A Study of the Therapeutic Working Alliance, Client Motivation for Therapy and Subsequent Self-Reported Charges in Abusive Behavior Among a Sample of Male Batterers From the Abuse Ceases Today Program

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A STUDY OF THE THERAPEUTIC WORKING ALLIANCE, CLIENT MOTIVATION FOR THERAPY AND SUBSEQUENT SELF-REPORTED CHANGES IN ABUSIVE BEHAVIOR AMONG A SAMPLE OF MALE BATTERERS FROM THE ABUSE CEASES TODAY PROGRAM

BY

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This study examined the impact of the therapeutic alliance and client motivation for therapy on program completion and changes in self-reported abusive behavior among a sample of 88 adult male domestic violence perpetrators who attended a group counseling program for male batterers. Results revealed evidence of significant differential Group change (completers vs. noncompleters) with regard to treatment outcome, as measured by decreased husband-to-wife psychological and physical aggression. In addition, Internal Motivation for Therapy and a strong Working Alliance were not significantly related to treatment completion. Level of education was not found to be a significant predictor of self-reported changes in abusive behavior (measured by the Conflict Tactics Scale-2). Relationship status was significantly, but marginally, related to only the Negotiation subscale of the CTS-2. It may be hypothesized that there are additional factors related to changes in self-reported abusive behavior that influence program completion.
CHAPTER I

INTRODUCTION

Background of the Problem

In recent years, there has been a documented increase in many forms of violence in the United States. While the rate of random acts of street violence are on the rise, research suggests that violence within the home places women and children at the greatest risk for physical violence or sexual assault (American Psychological Association, 1996).

While research concerning battered women has proliferated during the past three decades, there remains a relative dearth of empirical information regarding domestic violence perpetrators. The American Psychological Association has clearly advocated the treatment of violent perpetrators. They specifically have endorsed the idea that treatment with domestic violence perpetrators must "address the perpetrator's use of power and control as well as attitudes and perceptions that support acts of violence" (APA, 1996, viii).

Despite the backing of the APA, this approach to treating domestic violence perpetrators has yet to
withstand the rigors of empirical investigation. Thus, empirically validated research concerning the most effective treatment for domestic violence perpetrators is yet to be determined.

Thus, the Committee on the Assessment of Family Violence Interventions identifies the improvement of evaluation of family violence interventions as one of the "most crucial needs" in this field. Specifically, determining "what works", "for whom", "under what conditions", and "at what cost" represents the effort to elucidate key factors in the change process for domestic violence perpetrators (National Research Council, 1998).

Literature concerning the efficacy of treatment for male batterers has produced inconsistent results. Dutton (1986) in a quasi-experimental design examined post-conviction recidivism rates for men convicted of domestic violence. Fifty men who completed a 16-week treatment program had a 4% recidivism rate for a post-treatment period of up to three years. A comparable group who had not received treatment had a 40% recidivism rate during the same period. This research suggests the efficacy of treatment. However, factors such as small numbers of participants, short follow-up periods, and a lack of
alternative hypotheses concerning the reduction in violence have plagued many studies.

The Costs Associated with Domestic Violence

The annual cost of domestic violence in the United States has been estimated to range from a minimum of $1.7 billion (Strauss, 1986) and $140 billion (Miller, 1994). In an effort to explain the wide variation of estimated costs, it is important to note the direct and indirect costs of domestic violence. The direct costs include those factors involved in providing treatment and services. Indirect costs include such variables as "reduced productivity, diminished quality of life (pain and suffering) and decreased ability to care for oneself or others." (National Research Council, 1998, p. 73). The exact cost associated with the impact of domestic violence is unknown. Factors such as the desegregated nature of programs and services and the reliance on different reporting measures and units of analysis make the exact cost associated with domestic violence elusive. However, it is known that the injuries and mental health problems that occur in the wake of family violence have imposed a heavy burden on a broad range of service providers, including women's shelters, schools, hospitals, mental health
clinics, police stations, and district attorney's offices. Responses to reports of domestic violence or the endangerment of children for example involve time-consuming and costly investigations to determine program eligibility by a broad range of social service programs, including child protective services, children and family resource programs, child welfare, and foster care offices (Adams, as cited in Chalk & King, 1996).

In addition the legal system has been burdened by the problem of family violence, especially in handling cases involving decisions about child placement, termination of parental rights and abuse by intimate partners. Furthermore, the additional costs associated juvenile courts, longer-term foster care, drug or alcohol treatment, adult criminal activities, foregone future earnings, and potential welfare dependence have not been quantified despite being acknowledged as consequences of maltreatment. General Accounting Office Statistics from the Commonwealth of Massachusetts revealed that a victim sought a restraining order once every ten minutes against an abusive partner during a two-year period. (Adams, as cited in Chalk & King, 1996).
Male Socialization and Domestic Violence

Many theorists including Meth and Pasick (1990) asserted that much of male socialization in conventional American society has been detrimental to the emotional development and functioning of men. They further asserted that the full realization of men's potential is limited particularly in the area of interpersonal relationships as husbands, fathers, lovers, sons, and friends. (Meth and Pasick, 1990). More specifically, Meth and Pasick (1990) argued that traditional male socialization not only limits the development of human potential, it also fosters and condones the use of abusive behavior as a means of expressing emotion and resolving conflict.

"Men learn to devalue, or at least deny, the need for internal rewards (Farrell, 1986 as cited in Meth & Pasick, 1990, p.14). For a multitude of men, emotional support and nurturing connote weakness. Although many men may attempt to project a powerful image, many are not attune to their internal feelings. While an in depth exploration of this topic is beyond the scope of this paper, the statistics on the differences in males' and females' physical health provides fodder regarding the ways in which men may physically suffer from a lack of emotional development."
Specifically, according to the U.S. Bureau of Census, (1984) women outlive men by an average of 7.8 years, while men suffer from approximately 98% of the major diseases. The deleterious effects of gender stereotypes have continued to be documented. The U.S. Department of Health and Human Services (1990) state that men are four times more likely to suffer from heart disease than women before the age of 50. In addition, men’s life expectancy also averages eight years less than that of women. (U.S. Bureau of the Census, 1990 as cited in Andronico, 1999).

As previously noted, boys are taught to suppress emotion, stay in control, and “act like a man”. In other words, they are conditioned to behave in ways that are harmful to themselves and others. Social reinforcement as well as punishment are powerful factors that influence the propensity for men to deny emotions (other than anger), remain in control, and strive to be fiercely independent. (Kivel, 1993). Much to their detriment, many men resist opening themselves up for fear of being vulnerable and dependent. Unfortunately, these variables combine to create a breeding ground for the existence, maintenance, and perpetuation of abusive and controlling behavior. (Kivel, 1993).
Statement of the Problem

Domestic violence is the leading cause of injury to women in the United States. Results from the 1990 National Family Violence Survey (NFVS) reveal that 1.8 million women annually are beaten by intimate partners. In contrast, 1992-1993 National Crime Survey statistics estimate that 660,000 women are assaulted by strangers. This data suggests that women are three times more likely to suffer an attack in the privacy of their own home rather than be victimized by a stranger on the street. (Strauss & Gelles, 1990 in Kandel-Englander, 1997). In addition, the following statistics highlight the extent to which domestic violence is a pressing current social problem in the United States:

1. Every 21 days, a woman is killed by domestic violence.
2. More than three million children witness acts of domestic violence each year.
3. One in ten calls made to alert police of domestic violence is placed by a child in the home.
4. More than 53 % of male abusers beat their children.
5. One of every three abused children becomes an adult abuser or victim.
6. Victims and abusers are found in every social and economic class, race, religious group, and sexual orientation.

(Department of Health and Human Services, 1996.

Group Treatment for Domestic Violence Perpetrators

The primary treatment modality for domestic violence perpetrators is group work. (Harway & Evans, 1999 as cited in Andronico, 1999). Alonso and Rutan, (1984) asserted that clinical experience and research have demonstrated that group treatment can engender change not as easily achieved in other modalities.

While the group modality had been firmly established as the predominant form of treatment, the specific content of batterer groups continues to vary. Cognitive and behavioral therapies have emerged from the early forms of consciousness raising groups. Legislative changes radically altered the size and scope of programs by instituting court-mandated counseling to address the issue of domestic violence. The unique philosophical underpinnings of each organization that treated domestic violence perpetrators created a diversity of batterer programming that differed (and continues to differ) in format, duration, training and content. (Gondolf, 1995).
Differences of opinion among a diverse group of mental health professionals persist regarding the relative emphasis on counseling and education during treatment. In addition, duration of treatment continues to be a question that remains unresolved. Program duration can vary from three months to as long as a year. No consensus currently exists with regard to the optimal time period for treatment efficacy. (Harway & Evans, 1999 as cited in Andronico, 1999). Diverse treatment approaches, low compliance rates and high dropout rates are problems that interfere with treatment efficacy and continue to plague clinicians.

Significance of the Research

Court-ordered batterer treatment is one response to the problem of domestic violence. Questions concerning its efficacy however, continue to emerge (National Research Council, 1998 as cited in Levesque, Gelles & Velicer, 2000). A number of meta-analytic studies have been conducted to answer the question regarding batterer treatment efficacy. The results have been inconsistent. Saunders & Azar (1989) in Levesque, et.al., 2000 concluded that batterer treatment does in fact reduce recidivism. Other researchers are less optimistic. They either withhold judgment or encourage "cautious optimism" with
regard to the efficacy of treatment (Tolman & Bennett, 1990 in Levesque, et. al., 2000).

This research sought to illuminate factors in the change process for abusive men undergoing group treatment. Harway and Evans (1999) note that batterers do not differ significantly from other men in the general population psychologically (as cited in Andronico, 1999). Thus, this research has implications for clinicians working with families, couples, as well as individual men and boys. This research has potential far reaching implications due to the intergenerational genesis of abusive behavior.

The Abuse Ceases Today Program

The Abuse Ceases Today (ACT) Program is a 26-week group treatment program for male domestic violence perpetrators sponsored by the Jersey Battered Women's Service (JBWS). The ACT Program, located in Northwestern New Jersey utilizes a Cognitive-Behavioral psychoeducational standardized approach to treatment created by Pence and Paymar (1988). Most clients are court-ordered. All clients attend a two-hour group session with voluntary clients once a week. Upon completion of two, one-hour orientation sessions, clients are placed in one of seven available ongoing groups facilitated by two
group facilitators. On average, each group is facilitated by one male and one female master's level therapist. An exception must be noted. One of the seven groups is facilitated by one male master's level therapist. Each worker is supervised by the ACT Program Director, a Ph.D. level psychologist. Each group contains an average of 12 to 15 clients per group, a majority of whom are court-ordered to attend. African-American, Caucasian, Hispanic and Asian men between the ages of 20 to 75 years of age of varying socioeconomic groups and educational levels attend the program.

The focus of this research involves an analysis of self-reported changes in abusive behavior toward female intimate partners. One of the ways in which to achieve that goal is to analyze the specific factors in batterer treatment programs that facilitate change. Preliminary identification of factors that promote change represents a beginning in the quest to assist and facilitate change in male batterers. More specifically, this research questions the roles of the therapeutic working alliance its impact on client motivation to change and their subsequent potential impact on reduction in abusive behavior.
Research Questions

1. Will the variables of client motivation for therapy, therapeutic alliance and number of sessions attended significantly account for self-reported changes in male batterers abusive behavior?

2. Will the quality of the therapeutic alliance impact male batterers motivation for therapy?

3. Will the variables of substance abuse, education and relationship status impact changes in male batterers abusive behavior.

Research Hypotheses

Hypothesis 1
Program completers will demonstrate statistically significant lower scores on the second administration of The Conflict Tactics Scale as compared to the non-completer comparison group.

Hypothesis 2
Positive therapeutic alliance and high level client motivation will predict program completion in a sample of male batterers.

Hypothesis 3
Lower educational levels, involvement in current relationship and active substance use will predict higher scores on the Conflict Tactics Scale.

With regard to the third hypothesis, it is important to note that "involvement in current relationship" includes those who remained with their partner (the victim at the time of the ACT Program referral) as well as those engaged in more recently established intimate relationships.

Definition of Terms

For the purpose of clarity, the major terms used in this study are defined below:

Abuse Ceases Today (ACT) Program: The Abuse Ceases Today (ACT) Program (herein referred to as the "ACT Program") is a 26-week group-counseling program for male batterers.

Battering: Battering is defined as a force in an intimate relationship in which the batterer attempts to gain control over their intimate partner’s actions, thoughts, and feelings. Battering may involve physical violence or verbal and emotional abuse to control their partners. It is important to note that battering constitutes a spectrum of behaviors. It is a strategy for
maintaining power in a relationship. The terms batterer and
domestic violence perpetrator are used interchangeably.
(Pence & Paymar, 1993) New Jersey state law identifies
"domestic violence" as any one of the following acts:
1. Homicide
2. Assault
3. Terroristic threats
4. Kidnapping
5. Criminal restraint
6. False imprisonment
7. Sexual assault
8. Criminal sexual contact
9. Lewdness
10. Criminal mischief
11. Burglary
12. Criminal trespass
13. Harassment
14. Stalking

Extrinsic motivation: Extrinsic motivation behaviors are those behaviors, which are performed to receive a reward or to avoid some punishment once the behavior has ended. (Deci & Ryan, 1985, as cited in Pelletier, Tuson & Haddad, 1997, p. 415).
Intrinsic motivation: Intrinsically motivated behaviors are those behaviors, which are performed voluntarily in the absence of material rewards or extrinsic constraints. (Deci & Ryan, 1985, as cited in Pelletier, Tuson & Haddad, 1997, p. 415).

Recidivism: Refers to rearrest or reconviction for criminal behavior. For purposes of this study, recidivism rates will specifically refer to the rearrest or reconviction on domestic violence charges. (National Research Council, p. 164).

Therapeutic Alliance: Collaboration between therapist and client is at the core of the alliance concept. The alliance concept focuses on the importance of the client and therapist forming a partnership against the common foe of the client's debilitating pain. (Bordin, 1975, Luborsky, 1976 as cited in Horvath & Greenberg, 1994, p. 1).

Delimitations
Self-report measures utilized in this study pose a potential threat to the validity of the research as a result of the factors of social desirability and acquiescence (Borg & Gall, 1996).
Internal and external validity of the study is threatened as a result of the voluntary nature of participation in the study.

Due to the self-selected nature of the participants, and the derivation of the sample from one program in one particular geographic region, generalizations to the treatment of batterers in general must be made with caution.

The Working Alliance Inventory (WAI) (Horvath, and the Client Motivation for Therapy Scale (CMOTS), (Pelletier, 1997) have not been utilized within a group treatment modality and therefore represent a limitation of this study. However, it is important to note, as Borg and Gall (1989) asserted, when there is good content validity as well as its suitability as the most appropriate measure available, make it acceptable for use in a research study.

The population of interest for this study is male domestic violence perpetrators. The research sample to be included in this study is limited to adult male batterers.

While many couples have experienced abuse in their intimate partnerships, investigation of gay and lesbian battering is an area of inquiry that is beyond the scope of
this research. In addition, females involved in heterosexual partnerships can also batter and abuse their partners. Female domestic violence perpetrators are also beyond the scope of this research. Given the nature of the Abuse Ceases Today Program as a program that serves male perpetrators of domestic violence, this study is limited to male-female intimate violence.
The fact that a considerable amount of violence of all types occurs within families has been well documented by many researchers. While women's use of violence in intimate relationships (Johnson, 1995) is gaining more attention, it is beyond the scope of this research. As it currently stands, researchers have documented the fact that much of the familial violence that occurs is directed against women. The focus on victims of domestic violence has been focused on female victims of domestic violence. As a result, much of the attention in the domestic violence field has been focused on female victims of domestic violence. However, the fact that a considerable amount of violence of all types occurs within families has been well documented.
this specific population. Client motivation for therapy and the therapeutic working alliance were the predictor variables hypothesized to affect changes in abusive behavior in a sample of male batterers from the Abuse Ceases Today Program.

Why men batter?

Recent findings suggest that a combination of variables impact the development of abuse against one's intimate partner. Specifically, research highlights the role of neurochemical, psychological, social and physical risk factors which may interact and contribute to violent behavior. It is important to note that risk factors do not imply a direct cause and effect relationship. These factors identify important variables that have the potential to impact violent behavior. The following individual influences have been identified by the American Psychological Association Task Force on Violence and the Family (1996).

Individual influences include: (a) fighting within the home of origin, (b) exposure to parental violence, (c) previous violence in other relationships, (d) isolation from family and friends, (e) high levels of expressed anger and impulsivity, (f) aggressive
response to actual and perceived stress, (g) Rigid acceptance of traditional concepts of men’s entitlement to superiority and control over family members, (h) Biological and neuropsychological factors, inherited or acquired, (i) Physical or mental limitations or disabilities, (j) Alcohol and drug abuse.

According to the same APA Presidential Task Force, it is important to note the sociocultural risk factors which influence abusive behavior: (a) Acceptance of marital fighting, (b) Widespread assumption and social expectations that men are superior to women and are entitled to exert control over their family members, (c) Poverty, (d) Guns in the home or easy access to weapons, (e) Acceptance of violence when perpetrated by institutions or groups of people in authority, (f) Acceptance of violence in the media, (g) Violence in the culture, (h) Gender stereotypes, and (i) Religious ideology encouraging men’s control of family members.

The APA Presidential Task Force on Family Violence emphasizes the fact that while children who witness violence are at greater risk for becoming perpetrators themselves, there is no inevitable link between having
witnessed abuse as a child and becoming a family violence perpetrator as an adult. (p.22)

It is important to note the existence of conflicting research with regard to the impact of socioeconomic status and domestic violence incidents. "Street violent men seem to come from lower social classes, but family-violent men do not necessarily come from lower social classes in comparison to nonviolent men. This does not mean that family violence is unrelated to social class, but is merely less strongly related to social class when, when compared to street and pan-violence." (Kaufman-Kantor et al., 1987/1990 as cited in Kandel-Englander, 1997, p.36).

Group Treatment in Batterer Intervention: An Overview

The emergence of interventions for domestic violence perpetrators began in the late 1970's. Intervention began at the state and local level prompted by battered women's advocacy groups as well as men's groups (Caesar & Hamberger, 1989 as cited in Gondolf, 1995). The primary treatment modality was and continues to be group work. (Harway & Evans, 1999 as cited in Andronico, 1999). The rationale for the group form of treatment lies in the belief that men were socialized together into an inherently sexist culture and thus, they can be "resocialized" in
groups of men. An additional rationale for group work lies with the powerful impact modeling has on humans. It is suggested that more experienced group members may confront new group members more effectively than the therapist on issues concerning denial and use of abusive behavior. This process serves the added purpose of reinforcing the more experienced group member's newly formed beliefs and behavior change (Harway & Evans, 1999 as cited in Andronico, 1999). Harway and Evans, 1999 assert that the "best" reason for group work in the treatment of batterers lies in the ability for men to witness other men making positive changes which takes the fear and shame out of admitting to one's own problems. Thus, they argue that group work is intended to facilitate changes in interpersonal functioning. Alonso and Rutan, (1984) asserted that clinical experience and research have demonstrated that group treatment can engender change not as easily achieved in other modalities. Dynamics such as cohesion, the strength of group norms, commitment, and self-disclosure in groups have all been identified and described by Yalom (1995) as those dynamics that serve to facilitate change. Most importantly, as Andronico (1999) stated, "As men observe other men coping in groups, they
discover alternatives to misusing power (e.g. violence) when they are feeling powerless." (p. xix).

While the group modality had been firmly established as the predominant form of treatment, the specific content of batterer groups varied and continues to vary. Psychologists and social workers utilized techniques from cognitive and behavioral therapies to transform what began as primarily consciousness raising groups into psychoeducationally oriented programs that maintained and reinforced the original anti-sexist message. The late 1980's was a time in which pro-arrest legislation brought about court-mandated counseling. These legislative changes significantly altered the size and scope of programs. As a result of this increase, there was also a diversification of batterer programming. In addition, the organization in which each batterer program was based reflected the unique philosophical underpinnings of each organization. The programs affiliated with battered women's shelters versus independent batterer programs and those programs encompassed within mental health clinics or family services all have the potential to share common goals but differ in the methods utilized to accomplish their stated objectives. Hence, these differences have resulted in variations in
format, duration, training and content, which continue to persist (Gondolf, 1995). More specifically, differences of opinion among a diverse group of mental health professionals persist regarding the relative emphasis on counseling and education during treatment. In addition, duration of treatment continues to be a question that remains unresolved. Program duration can vary from three months to as long as a year. No consensus currently exists with regard to the optimal time period for treatment efficacy (Harway & Evans, 1999 as cited in Andronico, 1999). It is important to note that some semblance of a unified approach exists in what has been identified as a gender-based, cognitive-behavioral modality whereby "men are confronted with the consequences of their behavior, held responsible for their abuse, have their rationalizations and excuses confronted, and are taught alternative behaviors and reactions." (Gondolf, 1995). However, it is important to note that several additional modalities currently exist. These treatment approaches include "healing men's trauma, redirecting emotions (particularly anger), and addressing couple communications and interactions." (Adams, 1988; Caesar & Hamberger, 1989 as cited in Gondolf, 1995). Thus, given the diversity of
philosophical underpinnings of treatment as well as diverse
treatment approaches, low compliance rates, and high
dropout rates, it is apparent that conflicting research
regarding the efficacy of batterer treatment is to be
expected.

Many batterer treatment programs conceptualize
partner abuse from a social learning perspective. Thus,
violece is considered a learned behavior rather than the
result of psychopathology or character deficit. Therefore,
given the fact that many batterers witnessed domestic
violence as children, the role of modeling and conditioning
in the learning process is believed to be strong. This
perspective asserts that the cumulative impact of social
learning and cultural values results in attitudes and
beliefs that offenders use to justify abuse. In addition,
social norms and patterns embedded in patriarchal social
structure are believed to reinforce both attitudes and
violent behavior. The philosophical underpinnings of many
court-affiliated treatment programs are fairly consistent.
The following identifies the predominant goals of many
court-ordered treatment programs.

1. To increase the offender's responsibility for his
   battering behavior;
2. To develop behavioral alternatives to battering;
3. To increase constructive expression of all emotions, listening skills, and anger control;
4. To decrease isolation and develop personal support systems;
5. To decrease dependency on and control of the relationship;
6. To increase the batterers' understanding of the family and social facilitators of domestic violence.

Many domestic violence perpetrator programs conceptualize the work according to the following perspective:
(a) violence is a learned behavior that can be unlearned,
(b) violent behavior is a choice, (c) the batterers' violence does not result from loss of control, but from taking control, (d) violence has a negative impact on every member of the family, (e) provocation does not justify aggression, (f) traditional family roles can lead to unequal power relationships.

Treatment is intended to facilitate improvement in interpersonal and communication skills, confront denial and decrease a sense of isolation. The format generally consist of weekly meetings of groups of men conducted with

Treatment Program Non-Compliance and Dropout

Researchers have concluded that the majority of batterer programs experience a participant dropout rate of 40% to 60% within the first three months of treatment. (Cadsky, Hanson, Crawford, & Lalonde, 1996 as cited in Taft, Murphy, Elliott & Morrel, 2001). In addition, Gondolf (1995) asserted that approximately 50% of men who are referred to domestic violence treatment programs, never actually begin the program. For example, he notes that men may make an appointment and may even attend an orientation session. However, he notes that many of these initial appointments result in “no shows”, and even if there is an initial contact with the program, it may not result in officially entering the program. Gondolf and Foster, (1991) asserted that as few as 10% of men referred to a program actually completed it (as cited in Gondolf, 1995). Clearly, these statistics identify a need to gain a better understanding how to address the resistance of this population. Interestingly, a number of researchers found a positive relationship between treatment program dropout and the perpetration of more severe acts of domestic violence.
These same researchers also found program dropouts to be more likely to reoffend, have previous criminal offenses, alcohol and drug problems, and anti-social or narcissistic tendencies (DeMaris & Jackson, 1987; Grusznski & Carillo, 1988; Hamberger & Hastings, 1989; Saunders & Parker, 1989 as cited in Gondolf, 1995). However, it is important to note that Chen (1989), did not find a significant difference between individuals who attended a program for three weeks or less and those who completed the three-month program. Thus, more violent tendencies of program dropouts has been difficult to document and has not been well substantiated.

It is also important to note that Taft et al. (2001) found that those who are younger, lack a formal education, have lower income, are not married and have higher rates of unemployment or a history of unemployment are other factors associated with early drop out.

Court-ordered clients are more likely to remain in treatment than self-referred clients. In addition, evidence points to a pattern whereby minority group members are more likely than Caucasian clients to drop out from batterer's treatment programs (Taft, et. al. 2001).

Effects of Domestic Violence Treatment on Recidivism
Court-ordered batterer treatment is one response to the problem of domestic violence. Questions concerning its efficacy however, continue to emerge (National Research Council & Institute of Medicine, 1998 as cited in Levesque, Gelles & Velicer, 2000). A number of meta-analytic studies have been conducted to answer the question regarding batterer treatment efficacy. The results have been inconsistent. Saunders & Azar (1989) in Levesque, et. al., 2000 concluded that batterer treatment does in fact reduce recidivism. Other researchers are less optimistic. They either withhold judgment or encourage “cautious optimism” with regard to the efficacy of treatment (Tolman & Bennett, in Levesque, et. al., 2000). Inconsistent findings are often the result of the source of information used to draw conclusions. For example, a meta-analytic review of seven studies relying on partner report found no “overall effect” for batterer treatment. While a similar review of 11 studies relying on police reports and court records found a small effect. The problem of deciphering the overall impact of treatment is further complicated by the fact that a “significant portion” of batterers do not complete treatment. Pirog-Good (1986) found an average of 40% attrition rate nationwide. While Levesque (1988), found
a similar attrition rate of 36% in a meta-analysis of 21 treatment outcome studies (as cited in Levesque, et. al., 2000). An explanation for the attrition rate was not the focus of the research.

Studies reporting recidivism rates for batterers have yielded conflicting results. Kandel-Englander (1997) reported “recidivism in family violence appears to be the rule rather than the exception.” The previous statement is an overgeneralization and is prone to generate misinformation with regard to the efficacy of batterer treatment. Dutton (1986) conducted a three-year follow-up study which found re-arrest rates of treatment completers to be significantly lower than untreated batterers, 4% to 40% respectively (Babcock & Steiner, 1999). To date, there is no definitive response to the question of who is most likely to benefit from batterer treatment programs. Questions remain as to which individuals will respond (i.e., cease their abusive behavior) to more authoritarian measures such as incarceration, versus those who are more likely to benefit from treatment. Many batterer recidivism studies suffer from an analysis of findings from short-term follow-up periods. Given the intermittent nature of abusive behavior as well as the existence of an inverse
relationship between the amount of time that has elapsed after program completion and recidivism rates, a minimum of a one-year follow-up is recommended to adequately evaluate recidivism rates. (Babcock & Steiner, 1999). Results from a study conducted by Babcock and Steiner (1999) indicated an inverse relationship between number of treatment sessions attended and the number of posttreatment arrests for domestic violence. The findings of this study are supported by the number of participants (387), which was conducted over a two-year period. This research also highlights the role of extrinsic versus intrinsic motivation to treatment completion. The coordinated legal response appears to be a significant component in the intervention of domestic violence as a result of its impact on treatment compliance. This finding suggests the possibility of exploring extended court and probation involvement to increase treatment compliance. In addition, future research should involve an analysis of the experience of ethnic minorities as well as socially and economically disenfranchised individuals who comprise a high percentage of treatment noncompleters. The need for culturally sensitive interventions to increase compliance is clearly needed. It is important to note that many
domestic violence recidivism studies evaluate program effectiveness on the basis of reduction in physical abuse and/or domestic violence arrests post treatment. Given the dynamics of battering relationships it is likely that physical abuse is reduced while emotional and verbal abuse escalates. It is problematic that many studies are not measuring different forms of abusive behavior especially given the shroud of secrecy that often permeates abusive relationships. (APA, 1996). In addition, the fact that length of treatment varies, makes it difficult to generalize the findings from many of the studies conducted on batterer treatment efficacy. The recent trend in recommended length of treatment is one-year. Data from two evaluations of long-term treatment reveal lower levels of recidivism when compared to evaluations of short-term programs (Gondolf, 1997).

In summary, inconsistent results remain problematic for accurate analysis of the efficacy of domestic violence treatment. Differing lengths and type of treatment as well as the heterogeneity of batterers and the incongruent measurement of abusive behavior are just a few of the important differences in methodology, which yield inconsistent results. Thus, inconsistent findings have
resulted in an inability to reach a consensus regarding what constitutes effective treatment for batterers (Gondolf, 1997).

Motivation for Therapy

Given the preceding data, the question of motivation for treatment becomes an important area of inquiry with this population. Research supports the fact that treatment can be beneficial (Saunders & Azar, as cited in Levesque et al., 2000). However, not everyone benefits from treatment to a degree that is satisfactory. The preceding data supports the fact that a considerable amount of clients prematurely decide to stop treatment. This contributes to contradictory and inconsistent research conclusions about treatment efficacy. One plausible explanation for the difficulty in demonstrating a therapeutic effect is the failure of clients to comply with the "therapeutic regimen" resulting in a difficulty maintaining the gains acquired through treatment (Garfield & Bergin, 1994; Mash & Hunsley, 1993; as cited in Pelletier, Tuson, & Haddad, 1997).

Thus, motivation is an area of inquiry particularly relevant to the issues of attrition, compliance and maintenance of change. Deci and Ryan have paid considerable
attention to the issues of intrinsic motivation and self-determination. Their work has considerable potential to assist in understanding factors related to the effectiveness of treatment. They posit that the particular type of motivation utilized by the client has a distinct impact on "the maintenance and integration of therapeutic changes." (in Pelletier, et. al., 1997). Secondly, they identify therapeutic conditions that may facilitate or hinder clients' motivation to change. In addition, they explore the issue of "internalization" of changes, a factor seen as crucial to long-term change. Specifically, they posit that initial external forces motivating the client to change will become internalized to "form a permanent part of his or her character" (Pelletier et. al., 1997, p. 415).

Pelletier, et. al. (1997) presented a measure of motivation to change that may be used in studies addressing the impact of client motivation on behavior change, psychotherapy outcomes and client's well being. The Client Motivation for Therapy Scale (CMOTS) measures the different forms of motivation outlined in Deci and Ryan's Self-Determination Theory. Deci and Ryan (1985) suggested the existence of three basic types of motivation that regulate human behavior: intrinsic, extrinsic, and amotivation.
Intrinsically motivated behaviors are voluntary, devoid of any external or material rewards or constraints. They are behaviors in which individuals engage for pure pleasure or satisfaction. Deci and Ryan (1985) further posit that intrinsically motivated behaviors are internally regulated and thus are more likely to be performed in a consistent manner. This form of motivation is based on one's need to "feel competent and self-determined" (in Pelletier, et. al., 1997, p. 415).

Extrinsic motivation is the antithesis of intrinsic motivation. In other words, extrinsically motivated behaviors are performed for the sake of external rewards or to avoid punishment once the behavior has ceased (Deci, as cited in Pelletier, et. al, 1997). Extrinsic motivation has been dissected into four specific types, which range along a continuum of increasing self-determination. According to Deci and Ryan (1985) the four types, ranged from the lowest to highest manifestation of self-determination are hypothesized to be: external regulation, introjection, identification, and integration. Specifically, external regulation involves the regulation of behavior through external sources such as material rewards, constraints or punishment (Deci & Ryan, 1985).
Introjected regulation is the second type of extrinsic motivation listed on the continuum. It involves former extrinsically motivated behaviors that have been internalized. The presence of external factors no longer need be present to motivate a behavior. Internal pressures such as guilt, anxiety, or emotions related to self-esteem have replaced the external forces. Identified regulation involves behavior that is performed for extrinsic reasons (money, power, etc.) but is self-determined, internally regulated and consistent with one's values. Lastly, integrated regulation refers to behavior that is performed not only because an individual values its significance, but also because it is consistent with his or her self-identity. This is the most fully self-determined type of extrinsic motivation (Deci & Ryan, as cited in Pelletier, 1997).

Amotivation is the last type of motivation identified by Deci and Ryan (1985). This type of motivation is hypothesized to be consistent with an individual's feelings of incompetence and lack of control. Furthermore, this type of motivation is characterized by no real sense of purpose or understanding for engaging in a particular activity. For example, a client who has been referred to therapy, yet
is consumed with a sense of hopelessness and is convinced that therapy is a "waste of time". (as cited in Pelletier, 1997, p. 416).

It is important to note that Deci and Ryan (1985) conceptualize motivation to be a "dynamic concept". They posit that client's motivational type is subject to change at different points in the treatment process as a result of situational influences, such as therapist interpersonal style. "Much of the research efforts regarding intrinsic motivation and self-determination have been toward the explication of factors in the environment that induce losses of motivation and self-determination, or alternatively, factors that might enhance intrinsic motivation and self-determination" (Pelletier, et. al., 1997, p. 417). The therapeutic context is an important aspect of therapy. Therapist intervention style is posited to have a significant impact on the type of client motivation. Autonomy supportive, involved, and informative therapists are hypothesized to facilitate greater integration of change in their clients than controlling, noninvolved, and noninformational therapists, because the former facilitates increased self-determination, perceived internal locus of causality, and perceived competence.
There is considerable evidence to support the importance of providing choice to clients and fostering an internal locus of causality for maximizing psychotherapy effectiveness. For example, Bastien and Adelman (1984) found that adolescents who perceived having a choice for remaining at a rehabilitation facility showed greater treatment progress than did those who did not perceive such a choice. In addition, studies that "manipulated the degree of choice" in therapy supported these findings. For example, one study exposed clients to a controlling, confrontive therapist who had a "teaching" style and exposed other clients to a therapist who exhibited "facilitating" and "supportive" behaviors (Patterson & Forgatch, as cited in Pelletier et al., 1997). The facilitative, supportive therapist was associated with increased likelihood of client compliance.

In addition, a fairly recent study conducted with problem drinkers supported a similar conclusion that a directive-confrontational style yielded significantly more resistance from clients, which resulted in poorer outcomes at one-year follow-up. Comparatively, therapy outcomes were markedly improved when a more autonomy supportive intervention style was used.
In addition, research has supported the hypothesized link between motivation type and treatment outcomes. A number of studies have investigated the relationship among Deci and Ryan’s (1985) six types of motivation and the associated consequences. It follows that an increase in internally regulated, self-determined behavior will result in more positive outcomes. While the continuum of extrinsically and amotivational behaviors will yield varying degrees of negative outcomes and consequences. In general, studies have found that more self-determined forms of motivation can lead to enhanced learning, greater interest, increased life satisfaction, persistence, and improved health (Deci, Vallerand, Pelletier, & Ryan, 1991; Ryan & Connell, 1989; Vallerand & Bissonnette, 1992; Blais, Sabourin, Boucher & Vallerand, as cited in Pelletier, et al., 1997, p. 419). The notion that motivation is a dynamic concept and that therapists have the potential to impact the type of client motivation provides a sense of direction for elucidating factors that may improve or hinder the efficacy of treatment interventions.

Some researchers have attributed social influences, such as the patriarchal social structure as one of the most influential factors underlying men’s violence against
women. Specifically, Aldarondo, 1999; White & Gondolf in press; Pence & Paymar, 1993 have highlighted the role of societal influences on the behavior of abusive men. Specifically, they underscore the influence of traditional gender roles, which serve to encourage and reinforce male dominance as a significant factor in male to female violence. Other researchers focus on the psychological influences and the potential psychopathology of perpetrators. The assumption is that the etiology of violence is a result of psychological dysfunction. This argument is weakened by the work of Holtzworth-Munroe & Stuart, 1994, which revealed that approximately 50% of abusive men do not have diagnosable clinical disorders. Specifically, a number of researchers argue that psychopathology is found only with "the most severely violent men." (Aldarondo, 1999; White & Gondolf in press; Pence & Paymar, 1999. It is important to note that defining the etiology of male violence against women is one of the problems with this type of research.

Research has empirically validated that domestic violence perpetrators constitute a heterogeneous group. Although all violent husbands share a common behavioral problem (i.e., intimate partner violence), previous
research suggests that the shape and form of the problematic behavior differ across subgroups of domestically violent men (Holtzworth-Munroe & Stuart, 1994).

In addition to investigating changes in behavior among domestic violence perpetrators, this study focused on the impact of the therapeutic working alliance on the efficacy of the ACT Program treatment model. The impact of the relationship between the therapist and the client is a well-documented area of therapy outcome research (Horvath & Symonds, 1991). The therapeutic relationship has been conceptualized by some theorists and practitioners as something separate from the active ingredients of therapy, as a prerequisite for the change process rather than as an intrinsic part of it. Safran and Segal (1990) argued that it is this view that perpetuates a "mechanistic approach to therapy that fails to recognize the fundamentally human nature of the therapeutic encounter and the change process."

Safran and Segal (1990) clearly stated that their view does not preclude the necessity of therapists learning solid theory and skills. They clarify that "it does mean, however, that the relevant theory must clarified the
process through which this human encounter brings about change, and that the relevant skills must include the ability to use one’s own humanity as a therapeutic instrument.

Harry Stack Sullivan defined the therapeutic relationship as follows: "Two people, both with problems in living, who agree to work together to study those problems, with the hope that the therapist has fewer problems than the patient" (Kasin, 1986 as cited in Safran & Segal, 1990, p. 5) It was Greenson (1967) who first used the term "working alliance" and defined it as the "positive collaboration between client and therapist." The quality of the therapeutic working alliance has been identified by Greenson, 1967 as one of the essential components for successful outcome in therapy (Horvath & Symonds, 1991). The working alliance has been conceptualized as a "therapeutic partnership". This conceptualization allows one to consider the therapist's contributions and the complex interaction that takes place between client and therapist (Horvath & Symonds, 1991). "The working alliance as it is currently investigated, is a pantheoretic construct that 'substitutes' the idea that the relationship is therapeutic in itself. It is the belief that working
alliance makes it possible for the patient to accept and follow the treatment faithfully." (Bordin, as cited in Horvath & Symonds, 1991, p.2.)

Last, while there are varying definitions for the concept of the therapeutic working alliance, there exists a general consensus that this construct contains a key element, namely that the working alliance captures the collaborative nature of the relationship between the client and the therapist and the capacity for both the client and therapist to negotiate the "breadth and depth of the therapy." (Bordin, 1980; Horvath & Greenberg, 1989; Luborsky, 1976; Marmar, Weiss & Gaston, 1989; Marziali, 1984; Strupp & Hadley, as cited in Horvath & Symonds, 1991).

Impact of the Working Alliance on Treatment

In addition to the growing theoretical interest in the therapeutic relationship, there has been an expanding empirical literature demonstrating that patients perceive the relationship as crucial, regardless of whether or not the therapist emphasizes its importance. (Safran & Segal, 1990, p. 22).

Psychotherapy researchers have attempted to delineate variables that will predict treatment outcome as a result
of failing to find significant individual differences in treatment outcome combined with the failure to demonstrate consistent differences among treatments. Initial research in this area focused on patient characteristics identified prior to treatment. Luborsky (1980) found that the success of predictive measures based on pre-treatment information was generally nonsignificant, and that the best of them predicted only 5% to 10% of the outcome variance. This led Luborsky to speculate that he crucial predictive factors may not be apparent until the patient and therapist have had a chance to interact. Luborsky (1980) found that the assessment of different psychotherapy process characteristics and aspects of the therapist-patient interaction has shown more promise (as cited in Safran & Segal, 1990, p. 32). Sloane (1975) found that successful patients in behavior therapy found the personal interaction with the therapist to be the single most important part of their treatment (Safran & Segal, 1990, p.22). In addition, Alexander (1976) found that relationship variables contributed significantly to outcome in the behavioral treatment of delinquents and their families. Persons and Burns (1985) found that patients' assessments of the
quality of the therapeutic relationship were significantly related to mood changes in cognitive therapy.

"The empirical evidence has thus been consistent in implicating the therapeutic relationship as an important variable in the change process, even though cognitive-behavioral theory has not consistently done so." (Safran & Segal, 1990, p. 23). Research conducted by Horvath and Symonds (1991) and substantiated by additional research (Tichenor & Hill, as cited in Horvath & Symonds, 1991; Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997) suggested that client reports of the therapeutic alliance were superior predictors of outcome. In addition, it is important to note that research supports the measurement of a general alliance dimension rather than evaluate the alliance as a result of the intercorrelations among the three subscales, which range from .87 to .96 (Tracey & Kokotovic, 1989). Length of time in treatment: Kokotovic and Tracey (1990) reviewed the research, which suggested the measurement of the alliance should not be conducted before the third session as a result of the time necessary to build an alliance. Interesting, Gelso and Carter (1985) revealed that this recommendation with regard to the measurement of the alliance has not been empirically
validated (In Kokotovic & Tracey, 1990). Results from a meta-analytic study conducted by Horvath and Symonds (1991), did not reveal significant results with regard to the relationship between alliance, length of treatment and outcome. In addition, it is important to note that the same meta-analytic study conducted by Horvath and Symonds (1991), did not reveal significant results for the type of treatment and its impact on the alliance. This result supports the pantheoretical perspective of the working alliance construct. However, research conducted with outpatient alcoholics suggests that the therapeutic alliance and its impact on client motivation contributes to the efficacy of treatment. (Ahadi & Diener, 1989; Strube, 1991 in Connors, et al. 1997). Research with compulsory treatment for substance abusers reveals that successful behavior change is correlated to attachment to therapists and autonomous motivation (Lovejoy, et al., as cited in Cameron-Wild, Cunningham, & Hobdon, 1998). It is important to note that these findings are the result of one study and should be interpreted with caution. The generalizability of these findings is not possible as a result of the underrepresentation of diverse groups of individuals.
The Alliance Across Theoretical Orientations

In contrast to the psychodynamic tradition, behavioral and cognitive-behaviorally oriented therapists have de-emphasized the importance of the transference relationship in the psychotherapy process. The traditional cognitive-behavioral position on this issue has been that the therapeutic cultivation and management of the transference relationship has little impact upon the patient's everyday life. Albert Bandura (1969) stated, "Whatever the patients may reenact with the psychotherapist, relatively few beneficial effects of these reenactments trickle down to daily interpersonal living. Most likely the artificial relationship provides substitute gratifications for those lacking in the patient's natural relationships instead of serving as a major vehicle for personality change" (as cited in Safran & Segal 1990, p. 26). Other cognitive behaviorists such as, Goldfried and Davison (1976) and Goldfried (1982) have taken a more flexible position and recommend that therapists consider problematic in-session behavior exhibited by patients as a sample of the problem behavior that initially brings them into therapy. First hand observations of the patient's current functioning. Second, focusing on the therapeutic relationship can be
emotionally riveting to the patient. Third, that to the extent that the patient’s current problems are reenacted in the therapeutic relationship, the patient can make discoveries and try out new behaviors that will generalize outside of therapy.

In analyzing similarities and differences between psychodynamic and cognitive-behavioral perspectives, Arnkoff (1983) made the following distinctions: the cognitive-behavioral perspective places less emphasis on past history than does the psychodynamic perspective, and, the focus in cognitive therapy is more present-oriented; cognitive-behavior therapy focuses on dysfunctional cognitions and behavioral deficits and excesses, whereas psychodynamic therapy focuses on psychosexual conflicts and motivational states; transference issues are more central to psychodynamic therapy than to cognitive therapy; cognitive therapists may treat transference issues as distortions in the patient’s perception of the therapist, but it is not assumed that changes in the patient’s perception as a result of addressing these distortions will necessarily generalize to out-of-session perceptions and behaviors (Safran & Segal, 1990, p. 27).
Foa and Emmelkamp (1983) attempted to have researchers specify some of the subtle interactional processes that are important in effective cognitive-behavioral treatment. Writings of this kind, however, have been relatively rare in the cognitive-behavioral literature. They argue that specifying the subtleties of relationship skills is only part of the battle. They further assert that it is just as important to develop an theoretical model that integrates and clarifies the relationship between specific and nonspecific factors. The ultimate objective is to enhance practitioners' ability to facilitate the therapeutic process. (as cited in Safran & Segal, 1990, p. 29).

The preceding review attempted to document the growing interest among cognitive therapists in the therapeutic relationship as an arena for exploring and modifying dysfunctional behaviors and beliefs. Yet as Jacobson (1989) reminded us, "Although psychoanalytic theorists and therapists have been writing about the healing potential of the therapist-client relationship for decades, it has only recently crept into the cognitive-behavioral literature" (as cited in Safran & Segal, 1990, p. 27). Thus, Wolfe and Goldfried (1988) emphasized the importance of delineating and elucidating factors across theoretical orientations in
an attempt to develop a taxonomy of effective therapeutic change processes. This is a potentially fruitful area of inquiry that appears to have far reaching implications for practitioners regardless of theoretical orientation (as cited in Hanna & Ritchie, 1995). According to Hanna and Ritchie (1995) the following factors were requisite conditions in the process of client change:

(a) insight or a new understanding was perceived as the most potent common factor of change, (b) confronting or acknowledging problems was also an important condition of change, (c) reinterpretation or perception of stress in a novel manner was the third most powerful change variable. Further research must be conducted to delineate whether or not these factors are also imperative to the change process with specific groups such as male batterers.

Questions such as how and at what point does a decision to change become manifest remain unanswered.

Conflict Tactics

Coser (as cited in Straus, Hamby, Boney-McCoy, & Sugarman, 1996) used “conflict” to refer to the means or behavior used to pursue one’s interest rather than conflict of interest itself. In the context of this study, Coser’s
term will be utilized. Therefore, “conflict” will refer to “conflict tactics” which is defined as the overt actions of an individual utilized to resolve conflict. The focus pertains to how individuals approach conflict resolution. For example, some individuals may attempt to resolve conflicts through democratic means while others may resolve differences by brute physical force or threats and intimidation. Therefore, the means by which male batterers resolve conflict pre and post-treatment is the variable of interest in this study. It is hypothesized that treatment will impact a change in the manner in which conflicts are resolved from physical force, threats and intimidation to resolution of conflict based on negotiation and nonviolent/nonabusive means.

Summary

The review of literature supports investigating the impact of client motivation for therapy and the quality of the therapeutic working alliance on changes in abusive behavior from a sample of domestic violence perpetrators. Court-ordered batterer treatment is one facet of the coordinated response to the problem of domestic violence, a number of questions concerning treatment efficacy, program compliance and recidivism remain unresolved. Researchers
have concluded that the majority of batterer programs experience a participant dropout rate of 40% to 60% within the first three months of treatment (Cadsky, Hanson, Crawford, & Lalonde, 1996 as cited in Taft, Murphy, Elliott & Morrel, 1999). Saunders & Azar as cited in Levesque, et.al., 2000) concluded that batterer treatment does in fact reduce recidivism. Other researchers are less optimistic. They either withhold judgment or encourage "cautious optimism" with regard to the efficacy of treatment (Feldman & Ridley, 1995; Rosenfeld, 1992; Tolman & Bennett, as cited in Levesque, et. al., 2000). These studies suggest that inconsistent findings are often the result of the source of information used to draw conclusions. Many batterer recidivism studies suffer from an analysis of findings from short-term follow-up periods.

Empirical evidence has been consistent in implicating motivation for therapy and the therapeutic relationship as important variables in the therapeutic change process (Safran & Segal, p. 23). An attempt to develop a taxonomy of effective therapeutic change processes is a potentially fruitful area of inquiry that appears to have far reaching implications for practitioners regardless of theoretical orientation (as cited in Hanna & Ritchie, 1995).
Therefore, in addition to investigating the roles of client motivation for therapy and the therapeutic alliance, (the hypothesized variables implicated in affecting individual change processes) the means by which male batterers resolve conflict pre and post-treatment was an important area of inquiry.
CHAPTER III

METHODOLOGY

Recruitment, Selection and Description of Participants

This experiment is a correlational field study. Participants were adult male batterers between the ages of 18 and 75. They were recruited from the Abuse Ceases Today (ACT) Program, which is located in a moderately large suburban area in the Middle Atlantic Region of the United States.

Baseline data regarding the type and frequency (i.e. physical, verbal) of abusive behavior was collected on all clients referred to ACT using the Revised Conflict Tactics Scale (CTS2). However, only the baseline data from those who volunteered for the study was included. For those who chose not to participate in the study, the information remained in their confidential program file.

The research protocol included: The Client Motivation for Therapy Scale (CMOTS), The Revised Conflict Tactics Scales (CTS2), the Working Alliance Inventory (WAI), and a demographic questionnaire. (intended to update information from the intake interview, i.e., changes in income, relationship status and active substance abuse) were
distributed to the participants and subsequently completed and returned to the researcher. Each informed consent form was sealed in a separate envelope and collected separate from the research protocol. The participants were read a brief description of the research as well as standard instructions intended to ensure that all groups received the same information about how to respond. Informed consent as well as the research protocols were coded prior to distribution so that the researcher was able to link their responses with baseline data.

Participant Response Rate

The response rates required for the data analyses, which includes multiple regression, varies. McLaughlin and Marascuilo (1990), recommended identifying the number of predictor variables in the analysis multiplied by ten. This formula was recommended for both multiple analysis of variance as well as logistic regression analysis. Thus, the manova utilized in this study contained five predictor variables in addition to two groups (completers and noncompleters). According to the formula \((10 \times (5 \text{ predictor variables} + 2 \text{ groups}))\), a minimum of 70 participants was needed. Applying this same formula to the logistic regression analysis, a minimum of 40 participants
was recommended \((10 \times (2 \text{ predictor variables} + 2 \text{ groups})\)). "Green (1991), recommended a formula for determining the response rate needed for a medium-size relationship between the independent variables and the dependent variable, \(\beta = .05\) and \(\beta = .20\), for multiple regression which is \(N > 50 + 8m\), where \(m\) is the number of predictor variables in the analysis. Using this formula, \([50 + (8)(4)]\), the minimum response rate needed for the present study was 82 participants.

Research Instruments

The surveys proposed for use in this research study include an informed consent form and the following instruments: (a) The Revised Conflict Tactics Scale - 2nd Edition (CTS2) (Strauss, et al.); (b) Client Motivation for Therapy Scale (CMOTS) (Pelletier, et al.); (c) The Working Alliance Inventory (WAI) (Horvath, 1992); (d) Demographic Sheet.

The Revised Conflict Tactics Scale (CTS2)

The CTS2 (Strauss, 1979, 1990a), "measures both the extent to which partners in a dating, cohabiting, or marital relationship engage in psychological and physical attacks on each other and also their use of reasoning or negotiation to deal with conflicts." (Straus, Hamby, Boney-
McCoy & Sugarman, 1996, p. 283). The CTS2 uses a Likert scale. The CTS2 is an updated version of the original CTS and items to enhance content validity and reliability; revisions to improve "clarity and specificity"; more discrimination between scales; scales to measure sexual coercion and physical injury. Base of administration was another goal of the revision of the scales. Reliability ranges from .79 to .95. There is preliminary evidence of construct validity." (Straus, et. al., 1996, p. 283).

The Client Motivation for Therapy Scale (CMOTS)

The CMOTS is a 24-item instrument designed to measure client motivation for therapy. The scale is based on the theoretical perspective of human motivation and self-determination proposed by Deci and Ryan who postulate the existence of six different types of motivation that are classified along a continuum of increasing autonomy. The six subscales of the CMOTS correspond to the six different types of motivation postulated by the theory and appear to fall along a self-determination continuum. The subscales are: intrinsic motivation (items 3, 4, 12, 16); integrated regulation (items 17, 18, 23, 24); identified regulation (items 6, 7, 15, 20); introjected regulation (items 5, 9, 10, 19); external regulation (items 1, 11, 21, 22); and
amotivation (items 2, 8, 13, 14). The CMOTS is a valuable measure that practitioners can use to address the impact of client motivation on psychotherapy effectiveness and mental health. The CMOTS internal consistency, with alphas for the subscales that range from .70 for external regulation to .92 for intrinsic motivation.

The Working Alliance Inventory (WAI)

The Working Alliance Inventory was developed and validated using Bordin's (as cited in Horvath & Greenberg, 1994) model of the alliance. The model is "pantheoretical." Bordin's primary objective was to evaluate the alliance construct..."investigate therapeutically active factor(s) shared by all forms of therapies." (Horvath, p.110). Bordin (1975) defined the working alliance as the active relational element in all change-inducing relationships.

Bordin's conceptualization of the alliance differed from unconscious projections of the client (transference). He emphasized the role of the client's positive collaboration with the therapist against the common foe of the client's pain and self-defeating behavior. Task, Bond and Goal are the three elements of the therapeutic alliance according to Bordin (as cited in Horvath & Greenberg, 1994,
This conceptualization provides an important bridge between the "relationship" and "technique" aspects of therapy. The Goals negotiated and agreed on frame the client's wishes within the therapist's theoretical and practical wisdom, the Tasks represent both the means to achieve these ends and the client's willingness to engage in solving the problem in a new way. This relationship is not seen as a separate or independent process, but as a form of active collaboration, the development of which is directly linked to the therapeutic agenda. The very act of negotiating and defining this agenda is central to the development of the positive alliance and to the therapeutic change process. Thus, although the working alliance takes account of generic factors that are common to the universe of positive relationships, such as liking, trust, and compatibility (i.e., Bond), it emphasizes those components of the interpersonal dynamic that are specific to the therapeutic enterprise such as the commitment to therapeutically sound and realistic goals and active endorsement of a set of procedures or tasks that will enable the client to reach those objectives.

Evidence of convergent validity of the WAI was found by a number of researchers. The WAI was found to correlate
positively with other alliance measures. Specifically, Safran and Wallner (1991) reported correlations between the global California Psychotherapy Alliance Scale (CALPAS) scores and the WAI of .84, .79, and .72, for the Goal, Task, and Bond scales respectively. The correlations between the client version of the WAI and the Helping Alliance and the Vanderbilt Scales are also significant though slightly lower (Greenberg & Adler, 1989; Tichenor & Hill, as cited in Horvath & Greenberg, 1994, p. 115). The question of discriminant validity was supported by a number of researchers. For example, the relation between the WAI and the Counselor Rating Form (CRF) which measures the relationship dimensions of expertness, attractiveness, and trustworthiness - based on Strong's (1968) interpersonal influence model demonstrated a significantly lower relationship than the WAI and other alliance measures.

Reliability estimates for the instrument, based on item homogeneity (Cronbach's Alpha), range from .93 to .84, with most reported coefficients in the upper range (Adler, 1988; Horvath, 1981; Moseley, 1983; Plotnicov, 1990; Watkins, as cited in Horvath & Greenberg, 1994, p. 115). Reliability estimates for the subscales are lower, but in the similar range (.92 to .68). Test-retest reliability
for the whole scale across a 3-week interval is .80; and for the component scales, the range is between .74 and .66 (Plotnicov, as cited in Horvath & Greenberg, 1994, p. 115). Taken together, these results support the scale’s reliability.

Last, a demographic questionnaire for purposes of obtaining descriptive data concerning age, race, socioeconomic status, and time spent in the program will be utilized.

Procedure

Participants were recruited from the Abuse Cases Today (ACT) Program. The Revised Conflict Tactics Scale -2 was administered to each new client as part of the standard intake interview prior to participation in the ACT Program. Access to the data gathered from the first administration of the Revised CTS-2 was accessed upon client’s consent to participate in this research project. Thus, it is important to note that participation in this study was completely voluntary and open to each client of the ACT Program. Voluntary participants received a research packet that contained a second copy of the Revised Conflict Tactics Scale-2, (intended to update the researcher regarding self-reported changes in abusive behavior) the
Working Alliance Inventory, The Client Motivation for Therapy Scale and a demographic data sheet. At designated times, research groups were conducted for the group administration of the study. The experimenter read the informed consent to each group and answered questions regarding the research. Participation in this study required approximately 30 minutes.

The variables of interest in this study consisted of client motivation for therapy, number of sessions attended, and the general alliance dimension of the therapeutic working alliance.

Methods of Data Analyses

Hypothesis 1 Program completers will demonstrate statistically significant lower scores on the second administration of the Revised Conflict Tactics Scale (CTS2) as compared to the non-completer comparison group. The method of analysis for this hypothesis was a one-way multiple analysis of variance (MANOVA) comparing the two groups - completers and dropouts - on the five CTS posttest subscales.

Hypothesis 2 Positive therapeutic alliance and high level client motivation will predict program completion in a sample of male domestic violence perpetrators. The method
of analysis for this hypothesis was a logistic regression. The independent variables of therapeutic alliance and client motivation were used to predict the dependent variable of program completion. 

Hypothesis 3 Lower education levels and involvement in current relationship were used to predict higher scores on the Conflict Tactics Scale. (Substance abuse was removed from the analysis as a result of nonsignificant number of participants reporting substance abuse problems). The method of analysis utilized for this hypothesis was a multiple regression (enter method). The independent variables of education and relationship status were used to predict the dependent variable of change in abusive behavior as measured by the Revised Conflict Tactics Scales (CTS2).

Analysis of the data was performed through the Statistical Package for the Social Sciences (SPSS). The level of significance was set at the .05 conventional significance level.

The purpose of this study was to examine the relationship between client motivation for therapy, the therapeutic working alliance and subsequent changes in abusive behavior with a sample of adult male batterers from
the Abuse Ceases Today (ACT) Program. The research was important for mental health professionals working with male batterers. It was an attempt to delineate what impacts the change process for this specific population of people who have a tendency to refuse acknowledgement of the impact of their behavior on their victims. Specifically, they have a tendency to minimize, deny and blame other people for their actions. This research has the potential to inform clinicians' work with batterers.
CHAPTER IV

RESULTS

Description of the Sample

Eighty-eight individuals chose to participate in this study. Forty-eight participants, (54.5%) attended more than 21 out of a possible total 26 sessions and were thus identified as "program completers". The "non-completer" group consisted of those individuals who attended a minimum of five sessions, but were no longer actively participating in the program. This group consisted of 40 individuals, which represented 45.5% of the study participants.

Taken as a whole, this group is relatively well educated. Ten percent of the sample consists of individuals with less than a high school education, 34% have earned a high school diploma, 33% have attended college, and 23% have attended graduate school. Given the U.S. census data, these figures indicated that the individuals who participated in this study were well above average (U.S. Census Bureau, 2000). Fifty-five percent of the total sample (N = 88), are currently involved in a relationship. It is important to note that relationship involvement included both those ACT Program participants continuing in
relationships with their original partners/victims at the time of the ACT Program referral as well as those who began relationships with new intimate partners after they began participation in the program. Participants overwhelmingly (96.6%) denied active substance abuse. Participants ranged in age from 19-63 years. The mean age of the participants was 44.2 years.

Table 1 provides the Mean and standard deviations for the five subscales of pretest Conflict Tactics Scale.

Table 1

Conflict Tactics Scale Pretest Means and Standard Deviations by Group

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th>Completers (N=48)</th>
<th>Non-Completers (N=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Negotiation</td>
<td>80.60</td>
<td>42.45</td>
</tr>
<tr>
<td>Psychological Aggression</td>
<td>3.55</td>
<td>1.21</td>
</tr>
<tr>
<td>Physical Assault</td>
<td>1.54</td>
<td>1.56</td>
</tr>
<tr>
<td>Sexual Coercion</td>
<td>0.78</td>
<td>1.38</td>
</tr>
<tr>
<td>Physical Injury</td>
<td>0.34</td>
<td>1.28</td>
</tr>
</tbody>
</table>
Prior to hypothesis testing, the pre- and posttest versions of the five subscales of the Conflict Tactics Scale -- (1) Negotiation, (2) Psychological Aggression, (3) Physical Assault, (4) Sexual Coercion and (5) Physical Injury -- were screened for evidence of nonnormality and outliers. Univariate frequency distributions were inspected along with the skewness and kurtosis statistics for these five variables. Four of the five subscales - Psychological Aggression, Physical Assault, Sexual Coercion and Physical Injury -- were skewed and were subsequently logarithmically transformed to mitigate this problem. Tabachnick and Fidell, 1996 recommend modifying the distribution in such a way so as to diminish the influence the outliers in determining the statistical results of the study. A logarithmic transformation is specifically recommended when the distribution is substantially different from normal.

In order to decide on an appropriate analytic strategy for testing Hypothesis 1, a oneway, multivariate analysis of variance (MANOVA) was conducted in which the program completers and dropouts were compared on the pretest version of the Conflict Tactics Scale. Had significant differences been found in this analysis, the pretest versions of the five subscales would have been used as
covariates in examining differences between the two groups on the posttest measures. However, the multivariate significance test for this analysis indicated that the two groups did not differ significantly on the five pretest CTS subscales \( F = .98, \text{df}=(5,81), p=.43 \). (Inspection of the univariate results also failed to find any significant differences between completers and dropouts on any of the five subscales).

In addition to evaluating the pretest measures of the CTS as possible covariates, the two groups were also compared with respect to three demographic variables, which might also have served as possible covariates. Crosstabulation/chi-square analyses comparing the two groups on the proportion of each group either in a relationship, i.e., with a "partner" \( \chi^2 = 1.47, (1), p=.23 \), or currently abusing drugs \( \chi^2 = .19, (1), p=.67 \) were statistically nonsignificant. Similarly, the two groups did not differ in terms of their average level of education \( t = .87, (86), p=.39 \). A third variable, current substance abuse, was dropped from further consideration in view of the fact that only 3 respondents (3%) in the sample acknowledged substance abuse. Given these findings, a oneway multivariate analysis of variance comparing the two
groups - completers and dropouts - on the five CTS posttest subscales was conducted.

**Hypothesis 1**

Hypothesis 1 states that program completers will display statistically significant lower scores on the Conflict Tactics Scale at posttest than will program dropouts.

Table 2 presents the five posttest CTS subscale scores for the completers and the dropouts. The multivariate significance test (Hotelling's Trace) indicates that there is a statistically significant difference between completers and dropouts on the set of five posttest outcomes, taken as a set \((F = 2.47, \text{ df} = (5, 80), p = .04)\). Given that fact, the univariate significance tests were examined to determine which dependent variables may be contributing to the multivariate result. These results indicated that the two groups differed on both psychological aggression \((F = 5.93, \text{ df} = (1, 84), p = .02)\) and physical aggression \((F = 5.63, \text{ df} = (1, 84), p = .02)\). However, the homogeneity of variance assumption was violated for physical assault dependent variable. Given that fact, a Mann-Whitney test, i.e., a nonparametric "t-test" which makes no homogeneity
assumption, was used to evaluate the difference between the
two groups of respondents. This test did not corroborate
the univariate result found in the oneway MANOVA. That is
to say, the completers and dropouts were not found to be
statistically different from one another on this variable
\((Z = -1.56, p=.12)\). As such, the only reliable difference
on which the completers and dropouts differ is
psychological aggression. Consistent with the hypothesis,
the completers' average (backtransformed) score on this
variable is less than half that of the dropout group.
(Backtransformed means 15.13 and 33.93 for completers and
noncompleter's respectively). However, and contrary to the
claims made in Hypothesis 1, the completers and dropouts
did not differ on any of the four other subscales of the
CTS (see table 2).
Table 2

Conflict Tactics Scale Posttest Means and Standard Deviations by Group

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th>Completers (N=48)</th>
<th>Non-Completers (N=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Negotiation</td>
<td>83.98</td>
<td>47.47</td>
</tr>
<tr>
<td>Psychological Aggression</td>
<td>2.72</td>
<td>1.61</td>
</tr>
<tr>
<td>Physical Assault</td>
<td>0.34</td>
<td>1.13</td>
</tr>
<tr>
<td>Sexual Coercion</td>
<td>0.12</td>
<td>1.13</td>
</tr>
<tr>
<td>Physical Injury</td>
<td>0.16</td>
<td>0.98</td>
</tr>
</tbody>
</table>

Possible pre-post differences between the Completers and Dropouts on the five subscales of The Conflict Tactics scale were examined by conducting a multivariate, repeated measures analysis of variance in which Group membership (Completers vs. Dropouts) served as the between subjects factor and Time (pretest vs. posttest) served as the within subjects factor. There are three possible effects that can be evaluated in this type of analysis: (1) the Group effect, that is, averaging over "time", pretest and posttest, are there statistically significant mean
differences on the five CTS subscales? (2) the Time effect, that is, averaging over group, Completers and Dropouts, are there statistically significant differences between the "pre" and "post" measures of these five subscales, and most importantly, (3) the Group x Time interaction effect which addresses whether there has been statistically significant differential group change on these same five subscales. Table 3 presents the multivariate Source Table from this analysis.

Table 3

Multivariate, Repeated Measures Analysis of Variance of the Conflict Tactics Scale

<table>
<thead>
<tr>
<th>Effect</th>
<th>F</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1.123</td>
<td>(5,79)</td>
<td>.36</td>
</tr>
<tr>
<td>Time</td>
<td>2.813</td>
<td>(5,79)</td>
<td>.02</td>
</tr>
<tr>
<td>Group x Time</td>
<td>2.924</td>
<td>(5,79)</td>
<td>.02</td>
</tr>
</tbody>
</table>

As seen in Table 1, there is a statistically significant, multivariate interaction effect implying that there is evidence of significant differential Group change on at least some of the CTS subscales. Visual inspection of the univariate results indicated that for two of the five CTS subscales, i.e., Psychological Aggression (F=5.60,
df=(1,83), p=.02) and Physical Aggression (F=6.90, df=(1,83), p=.01), there is evidence of differential group change. In order to follow-up these two significant interaction effects tests of simple main effects were conducted. For both subscales these subtests indicated significant (p<.05) improvement, i.e., decline, in the (log-transformed) means of the Completer group, but no evidence of significant decline in the Dropout group (Psychological Aggression: Completers = 34.88 (pretest) to 14.75 (posttest) vs. Dropouts = 30.63 (pretest) to 33.92 (posttest); Physical Aggression: Completers = 4.65 (pretest) to 1.44 (posttest) vs. Dropouts = 2.91 (pretest) vs. 2.95 (posttest). For clarification, the means reported in the text have been "backtransformed" by taking the antilogs of the logarithmically transformed mean scores for each group at each time point.

Prior to executing this analysis the six subscales of the Client Motivation for Therapy measure were submitted to a Principal Components Analysis in order to evaluate the underlying dimensionality of this measure. This analysis indicated that there were two summary dimensions, or principal components, which accounted for 76% of the variation in the original set of six subscales. Visual
inspection of the rotated component loadings indicated that Intrinsic Motivation (.89), Integrated Regulation (.93), Identified Regulation (.94), and Introjected Regulation (.84) defined the first of these two dimensions. The second dimension was defined by External Regulation (.85) and Amotivation (.56). The factor scores operationalizing these two dimensions - "Internal Motivation for Therapy" and "External Motivation for Therapy" were subsequently used, along with the total score from the Working Alliance Inventory, in testing Hypothesis 2. Also, prior to conducting the logistic regression analysis the three predictors were standardized to enhance the interpretability of the results.

Hypothesis 2

Table 4 presents the findings for Hypothesis 2 which predicts that program participants with both better "working alliances" with their therapists and higher levels of client motivation will be more likely to successfully complete the program. In order to test this second hypothesis a binary logistic regression analysis was conducted. The predictors, taken together, were significantly related to the dependent variable in this analysis, i.e., the completion of, or dropout from the
program \( (\chi^2 = 10.88, (3), p = .02) \). Inspection of the odds ratios associated with each predictor indicated that higher scores on the Internal Motivation for Therapy principal component (odds ratio: 1.61, \( p = .06 \)) and higher scores on the Working Alliance Inventory (odds ratio: 1.55, \( p = .10 \)) were not significantly related to successful completion of the program at the \( p < .05 \) level. External Motivation for Therapy was clearly nonsignificantly related to this outcome (odds ratio: 0.98, \( p = .94 \)).

Table 4

Logistic Regression Analysis of Program Completion as a Function of Therapeutic Alliance and Motivation for Therapy

<table>
<thead>
<tr>
<th>Variables</th>
<th>B</th>
<th>Wald test (z-ratio)</th>
<th>p</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZWAI</td>
<td>.435</td>
<td>2.75</td>
<td>.097</td>
<td>1.55</td>
</tr>
<tr>
<td>ZCMI</td>
<td>.474</td>
<td>3.55</td>
<td>.060</td>
<td>1.61</td>
</tr>
<tr>
<td>ZCM2</td>
<td>-.018</td>
<td>.006</td>
<td>.939</td>
<td>.982</td>
</tr>
</tbody>
</table>

Note. ZWAI = Working Alliance Inventory, ZCMI = Internal Motivation for Therapy, ZCM2 = External Motivation for Therapy. Prior to conducting the logistic regression analysis the three
predictors were standardized to enhance the interpretability of the results.

**Hypothesis 3**

*Hypothesis 3* predicts that lower educational levels and involvement in a current relationship will predict higher scores on the Conflict Tactics Scale posttest measures. Table 5 presents these correlations. Visual inspection of the table indicates that education is unrelated to any of the CTS subscales (all, p > .05). With regard to involvement in a relationship, this variable is significantly, albeit marginally, related to only one of the five CTS subscales — Negotiation (r = .21, p = .05). In the first instance, this finding indicates that program participants currently involved in a relationship report somewhat higher scores on the Negotiation subscale of the CTS.
Table 5

Pearson Correlations between the CTS Subscales and Education and Current Involvement in a Relationship

<table>
<thead>
<tr>
<th>Relationship Involvement</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negotiation</td>
<td>.21*</td>
</tr>
<tr>
<td>Psychological Aggression</td>
<td>.20+</td>
</tr>
<tr>
<td>Physical assault</td>
<td>.05</td>
</tr>
<tr>
<td>Sexual Coercion</td>
<td>.10</td>
</tr>
<tr>
<td>Physical Injury</td>
<td>-.02</td>
</tr>
</tbody>
</table>

Note. *p<.05  
+ p<.10

Summary

Based on the statistical analyses conducted on the collected data, Hypothesis 1 was supported in the current study. These results indicated that the two groups differed on both psychological aggression (F=5.93, df=(1,84), p=.02) and physical assault (F=5.63, df=(1,84), p=.02). However, the homogeneity of variance assumption was violated for physical assault dependent variable. Given that fact, a Mann-Whitney test, i.e., a nonparametric "t-
test" which makes no homogeneity assumption, was used to evaluate the difference between the two groups of respondents. This test did not corroborate the univariate result found in the oneway MANOVA. As such, the only reliable difference on which the completers and dropouts differ is psychological aggression.

Inspection of the odds ratios associated with the second hypothesis indicated that it was not supported. Specifically, results revealed that Internal Motivation for Therapy and a strong Working Alliance were not significantly related to successful completion of the program.

Last, hypothesis three was only partially supported. Education was not a significant predictor. Education is unrelated to any of the CTS subscales. Relationship involvement is significantly, but marginally, related to only the Negotiation subscale of the CTS.
CHAPTER V
DISCUSSION

The purpose of this study was to investigate the impact of the therapeutic working alliance and client motivation as it relates to program completion and a reduction in abusive behavior in a sample of domestic violence perpetrators. The primary objective of the Abuse Ceases Today Program is to assist clients in changing their abusive behavior. From the program's perspective, the goals are the same for each client.

This particular study sought to elucidate variables that are relevant in facilitating change (defined as a reduction in physical, psychological and emotional abuse) in a sample of domestic violence perpetrators.

What follows is a discussion of the results from the hypotheses testing.

Research Hypotheses

Research hypothesis 1

Program completers will demonstrate statistically significant lower scores on the Conflict Tactics Scale as compared to the non-completer comparison group.
When subjected to a multiple analysis of variance (MANOVA), results revealed that completers' scores on the Conflict Tactics Scale were statistically significantly lower than noncompleters. In other words, non-completers reported more psychological aggression than completers. Thus, hypothesis 1 was supported. However, in an effort to determine which dependent variables were contributing to the overall result, examination of the univariate significance tests was conducted. These results indicated that the two groups differed on both self-reported psychological and physical assault. While this study relied on self-reported changes in abusive behavior and is clearly not analogous to Gondolf’s (1991) evaluation from over 30 single site programs, the results are strikingly similar. Gondolf (1991) demonstrated that program completers demonstrated a reduction in physical violence as well as threats and verbal abuse (p.3). The results from this study serve to follow this trend in the data. However, with the current study, the homogeneity of variance assumption was violated for the physical assault dependent variable. Given that fact, a Mann-Whitney test, i.e., a nonparametric "t-test" which makes no homogeneity assumption, was used to evaluate the difference between the
two groups of respondents. This test did not corroborate the univariate result found in the oneway MANOVA. Therefore, the completers and dropouts were not found to be statistically different from one another on this variable. As such, the only reliable difference on which the completers and dropouts differ is psychological aggression. Thus, the completers and dropouts did not differ on any of the four other subscales of the CTS. In light of these findings, it is imperative to consider why this program failed to have a positive impact on variables other than psychological aggression.

One explanation for the lack of impact is that the program treatment is potentially insufficient to facilitate change or that there is greater impact on certain kinds of abuse - and that perpetrators are more willing to discuss non-physical abuse. It is possible that the intensity, and duration of treatment was insufficient and treatment strategies were ineffective. Debates concerning the duration of treatment continue in the domestic violence field. Currently, treatment duration ranges from short-term 5-week educational programs to programs extending over several years. It is important to note that evaluation of those programs that have been extended to 18 to 21 weeks,
did not find treatment to be more efficacious than programs shorter in duration (Edleson, 1990). While it is important to refrain from drawing firm conclusions from this research as these findings have not been replicated. However, this finding suggests that 26 weeks may also be an insufficient amount of time to facilitate reductions in abusive behavior.

It is important to note that this study examined one program operating in a single jurisdiction. Features of the setting and treatment program not measured in this evaluation might well have influenced the observed outcomes. Thus, it is highly recommended that this study should be replicated in different settings before concluding that similar treatment is not effective.

The response to domestic violence cases in Morris County included several features likely to contribute to successful criminal justice system intervention. The Abuse Ceases Today Program regularly communicates with probation officers and the Morris County Family Court system. These efforts have been identified in previous research as important components of a coordinated domestic violence response and were in place during the treatment evaluation.

Hypothesis 2
Positive therapeutic alliance and high level client motivation will predict program completion in a sample of male spousal abusers.

To test this hypothesis, a binary logistic regression analysis was conducted. The predictors, taken together, were significantly related to the dependent variable in this analysis, i.e., the completion of, or dropout from the program ($\chi^2 = 10.88, (3), p = .02$). However, inspection of the odds ratios associated with each predictor indicated that higher scores on the Internal Motivation for Therapy principal component (odds ratio: 1.61, $p = .06$) and higher scores on the Working Alliance Inventory (odds ratio: 1.55, $p = .10$) were not significantly related to completion of the program at the $p < .10$ level.

In an effort to understand how the odds ratios associated with an overall significant result for the logistic regression could be nonsignificant, Rodgers (1995) highlighted the fact that the odds ratios makes a statement regarding the sample study and the population that the sample was intended to represent. In this research, the question consists of whether or not the sample utilized in this study can be generalized to the population of domestic violence perpetrators. Thus, it involves the likelihood of
particular odds in a sample as it relates to the population from which the sample was drawn. The increase in odds of group membership in the predictor is estimated while controlling for other predictors (p. 186). Therefore, there are factors in the sample population that do not correspond to the general population. While the exact reasons remain unknown, the sample population was found to be more highly educated than the general population.

This finding is consistent with research conducted by Brown and O'Leary (2001), who investigated group treatment for spouse abuse.

Results from their research also found that working alliance was not related to treatment completion. This finding is further supported with previous research that failed to find a difference between alliance and treatment completion. It is important to note that Brown and O'Leary's work was conducted with couples rather than individual male batterers. However, their research indicated that the therapeutic alliance was unrelated to many of the couples' decision to discontinue treatment. (Brown, O'Leary, & Faldbau, 1997 as cited in Brown & O'Leary, 2001). While Brown and O'Leary's (2001) work did not support the relationship between therapeutic working
alliance and treatment completion, results indicated that the working alliance was related to treatment success (i.e., decreased mild and severe psychological and physical aggression). Results from the current research do not support the hypothesis concerning role of therapeutic alliance and motivation for therapy in treatment completion. A number of possibilities exist to explain this finding. First, while there are conflicting findings, previous research has found that clients who discontinue treatment are more likely to reoffend, have previous criminal offenses, alcohol and drug problems, and anti-social or narcissistic tendencies. These factors may impede individual client's ability to form an alliance with a therapist and may not be motivated for therapy as a result of these confounding variables. In addition, clients who complete the program may do so for a variety of reasons not measured in this analysis. For example, their motivation for attending therapy may be related to external variables such as the threat of law enforcement involvement, incarceration, and overall involvement with the family court system (DeMaris & Jackson, 1987; Grusznski & Carillo, 1988; Hamberger & Hastings, 1989; Saunders & Parker, as cited in Gondolf, 1995). In addition, dynamics
such as cohesion, the strength of group norms, commitment, and self-disclosure in groups have all been identified and described by Yalom (1995) as those dynamics that serve to facilitate change. These variables were not measured in the present research study. Therefore, investigation of these variables in facilitating changes in abusive behavior for this specific population is highly recommended.

Hypothesis 3

Lower educational levels and involvement in current relationship will predict higher scores on the Conflict Tactics Scale. Education was unrelated to any of the CTS subscales (all, p > .05). With regard to involvement in a relationship, this variable is significantly, albeit weakly, related to only one of the five CTS subscales — Negotiation ($r = .21$, $p = .05$). It also displays a similarly weak relationship to (log transformed) Psychological Aggression but only at the $p < .10$ level ($r = .20$, $p < .10$). In the first instance, this finding indicates that program participants currently involved in a relationship report somewhat higher scores on the Negotiation subscale of the CTS. Also, these same individuals also report somewhat higher scores on the Psychological Aggression subscale of the CTS.
There has been evidence to support the idea that those client's who drop out of treatment programs tend to be younger, less educated, lower income, unmarried and suffer from higher unemployment or a history of unemployment. In addition, minority group members are more likely than Caucasian clients to drop out from batterer's treatment programs. (Taft, et. al. 2001). Yet, as previously noted, those clients who discontinued treatment have not been found to have higher levels of abusive behavior during the treatment period. Thus, as Gondolf (1993) surmised, there did not appear to be conclusive evidence to support the notion of a "batterer profile". He explains that research studies suffered from small sample size and contradictory findings. Gondolf (1993) cites the work of Hamberger and Hastings (1991) that did not find batterers as a group to differ significantly from the general population. Thus, the assertion that there exists "identifiable subgroups" of men who batter remains unsubstantiated. Gondolf (1993) further asserted that it is more likely that "batterers can be found in any group of men, from those who are socially prominent and accomplished to those who are socially disenfranchised." (as cited in Andronico, 1999, p. 360). Thus, Gondolf's (1993) work supported the finding in the
current study concerning education being unrelated to higher scores on the Conflict Tactics Scale. In addition, results from the current study found a weak relationship between involvement in a current relationship and the Negotiation and Psychological Aggression subscales of the Conflict Tactics Scale. While the strength of the finding is in question, this result points to the fact that those client's currently involved in a relationship are attempting to negotiate with their partners, while also reporting higher levels of psychological aggression. Given the social learning theory upon which The Act Program is based, this finding is not surprising. Thus, while there are numerous variables not measured in this study that could impact the results, one possible explanation for the findings is that a six-month period of time is insufficient to adequately change deeply entrenched behavior patterns. Replication of this study is necessary to support this preliminary conclusion.

In conclusion, research has supported the idea that few batterers are severely disturbed (Hamberger & Hastings, as cited in Gondolf, 1993). Investigations have also supported the notion that a majority of batterers are themselves survivors of childhood abuse or have experience
in watching abuse. The social learning theory postulates that their abusive behavior is often patterned on the abuse they suffered (Strauss, Gelles, & Steinmetz, 1980). In addition, the abuse has been identified by theoreticians as the way some people cope with the abuse they suffered. Further, Harway and Evans, (1999) asserted that "education and re-training are simply inadequate to significantly change most batterers. Batterers need healing and recovery, like any other victim, before they can stop using the coping patterns caused by their own victimization." (Harway & Evans, 1999 in Andronico, 1999, p. 366). As a result of many of the nonsignificant findings of this research, as previously stated, it may be hypothesized that the treatment approach utilized is insufficient in helping adult's who were victimized as children adequately heal.

Limitations

A number of limitations exist. The outcome of the study was based on self-report measures. Given the tendency for batterers to minimize and deny their behavior, it is reasonable to question the veracity of the information that was obtained. Pence and Paymar (1993) identified participant denial and minimization of the "extent and effects of their violence and controlling behavior" as one
of the most pressing dilemmas a group facilitator must address. The use of minimization and denial among male batterers is an important consideration as a result of the fact that "most batterers deny or minimize their behavior" (Pence & Paymar, 1993, p. 77). In addition to the impact of minimization and denial, Holtzworth-Munroe (1992) noted the importance of acknowledging the high degree of resistance for treatment among domestic violence perpetrators court mandated to attend counseling. Holtzworth-Munroe (1992), specifically emphasized the inclination for perpetrators to "externalize responsibility for anger and aggression".

In addition, the sex of the researcher conducting the study with the male participants - it is impossible to determine how or to what degree the outcome of the study was impacted by the presence of a female researcher. In addition, the measures utilized in the study were not specifically created for use within a group setting. This study represented a beginning effort to elucidate factors of client change with male batterers. Thus, the next goal for this researcher will be to conduct a longitudinal study with one particular group of individuals.
Future Research

1. A longitudinal exploration of homogeneous groupings of domestic violence perpetrators based on severity, intensity and frequency of violence in combination with partner contact to substantiate the findings to address the question of treatment efficacy would potentially provide valuable information for treatment protocols.

2. A study of the efficacy of program specific retention measures (family court notification of client noncompliance, stiff penalties for dropping out, transitional supports and mentors) appears to be a worthwhile venture to assist programs in identifying factors that assist in reducing dropout rates and increasing retention.

3. An exploration of the effectiveness of more extensive assessments, case management and referrals in identifying and treating "dual diagnosis" cases in batterer programs appears to be a fruitful area of inquiry.
4. A study of the efficacy of contact and safety checks with the victim, (absent in many programs) appears to be a worthwhile area of inquiry.

5. A longitudinal study that focuses on therapist specific variables that facilitate group attendance enhancing variables is an area of inquiry that has the potential to yield valuable information concerning treatment compliance with domestic violence perpetrators.

6. A qualitative investigation of the change process for male batterers pre and post-treatment has the potential to yield far more specific and valuable information concerning what works for whom and under what conditions.

7. A nationwide survey of relapse prevention work and client follow-up measures is needed to inform practitioners concerning subsequent steps in supporting clients in the process of change.
A study of the dynamic interaction between group leadership and group climate on group member outcome is an overlooked area of research in general, but especially in the domestic violence literature that seems to be ripe for investigation.

Orlinsky, 1994 noted the existence of a "vast" amount of literature concerning the individual counseling process. Yet, with respect to the volume of research in this area, there is a paucity of research concerning racial and cultural factors in the counseling process (Helms, 1994; Sue & Sue, 1990 as cited in Heppner, Kivlighan, & Wampold, 1999). This is especially true with domestic violence perpetrators.

There has been a relative paucity of research on the impact of the therapist and the "therapeutic relationship" on group cohesion. Thus, a research study investigating these variables has the potential to make a significant contribution to the field.
11. Investigation of female battering is a grossly under-researched area of inquiry. While statistically women are far more likely to be victims of domestic violence rather than perpetrators, many of the studies conducted have focused on physical forms of abuse. While it is certainly important to guard against victimizing and blaming victims, it is also crucial to investigate the ways in which female aggression is manifested in intimate partnerships. This is especially important as children often witness the abusive behavior of their parents and can suffer trauma from having witnessed abusive acts.

12. Gay and lesbian battering is another important yet under-researched area of investigation.

13. A replication of the current study comparing court ordered versus voluntary clients would potentially yield useful information regarding the role of court mandated treatment on treatment effectiveness.
Summary and Conclusion

It appears abundantly clear that there is a tremendous amount of information still unknown about how to best facilitate the change process for male batterers. As previous research has suggested, a majority of "male batterers" do not differ significantly from the general population based on psychological profiles. If that finding is accurate, and as the findings of this research suggest, a "one size fits all" approach to treating domestic violence perpetrators does not seem to be the most efficacious method. While this research attempted to answer some important questions, it seems to have raised many more potentially fruitful areas of inquiry.


United States Department of Health and Human Services.


Appendix A

Letter to Participants
Dear Prospective Study Participant:

I would like to thank you in advance for taking the time to review this information. I am a doctoral candidate in the Counseling Psychology Program, and Dr. Laura Palmer is the Co-Director of Training. Counseling Psychology Program, Department of Professional Psychology and Family Therapy at Seton Hall University. In partial fulfillment of the requirements for my program, I am conducting a research study with Abuse Cases Today clients. This is a study being conducted by a researcher currently enrolled at Seton Hall University. All potential participants have been identified through the Abuse Cases Today Program. The sample for this study will include all current ACT Program clients who are not involved in the group facilitated by the primary researcher.

The purpose of the study is to research the impact of the client’s perception of the therapy state: a finance (operationalized using the Working Alliance Inventory) and the client’s motivation for change (operationalized using the Client Motivation for Therapy) and their relation to changes in abusive behavior. This research is to be intended to increase our understanding concerning how counselors may improve client services. Therefore, the researcher would like you to help in identifying factors that assist or prevent client changes in abusive behavior as associated with the ACT Program. Your participation in this survey is voluntary and will in no way impact your standing in the Abuse Cases Today Program. You may withdraw at any point during this process. For court ordered clients, a decision not to participate or to withdraw will not affect your legal standing. It is important to understand that participation in this study is completely voluntary. There is no penalty for a decision not to participate. Those participants who choose to complete the forms enclosed in the research packet, a $10 stipend will be issued.

I am asking you to complete a consent form, demographic data sheet and three surveys (The Working Alliance Inventory, the Client Motivation for Therapy Scale [CMOTS], the Conflict Tactics Scale 2) that I would like you to complete and return. This data will be compared to baseline data from the Conflict Tactics Scale 2 taken at the intake interview prior to your participation in the ACT Program. It is essential to note that these data will not be analyzed individually. Therefore, it is important to understand that personal progress in the ACT Program will not be analyzed and will thus remain anonymous. To assist in the collection of data, an audiocassette recorder for each survey and the demographic data sheet will be provided to individuals upon request.

Also enclosed in the informed Consent Form is an explanation. Please read it carefully. It is complete your decision regarding whether or not to participate in the study. If you decide to complete the surveys and return it to me, please sign and date the informed Consent Form. All of the information you provide will be kept confidential. Names will not be required on the enclosed instruments. Clients will sign a consent form with their randomly assigned number (for tracking purposes only) which authorizes access to the client’s file. The consent forms will be filed separately and retained in a locked file cabinet so that no identifying information will appear on the data utilized by the researcher.

College of Education and Human Services
Department of Professional Psychology and Family Therapy
Tel: 973.761.9451
400 South Orange Avenue • South Orange, New Jersey 07079-2683
However, for accurate analysis of the data, number will be assigned to each research packet so that information obtained at the intake interview can be compared to the information collected at the time of data collection. It is extremely important to emphasize that this information will be used for research purposes only. The information provided will not be reported to any court or agency. However, it is important to note the existence of the possibility for referral of research data under a court order. Upon receipt of your completed materials, a number will be placed on them to identify them as complete. It is important to note that the researcher is a component of the Abuse Center Today Program. Thus, it is important to emphasize the fact that the research procedures have been carefully thought out to ensure that the anonymity, confidentiality, and treatment of each participant will not be compromised. Last, this data will be kept in a locked file cabinet.

If you elect not to participate, your present or future participation in the Abuse Center Today Program will not be impacted in any way. If you have any questions or concerns, you may contact the Abuse Center Today Program Office (973) 539-7811 or Dr. Laura Palmer, supervising psychologist at Seton Hall University at (973) 275-37-40. This project has been reviewed and approved by the Seton Hall University Institutional Review Board for Human Participants. Research and the Abuse Center Today Program of the Jersey Battered Women's Services, Inc. Both committees believe that research procedures the IRB has designed adequately safeguard your privacy, welfare, civil liberties, and rights. The Chairperson of the IRB may be reached through the Office of Grants and Research Services. The telephone number of the Office is (973) 275-3974. If participation in this study causes you any undue stress, or if you have specific questions regarding this research, you may contact the researcher at the Abuse Center Today Office at (973) 539-7801. In the unlikely event that you find the nature of this research distressing, an ACT Program counselor will be available for assistance and if necessary to make appropriate referrals. Thank you for your time and your donation.

Sincerely,

Jennifer M. Lautrett, M.A.
Doctoral Candidate
Professional Psychology & Family Therapy
Seton Hall University

Sincerely,

Laura Palmer, Ph.D.
Co-Director, Counseling Psychology Program
Professional Psychology & Family Therapy
Seton Hall University
Appendix B

Client Motivation for Therapy Scale

Permission to use the Client Motivation for Therapy Scale (CMOTS)
Dear Jennifer,

Here is the scale.

WHY ARE YOU PRESENTLY INVOLVED IN THERAPY?

Using the scale below, please indicate to what extent each of the following items corresponds to the reasons why you are presently involved in therapy by circling the appropriate number to the right of each item. We realize that the reasons why you are in therapy at this moment may differ from the reasons that you initially began therapy. However, we are interested to know why you are in therapy at the present moment.

1. Because other people think that it's a good idea for me to be in therapy. 1 2 3 4 5 6 7
2. Honestly, I really don't understand what I can get from therapy. 1 2 3 4 5 6 7
3. For the pleasure I experience when I feel completely absorbed in a therapy session. 1 2 3 4 5 6 7
4. For the satisfaction I have when I try to achieve my personal goals in the course of therapy. 1 2 3 4 5 6 7
5. Because I would feel guilty if I was not doing anything about my problem. 1 2 3 4 5 6 7
6. Because I would like to make changes to my current situation. 1 2 3 4 5 6 7
7. Because I believe that eventually it will allow me to feel better. 1 2 3 4 5 6 7
8. I once had good reasons for going to therapy, however, now I wonder whether I should quit. 1 2 3 4 5 6 7
9. Because I would feel bad about myself if I didn't continue my therapy. 1 2 3 4 5 6 7
10. Because I should have a better understanding of myself. 1 2 3 4 5 6 7
11. Because my friends think I should be in therapy. 1 2 3 4 5 6 7
12. Because I experience pleasure and satisfaction when I learn new things about myself that I didn't know before. 1 2 3 4 5 6 7
13. I wonder what I'm doing in therapy; actually, I find it boring. 1 2 3 4 5 6 7
14. I don't know; I never really thought about it before. 1 2 3 4 5 6 7
15. Because I believe that therapy will allow me to deal with things better. 1 2 3 4 5 6 7
16. For the interest I have in understanding more about myself. 1 2 3 4 5 6 7
17. Because through therapy I've come to see a way that I can continue to approach different aspects of my life. 1 2 3 4 5 6 7
18. Because through therapy I feel that I can now take
responsibility for making changes in my life. 1 2 3 4 5 6 7
19. Because it is important for clients to remain in therapy until it's finished. 1 2 3 4 5 6 7
20. Because I believe it's a good thing to do to find solutions to my problem. 1 2 3 4 5 6 7
21. To satisfy people close to me who want me to get help for my current situation. 1 2 3 4 5 6 7
22. Because I don't want to upset people close to me who want me to be in therapy. 1 2 3 4 5 6 7
23. Because I feel that changes that are taking place through therapy are becoming part of me. 1 2 3 4 5 6 7
24. Because I value the way therapy allows me to make changes in my life. 1 2 3 4 5 6 7

Intrinsic motivation: 3, 4, 12, 16; Integrated regulation: 17, 18, 23, 24;
Identified regulation: 6, 7, 15, 20; Introjected regulation: 5, 9, 10, 19;
External regulation: 1, 11, 21, 22; Amotivation: 2, 8, 13, 14.

Luc G. Pelletier, Ph.D.
Director, Experimental Program Directeur, Programme Expérimental
School of Psychology École de Psychologie
University of Ottawa Université d'Ottawa
P.O. Box 450, Stn. A C.P. 450, Succ. A
Ottawa, Ontario K1N 6N5 Ottawa, Ontario K1N 6N5
(613) 562-5800 ext.4201
(613) 562-5147 (FAX)
Appendix C

Permission to use the Revised Conflict Tactics Scales (CTS2)
Dear Jennifer Lauretti,

Enclosed is your copy of the agreement concerning your use of the CTS2 and/or the CTPC.

I am delighted that you are going to use the revised CTS and that you will be assisting us in compiling normative data by providing the data for the cases you will be testing of the results of psychometric analyses of that data. It will be a pleasure to acknowledge your contribution in publications that use that data.

If you have questions about the CTS, please feel free to contact me. I am often within reach by phone, so e-mail may be the best vehicle for that reason and because it makes it easier for me to respond.

I hope your study goes well.

Sincerely,

Murray A. Straus

Murray A. Straus
Professor of Sociology & Co-Director
Family Research Laboratory

18 May 2000
Appendix D

Revised Conflict Tactics Scales (CTS2)
The Conflict Tactics Scale (CTS2)

RELATIONSHIP BEHAVIORS

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please circle how many times you did each of these things in the past year. If you did not do one of these things in the past year, but it happened before that, circle "7".

How often did this happen?

1 = Once in the past year  
2 = Twice in the past year  
3 = 3-5 times in the past year  
4 = 4-6 times in the past year  
5 = 11-20 times in the past year  
6 = More than 20 times in the past year  
7 = Not in the past year, but it did happen before  
0 = This has never happened

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<td>1. I showed my partner I cared even though we disagreed.</td>
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<td>2. My partner showed care for me even though we disagreed.</td>
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<td>3. I explained my side of a disagreement to my partner</td>
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<td>4. My partner explained his or her side of a disagreement to me.</td>
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<td>5. I insulted or swore at my partner.</td>
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<td>6. My partner did this to me.</td>
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<td>7. I threw something at my partner that could hurt.</td>
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<td>8. My partner did this to me.</td>
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<td>9. I twisted my partner’s arm or hair.</td>
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<td>10. My partner did this to me.</td>
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<td>11. I had a sprain, bruise, or small cut because of a fight with my partner.</td>
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<td>12. My partner had a sprain, bruise, or small cut because of a fight with me.</td>
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<td>13. I showed respect for my partner’s feelings about an issue.</td>
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<td>14. My partner showed respect for my feelings about an issue.</td>
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<td>15. I made my partner have sex without a condom.</td>
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<td>16. My partner did this to me.</td>
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<td>17. I pushed or shoved my partner.</td>
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18. My partner did this to me.
19. I used force (like hitting, holding down, or using a weapon) to make my partner have oral or anal sex.
20. My partner did this to me.
21. I used a knife or gun on my partner.
22. My partner did this to me.
23. I passed out from being hit on the head by my partner in a fight.
24. My partner passed out from being hit on the head in a fight with me.
25. I called my partner fat or ugly.
26. My partner called me fat or ugly.
27. I punched or hit my partner with something that could hurt.
28. My partner did this to me.
29. I destroyed something belonging to my partner.
30. My partner did this to me.
31. I went to a doctor because of a fight with my partner.
32. My partner went to a doctor because of a fight with me.
33. I choked my partner.
34. My partner did this to me.
35. I shouted or yelled at my partner.
36. My partner did this to me.
37. I slammed my partner against a wall.
38. My partner did this to me.
39. I said I was sure we could work out a problem.
40. My partner was sure we could work it out.
41. I needed to see a doctor because of a fight with my partner, but I didn't.
42. My partner needed to see a doctor because of a fight with me, but didn't.
43. I beat up my partner.
44. My partner did this to me.

45. I grabbed my partner.

46. My partner did this to me.

47. I used force (like hitting, holding down, or using a weapon) to make my partner have sex.

48. My partner did this to me.

49. I stomped out of the room or house or yard during a disagreement.

50. My partner did this to me.

51. I insisted on sex when my partner did not want to (but did not use physical force).

52. My partner did this to me.

53. I slapped my partner.

54. My partner did this to me.

55. I had a broken bone from a fight with my partner.

56. My partner had a broken bone from a fight with me.

57. I used threats to make my partner have oral or anal sex.

58. My partner did this to me.

59. I suggested a compromise to a disagreement.

60. My partner did this to me.

61. I burned or scalded my partner on purpose.

62. My partner did this to me.

63. I insisted my partner have oral or anal sex (but did not use physical force).

64. My partner did this to me.

65. I accused my partner of being a lousy lover.

66. My partner did this to me.

67. I did something to spite my partner.

68. My partner did this to me.

69. I threatened to hit or throw something at my partner.

70. My partner did this to me.
71. I felt physical pain that still hurt the next day because of a fight with my partner.
72. My partner still felt physical pain the next day because of a fight we had.
73. I kicked my partner.
74. My partner did this to me.
75. I used threats to make my partner have sex.
76. My partner did this to me.
77. I agreed to try a solution to a disagreement my partner suggested.
78. My partner agreed to try a solution I suggested.
Appendix E

Permission to use the Working Alliance Inventory
August 2, 2000

Dear Ms. Lauretti,

You have my permission to duplicate and use the Working Alliance Inventory (WAI) as you require for your investigation. This permission extends to all forms of the WAI for which I hold copyright privileges, but limited to use of the inventory for not-for-profit research. This permission also includes your and your publisher's right to publish portions of the WAI relevant to your work in hard copy or electronic form.

I would appreciate it if you shared the results of your research when your work is completed. If I can be of further help, do not hesitate to contact me.

Sincerely,

Dr. Adam O. Horvath
Faculty of Education and
Department of Psychology

Ph# (604) 291-3624
Fax: (604) 291-3203
e-mail: Horvath@sfu.ca
Internet: www.educ.sfu.ca/alliance/waifront.html
Appendix F

Working Alliance Inventory
Working Alliance Inventory

Instructions

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her therapist (counselor). As you read the mentally insert the name of your therapist (counselor) in place of the text.

Below each set of instructions there is a seven point scale:

1. Never
2. Rarely
3. Unusually
4. Somewhat
5. Often
6. Always

Instructions

This is a simple scale. A sentence is either CONFIDENTIAL: neither your therapist nor the agency will see your answer. Work fast: your first impressions are the ones we would like to see. (PLEASE DON'T FORGET TO RESPOND TO EVERYONE.)

If the statement describes the way you always feel (or think) circle the number 7; if it never applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

© A.C. Horvath 1981 1984

Thank you for your cooperation.
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<td>I understand each other.</td>
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<td>I perceive accurately that my goals are</td>
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<td>I find what I am doing in therapy concludes faster.</td>
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<td>and I continue to improve with this.</td>
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<td>10</td>
<td>I disagree with the actions that I might take in therapy to help improve my situation</td>
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<td>11</td>
<td>I believe that the combination of these is not the best way to help me improve.</td>
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WANG p. 3
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<thead>
<tr>
<th>12.</th>
<th>I do not understand what I am trying to accomplish in therapy.</th>
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<tbody>
<tr>
<td>Never</td>
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<tr>
<td>13.</td>
<td>I am afraid of what I am trying to accomplish in therapy.</td>
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<td>Never</td>
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<td>14.</td>
<td>The goals of therapy are depersonalized to me.</td>
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<td>Never</td>
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<td>15.</td>
<td>I find what I am doing in therapy is unrelated to my problems.</td>
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<td>Never</td>
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<td>16.</td>
<td>I feel that therapy will not help to accomplish the changes that I want.</td>
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<td>Never</td>
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<td>17.</td>
<td>I believe therapy is good for me.</td>
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<td>Never</td>
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<td>18.</td>
<td>I am clear on what is expected of me in therapy.</td>
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<td>Never</td>
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<td>19.</td>
<td>I respect each other in therapy.</td>
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<td>Never</td>
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<td>20.</td>
<td>I feel that therapy is not going in the right direction.</td>
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<td>21.</td>
<td>I am confident in my ability to help me.</td>
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<td>and I am working toward mutually agreed upon goals.</td>
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**Note:** The table includes Likert scale responses ranging from 1 (Never) to 5 (Always) for various aspects of therapy.
<table>
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<th>25. I feel that</th>
<th>appreciated me.</th>
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<td>1 2 3 4 5 5 7</td>
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<td>26. We agree on what is important for me to work.</td>
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<td>27. As a result of these sessions I am able to increase my ability to change.</td>
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<td>28. My relationship with is very important to me.</td>
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<td>29. I have the feeling that if I say or do the wrong things, I will stop working with.</td>
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<td>30. I have the feeling that if I say or do the wrong things, I will stop working with.</td>
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<td>31. I am frustrated by the things I am doing in therapy.</td>
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<td>32. We have attempted a good idea but we agreed with the kind of changes that would be good for me.</td>
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<td>33. The things I am doing in therapy don't make sense.</td>
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<td>Statement</td>
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<td>34. I don't know what to expect as the result of my therapy.</td>
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<td>35. I believe the way we are working with my pet blunts contact.</td>
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<td>36. I feel the pain when I do things that hurt does not appear in.</td>
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Appendix G

Demographic Questionnaire
1) How many sessions of the ACT Program have you attended?

- Less than three ____________________________ 3-9 sessions
- 10-16 sessions
- 23-26 sessions ____________________________ more than 26 sessions

2) How long have you participated in the ACT Program?

- Less than one month ____________________________ 1-3 months
- 4-6 months ____________________________ more than 6 months

3) What is your current Relationship Status?

- Single ____________________________ Married
- Widowed ____________________________ Living with Partner
- Divorced

4) Are you currently involved with the same person with whom you were involved at the time of the ACT Referral?

- Yes ____________________________ No

5) What is your employment status? Please check as many as applies to you

- Self-employed ____________________________ Full-time
- Part-time ____________________________ Unemployed ____________________________ Retired
- Other

6) What is your highest educational attainment?

- High school ____________________________ 2-year college
- 4-year college ____________________________ Graduate
- Other

7) Current substance abuse (Alcohol / drugs)

- Yes ____________________________ No

8) Are you currently in the care of a psychiatrist and/or psychotherapist?

- Yes ____________________________ No