IPV Perpetrator groups: Client engagement, and the role of facilitators

(preliminary draft of literature review and methods)

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Group treatment for perpetrators of intimate partner violence (IPV), commonly known as batterer intervention programs, or BIPs, have been found to be marginally effective in lowering rates of physical and psychological abuse post-treatment (Babcock et al., 2016). There is some evidence that approaches based on cognitive-behavioral therapy (CBT) principles are more effective overall than those based on gender-based “feminist” models such as Duluth (Miller, Drake, & Natziger, 2013); however, surveys of BIPs indicate that most perpetrator treatment programs use some combination of Duluth and CBT, and other models (e.g., psychodynamic, trauma-informed), making it difficult to ascertain what works (Cannon, Hamel, Buttell, & Ferreira, 2016). Furthermore, nearly all of the research has focused on male perpetrators, and far less is known about the needs of abusive women.

Much of the debate among researchers and treatment providers regarding the superiority of one model over the other centers around the causes of IPV – e.g., whether it is male patriarchal attitudes (Duluth), family-of-origin issues (psychodynamic and trauma-informed models), or irrational beliefs and poor coping skills (CBT; see Hamel, in press, for a review). However, current research indicates that there are several important risk factors, and a consensus has emerged about IPV scholars that different client populations have different needs and require differing approaches – in terms not only of the risk factors addressed, but the length and intensity of the treatment and the way treatment is delivered. In that, the Risk-Need-Responsivity (RNR) model of offender treatment has promise (Babcock et al., 2016).

These findings suggest that it would be more productive to identify the treatment factors that predict lower recidivism rates across treatment models. Given that recidivism rates are significantly higher among program drop-outs (Daly & Pelowski, 2000), and given the number of group sessions that clients attend and the completion of the program both have an effect on the frequency and gravity of subsequent violent behavior ([Bennett, Stoops, Call, & Flett, 2007](#_ENREF_3)), it would make sense to also identify factors than increase client engagement in the group process. Indeed, in Rondeau et al.’s (1999) study, one of the main reasons given by IPV perpetrators who dropped out of the group was the that they did not feel engaged. Engagement in the group also seems to have influenced the men’s ability to maintain what they had learned by the end of the program ([Contrino et al., 2007](#_ENREF_6)).

General psychotherapy outcomes studies have consistently found client engagement in therapy, primarily through a strong working alliance, to be associated with greater motivation and better treatment outcomes (e.g., reductions in anxiety, depression; Wampold & Imel, 2015). Research on groups, including groups for involuntary clients, has also found a working alliance between client and facilitator, along with a well-functioning group process, to be associated with positive treatment outcomes (Corey, Corey, & Corey, 2010; Fuhriman & Burlingame, 1990; Morran, Stockton, & Whittingham, 2004). In the field of IPV, findings from randomized clinical trial (RCT) research indicates that the application of Motivational Interviewing and similar client-centered principles to the group process strengthen the working alliance between client and facilitator and predict greater group compliance as well as lower rates of recidivism post-treatment (Alexander, Morris, Tracy, & Frye, 2010; Musser, Semiatin, Taft, & Murphy, 2008; Scott, King, McGinn, & Hosseini, 2011; Taft, Murphy, King, Musser, & DeDyn,2003).

Few questionnaires have been developed to measure client engagement in BIPs. The Group Engagement Measure (GEM; Chovanec & Roseborough, 2017; Macgowan, 2006), measures client engagement in terms of attendance, contributing, relating to facilitator, contracting (support group norms), working on own problems, and working on other group members’ problems. It is intended to be administered by group facilitators, not by group members. (See Table 1.) The Working Alliance Inventory (WAI) has been used in BIP studies involving motivational interviewing approaches, but whereas WAI ratings by facilitators predict positive treatment outcomes, WAI ratings by clients may not (Taft et al., 2003), and the WAI only focuses on one aspect of the group process.

In groups, other processes are at play. A separate line of methodologically-sound ethnographic/ qualitative research, many of them based in grounded theory, has been conducted by various investigators, in which male BIP clients were interviewed, primarily with open-ended questions, to find out more about their group experiences (McGinn, McColgan, and Taylor, 2017; Morrison, Cluss, Hawker, Miller, George, Bicehouse, Fleming, & Chang, in press; Scott & Wolfe, 2000; Roy, Chateauvert, & Richard, 2013; Roy, Chateauvert, Drouin, & Richard, 2014; Roy, Doel, & Bertrand-Robitaille, 2015; Silvergleid & Mankowski, 2006; Wangsgaard. 2001). What makes these findings so valuable is that they address these processes and delineate the facilitator’s role in helping clients become engaged and motivated to change.

Specifically, BIP clients favor facilitators who are caring and committed; are non-judgmental; maintain a safe, working group environment; are honest, humble and genuine; are willing to challenge client behaviors, but in non-confrontational in respectful, non-confrontational ways; and who are knowledgeable about IPV and able to provide information and tools with which to change. However, other aspects of group processes involve relationships with other members, that contribute to group cohesion (Chovanec, 2012; McGinn, McColgan, and Taylor, 2017; Parra-Cardona et al., 2013; Roy, Doel, & Bertrand-Robitaille, 2015; Taft et al., 2003). The other men’s stories create a mirror, or reciprocal, effect that helps men to engage and work through their violence. These group processes dovetail with studies on therapeutic factors ([Lindsay, Roy, Montminy, Turcotte, & Genest-Dufault, 2008](#_ENREF_20); [Waldo, Kerne IV, & Kerne, 2007](#_ENREF_42)).

The Study

Interested in how this wealth of qualitative and quantitative data could be used to improve treatment delivery and clinical training, we developed two self-report client questionnaires. Given that the core of MI is allowing clients to take the lead in finding their own solutions, and that MI approaches predict positive outcomes, we thought these client-driven questionnaires, together with the GEM, might provide a standardized and practical way for group facilitators to improve their leadership skills, as well as provide supervisors and outside agencies (e.g., Probation) useful criteria for training and evaluation purposes.

The first of these questionnaires, adapted from the categories proposed by Morrison et al. (in press) and supplemented by the McGinn et al. (2017) review, that enumerates those qualities that BIP clients say helps them become engaged and motivated to change (CRF; see table 2). We made sure to keep all the items, especially those having to do with specific skills and tools, ideologically neutral, so that respondents can interpret each item according to their own experience. For example, a client may not endorse “learned to overcome my patriarchal beliefs” if he does not perceive himself in that way, whereas “changed some of my cognitions or pre-suppositions about people” would be more inclusive and capture a more inclusive set of responses.

 In addition to providing useful information about the role of facilitators in helping engage and motivate clients, findings from the client interview studies also identified the positive benefits of their group experience. One way to measure treatment outcomes, aside from tracking recidivism rates, is to look at improvements in areas of functioning that are may be related to, or an essential requirement for violence desistance – e.g., better impulse control, acquisition of pro-social interpersonal skills, and increased self-efficacy. Indeed, the study of male perpetrators by [Westmarland and Kelly (2013)](#_ENREF_21) showed that, according to feedback from female partners, perpetrators, practitioners and funders/commissioners, success of a BIP program is associated with particular changes. These include an improvement in the relationship between perpetrator and partner or ex-partner, a safe and positive shared parenting approach, increased consideration for the well-being of self and others, and a better awareness of the consequences of violence. We therefore created a second questionnaire, the Client Perceived Benefits of Group (CPBG; see table 3).

 To obtain additional information about the role played by facilitators in engaging clients in the group process, we asked that they complete the short version of the NEO personality inventory, the NEO-FFI-3 (McCrae & Costa, 2010). We also asked about the number of years each facilitator had conducting IPV perpetrator groups.

In this study, we wanted to determine the following:

1. Do CRF ratings predict higher CPBG scores?
2. Are high GEM scores from facilitators predictive of high CPGB scores?
3. Do CRF scores correlate with GEM ratings? For example, when a group member gives a high positive rating to a facilitator’s group leadership abilities, is the facilitator likely to rate that member as positively engaged in group?
4. Are either CRF or CPBG scores associated with a particular facilitator personality profile, as measured by the NEO-FFI-3?
5. Are either CRF or CPBG scores associated with facilitator experience?
6. What differences, if any, were there between male and female clients?
7. How do agency overall treatment approach and facilitator age, sex, ethnic background, education, and clinical experience impact CRF scores?

**Method**

Court-certified batterer intervention program directors throughout the greater San Francisco Bay Area, California, were contacted by the first author in the Summer of 2019. Agency directors who agreed to participate in the study were all given copies of the various questionnaires in advance, and the first author was available to answer any questions. To obtain an acceptable sample size, agency directors were asked to invite all available facilitators to participate in the study. As an incentive for study participation, all directors and facilitators were offered a free 8-hour online CEU training course.

Data collection involved two discrete phases. In the first phase, participating agency directors were first asked to complete two initial questionnaires: (a) one asking about the agency’s approach to treatment (e.g., Duluth, CBT, MI, etc.) and the directors’ views on IPV risk factors; and, (b) the other asking for information on the age, gender, ethnic background, education level, and BIP group experience for each facilitator who agreed to participate in the study. In the second phase of data collection, agency directors were tasked with requesting that each participating facilitator at their agency (1) complete the short-form NEO -FFI-3, and (2) use the GEM to rate each client in one of their groups, and indicate how many weeks each had been attending (a previous study found engagement rates among BIP group clients to rise over time; Chovanec & Roseborough, 2017). For example, at agency X, the director would identify the group leader, Jane Doe, as facilitator 1 and each client in her group would be 1A, 1B and so on. Directors were instructed to assign a letter to each client, and to arrange a date to personally administer the client questionnaires to each group at the mid-point of the group. They were further instructed to inform the clients about the study procedure, its voluntary nature, the benefits of cooperating (allowed to leave group earlier than usual), and issues of confidentiality. Clients who agreed to cooperate were not asked to put their names on their questionnaires; rather, the directors were instructed to write on each questionnaire the letter corresponding to the GEMs previously completed. Upon completion, clients were asked to put their questionnaires face-down, after which the agency director put them all in a large envelope, sealed it and delivered the envelope to the first author. In this way, the directors were privy to the raw data as it was being collected, but the research team was only provided with de-identified data for conducting the study analyses. Participating clients were reassured that questionnaire responses would never be made available to their facilitators, the agency, or outside parties such as Probation, and were given the first author’s contact information if they had any questions.

Table 1. Group Engagement Measure

Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Scored by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_

1 =Rarely or none of the time; 2 =A little of the time; 3= Some of the time; 4 =A good part of the time;
5 =Most/all of the time

**I. Attending**

1. Arrives at or before start time. 1 2 3 4 5
2. Stays until the end of sessions or leaves only for important reasons. 1 2 3 4 5
3. Does not hurry to leave at the end of sessions. 1 2 3 4 5

**II. Contributing**

1. Contributes his/her share of talk time (not too much, not too little.) 1 2 3 4 5
2. Seems to follow and understand what others are saying. 1 2 3 4 5
3. Responds thoughtfully to what all others are saying (not just one or two.) 1 2 3 4 5
4. Verbally interacts with members on topics related to the group's purpose. 1 2 3 4 5
5. Participates in group projects/activities. 1 2 3 4 5

**III. Relating to worker (group facilitator)**

1. Follows guidance of the worker (e.g., discusses what worker wants group 1 2 3 4 5
to discuss, is involved in activities suggested by the worker).
2. Shows enthusiasm about contact with worker (e.g., demonstrates interest in 1 2 3 4 5
the worker, eager to speak with worker).
3. Supports what the worker is doing with other members (e.g., by staying on topic 1 2 3 4 5
or expanding on discussion).

**IV. Relating with members**

1. Likes and cares for other members. 1 2 3 4 5
2. Helps other members to maintain good relations with each other (e.g., by encouraging 1 2 3 4 5
members to work out interpersonal problems, by cheering up members, and so forth.)
3. Helps and encourages other members. 1 2 3 4 5

**V. Contracting**

1. Expresses continual disapproval about the meeting times. 1 2 3 4 5
2. Expresses continual disapproval about the number of meetings. 1 2 3 4 5
3. Expresses continual disapproval about what the group members are doing together. 1 2 3 4 5

**VI. Working on own problems**

1. Partializes problems and works on their parts. 1 2 3 4 5
2. Makes an effort to achieve his/her particular goals. 1 2 3 4 5
3. Works on solutions to specific problems. 1 2 3 4 5
4. Tries to understand the things he/she does. 1 2 3 4 5
5. Reveals feelings that help in understanding problems. 1 2 3 4 5

**VII. Working with other's problems**

1. Talks with (encourages) others in ways that help them focus on their problems. 1 2 3 4 5
2. Talks with (encourages) others in ways that help them partialize or specify their problems. 1 2 3 4 5
3. Talks with (encourages) others in ways that help them do constructive work on 1 2 3 4 5
solving their problems.
4. Challenges others constructively in their efforts to sort out their problems. 1 2 3 4 5
5. Helps others achieve the group's purpose. 1 2 3 4 5

SCORES (for each category, divide total by number of items completed)

I \_\_\_\_\_\_\_ II \_\_\_\_\_\_\_ III \_\_\_\_\_\_\_ IV \_\_\_\_\_\_\_ V \_\_\_\_\_\_\_ VI \_\_\_\_\_\_\_ VII \_\_\_\_\_\_\_ Total Score: \_\_\_\_\_\_\_

Table 2. Client Rating of Facilitator (CRF)

1. Invested and committed.
* Wanted to help, concerned about use, cared about us
* Committed to helping us overcome our abusive behavior, so we do not return to the same situation that got us into the program
1. Non-judgmental
* Open-minded, allowed group members to have their own opinions
* Humble, did not act like he/she is perfect
* Did not put group members down
1. Group environment
* Helped members participate in the group and engage positively with each other
* Helped members to learn from one another
* Created a comfortable, relaxed group environment
* Encouraged each of us to talk, without being too pushy about it
* Listened, and seemed genuinely interested in what we had had to say, and regarded each member as a separate individual with their own needs
* Did not favor one member over another
* Discouraged members from “colluding” – that is, from supporting each other’s abusive, destructive, or illegal behavior
1. Honesty and challenging behaviors
* Challenged us on some of our behaviors
* When he/she did confront a member, the intention was not to punish, but to help that member get honest, learn from his/her experiences, and change their behaviors

Supported our efforts to change our behaviors

1. Experience and Expertise in IPV
* Knowledgeable about intimate partner violence – its dynamics, what causes it, and how it affects others
* Gave us useful tools and information
* Relayed this knowledge to us in a way that made it easy to understand

Table 3. Client Perceived Benefits of Group (CPBG)

The group helped me to:

1. Better control my emotions, including anger
2. Become aware of the negative and distorted thinking that leads me to become abusive
3. Improve my ability to communicate with my partner
4. Improve my ability to communicate with others
5. Improve my ability to resolve conflicts with my partner
6. Improve my ability to resolve conflicts with others
7. Develop more empathy for my partner
8. Develop more empathy for others
9. Feel more empowered, so I can get my needs met appropriately
10. Reduce my emotional dependency on my partner

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