Treatment Needs of Women Arrested for Domestic Violence

A Comparison With Male Offenders

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*Rising numbers of women arrested for domestic violence present many theoretical and practical challenges. At the theoretical level, there is ongoing debate about whether women are equally aggressive as men. At the practical level, little research is available to guide how female cases are handled in the criminal justice system. In this study, data were obtained regarding demographic characteristics, mental health functioning, and childhood familial dysfunction for a large sample of male (*n = *2,254) and female (*n = *281) domestic violence offenders. The women were demographically similar to the men, and few differences were noted in their childhood experiences. Women were more likely than men to have previously attempted suicide, whereas more men had conduct problems in childhood and substance abuse in adulthood. Compared to the male offenders, women reported more symptoms of personality dysfunction and mood disorder. Treatment implications of these findings are discussed.*

Keywords: *partner abuse; female offenders; personality traits; gender differences*

A significant body of research has been accumulated over the past few decades characterizing the family histories and psychological functioning of those convicted of abusing an intimate partner (for reviews, see Gleason, 1997; Holtzworth-Munroe, Bates, Smutzler, & Sandin, 1997). This literature has both fostered the development of theoretical typologies that help us understand the etiology of this behavior (e.g., Holtzworth-Munroe & Stuart, 1994) and shaped the intervention strategies we employ once these individuals are apprehended (Hamberger, 1997; Healey, Smith, & O'Sullivan, 1998; Pence & Paymar, 1993). Because this past research focused exclusively on

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male offenders, the applicability of available theories and treatments to women arrested for domestic assault remains unknown. This knowledge deficit has become more problematic as the number of women arrested for domestic violence has risen in recent years (see, for example, State of California, 1999). The present study provides one of the first comparisons of the psychological functioning and family backgrounds of convicted male and female domestic violence offenders.

LITERATURE REVIEW

Although women account for a minority of those arrested in the United States, Uniform Crime Report (FBI, 2001) data suggest that the gender gap has decreased in recent years. Some of the biggest increases in female arrests have been observed with assaults. The number of aggravated assaults involving female defendants increased 46.2% from 1991 to 2000, and women now account for 20.0% of those charged with this offense (up from 13.4%). One factor that might have contributed to the increasing number of women charged with assault is the widespread practice of mandatory arrest for incidents of domestic violence (Sherman & Cohn, 1989). As might be expected, mandatory and pro-arrest laws have increased the number of people arrested and prosecuted for domestic violence charges (Mignon & Holmes, 1995; Victim Services Agency, 1989). An unexpected consequence of these laws has been a significant increase in the number of women arrested for this offense (Martin, 1997; Saunders, 1995; State of California, 1999).

Whether women *should* be arrested for domestic violence remains subject to considerable debate. Most researchers and practitioners believe that the majority of women arrested were acting in self-defense (e.g., Hamberger & Potente, 1994; Saunders, 1995) and that arresting the women might only deter them from seeking police assistance during future assaults. Although in the minority, others have argued that domestic assaults perpetrated by females have been systematically ignored by our legal system and that such arrests are often justified (McNeely, Cook, & Torres, 2001).

A parallel and particularly contentious debate about the equivalency of violence between the genders has been waged within the family violence research community. Straus (1978) and Archer (2000) have presented data showing that women are as likely as men to use physical aggression against an intimate partner. Other researchers have been reluctant to accept these results given their observations in clinical settings. Shelter data, hospital records, police reports, homicide data, and victimization surveys all indicate that women are disproportionately the victims of domestic assault (Cascardi

& Vivian, 1995; Greenfeld et al., 1998; Kurz, 1998; McLeod, 1984; Saunders, 1988; Tjaden & Thoennes, 2000). These discrepant findings have led to further discussion about methodological limitations in marital violence research (e.g., Arias & Beach, 1987; R. Dobash, Dobash, Cavanagh, & Lewis, 1998; Saunders, 1988) and the responsibility of researchers to consider the policy implications of their work (Archer, 2000; White, Smith, Koss, & Figueredo, 2000).

As these debates continue to be waged in the research community, judges, prosecutors, probation departments, and treatment providers are increasingly faced with the question of what to do with women arrested on domestic violence charges. Virtually all of the research done with domestic violence offenders has focused on male perpetrators. Only a few studies focusing on women convicted of intimate partner abuse have been reported in the literature.

Henning and Feder (in press) compared 5,578 men and 1,126 women arrested for assaulting an opposite-sex intimate partner. Victims of female arrestees reported less severe prior domestic violence and were less likely than the victims of male arrestees to currently feel their partner is a serious threat. Female arrestees also were significantly less likely to have prior criminal charges on their record than the males. Finally, male defendants were more likely to have alcohol and/or drug problems than female defendants. In summarizing their findings, Henning and Feder concluded that female domestic violence arrestees as a group present with fewer risk factors for recidivism than male arrestees.

Abel (2001) compared women attending a court-ordered batterers' intervention program ($n = 67$) with women receiving victim counseling services related to their abuse ($n = 51$). Although victims and female offenders reported similarly high levels of exposure to prior violence, female offenders evidenced fewer trauma symptoms. Treatment recommendations emanating from these findings focused on the need for counselors to address prior victimization when working with female offenders.

Hamberger and Potente (1994) reviewed the literature on female domestic aggression and interviewed 67 women arrested for domestic violence. They concluded that most of these women were really victims who responded defensively to their partners' assault. In their opinion, interventions with female offenders should focus on victimization, safety planning, and other issues concerning the oppression of women.

In summary, the available research suggests that many if not most of the women arrested for intimate partner violence are victims of abuse who may have been acting in self-defense. In this regard, they appear to differ from male offenders, whose violence is more often related to power and control

issues (e.g., R. E. Dobash & Dobash, 1979) or concerns about abandonment (Dutton, 1999). Traditional domestic violence programs that focus on power and control and negative attitudes toward women likely have limited utility for the female offenders.

Whether female offenders differ from male domestic violence offenders in others regards has not been sufficiently examined to date. Studies looking at the childhood experiences of abusive males have found high rates of physical abuse, neglect, and other familial risk factors (Holtzworth-Munroe et al., 1997). Higher than expected rates of substance abuse, marital dissatisfaction, cognitive impairment, psychological distress, and personality dysfunction have also been found among samples of male batterers (Gleason, 1997; Holtzworth-Munroe et al., 1997). Although not always addressed in treatment, these characteristics have played an important role in the development of theories on the etiology and maintenance of this behavior (e.g., Dutton, 1999; Holtzworth-Munroe & Stuart, 1994). Further efforts to compare and contrast male and female domestic violence offenders may lead to more effective management of female clients and the development of theories specific to women's use of aggression.

In the present study, we collected demographic information, family of origin characteristics, and mental health data on a large sample of men and women convicted of intimate partner abuse. These data were used to conduct exploratory analyses that highlight gender differences and similarities across these areas.

METHOD

Data Collection

An estimated 3,200 men and women were arrested, convicted, and placed on probation for assaulting an opposite sex intimate partner in Shelby County, Tennessee, between January 1999 and April 2001. All of these individuals were ordered to complete a comprehensive psychological assessment through the local Domestic Violence Assessment Center (DVAC). Seventy-nine percent of these individuals (2,254 men and 281 women) had completed their DVAC evaluation by May 2001, and these cases comprised the sample for the study.

The assessment process involved the following four stages: First, a counselor met briefly with each offender to assess reading ability, to obtain informed consent for the evaluation, and to complete release of information agreements. Second, offenders were escorted to a large group room where

they completed paper-and-pencil tests under the supervision of trained proctors. Questionnaires were read to illiterate offenders (11.1% of the sample). Third, each offender completed a 30 to 60-minute clinical interview with a DVAC counselor. Once the first three stages were completed, the staff scored all measures, entered the information into the DVAC computer database, and wrote an evaluation report for the court. Data for this study were extracted from the DVAC database under a university-approved research agreement.

Measures and Variables

Available demographic information included age, race, level of education, current employment status, and relationship to the victim at the time of the offense. Offenders also were asked about recent job and housing changes, whether they were currently living with the victim, and whether they wanted to continue the relationship.

During their evaluation, clients answered items regarding early childhood experiences potentially related to current psychological functioning. Single-item questions, answered dichotomously (yes or no), included the following: (a) "Did you live with both of your biological parents until you were age 16?"; (b) "Did either of your parents or caregivers ever spend time in prison during your childhood (under age 16)?"; and (c) "Did either of your parents or caregivers ever abuse alcohol or drugs during your childhood?"

Childhood exposure to interparental violence was assessed using the nine-item Physical Aggression subscale of the Conflict Tactics Scale (CTS) (Straus, 1990). For each scale item, respondents answered (yes or no) whether they had "ever witnessed their father (stepfather) do this to their mother" during childhood. The same questions were used to assess maternal-to-paternal aggression. Prior factor analyses of the CTS have suggested that the scale can be divided into two severity levels (Pan & Neidig, 1994). Thus, four items (beat up, choked, threatened with a gun or knife, and attacked with a gun or knife) were classified as severe abuse, while all the other items were considered mild-moderate abuse. Using this classification system, responses were recoded into two dichotomous variables for analyses: (a) witnessed mild-moderate interparental violence, reflecting whether the offender responded positively to any of the five lower severity items, and (b) witnessed severe interparental violence, indicating whether the offender affirmed any of the four higher severity items.

Offenders' experiences of childhood physical abuse by their caregivers were assessed using the child abuse version of the CTS (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998). Offenders indicated (yes or no) whether they had ever experienced the actions described in the 13 items that comprise

this scale, and responses were used to derive two factors from the measure. The first 6 items describe the use of physical punishments often labeled *corporal punishment* (e.g., spanked you on the bottom; slapped you on the face, head, or ears), while the final 7 items reflect more severe or infrequent actions that typically would be considered abusive (burned or scalded you, grabbed you by the neck or choked you). These distinctions were used to recode offenders' responses on this scale into two dichotomous items. One item reflects whether a caregiver ever *physically abused* them during childhood, and the other identifies whether their caregivers ever used *corporal punishment*.

A number of questions were included in the evaluation regarding offenders' mental health history. These included whether the individual had ever been (a) "in treatment for a substance abuse/dependence problem"; (b) "prescribed medication for 'nerves,' depression, anxiety, or sleep problems"; (c) "hospitalized or treated for psychosis, schizophrenia, mania or another major mental illness"; and (d) "ever attempted suicide." A novel scale concerning childhood conduct problems was created for use in the clinic. Clients were asked to answer yes or no to eight items characteristic of childhood conduct disorder as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) (American Psychiatric Association, 1994). The scale evidenced moderate internal consistency (alpha = .68).

Several aspects of the offenders' current mental health functioning were assessed. The 15-item Locke-Wallace Marital Adjustment Test (Locke & Wallace, 1987) was used to assess current marital or relationship satisfaction. Clients completed the measure with reference to the victim from their instant offense. Total scores below 100 are suggestive of clinically significant relationship distress (Locke & Wallace, 1987).

To identify current problematic substance use, offenders completed the Substance Abuse Subtle Screening Inventory–III (SASSI-III) (Miller, 1999), a self-report questionnaire designed to identify individuals with high probability of a substance use disorder. The SASSI-III also contains two validity scales: Random Answering Pattern, used to identify random responding, and Defensiveness, used to gauge defensiveness. Clients in this study were asked to complete the measure with reference to their use of substances over the past year. Research on the SASSI-III has shown it to be highly accurate in identifying individuals independently diagnosed with substance dependence (Lazowski, Miller, Boye, & Miller, 1998).

The offenders' current intellectual functioning was estimated using the Shipley Institute for Living Scale (SILS) (Zachary, 1986), a commonly used screening instrument consisting of 60 items comprising two subscales (e.g., Vocabulary and Abstraction). Total SILS scores were converted to Wechsler

Adult Intelligence Scale–Revised full-scale IQ scores as directed in the scoring manual. Because the SILS is a self-administered paper-and-pencil measure that requires some degree of reading ability, it was not administered to clients who failed the reading screen (11.1%).

Finally, current psychological functioning of the offenders was assessed using the Millon Clinical Multiaxial Inventory–III (MCMI-III) (Millon, 1994), which consists of 175 true-false questions that yield 4 Validity subscales, 14 Personality subscales (Axis II, *DSM-IV*), and 10 Clinical Syndrome subscales (Axis I). Individual items on these subscales largely reflect the diagnostic criteria established in the *DSM-IV.* Cutoff scores for each subscale were determined by comparison to psychiatric patients with known disorders. Moreover, the base scores and clinical cutoffs also are adjusted to accommodate for gender differences in the normative sample and response style. The MCMI-III is the most commonly used measure of personality and clinical functioning in recent studies with domestic offenders (Gondolf, 1999). Consistent with the prior research, we established a clinical cutoff of 75 or higher (base rate) to identify participants with mental health problems.

Statistical Analyses

Comparisons between male and female domestic violence offenders were made using independent *t* tests with continuous measures and chi-square analyses for dichotomous variables. Given the number of comparisons made, only those where the probability value was $p < .01$ or less were regarded as significant. A more conservative approach to reading the results would be to consider as significant only those analyses with probability values exceeding $p < .001$.

RESULTS

Demographic information on the 2,254 male and 281 female domestic violence offenders participating in this study is presented in Table 1. A majority of offenders of both genders were African American (84.2%), dating their victim (63.0%), and young to middle-aged ($M = 32.5$, $SD = 9.3$, range = 18 to 69). No gender differences were observed on these factors. Similarly, roughly equivalent proportions of the males and females were currently living with their victims and had children in common. Females were significantly more likely to have attended college but were less likely to be working outside the home than males.

TABLE 1: Demographic Characteristics of Male and Female Domestic Violence Offenders

Offender Demographic	*Male (n = 2,254) (%)*	*Female (n =281) (%)*
Mean age (*SD*)	32.6 (9.4)	31.3 (8.7)
Race		
African American	83.9	86.4
Caucasian	13.1	12.5
Other	3.0	1.1
Highest educational attainment		
Less than high school	35.7	34.4*
High school degree or GED	42.2	35.5
Partial or complete college degree	22.1	30.1
Relationship to victim		
Spouse or ex-spouse	37.0	36.3
Current or former dating partner	63.0	63.7
Currently living with victim (yes)	23.6	23.8
Have children with victim (yes)	47.8	49.6
Current work status outside home		
Full-time	58.2	42.8**
Part-time or temporary work	15.0	18.1
Unemployed	26.8	39.1
Two or more recent job changes (yes)	20.5	16.8
Two or more recent housing changes/moves (yes)	12.9	15.9

NOTE: Actual sample sizes vary by comparison due to missing data. Gender comparisons were made using *t* tests and chi-square analyses.
*$p < .01$. **$p < .001$.

Male and female offenders were compared on a range of childhood experiences that might contribute to adult adjustment problems (see Table 2). No gender differences were observed in the proportion of men and women from broken homes, exposed to parental criminality, or with parents who abused substances. Females were just as likely as males to report childhood physical abuse and exposure to minor forms of interparental physical aggression. Males, however, were slightly more likely than females to report corporal punishment by their caregivers, while women were slightly more likely to have been exposed to severe domestic violence in childhood. Analyses revealed several differences in the mental health histories of male and female offenders (see Table 2). Significantly more male offenders reported prior treatment for substance abuse, most often as mandated by the court. Women, on the other hand, were nearly twice as likely to have been previously treated

TABLE 2: Self-Reported Childhood Experiences (Before Age 16), Mental Health History, and Current Functioning of Male and Female Domestic Violence Offenders

	Male (% Yes)	*Female (% Yes)*
Childhood experiences		
Did not live with both parents through age 16	55.8	61.9
Parent/caregiver spent time in prison	7.1	7.6
Parent/caregiver abused alcohol or drugs	15.9	21.6
Witnessed mild-moderate interparental violence	26.5	27.4
Witnessed severe interparental violence	14.0	20.6*
Parent/caregiver used corporal punishment	87.9	81.5*
Physically abused by parent/caregiver	30.4	34.7
Mental health history		
Prior treatment for substance abuse/dependence	15.4	8.6*
Ever prescribed psychotropic medication	9.6	18.0**
Hospitalization or treatment for major mental illness	2.7	4.7
Prior suicide attempt(s)	3.8	11.9**
Mean childhood conduct problems (*SD*)	1.8 (1.7)	1.3 (1.6)*
Current mental health functioning		
Relationship dissatisfaction (LWMAT < 100)	41.5	44.2
Offender wants to continue relationship with victim		
Yes	50.0	31.1**
No	35.6	39.4
Uncertain	14.4	29.5
Estimated WAIS-R IQ (SILS)[a]		
Borderline to mentally deficient	36.7	33.7
Low average	25.5	22.3
Average or higher	37.8	43.9
Risk of substance dependence on the SASSI-III[b]		
High risk	18.1	8.0**
Low risk	49.9	61.8
Low risk with elevated defensiveness score	31.9	30.3

NOTE: LWMAT = Locke-Wallace Marital Adjustment Test; WAIS-R = Wechsler Adult Intelligence Scale–Revised; SILS = Shipley Institute for Living Scale; SASSI-III = Substance Abuse Subtle Screening Inventory–III.
a. Excludes offenders who failed a brief reading screen (11.1% of total sample).
b. Excludes offenders who answered the SASSI-III in a random manner (8.4%).
*$p < .01$. **$p < .001$.

with psychotropic medication, and they were three times as likely as the men to have previously attempted suicide. A final difference concerned childhood behavior: Male offenders reported significantly more conduct problems before age 16.

Table 2 displays findings regarding the current psychological functioning of the male and female domestic violence offenders. The proportions of men and women reporting clinically significant relationship distress on the Locke-Wallace Marital Adjustment Test were roughly equivalent; however, it is interesting to note that twice as many females expressed uncertainty about resuming their relationship with their spouse/partner as compared to the males. Analyses of offenders' intellectual functioning, as determined by the SILS, indicated similar percentages of men and women with lower IQs. Finally, more men than women were classified on the SASSI-III as high risk for alcohol or drug dependence in the past year.

The current psychological functioning of male and female offenders also was assessed using the MCMI-III. Specifically, we sought to determine whether more female offenders evidenced personality (Axis II) and/or clinical dysfunction (Axis I) than male offenders. Because administration of the MCMI-III was discontinued in later DVAC evaluations due to time constraints, only a subset of the larger sample had MCMI-III profiles available for review (1,261 males and 122 females).

A three-step approach was used in analyzing the MCMI-III data. First, we examined whether men and women differed in their style of responding (i.e., validity, social desirability, faking bad, disclosure). Second, an overall MANOVA was run to test for gender differences on each set of subscales (i.e., Personality and Clinical Syndrome) using base scores. Finally, chi-square analyses were conducted with each of the Clinical Syndrome and Personality subscales to determine whether there were gender differences in the proportion of cases with scale scores meeting the clinical cutoff (i.e., base rate ≥ 75).

Equivalent proportions of men (8.2%) and women (8.2%) failed to respond appropriately on the MCMI-III's Validity subscale, using a cutoff of one or more items. These cases were excluded from further analyses, leaving complete data on 1,158 men and 112 women. Analyses on the Disclosure, Desirability, and Debasement subscales yielded no significant gender differences. The means for these three scales indicated a high level of socially desirable responding by DVAC clients (women, 49.4, 74.3, 40.6; men, 48.1, 76.7, 36.4; respectively).

The Wilk's criterion for the first MANOVA testing gender differences on the 10 clinical syndromes indicated that the combined scales varied reliably as a function of the offenders' gender, $F(10, 1254) = 6.36$, $p < .001$. Subsequent chi-square analyses revealed five significant gender differences (see Table 3). Female offenders were more likely than male offenders to score in the clinical range for delusional disorder, major depression, bipolar disorder, somatoform disorder, and thought disorder. It should be noted that these last three syndromes were rare in both men and women, occurring in less than 1 in

TABLE 3: Millon Clinical Multiaxial Inventory–III (MCMI-III) Results on Clinical and Personality Functioning of Male and Female Domestic Violence Offenders

	% MCMI-III Base Rate Score ≥ 75	
	Male (n = *1,158)*	*Female* (n = *112)*
Clinical syndromes (Axis I)		
Anxiety	29.6	21.4
Delusional Disorder[a]	4.2	11.6**
Major Depression[a]	1.6	10.7**
Bipolar	3.6	9.8**
Dysthymia	8.2	9.8
PTSD	3.2	5.4
Alcohol	10.0	4.5
Somatoform	0.3	3.6**
Thought Disorder[a]	0.7	3.6*
Drugs	2.1	2.7
One or more elevated subscales	**35.2**	**33.0**
Personality patterns (Axis II)		
Compulsive	17.2	50.0**
Histrionic	3.1	36.6**
Narcissistic	23.7	33.0
Schizoid	18.5	17.9
Paranoid[b]	13.6	17.9
Masochistic	10.1	12.5
Depressive	12.9	12.5
Borderline[b]	2.8	11.6**
Avoidant	16.9	11.6
Negativistic	16.4	9.8
Dependent	12.8	8.9
Schizotypal[b]	4.7	5.4
Antisocial	8.1	3.6
Sadistic	1.7	1.8
One or more elevated subscales	**69.8**	**94.6****

NOTE: PTSD = post-traumatic stress disorder. Scales listed in order of prevalence based on female offenders.
a. Severe clinical syndrome.
b. Severe personality pathology.
*$p < .01$. **$p < .001$.

10 of the clients. Furthermore, the majority of both men (64.8%) and women (67.9%) had no elevated clinical scales.

A second MANOVA was used to determine whether there were overall gender differences on the Personality subscales of the MCMI-III. The resulting Wilk's criterion indicated that the combined dependent variables reliably

differed as a function of the offenders' gender, $F(14, 1249) = 31.67$, $p < .001$. Chi-square analyses on the 14 subscales indicated several significant differences between male and female offenders (see Table 3). Females, as compared to males, were more likely to evidence symptoms of compulsive personality disorder, histrionic personality disorder, and borderline personality. Noticeable gender differences also were observed in the number of clients with elevated Personality subscales. Of the females in the sample, 95% were elevated on one or more of the Personality subscales compared to 69.8% of the males.

DISCUSSION

Many of the female domestic violence offenders in the study were exposed to physical aggression in their homes of origin. In all, 1 out of every 4 witnessed interparental violence, a third were physically abused by a caregiver, and most of the women (81.5%) reported that their parents used corporal punishment. Additional familial risk factors reported by the women include high rates of parental separation and parental substance abuse. Analyses comparing male and female offenders suggest greater similarities than differences in their family experiences as children. Whether larger gender differences are found when factors such as sexual abuse and dating violence are examined will have to be addressed in future studies, as these data were not available in the present data set.

Prior research suggests that early exposure to family violence negatively influences adult adjustment (Henning, Leitenberg, Coffey, & Bennett, 1997), which in turn may exacerbate conflicts in women's current intimate relationships. Consequently, given the findings of this study, it is advisable that service providers working with female offenders be sensitive to and assess for familial risk factors such as physical abuse and witnessing interparental violence. The findings also raise the question of whether childhood exposure to family violence is a causal risk factor for women's use of aggression in intimate relationships. Studies routinely find higher rates of interparental violence and childhood physical abuse in martially abusive men as compared to nonabusive men (Schumacher, Feldbau-Kohn, Slep, & Heyman, 2001). Theories integrating these findings (i.e., social learning theory) suggest that men are abusive toward their female partners because they observed physical aggression being reinforced in their homes of origin. An alternative perspective suggests that family violence leads to the development of anxious attachment styles and hypersensitivity to abandonment in intimate relationships (Dutton, 1999). Further studies exploring the attachment styles of female

offenders and their attitudes toward the use of physical aggression will be helpful in determining whether these theories can account for female-perpetrated intimate partner abuse.

Another area of similarity between the male and female offenders sampled was the rate of clinically significant relationship distress. Nearly one half of all the men and women reported being dissatisfied in their relationship with the victim from the current offense (i.e., spouse/partner). At least with males, low relationship satisfaction is a risk factor for intimate partner abuse (Schumacher et al., 2001), and continuing discord is believed to predict recidivism among maritally violent men (e.g., Kropp, Hart, Webster, & Eaves, 1995). Thus, treatment programs for male offenders often address marital communication skills and assertiveness, along with an examination of how the men's aggression may be contributing to the discord in their relationships (Hamberger, 1997). Whether relationship dissatisfaction predicts further physical assaults by women has not been studied. Moreover, although the rate of dissatisfaction was similar between the men and women, it is possible that the reasons for their low relationship satisfaction are different. Female offenders are more likely to have been dually arrested than males (Henning & Feder, in press), and many of the women in reality may be victims rather than primary aggressors in their relationships (Saunders, 1995). The women's dissatisfaction, therefore, may be largely influenced by their partners' abusive behavior, whereas relationship dissatisfaction for men may derive primarily from concerns about abandonment and loss of control (Dutton, 1999).

From a clinical standpoint, the high prevalence of relationship dissatisfaction among the female offenders warrants special attention during treatment. Compared to the male offenders, women were twice as likely to express uncertainty about continuing their relationship (29.5% vs. 14.4%), and another 39.4% planned to leave their spouse/partner. Given that many of these women are probably in relationships with abusive men, and that the ending phase of a relationship is a particularly high-risk period for lethal violence (Dutton, 1999), safety planning should be included as an early component of any treatment for female offenders. Additional planning and support may be needed by women who share children with their partners due to the continued contact required to arrange visitation, to safely navigate custody hearings, and to endure the sometimes complex process of separation and divorce. Services for the children need to be considered as well.

The mental health histories of the women in our sample differed from the males in several other ways that have implications for treatment. First, more women than men had previously attempted suicide. This raises concerns about the women's risk for self-injurious behavior and suggests that clini-

cians carefully evaluate suicide risk during intake assessments. Second, prior use of psychotropic medication was more common among the women. Clinicians may need to spend more time with female clients to obtain additional information on their treatment histories. Third, significantly fewer women than men evidenced problematic substance use. Finally, the female offenders were less likely to report serious conduct problems during childhood as compared to the men. This latter finding, in conjunction with prior research showing higher rates of adult criminality among male offenders (Henning & Feder, in press), suggests that the women are probably at lower risk for recidivism and noncompliance. Accordingly, women may not require as much supervision and monitoring as men while on probation and during treatment.

Analyses addressing the current psychological functioning of the female clients revealed several other findings that have implications for treatment. First, no gender differences were observed on the MCMI-III's Social Desirability or Validity subscales: Both groups tended to respond in ways that made them look favorable. This finding highlights that clinicians should obtain collateral reports whenever possible and not simply assume that the self-reports of female clients are valid. Second, women were more likely than men to evidence clinically significant elevations on certain Clinical Syndrome subscales of the MCMI-III (e.g., major depression, bipolar, delusional, somatoform, and thought disorder), but the proportion of men and women with one or more elevated Clinical Syndrome subscales did not differ. Indeed, two thirds of both men and women had no significant elevations on the Clinical Syndrome subscales. Of particular note was the finding that very few (5.4%) of the women studied scored in the clinical range for post-traumatic stress disorder, a finding that corresponds to Abel's (2001) report that in her study female domestic violence offenders reported fewer trauma symptoms than female victims receiving counseling. Just trauma counseling and traditional victim services alone are unlikely to meet the needs of most female offenders. By comparison, clinical services to address mood disturbances may be of greater priority.

Significant gender differences were observed on the MCMI-III's personality scales, with 95% of the women having one or more clinically elevated Personality subscales compared to 70% of the men. The most commonly elevated Personality subscales for both men and women were the Compulsive and Narcissistic subscales. Compared to men, women were more likely to evidence elevations on the Histrionic and Borderline subscales. This finding suggests that many of the women convicted of intimate partner abuse are likely to have long-standing personality traits that may complicate their occupational, social, and intimate relationships. Some of these traits, such as

emotional instability or an inflated sense of self-importance, actually may increase the likelihood of responding aggressively to marital/dating conflicts (Baumeister & Smart, 1996). This suggests that the women's interpersonal skills and capacity for emotional regulation should be evaluated and treated accordingly. Anger management, assertiveness, and communication skills are additional services that have been recommended for females convicted of intimate partner abuse (Hamberger & Potente, 1994).

It could be argued that our findings on the prevalence of personality disorders among female domestic violence offenders are misleading or methodologically biased. For example, the MCMI-III has been widely criticized for overpredicting personality disorders (Choca & Van Denburg, 1997; Hart, Dutton, & Newlove, 1993). In addition, some of the women in this study are likely to be victims of domestic abuse rather than perpetrators (Saunders, 1995); consequently, the observed clinical elevations may reflect their efforts to adapt to the erratic behavior of an abusive partner. Hamberger and Potente (1994) quoted one woman convicted of domestic abuse as saying, "When you've been beaten for 12 years, you become compliant if it's in your best interests" (p. 133). Finally, there may be systematic biases in criminal justice leading to an overrepresentation of women with significant psychopathology in probation samples. Women with personality traits like those seen in the present study (e.g., histrionic, narcissistic, borderline) might interact negatively with the police or court personnel and, consequently, be arrested, prosecuted, and convicted at high rates (e.g., Rauma, 1984). Women without such characteristics might be more likely to be classified as victims who acted in self-defense. Further research will be needed to identify the factors that influence arrest decisions and prosecutorial discretion with female offenders.

Finally, it should be noted that 86% of the female offenders in this study were African American. This raises questions about the generalizability of our findings that will only be answered when the present study is replicated with a more racially diverse sample. Additional information on the prior victimization of female offenders also should be explored, including childhood sexual abuse, dating violence, and the history of maltreatment in the relationship with their current spouse/partner. The latter information, in conjunction with the criminal records of both parties, might be used to differentiate female victims from female offenders or mutual combatants. Comparisons of the family histories and mental health functioning of these types of female clients will be particularly useful in developing more comprehensive theories and treatments to address the problem of female aggression in intimate relationships.

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