

ABSTRACT

Title: RETENTION OF COUPLES IN TREATMENT OF DOMESTIC VIOLENCE

Mary Sarah Kursch, M.S., 2005

Directed By: Assistant Professor, Jaslean LaTaillade,
Department of Family Studies

The treatment of choice for intimate partner violence (IPV) has been gender specific psychoeducational groups for offenders, but these groups have high drop out rates (Babcock & La Taillade, 2000). An alternative therapy available for the treatment of IPV is couple therapy. The current study explored variables predictive of couple retention in a treatment outcome study designed to prevent IPV. Sixty-nine couples seeking therapy for mild-to-moderate levels of physical and psychological abuse in their relationship were included. Couples received one of two treatment protocols to address IPV, as part of the Couples Abuse Prevention Program (CAPP): (1) treatment as usual; and (2) cognitive behavioral therapy. Specific pre-treatment variables examined included relationship satisfaction, communication patterns, psychological and physical aggression, pre-treatment levels of psychopathology, and client and therapist perceptions of the efficacy of treatment. Findings regarding variables discriminating between treatment completers and non-completers, and clinical implications for treatment of IPV were discussed.

RETENTION OF COUPLES IN TREATMENT OF INIMATE PARTNER
VIOLENCE.

By

Mary Sarah Kursch

Thesis submitted to the Faculty of the Graduate School of the
University of Maryland, College Park, in partial fulfillment
of the requirements for the degree of
Masters of Science
2005

Advisory Committee:

Assistant Professor Jaslean LaTaillade, Ph.D., Chair

Professor Norman Epstein, Ph.D.

Instructor Carol Werlinich, Ph.D.

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Dedication

I would like to dedicate this work to the MFT graduates of 2005.

The meeting of two personalities
is like the contact of two chemical substances:
if there is any reaction, both are transformed.

Carl Jung (1875-1961)

Acknowledgements

I would like to thank the following people for all they have done for this work:

God – “Maybe it’s intuition, but some things you just don’t question. Like in your eyes, I see my future in an instant. And there it goes, I think I’ve found my best friend. I know that it might sound more than a little crazy, but I believe. I knew I loved you before I met you. I (thought) I dreamed you into life. I knew I loved you before I met you. I have been waiting all my life. There’s just no rhyme or reason, only this sense of completion. And in your eyes I see the missing pieces I’m searching for. I think I’ve found my way home. A thousand angels dance around you. I am complete now that I’ve found you.” -Savage Garden

My Family – Thank you for being my constant in a world of chaos, my passion when I had none, my support when I could no longer stand, and my freedom when I was in chains. “Have I told you lately?”

Justin – Thank you for teaching me to “Be mild with the mild, shrewd with the crafty, confident to the honest, rough to the ruffian, and a thunderbolt to the liar. But in all this, never be unmindful of your own dignity.” –David Paul Jones I love you.

The MFT Graduates of 2005 – “When the character of a man is not known to you, look at his friends” – Japanese proverb. I would be proud to have others search for clues to my character in you.

The MFT Graduates of 2004 and 2006 – “My definition of an expert in any field is a person who knows enough about what’s going on to be scared.”- J. P. Plauger Thank you for sharing, normalizing, and facing your fears along with me.

Jaslean LaTaillade – Thank you for teaching me so much about the person that I want to be and for your presence on this journey.

Norm Epstein – Thank you for being such a beautiful combination of success and humility. Your strength in both areas is an inspiration to me. I hope to emulate you in pursuit of excellence and generous humility.

Carol Werlinich – “Only passions, great passions, can elevate the soul to great things. –Denis Diderot Thank you for teaching me to look toward the pursuit of my passions. You are one of those special life changing people that taught me to dream and for that I will always be grateful.

Sister Mary Paschal, Sam, Casey, Monica, Missy, and Sean – “A faithful friend is a sturdy shelter; he who finds one finds a treasure. A faithful friend is beyond price, no sum can balance his worth. A faithful friend is a life saving remedy such as he who fears God finds for he who fears God behaves accordingly and his friend will be like himself.” – Scripture Thank you for being so loving and so inspirational in my life. I love you.

Brian – You are a formatting genius, thank you for saving my life!

Lindsey and Ales – What can I say, you have been my companions on every step of this journey and I can’t imagine having taken a single step with anyone else. I’m so glad that we spent this time together. I love you.

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Chapter 1: Introduction

STATEMENT OF THE PROBLEM

In the field of marriage and family therapy, there is little consensus about the appropriate treatment protocol for individuals and couples who are engaged in intimate partner violence (IPV). At present the treatment of choice is gender specific psychoeducational groups for offenders, but this modality may not provide the most effective results for couples engaged in the cycle of intimate partner violence. These gender specific treatments (GST) are offered only to abusers in a group therapy format and are largely ineffective in promoting lasting change among participants (Babcock & La Taillade, 2000). Research on GST groups has shown that such approaches are limited in their effectiveness in reducing violence; in fact, a high percentage of men who participate in such programs drop out and/or re-offend after treatment (Babcock & La Taillade, 2000). Because persons who use violence against their partners tend to be heterogenous as a group in terms of their frequency and severity of violence utilized, presence of psychopathology, use of violence outside the relationship, and marital satisfaction and stability (Jacobson & Gottman, 1998; Stuart & Holtzworth-Munroe, 1995), GST approaches are not likely to be universally effective. In fact, there is increasing consensus in the field of violence intervention and prevention that all offenders do not need the same treatment approach (Stith, Rosen, McCollum, & Thomsen, 2004).

While GST is designed to encourage male batterers who engage in severe IPV to take personal responsibility for their violent acts, several researchers have identified another subgroup of couples who report low-levels of violence, tend to be

in stable relationships, and never (or rarely) escalate to the point of severe violence characteristic of battering (Jacobson & Gottman, 1998). For such couples, a conjoint approach that addresses systemic as well as individual cognitive and behavioral risk factors for IPV may be the most appropriate and effective treatment. Since relationship distress and conflict are strong predictors of IPV, failure to address these issues within the context of the couple relationship may increase the risk for violence. In addition, unlike battering relationships, the female partners in couples reporting low levels of violence are not fearful of participating in conjoint treatment and wish to remain in their relationships. Such couples who are willing to participate and remain in couple therapy for IPV may have higher levels of investment for changing problematic patterns in their relationships than those couples who choose not to participate in couple treatment, and as a result, may demonstrate lower drop out rates than those in GST.

PURPOSE

With the introduction of couple based treatment for IPV in recent years, the issue of which treatment modality is most appropriate, GST or couple based treatment, has become increasingly complicated. This issue is further complicated by the fact that the current standard treatment, GST, is riddled with problems including low client retention rates and failure to address relational issues with the partners of the offenders. Couple therapy for IPV was developed as an alternative to GST in attempt to remedy some of the difficulties inherent in GST approaches. Until recently, it was considered too dangerous for couples with a history of violence to be treated together. However, it has increasingly become more acceptable to treat

couples with low levels of violence in conjoint treatment. Because retention of clients is of such concern in the treatment of IPV, the current study is intended to determine those specific characteristics of individuals, couples, and the treatment process that impact retention of couples in therapy for IPV. Most of the research about retention rates in therapy has focused on the retention of individuals in GST. However, few studies exist which examine retention of couples in conjoint treatment of IPV. The purpose of the current study is to determine what factors influence the retention rates of psychologically and physically violent couples in conjoint therapy. The influence of individual psychopathology, the couples' level of functioning (including relationship satisfaction, communication, and commitment to the relationship), severity of abuse, demographic variables, clients' and therapists' perceptions of the utility of treatment, and treatment condition will be examined to determine the level of influence that each variable has on couple therapy retention rates.

LITERATURE REVIEW

Treating Intimate Partner Violence: Gender-Specific and Conjoint Approaches

Intimate partner violence (IPV) is considered a serious social and public health problem, with often devastating medical and psychological consequences for partners and family members, including physical injuries, clinical disorders, as well as child abuse and behavior problems. Although the treatment approach most often employed to address IPV involves gender specific treatment (GST; i.e., separate men's and women's groups), research on these approaches has shown that such

treatment modalities are limited in their effectiveness in reducing violence. More specifically, such approaches are characterized by high rates of drop out (one-third to one-half of all participants) during the course of treatment (Babcock & LaTaillade, 2000).

Despite these limitations, GST is most often the treatment of choice for severe and violent offenders, as well as those mandated to treatment by the courts; less violent offenders often are not required to receive any treatment. Furthermore, because GST is specifically designed for batterers, it has not been adapted for use with less violent offenders or those couples who engage in low-level violence. Such approaches may not be appropriate for a subgroup of couples that engage in low-level psychological and physical abuse and comprise over half the population of couples seeking marital therapy (Brown, O'Leary, and Feldbau, 1997). Given that there exists a population of males who do not engage in battering, are likely to be in stable relationships, and demonstrate lower levels of IPV, alternate treatment approaches warrant consideration. Conjoint approaches that address systemic issues pertaining to the couple, their family and their surrounding community, as well as individual cognitive and behavioral risk factors for IPV may be the most appropriate and effective treatment for these couples.

There is considerable debate, however, about whether conjoint treatment for heterosexual couples who report IPV is safe, particularly for women who are likely to be the more vulnerable member of the relationship. Feminist therapists and advocates posit that couple therapy, which emphasizes mutual responsibility for relationship problems, may place women in a particularly vulnerable position because of the

power imbalance already present in such relationships (Babcock & La Taillade, 2000). However, GST approaches often remain the treatment of choice for IPV (Stith, Rosen, & McCollum, 2003). The rationale for such groups is that they are less likely to endanger female partners of abusive males, because no relationship-specific issues are explored during the course of treatment and escalation patterns that the couple employs during conflict are avoided.

These group treatments, according to some studies (Harris, Savage, Jones, & Brooke, 1998; Brannen, & Rubin, 1996; & O'Leary, Heyman, & Neidig, 1999) appear to have similar treatment success to couple-based treatment for intimate partner violence. However, other research has found that couples' treatment is much more effective in decreasing aggression and attitudes about the acceptability of violence against female partners (Stith, Rosen, McCollum, & Thomsen, 2004). In fact, there is some evidence to suggest that GST groups for violent men have negative consequences for some men as in these groups they find other men who share similar beliefs about the appropriateness of violence in intimate relationships. This may lead men to continue being violent rather than finding new ways to interact with their partners (Stith, Rosen, McCollum, & Thomsen, 2004).

In such groups, the participants are often very heterogeneous with regard to relationship functioning, presence of psychopathology, and frequency and severity of violence (Stuart & Holtzworth-Munroe, 1995); as such, males in these groups share few similarities with each other except their involvement in IPV. The nature of these groups makes treatment modification for each individual and the unique dynamics of each violent relationship nearly impossible. Not surprisingly, Brown, O'Leary, and

Feldbau (1997) found that the most frequently cited reason for drop out in such groups was “that the group format did not enable them to address their individual couple issues” (p. 365). In addition, the group setting may make it particularly difficult to foster therapist-client alliances that would be effective in promoting the necessary change. Additionally, group therapy is often offered to individuals who have been court-ordered for therapy; mandated clients typically have little investment in the therapeutic process or in improving their relationships. As such, participants may be less inclined to remain in treatment.

Unfortunately, there is very limited research available comparing the effectiveness of conjoint treatment to other treatment modalities available for IPV in reducing or eliminating violence. Conjoint treatment appears to be a viable and pragmatic treatment approach because of the therapist’s ability to examine and alter specific relational behavior patterns that may lead to violence. Such a model would provide greater freedom to focus on the relational patterns and topics that precipitate escalation to violent behavior in these relationships.

Couple therapy presupposes that violence is the result of the way in which a couple interacts with each other. Couple therapy acknowledges the role that violence plays in the relationship as a means for obtaining and maintaining power (Babcock & La Taillade, 2000). In this view, violence is seen as an important aspect of the way that the couple functions as a unit and as such must be explored and replaced with more effective conflict resolution strategies (Shoham, Rohrbaugh, Stickle, & Jacob, 1998). In some cases, the violence that occurs in relationships is of such a low-level of severity that it neither causes injury to, nor instills fear in, the more vulnerable

partner. In such cases, involving both partners in treatment is ultimately beneficial as the patterns that lead to physical aggression may be identified in the therapeutic process (Bograd & Mederos, 1999). Thus, couple treatment for IPV provides a relational focus that psychoeducational GST groups cannot.

The objections of those concerned about a systemic approach to IPV are based in a desire to ensure that victims, most often women, are not blamed for the violent acts committed against them. However, this systemic view does not seek to blame the woman for the violence, but merely to identify the patterns utilized by the couple prior to violent escalation and the larger community norms in which the couple functions which may endorse violence. In this view, women do not cause violence, but do play a role in the patterns the couple utilizes prior to escalating to violence. In addition, in couple based treatment, each partner is held responsible for his or her own violent acts. In treating these patterns, the hope of systemic therapists is to stop the pattern that leads to violence before it can occur.

Often in domestically violent couples, *both* partners use physical violence (Stith, Rosen, & McCollum, 2003). Thus, while often the major concern of professionals working with physically violent heterosexual couples is a fear of male to female aggression, the majority of such couples seeking treatment report bi-directional violence (Stith, Rosen, & McCollum, 2003). Because of this, it is apparent that conjoint treatment, which addresses the violence of *both* partners, may be more effective than the treatment of only one individual. By identifying each partner's role in the escalation patterns that lead to violence and encouraging personal

accountability for each person's behavior, the aggressive behavior can be short-circuited (Bograd & Mederos, 1999).

Couple therapy allows for greater interaction with the therapist, in turn fostering alliance, which is predictive of continuance in therapy (Raytek, McCrady, Epstein, & Hirschch, 1999). In addition, couples who are willing to participate and remain in couple therapy for intimate partner violence may have higher levels of investment in changing problematic patterns in their relationships than those couples who choose not to participate in treatment or who participate in treatment modalities less specifically focused on their individual and relational concerns.

INDIVIDUAL AND RELATIONAL FACTORS RELATED TO RETENTION IN TREATMENT OF IPV

Depressive and Trauma Symptomology

Nelson (1999) stated that among clients who attended a university based counseling center, "Cluster analyses of clients by presenting problem and psychological severity level indicated that those clients with the greatest psychological distress were least satisfied with counseling services" (p.1925). This finding again points to the need to match treatment to the individual needs of the clients and the way in which client levels of psychopathology influence continuance in therapy. It is important to match treatment to the needs and psychological concerns of both the victims and the perpetrators of violence. An area of concern is possible psychopathology experienced by victims of violence, specifically posttraumatic stress disorder and depression, which may occur at a higher rate than in

the general population as a result of violence. Eighty-one percent of women who experience violence meet criteria for a diagnosis of posttraumatic stress disorder (PTSD) as identified by the Mississippi Scale for PTSD and the PTSD Self-Report Scale (Kemp, Green, Hovanitz, & Rawlings, 1995). Schlee, Heyman, and O'Leary (1998) indicate that for battered women in couple based treatment for IPV, a diagnosis of PTSD is not associated with drop out from treatment, but such a diagnosis can raise special concerns for the individual and the couple throughout the course of treatment. For example, women who are diagnosed with PTSD often engage in avoidance symptoms that must become a focus of couple based treatment. Given that male perpetrators of violence are likely to have witnessed and/or experienced physical abuse in their family of origin (Sugarman & Hotaling, 1989). Trauma symptoms must be assessed not only in the victim of violence, but in both members of the couple receiving treatment.

With regard to depression, Shisman, Uebelacker, and Weinstock (2004) found that depressive symptoms in either spouse affect the level of satisfaction of both partners with the relationship which may in turn be related to retention in treatment. Pan, Neidig, and O'Leary report that violent men are more likely than are non-violent men to exhibit symptoms of depression. It is possible that for both male and female partners seeking conjoint treatment for violence, that reports of trauma and/or depressive symptoms may influence retention rates.

Much of the research about psychopathology and its impact on IPV focuses largely on female partners. There is evidence to suggest that violent men are more likely to exhibit psychopathological symptoms than non violent men. Magdol,

Moffitt, Avshalom, Newman, Fagan, and Silva (1997) report that violent men are more likely than non-violent men to exhibit symptoms of antisocial personality disorder, anxiety, bipolar disorder, and psychotic disorders. Dutton and Golant (1995) report that violent men are more likely than are violent men to suffer from borderline personality disorder.

Relational Functioning

Another variable that the couple brings to therapy is their level of functioning as a couple. The general level of functioning of the couple as a unit is largely predictive of how the couple will progress throughout the course of therapy. One important area of couple's functioning that is predictive of treatment drop out is communication style. Heyman, Brown, Feldbau-Kohn, and O'Leary (1999) in a study of conjoint treatment for IPV found that treatment drop out was predicted by high levels of husbands' verbal hostility following self-disclosure statements by the wife. Because of this, it appears that not only the communication patterns utilized by the couple, but also each partner's relative abilities in the area of communication skills is important in predicting which couples will drop out of treatment.

Another important area of relationship functioning that may affect the course of treatment is the couple's initial level of satisfaction with their relationship. Interestingly, Epstein, McCrady, Miller, and Steinberg (1994), in a study of drop out of couples in conjoint alcoholism treatment, found that marital satisfaction at the beginning of treatment does not impact a couple's likelihood of dropping out of treatment. However, this finding seems counter intuitive, as it is likely that couples who are more satisfied with their relationship will find their relationships more

worthy of working to improve and thus will remain in treatment throughout the course of the treatment protocol. Epstein et al.'s research study has not been replicated. It is important to note that the population examined for that study, couples in treatment for alcoholism, may differ from those in the present study which consists of couples experiencing treatment for IPV.

Holtzworth-Munroe et al. (2002) report that couples in which the male partner is physically violent experience higher levels of marital dissatisfaction than those in non-distressed and non-violent couples. The authors report that male physical IPV frequently leads to the dissolution of relationships. This finding is important in understanding the impact of relationship satisfaction on retention in therapy, as those couples that experience IPV may be more likely to dissolve their relationship and/or terminate treatment than those couples who do not experience IPV or who experience lower levels of IPV. Thus, level of physical violence in the couple relationship as it impacts relationship satisfaction may also impact retention of couples in treatment of IPV.

The third area of relationship functioning examined in the present study is the level of commitment of each individual to the couple relationship. Epstein et al. (1994) found that the individuals' level of commitment was one of several factors that were related to drop out from therapy. This finding is interesting in that it makes no claims about whose level of commitment is necessary for the couple to remain in treatment. It appears as though the commitment of either individual will result in lower levels of drop out. Examining this variable through the lens of gender may be

helpful in isolating whether or not there is a particular member of couples' relationships that is essential to clients' continuance in therapy.

Severity of Abuse

The severity of abuse utilized in the relationship, particularly psychological abuse, has been found to be predictive of drop out in couple based treatments not specific to IPV (Heyman & Neidig, 1997). Low levels of wives' physical aggression and high levels of husband's psychological aggression have been found to be predictive of the completion of treatment treatment (Heyman & Neidig, 1997). In couples presenting for treatment for IPV where the wife is not aggressive, couples are more likely to drop out of treatment (Heyman & Neidig, 1997). Brown, O'Leary, and Feldbau (1997) reported that "in particular, husbands' severe psychological aggression and wives' mild psychological aggression were positively associated with treatment drop out" (p. 380). This study found that husband's physical aggression was predictive of drop out, but wives' physical aggression was not (Brown, O'Leary & Feldbau, 1997). Brown, O'Leary, and Feldbau (1997) suggest that the attention paid to physical aggression in IPV treatment may lead to the disillusionment of male partners, as they feel blamed for the cycle of violence while they continue to experience psychological aggression from their female partners. In addition, there may be some association between male withdrawal from treatment of IPV and a decreased likelihood of male perpetrators' willingness to take responsibility for physical violence, but evidence for such relationships has not been found in the literature.

Demographic Variables

Certain demographic variables consistently point toward treatment drop out across many different kinds of therapy. Younger clients, those with lower socioeconomic status, those with lower levels of education, and individuals who are from minority groups, are all more likely to drop out of therapy before completing treatment programs (King & Canada, 2003; Orlando, Chan & Morral, 2003; and Campbell, Baker & Bratton, 2000). Clients who experience a variety of life stressors as a result of their age, socioeconomic status, education level, or ethnicity are likely to find it more difficult to both attend and engage in treatment simply because of the number and severity of stressors already experienced in their daily lives. When life circumstances are accounted for however, it may not be that demographic characteristics in and of themselves are sufficient to predict retention of couples in treatment of IPV, as these characteristics are also related to other salient variables including life stress, psychological functioning, availability of resources, etc., which affect the ability of couples to attend treatment.

Client Evaluation of the Utility of Treatment

Clients' evaluation of the utility of sessions may predict continuance in treatment. Moore and Kenning (1996) found that clients who remained in therapy for long periods of time, who were self referred for treatment, and who felt as though they had completed treatment had higher levels of satisfaction with treatment than clients who did not remain in treatment for long periods of time, were not self referred, or who did not complete treatment. The authors reported several reasons for

dissatisfaction with treatment, including lack of directiveness on the part of the therapist, and concerns about videotaping procedures. It may be that those who remain in therapy over longer periods of time are those clients who were more able to attend to and were more invested in therapy at the beginning of treatment. Research on client perceptions of therapy as a predictor of retention in treatment is scarce, however, as only 54% of therapy training clinics collect feedback from their clients about their level of satisfaction with the treatment they receive (Serafica & Harway, 1980). For this reason, the amount of influence that client satisfaction has in predicting drop out rates is largely an unstudied aspect of retention. However, client satisfaction and clients' evaluation of the utility of therapy are not necessarily the same construct. Clients may be very satisfied with therapy sessions, but may not be demonstrating treatment gains; similarly, clients may report dissatisfaction with a particular session, but may have found the treatment overall very useful. Brown, O'Leary, and Feldbau (1997) state that "we might expect that if a couple believed that the intervention program was not addressing their primary problem(s), they would be more likely to drop out of the program" (370). The authors' emphasize the importance of goal matching between the therapist and the clients for both the maintenance of the therapeutic alliance and the success of therapy (Brown, O'Leary, and Fledbau, 1997). For this reason, the current study assessed clients' evaluation of the utility of sessions as a predictor of client retention.

Therapist Evaluations of the Utility of Treatment

Therapist perception of the utility of treatment as a predictor of treatment retention is an area that is understudied in the literature. As the alliance between the therapist and the client is pivotal to the continuation and success of therapy, it is important to explore the role that therapist perceptions play in forming and maintaining the therapeutic relationship with clients, as well as the effect that the therapeutic relationship has on client retention rates. If a therapist is unhappy with clients, the course of therapy, or a treatment protocol, it is likely that such a condition will have a large impact on the course of therapy and on the retention of clients. However, research about the specific effects of therapist perceptions of the utility of treatment on client retention in the treatment of IPV is not extensive and so this part of the present study is largely exploratory.

Treatment Condition

In a similar way, the treatment modality utilized by the therapist appears to influence client retention rates. Shoham, Rohrbaugh, Stickle, and Jacob (1998), in comparing the retention rates of couples completing alternative treatments for alcoholism, found that couples placed in the cognitive behavioral therapy (CBT) condition were more likely to drop out of therapy than were couples placed in the family systems condition. Only 10 of 30 CBT cases completed treatment while 18 of 33 family systems cases completed treatment resulting in 33% and 54% retention rates for the CBT cases and the family systems cases respectively (Shoham et al., 1998). CBT may have higher drop out rates in therapy because it is a structured form

of intervention that requires quantitative changes in the couple's relationship as indicators of positive clinical changes. This treatment modality requires clients to acquire and practice new skills both in and outside of treatment sessions in order to change their relationship. If one or both partners are resistant to changing the status quo, termination of therapy may provide the couple with an effective way to maintain their homeostasis. However, Butler, Fennell, Robson, and Gelder (1991) present contradictory evidence in their comparison study of behavioral therapy and CBT which indicates that CBT has higher retention rates than behavior therapy. Retention rates in therapy across treatment modalities have not been explored across treatment studies, which prevent drawing definitive conclusions regarding the influence that treatment conditions have on client retention. Stanton and Shadish (1993) in a meta-analysis of the literature of retention in family and couple treatment, found that 67% of studies reported drop out rates of less than 20%. Brown, O'Leary, and Feldbau (1997) note that Hahlweg and Markman (1988), in their review of retention in BMT studies, found that the average drop out rate from behavioral marital therapy was 6%. It is important to note that only 6 of the 17 studies reviewed (35%) reported rates of drop out. The majority of the studies reviewed explore retention rates of substance abuse treatment, rather than IPV treatment, and may or may not be applicable to the population represented in the present study. Brown, O'Leary, and Feldbau (1997), in examining the research pertaining to general studies about retention of couples in therapy, found that there simply is not a substantial body of research pertaining to the retention of couples in any form of treatment, let alone research specifically designed to examine the retention rates of couples in treatment of IPV.

HYPOTHESES

1. Couples with higher levels of individual partners' depression symptoms are more likely to drop out of treatment.
2. Couples with higher levels of individual partners' trauma symptoms are more likely to drop out of treatment.
3. Couples with lower levels of relationship satisfaction will be more likely to drop out of treatment.
4. Couples that are more committed to their relationship will be less likely to drop out of treatment.
5. Couples that utilize constructive communication will be less likely to drop out of treatment.
6. Couples in which the male uses high levels of physical abuse and the female uses low levels of physical abuse will be more likely to drop out of treatment.
7. Couples in which the male uses high levels of psychological abuse and the female uses low levels of psychological abuse will be more likely to drop out of treatment.
8. Couples with higher levels of income will be less likely to drop out of treatment.
9. Couples with higher levels of education will be less likely to drop out of treatment.

10. Couples who do not identify themselves as belonging to an ethnic minority group will be less likely to drop out of treatment.
11. Couples who believe that their treatment is efficacious will be less likely to drop out of treatment.
12. Therapists who report that therapy is efficacious will have clients who are less likely to drop out of treatment.
13. Clients in the CBT condition are more likely to drop out of treatment than are clients who are in the UT condition.

Chapter 2: Method

PARTICIPANTS

The sample for the present study consisted of 69 heterosexual couples who voluntarily presented for couples therapy between November 2000 and February 2004 at the Family Service Center (FSC), a therapy clinic staffed by graduate students in the marriage and family therapy (MFT) program at the University of Maryland. Female subjects in the sample made an average of \$22,117.62 a year, while men made an average of \$31,691.18 a year. The employment status of the women in the study was as follows; 53.6% of women were employed full time, 15.9% of women were employed part time, 7.2% of women were homemakers and not employed outside the home, 14.5% of women were students, 8.7% of women were unemployed, and none were retired. The employment status of the men in the study was as follows; 73.9% of men were employed full time, 7.2% were employed part time, 1.4% of men were homemakers and not employed outside the home, 8.7% were students, 7.2% were unemployed, and 1.4% were retired. Women in the sample received higher levels of education than men. In this sample, 74% of men and 86% of women had completed at least some college level education. Among the couples in the study, 59% were currently married and living together, 3% were married and separated, 19% were living together but not married, and 19% were dating and not living together. The couples mean length of relationship was 5.09 years (as reported by female partners), with a range from 0 to 21 years in duration. The average age of

men in the study was 32.94 years of age while the average age of females was 32.13 years of age.

The ethnic group breakdown of the sample was as follows: 44.9% of females and 55.1% of males identified themselves as White; 43.5% of females and 36.2% of males in the study identified themselves as African American; 4.3% of females and 2.9% of males identified themselves as Hispanic; 2.9% of females and no males identified themselves as Asian American or as Pacific Islander; no females and 1.4% of males identified themselves as Native American; and the remainder of the sample did not specify their racial or ethnic group (4.3% of females and males, respectively). Because of the diversity of this sample and the number of variables being used in the present study, it was necessary to condense ethnic group membership into a dichotomous variable of minority versus non-minority group membership. In doing so, it is understood that important information about differences between groups in therapy may be missed and further analysis in this area is recommended.

A pre-existing data set collected from a larger study on conjoint treatment of violence, the Couples Abuse Prevention Program (CAPP), was used for the current study. As such, the present study is a secondary analysis of those data. The procedures described are those utilized for data collection in the original CAPP study.

All couples recruited for the current study met the following criteria: (1) they were 18 years of age or older; (2) they were in a heterosexual relationship; (3) they lived in the Washington D.C. metropolitan area; (4) they could speak and write English fluently; (5) they voluntarily sought conjoint therapy, and reported that they were committed to improving their current relationship; (6) they reported mild to

moderate levels of psychological and/or physical abuse; (7) they reported that they were unafraid to live with and/or participate in sessions with their partner; and (8) they did not report an untreated substance abuse problem.

MEASURES

Demographics

All couples completed a self-report form which asked each partner to provide identifying information as well as information about their relationship status, the number of years that they have been with their partner, occupational status, yearly income, ethnic group membership, years of education and degrees received. (Please see Appendix B.)

Depressive and Trauma Symptomology

Depression was assessed with the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock & Erbaugh, 1961), a measure that is widely used to assess the presence and severity of depressive symptomology. This 21-item self report measure has a high level of internal consistency with psychiatric patients having a coefficient alpha of 0.86 and non-psychiatric clients having a coefficient alpha of 0.81 (Beck, Steer & Garbin, 1988). (Please see Appendix B.)

The Trauma Symptom Inventory Revised (TSI-R) (Briere, 1995) is a self report measure that assesses symptoms of posttraumatic stress disorder (PTSD) and will be used in the current study to assess trauma related symptoms. “Reliability coefficients for the final version of the TSI clinical scales ranged from .74 to .90” (Briere, 1995,

p. 33). For the present study, an abbreviated TSI measure (developed by the researchers conducting the CAPP study) was being used. The total score for this abbreviated TSI assesses the following dimensions of trauma reported:

- The Intrusive Experiences Subscale that identifies “items reflecting intrusive posttraumatic reactions and symptoms... [including] nightmares, flashbacks...upsetting memories that are easily triggered by current events, and repetitive thoughts of an unpleasant previous experience that intrude into awareness,” (Briere, 1995, p. 13). This subscale includes items 1, 5, 7, 27, 29, 31, 32, and 33; please refer to Appendix B for descriptions of individual items.
- The Defensive Avoidance Subscale identifies “a history of aversive internal experiences that [the respondent] repeatedly seek[s] to avoid,” (p.13). This subscale includes items 2, 4, 11, 26, 30, 34, 37, and 39; Please refer to Appendix B for descriptions of individual items.
- The Anger/Irritability subscale identifies “the extent of angry mood and irritable affect experienced by the respondent,” including angry cognitions (p. 13). This subscale includes items items 3, 8, 16, 17, 18, 22, 25, 28, and 41; Please refer to Appendix B for descriptions of individual items.
- The Dissociation subscale identifies “a largely unconscious defensive alteration in conscious awareness, developed as an avoidance response to overwhelming, often post-traumatic, psychological distress,” (p.

14). This subscale includes items 6, 9, 12, 14, 19, 21, 35, 36, and 38; Please refer to Appendix B for descriptions of individual items.

- The Anxious Arousal subscale identifies “symptoms of anxiety and autonomic hyperarousal,” (p. 14). This subscale includes items 10, 13, 15, 20, 23, 24, 40, and 42; please refer to Appendix B for descriptions of individual items.

The version of the TSI used for the present study consists of 42 items while the original instrument consists of 100 items. This abbreviated version of the TSI is being used in the CAPP study protocol. The original TSI was abbreviated by Epstein and Werlinich (2000) in order to assess for trauma symptoms in a more abbreviated format because of the number of forms being used in the CAPP protocol.

Relationship Functioning

Several aspects of relationship functioning were assessed in the current study. Marital satisfaction was assessed using the Dyadic Adjustment Scale (DAS, Spanier, 1976). This 32-item self-report measure correlates highly with other measures of dyadic adjustment and discriminates between married and divorced spouses (Spanier, 1976). The DAS appears to be highly reliable having internal consistency ranging from .78 to .96 for the individual sub-scales present in the measure (Spanier, 1989). Spanier (1989) describes each of these subscales as follows:

- The Dyadic Consensus subscale identifies the level of consensus of the couple on important matters like money, religion, friends, household chores, time spent together, and leisure activities.

- The Dyadic Satisfaction subscale “measures the amount of tension in the relationship, as well as the extent to which the individual has considered ending the relationship” (12). The subscale is scored such that higher scores indicate higher levels of satisfaction with the relationship and higher levels of commitment to the relationship.
- The Affectional Expression subscale examines each individual’s level of satisfaction with the way in which the couple expresses affection and with the sexual relationship of the couple.
- The Dyadic Cohesion subscale identifies the level of shared interests and activities of the couple.

The DAS was used in the current study to help to assess for the couples’ level of satisfaction. (Please see Appendix B.)

The Communication Patterns Questionnaire (CPQ, Christensen, 1987) assesses each partner’s perception of the couple’s communication before, during, and after interactions in which the couple discusses difficulties in their relationship. This self-report measure was used to identify how well the partners believe that they function in relation to their communication skills when discussing important issues. In particular, the Mutual Constructive Communication subscale (items A2, B2, B4, C1, C3, and C5) the Destructive Communication subscale (items B1, B5, B6, B7, B8, B9, B10, B11, C4, and C8), and the Mutual Avoidance subscale (items A1, A3, BC2, C6, C7, and C9) will be used to help to identify the presence of constructive and ineffective communication skills utilized by the couple. (Please see Appendix B.)

The Marital Status Inventory - Revised (MSI-R; Epstein & Werlinich, 2000) will be used in the current study to identify the partners' level of commitment to their relationships. The original 14-item measure was designed to assess whether an individual partner had taken any steps toward the dissolution of the couple's relationship and so indirectly measures each person's level of commitment to the relationship (Weiss & Cerreto, 1980). The revised version of the measure has 18 items and was adapted by Epstein and Werlinich (2000) to be applicable for use with both married and non-married couples. Weiss and Cerreto (1980) reported reliability and validity measures that were adequate for their original measure and found that couples who presented for marital problems scored higher on their measure than those presenting for child-related problems which indicates discriminant validity of the measure. (Please see Appendix B.)

Severity of Abuse

The Conflict Tactics Scale (CTS-2; Straus et al., 1996) is a self-report measure which assesses the way in which couples fight and the presence of violence in couples' relationships. The CTS-2 is a widely used measure which has been empirically validated many times with "the internal consistency reliability of the CTS-2 scales ranging from .79 to .95 (Straus, Hamby, Boney-McCoy, & Sugarman, 1996, p. 307). This measure was used in the current study to assess the use of physical aggression by both partners in the couples relationships. In particular, the physical assault scale (Items 7, 9, 17, 21, 27, 33, 37, 43, 45, 53, 61, & 73) which asks clients to report any incidents of physical violence in their relationship, and the injury scale (Items 11, 23, 31, 41, 55, & 71) which asks clients to report any incidents of

physical injury as a result of violence in their relationship will be utilized to assess for physical abuse being utilized in a relationship. (Please see Appendix B.)

The Multidimensional Emotional Abuse Scale (MDEAS; Murphy, Hoover & Taft, 1999) assesses the psychological or emotional abuse in a couple's relationship. The MDEAS utilizes 4 subscales to identify the use of emotional abuse in the couple's relationship. The first subscale is Restrictive Engulfment which "involves tracking, monitoring, and controlling the partner's activities and social contacts, along with efforts to squelch perceived threats to the relationship (Murphy & Hoover, 2001, 41). The second subscale is called Hostile Withdrawal which assesses avoidant behavior used by either member of the couple during conflict (Murphy & Hoover, 2001). Denigration is the third subscale which assesses the use of attacks to embarrass the partner (Murphy & Hoover, 2001). The final subscale is Dominance or Intimidation which assesses the use of "threats, property violence, and intense verbal aggression" (Murphy & Hoover, 2001, 42). A total score from these subscales for each partner were used in the present study. See Appendix B.

The self report measures utilized to assess for aggression in relationships (CTS2 and MDEAS) include questions about both one's own and one's partner's use of physical and psychological violence in relationships. Because the use of violence in relationships is an area in which many people would be expected to underreport such socially undesirable behavior, each partner's report about the other's use of violence in the relationship will be used to minimize the self report bias inherent in these measures.

Client Evaluation of the Utility of Treatment

Client evaluation of the utility of sessions was assessed using two forms created by the staff of the FSC, called the Couples Session Evaluation (SEC) or the Session Evaluation Questionnaire (SEQ). Both of these forms ask clients about their level of satisfaction with treatment. Following each session, clients are given an SEC or an SEQ which asks them to rate the session based on the work that was done in the areas of learning new skills and discussing important concerns and issues. These forms are used in the current study to assess the client's level of satisfaction with treatment. The question being utilized from the standard (SEC) form states "*overall, this session was helpful*". This item was rated on a four point Likert scale, from "Not at all" to "Very much", with higher numbers reflective of higher ratings. This question will be used to assess each partner's perceptions about the utility of treatment. The ratings reported by the clients across all completed sessions were then averaged, and that mean score for each partner was used in the present study. (Please see Appendix B.)

Therapist Evaluation of the Utility of Treatment

Therapists' satisfaction with the course of treatment was assessed based on their responses to questions listed at the end of their progress notes. After each session, the therapists complete questions about the appropriateness of the interventions provided to the concerns and issues the couple faces, their ability to adhere to the goals they had for that session, and their level of satisfaction with the session. These evaluations from the progress notes were used in the current study to assess the therapists' level of satisfaction with the course of therapy. Only the question that assesses therapist perceptions of the utility of treatment ("*overall I believe this session was...*") was

used for the present study. This item was rated on a four point Likert scale, from 1.) “Poor” to 4.) “Very good”, with higher numbers reflective of higher ratings. Since each couple is seen by a co-therapy team, the scores for this item are obtained from the progress notes completed by the team following each session. These scores were then averaged and the mean score from these sessions was used in the present study.

PROCEDURE

Within the standard treatment of the CAPP protocol, all partners participated in at least two days of assessment before treatment sessions begin. During the first day of assessment, the partners were taken into two separate rooms where each person completed an initial self-report battery of questionnaires that measured different aspects of individual psychopathology and couple functioning. Each partner was also individually interviewed about the presence of untreated substance abuse problems as well as instances of physical abuse that occurred in the relationship. The therapists then used the responses from the completed assessment packets to determine the couple’s eligibility to participate in the CAPP study. Couples were included in the CAPP study if they experienced at least mild levels of violence in their relationship during the 4 months prior to coming the FSC. Couples were excluded from the study if the violence in the relationship has resulted in physical injury to either partner which required medical treatment, if either partner reported an untreated substance abuse problem, or if either partner reported that they did not feel safe living with and/or participating in treatment sessions with their partner.

Couples who met inclusion criteria were then invited to participate in the study. If the partners agree to participate, they completed a second day of assessment. During this second assessment, approximately one week after the first assessment, the partners completed a ten-minute communication sample after which they continue completing the remainder of the self-report battery. Following completion of the entire assessment procedure, the partners participated in treatment sessions with their therapists.

Treatment Condition

All couples who met inclusion criteria for the original CAPP study were randomly placed into either the Cognitive Behavioral Therapy (CBT) condition or the usual treatment (UT) condition. Couples in the CBT condition underwent an intensive structured protocol that focused on decreasing the level of violence present in the couples' relationships. In contrast, the UT condition was less structured and couples participate in sessions grounded in family systems theoretical models other than CBT. Other models included structural family therapy, emotionally focused family therapy, narrative therapy, or experiential therapy.

In the UT condition, the couple participated in ten 90-minute, double sessions. In this treatment condition, the goals for each session was set by the therapists working with the couple and did not follow a structured protocol.

In the CBT condition, the couple participated in ten 90-minute, double sessions. Topics included psycho-education about forms of physical and psychological abuse; the long term effects of abuse; the way in which couple's patterns of interacting lead to violence; communication skills training; problem

solving skills training; and anger management techniques. Each session (or set of sessions) followed a protocol that provided continuity of treatment across therapists and couples.

Session 1 entailed a general overview of cognitive behavioral therapy as it was outlined in the CAPP program, identification of goals for therapy, a review of the assessment, and the beginning of some psychoeducation about the effects of abuse in relationships. The session concluded with the therapists teaching the couple “time-out” strategies and in the formation of a “no-violence agreement”, if needed. The “no-violence agreement” was a contract drafted by the therapists and clients that states that the couple would not engage in any form of physical aggression during the course of therapy. The contract also discussed alternative methods for diffusing the anxiety present in situations where violence was a possibility and provided resources for the clients to contact should they need additional assistance.

Session 2 began with further discussion of the couple’s goals for therapy. The therapists then began some didactic psychoeducation about the difference between content, what a couple says in a conversation, and process, the way in which a couple discusses a subject. The goals for treatment were redefined in terms of problems with content and process. The therapist then continued to use psycho-education to teach about anger, the physiological responses to anger, and the ways in which the problematic patterns outlined by the couple could be altered or avoided. The session concluded in discussing each partner’s hopes and dreams for their relationship.

Sessions 3 through 6 focused on the improvement of the couple’s communication skills. The couple discussed non-inflammatory issues while

practicing new communication skills as outlined by Baucom and Epstein (1990). The therapists and the couple also worked to identify themes which seem to be particularly difficult for the couple. These themes were discussed with the therapists in an effort to find effective ways of working around such themes. Each of these sessions concluded with a period of psychoeducation by the therapists which focused on anger, violence, and ways to manage negative thoughts through more positive realistic messages each person told themselves known as “self-talk.”

Sessions 7 through 9 were used to help the partners to develop their problem solving skills. The therapists taught the couple to implement the problem-solving skills defined by Baucom and Epstein (1990). The problem solving steps taught to couples included; problem definition, brainstorming of possible solutions, evaluating each solution, negotiating a trial period for an agreed upon solution, implementation of the plan, and evaluation of the solution decided upon. Each session concluded with an assignment for the couple to practice the skills they learned and to use their anger management skills.

Session 10 focused on the role that each person plays in the couple’s escalation pattern. Themes of personal responsibility for one’s own actions were discussed. The way in which power was managed and distributed in the relationship was discussed as well. The balance of power was also discussed in this session. The partners’ movement toward their goals was then discussed and a plan was made for how the partners could continue to implement all that they have learned.

Retention Classification

Brown, O'Leary, and Feldbau (1997) report that, while over 30 studies focus on the utility of treatment for intimate partner violence, only 5 studies have been published that report drop out rates. Many studies of IPV, however, consider completion of 70% to 75% of the treatment sufficient for couples to be considered to have not dropped out of therapy (Chen, Bersani, Myers & Denton, 1989; Brown, O'Leary & Feldbau, 1997). However, there is no universally recognized standard in the violence literature for defining treatment drop out (e.g., percentage of sessions attended by both partners). For the present study, all couples who completed less than 10 90-minute sessions, double the standard length of couple therapy sessions, were considered to have dropped out of therapy. This criterion for completion was identical to the criterion utilized by Brown, O'Leary, and Feldbau (1997) in their study of conjoint treatment of domestic violence required clients to attend 10 weekly 2-hour sessions; however these requirements represented only 70% of the total sessions included in their treatment protocol. For the present study, the decision was made that only those couples who completed all 10 90 minute sessions were to be considered to have completed treatment because in the CBT condition, each week was assigned specific topics and skills training. It is believed that these sessions are cumulative and without attending all 10 sessions, couples would not receive the full protocol, and thus could not be considered to have completed treatment.

Identifying completers versus drop outs from therapy based on the number of sessions completed is problematic in that clients may experience significant change at a certain point so as to make continuance in therapy unnecessary. To then consider

such clients to have dropped out of treatment is problematic. In addition, in the present study, there were cases in which only one partner dropped out of treatment while the other continued in individual therapy. This is in contrast to Brown, O’Leary, and Feldbau’s (1997), study as none of their participants continued in individual therapy, so the researchers had to make no decisions about whether or not individual clients who remained in treatment after couples therapy was terminated were considered to be drop outs. However, the authors state, “While there certainly are cases in which one partner continues in therapy after the other has terminated, the focus in the therapy often switches from couple issues to individual issues” (p. 376). Because of the nature of this study, an individual withdrawing from treatment is considered to have withdrawn from couple therapy. As such, the number of sessions completed *by the couple* is the sole determinant of a couple’s drop out. Of the 69 couples included in the current study, 29 (42%) completed the treatment protocol of the CAPP program and 40 (58%) did not complete.

Chapter 3: Results

DATA ANALYSIS PLAN

Given the substantial number of variables assessed, several statistical procedures were employed in order to identify variables that were significantly different between the group that completed treatment and the group that did not complete treatment. In order to begin to distinguish which variables actually had significant differences for each of the two groups (those who dropped out of treatment and those that did not drop out of treatment) first, a series of t-tests and chi-square analyses were utilized to test all hypotheses and determine which variables were significantly different between the two groups. Those variables that were found to be significantly different between the two groups were then entered into a discriminant function analysis to see which variables significantly discriminate between groups and to determine the most effective model for predicting drop out. Following are descriptions of the analyses used in the current study to test the hypotheses. An alpha level of $p < .05$ was used on each of the analyses to determine if the findings were significant.

Depressive Symptomology

It was hypothesized that couples with higher levels of individual partners' depression would be more likely to drop out of treatment. To test this hypothesis, t-tests were used to examine whether there was a statistical difference between the level of depressive symptomology experienced by men and women from couples who

drop out of treatment versus those couples who did not drop out of treatment. Means and standard deviations for the BDI scores of male and female partners are listed in Table 2, Appendix A. Men from couples who dropped out of treatment did not differ significantly in pre-treatment depression than those from couples who completed therapy; $t(67)=1.74$, ns. Similarly, women from couples who dropped out of treatment did not differ significantly in pre-treatment depression than those from couples who completed therapy; $t(67)=-.93$, ns.

Trauma Symptomology

It was hypothesized couples with higher levels of individual partners' trauma symptoms are more likely to drop out of treatment. A t-test was used to examine whether there was a statistical difference between the level of trauma symptomology experienced by individuals from couples who complete versus those individuals from couples who did not complete treatment. Means and standard deviations for the TSI scores of male and female partners are listed in Table 2, Appendix A. Men from couples who dropped out of treatment were significantly more likely to report greater pre-treatment trauma symptoms than those from couples who completed therapy; $t(67)=2.87$, $p<.01$. Female levels of trauma did not significantly differ between completers and non-completers $t(67)= 1.01$, ns.

Couple Functioning

It was hypothesized that couples who were less satisfied with their relationship at pre-treatment were more likely to drop out of treatment. To test the

hypothesis a t-test was used to examine whether there was a statistical difference in relationship satisfaction between individuals from couples who complete therapy versus those individuals from couples who did not complete treatment. The DAS was utilized to assess individual satisfaction with the couple relationship in the present study. Means and standard deviations for the DAS scores of male and female partners are listed in Table 3, Appendix A. Male reports on the DAS did not significantly differ between completers and drop outs; $t(67)=1.60$, ns. Likewise, female DAS scores were not predictive of retention rates in therapy; $t(67)=1.59$, ns.

A t-test was used to test the hypothesis that partners' pre-therapy commitment to their relationships would be higher among couples who remain in treatment, compared to the commitment of those couples that dropped out of treatment. The MSI-R was used in the current study to assess each partner's level of commitment to the relationship. Means and standard deviations for the MSI-R scores of male and female partners are listed in Table 3, Appendix A. Male reports on the MSI-R were not significantly different between completers and non-completers; $t(67)=.89$, ns. Female reports on the MSI-R were likewise not significantly different between the two groups $t(67)=1.20$, ns.

To test the hypothesis that partner's pre-therapy communication skills would be higher among couples who remain in treatment compared to the positive communication skills of drop outs, a t-test was used to determine whether couples who remain in treatment throughout the course of therapy utilize more constructive communication skills than those who drop out. The CPQ was the measure used to assess constructive communication in the present study. The CPQ consists of 3 sub-

scales; a) the mutual constructive communication sub-scale, b) the demand withdraw sub-scale, and c) the mutual avoidance sub-scale. As each of these subscales assesses for different areas of communication, each sub-scale was measured independently in an effort to identify each area of communication individually. Means and standard deviations for the CPQ scores of male and female partners are listed in Table 3, Appendix A. Males who reported higher levels of constructive communication were significantly less likely to complete treatment than couples in which males reported lower levels of constructive communication, $t(40)=2.55, p<.05$. Male reports of demand withdraw patterns were not significantly different between completers and drop outs $t(40)=-1.21, ns$. Similarly, male reports of their partners demand withdraw patterns were not predictive of treatment completion, $t(40)=.31, ns$. Male reports of mutual avoidance were not significantly different between the two groups $t(40)=-1.23, ns$. Female reports of constructive communication were not significantly different between the two groups $t(40)=-1.06, ns$. Female reports of their partner's demand withdraw patterns were similarly not significantly different between completers and drop outs $t(40)=.03, ns$. Female reports of their own demand withdraw pattern did not significantly differ between the two groups $t(40)=.55, ns$. Females who reported lower levels of mutual avoidance were more likely to drop out of treatment, but this likelihood was not significant $t(40)=-1.99, ns$.

Physical Abuse

To identify whether couples who remain in treatment experience higher levels of male to female physical aggression and lower levels of female to male physical

aggression in their relationship than do couples who drop out a t-test was used. In order to operationalize physical abuse, the CTS2 was used as the measure to identify the presence of abuse in couples' relationships. Means and standard deviations for the CTS2 scores of male and female partners are listed in Table 4, Appendix A. Male reports of female's use of abuse in the relationship were not significantly different between completers and drop outs $t(67)=1.25$, ns. Similarly, female reports of abuse utilized by their male partners in the relationship was not significantly different between the two groups $t(67)=-.76$, ns.

Psychological Abuse

It was hypothesized that Couples in which the male uses high levels of psychological abuse and the female uses low levels of psychological abuse will be more likely to drop out of treatment. A t-test was used to identify if emotional abuse is significantly different between those who complete treatment and those who drop out of treatment. The MDEAS was used to operationalize the idea of emotional abuse. Means and standard deviations for the MDEAS scores of male and female partners are listed in Table 4, Appendix A. Male reports of their own or their partner's use of psychological abuse in the relationship did not significantly differ between those that completed therapy and those that did not $t(67)=-.80$, ns. Similarly, female reports of their own or their partner's use of psychological abuse in the relationship was not significantly different between the two groups $t(67)=-.46$, ns.

Demographic Characteristics

It was hypothesized that clients who have lower levels of income, lower levels of education, are not employed, and who do identify themselves as belonging to an ethnic minority group will be more likely to drop out of treatment. In examining this hypothesis, several statistical analyses were performed. Differences between the two groups in yearly income were analyzed using t-tests. Chi-square analyses were utilized to determine if education level, employment status, and ethnic group membership were significantly different between these two groups, since these variables were coded as categorical data. Results of analyses for the demographic variables for both male and female partners are listed in Table 6, Appendix A. Male income was not significantly different between treatment completers and drop outs; $t(66)=-1.01$, ns. Similarly, female income level did not prove to be significantly different between the two groups $t(64)=.71$, ns. Men who identified as being of an ethnic minority were significantly more likely to drop out of treatment $\chi^2(1, N=69) = 6.08$, $p<.05$. Female's ethnic group membership was not significantly different between the two groups of treatment completion $\chi^2(1, N=69) = .23$, ns. Males' college level education was not significantly different between completers and drop outs $\chi^2(7, N=69)=3.59$, ns. Similarly, wife's college level education was not significantly different between the two groups $\chi^2(7, N=69) = 3.76$, ns. Males who were employed were not significantly different than males who were not employed in terms of distinguishing between treatment drop outs and those that did not drop out of treatment $\chi^2(5, N=69) = .41$, ns. Similarly, females who were employed were not significantly different than males who were not employed in terms of distinguishing

between treatment drop outs and those that did not drop out of treatment $\chi^2(4, N=69) = .75, ns$.

Client Perceptions of the Utility of Treatment

A t-test was used to determine whether couples who individually evaluated therapy as efficacious were less likely to drop out of treatment than were couples in which individually reported that therapy was not efficacious. Client self-reports on the SEC/SEQ forms were used to operationalize the concept of client perceptions of the utility of treatment. Means and standard deviations for the CTS2 scores of male and female partners are listed in Table 5, Appendix A. Male perceptions of the utility of treatment were not significantly different between treatment completers and those that dropped out of therapy; $t(64) = .32, ns$. Female perceptions of treatment utility were not significantly different between the two groups; $t(66) = .35, ns$.

Therapist Perceptions of the Utility of Treatment

A t-test analysis was used to determine whether therapists who perceive that therapy is efficacious have clients with lower drop out rates than therapists who do not perceive therapy to be efficacious. Means and standard deviations for the CTS2 scores of male and female partners are listed in Table 5, Appendix A. Therapist perceptions of the utility of treatment was not significantly different between couples who completed therapy and those who dropped out of therapy; $\chi^2(1, N=68) = 2.88, ns$.

Treatment Condition

A chi-square analysis was used to determine if clients in the CBT condition were more likely to drop out of treatment than were clients in the UT condition. Clients were randomly assigned to one of the two conditions prior to the beginning of therapy. Clients in the CBT condition were slightly more likely to drop out of treatment than those in the UT condition, however the finding was not significant $t(66)=1.71$, ns.

Discriminant Function Analysis

A DFA was run utilizing the significant variables from the previous t-tests: male TSI, male CPQ-Mutual Constructive Communication, and male ethnic group membership. The results of this final DFA yielded a significant function (Wilk's Lambda = .64, Chi-square of 17.34, $p = .001$). The model yielded a correct classification of 76.2%. Each of the variables entered into this DFA model significantly decreased the likelihood of drop out (TSI, CPQ Mutual Constructive Communication, and ethnic group membership). Please see Table 7 (Appendix A).

Chapter 4: Discussion

The results from the present study partially confirmed the hypotheses in that ethnic group membership, trauma symptoms, and communication quality of clients all appeared to be predictive of client drop out of therapy. However, contrary to expectations depressive symptomology, satisfaction with the relationship, level of commitment to the relationship, levels of physical and psychological abuse, client perceptions of the utility of treatment, therapists perceptions of the utility of treatment, and treatment condition were not predictive of retention in therapy.

The first hypothesis predicted that clients with higher levels of depression would have higher levels of drop out was not supported. The second hypothesis predicted that there would be no difference between the two groups in their experience of PTSD symptoms. It appears as though trauma symptoms in males are predictive of drop out in therapy. This finding is interesting in that the majority of the studies about IPV look at the depressive and trauma symptoms of the female victims rather than the male perpetrator of violence. Schlee, Heyman, and O'Leary (1998), in discussing the effects of female PTSD symptoms on treatment outcome, discuss at great length the specialized needs of women with PTSD in treatment. This is not to say that men have higher rates of depression or trauma in relationships affected by IPV, but that when such symptoms do occur it is more likely that the couple will not continue in treatment. More research must be conducted in this area before definitive conclusions are drawn. This finding indicates the importance of assessing both partners, but particularly male partners, for both current and past trauma as both may

impact retention in therapy. Couples with males exhibiting trauma symptoms are not as likely to remain in treatment in order to stop the violent pattern in which they are engaged. It may be that men who experience trauma symptoms were victims of violence at some point in their lives and the ramifications of those experiences of abuse make it difficult for these men to remain in treatment. Perhaps it is necessary to dedicate additional attention in treatment to include partners' past experience of violence in order to ensure that couples in which the male exhibits PTSD symptoms can remain in treatment.

Neither the satisfaction of the partners with their relationship nor their level of commitment to their relationship had any significant bearing on the drop out rates of couples in therapy. The finding that partner's satisfaction with their relationship is not predictive of drop out is consistent with the findings of Epstein et al. (1994) who found that in conjoint treatment for alcoholism, client levels of relationship satisfaction that were not predictive of retention rates in therapy. The finding that relationship commitment was unrelated to treatment completion supports former research (Epstein, et al., 1994) which indicates that partners' levels of commitment to their relationship are not predictive of retention in therapy.

The level of mutual constructive communication reported by the males was found to predict couple retention. This finding indicates that if the male reports that the couple does not communicate well the couple is less likely to remain in treatment. This finding seems to support the work of Heyman, Brown, Feldbau-Kohn, and O'Leary (1999) that client retention in couple therapy was heavily impacted by the communication patterns reported by the couple.

Neither physical nor verbal abuse was predictive of retention in therapy. In this study, neither the physical nor the psychological aggression of either partner is significantly predictive of retention in treatment. Previous studies have indicated that physical aggression of males and psychological aggression of females were predictive of client drop out (Brown, O'Leary, & Feldbau, 1997). The present study, however, indicates that the physical and psychological aggression of neither partner had a significant bearing on the continuance of therapy in conjoint treatment of IPV. It is important to note that this sample experienced low levels of violence and so this finding may not be applicable to samples that experience more severe levels of violence. In addition, the couples in this sample did not specifically seek treatment for IPV, so these results may not be applicable to a sample specifically seeking such treatment.

It was hypothesized that client demographic variables including income level, education level, employment status, and ethnic group membership would be predictive of retention rates in therapy. Among this group of variables, only male ethnic group membership was found to be predictive of drop out. This finding is not consistent with other studies that have been replicated numerous times indicating that income level, education level, employment status, and ethnic group membership are predictive of retention rates in therapy. It is interesting that in the present study, only male ethnic group membership was found to be predictive of retention rates in therapy. The significance of male ethnic group membership in predicting treatment drop out seems to indicate that there are some limitations of the CAPP study in its ability to address the specific needs of men from ethnic minority groups. As such, the

treatment protocol needs to be more sensitive to the concerns of this population in order to increase retention. The sample is unique from previous studies in the diversity of the level of income and education, employment status, and ethnic group membership of participants. Another possible explanation is that the CAPP protocol has been designed in a more sensitive way than other studies in order to attend to the needs of people from diverse demographic backgrounds and as such is more able to attend to the specific needs of a diverse group of clients than less sensitive treatment programs that do not attend to such needs. If this is the case, however, more work must be done to attend to the needs of men from ethnic minority groups to ensure that their needs are being met by the CAPP treatment protocol as well in order to ensure more equal retention rates across ethnic groups among male participants.

It was hypothesized that clients who perceive that their therapy is useful will have higher retention rates in therapy than clients who do not perceive that therapy is efficacious. Instead, the study found that client perceptions of the utility of treatment have no bearing on retention in therapy. This aspect of the present study was largely exploratory as very little research has been done in clinical settings to determine the impact of client perceptions as it relates to retention of clients in treatment (Serafica & Harway, 1980). This finding is surprising as it seems as though clients would not remain in treatment that they do not believe is efficacious. However, the measure used to assess client perceptions of the utility of treatment was very limited both in the items presented (only 1 item) and the variability of scores (likert scale from 1 to 4) which limits the applicability of this finding. Further study is necessary with a

more comprehensive measure of client perceptions of the efficacy of treatment in order to fully examine its relationship to treatment retention.

It was hypothesized that therapists who perceive that therapy is useful would have clients with higher retention rates in therapy than those therapists who do not perceive therapy to be useful. The findings from the present study indicate that therapist perceptions of the utility of treatment have little bearing on client retention rates. This finding is in striking contrast to the work of Messer and Wampold (2002) which found that “therapists within a given treatment account for a fairly large proportion of outcome variance (6-9%)” (23). In their study, more elements of therapist influence were assessed than perceptions of the utility of session. Perhaps the influence of therapists on drop out from therapy is a matter of other variables than perceptions about the utility of treatment that the present study did not assess (for example therapist skill level, level of adherence to the treatment protocol, and the matching of therapists based on demographic background to clients). In the present study a single item was used to operationalize therapist satisfaction, and that item was averaged across sessions attended by the couple. It is recommended that further research be done to attend to therapist perceptions about the utility of treatment as it applies to retention of clients in therapy.

It was hypothesized that clients in the CBT condition would be more likely to drop out of treatment than clients in the UT condition. The findings of the present study do not indicate a significant relationship between treatment condition and retention rates of couples in treatment of IPV. In order to examine this finding more closely, it would be important to replicate this study using more experienced

therapists with greater skill in implementing the CBT treatment protocol while still maintaining their basic clinical skills in session.

Gender Differences

An interesting finding of the current study is that male partner characteristics appear to have a larger influence on couple retention rates in therapy than do female characteristics. Among those variables in which there was a significant difference between those who drop out of treatment and those that remain in treatment, was the male partner's characteristic that differentiated the groups. An important implication of these findings is that the needs of the males present for couple based treatment of IPV are not being met. Perhaps the amount of attention being paid in such treatment to the elimination of violence in the couple's relationship does not allow significant attention to be paid to male trauma symptomology, male perceptions about the way in which the couple communicates, or the specific needs of males from minority groups. It is suggested that perhaps it is necessary for men who fall into these categories - men who experience trauma symptoms, report problems with the couple's communication, or who are from ethnic minority groups - may benefit from individualized treatment in conjunction with couple based treatment for IPV in order to address their individual concerns or that couple based treatment be modified to address these concerns in a more significant manner.

LIMITATIONS AND IMPLICATIONS FOR FUTURE RESEARCH

Overall Treatment Protocol

An important consideration of this study is that the current sample has been limited to include only couples who began the treatment phase of the protocol. Couples who completed some portion of the initial assessment phase but did not continue into the treatment phase of the protocol were not included in this sample. When couples call the FSC to obtain treatment they typically do not receive treatment until several weeks later as a result of the multiple assessment sessions required for the CAPP protocol. Many couples drop out of therapy during this assessment phase and do not actually continue with the protocol to the point that they would actually be included in this study. As a result, this study may not constitute a representative sample of couples in treatment of domestic violence, as it includes only couples who have been willing to persevere through two days of assessment and a delay in beginning therapy sessions.

Standardized Measures

An area of particular concern for the present study is the fact that there were no significant findings pertaining to the client and therapist perceptions about the utility of treatment and retention rates in therapy. It seems unlikely that clients who do not find therapy helpful would remain in treatment. More likely the measures used to operationalize clients' and therapist perceptions of the utility of treatment were not valid. Clients return their SEC (or SEQ) forms directly to their therapists at the FSC and so the margin for error is great as it seems unlikely that clients will be

free to express all of their concerns about treatment for fear of upsetting or disappointing their therapist. In addition, these measures were limited in their scope and may not effectively distinguish between clients and therapists who believe that therapy is useful and those that do not.

IMPLICATIONS FOR FUTURE RESEARCH

Differences Between Men and Women

The findings of the present study point toward the fact that all of the factors that discriminate between completers and drop outs for treatment of IPV are reported by male partners. These findings, however, are preliminary and should be replicated. These findings do point toward an interesting phenomenon; male characteristics determine whether or not couples receive treatment for intimate partner violence. It is of some concern that all of the characteristics that appear to influence drop out from therapy are held by male partners. At the FSC, it is typically the female partner who initiates contact for therapy. Perhaps therapy is a modality for working with couples that is more able to meet the needs of female partners than to meet the needs of male partners. More attention must be paid to the specific needs of male partners in treatment of IPV if couples are to remain in treatment in which the dissolution of the cycle of violence is to be discussed.

Client and Therapist Perceptions of the Utility of Treatment

Because the measures used to operationalize perceptions of the utility of treatment were measures of convenience that had been used in the FSC they were not tested to see if they did in fact measure client and therapist perceptions of the utility of treatment. It is unlikely that clients continue in treatment that they do not believe to be efficacious and so it is possible that the measures used in the present study were not sufficient to effectively measure perceptions about the utility of treatment. Instead, it is likely that the measures used were inadequate. For this study, a single item was used to measure this construct. This item was then averaged across all therapy sessions attended by the couple. It is hoped that future research will utilize more effective measures to discriminate between clients who believe treatment is effective, and those who do not in an effort to determine if perception about the utility of treatment does discriminate between clients who complete therapy and those who do not. In particular, research identifying differences in perceptions of utility between clients who drop out of treatment in the early, middle, and late stages of therapy would add to the present research.

CONCLUSIONS

The findings from the present study indicate that there are certain characteristics of male clients in particular (male levels of trauma, male perceptions of the couple's communication, and male ethnic group membership) that have a significant impact on retention of couples in treatment of intimate partner violence. If these variables can be assessed and addressed in treatment, it is likely that couples

who come to conjoint treatment for IPV will be more inclined to remain in and benefit from treatment. Further research is recommended to determine the influence of the client perceptions of the usefulness of therapy is recommended to determine whether there is an impact of male or female perceptions about therapy on couples dropping out of treatment of IPV.

Appendix A

Table 1
Demographic Information

Reported by Means						
Age						
Males	32.94 (7.82)					
Females	32.13 (8.12)					
Years Together						
	5.09 (4.67)					
Personal Income						
Males	\$31,691.18 (27852.23)					
Females	\$22,117.62 (18524.62)					
Reported by Percentages						
	Full Time	Part Time	Homemakers	Students	Unemployed	Retired
Employment Status						
Males	73.9	7.2	1.4	8.7	7.2	1.4
Females	53.6	15.9	7.2	14.5	8.7	0
Reported by Percentages						
	Caucasian	African American	Hispanic	Asian	Native American	UK
Ethnic Group Membership						
Males	55.1	36.2	2.9	0	1.4	4.3
Females	44.9	43.5	4.3	2.9	0	4.3

Table 2

Means and Standard Deviations for Individual Psychopathology Variables

Depression (BDI)	Completed	Dropped Out	<i>t</i> (df)
Males	9.21 (5.14)	12.48 (9.09)	1.74 (67)
Females	14.03 (8.55)	12.08 (8.71)	-0.93(67)

Trauma Symptoms (TSI-R)	Completed	Dropped Out	<i>t</i> (df)
Males	30.28 (15.31)	47.48 (29.48)	2.87 (67)
Females	48.79 (20.13)	43.63 (21.47)	-1.01 (67)

Table 3

Means and Standard Deviations for Relationship Functioning Variables

DAS	Completed	Dropped Out	<i>t</i> (df)
Males	87.10 (22.45)	95.58 (20.87)	1.61 (67)
Females	79.69 (23.75)	88.38 (21.83)	1.59 (67)
CPQ -Constructive Communication			
Males	9.21(1.56)	12.48 (1.51)	2.55 (40)*
Females	14.03 (1.53)	12.08 (1.76)	-1.01 (40)*
CPQ -Demand Withdraw Self			
Males	5.20 (1.76)	5.40 (1.87)	-1.21 (40)
Females	4.62 (1.82)	4.64 (2.17)	0.55 (40)
CPQ -Demand Withdraw Partner			
Males	5.20 (1.79)	5.40 (2.39)	0.31 (40)
Females	5.56 (2.17)	5.22 (2.28)	0.03 (40)
CPQ -Mutual Avoidance			
Males	4.70 (1.72)	3.97 (2.08)	-1.23 (40)
Females	4.88 (1.63)	3.92 (1.49)	-1.99 (40)
MSI-R			
Males	4.79 (3.64)	5.65 (4.18)	0.89 (67)
Females	6.45 (3.73)	7.65 (4.35)	1.20 (67)

Note. *= $p < .05$

Table 4

Means and Standard Deviations for Psychological and Physical Abuse Variables

Physical Abuse (CTS2)	Completed	Dropped Out	<i>t</i> (df)
Men	1.48 (2.75)	3.00 (6.09)	1.25 (67)
Women	2.21 (5.00)	3.80 (10.50)	0.76 (67)
Psychological Abuse (MDEAS)			
Men	8.21(11.90)	10.58 (12.20)	0.80 (67)
Women	10.86 (15.44)	12.73 (17.45)	0.46 (67)

Table 5
Means and Standard Deviations of Perceptions of Treatment Efficacy Variables

Client Perceptions (SEC)	Completed	Dropped Out	<i>t</i> (df)
Males	3.39 (0.46)	3.34 (0.65)	-0.32 (64)
Females	3.36 (0.47)	3.41 (0.56)	0.35 (66)
Therapist Perceptions (Progress Notes)			
	Completed	Dropped Out	
Therapist	3.37 (0.44)	3.30 (0.53)	-0.47 (44)

Table 6
Means, Standard Deviations, and Percentages for Demographic Variables

	<i>Drop out Group</i> (n = 29)	<i>Treatment Completion Group</i> (n = 40)	t (df)
Age			
Males	32.97 (8.51)	32.90 (6.89)	0.34
Females	31.69 (8.66)	32.72 (7.57)	0.17
Years Together			
	5.09 (5.09)	6.12 (4.35)	-0.75 (45)
Personal Income			
Males	28743.59 (31824.12)	35655.17 (20230.07)	-1.01 (66)
Females	23508.05 (19711.36)	20230.61 (16949.21)	0.71 (64)
			² (df)
Percent Education: Some College or More^a			
Males	93	97	3.59 (7)
Females	88	83	3.76 (7)
			² (df)
Percent Employed Full Time^b			
Males	65	86	3.76 (5)
Females	23	14	0.75 (4)
Percent Minority group Membership^c			
Males	53	24	6.94 (4)*
Females	55	44	2.60 (4)

Note. : a= Percent Education: Some College or More, b= Percent Employed Full Time, c= Percent of Minority Group Membership * = p < .05

Table 7
Discriminant Function Analysis

Predictor Variable	Univariate F	<i>p</i>	DF Coefficient
Male TSI	4.93	.03	.02
Male CPQ-Mutual Constructive Communication	6.49	.02	.42
Male Ethnic Group Membership	9.62	.00	1.48
Wilk's lambda	.64	.00	
Eigenvalue	.57		
% cases correctly classified	76.2%		

Table 8
Discriminant Function Analysis: Classification Table

		Predicted Status	
		Completed	Dropped Out
Actual Status			
Completed	4		16
Dropped Out	16		6
Percent			
Completed	20		80
Dropped Out	72.7		27.3

Appendix B

BDI (assessment)

Gender: _____ Date of Birth: _____ Therapist Code _____ Family Code _____

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the **PAST WEEK, INCLUDING TODAY!** Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. **Be sure to read all the statements in each group before making your choice.**

1. 0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.
2. 0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.
3. 0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.
4. 0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.
5. 0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all the time.
6. 0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.
7. 0 I don't feel I am worse than anybody else.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.
8. 0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.
9. 0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.
10. 0 I don't cry any more than usual.
1 I cry more than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.
11. 0 I am no more irritated now than I have ever been.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
 1 I am less interested in other people than I used to be.
 2 I have lost most of my interest in other people.
 3 I have lost all of my interest in other people.
13. 0 I make decisions about as well as I ever could.
 1 I put off making decisions more than I used to.
 2 I have greater difficulty in making decisions than before.
 3 I can't make decisions at all anymore.
14. 0 I don't feel I look any worse than I used to.
 1 I am worried that I am looking old or unattractive.
 2 I feel that there are permanent changes in my appearance that make me look unattractive.
 3 I believe that I look ugly.
15. 0 I can work about as well as before.
 1 It takes an extra effort to get started at doing something.
 2 I have to push myself very hard to do anything.
 3 I can't do any work at all.
16. 0 I can sleep as well as usual.
 1 I don't sleep as well as I used to.
 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
 3 I wake up several hours earlier than I used to and cannot get back to sleep.
17. 0 I don't get more tired than usual.
 1 I get tired more easily than I used to.
 2 I get tired more doing almost anything.
 3 I am too tired to do anything.
18. 0 My appetite is no worse than usual.
 1 My appetite is not as good as it used to be.
 2 My appetite is much worse now.
 3 I have no appetite at all anymore.
19. 0 I haven't lost much weight, if any, lately.
 1 I have lost more than 5 pounds.
 2 I have lost more than 10 pounds.
 3 I have lost more than 15 pounds.
I am purposely trying to lose weight. Yes ___ No ___
20. 0 I am no more worried about my health than usual.
 1 I am worried about physical problems such as aches, pains, an upset stomach or constipation.
 2 I am very worried about physical problems and it's hard to think of much else.
 3 I am so worried about my physical problems that I cannot think about anything else.
21. 0 I have not noticed any recent change in my interest in sex.
 1 I am less interested in sex than I used to be.
 2 I am much less interested in sex now.
 3 I have lost interest in sex completely.

TSI-A (assessment)

Gender: _____ Date of Birth: _____ Therapist Code _____ Family Code _____

Instructions: The items that follow describe a number of things that may or may not have happened to you. Read each one carefully, and then indicate on the answer sheet how often it has happened in the last **6 months** by circling the correct number. Circling a 0 means it hasn't happened at all in the last 6 months. Circling a 3 means it has happened often in the last **6 months**. Circling a 1 or 2 means it has happened in the last 6 months, but has not happened often.

Never

Often

_____ 0 1 2 3 _____

Please answer each item as honestly as you can. **Be sure to answer every item.**

*In the last **6 months**, how often have you experienced:*

		Never			Often
1/1.	Nightmares or bad dreams	0	1	2	3
2/2.	Trying to forget about a bad time in your life	0	1	2	3
3/3.	Irritability	0	1	2	3
4/4.	Stopping yourself from thinking about the past	0	1	2	3
5/8.	Flashbacks (sudden memories or images of upsetting things)	0	1	2	3
6/10.	Feeling like you were outside your body	0	1	2	3
7/12.	Sudden disturbing memories when you were not expecting them	0	1	2	3
8/15.	Becoming angry for little or no reason	0	1	2	3
9/20.	Your mind going blank	0	1	2	3
10/22.	Periods of trembling or shaking	0	1	2	3
11/23.	Pushing painful memories out of your mind	0	1	2	3
12/26.	Feeling like you were watching yourself from far away	0	1	2	3
13/27.	Feeling tense or "on edge"	0	1	2	3
14/29.	Not feeling like your real self	0	1	2	3
15/31.	Worrying about things	0	1	2	3
16/34.	Being easily annoyed by other people	0	1	2	3
17/35.	Starting arguments or picking fights to get your anger out	0	1	2	3
18/37.	Getting angry when you didn't want to	0	1	2	3
19/38.	Not being able to feel your emotions	0	1	2	3
20/41.	Feeling jumpy	0	1	2	3
21/42.	Absent-mindedness	0	1	2	3
22/45.	Yelling or telling people off when you felt you shouldn't have	0	1	2	3
23/51.	High anxiety	0	1	2	3
24/54.	Nervousness	0	1	2	3
25/57.	Feeling mad or angry inside	0	1	2	3
26/59.	Staying away from certain people or places because they reminded you of something	0	1	2	3

*In the last **6 months**, how often have you experienced:*

		Never			Often
27/62.	Suddenly remembering something upsetting from your past	0	1	2	3
28/63.	Wanting to hit someone or something	0	1	2	3
29/66.	Suddenly being reminded of something bad	0	1	2	3
30/67.	Trying to block out certain memories	0	1	2	3
31/70.	Violent dreams	0	1	2	3
32/72.	Just for a moment, seeing or hearing something upsetting that happened earlier in your life	0	1	2	3
33/74.	Frightening or upsetting thoughts popping into your mind	0	1	2	3
34/83.	Not letting yourself feel bad about the past	0	1	2	3
35/84.	Feeling like things weren't real	0	1	2	3
36/85.	Feeling like you were in a dream	0	1	2	3
37/87.	Trying not to have any feelings about something that once hurt you	0	1	2	3
38/88.	Daydreaming	0	1	2	3
39/89.	Trying not to think or talk about things in your life that were painful	0	1	2	3
40/91.	Being startled or frightened by sudden noises	0	1	2	3
41/93.	Trouble controlling your temper	0	1	2	3

DAS (Assessment)

Gender: _____ Date of Birth: _____ Therapist Code: _____ Family Code: _____

Most persons have disagreements in their relationship. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. Place a checkmark (✓) to indicate your answer.

	<i>Always Agree</i>	<i>Almost Always Agree</i>	<i>Occasionally Disagree</i>	<i>Frequently Disagree</i>	<i>Almost Always Disagree</i>	<i>Always Disagree</i>
1. Handling family finances						
2. Matters of recreation						
3. Religious matters						
4. Demonstrations of affection						
5. Friends						
6. Sex relations						
7. Conventionality (correct or proper behavior)						
8. Philosophy of life						
9. Ways of dealing with parents and in-laws						
10. Aims, goals, and things believed important						
11. Amount of time spent together						
12. Making major decisions						
13. Household tasks						
14. Leisure time interests and Activities						
15. Career decisions						
16. How often do you discuss or have you considered divorce, separation or terminating your relationship?						
17. How often do you or your partner leave the house after a fight?						
18. In general, how often do you think that things between you and your partner are going well?						
19. Do you confide in your partner?						

Gender: _____ Date of Birth: _____ Therapist Code: _____
 Family Code: _____

Directions: We are interested in how you and your partner typically deal with problems in your relationship.
 Please rate each item on a scale of 1 (=very unlikely) to 9 (=very likely). Very Very

A. WHEN SOME PROBLEM IN THE RELATIONSHIP ARISES: Unlikely Likely

1. Both members avoid discussing the problem.	1	2	3	4	5	6	7	8	9
2. Both members try to discuss the problem.	1	2	3	4	5	6	7	8	9
3. <i>Man tries to start a discussion while Woman tries to avoid a discussion.</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>9</i>
<i>Woman tries to start a discussion while Man tries to avoid a discussion.</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>9</i>

B. DURING A DISCUSSION OF A RELATIONSHIP PROBLEM: Very
Unlikely

1. Both members blame, accuse, and criticize each other.	1	2	3	4	5	6	7	8	9
2. Both members express their feelings to each other.	1	2	3	4	5	6	7	8	9
3. Both members threaten each other with negative consequences.	1	2	3	4	5	6	7	8	9
4. Both members suggest possible solutions and compromises.	1	2	3	4	5	6	7	8	9
5. Man nags and demands while Woman withdraws, becomes silent, or refuses to discuss the matter further.	1	2	3	4	5	6	7	8	9
<i>Woman nags and demands while Man withdraws, becomes silent, or refuses to discuss the matter further.</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>9</i>
6. Man criticizes while Woman defends herself.	1	2	3	4	5	6	7	8	9
<i>Woman criticizes while Man defends himself.</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>9</i>
7. Man pressures Woman to take some action or stop some action, while Woman resists.	1	2	3	4	5	6	7	8	9
<i>Woman pressures Man to take some action or stop some action, while Man resists.</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>9</i>
8. Man expresses feelings while Woman offers reasons and solutions.	1	2	3	4	5	6	7	8	9
<i>Woman expresses feelings while Man offers reasons and solutions.</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>9</i>
9. Man threatens negative consequences and Woman gives in or backs down.	1	2	3	4	5	6	7	8	9
<i>Woman threatens negative consequences and Man gives in or backs down.</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>9</i>
10. Man calls Woman names, swears at her, or attacks her character	1	2	3	4	5	6	7	8	9
<i>Woman calls Man names, swears at him, or attacks his character.</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>9</i>
11. Man pushes, shoves, slaps, hits, or kicks Woman.	1	2	3	4	5	6	7	8	9
<i>Woman pushes, shoves, slaps, hits, or kicks Man.</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>9</i>

Very **Very**

C. AFTER A DISCUSSION OF A RELATIONSHIP PROBLEM: Unlikely Likely

1. Both feel each other has understood his/her position	1	2	3	4	5	6	7	8	9
2. Both withdraw from each other after the discussion.	1	2	3	4	5	6	7	8	9

3. Both feel that the problem has been solved.	1	2	3	4	5	6	7	8	9
4. Neither partner is giving to the other after the discussion.	1	2	3	4	5	6	7	8	9
5. After the discussion, both try to be especially nice to each other.	1	2	3	4	5	6	7	8	9
6. Man feels guilty for what he said or did while Woman feels hurt.	1	2	3	4	5	6	7	8	9
----- Woman feels guilty for what she said or did while Man feels hurt.	1	2	3	4	5	6	7	8	9
7. Man tries to be especially nice, acts as if things are back to normal, while Woman acts distant.	1	2	3	4	5	6	7	8	9
----- Woman tries to be especially nice, acts as if things are back to Normal while Man acts distant.	1	2	3	4	5	6	7	8	9
8. Man pressures Woman to apologize or promise to do better, while Woman resists.	1	2	3	4	5	6	7	8	9
----- Woman pressures Man to apologize or promise to do better, while Man resists.	1	2	3	4	5	6	7	8	9
9. Man seeks support from others (parent, friend, children).	1	2	3	4	5	6	7	8	9
----- Woman seeks support from others (parent, friend, children).	1	2	3	4	5	6	7	8	9

Gender: _____ Date of Birth: _____ Therapist Code: _____ Family Code: _____

We would like to get an idea of how your relationship stands right now. Within the past four months have you...

- Yes ___ No___ 1. Had frequent thoughts about separating from your partner, as much as once a week or so.
- Yes ___ No___ 2. Occasionally thought about separation or divorce, usually after an argument.
- Yes ___ No___ 3. Thought specifically about separation, for example how to divide belongings, where to live, or who would get the children.
- Yes ___ No___ 4. Seriously thought about the costs and benefits of ending the relationship.
- Yes ___ No___ 5. Considered a divorce or separation a few times other than during or shortly after a fight, but only in general terms.
- Yes ___ No___ 6. Made specific plans to discuss separation with your partner, for example what you would say.
- Yes ___ No___ 7. Discussed separation (or divorce) with someone other than your partner (trusted friend, minister, counselor, relative).
- Yes ___ No___ 8. Discussed plans for moving out with friends or relatives.
- Yes ___ No___ 9. As a preparation for living on your own, set up an independent bank account in your own name to protect your interest.
- Yes ___ No___ 10. Suggested to your partner that you wish to have a separation.
- Yes ___ No___ 11. Discussed separation (or divorce) seriously with your partner.
- Yes ___ No___ 12. Your partner moved furniture or belongings to another residence.
- Yes ___ No___ 13. Consulted an attorney about legal separation, a stay away order, or divorce.
- Yes ___ No___ 14. Separated from your partner with plans to end the relationship.
- Yes ___ No___ 15. Separated from your partner, but with plans to get back together.
- Yes ___ No___ 16. File for a legal separation.
- Yes ___ No___ 17. Reached final decision on child custody, visitation, and division of property.
- Yes ___ No___ 18. Filed for divorce or ended the relationship.

Revised

CTS2 (ASSESSMENT)

Gender: _____ Date of Birth: _____ Therapist Code _____ Family Code _____

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please circle how many times you did each of these things **IN THE PAST 4 MONTHS**, and how many times your partner did them in the **IN THE PAST 4 MONTHS**. If you or your partner did not do one of these things in the past 4 months, but it happened before that, circle "0".

How often did this happen?

- 0 = Not in the past 4 months, but it did happen before
- 1 = Once in the past 4 months
- 2 = Twice in the past 4 months
- 3 = 3-5 times in the past 4 months
- 4 = 6-10 times in the past 4 months
- 5 = 11-20 times in the past 4 months
- 6 = More than 20 times in the past 4 months
- 9 = This has never happened

1. Never I showed my partner I cared even though we disagreed	0 1 2 3 4 5 6 9	
2. My partner showed care for me even though we disagreed	0 1 2 3 4 5 6 9	
3. I explained my side of a disagreement to my partner	0 1 2 3 4 5 6 9	
4. My partner explained his/her side of a disagreement to me	0 1 2 3 4 5 6 9	
5. I insulted or swore at my partner	0 1 2 3 4 5 6 9	
6. My partner did this to me	0 1 2 3 4 5 6 9	
7. I threw something at my partner that could hurt him/her	0 1 2 3 4 5 6 9	
8. My partner did this to me	0 1 2 3 4 5 6 9	
9. I twisted my partner's arm or hair	0 1 2 3 4 5 6 9	
10. My partner did this to me	0 1 2 3 4 5 6 9	
11. I had a sprain, bruise, or small cut because of a fight with my partner	0 1 2 3 4 5 6 9	
12. My partner had a sprain, bruise, or small cut because of a fight with me	0 1 2 3 4 5 6 9	
13. I showed respect for my partner's feelings about an issue	0 1 2 3 4 5 6 9	
14. My partner showed respect for my feelings about an issue	0 1 2 3 4 5 6 9	
15. I made my partner have sex without a condom	0 1 2 3 4 5 6 9	
16. My partner did this to me	0 1 2 3 4 5 6 9	
17. I pushed or shoved my partner	0 1 2 3 4 5 6 9	
18. My partner did this to me	0 1 2 3 4 5 6 9	
19. I used force (like hitting, holding down, or using a weapon) to make my partner have oral or anal sex	0 1 2 3 4 5 6 9	
20. My partner did this to me	0 1 2 3 4 5 6 9	
21. I used a knife or gun on my partner	0 1 2 3 4 5 6 9	
22. My partner did this to me	0 1 2 3 4 5 6 9	
23. I passed out from being hit on the head by my partner in a fight with me	0 1 2 3 4 5 6 9	
24. My partner passed out from being hit on the head in a fight with me	0 1 2 3 4 5 6 9	
25. I called my partner fat or ugly	0 1 2 3 4 5 6 9	
26. My partner called me fat or ugly	0 1 2 3 4 5 6 9	
27. I punched or hit my partner with something that could hurt	0 1 2 3 4 5 6 9	
28. My partner did this to me	0 1 2 3 4 5 6 9	
29. I destroyed something belonging to my partner	0 1 2 3 4 5 6 9	
30. My partner did this to me	0 1 2 3 4 5 6 9	
31. I went to a doctor because of a fight with my partner	0 1 2 3 4 5 6 9	
32. My partner went to a doctor because of a fight with me	0 1 2 3 4 5 6 9	

How often did this happen?

- 0 = Not in the past 4 months, but it did happen before 4 = 6-10 times in the past 4 months
 1 = Once in the past 4 months 5 = 11-20 times in the past 4 months
 2 = Twice in the past 4 months 6 = More than 20 times in the past 4 months
 3 = 3-5 times in the past 4 months 9 = This has never happened
 Never

33. I choked my partner	0 1 2 3 4 5 6 9	
34. My partner did this to me	0 1 2 3 4 5 6 9	
35. I shouted or yelled at my partner	0 1 2 3 4 5 6 9	
36. My partner did this to me	0 1 2 3 4 5 6 9	
37. I slammed my partner against a wall	0 1 2 3 4 5 6 9	
38. My partner did this to me	0 1 2 3 4 5 6 9	
39. I said I was sure we could work out a problem	0 1 2 3 4 5 6 9	
40. My partner was sure we could work it out	0 1 2 3 4 5 6 9	
41. I needed to see a doctor because of a fight with my partner, but I didn't	0 1 2 3 4 5 6 9	
42. My partner needed to see a doctor because of a fight with me, but didn't	0 1 2 3 4 5 6 9	
43. I beat up my partner	0 1 2 3 4 5 6 9	
44. My partner did this to me	0 1 2 3 4 5 6 9	
45. I grabbed my partner	0 1 2 3 4 5 6 9	
46. My partner did this to me	0 1 2 3 4 5 6 9	
47. I used force (like hitting, holding down, or using a weapon) to make my partner have sex	0 1 2 3 4 5 6 9	
48. My partner did this to me	0 1 2 3 4 5 6 9	
49. I stomped out of the room or house or yard during a disagreement	0 1 2 3 4 5 6 9	
50. My partner did this to me	0 1 2 3 4 5 6 9	
51. I insisted on sex when my partner did not want to (but did not use physical force)	0 1 2 3 4 5 6 9	
52. My partner did this to me	0 1 2 3 4 5 6 9	
53. I slapped my partner	0 1 2 3 4 5 6 9	
54. My partner did this to me	0 1 2 3 4 5 6 9	
55. I had a broken bone from a fight with my partner	0 1 2 3 4 5 6 9	
56. My partner had a broken bone from a fight with me	0 1 2 3 4 5 6 9	
57. I used threats to make my partner have oral or anal sex	0 1 2 3 4 5 6 9	
58. My partner did this to me	0 1 2 3 4 5 6 9	
59. I suggested a compromise to a disagreement	0 1 2 3 4 5 6 9	
60. My partner did this to me	0 1 2 3 4 5 6 9	
61. I burned or scalded my partner on purpose	0 1 2 3 4 5 6 9	
62. My partner did this to me	0 1 2 3 4 5 6 9	
63. I insisted my partner have oral or anal sex (but did not use physical force)	0 1 2 3 4 5 6 9	
64. My partner did this to me	0 1 2 3 4 5 6 9	
65. I accused my partner of being a lousy lover	0 1 2 3 4 5 6 9	
66. My partner accused me of this	0 1 2 3 4 5 6 9	
67. I did something to spite my partner	0 1 2 3 4 5 6 9	
68. My partner did this to me	0 1 2 3 4 5 6 9	
69. I threatened to hit or throw something at my partner	0 1 2 3 4 5 6 9	
70. My partner did this to me	0 1 2 3 4 5 6 9	
71. I felt physical pain that still hurt the next day because of a fight with my partner	0 1 2 3 4 5 6 9	
72. My partner still felt physical pain the next day because of a fight we had	0 1 2 3 4 5 6 9	
73. I kicked my partner	0 1 2 3 4 5 6 9	
74. My partner did this to me	0 1 2 3 4 5 6 9	
75. I used threats to make my partner have sex	0 1 2 3 4 5 6 9	
76. My partner did this to me	0 1 2 3 4 5 6 9	
77. I agreed to try a solution to a disagreement my partner suggested	0 1 2 3 4 5 6 9	
78. My partner agreed to try a solution I suggested	0 1 2 3 4 5 6 9	

Y:Couples Research/CTS-R.Rev.06/08/04

MDEAS (Assessment)

Gender: _____ Date of Birth: _____ Therapist Code: _____

Family Code: _____

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please circle how many times you did each of these things IN THE PAST 4 MONTHS, and how many times your partner did them in the IN THE PAST 4 MONTHS. If you or your partner did not do one of these things in the past 4 months, but it happened before that, circle 7.

- (1) Once (4) 6-10 times (7) Not in the past four months, but it did happen before
 (2) Twice (5) 11-20 times (0) This has never happened
 (3) 3-5 times (6) More than 20 times

1. Asked the other person where s/he had been or who s/he was with in a suspicious manner.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
2. Secretly searched through the other person's belongings.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
3. Tried to stop the other person from seeing certain friends or family members.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
4. Complained that the other person spends too much time with friends.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
5. Got angry because the other person went somewhere without telling him/her.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
6. Tried to make the other person feel guilty for not spending enough time together.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
7. Checked up on the other person by asking friends where s/he was or who s/he was with.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
8. Said or implied that the other person was stupid.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
9. Called the other person worthless.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
10. Called the other person ugly.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
11. Criticized the other person's appearance.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
12. Called the other person a loser, failure, or similar term.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0

13. Belittled the other person in front of other people.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
14. Said that someone else would be a better girlfriend or boyfriend.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
15. Became so angry that s/he was unable or unwilling to talk.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
16. Acted cold or distant when angry.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
17. Refused to have any discussion of a problem.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
18. Changed the subject on purpose when the other person was trying to discuss a problem.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
19. Refused to acknowledge a problem that the other felt was important.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
20. Sulked or refused to talk about an issue.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
21. Intentionally avoided the other person during a conflict or disagreement.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
22. Became angry enough to frighten the other person.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
23. Put her/his face right in front of the other person's face to make a point more	You: 1 2 3 4 5 6 7 0

forcefully.	Your partner: 1 2 3 4 5 6 7 0
24. Threatened to hit the other person.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
25. Threaten to throw something at the other person.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
26. Threw, smashed, hit, or kicked something in front of the other person.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
27. Drove recklessly to frighten the other person.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0
28. Stood or hovered over the other person during a conflict or disagreement.	You: 1 2 3 4 5 6 7 0 Your partner: 1 2 3 4 5 6 7 0

**COUPLE INFORMATION
& INSTRUCTIONS**

This is a first in a series of questionnaires you are being asked to complete that will contribute to the knowledge about couple therapy. In order for our research to measure progress over time we will periodically re-administer questionnaires. Please answer the questions at a relatively fast pace, usually the first that comes to mind is the best one.

There are no right or wrong answers.

4. Date: _____
1. Case #: _____
2. Therapist's(s') Code: _____
3. _____

The following information is gathered from each partner separately.

Name: (Print) _____ **Address:** _____

E-mail address: _____ zip _____

Phone Numbers: (h) _____ (w) _____
(cell) _____ (fax) _____

5. Gender: M F 6. SS# _____ 7. Age (in years) _____

8. You are coming for: a.) Family _____ b.) Couple _____ c.) Individual Therapy _____

9. **Relationship status** to person in couple's therapy with you: _____ 10. **Years Together:** _____

1. Currently married, living together
2. Currently married, separated
3. Divorced
4. Living together, not married
5. Separated, not married
6. Dating, not living together

11. What is your **occupation** ? _____ 12. What is your **current employment status** _____

- | | |
|---|--|
| <ol style="list-style-type: none"> 1. Clerical sales, bookkeeper, secretary 2. Executive, large business owner 3. Homemaker 4. None – child not able to be employed 5. Owner, manager of small business 6. Professional - Associates or Bachelors degree 7. Professional – master or doctoral degree 8. Skilled worker/craftsman 9. Service worker – barber, cook, beautician 10. Semi-skilled worker – machine operator 11. Unskilled Worker 12. Student | <ol style="list-style-type: none"> 1. Employed full time 2. Employed part time 3. Homemaker, not employed outside 4. Student 5. Disabled, not employed 6. Unemployed 7. Retired |
|---|--|

13. Personal **yearly gross income:** \$ _____ 14. **Race:** _____

1. Native American
2. African American
3. Asian/Pacific Islander
4. Hispanic
5. White
6. Other (specify) _____

15. What is your **country of origin**? _____

What was your **parent's country of origin**? 16. _____ (father's) 17. _____ (mother's)

18. Highest Level of **Education** Completed: _____

- | | |
|--|--|
| <ol style="list-style-type: none"> 1. Some high school education 2. High school diploma 3. Some college 4. Associate degree 5. Bachelors degree | <ol style="list-style-type: none"> 6. Some graduate education 7. Masters degree 8. Doctoral degree 9. Trade School |
|--|--|

19. Number of people in household: _____ 20. Number of **children who live in home** with you: _____

21. Number of children who **do not live** with you: _____
Names and phone number of **contact people** (minimum 2):

22. What is your **religious** preference? _____ 1. Mainline Protestant (e.g., Episcopal, Lutheran, Methodist, Presbyterian, Unitarian)

- 2. Conservative Protestant(e.g., Adventist, Baptist, Pentecostal)
- 3. Roman Catholic
- 4. Jewish
- 5. Other(e.g., Buddhist, Mormon, Hindu)
- 6. No affiliation with any formal religion

23. How often do you **participate in organized activities of a church or religious group**? _____

- 1. several times per week
- 2. once a week
- 3. several times a month
- 4. once a month
- 5. several times a year
- 6. once or twice a year
- 7. rarely or never

24. How **important is religion or spirituality** to you in your daily life? _____

- 1. Very important
- 2. Important
- 3. Somewhat important
- 4. Not very important
- 5. Not important at all

25. **Medications:** ___ Yes _____ No If yes, please list the names, purpose, and quality of **medication(s)** you are currently taking. Also list the name and phone number of the medicating physician(s) and primary care physician:

Medications: _____

Primary Care Physician: _____ **Phone:** _____

Psychiatrist? Yes/No Name & Phone, if yes. _____ **Phone:** _____

Legal Involvement:

26. A. Have you ever been involved with the police? Yes/No (circle)
If yes, what happened? Explain: _____

27. B. Have formal, legal procedures (i.e., ex-parte orders, protection orders, criminal charges, juvenile offenses) been brought against you? Yes/No (circle)

If yes, what happened? Explain: _____

28. If formal procedures were brought, what were the results (e.g., eviction, restraining orders?) _____

Many of the questions refer to your "family". It will be important for us to know what individuals you consider to be your family. Please list below the names and relationships of the people you will include in your responses about your family. Circle yourself in this list.

29. (Number listed in family) _____
Name Relationship

List the concerns and problems for which you are seeking help. Indicate which is the most important by circling it. For each problem listed, note the degree of severity by checking (√) the appropriate column.

	4-Severe	3-Somewhat Severe	2 – Moderate	1 – Mild
30.	31.			
32.	33.			
34.	35.			
36.	37.			

38. The most important concern (circled item) is # _____

COUPLE
Session Evaluation

Session #: _____ Date: _____ Therapist Code: _____
Gender: _____ Date of Birth: ____ Therapist Code: _____ Family Code:

1. My partner and I had an opportunity to discuss important concerns about our relationship.
Not At All A Little A Moderate Amount Very Much

2. This session helped me learn new ways to reduce conflict in our relationship.
Not At All A Little A Moderate Amount Very Much

3. During the session, my partner and I had an opportunity to practice new ways to deal with conflict and anger.
Not At All A Little A Moderate Amount Very Much

4. Overall, this session was helpful.
Not At All A Little A Moderate Amount Very Much

5. What was most helpful about this session?

6. What was least helpful about this session?

Session #: _____ Date: _____ Therapist Code: _____

Gender: _____ Date of Birth: _____ Therapist Code: _____ Family Code: _____

1. In this session, we discussed important concerns and issues.

Not At All A Little A Moderate Amount Very Much

2. In this session, we explored new ways to deal with concerns and issues.

Not At All A Little A Moderate Amount Very Much

3. During the session, we practiced new ways of dealing with concerns and issues.

Not At All A Little A Moderate Amount Very Much

4. Overall, how helpful was this session:

Not At All A Little A Moderate Amount Very Much

5. What was most helpful about this session?

6. What was least helpful about this session?

Case Number _____
Session Number _____
Date _____
Therapist Code _____

Progress Notes

Name(s) and age(s) of client(s) present at this session:

Therapy Model:

Therapy Goals (complete as appropriate for the current session and mark with a star *):

- 1. Initial assessment/goals regarding risk factors: _____
- 2. Current session goals: _____
- 3. Overall/general goals: _____

Objective information (content/themes discussed, client's language, client's responses to previous homework or strategies):

Interventions used to meet current session goals:

Evaluation of current session (circle your response):

1. I felt the intervention(s) in this session were appropriate for the family/couple/individual

 x x x x
1. Not at all appropriate 2 3 4. Very Appropriate

2. The goals for the session were addressed

 x x x x
1. Not at all addressed 2 3 4. Thoroughly Addressed

3. Overall I believe the session was

 x x x x
1. Poor 2 3 4. Very Good

Notes/ reminders for therapist _____

Therapist's Signature

Therapist's Signature

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