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Transforming into Men Who Matter: Increasing Empathy in Domestic Abuse Treatment

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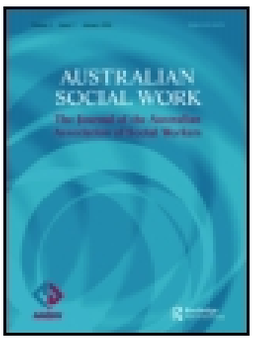

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Transforming Into Men Who Matter: Increasing Empathy in Domestic Abuse Treatment

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ABSTRACT

Men referred to domestic abuse treatment are typically involuntary clients, ranging from being legally mandated to being under significant pressure from others to attend. Such treatment programs have mixed results in achieving change in abusive behaviours. Most programs emphasise taking responsibility for abusive behaviour by examining the precursor thinking beliefs and values, with less attention paid to learning new interpersonal skills that replace antisocial behaviours with prosocial alternatives. Empathy provides a measurable moderator of moving beyond simply acknowledging responsibility for past abuse into learning and applying prosocial relationship enhancement skills with their treatment cohort, families, and significant others. This paper describes a program that builds empathy skills through a series of program and mentalisation tasks that include routine client feedback using the Partners for Change Outcome Management System (PCOMS). Evidence of increased retention and statistically significant changes in empathy using the Social Empathy Index are provided from a previous study examining the same program. The practice and research implications for domestic abuse clients and other involuntary populations are discussed.

IMPLICATIONS

- Involuntary clients continue to have high dropout rates across a range of client populations and are a challenge to engage in the change process. With the application of the client feedback tools and relationship enhancement skills described in this paper professionals can more effectively engage other types of involuntary clients in their change efforts.
- The focus on empathy and relationship enhancement skills can lead to reduced treatment dropout across involuntary client populations referred for substance use, domestic violence, or other offender behaviours.

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Involuntary Clients; Domestic Violence; Social Work Practice

In a journey to better understand and become more effective with involuntary clients in the domestic abuse treatment setting this author has conducted two previous studies that have led to the application of a collection of client feedback tools within the framework of empathy building for domestic abuse treatment. One study reported on interviews with involuntary group facilitators from North America in their use of a client feedback system called the Partners for Change Outcome Management System (PCOMS)

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(Chovanec, 2016). Findings from that study guided the application of PCOMS in domestic abuse treatment for the second study (Chovanec, 2018). The application of PCOMS resulted in high retention rates. Twenty-one of the 25 participants (84%) completed with those exposed to the tools from the start ($n = 14$) in this open-ended program, retaining all but one participant. Most participants (20 out of 25) were court-ordered to complete 18 sessions and eight tasks. However, attendance averaged 21 sessions ($Mdn = 21$, $Mo = 18$), three sessions more than required. This study also found significant increases in empathy scores using the Social Empathy Index (Segal, Gerdes, Lietz, Wagaman, & Geiger, 2017) to measure empathy before and after treatment. Treatment completers ($n = 20$) produced a statistically significant change in empathy scores ($t = 3.013$, $p < .007$), with a pre-treatment mean score of 167.60 ($SD = 28.19$) leading to a post-treatment mean score of 182.70 ($SD = 23.36$). The purpose of this paper is to describe in more detail the empathy framework and the PCOMS application used in the previous study and how to build on this initial evidence including implications in work with other involuntary populations.

> *Mike attends his first domestic abuse program meeting as a condition of sentence for a 5th degree assault that occurred during an argument with his wife of three years that "got out of control". He says he should not have pushed her but also feels his wife needs to go to a group too. She has threatened to leave a number of times and he has stayed in the relationship for his kids but now feels bad his kids have to witness their battles. Involuntary participation is common for men entering treatment for domestic abuse.*

Rooney and Mirick (2018) defines involuntary as formal pressures applied through a mandate, for example, court order, probation, or non-mandated informal pressure from others, that is, partners, lawyers, child protection workers, or other professionals. A majority of men referred to domestic abuse treatment are court-ordered (Jewell & Wormith, 2010). Involuntary clients' high attrition and recidivism rates are a challenge. A meta-analysis of 35 domestic abuse treatment studies found the attrition rate of 37.5% increased to 50% when dropouts were tracked from intake (Oliver, Stockdale, & Wormith, 2011). Also contributing to the concern about dropout is the greater likelihood of relapse or recidivism by program dropouts who are either violent or non-violent offenders (Bennett, Stoops, Call, & Flett, 2007). An additional safety risk is to women whose abusive partner returns home after promising to attend domestic abuse treatment, yet he drops out before completing treatment (Gondolf, 1988).

Empathy building within open-ended groups is proposed as a significant contributor to men stopping their abusive behaviour and re-engaging their partners, families, and the community at large. Empathy training has been found to build relationship enhancement skills across a number of groups including university students and health professionals (Teding van Berkhout & Malouff, 2016). Studies of empathy skills applied to men in domestic abuse treatment are limited (Chovanec, 2018; Zosky, 2016). This paper applies the Partners for Change Outcome Management System (PCOMS), a collection of two client feedback tools that support activities essential for a collaborative environment and a focus on empathy building. The application of PCOMS in domestic abuse treatment contributes to empathy building through strengthening relationships, validating client voice, and self-accountability (Duncan, 2014); while additionally promoting mentalisation, a cognitive, and emotional process used to

understand self and others (Allen & Fonagy, 2006). These tools build relationships that significantly improve client outcomes and retention in several random controlled studies (Schuman, Slone, Reese, & Duncan, 2014; Slone, Reese, Mathews-Duvall, & Kodet, 2015). However, application of the tools has been limited with involuntary clients and specifically for men in domestic abuse treatment.

Literature Review

Empathy

Segal et al. (2017) define basic empathy as feeling and understanding the emotions and experiences of others. It includes: (1) an affective response and cognitive appraisal of another person, (2) the ability to identify another's point of view while maintaining a clear sense of self, along with (3) effective emotional regulation and perspective-taking. Empathy has been a key element of relationship building in psychotherapy for decades (Rogers, 1957) and a long-time moderator of treatment outcomes from the client's view of the therapeutic alliance (Lambert, 2013). Motivational Interviewing (Miller & Rollnick, 2013) incorporates a collection of relationship enhancements skills, such as, open-ended questions, affirmations, reflections, and summaries that are foundational to building empathy. Research supports the use of these skills in better engaging clients in the treatment process.

Segal et al.'s (2017) Social Empathy Index (SEI), building upon their definition of empathy, incorporate recent neuroscience to measure social and interpersonal empathy. This 40-item instrument assesses seven components of empathy including emotional regulation, affective response, affective mentalising, self–other awareness, perspective-taking, contextual understanding of systemic barriers, and macro self–other awareness/perspective-taking. The instrument has been used effectively to examine and build empathy in the social work classroom (Adelman, Rosenberg, & Hobart, 2016) and with medical students (Wellbery, Barjasteh, & Korostyshevskiy, 2019).

Mentalisation

Mentalising is a developmental concept used to describe a person's internal dialogue and reactions to the external world, including self and others (Allen & Fonagy, 2006). It encompasses empathy as the mentalisation process that helps us understand both our own and others' experiences and world views. Mentalising includes a range of cognitive operations including attending, anticipating, perceiving, recognising, remembering, interpreting, imagining, and reflecting (Allen & Fonagy, 2006). Bateman and Fonagy (2019) outline mentalisation-based treatment that has been successfully applied with those diagnosed with Borderline Personality Disorder, Antisocial Personality Disorder, and those impacted by bullying in schools (Twemlow & Fonagy, 2006). Attachment theory suggests we learn mentalisation and our ability to empathise through our significant care givers (Bateman & Fonagy, 2019). Empathy is learned through reciprocal experiences with others who provide emotional recognition and regulation while building mutually supportive relationships that counter isolation, a key roadblock to psychological growth and healthy living. Mentalising about self and significant others is key in building empathy skills.

Client Feedback

A common theme found in the literature on involuntary populations is the struggle to sustain engagement and support of clients in behaviour change. Empathy building in domestic abuse programs focuses on replacing abusive behaviours towards self and others with prosocial relationship enhancement skills. While a number of studies have examined empathy in offender populations, most identify emotional deficits compared to a non-offending population. A meta-analysis of 35 studies found low cognitive empathy was strongly linked to offending (Jolliffe & Farrington, 2004). Although there is limited discussion of the concept of empathy in the domestic abuse literature, Stosny (1995) describes a compassionate approach to treat offenders. He views the concept of compassion as similar but different from empathy. He suggests compassion is deeper and more intense than empathy and that only compassion can repair the intrapsychic hurt that causes abuse. Components of empathy, specifically deficits in emotional regulation and perspective taking have been linked to different types of abuse (Covell, Huss, & Langhinrichsen-Rohling, 2007) yet few domestic abuse programs have examined empathy changes before and after treatment. Zosky (2016), in a closed group domestic abuse program ($N = 246$) found a significant change ($p = .000$) in empathy scores on the Questionnaire Measure of Emotional Empathy (QMEE) (Mehrabian & Epstein, 1972) that was negatively correlated with scores on the Aggression Questionnaire (Buss & Perry, 1992) (high empathy with low aggression). In contrast to Zosky (2016), the author's study examined a group format that was open-ended rather than closed and did not measure changes in abusive behaviour.

Partners for Change Outcome Management System (PCOMS)

PCOMS developed from the common factors of change research on what most contributes to client change across therapy models. Bordin (1979) identified four factors and their estimated contributions to outcome variances that were subsequently substantiated by Lambert (2013):

1. client/life variables (40%)
2. relationship factors (30%)
3. hope, expectancy, and placebo (15%)
4. model/technique (15%).

Given that the largest contributor is client/life variables, Lambert, Duncan and others created tools that focused on the client's voice. Lambert et al.'s (1996) Outcome Questionnaire-45 was the first valid and reliable client feedback tool. However, the unwillingness of practitioners to spend the time needed to administer and interpret this instrument drove Miller, Duncan, Brown, Sparks, and Claud (2003) to develop a more feasible—less than 5 min to administer—yet reliable and valid set of instruments, called the PCOMS. These tools support privileging the client's voice in all decisions by gathering direct feedback during the therapy process (Duncan, 2014). These two tools and the associated graphing of the results help clinicians model empathy by understanding clients' experience and tracking clients' distress. The Outcome Rating Scale (ORS) begins with the client mentalising her or his individual lived experience and level of distress in the past week and the

Session Rating Scale (SRS) evaluates his or her experience during the session before it ends. Both scales' visual analogue subscales provide quantitative and qualitative data for clients and clinicians monitoring of changes that do or do not occur during therapy without changing the treatment model or therapeutic technique (Duncan, 2014).

PCOMS has been used successfully in building relationships that retain both voluntary and involuntary clients and improve outcomes in several modalities across a variety of practice models. Five randomised clinical trials comparing PCOMS with treatment as usual led to it being registered in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (Anker, Duncan, & Sparks, 2009; Reese, Norsworthy, & Rowlands, 2009; Reese, Toland, Slone, & Norsworthy, 2010; Schuman et al., 2014; Slone et al., 2015). Although including client feedback has been found to increase retention and improve outcome, less is known about the use of these tools by facilitators in domestic abuse treatment.

Integration of PCOMS in Domestic Abuse Treatment with Focus on Empathy Building

Program Setting

The Domestic Abuse Program treats a maximum of 10 participants in an open-ended psycho-educational group format. Usually as men are discharged, two or three men enter the program each month. A $25 fee per group is required and men must attend a minimum of 18, 2-hour sessions, once a week that cover 18 educational topics. Participants are also required to complete seven sequential tasks that are presented in group (see Figure 1). Through the tasks, men demonstrate learned skills including recognising individual cues that escalate conflict, demonstrating empathy for their victim, taking responsibility for past abusive behaviour, and using relationship enhancement skills with significant others. These skills are practiced during group and through role-plays. By the fourth week participants are encouraged to begin the program tasks, though latitude is allowed so that tasks are completed when the person feels ready.

PCOMS Application

With the ORS, clients rate their previous week's lived experience from low to high levels of "how you have been doing in the past week" in four domains; individually (personal wellbeing), interpersonally (family, close relations), socially (school, work, friendships), and overall (general sense of wellbeing). Discussion focuses on what events account for increases, decreases, or no changes since the last rating. The scores guide the development of client directed goals and specific tasks addressing the client's reason(s) for seeking treatment. The Group Session Rating Scale (GSRS) is used once a month at the end of the group. The GSRS provides feedback about the quality of the therapeutic alliance on four subscales identifying the degree to which: "I felt heard, understood, and respected"; "We worked on and talked about what I wanted to work on and talk about"; "The therapist's approach is a good fit for me"; and "Overall, today's session was right for me". The subsequent discussion suggests what the clinician and other participants may do to improve the next interaction.

1) *Self-Control Plan*
   - Identify your cues including emotions, self-talk and physical reactions that triggered abusive incidents.
   - Identify level of frustration indicating that the individual needs to leave the situation.
   - Identify time-out plans including what you will do, where you will go, and how you plan to inform your partner.
   - Identify weekly exercise and relaxation plans.
2) *Taking Responsibility for Most Violent Incident*
   - Articulate cues that escalated emotions in most violent incident.
   - Identify initial intentions for using abusive actions.
   - Identify impact of abuse on children (if they were present).
   - Redo abusive incident using the completed *Self-Control Plan*.
3) *Building Support Network*
   - Meet with a group member a minimum of 30 minutes outside the group (4x).
   - Discuss how you will maintain the changes you are making in the program.
4) *Empathy Exercise*
   - Reflect on incident leading to program referral from the perspective of your victim.
   - Identify what you think the victim would report what s/he was doing, thinking, and feeling at the time of the abusive incident.
   - Identify what you think your victim was needing at the time of the abusive incident.
5) *Role Play Exercise*
   - Identify a *potential* conflict with a significant other they anticipate having.
   - Identify the cues you anticipate being triggered by the contact with the significant other and identify strategies to remain regulated.
   - Anticipated exchange with your significant other is role-played in the group with you playing your significant other and a group member playing you.
   - Review communication skills with the group, i.e., validation, reflections, and applied to the incident with the group facilitator's coaching.
   - Identify key phrases, words learned in the role-play to use with your significant other and assess your level of confidence in carrying out the actual exchange.*
6) *Relapse Prevention*
   - Identify potential conflict with others they anticipate after program completion, i.e., conflicts with significant others, ex-partners, children.
   - Rate your level of confidence in managing the anticipated conflict, with the least confident situation discussed with the group to identify problem solving strategies.
7) *Final Presentation*
   - Articulate how you benefited from the group and what you still need to work on.
   - Identify how you plan to remain non-abusive in the future.
   - Identify what changes in your lifestyle you have and/or will make to reduce stress and work towards relating to current or future partners more fairly.

Note. *To increase safety, the task can be modified to conducting a phone call, writing a letter. or for those legally not able to have contact with the significant other, a letter read to the group.

Figure 1 Program Tasks/Criteria

Treatment Protocol

The group begins with a breathing exercise that is modelled by the facilitator as group members stand and participate. Then a group member is asked to read aloud the set of group guidelines that include program requirements plus rules identified by the group members. Participants then present their program tasks facilitated by others who have completed the given task. After a break an educational topic is discussed, for example, reflective listening, the ORS is completed and the overall and interpersonal subscale

scores are entered on a scoreboard that graphs the ORS scores over time. They then answer three questions on a weekly task sheet examining their interpersonal score and the experiences that reflect the given score, how those important relationships have changed since the incident that brought them in; and one weekly goal for improving the relationships with their victim. The facilitator then records the overall scores of each group member and models a check-in with the group member with the lowest score, asking the three questions on the task sheet and summarising his check in. That group member than checks in with the person with the next lowest score, asking the same three questions and summarising the check-in. This is done until all the group members have completed the check in.

New members enter the group once a month when openings occur. After the breathing exercise, group veterans introduce themselves first, describe the incident that led to them entering the group, what they take responsibility for from the incident, and how they think the new men feel about being there. The new members then identify how accurate the veterans were in guessing how they felt about being there. Ground rules are then reviewed, and program tasks are presented for the remainder of the first half of the session. The second half of the introduction session remains the same as other sessions. Once a month, participants complete the Group Session Review Scale (GSRS) in the last five minutes of the group meeting, assessing the alliance among themselves and the facilitator. The facilitator collects the written feedback and reviews in the next session, responding to any concerns that are raised.

Creating Group Environment Conducive to Empathy Building

An environment conducive to empathy building is created through developing a mutual sense of safety, respect, and predictability that is separate to the court process from which many of the men are referred. Clear program goals and expectations are presented to the group member in intake prior to their first group session. Only attendance and program task completion are reported to probation for those who are court ordered. PCOMS data are used to provide feedback to the group members only. Group guidelines are developed collaboratively between the facilitator and group members and include both program mandates and group member requests. Guidelines are reviewed and potentially revised each week.

Building Empathy Skills

Empathy building occurs via modelling of the facilitator and group members. Program tasks, the consistent use of PCOMS and group routines encourage group members to build the following components of empathy (See Figure 2). Affective responding is attending to another person and occurs with the aid of mirror neurons that get triggered when observing others (Segal et al., 2017). This automatic and involuntary attention produces "mirroring" or physiologically simulating the experiences of others. Humans are "hardwired" to mimic one another setting the stage for experiential connections. In the program men are continually observing the facilitator and other group members in each session.

Affective mentalising is the initial cognitive processing that occurs in observing emotions in others (Segal et al., 2017). Stories or explanations of events leads to images, mental maps, perceptions, or cognitive processing of the subjective meaning of another's experiences that triggers affective or physiological responses as if it is happening to oneself with an initial cognitive appraisal of the situation. It bridges affective reaction and cognitive reasoning. Participants are asked to identify emotions and self-talk in the *Self-Control Plan* and the *Taking Responsibility for Most Violent Incident* task that reviews past abusive incidents with others. In addition, emotions and self-talk are anticipated in the *Role Play*

Affective Responding
- Group format allows for group members to observe facilitator and other group members. Role plays are done in a fish-bowl setting.

Affective Mentalising
- Self-Control Plan
- Taking Responsibility for Most Violent Incident
- Role-play
- Outcome Rating Survey (ORS) weekly check in

Self–Other Awareness
- Role-play
- Outcome Rating Survey (ORS) weekly check in

Perspective Taking
- Empathy task
- Role-play
- Outcome Rating Survey (ORS) weekly check in

Emotional Regulation
- Weekly Square Breathing
- Self-Control Play
- Taking Responsibility for Most Violent Incident
- Role-play
- Relapse Prevention

Contextual Understanding
- Empathy task
- Role-play
- Outcome Rating Survey (ORS) weekly check in

Macro Self–Other Awareness (Men and Women)
- Empathy task
- Role-play
- Outcome Rating Survey (ORS) weekly check in

Figure 2 Empathy components (Segal et al., 2017) linked to program activities

task in which a potential conflict with a significant other is identified. The anticipated reactions and how best to stay regulated including positive self-talk are covered in role play.

Self–other awareness follows the affective response and is the ability to maintain self-awareness concurrently with the awareness of the other, consciously (cognitively) recognising the differences between the experiences, feelings, and thoughts of another person and our own reactions: although I feel the emotion, the cause is the other's experience, not mine, thereby linking these awarenesses without one blocking the ability to be aware of the other (Segal et al., 2017). For example, listening to another person's grief may trigger one's past experiences or trauma. Managing one's sadness as separate from and so as not to interfere with the other's sadness is key. Group members explore their self–other awareness through the role play task by exploring their internal reactions in the role play while simultaneously focusing on the significant other's responses. Other group members are asked to observe and comment on this as well. The ORS check-in also may examine self–other awareness.

Perspective-taking is a more complex skill requiring mental flexibility to move from self to understand the context of the other's perspectives (Segal et al., 2017). This cognitive processing or "stepping into her/his shoes" involves toggling between my perspective/interpretations to explore the experience's meaning from the other's point of view. Theory of mind is at work without succumbing to the fundamental attribution error, the tendency to explain another's behaviour based on one's own internal reactions. The *Empathy* task requires describing the abusive incident from the victim's perspective. Group members are also asked to assist in elucidating the victim's perspective. Perspective taking is worked on in preparation for conversations with significant others through the role play task in addition to the weekly check-ins using the ORS.

Emotional Regulation, the last component of interpersonal empathy, is the ability to manage or modulate the intensity, duration, direction, and form of one's emotions (Segal et al., 2017). The ability to sense another's feelings without becoming swept away into or overwhelmed by the other's emotions as if it is one's own is foundational in avoiding emotional escalation. Every group session starts with a "square breathing" exercise where the group facilitator models and asks men to participate. The *Self-Control Plan* task focuses on identifying cues during a range of emotional situations and the role play task asks men to identify and manage their emotions during the role play. *Re-lapse prevention* examines strategies in regulation for anticipated challenges after program completion.

Contextual understanding is one of two components of social empathy. It is the ability to gain knowledge of the other person's current and past contexts and past histories to understand what is emotionally significant for that other person and what motivates their actions (Segal et al., 2017). This involves understanding the impact of social, political, and economic barriers, privilege experiences, historically and currently, of groups different from ours. Contexts are explored in both the empathy and role play tasks as men make efforts to understand their significant other's comments and behaviours. Weekly check-ins also provide opportunities to explore contexts of others by whom participants are challenged outside the group. Macro self–other awareness/perspective-taking is the other component of social empathy. It is the ability to understand the perspective of another group or culture by stepping into the social, political, and economic experiences of others and process what it may be like to live as a member of their group (Segal et al., 2017). This

component comes into play in the empathy and role play tasks as men make efforts to understand their significant others and differences between men and women. Challenges men report in their weekly check-ins also provide opportunities for group discussion on understanding a woman's perspective.

Discussion

Retention

The use of PCOMS by professionals has shown to consistently retain clients in treatment with a variety of populations including involuntary clients in substance abuse treatment (Schuman et al., 2014). In domestic abuse treatment, using PCOMS with an Empathy framework, this author found men averaging more group sessions ($Mn = 21$ sessions) than the required 18 sessions, which is significant given most were court ordered to attend. Three participants stayed longer, two completed in 28 sessions and the other one extended his program to 32 sessions. This speaks to the building of the alliance that occurs between facilitator and group members and between group members.

Increase in Empathy as Measured by Changes in Social Empathy Index Scores

Using an empathy framework that is measured at pre- and post-treatment can help guide the treatment response. Chovanec (2018) in examining the components of empathy scores on the items representing self–other awareness ($p < .050$), perspective taking ($p < .033$), and contextual understanding ($p < .001$) were significantly higher from pre- to post-treatment. Emotional regulation ($p < .105$) and macro self–other awareness/perspective-taking ($p < .089$) item scores were close to significance. This data suggests the group discussions prompted by the men's completion of the empathy and role play tasks, and the weekly check-ins about challenges in relationships may have contributed to the significant changes in empathy scores. Zosky (2016) found significant changes in empathy in a domestic abuse program using a different instrument. However, the attrition rate was significantly higher (50%) compared to the author's (2018) study (16%). It is recommended the SEI be used in other domestic abuse programs and involuntary groups. Pre and post measures of empathy with other involuntary populations could more accurately assess professionals' efforts in empathy building. Using the seven components of empathy, facilitators could assess and modify their program based on the data gathered.

PCOMS Contribution to Empathy Building

PCOMS structure focuses the client to reflect weekly on their lived experience. Men are asked to mentalise about their lived experience on a weekly basis. Comparing their scores over time helps identify key changes that do or do not occur between sessions. This self-mentalisation (Duncan, 2014), when added to intentionally sharing at least some of the details within a safe, respectful, and reciprocal peer group, has the potential to produce dynamic and prosocial self-image and associated empathy skills. The sense of belonging plus feedback ameliorates emotional disconnection paving the way for replacing abusive behaviour with skills that enhance relationships within the group when

serving as a role model. Social capital and associated skills likely generalise beyond the group setting when taking a whole person approach that focuses on people's quality of life and not just the offenses. In criminal justice this suggests an advocacy role for service providers who forge partnerships with family members, local authorities and others all of whom have a role in crime desistance. A desistence-focused approach to working with groups that has more of an appreciative, rather than correctional emphasis can be strength-based and collaborative, creating the kinds of environments for and resources of social recognition that improve engagement, retention, and program outcomes with offender populations.

Howells and Day (2006) propose that for people under criminal justice supervision to successfully engage in treatment they must experience and accurately label their emotions and be willing to self-disclose these emotions to others. PCOMS provides the structure for men to explore their lived experience, monitor levels of distress, and identify goals to reduce that distress. Using the relationship enhancement skills articulated in Motivational Interviewing (Miller & Rollnick, 2013), such as validation and reflection, the men receive from the facilitator and provide these skills to each other on a weekly basis. It is suggested that this activity builds alliances and mentalisation, key in developing regulation and empathy skills. Using these skills can also lead to stronger peer support for those involuntary clients wanting to maintain the changes made. To confirm this, more research needs to be conducted to examine empathy building and its impact on social supports.

Recommendations for Future Research

A major limitation of the study that examined the program described in this paper was the lack of a comparison group (Chovanec, 2018). A study comparing treatment as usual to PCOM-informed treatment is underway. Retention will be tracked as well as empathy measured using the SEI before and after treatment. By comparing treatment as usual to programs using PCOMS, facilitator and participant effect on outcomes and efforts to build empathy with offenders in treatment can be better examined.

Conclusion

This paper proposes empathy can be increased with offenders through a program that integrates the use of client feedback tools through PCOMS with a collection of program tasks and psychoeducation to assist them in re-engaging with their partners, families, and their communities. The empathy building process is described, which includes program tasks and client feedback tools that asks men to reflect on their significant relationships, articulate weekly goals that support the change process and increase their relationship enhancement skills. The seven components of empathy serve as a potential framework to guide facilitators' efforts in building empathy skills in an open-ended group format. Pre and post measures of empathy using the Social Empathy Index (SEI) provide data that can guide empathy building efforts. Client voice is strengthened as well as empathy skills increased. In the qualitative portion of the Chovanec (2018) study of the program, men's reactions to the application of PCOMS to build empathy capture the essence of the program from their perspective. Mike, who was described at the beginning of this paper said what was most helpful to him was the following:

> The breathing exercises would be one of them, for example. For sure when I feel like it's becoming an argument with someone, a significant other or otherwise, just taking and just breathing and focusing on that. And then also the listening skills too, I suppose, right? Being able to try to put myself in their shoes and better understand what they're going to and what they're saying before I just jump down their throat. (Transcript 1, p. 4, ll. 109–113)

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