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Introduction
One of the main contributions of the transtheoretical model of behavior change (TTM; Prochaska & DiClemente, 1984) has been to sharpen our conceptual focus on motivation and readiness to change. The idea that individuals (and larger systems as well) proceed through an orderly set of stages in preparing for, accomplishing, and maintaining behavior change has been a major insight with wide applicability to addictive behaviors, psychotherapy, and health behavior promotion (Prochaska & DiClemente, 2005; Prochaska, DiClemente, & Norcross, 1992; Prochaska, Johnson, & Lee, 1998).

THE STAGES OF CHANGE

The TTM explains intentional behavior change along a temporal dimension that utilizes both cognitive and performance-based components. Existing research has found that individuals move through a series of stages (precontemplation, contemplation, preparation, action, and maintenance) in the adoption of healthy behaviors or cessation of unhealthy ones (Prochaska & Velicer, 1997).

Precontemplation is the stage in which an individual has no intent to change behavior in the near future, usually measured as the next
6 months. With respect to behavior change, precontemplators are characterized as resistant, unmotivated, or demoralized. They tend to avoid information, discussion, or thoughts with regard to changing the targeted health behavior.

In the contemplation stage individuals express an intention or desire to change without a clear and immediate plan to enact the desired changes. They are aware of the benefits of changing, but remain aware of the costs, risks, or drawbacks. Contemplators are often seen as either ambivalent to change or as procrastinators.

Preparation is the stage in which individuals express a clear intention to change, usually within the next month, and may have begun taking initial steps. Given its shorter time frame, the preparation stage is often viewed as a transition rather than stable stage, with individuals intending to take imminent and concrete steps toward the target goal.

Action is the stage in which an individual has been making overt and measurable lifestyle changes, typically for a period of less than 6 months. Finally, in the maintenance stage, individuals have successfully altered their behavior and may need to take additional steps to prevent relapse and consolidate gains secured during the action stage. Those in maintenance are also distinguishable from those in action in that they tend to report higher levels of self-efficacy and resistance to relapse.

Approximately a decade ago, several scholars recognized the potential utility of the TTM for understanding the change process in both perpetrators (Daniels & Murphy, 1997; Dutton, 1995) and victims (Brown, 1997) of intimate partner abuse. With respect to perpetrators, the need for greater emphasis on motivation and readiness to change was starkly apparent in the tendency of many perpetrators to deny or minimize personal problems, blame others for their behavioral difficulties, failure to attend court-ordered services, overt resistance to counseling, and noncompliance with directive behavior change interventions. Clinical observations with both victims and perpetrators further revealed frequent cycling through periods of separation and reunification, a steady accrual of negative consequences associated with relationship problems and abuse, and the need for a lengthy period of self-evaluation and support prior to significant life change. Such circumstances resemble the change process facing those with addictions and the challenges of health behavior promotion, both instances in which the TTM had been successfully applied.
MOTIVATIONAL INTERVIEWING

Motivational interviewing (MI) is a therapeutic strategy and counseling approach that is based on the recognition that clients who need to make changes approach counseling at different levels of readiness to change (Miller & Rollnick, 2002). As such, it is intimately related to models of change that delineate different phases or stages such as the TTM. As in the case of the TTM, MI was initially developed to assist therapists to work with alcohol- and drug-dependent individuals who were often resistant to more traditional methods of counseling developed for purely voluntary and self-motivated clientele.

The overall focus of MI was to engage alcohol- and drug-abusing clients, commonly referred as a result of complaints by family members and/or violations of the law. Specific interviewing methods are employed that are designed to mobilize intrinsic motivation within the client’s circumstance by developing cognitive and behavioral discrepancies and by exploring and resolving the sources of ambivalence that inhibit change. As in the case of the TTM, there are similarities between the motivational dynamics of the substance-abusing and the partner-abusing client, who is also doing harm to family members and violating the law through acts of domestic violence. These similarities have made the use of MI strategies well worth investigating for their potential utility in cases of intimate partner violence.

Motivational interviewing attempts to establish a therapeutic alliance with the client by using a high level of empathic listening, affirming the client’s autonomy and choice, and matching interventions to the client’s stage of change. As such, it is intended to create a nonjudgmental, nonconfrontational, and nonadversarial climate in which the client is “accepted” despite the presence of “unacceptable behavior.” The approach attempts to increase the client’s awareness of the potential problems caused, consequences experienced, and risks faced as a result of the unhealthy behavior in question. Therapists help clients realize the benefits of change and help them become motivated and committed to achieve it.

Motivational interviewing is based on four basic therapeutic principles.

1. Assessment of the client’s stage of change and perspective to allow the therapist to communicate understanding, empathy, and congruence with the client’s perspective.
2. Development of cognitive and attitudinal discrepancies to help clients appreciate the value and potential benefits of change by exploring the difference between how clients want their lives to be versus how they currently are functioning, thinking, and behaving.

3. Acceptance of resistance by defining the client’s defenses and reluctance to change as a process and phase rather than a pathological sign of character flaw and failure.

4. Support self-efficacy by embracing the client’s autonomy and power to change, or not to change, to facilitate movement toward active decision making and action.

The chapters in this book represent important applications of the TTM and MI strategies to intimate partner violence (IPV) and abuse. These studies include descriptive longitudinal research on both victims and perpetrators of abuse, measurement issues in assessing stages of change, and applications of motivational interviewing methods for facilitating change. Many of the contributions have been drawn from recently published issues of the journal Violence and Victims (vol. 23, numbers 4 and 5). Other chapters have been modified or added to the present book version to allow for a more expanded and updated treatment of these topics.

Stages of Change in Perpetrators of Domestic Violence and Abuse

Five chapters in this book focus on application of the TTM to male perpetrators of IPV. Begun and colleagues (chapter 9) provide a nice example of the psychometric sophistication of recent efforts to develop and validate measures of the stages of change for this population. They have put considerable effort into developing items that reflect the distinct stages of change for abusive individuals. Their chapter describes the factor structure of the revised measure, including detailed information to support the addition of a maintenance factor. It also discusses some of the prior data on the validity of this instrument.

Levesque, Driskell, Prochaska, and Prochaska (chapter 3) describe the TTM’s stages and examine the acceptability of a computer-administered multimedia stage-matched expert system intervention among 58 men who have battered. Thirty-three of the men were recruited at program intake and 25 from ongoing groups. The expert system assessed the stage of change, decisional balance, processes of change, self-efficacy,
and strategies used to progress to ending violence. The participants were provided immediate individualized feedback during their intervention. Overall, the vast majority (87%) of these men reported that the program was easy to use, and most (98%) felt that the system could “probably” or “definitely” help change their attitudes or behaviors.

In applying the stage-of-change model to partner-violent men, three of these studies uncovered interesting similarities and differences. Alexander and Morris (chapter 6) identified two distinct stages-of-change clusters, one reflecting a classic precontemplation/immotive profile and the other reflecting a contemplation/preparation profile with greater readiness to attempt personal change. In identifying four clusters, Eckhardt, Holtzworth-Munroe, Norlander, Sibley, and Cahill (chapter 5) appear to have divided those who were relatively unprepared for change into a “reluctant” cluster, who deny any problem with abuse or any need for change, and a “preparticipation” cluster, who have a “flat” profile reflecting some acknowledgment of problems and the need for change but no clear commitment to the change process. In addition, their analysis identified an “unprepared” action cluster of men who are relatively high on the active change scale but low on scales reflecting cognitive preparation to change and awareness of relapse potential. Brodeur, Rondeau, Brochu, Lindsay, and Phelps (chapter 7) uncovered five clusters. Similar to Eckhardt and colleagues (chapter 5), they found several early-stage groups, labeled reluctant, immotive, and preparticipation. In addition, they found two action clusters distinguished by whether they also reported high fear of relapse.

The differences between these three studies reflect an inherent limitation in cluster and profile analysis, namely, that there is no universally accepted way nor any hard-and-fast statistical criterion to rely on in choosing the number of clusters. Greater parsimony and simplicity may result from fewer clusters, yet important subgroup distinctions may be uncovered from having more clusters. Given the inherently descriptive nature of cluster-analytic techniques, newer approaches such as latent class analysis, mixture modeling, and taxometric analysis may provide some advantages for determining whether observed data conform to a predicted categorical structure or whether continuous variable indicators, such as observed scores on stage-of-change scales, appear to result from an underlying categorical causal process. To date, applications of the TTM stage concept have likewise relied almost exclusively on cluster analysis, and therefore the hypothesized stage categories have not been systematically subjected to confirmatory tests.
In addition, readers must be mindful of the fact that cluster analysis creates profiles based on relative rather than absolute scale scores. Thus, these clusters should be conceptualized as prepared or unprepared for change relative to their sample counterparts and not necessarily as prepared or unprepared for change in an absolute sense. This scoring and assignment method places limitations on the clinical use of these findings in the individual case.

It is also important to note that Alexander and Morris (chapter 6) sampled individuals who presented for an initial counseling intake at a suburban, community-based domestic violence agency, whereas Brodeur and colleagues (chapter 7) sampled men presenting at urban counseling programs who were willing to participate in a research study, whereas Eckhardt and colleagues (chapter 5) sampled directly from the court in an urban area. The court sample included a large number of cases who never attended intake orientation at a domestic violence program and was characterized by a very high rate of probation violation. Thus, it is likely that this sample contained a greater proportion of individuals who were unwilling to acknowledge problems with abusive behavior or the need for change. Sample variations in ethnic, cultural, and linguistic backgrounds may also influence how individuals respond to assessment measures in ways not yet studied and known.

Despite important differences in sampling and data analysis, two of the three studies revealed significant differences among those in different stage of change clusters. Those who appear relatively more ready to change self-reported more abusive behavior than those who appear relatively less ready to change. However, the Alexander and Morris (chapter 6) study found that abuse reports from victim partners were more similar across clusters, suggesting that the self-report results may reflect the willingness to disclose abusive behavior rather than actual subgroup differences in perpetration of abuse. Along similar lines, in the study by Eckhardt and colleagues (chapter 5), those in the decision-making cluster who appeared most ready to change also acknowledged the greatest level of problems with hostile thinking and anger. Likewise, Alexander and Morris (chapter 6) found that those in the prepared cluster self-reported more anger as well as greater anxiety and depression than those in the immotive cluster. Interestingly, they also found that the prepared cluster showed greater reductions in self-reported anxiety and depression and greater increases in self-reported anger control after treatment. These findings underscore the importance of assessing anger in men who are violent and abusive toward intimate partners (cf. Maiuro &
Eberle, 2008). The present results specifically suggest that anger and hostility may not only be an important focus of treatment for many abusive men but also may provide a diagnostic marker of emotional awareness or “mindfulness” associated with readiness to change.

In all three of these studies, stage-of-change cluster was not predictive of treatment completion. Likewise, in the intervention study by Musser and colleagues (chapter 4), motivational interviewing affected positive group behavior, homework compliance, and the working alliance but did not affect treatment session attendance. It appears that session attendance is influenced by factors other than self-reported motivational or readiness to change among partner-abusive men. For example, given that the samples were predominantly or exclusively court ordered to treatment, session attendance may reflect participant’s fear of legal reprisals for noncompliance. Practical barriers, such as transportation, work schedules, and child care, may also limit compliance for those who are otherwise motivated to attend. Conversely, these findings may reflect complications in measuring readiness to change, wherein self-reports are influenced both by genuine attitudes and by impression management, watering down the prediction of treatment compliance.

Finally, in two of the three investigations, although the results should be considered preliminary because of limited availability of follow-up data, the tendency to score high on the precontemplation scale was predictive of continuing problems with abuse. Thus, stage-of-change clustering may be less useful in predicting abuse recidivism relative to continuous variable measurement of precontemplation, which indicates denial of a need for change.

The study by Eckhardt and colleagues (chapter 5) provides additional interesting findings with respect to the prominent typology model proposed by Holtzworth-Munroe and Stuart (1994) and Holtzworth-Munroe, Meehan, Herron, Rehman, and Stuart (2000). In addition to replicating a number of correlational findings for the typology, the results showed associations with stage-of-change clusters that were somewhat inconsistent with the hypotheses. Most notably, the least severely abusive and least pathological subgroup (family only) were overrepresented in the reluctant (precontemplation) cluster, whereas the more pathological and severe types of abusers (borderline/dysphoric and generally violent/antisocial) were overrepresented in the decision-making or unprepared action clusters, demonstrating greater perceived need for change and/or self-reported efforts to change. These findings suggest a possible need to correct for “test taking attitude” differences that may
exist between subtypes of abusers when assessing readiness to change. The fact that abuser subtype was significantly associated with program completion and criminal recidivism, whereas stage cluster was not, also speaks to the possible greater power of abuser subtype as an initial predictor of outcome.

**Stage-of-Change Profiles for Victims of Intimate Partner Abuse**

Chapter 12 by Burkitt and Larkin is unique in several respects, most notably in using a prospective design with a sample of IPV victims obtained from a level I trauma center. The emergency medicine and public health perspective on change in abused women is very important, as those who present for medical services may reflect a broader cross-section of abused women in comparison to those who seek counseling or shelter services at domestic violence programs. Thus, stage-of-change and related phenomena can be studied in this population separately from the dynamics of help seeking for self-identified abuse victimization. In addition, the sample was rather severely affected by IPV, with more than four-fifths reporting injuries and more than two-thirds having obtained medical care for IPV.

The study sample exhibited an interesting pattern of movement through the stages of change over time, with a sizable number of women shifting toward action and the general trend being progression of a cluster of behavioral tendencies over the course of the study. Interestingly, those who progressed further on the stage-of-change measure were considerably more likely to end their relationships by the follow-up assessment. Burkitt and Larkin (chapter 12) also identified a number of important factors that differ across stage-of-change clusters, including decisional balance regarding the pros and cons of leaving the relationship, temptation to remain in or return to the abusive relationship, the use of community resources, and the presence of children. Thus, this chapter highlights the utility of the TTM in understanding both the emotional and the practical barriers to change as well as the general tendency for seriously abused women in the community to eventually leave the abusive partner.

Burke, Mahoney, Gielen, McDonnell, and O’Campo (chapter 11) also examine women’s experience of interpersonal victimization (mainly severe physical abuse) by comparing stage assignment (precontemplation, contemplation, preparation, action, and maintenance) with safety
behaviors, stage of leaving the relationship, and desired services. They develop a novel approach for assigning women to stages of change based on prior in-depth qualitative interviews and the use of logic similar to that employed with addictive and health promotion behaviors. The majority of their sample (65%) of 96 abused, urban women (primarily African American and low income) from six health care settings were in the action stage, reporting that they had been exposed to abuse and had taken action to keep themselves safe from abuse within the past 6 months. Burke and colleagues found interesting and complex links between stage of change and use of safety behaviors, with most extensive use in the pre-action stage. This result may have been due in part to the nonlinear and variable rates of progression between safe and unsafe situations inherent to the lives of battered women (Chang et al., 2006). This study provides unique insight into the relationships between stages of change and clinically important behavioral variables, including safety behaviors and perceived need for services.

**Readiness to Change in a Sample of Women Batterers Compared to a Comparison Group of Men Charged With Abuse**

The study conducted by Simmons, Lehmann, and Cobb (chapter 10) is unique in offering data on a group of women charged with domestic violence, using a comparison sample of men charged with similar behavior. The groups were compared on a variety of risk factors, attitudes toward the use of violence in their intimate relationships, as well as their self-report stage of change as measured by the University of Rhode Island Change Assessment for Domestic Violence (URICA-DV; Levesque, Gelles, & Velicer, 2000). Most women were found to be in the action stage of change at the point of pretreatment. No differences were found between women and men on precontemplation, contemplation, and action indices. Interestingly, the only difference in readiness to change that emerged was a relatively small one with regard to maintenance of non-violence with one’s partner, with men scoring higher than women on this subscale. Although such results appear counterintuitive given the fact that men are often presumed to have more ingrained traits related to aggression, the authors argue that these differences may stem from the women’s tendency to perceive their own violence to be more justifiable than men’s violence. It would be of interest to see if these gender differences continued to be present when the offender samples were refined
by limiting the men and women selected to “primary aggressors.” Such results support the importance of using contextual and gender-sensitive frames of reference when interpreting stage-of-change data, and the need to further explore attitudes that may moderate the associations between readiness to change and successful cessation of violent behavior.

**Motivational Interviewing With Abuse Perpetrators**

Chapters 2, 4, and 8 provide encouraging findings from experimental tests of motivational interviewing (MI) for partner-abusive men. Chapter 8 presents findings from a novel application of MI to a nonadjudicated community sample of men. Using an approach modeled after the “Drinker Check-up,” an early application of MI to individuals with concerns about their drinking, the study solicited participants with personal concerns about their abusive behavior through community announcements and advertisements. The investigators targeted a subgroup of respondents who had children. They found that participants who received a brief telephone MI intervention with personalized assessment feedback had lower levels of abusive behavior over the subsequent 30-day interval than those in the control group. Although readiness to change, formal treatment seeking, and willingness to participate in an optional in-person session after the initial phone consultation were not significantly higher among those who received MI, the results for at least temporary decreases in abusive behavior subsequent to the brief MI intervention provide encouragement for continued examination of motivational therapy with abusive men.

The studies presented in chapters 2 and 4 provided two sessions of MI to partner-abusive men prior to their assignment to standard group counseling. In the Kistenmacher and Weiss (chapter 2) study, the control group was randomly assigned to receive no pregroup intervention. In the study by Musser and colleagues (chapter 4), the control group was constructed on a quasi-random basis in which cohorts of consecutive intakes were assigned to receive a structured intake with no MI versus the MI intervention.

The findings by Kistenmacher and Weiss (chapter 2) focus on readiness to change and the tendency to externalize blame for abusive behavior. The MI group showed increases in contemplation and action and increases in responsibility assumption for their abusive behavior, suggesting progression through the stages of change associated with the MI intervention. Interestingly, the outcome measures were taken immedi-
ately after the second MI session and were therefore likely sensitive to the short-term effects of this counseling style.

The study by Musser and colleagues (chapter 4) likewise found evidence for increased personal responsibility assumption for abusive behavior associated with MI but in a very different mode of assessment, namely, coded verbalizations during early group treatment sessions. In addition, those who received MI in this study expressed greater belief in the value of treatment, completed considerably more structured home assignments in the cognitive-behavioral therapy (CBT) program, and ended up with higher therapist ratings of the working alliance late in treatment. They also engaged in more help seeking outside the CBT program than those in the control group. Interestingly, no differences emerged on the stages-of-change measure in this latter study, perhaps because this outcome was assessed during the first group treatment session, possibly also due to variable time durations from the initial completion of intake (due to the lag in constructing treatment groups). Finally, it is interesting to note that some of the factors influenced by the MI intervention in the Musser and colleagues study (chapter 4), specifically therapist ratings of the alliance and homework compliance, have been shown to predict lower postintervention abuse (Taft, Murphy, King, Musser, & DeDeyn, 2003).

**CONCEPTUAL AND EMPIRICAL CHALLENGES**

**The Influence of Relationship Context**

The individual level of analysis inherent in most applications of the TTM may be complicated by problems that are significantly influenced by interactional, multiperson processes. In application to abuse perpetrators, for example, some individuals may be violent in the presence of specific relationship and life conditions. A response to physical attacks by the partner is perhaps the most obvious example. The discovery of a partner’s infidelity, imminent separation, child custody disputes, or other acute relationship stressors may likewise enhance the risk for interpersonal conflict to escalate to physical assault. For victims, factors such as the abusive partner’s involvement in counseling, with the attending hope for change, may substantially influence decisions to leave the abusive relationship (Gondolf, 1988). In brief, relationship circumstances and the other intimate partner’s behaviors and attitudes may
play a substantial interactive role in readiness to change in an abusive relationship.

**The Complexity of the Target Behavior**

To date, most of the applications of the TTM focus on relatively simple and quantifiable target behaviors, such as smoking, use of alcohol and drugs, or physical exercise. Although aspects of physical assault (e.g., pushing, hitting, and so on) can be operationalized in a relatively straightforward way, other aspects of partner abuse problems, including the many forms of coercion and emotional abuse, are more idiosyncratic and complex. The target behavior for change is particularly complex with regard to victims of partner violence, as it may involve altering their own relationship or help-seeking behaviors, influencing the partner to get help, and/or leaving the abusive relationship. Likewise, those in abusive relationships may define their problem(s) in a number of distinct ways. For some, the problem is perceived as “having gotten in trouble with the law.” For others, it may involve attributions about drinking or drug abuse. Some individuals may define the problem as belonging entirely to the partner rather than oneself. Some conceptualize the problem as a bad temper, others as a bad relationship. Similarly, some victims want the abuse to end but not the relationship, and may then be willing to engage in some action steps but not others. Such variables may influence assessment of readiness to change in complex ways, depending in part on the manner in which the questions are asked and the context in which the assessment takes place.

These caveats are illustrated in the present text as several different strategies to measure stages of change in abusive individuals are represented, using different means to identify the problem behavior. For example, the URICA-DV developed by Levesque and colleagues (2000) and used by Eckhardt and colleagues (chapter 5) and Brodeur and colleagues (chapter 7) explicitly mentions partner violence in the scale items. The adapted URICA used by Alexander and Morris (chapter 6) also has a general introduction that orients the participant to domestic violence. However, the item wordings refer to “the problem” without explicit reference to violence or abuse. Finally, the Safe-at-Home measure developed by Begun and colleagues (chapter 9; 2003) uses a variety of different terms and phrasings to identify the problems and attitudes
about change, wordings that arose in focus groups with treatment providers. Thus, differences in findings may in part reflect divergence in abusive individuals’ reactions to the way that their problems are described or worded in the various measures.

**Disclosure and Response Bias**

Perhaps the greatest challenge in assessing readiness to change and its implications for partner violence arises from individual differences in honesty and self-disclosure, which are likely influenced by perceived costs and benefits of responding in a socially desirable fashion to the assessments. Such influences are readily apparent in several studies to date. For example, the unexpected findings of Eckhardt and colleagues (chapter 5) regarding stage-of-change cluster and violence subtype are very interesting. In their data, those with fewer or less objective indications of an abuse problem were also very unlikely to acknowledge the need for change. It may be that at some level of abusive behavior perpetration, denial breaks down, making it very difficult not to acknowledge having some type of problem.

A multisite study in Maryland using the URICA with clinical male partner-violent offenders revealed two distinct clusters of individuals with relatively high readiness to change scores (Murphy, Alexander, Black, & Morris, 2005). One cluster had the classic profile of a prepared or committed group with low precontemplation scores and relatively high scores on the contemplation, action, and maintenance scales. A second cluster had very high precontemplation scores, average contemplation scores, and high action and maintenance and were labeled the false maintenance cluster. At baseline, the prepared group had considerably lower scores on a measure of impression management and higher self-reports of abusive behavior than the false maintenance cluster, yet their collateral partner reports of abuse were quite similar (with the false maintenance cluster having somewhat higher levels of sexual coercion). At a collateral partner follow-up 6 months later, the prepared cluster had low prevalence rates of partner violence, whereas the false maintenance cluster had very high rates. These data suggest that some individuals who appear motivated on overall readiness-to-change scores are expressing a belief that they have already solved the problem with abuse without having gone through the efforts normally needed to make lasting behavior change.
FUTURE PROSPECTS

Clinical Applications

Intervention work with partner-violent individuals would greatly benef- it from accurate preintervention screening to detect cases at very high risk for severe and repetitive violence recidivism (Gondolf, 2002). To date, traditional risk-screening strategies adopted from criminal justice interventions, most notably those assessing psychopathic personality traits and related risk indicators, have afforded modest and inconsistent prediction of abuse recidivism in samples of clinical partner-violent men (Dutton, Bonarchuk, Kropp, Hart, & Ogloff, 1997; Gondolf & White, 2001; Kropp & Hart, 2000; Remington & Murphy, 2001). Several other risk assessment or prognostic instruments suggest that the major recidi- vism predictors relate to the level, severity, and extent of previous partner violence (Hilton et al., 2004; Kropp & Hart, 2000; Murphy, Morrel, Elliott, & Neavins, 2003) or victim predictions of risk for future violence (Weisz, Tolman, & Saunders, 2000).

Considerable optimism accompanied initial applications of the TTM to abusive clients in counseling, reflecting the hope that the stage of change construct might provide sound prediction of treatment response and/or a mechanism for assignment to different interventions. As with many new applications, reality appears to be more complex than initial expectations, as the predictive findings have not always turned out as expected despite evidence that the measures have sound psychom- etric properties. Thus, as yet, measures of readiness to change have not afforded strong prediction of intervention response despite having provided conceptually interesting findings. Conversely, the research presented by Burkitt and Larkin (chapter 12) suggests that change in relationship status over time may be a more predictable outcome from TTM variables for victims than is violence cessation for offenders.

Motivational interviewing, an intervention approach that relies in part on the stage-of-change concept, looks promising as an early inter- vention for partner-violent men in initial clinical trials. The significant impact of MI has been demonstrated in reducing initial resistance to treatment and enhancing treatment engagement. These findings need to be considered in light of two important known facts about partner- violent individuals. First, many of them are resistant to treatment. Sec- ond, to date, no specific intervention approach has been shown to be significantly more helpful than any other for this population (Babcock,
Green, & Robie, 2004). Thus, the mere fact that two trials have shown initial evidence of the utility of a specific intervention approach with this population is very encouraging, even though the outcomes are relatively modest in scope.

The present findings help bolster the conclusion emerging from other recent research on partner-abusive men, namely, that introductory supportive, empathic, alliance-building clinical strategies may improve intervention outcomes for this population. First, the collaborative working alliance between therapist and client has been associated with lower posttreatment abuse in two separate studies with distinct intervention formats (Brown & O’Leary, 2000; Taft et al., 2003). Likewise, supportive communication about treatment attendance after missed sessions, which included a personalized handwritten note and a phone call to express concern and encourage attendance, was associated with increased session attendance and lower dropout for this population (Taft, Murphy, Elliott, & Morrel, 2001). The presently reported studies offer firm support that MI can effect the client’s report of active change efforts, positive verbalizations during treatment sessions, and compliance with structured treatment task.

Research Directions

Several potentially important research directions are suggested throughout this publication. First, better strategies are needed for taking response biases into account in assessing readiness to change. It may be helpful to develop methods that do not rely on self-report and to use techniques such as cluster analysis and mixture modeling to separate out groups who are genuinely motivated to change from those who may be endeavoring to fake good on self-report assessments. Such statistical methods may need to use measures of response tendencies in addition to the transtheoretical measures to achieve these goals, as simple statistical control for social desirability may not be sufficient to detect complex response patterns. Second, as noted by Kropp, one of the developers of the Spouse Assault Risk Assessment Guide, the goal is not simply to predict poor intervention response or recidivism but rather to use risk information in order to prevent future violence from occurring (Douglas & Kropp, 2002; Kropp, 2004). Thus, future studies may profitably focus on readiness to change as part of a more comprehensive risk-management and violence-prevention strategy. Matching clients to treatments on the basis of readiness to change is one potential direction for this work, but
there are others as well, such as increased monitoring and safety planning for high-risk cases and the use of more extensive pretreatment preparation strategies to overcome initial resistance to change.

Another interesting direction involves the integration of motivational interviewing with other treatment techniques. As a general counseling approach, MI is quite distinct from behavioral and cognitive approaches and a number of other interventions, including pure-form client-centered therapy (Miller & Rollnick, 2002). Thus, there may be a challenge in shifting from MI to the more directive types of treatment strategies that are predominant in work with abusive clients. In fact, in a randomized trial of methods to help clinicians learn motivational interviewing for use with substance-abusing clientele, Miller, Yahne, Moyers, Martinez, and Pirritano (2004) found that the main changes observed were with regard to a decrease in therapist behaviors that were inconsistent rather than consistent with the principles of MI. Each approach may have its advantages, with MI primarily used to address ambivalence and reluctance to change during early stages of change, whereas more directive interventions may be more helpful and appropriate at later stages. Further treatment development is needed to address the best ways to integrate such approaches (cf., Murphy & Eckhardt, 2005).

A third direction involves new intervention or assessment approaches that are based on or related to a stage-of-change model. Two general strategies for intervention that have developed in other areas of behavior change may apply here. One approach involves the use of multiple doses of relatively brief, targeted feedback and guidance that is specifically tailored to the individual’s stage of change (e.g., Brug & van Assema, 2000; Dijkstra, De Vries, Roijackers, & van Breukelen, 1998), such as using automated protocols for delivering targeted feedback. The second approach involves developing a general sequential treatment process that is derived from a stage-of-change model (Morris & Alexander, 2005; Valesquez, Maurer, Crouch, & DiClemente, 2001).

From an assessment perspective, we now have a number of different methods and instruments for assessing stages of change. In a recent study, some of the same investigators featured in the current volume (Levesque, Velicer, Castle, & Greene, 2008) have developed a measure of “therapeutic resistance” to assess mind-sets and attitudes that might stand in the way of or discourage change. This new research represents a significant advance in the conceptualization of client resistance beyond the often mentioned denial and victim blaming to include system blaming, ongoing problems with the partner, problems in the treatment
relationship or alliance, social justification, hopelessness, isolation, as well as countercontrolling reactance of an active or passive nature.

A fourth direction for future research involves more detailed application of specific components of the TTM, such as the processes of change, levels of change, decisional balance, and self-efficacy. Initial efforts have been made to address some of these constructs, such as victim changes over time in the study by Burkitt and Larkin (chapter 12) and treatment attendance and compliance in the study of Brodeur and colleagues (chapter 7). However, any attempt at component analysis remains in its infancy, in part because of a lack of assessment methods, when compared to the basic stage-of-change construct.

**GENERAL SUMMARY**

This book provides a sound and promising basis for applying TTM and MI concepts to facilitate change in both victims and perpetrators of intimate partner abuse. These studies also illustrate both the benefits and the challenges inherent in assessing and applying the concepts of readiness and motivation to change in this area. Despite many conceptual and measurement challenges, their results indicate that greater attention to stages of change and motivation to change in interventions for both perpetrators and victims of intimate partner abuse may have considerable payoff in refining our intervention methods for domestic violence and abuse. We hope this collection of studies will be useful not only as a summary and discussion of our present understanding but also as a stimulus for future development of the field.

**REFERENCES**


