Identifying Pre-Treatment Factors Predicting Attrition From Treatment for Domestic Violence

Noora Julin, 38797

Master's Thesis in Psychology

Supervisor: Minja Westerlund

Faculty of Arts, Psychology and Theology

Åbo Akademi University

2020

Noora Julin

ÅBO AKADEMI UNIVERSITY – FACULTY OF ARTS, PSYCHOLOGY AND THEOLOGY

Subject: Psychology	
Author: Noora Julin	
Title: Identifying Pre-Treatment Factors Predicting Attrition From Treatment for Domestic Violence	
Supervisor: Minja Westerlund	
Abstract: Domestic violence occurring between people in close relationships, that is romantic relationships or families, is a phenomenon occurring worldwide and much research on treatment of domestic violence has been published. Interventions for domestic violence for perpetrators aim to prevent violent behavior, whereas interventions for victims often aim to support and/or protect the victim in various ways. Treatment attrition appears to be a problem affecting all kinds of psychological treatments, treatment of domestic violence in particular. Research has described a few predicting factors for treatment attrition, including demographic factors, violence-related factors, substance use and motivational factors. This thesis is based on a study that strived to identify pre-treatment measured predicting factors for treatment attrition at a Finnish outpatient treatment agency providing treatment for perpetrators, victims and their relatives. I conducted a survey study and the sample consisted of *N*=22 participants. I measured pre-treatment factors that had been found to predict treatment dropout in earlier studies, that is, demographic factors, substance use and readiness to change. The results indicated small, however not significant, differences between the treatment completers and dropouts on the measured predicting factors. Small effect sizes appeared for the age, alcohol use and readiness to change, and a large effect size appeared for subsistence, and these are discussed further. This study has some limitations that should be taken into consideration when perceiving the results. Further research on the topic is necessary in order to make conclusions about the results that appeared in this study.	
Keywords: Domestic Violence, Treatment Attrition, Drop Out, Predicting Factors	
Date: 28.1.2020	**Page count:** 56
Level: Master's Thesis	

Noora Julin

ÅBO AKADEMI – FAKULTETEN FÖR HUMANIOIRA, PSYKOLOGI OCH TEOLOGI

Ämne: Psykologi
Författare: Noora Julin
Rubrik: Identifiering av predicerande faktorer för avbrytande av behandling för våld i nära relationer
Handledare: Minja Westerlund
Abstrakt Våld i nära relationer, både mellan partners i romantiska relationer och mellan familjemedlemmar eller andra närstående, är ett fenomen som förekommer överallt i världen och ämnet har väckt mycket intresse bland forskare. Avbrytande av behandling förekommer inom alla typer av psykologisk behandling, även inom interventioner för våld i nära relationer. Forskarna har presenterat en del faktorer som predicerar avbrytande av dessa interventioner, bland annat demografiska faktorer, våldsrelaterade faktorer, substansbruk och motivation. Denna avhandling baserar sig på en studie som eftersträvade att identifiera predicerande faktorer för avbrytande av behandling för våld i nära relationer vid en anstalt i Finland, där interventioner för utövare, offer och deras närstående erbjuds. Studien utfördes med hjälp av ett frågeformulär och samplet bestod av N=22 deltagare. Vi mätte faktorer som visat sig predicera avbrytande av behandling i tidigare studier, det vill säga demografiska faktorer, substansbruk och motivation. Resultaten tyder på små skillnader mellan grupperna på de variabler vi mätte, men dessa skillnader visade sig vara icke-signifikanta. Data-analyserna resulterade dock i effektstorlekar, som tyder på små effekter för ålder, alkoholanvändning och beredskap till förändring samt en stor effekt för utkomst. Dessa effekter diskuteras vidare i avhandlingen. Vid tolkning av dessa resultat bör det beaktas att studien har en del begränsningar som kan antas påverka resultaten. Vidare forskning inom detta ämnesområde är nödvändig för att man ska kunna dra slutsatser om resultaten från denna studie.
Nyckelord: Våld i nära relationer, familjevåld, avbrytande av behandling, predicerande faktorer
Datum: 28.1.2020 | **Antal sidor:** 56
Nivå: Pro gradu-avhandling

Noora Julin

Acknowledgements

In Turku, January, 2020

I would like to thank the staff at Pilari in Turku, Finland, for the co-operation throughout this process and the providence of the data. Thank you for arranging time for discussing ideas for the study and later for the work you did at conduction of the data collection. Without your involvement, this study could not have been executed.

Further, I want to express my sincere gratitude to my supervisor Minja Westerlund for all the support and guidance throughout the whole process. Thank you for sharing your knowledge and your inspiring ideas. Thank you for cheering me on and keeping the hopes up at times when I felt stuck. It has been a pleasure working together with you.

Finally, I want to thank my family and friends, who have supported me, believed in me and pushed me forward from the beginning of this process.

Table of contents

1 Introduction

Domestic violence is a worldwide problem that affects a large number of people and their daily lives. The definitions of domestic violence differ considerably, however, often domestic violence refers to any kind of abuse – such as physical, emotional, and sexual – between intimate partners often living in the same household (e.g. "domestic violence", 2019). The definition often includes only violence between intimate partners, but there are also calls for a broader definition of the term to include both violence occurring between intimate partners and/or family members (e.g. Barocas, Emery & Mills, 2016). Other terms, such as intimate partner violence, domestic abuse and family violence, are used to describe similar type of violence in the literature, however, domestic abuse could be used as a broader term to include all these types of violence. In this thesis, the term domestic violence will be used to describe violence occurring between individuals who have a close familial relationship to each other, for example partners in a romantic relationship and/or members of a family or other relatives.

Domestic violence can affect the victim in various ways, with consequences ranging from physical injuries (e.g. wounds and fractures) and psychosomatic complaints (e.g. pain in the head and back) to psychological disturbances (e.g. depression, insomnia and posttraumatic stress) and psychosocial consequences (e.g. fear) (Ansara & Hindin, 2011; Flury, Nyberg & Riecher-Rössler, 2010). Therefore, prevention of domestic violence is important and the literature on the topic presents interventions both for perpetrators, victims and other family members. However, as is the case for several other psychological interventions, a high attrition rate is a problem for these treatment programs and may have adverse effects (Ogrodniczuk, Joyce, & Piper, 2005), for example reduced treatment efficacy (Clarkin & Levy, 2004) and negative effects on cost-effectiveness of these treatments (April & Nicholas, 1996). Some factors that have previously been associated with attrition are demographic factors, the type of violence perpetrated, motivational factors and substance use.

Further knowledge about the predicting factors could help identify the participants who may have a higher risk of dropping out of the treatment programs and to modify the programs to correspond better to the needs of the clients. This study aims to identify predicting factors for treatment attrition from an outpatient treatment service in Turku, Finland.

1.1 Prevalence of Domestic Violence

Most research concerning domestic violence appears to echo the view about women being victims and men being perpetrators (Barber, 2008; Carney, Butell & Dutton, 2007; Drijber, Reijnders, & Ceelen, 2013) and cases of men as victims of domestic violence may be underreported due to the existing attitudes about men as victims and women as perpetrators (Shuler, 2010). The World Health Organization (WHO) estimated the global life time prevalence of intimate partner violence among ever-partnered women to be 30% (WHO, 2013). The European Union Agency for Fundamental Rights (FRA) conducted a survey study concerning experiences of violence among women across 28 EU member states, and found that 22% of women had experienced physical and/or sexual violence and 43% had experienced psychological violence by a partner since the age of 15 (FRA, 2014).

According to the annual national victim survey conducted on a Finnish sample by the Institute of Criminology and Legal Policy at Helsinki University in 2017, 4.8% of women and 2.5% of men had experienced physical and/or sexual violence or a threat of violence by their present or former partner in 2017 (Danielsson & Näsi, 2018). According to the FRA report presented above, 30% of Finnish women had experienced physical and/or sexual violence and 53% had experienced psychological violence by a partner since the age of 15 (FRA, 2014).

In 2017, 8300 cases of domestic violence were reported to the Finnish police (Official Statistics of Finland [OSF], 2018). Violence between present and former married or

cohabiting partners was the most prominent type of domestic violence against adults, representing 79% of the cases. However, research has shown that only about 10% of the cases of partner violence against women and 3% of the cases of partner violence against men are reported to the police (Danielsson & Salmi, 2013).

When it comes to perpetration of domestic violence, some research has suggested that men and women are equally violent, however, there is variation in the forms of domestic violence (Johnson, 2006) and the consequences of victimization of domestic violence, so that women suffer more severe injuries (Tjaden & Thoennes 2000), more psychological injuries, more fear and more deaths than men (Danielsson & Salmi, 2013; Straus, 2009; Straus, 2011). According to data from Sweden, 85% of violence in romantic relationships is perpetrated by men against women and 14% of women against men (The Swedish National Council for Crime Prevention [Brå], 2009). This reflects an important aspect in the gender ratios in domestic violence, the gender symmetry controversy. This refers to differences found in the prevalence rates on women as perpetrators of domestic violence, depending on the focus used in studies, that is perpetration rates or effects of victimization (Straus, 2011). A reflection on this is that the research on female perpetrators of domestic violence is much less extensive than the research on male perpetrators (Greene & Bogo, 2002).

1.2 Interventions for Domestic Violence

Research about interventions for domestic violence addresses interventions both for perpetrators and for victims. However, most of the research on this topic appears to be focused on interventions for perpetrators, with men being perpetrators and women being victims. With the growing awareness about women's perpetration of domestic violence (e.g. Archer, 2000; Langhinrichsen-Rohling, Misra, Selwyn & Rohling, 2012; Straus, 2011),

researchers have emphasized the importance of providing preventive treatment also for female perpetrators (e.g. Barocas et al., 2016).

Researchers in the field have presented two viewpoints on the treatment of domestic violence perpetrators more often than others: the cognitive-behavioral viewpoint and the feminist viewpoint, also called the Duluth-model (Babcock, Greene & Robie, 2004). These treatment programs generally aim to prevent violence, however, the viewpoints on the causes of violent behavior and the methods used are different. According to the Duluth- model, male domestic violence is used as a method of power and control (Corvo, Dutton & Chen, 2009) and the treatment, therefore, aims to challenge the man's perceived right to control his partner. The cognitive-behavioristic model is developed by psychologists and makes the violence the primary focus for the treatment (Babcock et al., 2004). Within this type of treatment, violence is viewed as a learned behavior. The treatment consists of skills training, anger management and awareness about the alternatives to violence (Babcock et al., 2004).

Treatment options provided for victims of domestic violence have not been studied as much as treatment for perpetrators (Stith, Rosen, McCollum, 2003). Domestic violence agencies typically provide a combination of the following services to the victims of domestic violence: crisis hotline, counseling, advocacy and emergency shelter (Bennet, Riger, Schewe, Howard & Wasco, 2004).

The dominant approach for treating domestic violence is to treat both parts separately, however, it seems that a conjoint treatment of the partners could be beneficial in some cases (Harris, 2006). Conjoint treatment could be beneficial due to the fact that the violence may be bilaterally perpetrated and the conjoint treatment enables working with underlying relationship dynamics (Stith & McCollum, 2011). Conjoint treatment can be organized in different forms, for example domestic violence-focused couples' treatment (DVFCT) (Stith, McCollum & Rosen, 2011). The literature on conjoint treatment has highlighted the

importance of proper risk assessment and screening prior to and during the conjoint treatment, as well as proper training for the counselors (Bradley, Drummey, Gottman & Gottman, 2014; Mayer, 2017; Stith & McCollum, 2011). Another approach to the treatment of domestic violence that is gaining popularity is the "whole family" approach (Stanley & Humphreys, 2015). These treatments vary in their forms, but the common aim is to engage with all family members – parents and children, which enables working on issues regarding for example motherhood and fatherhood.

In Finland, the multi-agency risk assessment conference (MARAC) model is often the intervention used for individuals dealing with serious intimate partner violence (Finnish Institute for Health and Welfare, 2019). The MARAC-model strives to prevent violence through multi-professional work with the victim, assessing the client's situation and creating a safety plan for the client (Piispa & October, 2017). The national Victim Support Finland (RIKU) also provides support for victims of domestic violence through counselling and guidance in possible criminal procedures (Victim Support Finland [RIKU], 2019). The so called Jussi-työ is a service provided for male perpetrators of domestic violence and aims to prevent and cease the violent behaviour through identifying problems in the close relationships, discussing background factors to the violent behaviour and teaching the client to identify and avoid violent behavior (Federation of Mother and Child Homes and Shelters, 2020). This type of treatment is fairly similar to the cognitive-behavioral treatment programs discussed above.

1.3 Treatment Attrition in Intervention Programs for Domestic Violence

The research on attrition in programs for domestic violence has mainly focused on group intervention programs for perpetrators. The percentages of dropouts vary across different studies; for group interventions with male batterers Babcock et al. (2004) found

attrition rates varying between 18% and 68% and Daly and Pelowski (2000) found attrition rates varying between 22% and 99%. Jewell and Wormith (2010) stated that treatment programs for male domestic violence perpetrators have high attrition rates, ranging from 15% to 58%, and Stover, Meadows and Kaufman (2009) found attrition rates for perpetrator treatments varying between 29% and 30%. The high attrition rates may be due to a failure to address the individual needs of the participants (Sartin, Hansen, & Huff, 2006). It should also be noted, that there are variations in the definition of treatment attrition between the studies, which could explain some of the variation in the results.

Studies identifying predicting factors for attrition in treatment programs for domestic violence have mainly focused on perpetrators. Three broader categories of variables predicting treatment attrition have been presented: demographic variables, violence-related variables and intrapersonal characteristics (Daly & Pelowski, 2000; Jewell & Wormith, 2010).

Demographic factors that have showed predicting value across different studies are age, level of education and income. In a meta-analysis by Jewell and Wormith (2010), the demographic factors were found to be better at distinguishing between treatment completers and dropouts than violence-related and intrapersonal variables. Among the demographic factors, employment, age and income were the strongest predictors. Participants who were employed, older and had higher incomes were more likely to complete the treatment. Similar results were found earlier by DeMaris (1989); younger men with lower incomes and men who were unemployed were more likely to drop out of the treatment. Daly and Pelowski (2000) also stated that a young age, unemployment, lower incomes and lower education predicted treatment attrition and that men who tend to drop out of treatment more often tend to be unmarried or childless. Tutty, Bidgood, Rothery and Bidgood (2001) on the other hand, found no difference in income between treatment completers and those who dropped out.

Buttell and Carney (2002) found significant differences between the ages of treatment completers and dropouts among male batterers attending a group intervention, whereas the differences on other measured predictors were not significant.

Among the violence-related factors, Jewell and Wormith (2010) found that participants who were court mandated to treatment were more likely to complete it than those who were not court mandated. On the other hand, Tutty et al. (2001) found that the dropouts were no more likely to be court mandated than the completers. Previous domestic violence offences and criminal history were modestly positively associated with treatment completion. DeMaris (1989) found that men with previous arrests were more likely to drop out.

DeMaris (1989) found that the relationship to the victim was a significant predictor; men who reported the victim being their wife were more likely to complete the treatment than the men reporting not being married to the victim. Tutty et al. (2001) again found that living with the other part did not differ between the treatment completers and dropouts. The endurance of the violence has also been found to predict treatment dropout so that men who reported a longer endurance of the violence were more likely to drop out of the treatment (DeMaris, 1989). Earlier criminal history has also been found to be a significant predictor of treatment attrition among domestic batterers (Duplantis, Romans & Bear, 2006). Daly and Pelowski (2000) did also find that earlier criminal history, as well as exposure to violence in childhood and battering history, were factors with some predicting value for treatment attrition.

Among the intrapersonal characteristics, results from the meta-analysis by Jewell and Wormith (2010) indicated that higher substance use was associated with higher attrition rates. Substance use has been found to be a significant predictor of treatment dropout also by other researchers (Daly & Pelowski, 2000; DeMaris, 1989; Duplantis et al., 2006).

Another intrapersonal factor, motivation, has also been brought up as an important distinguishing factor between dropouts and treatment completers (Daly & Pelowski, 2000), in line with earlier findings (DeMaris, 1989). Researchers have found that the participants' measured stage of readiness to change has been associated with treatment completion in psychological interventions (Choi, Adams, Morse & MacMaster, 2015; Smith, Subich & Kalodner, 1995). Readiness to change is usually described using four stages of readiness to change that are associated with a certain level of motivation (Choi, Adams, MacMaster & Seiters, 2013). In their article, McConnaughy, DiClemente, Prohaska and Velicer (1989) described clients in the different categories. The precontemplators were described as clients who may enter the counselling due of pressure from others and they were not considered making the choice to change themselves. These clients were considered more likely to drop out of the treatment. Contemplators were considered to be aware of an issue and being interested in determining whether the issue is resolvable and whether counselling could be helpful for them, whereas clients belonging to the action category were considered to have begun to take action to make changes in their lives. The clients in the maintenance stage were considered having done some changes before entering counselling and may be seeking for example specific skills for preventing relapse or consolidate previous strategies (McConnaughy et al., 1989). To my knowledge, there are no previous studies concerning the effects of readiness to change on treatment attrition from treatment for domestic violence. However, one could expect that readiness to change could have some predicting value for treatment attrition from interventions for domestic violence due to its effects on other types of psychological treatments.

In conclusion, it can be stated that demographic factors, especially age, income and level of education, have generally predicted attrition from treatment programs best. Violence-related factors, such as previous experiences of violence and a criminal record have shown

some predicting value in a few studies. Substance use has also been found to be associated with treatment attrition. Motivational factors, such as readiness to change, have been associated with treatment attrition in psychological treatment, however, these factors have not been studied to the same extent as the other factors for treatment of domestic violence.

The number of studies examining predictors for dropout in treatment programs for the victims and conjoint treatment programs is limited. Stover et al. (2009) found attrition rates between 14% and 50% for conjoint treatment programs for couples seeking help for domestic violence. Conjoint programs differ from other types of treatments, which may affect the dropout from these types of treatments. There might be other predictors involved in predicting drop out of a conjoint treatment program compared to predictors of attrition in individual counseling, however, to my knowledge, studies about this matter have not been conducted.

1.4 Treatment Service Pilari

In Turku, the Association for Child and Mother Homes and Shelters in Turku) has an outpatient treatment service called Pilari, offering short-term treatment for individuals dealing with domestic violence and/or a threat of it. Counseling is offered to perpetrators, victims and relatives, and Pilari is offering individual sessions, couples' sessions and/or family sessions to the clients. The intervention structure is built on five sessions, using solution- and resource-focused methods. The counseling offered is free of charge and the clients seek treatment on a voluntary basis. When comparing to the different types of treatment mentioned above, this type of treatment can be seen as more similar to the cognitive-behavioristic treatment than the Duluth-model. Due to the fact that Pilari offers individual, couples' and family sessions, there are also elements of conjoint treatment and a "whole family approach".

According to the criteria of quality by the Federation of Mother and Child Homes and Shelters in Finland (2013) that describe the treatment offered at Pilari and other similar agencies, the treatment offered to victims of domestic violence aims to end the violence or the living under a threat of violence, strengthen the victim's own coping mechanisms and support the victim's life management. The treatment for perpetrators aims to prevent violence and end the violent behavior, help the perpetrator to take responsibility of his or her actions, and find new solutions for conflict situations (Federation of Mother and Child Homes and Shelters in Finland, 2013).

Pilari received 252 clients in 2018, 138 (55%) of whom were women (Pilari, 2019**)**. Half of the clients were victims of domestic violence, 45% were perpetrators and the remaining five percent of the clients were relatives to a victim and/or a perpetrator. The most common type of violence among the clients was psychological violence, occurring in 30% of the cases followed by physical violence in 29%, threat of violence in 20% and sexual violence in three percent of the cases. Most of the clients attended between one and four sessions, the largest group being the ones who attended one session (26%). The total number of sessions held at Pilari in 2018 was 766, out of which individual sessions appeared to be the most frequently occurring type (74%, $n = 568$), followed by couple sessions (20%, $n = 156$) and family sessions (6%, $n = 42$). I could not derive information regarding treatment attrition from the data obtained.

1.5 The Current Study

The present study assesses whether there are pre-treatment factors that predict attrition from the treatment in Pilari. Prior to the study, I formulated the following hypotheses based on earlier literature:

1. The participants dropping out of the treatment will be younger, less educated and be more often unemployed than those who complete their treatment.
2. Higher substance use will positively predict treatment dropout.
3. Higher scores on readiness to change will predict treatment completion.

In addition, I also explored the types of violence currently and previously experienced by the participants. This study is the first study to examine predictors for discontinuation of treatment from Pilari and according to my knowledge, this is the first study on this topic in Finland.

2 Method

2.1 Participants

The sample in this study consisted of $N = 22$ participants. The participants were clients at Pilari and were recruited by the staff members at Pilari at their first session at Pilari. Further demographic information on the sample is presented in Table 1.

2.2 Procedure

Prior to the data collection, I gave the staff members at Pilari written and verbal instructions on how to inform the participants about the study in order to ensure an identical recruitment situation for the participants.

I conducted the first part of the data collection between February 5th and May 3rd 2019. The data collection period was extended from what was originally planned in order to secure a larger sample. The participants were invited to participate in the study by the staff member of Pilari at the end of their first counselling session. The participants received written information about the study on an informed consent form. Prior to completing the questionnaire, all participants gave their consent to participating in the study and the

permission for the staff at Pilari to hand out their client number to me. The participants returned the informed consent form and the filled questionnaire in a closed envelope, in order to ensure that only I had access to the answers. The staff member wrote the participant's client number on the envelope. The filled questionnaires were securely stored at Pilari until I collected all the questionnaires at the end of the first part of the data collection. After this, the questionnaires were securely stored at Åbo Akademi University until they were destroyed after the completion of the thesis.

I conducted the second part of the data collection on September 13th 2019, when all participants had completed the treatment period at Pilari. I obtained the number of attended sessions of each participant and information on whether the termination of treatment was planned or unplanned. An unplanned termination of treatment, that is treatment attrition, was defined as a participant not attending a prearranged meeting without announcement. All information gathered at the second part of the data collection was derived from the electronic client management system at Pilari by one of the staff members. Neither the informed consent form nor the questionnaire contained the name of the participants, and thereby the participants remained anonymous to me.

2.3 Measures

The data was collected using a questionnaire with multiple-choice questions and a few open-ended questions (see Appendix for full questionnaire). At the beginning of the questionnaire, relevant terms were defined and written instructions for filling in the questionnaire were found on the questionnaire. Prior to the onset of the data collection, the questionnaire was piloted with university students, staff members at the university and other adults, and relevant changes to the questionnaire were made according to the feedback from the piloting. The final version of the survey was approved by the staff at Pilari prior to the

onset of the data collection. The questions were divided into five sections: demographic information, violence-related information, previous experiences of violence and help seeking, substance (ab)use and readiness to change.

For the demographic data, I asked the participants about their gender, age, mother tongue, marital status, number of children, level of education and subsistence.

Violence-related information that concerned the currently and previously experienced domestic violence was measured with questions about the type of violence (i.e. physical, psychological, sexual, a threat of violence and/or other forms of violence), the participant's role in the violent situations (i.e. victim, perpetrator or relative) and the relationship to the other part in the violent situations (i.e. marriage, cohabitant, dating, divorced, ended relationship, child, parent or other relative). I also asked whether the participant was living with the other part and about police involvement in the currently experienced domestic violence. In addition, an open-ended question about the number of relationships where domestic violence had previously occurred and a dichotomous question about whether the participant had previously sought help for the currently or previously experienced domestic violence were included in the questionnaire. Multiple-choice questions regarding experiences of other types of violence (i.e. hitting or attacking or a threat of hitting or attacking, and bullying) were added to the questionnaire including questions about the participant's role in these situations (i.e. victim and/ or perpetrator).

Substance use was measured with questions regarding how often the participant uses tobacco, alcohol, drugs and prescription drugs. The participants reported their substance use on a 6-point scale with answer choices from 0 (never) to 5 (daily).

Readiness to change was measured with the Finnish version of the 32-item version of The University of Rhode Island Change Assessment Scale (URICA) (McConnaughy, Prochaska & Velicer, 1983). The URICA consists of statements, measuring four theoretically

derived subscales that the participants scored on a 5-point scale (Tambling & Johnson, 2012). Higher total scores on the scale indicate higher readiness to change. The internal consistency of the measure has proven to be at least good for all four subscales, with Cronbach's alpha reaching from .79 to .84 on the subscales (McConnaughy et al., 1989). The URICA-DV (URICA- Domestic Violence; Levesque, Gelles & Velicer, 2000), could have been suitable for the purpose of this study, but it is not available in Finnish and a translated version of the assessment scale could have had an impact on the reliability and validity of the scale. Further, the URICA-DV was developed to assess readiness to change in perpetrators, and the measure's suitability for victims should be taken into account.

2.4 Ethical Considerations

The research plan and the informed consent form were submitted to and approved by the Board of Management of the Association for Child and Mother Homes and Shelters in Turku and the Board for Research Ethics at Åbo Akademi University prior to the onset of the data collection.

2.5 Data Analyses

The statistical analyses were performed using IBM SPSS Statistics 24.0 for Windows. In this study, the predictors of treatment attrition were analyzed according to the hypotheses stated above.

I started by testing the first hypothesis with an independent samples t-test to compare the mean age between the completers and dropouts. Next, I conducted a Fisher's exact test to compare the completers with the dropouts on the employment variable, which was calculated into a new variable with two categories: employed (n = 12) or not employed (i.e. unemployed, student, family leave or retired) (n = 10). To compare the completers and

dropouts on their level of education, I performed also performed a Fisher's exact test after grouping the participants into two new categories: primary school or vocational school (n = 13) and higher education (i.e. upper secondary school, university on applied sciences and university) (n = 9).

To test the second hypothesis about substance use predicting treatment attrition, I performed Fisher's exact tests for alcohol use and smoking separately to determine whether there were differences in substance use between the completers and the dropouts. To determine the effect of alcohol use, two new categories were calculated: participants reporting using no alcohol or more seldom than once a month (n = 10) and those using alcohol more often than once a month (n = 12). Regarding smoking, participants reporting no smoking (n = 14) were compared to the participants reporting any smoking (n = 8).

Finally, I turned to the third hypothesis. The participants' total scores on the URICA were calculated and, according to a scoring model from University of Maryland, Baltimore County (UMBC, retrieved 13.11.2019 from habitslab.umbc.edu/urica-readiness-score/), each participant's score was converted into a category describing his or her stage of readiness to change. I performed an independent samples t-test to determine whether the mean scores on the URICA-scale were significantly different between the completers and the dropouts. As an additional, exploratory analysis, I used a Pearson's chi-square test to assess whether the URICA-categories of readiness to change were associated with treatment completion.

3 Results

A total of 6 participants (27.3%) attritted from treatment at Pilari. The participants attended a total number of 124 sessions at Pilari, the individual sessions being the most prominent type (n = 88, 71%), followed by couples' sessions (n = 32, 25.8%) and family sessions (n = 4, 3.2%). A total of 14 participants (63.6%) attended only individual sessions,

two participants (9.1%) attended only couples' sessions, four participants (18.2%) attended individual and couples' sessions, one participant (4.5%) attended couples' sessions and family sessions and one participant (4.5%) attended all three types of sessions. The results show that the number of attended sessions among the participants varied between 1 and 13 (M = 5.6, SD = 3.1). The participants who dropped out of treatment attended less sessions (M = 3.5, SD = 2.4) than the participants who ended their treatment according to plans (M = 6.4, SD = 2.9) and these differences appeared to be significant (t(20) = 2.17, p = .042, d = 1.09). Levene's test for equality of variances was not significant (p = .760), and, therefore, equal variances could be assumed.

3.1 Demographic Information and Violence-Related Information

As mentioned above, demographic information about the sample is presented in Table 1. A total of 19 participants (86.4%) reported currently occurring domestic violence in their lives and three participants reported no currently occurring domestic violence. Regarding the endurance of the violence, eight participants (36.4%) reported the endurance of the violence being more than 5 years, followed by 1month-1 year (22.7%), 1 year-2years (13.6%), 2 years-5 years (13.6%) and less than a month (9.1%).

Table 2 presents the different types of violence that occurred in the sample and the different roles in the violent situations among the participants. The results indicate that emotional violence was the most frequently occurring type of violence among the participants, followed by threat of violence, physical violence, other type of violence and sexual violence. The result also indicated that most of the participants reporting currently occurring domestic violence (n = 13, 68.4%), reported more than one type of violence.

Half of the participants were married to the other part of the currently occurring domestic violence, the second biggest group being the ones cohabitating (18.2%). One

participant reported being divorced and two participants had ended the relationship with the other part. Three participants reported the other part being a family member; one reported the other part being the participant's parent, two participants reported the other part being their child. Most of the participants (68.2%) were currently living with the other part of the relationship where the violence occurred, five participants reported not living with the other part and two participants did not answer the question. Regarding police involvement, six participants (27.3%) reported police involvement in the currently occurring domestic violence. A total of 16 participants (72.3%) reported that they had not previously sought help to the currently occurring domestic violence.

Regarding earlier experiences of violence, a total of 15 participants (68.2%) had experienced previous hitting or attacking, and 19 participants (86.4%) had experienced a threat of hitting or attacking. A total of 13 participants (59.1%) reported previous experiences of bullying as victims and/or perpetrators. A majority of the participants, $n = 16$ (72.7%), reported previous experiences of domestic violence.

Table 1
Demographic information

		n (%)
Gender		
	Male	9 (40.9%)
	Female	13 (59.1%)
Age (years)		
	18-29	3 (14.3%)
	30-39	7 (33.3%)
	40-49	9 (42.9%)
	Above 50	2 (9.5%)
Mother tongue		
	Finnish	22 (100%)
Marital status		
	Single	1 (4.5%)
	Relationship	2 (9.1%)
	Married	14 (63.6%)
	Cohabitant	3 (13.6%)
	Divorced or separated	2 (9.1%)
Level of education		
	Primary school	1 (4.5%)
	Vocational education	10 (45.4%)
	Upper secondary school	3 (13.6%)
	University of applied sciences	4 (18.2%)
	University	2 (9.1%)
	Other	2 (9.1%)
Subsistence		
	Employed	12 (55.4%)
	Unemployed	4 (18.2%)
	Student	2 (9.1%)
	Family leave	2 (9.1%)
	Retired	2 (9.1%)

Note. The sample size is *N* = 22. One respondent did not report his/her age, therefore, the calculations regarding the age are made with a sample size of *N* = 21.

Table 2

Type of violence and roles in the violent situations among the participants

Type of violence and role	**Responses among completers *n* (%)**	**Responses among dropouts *n* (%)**	**All *n* (%)**
Physical violence			
No	7 (50%)	2 (40%)	9 (47.4%)
Perpetrator	4 (28.6%)	2 (40%)	6 (31.6%)
Victim	7 (50%)	2 (40%)	9 (47.4%)
Relative	1 (7.1%)	0	1 (5.3%)
Emotional violence			
No	3 (21.4%)	1 (20%)	4 (21.2%)
Perpetrator	5 (35.7%)	4 (80%)	9 (47.4%)
Victim	9 (64.3%)	4 (80%)	13 (68.4%)
Relative	1 (7.1%)	0	1 (5.3%)
Sexual violence			
No	13 (92.9%)	5 (100%)	18 (94.7%)
Perpetrator	0	0	0
Victim	1 (7.1%)	0	1 (5.3%)
Relative	0	0	0
Threat of violence			
No	4 (28.6%)	3 (60%)	7 (36.8%)
Perpetrator	4 (28.6%)	1 (20%)	5 (26.3%)
Victim	9 (64.3%)	2 (40%)	11 (57.9%)
Relative	1 (7.1%)	0	1 (5.3%)
Other violence			
No	13 (92.9%)	4 (80%)	17 (89.5%)
Perpetrator	0	0	0
Victim	1 (7.1%)	1 (20%)	2 (10.5%)
Relative	0	0	0

Note. The questions were left unanswered by 3 participants (2 completers and 1 dropout), therefore, the total sample size is *N* = 19 (*n* = 5 dropouts and *n* = 14 completers). Some participants reported more than one role in the violent situations (e.g. victim and perpetrator for physical violence), therefore, overlap in the numbers exists.

3.2 Hypothesis Testing

The results from the independent samples t-test on the ages among the completers and dropouts showed that the mean ages were different for completers (M = 38.13, SD = 8.76) and dropouts (M = 40.80, SD = 4.32). These differences were, however, not significant (t(19) = -0.65, p = .524, d = 0.39). Levene's test for equality of variances was not significant (p = .061), and, therefore, equal variances could be assumed. This analysis was made on a sample of 21 participants (n = 16 completers, n = 5 dropouts), because one participant's age was not reported in the questionnaire.

Regarding subsistence, there was no significant difference between the completers and dropouts (p = .162, Fisher's exact test, OR = 6.43, 95% CI [0.6, 68.31]). For the level of education, the results showed no significant difference on level of education between the completers and dropouts (p = .655, Fisher's exact test, OR = 1.67 (95% CI [0.25, 11.07]).

When assessing the effect of substance use, tobacco and alcohol were the only substances that the participants reported using. Therefore, drugs and prescription drug abuse were excluded from the analyses. A total of 8 participants (37.4%) reported smoking and 18 participants (72.3%) reported alcohol use. The results on smoking indicated no significant differences on smoking between the completers and dropouts (p = 1.00, Fisher's exact test, OR = 0.83, 95% CI [0.12, 6.01]). There were no significant differences between the completers and dropouts regarding alcohol use (p = .646, Fisher's exact test, OR = 2, 95% CI [0.28, 14.2]).

The total score on the URICA varied between 5.29 and 13.14 (M = 9.86, SD = 1.98). The independent samples t-test indicated that the difference in the mean scores on the URICA between the completers (M = 9.71, SD = 1.95) and dropouts (M = 10.29, SD = 2.17) was not significant, t(20) = -0.60, p = .554, d = 0.28. Levene's test of equality of variances was not significant (p = .697) and, therefore, equal variances could be assumed. Three of four

categories of readiness to change were represented among the participants; contemplation being the most prominent one (n = 13), followed by action (n = 5) and precontemplation (n = 4). The chi-square test regarding the different categories and treatment completion showed no significant results, χ^2 (2, N = 22) = .534, p = .766, V = .156). However, the sample was so small that I did not meet the requirements of 80% of cells having expected counts reaching 5, which is a requirement for the chi-square test (Field, 2013). Therefore, I decided to analyze the data again, this time with a Fisher's exact test. This analysis did also result in not significant differences between the completers and dropouts (p = .808, Fisher's exact).

4 Discussion

In this study, I investigated pre-treatment measured factors that would predict attrition from treatment for domestic violence. The results indicate differences between the participants who completed the treatment and those how dropped out of the treatment. These differences were, however, not significant. A few small and one large effect size appeared in the results on the age, subsistence, alcohol use and URICA-score variables. The effect sizes indicated that those who were older were slightly more likely to attrit and the participants who were employed were moderately more likely to attrit. The participants reporting alcohol use more often than once a month were slightly more likely to attrit and those having a higher total score on the URICA-scale were also slightly more likely to attrit from treatment. These effects sizes may suggest that these variables are associated with treatment attrition but, due to the small sample size, these differences may not have reached statistical significance. Further research with well-powered studies would be necessary to confirm these differences.

Regarding the demographic factors as predictors for treatment drop out, the data analyses showed differences between the groups on age, level of education and subsistence. The results indicated a small difference on the mean ages between the completers and

dropouts, indicating the dropouts being older than the completers. This result is contradictory to earlier research on the topic and the hypothesis, and could be indicative of the treatment methods used at Pilari being more suitable for younger participants. Younger clients may also find it easier to establish changes in their lives, whereas older clients find it more difficult, especially if the violence has continued many years. However, the effect size indicates a small effect, which could indicate that age in fact has predicting value for treatment attrition, but this effect did not reach statistical significance due to the small sample.

There were no significant differences between the groups on the subsistence and level of education variables, which is also contradictory to our hypothesis and also to earlier studies. The fact that there were no differences on level of education between the completers and dropouts could be explained by the fact that more than half of the participants (n = 12) had reported vocational education as their highest completed level of education, illustrating that the variation on level of education was relatively small within this sample. This could illustrate the fact that the education in Finland is usually free of charge, and almost all people are given the opportunity to obtain an education, whereas the situation is different for example in the USA. Therefore, it could be argued that the variation among people with similar levels of education is greater in Finland, whereas the groups are more homogenous in the USA, leading to level of education becoming a stronger differentiating factor between people in the USA than in Finland and, therefore, also affecting treatment attrition stronger.

The insignificant differences between the completers and dropouts on subsistence could also be explained by the fact that over half of the participants (n = 12) reported being employed and other options, such as unemployed persons or students, were rarely represented among the participants. Despite the insignificant results, the analyses did, however, result in a large effect size for subsistence, indicating that among the participants were not employed (n = 10), the majority (n = 9) completed their treatment. This could indicate that this variable

could in fact differ between the groups, but the difference did not reach statistical significance, which may have been due to the small sample size. This result is contradictory to the hypothesis and earlier research, which makes this an interesting finding, especially due to the large effect size. It could be argued that people in their working life do not have the resources to make changes in their lives, leading to treatment attrition. However, it should be noted that in the category "not in working life" were also students and participants being on family leave, so they are not considered to be unemployed, as is the case for the dropouts in earlier studies.

For substance use, there were no significant differences between the completers and dropouts on the smoking variable and alcohol use variable. This finding is also contradictory to our hypothesis about substance use being a predicting factor for treatment attrition. Indicated by a small effect size, alcohol use was relatively more frequent among the dropouts than the completers, which is consistent with the hypothesis. Alcohol use is sometimes associated with for example impulsive behavior (e.g. Kravitz, Fawcett, McGuire, Kravitz & Whitney, 1999), which could explain treatment dropout from interventions for domestic violence. However, the sample in this study was so small that no conclusions about the variables for substance use can be drawn without further research.

Results indicated a small difference on the total URICA-score between the completers and dropouts, the dropouts having higher scores on the URICA-scale than the completers, indicating higher readiness to change among the dropouts. This is contradictory to the hypothesis. Higher scores among the dropouts could indicate that participants with higher scores do not perceive the treatment as being necessary for them, leading to treatment attrition. The effect size indicates a small effect, which could indicate that a larger sample could have resulted in a statistically significant result. The differences between the groups in this study were, however, small and further research on this topic is necessary in order to

confirm these results. The URICA-categories did not differ significantly between the participants in the different groups, which was also contradictory to what I anticipated. This result could be explained by the fact that a clear majority (n = 13) of the participants represented the contemplation category and, therefore, the variation within the sample was relatively small. It could also be argued that due to the fact that the clients' individual needs and wishes are taken into consideration when planning the treatment at Pilari, the differences on the clients' readiness to change, or other similar characteristics, may not be distinguishing factors among the completers and dropouts, whereas this would be the case in treatment programs that are the same for all clients.

One point that should be noted when perceiving the results from this study is that most research on the topic is conducted in the USA and, therefore, the results of the earlier studies may not reflect the situation in Finland. As mentioned earlier, the methods used in Finland vary from the ones used in the USA and, therefore, different factors for treatment attrition may be relevant in the different countries. Another important aspect that should be taken into consideration when viewing the results is that most research on treatment of domestic violence is based on samples consisting of men participating in group interventions. It can be presumed that group interventions and individual, couple or family interventions differ from each other in ways that may also affect the factors leading to treatment attrition.

To conclude, it can be stated that there were some differences that appeared between the completers and dropouts, on demographic factors (i.e. age and subsistence), alcohol use and readiness to change, most of them not significant. However, a few effect sizes indicated possible associations and these effects would be necessary to study further with larger sample sizes.

4.1. Limitations

The results of the current study are limited in various ways and further research on the topic is relevant and necessary in order to be able to make conclusions about the researched questions.

First, there are limitations concerning the sample. The size of the sample in the study remained small, consisting of 22 persons, which affects the reliability of the results and complicates finding statistically significant results. The first data collection period was extended with a few weeks, in order to increase the number of participants. However, due to the schedule of this study, a longer data collection period was not possible.

The sample in the study was also not randomly chosen, because the staff at Pilari made the final decision about recruitment. Even though I gave written and verbal instructions to the staff at Pilari about presenting the possibility to participate to every client equally, the final decisions were not made by me. However, the sample in the current study consisted of persons of different ages and different education levels, which could be seen as an indicator that the sample was somewhat homogeneous.

The sample consisted of Finnish-speaking persons in one region of Finland and, therefore, the results cannot with certainty be generalized to other populations. As mentioned earlier, domestic violence is a phenomenon that has strong connections to cultural and societal factors, which could mean that the results of this study are illustrating the situation in Finland among people living in the Turku region.

There are also limitations considering the design used in the study. One of the most significant limitations is the absence of a control group. Control groups are relevant, because they can show that the effect is due to something in the researched area. I did also not control for the type of sessions that the participants attended (i.e. individual, couples' or family sessions), which may lead to the results being affected by the type of sessions that the

participants attended rather than personal, pre-treatment measured, characteristics of the participants.

Another limitation regarding the method used in this study is that I was not able to control the situation when the participants filled in the questionnaire. By giving the staff at Pilari written instructions on how to tell about the study for the participants, how to recruit participants and when to let them fill in the questionnaire, I strived for identical situations for the participants. However, it is not possible to verify, whether the instructions have been followed.

At the beginning of the questionnaire, relevant words were explained; that is, close relationship and relative. However, the different types of violence were not explained in the questionnaire. The different forms of violence used in the questionnaire were physical violence, psychological violence, sexual violence, threat of violence and other violence. Even though the option "other violence, what?" was added to the questionnaire, it cannot be stated that all forms of domestic violence were measured with the questionnaire.

There is also a possibility that the staff at Pilari made more effort to keep the clients who participated in the study in the treatment, because they knew what the study concerned. These aspirations to keep the participants in treatment longer may also be unconscious and may lead to a lower attrition rate.

4.2. Recommendations for Further Research

To my knowledge, this study was the first one to examine this kind of treatment for domestic violence in Finland. Even though the results should be considered together with the limitations of the study, including the sample size, the results indicated no significant pre-treatment measured predictors for treatment attrition in the sample. The results from this study present information that could be necessary to take into consideration at the beginning

of the treatment with new clients at Pilari and possibly other treatment agencies. However, the limitations of this study affect the possibility to generalize the results to a larger population. Further research on the predicting factors of attrition from these treatment programs is needed in order to further develop these treatment programs as well as the recruitment of participants to the programs. Being able to identify predicting factors for treatment attrition could help practitioners identify the participants with higher risk of treatment attrition at the onset of the treatment and take individual risk factors into consideration when planning and applying the treatment. Further research, especially about interventions for victims, conjoint treatment programs and the "whole family" approach would be necessary in the field. Also other factors, such as personality factors and factors relating to the treatment itself would be necessary to research in order to further develop the intervention programs. As mentioned earlier, treatment attrition has an effect on the effectiveness of the treatment programs as well as the cost effectiveness, whereby, it would be important to develop the intervention programs so that they met the individual needs of the participants as well as the needs of the participants in general.

4.3. Conclusions

Treatment attrition seems to be a considerable problem for interventions for domestic violence and earlier research has found that some demographic factors, substance use and motivational factors could be predicting treatment attrition. This study examined similar pre-measured factors among patients at a treatment service in Turku, Finland. The results from this study indicated no significant differences on the pre-treatment measured factors between the treatment completers and dropouts in the sample. Yet, some differences between treatment completers and dropouts were nevertheless of notable size, such as age,

subsistence, alcohol use and the URICA-score. The role of these variables warrants further research using more robust sample sizes.

The fact that there were no significant differences on the measured factors between the completers and dropouts could also indicate that the factors leading to treatment dropout are not associated with pre-treatment measured client-related factors, but rather with factors related to the treatment itself. Further research is necessary for the development of the treatment programs in order to make them meet the clients need in a better way.

5 Swedish Summary

Identifiering av predicerande faktorer för avbrytande av behandling för våld i nära relationer

Våld i nära relationer förekommer överallt i världen och påverkar många människors vardag. Våld i nära relationer innebär våld som förekommer mellan partners i romantiska förhållanden och/eller familjemedlemmar, det vill säga barn och andra släktingar (Barocas m.fl., 2016; Domestic violence, 2019), och denna samma definition på termen ”våld i nära relationer” kommer att användas i denna avhandling. I denna avhandling kommer termerna utövare och offer användas för att beskriva de olika parterna i de våldsamma situationerna. Våld i nära relationer kan ge upphov till olika följder för offret, exempelvis fysiska skador, psykosomatiska besvär, psykologiska symptom och psykosociala konsekvenser (Flury, Nyberg & Riecher- Rössler, 2010; Ansara & Hindin, 2011). Största delen av forskningen om våld i nära relationer handlar om män som utövare och kvinnor som offer (Barber, 2008; Carney, Butell & Dutton, 2007; Drijber, Reijnders, & Ceelen, 2013). Detta speglas även i prevalenssiffrorna för våld i nära relationer som visar att 4,8% till 53% av alla kvinnor blir offer för denna typ av våld (Danielsson & Näsi, 2018; FRA, 2015). Våld i nära relationer tenderar att underrapporteras av olika anledningar, exempelvis på grund av offrens känslor av

skam och lojalitet samt möjliga beroendeförhållanden till utövaren (Drijber m.fl., 2013; Skinnari, Jonsson & Vesterhav, 2019). Våld i nära relationer som utövas av män mot kvinnor framkommer oftare än våld som utövas av kvinnor mot män (Danielsson & Salmi, 2013), även om forskare har betonat att kvinnor utövar lika mycket våld i nära relationer som män (Brottsförebyggande rådet (BRÅ), 2009; Johnson, 2006).

Litteraturen presenterar olika typer av interventioner för våld i nära relationer. Största delen av forskningen inom området handlar om män som utövare och kvinnor som offer, men forskare har betonat vikten av preventiva interventioner även för kvinnor som utövare av våld (t.ex. Langhinrichsen- Rohling m.fl., 2012; Straus, 2011). Inom forskningen förekommer två huvudsakliga typer av interventioner för utövare av våld i nära relationer; den så kallade Duluth-modellen, där våld ses som ett medel för män att kontrollera kvinnor och där man eftersträvar förändringar i männens kvinnosyn, samt den kognitiv-behavioristiska metoden där våld betraktas som ett inlärt beteende och där behandlingen består av exempelvis färdighetsträning och hantering av ilska (Babcock, Greene & Robie, 2004). Litteraturen om interventioner för offren är inte lika omfattande, men det som oftast erbjuds till offren är kristelefoner, samtalsstöd och olika typer av skyddsboende (Bennet, Riger, Shewe, Howard & Wasco, 2004; Stith, Rosen, McCollum, 2003). Vid sidan om de interventioner som riktar sig till enskilda individer, förekommer det interventioner där par, även hela familjer, behandlas tillsammans. Vid dessa interventioner lyfter forskarna fram vikten av konstant uppföljning av våldet samt tillräcklig utbildning av dem som arbetar med dessa par och familjer (Bradley m.fl., 2014; Mayer, 2017; Stith & McCollum, 2011). I Finland erbjuds hjälp för personer som lider av våld i nära relationer exempelvis via den så kallade MARAK-modellen (Institutionen för välfärd och hälsa, 2019), där man strävar efter att förebygga våld genom ett mångprofessionellt samarbete med klienten. Även andra sätt att behandla våld i nära relationer finns, exempelvis via Brottsofferjouren (RIKU) (Brottsofferjouren, 2019) och

Jussi-työ (Förbundet för mödra- och skyddshem, 2020). Av de interventioner som presenterades ovan, nämligen den kognitiv-behavioristiska metoden och Duluth-modellen, liknar interventionerna som erbjuds i Finland mer den första.

Avbrytande av behandling är ett problem som förekommer i alla typer av psykologisk behandling, därmed även interventioner för våld i nära relationer. Avbrytande av behandling har undersökts främst i gruppinterventioner för män i Nordamerika och forskare har presenterat olika siffror på andelen personer som avbryter behandlingen, varierande från 15% till 99% (Babcock m.fl., 2004; Daly & Pelowski, 2000; Jewell & Wormith, 2010; Stover m.fl., 2009). Den höga andelen av de som avbryter behandlingen kan bero på att interventionerna inte lyckas möta de individuella behoven hos deltagarna (Sartin, Hansen & Huff, 2006). Forskare har även studerat enskilda predicerande faktorer för avbrytande av behandling. Studierna har påvisat tre huvudsakliga typer av faktorer som har predicerat avbrytande av behandling för våld i nära relationer; demografiska faktorer, våldsrelaterade faktorer och personliga egenskaper hos deltagarna (Daly & Pelowski, 2000; Jewell & Wormith, 2010). Bland de demografiska faktorerna har arbetslöshet, lägre ålder och lägre inkomster visat sig predicera avbrytande av behandling starkast (t.ex. Daly & Pelowski, 2000; DeMaris, 1989; Jewell & Wormith, 2010). Bland våldsrelaterade faktorer har bland annat tidigare brottsligt beteende och varaktigheten av det våldsamma beteendet visat sig predicera avbrytande av behandling hos män (DeMaris, 1989; Duplantis, Romans & Bear, 2006; Jewell & Wormith, 2010). Personliga egenskaper som har visat sig vara sammankopplade med avbrytande har varit substansanvändning, tidigare erfarenheter av våld och motivation (Daly & Pelowski, 2000; Jewell & Wormith, 2010; Smith m.fl., 1995). Smith m.fl. (1995) och Choi m.fl. (2015) påvisade, att deltagarnas beredskap till förändring var sammankopplad med avbrytande av psykologiska interventioner överlag. Beredskap till förändring brukar definieras med hjälp av fyra stadier; stadiet innan övervägande (*eng*.

precontemplation) övervägande (*eng*, contemplation), åtgärdande (*eng*. action) och upprätthållande (*eng*. maintenance), som illustrerar hur beredd personen är till att åstadkomma förändring (Choi m.fl., 2013).

Det finns en begränsad mängd forskning kring interventioner för par och/eller familjer eller för offer av våld i nära relationer. I en studie av Stover m.fl. (2009) framkom det att 14–50% av deltagarna i interventioner för par avbröt behandlingen. Det bör trots allt framhävas att dessa typer av interventioner skiljer sig mycket från de interventioner som är riktade mot män som utövare. Därför kan man även anta att avbrytande av interventioner för par och/eller familjer kan vara sammankopplade med andra faktorer än de som diskuterats ovan.

Syftet med denna studie är att identifiera faktorer som kunde predicera ett oplanerat avslut av behandlingen vid en öppenvårdsanstalt, Pilari, i Åbo i Finland. Pilari erbjuder behandling för personer som drabbas av våld i nära relationer för så väl utövare, offer som närstående. Behandling ordnas i form av individuella träffar, parträffar eller familjeträffar, beroende på individens situation, behov samt önskemål. Målet med behandlingen vid Pilari är bland annat att minska på våldet och lära utövaren nya sätt att hantera konfliktsituationer och stöda offrets livshantering. Hypoteserna för studien baserar sig på tidigare forskning och är följande:

1. Deltagarna som avbryter behandlingen kommer att vara yngre, ha lägre utbildning och vara oftare arbetslösa än de som avslutar behandlingen som planerat.
2. Högre substansanvändning kommer att predicera avbrytande av behandlingen.
3. Högre poäng på beredskap till förändring kommer att predicera ett planerat avslut på behandlingen.

Metod

Samplet i studien bestod av $N = 22$ klienter vid Pilari. Deltagarna rekryterades till studien av personalen vid Pilari under deltagarnas första träff. Datainsamlingen för denna

studie utfördes i två delar. Under den första delen av datainsamlingen rekryterades deltagare varefter deltagarna fyllde i en samtyckesblankett och ett frågeformulär. Den andra delen av datainsamlingen utfördes då alla deltagare hade avslutat sin klientkontakt vid Pilari. I detta skede samlades information om mängden besök och ifall behandlingen avslutats planerat eller oplanerat. Informationen samlades in med hjälp av klientnumren som överlämnades till forskaren i den första delen av datainsamlingen och således förblev deltagarna anonyma för forskaren genom hela datainsamlingsprocessen.

De predicerande faktorerna för avbrytande av behandling mättes med hjälp av ett frågeformulär som bestod av flervalsfrågor samt några öppna frågor (se Appendix för det fullständiga frågeformuläret). Innan datainsamlingen påbörjades, piloterades frågeformuläret och relevanta förändringar gjordes på basen av den feedback som framkom i piloteringen. Frågorna i frågeformuläret var uppdelade i fem delar; demografisk information, våldsrelaterad information, tidigare erfarenheter av våld, substansanvändning och beredskap till förändring. Frågorna i de tre första delarna bestod av flervalsfrågor och enstaka jo/nej-frågor. Substansanvändningen mättes med en 5-gradig skala och beredskap till förändring mättes med den finska versionen av URICA-måttet (McConnaughy m.fl.,1983) som har påvisat god reliabilitet (McConnaughy m.fl., 1989).

Innan datainsamlingen inleddes, beviljades studien etiskt tillstånd av den forskningsetiska nämnden vid Åbo Akademi och styrelsen för Åbo mödra- och skyddshem rf. Alla forskningsetiska principer tillämpades i utförandet av denna studie.

Data analyserades med IBM SPSS Statistics 24.0 för Windows. För att testa den första hypotesen utfördes ett t-test för oberoende sampel för åldervariabeln och Fisher's exact test för utbildningsnivån samt utkomst. För att testa den andra hypotesen om substansanvändning utfördes ett Fisher's exact test. Variablerna för utbildningsnivå, utkomst och alkoholanvändning kalkylerades om för att säkerställa tillräckligt stora grupper, så att

testen kunde utföras. För att testa den tredje hypotesen om beredskap till förändring, tilldelades varje deltagare, på basis av totalpoängen, en kategori som beskrev hans/hennes beredskap till förändring (d.v.s. stadiet före övervägande, övervägande, åtgärdande eller upprätthållande). Ett Fisher's exact test utfördes för att upptäcka skillnader i de olika URICA-kategorierna och ett t-test för oberoende sampel utfördes för att undersöka skillnaderna i totalpoängen på URICA-måttet mellan de olika grupperna.

Resultat

Totalt 6 deltagare (27,3%) avbröt behandlingen vid Pilari. Mängden sessioner som deltagarna hade deltagit i varierade mellan 1 och 13 (M = 5,6, SD = 3,1). Sammanlagt deltog deltagarna i 124 träffar, varav individuella träffar var den oftast förekommande typen av träffar (n = 88, 71%), följt av parträffar (n = 32, 25,8%) och familjeträffar (n = 4, 3,2%). Deltagarna som avbröt sin behandling vid Pilari deltog i färre träffar (M = 3,5, SD = 2,4) än de som avslutade behandlingen som planerat (M = 6,4, SD = 2,9) och dessa skillnader visade sig vara signifikanta (t(20) = 2,17, p = 0,042, d = 1,09). Demografisk information om deltagarna finns i Tabell 1. Totalt 19 deltagare (86,4%) uppgav att det förekom våld i nära relationer i deras liv för tillfället. Tabell 2 presenterar de olika typerna av våld som förekom i samplet och vilka roller deltagarna hade i de våldsamma situationerna. Resultaten indikerar att emotionellt våld var den oftast förekommande typen av våld bland deltagarna och de flesta av deltagarna som rapporterade våld i nära relationer i deras nuvarande livssituation (n =13, 68,4%), rapporterade flera olika typer av våld.

När det gäller de demografiska faktorerna som predicerande faktorer för avbrytande av behandling, indikerade resultaten att medelåldern mellan de som avbröt behandlingen (M = 40,80, SD = 4,32) och de som avslutade den som planerat (M = 38,13, SD = 8,76) skiljde sig från varandra. Dessa skillnader var dock inte signifikanta (t(19) = -0,65, p = 0,524, d = 0,39). Denna analys gjordes på mindre ett sampel med N = 21 deltagare (n =16 med planerat

avslut och *n* = 5 avbrytare), eftersom en deltagare inte uppgivit sin ålder på frågeformuläret. Avbrytarna och deltagarna med ett planerat avslut skiljde sig inte signifikant från varandra för variablerna för utkomst (p = 0,162, Fisher's exact test, *OR* = 6,43, 95% CI [0,6; 68,31]) eller utbildningsnivå (p = 0,655, Fisher's exact test, *OR* = 1,67 (95% CI [0,25; 11,07]).

När det gäller substansanvändning, förekom det endast tobaksrökning och alkoholanvändning bland deltagarna. Totalt 8 deltagare (37,4%) rapporterade tobaksrökning och 18 deltagare (72,3%) rapporterade alkoholanvändning. Resultaten från analyserna tyder på att varken tobaksrökning (p = 1,00, Fisher's exact test, *OR* = 0,83, 95% CI [0,12; 6,01]) eller alkoholanvändning (p = 0,646, Fisher's exact test, *OR* = 2, 95% CI [0,28; 14,2]) skiljde sig signifikant grupperna emellan.

Poängantalet på URICA-måttet varierade bland deltagarna mellan 5,29 och 13,14 (M = 9,86, SD = 1,98). Resultaten från data-analyserna indikerar att medeltalen på poängen skiljde sig mellan de som avbröt behandlingen (M = 10,29, SD = 2,17) och de som avslutade den som planerat (M = 9,71, SD = 1,95). Dessa skillnader var dock inte signifikanta (t(20) = -0,60, p = 0,554, d = 0,28). Tre av fyra URICA-kategorier var representerade bland samplet och resultaten visade att det inte förekom signifikanta skillnader mellan de olika kategorierna bland avbrytarna och de som avslutade behandlingen som planerat (p = 0,808, Fisher's exact test).

Diskussion

Majoriteten av resultaten från data-analyserna visade sig vara icke-signifikanta. När det gäller de demografiska faktorerna som predicerande faktorer för avbrytande av behandling, framkom en liten skillnad mellan medelåldern på grupperna som tydde på att de som avbröt behandlingen var äldre än de som avslutade den som planerat, men skillnaden mellan medelåldrarna var inte signifikant. Detta resultat är oförenligt med tidigare forskningsresultat och den första hypotesen, men analysen tyder dock på en liten effekt. Detta kan exempelvis

förklaras med att behandlingen vid Pilari är mer lämplig för yngre personer och yngre personer har lättare att åstadkomma större förändringar i sina liv. Data-analyserna uppvisade ingen signifikant skillnad mellan grupperna på utkomst och utbildningsnivå vilket även stred emot förväntningarna och tidigare forskning. Detta resultat kan förklaras med att variationen på dessa variabler var relativt liten i hela samplet. Resultaten indikerar dock på en stor effektstorlek för utkomst, så att majoriteten av de personer som inte befann sig i arbetslivet hörde till dem som avslutade behandlingen som planerat. Detta ät ett intressant fynd och kan förklaras exempelvis med att stora livsförändringar kräver mycket resurser, vilket personer som inte är i arbetslivet har mer av än de som är i arbetslivet.

Alkoholanvändning och tobaksrökning visade sig inte heller vara signifikant de olika grupperna emellan. Relativt sett, visade sig alkoholanvändning vara mer vanligt bland dem som avbröt behandlingen, vilket överensstämmer med hypotesen. Detta kan bero på att alkoholanvändning ofta är kopplat med exempelvis impulsivt beteende (t.ex. Kravitz m.fl., 1999), som i sin tur kunde leda till avbrytande av behandling. Resultaten anger en skillnad mellan totalpoängen på URICA-måttet mellan de två grupperna, så att de som avbröt behandlingen hade högre poäng, vilket var motstridigt med den tredje hypotesen. Högre poäng på URICA-måttet indikerar högre beredskap till förändring, vilket kunde leda till att deltagarna inte anser att den behandling de fått vid Pilari är relevant för dem, vilket i sin tur leder till avbrytande av behandling. Skillnaderna på URICA-kategorierna mellan grupperna var inte heller statistiskt signifikanta, vilket kunde förklaras med att klienternas behov och önskemål tas i beaktande vid planeringen av behandlingen vid Pilari, vilket kunde leda till att beredskap till förändring inte påverkar deltagarnas avbrytande av behandling, vilket kunde vara fallet i behandlingsprogram där interventionen ser likadan ut för alla klienter.

Avslutningsvis kan det konstateras att det inte framkom signifikanta skillnader på de mätta variablerna mellan de deltagare som avbröt behandlingen och de som avslutade den

som planerat. Dock kan det inte garanteras att dessa faktorer inte de facto predicerar avbrytande av behandling, eftersom ett litet sampel kan försvåra upptäckandet av skillnader mellan grupperna. Det framkom effektstorlekar för ålder, utkomst, alkoholanvändning samt URICA-poängen som kunde indikera att dessa faktorer har en inverkan på avbrytandet av behandlingen, fastän resultaten inte nådde statistisk signifikans. Det behövs fortsatt forskning inom ämnet för att bekräfta resultaten från denna studie.

Denna studie har dock vissa begränsningar som påverkar tillförlitligheten av dessa resultat. För det första finns det begränsningar som gäller samplet; samplet var litet, det var inte slumpmässigt valt och det bestod av endast finskspråkiga deltagare. Dessa begränsningar har en betydande inverkan på möjligheten att generalisera resultaten till en större population. För det andra finns det begränsningar gällande studiens upplägg och metoden som användes. I studien saknas en kontrollgrupp, vilket innebär att de resultat som framkom, inte nödvändigtvis är beroende av de faktorer som mättes. Forskaren kunde inte heller kontrollera situationen där deltagarna fyllde i frågeformuläret, och därmed kan det inte garanteras att situationen var identisk för alla deltagare. När det gäller frågeformuläret kan det inte garanteras att alla typer av våld i nära relationer blev uppmätta med hjälp av formuläret. För det tredje är det möjligt att personalen vid Pilari arbetade på ett annorlunda sätt med klienterna som var med i studien för att hålla kvar klientkontakten, vilket kan ha påverkat resultaten.

Sammanfattningsvis kan det konstateras att resultaten från studien kan bidra med viktig information som kan vara nödvändig i planerandet av behandlingar vid Pilari och andra liknande anstalter, även om möjligheten att generalisera resultatet påverkas starkt av de begränsningar som diskuterades ovan. Fortsatt undersökning inom ämnesområdet är nödvändig för utvecklingen av interventionerna, speciellt för interventioner som inte är gruppinterventioner och som riktar sig till offer för våld i nära relationer och interventioner

för par och/eller familjer. Även andra faktorer som kunde predicera avbrytande av behandling, exempelvis personlighetsfaktorer och interventionsrelaterade faktorer, bör undersökas vidare. Avbrytande av behandling påverkar effektiviteten av interventionerna samt kostnadseffektiviteten, vilken är orsaken till att det vore viktigt att hitta de faktorer som kunde predicera avbrytning och utveckla interventionerna så att de bättre kunde möta deltagarnas behov.

References

Ansara, D. L., & Hindin, M. J. (2011). Psychosocial consequences of intimate partner violence for women and men in Canada. *Journal of Interpersonal Violence, 26*(8), 1628-1645. doi:10.1177/0886260510370600

April, D., Nicholas, L.J. (1996) Premature termination of counselling at a university Counselling Centre, *International Journal for the Advancement of Counselling*, *19*, 379-387, doi:10.1007/bf00129159

Archer, J. (2000). Sex differences in aggression between heterosexual partners. *Psychological Bulletin, 126*(5), 651-680. doi:10.1037/0033-2909.126.5.651

Babcock, J. C., Green, C. E., & Robie, C. (2004). Does batterers' treatment work? A meta-analytic review of domestic violence treatment. *Clinical Psychology Review, 23*(8), 1023-1053. doi:10.1016/j.cpr.2002.07.001

Barber, C. F. (2008). DV against men. Nursing Standard, 22(51), 35–39. doi:10.7748/ns2008.08.22.51.35.c6644

Barocas, B., Emery, D., & Mills, L. (2016). Changing the domestic violence narrative: Aligning definitions and standards. *Journal of Family Violence, 31*(8), 941-947. doi:10.1007/s10896-016-9885-0

Bennett, L., Riger, S., Schewe, P., Howard, A., & Wasco, S. (2004). Effectiveness of Hotline, Advocacy, Counseling, and Shelter Services for Victims of Domestic Violence: A Statewide Evaluation. *Journal of Interpersonal Violence*, *19*(7), 815–829.

Bradley, R., Drummey, K., Gottman, J., & Gottman, J. (2014). Treating couples who mutually exhibit violence or aggression: Reducing behaviors that show a susceptibility

for violence.*Journal of Family Violence, 29*(5), 549-558. doi:10.1007/s10896-014-9615-4

Buttell, F., & Carney, M. (2002). Psychological and demographic predictors of attrition among batterers court ordered into treatment. *Social Work Research, 26*(1), 31-41.

Carney, M., Butell, F., & Dutton, D. (2007). Women who perpetrate intimate partner violence: a review of the literature with recommendations for treatment. *Aggression and Violent Behaviour, 12*(1), 108–115.

Choi, S., Adams, S. M., MacMaster, S. A., & Seiters, J. (2013). Predictors of residential treatment retention among individuals with co-occurring substance abuse and mental health disorders. *Journal of Psychoactive Drugs, 45*(2), 122-131. doi:10.1080/02791072.2013.785817

Choi, S., Adams, S. M., Morse, S. A., & MacMaster, S. (2015). Gender differences in treatment retention among individuals with co-occurring substance abuse and mental health disorders. *Substance use & Misuse, 50*(5), 653-663. doi:10.3109/10826084.2014.997828

Clarkin, J.F, Levy, K.L. (2004). Research on Client Variables in Psychotherapy. In M.Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change, (5th ed.)*, New York, NY: John Wiley & Sons, Inc.

Corvo, K., Dutton, D, & Chen, W. (2009). Do Duluth model interventions with perpetrators of domestic violence violate mental health professional ethics? *Ethics & Behavior*, *19*(4), 323-340. doi: 10.1080/10508420903035323.

Daly, J. E. & Pelowski. S. (2000). Predictors of dropout among men who batter: A review of studies with implications for research and practice. *Violence and Victims, 15*(2), 137-160. doi:10.1891/0886-6708.15.2.137

Danielsson, P. & Näsi, M. (2018). Suomalaiset väkivallan ja omaisuusrikosten kohteena 2017– Kansallisen rikosuhritutkimuksen tuloksia. Katsauksia 31/2018. Helsinki: Kriminologian ja oikeuspolitiikan instituutti, Helsingin yliopisto

Danielsson, P. & Salmi, V. (2013) Suomalaisten kokema parisuhdeväkivalta 2012. Kansallisen rikosuhritutkimuksen tuloksia. Verkkokatsauksia 34/2013. Helsinki: Oikeuspoliittinen tutkimuslaitos.

DeMaris, A. (1989). Attrition in batterers counseling - the role of social and demographic-factors. Retrieved from http://scholarworks.bgsu.edu/soc_pub/13

Domestic Violence. (2019). In *Encyclopaedia Britannica*. Retrieved 24.1.2020 from: https://www.britannica.com/topic/domestic-violence

Drijber, B., Reijnders, U., Ceelen, M.. (2013). Male victims of domestic violence. *Journal of Family Violence, 28*(2), 173-178. doi:10.1007/s10896-012-9482-9

Duplantis, A. D., Romans, J. S. C., & Bear, T. M. (2006). Persistence in domestic violence treatment and self-esteem, locus of control, risk of alcoholism, level of abuse, and beliefs about abuse. *Journal of Aggression, Maltreatment & Trauma, 13*(1), 1-18. doi:10.1300/J146v13n01_01

European Union Agency for Fundamental Rights. (2014). *Violence against women: an EU-wide survey.* Luxembourg: Publications Office of the European Union.

Federation of Mother and Child Homes and Shelters (Ensi- ja Turvakotien Liitto). (2013). *Väkivaltatyön laitos- ja avopalvelutyön laatukriteerit 2.0*. Helsinki: Ensi- ja Turvakotien liitto.

Federation of Mother and Child Homes and Shelters (Ensi- ja Turvakotien Liitto). (2020). Turvakodit ja väkivallan ehkäisy. Retrieved: 17.1.2020 from: https://ensijaturvakotienliitto.fi/tietoa-liitosta/nain-me-autamme/turvakodit-muu-vakivaltatyo/#jussi-tyo

Field, A. P. (2013). *Discovering statistics using IBM SPSS statistics : and sex and drugs and rock 'n' roll.* 4th ed. Los Angeles: Sage.

Finnish Institute of Health and Welfare (Terveyden ja hyvinvoinnin laitos [THL]). (2019). MARAK-moniammatillinen riskiarviointi. Retrieved: 5.1.2020 from: https://thl.fi/web/lapset-nuoret-ja-perheet/tyon_tueksi/menetelmat/marak

Flury, M., Nyberg, E., & Riecher-Rössler, A. (2010). Domestic violence against women: Definitions, epidemiology, risk factors and consequences. *Swiss Medical Weekly, 140*, w13099. doi:10.4414/smw.2010.13099

Greene, K., & Bogo, M. (2002). The different faces of domestic violence: Implications for assessment and treatment. *Journal of Marital and Family Therapy*, 28 (4), 455-466

Harris, G. E. (2006). Conjoint therapy and domestic violence: Treating the individuals and the relationship. *Counselling Psychology Quarterly, 19*(4), 373-379. doi:10.1080/09515070601029533

Jewell, L. M., & Wormith, J. S. (2010). Variables associated with attrition from domestic violence treatment programs targeting male batterers. *Criminal Justice and Behavior, 37*(10), 1086-1113. doi:10.1177/0093854810376815

Johnson, M. P. (2006). Conflict and Control: Gender Symmetry and Asymmetry in Domestic Violence. *Violence Against Women*, *12*(11), 1003-1018. doi:10.1177/1077801206293328

Kravitz, H. , Fawcett, J. , McGuire, M. , Kravitz, G. & Whitney, M. (1999). Treatment Attrition Among Alcohol-Dependent Men. *Journal of Clinical Psychopharmacology, 19*(1), 51-56.

Langhinrichsen-Rohling, J., Misra, T.A., Selwyn, C., Rohling, M.L. (2012) Rates of bidirectional versus unidirectional intimate partner violence across samples, sexual orientations, and race/ethnicities: A comprehensive review. *Partner Abuse*, *3*(2), 199-230. doi: 10.1891/1946-6560.3.2.199

Levesque, D., Gelles, R., & Velicer, W. (2000). Development and validation of a stages of change measure for men in batterer treatment. *Cognitive Therapy and Research, 24*(2), 175-199. doi:1005446025201

Mayer, A. G. K. (2017). Intervening with couples experiencing domestic violence: Development of a systemic framework. *Australian and New Zealand Journal of Family Therapy, 38*(2), 244-255. doi:10.1002/anzf.1217

McConnaughy, E. A., DiClemente, C. C., Prochaska, J. O., & Velicer, W. F. (1989). Stages of change in psychotherapy: A follow-up report. *Psychotherapy*, 26, 494-503.

McConnaughy, E. A., Prochaska, J. O., & Velicer, W. F. (1983). Stages of change in psychotherapy: Measurement and sample profiles. *Psychotherapy: Theory, Research and Practice*, 20, 368-375.

Official Statistics of Finland [OSF]. (2017): Statistics on offences and coercive measures [e-publication]. Retrieved from: https://www.stat.fi/til/rpk/2017/15/rpk_2017_15_2018-05-31_tie_001_en.html.

Ogrodniczuk J.S., Joyce, A.S, & Piper, W.E. (2005). Strategies for reducing patient-initiated premature termination of psychotherapy. *Harvard Review of Psychiatry, 13*, 57-70.

Piispa, M. & October, M. (2017) Vaikuttava työkalu toistuvaan parisuhdeväkivaltaan puuttumiseen. *Yhteiskuntapolitiikka*, *82*(3), 304-312.

Sartin, R. M., Hansen, D. J., & Huss, M. T. (2006). Domestic violence treatment response and recidivism: A review and implications for the study of family violence. *Aggression and Violent Behavior, 11*(5), 425-440. doi:10.1016/j.avb.2005.12.002

Shuler. C. A. (2010). Male victims of intimate partner violence in the United States: An examination of the review of literature through the critical theoretical perspective. *International Journal of Criminal Justice Sciences, 5*(1), 163-173.

Skinnari, J., Jonsson, A., & Vesterhav, D. (2019). *Tystandskulturer. En studie om tystnad mot rättsväsendet. Rapport 2019:10.* Stockholm: Brottsförebyggande rådet (BRÅ).

Smith, K. J., Subich, L. M., & Kalodner, C. (1995). The transtheoretical model's stages and processes of change and their relation to premature termination. *Journal of Counseling Psychology, 42*(1), 34-39. doi:10.1037//0022-0167.42.1.34

Stanley, N., & Humphreys, C. (2015). Identifying the key components of a 'whole family' intervention for families experiencing domestic violence and abuse. *Journal of Gender-Based Violence, 1*(1), 99-115. doi:10.1332/239868017X14913081639164

Stith, S. M., McCollum, E. E. (2011). Conjoint treatment of couples who have experienced intimate partner violence. *Aggression and Violent Behavior, 16*(4), 312-318. doi:10.1016/j.avb.2011.04.012

Stith, S. M., McCollum, E. E., & Rosen, K. H. (2011). Couples therapy for domestic violence: Finding safe solutions. American Psychological Association.

Stith, S. M., Rosen, K. H., & McCollum, E. E. (2003). Effectiveness of couples treatment for spouse abuse. *Journal of Marital and Family Therapy, 29*(3), 407-426. doi:10.1111/j.1752-0606.2003.tb01215.x

Stover, C. S., Meadows, A. L., & Kaufman, J. (2009). Interventions for intimate partner violence. *Professional Psychology: Research and Practice, 40*(3), 223-233. doi:10.1037/a0012718

Straus, M. A. (2009). Why the overwhelming evidence on partner physical violence by women has not been perceived and is often denied. *Journal of Aggression, Maltreatment & Trauma, 18*(6), 552-571. doi:10.1080/10926770903103081

Straus, M. A. (2011). Gender symmetry and mutuality in perpetration of clinical-level partner violence: Empirical evidence and implications for prevention and treatment. *Aggression and Violent Behavior, 16*(4), 279-288. doi:10.1016/j.avb.2011.04.010

Tambling, R. B., & Johnson, L. N. (2012). An exploratory factor analysis of the URICA among couple therapy participants. *The Family Journal, 20*(1), 63-69. doi:10.1177/1066480711429537

The Swedish National Council for Crime Prevention (Brottsförebyggande rådet). (2009). *Våld mot kvinnor och män i nära relationer - Våldets karaktär och offrens erfarenheter av kontakter med rättsväsendet. Rapport 2009:12.* Stockholm: Brottsförebyggande rådet

Tjaden, P., & Thoennes, N. (2000). Prevalence and Consequences of Male-to-female and Female-to-male Intimate Partner Violence as Measured by the National Violence Against Women Survey. *Violence Against Women*, *6*(2), 142-161. doi:10.1177/10778010022181769

Tutty, L. M., Bidgood, B. A., Rothery, M. A., & Bidgood, P. (2001). An evaluation of men's batterer treatment groups. *Research on Social Work Practice, 11*(6), 645-670. doi:10.1177/104973150101100602

Victim Support Finland [RIKU]. (2019). Domestic violence can affect anyone. Retrieved 17.01.2020 from https://www.riku.fi/en/various-crimes/domestic-violence/

World Health Organization. (2013). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence.* Geneva: Department of Reproductive Health and Research, World Health Organization.

Appendix

KYSELYLOMAKE - ASIAKASKOKEMUSTUTKIMUS

Päivämäärä: Asiakasnumero:

Luethan nämä ohjeet ennen kuin vastaat lomakkeen kysymyksiin. Alla olevat kysymykset liittyvät taustaasi, kokemuksiisi erilaisista tilanteista sekä ajatuksiisi ihmissuhteista ja nykyisestä elämäntilanteesta.
Osa kysymyksistä liittyvät lähisuhteisiin. *Lähisuhteella tarkoitetaan suhdetta sinua läheiseen ihmiseen; parisuhdetta, suhdetta perheenjäseneen tai suhdetta muuhun sukulaiseen.*
Osassa kysymyksiä esiintyy vastausvaihtoehto *”läheinen”. Läheisellä tarkoitetaan henkilöä, joka ei itse ole ollut väkivallan kokijana tai tekijänä, vaan ollut tilanteessa, jossa väkivallan kokija ja/tai tekijä on henkilön läheinen (esimerkiksi perheenjäsen tai puoliso).*
Kyselyyn vastataan nimettömästi, eikä tutkija voi yhdistää vastauksia yksittäisiin henkilöihin.
Kiitos etukäteen tutkimukseen osallistumisesta!

Taustatiedot:
Sukupuoli: ☐ nainen ☐ mies ☐muu

Ikä:_____

Äidinkieli: ☐ suomi ☐ ruotsi ☐ muu, mikä?_____

Siviilisääty: ☐ naimaton ☐ avioliitossa ☐ avoliitossa ☐ parisuhteessa ☐ eronnut

Onko sinulla lapsia? ☐ kyllä ☐ ei
Mikäli vastasit kyllä, kuinka monta lasta sinulla on?:_____

Koulutustaso (merkitse korkein suorittamasi koulutustaso):
☐ peruskoulu ☐ ammattikorkeakoulu
☐ ammattikoulu ☐ yliopisto
☐ lukio ☐ muu, mikä?_____

Oletko tällä hetkellä
☐ työelämässä ☐ opiskelija ☐ eläkkeellä
☐ työtön ☐ perhevapaalla

Mistä sait tietoa Pilarin palvelusta?
☐ Itse löytänyt, esim. internetistä ☐ Mielenterveyspalveluista
☐ Poliisilta ☐ Sosiaaliviranomaiselta
☐ Päihdehuollosta ☐ Terveydenhuollon viranomaiselta
☐ Turvakodista ☐ Pilarin työntekijä otti yhteyttä
☐ Muu, mikä?_____

Seuraavat kysymykset koskevat tämänhetkisessä elämässäsi esiintyvää väkivaltaa tai sen uhkaa. <u>Nämä kysymykset koskevat sitä lähisuhdetta, johon haet apua Pilarista.</u>

Esiintyykö tämänhetkisessä elämässäsi väkivaltaa tai väkivallan uhkaa jossakin lähisuhteessa?
☐ kyllä ☐ ei

Mikäli vastasit kyllä, missä muodossa väkivaltaa esiintyy ja mikä on roolisi väkivaltatilanteissa? Voit merkitä useampia vaihtoehtoja.

☐ fyysinen väkivalta	☐ kokija	☐ tekijä	☐ läheinen
☐ henkinen väkivalta	☐ kokija	☐ tekijä	☐ läheinen
☐ seksuaalinen	☐ kokija	☐ tekijä	☐ läheinen
☐ väkivallan uhka	☐ kokija	☐ tekijä	☐ läheinen
☐ muu, mikä?_____	☐ kokija	☐ tekijä	☐ läheinen

Mikä on suhteesi väkivallan toiseen osapuoleen?

☐ avoliitto	☐ eronnut	☐ toinen osapuoli on lapseni
☐ avioliitto	☐ päättynyt seurustelusuhde	☐ toinen osapuoli on vanhempani
☐ seurustelusuhde		☐ muu lähisukulainen

Onko sinulla ja väkivallan toisella osapuolella yhteisiä lapsia? ☐ kyllä ☐ ei
Mikäli vastasit kyllä, kuinka monta yhteistä lasta teillä on?:_____

Kuinka kauan väkivaltaa on esiintynyt nykyisessä lähisuhteessa?
☐ alle kuukauden ☐ 1kk-1vuosi ☐ 1v-2v ☐ 2v-5v ☐ yli 5v

Asutko tällä hetkellä väkivallan kokijan/tekijän kanssa?
☐ kyllä, tekijän kanssa ☐ kyllä, olemme molemmat kokijoita ☐ en
☐ kyllä, kokijan kanssa

Oletko aiemmin hakenut apua tässä lähisuhteessa esiintyvään väkivaltaan?
☐ kyllä ☐ ei

Onko poliisi puuttunut tässä lähisuhteessa esiintyvään väkivaltaan?
☐ kyllä ☐ ei

Merkitse alla olevaan taulukkoon, mitä päihteitä käytät, ja kuinka usein käytät niitä.

	En käytä	Päivittäin	Viikoittain	Kuukausittain	Harvemmin
Tupakka	☐	☐	☐	☐	☐
Alkoholi	☐	☐	☐	☐	☐
Huumeet	☐	☐	☐	☐	☐
Lääkkeet päihteenä	☐	☐	☐	☐	☐

Seuraavat kysymykset liittyvät <u>aiempiin kokemuksiisi lähisuhdeväkivallasta</u>:
Oletko aiemmin kokenut lähisuhdeväkivaltaa? ☐kyllä ☐ei

Mikäli vastasit kyllä, kuinka monessa aiemmassa lähisuhteessa olet kokenut väkivaltaa?
Vastaus: _____
Missä muodossa aiemmat väkivaltakokemukset ovat esiintyneet ja mikä roolisi on ollut väkivaltatilanteissa?

☐ fyysinen väkivalta	☐ kokija	☐ tekijä	☐ läheinen
☐ henkinen väkivalta	☐ kokija	☐ tekijä	☐ läheinen

☐ seksuaalinen väkivalta	☐ kokija	☐ tekijä	☐ läheinen
☐ väkivallan uhka	☐ kokija	☐ tekijä	☐ läheinen
☐ muu, mikä?_____	☐ kokija	☐ tekijä	☐ läheinen

Mikä on suhteesi edellisen väkivaltakokemuksen tai edellisten väkivaltakokemusten toiseen osapuoleen? Voit valita useamman vaihtoehdon, mikäli sinulla on useampia aiempia kokemuksia.

☐ avoliitto	☐ eronnut	☐ toinen osapuoli on lapseni
☐ avioliitto	☐ päättynyt seurustelusuhde	☐ toinen osapuoli on vanhempani
☐ seurustelusuhde		☐ muu lähisukulainen

Haitko apua edelliseen lähisuhdeväkivaltakokemukseen?
☐ kyllä ☐ ei

Seuraavaksi näet kuvauksia erilaisista väkivaltatilanteista jotka voivat liittyä aiempiin väkivaltakokemuksiin <u>aikuisiällä tai lapsuudessasi</u>. Tilanteet eivät koske ainoastaan lähisuhteita, vaan kaikenlaisia väkivaltatilanteita. Vastaa jokaisen kuvauksen kohdalla, oletko kokenut sellaista väkivaltaa, ja mikä roolisi on ollut niissä tilanteissa.

Lyöminen tai kimppuun käyminen	☐ ei	☐ kokija	☐ tekijä
Uhkaus lyömisestä tai kimppuun käymisestä	☐ ei	☐ kokija	☐ tekijä
Koulukiusaaminen	☐ ei	☐ kokija	☐ tekijä

<u>Vastaathan jäljellä oleviin kysymyksiin vain, jos olet itse ollut kokijana tai tekijänä väkivaltatilanteissa, joita esiintyy lähisuhteessa, johon nyt haet apua.</u> Mikäli et itse ole ollut väkivallan kokijana tai tekijänä, sinun ei tarvitse vastata viimeisiin kysymyksiin.

Alla olevat väitteet kuvaavat sitä, miten henkilö saattaa kokea miettiessään elämässään olevia ongelmia. Ole hyvä ja vastaa miten voimakkaasti olet samaa/eri mieltä väitteiden kanssa, merkitsemällä väitteen perään numero 1-5. Tee valinta sen mukaan, miten koet nyt, ei sen mukaan mitä olet kokenut aiemmin tai haluaisit kokea tulevaisuudessa.

1 = vahvasti eri mieltä
2= eri mieltä
3= en tiedä
4= samaa mieltä
5= vahvasti samaa mieltä

1. Minun mielestäni minulla ei ole mitään ongelmia, joiden tulisi muuttua.___
2. Ajattelen, että saattaisin olla valmis tekemään töitä itseni kanssa.___
3. Teen jotain niiden ongelmien voittamiseksi, jotka ovat vaivanneet minua.___
4. Ongelmieni työstäminen saattaisi olla hyödyllistä.___
5. Minä en ole ongelma. Tällä olemisessani ei ole juuri mitään mieltä.___

6. Minua huolestuttaa, että saattaisin lipsahtaa takaisin niihin ongelmiin, jotka olen jo ratkaissut, siksi olen täällä hakemassa apua.___
7. Teen vihdoin työtä ratkaistakseni ongelmani. ___
8. Olen ajatellut, että saattaisin haluta muuttaa jotain itsessäni. ___
9. Olen onnistunut työskentelemään ongelmieni kanssa, mutta en ole varma jaksanko jatkaa yksin. ___
10. Toisinaan ongelmani on vaikea, mutta työstän sitä. ___
11. Muutoksen yrittäminen on pitkälti ajanhukkaa, koska ongelma ei liity minuun. ___
12. Toivon, että tämä paikka auttaa minua ymmärtämään itseäni paremmin. ___
13. Minussa on vikoja, mutta ei varsinaisesti mitään sellaista minkä tarvitsisi muuttua. ___
14. Työskentelen todella kovasti muuttuakseni.___
15. Minulla on ongelma ja ajattelen, että minun todella pitää työstää sitä. ___
16. En kykene jatkamaan muutosten toteuttamista niin hyvin kuin olin toivonut ja olen täällä estääkseni ongelman pahenemisen. ___
17. Vaikka en aina onnistu muuttumisessa, ainakin teen töitä ongelmieni kanssa. ___
18. Luulin, että kunhan saan ongelmani ratkaistuksi, olisin vapaa siitä, mutta huomaan yhä edelleen kamppailevani sen kanssa. ___
19. Toivon, että minulla olisi enemmän ideoita siitä, miten ratkaista ongelmani. ___
20. Olen alkanut työskennellä ongelmieni kanssa, mutta toivoisin saavani apua. ___
21. Ehkä tämä paikka pystyy auttamaan minua. ___
22. Saatan tarvita nyt vahvistusta, jotta voin säilyttää ne muutokset, jotka olen aikaansaanut. ___
23. Saatan olla osa ongelmaa, mutta en oikeastaan ajattele olevani. ___
24. Toivottavasti jollakulla täällä olisi antaa hyviä neuvoja. ___
25. Kuka tahansa voi puhua muuttumisesta, mutta minä teen aidosti jotain. ___
26. Kaikki tämä psykologinen puhe on tylsää. Miksi ihmiset eivät vain voisi unohtaa ongelmiaan. ___
27. Olen täällä ehkäistäkseni repsahduksen ongelmassani. ___
28. Se on turhauttavaa, mutta ajattelen että ongelmani, jonka luulin jo ratkaisseeni, on uusiutunut. ___
29. Minulla on huolia, mutta niin on kaikilla. Miksi käyttää aikaa niiden murehtimiseen. ___
30. Työskentelen aktiivisesti ongelmani kanssa. ___
31. Selviytyisin ennemmin ongelmieni kanssa kuin yrittäisin muuttaa niitä. ___

32. Kaiken sen jälkeen, jonka olen tehnyt ratkaistakseni ongelmani, se tulee silloin tällöin takaisin kummittelemaan**.** ___

PRESSMEDDELANDE

Bakgrundsfaktorer förutsäger inte avbrytande av behandling för våld i nära relationer

Pro gradu-avhandling i psykologi
Fakulteten för humaniora, psykologi och teologi vid Åbo Akademi

Resultaten från en Pro gradu-avhandling vid Åbo Akademi tyder på att bakgrundsfaktorer och motivationsfaktorer inte kan förutsäga avbrytning av behandling för våld i nära relationer. Undersökningen gjordes vid Pilari, en anstalt som erbjuder hjälp för personer som upplever våld i nära relationer i Åbo. I studien hittades inga signifikanta skillnader på deltagarnas bakgrundsfaktorer (t.ex. ålder och utbildningsnivå), substansbruk och beredskap till förändring mellan de deltagare som avbröt behandlingen och de som avslutade den som planerat. Dessa resultat är oförenliga med tidigare forskning som påvisat signifikanta skillnader på de variabler som mättes i studien.

Syftet med studien var att identifiera möjliga bakgrundsfaktorer eller personliga egenskaper hos klienterna vid Pilari, som kunde skilja mellan de klienter som avbryter behandlingen och de som avslutar behandlingen som planerat. Studien är den första av sitt slag i Finland. Undersökningen genomfördes med hjälp av ett frågeformulär som deltagarna fyllde i under sitt första besök vid Pilari. Undersökningen utfördes under våren 2019 av Pro gradu-skribent Noora Julin under handledning av doktorand Minja Westerlund.

Ytterlig information fås av:
Noora Julin
Psykologistuderande
Psykologi/Åbo Akademi
noora.julin@abo.fi