Role of Self-Determined Goals in Predicting Recidivism in Domestic Violence Offenders

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Objective: This study investigated the role of self-determined goals in predicting recidivism in domestic violence offenders. Method: The study was a posttest design with an annual follow-up of recidivism data of 88 court-mandated batterers who attended a solution-focused, goal-directed treatment program. We hypothesized that goal commitment, goal specificity, and goal agreement would predict recidivism, and that confidence to work on goals would affect the degree to which these factors predicted recidivism. Results: The recidivism rate for program participants was 10.2%, and the final model accounted for 58% of variance in recidivism. The model indicated that goal specificity and goal agreement positively predicted confidence to work on goals, which negatively predicted recidivism. Conclusions: Significance of the study was discussed with respect to the potential positive impact of utilizing self-determined goals, language of "self-determination," and "strengths and solutions" in batterer treatment as well as advances in social work intervention research.

Keywords: *self-determined goal; domestic violence offenders; solution-focused treatment; recidivism*

Goals for change as determined by clients have an important and pervasive impact on the therapeutic process (Elliot & Church, 2002; Foster & Mash, 1999). A major challenge encountered by most clients in social work treatment is that they know when they have a problem but they do not know when the problem has been successfully addressed. When this happens, clients may be in treatment for a long time because there are no clear indicators of health and wellness. Goal setting becomes crucial in successful treatment because it gauges clients' progress toward beneficial solutions to their problems (Maple, 1998). Both client and therapist will be able to see when the goals have been reached. When goals are defined as a major focus of treatment, accountability for changing one's behavior can be effectively achieved. The use of goals shifts the focus of attention from what cannot be done to what can be accomplished; it moves clients away from blaming others or themselves and holds them accountable for developing a better, different future. Goals also increase the client's awareness of their choices and offer them an opportunity to play an active role in their treatment (Lee, Sebold, & Uken, 2003). Consequently, clients' goals influence how they orient to treatment, participate in the process, and evaluate the effectiveness of the treatment efforts (Elliot & Church, 2002). Utilizing a client's self-determined goal in treatment is consistent with a strengths-based perspective that emphasizes the client's empowerment and self-determination (Greene, Lee, & Hoffpauir, 2005; Salebeey, 1996).

Society has instigated diverse responses to domestic violence, which has plagued our society and deeply hurt our families and children, in an attempt to end it. However, despite the proliferation of batterer programs across the country, most conventional treatment programs of domestic violence offenders do not fully utilize their clients' self-determined goals as an integral part of their treatment efforts. Choices for treatment for domestic violence offenders can be more than a clinical decision. Hanson (2002) suggests that the field of treatment of domestic violence offenders is political as well as empirical. "One does certain things not because they work, but

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because they are right—right, that is, in terms of the ultimate definitions of reality promulgated by the . . . experts" (Berger & Luckman, 1966, p. 118). Current batterer treatment programs are dominated by a deficits perspective, which is a result of the existing understanding of the etiology of domestic violence as well as the assumption that batterers need to be re-educated and punished for their behaviors. Consequently, treatment programs are mostly psychoeducational in nature and focus on confronting batterers to recognize and admit their violent behaviors, take full responsibility for their problems, raise awareness of patriarchal power and control (Pence & Paymar, 1993; Russell, 1995), learn new ways to manage their anger, and communicate effectively with their spouses (Geffner & Mantooth, 1999; Wexler, 1999). Treatment that focuses on utilizing the client's self-determined goals, on the other hand, emphasizes the client's strengths and empowerment; assumptions and values that are antithetical to a deficits perspective of domestic violence offenders.

Although the significant contributions of conventional, feminist-cognitive-behavioral treatment approaches in advancing treatment for domestic violence offenders can never be overestimated, questions have been raised regarding the effectiveness of these programs both from a clinical and outcome perspective. A major therapeutic hurdle when working with this population is the issue of motivation (DeJong & Berg, 1999). Most domestic violence offenders are involuntary, court-mandated clients who are not self-motivated to receive treatment. Many practitioners working with the court-mandated domestic violence offenders are only too familiar with the defensiveness that is commonly manifested in constant evasiveness, silence, phony agreement, and vociferous counterarguments when participants are confronted with their problems of violence (Murphy & Baxter, 1997). Many of them stop attending the programs altogether. Gondolf and Foster (1991) studied the attrition rates of a 32-session batter program, and of the 27 participants who attended the first session, only 7.4% completed 32 sessions. Cadsky, Hanson, Crawford, and Lalonde (1996) reported a 75% noncompletion rate of participants who were recommended for treatment at male batterer treatment programs in Canada.

Findings of empirical studies of the effectiveness of current treatment programs are not conclusive. Reviews of domestic violence offender treatment programs generally report recidivism rates ranging from 20% to 50% in the year after completion of program (e.g., Edleson, 1996; Rosenfeld, 1992; Tolman & Edleson, 1995). The rates of early dropouts from these treatment programs have been fairly high (Cadsky et al., 1996; Edleson & Syers, 1990). The recidivism rate of the Duluth Domestic Abuse Intervention Program, on which the Duluth model is developed, was 40% (Shepard, 1992). The Duluth model is the most widely used treatment approach for treating domestic violence offenders that adopts a feminist-cognitive-behavioral perspective. Saunders (1996) also reported a recidivism rate of 45.9% for the feminist-cognitive-behavioral treatment models. Two large-scale experimental evaluations have found batterer treatment programs to be largely ineffective in that there were no significant differences between those who received group treatment and those who did not in terms of their attitudes, beliefs, and behaviors (Feder & Forde, 2000) or victims' reports of new violent incidents (Davis, Taylor, & Maxwell, 2000). The inconclusive research and practice evaluations, on the other hand, can be an invitation for helping professionals to revisit the existing paradigm of treatment for domestic violence offenders.

The designs of outcome evaluations of batterer treatment programs have also been under increasing scrutiny for their narrow focus. Currently, most evaluations of treatment programs for domestic violence offenders adopt an input-output design in measuring outcomes (Gondolf, 1997). The focus of evaluation is on fixed behaviors of offenders, usually violence, when they enter and leave the program (Tolman & Bennett, 1990). The input-output model is a useful, straightforward, and expedient research design although it does not include other factors or variables that can be crucial to understanding the effectiveness of these programs. Among different limitations, such a model does not examine components within the program that may account for successful outcomes (Fagan, 1989; Valliant, 1982).

This article discusses a study that examined a treatment program that primarily utilizes clients' self-determined goals as the venue of change. The study examined the role of self-determined goals in predicting recidivism in domestic violence offenders. The authors would like to generate useful dialogues among helping professionals to revisit treatment practices, orientations, and assumptions regarding treatment of domestic violence offenders as well as research practices with such a population.

Empirical Evidence of Useful Goals

Despite the importance of goal setting and the routine procedure of deriving treatment goals in social work practice, there is relatively little theoretical or empirical work regarding the assessment of client's goals and the goal-setting process in treatment (Elliot & Church, 2002;

Hayes, 1993). Goal-setting theory is one of the best established and empirically tested theories developed by Edwin A. Locke and Gary P. Latham (1990, 2002) in the field of organizational psychology. The theory was developed based on empirical research conducted by Locke and Latham over nearly four decades, as well as T. Ryan's (1970) premise that conscious goals affect action. Goal-setting theory focuses on the relationship between conscious performance goals and task performance. A goal is defined as the object or aim of an action.

The theory postulates that goals affect performance primarily through four mechanisms: (a) Goals serve as a directive function in that they direct attention and effort toward goal-relevant activities and away from goal-irrelevant activities (Locke & Bryan, 1969); (b) goals serve an energizing function; (c) goals affect persistence; and (d) goals affect action indirectly by leading to the discovery and use of task-relevant knowledge and strategies (Wood & Locke, 1990). The theory further suggests that goal setting and task performance, among other factors, is mediated by goal commitment, self-efficacy, and feedback (Locke & Latham, 2002). High commitment to goals is attained when the individual is convinced that the goal is important and the goal is attainable. Participation in goal setting and self-determined goals have been found to be effective in gaining goal commitment (Latham, Winters, & Locke, 1994). People are most likely to believe they can attain a goal when they believe that it is within their capacity. In other words, they develop self-efficacy, that is, task-specific confidence in goal accomplishment (Bandura, 1986). For people to pursue goals effectively, they also need feedback as a means of checking or tracking their progress toward the goal. Goal setting is most effective when there is feedback showing progress in relation to the goal (Locke, 1996). In addition, feedback is most effective in motivating improved performance when it is used to set goals (Locke & Latham, 1990).

Different aspects of using goals in treatment have also been discussed in the literature. Consistent with goal-setting theory, literature indicates that self-determined goals are associated with positive outcomes in treatment (Gordon, 1996; Maple, 1998). Therapeutically useful goals should be client initiated and driven.

> The setting of goals and patterns of behavior, which are imposed mechanically or externally, and without understanding, serves to produces a rigid structure in the mind that blocks the free play of thought and the free movement of awareness and attention that are necessary for creativity to act. (Bohm & Peat, 2000, p. 231)

In addition, goal specificity is associated with positive outcomes (O'Hearn & Gatz, 2002; Weissberg, Barton, & Shriver, 1997). Avoidance goals, that is, goals stated in the form of avoiding certain actions, are associated with negative outcomes in treatment. Besides components suggested by goal-setting theory, literature also postulates additional treatment process variables that influence treatment outcomes. One widely discussed variable pertains to the client and therapist agreeing to the content of the goal. Goal agreement between client and therapist is important for the client's success in treatment (Busseri & Tyler, 2004; Long, 2001). Conversely, negative treatment outcomes in terms of decreased client satisfaction, treatment incompliance, and premature termination were associated with incongruity of goal content between client and therapist (Goin, Yamamoto, & Silverman, 1965) or with clients' requests that were ignored or overruled (Lazare, Eisenthal, & Wasserman, 1975).

Findings derived from studies of goal-setting theory and other research pertaining to using goals in treatment have important implications for understanding benefits of the goal-setting process in treatment. Building on empirical evidence and characteristics of useful goals, the goal-setting process should enlist the following:

- Self-determined goals to enhance commitment: Clients define a goal that is personally meaningful and useful for them so that they are self-motivated and committed to goal accomplishment.
- Self-efficacy and confidence to work on goals:
  Clients define a goal that involves a small change within their capacity so that they have confidence to work on a self-determined goal that is attainable and feasible. Big goals usually set the clients up for failure, as they may have neither a clear idea of nor the ability to accomplish the many intermediate steps that may lie in between.
  The goal should be initiated and maintained by the client and should not be dependent on the initiation of someone or something else. People have more control over what they do and can change themselves, but not others.
- Goal specificity:
  The goal should be stated in as specific terms as possible or in behavioral terms so that the client has a clear direction and a "behavioral map" to guide goal-oriented behaviors.
  The goal should be stated in a positive form so that the client has a clear idea about what she or he will be doing versus what she or he will not be doing; not doing something does not keep the client focused on goal attainment.
  The goal should be stated in a process form because the process is indicative of specific steps and tasks, whereas the end goal is not.
- Feedback:
  Clients can practice and report their goal behaviors and efforts on a regular basis so that constant feedback can be provided. Feedback helps clients develop clear ideas whether they are moving in the right direction.

Feedback gives the therapist the opportunity to compliment the client and reinforce positive changes.
Goal setting can be beneficially adjusted based on feedback to improve performance.

- Client-therapist goal-content agreement: Clients and therapists should mutually agree upon the goal so that they can work collaboratively and join their efforts in accomplishing the goal.

Utilizing Goals to Create a Context for Change: Treating Domestic Violence Offenders

The Plumas Program is a goal-directed, solution-based, domestic violence group treatment program co-led by a female and male therapist since 1991. The program primarily utilizes goals to create a context for participants to identify, notice, rediscover, and reconnect with their strengths and resources in addressing problems with domestic violence. Goals are a mandatory part of group involvement and serve as a major focus of group activity where change is expected to occur. Such a treatment approach was inspired by the work of Insoo Kim Berg, Steve de Shazer, and their associates at the Brief Family Therapy Center in Milwaukee (Berg & Kelly, 2000; de Shazer, 1991). Consequently, the program also uses an approach that holds domestic violence offenders accountable for solutions rather than responsible for problems (detailed description of the treatment approach can be found in Lee et al., 2003).

Treatment includes eight 1-hour group sessions over a 3-month period. For discussion purposes, we can roughly divide the group process into three stages, even though the process is more cyclical and continuous rather than discrete and linear: (1) developing useful goals, (2) providing feedback in terms of noticing and amplifying changes as a result of goal efforts, and (3) consolidating changes.

Developing Useful Goals

The treatment program perceives that the primary purpose of treatment is creating a context for clients to engage in a change process that will benefit them personally and/or interpersonally, which in turn helps them successfully address the problem of violence. Helping clients to develop useful goals, therefore, constitutes a major therapeutic task. Because participants have developed and determined their personal goals, the goals chosen by individual participants are assumed to be reflective of their unique life circumstances and therefore would be diverse and varied. We do not educate participants or require them to set particular treatment goals related to the problem of violence. Externally imposed goals would only serve to dampen motivation for change, make the treatment process irrelevant, and block creativity to change (Bohm & Peat, 2000).

The focus of treatment is not so much on determining the goal content but on facilitating the process of goal development and goal accomplishment in participants. During the intake interview, the group facilitator shares with potential participants that they must develop a goal that they will work on throughout the eight sessions in order to stay in the program, and encourages them to start thinking about it. The major task of the first session, in addition to sharing with participants the group rules, is devoted to presenting and clarifying the goal task to participants. Building on existing literature about useful goal development, we give the task of developing a goal and describe the parameters of a useful goal in the following manner:

- "We want *you* to create a goal for *yourself* that will be *useful* to *you* in improving your life" (self-determined goal to enhance commitment).
- "The goal should be one that is *interpersonal* in nature, that is to say that when you work on the goal, another person will be able to *notice* the changes you've made and potentially they could be affected by the change in how you behave" (interpersonally related, observable, and specific).
- "Another way to think about this is that if you brought us a videotape of yourself working on your goal, you would be able to point out the different things you were *doing* and maybe even note how these changes affected the other people on the tape" (goal specificity).
- "The goal needs to be something *different*, a behavior that you have not generally done before" (different and new).
- "The goal does not need to be something big. In fact, it is better to keep it small and doable" (self-efficacy to enhance confidence to work on goal).
- "Keep in mind that because you will be expected to *report* on your goal work every time we meet so that we can keep track of the progress, it is important that your goal be a behavior you can do at least a few times a week" (feedback).

We carefully and thoroughly described the parameters of useful goals for the participants. Note that we added two new criteria for useful goals in addition to the characteristics suggested by goal-setting theory and existing literature in response to the population we serve as well as a solution-focused approach to treatment. These are: (a) goal behavior should be interpersonally related and (b) goal behavior should be different and new. Because domestic violence is fundamentally an interpersonal phenomenon, it will be beneficial for the offender to develop a goal that is interpersonally related. Our focus on goal behavior that is new and different is based on a systems perspective (Bateson, 1979). Domestic violence offenders are likely to engage in ineffective and oftentimes repetitive attempts to

cope with their problems, which constitutes the feedback mechanism that maintains the problems of violence in intimate relationships. The purpose of treatment is to facilitate new, different, alternative behaviors that are more likely to create beneficial feedback mechanisms, which will maintain a new pattern of solution behaviors (de Shazer, 1991). Consequently, goal behaviors that are new and different will increase the likelihood that the client will engage in alternative, beneficial solution behaviors rather than repeating the ineffective but habitual behavioral patterns (Berg & Kelly, 2000).

Because participants developed and determined their personal goals, the goals chosen by individual participants were as diverse as they were themselves. Three major themes of goals chosen by the participants were goals focusing on the self (e.g., controlling anger, increasing self-confidence, etc.), goals focusing on relationships (e.g., listening to spouse or partner, being aware of other's needs, being nice, spending more time with family members, giving space to self and others, etc.), and goals focusing on developing helpful attitudes (e.g., staying positive, staying focused on goals, taking responsibility, accepting others, being relaxed, being open and flexible, etc.) (Lee et al., 2003).

Providing Feedback: Noticing and Amplifying Goal Efforts and Changes

Goal-setting theory postulates that feedback provides indicators for progress and motivates improved task performance (Locke & Latham, 1990). Clients need timely feedback when developing and practicing new behaviors and skills. For beneficial change to occur, clients should be able to fully envision the positive benefits of the goal behaviors, experiment with goal behaviors, and notice differences between the new goal behaviors and their previous behaviors. They also need the ability to *observe* and *evaluate* beneficial consequences of their goal efforts. In this program, we use therapeutic dialogues to facilitate a process that provides feedback to participants regarding their goal efforts. The facilitator uses a great number of evaluative questions that help participants provide self-initiated feedback (for a detailed description of these questions, please refer to Lee et al., 2003). These questions require participants to self-evaluate the feasibility, helpfulness, effect, and limitations of their goal behaviors on other people and their personal situation. We believe that this is a better way to facilitate feedback; that is, instead of providing feedback to participants regarding their efforts and behaviors, it is more helpful for them to carefully evaluate and think about their situation and come up with ideas and perceptions of their own. They are more likely to have ownership of these perceptions because these are not externally imposed, and these perceptions are more likely to be viable and appropriate in their own context. The facilitators also provide feedback via listening responses, affirming responses, restating responses, expanding responses, and complimentary responses (Lee et al., 2003).

In terms of the treatment process, once participants have established a workable goal, they are expected to work on the goal between sessions and report on their efforts during each group session. As participants begin to behave in a way that is consistent with their goal, the group facilitators engage them in a feedback process that helps them to see all the possible benefits of their goal behavior. The focus of the feedback process is to: (a) help participants evaluate and notice what is helpful, (b) observe the broader impact that their efforts have had on their personal development and the development of others, (c) amplify how their goal-related efforts have affected the social dynamics of their lives, even if the changes seem insignificant or small, (d) encourage and compliment all goal efforts, and (e) optimize the goal efforts by helping participants attach as much meaning as possible to their goal work. The purpose is to "make the ordinary extraordinary" so that the goal and the resulting behaviors are noticed, expanded, amplified, and experienced as being of great benefit and importance to participants (Lee et al., 2003).

Consolidating Change

As a result of developing and accomplishing self-initiated, personally meaningful goals, participants usually have a positive outlook about themselves and their life toward the end of treatment. There was a significant increase in participants' self-esteem from pretreatment to posttreatment (Lee, Uken, & Sebold, 2004). The pertinent question, however, is whether they will be able to maintain or follow the path that they have already started. A major challenge in the field of treatment of domestic violence offenders is the reduction of recurrence of violent behaviors after completion of treatment. In our experience, we have found that change will be more long lasting when participants begin to describe themselves differently (Lee et al., 2003). This process of ascribing a new description of self is the antithesis of diagnosing problems. Instead of using problem "labels" to describe themselves, such as "domestic violence offender" or "being bad tempered," the participant solidifies descriptions that match the solutions that they

create as a result of their goal efforts. From a therapeutic point of view, it is important to help participants: (1) evaluate and increase awareness of the positive changes, (2) consolidate change descriptions into phrases (such as "an honest man," "a caring mother," "a good parent," "a loving husband") that encapsulate the overall change so that participants develop "the language of success" in place of the "language of problem" in describing the self, and (3) connect participants' goal work to the future by developing a roadmap that identify indicators of progress (Lee et al., 2003).

THIS STUDY

The study was a posttest design with an annual follow-up of recidivism data to investigate the role of self-determined goals in predicting recidivism in domestic violence offenders. Data were based on multiple reporting sources that included program participants, program facilitators, and official arrest records. The study was part of a larger outcome study that evaluated the effectiveness of a goal-directed, solution-focused approach for treating domestic violence offenders (Lee et al., 2004).

Research Participants

Study participants were male or female court-mandated domestic violence offenders who were offered the opportunity to avoid prosecution by completing the group treatment program and abstaining from further violent conduct. Some of them pleaded guilty and were court ordered to attend the program. To complete the treatment program, participants were required to attend at least seven out of eight group sessions. The intake staff asked participants for their formal written consent regarding participation in the program evaluation. Participants were clearly told that neither participation nor refusal would affect their legal situation. No incentives were offered to participants. The study was reviewed for institutional review board approval.

Data analyses were based on data of participants of 16 groups that were conducted between October 1996 and February 2004. There were a total of 127 participants in these groups. All participants attended at least seven out of eight group sessions. However, data for 39 participants were not included in this analysis due to missing information in some of the assessments. Respondents entered in this analysis consisted of 88 program participants: 70 men (79.5%) and 18 women (21.5%). The age of the program participants ranged from 19 to 74 years (M = 37.5, SD = 9.8). Program participants were predominantly Caucasian (87.5%), with 6.8% African Americans, 2.3% Native Americans, and 3.4% Hispanic Americans. Participants had attained an average of 12.6 years of education (SD = 1.76; range = 8-19). Regarding the marital status of program participants, 50% were currently married or lived with a partner, 38.6% were divorced or separated, and 11.4% had never married. Among the participants 85.1% were gainfully employed, with approximately half of the participants self-identified as laborers (49.4%), 9.2% professionals, 11.5% service workers, 6.9% students, 2.3% on welfare or disability, 3.4% business owner or self-employed, 2.3% homemakers, and 14.9% unemployed (see Table 1). When comparing the 88 participants in this analysis with the 39 participants not included due to incomplete data, there were no significant differences in demographic variables, mental health diagnoses, or childhood experiences, including abuse, parental substance use, and parental divorce. In addition, there were no significant differences in recidivism rates of the two groups.

A mental status examination was conducted at intake by an experienced licensed clinical social worker. Using *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. [*DSM-IV*], American Psychiatric Association, 1994) criteria, 17% of the program participants had an Axis I diagnosis, 29.5% had personality characteristics that suggested an Axis II diagnosis of personality disorder, and 3.4% had an Axis III diagnosis of brain injury. The Global Assessment Function (GAF) scores of participants ranged from 50 to 74 (M = 61.2, SD = 3.8), meaning that an average program participant was able to function in social, occupational, or school settings with only mild symptoms (see Table 2).

The study also collected information about the participants regarding their involvement in criminal offenses and childhood experiences. Of the 88 participants, 66.3% had substance and/or alcohol abuse problems and 26.1% had criminal offenses other than domestic violence charges. In addition, 41.7% of program participants experienced parental divorce or separation, 52.9% were children of alcoholics, and 47.7% had experienced abuse as children. This profile is consistent with what is suggested by existing literature regarding characteristics of domestic violence offenders in that a sizable number of offenders have problems with substance abuse and/or experienced abuse as children (Saunders, 1995).

The Model

Based on the goal-setting theory developed by Locke and Latham (1990, 2002), studies on goal and treatment outcomes, and the treatment design of our program, a

TABLE 1. ***Demographic Information for Program Participants (N = 88)***

	%
Gender	
Male	79.5
Female	21.5
Ethnicity	
White American	87.5
African American	6.8
Native American	2.3
Hispanic American	3.4
Age	
20 or younger	3.3
21-30	16.7
31-40	44.4
41-50	30.0
51 and older	5.6
Years of education	
Less than high school	12.6
High school	49.4
College	36.7
Graduate and above	1.3
Occupation	
Unemployed	14.9
Laborer	49.4
Professional/technician	9.2
Service	11.5
Student	6.9
Welfare/disabled homemaker	2.3
Own business	3.4
Homemaker	2.3
Marital status	
Single	11.4
Married	50.0
Divorced or separated	38.6

TABLE 2: Diagnostic and Statistical Manual of Mental Disorders *(4th ed.)*[a] *Diagnoses of Program Participants (N = 88)*

	%
Axis I	
No diagnosis	83.0
Intermittent explosive disorder	4.5
Bipolar disorder	3.4
Schizophrenia	2.3
Major depression	1.1
Impulse control disorder	1.1
Posttraumatic stress disorder	1.1
Attention deficit hyperactive disorder	1.1
Adjustment disorder	1.1
NOS	1.1
Axis II	
No diagnosis	70.5
Antisocial personality disorder	19.3
Dependent personality disorder	2.3
Personality disorder NOS	3.4
Borderline personality disorder	1.1
Paranoid personality disorder	1.1
Narcissistic personality disorder	1.1
Obsessive-compulsive personality disorder	1.1
Axis III	
No diagnosis	87.4
Brain injury	3.4
Other medical conditions	9.2
Global Assessment Functioning	
M = 61.6	
SD = 4.1	
Range = 50-74	

NOTE: NOS = not otherwise specified.
a. (American Psychiatric Association, 1994).

model of factors related to the process of goal setting that influenced treatment outcomes was constructed. Figure 1 illustrates the model. We hypothesized that goal commitment, goal specificity, and goal agreement would predict recidivism as mediated by confidence to work on goal. Greater goal commitment, goal specificity, and goal agreement between facilitator and program participants, and greater confidence to work on goals, would positively predict nonrecidivism. To note, goal-setting theory postulates that the feedback process mediates the relationship between goal setting and task performance. Feedback process, however, was not included in the model because the structure of this treatment program prescribes feedback as a given process of treatment. All participants were required to report their goal efforts at each session, and the facilitators devoted their therapeutic efforts to help them self-evaluate their goal efforts.

In addition, demographic characteristics, mental health status, and childhood experience have been identified as risk factors for domestic violence as shown in many investigations (Saunders, 1995); bivariate analyses were performed to identify individual factors that were significantly associated with recidivism. Brain injury and experience of child abuse were entered as controlled variables in the model because of significant association between these variables with recidivism.

Predictor Variables

Goal Commitment

Goal commitment was measured using a 3-point Likert-type scale completed by the group facilitators at termination that evaluated participants' commitment to goal accomplishment during the treatment. The facilitator was asked, "How committed was the participant toward goal accomplishment?" where 1 = *low commitment*, 2 = *moderate commitment*, and 3 = *high commitment*.

Goal Agreement

Goal agreement was measured using a 3-point scale completed by group facilitators at termination that

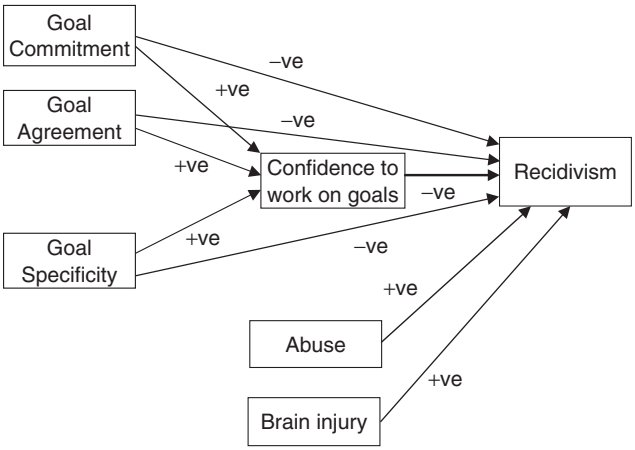


Figure 1: Hypothetical Model of Goal Setting and Recidivism

evaluated the extent to which the goal was mutually agreed upon by the participant and the facilitator. The facilitator was asked, "How much do you agree with the client's self-determined goal as a helpful goal?" where 1 = *low agreement*, 2 = *moderate agreement*, and 3 = *high agreement*.

Goal Specificity

Goal specificity was measured using a 3-point Likert-type scale completed by the facilitators at termination that evaluated participants' self-determined treatment goals as behaviorally described, positively stated, and stated as small steps and in process form. The facilitator was asked, "How specific is the goal self-determined by the participant?" Goal specificity was being defined as goals being (a) behaviorally described, (b) positively stated, (c) stated as small step, and (d) stated in process form. 1 = *low goal specificity*, 2 = *moderate goal specificity*, and 3 = *high goal specificity*.

Mediating Variable

Confidence

Confidence to work on goals was measured by participants' self-reported level of confidence to continue working on their goals upon completion of the treatment program. During the last group session, program participants were asked, "How confident are you to continue working on the goals on a 1-to-10 scale, with 1 meaning little confidence and 10 meaning great confidence?"

Predictor and meditating variables were assessed on participants' completion of the treatment program and not earlier because goal setting is a developmental process. Oftentimes, participants changed their attitudes toward goal development and accomplishment or the goal content as a result of the treatment process.

Dependent Variable

Recidivism measured the rate of participants' recommitting violent behaviors after attending the treatment program. We collected the cumulative recidivism rates of participants, meaning that we collected posttreatment recidivism data for all participants on an annual basis. Data on recidivism were collected from the victim witness office, probation office, and district attorney's office between 1997 and 2004. Definitions of recidivism by each source were different because of the differences in the function of each institution and the reporting venue. For instance, the district attorney's office documented cases of domestic violence that were reported and charged. The victim witness office documented cases of domestic violence whenever a victim was referred for service regardless of whether a charge was pressed against the offender or when there was a request for a restraining order. This study used more inclusive criteria that defined recidivism as (a) a participant arrested for charges related to domestic violence, (b) a domestic violence charge pressed against a participant, (c) the spouse or partner of a participant referred to receive services from the victim witness office, or (d) a request for a restraining order against a participant.

Method of Data Analysis

Data collected from various instruments were checked and coded for data processing and statistical analyses. The M*plus* statistical program 3.12 (Muthén & Muthén, 2005) was used to test the relationships between the predictor, mediator, and dependent variables. M*plus* was selected for data analysis because it allows for the specification of the endogenous variables (i.e., recidivism) in the path model as categorical. Results from path analysis with categorical variables produced a probit regression coefficient for each regression relation in which the dependent variable is categorical and an ordinary least squares (OLS) regression coefficient for each regression relation in which the dependent variable is continuous. A weighted least squares (WLS) parameter estimate with conventional standard errors and chi-square test statistics that use a full-weighted matrix was employed as the estimator in this analysis.

RESULTS

In this path analysis, we examined the role of setting self-determined goals in predicting recidivism in domestic violence offenders. Brain injury and experience of child abuse were introduced into the model as control variables because of their significant association with recidivism. The recidivism rate for participants who completed the Plumas Program was 10.2% (see Table 3). This recidivism rate was compiled by counting all reoffending cases that were reported by the victim witness office, the probation office, or the district attorney's office. The program completion rate was 92.8%; it was calculated by comparing the number of participants who enrolled in the program and attended the first group meeting and the number of participants who attended at least seven of eight group sessions. No significant differences in recidivism rates were found between the genders. Specifically, 11.4% of male participants and 5.6% of female participants had reoffending records at the victim witness office, the probation office, and/or the district attorney's office.

The hypothetical model in Figure 1 was analyzed using path analysis with categorical dependent variables in M*plus*. Table 4 presents descriptive statistics of the measurements. The initial result of the hypothetical model lacked a good fit to the data; χ^2 ($df = 10$, $N = 88$) = 33.387, $p = .0002$, Comparative Fit Index (CFI) = .849, root mean square error of approximation (RMSEA) = .163. We modified our model parameters and arrived at a final model that was a good fit to the data; χ^2 ($df = 9$, $N = 88$) = 7.966, $p = .538$, CFI = 1.0, RMSEA = 0.0. The mean adjusted χ^2 is a robust measure of differences in fit between models. Values of 1.0 for the CFI indicates perfect fit. Values of less than .05 for the RMSEA also indicate good fit between the model and the data. Figure 2 shows findings of the final model.

The final model accounted for a total of 58% of variance in recidivism. Consistent with the hypothetical model (see Figure 1), the final model indicated that goal specificity and goal agreement positively predicted confidence to work on goals (r = .45 and .20, respectively), which negatively predicted recidivism (probit coefficient = –.08, SE =.04). A probit coefficient of –.08 indicated that one unit increase in the confidence to work on goals results in a decrease of .08 standard deviation in the predicted Z score of cumulative normal probability distribution of recidivism (see Table 5). In addition, goal specificity showed a direct path to recidivism and negatively predicted recidivism (probit coefficient = –.82, SE = .28). The controlled variable of brain injury also significantly predicted recidivism (probit coefficient = 1.13, SE = .25). Experience of childhood abuse and goal commitment did not significantly predict recidivism and were excluded from the final model in this analysis.

TABLE 3: ***Sources of Recidivism Reports (N = 88)***

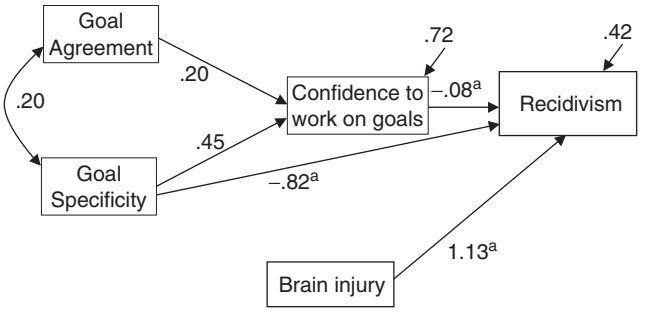
Source of Report	*%*	*n*
District attorney (DA)	5.7	5
Probation office (PO)	4.5	4
Victim witness (VW)	10.2	9
DA, PO, or VW	10.2	9

TABLE 4: ***Descriptive Statistics of the Measurements (N = 88)***

Measurement	*%*	M	SD	*Range*
Recidivism	10.2			
Experience of abuse as child	47.7			
Brain injury	3.4			
Goal agreement		2.68	0.54	1–3
Goal specificity		2.45	0.73	1–3
Confidence to work on goals		7.56	3.59	1–10
Commitment		2.25	0.59	1–3

DISCUSSION AND APPLICATIONS TO SOCIAL WORK

Findings of the study showed initial evidence of the positive impact of utilizing participants' self-determined goals in reducing recidivism among domestic violence offenders. The final model accounted for 58% of variance in recidivism. The model indicated that goal specificity and goal agreement positively predicted confidence to work on goals, which negatively predicted recidivism (see Figure 2). In other words, the more specific the participants' self-determined goals and the greater agreement between program participants and facilitators about the usefulness of the goals, the greater the confidence participants had in their continued work on their goals at termination, which would negatively predict recidivism. Goal specificity in itself was also related to lower recidivism rates in offenders. Goal commitment, however, did not predict recidivism. It could be possible that the nature of the goal in terms of how specific it was as well as the relational dynamics between program participants and facilitators with respect to their consensus about the goal constituted core treatment components that predicted recidivism in offenders. In this treatment



x^2 (df = 9, N = 88) = 7.966, p = .538, CFI = 1.0, RMSEA = 0.0

[a] parameters represent the probit estimates for recidivism as a categorical variable

Figure 2: Final Model of Goal Setting and Recidivism

TABLE 5: *Probit Estimates of Direct Effect on Recidivism (N = 88)*

Measurement	*Probit Coefficient*	SE	*Lower 2.5%*	*Upper 2.5%*
Brain injury	1.133	0.246	0.651	1.616
Confidence to work on goals	–0.080	0.038	–0.006	–1.154
Goal specificity	–0.818	0.277	–1.361	–0.275

NOTE: The interpretation of the probit coefficient is not straightforward. The probit model is defined as Pr(y = 1|x) = ϕ(xb) where ϕ is the standard cumulative normal probability distribution and xb is called the probit score or index. This indicates that a one-unit increase in the confidence to work on goals results in a –0.08 standard deviation decrease in the predicted probit index. A confidence to work on goals Level 5 compared to a confidence to work on goals Level 1 would reduce the probability of recidivism by a factor from .47 to .35, assuming effects of other variables are constant. Similarly, a one-unit increase in goal specificity will bring a change of –0.82 standard deviation decreases in the predicted probit index. A goal specificity level of 2 compared to a goal specificity of 1 would reduce the probability of recidivism by a factor from .20 to .05. The probit coefficient for brain injury can be interpreted to mean that the change from 0 (no brain injury) to 1 (brain injury) increases the predicted probit index by 1.133 standard deviations, which changes the probability level of recidivism by a factor of .87 from .50.

program, we defined a goal as something that was personally meaningful to and self-determined by the participant. Such a goal definition might have already implicated participants' commitment to goal accomplishment. As such, goal commitment, as evaluated by group facilitators, may not be completely adequate to capture the construct.

Limitations of this study must be acknowledged. First, the sample size was limited and it was a purposive sample. In addition, there was no control or comparison group with randomized assignment procedures to compare the effectiveness of this approach with other established models of treatment. Another limitation of this study was the use of self-reports to measure process variables including goal commitment, goal specificity, goal agreement, and confidence to work on goals. Hence, findings could be affected by the problem of reporting bias. For instance, participants' self-reports of their confidence to work on goals only represented their self-evaluation, which could be different from the observations of a third person. Similarly, group facilitators' evaluation of participants' goal characteristics can be influenced by factors such as relationship; that is, facilitators who had a better relationship with a particular program participant might tend to provide more positive evaluation of goal specificity and/or agreement. On the other hand, self-report is a valid and commonly used method to examine respondents' self-evaluation and understanding of their experience. In addition, goal commitment, goal agreement, goal specificity, and confidence were all assessed by single-item, three-level Likert-type scale measures. The use of single-item measures would potentially increase the likelihood of measurement errors. Third, the study only included 88 participants out of 127 participants because of incomplete data for 39 participants. Although there were no significant differences between the two groups in all demographic variables, childhood experiences, and *DSM-IV* diagnoses, findings could still be influenced by the problem of measurement attrition (Fraser, 2004). Fourth, this study used official records from a district attorney's office, victim witness office, and probation office to define recidivism rates of program participants and did not include other reporting sources, such as spouses or partners of participants, to measure recidivism. Although we had employed inclusive criteria to define recidivism among program participants, domestic violence could occur in other forms, such as verbal or emotional abuse, that may not be reportable. There is also the problem of victims underreporting violent incidents. These limitations pose challenges to and raise suggestions for future research regarding domestic violence treatment programs. Specific recommendations for future investigations include: (1) use a larger sample size that uses representative samples, (2) include control or comparison groups using randomized assignment procedures, (3) use more refined, multiple-item, and/or standardized instruments to measure predictors and mediating variables that would decrease the likelihood of measurement errors, (4) use multiple reporting sources to avoid reporting bias, (5) use multiple reporting sources to measure recidivism rates, and (6) carefully monitor the data collection process to reduce problems in measurement attrition.

Potential contributions of the study should be understood in the context of advancement and challenges of social work intervention research. Mark Fraser (2004)

discussed substantive and methodological advances in intervention research that include, among others, development of practice-relevant microsocial theories as well as analytic advances in decomposing complex phenomena related to social work intervention. This study tested practice-relevant constructs from goal-setting theory for treating domestic violence offenders. It constitutes part of a broader effort to develop, refine, and test the utility of goal-setting theory in treatment of domestic violence offenders. In terms of methodological advances, the design of this study moved beyond the conventional input-output model in measuring outcomes of batterer programs (Gondolf, 1997) and included an investigation of treatment components and trajectories that account for outcomes. The use of M*plus* statistical program 3.12 (Muthén & Muthén, 2005) to test the model also represents an advance in using analytic tools to examine models and trajectories when the endogenous variables in the path model are categorical.

The ultimate purpose of intervention research is the development and advancement of effective treatment models for the benefit of clients. Intervention research and practice are intimately related, mutually informing, and inseparable. The primary purpose of this study is to examine the utility of self-determined goals as a venue for change in treatment of domestic violence offenders so that findings of the study can inform further development and refinement of practice. Findings of this study provided empirical evidence regarding the role of self-determined goals in reducing recidivism in domestic violence offenders. Different from most current batterer treatment programs that are dominated by a deficits perspective and being psychoeducational in nature, this treatment program uses the language and symbols of self-determination and strengths for treating domestic violence offenders. Because goals are participants' construction and there are exceptions to all problem patterns (de Shazer, 1985), one unique characteristic of this program is that it does not exclude participants based on *DSM-IV* diagnoses or substance use, as we believe offenders have abilities to accomplish self-determined, personally meaningful goals. Such an approach also sends a powerful message to domestic violence offenders that they have the ability to make positive changes and they themselves are the only ones responsible to make that happen (Lee et al., 2003).

The use of the language and symbols of self-determination and strengths and solutions for treating domestic violence offenders is not without controversy. A goal-directed approach for treating domestic violence offenders can be viewed as part of the pluralistic, societal effort to develop pragmatic solutions to end the more immediate, visible violence in intimate relationships. Diversity and multiple voices are imperative in the search for effective treatment of domestic violence offenders. A single voice or a single vision can only replicate the dynamic of dominance in abusive relationships. While doing so, it is important to evaluate the effectiveness of a particular treatment program and carefully examine the associated mechanisms and processes that contribute to its effectiveness so that treatment is based on an informed position in addition to ethical choices, clinical, or ideological preferences (Gingerich & Eisengart, 2000).

REFERENCES

American Psychiatric Association. (1994) *Diagnostic and statistical manual of mental disorders* (4th ed). Washington, DC: Author.

Bandura, A. (1986). *Social foundations of thought and action: A social-cognitive theory*. Englewood Cliffs, NJ: Prentice Hall.

Bateson, G. (1979). *Mind and nature: A necessary unity.* New York: Dutton.

Berg, I. K., & Kelly, S. (2000). *Building solutions in child protective services.* New York: Norton.

Berger, P. L., & Luckmann, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge*. New York: Doubleday.

Bohm, D., & Peat, D. F. (2000). *Science, order, and creativity: A dramatic new look at the creative roots of science and life* (2nd ed.). London: Routledge.

Busseri, M. A., & Tyler, J. D. (2004). Client-therapist agreement on target problems, working alliance, and counseling outcome. *Psychotherapy Research*, *14*, 77-88.

Cadsky, O., Hanson, R. K., Crawford, M., & Lalonde, C. (1996). Attrition from a male batterer treatment program: Client-treatment congruence and lifestyle instability. *Violence and Victims*, *11*, 51-64.

Davis, R. C., Taylor, B. G., & Maxwell, C. D. (2000). *Does batterer treatment reduce violence? A randomized experiment in Brooklyn.* New York: Victim Services.

DeJong, P., & Berg, I. K. (1999, March). *Co-constructing cooperation with mandated clients*. Paper presented at the Council on Social Work Education, 45th Annual Program Meeting, San Francisco.

de Shazer, S. (1985). *Keys to solutions in brief therapy.* New York: Norton.

de Shazer, S. (1991). *Putting difference to work.* New York: Norton.

Edleson, J. L. (1996). Controversy and change in batterers' programs. In J. L. Edleson & Z. C. Eisikovits (Eds.), *Future interventions with battered women and their families* (pp. 154-169). Thousand Oaks, CA: Sage.

Edleson, J. L., & Syers, M. (1990). Relative effectiveness of group treatments for men who batter. *Social Work Research Abstracts*, *26*, 10-17.

Elliot, A. J., & Church, M. A. (2002). Client-articulated avoidance goals in the therapy context. *Journal of Counseling Psychology*, *49*, 243-254.

Fagan, J. (1989). Cessation of family violence: Deterrence and dissuasion. In L. Ohlin & M. Tonry (Eds.), *Family violence* (pp. 377-425). Chicago: University of Chicago Press.

Feder, L., & Forde, D. R. (2000, June). *A test of the efficacy of court-mandated counseling for domestic violence offenders: The Broward*

experiment (Executive summary of final report). Washington, DC: National Institute of Justice.

Foster, S., & Mash, E. (1999). Assessing social validity in clinical treatment research: Issues and procedures. *Journal of Consulting and Clinical Psychology*, *67*, 308-319.

Fraser, M. (2004). Intervention research in social work: Recent advances and continuing challenges. *Research on Social Work Practice*, *14*, 210-222.

Geffner, R., & Mantooth, C. (1999) *Ending spouse/partner abuse, A psychoeducational approach for individuals and cou*ples. New York: Springer.

Gingerich, W. J., & Eisengart, S. (2000). Solution-focused brief therapy: A review of the outcome research. *Family Process*, *39*, 477-498.

Goin, M., Yamamoto, J., & Silverman, J. (1965). Therapy congruent with class-linked expectations. *Archives of General Psychiatry*, *13*, 133-137.

Gondolf, E. W. (1997). Expanding batterer program evaluation. In G. Kaufman Kantor & J. L. Jasinski (Eds.), *Out of the darkness: Contemporary perspectives on family violence* (pp. 208-218). Thousand Oaks: CA: Sage.

Gondolf, E. W., & Foster, R. A. (1991). Pre-program attrition in batterers programs. *Journal of Family Violence*, *6*, 337-349.

Gordon, K. (1996). Resilient Hispanic youths' self-concept and motivational patterns. *Hispanic Journal of Behavioral Sciences*, *18*, 63-73.

Greene, G. J., Lee, M. Y., & Hoffpauir, S. (2005). The language of empowerment and strengths in clinical social work: A constructivist perspective. *Families in Society*, *86*, 267-277.

Hanson, B. (2002). Interventions for batterers: Program approaches, program tensions. In A. R. Roberts (Ed.), *Handbook of domestic violence intervention strategies: Policies, programs, and legal remedies* (pp. 419-448). New York: Oxford University Press.

Hayes, S. (1993). Treatment implications of psychological assessment. *Psychological Assessment*, *5*, 251-253.

Latham, G. P., Winters, D., & Locke, E. A. (1994). Cognitive and motivational effects of participation: A mediator study. *Journal of Organizational Behavior*, *15*, 49-63.

Lazare, A., Eisenthal, S., & Wasserman, L. (1975). The customer approach to patienthood: Attending to patient requests in a walk-in clinic. *Archives of General Psychiatry*, *32*, 553.

Lee, M. Y., Sebold, J., & Uken, A. (2003). *Solution-focused treatment with domestic violence offenders: Accountability for change.* New York: Oxford University Press.

Lee, M. Y., Uken, A., & Sebold, J. (2004). Accountability for solutions: Solution-focused treatment with domestic violence offenders. *Families in Society*, *85*, 463-476.

Locke, E. A. (1996). Motivation through conscious goal setting. *Applied and Preventive Psychology*, *5*, 117-124.

Locke, E. A., & Bryan, J. (1969). The directing function of goals in task performance. *Organizational Behavior and Human Performance*, *4*, 35-42.

Locke, E. A., & Latham, G. P. (1990). *A theory of goal setting and task performance.* Englewood Cliffs, NJ: Prentice Hall.

Locke, E. A., & Latham, G. P. (2002). Building a practically useful theory of goal setting and task motivation: A 35-year odyssey. *American Psychologist*, *57*, 705-717.

Long, J. R. (2001). Goal agreement and early therapeutic change. *Psychotherapy*, *38*, 219-232.

Maple, F. F. (1998). *Goal-focused interviewing.* Thousand Oaks, CA: Sage.

Murphy, C. M., & Baxter, V. A. (1997). Motivating batterers to change in the treatment context. *Journal of Interpersonal Violence*, *12*, 607-619.

Muthén, B. O., & Muthén, L. K. (2005). *Mplus® statistical analysis with latent variables, user guide*. Los Angeles, CA: Author.

O'Hearn, T. C., & Gatz, M. (2002). Going for the goal: Improving youth's problem-solving skills through a school-based intervention. *Journal of Community Psychology*, *30*, 281-303.

Pence, E., & Paymar, M. (1993). *Education groups for men who batter: The Duluth model.* New York: Springer.

Rosenfeld, B. (1992). Court-ordered treatment of spouse abuse. *Clinical Psychology Review*, *12*, 205-226.

Russell, M. N. (1995). *Confronting abusive beliefs, group treatment for abusive men*. Thousand Oaks, CA: Sage.

Ryan, T. A. (1970). *Intentional behavior.* New York: Ronald Press.

Saleebey, D. (1996). The strengths perspective in social work practice: Extensions and cautions. *Social Work*, *41*, 296-304.

Saunders, D. G. (1995). Prediction of wife assault. In J. C. Campbell (Ed.), *Assessing dangerousness: Violence by sexual offenders, batterers, and child abusers* (pp. 68-95). Thousand Oaks, CA: Sage.

Saunders, D. G. (1996). Feminist-cognitive-behavioral and process-psychodynamic treatments for men who batter: Interaction of abuser traits and treatment models. *Violence and Victims*, *11*, 393-413.

Shepard, M. (1992). Predicting batterer recidivism five years after community intervention. *Journal of Family Violence*, *7*, 167-178.

Tolman, R. M., & Bennett, L. W. (1990). A review of quantitative research on men who batter. *Journal of Interpersonal Violence*, *5*, 87-118.

Tolman, R. M., & Edleson, J. L. (1995). Intervention for men who batter: A review of research. In S. Stith & M. A. Straus (Eds.), *Understanding partner violence: Prevalence, causes, consequences, and solutions* (pp. 262-274). Minneapolis, MN: National Council on Family Relations.

Valliant, G. (1982). *The natural history of alcoholism.* Cambridge, MA: Harvard University Press.

Weissberg, R. P., Barton, H. A., & Shriver, T. P. (1997). The social-competence promotion program for young adolescents. In T. Gullotta & G. Albee (Eds.), *Primary prevention works* (pp. 269-289). Newbury Park, CA: Sage.

Wexler, D. B. (1999). *Domestic Violence 2000: An integrated skills program for men, group leader's manual and resources for men*. New York: Norton.

Wood, R., & Locke, E. A. (1990). Goal setting and strategy effects on complex tasks. In B. Shaw & L. Cummings (Eds.), *Research in organizational behavior* (Vol.2, pp. 73-109). Greenwich, CT: JAI.