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RESISTANCE, RELUCTANCE, AND READINESS IN PERPETRATORS OF ABUSE AGAINST WOMEN AND CHILDREN

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Perpetrators of abuse and violence against women and children are often reluctant participants in intervention programs. They frequently fail to attend scheduled appointments, are sometimes openly hostile to intervention staff, and often judge program materials as irrelevant to their situation. Recognizing this problem, researchers and practitioners have begun to develop models and tools to more appropriately assess and intervene with reluctant clients. Unfortunately, the resulting proliferation and inconsistent application of terms and theories have led to considerable confusion in characterizing reluctant clients and have significantly hampered research on strategies that may be helpful to better meet the needs of this client group. The purpose of this review is to help standardize the definition and measurement of treatment reluctance as it applies to violence perpetration and to review evidence for the importance of these aspects of client reluctance to intervention. Recommendations for assessing reluctance in research and clinical practice are also provided.

Key words: *resistance; motivation; treatment engagement; readiness; denial; sex offender; batterer; review; abuse*

IN THE PAST 10 TO 20 YEARS, there has been a resurgence of interest in understanding and better meeting the needs of clients who fail to engage in intervention. These clients are described relatively easily by clinicians—they fail to attend scheduled appointments, they often express their dissatisfaction with the available treatment, and they are sometimes openly hostile to treatment staff. Perpetrators of violence often fall into this category. Approximately one third of men attending batterer intervention programs agree with statements such as, “I am not the problem one; it

doesn’t make sense for me to be here,” and “I don’t have a problem that I need to change” (Scott & Wolfe, 2003). Among child sexual offenders, this presentation appears to be the norm, as evidenced by the fact that most intervention programs for this population begin with the explicit goal of having the offender acknowledge that his behavior was problematic (Beech & Fisher, 2002; Lawson, 2003; O’Donohue & Letourneau, 1993; Veach, 1997). Finally, there is evidence that a proportion of parents who are physically and emotionally abusive toward their children are reluctant to

KEY POINTS OF THE RESEARCH REVIEW

- Research on client reluctance would benefit from standardization of terms. Definitions are provided for the terms *engagement*, *motivation*, *denial*, *resistance*, *readiness*, and *responsivity*.
- Engagement in intervention is associated with lower rates of postintervention violence perpetration.
- Evidence for the importance of reducing offender denial is mixed.
- Additional studies are needed to determine whether motivation and ambivalence play an important role in predicting intervention success among perpetrators of violence.
- Strong measures are available for the assessment of engagement, therapeutic alliance, and denial among offenders. Stage-of-change measures are also useful to assess aspects of denial, motivation, and engagement.

enter and complete available intervention programs (Gelles, 2000; Girvin, 2004; Littell & Girvin, 2005).

Studies increasingly link reluctant client presentation with dropout and recidivism. Among male batterers and sexual offenders, factors such as denial and noncompliant behavior are associated with premature termination from treatment (e.g., Daly & Pelowski, 2000; Wormith & Olver, 2002), which, in turn, is a significant predictor of recidivism (Gondolf, 2002; Miner & Dwyer, 1995). This association has also been found in child maltreatment, with studies suggesting that those clients who drop out of treatment are at higher risk for future abuse perpetration (Harder, 2005).

Despite growing recognition of reluctant client presentation, clear theoretical definitions and explanations of this problem have remained elusive. Terms such as resistance, denial, motivation, readiness, and responsivity have all been used to describe reluctant client behaviors, sometimes interchangeably. Moreover, these terms have been used to incorporate factors as diverse as clients' attitude toward treatment, their shame about offending, the match between the demands of intervention and clients' cognitive capacity, the alliance between therapist and client, and the physical state of the treatment location. The proliferation of terms and their wide application have helpfully expanded the range of variables examined but have also

increased confusion over identifying the characteristics of clients who are reluctant to engage in treatment and conducting research on strategies that may be helpful to better meet the needs of this client group. Adding to the problem is a dearth of recommendations as to how to measure and apply these concepts. As a result, any theoretical clarity that has been gained in the past decade has tended to degrade in application to empirical and clinical work.

The first purpose of this review is to provide clarity and standardize the definition and measurement of treatment reluctance as it applies to violence perpetration. Various terms used to refer to client reluctance are defined and differentiated, with reference to recently published theoretical reviews and commentaries on denial (Schneider & Wright, 2004), motivation (Drieschner, Lammers, & van der Staak, 2004), readiness (Ward, Day, Howells, & Birgden, 2004), responsivity (Serin, 1998; Serin & Kennedy, 1997), and resistance (Arkowitz, 2002). The integrated conception of treatment motivation is then presented as a promising model for combining ideas around client reluctance. Drawing on literature from the study of domestic violence, sexual offending, and child abuse, we next review evidence on the importance of these aspects of treatment reluctance to problem behavior and to intervention. Finally, we provide recommendations for assessing client reluctance in research and clinical practice.

DEFINITIONS OF COMMONLY USED TERMS

Clients who present reluctantly at intervention programs have been described as unengaged, having low motivation, being in denial, having low levels of responsivity and readiness, and being resistant. Although not immediately apparent, these terms all have slightly different meanings and implications as outlined below and summarized in Table 1. To aid in this discussion, a short case example is presented and operational definitions of each term are provided with reference to this case.

George was mandated to an intervention program for domestic violence in response to a charge of assault against his wife. He was late for his first

TABLE 1: Definitions of Terms Used to Describe Reluctant Client Presentation

| <i>Term</i> | <i>Definition</i> |
|--------------------------|--|
| Treatment engagement | Clients' behavioral compliance with the basic expectations or demands of the intervention situation (e.g., session attendance, participation in intervention activities). |
| Treatment motivation | An internal force that moves an organism to engage in a particular behavior. Motivation is most closely related to individuals' intention to change. |
| Denial | Occurs when an individual's account of happenings is inconsistent with the objective truth of what occurred. Denial can occur at a conscious or unconscious level. |
| Resistance/ambivalence | Appropriately used when a client is sufficiently motivated and engaged in change, generally, but is "stuck" at a particular point due to conflicts (both conscious and unconscious) between his or her wishes and fears. |
| Treatment responsiveness | The extent to which clients are able to absorb the content of a program (e.g., clients' cognitive ability or adequacy of funding for treatment program). Often expanded to include factors that predict whether a client will, or will not, absorb program content. |
| Treatment readiness | The presence of characteristics (states or dispositions) within either the client or the therapeutic situation that are likely to promote engagement in therapy and that, thereby, are likely to enhance therapeutic change. Treatment readiness represents a combination of responsiveness, motivation, and client's perception of the meaningfulness of treatment. |

intervention session and participated only minimally. He admitted to slapping his wife but not to causing her any physical harm, although bruises are documented in the police report. He also asserted that his actions were within the boundaries of typical marital conflict. George stated that he is attending intervention to avoid further sanction from the legal system. Although he desires a more harmonious marital relationship, he currently has no intention to change any of his ways of relating to his wife and other family members. George identifies most strongly with his Brazilian culture and, with his wife and family, speaks predominantly Portuguese. However, he speaks exclusively English at work and has developed fluency.

Treatment Engagement

Treatment engagement has been defined as clients' behavioral compliance with the basic expectations and demands of the intervention situation (Drieschner et al., 2004). These demands typically include attending sessions, participating in intervention activities, thinking about intervention activities between sessions, and avoiding overly critical and hostile actions. Other terms that have been used as synonyms of treatment engagement include compliance, adherence, treatment involvement, basic behavior, and client-role performance (see review by Drieschner et al., 2004).

Two aspects of the definition of treatment engagement are emphasized in the literature. The first is reference to *observable behaviors* that are under clients' voluntary control. In the above

example, the facts that George attended intervention, arrived late, and participated minimally in discussions are relevant to judging his treatment engagement. Inferences about George's attitudes or intentions and reflections on possible barriers to greater participation are not relevant to defining his engagement.

Second, it is important to recognize that the basic demands of intervention differ somewhat according to the treatment approach. Expectations of attendance and participation are virtually universal; however, expectations around homework completion, level of in-session disclosure, and acceptable range of in-session acting out vary depending on the treatment. Also, some programs may have specific rules that clients must follow. For example, in programs targeting abuse, avoidance of violence and of being in situations that convey high risk for violence is often required. This difference in demands means that operational definition of treatment engagement may vary somewhat with reference to the specific treatment being considered.

Treatment Motivation

Drawing on an excellent conceptual review of the literature on treatment motivation by Drieschner et al. (2004), this article defines motivation as the "internal force that moves an organism to engage in a particular behavior" (p. 1117). Thus, motivation is most similar to the

idea of intention. Drieschner and his colleagues identify two main sources of conceptual confusion surrounding the definition and use of the term *motivation*. The first is the common practice of failing to specify a behavioral object of motivation. For example, when a client is described as having high "motivation to change," it is unclear whether this description refers to the client's intentions around pretreatment planning (e.g., motivation to find out information about available treatments), treatment entry behaviors (e.g., motivation to call a specific intervention program), treatment engagement (e.g., attendance and participation), intention to change behaviors without engaging in treatment, or all of the above. The term *motivation* is also sometimes inappropriately used with a state as its object rather than a behavioral goal. For example, a client may be inappropriately described as highly motivated to feel less depressed. As "feeling less depressed" is a state, and not a possible behavior in which clients can engage, this client is better described as having a strong desire or wish, rather than a strong motivation, to be nondepressed.

A second source of confusion results from conceptual and operational definitions that entangle motivation with resulting behaviors. For example, it is not uncommon to find motivation defined in terms of the probability that a person will enter into, continue, and/or adhere to a specific intervention (e.g., Howells & Day, 2002; Serin & Kennedy, 1997). The problem with such definitions is the circularity resulting from inferring motivation (i.e., intention) from the behavior it is assumed to predict (i.e., engagement). With such definitions, we also lose the opportunity to consider the many factors (e.g., timing of intervention, financial considerations) that are likely to influence whether a client's motivation to engage in intervention does, or does not, translate into treatment engagement.

Applied to the case of George, we can describe at least two forms of motivation—motivation to attend treatment and motivation to alter his behavior. We know that George wants to avoid further legal sanction and can assume from our description that he is motivated to attend treatment. In contrast, although George *wishes* that his relationship with his wife would improve, he

is not currently motivated to change any of his relationship behaviors as evidenced by the statement that he has "no intention to change any of his ways of relating to his wife."

Denial

The term *denial* is generally used to describe inconsistencies between an individual's reports of what happened and what is assumed to be the objective truth. An example of denial from the case of George is his report that there was no physical harm to his partner despite police report evidence to the contrary. Much of the literature on denial has focused on whether denial is a conscious or unconscious process. Manousos and Williams (1998) limit the definition of denial to cases where knowledge is unconscious (rather than conscious) and cite neuropsychological research demonstrating that people's actions are regularly influenced by stimuli that are not processed, or are only partially processed, at a conscious level (Westen, 1999). Denial is also commonly used to refer to cases where a client consciously misrepresents his or her offending behavior. This form of denial may, in fact, be adaptive in legal and child protection contexts where questions of guilt and punishment predominate, although it is generally regarded as problematic in offender programs associated with these systems.

At the surface, it seems reasonable to suggest that conscious and unconscious forms of denial be defined and studied separately. However, there are a number of important barriers to such separation. First, it is generally believed that individuals' accounts of offending are usually distorted by both unconscious and conscious denial and that different aspects of a single offense are subject to different degrees of denial. Accurate assessment of whether denial is or is not conscious is another barrier. For example, George may (consciously or unconsciously) deny that he physically harmed his partner but admit that she was emotionally harmed. Alternatively, he may (consciously or unconsciously) admit to some level of harm but assert that his wife is exaggerating her injuries. Finally, separation of conscious and unconscious denial may not be warranted on theoretical grounds as

both are expected to serve similar self-protective functions for offenders who might otherwise be overwhelmed with shame (Bumby, Marshall, & Langton, 1999; Finkelhor, 1984; W. D. Murphy, 1990; Schneider & Wright, 2004; Wallace & Noskos, 1993). Both allow the offender to avoid taking responsibility for his or her behavior and contribute to the development of a distorted set of cognitions that refute the offense (e.g., complete denial of act), minimize its effect (e.g., denial of harm to the victim), depersonalize choices around offending (e.g., denial of planning or risk for relapse), and contribute to risk for reoffending.

Responsivity

The concept of responsivity is originally derived from the literature assessing the success of criminal justice interventions according to the principles of risk, needs, and responsivity (Andrews & Bonta, 2003). Among these, the principle of responsivity states that to enhance the efficacy of interventions, styles and modes of treatment service must be closely matched to the preferred learning style and abilities of the offender (Bonta, 1995; Serin, 1998). Thus, *responsivity* may be best defined as the extent to which clients are able to absorb the content of the program (Ward et al., 2004). From this starting point, responsivity can be broken down into internal and external responsivity factors (Andrews, 2001). Internal factors refer to characteristics of the client that must be addressed by the intervention program to maximize outcome efficacy. Examples include client learning style, cognitive ability, problem solving, language and literacy, and personality characteristics. In the case of George, a key internal responsivity factor is likely the ability of the intervention program to address domestic violence within a context that appropriately recognizes his identification with Brazilian culture. External responsivity factors include all therapist and setting characteristics that may affect clients' engagement in treatment. These include location and timing of intervention, availability of adequate recourses for programs, training of intervention staff, and support provided to the client outside of intervention sessions. In George's case, external responsivity

factors may include his wife's support of intervention, the distance he needs to travel to attend intervention, the ability of the therapists to make him feel welcome at the intervention program, and adequacy of funding.

A strength of the concept of responsivity is its reminder that client behaviors are affected by factors controlled by treatment providers as well as by clients themselves. Moreover, this concept reminds researchers and practitioners of the importance of the interaction of clients' abilities and characteristics and intervention design. However, balancing these strengths are significant problems resulting from the breadth of the term responsivity. Factors encompassed by the label of internal responsivity range from static demographic characteristics (e.g., client's age) and stable personality traits (e.g., neuroticism, openness, and narcissism) to dynamic states (e.g., attitudes toward being mandated to intervention) and dispositions (e.g., level of felt hostility) (see Serin & Kennedy, 1997). A similar observation could be made for factors grouped under the label external responsivity, which includes everything from the provision of adequate program funding to therapists' capacity to be engaging. The problem is that, except for their proposed or actual statistical relationship to treatment engagement, it is unclear what brings these heterogeneous factors together. The listed range of responsivity factors is likely to affect client's engagement in treatment in different ways, through different mechanisms, and with different results (Ward et al., 2004).

Readiness

The term *readiness* has been defined as the presence of characteristics (states or dispositions) within either the client or the therapeutic situation that are likely to promote engagement in therapy and that, thereby, are likely to enhance therapeutic change (Howells & Day, 2002). Ward et al. (2004) distinguish readiness from responsivity by its focus on positive predictors of engagement rather than barriers to intervention, which he hopes will promote a more hopeful and helpful view of client change potential. Despite this difference in focus, the concept of readiness overlaps considerably with that of

responsivity in its incorporation of a large range of internal and external factors that may relate to treatment motivation and engagement. In fact, Serin (1998) presents readiness as a dimension of responsivity, whereas Ward et al. (2004) suggest that responsivity is an aspect of readiness. Regardless, the similarity of these two concepts means that the concept of readiness shares many of the problems of the definition of responsivity. Specifically, the term readiness can be criticized for the grouping of unlike predictors, lack of rationale for inclusion of some factors and exclusion of others, and lack of clarity as to how the term readiness is different from a more general description of predictors of treatment engagement.

Resistance

A final term to consider is resistance. The concept of resistance has a very long history in the field of psychotherapy. It has been discussed in writings of prominent therapists in all psychotherapy schools and is widely recognized as one of the most important targets of therapeutic work. In 2002, a special issue of the *Journal of Clinical Psychology* (Vol. 58, No. 2) addressed this topic. On the basis of an integrative commentary from these articles, Arkowitz (2002) suggests that resistance is best used to describe situations where a client is *ambivalent about change*. Specifically, he states that resistance may be "inferred when clients (i) have expressed some desire to change in their statements of behaviors; (ii) have identified strategies or therapies that are likely to be helpful in making those changes; (iii) believe that changing will improve their overall quality of life; (iv) experience distress about not changing; and yet, (v) show some alternation between approaching or avoiding the tasks necessary for change" (p. 220). Presumably, this alternation occurs due to conflicts (both conscious and unconscious) between clients' wishes and fears. An example would be if, during therapy, George developed motivation to regularly communicate with his wife about his insecurity around her relationships with male friends, believed that his lack of communication was harming their relationship, was distressed about not sharing his thoughts and feelings, but was

also fearful that if he shared his insecurities, his wife would lose interest in him and potentially leave the relationship and, as a result, alternated between engaging and not engaging in change attempts. Due to its focus on these conflict situations, Arkowitz suggests that the more descriptive term *ambivalence* should be adopted in place of the term *resistance*.

Summary

In summary, there are a variety of terms typically used to describe clients who approach intervention reluctantly. Treatment engagement refers to the extent to which a client performs in ways that are appropriate to the treatment situation. Behaviors such as attending, participating, and attempting change are indicative of higher levels of treatment engagement. Motivation, on the other hand, is the internal force or intention that plays a key role in prompting these behaviors. Denial refers to the degree to which a client's explanation of events matches objective indicators and likely functions to protect an individual from negative self and other evaluation. Resistance is conceptualized as clients' ambivalence about making a specific change in the context of generally good motivation and treatment engagement. Finally, responsivity and readiness are somewhat more difficult to define as they encompass a number of loosely related variables. However, both add to our conception of client reluctance by promoting consideration of a full range of factors that likely relate to change motivation and treatment engagement.

THEORETICAL RELATIONSHIPS BETWEEN CLIENT ENGAGEMENT, MOTIVATION, DENIAL, RESPONSIVITY, READINESS, AND RESISTANCE

As emphasis on meeting the needs of clients who are reluctant to engage in intervention has increased, so too has attention to theoretical models that integrate ideas around client reluctance. There are now a number of models available including the transtheoretical model of change (Prochaska & DiClemente, 1982, 2005; Prochaska, DiClemente, & Norcross, 1992), the multifactor offender readiness model

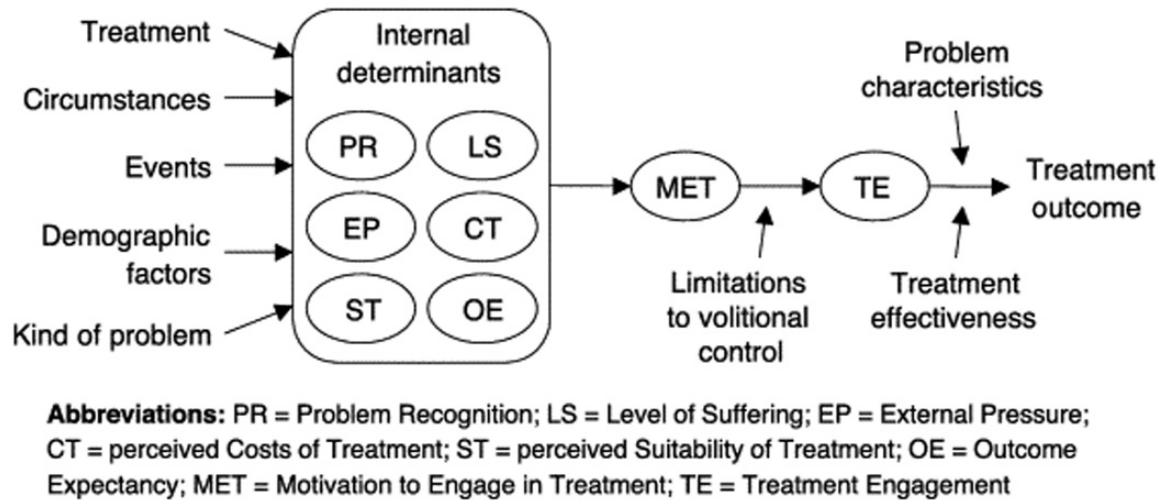


FIGURE 1: Integral Conception of Treatment Motivation and Related Concepts
SOURCE: Drieschner, Lammers, and van der Staak (2004).

or MORM (Ward et al., 2004), and the integral conception of treatment motivation (Drieschner et al., 2004). Among these, we have chosen to review the integral conception of treatment motivation as one of the most helpful for understanding and guiding research on client reluctance. Drieschner et al.'s (2004) model, as shown in Figure 1, proposes that treatment engagement is predicted by client motivation, which in turn is predicted by a large number of potential determinants of change. Internal determinants are defined as dynamic factors (i.e., able to be changed) through which more stable internal and external factors affect motivation. Included in Drieschner and colleagues' list of internal determinants is denial and many of the factors encompassed by responsivity and readiness. Other factors that influence change, called remote factors, include all other client, therapist, and intervention characteristics that might affect outcome but that are not easily changed (e.g., client learning style). These factors are expected to influence clients' motivation and engagement either directly or through their effect on internal determinants of change.

The strength of Drieschner et al.'s (2004) model is its clear separation of forms of reluctance and

its specification of dynamic cognitive factors that are useful targets for clinicians wishing to improve engagement. This model also has the strength of distinguishing between the effect of motivation and engagement and the treatment program itself on outcome. In other words, this model allows for the possibility that an offender is fully motivated and engaged in treatment but that the treatment program is ineffective. A weaker point in the model is the lack of explicit focus on the interaction on internal and remote determinants of change. As emphasized in models of responsivity and readiness, there is a dynamic interplay between intervention programs, therapists, and clients, and the nature of these interactions significantly affects internal determinants of change. A second criticism derives from the lack of empirical evidence that change in internal determinants *precedes* motivation, which *precedes* engagement. It is possible that engagement itself causes important changes in internal determinants, resulting in a process that is far more iterative than Drieschner and colleagues' model suggests. Nevertheless, their model has added significantly to the literature and provides a solid framework for additional research in this area.

RESEARCH ON MOTIVATION, ENGAGEMENT, DENIAL, AMBIVALENCE, RESPONSIVITY, AND READINESS AMONG PERPETRATORS OF ABUSE AGAINST WOMEN AND CHILDREN

The following section reviews literature on the relationship between motivation, engagement, denial, ambivalence, and behavior change. Studies were found by scanning the PsycINFO database for the terms *denial*, *engagement*, *ambivalence*, *responsivity*, *readiness*, and *motivation* and through follow-up of all leads contained in published articles. Focus was placed on studies of individuals who have abused their children or their intimate partners or who have had sexually abused children.

Treatment Engagement

For many offender treatment programs, ensuring basic treatment engagement (i.e., program attendance) remains a major challenge. For example, a review of the literature on attrition from batterer intervention programs found that dropout rates often vary between 50% and 70% (Daly & Pelowski, 2000). These high dropout rates remain even when men are mandated to intervention. Studies of treatment programs for sexual offenders against children and parents who have maltreated their children show similarly high rates of dropout (Chaffin et al., 2004; Moore, Bergman, & Knox, 1999). Consistent with the theorized relationship between treatment engagement and positive outcomes, studies have shown that clients who drop out of treatment are at greater risk for subsequent violence and recidivism (e.g., Dutton, Bodnarchuk, Kropp, Hart, & Ogloff, 1997; Hanson & Bussiere, 1998; Seto & Barbaree, 1999). For example, Gondolf (2002) found that batterers who dropped out of intervention were considerably more likely to reassault their partners than nondropouts (40% vs. 28%). Similarly, a large-scale study of sexual offender treatment found that rates of reoffense were higher among men who dropped out of treatment than among men who completed at least a year of treatment (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005). Although

debate continues as to whether dropout itself is key to predicting reoffending, or whether both dropping out and reoffending are both predicted by a more important third variable (e.g., level of psychopathology), lack of treatment engagement is, at the very least, a good marker for the likelihood of recidivism.

Going beyond basic attendance, studies have begun to examine the implications of levels of engagement on rates of subsequent violence and abuse. Several studies have now documented that a variety of indicators of group engagement, such as homework compliance, active participation, self-disclosure, and help seeking, is associated with lower subsequent relationship violence and/or criminal recidivism among batterers (Taft, Murphy, Elliott, & Morrel, 2001; Taft, Murphy, King, Musser, & DeDeyn, 2003). Similarly, in studies of sexual offenders, higher degrees of emotional expression in group intervention sessions predict greater improvements in treatment targets (Beech & Hamilton-Giachritsis, 2005). Results are not, however, consistent across all studies (see Seto & Barbaree, 1999, for contrasting findings) and there is an absence of empirical work on the importance of engagement in predicting outcomes among child-abusing parents.

Treatment Motivation

To date, few studies have examined the influence of the motivation of abusive and violent individuals' either to attend treatment or to change their behavior. There are likely very good reasons for this. As reviewed, motivation is best conceptualized as an internal force, or intention, to change. As such, the most obvious method to assess motivation is self-report. Among perpetrators of violence and abuse, self-report is likely to be biased by the social stigma attached to violence perpetration and the judicial context in which most research is done. It is, for example, somewhat unlikely that a father who has been charged with assaulting his children will report that he does not intend to change his behavior in the future or that he intends to avoid going to intervention, even on an anonymous survey. It is perhaps for these reasons that studies of motivation often use a

confusing combination of indicators more accurately labeled as treatment engagement and/or denial. An exception is a recent study by Littell and Girvin (2005). These researchers examined the association of problem recognition and motivation (i.e., intention to change) on treatment outcomes for 353 primary caregivers referred to child protective services. Results of this study found that client-reported intention to change at the beginning of treatment was a significant predictor of improvements in housing, children's school problems, caregivers' social network, and positive life events 16 weeks later. Furthermore, higher intention scores at Time 1 predicted reductions in the likelihood of substantiated reports of childhood maltreatment 1 year later.

Research on therapeutic alliance also taps into client motivation, in its focus on correspondence between the client and therapist on therapy tasks and goals (i.e., is there agreement on the intentional tasks of therapy?). Therapeutic alliance shows a particularly strong relationship to outcomes (Horvath & Symonds, 1991). For example, studies with partner-violent men and with sex offenders have indicated that the working alliance is predictive of treatment completion (e.g., Brown, O'Leary, & Feldblau, 1997; Cadsky, Hanson, Crawford, & Lalonde, 1996; Rondeau, Brodeur, Brochu, & Lemire, 2001) and treatment outcome (e.g., Brown & O'Leary, 2000; Taft et al., 2003). These results provide strong preliminary support for the importance of change intentions to outcome among offender populations; however, considerably more research needs to be done both on measurement and on relation of motivation to outcomes to draw conclusions.

Denial

Denial of problem behaviors is common among perpetrators of violence against women and children (Gelles, 2000; Pence & Paymar, 1993) as well as in populations of offenders, more generally (Serin & Kennedy, 1997). There is some research to suggest that denial has a strong inverse relationship to treatment progress with sex offenders (Levenson & Macgowan, 2004) and, conversely, that admission of guilt and

accepting personal responsibility are associated with positive treatment outcomes (Barrett, Wilson, & Long, 2003). Batterers who deny abusing their partners or who perceive no need for treatment tend to drop out of treatment at higher rates than other men (Cadsky et al., 1996). Moreover, several studies have found that men in the transtheoretical model's precontemplation stage of change (which includes denial in its definition) show little positive change over the course of treatment (e.g., Levesque, Gelles, & Velicer, 2000; Scott & Wolfe, 2003). Finally, Littell and Girvin (2005) report that poor problem recognition predicted subsequent reports of child maltreatment.

Despite these findings, results linking denial to positive outcome are not consistent either within or across studies. For example, although problem recognition in Littell and Girvin's (2005) study was related to later reports of maltreatment, it showed no relation to subsequent rates of abuse *substantiation*. Henning and Holdford (2006) found that, in a large sample of men arrested for assaulting their intimate partner, denial of the offense was unrelated to police-reported violence 12 to 50 months later, but clinician rating of men's minimization was related. In a meta-analysis of studies on reassault among sexual offenders, Hanson and Bussiere (1998) found that denial was unrelated to sexual recidivism but was weakly correlated with general recidivism. Substantial methodological variability in defining and measuring denial likely contributes to these divergent results (Lund, 2000; Schneider & Wright, 2004). Another possible explanation for these discrepant findings is that denial may be related to motivation and may predict treatment engagement, but it may have less of a role in predicting change over time, which is affected by a variety of factors external to intervention programs (Drieschner et al., 2004). Additional studies, with improved measures of denial and larger samples, are needed to clarify these relationships.

Resistance/Ambivalence

Ambivalence toward change has been directly studied with reference to a variety of

health-related behaviors such as smoking cessation, alcohol and drug use, and engagement in exercise. Overall, results from these studies suggest that progress toward change is related to increases in perceived benefits and decreases in the perceived costs of change (Prochaska et al., 1994). A limited number of studies have explored pros and cons of change among perpetrators of abuse. These studies have found that batterers who deny or are unwilling to disclose problem behaviors recognize few pros and more cons of change than batterers who indicate that they are motivated to change (Levesque et al., 2000; Rondeau, Lindsay, Brochu, & Brodeur, 2006). The association between level of ambivalence and violence recidivism has been examined in only one study to date, with nonsignificant results (Rondeau et al., 2006).

Although there has been relatively little research on the relationship between ambivalence and offending behavior, there is a rapidly growing literature on therapeutic strategies that are most and least helpful for moving clients beyond ambivalence and toward change. Historically, therapists and therapy models have placed considerable emphasis on the need to immediately and directly confront client problem behaviors. These confrontation tactics were seen as essential to avoid therapist collusion with clients' abusive behavior, to push offenders into a position in which they would assume personal responsibility for their personal behavior and accept help from the therapist (Kear-Colwell & Pollock, 1997; Pence & Paymar, 1993). In contrast to these theoretical models and practices, recent studies have demonstrated that overly aggressive and confrontational tactics reduce the effectiveness of treatment and contribute to a lack of engagement of offenders (Drapeau, 2005; Marshall et al., 2003). For example, Marshall and his colleagues (2003) reported that use of a confrontational style was negatively related to improvements among sexual offenders enrolled in treatment. The use of hostile and critical therapist behaviors with domestic abuse perpetrators has also been criticized (C. M. Murphy & Baxter, 1997). Instead, researchers and clinicians have shifted toward a focus on strategies that increase client readiness and engagement in

therapy. Example works include McMurrans' (2002) strategies for increasing client motivation for offenders, the implementation of pre-group motivational sessions for batterer clients (Musser, Semiatin, Taft, & Murphy, in press), and the identification of therapist behaviors and therapeutic skills that can best promote therapeutic benefits in sex offenders (Marshall & Serran, 2004; Marshall et al., 2002). Excellent recommendations are also available in Miller and Rollnick's (2002) text on motivational interviewing and from the motivational interviewing Web site (<http://www.motivationalinterview.org/>).

Summary

In summary, there is a growing body of research on the importance of a variety of aspects of client reluctance to intervention outcome. Among the factors reviewed, strongest support is available for the relationship of treatment engagement to subsequent reductions in abuse perpetration. The limited number of studies available to date precludes any conclusions about motivation and ambivalence; however, there is enough preliminary support to recommend that additional studies be conducted. Denial appears to be a good predictor of treatment engagement, but the strength of its relationship to improved outcomes remains unclear. Lack of consistent conceptual and operational definitions is a key concern for attempting to integrate results across studies.

MEASUREMENT OF KEY CONSTRUCTS IN RESEARCH ON TREATMENT RELUCTANCE

For researchers and program evaluators to examine the importance of different aspects of client reluctance, reliable, valid, and conceptually clear measurement instruments are needed. In the final section of this article, we describe published measures of treatment reluctance. We note, at the onset, that there is a dearth of psychometrically strong and conceptually clear measures available. Measures are summarized in Table 2, and we have posted copies of all noncopyrighted assessments at the following address: <http://fcis.oise.utoronto.ca/~scottlab/>. Scales are loosely grouped into

general assessments of engagement and denial, followed by population-specific measures.

Group engagement measure (GEM). The GEM is a 37-item counselor report measure of treatment engagement. Seven forms of engagement are represented: attendance (e.g., "the member does not hurry to leave at the end of session"), contribution (e.g., "the member contributes his or her share of talk time"), relating to worker positively (e.g., "the member interferes with or contradicts work that the worker is doing with other members in destructive ways"—reversed), relating with group members (e.g., "the member shows enthusiasm for conversations with at least one other member"), contracting (e.g., "the member expresses continual disapproval about the meeting times"), working on own problems (e.g., "the member makes an effort to achieve his or her particular goals"), and working on other members' problems (e.g., "the member challenges others constructively in their efforts to sort out their problems"). Although originally designed as a counselor-report measure, the GEM has been adopted for use as a self-report instrument (Levenson & Macgowan, 2004).

Homework Compliance Scale. Another useful indicator of engagement is clients' compliance with homework assignments. In a recent review of literature on homework compliance, Kazantzis, Deane, and Ronan (2004) found that this construct is most often assessed with a single homework quantity item rated on a scale of 0 (*the patient did not attempt the assigned homework*) to 6 (*the patient did more of the assigned homework than was requested*). Although efficient, Kazantzis and colleagues (2004) point out that using a single item does not allow for assessment of quality of homework compliance or for an understanding of why homework was or was not completed. They propose a 12-item Homework Compliance Scale client self-report measure to replace the single-item assessment. This scale assesses factors that influence compliance at the client (e.g., "How much did you enjoy the assignment?"), therapist (e.g., "How specific were the guidelines for how to do the assignment?"), and task (e.g., "How difficult was the assignment?") levels, as well as overall quality and quantity of homework completed.

Therapeutic alliance. A variety of instruments is available to assess therapeutic alliance including the California Psychotherapy Alliance Scales (Marmar, Weiss, & Gaston, 1989), the Penn Helping Alliance Rating Scale (Luborsky, Crits-Cristoph, Alexander, Margolis, & Cohen, 1983), the Vanderbilt Therapeutic Alliance Scale (Hartley & Strupp, 1983), the Combined Alliance Short Form (Hatcher & Barends, 1996), and the Working Alliance Inventory (Horvath & Greenberg, 1986). These measures share a common conceptualization of therapeutic alliance and studies have shown them to be strongly intercorrelated. Although all of the above measures have adequate reliability, we have chosen to present more in-depth information on the Working Alliance Inventory (WAI) because it is very commonly used and can be administered in a variety of formats. The original version of the WAI is a 36-item client-report measure of the perceived correspondence on therapy tasks (e.g., "My therapist and I agree about the things I will need to do in therapy to help improve my situation"), goals (e.g., "My therapist does not understand what I am trying to accomplish in therapy"), and the bond between the client and therapist (e.g., "I believe my therapist likes me") (Horvath & Greenberg, 1986). Short-form versions of the WAI have also been developed for both client and therapist use (Tracey & Kokotovic, 1989). Long and short versions are highly correlated (Busseri & Tyler, 2003; Tracey & Kokotovic, 1989). Finally, two observer forms of the WAI are available, one that corresponds with the long version and the other with the short form (Tichenor & Hill, 1989). Items for all forms of the WAI are available from cited articles.

Stage-of-change measures. There are a number of assessment measures based on the transtheoretical model of change. The most general measure is the University of Rhode Island Change Assessment Scale (URICA; McConaughy, DiClemente, Prochaska, & Velicer, 1989). The eight precontemplation items on this scale mostly assess client denial in a treatment context (e.g., "Being here is pretty much a waste of time for me because the problem doesn't have to do with me," "As far as I am

TABLE 2: Measures That Capture Components of Treatment Motivation and Related Concepts

| <i>Scale</i> | <i>Characteristic</i> | <i>Target Group</i> | <i>Reliability/Validity</i> | <i>Availability</i> |
|--|---|---|--|---|
| Group Engagement Measure (GEM) | Original GEM 37-item observer report of seven dimensions of engagement | Group therapy | Showed construct validity and criterion validity | Items publicly available from Macgowan & Newman (2005) |
| Homework Compliance Scale | 12-item self-report scale measuring homework quality and quantity and assessing factors related to compliance | Any client's assigned homework | Psychometric properties not yet established but theoretically superior to more commonly used single-item assessments | Items publicly available from Kazantzis, Deane, & Ronan (2004) |
| Working Alliance Inventory (WAI) | 36-item long and 12-item short versions for client, therapist, and observer | Generally applicable | Strong psychometric properties; results support the interchangeability of short and long WAI scales | Items for all versions publicly available from Horvath & Greenberg (1986), Tracey & Kokotovic (1989), and Tichenor & Hill (1989) |
| University of Rhode Island Change Assessment Scale (URICA) | 24-item self-report measure of four stages of change, useful for assessing denial/willingness to disclose, motivation, outcome expectancy, and change behaviors | Generally applicable | Items have good internal consistency, although there is debate about the underlying factor structure of this and other stage-of-change measures | Items publicly available from McConaughy, DiClemente, Prochaska, & Velicer (1989) |
| URICA-Domestic Violence (URICA-DV); URICA-DV2 | 20-item self-report; provides four subscales (precontemplation, contemplation, action, maintenance), as well as a Readiness to Change Index | Adult male batterers | Acceptable internal consistency; cluster analysis has suggested both three- and seven-factor URICA-DV cluster solutions | Items for the URICA-DV publicly available from Levesque, Gelles, & Velicer (2000); URICA-DV2 items available for purchase at www.prochange.com |
| Safe at Home Instrument | 35-item self-report; items useful for measuring motivation and engagement in change behaviors | Adult male batterers | Exploratory and confirmatory factor analyses for three-factor structure | Items publicly available in Begun et al. (2003) |
| Attitudes Towards Correctional Treatment (ACT) Scale | 33-item offender report produces a total motivation score, in addition to five subscale categories | Adult criminal offenders | Data indicate satisfactory internal consistency statistics and test-retest coefficients | Items publicly available from Baxter, Marion, & Goguen (1995) |
| Facets of Sexual Offender Denial (FoSOD) | 58-item self-report produces six subscales | Adult sex offenders | Subscales reliable and valid; strong internal reliability; evidence for construct, convergent, and discriminant validity | Items available for purchase from www.capestrategies.com |
| Multiphasic Sex Inventory II | 560-item true/false self-report measure of a broad range of characteristics of sexual offenders, including subscales of denial and attitudes towards treatment | Adult males suspected of sexual deviance; alternate forms for female and adolescent offenders | Good internal consistency for denial and attitudes towards treatment subscales; but items are not designed to be examined independent of overall battery | Items available for purchase from Nichols and Molinder Assessments, Inc. |
| Sexual Violence Risk-20 | 20 assessor-rated items; 2 of 20 items tap offender minimization and denial, and another taps negative attitudes towards intervention | Adult male sexual offenders | Reluctance items not examined separately; overall scale shows good reliability and validity | Items available for purchase from Psychological Assessment Resources, Inc. |
| Sex Offender Treatment Needs and Progress Scale | 22 assessor-rated items; 5 items measure aspects of offender denial, motivation, and engagement | Adult male sexual offenders | Currently considered an experimental measure; reliability and validity data still being collected | Items available from the authors at http://www.nicic.org/Library/Default.aspx?Library=019462 |
| Juvenile Sex Offender Assessment Protocol-II | 28 assessor-rated items; one item assesses motivation and one assesses denial | Male sexual offenders between the ages of 12 and 18 | Reluctance items not examined separately; overall scale shows good preliminary reliability and validity | Items available from the authors at http://www.nicic.org/Library/Default.aspx?Library=016747 |

concerned, I don't have any problems that need changing"). Eight contemplation items assess a combination of motivation (e.g., "I've been thinking that I might want to change something about myself") and outcome expectancies (e.g., "Maybe this place will be able to help me"). Finally, the eight action items assess engagement in change behaviors. Items from the URICA are available in McConaughy et al. (1989). The URICA has been used in studies of batterers (Scott & Wolfe, 2003) and maltreating parents (Littell & Girvin, 2005) with some minimal modifications.

Criticisms that the URICA is nonspecific in its identification of the problem to be changed have led to the development of population-specific measures. The University of Rhode Island Change Assessment Scale–Domestic Violence (URICA-DV) and its updated version, the URICA-DV2, are designed to assess batterers' reluctance to change their violence. Similar to the URICA, items from precontemplation, contemplation, and action subscales each tap different aspects of reluctance. The Safe at Home is another stage-of-change instrument developed specifically for use among batterers. Items on the precontemplation subscale of this measure assess a variety of aspects of client reluctance, including denial (e.g., "It's no big deal if I lose my temper from time to time"), partner blaming (e.g., "It's her fault that I act this way when we disagree"), and motivation to attend intervention (e.g., "I'll come to groups but I won't talk"). Items on the contemplation scale assess client motivation to change ways of dealing with anger and conflict, and items on the preparation/action subscale assess clients' use of a variety of change strategies. Safe at Home items are published in Begun et al. (2003).

Attitudes Towards Correctional Treatment (ACT) Scale. Another scale that researchers and clinicians might consider is the ACT Scale (Baxter & Tweedale, 1995). This 33-item self-report scale provides assessment across a variety of domains of client reluctance, some of which are more theoretically clear than others. Specifically, the eight items of the optimism/pessimism about treatment outcome scale provide a decent assessment of outcome expectancy, and the five

items on the perceptions of staff subscale assess the aspect of therapeutic alliance relating the bond with the therapist. Items on the scales labeled motivation and perceived need for treatment appear to assess a combination of outcome expectancy and motivation. Finally, items on the last two subscales assess clients' comfort with sharing personal information. Items for the ACT Scale are available from Baxter, Marion, and Goguen (1995).

Facets of Sexual Offender Denial (FoSOD). The FoSOD is a 66-item self-report measure of six facets of pedophile denial: refutation of sexual offense, denial of extent, denial of intent, assertion of victim desire, denial of planning, and denial of relapse potential. From a theoretical standpoint, the FoSOD is perhaps the most comprehensive measure yet developed to assess denial. Identified subscales are reliable and valid, with evidence of both convergent and discriminant validity (Schneider & Wright, 2001). The FoSOD is commercially available at <http://www.capestrategies.com/pro.html>. It is recommended as an assessment of denial among sex offenders and as a model for researchers developing denial measures for use with other populations.

Multiphasic Sex Inventory II (MSI-II). The MSI-II (Nichols & Molinder, 1996) is a 560-item true/false standardized self-report measure of a broad range of characteristics of sexual offenders. This measure differs from ones discussed previously in that assessment of reluctance is only one small component of the overall assessment instrument. Internal consistency of the two subscales on reluctance varies with much stronger reliability of the denial subscale ($\alpha = .82$) than the attitudes towards treatment subscale ($\alpha = .56$). Research on other aspects of reliability and validity has concentrated on composite scores or on the scale as a whole rather than on individual subscales.

Sexual offender risk assessment ratings. There is a variety of instruments designed to aid in reviewing risk factors and in monitoring the progress of sexual offenders. On these instruments, assessors are instructed to use a variety of data sources (e.g., file review, interview, collateral

reports) to make judgments about offenders' risk or needs across a range of items. Items are usually scored on a 3- or 4-point scale ranging from *no or minimal presence of the risk factor or need* to *clear presence of the risk factor or need*. Recently, items tapping offender reluctance have been included on these instruments. For example, the Sexual Violence Risk-20 measure includes one item on offender minimization and denial and another on negative attitudes toward intervention (Boer, Hart, Kropp, & Webster, 1997). On the Sex Offender Treatment Needs and Progress Scale (McGrath & Cumming, 2003), 5 of the 22 items tap aspects of offender reluctance: admission of offense behavior, acceptance of responsibility and items on offender, stage of change, cooperation with treatment, and cooperation with community supervision. Finally, the 28-item Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II; Prentky & Righthand, 2003) includes items on acceptance of responsibility and internal motivation to change. The reliability and validity of reluctance items on these scales have not been examined individually, although the psychometric properties of the scales overall tend to be good.

CONCLUSION

Recent years have seen increased attention to reluctant client presentation as a potential predictor of the efficacy of interventions with individuals who have been violent and abusive in their families. In an attempt to promote

additional research in this area, this article reviewed aspects of client reluctance and provided clear definitions for the terms *engagement*, *motivation*, *denial*, *resistance*, *readiness*, and *responsivity*. Review of research in each of these areas provided strong support for the importance of treatment engagement and preliminary support for the importance of client motivation. Mixed evidence was garnered for the influence of problem denial. Responsivity and readiness were both identified as broad labels encompassing a range of client, therapist, intervention, and setting characteristics that are likely to influence outcome. Further research is needed in all of these areas, with attention to potential differences in reluctance among different types of offender populations.

Overall, results of this review suggest that we are making good progress in better understanding and assessing the needs of reluctant clients. However, given the focus placed on denial and engagement in many court-based intervention programs, more research is urgently needed. Such research has significant potential to alter intervention. For example, evidence of the importance of engagement, alliance, and the avoidance of harsh confrontations has already started to change practice in the treatment of alcohol and drug problems and is affecting interventions for sexual offenders against children. Similar improvements are likely in the treatment of batterers, sexual offenders, and abusive parents as research in this area becomes more sophisticated.

IMPLICATIONS FOR PRACTICE, POLICY, AND RESEARCH

- Given support for the relationship between engagement and outcome, intervention programs should increase efforts to engage reluctant clients.
- Additional research is urgently needed on the importance of client denial given the current disconnect between practice and emerging empirical findings.
- Research in this emerging area will benefit from standardized definitions of terms and from use of theoretically clear assessment measures.

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