CLIENT VARIABLES RELATED TO TREATMENT PERSISTENCE AND NON-PERSISTENCE IN DOMESTIC VIOLENCE TREATMENT

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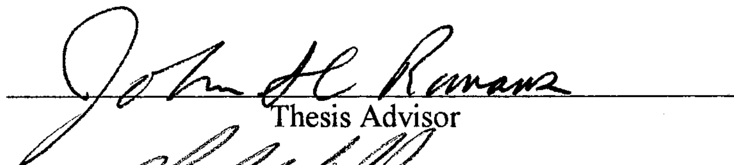

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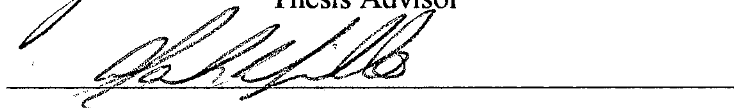

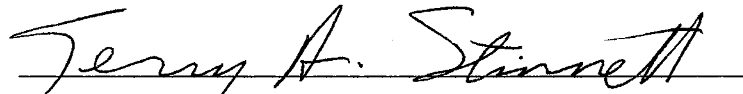

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CHAPTER I

INTRODUCTION

Introductory Statements

Society, the judicial system, and the social sciences have throughout history sought to ameliorate the problem of family violence. A brief review of history of societal treatment for male spouse abusers shows circular patterns of reprimanding and punishing abusers for their acts and then later ignoring family violence. Many individuals today can recall a time when family abuse was not a crime and consequently, those individuals may consider the police and domestic violence agencies to be an interference in their personal family. For the greater part of American history, the approach to male spouse abusers has been lenient. Men are rarely prosecuted for their crime because spouse abuse goes unreported, no arrest is made, or the man avoids treatment. The purpose of this study is to investigate the characteristics of individuals and their persistence or non-persistence in a therapeutic domestic violence treatment program.

Domestic violence is a serious problem in the United States. Strauss and Gelles (1988) conducted the 1985 National Family Violence Resurvey. Estimates concerning the prevalence of family violence for the United States were gathered from a sample of 6,002 households. It was estimated that at least one out of six (16%) American couples experienced at least one incident of physical assault during 1985, with approximately 8.7 million couples in the U.S. experiencing at least one assault during the year. When considering husband-to-wife violence, approximately one out of eight husbands committed one or more violent acts during the year of the study. Unfortunately, many of

these assaultive husbands do not get psychological counseling for their inappropriate behavior.

An outcome study by Gondolf (1998) suggested that domestic violence programs do reduce the number of re-assaults, and even more likely, reduce re-arrests for violence. However, Pirog-Good and Stets (1986) estimated 40% of men who enter counseling programs for abusive behavior never complete the program. This suggests the importance for further research on dropout from domestic violence treatment.

Garfield (1986) stated that client variables should be considered important for research investigations and theoretical discussions in psychotherapy. The following client variables will be reviewed for this study: referral source (court-referred or non-court-referred), substance abuse, severity of abusive behavior, self-esteem, locus of control, and beliefs about wife beating. These variables are of interest as they may relate to abusive behavior and dropout from therapy.

Some researchers have used referral source as a variable and differentiated between court-referred and non-court-referred clients, but conflicting results have been found. Dutton and Starzomski (1994) found no significant difference between court-referred clients and non-court-referred clients on demographic variables. In contrast, Barrera, Palmer, Brown, and Kalaher (1994) found that court-referred men were more likely to be separated from their spouse, more often reported substance abuse during the most recent assault, and showed higher rates of denial and social introversion than non-court-referred men.

There is question about the association between court-referral and treatment attendance. Findings from researchers are contradictory concerning court-referral as a

predictor of treatment completion. In a study by Grusznski and Carrillo (1988) concerning who completes battering treatment programs, results suggested that court referral was not associated with treatment completion. In contrast, Hamberger and Hastings (1989) found that court mandated clients completed treatment more often than self-referred clients did. Gondolf (1998) investigated a treatment site that used court appointed liaisons to increase communication between the treatment setting and the court system, resulting in a dramatic decrease in the number of no shows and dropouts from the program. This suggests that consequences for noncompliance may affect attendance rates.

Research on alcoholism suggests a relationship between alcoholism and the incidence of domestic violence and dropout from treatment. Russell, Lipov, Phillips, and White (1989) reported that alcohol use was a problem for 42% of violent males and by none of the non-violent men in their sample. DeMaris and Jackson (1987) stated that men who admitted to having problems due to alcohol use were more likely to dropout of a treatment program. Richmond (1992) and MacNair and Corazzini (1994) reported that drug and alcohol abuse was a good predictor of client dropout in that the majority of dropouts from these studies reported an alcohol or drug problem at the time of intake.

Research on the relationship between self-esteem and partner abusiveness is ambiguous. Russell et al. (1989) found that most of the maritally distressed couples selected for the sample had significantly low self-esteem scores. Prince and Arias (1994) indicated that desirability of control, perceived personal control and self-esteem interact, which suggests that the relationship between self-esteem and partner abusiveness is complex. Very little research has examined the relationship of client's level of self-esteem and dropout from counseling programs. Robbins, Mullison, Boggs, Riedesel, and

Jacobsen (1984) investigated differences in self-esteem between 130 subjects who attended a career development workshop and 56 subjects who signed up but did not attend. Comparisons were made based on an interest inventory and a checklist of values and abilities, including questions regarding self-esteem. All participants completed these measures during registration for the workshop. Results indicated that clients who "forgot or was discouraged" had lower self-esteem and participated in fewer information seeking activities. Non-attenders who "believed they had already attained their goals" had higher self-esteem, higher ratings of career decidedness, participated in more information seeking behaviors, and had a higher academic orientation.

Studies concerning locus of control suggest that external locus of control as compared to internal locus of control is associated with abusive behavior and treatment dropout. Saunders, Lynch, Grayson, and Linz (1987) reported that violent men who were being treated for abusive behavior were more likely to believe that violence is appropriate in a marital relationship. Rouse (1984) suggests that external locus of control may be associated with abuse but is not a strong predictor of abusive behavior. In relation to treatment dropout, Kolb, Beutler, Davis, Crago, and Shanfield (1985) found that clients who dropped out of treatment reported higher levels of expected internal locus of control in interpersonal relationships.

Significance of the Study

Clinical practitioners commonly agree that client's premature termination from therapy is a major concern. Garfield (1986) noted a consistent occurrence of dropout in psychotherapy over a period of decades from differing clinical settings from a variety of

regions. Although an abundance of researchers have investigated the problem of client dropout from psychotherapy in general, flaws have characterized their studies.

One major problem with current research on the dropout problem is a lack of consistency in defining terms. The operational definitions for terms such as "treatment dropout" and "treatment completer" have been arbitrarily assigned in a multitude of studies. Garfield (1986) stated that "one must carefully scrutinize research reports in this area to ascertain operational definitions of the categories used, otherwise generalization is hampered" (p. 219). This lack of consistency in operational definitions leads to generalization problems and in addition, studies are not comparable.

There is no method of identifying clients that are at risk for dropout of domestic violence treatment. Although some researchers have attempted to create a profile of treatment dropouts, the focus has typically been on identifying abnormal personality types. Previous studies on dropout from general psychotherapy have considered correlates such as social class, sex, age, diagnosis and educational level. Garfield (1986) indicated that there is a frequent relationship between a) social class and dropout, b) somewhat less frequent a relationship between education level and dropout, and c) no relationship between sex, age, or diagnosis and length of stay in psychotherapy.

A few studies have investigated correlates of dropout from domestic violence treatment. Dutton, Bodnarchuk, Kropp, Hart, and Ogloff (1997) found that men who completed treatment tended to be more educated, were more likely to have full-time employment, were more likely to be in a relationship, and had lower rates of criminal offenses than men who did not complete treatment. Hamberger and Hastings (1989) found results indicating that domestic violence treatment dropouts were typically younger

clients with lower education levels, and higher rates of criminal activity prior to treatment. Dropout clients indicated more borderline and schizoidal type personality tendencies than the completer clients did (Hamberger and Hastings). Faulkner, Cogan, Nolder, and Shooter (1991) found no differences on age, ethnicity, marital status, or education between men who completed domestic violence treatment and men who did not. Faulkner et al. reported that men who completed the program had lower scores on the Millon Clinical Multiaxial Inventory (Millon, 1983) for drug and alcohol abuse when compared with men who did not complete the program.

This study extends the investigation of dropout problems in domestic violence treatment using archival data to examine the beliefs, perceptions, and attitudes of subjects for a non-pathological approach to determining differences in clients. Participants for this study were selected from a domestic violence agency that incorporated the use of the instruments selected. Instruments were selected because there was an expected relationship between persistence in treatment and the variables measured by the instruments (self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim).

In addition, this study will contribute to the research by using agreed upon operational definitions for research. Through this investigation, knowledge can be gained about who will be at risk for dropping out, why these clients leave treatment early, and how we can improve services to continue treating those clients at risk for dropout.

Definition of Terms

The following are definitions of the terms used throughout this study.

Treatment: Treatment consisted of a possible 54 hours of meetings with a therapist. Treatment possibilities consisted of meetings with a therapist during a one-hour consultation appointment, a two-hour intake appointment, two 1-½ hour drug and alcohol education groups, and 24 two-hour domestic violence treatment groups. Treatment groups experienced different components of available treatment. Clients were designated as belonging to one of four groups (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse) based upon self-report with a therapist at the first meeting. Consequently, subjects for this study were grouped according to four treatment groups (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse). Further, group therapy was offered in an open format so that new persons were allowed to rotate into the group. Treatment meetings consisted of presentation of new material through lecture, video observation, and/or group discussion of provided handouts. All treatment was conducted by one of several master's level counselors, master's level practicum students, or a staff psychologist according to an agency curriculum.

Sessions completed: a session will be considered as completed if a therapist has noted attendance in the client's file. Hours of treatment sessions completed will be used as the independent variable.

Dropout: a client who has been accepted for treatment and has attended at least one meeting with a therapist, and who discontinues treatment on his own initiative by

failing to come to any future arranged visits with a therapist (Garfield, 1986). Clients failing to attend at least one meeting were not considered dropouts because they have refused treatment. Clients who notify the agency (as noted in client files) that they were incarcerated, were seeking treatment elsewhere, or have moved out of the area were not considered dropouts.

Abuse: male violence toward women, which encompasses physical, visual, verbal, or sexual acts that are experienced by a woman as a threat, invasion, or assault and that have the effect of hurting or degrading her and/or taking away her ability to control contact with another individual (Koss, Goodman, Browne, Fitzgerald, Keita, & Russo, 1994). For this study, it was measured by the Center for Social Research Abuse Index (a modified version of the intake questions used at the Minnesota Domestic Abuse Project, 1996) to determine differences in severity of abusive behavior among subjects.

Self-esteem: the evaluative component of self-concept, which is how we view ourselves (Hudson, 1982). The Index of Self-Esteem (Hudson) was used as a measure of this variable.

Locus of control: "whether or not an individual believes that his own behavior, skills or internal dispositions determine what reinforcements he receives." (Rotter, Chance, & Phares, 1972, p. 56) For this study, it was measured by the Adult Nowicki-Strickland Locus of Control Scale (Nowicki & Duke, 1973).

Beliefs about wife beating: the beliefs that individuals hold regarding wife battering behavior. These beliefs were measured by the Inventory of Beliefs About Wife Beating (IBWB) (Saunders et al., 1987). This instrument measure is comprised of the following subscales: Wife Beating Is Justified (WJ), which is the degree to which the

individual believes that the battering behavior is justifiable; Wife Gains From Beatings (WG) which is the degree to which the individual believes that the victim benefits from the battering behavior; Help Should Be Given (HG), which is the degree to which the individual believes that help should be given to victims of batterers; Offender Should Be Punished (OP), which is the degree to which the individual believes that the batterer should be punished for their battering behavior; Offender Is Responsible (OR) which is the degree to which the individual believes that the batterer is responsible for the battering behavior, and Sympathy Should be Given to Victims (SYMP) which is the degree to which the individual believes that sympathy should be given to victims of batterers.

Non-court-referred: encompasses all abusers seen at the domestic violence agency who were not being treated due to a conviction by the court of wife assault, and consequently were not court-referred. These individuals were often encouraged to seek services at the domestic violence agency by family, friends, significant others, or co-workers.

Court-referred: includes all abusers seen at the domestic violence agency as a mandatory consequence of conviction by the court of wife assault or as a result of being court-ordered due to recommendations made by the State Department of Human Services.

Substance abuse: includes all abusers seen at the domestic violence agency who reported problematic substance abuse as evidenced by substance use at the time of their last violent episode or a pattern of problematic substance use which interferes with their interpersonal/family life, legal status, employment, financial status, or medical status as

perceived by the therapist who completed the intake. For this study, the MacAndrew Test Revised (MacAndrew, 1965) was used to estimate clients' alcoholism risk for data analyses.

Court-referred with substance abuse: includes all abusers seen at the domestic violence agency for a mandatory court-ordered consequence of abusive behavior and also reported substance use at the time of the last violent episode or a pattern of problematic substance use. These clients were required to attend a two-hour intake appointment, two 1 ½ hour drug and alcohol education groups, and 48 hours of domestic violence treatment groups.

Court-referred without substance abuse: includes all abusers seen at the domestic violence agency for a mandatory court-ordered consequence of abusive behavior and did not report problematic substance use. These clients were required to attend a two-hour intake appointment, and 48 hours of domestic violence treatment groups.

Non-court-referred with substance abuse: all abusers seen at the domestic violence agency who were not court-mandated for treatment but reported substance use at the time of the last violent episode or a pattern of problematic substance use. These clients were required to attend a one-hour consultation appointment (to assess appropriateness for treatment), a two-hour intake appointment, two 1 ½ hour drug and alcohol education groups, and 48 hours of domestic violence treatment groups.

Non-court-referred without substance abuse: all abusers seen at the domestic violence agency that were not court-mandated for treatment and did not report problematic substance use. These clients were required to attend a one-hour consultation

appointment (to assess appropriateness for treatment), a two-hour intake appointment, and 48 hours of domestic violence treatment groups.

Research Questions

The following research questions were developed for this study.

1. Is there a relationship between the number of hours a subject attends treatment and the following variables: self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim?

2. Is there a relationship within groups (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse) on the number of hours a subject attends treatment and the following variables: self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim?

3. Which subset of variables (self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim) is most effective for classification of subjects to group membership

(court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse)?

Null Hypotheses

The following null hypotheses will be tested using an alpha .05 level of significance.

HO: 1 There is no relationship between the number of hours a subject attends treatment and the following variables: self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim.

HO: 2 There is no relationship within groups (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse) on the number of hours a subject attends treatment and the following variables: self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim.

HO: 3 There is no difference in subsets of variables (self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy

should be given to the victim) that is most effective for classification of subjects to group membership (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse).

Limitations

Many of the limitations of this study were unavoidable at the time of data collection. The subjects of this study were clients at one domestic violence agency that incorporated the instruments discussed in this study. The subjects were administered the assessments at the time of intake and prior to the development of this study. However, the use of archival data allowed for a large sample to be collected in a short amount of time.

Data was collected from only male abusers from one domestic violence agency in the Midwest. The limitation of using one agency, however, is that the sample may not be representative of all abusers. The administration of the instruments was the same for all subjects. Therefore, counterbalancing was not used to counter the effects due to the order of presentation such as sequencing effects. Although the instruments were always given at the time of intake, the point of intake may have varied with each client. Subjects who were prepared to enter treatment completed the instruments during the initial face-to-face contact with a therapist, while individuals in need of crisis intervention or consultation completed the instruments at a second meeting for intake. Another limitation is that no attempt was made to determine if subjects had completed the same or similar instruments prior to this study. Also, no attempt was made to determine if English was the primary language of the subject. Subjects who could not read the instruments because they were Non-English speaking persons or due to illiteracy were read the items aloud by the

therapist and were asked for a response. Finally, differences among staff members who administered the instruments and provided group therapy may have influenced the results due to differing experiences of treatment.

Some limitations were based on the instruments selected for this study. One limitation of instrumentation is that reliability and validity information on the Center for Social Research Abuse Index (CSR) was not available. Also, the instruments used in this study were self-report. The limitation of self-report instruments is that positive or negative impression management, or amount of self-disclosure by the subject may affect results.

CHAPTER II

REVIEW OF THE LITERATURE

In this chapter, several topics will be reviewed. The prevalence of domestic violence in the United States will be discussed first. Next, the treatment of male batterers will be discussed including a history of the treatment of male spouse abusers, a review of common theories of domestic violence, and the outcomes of such treatments. The problem of client dropout from general psychotherapy and then domestic violence treatment specifically will be explored. Finally, the variables that are of interest in this study will be reviewed as they relate to domestic violence and to dropout from therapy. The variables of interest are substance abuse, self-esteem, locus of control, beliefs about wife beating, and referral source (court-referred or non-court-referred).

Prevalence of Violence

Statistics suggest that violence within families is a frequent occurrence. The U. S. Department of Justice, Bureau of Justice Statistics (USDOJ, BJS) (1998) suggested that 95% of victims of domestic violence are women and that 2.1 million women are beaten every year. Statistics also suggest that one woman is beaten in her home every 15 seconds and 50,000 women were killed by their partners between 1980 and 1990 (USDOJ, BJS). These high rates of violence suggest that more research is needed to better understand the problem, improve treatment, and prevent abuse.

A study by Straus and Gelles (1986) estimated that violence occurs between 28% and 55% of heterosexual relationships. Strauss and Gelles (1988) conducted the 1985 National Family Violence Resurvey using a sample of 6,002 households and estimated

the prevalence of family violence for the United States. It was estimated that at least one out of six (16%) American couples experienced at least one incident of physical assault during 1985, with approximately 8.7 million couples in the United States experiencing at least one assault during the year. When considering husband-to-wife violence, approximately one out of eight husbands committed one or more violent acts during the year of the study. The Strauss and Gelles (1988) study indicated that the majority of assaults against women were minor such as pushing, slapping, shoving, or throwing things. However, about 39% of assaults were severe attacks such as kicking, punching, biting, and choking.

Gondolf (1998) examined the prevalence of battering behavior that occurs while the abuser is attending treatment. Based on follow-up questionnaires, a significant number of men (44%) admitted to re-assaulting their partners within the first three months of domestic violence treatment. The majority of re-assaulters (59%) admitted that they acted abusive more than once during treatment. The subjects identified as victims in the Gondolf study reported that assaults were typically psychological and verbal. About 70% of the men were verbally abusive, 45% used controlling tactics, and 16% stalked their partners.

Treatment of Male Abusers

A historical review reveals a past of varied messages to men concerning the tolerance of violence against women. The last three decades have been characterized by strict laws protecting the well being of women and an increase in research, theories, and treatment for abusive behavior. Some theories of domestic violence treatment for abusers will be reviewed. Finally, research on the outcome of this type of treatment is presented.

History

A historical look at the treatment of male spouse abusers reveals religious, social, cultural, political, and moral influences. Addressing the male abuser's aggression began as a religious and moral mission, but the responsibility and accountability for actions of violating human rights has been relieved from the abuser time and again. The examination of these historical patterns, may be important as these messages relate to current perpetrator's reluctance to change their behavior, and hence dropout of treatment. It may also be relevant to the underreporting of violence by victims of abuse.

As early as 1640, when the Puritans established their New World, the issue of domestic violence became a public concern (Pleck, 1987). Preventing a man from abusing his wife was based on the religious mission to uphold the values of a peaceful community. As good members of their society, Puritans watched over each other and became involved in each other's personal lives. At this time, there was a lack of absolute family privacy, but the Puritans believed that any acts of cruelty, violence, assaultive, or sinful behavior would threaten the protection provided by their God (Pleck, 1987). The religious mission discouraged family separation or divorce. Family members were advised to stay together and work out their problems. The male-dominated household was the norm; and anything else was a disgrace (Pleck, 1987).

Legislation against wife beating began in early colonial times. In the New England colonies of Massachusetts Bay, spouse abuse became illegal in 1641. The Massachusetts Colony Law Statutes wrote the "Body of Liberties of 1641": Every married woman shall be free from bodily correction or stripes by her husband unless it be in his own defense upon her assault (McCue, 1995). Puritan religious leaders shamed

wife beaters for their embarrassment to the community; and church courts began trying cases of spouse abuse and other cruelties of committed church members. The goal was to make the accused person confess, be forgiven by God, and return to the family to uphold a moral and peaceful life. Puritan laws served only as a guide to upholding moral principles; and since punishing the abuser threatened the stability of the family, it was seldom carried out (Caesar & Hamberger, 1989).

Wife beating became illegal according to Pilgrim's law in 1672 (Pleck, 1987). If found guilty, the abuser was punishable by a five-pound fine or a public whipping. In addition, if a woman was found to be beating her husband, it was also illegal and the court determined punishment. Abusers were punished in other ways as well. The public would seek out the abuser and punish him, like vigilantes, performing whippings and floggings (Pleck, 1987).

Divorce was rare in the Puritan community of Massachusetts. Between 1663 and 1682 there were only 4 complaints of wife beating; and from 1683 to 1702 there was only 1 complaint per decade (Pleck, 1987). One might assume that the rate of wife beatings had decreased. But according to McCue (1995), although wife beating was disapproved of, women still had to live with it; and consequently, it went unreported.

Later, family violence disappeared from the concern of society for many years. Society shifted focus to public crimes and violence that happened outside of the family. The Temperance movement of the 1840's focused on alcohol as the cause of violence that was occurring. Still, men were neither punished nor reformed for violence toward women, and laws that protected women from wife abuse were eliminated in many states

including North Carolina, Mississippi, Maryland, Alabama, and Massachusetts (Pleck, 1987).

The 1900's brought about the Progressive Era and the establishment of family and domestic relations courts. These courts were designed to deal specifically with cases of family violence, but often strongly encouraged women to be subservient and compliant (McCue, 1995). Psychiatry advanced as a profession in the 1920's and clinics began offering marriage counseling, yet frequently, only women attended because husbands were reluctant (Pleck, 1987).

It took societal fear of violent crime rates in 1960 to turn society's focus back to family violence. News reports of muggings, assaults, and murder brought fear to the public and encouraged action. The Anti-Rape Movement in the 1970's made victimization a visible reality to the public (McCue, 1995). Pleck (1987) noted that it is the emotional salience of victimization that keeps it in the social spotlight. Abused women began professing publicly that not only were they in danger on the street, but also 24-hours a day in their own homes.

As a result of the Women's Movement, from 1975 to 1977 media boosted awareness of wife beating through television, magazines, and movies. Depictions of a woman's bruised face on the cover of a magazine were often used to shock the public into paying attention (McCue, 1995). Female activists blamed the American culture's addiction to sex and violence for the ignorance about family violence (Pleck, 1987).

The public attention to this issue sparked the need for research and treatment for abusive behavior. More laws were established to protect women and mandate male batterers into treatment. This mandated treatment, for the first time in history, did not

allow men to be excused for their behavior. Research from the 1970's suggested that spouse abuse was rooted in sociocultural, political, and religious traditions (Hamberger & Lohr, 1989). The Cycle of Violence, a common topic in domestic violence treatment today, became known and understood by service providers.

The primary focus of domestic violence research on abusers in the 1970's was on treatment approaches. This research from the 1970's resulted in a number of different treatment approaches such as: the feminist approach, the cognitive-behavioral approach, the family systems approach, and integrative approaches. Like the field of psychology itself, no one paradigm is dominant.

Research and treatment for abusive behavior in the 1980's shifted focus toward individual characteristics and interpersonal styles of batterers. This research provided some understanding of the abuser and this understanding had an impact on treatment. For example, abusers were found to be typically possessive, controlling, impulsive, or compulsive (McCue, 1995). Abusers may also have difficulty in emotional closeness or non-sexual intimacy, feelings of inadequacy, lack of trust, fear of abandonment, feelings of vulnerability and insecurity, have few outside friends and have difficulty dealing with stress (Caesar & Hamberger, 1989).

As of 1980, protective orders became available in 27 states to legally bind a batterer from contact with his partner. This gave female victims relief and protection from further violence. In addition to the protective order, many men were ordered to attend counseling programs (Caesar & Hamberger, 1989).

A survey by Pirog-Good and Stets-Kealey (1985) estimated that there were about 89 domestic violence programs offering treatment for abusers in existence in the United

States between the Fall of 1984 and Spring of 1985. Roberts (1984) identified several treatment approaches and formats being used by surveying domestic violence counseling agencies. About 60% of those agencies surveyed used a group-counseling format, 25% used individual or couples counseling. Other formats used were self-help groups and peer counseling. Some of the most common topics discussed in counseling for abusers were communication skills, conflict resolution, cognitive-behavioral use of stress management and anger management, and relaxation and time-outs (Roberts, 1984). One of the most common treatment approaches being used is cognitive-behavioral. This is because of its strong base on empirically derived principles, which makes treatment evaluation easier (Caesar & Hamberger, 1989).

The most recent legislation to impact this issue is the Violence against Women Act in 1994. This act made wife beating a federal crime. Legislation also provided a grant initiative for the STOP program (services, training, officers, and prosecutors). This program assists law enforcement officers and prosecutors in the development of a response to this issue to improve the design, delivery, and coordination of services for domestic violence. Since 1995, more than $400 million dollars has been awarded to states and territories for law enforcement and victims' services.

Pleck (1987) noted the circular tendency for each generation to reject the previous generation's missions and concerns. This hindered growth for treatment, and the message to people involved in family violence situations was unclear. Women didn't know whether or not it was legal for their husbands to beat them. Until the 1970's, men were either punished or ignored for abusiveness, but not held responsible for dealing with their own emotional problems.

Theories

There are three main theories about domestic violence; they are Feminist, Family Systems, and Psychological. Each of these theories considers different causes for the problem and suggests different interventions. Currently, most treatment programs incorporate parts from each of the different theories in their practice (Healey, Smith, & O'Sullivan, 1998).

Feminist Theory.

The feminist approach is sometimes called the social problem model because it is based on the problems of the patriarchal organization of society. The assumption of this model is that men hold a dominant role in most social settings (Healey et al., 1998). According to the feminist approach, the problem is that a male-dominated society encourages gender inequality within homes. Gender inequality is related to domestic violence when men hold a position of entitlement, power, and control and use aggression to maintain their status of dominance with physical, verbal, and emotional abuse (Healey et al.).

The feminist approach to domestic violence focuses on changing beliefs and attitudes about gender roles. The goal is to build equality across genders, while supporting non-violence. A clinical setting using this approach may confront men about their use of power and control tactics against their partners. Men are encouraged to be more accountable and responsible, honest, trusting, and trustworthy.

Similar to the other theories that will be presented, the feminist approach has its strengths and weaknesses. According to Gondolf and Hanneken (1987), approximately

80% of domestic violence treatment programs draw from the feminist theory in their program approach. Some of the most commonly used techniques are sex-role re-education, self-esteem building, and a "stop the violence" focus (Gondolf & Hanneken). The feminist approach has been criticized as being too confrontive to men, driving them into isolation, guilt, and shame (Healey et al., 1998). Dutton (1994) criticized the Feminist approach for ignoring individual client factors through an overemphasis of the role of society on domestic violence issues.

Family Systems Theory.

Another theoretical approach to domestic violence is the family systems model. Family systems theorists typically use the term "family violence" to refer to abuse. The term "family violence" is used to describe patterns of wife abuse that occur within a family that may have existed in both husband and wife's family of origin (Geffner, Mantooth, Franks, & Rao, 1989). According to family systems theory, family violence is a result of lack of structure and destructive family interactions. The focus of treatment is on developing communication skills among all family members. Often, the treatment of choice is couples counseling with the goal of family preservation.

The advantage of this theory is that many clients favor the focus of family strengthening as opposed to separation (Geller & Wasserstrom, 1984). On the other hand, couples counseling in domestic violence cases could put both partners at risk for a violent outbreak due to what may be discussed in couples session. Another criticism of the family systems approach is that it indicates a shared blame for violence, which differs from the feminist and cognitive-behavioral models that maintain the victim's innocence (Healey et al., 1998).

Psychological Theory.

The Psychological theory of domestic violence is a broad category of approaches that focus on the individual's problems as they relate to domestic abuse. It encompasses psychological counseling theories such as psychodynamic and cognitive-behavioral approaches to domestic violence (Healey et al., 1998). The psychological perspective focuses on the underlying emotional problems of the individual that contribute to the abuse. Psychodynamic and cognitive-behavioral theories will be reviewed with regard to differences in interventions.

The psychodynamic approach focuses on abusive behavior as a result of deep-rooted problems within the individual that must be resolved (Healey et al., 1998). This approach involves uncovering unconscious issues and resolving them on a conscious level. It has been used in both individual and group format for battering treatment.

Psychodynamic group treatment has been shown to have high satisfaction and attendance rates (Healey et al., 1998). On the other hand, feminist theorists have criticized it because it lends itself to excusing abusive behavior (Adams, 1988). Adams argued against the psychodynamic approach because it undermines the batterer's ability to change the pattern of behavior.

Another psychological theory of domestic violence is the cognitive-behavioral approach. This approach assumes that an individual can change the way he or she thinks and behaves with training and skill building techniques. Cognitive-behavioral theory of domestic abuse attributes battering behavior to learned inappropriate responses through either modeling or reinforcement (Healey et al., 1998). The focus of the cognitive-behavioral approach is on improving behavior, which may be accomplished by first

identifying the chain of events that lead to battering behavior. Therapy typically focuses on teaching conflict resolution skills, relaxation techniques, and effective communication (Hamberger & Lohr, 1989).

There are a few advantages of the cognitive-behavioral approach. First, the batterer is held entirely responsible for their behavior. Secondly, this approach is conducive to brief therapy. Finally, it is simplistic in that the present behavior is the focus of treatment rather than possible underlying childhood trauma. This simplicity is also a possible criticism because the client's history or culture could be ignored.

Outcome and Recidivism

The outcome of domestic violence treatment is particularly important due to the consequences for nonsuccess of treatment. The majority of outcome studies for domestic violence treatment have found inconclusive results (Davis & Taylor, 1997). Methodological errors such as sampling problems and short follow-up periods (concerning what happens to clients after they leave treatment) have hindered these studies from obtaining significant findings. It should also be noted that studies of recidivism rates have been limited by the degree to which domestic violence incidents are reported. It is estimated that as many as half of all violent incidents go unreported (USDOJ, BJS, 1998). However, some studies have found significant results and will be reviewed.

In 1997, Dutton et al. conducted a follow-up study of 446 domestic violence clients. Criminal records were obtained on the subjects to investigate rates of recidivism after leaving treatment. Subjects were categorized as treatment completers (those who

attended at least 12 out of 16 sessions) or non-completers (those who attended less than 12 sessions). Subjects were also grouped according to their referral sources, which were voluntary or court mandated. Dutton et al. found that voluntary treatment completers were the least likely to recommit assault. Treatment completers regardless of referral source were less likely to commit violent crimes and assaults following treatment when compared to non-completers. Finally, non-completers that were voluntarily attending sessions were actually more likely to recommit offenses in comparison to the court-mandated non-completers.

Previous studies by Dutton (1986) indicated that approximately 96% of abusers who attend treatment for abuse would not recommit violent assaults. On the other hand, about 60% of untreated abusers also will not recommit violence. In a similar finding, Chen, Bersani, Myers, and Denton (1989) reported that about 95% of abusers who attended treatment would halt their violent behavior. The results from the control group in this study suggested more favorable outcomes for abusers who did not attend treatment. Chen et al. reported that 90% of those left untreated would improve their behavior regardless. In a 1996 study by Dobash, Dobash, Cavanaugh, and Lewis, 93% of treatment completers and 90% of untreated men did not recommit violent assaults.

Gondolf (1998) took a different approach to previous studies investigating domestic violence treatment outcome and compared four domestic violence treatment sites on effectiveness across differing approaches and treatment lengths. This study examined a sample of 210 men from each of the four sites for a total sample of 840 subjects. Results suggested that domestic violence programs do reduce the number of re-assaults, and even more likely, reduce re-arrests for violence. No differences were found

between treatment programs, which suggested no one type of treatment program is superior to another. The recidivism rate for subjects indicated that 39% of the men in treatment re-assaulted their partner (according to police and partner reports). This suggests that 61% of the men who attended treatment would not re-commit violence, which is less optimistic than results from previously mentioned studies. Gondolf's study was limited by the lack of a control group and a short follow-up period (15 months).

The Dropout Problem in General

Client dropout is a common problem recognized in the field of psychotherapy (Garfield, 1986). The focus of many studies has been on identifying characteristics of clients who are at risk for dropping out. Fiester & Rudestam (1975) suggested that no clear profile would be found for dropouts. Instead, only patterns of characteristics with confounding interactions would be detected. Thus, it is unlikely that dropouts will be completely different from non-dropouts in therapy. Fiester and Rudestam performed a multivariate analysis of dropout by clients while considering the context of the treatment facility. A sample was gathered of 120 adult clients from a general-hospital-based community mental health center and 61 from a state supported outpatient mental health clinic. Therapists involved in the study were from a variety of professional backgrounds such as medicine, ministry, and psychology. Before the study, the following information was gathered on therapists: age, sex, profession, experience in years, personal therapy, education, and occupational level of family of origin. Upon the first session, data was obtained from each client concerning the following: demographics, previous clinic contact, previous care elsewhere, chronicity of the problem, present state of adjustment, extent of family support for seeking help, and pre-therapy expectations. Questions

concerning pre-therapy expectations included the following: number of sessions expected to attend, general orientation to the therapist (doctor, minister, teacher, or friend), anticipated role of therapist, anticipated satisfaction, and goals for therapy. The purpose of the study was to investigate the interaction among variables classified as patient's input (demographic and pre-therapy expectations), therapist's input (demographic), and the patient's perception of the therapy process as the patient related to the dropout process. After the client's first session, they were again asked about their therapy expectations and completed the Orlinski and Howard Therapy Session Report (1966).

Seventy-one of the total 181 subjects sampled prematurely terminated (defined as discontinuation of therapy without the advisement of a therapist) and were classified as dropouts. Qualitative differences were found between dropouts and non-dropouts. Dropouts reported more often that their therapist was more helpful, that they talked less to their therapist about attitudes and feelings, felt angrier during the session, felt more attentive to what the therapist was saying, and saw the therapist as being more affectionate, involved, and serious in the session. In summary, this study suggests that dropout from therapy is indicative of interactions among a number of variables rather than easily defined characteristics.

Richmond (1992) added to the research on client dropout by controlling for the level of experience and theoretical approach of therapists. A relatively large sample of 624 clients was obtained from a mental health clinic setting. The therapist participants were 85 pre-doctoral interns working within an insight-oriented dynamic therapy model. The purpose of the study was to demonstrate differences between dropout and non-dropouts across three phases of therapy: intake, evaluation, and therapy. A therapist

completed an intake file on each client that included the Brief Psychiatric Rating Scale (Overall & Gorham, 1962), a measure of 18 psychiatric symptoms in a 7-point Likert-type format. Clients were grouped according to four possible outcomes: dropped out after first session; completed the three-session evaluation process, but did not begin therapy; terminated therapy; or completed therapy. As compared to clients who completed therapy, clients who dropped out at intake were less likely to have a personality disorder diagnosis, and/or drug abuse as the primary complaint. Clients who dropped out during the evaluation phase were more likely to exhibit external problem behaviors such as domestic violence when compared to clients who completed therapy. Clients who dropped out during the therapy phase were more likely to have a personality disorder diagnosis and more likely to have external problems such as domestic violence when compared to clients who completed therapy. Common variables associated with dropout were lower levels of guilt feelings, lower level of education, being more tense and suspicious, being a member of a minority group, having domestic violence problems, and drug and alcohol abuse problems. It should be recalled however, that these variables were measurements of the therapists' perceptions of clients. This study suggested that there are differences in client dropout associated with the phases of treatment.

Psychotherapy formats such as group treatment lends itself to ease of investigation due to the large number of subjects that can be gathered at once. Consequently, many researchers have investigated the characteristics of dropout clients who attend group counseling. Dropout from a variety of group treatment settings will be reviewed.

Hunt and Andrews (1992) studied the problem of client dropout in a group format and found relatively small rates of dropout. Data was gathered from a specialized treatment facility for anxiety disorders over a three-year period. The purpose of the study was to determine when clients typically dropped out of a cognitive-behavioral treatment program for anxiety disorders. In their study, all clients were referred by a general practitioner for treatment of anxiety disorders such as panic disorder, agoraphobia, social phobia, or generalized anxiety disorder. Clients were scheduled for an initial screening session to determine whether they met the severity criteria for treatment. Next, the clients were required to attend an intake session before beginning the program. Finally, the clients began the treatment group, which focused on their particular type of anxiety disorder. Attendance at the intake interview and all counseling sessions was recorded for all clients. Clients were then tracked to determine how many remained in treatment at several points in time. Persistence was tracked at the pre-treatment intake, the first day of treatment, the end of the first week of treatment, the first day of the second week, and the last day of treatment. The results indicated that 17% of patients who began the treatment for anxiety disorders did not complete the treatment. Hunt and Andrews suggest this low number of dropouts may be attributable to the motivation shown by the client to seek treatment after a referral from their general practitioner and the highly structured, time-limited treatment approach.

Dropout research with other group populations has suggested higher rates of dropout in comparison to the study by Hunt and Andrews (1992). Chaffin (1992) investigated factors that were associated with dropout of a two-year program for intrafamilial sexual offenders. Thirty-six subjects were tracked from intake to dismissal

from therapy. The author noted that none of the subjects attended treatment without persuasion from some significant member of their lives. Treatment consisted of open, informal group treatment for a minimum of two years to be considered as a completer. Instruments used were the MMPI, stress level index, and a substance abuse potential measure. Results from the study indicated a higher rate of personality-disturbed subjects among the non-completers. No differentiation was made between court-referred and non-court referred subjects; therefore, it could not be determined if legal consequences contributed to the completion rate of subjects.

Atkinson and Fischer (1996) performed another study of dropouts from codependency group therapy. This study tested two hypotheses that had been supported in previous literature concerning group attendance. The first hypothesis tested factors associated with aiding group attendance such as: professional (child protective services or criminal justice system), family and friend's encouragement, stressors, external locus of control, positive perceptions, and propensity for self-disclosure. The second hypothesis tested factors that were thought to hinder group attendance such as denial of and resistance to change and availability of and ability to attend groups. Participants consisted of 68 women under the age of 65 and had a codependency score on the Spann-Fischer Codependency Scale (Fischer, Spann, & Crawford, 1991) higher than 60, which were comparably high scores (Atkinson & Fischer). The sample was divided into two groups. The groups were attenders (those who had attended a support group in the last year) and non-attenders (those who had not attended a support group in the previous year). Results indicated that people who attend support groups had more encouragement from professionals and family, a greater number of deaths in the family, greater difficulty with

careers, more emotional discomfort, more difficulty with interpersonal relationships, greater recognition of addictions, a greater number of family members with addictions, and a greater level of self-disclosure. Results also supported factors that were believed to hinder group attendance. Non-attenders denied the existence of a serious problem more often than those attending groups did. This study's limitations included a small sample of convenience, which may hinder generalizability, and high scores of codependency may have confounded the self-report responses from subjects.

Although much information has been gathered on dropout clients in general, few have focused specifically on the mental health clinic setting. Fiester, Mahrer, Giambra, and Ormiston (1974) completed a study utilizing a relatively large sample size at a mental health clinic in Illinois. Archival data was collected on 618 subjects including information on the following: sex, age, religion, education level, closeness of residence in reference to the clinic, marital status, employment level, income, previous clinic contact, previous psychiatric care at other facilities, source of referral, presenting problem, psychiatric diagnosis, and recommendation for further treatment. Results of the study indicated that no differences existed between clients who completed therapy as opposed those who prematurely terminated. The only difference found was that therapists typically recommended further treatment for clients that dropped out of therapy.

Some studies have focused on the pre-treatment dropouts of therapy. These clients schedule an intake appointment and then fail to attend that interview, thus terminating treatment. Studies investigating pre-treatment dropout have a common assumption that treatment begins with the scheduling of services.

Orne and Boswell (1991) investigated pre-treatment dropout from a mental health center. Subjects were 721 individuals scheduling an intake at one mental health center. The study considered the following variables: patient's age, gender, marital status, parental status, previous mental health care, pairing of patient and interviewer in gender, and number of days from scheduling to actual intake day. Significant relationships were found between number of days between intake and tendency to dropout, but a clear inverse relationship was not indicated. Some individuals with a relatively long wait (10 days) dropped out less than subjects with medium waits (4-9 days). Subjects with short waits (0-3 days) dropped out the least in comparison to subjects with medium or long waits until their intake appointment. No significant relationships were found when considering gender of patient, the interviewer's gender, or the matching of patient to interviewer in gender. Previous mental health treatment also showed no significant relationship with the dropout rate.

Another study that considered pre-treatment dropouts was performed by Kolb et al. (1985). Ninety-one subjects participated in the study, which required them to complete both pre-treatment and post-treatment assessments. The pre-treatment assessments used were the Internal-External Locus of Control Scale (Rotter, 1966) and the Eysenck Personality Inventory (Eysenck & Eysenck, 1968). After completion of psychotherapy or immediately upon premature termination, subjects were asked to complete the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1972), the Psychotherapy Process Inventory (Baer, Dunbar, Hamilton, & Beutler, 1980), and the Personal Evaluation (Beutler & Crago, 1983). Post-treatment data was obtained on only 55 of the total 91 subjects, 13 of the 24 dropout subjects were included in this group of 55. In addition to

assessments completed by the clients, data was also gathered from therapists in reference to the subjects of the study. Therapists completed discharge summaries that were similar to the Personal Evaluation that each client completes and a Global Severity Index of the SCL-90R (Derogatis, Rickels, & Rock, 1976). One-way analysis of variance revealed pre-therapy variables already differentiated clients who completed therapy as opposed to dropouts. Clients who dropped out reported higher levels of expected internal locus of control in interpersonal relationships. Post-treatment assessments also revealed differences between dropouts and treatment completers. Dropouts rated their therapists as having fewer facilitative relationship skills. Therapists rated dropouts as having been less involved in therapy and having received less directive support than clients who completed treatment have. Similar to previous findings by Fiester and Rudestam in 1975, which suggested that a therapist will recommend further treatment for dropouts, therapists in this study rated those who remained in therapy as having made more positive changes than those clients who dropped out.

Reiher, Romans, Andersen, and Culha (1992) replicated previous studies considering dropout of clients following intake but prior to therapy and extended the finding to investigate gender differences. This study gathered 488 subjects who were seen for intake and referred for counseling services. Data was also recorded concerning the gender pairing of clients with counselors. This study reported that 16% of subjects did not return for the first scheduled counseling appointment. Comparisons of gender pairing showed that male counselors more often referred clients to another male counselor regardless of client gender. In addition, female counselors more often referred clients to another female counselor regardless of client gender.

Dropout in Domestic Violence Treatment

Overall, studies suggest that completion of domestic violence treatment may be associated with less of a risk for subsequent abusive behavior. Consequently, the dropout rate within this treatment setting is important. Some characteristics of dropouts from domestic violence treatment have been identified and will be reviewed.

Pirog-Good and Stets-Kealey (1985) investigated clients who drop out of abuser treatment programs. This study consisted of a national survey of treatment programs for batterers. The results suggested that 60 out of every 100 men who enrolled for treatment would eventually complete the program. Out of those 60 completers that 42 to 53 (70% to 80%) of them will not batter again, based on follow-up arrest rates (Pirog-Good & Stets-Kealey, 1985). In addition, a follow-up study was performed with subjects who dropped out of treatment. Subjects who dropped out reported the following: lack of motivation or loss of interest (18%), the wife left (17%), the wife returned (17%), the client had problems following treatment format (11%), and client denied his violence (8%).

In 1997, Dutton et al. monitored 446 men requesting counseling at a domestic violence program in Canada. This follow-up study investigated the differences between clients who completed treatment and clients who did not complete treatment based on criminal records. The length of the follow-up period for each subject was determined by subtracting the date of the subject's last session from the date the criminal record was examined. Length of client follow-up times ranged from four months to 11 years with the average being 5.2 years. Subjects were categorized as treatment completers if they attended at least 12 out of 16 sessions. Non-completers were clients who attended less than 12 sessions. Subjects were also grouped according to their referral sources, which

was either voluntary or court mandated. Significant differences were found between treatment completers and non-completers. This study found that treatment completers tended to be more educated, more likely to have full-time employment, and were more likely to be in a relationship. Completers also had lower rates of prior criminal offenses, violent crimes, and assaults than non-completers did. More importantly, it was found that treatment completers were less likely to commit violent crimes and assaults following treatment. Overall, members of the group that were identified as voluntary treatment completers were least likely to recommit assault.

Domestic violence issues have been found to be associated with a number of other variables associated with high risk for client dropout (Richmond, 1992), yet few researchers have examined characteristics of dropouts from domestic violence treatment centers. Hamberger and Hastings (1989) performed a study to identify the characteristics of treatment completers and non-completers of male spouse abuse programs. They examined 156 men who presented for cognitive behavioral treatment for domestic violence. Forty of the men voluntarily appeared for treatment, while 116 were obligated as part of a criminal court sentencing. Treatment consisted of three intake/assessment sessions, followed by 12 group-counseling sessions, and finally a post-intervention evaluation. Information was gathered from these individuals concerning their criminal activities prior to treatment along with other demographic data such as age and education level. In addition, each participant was given the Millon Clinical Multiaxial Inventory (1983), which measures personality characteristics and may indicate a personality disorder.

The subjects were divided into two groups. The first group, called completers, had attended the intake session and all counseling sessions. The non-completers were those men who attended at least one intake session but did not complete the recommended 12 counseling sessions. The results of the study indicated that dropouts were typically younger clients with lower education levels, and higher rates of criminal activity prior to treatment. The personality characteristics typically seen in dropout clients indicated more borderline and schizoidal type tendencies in comparison to the completer clients.

Faulkner et al. (1991) identified some characteristics of treatment completers and non-completers in a domestic violence service setting. This study examined both men and women in the counseling program. Unfortunately, only a small number of subjects were sampled, 34 men and 40 women. Data was collected through a pretreatment interview, the use of the Male/Female Relations Inventory (Spence, 1980) and the Millon Clinical Multiaxial Inventory (1983). Following the intake procedure, clients entered a four-week treatment program that involved sessions lasting two hours long and meeting twice a week.

Using the data collected at the initial intake, subjects who completed the program (two-hour sessions twice a week for eight weeks) were compared to those who dropped out. Faulkner et al. (1991) found no differences in completers vs. non-completers in age, ethnicity, marital status, or education for both the men and women. This was contradictory to results found by Pirog-Good and Stets (1986) with a domestic violence treatment sample. Blue-collar workers or people who were unemployed were least likely to complete treatment and Caucasians were less than likely than people of color to complete treatment (Pirog-Good & Stets, 1986). According to Faulkner et al. (1991), men

who completed the program had higher scores on the Millon Clinical Multiaxial Inventory (Millon, 1983) for drug and alcohol abuse. The men who were court mandated for treatment completed the program more often than did men who appeared voluntarily.

Similar to the studies that investigated the interactions of variables that may contribute to attendance in therapy (Fiester and Rudestam, 1975), Pirog-Good and Stets (1986) explored the characteristics of domestic violence programs associated with high completion rates of clients. Pirog-Good and Stets used data from a national survey sent to battering prevention programs. The purpose of the survey was to collect information on program and client characteristics and client completion rates. A total of 59 (out of estimated 89) battering prevention programs responded to the survey. The results of the survey found that agencies with the highest rates of completion had the following characteristics: a short participation program, likely or very likely referrals from police, judges, and district attorneys, and no required client fees. This suggests that coordination with the court system, reducing or eliminating client fees, and shortening treatment programs will raise completion rates (Pirog-Good & Stets).

Court-Referred and Self-Referred Clients

Few researchers have investigated differences between clients who are court mandated to attend domestic violence treatment and those that attend treatment voluntarily. Researchers who have differentiated the groups have found conflicting findings about demographic characteristics of these batterers. Previous studies have also examined the variables such as beliefs, psychological disorders, locus of control, and conflict tactics skills by referral source. Studies relating referral source to dropout from

domestic violence treatment were unavailable for this study.

Hall, Romans, and Duplantis (1998) compared 183 court-referred men with 53 non-court-referred men who abused their wives. Results indicated that court-referred abusers scored lower on self-reported levels of abuse, on beliefs that help should be given to victims, and the beliefs that the offender is responsible for the abuse in comparison to non-court-referred abusers. Court-referred abusers scored higher than non-court-referred abusers did on the belief that the wife gains from abuse and that wife beating is justified. This suggests that court-referred abusers hold more beliefs associated with denial of problematic behavior.

Barrera et al. (1994) identified differences in demographic data between court-referred and non-court-referred men in an abuser's treatment program. A comparison was performed using 86 court mandated clients and 42 voluntary clients. This study reported that voluntary clients were more educated, more likely to have a full time job, had greater income, and had more social support, but reported more interpersonal problems. Court-referred men were typically separated from their spouse, more often reported substance abuse during the most recent assault, and showed high rates of denial and social introversion.

In contrast, Dutton and Starzomski (1994) found no significant difference between court-referred clients and non-court-referred clients on demographic variables. This comparison of 38 court-referred and 40 voluntary clients used a small sample but gathered a more equal number of subjects in each comparison group than previous researchers in this area. Contrary to findings by Barrera et al. (1994), age, education, alcohol use, ethnicity, and occupational status indicated no differences between groups.

Dutton and Starzomski found men who attended treatment voluntarily showed signs of greater symptomology on borderline personality organization, marital conflict, anger, depression, frequency of use of verbal abuse, and trauma symptoms associated with childhood sexual abuse (dissociation, anxiety, depression, and sleep disturbance) as compared to men who were court ordered to treatment.

An earlier study by Dutton (1986) also found no differences between court-referred and non-court-referred domestic violence treatment subjects on demographic variables, frequency of assaults, and severity of assaults. However, differences were found on scores of conflict tactics and locus of control. Court-referred clients were more likely to indicate an external locus of control by attributing the assault to outside factors such as situation or victim factors as compared to voluntary male clients who indicated more internal locus of control characteristics.

Court-Referred and Self-Referred Client Dropout

Several studies have noted that court-referral may be associated with treatment attendance, but findings from researchers are contradictory concerning court-referral as a predictor of treatment completion. In a study by Grusznski and Carrillo (1988) concerning who completes battering treatment programs, results suggested that court referral was not associated with treatment completion. In contrast, Hamberger and Hastings (1989) found that court mandated clients completed treatment more often than self-referred clients did. It is important to note, however, that one-third of the court-mandated subjects in the Hamberger and Hastings study still dropped out.

Some domestic violence treatment centers use the legal consequences of non-compliance to encourage their clients to continue treatment. Gondolf (1998) investigated a treatment site that used court appointed liaisons for better communication between the treatment setting and the court system. The court liaison simply reports to the court if a referred man does not attend a scheduled appointment, which results in a warrant for arrest. Results indicated a dramatic decrease in the number of no shows and dropouts from the program. This suggests that consequences for noncompliance may affect attendance rates.

Alcoholism and Partner Abusiveness

Research on alcoholism suggests a relationship between alcoholism and the incidence of domestic violence. Although alcohol use is not a predictor for abusive behavior, treatment programs have focused on alleviating the negative effects of substance abuse on relationships by focusing on abstinence from alcohol and drugs (Geffner & Rosenbaum, 1990).

Russell et al. (1989) studied 42 couples that reported marital distress at intake for services at a family-counseling agency. Subjects were grouped into couples who used violence during marital conflict (n=32) and couples who did not resort to violence during conflict (n=10). Alcohol use was reported as a problem by 42% of the violent males and by none of the non-violent men.

Kantor and Straus (1987) obtained a nationally representative sample of 5,159 families. The purpose of the study was to explore the relationship between alcohol consumption, occupational status, approval of violence, and wife abuse. Subjects were interviewed using measures of drinking severity, conflict tactics, and occupational status.

The questions, "Are there situations that you can imagine in which you would approve of a husband slapping his wife?" and "Were you drinking at the time the violence occurred?" were also asked. Results of the study suggested a linear association between drinking and wife abuse. In addition, non-drinkers (7%), moderate drinkers (11-14%), and binge drinkers (19%) indicated a substantial amount of wife abuse. In contradiction to other researchers' findings, Kantor and Straus added that 76% of abusers reported they were not under the influence of alcohol during the incident.

A longitudinal study by Heyman, O'Leary, and Jouriles (1995) investigated alcoholism risk, marital adjustment, and conflict tactics, and personality variables among 272 couples over 30 months of marriage. The Michigan Alcohol Screening Test (Selzer, 1971) was used in addition to other assessments relevant to the study. Findings suggested a significant relationship between husbands' problem drinking and serious husband-to-wife aggression before the marriage and at six months after marriage. At 18 months of marriage, problem drinking was not related to aggression. At 30 months of marriage, problem drinking, total consumption of alcohol, and aggressive personality traits were not related to serious husband-to-wife aggression. This suggests a lessening of the relationship between alcohol and husband-to-wife aggression over time. Most importantly, the group categorized as aggressive prior to marriage continued serious husband-to-wife abuse over the 30-month period, regardless of their alcohol consumption.

Alcoholism and Client Dropout

Several studies have addressed the impact of substance abuse on attendance in general from psychotherapy. Fewer studies have linked substance abuse to dropout from

domestic violence treatment. Overall, the majority of these studies have indicated a connection between substance abuse and attrition.

In a study by DeMaris and Jackson (1987), characteristics of dropouts from domestic violence treatment were examined. In addition to lower income, a prior history of legal problems, and low motivation, men who admitted to having problems due to alcohol use were more likely to dropout of the program.

The Faulkner et al. (1991) study resulted in some interesting findings concerning drug and alcohol abuse of treatment completers and non-completers in a domestic violence service setting. The study found that individuals with significant drug abuse scores on the Millon Clinical Multiaxial Inventory (Millon, 1983) are more likely to drop out of treatment than individuals with lower scores. Faulkner et al. reported that the factor of alcohol abuse approached but did not attain significance for predicting dropout.

Richmond (1992) studied the impact of substance abuse on attrition from general psychotherapy. This study reported that drug and alcohol abuse was a good indicator of client dropout. Similarly, MacNair and Corazzini (1994) found alcohol and drug problems to be a significant predictor of client dropout from an open-ended university group-counseling program.

Dropouts from treatment are a serious concern in substance abuse counseling (Siegal, Fischer, Rapp, Wagner, Forney, & Callejo, 1995). Studies that have investigated the rates of dropout in clients with substance abuse issues have found similar results. In comparison to the majority of studies about clients who terminate counseling early in general, the rates appear similar.

The rates of dropout from substance abuse treatment appear to be similar to general psychotherapy dropout. Baekeland and Lundwall (1975) found that 52 to 75% of substance abusers dropout of treatment before their fourth session and 82% drop out within four months of long-term residential programs. Craig (1985) found support for this high attrition rate in a Veterans Hospital setting for substance abuse treatment. Craig reports the dropout rate as generally about 50% but often was as high as 70%. Agosti, Nunes, & Ocepeck-Welikson (1996) reported a 55% dropout rate in an outpatient cocaine abuse treatment facility.

Self-Esteem and Partner Abusiveness

Self-esteem has been linked to partner abusiveness is several studies. Russell et al. (1989) conducted a study using the Hudson Index of Self-Esteem (1982). This study used a sample of 42 couples that reported marital distress in their application for services at a family-counseling agency. The sample was divided for comparison into couples who used violence during marital conflict and couples who did not resort to violence during conflict. Results of the study suggested that the groups did not differ significantly on level of self-esteem. Further, the self-esteem scores suggested that most of the couples selected for the sample had significantly low self-esteem.

Prince and Arias (1994) related self-esteem to partner abusiveness. Similar to the study by Russell et al. a comparison was performed between abusive and non-abusive subjects. The participants in the Prince and Arias study were 47 non-abusive men recruited through community announcements and 25 abusive men recruited from a court mandated batterers group. The purpose of the study was to examine the relationship

between domestic violence and the abuser's desired and perceived control over events in their own life.

Subjects completed the questionnaires assessing self-esteem, desirability of control, and perceived personal and interpersonal control. The results indicated a significant three-way interaction among desirability of control, perceived personal control, and self-esteem. Comparisons of abusive and non-abusive men on the above mentioned measures suggested two subgroups were at high risk of abusive behavior. The subgroups identified as high risk for abusiveness were: men low on self-esteem, low on desirability of control, and low on perceived control and men high on self-esteem, high on desirability of control, and low on perceived control. These complicated findings of the study suggest a mixed relationship between self-esteem and abusiveness.

Rouse (1984) studied 79 men who responded to a mailed questionnaire packet. The men were questioned about their abusive behavior, childhood exposure to violent models, current level of self-esteem, and locus of control. Some of the subjects (n=55) also completed a questionnaire concerning conflict tactics. The results revealed a relationship between low self-esteem and abusive behavior that did not reach statistical significance. Higher self-esteem was associated with greater perceived impulse control, greater sense of personal self-efficacy, less attribution to luck, and less sense of fatalism. In this study self-esteem was highly correlated with the locus of control indexes.

Self-Esteem and Dropout

Very little research has examined the relationship of client's level of self-esteem and dropout from counseling programs. One study was found to examine the self-esteem of career counseling participants and their attendance at a career development workshop.

Robbins, Mullison, Boggs, Riedesel, and Jacobsen (1984) investigated the differences between 130 subjects who attended the workshop and 56 subjects who did not attend. A follow-up interview was performed with subjects who did not attend the workshop to determine reasons for non-attendance. These reasons provided the following three categories for non-attenders: "forgot or felt discouraged", "had scheduling problems", and "believed they had already met their goal". Comparisons were made across the different categories of subjects based on an interest inventory and a checklist of values and abilities, including questions regarding self-esteem. All participants completed these measures during registration for the workshop. Results indicated that the "forgot or was discouraged group" had lower self-esteem and participated in fewer information seeking activities. Non-attenders who "believed they had already attained their goals" had higher self-esteem, higher ratings of career decidedness, participated in more information seeking behaviors, and had a higher academic orientation.

Locus of Control and Partner Abusiveness

Studies that examined locus of control in relation to abusiveness suggested mixed findings. The previously mentioned study by Rouse (1984) examined the locus of control of men in addition to their abusive behavior, childhood exposure to violent models, and current level of self-esteem. The relationship that was found between external locus of control and abusive behavior did not reach statistical significance. Rouse suggested that external locus of control is not a strong predictor of abusive behavior.

In support of the findings by Rouse (1984), the study by Dutton (1986) suggested that locus of control cannot predict abusive behavior but may be used to differentiate abusers. Both external and internal locus of control was exhibited in this study of abusive

men. Results indicated significant differences on locus of control between court-referred and non-court-referred men attending domestic violence treatment. Subjects who were court mandated to attend treatment typically attributed the cause of their violence to outside factors. This study suggested that court-referred batterers display an external locus of control more often than non-court-referred batterers do. In contrast, Hall et al. (1998) found no differences between court-referred batterer and than non-court-referred batterers on locus of control.

Rynerson and Fishel (1993) performed a pre-treatment/post-treatment study to identify changes in locus of control and relationship satisfaction among male and female participants of a domestic violence prevention program. A sample of 149 subjects completed the Nowicki-Strickland Locus of Control Scale (Nowicki & Duke, 1973) and the Dyadic Adjustment Scale (Spanier, 1976). There were no significant differences between male and female subjects on locus of control. Scores consistently indicated an external locus of control for the sample. The hypothesis that participants would demonstrate less of an external locus of control following treatment was supported.

Locus of Control and Dropout

Kolb et al. (1985) studied 69 subjects at a university affiliated outpatient psychiatry clinic. Twenty-four subjects dropped out of treatment without the consent of their therapist. Subjects were examined on the Internal-External Locus of Control Scale (Rotter, 1966) and a number of other assessments relevant to the study. Clients who dropped out reported higher levels of expected internal locus of control in interpersonal relationships in comparison to clients who remained in treatment.

Boggs (1984) investigated 114 clients at an alcoholism treatment facility. Eighty-five subjects completed their treatment and 25 dropped out. Participants completed the Internal-External Locus of Control Scale (Rotter, 1966) and a drinking-related locus of control questionnaire, in addition to a self-concept scale. This study indicated a complicated interaction of internal locus of control, age, sex, education, number of times in treatment, and dropout from therapy suggesting that the each of these variables are dependent on the context of the other variables.

Payne (1981) explored the effects of pretreatment orientation on client's anxiety and internal or external locus of control. The sample of 64 females and 40 males was obtained at a university-counseling center and randomly assigned to one of two pretreatment groups or a control group. All subjects completed an anxiety scale and the Internal-External Locus of Control Scale (Rotter, 1966) with those subjects attending an orientation completing it immediately after that meeting. Results indicated that pretreatment did not have an effect on the client's locus of control or their attendance in counseling.

O'Leary, Rohsenow, and Donovan (1976) investigated the relationship of locus of control with drop out of an alcoholism treatment program. This study found no differences in locus of control among men who dropped out after two weeks, dropped out between two weeks and 60 days, and those who completed the 60-day program. Results did indicate that subjects who completed the 60-day program but dropped out of aftercare within the next year exhibited more internal locus of control than subjects who did not drop out of aftercare.

Beliefs about Wife Beating and Partner Abusiveness

Saunders et al. (1987) reported that violent men who were being treated for abusive behavior were more likely to believe that violence is appropriate in a marital relationship. In 1992 a study was performed by Saunders utilizing the Inventory of Beliefs About Wife Beating. A sample of 165 men completed assessments prior to treatment for abusive behavior. Through cluster analysis, three types of batterers were identified: family-only aggressors, generalized aggressors, and emotionally volatile aggressors. Results indicated that batterers who were violent only with family members had the most liberal attitudes toward women. Generally violent men had the most rigid/conservative attitudes of the sample. Men who were identified as emotionally volatile batterers had relatively conservative sex role attitudes.

Hall et al. (1998) used the Inventory of Beliefs about Wife Beating in a comparison study of court-referred and non-court-referred abusers. Results indicated that court-referred abusers scored lower on beliefs that help should be given to victims, and the beliefs that the offender is responsible for the abuse than did non-court-referred abusers. Court-referred abusers scored higher than non-court-referred abusers did on the belief that the wife gains from abuse and that wife beating is justified.

Similarly, Shields, McCall, and Hanneke (1988) categorized batterers into three groups of abusers: family only, non-family only, and generally violent. This study found that generally violent men had positive attitudes toward violence and believed that it was justified. Family only batterers were the least likely to have positive attitudes toward violence or believe that it is justified.

Kristiansen and Giuletti (1990) examined the effects of gender, attitudes toward

women, and beliefs in a just world in relation to perceptions and attributions of a hypothetical incidence of wife abuse. A sample of 157 university students completed The Attitudes Toward Women Scale (Spence, Helmreich, and Stapp, 1973), a measure of belief in a just world (BJW) and a questionnaire about perceptions and attributions regarding the perpetrator and victim of an instance of wife abuse. Results indicated that male subjects with less favorable attitudes about women blamed and derogated the female in the wife abuse scenario more often than did male subjects with positive attitudes about women.

Beliefs about Wife Beating and Dropout

A review of the literature revealed no studies investigating the relationship between beliefs about wife beating and dropout from therapy. Beliefs about wife beating has been limited to physical violence and sex-role research, which limits the number of studies that may have investigated its relationship to dropout. This suggests that this investigation will contribute to the literature in this area.

Summary

A review of the literature suggests that domestic violence treatment persistence is an important issue for investigation. Historically, abusers have received mixed messages concerning the tolerance and legal implications of violence against women. Three main theories about domestic violence have been developed: Feminist, Family Systems, and Psychological. Each of these theories suggested different origins of domestic violence and suggested different interventions.

Pirog-Good and Stets (1986) estimated 40% of men who enter counseling programs for abusive behavior never complete the program. An outcome study by Gondolf (1998) suggested that domestic violence programs do reduce the number of re-assaults and even more likely reduce re-arrests for violence. These findings suggest the importance of research on dropout from domestic violence treatment.

The few researchers that have differentiated between court-referred and non-court-referred clients have found conflicting results. Dutton and Starzomski (1994) found no significant difference between court-referred clients and non-court-referred clients on demographic variables. In contrast, Barrera et al. (1994) found that court-referred men were more likely to be separated from their spouse, more often reported substance abuse during the most recent assault, and showed higher rates of denial and social introversion than non-court-referred men.

Research on alcoholism suggests a relationship between alcoholism and the incidence of domestic violence. Russell et al. (1989) reported that alcohol use was a problem by 42% of violent males and by none of the non-violent men. DeMaris and Jackson (1987) stated that men who admitted to having problems due to alcohol use were more likely to dropout of the program. Richmond (1992) and MacNair and Corazzini (1994) reported that drug and alcohol abuse was a good predictor of client dropout.

The relationship between self-esteem and partner abusiveness is mixed. Russell et al. (1989) found that most of the marital distressed couples selected for the sample had significantly low self-esteem scores. A study by Prince and Arias (1994) indicated a significant three-way interaction among desirability of control, perceived personal control, and self-esteem.

Studies concerning locus of control and abusive behavior are conflicting. Kolb et al. (1985) found that clients who dropped out reported higher levels of expected internal locus of control in interpersonal relationships. On the other hand, Rouse suggests that external locus of control may be more associated with abuse but is not a strong predictor of abusive behavior. Saunders et al. (1987) reported that violent men were more likely to believe that violence is appropriate in a marital relationship.

The limited research concerning dropout of domestic violence clients has led to the following research questions:

1. Is there a relationship between the number of hours a subject attends treatment and the following variables: self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim?

2. Is there a relationship within groups (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse) on the number of hours a subject attends treatment and the following variables: self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim?

3. Which subset of variables (self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim) is most effective for classification of subjects to group membership (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse)?

CHAPTER III

METHOD

Participants

The participants were male clients who requested counseling or were mandated to attend counseling by the court system. The sample of male abusers for this project was limited to clients at one domestic violence agency in a Midwestern city with a population of approximately 370,000. Archival data were used. Data were extracted from existing files of male abusers who completed their first intake. In order to describe the sample the following demographics were drawn from existing files and recorded: age, race, income, and level of education.

A total of 313 participants were selected. The age of participants ranged from 18 to 72 with a mean of 33 and standard deviation of 9.07. Participant's income ranged from $0 to $82,500 with a mean of $19,188 and standard deviation of $13,746. The level of education of participants ranged from 5 to 21 years with a mean of about 12 years and standard deviation of 2.05. There were 55 African American males, 44 Native American males, 207 Caucasian males, and 7 Hispanic males in the sample.

With reference to the treatment groups, there were 106 court-referred without substance abuse participants, mean age 33, mean income $17,245, and mean of 12 years of education. There were 133 court-referred substance abuse participants, mean age 32, mean income $18,834, and mean of 12 years of education. There were 33 non-court-referred without substance abuse participants, mean age 35, mean income $20,213, and

mean of 12 years of education. There were 41 non-court-referred substance abuse participants, mean age 34, mean income $24,492, and mean of 12 years of education.

A summary of the demographic information was extracted by examination of the frequency distribution. The majority of the abusers were between 18 and 35 years of age at the time the intake was completed. Asian batterers were not represented in this sample. There were 7 Hispanic men in the court-referred groups and zero in the non-court referred-groups. Caucasian men.

Instrumentation

The assessments administered during the intake session included the Index of Self Esteem (Hudson, 1982), the Adult Nowicki-Strickland Locus of Control Scale (Nowicki & Duke, 1973), the MacAndrew Alcoholism Scale (MacAndrew, 1965), the Center of Social Research Abuse Index (modified version of the intake questions used at the Minnesota Domestic Abuse Project, 1996), and the Inventory of Beliefs About Wife Beating (Saunders et al., 1987). These assessment tools were used to gather information about the male abuser in the following areas: self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, and beliefs about wife beating (belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and belief that sympathy should be given to the victim).

Index of Self-Esteem (ISE) (Hudson, 1982)

The Index of Self-Esteem (ISE) (Hudson, 1982) is a 25-item scale. Higher scores on the ISE were indicative of lower self-esteem. According to Hudson, the ISE measures

the "degree, severity, or magnitude of a problem the client has with self-esteem" (Hudson, p. 3). Scores on the ISE range from 0-100, with scores above 30 usually indicating clinically significant problems in the area of self-esteem.

Abell, Jones, and Hudson (1984) performed a revalidation of the ISE by investigating the reliability, internal consistency, discriminant validity, and factorial validity. Reliability of the ISE was estimated using Cronbach's Alpha coefficient as a measure of internal consistency. Past standardization samples resulted in Alpha = .9, and the clinical revalidation sample resulted in Alpha = .9. The test-retest reliability was r =.92. Regarding the discriminant validity, scores on the ISE were significantly higher for clients who presented with issues related to self-esteem than for clients who did not have self-esteem issues. The point-biserial correlation between the ISE scores and criterion group status was also tested and was .78. The item-total correlations ranged from r =.37 to r =.79.

Adult Nowicki-Strickland Locus of Control Scale (ANSIE) (Nowicki & Duke, 1973)

The Adult Nowicki-Strickland Locus of Control Scale (ANSIE) (Nowicki & Duke, 1973) is a 40-item questionnaire designed to measure locus of control (Nowicki & Duke). According to Rotter (1972), locus of control refers to whether an individual perceives both positive and negative outcomes as being contingent on his behavior (internal) or the result of others, luck, or fate (external). The ANSIE was written so that individuals can understand it with at least a fifth grade reading capability and could respond with yes or no.

Nowicki and Duke (1973) gathered data from 12 independent studies using a total of 766 subjects. Measures of internal consistency yield values of .66 to .75. Split-half reliability ranged from .74 to .86 (N=158), and test-retest reliability over a six-week period of $\underline{r}$ =.83 (N=48). Construct validity was supported with significant correlations ($\underline{r}$=.68, $\underline{r}$ =.48, $\underline{r}$ =.44) between the ANSIE and the Rotter Internal-External Locus of Control Scale (Rotter, 1966).

MacAndrew Alcoholism Scale (MAC) (MacAndrew, 1965)

The MacAndrew Alcoholism Scale (MAC) (MacAndrew, 1965) was developed to differentiate clients with alcoholism from non-alcoholics (MacAndrew). The MAC is part of the Minnesota Multiphasic Personality Inventory. It consists of 49 true-false statements, each of which is worth one point. The cut off point for alcoholism is 24 points. Thus, a score of 24 or more points results in an individual being classified as alcohol dependent.

MacAndrew (1979) conducted several studies in which alcoholics were reliably discriminated from non-alcoholics. However, researchers question the meaning and diagnostic validity of the MAC (Wolf, Schubert, Patterson, Grande, & Pendleton, 1990). Wolf et al. conducted a study of 205 inpatients of an acute psychiatric ward in an effort to evaluate the MAC. Results of the assessment showed subjects with antisocial personality disorder but not alcoholism or drug dependence and those subjects with antisocial personality disorder, drug dependence and alcoholism obtained the highest scores on the MAC. Wolf et al. notes that the majority of subjects with substance abuse issues were correctly identified, but that the MAC may also indicate dimensions of personality.

Center for Social Research Abuse Index (CSR)

The Center for Social Research Abuse Index (CSR) was used to estimate severity of abuse exhibited by the client. It is a modified version of a questionnaire used at the Minnesota Domestic Abuse Project. This brief screening instrument consists of 26 questions that are answered using a 4-point Likert-type scale. Scores range from 0-120 with the following divisions: 0-12, not abusive; 13-34, moderately abusive; 35-91, seriously abusive; 92-120, dangerously abusive. Hall (1998) conducted a study to differentiate between court-referred and non-court-referred abusers on a number of variables including the CSR. A Cronbach's Alpha was generated from 100 CSR questionnaires that were randomly selected from the total sample resulting in Alpha =.72.

Inventory of Beliefs About Wife Beating (IBWB) (Saunders et al., 1987)

The Inventory of Beliefs About Wife Beating (IBWB) (Saunders et al., 1987) was used to measure attitudes and beliefs about wife beating. This 31-item questionnaire requires subjects to respond to a 7-point Likert-type scale (strongly agree=1 and strongly disagree=7). The IBWB was modified by the agency to be non-specific to marital relationships. Non-specific pronouns have replaced words that imply only marital relationships such as: "partner" instead of "wife," "women" instead of "wife," "men" instead of "husbands" and "partner" instead of "husband". Also, the word "hit" was substituted for the word "beaten".

Saunders et al. (1987) assessed the reliability and validity of the IBWB using a sample comprised of individuals who were expected to differ concerning their beliefs about wife beating. Data was collected from 675 students, 94 residents of a Midwestern

city, 71 men who batter, and 70 advocates for battered women. The IBWB is comprised of the following five subscales with their corresponding standardized alpha coefficients: Wife Beating Is Justified (WJ) .86, Wife Gains From Beatings (WG) .77, Help Should Be Given (HG) .67, Offender Should Be Punished (OP) .61, and Offender Is Responsible (OR) .62. Results confirmed significant differences at the $p<.0001$ level between abusers and advocates for battered women on the subscales of the IBWB. College student's scores were moderately in between abusers and advocates on the subscales. Construct validity was assessed through a series of comparisons, which yielded positive results. Saunders et al. (1987) investigated the construct validity by predicting that general hostility toward women would be related to blaming women for abuse. Therefore, correlations between the Hostility Toward Women Scale (Check & Malamuth, 1983) and the five IBWB subscales were examined. Those correlations are as follows: WJ ($r=.34$, $p<.001$), WG ($r=.27$, $p<.001$), HG ($r=-.18$, $p<.05$), and OP ($r=-.14$, $p<.05$). Responses to statements suggesting a propensity toward violence against significant others were compared with the attitudes that wife beating is justified and that wives gain something from abuse. The statement " I have a good chance of becoming violent in a dating or marital relationship," yielded the following correlations: WJ ($r=.30$, $p<.001$) and WG ($r=.28$, $p<.01$). The statement " There are times I would have hit a partner," yielded the following correlations: WJ ($r=.21$, $p<.05$) and WG ($r=.21$, $p<.05$). Third, psychoticism, extroversion, and neuroticism were examined as correlates with the IBWB, but no consistent association was found. The two correlations that were significant were extroversion and HG ($r=.17$, $p<.10$), and neuroticism and OP ($r=.15$, $p<.01$). Finally, male and female students were compared on the subscales of the IBWB with the

prediction that greater identification with victims (based on gender) would result in greater identification with beliefs against wife beating. Significant differences (p,<.001) were found on all subscales except the OR subscale. The following differences differentiated between men and women: women were less likely to view wife beating as justified, less likely to believe that wives gain from beatings, more likely to believe that help should be given to the victim, and more likely to believe the offender should be punished.

Procedure

Archival data were used for the study. Clients were grouped into one of four treatment groups based on information obtained from the intake file. The four groups were court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse. Subjects were classified as court-referred or non-court-referred based on case file notations on the client's referral source. Subjects were classified with substance abuse based on the intake counselor's determination of substance abuse and notation of substance abuse on the intake form. One limitation of this study is that differences among staff members may have influenced this original grouping.

Each of the four groups experienced treatment differently. The first group, court-referred with substance abuse, was required to attend a two-hour intake appointment, two 1½ hour drug and alcohol education groups, and 48 hours of domestic violence treatment groups. The next group, court-referred without substance abuse, was required to attend a two-hour intake appointment, and 48 hours of domestic violence treatment groups. The non-court-referred with substance abuse group attended a one-hour consultation

appointment, a two-hour intake appointment, two 1½-hour drug and alcohol education groups, and 48 hours of domestic violence treatment groups. The non-court-referred without substance abuse group attended a one-hour consultation appointment, a two-hour intake appointment, and 48 hours of domestic violence treatment groups. The one-hour consultation session was required for non-court-referred clients. The purpose of this meeting was to assess the client for appropriateness for treatment. Clients were asked to briefly describe their reasons for scheduling an appointment with the agency and questions concerning their abusive behavior.

The two-hour intake session was required for all clients. During this session, a biopsychosocial assessment was conducted. The intake packet consisted of demographic information, background information, treatment plan, a nonviolence contract, consent for treatment, and consent for follow-up. The following assessments were also included: the Clinician's Estimate of Success in the Program and Clinician's Estimate of Social Isolation (a modified version of a questionnaire used at the Minnesota Domestic Abuse Project, 1996), Inventory of Beliefs About Wife Beating (Saunders et al., 1987), Center for Social Research Abuse Index (a modified version of a questionnaire used at the Minnesota Domestic Abuse Project,1996), Adult Nowicki-Strickland Locus of Control Scale (Nowicki & Duke, 1973), Personal Reaction Inventory (a modified version of a questionnaire used at the Minnesota Domestic Abuse Project, 1996), Index of Self-Esteem (Hudson, 1982), It's Best to Know (a modified version of "What are the Signs of Alcoholism?" from the National Council on Alcoholism, 1996), and the MacAndrew Test-Revised (MacAndrew, 1965). The packet was put together in this same order for

each client. The material obtained during intake was then maintained in an individual client file, which was the source of data.

Drug and alcohol education groups consisted of presentation of new material through lecture, video observation, and/or group discussion of provided handouts. Substance abuse topics such as effects of alcohol on the mind and body, addictive personalities, and the recovery model were discussed. Clients assigned to this group attended two 1½-hour sessions.

Treatment groups for abusers at Domestic Violence Intervention Services of Tulsa were based on cognitive-behavioral and feminist theories of domestic violence. In this program, gender-equality was encouraged while clients are asked to examine their sex-role beliefs. Abusers were held responsible for their behavior while counseling aimed at stopping the violence and diminishing guilt and shame. In addition, clients were confronted about their abusive behavior and taught respectful communication.

Consultations, intakes, drug and alcohol education, and domestic violence treatment groups were conducted by one of several master's level counselors, master's level practicum students, or a staff psychologist. Data were gathered from case files compiled from June 1995 to December 1997.

Analyses

Two multiple regression analyses were performed with hours of treatment being the dependent variable and the independent variables as follows: Index of Self-Esteem (ISE), Adult Nowicki-Strickland Locus of Control (ANSIE), MacAndrew Alcoholism Scale (MAC), Center for Social Research Abuse Index (CSR), along with the six

subscales of the Inventory of Beliefs About Wife Beating (IBWB), Wife Beating is Justified (WJ), Wife Gains from Beatings (WG), Help Should Be Given (HG), Offender Should Be Punished (OP), Offender is Responsible (OFFRESP), and Sympathy for Battered Wives (SYMPATHY). A stepwise selection method was used for the linear regression model. Variables that did not contribute a significant amount to the equation were eliminated through this process.

A discriminant analysis was used to classify subjects into groups and to determine the nature of significant differences between the groups. Referral source was used as the grouping variable and the following for discriminating variables: hours of treatment, Index of Self-Esteem (ISE), Adult Nowicki-Strickland Locus of Control (ANSIE), MacAndrew Alcoholism Scale (MAC), Center for Social Research Abuse Index (CSR), along with the six subscales of the Inventory of Beliefs About Wife Beating (IBWB), Wife Beating is Justified (WJ), Wife Gains from Beatings (WG), Help Should Be Given (HG), Offender Should Be Punished (OP), Offender is Responsible (OFFRESP), and Sympathy for Battered Wives (SYMPATHY). A stepwise selection method was used to produce the best model and remove variables with little contribution.

CHAPTER IV

RESULTS

Introduction

Two multiple regression analysis and discriminant function analysis were performed. The Statistical Package for the Social Sciences for Windows 9.0 (1998) program was utilized to analyze the data. Data were collected on 313 subjects. Means and standard deviations for the entire sample are provided in Table 1. In addition, means and standard deviations of the sample split into the four groups are provided in Table 2.

Comparisons between the four groups were made to decide if they were representative of a normal sample. The Kruskal-Wallis Chi-Square test was utilized. No significant differences were found between the four groups (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse) on the following demographic variables: age p =.457, race p =.157, education p =.067, and income p =.061.

Analysis

Data analyses were conducted and tested at the .05 level of significance in order to answer the following research questions:

1. Is there a relationship between the number of hours a subject attends treatment and the following variables: self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be

punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim?

2. Is there a relationship within groups (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse) on the number of hours a subject attends treatment and the following variables: self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim?

3. Which subset of variables (self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim) is most effective for classification of subjects to group membership (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse)?

The following null hypotheses were formulated from the previously mentioned research questions:

HO: 1. There is no relationship between the number of hours a subject attends treatment and the following variables: self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be

punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim.

HO:2 There is no relationship between groups (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse) on the number of hours a subject attends treatment and the following variables: self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim.

HO: 3. There is no difference in subsets of variables (self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim) that is most effective for classification of subjects to group membership (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse).

Research Question One

Is there a relationship between the number of hours subjects attend treatment and the following variables: self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse,

belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim?

A multiple regression was performed with hours of treatment being the dependent variable and the independent variables were as follows: Index of Self-Esteem (ISE), Adult Nowicki-Strickland Locus of Control (ANSIE), MacAndrew Alcoholism Scale (MAC), Center for Social Research Abuse Index (CSR), along with the six subscales of the Inventory of Beliefs About Wife Beating (IBWB), Wife Beating is Justified (WJ), Wife Gains from Beatings (WG), Help Should Be Given (HG), Offender Should Be Punished (OP), Offender is Responsible (OFFRESP), and Sympathy for Battered Wives (SYMPATHY). A stepwise selection method was used for the linear regression model. In addition, the stepwise selection was able to eliminate variables that did not contribute a significant amount to the equation.

Results are presented in Table 3. Findings indicated that scores on the MacAndrew Scale of Alcoholism were significantly associated with the number of hours a subject attended treatment (Adjusted R^2= .025). This suggests that 2.5% of the variance in hours of treatment can be accounted for with the MacAndrew Alcoholism score. This small relationship was linear. As the MacAndrew Alcoholism score increased, the number of hours of treatment decreased, suggesting that alcoholism is associated with treatment dropout.

Research Question Two

2. Is there a relationship within groups (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and

non-court-referred without substance abuse) on the number of hours a subject attends treatment and the following variables: self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim?

The four groups formed on the basis of referral source (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse) were not found to be significantly different on demographic variables, which allowed for comparisons to be made between groups. This was similar to Dutton and Starzomski's findings (1994) in which no significant differences were found between the court-referred and non-court-referred groups demographically.

The sample was split according to referral source into four treatment groups. A multiple regression was performed with hours of treatment being the dependent variable and the independent variables were as follows: Index of Self-Esteem (ISE), Adult Nowicki-Strickland Locus of Control (ANSIE), MacAndrew Alcoholism Scale (MAC), Center for Social Research Abuse Index (CSR), along with the six subscales of the Inventory of Beliefs About Wife Beating (IBWB), Wife Beating is Justified (WJ), Wife Gains from Beatings (WG), Help Should Be Given (HG), Offender Should Be Punished (OP), Offender is Responsible (OFFRESP), and Sympathy for Battered Wives (SYMPATHY). A stepwise selection method was used for the linear regression model because there was an expected correlation among variables. Results are presented in

Table 4.

The court-referred non-substance abuse group revealed one variable that made a significant contribution to the model. The MacAndrew Alcoholism Scale (MAC) (Adjusted R^2= .045) accounted for 4.5% of the variance in hours of treatment for the court-referred non-substance abuse group. Similar to the results of research question one, high alcoholism scores resulted in fewer hours of treatment completed, suggesting that high risk of alcoholism is also a risk factor to client dropout.

The court-referred with substance abuse group revealed that the Inventory of Beliefs About Wife Beating (IBWB) subscales' Help Should Be Given (HG) (Adjusted R^2= .038) and Sympathy for Battered Wives (SYMP) (Adjusted R^2= .070) together accounted for 10.8% of the variance in hours of treatment for the court-referred with substance abuse group. Higher scores on HG and SYMP were associated with higher numbers of hours in treatment. Since high scores on the IBWB are indicative of negative attitudes toward wife beating, this data suggests that subjects with beliefs that help and sympathy should be given to victims attended more treatment.

The third group was the non-court-referred without substance abuse group. Two subscales of the Inventory of Beliefs About Wife Beating (IBWB) were identified as contributing to the model. The Offender Should Be Punished (OP) (Adjusted R^2= .147) and Offender is Responsible (OR) (Adjusted R^2= .330) together accounted for 47.7% of the variance in hours of treatment for the non-court-referred without substance abuse group. This was, by far, the greatest amount of variance accounted for by the variables. Again, higher scores on OR and OP were associated with a greater number of hours in

treatment, suggesting that stronger beliefs that the offender is responsible and the offender should be punished were associated with greater persistence in treatment.

Group four, the non-court-referred substance abuse group, resulted in no significant predictors of treatment hours completed. One might assume that there is a complex relationship between hours of treatment and the independent variables for the non-court-referred substance abuse group. This complex relationship may have decreased the possibility that any particular predictors would contribute a significant amount to the understanding of variation within this group.

Research Question Three

3. Which subset of variables (self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim) is most effective for classification of subjects to group membership (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse)?

A discriminant function analysis was used to classify subjects into groups to determine which subset of variables is most effective for prediction. The discriminant function was also used to describe the nature of significant differences between the groups. Referral source was used as the grouping variable with the following discriminating variables: hours of treatment, Index of Self-Esteem (ISE), Adult Nowicki-Strickland Locus of Control (ANSIE), MacAndrew Alcoholism Scale (MAC), Center for Social Research Abuse Index (CSR), along with the six subscales of the Inventory of

Beliefs About Wife Beating (IBWB), Wife Beating is Justified (WJ), Wife Gains from Beatings (WG), Help Should Be Given (HG), Offender Should Be Punished (OP), Offender is Responsible (OFFRESP), and Sympathy for Battered Wives (SYMPATHY). A stepwise selection method was used to produce the best model and remove variables with little contribution. The discriminant analysis was significant and results are reported in Table 5.

Function one was extracted and is most closely associated with the measurements of MacAndrew Alcoholism Scale, Help Should be Given Scale, and Wives Gain from Abuse scale. Function two was also extracted and is associated with the measurements of the Adult Nowicki-Strickland Locus of Control Scale (ANSIE), Wife Gains from Abuse, and Sympathy Should be Given scales. These two functions indicate that substance abuse, locus of control, and more importantly, beliefs about wife beating are related to differences between groups. Table 6 outlines the structure matrix, which shows the correlation between each dependent variable and the overall canonical function.

Classification results produced by the discriminant analysis are presented in Table 7. Approximately 49% of the original grouped cases were correctly classified. Random assignment of cases into groups might result in classifying 25% correctly (SPSS Base Application Guide, 1999). Table 7 provides the count and percentage of correctly classified cases relative to actual group membership.

In summary, the first regression analysis examined the sample as a whole and suggested that the MacAndrew Alcoholism Scale was significantly associated with hours of treatment completed. The second research question resulted differing results. Little variance in hours of treatment could be accounted for in the court-referred non-substance

abuse group (4.5% by the MacAndrew Alcoholism Scale) and in the court-referred substance abuse group (10.8% by the Help Should Be Given and Sympathy for Battered Wives scales). On the other hand, approximately 47% of the variance in hours of treatment could be accounted for in the non-court-referred without substance abuse group by the Offender is Responsible and Offender Should be Punished scales. No variables were selected for non-court referred group with substance abuse group. The discriminant analysis revealed significant results for prediction of group membership based on the MacAndrew Alcoholism Scale, Help Should be Given Scale, Wife Gains from Abuse, Sympathy should be Given, and Adult Nowicki-Strickland Locus of Control Scale. Approximately 49% of cases could be correctly classified into referral source groups.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

This study was designed to investigate the characteristics of male perpetrators of domestic violence abuse in relation to treatment persistence or non-persistence in a therapeutic domestic violence treatment program. Three main questions were examined: 1) the relationship between the number of hours a subject attends treatment and the following variables: self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, and beliefs about wife beating, 2) the relationship within groups (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse) on the number of hours a subject attends treatment and the following variables: self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, and beliefs about wife beating, 3) to determine which subset of variables (self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim) is most effective for classification of subjects to group membership (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse).

The participants in this study were 313 males who completed an intake session at a domestic violence intervention agency in the Midwest. Information was drawn from

existing files that were established between June 1995 and December 1997. The data consisted of subject scores on the Index of Self Esteem (Hudson, 1982), Adult Nowicki-Strickland Locus of Control Index (Nowicki & Duke, 1973), MacAndrew Alcoholism Scale (MacAndrew, 1965), Center for Social Research Abuse Index (modified version of the intake questions used at the Minnesota Domestic Abuse Project, 1996), and the six scales of the Inventory of Beliefs About Wife Beating (Wife Beating is Justified, Wife Gains from Abuse, Help Should Be Given to Victims, Offender Should Be Punished, Offender is Responsible, and Sympathy Should Be Given to Victims) (Saunders et al., 1987).

The following null hypotheses were formulated and tested at the .05 level of significance.

HO: 1. There is no relationship between the number of hours a subject attends treatment and the following variables: self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim.

HO: 2 There is no relationship within groups (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse) on the number of hours a subject attends treatment and the following variables: self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be

punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim.

HO: 3. There is no difference in subsets of variables (self-esteem, locus of control, risk of alcoholism, self-reported levels of abuse, belief that wife beating is justified, belief that wife gains from abuse, belief that help should be given to victims, belief that the offender should be punished, belief that the offender is responsible, and the belief that sympathy should be given to the victim) that is most effective for classification of subjects to group membership (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse).

Overall results indicated that the MacAndrew Alcoholism Scale (MacAndrew, 1965) and specific subscales of the Inventory of Beliefs about Wife Beating (Saunders et al., 1987) accounted for variation in the number of hours clients attended treatment. Furthermore, a subset of variables, specifically risk of alcoholism, locus of control, and beliefs about wife beating correctly classified 49% of cases into the four groups (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse).

Practical Implications

The results of this study present several practical implications for the field of domestic violence counseling. Findings indicate that the scores on the MacAndrew Alcoholism Scale (MacAndrew, 1965) and subscales of the Inventory of Beliefs about Wife Beating (Saunders et al., 1987) are useful in understanding subject's persistence in domestic violence treatment. This may have significant implications for theories and

treatment of domestic violence.

The first regression analyses examined the sample as a whole and suggested that the risk of alcoholism was significantly associated with hours of treatment completed. These findings are in accord with previous studies confirming that alcoholism is associated with lessened persistence in treatment. According to DeMaris and Jackson (1987), men who admitted to having relationship problems due to alcohol use were more likely to dropout of the program. Faulkner et al. (1991) found that individuals with significant drug abuse scores on the Millon Clinical Multiaxial Inventory (Millon, 1983) were more likely to drop out of treatment than individuals with lower scores. Richmond (1992) reported that drug and alcohol abuse was a good indicator of client dropout. Similarly, MacNair and Corazzini (1994) found alcohol and drug problems to be a significant predictor of client dropout. The association between alcoholism and dropout is also common within substance abuse treatment centers as reported by Baekeland and Lundwall (1975), in which 52 to 75% of substance abusers dropped out of treatment before their fourth session and 82% dropped out within four months of long-term residential programs. One might assume that there is a need to address substance abuse issues prior to domestic violence treatment.

When the sample was split according to referral source for regression analysis, a different subset of variables was extracted for each referral source to account for the variance in hours of treatment. The different subsets involved the MacAndrew Alcoholism Scale or the following subscales of the Inventory of Beliefs about Wife Beating: Help Should Be Given, Sympathy for Battered Wives, Offender Should Be Punished, and Offender is Responsible. This suggests that referral source had an effect on

variables associated with treatment persistence.

Previous research relating referral source to persistence in treatment was unavailable to this study, which illustrates the importance of further research. However, the findings from this study concerning the relationship of referral source with treatment persistence are inconclusive. Examination of mean hours in treatment reveals that on average, court mandated clients appear to have attended more sessions than non-court referred clients, but referral source was not found to be a statistically significant predictor of treatment persistence. The lack of statistical significance could lead one to believe that court mandated attendance with the possible consequence of incarceration for attrition is not adequate motivation for persistence in treatment.

Little variance in hours of treatment could be accounted for in the two court-referred groups (4.5% in the court-referred non-substance abuse group and 10.8% in the court-referred substance abuse group). However, beliefs about offender responsibility and punishment accounted for approximately 47% of the variance in hours of treatment in the non-court-referred without substance abuse group. The variables selected for this treatment group were the Offender Should Be Punished and Offender is Responsible subscales. These scales are aimed at identification of beliefs of accountability for the abuser, which is consistent with this referral source in that these clients voluntarily attended treatment and may have a greater sense of responsibility for the abuse and belief that abusers should punished in comparison to the court-mandated group. On the other hand, no variables were significantly related to treatment hours completed in the non-court referred substance abuse group.

Subscales of the IBWB and the MAC were more useful for accounting for

variance than other variables in the study, suggesting that attitudes and beliefs about wife beating and alcoholism are associated with persistence in treatment. The IBWB has not been used in previous studies investigating persistence in domestic violence treatment. The constructs measured by the IBWB (attitudes of blame toward battered women, propensity toward violence, and lack of identification with the victim) determine subjects' negative attitudes concerning wife beating. One might assume that this would lead to a desire to prevent or cease abusive behavior. Thus, negative attitudes about wife beating may be related to subject's persistence in treatment as a means to learn healthier behaviors. In reference to scores on the MAC, previous researchers have found alcoholism to be related to dropout from therapy (DeMaris & Jackson, 1987; Faulkner et al., 1991; Richmond, 1992; & MacNair & Corazzini, 1994). Similar to findings from research question one, the findings from this study are in agreement in that higher scores on the MAC were associated with higher rates of dropout from treatment. Again, there is a need to address substance abuse issues prior to domestic violence treatment.

The discriminant analysis revealed significant results for prediction of group membership based on the MacAndrew Alcoholism Scale, Help Should be Given Scale, Wife Gains from Abuse, Sympathy should be Given, and Adult Nowicki-Strickland Locus of Control Scale. Approximately 49% of cases could be correctly classified into referral source groups, suggesting that alcoholism and beliefs about wife beating are useful for discriminating between the referral groups. This finding suggests differences between the groups in substance abuse disorders and core beliefs about domestic violence, which may suggest a need for differential treatment.

These findings verify that the MacAndrew Alcoholism scores in addition to the beliefs about wife beating and locus of control variables are related to the correct classification of subjects into substance abuse or non-substance-abuse groups completed at the time of intake based on report of substance use at the time of last violent episode or a pattern of problematic substance use. The IBWB also contributed to the correct classification of subjects into groups, suggesting that there is a relationship between attitudes about wife beating and subjects' referral source (court-referred with substance abuse, court-referred without substance abuse, non-court-referred with substance abuse, and non-court-referred without substance abuse). Negative beliefs about wife beating (beliefs that battering is inappropriate) were more commonly associated with non-court-referred abusers, who entered treatment without a court mandate. Similar findings were also concluded in a previous study. Hall et al. (1998) used the Inventory of Beliefs about Wife Beating and reported that non-court-referred abusers indicated more negative attitudes about wife beating in comparison to court-referred abusers.

The variables investigated in this study are more closely related to the cognitive-behavioral theory of domestic violence. This approach assumes that an individual can change the way he or she thinks and behaves with training and skill building techniques. Therefore, clients may be able to change their beliefs and attitudes as measured through an instrument such as the Inventory of Beliefs about Wife Beating (Saunders et al., 1987). Addressing these beliefs early in treatment may increase the number of sessions clients attend.

Therapists must address substance abuse issues with male perpetrators of domestic violence when a client enters treatment given its relation to treatment

persistence. Substance abuse can have negative effects on relationships, which is why abstinence from alcohol and drugs is the focus of many domestic violence treatment programs (Geffner & Rosenbaum, 1990). It might seem logical to refer all clients who present with substance abuse issues during intake to a drug and alcohol treatment facility. However, clients with addictions have a tendency to drop out of all types of psychological counseling, including substance abuse treatment. Another obstacle for treating clients with substance abuse is that problems with alcohol and drugs may be underreported and these problems may not be addressed in counseling. The focus should be to discuss these tendencies with clients as early in treatment as possible so that the client may recognize how addiction effects desire to continue treatment.

The goal of this study was to identify the attitudes, perceptions, and characteristics of clients at risk for dropping out of treatment. Knowledge concerning which variables are most closely associated with retention of clients in treatment can lead us to improving services to continue treating those clients that might have dropped out.

Limitations

Many of the limitations of this study were unavoidable at the time of data collection. The subjects of this study were clients at one domestic violence agency that incorporated the instruments discussed in this study. The subjects were administered the assessments at the time of intake and prior to the development of this study. However, the use of archival data allowed for a large sample to be collected in a short amount of time.

Data was collected from only male abusers from one domestic violence agency in the Midwest. The limitation of using one agency, however, is that the sample may not be representative of all abusers. The administration of the instruments was the same for all

subjects. Therefore, counterbalancing was not used to counter the effects due to the order of presentation such as sequencing effects. Although the instruments were always given at the time of intake, the point of intake may have varied with each client. Subjects who were prepared to enter treatment completed the instruments during the initial face-to-face contact with a therapist, while individuals in need of crisis intervention or consultation completed the instruments at a second meeting for intake. Another limitation is that no attempt was made to determine if subjects had completed the same or similar instruments prior to this study. Also, no attempt was made to determine if English was the primary language of the subject. Subjects who could not read the instruments because they were Non-English speaking persons or due to illiteracy were read the items aloud by the therapist and were asked for a response. Finally, differences among staff members who administered the instruments and provided group therapy may have influenced the results due to differing experiences of treatment.

Some limitations were based on the instruments selected for this study. One limitation of instrumentation is that reliability and validity information on the Center for Social Research Abuse Index (CSR) was not available. Also, the instruments used in this study were self-report. The limitation of self-report instruments is that positive or negative impression management, or amount of self-disclosure by the subject may affect results.

Recommendations for Further Research

Further research is recommended in the area of domestic violence counseling and treatment completion. To address the limitations of this study, self-report measures have hindered results due to socially desirable response sets. It would be useful to include a

social desirability scale in further studies of this nature. In addition, research that expands the sample population is needed to increase the representativeness of the study.

A qualitative study would be useful to further investigate the factors that influence treatment completion, drop out and progress. Follow-up studies are also necessary to investigate the consequences of non-attendance by court-mandated clients to determine if perpetrators are re-offending and/or being held responsible. Also, further research is needed to expand the available literature concerning the differences between court-referred and non-court-referred clients and its implications for treatment.

Conclusions

This study has noted the importance of researching issues relevant to better treatment for abusers. A review of the literature suggests that domestic violence treatment persistence is an important issue for investigation. Historically, abusers have received mixed messages concerning the tolerance and legal implications of violence against women. It is important to recall the circular tendency of society to range from lack of concern to vigilance against domestic abuse (Pleck, 1987).

Three main theories about domestic violence have been developed: Feminist, Family Systems, and Psychological. Each of these theories suggested different origins of domestic violence and suggested different interventions. The research questions of this study most closely resembled the cognitive-behavioral psychological theory of domestic violence treatment.

Pirog-Good and Stets (1986) estimated 40% of men who enter counseling programs for abusive behavior never complete the program. An outcome study by Gondolf (1998) suggested that domestic violence programs do reduce the number of re-

assaults and even more likely reduce re-arrests for violence. These findings suggest the importance of research on dropout from domestic violence treatment.

The few researchers that have differentiated between court-referred and non-court-referred clients have found conflicting results. Dutton and Starzomski (1994) found no significant difference between court-referred clients and non-court-referred clients on demographic variables. In contrast, Barrera et al. (1994) found that court-referred men were more likely to be separated from their spouse, more often reported substance abuse during the most recent assault, and showed higher rates of denial and social introversion than non-court-referred men.

Research on alcoholism suggests a relationship between alcoholism and the incidence of domestic violence. Russell et al. (1989) reported that alcohol use was a problem by 42% of violent males and by none of the non-violent men. DeMaris and Jackson (1987) stated that men who admitted to having problems due to alcohol use were more likely to dropout of the program. Richmond (1992) and MacNair and Corazzini (1994) reported that drug and alcohol abuse was a good predictor of client dropout.

The relationship between self-esteem and partner abusiveness is mixed. Russell et al. (1989) found that most of the marital distressed couples selected for the sample had significantly low self-esteem scores. A study by Prince and Arias (1994) indicated a significant three-way interaction among desirability of control, perceived personal control, and self-esteem.

Studies concerning locus of control and abusive behavior are conflicting. Kolb et al. (1985) found that clients who dropped out reported higher levels of expected internal locus of control in interpersonal relationships. On the other hand, Rouse suggests that

external locus of control may be more associated with abuse but is not a strong predictor of abusive behavior. Saunders et al. (1987) reported that violent men were more likely to believe that violence is appropriate in a marital relationship.

Although no set of characteristics, beliefs, or attitudes proves to be representative of abusers who complete treatment or those who do not, some variables have proven to be useful. The first regression analyses examined the sample as a whole and suggested that the MacAndrew Alcoholism Scale was significantly associated with hours of treatment completed. The second research question resulted in differing findings. Little variance in hours of treatment could be accounted for in the court-referred non-substance abuse group (4.5%) and in the court-referred substance abuse group (10.8%). On the other hand, approximately 47% of the variance in hours of treatment could be accounted for in the non-court-referred without substance abuse group. No variables were selected for the non-court referred group with substance abuse group. The discriminant analysis revealed significant results for prediction of group membership based on the MacAndrew Alcoholism Scale, Wife Gains from Abuse, and Sympathy should be Given scales. Approximately 49% of cases could be correctly classified into referral source groups.

This study found that the MacAndrew Alcoholism Scale (MacAndrew, 1965) and the subscales of the Inventory of Beliefs about Wife Beating (Saunders et al., 1987) are useful for accounting for variance in the number of hours clients attend treatment. Furthermore, this study correctly classified individuals into the four groups in approximately 49% of the cases.

This study has suggested some practical implications aimed at increasing the number of sessions that clients attend. First, it may be useful to address clients according

to treatment group since findings suggested that referral source had an effect on variables associated with treatment persistence. One salient issue is the need to address substance abuse issues prior to domestic violence treatment with clients. Some clients in this study attended two one-and-a-half hour drug and alcohol education groups. A selective screening of clients at intake may be useful for referral to drug and alcohol education groups. Another recommendation may be referral to drug and alcohol treatment facilities for more long term specialized treatment. Another recommendation is that beliefs about wife beating be explored early in treatment. The findings from this study indicated that beliefs against wife beating might be related to subject's persistence in treatment. In addition, beliefs of accountability for the abuser may also be related with persistence. This emphasizes the need to address beliefs and attitudes early in treatment so that clients may become more aware of their thinking and consider continuation of treatment.

In summary, this study appears to contribute new information to the body of literature concerning client persistence in domestic violence treatment and differences between court-referred and non-court-referred clients. This knowledge could provide a rationale for addressing issues of addiction and attitudes about wife beating early in treatment to decrease the dropout rate. Finally, this study reveals the need for further research on persistence and referral source with follow-up data on outcome.

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Table 1

Means and Standard Deviations for Variables

Variables	N	Minimum	Maximum	Mean	Std. Deviation
Hours in Treatment	313	2	100	31.64	21.27
Index of Self-Esteem	311	0	76	27.40	16.66
Adult Nowicki-Strickland Locus of Control	312	1	33	10.95	4.99
MacAndrew Alcoholism Scale	289	0	39	22.91	4.75
Center for Social Research Abuse Index	238	0	78	24.75	14.55
Wife Beating is Justified	313	.83	5.17	1.86	.78
Wife Gains from Abuse	313	.75	5.00	2.62	1.01
Help Should be Given to Victims	313	2.33	6.83	4.80	.82
Offender should be Punished	313	1.00	8.75	4.52	1.37
Offender is Responsible	313	.00	8.75	4.53	1.22
Sympathy Should be Given to Victims	313	2.14	4.42	3.10	.42

Table 2

Means and Standard Deviations for Variables by Groups

Variable	Referral Source	N	Mean	Std. Deviation
Hours of Treatment	Court-Referred Non-Substance Abuse	106	34.41	19.86
	Court-Referred Substance Abuse	133	32.30	20.45
	Non-Court Referred Non-Substance Abuse	33	25.52	22.15
	Non-Court Referred Substance Abuse	41	27.27	25.47
Index of Self-Esteem	Court-Referred Non-Substance Abuse	105	24.32	16.57
	Court-Referred Substance Abuse	132	26.53	15.05
	Non-Court Referred Non-Substance Abuse	33	30.76	17.83
	Non-Court Referred Substance Abuse	41	35.39	18.39
Adult Nowicki-Strickland Locus of Control Scale	Court-Referred Non-Substance Abuse	105	10.14	4.62
	Court-Referred Substance Abuse	133	10.84	4.82
	Non-Court Referred Non-Substance Abuse	33	11.39	5.64
	Non-Court Referred Substance Abuse	41	12.98	5.49
MacAndrew Alcoholism Scale	Court-Referred Non-Substance Abuse	96	20.73	3.59
	Court-Referred Substance Abuse	126	24.21	4.56
	Non-Court Referred Non-Substance Abuse	27	23.04	3.42
	Non-Court Referred Substance Abuse	40	23.93	6.50
Center for Social Research Abuse Severity Index	Court-Referred Non-Substance Abuse	91	19.00	12.17
	Court-Referred Substance	95	27.08	14.57

	Abuse			
	Non-Court Referred Non-Substance Abuse	29	26.66	14.17
	Non-Court Referred Substance Abuse	23	35.48	15.07
Wife beating is Justified	Court-Referred Non-Substance Abuse	106	1.82	.75
	Court-Referred Substance Abuse	133	1.97	.86
	Non-Court Referred Non-Substance Abuse	33	1.87	.72
	Non-Court Referred Substance Abuse	41	1.62	.57
Wife Gains from Abuse	Court-Referred Non-Substance Abuse	106	2.36	.99
	Court-Referred Substance Abuse	133	2.90	.98
	Non-Court Referred Non-Substance Abuse	33	2.30	.77
	Non-Court Referred Substance Abuse	41	2.66	1.08
Help Should be Given to Victims	Court-Referred Non-Substance Abuse	106	5.01	.80
	Court-Referred Substance Abuse	133	4.62	.82
	Non-Court Referred Non-Substance Abuse	33	4.93	.73
	Non-Court Referred Substance Abuse	41	4.76	.82
Offender Should be Punished	Court-Referred Non-Substance Abuse	106	4.63	1.30
	Court-Referred Substance Abuse	133	4.52	1.40
	Non-Court Referred Non-Substance Abuse	33	4.21	1.14
	Non-Court Referred Substance Abuse	41	4.51	1.65
Offender is Responsible	Court-Referred Non-Substance Abuse	106	4.60	1.24
	Court-Referred Substance Abuse	133	4.42	1.23
	Non-Court Referred Non-Substance Abuse	33	4.58	1.07
	Non-Court Referred Substance Abuse	41	4.66	1.27
Sympathy Should	Court-Referred Non-	106	3.06	.44

be Given to Victims	Substance Abuse			
	Court-Referred Substance Abuse	133	3.16	.43
	Non-Court Referred Non-Substance Abuse	33	3.03	.34
	Non-Court Referred Substance	41	3.01	.37

Table 3

Regression Summary for Question One: Relationship Between Hours of Treatment Completed and the Following: Self-esteem, Locus of Control, Risk of Alcoholism, Self-reported Levels of Abuse, and Beliefs about Wife Beating

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1 (MacAndrew Alcoholism Scale)	.171	.029	.025	21.24

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	2895.35	1	2895.352	6.418	.012
	Residual	96084.76	213	451.102		
	Total	98980.12	214			

Table 4

Regression Summary for Question Two: Within Groups Relationship Between Hours of Treatment Completed and the Following: Self-esteem, Locus of Control, Risk of Alcoholism, Self-reported Levels of Abuse, and Beliefs about Wife Beating

Group	Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change
1	1	.239 a	.057	.045	20.59	.057
	2					
2	1	.220 b	.049	.038	19.41	.049
	2	.302 c	.091	.070	19.08	.043
3	1	.431 d	.186	.147	20.56	.186
	2	.625 e	.390	.330	18.23	.204
4	1					
	2					

Groups:

1 Court-Referred Non-Substance Abuse Group
2 Court-Referred Substance Abuse Group
3 Non-Court-Referred Non-Substance Abuse Group
4 Non-Court-Referred Substance Abuse Group

Predictors:

a MacAndrew Alcoholism Scale
b Help Should be Given to Victims
c Help Should be Given to Victims, Sympathy Should be Given to Victims
d Offender is Responsible for the Abuse
e Offender is Responsible for the Abuse, Offender Should be Punished

Dependent Variable:
Hours of Treatment Completed

Table 4

Regression Summary for Question Three: Within Groups Relationship Between Hours of Treatment Completed and the Following: Self-esteem, Locus of Control, Risk of Alcoholism, Self-reported Levels of Abuse, and Beliefs about Wife Beating

Group	Model		Sum of Squares	df	Mean Square	F	Sig.
1	1 (a)	Regression	2029.55	1	2029.552	4.786	.032
		Residual	33504.0	79	424.101		
		Total	35533.55	80			
	2	Regression					
		Residual					
		Total					
2	1 (b)	Regression	1673.741	1	1673.741	4.443	.038
		Residual	32772.034	87	376.690		
		Total	34445.775	88			
	2 (c)	Regression	3149.546	2	1574.773	4.327	.016
		Residual	31296.229	86	363.910		
		Total	34445.775	88			
3	1 (d)	Regression	2030.978	1	2030.978	4.803	.040
		Residual	8879.630	21	422.840		
		Total	10910.609	22			
	2 (e)	Regression	4260.325	2	2130.163	6.406	.007
		Residual	6650.283	20	332.514		
		Total	10910.609	22			
4	1	Regression					
		Residual					
		Total					
	2	Regression					
		Residual					
		Total					

Groups:
1 Court-Referred Non-Substance Abuse Group
2 Court-Referred Substance Abuse Group
3 Non-Court-Referred Non-Substance Abuse Group
4 Non-Court-Referred Substance Abuse Group

Predictors:
a MacAndrew Alcoholism Scale
b Help Should be Given to Victims
c Help Should be Given to Victims, Sympathy Should be Given to Victims
d Offender is Responsible for the Abuse
e Offender is Responsible for the Abuse, Offender Should be Punished

Dependent Variable:
Hours of Treatment Completed

Table 5

Significance of Discriminant Function

Function	Eigenvalue	Canonical Correlation	Wilk's Lambda	Chi-Square	df	Sig.
1	.334	.501	.679	81.324	12	.000
2	.093	.291	.906	20.746	6	.002

Table 6

Structure Matrix

Variables	Function	
	1	2
MacAndrew Alcoholism Scale	.725	-.001
Center for Social Research Abuse Severity Index	.309	.018
Adult Nowicki-Strickland Locus of Control Scale	.337	-.580
Sympathy should be Given	.089	.522
Offender is Responsible	-.105	-.214
Wife Gains from Abuse	.451	.534
Help Should be Given	-.479	-.121
Wife Beating is Justified	.079	.281
Index of Self-Esteem	.237	-.209
Offender Should be Punished	-.107	-.127
Hours of Treatment	.020	.016

(negative sign represents inverse relationship)

Table 7

Classification Results

Original Grouped Cases		Predicted Group Membership			
	Treatment Group	Court-Referred Non-Substance Abuse	Court-Referred Substance Abuse	Non-Court-Referred Non-Substance Abuse	Non-Court-Referred Substance Abuse
Count	Court-Referred Non-Substance Abuse	57	11	15	13
	Court-Referred Substance Abuse	19	58	20	29
	Non-Court-Referred Non-Substance Abuse	8	8	6	5
	Non-Court-Referred Substance Abuse	9	5	6	20
Percentage	Court-Referred Non-Substance Abuse	59.4	11.5	29.6	15.6
	Court-Referred Substance Abuse	15.1	46	12.5	15.9
	Non-Court-Referred Non-Substance Abuse	29.6	29.6	22.2	18.5
	Non-Court-Referred Substance Abuse	22.5	12.5	15	50

Appendix A

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

DATE: 11-30-98 **IRB #: ED-99-046**

Proposal Title: MALE DROPOUTS FROM DOMESTIC VIOLENCE TREATMENT

Principal Investigator(s): John S.C. Romans, Amanda D. Duplantis

Reviewed and Processed as: Exempt

Approval Status Recommended by Reviewer(s): Approved

Signature: Date: December 1, 1998

Carol Olson, Director of University Research Compliance
cc: Amanda S. Duplantis

Approvals are valid for one calendar year, after which time a request for continuation must be submitted. Any modification to the research project approved by the IRB must be submitted for approval. Approved projects are subject to monitoring by the IRB. Expedited and exempt projects may be reviewed by the full Institutional Review Board.

VITA

Amanda Domangue Duplantis

Candidate for the Degree of

Doctor of Philosophy

THESIS: CLIENT VARIABLES RELATED TO TREATMENT PERSISTENCE AND NON-PERSISTENCE IN DOMESTIC VIOLENCE TREATMENT

Major Field: Applied Behavioral Studies

Education: Graduated from South Terrebonne High School, Bourg, Louisiana, in May, 1990; received Bachelor of Arts degree in Psychology and a Master of Arts degree in Psychological Counseling from Nicholls State University, Thibodaux, Louisiana, in May, 1994 and July 1996 respectively; completed requirements for Doctor of Philosophy degree at Oklahoma State University in December, 2000.

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