something at her	1	2	3	4	5
7. Pushed, grabbed, or shoved her	1	2	3	4	5
8. Put down her family and friends	1	2	3	4	5
9. Accused her of paying too much attention to someone or something else	1	2	3	4	5
10. Put her on an allowance	1	2	3	4	5
11. Used her children to threaten her (example: told her that she would lose custody, said you would leave town with the children)	1	2	3	4	5
12. Became very upset with her because dinner, housework, or laundry was not ready when you wanted it or done the way you thought it should be	1	2	3	4	5

1= never 2 = Rarely 3 = Occasionally 4 = Frequently 5 = Very frequently					
13. Said things to scare her (examples: told her something "bad" would happen, threatened to commit suicide)	1	2	3	4	5
14. Slapped, hit, or punched her	1	2	3	4	5
15. Made her do something humiliating or degrading (example: begging for forgiveness, having to ask your permission to use the car or do something)	1	2	3	4	5
16. Checked up on her (examples: listened to her phone calls, checked the mileage on her car, called her repeatedly at work)	1	2	3	4	5
17. Drove recklessly when she was in the car	1	2	3	4	5
18. Pressured her to have sex in a way that she didn't like or want	1	2	3	4	5
19. Refused to do housework or childcare	1	2	3	4	5
20. Threatened her with a knife, gun, or other weapon	1	2	3	4	5
21. Told her that she was a bad parent	1	2	3	4	5
22. Stopped her or tried to stop her from going to work or school	1	2	3	4	5
23. Threw, hit, kicked, or smashed something	1	2	3	4	5
24. Kicked her	1	2	3	4	5
25. Physically forced her to have sex	1	2	3	4	5
26. Threw her around	1	2	3	4	5
27. Physically attacked the sexual parts of her body	1	2	3	4	5
28. Choked or strangled her	1	2	3	4	5
29. Used a knife, gun, or other weapon against her	1	2	3	4	5

Please place an X in one box that best describes your answer to each question						
	0	**1**	**2**	**3**	**4**	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many standard drinks containing alcohol do you have on a typical day when you are drinking?	1-2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down	No		Yes, but not in the last year		Yes, during the last year	
					Total	

The following questionnaire asks questions about your alcohol use.

This questionnaire is confidential. In order to answer this questionnaire accurately, specifically questions 2 and 3, it is important that you understand what a **standard drink** is.

All bottles of wine, beer and spirits and cans or casks have a standard drinks label on them. Standard drinks measures the amount of alcohol, not the amount of liquid you are drinking.

1 standard drink = 10g of alcohol

Here are some examples of common drinks to help you work out how many standard drinks there are in what you are drinking.

drink	Amount/percentage	Number of standard drinks
Wine	3 litre cask	30
	750ml bottle at 14%	8.3
	750ml bottle of sparkling wine at 12% (Lindauer)	7.1
Beer	330ml can or bottle at 4% (Lion Red, Tui, Export Gold, Waikato, Speight's)	1.0
	750ml bottle at 5% (Steinlager)	2.9
	650ml bottle at 5% (Heineken)	2.6
	440ml can at 4% (Bruer)	1.5
RTD'S	275ml bottle at 5% (Breezer, Cruiser)	1.1
	250ml can at 5% (Codys)	1
	375ml can at 9% (Bulleit Bourbon)	2.7
Spirits	700ml bottle at 40%	22
	1000ml bottle at 47%	37
	1125ml bottle at 45%	40

URICA

Each statement describes how a person might feel when first starting to attend a group at _____

Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you feel **right now**, not what you have felt in the past or would like to feel.

For all the statements that refer to your **"problem**", answer in terms of the problem that bought you here- **Partner abuse**. And **"here"** refers to **_____.**

There are FIVE possible responses to each of the items in the questionnaire:

Strongly disagree, disagree, undecided, agree, and strongly agree.

Circle the number that best describes how much you agree or disagree with each statement.

Questions	Strongly disagree	Disagree	Undecided	Agree	Strongly Agree
1. As far as I'm concerned, I don't have any problems that need changing.	1	2	3	4	5
2. I think I might be ready for some self-improvement.	1	2	3	4	5
3. I am doing something about the problems that had been bothering me.	1	2	3	4	5
4. It might be worthwhile to work on my problem	1	2	3	4	5
5. I'm not the problem one. It doesn't make much sense for me to be here.	1	2	3	4	5
6. It worries me that I might slip back on a problem I have already changed, so I am here to seek help.	1	2	3	4	5
7. I am finally doing some work on my problem.	1	2	3	4	5

	Strongly disagree	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**
8. I've been thinking that I might want to change something about myself.	1	2	3	4	5
9. I have been successful in working on my problem, but I'm not sure I can keep up the effort on my own.	1	2	3	4	5
10. At times my problem is difficult, but I'm working on it.	1	2	3	4	5
11. Being here is pretty much of a waste of time for me because the problem doesn't have to do with me.	1	2	3	4	5
12. I'm hoping this place will help me to better understand myself.	1	2	3	4	5
13. I guess I have faults, but there's nothing that I really need to change.	1	2	3	4	5
14. I am really working hard to change.	1	2	3	4	5
15. I have a problem and I really think I should work on it.	1	2	3	4	5
16. I'm not following through with what I had already changed as well as I had hoped, and I'm here to prevent a relapse of the problem.	1	2	3	4	5
17. Even though I'm not always successful in changing, I am at least working on my problem.	1	2	3	4	5
18. I thought once I had resolved the problem I would be free of it, but sometimes I still find myself struggling with it.	1	2	3	4	5
19. I wish I had more ideas on how to solve my problem.	1	2	3	4	5
20. I have started working on my problems but I would like help.	1	2	3	4	5

	Strongly disagree	Disagree	Undecided	Agree	Strongly Agree
21. Maybe this place will be able to help me.	1	2	3	4	5
22. I may need a boost right now to help me maintain the changes I've already made.	1	2	3	4	5
23. I may be part of the problem, but I don't really think I am.	1	2	3	4	5
24. I hope that someone here will have some good advice for me.	1	2	3	4	5
25. Anyone can talk about changing; I'm actually doing something about it.	1	2	3	4	5
26. All this talk about psychology is boring. Why can't people just forget about their problems?	1	2	3	4	5
27. I'm here to prevent myself from having a relapse of my problem.	1	2	3	4	5
28. It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved.	1	2	3	4	5
29. I have worries but so does the next guy. Why spend time thinking about them?	1	2	3	4	5
30. I am actively working on my problem.	1	2	3	4	5
31. I would rather cope with my faults then try to change them.	1	2	3	4	5
32. After all I had done to try and change my problem, every now and again it comes back to haunt me.	1	2	3	4	5

Working Alliance Inventory
Short Form (C)

Instructions

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her facilitator.
As you read the sentences mentally insert the name of your facilitator in place of _____in the text.
Below each statement inside there is a seven point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you always feel (or think) circle the number 7; if it never applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

This questionnaire is CONFIDENTIAL; neither your facilitator nor the agency will see your answers.

Try not to spend too much time on each question; your first impressions are the ones we would like to see

Thank you for your cooperation.

1. _____ and I agree about the things I will need to do in the group sessions to help improve my situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

2. What I am doing in the group sessions gives me new ways of looking at my problem.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

3. I believe _____ likes me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

4. _____ does not understand what I am trying to accomplish in the group sessions.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

5. I am confident in _____ 's ability to help me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

6. _____ and I are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

7. I feel that _____ appreciates me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

8. We agree on what is important for me to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

9. _____ and I trust one another.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

10. _____ and I have different ideas on what my problems are.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

11. We have established a good understanding of the kind of changes that would be good for me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

12. I believe the way we are working with my problem is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

Working Alliance Inventory
Short Form (T)

Instructions

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her clients.
As you read the sentences mentally insert the name of your client in place of _____in the text.
Below each statement inside there is a seven point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you always feel (or think) circle the number 7; if it never applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

This questionnaire is CONFIDENTIAL; neither your client nor the agency will see your answers.

Try not to spend too much time on each question; your first impressions are the ones we would like to see

Thank you for your cooperation.

1. _____ and I agree about the steps to be taken to improve his situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

2. My client and I both feel confident about the usefulness of our current activity in group sessions.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

3. I believe _____ likes me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

4. I have doubts about what we are trying to accomplish in group sessions.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

5. I am confident in my ability to help_____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

6. We are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

7. I appreciate _____ as a person.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

8. We agree on what is important for _____ to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

9. _____ and I have built a mutual trust.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

10. _____ and I have different ideas on what his real problems are.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

11. We have established a good understanding between us of the kind of changes that would be good for _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

12. _____ believes the way we are working with his problem is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

Interview Questions

Did your attitude to attending this programme change over the course of the programme? In what way?

Do you feel like the programme has helped you? Why/why not

Can you tell me what parts/sessions of the programme you found most helpful?

Can you tell me what parts/sessions of the programme you found the least helpful?

Are there any issues or topics that we didn't cover that you think we should have?

Would you like to make any comments or give feedback on anything else to do with the programme?

Appendix B

Facilitator Information sheet

Facilitator consent form

Facilitator consent form

Participant Information sheet

Participant consent form

Evaluation of a community based programme for male perpetrators of intimate partner violence.

You are invited to participate in a study!

INFORMATION SHEET FOR FACILITATORS

The purpose of this study is to evaluate the _____ men's programme. The results will be used to provide information about the programme and recommendations to improve it, and to contribute to the research on family violence in NZ. My name is Sally Hetherington and this research will form my Masters thesis. I am a Masters student at Massey University as well as a part time employee of _____.

Participating in this project

Men's group research participants

I hope to recruit 26 participants to this study. All men contacting _____ making arrangements to start attending will be invited to participate in this study provided they meet the following criteria;

- Have problems with partner abuse
- Are currently in a relationship.
- Are Maori or Pakeha/NZ European

_____ Facilitator participants

I hope to recruit facilitators as participants to this study based on the following criteria;

- They are facilitators in a Men's group
- They facilitate groups in _____ and _____
- They do not co-facilitate with the researcher

If you meet this facilitator participant criteria and are interested in participating in this research, the following description is an outline of what you can expect as a participant.

We will talk about the research, and I will answer any questions you have. Once you have decided to participate in this study you will be asked to fill in a consent form. I would like to report your ethnicity, highest qualification and length of time facilitating at _____. This information is usually reported in research reports although answering these questions is optional. I have provided space on the consent form for this information to be written. It will be used to provide a description of the facilitators as a group and will not be matched with any results of the study or used in any way to evaluate performance. At this time you will also be allocated a code. This code will then be used on all future documentation you fill in. Your name will not appear on any other forms and at no time will the information you provide on those questionnaires be shared with anyone from _____.

I will be meeting with men's group research participants five times during the research. During those meetings those participants will be completing questionnaires. One of those questionnaires asks about the working alliance between group participants and facilitators. I would like facilitators to complete this questionnaire (either verbally or in writing) three separate times for each research participant in their group. The questionnaire should take no more than 5 minutes to complete. As the men's group research participants will be starting the groups at different times, I will provide you with these questionnaires in person at the appropriate times.

While I am a part time employee of _____ this study is not being carried out for _____. None of the information you give me will be shared with the men's group research participants, other facilitators, coordinators or Trustees at_____. The answers you provide to the questionnaires will remain confidential.

All the documents you fill in will be kept securely at my home. Your consent form will be the only document with your name on it and these will be kept securely for 5 years and then shredded. I will provide you with a written summary of the results when the study is finished.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to decline to answer any particular question;

- withdraw from the study at any time.
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.

Support Processes

If filling out the questionnaire has raised some issues for you, I am available to discuss this with you. I would also encourage you to discuss this in supervision. Please remember the use of this questionnaire is not for the purposes of evaluating your performance.

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application _08/032 . If you have any concerns about the conduct of this research, please contact Dr Denise Wilson, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x9070, email humanethicsnorth@massey.ac.nz.

If you have any questions please don't hesitate to ask. I can be contacted regarding this research by leaving a message at _____. My supervisor at Massey University is Mei Wah Williams and she can be contacted on 09 4140800 xtn41222.

Thank you

Sally Hetherington

Evaluation of a community based programme for male perpetrators of intimate partner violence.

FACILITATOR PARTICIPANT CONSENT FORM

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: ..... **Date:** .....

Full Name - printed .....

Highest qualification gained_____

Length of time facilitating men's groups at _____ for:_____years _____months

Ethnicity_____

Evaluation of a community based programme for male perpetrators of intimate partner violence.

You are invited to participate in a study!

INFORMATION SHEET

The purpose of this study is to evaluate the _____ men's programme. The results will be used to improve the programme and contribute to the research on family violence in NZ. My name is Sally Hetherington and this research will form my Masters thesis. I am a Masters student at Massey University as well as a part time employee of _____.

Participating in this project

I hope to recruit 26 participants to this study. All men contacting _____ making arrangements to start attending will be invited to participate in this study provided they meet the following criteria;

- Have problems with partner abuse
- Are currently in a relationship.
- Are Maori or Pakeha/NZ European

If you meet this criteria and are interested in participating in this research the following description is an outline of what you can expect as a participant.

- We will talk about the research, and I will answer any questions you have. Once you have decided to participate you will fill in a consent form. At that time you will be allocated a code. This code will then be used on all future documentation you fill in. Your name will not appear on any other forms and at no time will the information you provide on those questionnaires be shared with anyone from _____

- You will then be asked to complete a number of questionnaires. Every time you complete any questionnaires you have the choice of doing so either verbally or in writing. The questionnaires ask about you, how you came to_____, your alcohol use, relationship abuse, and your motivation for attending the programme. I anticipate our first meeting to take approximately 30 minutes.

- Our second meeting will be after you have completed your 4th session. At this meeting you will be asked to complete more questionnaires. One of these asks for your thoughts about the working alliance you have formed with your group facilitators. It is important you know that your group facilitators will also be asked to fill in a similar form regarding their perception of the working alliance they have developed with you. Remember, the information you provide on those questionnaires will not be shared with anyone from_____. I anticipate this meeting will take approximately 10 minutes.

- Our third meeting will be after you have completed your 12th session. Once again you will be asked to complete questionnaires. I anticipate this will take approximately 10 minutes.

- Our fourth meeting will be after you have completed your 18th and final session. I will ask you again to fill out questionnaires and I would also like to talk with you about how you found the programme. It is an opportunity for you to provide feedback and suggestions. I anticipate this will take approximately 20 minutes.

- We will meet again 1 month after you have finished the programme. This is to fill in questionnaires and I anticipate this will take no more than 15 minutes.

Part of the study looks at attendance and drop out rates of participants in the programme. This means that with your permission I would keep note of your attendance at the programme. This would involve me looking at the attendance roll.

While I am a part time employee of _____this study is not being carried out for _____. None of the information you give me will be shared with any facilitators or coordinators at _____. The answers you provide to the questionnaires will remain confidential.

All the documents you fill in will be kept securely at my home. Your consent form will be the only document with your name on it and these will be kept securely for 5 years and then shredded.

I will be providing a summary of the results when the study is finished. If you would like to receive a copy of this summary then please indicate this and provide contact details on the consent form.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any time.
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.

Support Processes

If filling out the questionnaires has raised some issues for you in regard to partner violence I encourage you to use the groups to discuss these issues. The purpose of the groups is to

provide a forum in which to talk, listen and work through things in a confidential and non judgmental manner.

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 08/032 . If you have any concerns about the conduct of this research, please contact Dr Denise Wilson, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x9070, email humanethicsnorth@massey.ac.nz.

If you have any questions please don't hesitate to ask. I can be contacted regarding this research by leaving a message at _____. My supervisor at Massey University is Mei Wah Williams and she can be contacted on 09 4140800 xtn41222.

Thank you

Sally Hetherington

Evaluation of a community based program for male perpetrators of intimate partner violence.

PARTICIPANT CONSENT FORM

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to participate in this study under the conditions set out in the Information Sheet.

I agree to allow information regarding my attendance to be viewed and recorded by the researcher for the purposes of this study.

Signature: ..... **Date:** .....

Full Name - printed .....

Please send me a summary of the study results. **Yes** ☐ **No** ☐

Postal or email address_____