Resistance and perceptions of punitiveness as a function of voluntary and involuntary participation in domestic violence treatment programs

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RESISTANCE AND PERCEPTIONS OF PUNITIVENESS AS A FUNCTION OF VOLUNTARY AND INVOLUNTARY PARTICIPATION IN DOMESTIC VIOLENCE TREATMENT PROGRAMS

A Thesis
Presented to the Faculty of California State University, San Bernardino

In Partial Fulfillment of the Requirements for the Degree Master of Arts in Criminal Justice

by Aimee Kristine Cassiday June 1997
RESISTANCE AND PERCEPTIONS OF PUNITIVENESS AS A FUNCTION OF VOLUNTARY AND IN Voluntary AND INVOLUNTARY PARTICIPATION IN DOMESTIC VIOLENCE TREATMENT PROGRAMS

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ABSTRACT

In a treatment paradigm, client resistance is generally seen as an impediment to treatment success. In recent years the criminal justice system has dealt with domestic violence offenders by mandating treatment. Yet, clinical observations of domestic violence offenders in treatment suggest that this population is often highly resistant to treatment. While there is extensive literature on resistance and batterers’ treatment, there is a dearth of empirical research which addresses these issues within a single paradigm. The current study attempts to bridge a gap in research by measuring resistance to treatment among court-mandated domestic violence offenders in treatment. Additionally, this study will address the court-ordered component of treatment resistance by implementing independent variable measures of voluntary/involuntary treatment participation.
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Chapter One

Introduction

Police implementation of mandatory arrest policies in cases of misdemeanor domestic violence has led to an increase of domestic violence offenders within the court system (Davis & Smith, 1995; Sherman & Cohn, 1989; Zorza, 1992). The trend in court response to domestic violence has been to mandate treatment for battering behavior. Yet, mandating treatment often creates a problem for treatment program staff, as desire, motivation, and amenability to treatment have been cited as necessary components for effective treatment (Dunham & Mauss, 1982; Amodeo & Liftik, 1990; Schottenfeld, 1989). Domestic violence offenders who are coerced into treatment have been characterized by treatment professionals as lacking the motivation for treatment, and as generally resistant towards treatment efforts (Dreas, Ignatov & Brennan, 1982; Dutton, 1986; Glickin, 1995; Star, 1983). The current study will attempt to empirically address the issue of resistance from a treatment paradigm, while also addressing the issue of mandating treatment from a criminal justice paradigm.

Criminal Justice and Domestic Violence

Until late 1995, diversion, as a means of mandating treatment, was a common court response to domestic violence offenders in California (California Penal Code 1000.6: West’s Annotated California Codes, 1985). Under California’s domestic violence diversion law, a misdemeanor offender was not required to enter a plea of guilt, nor did he\(^1\) participate in any further formal court processes. In the initial court contact, the offender would be offered diversion, if he qualified, and would turn in documentation to

\(^1\) While the author recognizes that domestic violence transcends specific genders and sexual orientations, for purposes of uniformity and clarity, all reference to batterers and victims will assume a male batterer within a heterosexual relationship.
the court once he had completed the program. Charges against him would subsequently be dropped.

Diversion appeared to have numerous benefits to the criminal justice system, as well as to the offender. For example, diversion offered a way for the court to respond in cases that ordinarily would be difficult to prosecute because of a lack of evidence and/or victim testimony (Buchanan & Hankins, 1983; Davis & Smith, 1995; Steinman, 1989). Traditionally, these cases would have to be dropped with no further criminal justice intervention, simply because prosecution was difficult (Davis & Smith, 1995). For those cases which had a chance of prosecution, diversion seemed ideal. This is because from the pragmatic standpoint of the criminal justice system, diversion offered a significant cost savings, as domestic violence offenders did not officially go “through” the system, nor were they incarcerated (Agopian, 1977; Finn, 1987). In addition, diversion relieved some court overcrowding by pushing the offender out of the courtroom and into treatment (Fields, 1994). Diversion also seemed ideal for those cases which had little chance of prosecution, because it allowed the court to sanction treatment to those individuals who may not have sought treatment on their own.

Other reasons that diversion became a common response to domestic violence center on the belief that it benefited the offender. From a labeling perspective, diversion avoided the stigmatization associated with being convicted of a crime (Agopian, 1977; Fields, 1994; National Advisory Commission on Criminal Justice Standards and Goals, 1973). In addition, diversion offered the offender a chance to stay in the community and rehabilitate himself (Fields, 1994; Finn, 1987; Parnas, 1971). The implications for keeping an offender in the community are that his family may remain intact, and he has the opportunity for employment, which would provide financial support for his family.
and allow him to be a productive and contributive member of society (Finn, 1987; Parnas, 1971).

Despite its apparent advantages, diversion has been criticized on several levels. Some have argued that diversion does not lessen the demands on the criminal justice system by directing certain offenders out of court, claiming instead that diversion is "widening the net" of individuals in the system, rather than narrowing it (Blomberg, 1980; Canagarayar, 1980; Gottheil, 1979). Blomberg (1980) cites evidence that diversion has been applied to individuals who previously would not have been subject to criminal justice system interventions. However, this evidence may not be valid in light of mandatory arrest policies. This is because domestic violence is the only offense that has been subjected to an offense-specific mandatory arrest policy (Sherman et al., 1992). In cases of domestic violence, it may be that police policies are widening the net, and diversion is preferred for its’ narrowing effects. Thus, it is not diversion per-se that is widening the net, but rather, diversion is a response to other system policies that are widening the net.

The second argument against diversion is specific to domestic violence diversion. This argument purports that diversion is an inadequate approach to domestic violence, as domestic violence should be treated as a serious crime. Additionally, offenders are not required to acknowledge responsibility for their offense, diverted offenders are not "supervised" appropriately, and there is no standardization of treatment in diversion programs (Hayden, 1995a; Hayden, 1995b; Alpert, 1995).

As a result of these arguments, two California Bills were introduced in the 1995-1996 Senate Session (Assembly Bill 168 & Senate Bill 169). Assembly Bill 168 (Alpert, 1995) attempted to address several issues. Among these are the offender’s acknowledgment of responsibility, and the inability of district attorneys to prosecute domestic violence offenders because of lack of evidence and/or testimony. This Bill proposed a deferred
entry of judgment, so that offenders would have to make a plea of guilt before participation in treatment, but charges would be dropped if the offender successfully completed the treatment program. Thus, the only standard for prosecution in these cases would be the offender’s failing to complete treatment.

California’s Senate Bill 169 (Hayden, 1995a) however, attempted to address all problematic issues of diversion by repealing PC 1000.6 (misdemeanor domestic violence diversion) (West’s Annotated California Codes, 1985) and amending the California Penal Code on conditions of probation (PC 1203.097) (Hayden, 1995b). In effect, this Bill proposed to eliminate diversion as a court response to domestic violence, requiring the court to respond in a "traditional" manner. Offenders would be required to enter a plea and the court would be required to follow through until prosecution. Once prosecuted, the offender could be sentenced to probation, but the conditions of probation required participation in a batterers’ treatment program.

For various ideological reasons, AB 168 (Alpert, 1995) was vetoed, and SB 169 (Hayden, 1995a) was passed and went into effect on October 5, 1995 (Hayden, 1995b). Thus, diversion, as it has been defined and discussed, is no longer a legal court response to misdemeanor domestic violence offenders in California. Treatment, while still an optional court mandate, has been defined in terms of a mandatory condition of probation, instead of an implementation of diversion. This creates several problems for the criminal justice system, and for the treatment community.

Statement of the Problem

In regards to the criminal justice system, California’s SB 169 (Hayden, 1995a) creates two problems. One problem is that it inadvertently “widens the net”, by bringing all arrested and charged domestic violence offenders into the court process. While it was argued that diversion was a response to the net widening caused by arrest policies,
California’s SB 169 means that the court system is no longer able to “narrow the net”, and thus, may be contributing to the net widening phenomena. Another problem with the implementation of SB 169 is that it requires prosecution in cases of domestic violence. And yet, prosecution has historically been difficult in these cases (Davis & Smith, 1995). So, while SB 169 (Hayden, 1995a) is an attempt to treat domestic violence as a “serious crime”, it may be that more cases are dropped either because of difficulty in prosecution, or because the court system has a way of circumventing policy for its own benefit (Walker, 1994). If mandatory arrest policies, along with mandatory prosecution, do in fact widen the net, the court system may respond to this by selectively dropping the charges in some cases. This would, unfortunately, counter the ideology purported by SB 169 (domestic violence is a serious crime, and should be treated as such). While this seems to be a legitimate problem, it is entirely speculative at this point, as SB 169 has not been in effect long enough to observe its consequences. However, we can address the direct benefits and consequences of SB 169 in terms of the ideologies of both the criminal justice system and the treatment community.

On the face of it, SB 169 (Hayden, 1995a) seems ideal. This is because it addresses two essential, and often conflictual, ideological/technical models for responding to offenders (Mederer & Gelles, 1989). The first (the legal model) purports that crime can only be controlled through swift and certain punishment (Mederer & Gelles, 1989; Miller, 1973; Walker, 1994). Senate Bill 169 directly adheres to this model by responding to domestic violence through certainty of punishment. Diversion has not been seen as punishment, but prosecution with probation has been (Ford, 1991; Petersilia & Deschenes, 1994). However, in terms of swiftness of punishment, it is difficult for prosecution to be a “swift” process. (One of the perhaps unintended advantages of diversion was that it offered a much swifter response than the traditional trial/prosecution
process (Fields, 1994)). Perhaps certainty of punishment is preferred over swiftness of punishment in cases when both cannot be simultaneously achieved.

The second model (the treatment/medical model) purports that the legal model is insufficient because it does not address the etiology of the offense, that criminal behavior is a “disease”, and that only through compassionate treatment models can we affect criminal behavior (Dunham & Mauss, 1982; Mederer & Gelles, 1989; Walker, 1994). California’s SB 169 (Hayden, 1995a) also supports a treatment model by mandating treatment as a condition of probation. Thus, not only does SB 169 satisfy the agendas of two often competing ideologies, when these ideologies are combined, a coercion effect is present (Dunham & Mauss, 1982).

Coercion is often seen as an essential element of effective treatment with domestic violence offenders (Chen et al., 1989; Dreas, Ignatov & Brennan, 1982; Geffner & Rosenbaum, 1990; Hamberger & Hastings, 1986; Mederer & Gelles, 1989). This belief is largely due to the idea that batterers do not seek treatment on their own (Dreas, Ignatov & Brennan, 1982; Dutton, 1986; Ganley, 1987; Hamberger & Hastings, 1986). While the coercion factor may be a necessary motivator to get batterers in treatment, it also creates a major dilemma for treatment program staff. This is because coercion implies unwillingness, thereby creating or intensifying resistance to treatment (Salmon, 1982; Schottenfeld, 1989; Star, 1983). Thus, it would be expected that domestic violence treatment clients who have voluntarily sought treatment would demonstrate a “normal” level of resistance, but that involuntary clients would demonstrate an “abnormal”, or elevated level of resistance. Some claim that all domestic violence offenders are coerced into treatment (Ganley, 1987; Schottenfeld, 1989). This point is made by two arguments. First, the psychological characteristics of batterers makes it highly unlikely they would seek treatment on their own (Dreas, Ignatov & Brennan, 1982; Dutton, 1986; Ganley,
1987; Hamberger & Hastings, 1986). Secondly, voluntary clients are generally seeking treatment in order to avoid the severing of the relationship with their victim (Dutton & Starzomski, 1994; Ganley, 1987; Hamberger & Hastings, 1986).

For the purposes of this study, all clients who are not court-mandated will be considered non-coerced (voluntary). This is because offenders who are motivated for treatment out of fear of losing relationships have a personal goal to benefit from treatment, and obtaining that goal would be perceived by the client as a major positive achievement. For court-ordered clients, there may not be a personally-defined treatment goal, and if there is, it may be based entirely on the criminal justice system. For example, these clients may desire to just “get through” the program with minimal motivation in order to avoid further criminal justice consequences (Dutton & Starzomski, 1994; Glicken, 1995; Star, 1983). In addition, the court-mandated clients may not view the program as an opportunity to change behavior, but rather as another (albeit less harsh) form of punishment (Ford, 1991; Ganley, 1987; Petersilia & Deschenes, 1994; Schottenfeld, 1989). When treatment is viewed as a punishment, it seems likely that levels of resistance would be higher (Schottenfeld, 1989).

Within the treatment community, resistance is generally defined as: “the trend of forces within the patient which opposes the process of ameliorative change” (Breshgold, 1989, p. 76). For the purposes of this study, this definition of resistance is too broad to be included as the sole construct of resistance. This is because from a treatment perspective, coercion is generally not factored into the definition of resistance. Resistance is often viewed as a “normal” reaction to the self-awareness demands of treatment (Higgs, 1992; Glicken, 1995; Sonkin, 1987). But, to what degree coercion intensifies resistance, or takes it to an “abnormal” level is empirically unknown. Up to this point, the majority of studies which included the coercion-resistance-treatment triad reported “clinical
observations”, but failed to empirically test these observations (Dreas, Ignatov & Brennan, 1982). This study will attempt to obtain empirical measures of resistance to domestic violence treatment programs, from both a coerced (involuntary) and a non-coerced (voluntary) client population.

Purpose and Significance of Study

Within the treatment community resistance is generally seen as an impediment to treatment success (Dunham & Mauss, 1982; Amodeo & Liftik, 1990; Schottenfeld, 1989). Yet “success” is the single goal of the criminal justice system (Warren, 1977; Wolk, Hartmann & Sullivan, 1994). If resistance is found to be relatively high throughout the treatment period, then the criminal justice system may not be justified in using penalties for lack of participation in treatment programs, or in making treatment a condition of probation (Warren, 1977). In addition, if probation/treatment proves to be as successful, or less successful than other court sanctions, then a major philosophical dilemma arises. This dilemma centers on the question of whether the criminal justice system should continue using probation/treatment as a means to control domestic violence offenders (Grusznski, 1986; Steinman, 1988; Ungerleider, 1976). This study, in a global sense, is an attempt to explore the issue of success in domestic violence treatment programs. However, this study is not specifically directed towards program evaluation, but will focus on a single variable of the success dimension. In addition, no comparison sanctions will be evaluated, so probation/treatment cannot be deemed successful or unsuccessful compared to other court sanctions. No evaluative conclusions can or should be drawn from this study, as it is more exploratory in nature. This study is important, however, because it may contribute to our understanding of what role coercion plays in the success of domestic violence treatment programs, as well as what role resistance, in general, plays.
In terms of resistance among domestic violence offenders in treatment, this study may aid future researchers within this paradigm, as the variables measured, and the measurement instrument have not been established in prior research. This study may provide a rudimentary basis for further research endeavors within the domestic violence treatment paradigm, and may further our understanding of research methods that can be utilized within this population. In a criminal justice paradigm, this study may also provide empirical data with which we can define and discuss success of treatment/probation, as well as debate whether treatment/probation is the most appropriate sanction for domestic violence offenders. In sum, the information provided by this study will benefit the research community, the treatment community, the criminal justice system, as well as individual batterers and their victims by furthering our understanding of "what works" and why or why not (Dutton, 1986; Gendreau, 1996; Salmon, 1982; Voorhis, Cullen & Applegate, 1995). Before any attempt is made to determine success, however, a discussion of how success is measured will facilitate understanding of how to define success.

**Criminal Justice, Domestic Violence, and Successful Interventions**

Within the criminal justice paradigm success is generally determined by recidivism rates (re-offense) (Voorhis, Cullen & Applegate, 1995). The use of recidivism rates in terms of domestic violence dates back to the Sherman and Berk (1984) Minneapolis Domestic Violence Experiment. They used recidivism as an indication of the relative success of various police responses to domestic violence. Because they found that arrest deterred (thereby reducing recidivism rates) a larger percentage of the suspects than did other police responses, they implied that arrest was more successful at meeting criminal justice goals than the alternative responses.
The Sherman and Berk (1984) study had a significant impact in at least two areas. First, it served to set the standard for outcome measurement in domestic violence research. While reducing recidivism (specific deterrence) is the central goal of the criminal justice system, there may be “levels” of success which are largely ignored by such a high standard for determining success (Schottenfeld, 1989; Tolman & Bhosley, 1991; Voorhis, Cullen & Applegate, 1995; Warren, 1977; Wolk, Hartmann & Sullivan, 1994). While treatment modalities and the criminal justice system share the same basic goal of reducing the likelihood that an offender will re-offend (Finn, 1985; Ganley, 1987; Mederer & Gelles, 1989), this remains an absolute measure from a criminal justice paradigm (Voorhis, Cullen & Applegate, 1995). Either one succeeds or one fails. For example, when we consider alcohol treatment, usually total abstinence from alcohol is the goal with which we define success, although total abstinence is less likely (Schottenfeld, 1989; Wolk, Hartmann & Sullivan, 1994). So, we either throw the baby out with the bath-water (declare all treatment unsuccessful and adopt a “nothing works” mentality about rehabilitation), or we change our definition of success. This issue is pertinent to the rehabilitation ideal, as narrow definitions of success have largely contributed to the nothing works mentality (Gendreau, 1996; Martinson, 1974; Voorhis, Cullen & Applegate, 1995).

A more realistic approach to the rehabilitation ideal may be to acknowledge several goals, realizing that the highest and hardest goal to reach is to reduce recidivism. The criminal justice system, on the other hand, appears to have one goal, which if not reached with statistically significant measures declares the sanction under question unsuccessful (Ganley, 1987; Voorhis, Cullen & Applegate, 1995). Clearly, while recidivism is the preferred measure of treatment success (Chen et al., 1989), deterrence (as obtained through criminal justice control) often does not have a long-term effect (Dunford, 1992;
Faulkner et al., 1992; Sherman et al., 1992). However, changes in attitude and/or obtainment of knowledge may have a more lasting effect on behavioral change (Gondolf, 1987; Mederer & Gelles, 1989; Saunders & Hanusa, 1986; Stoolmiller et al., 1993). Thus, for the purposes of this study, success will be broadly defined as any positive improvement in the client/offender’s attitude or behavior.

In sum, the Sherman and Berk (1984) study not only affected measurements of success, it also had a major impact on police departments’ domestic violence arrest policies (Sherman, 1992; Sherman & Cohn, 1989). Mandatory and preferred arrest policies became the standard, despite the fact that several replication studies found no significant deterrent effect of arrest (Berk, Campbell, Klap & Western, 1992; Dunford, Huizinga & Elliott, 1990; Hirschel & Hutchison, 1992; Hirschel, Hutchison & Dean, 1992). Because of the unpromising results of the replication studies, it has widely been argued that arrest is clearly not enough, and that some other criminal justice responses are necessary (Finn, 1987; Mitchell, 1992; Steinman, 1989). Perhaps that is why research interest in domestic violence seemed to shift from police response to court response. This study is primarily concerned with the court response. In particular, the current study will address court responses in terms of mandating treatment. By mandating treatment, the court is coercing offenders to enlist in treatment programs, which may make them angrier and more resistant than their non-mandated peers. This study will directly test the hypothesis that court-mandated batterers in treatment view treatment as a punishment, and are more resistant than non-mandated batterers. A review of the literature on the outcomes of various court responses to domestic violence, alternative modes of measuring success of treatment, voluntary and involuntary components of treatment success, characteristics of batterers, and resistance in relation to treatment outcomes will provide a backdrop for the current study.
Chapter Two
Review of the Literature

Court Response to Domestic Violence

There is a dearth of research on the various court responses to domestic violence. Perhaps this is due to jurisdictional differences in legislation and court standards. Indeed, it is difficult to generalize any conclusions made about court response, as variability in criminal justice policies is great. What the literature tends to reveal is either specific court processes, changes in court process, and evaluation of various court responses. Before discussing court responses to domestic violence, a brief review of police arrest policy is in order.

Prior to mandatory arrest policies in cases of domestic violence, domestic violence offenders were generally not present in the court system (Steinman, 1989). Even after mandatory arrest policies were implemented, prosecutor’s and probation officer’s decisions to not file charges or reinforce formal sanctions often undermined the larger purpose for mandatory arrest (Davis & Smith, 1995; Gamache, Edleson & Schock, 1988; Pirro, 1982; Zorza, 1992). Steinman (1989) studied the effects of arrest in both a pre-mandatory arrest and mandatory arrest policy period. He found that in Lincoln, Nebraska arrests during the pre-mandatory policy period increased recidivism when compared to no police action. He also found that in the mandatory arrest period, arrest decreased recidivism only when it was coupled with the coordinated action of other agencies. Similarly, Sherman et al. (1992) purport that arrest decreases recidivism in the short-term, but that a brief police custody experience increases recidivism in the long-term. Indeed, these findings suggest that a coordinated action should accompany arrest policies. In terms of coordinated action, Steinman (1989) also found that prior to the mandatory arrest policy, the court did not sanction probation or diversion in any case
of domestic violence. During the mandatory arrest policy period he studied, however, he found that 22% of the offenders were diverted, and 3% were placed on probation or in an anger management group. Thus, it is inferred that arrest in addition to diversion, probation, or anger management has more of an impact on recidivism than any other approach to domestic violence in this study. However, it is unclear what “diversion” is defined as in the Steinman (1989) study.

In California, domestic violence diversion tended to equate with anger management treatment. However, since diversion is no longer a legal sanction, anger management treatment now equates with prosecution and probation. This lack of definition makes it difficult to generalize Steinman’s (1989) results to California. In an earlier study, Steinman (1988) found that none of the post-arrest sanctions had a significant effect on recidivism rates when compared to arrest alone. He also reported a 20% recidivism rate among the offenders who had been formally charged with a crime (measured 12 months after the incident). Steinman’s (1989) later study seems to contradict the findings of his 1988 study. However, the findings of both studies may not be generalizable to California’s domestic violence offenders, as California’s implementation of diversion was different than Nebraska’s, and in California, until recently, divertees were not formally charged with an offense (Fields, 1994; Gottheil, 1979; West’s Annotated California Codes, 1984).

Interestingly, Steinman also found in his 1989 study that the positive effect of arrest, when combined with coordinated action in the mandatory arrest period, washed-out in cases when the victim had been the one to call police. It is difficult to speculate why the police/call variable would have a different effect. Ford (1991) is one of the few researchers that has come close to empirically testing this variable.
Based on the notion that a victim report of domestic violence further angers the offender, thereby increasing the likelihood that he will batter again, Ford (1991) included the victim-complaint variable in his study. He divided his sample into two distinct groups: those who were arrested because of a victim complaint to the prosecutor (VC), and those who were arrested on the scene (OSA). In this study, victim complaints sometimes resulted in a court summons or a warrant for arrest. In addition, on-scene-arrest was classified as a warrantless arrest. Thus, the VC group was not necessarily arrested on the scene. It is unclear if a mandatory arrest policy was in effect, or if OSA cases were initiated by a victim call to police. Ford (1991) tracked the domestic violence arrest cases in Indiana throughout the prosecution process and six months after case settlement. During the prosecution process he measured the defendant’s anger in regards to his experience with the criminal justice system. He used prosecution outcome, mode of arrest, and the measures of anger as predictor variables for recidivism in the prosecution and settlement periods. The various prosecution outcomes included: dismissal, pretrial diversion (counseling), conviction with sentencing to counseling as a condition of probation, and conviction with sentencing to a harsher sanction. Ford (1991) reported some interesting results of his study. First, he found that the OSA defendants were significantly more angry than the VC defendants. In addition, conviction was more likely than diversion to anger the defendants, but convicted defendants who were angry were no more likely to recidivate. So, in terms of the present study, the result of California’s SB 169 (Hayden, 1995a) may be that prosecuted offenders are angrier than the diverted offenders were. Although they may not demonstrate increased recidivism rates, they may enter domestic violence treatment significantly angrier than divertees did. While it may not be possible to compare diversion and prosecution-with-probation mandated treatment, the acknowledgment of
anger in Ford’s (1991) study plays a significant role in the present study. The present study will attempt to address this issue by measuring anger directed towards the criminal justice system (as a result of viewing probation mandated treatment as a punishment) within the construct of resistance.

Ford (1991) also found that those who experienced a warrant arrest (VC) and reported being angrier were three times more likely to recidivate than those who reported less anger (in the prosecution period). Thus, anger seems to be a variable in prediction of recidivism in some cases. Ford also found that diversion was experienced as punishing, but less so than other sanctions. Based on contingency tables, Ford (1991) reported that among the VC/angry/diverted group, 1 in 7 defendants recidivated within 30 days after case settlement, but only 1 in 50 defendants recidivated in the VC/not angry/diverted group. In sum, Ford concludes that the angry/diversion components do not make recidivism any more likely than the other court sanctions, but diversion/without anger enhances the preventative effect of diversion. Unfortunately, because of California’s SB 169 (Hayden, 1995a), comparison between diversion/treatment and prosecution-driven probation/treatment may not be possible. However, Ford’s (1991) finding is particularly relevant to the present study, as treatment programs for domestic violence offenders tend to focus on decreasing the anger/violence relationship. Thus, even if the offender is angry when he begins treatment, this anger (and potential for violence) may gradually decrease as the offender is exposed to more treatment (Dreas, Ignatov & Brennan, 1982; Ford, 1991). In the present study it is hypothesized that the clients who have spent more time in treatment will demonstrate significantly less anger (as included within the construct of resistance) towards the criminal justice system than will the clients who have been in treatment for a shorter period of time.
While Ford’s (1991) study contributes pertinent information to the formulation of the present study, a few problems with Ford’s study are evident. First, anger was measured prior to the actual implementation of the court sanction, thereby measuring a reaction to what the defendant perceived and anticipated the sanction to be, rather than a reaction to the actual sanction. Secondly, Ford’s measurement periods for recidivism are inconsistent across groups. The pre-settlement period was framed as the period after the case was filed, lasting until the case was settled in court. This creates a major problem, as no two cases spend the same time in the court process, and certainly no two sanctions will have the same process time. Realistically, diversion requires much less process time than does conviction. Thus, the convicted defendants probably spent more time in the process, meaning that they had more time within which to recidivate. Additionally, the post-settlement period was framed as the period immediately following the court settlement (30 days and 6 months). If “court settlement” can be construed as court disposition, then those defendants who were incarcerated may have had less actual time to recidivate. This is because incarcerated persons do not have the opportunity to re-offend, whereas the defendants who were diverted remained in the community, and thus had more of an opportunity to recidivate. While obviously this is a methodological problem, it does not have direct implications for the current study. This is mainly because this study addresses probation mandated treatment, and in Ford’s (1991) study, despite the potential for greater opportunity to recidivate, the probation-with-counseling group of offenders showed no significantly greater recidivism rates than the defendants who experienced other sanctions. The only variables which seemed to effect post-court sanction recidivism rates were anger/diversion.

In sum, it seems that successful criminal justice interventions with domestic violence offenders are at least in part, a function of how well the criminal justice system
coordinates its’ responses (Steinman, 1989). Yet, it also seems that interventions of the
criminal justice system may anger certain domestic violence offenders more than other
interventions, which in turn, may have an effect on the success of those interventions
(Ford, 1991). The underlying implication of this is that if an offender is angry about his
criminal justice system experience, and this experience includes some undefined aspect
of diversion, he may displace this anger on his partner, thereby battering again. However,
it is possible that a domestic violence offender not only displaces his anger onto the
victim, but also perceives himself to be a victim of the criminal justice system (Stosny,
1994). If this is the case, he would direct his anger towards the criminal justice system,
and the interventions imposed by that system. This study is concerned with probation
mandated treatment. Thus, it is hypothesized that batterers who are mandated to
treatment view this treatment as a punishment, and are therefore more resistant towards
treatment. Furthermore, this perception of punitiveness may have an effect on the success
of treatment. While the current study will not measure success in terms of recidivism, it
does address success in terms of within-treatment change. A further review of studies
which measured the success of batterers treatment programs will benefit an
understanding of the conceptualization of the current study.

Studies That Measured Success of Treatment

The widest definition of success purports that successful intervention equates with a
successful program (Wolk, Hartmann & Sullivan, 1994). But how “successful
intervention” is defined is the crux of this thesis. Several researchers have defined this
solely in terms recidivism. Lipsey (1992) (cited in Gendreau, 1996) analyzed the research
on recidivism outcomes in 443 distinct treatment programs. He claimed that 64% of
these showed, on average, a 10% recidivism rate. Additionally, the greatest reductions of
recidivism rates were found in community based programs. Beninati (1989) found in his
batterer treatment group that 19% of the clients reported new acts of violence during treatment. However, his treatment group was only 12 weeks in duration. Thus, the recidivism rate in this sample may be much higher if it is calculated at 12 months. On the other hand, Beninati used batterers' reports of violence, and batterers may self-report more violence during treatment, as they learn what constitutes a violent act (Gondolf, 1987). Gondolf (1987) also measured recidivism, and found that 40% of his domestic violence treatment sample recidivated within 10-12 months. DeMaris and Jackson (1987) found a 35% overall recidivism rate after treatment completion. However, these various studies do not reveal much in terms of success, because none of these studies used control groups to determine baseline measures of recidivism (Dutton, 1986). In other words, without a matched group who did not receive treatment, it is difficult to determine how much treatment may have effected recidivism rates. In addition, because of the large discrepancy between the 10% and 40% reported recidivism rates, it is important to determine what specific treatment factors (predictor variables) may influence these rates (Dutton, 1986).

Others measured recidivism, predicting that the number of treatment sessions the batterers attended would effect recidivism rates (Chen et al., 1989). They found that those who attended 75% or more of the treatment sessions were less likely to recidivate. Similarly, Gondolf (1987) estimated that in his sample, those who contacted the program, but did not enroll, were twice as likely to recidivate. Tolman and Bhosley (1991) found in their treatment sample of batterers that, according to victim reports, 41.5% of their sample recidivated within one year, and 72.6% showed indirect aggression (threats of abuse). However, there was a 50% treatment drop-out rate in this sample. Thus, these findings imply that success may be determined in part, by a batterers motivation for participation in the program, rather than the program intervention itself (Dunham &
Motivation has direct conceptual relevance to the present study, as a lack of motivation may be an inherent part of resistance. If certain batterers in this study demonstrate a higher degree of resistance (construed as a low level of motivation), then this may be a predictor for treatment drop-out and/or higher likelihood of recidivism. While the current study will not directly measure drop-out rates, it will measure resistance in terms of other variables, which may help to predict who is most likely to drop-out.

Several studies did not measure any behavioral change, but instead used psychological change as a determinant of success. For example, Saunders and Hanusa (1986) measured interpersonal anger, attitudes towards women, depression, and jealousy in a pre-test/post-test design. They found that the batterers in this sample demonstrated significantly less anger at post-test than they did at pre-test. When the researchers controlled this effect for response bias, however, the significant effect washed-out for all anger measures except the Anger Towards Partner Scale. They also found a significant positive change in the other constructs they measured. Thus, domestic violence treatment may be successful in terms of changing batterers’ attitudes and emotional responses. To test this, in the current study it is expected that batterers who have been in treatment longer will demonstrate lower levels of resistance and punishment-related anger than the batterers who have been in treatment a relatively shorter period of time.

A couple of other studies have used predictor variables for direct outcome in their samples. For example, Marques, Nelson, West, and Day (1994) measured in-treatment changes on three dimensions that were predicted to influence recidivism. Two of these dimensions included acceptance of personal responsibility for offense, and knowledge of the central tenets of the treatment program. As their sample was derived from an incarcerated sex offender population, the results of this study can not be generalized to
domestic violence offenders. However, this study demonstrates the general theme that is found in offender treatment literature: that acknowledgment of personal responsibility is possibly a predictor for positive treatment outcomes. The present study will include the denial of personal responsibility (blaming) as a dimension of resistance. Similarly, Carlson, Barr, and Young (1994) predicted that juvenile offenders who admitted they had a problem at intake, took responsibility for their problems, and thought they had a good possibility of being helped, would have a more positive intervention outcome. These predictor variables were used to shape the construct of amenability to treatment, and positive outcome was measured by improvement in a variety of interpersonal relations, school work, and clearer personal life goals. The researchers found that 74% of their sample denied being responsible for their problems. This is particularly relevant to the current study, as denial of responsibility (blaming) is a common characteristic of batterers (Beninati, 1989; Bernard & Bernard, 1984; Dreas, Ignatov & Brennan, 1982; Dutton, 1986; Ganley, 1987; Sakai, 1991; Saunders & Parker, 1989; Sonkin, 1987; Star, 1983). In spite of such a high percentage of denial of responsibility, Carlson, Barr, and Young (1994) found that amenability was not a direct predictor of program outcome. However, they did find that amenability was predictive of personal investment in the program, and personal investment was predictive of a more positive outcome. So, it seems that if one is amenable to treatment (not resistant), one would have more of a personal investment in treatment, and would thus be more successful with treatment. In other words, it may be that voluntary treatment participants are more invested in their treatment, and would therefore be more amenable, or less resistant to treatment.

Overall, it seems that the use of recidivism rates to solely define treatment success not only contributes to a narrow perspective of success, but is also inconsistent across samples, and thus, doesn’t offer much in terms of our ability to make conclusions about
treatment effectiveness. Alternative definitions of success tend to focus on within-treatment change on a variety of psychological, emotional, and attitudinal dimensions, which allows for a more conclusive measure of treatment effectiveness (Voorhis, Cullen & Applegate, 1995). The current study will implement an alternative definition of success by measuring resistance to treatment within the variable of time in treatment. Some studies did not measure within-treatment change, but attempted to predict treatment outcome based on the offender’s attitude during program intake (Carlson, Barr & Young, 1994). While they did not find that attitude had a significant effect on treatment outcome, they did find that it was correlated with a personal investment in treatment, and that an investment in treatment was predictive of treatment outcome. Within the context of the current study, the implications of this are that batterers who are less resistant to treatment may be those who have more of a personal investment in treatment. Because the voluntary and court-mandated aspects of treatment participation may be related to resistance to treatment, a review of the literature on this variable is pertinent.

Voluntary/Involuntary Treatment

Unfortunately, most of the research on domestic violence treatment that specifies court-ordered from non-court ordered samples, does not define this in terms of criminal justice process or sanctions. The current study will attempt to bridge this conceptual gap between criminal justice and community treatment, by including analysis of variables that are relevant to the criminal justice system, and variables that are relevant to the treatment community. Another problem with studies which analyzed the court-ordered and non-court ordered treatment clients, is that they tended to confuse definitions. Some researchers used “voluntary/involuntary”, some used “court-mandated/non-mandated”, some used “coerced/non-coerced”, and some used any combination of these. For the
purposes of this study all discussion of coerced, involuntary, or court-mandated/ordered samples will generally mean “sanctioned by the criminal justice system”, while all other terms will imply “not sanctioned by the criminal justice system”.

Rinella (1976) commented on the effects of criminal justice referrals in an in-patient psychiatric hospital. He stated that there was no discernible effect of mandated treatment on treatment outcomes, but that the criminal justice component had a large effect on clients’ attitudes. The mandated clients tended to view treatment as “another phase of incarceration”, rather than as an opportunity to rehabilitate themselves. He further purports that this attitude negatively affected the treatment environment. In addition, Rinella reported that the treatment staff tended to be more lenient with court-mandated clients, because they feared that any confrontation with the client could result in the client’s being incarcerated. To what degree that this effect may be present in the current study is unpredictable. While California’s SB 169 (Hayden, 1995a) specifically states that failure of the treatment program to adhere to specified standards will result in a withdrawal of probation approval, individual and professional judgments in terms of reporting are perhaps an inherent part of the standards of confidentiality. The client’s certainty of confidentiality is seen as a large contributor to trust, which is an essential component of an effective therapeutic relationship (Star, 1983; Sonkin, 1987; Ungerleider, 1976). Which individual staff members report, or fail to report to the court, may be based on personal ideology. However, while minor or infrequent problems may not be consistently reported to the probation department, it seems that the overall treatment prognosis would be reported, as it would benefit all who are involved.

Unfortunately, Rinella’s (1976) article only included observation, and did not attempt to empirically test these observations. The current study will attempt to obtain empirical measures of Rinella’s suggestion that court-mandated clients view treatment as an
extension of punishment. Similarly, other studies have reported empirical measures of the court-mandated variable in treatment, but none have focused on resistance or perceptions of punitiveness. For example, Grusznski (1986) studied the demographic characteristics of both coerced (court-ordered) and non-coerced (self-referred) batterers in treatment.

Grusznski (1986) found that there was an income difference between coerced and non-coerced clients. He also reported a significant difference in education. The non-coerced clients had an average of one more year of education than did the coerced clients. Grusznski also found that there were no differences between groups on self-reported levels of violence six months after treatment completion, and that 86% of coerced and 84% of non-coerced batterers reported previous experiences with mental health services. Thus, specific demographic variables seemed to predict which clients were voluntary and which were involuntary. However, a stepwise discriminate analysis of the data revealed that there was insufficient evidence to effectively discern between coerced and non-coerced clients. Grusznski's (1986) results may have direct implications for the current study, as differences between coerced and non-coerced batterers in treatment are expected. However, Grusznski used demographic variables as predictors for coerced and non-coerced treatment participants. While demographic variables will be measured, the predictor variables used in the current study will be punitive perceptions (as a construct of anger towards the criminal justice system) and resistance to treatment.

Unexpectedly, Grusznski (1986) discovered that treatment drop-out rates were similar for both groups. Similarly, Saunders and Parker (1989) reported on four studies that found no relation between mandated treatment and drop-out rates. However, Chamberlain et al. (1984) found that clients who were referred had higher treatment drop-out rates than clients who were self-referred. Perhaps this difference in findings is
due to the treatment sample. Grusznski’s sample consisted entirely of male batterers, while Chamberlain et al.’s sample consisted of males and females with a wide variety of clinical problems. In Grusznski’s (1986) initial study, and in a later study, he found that those who completed treatment had higher education and employment levels than did treatment drop-outs (Grusznski & Carrillo, 1988).

Additional studies also focused on treatment drop-out, but their treatment samples did not specifically include domestic violence offenders. While treatment drop-out is not a direct concern in the present study, the factors which contribute to treatment drop-out may bare some implications for the current study. Abel et al. (1988) found in their sample of incarcerated sex offenders that three characteristics of treatment drop-outs emerged. The two which may be relevant to the current study were the diagnosis of Antisocial Personality Disorder, and a higher amount of perceived pressure to participate. However, this sample included only voluntary treatment participants. While pressure to participate in treatment is the independent variable in the current study, unlike Abel et al.’s study, the current study will use “pressure to participate” as an inherent factor of the voluntary/involuntary variable, rather than as an individual perception.

Romney and Jose (1988) analyzed demographic variables in terms of treatment drop-out in an out-patient psychiatric facility. Similar to the results found by other studies (Grusznski, 1986; Grusznski & Carrillo, 1988), Romney and Jose found that 50% of clients which had an elementary school education dropped out, compared to a 32% drop-out rate among clients with a college education. Additionally, 58% of unemployed clients, 50% of laborers, and only 28% of managers dropped out of treatment in this sample. The researchers also report that 59% of clients between the ages of 13 and 15, and 51% of clients between the ages of 19 and 29 dropped out. Forty-seven percent of self or family-referred clients dropped out of treatment, and 70% of all those who
dropped out did so within the first five treatment sessions. Perhaps the most interesting finding in the Romney and Jose (1988) study is that 68% of clients diagnosed with a personality disorder dropped out of treatment. The personality disorder variable seemed to influence the drop-out rate more than other variables, as the highest drop-out rate was found among clients with personality disorders.

The Minnesota Multiphasic Personality Inventory (MMPI) is perhaps the most widely accepted psychiatric test for personality disorders. Mrad and Krasnoff (1977) used the MMPI to predict treatment drop-outs in a sample of incarcerated, male offenders. They found that only three of the psychological variables were statistically relevant to predicting treatment drop-out. Those who completed treatment had higher Beta IQ scores than did drop-outs. Additionally, treatment drop-outs had higher scores on the $K$ scale, and on the $Pa$ scale of the MMPI ($K$ measures intellectual defensiveness, and $Pa$ measures suspiciousness and hostility). While these results only approached statistical significance, they still provide support for the measurement of resistance in the current study. On the other hand, the results found by Mrad and Krasnoff (1977) may not be predictive of drop-outs in batterers’ treatment programs, as their sample of incarcerated offenders may be dissimilar to a sample of domestic violence offenders who are not incarcerated. Similar to Mrad and Krasnoff’s findings, Grusznski and Carrillo (1988) reported that in their sample of batterers, treatment drop-outs were “less friendly” (possibly hostile) and “less likely to admit they had problems” (denial/defensiveness). Unfortunately, this report was not empirically founded, but relied on the researchers’ observations. The current study will attempt to empirically measure these variables in relation to the construct of resistance. Additionally, Grusznski and Carrillo’s entire sample consisted of domestic violence offenders. Thus, it is empirically unknown to what
degree the personality characteristics observed by the researchers are specific only to batterers who drop-out of treatment, or are generalizable to all batterers.

In sum, the only known studies which have empirically addressed the involuntary and voluntary components of domestic violence treatment samples have focused on demographic variables (Grusznski, 1986). Studies which have addressed attitudinal factors of involuntary treatment participation have reported that involuntary clients tend to view treatment as an extension of punishment (Rinella, 1976). Unfortunately, studies that have addressed the perceptions of punitiveness of involuntary clients have either not specifically included domestic violence offenders, or have not empirically tested these perceptions. Furthermore, the studies which differentiated voluntary and involuntary treatment participants in terms of psychological characteristics, did so within the context of treatment drop-out (Abel et al., 1988; Chamberlain et al., 1984; Grusznski & Carrillo, 1988; Mrad & Krasnoff, 1977; Romney & Jose, 1988).

While the present study will not directly measure treatment drop-out, it is interesting to note that clients who perceived they were pressured to participate in treatment (whether actual or not) were the most likely to drop-out of treatment (Abel et al., 1988; Chamberlain et al., 1984), and that treatment drop-outs are often antisocial, defensive, and hostile (Abel et al., 1988; Grusznski & Carrillo, 1988; Mrad & Krasnoff, 1977). As hostility and defensiveness is often an indication of resistance, we may assume that involuntary clients are more resistant than voluntary clients, and are therefore more likely to drop-out of treatment. However, among domestic violence offenders, hostility and defensiveness may not be exclusive among involuntary clients, but rather, may be a common characteristic of all batterers. A review of the literature which addresses characteristics of batterers may provide further direction for the current study.
Batterer Characteristics

Consistent with Grusznski and Carrillo (1988), many researchers who report on the personality characteristics of batterers tend to do so from an observational, rather than an empirical approach (Bernard & Bernard, 1984). The empirical measures of batterer characteristics generally center on demographic variables. Because the information on the demographic variables of domestic violence offenders in treatment is abundant, a general profile of the "average" batterer seems appropriate.

The mean age of batterers in treatment is 31.5 (calculated by averaging all reported means) (Bernard & Bernard, 1984; Dutton & Starzomski, 1993; Faulkner et al., 1992; Saunders & Hanusa, 1986). The average years of education among batterers in treatment is 12.7 (calculated by averaging all reported means) (Bernard & Bernard, 1984; Dutton & Starzomski, 1993; Greene, Coles & Johnson, 1994; Saunders & Hanusa, 1986). The reported percentages for educational obtainment ranged from 4.8%-26% for high-school drop-outs, 32%-63.7% for batterers who completed high-school, 12.5%-16% for those who had vocational training, 26%-31.3% for those who had some college, and 4.3% for college graduates (Faulkner et al., 1992; Mollerstrom, Patchner & Milner, 1992). From these various results, it seems that the majority of batterers in treatment have a high-school level of education. In terms of employment, the reported percentages of unemployed batterers ranged from 14%-47.4%, with 31.1% being the median (Greene, Coles & Johnson, 1994; Faulkner et al., 1992; Roberts, 1987; Saunders & Hanusa, 1986). Of those who were employed, the percentages of blue-collar workers ranged from 34%-63%, with 62% being the median (Dutton & Starzomski, 1993; Greene, Coles & Johnson, 1994; Saunders & Hanusa, 1986). Similarly, Roberts (1987) reports that the "majority" of employed batterers in his sample were blue-collar workers.
In sum, the average male batterer in treatment is in his early thirties, tends to be high-school educated, and is probably either unemployed or employed as a blue collar worker. Thus, he will probably fall in the lower socioeconomic strata. This profile of batterers in treatment is consistent with the demographic variables found in batterers arrested, and those in court (Ford, 1991; Sherman et al., 1992; Steinman, 1988). However, this “batterer profile” should not be generalized to all batterers, as police are involved in domestic violence most often among the poorer and under-educated groups (Hirschel & Hutchison, 1992; Sherman et al., 1992). While domestic violence occurs at all socioeconomic levels (Dreas, Ignatov & Brennan, 1982; Roberts, 1987), it may be batterers in higher socioeconomic levels are under-represented in the criminal justice system, and in mandated treatment programs, because they either do not get arrested (Sherman et al., 1992), or they have greater access to private treatment resources (Dreas, Ignatov & Brennan, 1982).

Interestingly, Dutton and Starzomski (1993) found that batterers’ sociodemographic variables only accounted for 2% of the variance in reports of physical violence. Thus, this not only reinforces the idea that domestic violence occurs in all socioeconomic levels, it also implies that demographic variables are not important predictor characteristics for inter-personal violence. In fact, Dutton and Starzomski (1993) found that the largest percentages of variance on three types of abuse were accounted for by batterers’ beliefs, attitudes, and psychiatric measures. Similarly, other reported characteristics of batterers have focused on personality, psychopathology, and related psychological factors.

Prince and Arias (1994) studied control and desire for control among batterers. They found that two groups of batterers emerged. The first group had high self-esteem, a high desire for control, but had low levels of actual control. This profile is consistent with what Warren (1977) termed the “power oriented offender”. The second group
demonstrated low self-esteem, and a low desire for control, along with a low level of actual control. This type of batterer was characterized as “dependent, helpless, and powerless” (Prince & Arias, 1994).

Similarly, Greene, Coles, and Johnson (1994) studied psychopathology and anger among batterers. They found that four groups of psychopathology emerged. These groups were defined as non-pathological, schizoid/borderline, narcissistic/antisocial, and dependent/compulsive. The results also distinguished two types of anger. Batterers with under-controlled anger responded to minimal provocation with hostility, whereas batterers with over-controlled anger had rigid inhibitions, but responded with excessive violence. Greene, Coles, and Johnson also found that the batterers who had borderline personality features were the most likely to report intense depression and anger. While the research has not indicated that batterers represent any one personality disorder, the literature which does address abnormal personality features tends to focus on Borderline Personality Disorder (Dutton, 1995; Dutton & Starzomski, 1993; Dutton & Starzomski, 1994; Ganley, 1987; Geffner & Rosenbaum, 1990; Gillman, 1980; Sonkin, 1987).

Another possible characteristic of batterers is alcoholism. While none of the studies have defined this characteristic as “alcoholism”, it is apparent that alcohol abuse is correlated with domestic violence (Schuerger & Reigle, 1988; Sonkin, 1987). Among spouse abusers in the Air Force, 20% have a history of alcohol problems (Mollerstrom, Patchner & Milner, 1992). Roberts (1987) claims that 60-70% of batterers abuse alcohol. Sherman et al. (1992) report that in the Minneapolis Domestic Violence Experiment, 42% of the offenders were intoxicated at the time of the arrest (Sherman & Berk, 1984). Similarly, Mignon and Holmes (1995) revealed that in some police departments, the batterer’s involvement with alcohol increased arrest rates. Despite these findings, the role that alcohol plays in domestic violence remains a controversial subject (Geffner &
Rosenbaum, 1990). This is because some believe that alcohol causes violence (Flanzer, 1993), while others believe that violence is not a direct cause of intoxication, but that violent tendencies are an inherent part of batterers (Farabee, Nelson & Spence, 1993; Gelles, 1993). In relation to the latter belief, Lang et al. (1975) studied alcohol consumption, perceived alcohol consumption, and provoked aggression. They found that regardless of the actual amount of alcohol that subjects consumed, those who believed they had consumed alcohol behaved more aggressively than those who believed they had not consumed alcohol. Lang et al. further conclude that the subjects who are provoked to anger, but have been denied the opportunity to behave aggressively will consume more alcohol. In other words, alcohol did not cause aggression, but a belief that one was intoxicated did.

DeMaris and Jackson (1987) used a sample of batterers in treatment to analyze a host of variables in order to predict recidivism. They found that self-reported problems with alcohol significantly predicted recidivism. Steinman (1988) found that domestic violence which occurred between 3:00AM-6:00AM increased the recidivism rates of those offenders. Perhaps this specific time variable is indicative of alcohol and/or drug abuse, as it seems uncommon for one to be awake at those hours. Besides problems with alcohol, DeMaris and Jackson (1987) also used childhood experience with familial abuse as a predictor variable of recidivism. Although they did not find the abuse variable to be a statistically significant predictor of recidivism, several researchers have addressed childhood experiences of abuse as a characteristic of batterers (Egeland, 1993; Hamberger & Hastings, 1986; Rouse, 1984; Schuerger & Reigle, 1988; Straus, 1991).

Additional explanations of batterer characteristics have focused on observations of batterers’ attitudes, beliefs, and reactions to treatment. For instance, a few researchers have noted that batterers frequently externalize the blame for their abuse (Faulkner et al.,
1992; Star, 1983). Often this blame is directed into hostility towards the criminal justice system (Dreas, Ignatov & Brennan, 1982; Ganley, 1987; Star, 1983; Stosny, 1994). For example, Stosny (1994) states that domestic violence offenders tend to view themselves as being “forced into violent behavior for which they are unfairly punished with mandated treatment” (p. 687). This belief seems to imply that batterers deny their abusiveness. Indeed, several researchers have noted that the majority of batterers exhibit denial (Beninati, 1989; Bernard & Bernard, 1984; Dreas, Ignatov & Brennan, 1982; Dutton, 1986; Ganley, 1987; Sakai, 1991; Saunders & Parker, 1989; Sonkin, 1987; Star, 1983). Yet, clients who are most likely to benefit from treatment are those who consciously recognize that their violent behavior is a problem (Chamberlain et al., 1984; Farabee, Nelson & Spence, 1993; Sonkin, 1987; Star, 1983). Similarly, batterers exhibit several other psychological defense mechanisms, such as, distortion, minimization, and rationalization (Beninati, 1989; Bernard & Bernard, 1984; Dreas, Ignatov & Brennan, 1982; Ganley, 1987; Sakai, 1991; Star, 1983). In terms of defensiveness, Mrad and Krasnoff (1977) found that treatment participants who were more defensive were more likely to drop-out of treatment. It is possible that those who complete treatment (less defensive) are more amenable to treatment. Hence, increased defensiveness would be equated with resistance to treatment.

Several researchers have included the construct of resistance in reports of their observations of batterer characteristics (Dreas, Ignatov & Brennan, 1982; Dutton, 1986; Glicken, 1995; Star, 1983). However, in terms of when resistance was first observed, there seems to be a discrepancy in reports. Bernard and Bernard (1984) noted that in their treatment sample, the batterers initially appeared “amiable” and “eager to change”, but resistance (denial and minimization) soon followed. Dreas, Ignatov, and Brennan (1982), however, noted that batterers were initially hostile and resistant, but that this gradually
subsided. Perhaps this observational difference is due to the voluntary/involuntary component (Dutton & Starzomski, 1994; Farabee, Nelson & Spence, 1993). Bernard and Bernard’s (1984) sample consisted entirely of voluntary batterers, whereas Dreas, Ignatov, and Brennan’s (1982) sample consisted entirely of involuntary (court-mandated) batterers. There may be other explanations for this discrepancy.

First, mandated clients seem more likely to be initially resistant because of their hostility towards the criminal justice system, and resentment generated from perceiving treatment as a punishment (Dreas, Ignatov & Brennan, 1982; Schottenfeld, 1989; Star, 1983; Stosny, 1994). However, voluntary clients seem more likely to be initially amenable, as they may be going into treatment with a positive goal (Dutton & Starzomski, 1994; Ganley, 1987; Hamberger & Hastings, 1986). On the other hand, involuntary clients, through the increasing exposure to treatment, may become less defensive, and thus less resistant (Ford, 1991). However, voluntary clients may become more defensive/resistant through their increasing exposure to treatment, as they are confronted with their abuse, and perhaps had not expected this factor of treatment (Star, 1983).

In sum, domestic violence offenders in treatment tend to be in their early thirties, have high school educations, and tend to be either unemployed, or blue-collar workers. They also tend to have a childhood history of either experiencing or witnessing domestic violence, and to have problems related to alcohol. While domestic violence offenders do not characteristically suffer from any particular psychopathology, they tend to be classified more often in the literature as having Borderline Personality Disorder. Furthermore, the literature clearly indicates that defensiveness and resistance to treatment is a common characteristic of both voluntary and involuntary batterers in treatment. Unfortunately, no known studies have empirically addressed the issue of resistance.
among batterers in treatment. The current study will attempt to bridge this gap in research. Specifically, the perception of treatment as a punishment, and the hostility which accompanies this perception, will be directly measured as a component of the resistance construct (Schottenfeld, 1989). Thus, in the current study, it is expected that court-mandated clients will have higher levels of punitive attitudes (separated from, but within the construct of resistance). Before this hypothesis can be tested, a review of the literature on resistance is necessary.

Resistence

To encourage understanding, a discussion of the construct, operation, and theories of resistance must precede a review of the research on resistance. Unlike psychoanalysis, which postulates that resistance is a subconscious defense, the Gestalt approach views resistance as a function of the conscious awareness of specific undesirable aspects of self and the environment (Breshgold, 1989). Similarly, psychoanalysis views resistance as a loss of ego functioning, whereas Gestalt theory postulates that resistance is a direct demonstration of the ego functioning that is available (Davidove, 1991). Similar to psychoanalysis, Adlerian theorists view resistance as a “nonconscious” function. They also view resistance as equivalent to the fear of change, and postulate that resistance is evident by the inconsistency, or paradox, between stated behavior and actual behavior (Kopp & Kivel, 1990). Another theory of resistance is antithetical to resistance. From this perspective resistance is seen as a mere concept, rather than as a reality. In addition, this approach to resistance purports that, theoretically, resistance has proved unnecessary, and therefore, clinicians should take the client’s desire to change at face value (de Shazer, 1989).

Obviously, the variety of theory-driven definitions of resistance make it difficult to conduct research on resistance (Chamberlain et al., 1984). For the purposes of the current
study, the Adlerian theory of resistance seems most appropriate. This is because the Adlerian approach holds that while clients (batterers) suffer from symptoms (violence), they have a nonconscious investment in maintaining their violence, because it protects their self esteem and life style. Admittedly, this seems like a pathological model for resistance. However, the Adlerian approach equates resistance with the use of psychological defense mechanisms (denial, minimization, blame, etc.) as a means to preserve a favorable self-image, and given that batterers are highly defensive, the Adlerian definition of resistance seems the most applicable to batterers.

As theoretical interpretations of resistance have varied, the operationalization of resistance has also varied. Amodeo and Liftik (1990) discuss resistance among alcoholics. They define resistance within a construct of denial. This seems consistent with the domestic violence literature which addresses both denial and resistance as characteristic of batterers. Amodeo and Liftik disentangle the construct of resistance in terms of treatment and “recovery”. “Resistance to treatment” is constructed as admitting the problem (violence), but denying the treatment. “Resistance to recovery” is demonstrated when the client admits the problem, but minimizes or attributes it to only one source (i.e., “the problem is only violence” or “the problem is only psychological in nature”). While separating the construct of resistance into distinct types adds clarity to the operationalization of resistance, these types are not appropriate for the current study. This is because Amodeo and Liftik were addressing resistance within the paradigm of alcohol treatment, and both types of resistance require admission of the problem. Batterers characteristically deny they have a problem (Beninati, 1989; Bernard & Bernard, 1984; Dreas, Ignatov & Brennan, 1982; Dutton, 1986; Ganley, 1987; Sakai, 1991; Saunders & Parker, 1989; Sonkin, 1987; Star, 1983). Higgs (1992) defined resistance as “overt hostility”, and described several manifestations of this. Missing
appointments, refusing to speak, psychological defensiveness, negative comments, anger, distrust, and negative body language may be external indicators of resistance. In addition, Higgs (1992) professes that these various manifestations of resistance are usually directed towards the group leader (therapist, treatment staff). Indeed, the relationship which occurs between the client and the therapist (therapeutic relationship) has been characterized as the crux of treatment (Dunham & Mauss, 1982; Schottenfeld, 1989).

Several researchers have studied the therapeutic relationship in terms of the client’s role. The client is viewed as either opposing (resistant), or being in harmony with the therapist and his/her treatment goals. The client’s congruence with the therapist has been termed the “therapeutic alliance” or “the helping alliance” (Horvath & Symonds, 1991). Alexander and Luborsky (1986) reviewed a pencil and paper measure of the helping alliance (Penn Helping Alliance Scale). In addition, they postulated that client ratings on the helping alliance correlate with treatment outcome. Similarly, Horvath and Symonds (1991) evaluated 20 distinct data sets on the therapeutic alliance. They concluded that alliance is a significant variable which links the treatment process to treatment outcome. Implementing a strong research design, Muran et al. (1995) studied several variables to determine what accounted for client change in cognitive therapy. While their sample did not specifically include batterers, the cognitive treatment approach is the most commonly used among batterers (Dutton, 1995; Faulkner et al., 1992). The researchers found that therapeutic alliance was one of only two variables which significantly predicted treatment outcome. They further concluded that the therapeutic alliance was the better variable in terms of early treatment prediction.

Among other variables, Keijser, Hoogduin, and Schaap (1994) studied clients’ motivation for treatment, as well as the quality of the therapeutic relationship in relation to treatment outcome. They found that motivation for treatment, as well as the client’s
positive evaluation of the therapeutic relationship, correlated positively with treatment outcome. In other words, a client who is motivated to participate in treatment, and who perceives the therapeutic relationship in favorable terms, is more likely to experience a positive outcome from treatment. While these studies have addressed the therapeutic relationship in terms of client resistance and treatment outcome, we must keep in mind that the involuntary component of treatment participation has not been empirically addressed within the context of resistance or the therapeutic relationship. Indeed, the development of a positive therapeutic relationship may be severely hindered because of the court-order component (Schottenfeld, 1989). Thus, while mandating treatment would force batterers who would not ordinarily seek treatment to enroll in a treatment program, mandating treatment may inadvertently set-up domestic violence treatment to “fail”, if a positive therapeutic alliance cannot be maintained. Yet, the therapeutic alliance is not the sole responsibility of the therapist. A great deal of the therapeutic alliance is created by the client’s attitudes and perceptions. If a client enters treatment with a punitive perception, he may be likely to transfer that onto the therapist, and would thus begin treatment being resistant to it.

The psychology literature contains several empirical studies of resistance, however, no known studies have used batterers in their treatment samples. In addition, within the paradigm of psychology, resistance is generally measured through coding observable behavior to produce a resistance “score” (Chamberlain et al., 1984). Two known studies, however, have not used complicated coding systems, but have used paper and pencil measures of resistance. Chamberlain et al. (1984) measured client resistance at the beginning, middle, and end of treatment. Using the same time schedule, they also measured therapists’ subjective ratings of treatment success. Chamberlain et al. (1984) analyzed their data in relation to mandated/ non-mandated clients, and clients who
completed treatment and those who dropped-out. They found that the highest measures of resistance occurred during mid-treatment, but that early resistance was related to resistance in mid-treatment. They also found that the clients who demonstrated high resistance, dropped-out of treatment significantly more than did low resistance clients. This finding has major implications for resistance in batterers, as the treatment attrition rate amongst batterers has been reported as 50% (Dunham & Mauss, 1982; Glicken, 1995; Tolman & Bhosley, 1991). Interestingly, Chamberlain et al. (1984) also found that mandated clients had higher drop-out rates than did non-mandated clients. These findings may be interpreted to mean that mandated clients have higher resistance levels, and thus, are the most likely to drop-out of treatment. In relation to therapist ratings, the researchers found that therapists’ post-treatment ratings were not related to the level of client resistance in early treatment, and that cases rated as more “successful” had lower resistance levels at the end of treatment. Thus, in this study, therapists defined success in terms of the level of resistance present at the end of treatment.

In attempt to replicate Chamberlain et al.’s (1984) finding that the highest level of resistance occurred during mid-treatment, Stoolmiller et al. (1993) implemented a quadratic growth curve model to test the “struggle-and-working-through” hypothesis. Their findings empirically supported the clinical observation that clients with chronically high levels of resistance are the most likely to “fail” (recidivate) in treatment. Additionally, clients who are most likely to succeed are those who show increasing resistance over the first half of treatment, followed by consistently decreasing levels of resistance in the second half of treatment. These findings support the notion that it is not resistance which leads to treatment failure, but the failure of the client to “work through” the resistance (Amodeo & Lifitik, 1990; Higgs, 1992; Sonkin, 1987). In other words, resistance may not be a direct predictor of treatment failure, but the lack of motivation to
confront one’s resistance may be. Not only have batterers been characterized as resistant, they have also been characterized as lacking personal motivation for treatment (Armor, Head, Blackburn & Slone, 1989; Chen et al., 1989; Hamberger & Hastings, 1986). Yet, in congruence with Chamberlain et al.’s (1984) and Stoolmiller et al.’s (1993) findings, motivation has been deemed a dynamic variable, in that it waxes and wanes throughout the course of treatment (Sonkin, 1987). In sum, these findings may have direct implications for treatment-mandated batterers, as their motivation may not be goal-driven, but rather, may be a function of criminal justice control. However, some have claimed that the observed attitude of batterers, which has been conceptualized as a lack of motivation, is not a motivation problem, but a problem related to socialization.

Glicken (1995) postulates that treatment models are often incompatible with male socialization. This is because men are taught to believe that desirable masculine characteristics center on themes of power, control, dominance, and competition. Feminine characteristics have traditionally been associated with vulnerability, emotions, sensitivity, and compliance. Additionally, the belief that possessing feminine characteristics makes one less than a man is socially ingrained in some men. This perspective may be particularly relevant to batterers, as they tend to value traditional and rigid gender roles (Dutton & Starzomski, 1993; Steinman, 1988). Yet, treatment tends to require men to adopt characteristics that are antithetical to the masculine ideal (i.e., self-awareness, admission of problems, vulnerability, help-seeking) (Glicken, 1995; Saunders & Parker, 1989; Sonkin, 1987).

From this perspective, male resistiveness is not viewed as a pathology, but rather, as a “normal” reaction to treatment ideologies. Thus, resistance is not a function of hostility related defensiveness, but is a function of the fear of treatment, and fear of appearing stupid, anxious/nervous, or abnormal (Higgs, 1992; Sonkin, 1987). Additionally, this
perspectives of male resistance holds that motivation is solely determined by how much
the batterer values the (feminine) skills needed for effective treatment, and that treatment
staff should not expect batterers to be comfortable with treatment (Sonkin, 1987).

While the socialization hypothesis of resistance seems ideal because of its’
humanistic, non-pathological approach, it is not a problem-free way to conceptualize
resistance. Because socialized roles are taught from birth, they tend to be rigid and more
cognitively resistant to change. Thus, a batterer in treatment may internally maintain
resistance, while he externally appears amenable. For example, he may outwardly agree
with treatment goals, while disagreeing internally (Glicken, 1995). Because California’s
SB 169 (Hayden, 1995a) gives treatment staff the authority to deny treatment to batterers
who do not appear amenable, batterers learn from the beginning of treatment that if they
don’t convince the treatment staff of their amenability, they will suffer additional court
sanctions for their failure to comply with the conditions of probation (Dutton, 1986;
Ganley, 1987). This is why some have argued against coercing batterers into treatment
(Star, 1983).

In sum, the Adlerian approach to resistance seems the most applicable to batterers in
treatment for two reasons. First, Adlerians equate resistance with defense mechanisms,
such as denial and blaming (Kopp & Kivel, 1990), and batterers frequently deny their
abusiveness, and place the blame on others (Beninati, 1989; Bernard & Bernard, 1984;
Dreas, Ignatov & Brennan, 1982; Dutton, 1986; Ganley, 1987; Sakai, 1991; Saunders &
Parker, 1989; Sonkin, 1987; Star, 1983). Secondly, Adlerians view resistance in terms of
an inconsistency between the client’s stated behavior, and actual behavior (Kopp &
Kivel, 1990), and batterers are also characterized as outwardly appearing to comply with
treatment, while inwardly disagreeing with treatment ideologies (Glicken, 1995; Sonkin,
1987).
In addition, resistance is viewed within a context of a negative therapeutic alliance, and a negative therapeutic alliance is predictive of a negative treatment outcome (Alexander & Luborsky, 1986; Horvath & Symonds, 1991; Keijsers, Hoogduin & Schaap, 1994; Muran et al., 1995). For court-mandated clients, this may be indicative of a negative treatment outcome, as court-mandated clients tend to be more resistant to treatment (Chamberlain et al., 1984). However, resistance, in terms of motivation to participate in treatment, may be a dynamic variable, and thus, subject to change (Sonkin, 1987). While resistance creates a problem for treatment program staff, this problem may not be insurmountable. If treatment staff and clients can work effectively through the issues which contribute to the client’s resistance, a more positive treatment outcome may be more likely (Stoolmiller et al., 1993). Up to this point, no known studies have empirically addressed this issue within the paradigm of domestic violence, and the criminal justice system. The current study is an attempt to do that.
Chapter Three
Methodology

Research Design

This is a quasi-experimental research design, as there is no control group, and subjects are not randomly assigned to groups. The research design can best be expressed as a between-subjects, 3x2 factorial. This is because there are different subjects within each group, however, these subjects are not randomly assigned to these groups. There are two independent variables, one with three levels, and one with two levels, thus making it a 3x2 design (see Table 1. Research Design in next section).

Variables and Measurement

The first independent variable in this study is treatment classification. While this variable has been dichotomized as voluntary/involuntary (VOL/INV), it remains a single variable, as opposed to two distinct variables. Data on this variable can be measured at the nominal level. The second independent variable in this study is length of time in treatment (TiT). Consistent with research on resistance, this variable will be split into 3 segments. Batterers’ programs tend to be 52 weeks in length. Thus, each segment will be defined as 17 weeks. In other words, measurements of time in treatment will be grouped as 1-17 weeks (early-treatment), 18-34 weeks (mid-treatment), and 35+ weeks (late-treatment). Data obtained from the time in treatment variable can be analyzed on the ordinal level.

The dependent variables in this study are resistance (GR) and perceptions of punitiveness (PP). Resistance is conceptualized as an internal psychological-defense system that may be externally demonstrated through measures of beliefs about personal responsibility for violent behavior, and the relative value of treatment. Perceptions of punitiveness are conceptualized as internal emotions that may be externally demonstrated
through measures of belief and perception of the criminal justice system. While these variables are distinct in conceptualization, the concept of perceptions of punitiveness is theoretically within the construct of resistance. More specifically, perceptions of punitiveness and resistance are different versions of the same construct. However, they will be measured separately. These variables will be measured through a paper and pencil instrument, which will provide "scaled scores". These data can be analyzed on either an interval or ratio level.

The independent and dependent variables will all be statistically analyzed in relation to each other. These relationships may be expressed as VOL/INV x PP, VOL/INV x GR, VOL/INV x PP x TiT, and VOL/INV x GR x TiT. There are two groups within the VOL/INV variable, and three groups within the TiT variable. This research design can best be illustrated by a Table.

Table 1. Research Design

<table>
<thead>
<tr>
<th>Status</th>
<th>Count</th>
<th>Time in Treatment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1-17 wk.</td>
<td>18-34 wk.</td>
</tr>
<tr>
<td>Voluntary</td>
<td>n = 6</td>
<td>n = 2</td>
<td>n = 4</td>
</tr>
<tr>
<td>Involuntary</td>
<td>n = 33</td>
<td>n = 56</td>
<td>n = 43</td>
</tr>
<tr>
<td>Column Total</td>
<td>39</td>
<td>58</td>
<td>47</td>
</tr>
<tr>
<td>Total</td>
<td>27.1%</td>
<td>40.3%</td>
<td>32.6%</td>
</tr>
</tbody>
</table>

In terms of research design, the use of measures other than recidivism to determine success in domestic violence treatment has several advantages. One advantage is that
measurements of recidivism generally require a control group, whereas other success measures do not necessarily require a control group. Non-control group designs tend to be preferred in treatment studies because it is extremely difficult to obtain either a randomized or matched control group design. Not only is it difficult to find offenders who are not in treatment, but are characteristically similar to offenders who are, it is unethical to randomly assign batterers to either a treatment or no treatment condition. Obviously, this study will not use a control (non-treatment) group. While control group designs are often considered the strongest, given the independent variables in this study, a control group seems unnecessary. Another issue of research design centers on randomization. Again, the independent variables (VOL/INV and TiT) in this study pre-determine the groups, so randomization is impossible to even attempt in this study. However, this is not a major concern, as the non-randomization of the independent variables is a central issue in this study, and there is no specified treatment variable which would require randomization.

Another advantage of using measures of success other than recidivism, is that changes over time can be measured in individual offenders, thus providing a base-line, or comparison measure. Traditionally this is done in a pre-test/post-test research design. For practical reasons, this study will not include the pre-test/post-test condition. Rather, time will be used as an independent variable (TiT), and involuntary clients (INV) and voluntary clients (VOL) will be grouped into time segments. This approach has an obvious disadvantage. Individual base-line measures can not be calculated, so unknown variables may confound the time variable. In other words, individual measures of the dependent variables (GR and PP) at mid-treatment are grouped into a time segment (TiT) and compared with individual measures at early-treatment, which are also grouped into a time segment. Thus, it is difficult to confidently compare time-segmented groups, when
unknown variables may cause the groups (VOL/INV) to be dissimilar (incomparable).
The advantage of this design, however, is that a pre-test will not be given, so
test-sensitivity cannot influence results. However, because of the characteristics of
batterers and the treatment expectation that they be compliant (non-resistant), social
desirability may have a major influence on test response.

**Measurement Instrument**

Because there is no known research which used similar independent variables in
conjunction with the dependent variables in this study, no appropriate measurement
instrument was found. So, several paper and pencil instruments were reviewed, and
certain items were chosen for their face validity. These items, along with others which
were self-constructed, are what comprise the paper and pencil instrument used to
measure the dependent variables in this study.

A few of these items were adapted from the *Accessibility Scale* (AcS), which is a
scale that was developed to test amenability to treatment within a correctional setting
(Jacks, 1964). There is no report of reliability, and validity was reported as .57. A couple
of items were taken from Carlson, Barr, and Young’s (1994) study, which addressed the
admittance of problems, and personal responsibility for these problems. These items
were reworded to specify the problem as violence for this study. The researchers reported
no reliability, or validity measures. Two items that addressed perception of treatment
were adapted from the *Penn Helping Alliance Scale- Questionnaire Method* (HAq)
(Alexander & Luborsky, 1986). The Questionnaire Method was devised to measure the
client’s attitude toward therapy (treatment). Unfortunately, there is no report of reliability
for the Questionnaire Method, but, predictive validity was reported to range from .51 to
.72. Several items were taken from an evaluative study on drug and alcohol offenders
within a diversion/treatment program (Maring & Eisenberg, 1994). Some of these items
were taken exactly as they were reported, and some were reworded to specify violence instead of alcohol abuse. Several of the items which were taken from this study are included within the demographic scale in the current measurement instrument. As these researchers were not interested in empirically establishing their survey instrument, they did not report on the reliability or validity of this instrument. Additional demographic items, which are specific to domestic violence offenders, were taken from the survey instrument devised by Grusznski (1986). All other items were constructed by the author. In constructing these items, theories of domestic violence, reports of clinical observations found in the literature, and simplicity of statement were taken into account. For example, the current measurement instrument includes the item: “Does it bother you that you have to pay to participate in this program”. This item was included within the construct of resistance, as the literature reveals that program fee has been used as a variable in discussing resistance to treatment (Stosny, 1994).

The instrument used in the current study is a single test, with two “scales”. The Perception of Punitiveness Scale is intended to directly measure individual perception of fairness of the criminal justice system, individual perception of treatment as a punishment, hostility/resentment towards the criminal justice system and the treatment program, and individual perception of coercion/choice in relation to treatment participation. The General Resistance Scale is intended to directly measure individual perceptions of responsibility for violence, need for treatment, the treatment program in general, effectiveness of treatment, and commitment to treatment. Combining both Scales, this instrument contains 21 items. Fourteen of these items make up the General Resistance Scale, and 7 of these items make up the Perceptions of Punitiveness Scale. Every possible answer to each item has a set numerical value, so that each item receives a score. These values range from 0 to 4. Summing these values within each Scale will
provide a Scaled Score, which will become the unit of analysis. The General Resistance Scale has a scaled score with ranges from 0 to 56, and the Perceptions of Punitiveness Scale has a scaled score which ranges from 0 to twenty-eight.

This instrument also includes demographic items. In addition to the traditional demographic items, relationship with victim, referral source, number of absences and reasons for absences, and previous experience with treatment are included in the demographic measurement. There are 17 demographic items (see Appendix A for a representation of this instrument).

This instrument appears to have high face-validity, however this possibly creates two problems. First, high face-validity may encourage responses that are motivated by social desirability. Thus, resistance and perceptions of punitiveness may be under-reported. Secondly, this instrument is not empirically established, which weakens confidence of its internal validity and reliability. Without this confidence, it is possible that all results are compromised. In attempt to control for the social desirability bias, an instrument could be constructed with the goal of low face-validity, however, without empirically testing the instrument, results may be gravely compromised. In sum, it seems that social desirability biases can be partially discouraged through stressing to clients the importance of honesty, and reinforcing their trust in anonymity. On the other hand, at this point, nothing can be done about the potential lack of reliability and validity measurements of this instrument.

Hypotheses

While several hypotheses have been stated, a more direct statement of the hypotheses will add clarity to the intent and discussion of results of this study.

Hypothesis 1a: Clients who perceive the treatment program as punitive will score higher on the Perception of Punitiveness Scale (VOL/INV x PP)

Hypothesis 1b: Court-mandated clients will score higher than voluntary clients
Hypothesis 2: Clients who are resistant to treatment will score higher on the General Resistance Scale (VOL/INV x GR)

Hypothesis 3: Clients who score higher on the Perception of Punitiveness Scale will also score higher on General Resistance Scale (PP + GR)

Hypothesis 4a: Court-mandated clients who fall into the early-treatment group will score higher than coerced clients who fall into the late-treatment group on the General Resistance Scale (INV x GR x TiT)

Hypothesis 4b: Court-mandated clients who fall into the early-treatment group will score higher than coerced clients who fall into the late-treatment group on the Perception of Punitiveness Scale (INV x PP x TiT)

Sample

The sample consists of 135 male domestic violence offenders who have been mandated to treatment, and 12 voluntary, male, domestic violence offenders in treatment. Among the mandated subjects, 57.8% reported being mandated to treatment through probation, 15% reported being mandated through diversion, one subject reported being mandated through parole, and the remaining were mandated through other agencies (i.e., Child Protective Services). Among voluntary subjects, 6 were self-referred, 2 reported that they were referred by a friend or relative, 2 reported being referred by their counselor or therapist, one was referred by an unknown agency, and one was referred by his employer. The mean age of subjects was 34.9, and the ages ranged from 18 to sixty-eight.

This sample was obtained from 4 probation-approved domestic violence treatment programs within San Bernardino County, California. In total, there were 13 treatment groups, which averaged 11 subjects per group. Prior to obtaining the sample, treatment programs were surveyed in order to determine pertinent characteristics of the programs.
Of the 12 programs solicited, 6 returned the survey, and 4 expressed a willingness to participate in this study. Those programs that agreed to participate were matched on their fee, length of treatment, and number of members per treatment group. Only Spanish speaking groups, and women’s groups were excluded from the analysis in this study.

**Procedure**

Several treatment programs were selected from a list of probation-approved programs within San Bernardino County, California. These programs were sent a survey, and were further solicited for their participation in this study. Those programs that agreed to participate were given the measurement instrument (survey). Each program group leader read an informed consent statement in every group. Subjects who agreed to participate were then handed a survey, and asked to sign a consent form. The subjects then detached the consent form and handed it in to the program leader. The program leaders further instructed the subjects to indicate on the top sheet of their survey their actual voluntary/involuntary status in the group. They were also instructed to answer every question, and to indicate only one answer per question. Once the subjects finished filling out the survey, they handed it in to the group leader, and were then handed a debriefing statement. This entire process took, on average, about 30 minutes. The group then proceeded with their normal activities. When the group had adjourned, the group leaders then placed the surveys in an envelope, and coded the outside of the envelope to indicate the group number. The group leaders further recorded the group code, along with the date, time, number of group members, and number of research participants on a “data sheet”, which was kept separate from the completed survey materials. The signed informed consents were maintained by the treatment group leaders. All survey materials remained anonymous, and were given to the researcher for analysis.
The purpose of this study was to test the effects of voluntary and involuntary (VOL/INV) participation on resistance (RES) and perceptions of punitiveness (PP) in batterers’ treatment programs. Additionally, time in treatment (TiT) was predicted to effect the General Resistance (GR) and Perceptions of Punitiveness (PP) Scores on the measurement instrument implemented in this study.

**Variable Descriptives**

There were 135 cases that fell into the involuntary group, and 12 cases that fell into the voluntary group. Analysis of the TiT variable revealed that 26.5% of the cases were in the 1-17 week group, 39.5% were in the 18-34 week group, 32% were in the 35+ week group, and 2% had missing data. Statistical analysis also revealed that the mean General Resistance Score was 12.57, the median was 11, and the mode was twelve. Two percent were missing data. The highest score on the General Resistance Scale was 38 out of a possible fifty-six. Ninety-three percent of the cases scored below half of the total possible score (i.e., 28). For the Perceptions of Punitiveness Scores, the mean was 10.26, the median was 8, and the mode was three. More than 75% of the cases scored below 14, out of a possible 28 on the Perceptions of Punitiveness Scale. Fourteen cases had to be excluded from analysis because of missing data.

**Hypotheses Testing**

A t-test was performed to determine if involuntary subjects scored significantly higher than voluntary subjects on the Perceptions of Punitiveness Scale (Hypothesis 1b). This hypothesis was confirmed ($t(14.2) = -3.29, p < .01$), meaning that involuntary subjects did indeed score significantly higher (see Table 2. Perceptions of Punitiveness By Involuntary Status and Illustration 1. PP and GR By Involuntary Status). An additional
t-test was performed using the variables of General Resistance and VOL/INV. Although this combination of variables was not included in the hypotheses, they should be mentioned, as the analysis revealed a statistical significance in scores between the groups \( t(126) = -2.93, p < .01 \) (see Table 3. General Resistance By Involuntary Status and Illustration 1. PP and GR By Involuntary Status).

### Table 2. Perceptions of Punitiveness By Involuntary Status

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>( \bar{x} )</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary</td>
<td>10</td>
<td>6</td>
<td>3.94</td>
</tr>
<tr>
<td>Involuntary</td>
<td>123</td>
<td>10.6</td>
<td>7.04</td>
</tr>
</tbody>
</table>

### Table 3. General Resistance By Involuntary Status

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>( \bar{x} )</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary</td>
<td>10</td>
<td>5.2</td>
<td>3.97</td>
</tr>
<tr>
<td>Involuntary</td>
<td>118</td>
<td>13.1</td>
<td>8.53</td>
</tr>
</tbody>
</table>

### Illustration 1.

PP and GR By Involuntary Status

![Illustration 1](image-url)
While it was not hypothesized that involuntary treatment participants would score higher on the General Resistance Scale, it was hypothesized that those individuals which scored higher on the Perceptions of Punitiveness Scale would also score higher on the General Resistance Scale (Hypothesis 3). Statistical analysis revealed a positive correlation (.6273, p < .01), meaning that Hypothesis 3 was confirmed; thirty-nine percent of the variance in the General Resistance score was accounted for by Perceptions of Punitiveness.

Table 4. General Resistance and Perceptions of Punitiveness

<table>
<thead>
<tr>
<th></th>
<th>GRSCORE</th>
<th>PPSCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>GRSCORE</td>
<td>1.0000</td>
<td>.6273</td>
</tr>
<tr>
<td>( 128)</td>
<td>( 120)</td>
<td></td>
</tr>
<tr>
<td>P=.</td>
<td>P=.000</td>
<td></td>
</tr>
<tr>
<td>PPSCORE</td>
<td>.6273</td>
<td>1.0000</td>
</tr>
<tr>
<td>( 120)</td>
<td>( 133)</td>
<td></td>
</tr>
<tr>
<td>P=.000</td>
<td>P=.</td>
<td></td>
</tr>
</tbody>
</table>

To test whether the time in treatment (TiT) variable would effect General Resistance and Perceptions of Punitiveness Scores (Hypotheses 4a and 4b), a one-way ANOVA was performed on both dependent variables (GR and PP). Time in treatment was grouped into 3 segments (1-17 weeks, 18-34 weeks, and 35+ weeks). No significance was found for either variable. To further test the TiT variable, a Pearson’s r was performed on the raw number of weeks in treatment. This also showed no significance either for General Resistance or Perceptions of Punitiveness, meaning that TiT does not have a statistically significant effect on Perceptions of Punitiveness or General Resistance.
Predictor Variables

In order to discern other possible predictors for resistance and perceptions of punitiveness, additional analysis was performed. The raw General Resistance Score for each case was converted into one of four groups, each one representing 14 scale points. The grouping then became the variable for analysis. Because no subject scored above 38 on the Scale, there was no data available for group four. In the same manner, the Perceptions of Punitiveness Scores were collapsed into four groups, each one representing 7 scale points. Cross-tabulations were then performed on the General Resistance grouped scores and the Perceptions of Punitiveness grouped scores. The only variable that approached significance in the Perceptions of Punitiveness analysis was employment. Thus, employment status may be predictive of perceptions of punitiveness.

In the analysis of General Resistance, however, there were three variables that were statistically significant. The first was level of education ($\chi^2 (16, N = 128) = 28.15, p<.05$). The second was employment status ($\chi^2 (6, N = 128) = 12.88, p<.05$), and the third was annual income ($\chi^2 (10, N = 126) = 19.29, p<.05$). Thus, education, employment, and income seem to be predictive of resistance. The following Illustration
indicates that as income increases, resistance also increases at the higher scores, and as education increases, resistance increases at the lower scores.

Illustration 3.

General Resistance By Education and Income

Descriptive Statistics

Several additional demographic variables were analyzed for their frequency distributions. The mean age of subjects was 34.94, and the ages ranged from 18 to sixty-eight. More than 30% of the subjects had a high-school diploma, 29.5% had below a high-school education, almost 20% had some college education, and only 2.7% reported having a Master's degree or higher. Only 13% of the subjects were employed full-time. The highest percentage of subjects were employed part-time (61%), followed by the unemployment rate at almost 25 percent. Among those who reported being unemployed, 30.8% reported their unemployment to be due to a disability, and over 25% reported it to be due to a lack of employment opportunities. In terms of income, the highest percentage of subjects had an annual income of less than ten thousand dollars (37%). The demographic characteristics of this sample seem congruent with the demographic characteristics found in other samples of domestic violence offenders.
Further analysis revealed that nearly half of the subjects were married at the time of the survey, and over half reported that their spouse was the victim of their violence. Twenty-five percent of the subjects reported that their girlfriend had been the victim of their battering. Interestingly, a seemingly large percentage of subjects reported that they had battered a friend (12.3%). Perhaps this finding is due to lack of appropriate choice categories in the survey, as other relationships such as child/parent were not included. While some subjects wrote in this choice, others may have indicated that they had battered a friend only because the appropriate choice was not represented. Over 55% of the subjects reported that they were currently living with their victim.

Seven subjects (4.8%) reported that they had had prior treatment for domestic violence. Nearly 75% of the subjects reported that they had been absent from the group meetings. Of those who reported being absent, over three-quarters had 4 absences or less, and less than 3% reported being absent 11 times or more. The most frequently cited reasons for the absences were a lack of transportation (27%), and employment (27.7%). Further analysis on these variables indicated that absences, or number of absences were not correlated with either the General Resistance Scores, or the Perceptions of Punitiveness Scores. Also of relevance was the finding that nearly 16% of the subjects reported that they had engaged in abusive behaviors since they began treatment, and over 35% reported that they felt there was either some chance or a sure chance that they would assault someone again after they had completed the treatment program.

The final variables which were particularly relevant to this study were the treatment status, and the source of referral. As was expected, the largest percentage of the subjects (58.6) reported that their participation in treatment was a condition of probation. Interestingly, 15% reported that they were in treatment because they had been diverted from the criminal justice system. Most of the treatment group leaders had indicated that
they did not have any divertees in their programs, so a lack of understanding on the part of the subjects may have led them to indicate that they were divertees, when in fact, they were not. Because of this potential error, further statistical analysis was not performed to determine if the diverted group was different from the probation group on the dependent variables. When asked who had referred them to the treatment program, nearly half of the subjects reported that a judge had referred them. Almost 22% reported that they were referred by the probation department. The remaining subjects were referred by a variety of other agencies (see Illustration 4. Percentages of Referral Source).

Illustration 4.
Percentages of Referral Source

Summary
In sum, it seems that the demographic characteristics of this sample are similar to the characteristics found in other treatment samples of domestic violence offenders in terms of age, income, employment, and educational status. Additional analysis revealed that many of the batterers were married, that their wives were the victim of their battering, and that they are still living with their wives. As was expected, the majority of this
sample consisted of involuntary treatment participants, who were referred to treatment through the court system.

In terms of the dependent variables, it is evident that involuntary participants are more resistant and perceive treatment as more punitive than do voluntary participants. One unexpected finding was that education and income were positively correlated with Resistance Scores. As income increased, so did the Resistance Scores in the lower range of scores; and as education increased, the Resistance Scores increased at the higher range of scores. Also, the highest score on the General Resistance Scale was 38 out of a possible 56, implying that while involuntary treatment participants are more resistant, they are not “extremely” resistant.

Another variable in this study was time in treatment (TiT). It was expected that as subjects spent more time in treatment their General Resistance (GR) and Perceptions of Punitiveness (PP) Scores would significantly decrease (Hypotheses 4a and 4b). Statistical analysis revealed that there was no significant difference between the TiT groups on either the PP or GR variables. Nor was there a significant statistical difference when TiT was analyzed outside of the time groupings. Thus, these factors remain consistent across groups throughout the treatment period.

The final hypothesis in this study was that those who scored higher on the Perceptions of Punitiveness Scale would also score higher on the General Resistance Scale (Hypothesis 3). The correlation coefficient showed statistical significance, confirming the hypothesis. This bears particular implications for the validity of the measurement instrument and the constructs used to design the instrument, as perceptions of punitiveness were conceptualized as being independent from, yet within, the construct of resistance. In addition, the finding that involuntary treatment participants scored higher
on General Resistance and Perceptions of Punitiveness than the voluntary participants adds validity to the measurement instrument in this study.
Chapter Five

Conclusions

General Conclusions

The current study was an attempt to bridge a gap in research between the criminal justice system and community treatment programs. Not only has domestic violence drawn increasing public attention in recent years, it has also become a significant policy issue in terms of the criminal justice system. Current policies in California are to mandate treatment as a condition of probation in cases of misdemeanor domestic violence (Senate Bill 169, Hayden 1995a). This policy seems to be based on ideology, rather than on evidence of its effectiveness. Because this policy is relatively new, it has not been subjected to empirical scrutiny. In a global sense, this study attempted to examine factors which may contribute to the effectiveness or ineffectiveness of the current criminal justice policy for dealing with domestic violence offenders. More specifically, the question as to whether mandating treatment is the most effective policy was indirectly addressed in this study.

Several researchers had reported that they had observed domestic violence offenders in treatment to be hostile and resistant to treatment, and that these offenders also viewed treatment as a form of punishment, rather than as an opportunity to rehabilitate themselves (Dreas, Ignatov & Brennan, 1982; Dutton, 1986; Ford, 1991; Ganley, 1987; Glicken, 1995; Petersilia & Deschenes, 1994; Schottenfeld; Star, 1983). Other researchers noted that client resistance to treatment is a factor which influences the effectiveness of treatment (Alexander and Luborsky, 1986; Amodeo & Liftik, 1990; Dunham & Mauss, 1982; Horvath and Symonds, 1991; Keijser, Hoogduin, and Schaad, 1994; Muran et al., 1995; Schottenfeld, 1989). While the current study was not a direct attempt to determine treatment success, it was an attempt to examine the relationship
between the criminal justice system and factors which are associated with treatment success. These factors were conceptualized as resistance to treatment and perceptions of the punitiveness of treatment. It was hypothesized that involuntary treatment participants would score higher than the voluntary treatment participants on the General Resistance Scale, and the Perceptions of Punitiveness Scale, which were devised for this study.

Statistical analysis revealed that there was a significant difference, meaning that involuntary clients are almost 3 times more resistant (\( VOL \bar{x} = 5.20, INV \bar{x} = 13.19 \)), and view treatment almost 2 times more punitively than do voluntary clients (\( VOL \bar{x} = 6.00, INV \bar{x} = 10.61 \)). This finding empirically validates what many researchers have observed in dealing with batterers (Dreas, Ignatov & Brennan, 1982; Ganley, 1987; Star, 1983; Stosny, 1994). This finding may also have implications for the relative “success” of treatment. However, it would be premature to conclude that treatment is less successful with involuntary clients.

Success is traditionally determined by recidivism rates within a criminal justice paradigm. Yet, within a treatment paradigm, success is often viewed within the context of attitude, as well as behavioral change. Implementing the latter definition of success, the current study addressed success within the variable of time in treatment (TiT). It was hypothesized that as clients were exposed to more treatment, they would be less resistant to treatment, and their perceptions of the punitiveness of treatment would diminish. Indeed, past studies using other samples have shown that levels of resistance fluctuated with time (Chamberlain et al., 1984; Stoolmiller et al., 1993). Statistical analysis of this variable revealed that there was no significant differences within the TiT variable. This finding implies that the level of resistance and perceptions of punitiveness remain constant across the treatment period. However, further analysis revealed that the level of resistance was, at least in part, a function of the client’s level of education and his annual
income. It was interesting to discover that as the level of education increased resistance also increased at the lower range of resistance scores, and that as income increased resistance increased at the higher range of scores. At this point, any commentary on this finding would merely be speculation.

Measurement Instrument

In terms of the measurement instrument that was implemented for this study, the validation of the hypotheses also adds validity to the instrument. Because it was expected that involuntary clients would score higher on the Perceptions of Punitiveness Scale (Hypothesis 1b), the validation of this Scale was, in part, dependent upon the hypothesis testing. As the hypothesis was confirmed, it seems that the Scale measured what it was intended to measure. Additionally, although it was not directly hypothesized that involuntary clients would score higher on the General Resistance Scale, it was hypothesized that those clients who scored higher on the Perceptions of Punitiveness Scale (involuntary clients) would also score higher on the General Resistance Scale (Hypothesis 3). Additional analysis revealed that involuntary clients did score higher than voluntary clients on the General Resistance Scale, and that the two Scales were significantly correlated. Taken together, these findings imply validity of the General Resistance Scale, as well. In spite of this, caution must be taken in assuming that this instrument is entirely valid. Several problems with the instrument were noted in the course of this study.

Research Problems

One significant problem with the measurement instrument was found in the coding of the individual items. For example, the answer choice which indicated a degree of resistance was given a value of four in the dichotomous (yes/no) questions. Questions five and six on the General Resistance Scale (see Appendix A) were intended to be
measures of past and present denial of the individual’s problem controlling his anger. Particularly with question number six, it was difficult to determine what value to place on the answer choices. More specifically, a “yes” answer indicated that the individual currently felt he had a problem controlling his anger. So, a “yes” answer could have been taken to indicate resistance, in that the individual still had a problem, or it could have been taken to indicate a lack of denial, which would be indicative of no resistance.

Similar problems were found with other items in both Scales.

Additional problems were found in the measurement instrument in terms of the demographic items. For example, question seven on the Demographic Questionnaire seemed to be limited on answer choice (see Appendix A). While it was not expected that additional answer categories would be necessary, the number of individuals who wrote in alternative answers seemed high. The answer choices for this question obviously need to be expanded to include other relationship categories (i.e., “child” and “parent”). There was another item which seemed to be deficient in answer choice (question # 10). This item is particularly relevant, as it related to the source of treatment program referral, and was used to determine the involuntary/voluntary status of the individual. Several individuals wrote in answers, such as “CPS” (Child Protective Services), and “attorney” (Public Defender and District Attorney included). In addition, the high number of individuals who indicated that they had gotten into the treatment program through diversion by the court system (question # 9 on the Demographic Questionnaire), indicates that there may be some confusion about how one got into the program, or the terminology in the answer choices was unclear. Perhaps simple definitions of the answer choices would eliminate any possible error in the future.

While question number nine and ten on the Demographic Questionnaire may be modified for use in future studies, they remained the only means to establish
involuntary/voluntary status in this study. For reasons of client confidentiality, the researcher was denied access to treatment records, which hindered the ability to determine treatment status. So, in effect, what was measured may have been the clients’ perception of treatment status, rather than their actual status. The measurement instrument simply was not “sensitive” enough to this variable to have complete confidence of the absence of error. While the treatment group leaders were instructed to ask the survey respondents to indicate their status on the top sheet of the survey, again, there was no means to validate their status.

Another problem which was noted with the voluntary/involuntary variable related to the time in treatment (TiT) variable. A few subjects indicated that they were involuntary, but had been in treatment beyond the required 52 weeks. In fact, one treatment group was a “follow-up” group for individuals who wanted to remain in the program. Because these individuals were initially involuntary, it was difficult to determine at what point they should be labeled as voluntary. A final problem which seemed evident was the fact that the TiT variable did not prove to be a statistically significant predictor of either resistance or perceptions of punitiveness. Thus, very little can be said about the relative success of batterers’ treatment programs in terms of mandating treatment. However, it is a possibility that the TiT variable was not a significant predictor of resistance or perceptions of punitiveness in this study because of how it was measured. The best measure of the TiT variable may be the pre-test/post-test design, so that individual changes could be measured, rather than comparing groups. Through a pre-test/post-test design, a baseline could be established, so that we could determine if there was an individual difference in scores in early treatment and late treatment. This may give more indication of the success of treatment. While this study was not an attempt to directly measure success, the TiT variable was conceptualized as being related to the success of
treatment. The only other variables which could be construed as an indication of
treatment success were questions number ten and fourteen on the General Resistance
Scale (see Appendix A). These items asked clients if they had engaged in any abusive
behaviors while in treatment, and what they felt their chances were for assaulting
someone again after completion of treatment. Sixteen percent indicated that they had
engaged in abusive behaviors in the treatment period, and over 35% indicated that there
was at least some chance they would assault someone again after they had completed
treatment. There are obvious problems with these questions, if taken as the sole
indication of treatment success in terms of recidivism. First, self-reports of abusiveness
may be subject to under-reporting and over-reporting tendencies. This is because some
individuals may fear the repercussions for their honesty, thus, under-reporting their
abusiveness, while others, through treatment, may learn what constitutes abusive
behavior, and may over-report their own abusiveness. Secondly, just because one feels
there is a chance he may batter again does not mean he actually will. In fact, it may be
that those who felt they had a chance of battering again were those who did not deny that
their abusiveness was a problem, and had come to understand that it may take a lot of
effort to change the way they respond to conflict. If this is the case, then it seems those
individuals would be the least likely to batter again, as they recognized their violence to
be a problem. Thus, while these questions shed some light on the issue of recidivism,
they are not, in and of themselves, reliable measures.

**Future Directions**

It seems evident that other measures of success are necessary in order to make
conclusions about the mandating of treatment through the criminal justice system as a
means to control domestic violence. Future research which includes the calculation of
recidivism rates within samples of batterers mandated to treatment would greatly benefit
our understanding of the effectiveness of this policy (Senate Bill 169, Hayden, 1995a) in relation to its goals. While future studies could include the time in treatment variable as a means to define success, this variable may best be measured in a pre-test/post-test design. In addition, further research in the area of resistance to treatment and perceptions of punitiveness among domestic violence offenders in treatment would enable us to make the most effective policy decisions. Future studies could focus on the variables of income, education, and employment status in relation to how they effect resistance. Researchers could also further the understanding of what effects resistance and perceptions of punitiveness by including analysis of variables that were not examined in the current study. These types of studies may give indication of who is amenable to treatment before treatment is even mandated, which would greatly benefit not only the treatment programs, but the criminal justice system as well.
Appendix A
Survey and Measurement Instruments

Treatment Program Survey

1. Today’s Date ________________

2. Survey Filled Out By (Please Print) _______________________

   Title ______________________

3. Official Title of Program ______________________

4. How many individual groups are offered? ________________

5. How many times a week does the group meet? ________________

6. How long is the class (hours)? ________________

7. How long does the program run (weeks)? ________________

8. How many participants per group (on average)? ________________

9. Does the program include voluntary (not court-ordered clients)?  
   YES  NO

   If answered “YES”, please skip questions # 10 and 11

10. If voluntary clients are not included, is there a program offered for self-referrals?

    YES  NO

11. How does the program for voluntary clients differ from the program for
    court-mandated clients (structure, content, length, fee, etc.)?
12. What is the minimum fee for the program? $________ per __________

13. Are men and women included together in the groups? YES NO

14. Are heterosexuals and homosexuals included together in groups? YES NO

15. Are Spanish speaking groups offered? YES NO

16. Are Spanish speaking groups the ONLY groups offered? YES NO

17. How many absences are allowed? ________________

18. What disqualifies an individual for participation in a group? ________________

19. Are random drug and/or alcohol screens given? YES NO

20. Is a new client added to a pre-existing class? YES NO

21. What is the total number of court-ordered males currently enrolled in this program? ________________

22. What is the total number of voluntary males currently enrolled in this program? ________________
Subject Demographic Questionnaire

1. Today’s Date ____________________

2. Your Age ______

3. Are you (Circle One):
   - Single
   - Dating
   - Married
   - Separated
   - Divorced
   - Widowed

4. Education (Circle highest grade)
   - K-6
   - 7-8
   - 9-11
   - Highschool graduate
   - GED
   - Some college
   - A.A. Degree
   - B.A. Degree
   - Graduate Degree

5. Yearly Income (Circle One)
   - Below $10,000
   - $10,000-20,000
   - $21,000-30,000
   - $31,000-40,000
   - $41,000-50,000
   - Above $50,000

6. Are you currently (Circle One)
   - Employed (Part-time)
   - Employed (Full-time)
   - Unemployed
   - Retired

   If unemployed, is unemployment due to (Circle One)
   - Disability
   - Legal problems
   - Lack of jobs
   - No transportation
   - Other factors

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7. Of the following, which best describes your relationship with the person whom you are accused of assaulting (Circle One):

- Friend
- Lover
- Girlfriend
- Fiancée
- Wife

8. Are you and this person currently (Circle One)

- Living together
- Not living together

9. How did you get into this program (Circle One)

- Pretrial diversion
- Violated condition of probation
- Condition of parole
- Condition of divorce proceedings
- None of the above

10. Who referred you into this program (Circle One)

- Judge
- Probation Office
- Self-referred
- Women’s Shelter
- Friend/Relative
- Court Mediator
- Other (Please Specify) 

11. How many weeks have you been in this program? 

12. Have you been absent from any of the meetings since you began this program?

- Yes
- No

If yes, how many times have you been absent? 

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13. What is the most likely reason you would have to be absent? (Circle all that apply)

- Transportation
- Child Care
- Employment
- Sick
- Forgot
- Did not want to attend
- Other (Specify) ________________

14. Is this your first time in a treatment program for domestic violence?

- Yes
- No

If no, how many times have you been in treatment? ____________

**General Resistance Scale**

3. When you first came into this group, how did you feel about it? (Please mark with an X)

- Very Negative
- Negative
- Neutral
- Positive
- Very Positive

4. How has your opinion changed since your first contact with this program? (Please mark with an X)

- More Negative
- Unchanged
- More Positive

5. When you came into this group, did you think you had a problem controlling your anger? (Circle)

- Yes
- No

6. Do you feel you have a problem controlling your anger now? (Circle)

- Yes
- No
7. Please place an X next to the one statement you agree with:

- This program teaches me to deal with conflict.
- This program teaches me little that will help me in life.

8. Do you feel you are in the right treatment program? (Circle)
   
   Yes               No

10. Have you engaged in any abusive behaviors since starting this program? (Circle)
    
    Yes               No

12. If you felt you had a choice would you (Circle One):

    Continue the Program  Quit the Program  Seek Another Program

14. What do you feel your chances for assaulting someone are after you have completed this program?

    No Chance  Some Chance  Sure Chance

15. Please circle the one statement which best applies to you:

    I want to be in this program.   I don’t want to be in this program.

16. Do you have a plan for after-care following completion of your treatment? (Circle)

    Yes               No
17. Please place an X next to the one statement you agree with:

_____ It is someone else’s fault that I am in this program.

_____ I am responsible for my being in this program.

19. Do you feel you need to be in a treatment program?

Yes                 No

20. Do you feel the treatment you are receiving is helping you? (Please mark with an X)

Not at all       Very Little       Somewhat       Very Much

Perceptions of Punitiveness Scale
1. Please place an X next to the statement which best applies to you:

_____ I felt I had no choice in participating in this group.

_____ I felt I had a choice in participating in this group.

2. Does it bother you that you have to pay to participate in this program? (Circle)

Yes                 No

9. Considering my situation, I feel the criminal justice system treated me ______ (Circle)

too harshly  fairly  too mildly
11. Please place an X next to the statement which best applies to you:

_____ I'm glad I have been given the opportunity to participate in this program.

_____ This program is just part of the punishment I received.

13. Please place an X next to the statement which best applies to you:

_____ If it wasn't for the judge, I wouldn't be in this program.

_____ Even though this program is mandatory, I am glad I am in it.

18. Do you think that on the average, the criminal justice system punishes people (Please mark with an X):

Too Harshly   Sometimes Harshly   Fairly   Not Harshly Enough

21. Please place an X next to the one statement which you agree the with:

_____ This program is just a part of the punishment I have received.

_____ This program gives me the opportunity to change myself for the better.
References


