

ASSESSING THE CORRECTIONAL SERVICE OF CANADA  
HIGH INTENSITY FAMILY VIOLENCE PREVENTION PROGRAM

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By  
Leon Myles Ferguson

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## ABSTRACT

A family violence prevention program for incarcerated male offenders was evaluated. One hundred and one (101) offenders incarcerated in minimum and medium security facilities participated in a high intensity family violence prevention program offered by Correctional Services of Canada. Thirteen psychological, attitudinal, and behavioural measures were administered to the offenders. The measures were administered either pre-treatment only, pre- and post-treatment, or post-treatment only. Five measures were self-report measures completed by offenders, and eight were administered and scored by qualified corrections personnel. The offenders showed a number of positive pre- to post-treatment changes. Following treatment, offenders reported that they were less likely to rationalize their abusive behaviour or believe that being a man grants one special privileges and entitlements over women. Offenders were less likely to support the use of power and control tactics over women or to endorse an assortment of myths that can foster inequality and abuse. Following treatment, offenders were judged to have shown an improvement in their willingness to sympathize with their partner as well as an improvement in their conflict-resolution skills. Offenders were also judged to show substantial pre- to post-treatment improvements in their compliance with, and response to, treatment, as well as demonstrating an improved ability to apply the knowledge and skills learned from treatment. The Statistical Information on Recidivism (SIR) Scale failed to demonstrate concurrent and predictive validity on a sub-sample of these domestic violent offenders.

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## SPOUSE ABUSE IN CANADA

### **Defining Spouse Abuse**

While consensus about the precise definition of spouse abuse is elusive, spouse abuse has been taken by diverse theoreticians, researchers, and practitioners to involve a number of forms or dimensions lying on a continuum, each of which involves varying levels of: activity (e.g., physical vs. nonphysical; acts of commission vs. acts of omission), severity (e.g., mild vs. severe), frequency (e.g., acute vs. chronic), harm (e.g., serious vs. minor or trivial), and purposefulness (e.g., deliberate vs. willful blindness or reasonable foreseeability).

The notion of power and control is also central to the definition of spouse abuse. Highlighting this point, Johnson and Grant (1999) observe that, “Wife abuse is an attempt to control the behaviour of a wife, common-law partner or girlfriend. It is a misuse of power which uses the bonds of intimacy, trust and dependency to make the woman unequal, powerless and unsafe” (p. 1). Although different researchers may define “spouse abuse” broadly or narrowly, the subcategories of physical, sexual, economic, and psychological/emotional abuse are the most commonly recognized forms of spouse abuse (Hegarty, Sheehan, & Schonfeld, 1999).

Physical abuse involves using physical force in a way that injures a person or which threatens to injure and can take innumerable forms including hitting, choking, biting, shoving, pushing, burning, assaulting with a weapon and so on. Such abuse can range from less severe forms (e.g., slight bruising, light scratch marks) to very severe forms that can be life-threatening (e.g., broken bones, damage to internal organs). Physical abuse can and sometimes does end in death. In Canada, between 1978 and 1997, 1,485 females (and 442 males) were killed by their spouses (Fitzgerald, 1999). According to the Globe and Mail (2002), about 70 Canadian women a year are killed by a partner or ex-partner (As also reported by the Globe and Mail, 42% of Canadian men who kill their partner have no reported history of spouse abuse.).

Defining “sexual abuse” broadly to include more than unwanted physical contact, Health Canada (1995) suggests that sexual abuse can also take many forms such as making a woman perform sexual acts against her will, treating her like a sex object and even asserting control over a woman’s reproductive capacity by not letting her have an abortion, take birth control or accusing her of being attracted to other men (Health Canada, 1995).

Financial abuse also includes many forms of direct or indirect forms of control or domination such as stealing from or defrauding a partner, forcing a woman to be financially dependent on her partner who might, for example, refuse her access to the family’s money, prevent her from taking a job or perhaps denying her access to her own money (Health Canada, 1995). Economic abuse might include not paying child support or manipulating or exploiting a partner for one’s own gain.

Psychological abuse can also take many forms, all of which affect a woman’s psychological well-being: putting a woman down, insulting her, ignoring her, destroying her property, chronic rejection and criticism, isolating her from family and friends, confinement, intimidation and threats of harm to one’s self or one’s children, using male privilege or feelings of entitlement to exert control and dominance by making all the major decisions in the home or expecting the woman to cling to traditional gender roles. In brief, psychological abuse will invariably diminish a women’s sense of identity, dignity or self-worth (Appleford, 1989). Stating her case strongly, Walker (2000) likens psychological abuse to psychological torture.

## **Prevalence**

While it is difficult to obtain a full picture of spouse abuse because it tends to be an under-reported problem and, therefore, remains largely hidden from public view, the following statistics give an indication of the extent of spouse abuse in Canada. The most complete picture

is given by the 1999 General Social Survey (GSS) by Statistics Canada (2000, 2001). The GSS estimates that, in Canada, 8% of women married or living in a common-law relationship experienced some form of abuse by their partner during the five years prior to 1999. Overall, this amounts to about 690,000 women, who had a current or former partner between 1994 and 1999, experiencing at least one incident of violence (As an example of how discrepant estimates of the extent of spouse abuse can be, Rodgers (1994) has estimated that nearly 29% of Canadian women who have been married or living in a common-law relationship have been physically or sexually assaulted by a male partner.). While it is true that some women do commit acts of violence against their partner (the GSS reports that 7% of men experienced some type of violence), we must not be side-tracked by this reported fact into believing that there are not vast sex differences in spouse abuse. The GSS makes it clear that, although women can occasionally be abusive toward their partners, the frequency, severity of abuse and its consequences do not rise to the same levels as they do with men. The GSS reports that women were five times more likely than men to report being choked and almost twice as likely to report being threatened by a gun or knife. Women were six times more likely to be sexually assaulted and were more likely to report fearing for their lives or the lives of their children, and to report repeated victimization. Furthermore, the GSS reports that women were three times more likely than their partners to be physically injured and five times more likely to require medical attention. Berk, Berk, Loseke, and Rauma (1983) note that, “While there are certainly occasional instances of husbands being battered, it is downright pernicious to equate their experiences with those of the enormous number of women who are routinely and severely victimized” (p. 210).

While accepting the common-sense proposition that women are capable of violence toward their partners, many researchers argue that the motives underlying violent behavior can be radically different for men and women. Hamberger, Lohr, Bonge and Tolin (1997) suggest that



women are more likely to use violence to defend themselves, to escape from harm or to retaliate against their abusive partners. On the other hand, men tend to use violence as a means to control and dominate. Healey, Smith, and O’Sullivan (1998) argue that, while women are often arrested for battering, many are self-defending victims who are mistakenly arrested as primary or mutual aggressors. At any rate, while there are those who argue that women use violence to approximately the same extent as men, the present paper will not involve itself in this debate and focuses exclusively on male-to-female abuse.

The GSS does report a decline in wife assault in the five-year period prior to 1999. The GSS reports that national five-year rates declined from 12% in 1993 to 8% in 1999 (see Table 1.1). This decline was statistically significant in every province with the exception of Prince Edward Island, New Brunswick, Manitoba, and Saskatchewan.

**Table 1.1** Changes in Wife Assault Rates from 1993 to 1998

	Percentages	
	1993	1998
Canada	12	8
Nfld	9	4
P.E.I *	10	12
NS	13	8
NB*	9	9
Que.	10	8
Ont.	12	7
Man *	12	9
Sask*	9	11
Alta.	14	11
B.C.	14	10

*Note: \* Nonsignificant*

The GSS attributes this overall national decline to a number of factors including:

... the increased availability of shelters and other services for abused women, increased use of services and increased reporting to police by abused women ... mandatory arrest policies for men who assault their spouses, improved training for police officers and crown attorneys, and coordinated interagency referrals in many jurisdictions. Other factors that may also have played

a role include recent growth in the number of treatment programs for violent men, positive changes in women's social and economic status that may enable them to more easily leave abusive relationships, violence prevention programs, and changes in societal attitudes that recognize wife assault as a crime. (Health Canada, 2001, p. 27)

Despite this decline, it is useful to observe that spouse abuse is a very underreported phenomenon. Dutton (1987) suggests that only about 7% of spouse abuse cases are ever detected by authorities. The GSS (1999) estimates that in the five years prior to 1999, 37% of cases of spousal violence involving female victims were reported to the police (versus 15% where the male was the victim). The lesson learned is that despite the increased availability of shelters and other services for abused women, mandatory arrest policies, and improvements in women's social and economic status in society, domestic violence continues to be largely hidden from public view.

Although the 1999 GSS reports a significant general decline in wife assault, the GSS also found that Aboriginal women were significantly more likely to disclose victimization than non-Aboriginal women. Briefly, in the GSS, 25% of Aboriginal women reported being assaulted by a current or former partner during the five-year period prior to 1999, a rate which is three times that for non-Aboriginal women. Not only did Aboriginal women experience more violence than non-Aboriginal women, they also experienced more severe, life-threatening types of violence. The GSS reports that one-half (50%) of Aboriginal victims of abuse experienced potentially life-threatening abuse at the hands of their partners compared with 31% of non-Aboriginal victims. Aboriginal women were more likely to report serious physical and emotional consequences. While about 41% of Aboriginal victims reported physical injury, 18% received medical care for their injuries and 32% feared for their lives.

## **The Consequences of Spouse Abuse**

It is well-known that domestic violence can spawn a host of emotional, social, cognitive, physical and behavioral maladjustment problems. Defining partner abuse broadly to include physical assaults, sexual aggression, threats of harm, verbal harassment, sexual coercion, intimidation and put-downs, Browne (1993) chronicles a legion of potential psychological outcomes: shock, denial, withdrawal, confusion, fear, depression, suicidal ideation, substance abuse, chronic fatigue, intense startle reactions, disturbed sleeping habits and eating patterns, nightmares, passivity and a sense of helplessness. These experiences are so common and severe that many, like Browne (1993), go so far as to suggest that “Posttraumatic Stress Disorder” be used as a diagnosis for survivors of chronic domestic abuse.

Walker (1991) first coined the concept of “The Battered Woman Syndrome” (which is considered to be a sub-category of the larger, more inclusive category of Posttraumatic Stress Disorder). Walker draws upon the concept of Learned Helplessness in explaining why battered women often find it difficult to break free of an abusive relationship. According to Walker, women who feel trapped in an abusive relationship may develop a form of depression perhaps accompanied by illness, phobias, sleep disturbances and negative, pessimistic beliefs about their ability to escape the battering relationship. The constant threat of violence may eventually impair concentration causing certain physiological responses often associated with high states of anxiety. While an individual might normally escape if possible, the victim may come to believe that they are mired in a situation from which escape is impossible. If the woman perceives that running away is impossible, then mental escape will occur: denial, minimization, and rationalization can be subconsciously used as ways to psychologically escape the threat of violence. Furthermore, impairment will extend to the cognitive functions: The victim may ruminate about the abuse, dissociate herself when faced with painful events, and may have

recurring nightmares. Comparing The Battered Woman's Syndrome to the construct of Learned Helplessness that was developed by Martin Seligman, Walker (1979) argues that a battered woman may suffer cognitive, motivational, and behavioral deficits that virtually paralyze her because she comes to believe that she has no control over her life or partner's behavior. In short, the woman may become so traumatized and pessimistic and her perceptions so distorted that she might not perceive running away as a realistic option.

Myers (1996) observes that women may remain in an abusive relationship or do not seek outside help for any number of personal and situational reasons, some of which include: the fear that they will be harmed if they report their spouse to the police; the woman may feel that agencies, police, social and medical services are unsympathetic, overworked or otherwise unwilling to help; a woman might regard the family as a private haven and believe that seeking outside help will bring shame down on her family; many women are unaware of their basic legal rights or the existence of support services; a woman may believe that she lacks the financial resources to leave her abuser or seek outside help (Some researchers such as Strube and Barbour (1983), cite economic dependency as *the* primary reason abused women remain with their abusers.); a woman's religious beliefs may inhibit her from leaving. In addition, a woman may harbour her own gender stereotypes and believe that she somehow caused her partner's outburst, and that her partner's violence was, therefore, quite justified (Browne & Herbert, 1997). Furthermore, a woman might believe that she is capable of reforming her partner's behavior. And even though one's family outside the home may be aware of a problem, relatives might unwittingly contribute to the violence and a women's sense of isolation by their unwillingness to interfere in the private lives of family members. In addition, many couples are surprisingly accepting and tolerant of domestic violence. Dibble and Straus (1980) estimated that 28% of Americans believe that, on occasion, striking a spouse is necessary and tolerable. O'Leary,

Barling, Arias, Rosenbaum, Malone, and Tyree (1989) observe that many couples exhibit “normative” aggression where neither partner may characterize an incident as being unacceptably violent.

When discussing spousal violence one must also consider the impact that violence in the home may have upon children. Walker (2000) observes that 87% of the women who participated in her study reported that their children were aware of the violence in their homes. This is not out of line with other reported estimates. For example, estimates of the proportion of children who witness their mother being physically abused range from 68% (Leighton, 1989) to 80% (Sinclair, 1985). Such statistics prompt Health Canada (1996) to confidently claim that children are generally well aware of the violence that occurs in their homes.

For children, simply witnessing marital violence may be as detrimental to healthy adjustment as actually experiencing physical abuse (Jaffe, Wolfe, & Wilson, 1990). Children who witness violence in the home may suffer from low self-esteem, a lack of confidence, insecurity, fear, anxiety, feelings of guilt and responsibility over their parent’s problems, and may experience symptoms of depression, withdrawal, passivity, and feelings of hopelessness; adolescents may have suicidal ideations, may even attempt suicide, run away or abuse alcohol and drugs (Jaffe et al., 1990). Some of these problems (e.g., depression and anxiety) can even persist into adulthood. Lehmann (1995) argues that children who witness their mothers being physically abused can experience Posttraumatic Stress Disorder where the child relives the trauma (nightmares, intrusive thoughts, flashbacks, etc.). The child may become fearful, anxious, and hyper-vigilant; they may be prone to irritability and outbursts of anger and aggression. Health Canada (1996) reports that children who witness their mother being assaulted often have lowered school achievement, increased truancy and, when they are at school, may be withdrawn and/or aggressive (It is suggested that while girls have a greater tendency to become withdrawn and

depressed, boys have a greater tendency to act aggressively.).

One troublesome offshoot of children witnessing violence in the home is that the child, when he or she becomes an adult, may be apt to perpetuate the violence cycle as the person models or emulates the aggressive behavior they observe (Statistics Canada, 1993). Hotaling and Sugarman (1986) report that witnessing violence during childhood or adolescence is a major risk marker for future violence. While the relationship between witnessing abuse and becoming abusive in adulthood is not straight and certain, researchers such as McCord (1983) found that parental violence in a person's history was predictive of serious crimes such as assault, kidnapping, sexual assault and murder committed in adulthood. Widom (1989) also argues that violence in one's family history increases an individual's risk for becoming violent in adulthood. Jaffe, Wilson, and Wolfe (1988) suggest that children who witness violence in their homes are more likely to express attitudes tolerant of abuse as a means of resolving conflict. Saunders, Lynch, Grayson and Linz (1987) observe that witnessing marital violence has the indirect, subtle effect of influencing positive attitudes toward the use of violence as well as negative effects on egalitarian attitudes. However, an important caveat must be added lest we overstate the case. While some hold to the view that "violence begets violence," it is important to remember that, as applied to spouse abuse, this generalization is considered by many to be largely a myth (Widom, 1989). Children who witness spouse abuse are far from being predetermined to become abusive adults. Edelson (1999) observes that, even though it is common to talk about "effects" of witnessing marital violence on a child's development, it is more accurate to speak of an *association* between variables rather than cause-effect relationships. Although witnessing marital violence may be associated with certain behavior problems, witnessing abuse is not invariably predictive of later abusive behavior. Large numbers of children show no negative developmental problems and many show evidence of strong coping skills (Edelson, 1999). At the most, research

suggests that children who witness violence (or who are the victims of violence) *may* be more likely to become abusive adults; a host of other factors must be contributing to the development of violence in those who have witnessed and/or experienced violence as children.

Of course, children might not only witness violence or abuse; they themselves might also become victims. Walker (1984) observes that when spouse abuse does occur in a family, there is a high probability that child abuse is also happening. Walker (2000) reports that 53% of the men in her sample who admitted to battering their partner also reported battering their children. Straus, Gelles and Steinmetz (1980) claim in their study that there was a 40% overlap between wife assault and child maltreatment. Bowker, Aritell, and McFerron (1988) report that batterers also abused their children in 70% of those families studied and that the more severe the wife abuse, the more severely children were abused.

And while children are much more likely to be hurt by male batterers they are not completely out of harms way from their mothers. Health Canada (1996) suggests that abuse can lessen the coping resources of mothers which can, in turn, lead to less effective parenting, neglect, and child abuse. Walker (2000) reports that about 28% of the abused women in her sample admitted abusing their children. Although one does not want to give too much weight to the pecking-order myth, it is important to remember that children may be at an elevated risk to be abused by a mother who is herself the victim of abuse.

Finally, quite apart from its psychological, social, and behavioural consequences, spouse abuse has a broader societal cost. Greaves and Hankivsky (1995) estimate that spouse abuse costs Canadian society about \$4.2 billion per year in social services, education, justice, labour, employment as well as health and medical costs.

## MAJOR THEORIES THAT EXPLAIN MEN'S VIOLENCE AGAINST THEIR PARTNERS

The several theories that explain the underlying causes of spouse abuse can be grouped in a number of ways such as the psychological, biological, sociocultural theories or some combination of these. At the psychological level, researchers might focus on individual differences and consider the relationship between psychopathology or personality traits and male violence. At the biological level, scientists will home in on biological risk factors that they believe predispose individuals to violence or the extent to which men might be under a biological imperative to assert their dominance and sexual proprietariness over women. At the sociocultural level of explanation, scientists might study how family dynamics contribute to violence in the home, how structural factors such as environmental stress spawn abuse as well as how cultural values and practices contribute to male violence.

One useful way to order one's thinkings about spouse abuse is to conceptualize the various levels of explanation in terms of a nested model of categories similar to that proposed by Dutton (1995), consisting of the:

- (1) macrosystem: This level considers the broader cultural context and culture-based attitudes and beliefs. For example, the influence of patriarchy and the social norms and values that condone and promote general inequality, male domination and aggression;
- (2) exosystem: This level consists of those social structures or systems that connect the individual to their wider culture (e.g., family, friends, work groups) and which influences the immediate context where abuse occurs. For example, by refusing to get involved, one's family may unwittingly increase the likelihood of abuse. Moving down toward the individual even further, many researchers focus on the,
- (3) microsystem: This level focuses on the immediate environment within which abuse occurs. At this level one could consider, amongst other things, family relations such as a



couple's pattern of communication, level of conflict, or relationships with children.

Finally, there is the,

(4) ontogenic level: This is the level of the individual where explanations are framed in terms of psychological and biological forces that reside within the individual. At this level, one might consider an abuser's developmental history, his exposure to violent models, his ability to manage his emotions, etc.

While other multivariate models exist, they all share the virtue of assisting researchers in grouping their etiological inquiries into various levels of explanation. Dutton's model is not only useful because it aids in creating a hierarchy of explanation that can be used in grouping the wide assortment of theories that explain the "causes" of spouse abuse, but also because it conceptualizes spouse abuse as multidetermined by various levels while recognizing the innumerable interactions that can occur between levels. The model is also important for present purposes because it strongly influences the theoretical underpinnings of the family violence treatment programs offered by Correctional Service of Canada.

Turning to the psychological level of explanation, these explanations tend to reduce abusive behavior to forces that reside within the individual. Although one does not want to overstate the case, it is not unusual for spouse abusers to have some form of mental illness or personality disorder. Walker (2000) suggests that one common subtype of batterer is the Mentally Ill Batterer. Walker observes that an abuse disorder may interact with a coexisting paranoid and schizophrenic disorder, affective disorders including bipolar types and depression, borderline personality traits or perhaps obsessive compulsive disorders. She also asserts that a second subtype of batterer has an antisocial personality disorder that predisposes the person to be cunning, ruthless, and to use aggression instrumentally to satisfy his desires. In the present study, the Antisocial Personality Disorder Checklist (APD) and the Borderline Personality Organization

(BPO) were administered to offenders because both personality types are associated with higher than average rates of relationship violence. In addition to the Mentally Ill and Antisocial Batterers, Walker identifies a third, most common subtype: the Power and Control Batterer. This subtype of batterer fits most closely with the theoretical descriptions offered by the feminist perspective where these men, who are otherwise “normal” nevertheless harbour deeply rooted sexist attitudes and use violence instrumentally to assert dominance over their partner.

Although Walker (2000) groups batterers into the three subtypes of the Mentally Ill, Antisocial, and Power and Control Batterers, there are other ways to label batterer subtypes. Holtzworth-Munroe and Stuart (1994) differentiate between three subtypes that they label Family Only, Dysphoric/Borderline, and Generally Violent/Antisocial. While the Generally Violent/Antisocial batterer will act violently toward both family and non-family members, the Dysphoric/Borderline batterers engage in moderate to severe violence directed primarily against family members. Family Only batterers show little pathology or personality disorder and typically restrict their violence to family members only. Gondolf (1988) distinguishes between the Sociopathic, the Antisocial, and the Typical batterer. While the Typical batterer tends to commit the least severe abuse and generally is only violent toward his spouse, the Sociopathic batterer inflicts the most severe abuse and is dangerous to his spouse and other family or non-family members. Although the Antisocial batterer can also be extremely abusive and generally violent, he is less likely to be arrested than the Sociopathic batterer.

Although most batterer typologies have been developed from samples of community-based treatment programs, Wexler (2000) examines the issue of whether contemporary typologies of spouse abusers are applicable to federally incarcerated males with a history of spouse abuse. Wexler divided her population of offenders into native and non-native males. The results point to a trichotomy of batterers for non-native offenders and a dichotomy for native offenders. Wexler

reports that the largest proportion of non-native batterers can be classified as “generally violent.” The second largest group was the “antisocial batterer.” The third group can be classified as “family only” batterers. The native sample was dichotomized into “generally violent” batterers and a second group that had attributes of both the “antisocial” and “family only” batterers. However, although research into batterer typologies is on-going and continually becoming more refined, one immediate point to take away from this brief discussion of typologies is to remember that even though the trend is moving away from treating all family violent men as one homogeneous group, the precise delineation of the various subtypes of “abusive men” remains controversial and in need of further study.

Although the psychodynamic theories are not as popular in North American psychology as they once were largely because they have a notoriously difficult time gaining scientific support, the psychodynamic approaches nevertheless continue to have their adherents. Psychodynamic treatments focus on conflict, anxiety, and the attempt to minimize anxiety through the use of any number of defence mechanisms. As just one example of the use of a psychodynamic approach, Self Theory argues that violent impulses are the product of a failure to hone empathetic impulses in childhood (Barnett, Miller-Perrin, & Perrin, 1997). This lack of empathetic impulse is largely due to the failure of one’s caregivers to be emotionally responsive to the needs of the infant who experiences insecurity, fear, anger, distrust, feelings of abandonment and inferiority, all of which plague the person throughout life and which can become manifested in adulthood as violent behavior. The goal of psychodynamic treatment is to reduce the abuser’s conflict and anxiety while helping the abuser achieve better control over aggressive impulses through the use of mature coping strategies (e.g., sublimation).

Another prominent approach that is particularly important because of the central role it plays in the family violence programs offered by Correctional Service of Canada is social learning

theory.

Central to the social learning approach is the proposition that one way in which people learn is by modeling other people's behaviour. Whether or not an observed behavior is modeled depends in large part on the reinforcements or punishments received by the model and imitator. People are more likely to model an observed behavior when they observe the model's actions being reinforced and more likely to retain a behaviour when it is directly reinforced. Of course, observational learning can promote undesirable, as well as desirable behaviour. Earlier it was acknowledged that children who witness abuse in their homes sometimes become abusive adults. A Social Learning theorist would argue that the adult is simply modeling behaviour that they have observed or experienced in their home as children.

Although social learning theory is an important element used in the treatment of abusive offenders, the dominant approach used by Correctional Services of Canada is the cognitive-behavioural approach. While Social Learning theory focuses on observational learning, cognitive behaviourism favours both cognitive factors as well as simple learning by observation. Although it recognizes the importance of observational learning and the role of reinforcement in the acquisition and maintenance of behaviour, cognitive behaviourism emphasizes internal mediating processes; that is, the thoughts, beliefs, attitudes (cognitions) attached by a person to an event are regarded as the key element directing behaviour.

Within the cognitive-behavioral approach, the chain of events leading to violent or abusive behavior can be explained in relatively straightforward terms. Briefly put, the man might encounter an external stimulus (e.g., His partner fails to have dinner prepared when he arrives home from work.). He will then internally mediate, construct or interpret the event (e.g., "Dinner is late because she's lazy and doesn't respect me."), experience a certain state of arousal (e.g., anger, humiliation, righteous indignation) and decide (while perhaps being unaware

that a decision has been made) that he must respond in a certain way in order to, for example, quell his sense that he is being shown disrespect, and force his partner's compliance and submission. Thus, the person's initial anger and the expression of that anger is a function of physiological arousal and cognitive labeling of that arousal which itself is a function of internal and external cues and the person's overt and covert behavior in a situation (Browne & Herbert, 1997). In demonstrating the link between Social Learning Theory and Cognitive Behaviourism, Healey et al. (1998), suggests that men engage in abusive behavior because: (1) they imitate or model the abusive behavior of others that they have observed; (2) they often see aggressive, abusive behaviors rewarded; (3) abusive behavior often serves an instrumental function of enabling the abusive to satisfy a desired outcome and; (4) the abuse is often further reinforced through the victim's compliance and submission.

A basic tenet of the model is that abusive behaviour is the unfortunate byproduct of faulty patterns of thinking. An abusive occurrence is not a spontaneous eruption that any man would have had had they experienced the same event. Despite appearances to the contrary, the abuse is not without intent, and is largely the product of how a person interprets and understands his experiences. For example, a man who harbours deep patriarchal attitudes that devalue women may be more likely to act abusively toward women than a man whose attitudes and values are more democratic. If it is assumed that abusive behaviour is a product of faulty patterns of thinking, the goal of the cognitive-behavioural therapist would be to change the ways in which a patient thinks, feels, and acts; that is, by changing how clients think (by altering their basic interpretations or appraisal of their environment and the people in it) and providing them with better strategic responses, a client's overt behavioural problems can be ameliorated. Changing the way a person thinks may involve bluntly challenging their illogical, sexist, self-defeating ideas and teaching them a new, more constructive way of thinking. And since the model assumes

that cognitions cause emotions, changing how an abusive man thinks will simultaneously change how he feels. Learning to control one's negative emotions may also involve learning such techniques as thought-stopping, time-out and relaxation training. Finally, improving a person's behaviour might also involve social-skills training, such as improving their problem-solving abilities as well as their communication and conflict-resolution skills.

Consider next the physiological perspective. Whereas cognitive-behaviourism views aggression against women as largely the byproduct of faulty patterns of thinking, the physiologist would study the physiological basis of aggression. The physiologist would study the neural systems that influence aggression as well as the role of genetics and influence of biochemistry. Animals and human brains have neural systems (particularly structures of the limbic system including the amygdala and hypothalamus) that routinely produce aggression when stimulated or damaged (Moyer, 1983). Evaluation of violent inmates have revealed that many have suffered severe head injuries (Myers, 1998). Studies of twins provide support for the claim that there is a strong hereditary basis for aggression (Raine, 1993). If one identical twin admits to having a violent temper, the other twin will often independently report having a violent temper. On the other hand, this correspondence is less likely with fraternal twins. Hormones, alcohol, and other substances can also influence the systems that control aggression. It has been observed that violent men often have higher-than-average testosterone levels (Dabbs, 1992). Levels of anger in elderly men have been shown to correlate positively with their testosterone levels (Gray, Jackson, & McKinlay, 1991).

Turning to Evolutionary Theory, this viewpoint reduces male violence to a biological imperative where men are predisposed to the assertiveness and toughness that serve their reproductive goals of repelling sexual rivals and asserting a sexual monopoly over women (Mooney, 2000). Considered on a grand scale, male violence against women is not simply

reducible to some individual defect or a faulty way of thinking; instead, male violence serves an adaptive function as the male of the species seeks to pass on his genes and protect his investment in his spouse and offspring. While violence toward women may not be an acceptable cultural norm, male violence is an evolved adaptation that predisposes the male of the species to acts of violence that serve to defend him from potential rivals, monopolize his spouse's reproductive capacity, and maintain order and harmony within his family.

While all of these psychologically and physiological/biological based theories have something useful to add to the discussion, the belief that these modes of explanation cannot explain domestic violence in full has led many researchers to move their etiological quest outside the individual to consider the influence of social/structural and cultural conditions that may contribute to violence against women. At this level of explanation, researchers may study how numerous environmental stressors such as poverty, overcrowding, alienating work, isolation, and so on can produce intense frustration and anger that can culminate in eruptions of violence directed against family members. This obviously draws from the frustration-aggression hypothesis which posits a significant relationship between stress and family violence. Remove or reduce the stressors bearing down on the individual and family unit and the likelihood of family violence will decrease.

Still other social structural theories look at the family unit itself and attribute violence not simply to environmental stressors but to the family structure and family interactions (Healey et al., 1998). One factor that naturally creates a certain amount of tension within a family is the power differentials that exist between family members (Barnett et al., 1997). Perhaps, as suggested by the Interactional Model, both partners may be unwittingly contributing to violence because they are locked in a continuing struggle for dominance within the home. While the struggle for dominance may begin with harsh words and criticism, the struggle may eventually

escalate into open violence (Healey et al., 1998). And, of course, the amount of time that family members spend together coupled with the breadth and depth of their interactions make family life susceptible to bursts of anger and aggression. The inevitable disagreements and conflicts that occur within families may be further exacerbated when the family is under environmental stress from any number of directions (financial problems, overcrowding, etc.).

While the wide assortment of biological, psychological, and sociological explanations mentioned all say something useful about spouse abuse, the consensus of opinion is that each type of approach offers only a limited explanation about the causes of male violence toward their partners (Walker, 2000). While the connection between physiology and aggression is well-established, the physiological (and Evolutionary) explanations of male violence can be criticized for being limited because they tend to be insensitive to the role of the environment in facilitating stress and violence, and controversial because, if biology is the predominant cause of violence, then there may be less incentive for society to cure those social ills (e.g., poverty, discrimination, gender inequality) that may foster violence. Another complaint is that personal responsibility is diminished because blame is mainly borne by physical influences and not by rational agents or one's culture.

Turning to the psychological explanations, while calling an abuser mentally ill may be a convenient label to attach to a person, Mooney (2000) argues that the vast majority of abusers are not mentally ill in any traditional sense. Straus et al. (1980) indicates that fewer than 10% of instances of family violence can reasonably be attributed to mental illness, psychopathology or personality traits and characteristics.

Although personality traits can help to predict behavior, research is divided as to whether abusers differ significantly from non-abusers in terms of general psychological characteristics (Myers, 1996). Although some research suggests that spouse abusers are very insecure with



anxieties over inferiority and abandonment (Weitzman & Dreen, 1982), other research suggests that abusive men show few personality differences from non-abusive men other than perhaps less assertiveness with low self-esteem and poor social skills (Barnett et al. 1997). And while abusers have been characterized as having a high need for power and dominance, low assertiveness, and cognitive rigidity, such characteristics are generally considered to influence rather than cause abusive behavior (Appleford, 1989). Even though some researchers like Bernard and Bernard (1984) claim that some abusers have a character disorder, in general, research does not indicate that abusers are more likely to have a character disorder than non-abusers (Myers, 1996). And while the cognitive-behavioral approach is a dominant perspective in the area of domestic violence, it has a difficult time explaining why violent men may not be violent outside their home, how one's culture or subcultural values and norms influence behavior, and why some men will continue to abuse women even when their behavior is punished and they are aware that punishment may occur.

Rejecting the explanation that male violence is predominantly rooted in psychopathology, personality traits, subconscious conflicts, environmental stressors, irrational "self-talk", biology or some innate, biological imperative, the pro-feminist approach (which consists of different perspectives such as Liberal, Radical, Socialist, Marxist or Realist feminism) focuses on those cultural values, norms and systems of belief that do not offer equal rights and power to men and women and which evaluate women as social inferiors. It is only when constructs like male dominance and privilege, gender inequality, power imbalances in relationships, and sexist attitudes are introduced into the discussion does the problem of spouse abuse become more fully understood. Living in a patriarchal culture, men are vulnerable to developing oppressive sexist attitudes which predispose some men to act abusively. Contrary to our images of devilish villains, abuse does not require monstrous characters; it is enough to have ordinary men

corrupted by a culture where men have the upper-hand and can dominate women.

The major strength of the feminist perspective is the way in which it pulls explanations for male violence to the highest cultural levels where male violence is framed in terms of historical but mutable sociocultural values and practices. Those who adopt a pro-feminist approach might argue that although violence toward women may not be a cultural norm in countries like Canada, “Culture” may nevertheless lay the groundwork for spouse abuse through how our culture constructs such concepts as “gender”, “gender roles”, “male power and dominance,” and how it tolerates, condones and promotes, often in subtle forms, the use of aggression by men to assert power and dominance over women. As argued by Appleford (1989): “Adherence to cultural norms which sanction violence is thought to contribute to the development of family violence when in tandem with other influences such as sex role socialization and family dynamics” (p.9). However, abusive men, like culture, can change (although it must be conceded that, in the short-term at least, it is much easier to change men than it is to change culture). The feminist viewpoint readily draws upon a Humanist Liberal mode of discourse to argue that men are rational, moral beings who are, perhaps with the right help, freely capable of revising their biased beliefs and learning more democratic, egalitarian attitudes and values that lessen the likelihood that women will be undervalued.

While much of the debate surrounding the feminist account revolves around the reliability and validity of the empirical evidence tendered by the perspective, and while there is much room for debate about the finer details of the various feminist models, this perspective plays a critical role in the cognitive-behavioural approach used by Correctional Services of Canada to treat offenders.

## CONFIDENCE IN BATTERER INTERVENTION PROGRAMS

### **How Beneficial Are Batterer Intervention Programs?**

The ultimate question that can be asked about any family violence prevention program is: Does the program actually eliminate or at least reduce violence and abuse? Although this question is easily asked, it cannot be easily answered. The following, while not an exhaustive review of the literature, is meant to give the reader a sense of the ups and down in research on domestic violence.

Beginning on the negative side of the coin, many researchers have little confidence in the effectiveness of batterer intervention programs. Myers (1996) observes that, “Despite the proliferation of treatment programs over the past ten years, we know very little about their effectiveness” (p. 3). Kakar (1998) observes that, “Although domestic violence is an age-old issue, our knowledge of the problems, its various types and forms, causes and consequences, and how to address the problem remains limited. Many people, including the professionals, are not sure of the dynamics and processes of domestic violence. Our knowledge is surrounded by myths, misconceptions, distorted facts, and numbers” (p. 9). When discussing volunteer and court-mandated batterer programs, the Solicitor General (2000) suggests that, “Although some studies show positive treatment effects, there is insufficient research to make strong conclusions about whether treatment works for male batterers” (p. 1). And although different theoretical orientations claim to have the answers, as noted by Hanson and Wallace-Capretta (2000), “There is only weak evidence supporting the efficacy of any form of batterer treatment, and even less evidence that one treatment approach is superior to another” (p.1). The researchers conducted a multi-site study of treatment programs for abusive men and examined the relative effectiveness of four treatment programs that varied in length (12 to 25 weeks) and treatment approaches (existential, cognitive-behavioral, eclectic). Using recidivism rates as an outcome variable, the

researchers found relatively few differences between programs. The researchers observe that when there is a lack of difference among treatment approaches, it is difficult to determine whether the programs are equally effective or equally poor. The researchers also go on to say: “Alternatively, this lack of group differences can be considered evidence that we have yet to discover what really works with abusive men” (Hanson & Wallace-Capretta, 2000, pp. 17- 18). Continuing in the same vein, the following two recent studies also help explain the widespread skepticism that exists in the field of domestic violence.

Feder and Forde (2000) evaluated a batterer intervention program in Broward County, Florida which used the Duluth model (assumes patriarchal ideology encourages inequality which fosters abuse). An “N” of 404 men convicted of misdemeanor domestic violence were randomly assigned to either an experimental group (men sentenced to one year probation and 26 weeks of group counseling) or a control group (men sentenced to 1 year probation only). Batterer-victim violence was measured by new reports to legal authorities and victim reports of new incidents. The researchers also used a number of standardized scales to assess outcome such as the Inventory of Beliefs About Wife Beating and the Conflict Tactics Scale. What was the end result of the researcher’s hard work? In the words of the researchers: “The results of this study show that counseling had no clear and demonstrable effect on offender’s attitudes, beliefs, or behaviour”(p. 12). At the 12-month follow-up, about one-half (1/2) of the men viewed battering as acceptable in some situations and still tended to view their partner as “somewhat” to “equally” responsible for their abuse. The two groups did not demonstrate any difference in self-reported likelihood of future abuse and continued to harbour biased attitudes about the proper role of women. Further, 24% of the men in each group were re-arrested within one year.

Davis, Maxwell, and Taylor (2001) evaluated a program (based on the Duluth model) in Brooklyn, New York. Three hundred seventy six (376) batterers mandated to treatment were

randomly assigned to an experimental condition (some men received treatment in 26 weekly sessions while others attended for 8 weeks) or control group (men required to participate in 39 hours of community service). The follow-up measures included official reports of new incidents of domestic violence, and victim reports of new incidents of abuse. In addition, interviews were used to assess attitudes and cognitive behaviours among both batterers and victims. What did the researchers find after the 6 and 12 month follow-up? First, although the 26-week group had significantly fewer official complaints of abuse than the control group, those in the 8-week program did not. The study failed to find any significant differences between the groups in attitudes toward domestic violence or ways of dealing with violence. The researchers note that “The results of this study do not support the view that treatment leads to lasting changes in behaviour”(p. 20).

On the other hand, as might be expected there is a positive side to the coin. Palmer, Brown, and Barrera (1992) studied 56 men convicted of spouse abuse. Thirty men were randomly assigned to a 10-week batterer program (psycho-educational); 26 men were randomly assigned to probation only. The outcome measure, recidivism, was assessed by official reports of complaints or arrests. At the end of the 12-month follow-up period, the researchers observed that 3 of the 30 men (10%) assigned to the program reoffended while eight of the 26 (31%) receiving probation only reoffended during the follow-up period. The researchers take the study as providing modest support for the effectiveness of treatment.

Tutty, Bidgood, Rothery, and Bidgood (2001) evaluated men’s batterer treatment groups. The researchers evaluated a model developed by Pressman and Sheps (1994). The model provides men with “affective education [that] helps them to resolve their childhood traumas, provides a therapeutic group environment for learning new problem solving skills, and, above all, emphasizes their ending violent and controlling behaviors” (Pressman & Sheps (1994),

p. 477).

Drawing upon a battery of outcome measures, the researchers note a number of positive findings. Treatment completers demonstrated significant improvement on the construct of appraisal social support (suggesting that that the treatment groups were helpful in diminishing participant's sense of social isolation). There was also a significant improvement on completer's locus of control scores such that, after treatment, participants perceived themselves to have more personal control over their behaviour. Completers also reported a significant improvement in their perceived ability to cope with stress. Treatment group membership was also associated with significant improvements on the marital functions of roles, affective expression, and communication. Although participation in treatment was associated with higher self-esteem scores and while attitudes toward women and the family became less traditional, these changes were not statistically significant. The researchers conclude that, "The evidence from this study suggests that if men can be successfully recruited, participate in, and complete the perpetrator treatment groups, they are likely to experience a number of positive changes ..." (p. 666).

Amoretti, Landreville, and Rondeau (1997) evaluated the effectiveness of domestic violence programs offered by the Correctional Service of Canada in Quebec penitentiaries between April 1995 and April 1996. During this period 212 inmates participated in an institutional program. One year after their participation 97 participants had been released. At the time of their release, 30 of the 97 were involved in community-based therapy programs.

One measure of the effectiveness of treatment used by the researchers was number of returns to penitentiaries. Within one year after release 32 of the 97 released had returned. The researchers observed that 6 of the 30 (20%) who had both participated in an institutional program and followed a program after their release had been returned to prison within one year of being released. On the other hand, 26 (39%) of those inmates who had completed the institutional

program but who had not continued with community treatment following release returned to prison. The researchers concluded that, “Overall, it appears that domestic violence programs in Quebec penitentiaries have some success”(p.2). This study can also be used to highlight the importance of offenders participating in therapy following release from a facility.

Aubertin and Laporte (1999) evaluated a domestic violence program offered to inmates at the minimum-security Montee St-Francois Institution in Quebec. Sixty-eight inmates (68 of 84 accepted into the program) completed the program of which 51 had been released to date. Twenty-three of these 51 released offenders subsequently continued therapy for violent spouses in the community. Using reoffending with spousal violence as an outcome measure, the researchers compared those program participants who followed a post-release program of therapy with those who had not. Aubertin and Laporte observed that only 2 of the 23 inmates (8.6%) who had participated in a community therapy program had committed an act of spouse abuse compared with 6 of the 28 (21.4%) who followed no community therapy program. Thus, only 8 (15.7%) of those offenders who had been released reoffended with spouse abuse. Since, as the researchers observe, many studies put the rate of reoffending for spouse abuse at 30% to 70%, it would appear that the treatment program had a positive effect on recidivism rates (see Table 3.1).

**Table 3.1.** Reoffending Following Release

	Participated in Institution and Continued Therapy Following Release (n = 23)	Participated in Institution But Did Not Continue Therapy Following Release (n = 28)
Reoffended with Spouse Violence	2 (8.6%)	6 (21.4%)
Did Not Reoffend with Spouse Violence	21 (91.1%)	22 (78.6%)

The researchers also compared the return rate of these 51 offenders with the return rate of 44 offenders whose files showed a pattern of spousal violence but who did not participate in a treatment program either in the institution or upon release. The researchers observed that while 6 of the offenders (21.4%) who had participated in the institutional but not post-release treatment returned to a facility with spousal violence, 12 (27.8%) of those 44 offenders who did not receive any treatment returned with spousal violence (see Table 3.2).

**Table 3.2.** Return Rates with Spousal Violence

	Offenders Who Completed Institutional Program (n = 51)	Offenders Who Did Not Participate in Institutional Program (n = 44)
Participated in Post-Release Program	2/23 (8.6%)	n/a
Did Not Participate in Post-Release Program	6/28 (21.4%)	12/44 (27.8%)

In summary, despite the widespread skepticism about the effectiveness of treatment programs, there is room for optimism. Positive treatment effects are routinely found, although it must be conceded that such effects are often modest. Gondolf (1997) observes that, at the very least, batterer intervention programs are generally no less effective than other types of programs such as drunk driving and drug/alcohol treatment programs or sex offender programs. However, as the preceding discussion pointed out, it must be acknowledged that evaluations of the effectiveness of treatment are often inconsistent and disappointing. It must also be acknowledged that evaluations are routinely weakened by methodological flaws which cast doubt on the results, a subject to which we now turn.



## THE CHALLENGES FACED BY RESEARCH IN DOMESTIC VIOLENCE

Research in domestic violence is plagued by a host of challenges, some of the most chronic ones involving the definition, operationalization, and measurement of spouse abuse, a reliance on non-experimental and quasi-experimental designs, inconsistent follow-up periods, and high drop-out rates.

The first recognition must be that there is no standard, universally accepted definition of spouse abuse. The definition of “spouse abuse” is a product of negotiated understanding and consensus within different language communities and, as a result, does not have a fixed definition that is acceptable to everyone. Ultimately, researchers may employ a diversity of definitions depending on their theoretical orientation, research requirements, as well as on their own personal viewpoints (Barnett et al., 1997). When considering the constructive nature of words such as “aggression,” “violence,” and “criminal violence,” Blackburn comments on the value-ladenness of such concepts and warns of the “dependence of the identification of aggression and violence on the attributions and values of the observer” (as cited in Browne & Herbert (1997), p. 2). Echoing this point, Barnett et al. (1997) observe that labeling an interpersonal transaction as “abusive” can be a highly subjective matter. Although one might assume that including sexual abuse or emotional abuse in the definition of “spouse abuse” would not be controversial, Johnson and Grant (1999) note that “sexual abuse” is absent in many definitions of spouse abuse. The same can be said about emotional abuse. Although physical, sexual, emotional, and economic abuse are commonly accepted categories, many researchers prefer to exclusively focus on physical abuse because it is easiest to operationally define and verify (Hegarty et al. 1999). Of course, since researchers routinely include or exclude different available subcategories of spouse abuse, comparing different studies often becomes akin to comparing apples and oranges.

It would seem that the answer to the question, “What is spouse abuse and how should it be measured?” depends on whom one asks. An ambiguity in definition presents challenges for those researchers, practitioners, police personnel, judges, jurors, prosecutors, psychologists, activists, government officials, and others who must have consistent definitions with which to work. The following quote, although about family violence in general and not about spouse abuse in particular, nevertheless offers some useful insights into the constructive nature of “spouse abuse” and the difficulty, if not impossibility, of constructing a universal definition that satisfies all those competing claims-makers who have a vested interest in how spouse abuse is defined.

The claims-making process is not only important in the discovery of a social problem, but it also helps clarify conceptualizations of the problem. Indeed, “claims-makers do more than simply draw attention to particular social conditions. *Claims-makers shape our sense of what the problem is*” (Best, 1989, p.xix, emphasis added). Clearly, because competing claims-makers are rarely in agreement, there is not one universal definition of family violence or family abuse. Ultimately, researchers employ a diversity of definitions, depending on their particular research requirements and findings, as well as on their own theoretical and personal viewpoints. (Barnett et al., 1997, p. 10)

Research into the causes of spouse abuse is further complicated by the fact that a bewildering, seemingly endless supply of hypothetical constructs are used to help explain spouse abuse. Behavioural outcomes are readily linked to a legion of hypothetical constructs the nature and measurement of which often remain open to debate especially for those who wonder whether or not a construct is only a social construct that has no meaning outside the discursive culture which it inhabits. Even though it makes sense to acknowledge that the proper explanation of spouse abuse must draw from different levels of explanation, the fact that diverse researchers/claims-makers draw inspiration from different theoretical world-views and choose to link behavioural outcomes to a bewildering array of hypothetical states and processes places a heavy burden on the consumer of information to accept the logic that connects behavioural outcomes to those hypothesized internal states and processes that are ultimately regarded as subsisting spouse abuse. As mentioned, the definition of “spouse abuse” and those constructs

that are chosen for study as well as the measures used to tap into these categories very much depend upon the researcher's perspective or theoretical and personal viewpoint. The judicious researcher is justified in wondering about the ontological status of the construct; that is, it is legitimate for them to wonder if the construct has any sort of existence outside the symbolic realm of language. Researchers are being asked to accept, at least implicitly, a network of interrelated constructs preceding and ultimately culminating in some behaviour outcome. However, the veracity of an underlying theory and its implied hypothetical constructs as well as the logic that connects hypothetical constructs, their logical relationships, and some final behavioural outcome often seems murky and remains open to a great deal of debate among those who wonder if a construct ultimately resides inside a person to be part of a person's make-up or is simply a category or concept imposed from without but which has no meaning outside of a particular "regime of truth."

The array of models, paradigms, and hypothetical constructs used to explain spouse abuse often seems to reflect more than the sheer complexity of the problem and the need to draw from diverse levels of explanation. The hot debates that exist both within and between levels of explanation also reflects theoretical confusion and a lack of understanding about how "spouse abuse" should be properly defined and what really "causes" spouse abuse, a confusion that researchers, and academics must be prepared to tolerate until a theoretical world-view of spouse abuse develops that is more-or-less universally accepted.

Evaluating the effectiveness of treatment interventions is further complicated by the fact that different researchers may use varying standards when claiming treatment success. As noted by Rosenbaum (1988), while some researchers will regard a significant reduction of violence as a sufficient treatment gain, others require a *complete* cessation of violence as the criterion for program success. Although the most important outcome criterion for judging

treatment success is the reduction or cessation of abusive behaviours, for some researchers even the complete cessation of abuse is not enough; nothing short of a total conversion of program participants until “men are prepared to take social action against the wife-battering culture” (Gondolf, 1987, p. 347) is sufficient before claiming program success. From this point of view, abusive men must not only change their behavior, they must be willing to concede all of their beliefs and attitudes about male dominance and privilege. While ending physical violence is a worthy goal, it is clear that for some researchers and practitioners treatment programs must strive for more than the reduction or cessation of violence; only a complete ideological conversion of men is satisfactory.

Although non-experimental and quasi-experimental studies are routinely used to evaluate treatment programs, for those who expect the use of a rigorous scientific method, the paucity of true experimental designs is *the* major flaw in research on spouse abuse (Chalk, 2000). While some studies use an experimental design, Chalk (2000) observes that, “Most evaluation studies focus on program effects for clients who actually used or, more often, completed, a service intervention rather than comparing the characteristics of clients who received one set of services with those who received something different or perhaps nothing at all” (p. 32). But while random assignment to a treatment group or a control group may be the most desirable approach, random assignment to a treatment and control group may be very difficult if not impossible to implement in practice. As noted by Bennett and Williams (2001):

If randomization is done at the point of sentencing, the judge, prosecutor, and defense must all agree to it. Judges are often compelled to break with random assignment due to the characteristics of a certain case, usually to refer the batterer to a BIP (batterer intervention program) rather than to the alternative condition. Prosecutors also may object to the batterer not being in a BIP because they view the BIP both as a deterrent from future crime and as punishment for a past crime. (p. 3)

When discussing corrections research, Maltz (1984) also observes that quasi-experimental designs are the rule and not the exception. In many situations it simply is not possible to

randomly select participants from a population or randomly assign participants to different treatment conditions. As a result, the validity of such corrections research is immediately rendered suspect.

Another issue faced by researchers and practitioners involves the use of follow-ups to monitor the extent to which treatment gains are long-lasting. As noted by Johnson and Grant (1999), one of the major problems with research in the area of spousal violence is inconsistent and inadequate follow-up periods. Rosenbaum (1988) suggests that following treatment, a couple may enjoy a “honeymoon period” where violence has ceased, but which makes short follow-up periods inadequate in uncovering future violence. While Rosenbaum suggests that follow-up periods need to be at least six-months, others suggest that a twelve-month follow-up is more realistic and appropriate since lower percentages of success often occur in programs with lengthier follow-ups (Johnson & Grant, 1999).

Turning to drop-out rates, the high drop-out rates that can occur in intervention programs is a problem for research largely because it undermines the generalizability of research findings and can seriously inflate rates of apparent program success (Daly, Power, & Gondolf, 2001). In tracking the records of 200 inquiries into an 8-month treatment program, Gondolf and Foster (1991) report that from the point of initial inquiry into the batterer program to actual completion, only 1% completed the program. While this seems extreme, many studies routinely report that less than half of referred batterers complete treatment programs (Bennett & Williams, 2001).

A core problem with high rates of attrition is that the people most likely to drop out of a treatment program are often those most in need of treatment (Gondolf, 1997). As reported by DeHart, Kennerly, Burke, and Follingstad (1999), non-completers tend to be younger, less educated, enjoy a lower socio-economic status, single, report more exposure to childhood victimization, higher arrest rates, and are often more likely to have a substance abuse problem as

well as a psychiatric diagnosis (Dhart et al., 1999; Daly et al., 2001). Of course, as seen by Daly et al. (2001), failure to complete a program increases the likelihood of continued physical and psychological abuse.. A secondary problem with high drop-out rates is that the apparent success of a treatment program may be inflated since those who remain in a program are precisely those who are in the best position to benefit from treatment.

In summary, research on family violence is faced with a number of challenges. Some of these problems are fundamental while others are methodological. On the fundamental side, no universal approach has been identified. Although many researchers align themselves with a cognitive or cognitive-behavioural orientation, humanistic, family system, and psychoanalytic orientations also make their presence known; some therapists take an eclectic approach drawing freely from orientations. Although diversity is often a virtue, it can sometimes suggest a lack of understanding about the causes of domestic abuse and how it should be treated. And just as different researchers might differ from one another, so clients might differ from their therapist. For example, while a humanistic therapy orientation might make sense to one client, to another the psychodynamic approach might ring true. While some clients might be interested in learning how their patterns of thinking might be contributing to their abusive behaviour, others might prefer to gain insight into the childhood origins of their feelings. A client would be expected to react more favourably to a therapy orientation when they believe in it. In addition, therapists may differ about what yardstick to use for measuring treatment success. While some seem satisfied for there to be substantial reduction in abuse, others demand nothing less than the complete ideological conversion of men. On the methodological side, program assessments are routinely afflicted with a number of flaws. Sample sizes are often quite small; there is a heavy reliance on non-experimental and quasi-experimental designs; follow-up periods are often too short; recidivism data is often inadequate; drop-out rates are routinely high; programs are often

insensitive to cultural differences among participants. Conclusions about the effectiveness of treatment are often inconsistent and disappointing. When treatment gains are observed, they are usually small, and the lasting benefits of treatment are often questionable. Given the challenges faced by research into family violence, it seems clear that debates about the effectiveness of treatment will continue for some time to come.

#### INTERVENTION BY FEDERAL AND PROVINCIAL LEGISLATION AND THE CRIMINAL JUSTICE SYSTEM

Most researchers and practitioners appreciate the wisdom of turning from a unitary “one size fits all” approach toward one that is prepared to draw inspiration and understanding from diverse perspectives and treatment programs. Many also argue that treatment intervention is best seen as one link in a chain where the recognition is that “Batterer intervention programs alone cannot be expected to deter domestic violence; strong, coordinated criminal justice support is also needed ... The combined impact of arrest, incarceration, adjudication, and probation supervision may send a stronger message to the batterer about the seriousness of his behavior than what is taught in a batterer program” (Healey et. al, 1998, p. 79). Although the court system has historically been under-involved in combating domestic violence, public pressure has both led to an increase in public awareness about domestic violence while simultaneously demanding that the historical laissez-faire approach of the justice system give way to “get tough” policies on domestic violence (Valverde, MacLeod, & Johnson, 1995).

These “get tough” policies are seen in mandatory charging and prosecution policies that require police in all jurisdictions in Canada to charge in all spouse abuse cases where there is a reasonable basis to do so as well as requiring Crown prosecutors to prosecute in all such cases where there is a reasonable likelihood of conviction. Landau (1998) reports that mandatory

charging policies have been successful in: (1) increasing the number of charges laid in spouse assault cases; (2) promoting rigorous prosecution of spouse assault cases; (3) reducing the drop-out rate as victims proceed through the justice system, and; (4) increasing the use of probation and incarceration.

On the federal legislative front, a series of amendments have been made to the Canadian Criminal Code that strengthens the laws related to spouse abuse. Examples of recent legislative reforms include:

- Bill C-126 (proclaimed into force on August 1, 1993) created the anti-stalking offence of criminal harassment;
- Bill C-41 (proclaimed into force on September 3, 1996) requires the courts to take into account the abuse of a spouse or child as an aggravating factor in sentencing an offender;
- Bill C-27 (proclaimed into force on May 26, 1997) strengthens the criminal harassment (stalking) provisions in the Criminal Code. Murder committed while stalking a victim is first degree murder where the murderer intended to instill fear for the victim's safety;
- Bill C-15, re-introduced in March, 2001 proposes to amend the Criminal Code to increase the maximum penalty for criminal harassment from 5 to 10 years.

Examples of groundbreaking innovations on the provincial front include the development of the Winnipeg Family Violence Court and, in Saskatchewan, the passing of *The Victims of Domestic Violence Act*.

The Winnipeg Family Violence Court (FVC) began operation in 1990 (Health Canada, 2002). The FVC was the first of its kind in Canada and is a specialized court for cases of spousal, child, and elder abuse. The goals of the court are: (1) expeditious court processing; (2) rigorous



prosecution and; (3) more appropriate sentencing for family violence cases than that provided by non-specialized courts. The recruitment of specially trained prosecutors, judges, and other personnel helps to reduce the problems of biased attitudes and lack of awareness that often plague non-specialized courts. Because of the FVC, spouse abuse cases have gone from being treated as low-priority cases by the regular court system to high-priority cases adjudicated by personnel that are highly trained in issues related to domestic abuse.

In order to better assist victims of domestic violence and augment the response of the justice system to incidents of domestic violence, the Saskatchewan Government, in 1995, proclaimed *The Victims of Domestic Violence Act*, the first legislation of its kind in Canada. The objectives of the Act are:

- To promote the message that domestic violence is a serious concern;
- To provide victims with additional legal tools for dealing with family violence;
- To focus on assisting victims, in addition to prosecuting offenders;
- To facilitate better access by victims to longer-term remedies by expediting Victim Assistance Orders (Such an order can provide a number of remedies to a victim such as monetary compensation from an abuser for material losses suffered by the victim, restrain an abuser from contacting a victim, or a victim's family or employer.);
- To assist domestic violence victims who are unable to act on their own by allowing the use of Warrants of Entry (For example, if police are called to a home and there is cause for concern, but access to one's home is denied by an abuser, a Justice of the Peace is authorized to issue a warrant authorizing entry by police to examine the situation and, if necessary, to remove the victim for medical treatment.).

On March 10, 1994, when he rose in the Saskatchewan legislature to move second reading of the *Act*, Robert Mitchell, Q.C., Minister of Justice and Attorney General remarked that society

has come to recognize that:

... there are women living in our society who live in fear, who can't find safety, who can't find security, who cry out for help to make them safe and secure, and we have been so slow in responding – to our great shame. Now we are making progress. Our culture with its male orientation and its male understanding of problems, has slowly been coming to the recognition that there is a serious problem here around domestic abuse, particularly the abuse of women and children, and it is time we did something about it ... It is against that backdrop that this government, indeed this legislature, turns to the problem of domestic violence. And our response for this time, in this place, is this Bill. (Valverde et al., 1995, pp. 190 – 191)

It is clear that the field of family violence research and treatment has become closely intertwined with both the political and criminal justice systems. While policy- and crime-making is complicated by the fact that patterns of male-female behavior may vary according to class, race, ethnicity, religion, culture or subculture, and geography, male violence against women is no longer dismissed as a personal problem between spouses that does not trigger a significant public interest. There is little doubt that more and more Canadians do not endorse a “man’s home is his castle” and “hands off” policy with respect to domestic violence and expect public authorities to have some responsibility in controlling domestic violence and supporting the victims of domestic abuse.

While significant changes have occurred at the front-end of the criminal justice system, changes have also occurred at the post-conviction end. Yet another link in the chain forged by the criminal justice system is to provide family violence treatment programs to incarcerated offenders within the jurisdiction of Correctional Service of Canada.

## SPOUSE ABUSE AND OFFENDERS UNDER THE JURISDICTION OF CORRECTIONAL SERVICE OF CANADA

### **Prevalence**

When delivering effective treatment to abusive male offenders, it is crucial that treatment planners have up-to-date, reliable information about the prevalence of spouse abuse among

offenders, the characteristics of these men, the host of risk factors associated with spouse abuse, as well as the treatment gains produced by treatment programs.

Robinson and Taylor (1994) report that offenders are a major group at risk for committing acts of domestic violence. Using a file review method, the researchers reviewed the institutional files of 935 offenders admitted to Correctional Service of Canada institutions between June and November of 1992. The file review showed that 33.7 % of the offenders had perpetrated an act of family violence. Physical assault against family members was the most frequent type of abuse (26.9%) followed by sexual abuse (10.6%) and psychological abuse (5.2%). Of those files containing some evidence of physical or sexual assault, 80.2% of the assaults resulted in official charges and 47.85 % of the assaults resulted in injury requiring medical attention.

The file review observed that although other family members were also at risk, a female partner carried the brunt of the abuse. Hitting was the most frequent subtype of physical abuse followed by pushing, threats, kicking, and choking. Incidents involving shooting (4.1%) and stabbing (7.1%) also occurred among men who had assaulted their female partner. Estimates of either sexual or psychological abuse were far less frequent than estimates of physical abuse. Nearly ten percent of the files (9.3%) contained indications that the offender had sexually abused a female partner. Reports of psychological abuse were relatively low with 4.2% of the files containing any reference to psychological abuse.

Evidence of abuse of children was less common than abuse of a female partner (“child victims” refer to biological and step-children as well as child relatives such as nieces and nephews). The file review data indicated that 13.3% of offenders had abused children (abuse includes sexual, physical, and psychological abuse). Unlike the female partners who were most likely to be physically abused, the most frequent type of abuse against either a male or female child was sexual abuse (11%). Only 3.1% of the files provided evidence of physical

abuse. Finally, the file review suggested a rate of psychological abuse of 1.3% against a male or female child.

Examining regional differences, Robinson and Taylor report that the Prairie and Atlantic regions had the highest rates of family violence in Canada. In these regions about 40% of offenders had file evidence of any abuse (including physical, sexual, or psychological) against family members; outside of these regions the rate was about 30 percent. The Atlantic and Prairie regions also showed the highest rates of violence against children. In the Atlantic region, there was evidence that 17.4% of the offenders had been violent toward children. In the Prairie region, 12.2% of the files had evidence of violence against children.

### **Risk Markers**

The research literature on spouse abuse among men in the general population has explored the association between a number of demographic, psychological, attitudinal, and behavioral risk indicators and spouse abuse. The general literature concerning abusive men in the non-criminal population provides a useful backdrop against which can be compared the findings obtained in the Robinson and Taylor (1994) file review.

Drawing upon past studies that have identified a number of risk markers of spouse abuse, Robinson and Taylor examined such markers as age, education, marital history, employment stability, substance abuse problems, mental disorders, childhood victimization, and criminal history. All of the following reported differences are statistically significant.

The researchers report that their most notable finding was that there was a positive relationship between age and the perpetration of violence in their population of federal admissions. While many people might expect that younger men are more likely to act violently (e.g., Straus, Gelles, and Steinmetz (1980) report that marital violence occurs most frequently

between ages 18 and 30), Robinson and Taylor's (1994) data showed that the older offenders (30 years and over) were more likely (30.7%) to have evidence of family violence in their files than younger men (23%).

Studies (e.g., Appleford, 1989) often indicate that many spouse abusers have low educational attainment. Robinson and Taylor report that although 20.7% of offenders with a high school education had committed family violence compared to 30.8% of those without a high school diploma, education was less powerfully correlated with family violence than most of the other risk markers they considered such as alcohol problems or a diagnosis of a mental disorder.

When examining the relationship between number of marriages and violence against a female partner, Robinson and Taylor report that 35.3% of offenders in their sample who had been married three or more times had assaulted their partner compared to 25.8% of men who had been married fewer than three times.

Examining the association between alcohol problems, drug use, and mental illness with rates of family violence, the researchers uncovered a number of statistically significant findings. Evidence supporting the association between alcohol consumption and marital violence show ranges from less than 20% (Coleman & Straus, 1983) to 80% (Leonard & Jacob, 1988). In the Robinson and Taylor study, 34% of those offenders who showed evidence of alcohol problems had committed an act of family violence compared to 16.6% of those judged not to have a drinking problem. The researchers also observed that while alcohol problems were significantly correlated with spouse abuse, alcohol problems were not significantly associated with assaults against children. And even though alcohol problems were significantly associated with spouse abuse, drug problems were not. However, while studies often report a correlation between alcohol abuse and domestic violence, a cautionary-flag must be raised against regarding alcohol as a causal agent. When considering the relationship between alcohol and abuse the primary

lesson seems to be that “alcohol is neither a necessary nor a sufficient explanation for family violence, but is one factor often associated with it” (Yegidis, 1992, p. 522).

While it is not unusual for abusers to have a mental illness, many researchers (e.g., Walker, 2000) argue that since marital violence is so widespread it cannot be simply explained away as the misbehavior of a relatively small number of mentally ill men. Exploring the association between certain psychological risk markers and family violence, Robinson and Taylor report that a diagnosis of mental illness (included within this category were psychosis, anxiety/mood disorders and personality disorders) was significantly related to family violence. The data indicate that 36.2% of offenders with a diagnosed mental illness had committed an act of family violence compared to 24.3% for men without a diagnosed mental illness.

Robinson and Taylor also considered the relationship between family violence and criminal history such as number of convictions, violation of community supervision, prior federal admissions, sentence length, assaults against non-family members, and major offence type for the current admission. The data indicated that criminal history was unrelated to spouse abuse except for number of past convictions. Men who had 15 or more convictions were more likely to have assaulted their partner compared to men with fewer than 15 convictions. Those men with fewer than fifteen convictions showed more evidence of child abuse (18.6%) than men with more than fifteen convictions (6.1%).

One of the most important risk markers of marital violence is physical and sexual victimization in the family backgrounds of adult abusers (Appleford, 1989). Even witnessing but not experiencing violence or abuse in one’s family of origin is considered to be a major risk marker for future abuse (Hotaling & Sugarman, 1986). In the Robinson and Taylor (1994) study, childhood victimization (including physical and sexual abuse) was found to be significantly associated with later perpetuation of violence against family members. For

example, 42.4% of those offenders who had experienced any form of family violence as children showed evidence of perpetuation of family violence compared to 23.9% for men who had not been victimized by family members as children. The data indicates that witnessing abuse, experiencing abuse, both witnessing and experiencing abuse and being physically and sexual abused were significantly related to abuse against a female partner or children (with the exception that witnessing of abuse was unrelated to the perpetuation of abuse against children).

A file review study by Dutton and Hart (1992) also helps supplement the observations of Robinson and Taylor (1994). In their review of the institutional files of 598 male offenders from seven correctional facilities in Canada, Dutton and Hart observed that certain subtypes of incarcerated populations were more likely than certain other subtypes of incarcerated populations to have grown up in violent families where they had experienced physical and/or sexual assault or had witnessed physical and sexual abuse of other family members. Their findings also suggest that certain subgroups of male offenders are more likely to abuse alcohol and/or drugs and exhibit certain psychiatric and personality disorders compared with other subgroups of male offenders. Consider the following.

Dutton and Hart (1992) grouped offenders into three categories: (1) non-violent offenders (NV) who had no indication whatsoever of violent behavior in their files; (2) stranger-violent offenders (SV) whose files indicated violent behavior toward non-family members but who showed no evidence of violence toward their wives or other family members, and; (3) family-violent offenders (FV) whose files showed evidence of violence toward family members (the majority of whom also assaulted non-family members). A number of highly significant results were revealed.

Comparing groups, the data indicated that the FV group was the most likely to have been both physically and sexually abused. According to the file data, 41.4% of the FV group had been

physically abused in their family of origin compared with 29.9% of SV offenders and 14.9% of those in the NV group. Similarly, 17.5% of the FV offenders had experienced sexual abuse compared with 9.8% of SV offenders and 5.4% of NV offenders. When considering witnessing abuse in their family of origin, 20% of FV offenders had witnessed abuse compared with 11% of the SV group and 5.4% of the NV group.

Psychologically, the FV offenders also showed significantly higher indications of personality disorders. Although the SV and FV groups were equally likely to have a diagnosis of antisocial personality disorder (20.7% and 21.5% respectively), the FV group was more likely to have other types of personality disorder such as borderline or narcissistic (22% compared with 13.4% for SV offenders). Again, the NV group showed the lowest rates of antisocial personality disorder. Only 5.8% of the NV group showed evidence of an antisocial personality disorder or other types of personality disorders (e.g., borderline, narcissistic).

In summary, the FV offenders consistently reported more problems than both the SV and NV groups. The family-violent offenders were: (1) most likely to have been physically and/or sexually abused; (2) most likely to have witnessed abuse in their family of origin; (3) more likely than the SV group to be diagnosed with a borderline or narcissistic personality disorder although they were equally likely to have been diagnosed as antisocial, and; (4) significantly more likely to be diagnosed with an antisocial personality disorder or some other personality disorder such as borderline or narcissism when compared to the NV group.

Hanson and Wallace-Capretta (2000) report that the factors or variables associated with recidivism among male batterers appear to be the same as those factors associated with recidivism in the general criminal population. While the literature on male batterers has developed separately from the literature on general criminal offenders, Hanson and Wallace-Capretta observe that, "Nevertheless, criminal behavior is common among abusive men and it is



possible that the core processes underlying criminal behaviour may also contribute to partner abuse” (p. 2). The researchers chronicle a number of reported similarities between male batterers and general criminal offenders: Both groups tend to engage in impulsive behaviors (e.g., reckless driving, substance abuse, and employment instability); each population tend to be young, unmarried, have unstable lifestyles, have a vulnerability to stress, low verbal intelligence, negative attitudes and antisocial personality characteristics, as well as a history of criminal behavior, and; both populations have been reported to show negative emotionality which refers to a tendency to act aggressively, or perceive that they are often mistreated; both groups tend to perceive themselves as socially alienated.

Hanson and Wallace-Capretta (2000) examined recidivism risk factors in a sample of 320 male batterers recruited from five community treatment programs in Canada. Recidivism was based on both charges and convictions for any offence, including partner-related violence, during a 5-year follow-up period. Recidivism information was obtained from the Royal Canadian Mounted Police (R.C.M.P.) national criminal history records. Although program orientation varied (e.g., existential, cognitive-behavioral, feminist), each sought to teach men to accept responsibility for their violence, decrease attitudes that endorse and support abuse, and learn cooperative conflict-resolution strategies. The abusive men (with a number of their partners) were compared to a group of mostly non-abusive men (with a number of their partners). In addition to examining a number of demographic variables, the researchers examined a number of dynamic (changeable) and static (stable across time) predictor variables: verbal aptitude, perceived control in the marital relationship, anger/hostility, expectations of negative consequences for assaulting their partner, motivation to address their problems and change; self-reports of program completers concerning whether they thought they had benefited from treatment; the Level of Service Inventory-Revised (LSI-R) was used to address criminogenic risk

and needs; the participants also completed the Balanced Inventory of Desirable Responding (BIDR).

In discussing their findings, the researchers observe that, in general, many of those factors associated with recidivism among the male batterer sample appear to be the same factors associated with recidivism in the general criminal population. As with other criminal populations, the persistent batterers tended to be young, single, have unstable lifestyles (e.g., frequent moves, poor accommodation, unstable employment history, substance abuse) and low verbal intelligence, with little commitment to prosocial values while endorsing sexist attitudes that are tolerant of wife assault coupled with an adversarial approach to intimate relations.

On the other hand, a number of variables that were measured were unrelated to recidivism. There was no relationship between reports of negative family background and recidivism. Reported low levels of marital satisfaction, self-reports of anger/hostility, and desire to have greater control over a relationship with a partner were unrelated to recidivism. Self-reported motivation to change was unrelated to recidivism and battering men seemed undeterred by expectations of negative consequences, either social (e.g., disapproving friends) or official (e.g., arrest). Substance abuse and pro-abuse attitudes were positively related to recidivism at pre-treatment, but subsequent self-reported improvements were actually associated with increased recidivism.

Even though some well-established variables or factors were associated with increased recidivism, the researchers report that, “The present results suggest that it is difficult to assess whether abusive men have benefited from treatment. The men who failed to complete treatment appeared at increased risk. Among treatment completers, however, few variables differentiated between recidivists and non-recidivists” (p. 34). It would seem that although a portrait of persistent batterers emerged that is consistent with the literature (e.g., young, single, history of

substance abuse, etc.), at the same time, many well-established correlates of abuse were found to be unrelated to recidivism.

The risk markers that diverse researchers have found to be most closely associated with abuse are hardly surprising. Childhood physical and sexual victimization, witnessing violence in the home, diagnosed mental illness, antisocial personality disorder, low educational achievement, poverty, alcoholism and substance abuse, family dysfunction, and inconsistent parenting are common risk factors that top everyone's list of significant risk factors. However, the caveat that is constantly appended to this ever-growing list includes the warning that one has to always distinguish between factors as causes or correlates. In conclusion, although the relationship between risk markers and spouse abuse is not straight and certain and one wants to be cautious about assigning causality to any of these factors, an examination of the intrapersonal (e.g., low self-esteem, high power/control needs) and interpersonal elements (e.g., possessiveness, poor communication skills) as well as the historical (e.g., age, education level, childhood victimization) and situational characteristics (e.g., recent separation or divorce, change in employment) that can function as risk markers of spouse abuse are crucial in developing prediction models that try to identify men most likely to act abusively or who are most likely to benefit from treatment.

#### FAMILY VIOLENCE PROGRAMS AND CORRECTIONAL SERVICE OF CANADA

Correctional Service of Canada (CSC) has, since 1991, provided domestic violence treatment programs to federal offenders at various facilities across Canada. During 2000-01, 1,361 offenders were enrolled in family violence prevention programs (Correctional Service of Canada, 2001). Stewart, Hill, and Cripps (2001: 90), when discussing family violence programs in correctional settings, suggest that:

The principle goal of a relationship violence program is the elimination of all forms of violent and abusive behaviour by offenders against their intimate partners. The programs seek to reduce the physical, sexual, emotional, psychological, and financial abuse of intimate partners. Although most family violence programs do not specifically provide instruction on parenting, or on prevention of abuse of the elderly, a secondary goal of most programs is the elimination of all violent and abusive behaviour in the family. Intermediate goals are to develop perpetrator's insight into factors related to abuse; increase their awareness of the range of abusive attitudes and behaviours toward partners and children and the negative effects of these attitudes and behaviours in relationships; replace abusive attitudes and behaviours with non-abusive attitudes and behaviours; and develop a sense of responsibility for abusive and violent behaviours.

The program draws from a medical model based on prevention, diagnosis and treatment and favours the cognitive-behavioural approach while receiving guidance from feminist theory. During the course of treatment, participants will hopefully learn a lot about why they act abusively. As the program unfolds from session to session, participants will learn more about the prevalence of domestic abuse; they will learn how abuse affects their partner and children; they will learn about how various stressors such as poverty or alcohol abuse may be affecting their well-being and relationships. A central goal of treatment is to teach participants about the relationship between the way in which they think, feel, and behave. The offenders are taught that abusive behaviour is not simply a spontaneous, uncontrollable event or reaction. Instead, a person's abusive behaviour is largely a product of illogical, self-defeating beliefs and assumptions. These internal beliefs will affect how one feels and acts in the world. By this point in treatment, participants are learning that they are responsible for their abusive behaviour because they are ultimately responsible for how they think. Participants will explore their beliefs and attitudes and ask themselves if they hold deeply ingrained sexist attitudes that devalue women and children; they will learn more about the power and control tactics that people use to remain dominant in a relationship. They will consider the larger culture and question the extent to which it may be coloured by a patriarchal ideology that gives men a sense of privilege and entitlement over women. Participants will be asked to challenge their sexist beliefs and replace them with values and attitudes that are more democratic.

In addition to learning how our thinking colours our feelings, participants will also be given training in social skills development. They will learn to try and be more empathetic toward their partner and children. They will learn how to improve their critical thinking and conflict-resolution skills. Participants will learn how to dissect situations in a logical, orderly fashion so that they might be better understood. Participants will be taught to recognize the thoughts and feelings of others and communicate their feelings more constructively. Hopefully, by the end of treatment, participants have learned a better way to think, feel, and act.

Upon arrival at an institution, the offender's risk and need levels are assessed during an initial intake assessment process where a Case Management Officer may identify a number of need-areas: employment, marital/family, social interaction, substance abuse, community functioning, personal emotional orientation, and attitude (Johnson and Grant, 1999). Within the marital/family component of the intake assessment, the offender's childhood family experiences, current relationships with family members, and previous marital and family relationships are evaluated. It is during the marital/family component that the issue of spouse abuse may be revealed.

While the initial intake assessment focuses on a broad range of needs, the Family Violence Risk Assessment (FVRA) which is aimed specifically at family violence is also administered during the intake assessment. The FVRA consists of two steps. First, the offenders are screened using a set of four criteria (past assaults of family members, prior record of violence, being the victim of or witness to family violence as a child or adolescent, and personality disorder with anger, impulsivity or behavioral instability) to determine whether or not the offender is at risk to commit family violence (Johnson & Grant, 1999). If the above criteria are met, in whole or in part, a Case Management Officer subsequently completes the Spousal Assault Risk Assessment (SARA) guide to determine if the person's level of risk of spouse abuse is low, moderate or high.

Offenders classified as low risk on the SARA may be referred to the Family Violence Awareness Program, while moderate and high risk offenders may be referred to the Family Violence Treatment Programs. However, offenders may be excluded from taking the programs on the basis that they lack basic literacy, language competency and comprehension skills or are actively psychotic or suffering from a severe mental illness. Offenders who otherwise meet the criteria for inclusion into the programs but refuse to attend the program or who are otherwise resistant to treatment will also be excluded and will instead be offered a treatment primer (an information package containing fact sheets, books, videos, testimonials and biographies of men who have benefited from treatment) designed to help them consider the value of change and are offered a treatment place later if they are willing to accept the terms for participating in the program.

The family violence treatment programs consist of three levels of intensity: a high-intensity, moderate, and low-intensity level. The high-intensity program lasts about thirteen weeks, and consists of seventy-five sessions with each session lasting about two and one-half hours. The moderate-intensity program lasts between five to thirteen weeks and consists of two to five group sessions per week. Those assessed as low-risk on the SARA, have no apparent history of violence against women but whose attitudes toward women suggest that they are at risk for domestic violence are referred to the Living Without Violence in the Family Program. The program consists of between 5 to ten sessions of two and one half hours each. The low-intensity program is primarily an educational/awareness program that introduces participants to the various issues surrounding domestic violence (e.g., role expectations in the family, images of men, women, and children in the media, parenting, defining family violence, power and control, healthy relationships, recognizing the language of feelings, developing alternatives to abusive control). While both the high and moderate-intensity programs contain the educational, skills development, and relapse prevention element, the low-intensity program consists only of the

educational element. The high-intensity program also includes additional monitoring, before and after treatment to allow for observation, particularly in the community setting.

Taking the high-intensity program as an example of the type of treatment offered to offenders, the program consists of seven core areas: (1) motivational enhancement; (2) psycho-educational component; (3) cultural component; (4) autobiographies; (5) skills building; (6) relapse prevention and risk management, and; (7) a healthy relationships component (Correctional Service of Canada, 1999).

These seven core components are contained in ten modules that are used by group facilitators. Module 1, Motivational Enhancement, is designed, in part, to stimulate the offender's interest in the program and desire to change. Module 2, Awareness and Education, is used to increase awareness of the dynamics of family violence. The Power and Control Wheel is introduced to help participants identify the various categories of abuse and the specific types of behaviour that undermine a woman's sense of safety, security, self-esteem or confidence. The Equality Wheel will later be set-off against the Power and Control Wheel and is used to identify various target behaviours that promote nonviolence and equality: negotiation and fairness, non-threatening behaviour, respect, trust and support, honesty and accountability, responsible parenting, shared responsibility, and economic partnership. The ABC Model (Antecedent-Beliefs-Consequences) is also introduced. The Model highlights the idea that abusive behaviour is not simply a spontaneous, uncontrollable reaction to events, but is rather the product or consequence of one's faulty patterns of thinking. The Model helps offenders understand that they are ultimately responsible for changing their attitudes and beliefs as well as gaining the upper hand over their maladaptive emotions.

Module 3, Autobiography, gives participants the opportunity to think about and chronicle those events in their lives and family of origin that may continue to impact upon their current

behavior. Module 4, Cultural Issues, has participants examine the role that the larger, all-embracing culture plays in shaping those attitudes, norms, and values that have an impact on relationships between men and women and that are supportive of family violence. It is at this stage that Aboriginal cultural issues may be included for Aboriginal participants.

Modules 5, 6, and 7 consist of three components: Thinking Skills, Managing Emotions, and Social Skills. The Thinking Skills component uses the ABC model to illustrate the link between irrational beliefs, negative attitudes and the strong emotions that can lead to abusive, controlling behavior. The participants are taught to identify and dispute their problem thinking and learn to identify counter-beliefs and attitudes that are more conducive to the development of healthy relationships. The Managing Emotions module is used to help the participant identify and monitor their negative emotions. During this stage, offenders will be taught self-management techniques such as thought-stopping, taking a time-out and relaxation training that can help them learn to control their strong emotions. In Module 7, Social Skills, the main goal is to develop social skills such as interpersonal problem-solving, conflict-resolution, and communication skills, all of which can help to nurture healthy relationships.

The goal of Module 8, Parenting, is to develop empathy for those affected by family violence through discussion of the impact of abuse on one's family. The Abuse of Children Wheel is used to identify the range of directly abusive behaviors toward family members, especially children, and the Nurturing Wheel is used to increase understanding of being a nurturing parent.

Module 9, Relapse Prevention, teaches participants about those personal risk factors and situations that underlie abusive behavior. Participants are asked to develop a personal relapse prevention/risk management plan that emphasizes the importance of continued treatment and use of support services.

Module 10, Healthy Relationships, is the last module and is used to review all the program



material that has been covered while reviewing how the program material will help the participant develop healthier relationships.

Once the high-risk offenders have completed the family violence program they will also participate in a Maintenance Program. The program is geared toward a review of the relapse prevention plan developed by the offender in light of their current life circumstances and a review of the concepts and techniques introduced in the treatment program. In institutional settings, participants are required to attend the Maintenance Program for at least six months or until their release in the community where they will continue their participation in the community. Once in the community, those offenders whose risk levels are low and manageable may be discharged from maintenance programming after one or two sessions.

#### THE PRESENT STUDY

The primary purpose of the present study is to examine possible treatment-related change or improvement for offenders who participated in the high intensity family violence prevention program offered by Correctional Services of Canada (CSC). At this point, it is important to make two observations. First, in Canada, unlike in the United States of America, there is not a distinct “misdemeanor domestic violence” charge defined in the Canadian Criminal Code (CCC).

Although a man who assaults his spouse might be charged with some general type of assault (e.g., common, aggravated), there is not a distinct domestic violence offence defined by the CCC. Second, it is important to know that those offenders who had participated in the program were not necessarily incarcerated for committing some act of violence against their spouse. The participants were simply *judged* to be at risk for domestic violence on the basis of their initial intake assessment. As mentioned earlier, when an offender first arrives at a facility, there is an initial intake assessment conducted by a case management officer (CMO). During this

assessment, the CMO completes both the Family Violence Risk Assessment (FVRA) and the Spousal Assault Risk Assessment (SARA) guide. While the offender might be judged to be at risk for domestic violence and recommended for treatment, this does not entail that the offender had been charged with committing an act of violence against his spouse; he was simply *judged* to be at risk. In fact, the present offender sample had been convicted of a variety of violent and non-violent index offences which did not involve their spouse or partner.

Data collection consisted of thirteen psychological, attitudinal, and behavioural measures (described more fully below). Five psychometric measures were administered to offenders in a standard paper-and-pencil self-report format. Seven measures were completed by staff or program facilitators, and one measure was completed by Case Management Officers. In addition, basic recidivism data (release date from a facility and subsequent readmission date) was provided to the researcher by CSC. Five of the measures were administered pre-treatment only. Seven of the measures were administered pre- and post-treatment. One measure was administered post-treatment only. The present study examines: (a) the frequency of violent and non-violent index offences committed by offenders; (b) profiling information derived from those personality and attitudinal measures that were administered pre-treatment only; (c) the psychometric properties of the test battery; (d) the intercorrelations among the test battery. The study also: (e) examines the issue of treatment-related change by comparing pre- and post-treatment performance on several measures; (f) examines recidivism rates, and; (g) correlates several predictor variables with several dependent variables. Throughout the study, the performance of offenders is compared on four variables: Age (continuous variable), Level of Security (minimum, medium), Relationship Status (In a Relationship, Not in a Relationship), and the five jurisdictions or regions across Canada identified by CSC (Atlantic, Quebec, Ontario, Prairie, Pacific).

Studies of domestic violence provide evidence of the importance of considering the association of such demographic variables as age and marital status with spouse abuse. While Straus, Gelles, and Steinmetz (1980) report that domestic violence occurs most frequently between ages 18 to 30, Robinson and Taylor (1994) report that older offenders (30 years+) were most likely to have acted abusively. Hanson and Wallace-Capretta (2000) identifies relationship status (e.g., legally married, common law) as an important correlate of both spouse abuse and post-treatment recidivism. In their study, while the most abusive men were likely to be separated, those men who were married were less likely to recidivate than were the men who were single or who had separated or divorced. Robinson and Taylor (1994) identify region as an important correlate of domestic abuse. In their study, the researchers observe that the Prairie and Atlantic regions exhibited the highest rates of family violence in comparison to other regions. Therefore, the relationship between several demographic variables (i.e., age, marital status, region) and test scores was also investigated.

The reader is advised that the present study does not involve the testing of specific hypotheses derived from theory. Rather, it is exploratory in nature and was undertaken to determine whether participants responses to a battery of specifically chosen tests and measures were any different after completing a domestic violence program in comparison to their responses before the program.

## METHOD

### Participants

The findings for the present study are based upon data supplied by 101 offenders incarcerated in one minimum and seven medium security CSC facilities across five regions in Canada. The regions, facilities within the region, level of security of the facility, and number of participants from each facility include: (1) Atlantic region: Springhill Institution (med.,  $n = 12$ ); (2) Quebec region: Federal Training Centre (min.,  $n = 19$ ); (3) Ontario region: Bath Institution (med.,  $n = 10$ ), Joyceville Institution (med.,  $n = 5$ ), and Warkworth Institution (med.,  $n = 1$ ); (4) Prairie region: Bowden Institution (med.,  $n = 32$ ), and; (5) Pacific region: Matsqui Institution (med.,  $n = 9$ ), Mission Institution (med.,  $n = 12$ ). The data file provided the age for thirty-eight offenders. The age of the offenders ranged from 21 years to 64 years with a mean age of 37 years ( $SD = 8.23$ ). The data file provided the ethnic/cultural backgrounds of twenty-five offenders. The ethnic backgrounds of these twenty-five offenders include: First Nations ( $n = 7$ ), Cambodian ( $n = 1$ ), Canadian ( $n = 13$ ), Jamaican ( $n = 1$ ), American ( $n = 1$ ), Malato ( $n = 1$ ), Irish ( $n = 1$ ). In addition, the data file provided the relationship status of sixty-five offenders: married ( $n = 4$ ), common law ( $n = 22$ ), divorced ( $n = 8$ ), separated ( $n = 3$ ), single ( $n = 21$ ), widower ( $n = 7$ ). Because of the small amount of data, the relationship status of the offenders was collapsed into two groups: In a Relationship, Not in a Relationship.

The amount of missing data varies greatly depending on the measure or variable; that is, the sample (i.e.,  $N$ ) may vary widely from one variable and analysis to the next because the amount of missing data may vary widely.

## Measures

The following five self-report measures were completed by the offenders:

- Abusive Relationships Inventory (ABI) (Boer, Kroner, Wong, & Cadsky, undated). The ABI was administered at both pre- and post-treatment. The ABI was developed to assess the attitudes and beliefs of men who have been physically, mentally or sexually abusive toward their spouse. The Inventory measures tendencies to rationalize abusive behaviour and to project blame onto the spouse. The measure consists of thirty-three questions where responses are given on a five-point Likert scale ranging from 1 = Strongly Disagree to 7 = Strongly Agree. The ARI consists of four scales: (1) Rationales for Hitting (e.g., The rules of society say it is OK to use force on women when needed.); (2) Need for Control (e.g., A man who finds out his wife is having an affair is within his rights to beat her up.); (3) Legal Entitlement (e.g., If a husband forces his wife to have sex, it is not rape.), and; (4) Batterer's Myths (e.g., Women secretly desire to get beaten.). Boer, Kroner, Wong, and Cadsky (undated) report reliability coefficients for the four subscales of the ABI: Rationales for Hitting, .83; Need for Control, .84; Legal Entitlement, .75; Batterer's Myths, .71.
- Relationship Style Questionnaire (RSQ) (Griffin & Bartholomew, 1994). The RSQ was administered pre-treatment only. The RSQ measures adult attachment style. Sperling and Berman (1994) define adult attachment as the "stable tendency of an individual to make substantial efforts to seek and maintain proximity to and contact with one or a few individuals who provide the subjective potential for physical and/or psychological safety and security"(p. 8). The RSQ consists of thirty items that measure four attachment patterns: (1) Secure (comfortable with both intimacy and autonomy because secure individuals have a high regard for both self and others); (2) Fearful (hold a negative view

of self and fear intimacy); (3) Pre-Occupied (gain self-acceptance by continually seeking recognition from others), and; (4) Dismissing (deny their need for intimacy and do not have strong affiliative needs). Responses are given on a five-point Likert scale ranging from 1 = Not at all like me to 5 = Very much like me. Bartholomew (1989) reports that the four RSQ scales demonstrate moderate stability ratings: Secure, .71; Fearful, .64; Pre-Occupied, .59; Dismissive, .49.

- Paulhus Deception Scale (PDS) (Paulhus, 1990). The PDS was administered pre-treatment only. The Scale consists of forty items that measure two aspects of socially desirable responding: (1) The Self Deceptive Enhancement (SDE) subscale measures a person's tendency to be dishonest with oneself about one's socially undesirable qualities and characteristics; (2) Impression Management (IM) measures the tendency to want to impress others by presenting an overly favourable impression of oneself. Responses are given on a five-point Likert scale ranging from 1 = Not true to 5 = Very true. If respondents score high on the PDS, the sincerity of their answers to the various measures administered concurrent with the PDS become questionable. Paulhus (1991) reports that the two scales of the PDS demonstrate moderate reliability ratings: Self Deceptive Enhancement, .58; Impression Management, .85.
- Borderline Personality Organization (BPO) (Oldham, Clarkin, Applebaum, Carr, Kernberg, Lotterman, & Hass, 1985). The BPO was administered pre-treatment only. The BPO is a thirty item measure used to assess offenders for borderline personality disorder. Responses are scored on a five-point Likert scale ranging from 1 = Never true to 5 = Always true. The BPO assesses three components: (1) Loss of Reality (characterized by odd thinking, unusual perceptions, non-delusional paranoia, and quasi-psychosis); (2) Primitive Defences (chief of which is "splitting" in which a person or thing is seen as

all good or all bad. Other primitive defences are magical beliefs which is the belief that thoughts cause events, as well as projection identification, a process where the borderline tries to elicit in others the feelings he/she is having), and; (3) Identity Diffusion (a diffuse and internally contradictory concept of self – that is, borderlines do not have a realistic picture of what they are really like). The three scales are also summed to yield a total score. Oldham et al. (1985) report Cronbach's alpha for the BPO subscales as: Loss of Reality, .84; Primitive Defences, .87; Identity Diffusion, .92.

- University of Rhode Island Change Assessment (URICA) – B (Levesque, 1998). The URICA was administered at both pre- and post-treatment. The URICA is a generic measure of readiness to change that has been modified as a measure of change for men who are entering a male batterer's group. The scale consists of twenty items grouped into four scales: (1) Precontemplation (the individual is not even considering the possibility of change); (2) Contemplation (characterized by ambivalence where individuals may simultaneously consider and reject reasons to change); (3) Action (individual has made a commitment to change and is actively working to bring about change); (4) Maintenance (individuals are working to sustain any changes made). Responses are given on a five-point Likert scale ranging from 1 = Strongly disagree to 5 = Strongly agree. The scale is designed to be a continuous measure. Thus, respondents can score high on more than one of the four stages. McConaughy, Prochaska and Velicer (1983) report coefficient alphas for the four scales ranging from .88 to .89. For the subscales of Pre-Contemplation, Contemplation, Action, and Maintenance, DiClemente and Hughes (1990) report Cronbach's alphas of .69, .75, .82, and .90 respectively.

The following seven measures were administered to offenders but scored by program facilitators.

- Relapse Prevention Test – FV (RPT) (Preston & Murphy, 1996). The RPT was administered both pre- and post-treatment. The RPT is a structured interview in which the respondent is asked how he would respond in a number of situations related to family violence. The interview is audio taped to decrease distraction and to allow for scoring at a later time. There are a total of eight scenarios. There are two versions of the test – Version A and Version B. The administration of the test is counterbalanced so that Version A is administered at pre- test and Version B at post-test or vice versa. The test assesses a number of areas including: (1) recognition that a situation is one that could lead to violence; (2) development of problem-solving and emotions management skills, and; (3) ability to evaluate the effectiveness of solutions that offenders suggest to deal with the problem embedded within the situation. Responses are scored on a four-point scale ranging from 0 = Incompetent to 3 = Competent response. Reliability estimates are not available.
- Family Violence Vignettes (FVV) (1999). The FVV was administered both pre- and post-treatment. The measure consists of a series of five vignettes that assess how respondents might respond in five situations involving Jealousy, Employment and Finances, Family and Friends, Control Issues, and Sexual issues. Responses to the vignettes are audio taped and scored at a later time. Responses are scored on a scale ranging from 0 = Ineffective/incompetent response to 2 = Appropriate response (that shows emotional control, effective problem-solving skills, assertive but calming responses). There are two versions of the test – Version A and Version B. The administration of the test is counterbalanced so that Version A is administered at pre- test and Version B at post-test or vice versa. Reliability estimates are not available.



- Empathy Scale – FV (ES) (1999). The ES was administered both pre- and post-treatment. The Scale is a structured interview in which the respondent is given a number of situations or scenarios and asked how he would respond. The scenarios consist of three main types: Partner-centred scenarios, Child-centred scenarios, and Persons Outside Family scenarios. Three main areas are scored using a three-point scale (0, 1, 2): (1) Perspective Taking: Does the offender have no recognition, some recognition, or good recognition of the other person's thoughts and/or feelings?; (2) Affect: Does the offender have no or insincere expression, some expression, or good/sincere recognition of affect for the other person?; (3) Coping with Distress: Does the offender show an unhelpful, damaging response or a helpful, effective response. The scale consists of Versions A and B. Version A is administered at pre-test and Version B is administered at post-test or vice versa. Reliability estimates are not available.
- Treatment Readiness Rating Scale (TRR), Treatment Responsivity Rating Scale (RRS), and Treatment Participation and Gain (TPG) Scale (Serin & Kennedy, 1997). The TRR and RRS were administered both pre- and post-treatment. Correctional Service of Canada has invested heavily in the development and systematic assessment of treatment readiness, responsivity, and treatment participation and gain. The TRR assists staff in assessing treatment readiness prior to and following an offender's participation in the family violence treatment program. The Scale consists of eleven categories (e.g., Problem Recognition, Goal Setting, Motivation). Responses are scored on a four-point scale ranging from 0 = Ineffective response to 3 = Effective/Appropriate response. Individual items are also summed to yield a total score that represents an individual's overall readiness for treatment.

The RRS is completed by program staff at pre- and post-treatment. The Scale consists

of eleven items selected to represent potential responsivity factors that can influence offender's compliance with, and response to, therapeutic intervention (e.g., Procriminal Views, Callousness, Impulsivity); that is, these items tap into the offender's general interpersonal style that may facilitate or inhibit how they respond to treatment. The items are scored on a four-point scale ranging from 0 = Ineffective/inappropriate response to 3 = Effective/appropriate response. Individual items are also summed to yield a total score.

Unlike the TRR and RRS, the Treatment Participation and Gain Rating Scale (TPG) was administered post-treatment only. The Scale is used to assess how well offender's participated in their treatment as well as how much they have gained from treatment. The Scale consists of fifteen categories (e.g., Increased Knowledge, Offender Confidence, Disruptiveness). Individual items are scored on a four-point scale ranging from 0 = Poor/resistant response to 3 = Very good/full response. Individual items are also summed to yield a total score that reflects overall treatment gain. Reliability estimates for the three rating scales are not available.

- Antisocial Personality Disorder Checklist (APD). The APD was administered pre-treatment only. This is a checklist of criteria for the diagnosis of Antisocial Personality Disorder. A person with the disorder exhibits lack of conscience for wrongdoing and may be aggressive and ruthless. The Checklist consists of eleven items (e.g., There is a pervasive pattern of disregard for and violation of the rights of others occurring since the age of 15 years; Reckless disregard for safety of self and others). The items are scored in a Yes/No format. The Yes items are summed to yield a total score. Reliability estimates are not available.

The following measure was completed by a Case Management Officer at initial intake assessment and, therefore, was administered pre-treatment only.

- **Statistical Information on Recidivism Scale (SIR).** CSC uses several tools for risk assessment, one of which is The Statistical Information on Recidivism (SIR) Scale used to predict general recidivism. As seen in Table 9.1, the scale contains 15 items and combines measures of demographic characteristics and criminal history into a scale that is used to predict the likelihood of recidivating within 3 years of being released from a facility. An item can receive a positive or negative score. Simple summation of the items yields a total score ranging from -30 to +27 that cluster into five risk groupings: Very Good (+6 - +27), Good (+1 - +5), Fair (-4 - 0), Fair to Poor (-5 - -8), Poor (-9 - -30). Those offenders classified as “Very Good” are judged to be the least likely to recidivate.

**Table 9.1.** Statistical Information on Recidivism Scale Items

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1. Current Offence
2. Age at Admission
3. Previous Incarceration
4. Revocation or Forfeiture
5. Act of Escape
6. Security Classification
7. Age at First Adult Conviction
8. Previous Convictions for Assault
9. Marital Status at Most Recent Admission
10. Interval at Risk Since Last Offence
11. Number of Dependents at Most Recent Admission
12. Current Total Aggregate Sentence
13. Previous Convictions for Sex Offences
14. Previous Convictions for Break and Enter
15. Employment Status at Arrest

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## Procedure

It has been the practice of Correctional Service of Canada (CSC) to collect data on its family violence treatment programs on an on-going basis. Since the inception of the programs in 1999, approximately 1400 offenders have participated in either a low, moderate, or high intensity

program. In evaluating the efficiency of the programs, CSC has collected data from three major sources: (1) psychometric test battery completed by offenders who have participated in a family violence treatment program; (2) psychometric test battery completed by program staff or facilitators used to assess various aspects of offender's attitudes, beliefs, and behaviours, and; (3) recidivism risk information and spousal assault risk information collected by Case Management Officers. While the data provided by offenders and program facilitators are stored in CSC's national database, recidivism risk information (derived from the Statistical Information on Recidivism (SIR) Scale) as well as criminal history information are stored in the Offender Management System (OMS). The OMS is used to gather and store information on federal offenders and is used by CSC to share information about offenders with staff, police, and other authorized criminal justice partners. All aspects of an offender's incarceration are tracked in the OMS, including initial intake information, charges, sentencing, property, housing, medical information, and more. Although the data used in the present study were collected by CSC, the data has never been analyzed. Therefore, the researcher applied to have access to the data in order to conduct the present study.

Since the consent of the offenders to participate in the studies conducted by CSC was previously obtained from CSC, it was not necessary for the researcher to obtain consent from the offenders to analyze the data. However, there were two prerequisites that needed to be satisfied before the researcher could receive the data from CSC. First, formal consent to receive the data stored in CSC's national data-base as well as the OMS, and permission to analyze, interpret, and report the findings was obtained from authorized personnel with CSC. Specifically, approval was obtained following consultation with Scott MacDonald, Quality Assurance Coordinator of the family violence programs offered by CSC in the Prairie region (i.e., Manitoba, Saskatchewan, and Alberta), and Dr. Lynn Stewart, National Manager of Family Violence Programs offered by

CSC. Second, in order to protect the privacy rights of the offenders and to conform to Tri-Council ethical guidelines, it was necessary for authorized personnel from CSC to strip the raw data file of all information that might identify the offenders to the researcher. Once the data file was properly prepared, it was forwarded to the researcher who was responsible for statistically analyzing and interpreting the findings.

## RESULTS

The Results section consists of six subsections. Part 1 provides a detailed profile of the participants. Part II consists of a psychometric analysis of the test battery. Part III presents the intercorrelations between the various measures that were administered pre- and post-treatment. Part IV explores the issue of treatment-related change by considering pre- to post-treatment changes in mean score. Part V examines the concurrent and predictive validity of the Statistical Information on Recidivism (SIR) scale. The SIR is also correlated with recidivism data. Part VI presents the correlations between several predictor variables and several dependent variables.

### **Part 1. Detailed Profile of Participants**

Part 1 consists of three subsections: (1) Treating the age of the offenders as a dependent variable, a t-test or one-way analysis of variance (ANOVA) is performed in order to determine if there is a significant age effect for Level of Security (minimum, medium), Relationship Status (In a Relationship, Not in a Relationship), and Region (Atlantic, Quebec, Ontario, Prairie, Pacific); (2) The frequency of non-violent and violent index offences committed by the offenders is reported and assessed. T-tests and chi-square goodness-of-fit analyses are also performed in order to examine the relationship or association between the frequency of non-violent and violent index offences with the variables of Age, Level of Security, Relationship Status, and Region; (3)

Three personality measures were administered pre-treatment only: Borderline Personality Organization (BPO), Antisocial Personality Disorder Checklist (APD), and Relationship Style Questionnaire (RSQ). The age of the offenders is correlated (Pearson's  $r$ ) with the mean scale scores for each of the measures. T-tests and one-way ANOVA are also performed in order to determine whether or not there is a significant difference in the mean scores of the various scales/subscales on the three variables of Level of Security, Relationship Status, and Region.

### 1. Mean Age Difference on Level of Security, Relationship Status, and Region

As seen in Table 10.1, there was not a significant age effect for any of the three factors of Level of Security, Relationship Status, and Region.

**Table 10.1.** Comparing Level of Security, Relationship Status, and Region on Age

Groups	Age				
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>
Level of Security					
Minimum	10	40.20	10.97		
Medium	28	36.61	7.14	1.19	.24
<i>Note: Degrees of freedom = 36.</i>					
Relationship Status	<i>n</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>
In a Relationship	20	36.39	6.25		
Not in a Relationship	18	38.60	9.72	-.82	.42
<i>Note: Degrees of freedom = 36.</i>					
Region	<i>n</i>	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>
Atlantic	7	33.14	10.67		
Quebec	10	40.20	10.97		
Ontario	4	38.75	2.75		
Prairie	12	37.10	5.88		
Pacific	5	38.55	8.23	.80	.54

*Note: Degrees of freedom = 4,33.*

### 2(a). Frequency of Non-Violent and Violent Offences Committed by Offender Sample

Statistics Canada uses seven categories to classify major violent crimes: (1) homicide (includes first and second degree murder, manslaughter, and infanticide); (2) attempted murder;

(3) assault (levels 1 to 3)<sup>1</sup>; (4) sexual assault; (5) other sexual offences; (6) robbery, and; (7) other crimes of violence.<sup>2</sup> Although 101 offenders completed the test battery, the data file received by the researcher from Correctional Service of Canada contained the Canadian Criminal Code description of the various violent and non-violent index offences (Index offences are distinguished from offending history and refers to those offences which immediately led to an offender's present imprisonment and subsequent initial contact with the domestic violence program.) committed by 66 offenders. The researcher grouped the various offences into the seven overarching categories described by Statistics Canada.

As seen in the Table 10.2, the 66 offenders committed 217 non-violent offences and 182 violent crimes for a total of 399 offences. The most frequent violent crime was assault (levels 1, 2, 3); the least frequent violent crime was "other sexual offences" – that is, those sexual offences not including sexual assault.

**Table 10.2.** Frequency of Non-Violent and Violent Index Offences

Category	Frequency ( <i>n</i> = 66)	Percentage
Non-violent offences	217	54.4
Homicide	21	5.3
Attempted murder	4	1.0
Assault (1,2,3)	115	28.8
Sexual assault	11	2.8
Other sexual offences	1	3
Robbery	17	4.3
Other crimes of violence	13	3.3
Total	399	100

<sup>1</sup> Level 1 constitutes the intentional application of force without consent, attempt or threat to apply force, wearing a weapon and impeding another person. Level 2 is assault with a weapon, threats to use a weapon or assault causing bodily harm. Level 3 is aggravated assault and applies to anyone who wounds, maims, disfigures and endangers life.

<sup>2</sup> Includes discharging firearms, abductions, and assaults against a police officer or other public officer

Table 10.3 presents the frequency of the seven major violent crimes for four groups: Age (Median split,  $Md= 38$  years), Level of Security, Relationship Status, and Region. Overall, the most common major crime was assault (levels 1, 2, 3); the least frequent offence across all groups was “other sexual offences.” However, it is helpful to remind the reader about the amount of missing data. Although 101 offenders completed the test battery, a description of the non-violent and violent index offences was not provided for all 101 offenders; that is, even though 101 offenders completed the test battery,  $n= 66$  in terms of the data received describing the violent and non-violent index offences committed by the offenders.

**Table 10.3.** Counts for Violent Offences

Groups	n	Hom.	Att. Murder	Assault (1,2,3)	Sexual Assault	Other Sexual	Robbery	Other Violent
Age								
Younger (< 38)	18	3	1	47	2	0	6	7
Older (38>)	20	4	0	33	5	1	1	3
<i>n</i>	38							
Level of Security								
Minimum	13	3	1	22	4	1	3	1
Medium	50	18	3	93	7	0	14	12
<i>n</i>	63							
Relationship Status								
Married	4	0	0	10	2	0	3	2
Common Law	23	4	0	53	5	0	10	8
Divorced	8	4	1	9	1	1	0	0
Separated	3	0	0	9	1	0	0	0
Single	22	6	2	31	2	0	4	4
Widower	6	6	1	3	0	0	0	0
<i>n</i>	66							
Region								
Atlantic	11	5	1	34	1	0	6	5
Quebec	14	3	1	22	4	1	3	1
Ontario	7	4	1	10	1	0	1	2
Prairies	22	5	0	38	4	0	5	3
Pacific	9	4	1	11	1	0	2	2
<i>n</i>	63							



## **2(b). Comparing Violent with Non-Violent Offences and Violent with Both (Violent and Non-Violent) Types of Offence.**

To reiterate, while 101 offenders completed the test battery, the data file received by the researcher contained the Canadian Criminal Code description of the various violent and non-violent index offences committed by 66 offenders. These 66 offenders committed 217 non-violent index offences and 182 violent index offences for a total of 399 offences. In addition, of these 66 offenders, the data file contained the ages of 38 offenders ( $M= 37$  years,  $SD= 8.23$ ). These 38 offenders committed 112 non-violent offences and 74 violent offences. It is helpful to know that none of the offenders were incarcerated for committing a “non-violent only” offence; that is, all of the offenders had committed either a “violent only offence” or “both a non-violent and violent offence.”

Treating age as a dependent variable, a t-test was performed in order to compare age differences on the frequency of non-violent and violent offences. Although, as noted above, all of the offenders had been convicted for committing either a “violence only offence” or “both a non-violent and violent offence,” it is nevertheless of interest to distinguish between non-violent and violent offences and determine whether or not there are any significant age differences between the two groups. With an alpha level of .05, the effect of age was statistically significant,  $t(184) = 2.05$ ,  $p= .04$ . The mean age ( $M= 38.80$ ,  $SD= 7.46$ ) of the offenders who been convicted of committing a non-violent offence was greater than the mean age ( $M= 36.42$ ,  $SD= 8.00$ ) of those offenders who had been convicted of committing a violent offence.

A series of chi-square goodness-of-fit analyses was performed to examine the association between Type of Offence (non-violent and violent offences) with the three between-subject factors of Level of Security, Relationship Status, and Region. As seen in Table 10.4, there was a significant finding for Region,  $\chi^2(4)= 9.74$ ,  $p= .04$ . Although the largest frequency of violent

offences occurred in the Prairie region, the largest percentage of offenders within a region to commit a violent offence was in the Pacific region (60%). The smallest percentage of offenders within a region to commit a violent offence was in the Ontario (39%) and Prairie region (39%). Looking at odds instead of percentages, the offenders in the Pacific region were 2.3 times more likely to have committed a violent offence as were the offenders in the Prairie and Ontario regions. Similarly, the offenders in the Pacific region were twice as likely to have committed a violent offence as were the offenders in the Quebec region. While the chi-square is significant, the Cramer's coefficient of .15 indicates a weak degree of association between Type of Offence and Region.

**Table 10.4.** The Association Between Type of Offence (Non-Violent/Violent) and Level of Security, Relationship Status, and Region

Offence Type	Level of Security Counts		$\chi^2$	<i>p</i>			
	Min	Med					
Non-violent	47	170	.35	.55			
Violent	35	147					
<i>Note: Degrees of freedom = 1.</i>							
Offence Type	Relationship Status Counts		$\chi^2$	<i>p</i>			
	In a Relationship	Not in a Relationship					
Non-violent	83	134	2.90	.09			
Violent	85	97					
<i>Note: Degrees of freedom = 1.</i>							
Offence Type	Region Counts					$\chi^2$	<i>p</i>
	Atlantic	Quebec	Ontario	Prairie	Pacific		
Non-violent	42	47	29	85	14	9.74	.04
Violent	52	35	19	55	21		

*Degrees of freedom = 4. Cramer's V = .15.*

In addition to committing either a non-violent or violent offence, an offender could have committed *both* a non-violent *and* violent offence. Fifty-one (51) of the 66 offenders (77%) committed both a non-violent and violent offence. Of the 38 offenders for which their age was

available, 33 (86%) of these offenders committed both a non-violent and violent offence.

Treating age as a dependent variable, a t-test was performed in order to compare age differences between those offenders who committed a “violent only” offence and those who committed “both a non-violent and violent” offence. With an alpha level of .05, the effect of age was not statistically significant,  $t(36) = .03, p = .97$ . While the mean age of the offenders who committed a “violent only” offence was 37.75 ( $SD = 13.57$ ), the mean age of those offenders who committed both a non-violent and violent offence was 37.61 ( $SD = 7.80$ ).

Chi-square goodness-of-fit analyses were performed to examine the association between Type of Offence (Violent Only and Both Violent and Non-Violent) with the three between-subject factors of Level of Security, Relationship Status, and Region. As seen in Table 10.5, there were two significant findings. First, the significant finding for Relationship Status indicates that while 96% of those offenders who were in a relationship committed both a non-violent and violent offence, 66% of those offenders who were not in a relationship committed both types of offence. Looking at the odds rather than percentages, those offenders who were in a relationship were 12.5 times more likely to commit both types of offences as were those offenders who were not in a relationship. Second, there was a significant finding for Region. Although the largest frequency of both types of offences occurred in the Prairie region, when one looks instead at percentages, while 54% of the offenders in the Pacific region committed both a non-violent and violent offence, 93% of the offenders in the Quebec region committed both types of offences. Looking at the odds rather than percentages, this means that the offenders in the Quebec region were nearly 11 times more likely to commit both types of offences as were the offenders in the Pacific region. The offenders in the Prairie region were 8.3 times more likely to have committed both types of offences as were the offenders in the Pacific region. Cramer's  $V$  was .37 which indicates a moderate degree of association between variables.

**Table 10.5.** The Association Between Type of Offence (Violent Only/Both Non-Violent and Violent) and Level of Security, Relationship Status, and Region

Offence Type	Level of Security Counts		$\chi^2$	<i>p</i>			
	Min	Med					
Violent Only	1	13	2.20	.14			
Both Non-Violent and Violent	13	38					
<i>Note: Degrees of freedom= 1.</i>							
Offence Type	Relationship Status Counts		$\chi^2$	<i>p</i>			
	In a Relationship	Not in a Relationship					
Violent Only	1	13	8.03	.005			
Both Non-Violent and Violent	25	26					
<i>Note: Degrees of freedom= 1. Cramer's V= .35.</i>							
Offence Type	Region Counts					$\chi^2$	<i>p</i>
	Atlantic	Quebec	Ontario	Prairie	Pacific		
Violent Only	4	1	2	2	5	9.10	.05
Both	7	13	5	20	6		
<i>Degrees of freedom= 4. Cramer's V= .37.</i>							

In summary, the present analysis considered the relationship between Type of Offence (Violent/Non-Violent/Both) with the four factors of Age, Level of Security, Relationship Status, and Region. The offender sample (N= 101) committed 217 non-violent and 182 violent index offences. All of the offenders had committed either a “violent only” index offence or “both a violent and non-violent” index offence. Although the largest frequency of violent offences occurred in the Prairie region, when one considers likelihoods instead, the offenders in the Pacific region were most likely to commit a violent offence. When considering “both non-violent and violent” offences, while the largest frequency was in the Prairie region, when one instead considers likelihoods, the offenders in the Quebec region were most likely to have committed both a non-violent and violent offence.

### **3. Personality Characteristics and Between-Subject Comparisons**

Three self-report personality measures were completed by the offenders before the start of treatment: Borderline Personality Organization (BPO), Antisocial Personality Disorder Checklist (APD), and Relationship Style Questionnaire (RSQ). Both the borderline personality and antisocial personality have been implicated as two of the personality types associated with high rates of relationship violence (Correctional Service of Canada, 2001). The Relationship Style Questionnaire consists of four scales that measure four attachment patterns: Secure, Fearful, Pre-Occupied, Dismissive. Individuals with a fearful or pre-occupied attachment style can experience high levels of anxiety, anger, and jealousy which makes them particularly prone to relationship violence (Dutton, Saunders, Starzomski, & Bartholomew, 1994). For the present analysis, the age of the offenders is first correlated with the three measures. T-tests or one-way ANOVAs are then performed in order to compare mean test scores on Level of Security (minimum, medium), Relationship Status (In a Relationship, Not in a Relationship), and Region (Atlantic, Quebec, Ontario, Prairie, Pacific).

#### **(a) Borderline Personality Organization (BPO)**

The BPO consist of three subscales: Loss of Reality, Primitive Defences, Identify Diffusion as well as a Total scale score. The scale is scored on a 5-point Likert scale where 1= Never true and 5= Always true. Higher scores indicate greater pathology. However, cut-offs for the BPO were not available. Table 10.6 provides the overall mean scores on the BPO at pre-treatment.

**Table 10.6.** Pre-treatment Mean Scores on Borderline Personality Organization

Scale	*Norm			
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Loss of Reality <sup>1</sup> ( <i>n</i> = 84)	20.45	5.90		
Primitive Defences <sup>2</sup> ( <i>n</i> = 84)	21.90	7.20		
Identity Diffusion <sup>3</sup> ( <i>n</i> = 84)	20.02	6.90		
Total Score ( <i>n</i> = 84)	62.38	18.95	71.3	17.1

*Note: Higher scores indicate greater pathology.* <sup>1</sup> *These items reveal transient psychotic episodes that borderlines may experience.* <sup>2</sup> *These items reveal the use of such defences as splitting, magical beliefs, omnipotence, and idealization.* <sup>3</sup> *These items measure a marked unstable sense of self.*

*Note: \* Based on a group of 80 wife assaulters (Dutton, 1994). Oldham et al. (1985) report a mean score for diagnosed borderlines of 74.8.*

The age of the offenders was correlated (Pearson's *r*) with the mean scores for the three subscales of the BPO as well as the Total scale score. As seen in Table 10.7, there was not a significant correlation between the age of the offenders and any of the scales of the BPO.

Using a t-test, the mean scores for each of the subscales of the BPO were compared on the two levels of Level of Security and Relationship Status. As seen in Table 10.7, there were no significant between-group differences on any of the subscales of the BPO.

A one-way ANOVA was performed in order to make regional comparisons. As seen in Table 10.8, there was a significant regional effect for each subscale of the BPO as well as the Total scale score. First, there was a significant regional effect on the Loss of Reality subscale,  $F(4, 79) = 3.51, p = .01$ . The post hoc comparison of the means (Tukey's test,  $\alpha = .05$ ) found that the mean for the Atlantic region ( $M = 24.73, SD = 7.95$ ) was significantly larger than the mean for the Pacific region ( $M = 17.35, SD = 2.80$ ). The finding suggests that the offenders in the Atlantic region were more likely than the offenders in the Pacific region to report experiencing a difficulty in perceiving reality accurately. Second, there was a significant finding for the

Primitive Defences subscale,  $F(4, 79) = 3.27, p = .02$ . The post hoc examination of the means found that the mean for the Atlantic region ( $M = 24.64, SD = 8.55$ ) was significantly larger than the mean for the Pacific region ( $M = 18.60, SD = 5.00$ ). This finding suggests that the offenders in the Atlantic region were more likely than the offenders in the Pacific region to report the use of primitive defences (e.g., splitting, magical beliefs, feeling of omnipotence). Third, there was a significant region effect on the Identity Diffusion subscale,  $F(4, 79) = 3.16, p = .02$ . The mean for the Atlantic region ( $M = 25.10, SD = 9.35$ ) was subsequently found to be significantly larger than the mean for the Pacific region ( $M = 17.10, SD = 4.30$ ). This finding implies that the offenders in the Atlantic region were more likely than the offenders in the Pacific region to report having a diffuse, inaccurate picture of themselves. Fourth, there was a significant regional effect on the Total Scale score,  $F(4, 79) = 3.65, p = .01$ . The post hoc examination of the means found that the mean for the Atlantic region ( $M = 76.40, SD = 25.30$ ) was significantly larger than the mean for the Pacific region ( $M = 53.08, SD = 10.30$ ) suggesting that, across the three subscales of the BPO, the offenders in the Atlantic region reported greater pathology than did the offenders in the Pacific region.

**Table 10.7.** Correlation Between BPO and Age, and Comparing Mean Score Differences for Level of Security, and Relationship Status

Scale	BPO		Age	
	<i>M</i>	<i>SD</i>	<i>r</i>	<i>p</i>
Loss of Reality	20.45	5.90	-.11	.53
Primitive Defences	21.90	7.17	-.08	.62
Identity Diffusion	20.00	6.90	-.15	.37
Total Scale	62.38	19.00	-.12	.50

*Note: Age, n= 38. For all scales, n= 36.*

Scale	Level of Security				<i>t</i>	<i>p</i>
	Minimum		Medium			
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Loss of Reality	22.00	5.77	20.18	5.90	1.11	.27
Primitive Defences	24.38	6.00	21.40	7.36	1.50	.14
Identity Diffusion	21.44	6.13	19.84	7.00	.84	.40
Total Scale	67.80	17.15	61.42	19.23	1.22	.23

*Note: Degrees of freedom= 81. Minimum, n= 18; Medium, n= 67.*

Scale	Relationship Status				<i>t</i>	<i>p</i>
	In a Relationship		Not in a Relationship			
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Loss of Reality	20.10	5.83	21.03	6.20	-.60	.56
Primitive Defences	21.43	7.34	21.80	7.50	-.19	.85
Identity Diffusion	19.93	6.75	20.23	7.34	-.21	.83
Total Scale	61.35	19.12	63.05	19.85	-.33	.74

*Note: Degrees of freedom= 61. Yes, n=23; No, n= 40.*



**Table 10.8.** Mean Score Differences on Borderline Personality Organization for Region

Scale	Region												F	p	Comparison
	Atlantic (n= 11)		Quebec (n= 16)		Ontario (n= 16)		Prairie (n= 21)		Pacific (n= 20)		M	SD			
	M	SD	M	SD	M	SD	M	SD	M	SD					
Loss of Reality	24.73	7.95	22.00	5.77	19.88	6.90	20.43	4.80	17.35	2.80	3.51	.01	Atlantic>Pacific		
Primitive Def.	26.64	8.55	24.38	6.04	20.25	8.43	21.95	6.45	18.60	5.00	3.27	.02	Atlantic>Pacific		
Identity Diffusion	25.10	9.35	21.44	6.13	18.20	7.70	20.50	6.10	17.10	4.30	3.16	.02	Atlantic>Pacific		
Total scale	76.40	25.5	67.8	17.1	58.31	21.5	62.8	16.2	53.08	10.3	3.65	.01	Atlantic>Pacific		

*Note: Degrees of freedom for all groups= 4, 79.*

### (b) Antisocial Personality Disorder Checklist (APD)

The APD does not contain any subscales. The scale consists of 11 items scored in a Yes/No format. The items are summed to yield a total scale score. Neither cut-offs nor norms for the APD were available. The overall mean was 6.72 ( $SD= 3.14$ ).

The age of the offenders was first correlated (Pearson's  $r$ ) with the Total scale score. However, as seen in Table 10.9, there was not a significant correlation between the age of the offenders and the Total scale score.

T-tests were also performed in order to compare the APD on the two levels of Level of Security and Relationship Status. As seen in Table 13, there were no between-group differences on the APD.

**Table 10.9.** Correlation Between APD and Age and Comparing Mean Score Differences For Level of Security and Relationship Status

	Total			Age	
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>r</i>	<i>p</i>
APD	38	6.70	3.14	.07	.70
<b>Groups</b>					
Level of Security	<i>n</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>
Minimum	15	5.60	2.98		
Medium	52	7.05	3.16	-1.58	.12
<i>Note: Degrees of freedom= 65.</i>					
Relationship Status	<i>n</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>
In a Relationship	19	7.45	2.80		
Not in a Relationship	34	5.87	3.04	1.86	.07

*Note: Degrees of freedom= 51.*

Although there were no significant findings for Level of Security and Relationship Status, as seen in Table 10.10, there was a significant effect for Region,  $F(4, 63)= 3.15, p= .02$ . The post hoc examination of the means (Tukey's test,  $\alpha= .05$ ) found that the mean for the Pacific region ( $M= 8.33, SD= 3.15$ ) was significantly larger than the mean for the Prairie region ( $M= 5.50, SD= 2.76$ ) indicating that the offenders in the Pacific region were judged to display more anti-social personality traits than those offenders in the Prairie region.

**Table 10.10.** Mean Score Difference on the Antisocial Personality Disorder Checklist for Region

Scale	Statistic	Region					<i>F</i>	<i>p</i>	Comparison
		Atlantic	Quebec	Ontario	Prairie	Pacific			
APD	M	6.88	5.70	8.00	5.50	8.33			
Total	SD	3.08	2.98	2.27	2.76	3.15			
	N	8	15	4	20	21	3.15	.02	Pac>Prairie

*Note: Degrees of freedom for all groups = 4, 63.*

### (c) Relationship Style Questionnaire (RSQ)

The RSQ consists of four scales designed to assess four attachment patterns: Secure, Fearful, Pre-Occupied, and Dismissive. The scale is scored on a 5-point Likert scale where 1= Not at all like me and 5= Very much like me. Higher scores indicate more of the trait or quality. Table 10.11 provides the overall mean scores on the RSQ for the sample of offenders at pre-treatment.

**Table 10.11.** Pre-treatment Mean Scores on the Relationship Style Questionnaire

Scale	<i>M</i>	<i>SD</i>	Norms	
			<i>M</i> <sup>1</sup>	<i>M</i> <sup>2</sup>
Secure ( <i>n</i> = 86)	16.00	3.25	14.9	16.4
Fearful ( <i>n</i> = 86)	15.41	3.73	15.2	13.5
Pre-occupied ( <i>n</i> = 86)	10.38	3.40	12.1	10.6
Dismissive ( <i>n</i> = 86)	17.02	3.17	15.8	16.1

*Note: <sup>1</sup> Based on a group of 120 assaultive men referred for treatment for wife assault. Standard deviations not reported (Dutton, Saunders, Starzomski, and Bartholomew, 1994).*

*<sup>2</sup> Based on a control group of 40 non-violent, non-criminal men (Correctional Service of Canada, 1999).*

The age of the offenders was first correlated (Pearson's *r*) with the four subscales of the RSQ. As seen in Table 10.12, there was not a significant correlation between the age of the offenders and any of the scales of the RSQ.

T-test was performed in order to compare the mean scores on the RSQ at the two levels of

Level of Security and Relationship Status. As seen in Table 10.12, there were three significant between-group differences for Level of Security. First, there was a significant finding on the Secure scale,  $t(83) = -2.33, p = .02$ . An examination of the means shows that the mean for the medium security facilities ( $M = 16.35, SD = 3.33$ ) was significantly larger than the mean for the minimum security facility ( $M = 14.35, SD = 2.34$ ). Since higher scores suggest a more secure attachment pattern, this finding suggests that the offenders in the medium security facility displayed a stronger secure attachment pattern (e.g., both comfortable and confident with intimacy in their close relationships) than did the offenders in the minimum security facility. Second, there was a significant finding on the Fearful scale,  $t(83) = 2.34, p = .02$ . An examination of the means shows that the mean for the minimum security facility ( $M = 17.29, SD = 3.22$ ) is significantly larger than the mean for the medium security facilities ( $M = 14.99, SD = 3.74$ ). This finding suggests that the offenders in the minimum security facility displayed a stronger fearful attachment pattern (e.g. experience pervasive distrust and fear of rejection), than did the offenders in the medium security facilities. Third, there was a significant finding for the Pre-Occupied scale,  $t(53) = 3.57, p = .001$ . The mean for the minimum security facility ( $M = 12.88, SD = 3.31$ ) is larger than the mean for the medium security facilities ( $M = 9.79, SD = 3.16$ ), suggesting that the offenders in the minimum security facility reported a stronger pre-occupied attachment pattern (e.g., tenuous sense of self-worth, fear of rejection, jealousy) than did the medium security offenders.

Turning to Relationship Status, as seen in Table 10.12, there was a significant effect for the Dismissive subscale,  $t(63) = -2.72, p = .01$ . An examination of the means shows that those offenders who were not in a relationship at the time of testing ( $M = 17.80, SD = 3.19$ ) displayed a stronger dismissive attachment pattern (e.g., downplay the importance of attachment needs and maintain emotional distance in relationships) than did those offenders who were in a relationship

( $M= 15.52, SD= 3.31$ ).

A one-way ANOVA was also performed in order to compare the five regions on the four scales of the RSQ. As seen in Table 10.13, there was a significant between-groups effect for three of the four subscales. First, there was a significant finding on the Secure scale,  $F(4, 81)= 3.05, p= .02$ . The post hoc examination of the means (Tukey's test,  $\alpha = .05$ ) found that the mean for the Prairie region ( $M= 17.27, SD= 3.33$ ) was significantly larger than the mean for the Quebec region ( $M= 14.35, SD= 2.34$ ) indicating that the offenders in the Prairie region reported a stronger secure attachment style than did those offenders in the Quebec region. Second, there was a significant finding on the Fearful scale,  $F(4, 81)= 3.32, p= .01$ . The post hoc examination of the means found that the mean for the Quebec region ( $M= 17.29, SD= 3.22$ ) was significantly larger than the mean for the Pacific region ( $M= 13.80, SD= 3.85$ ). This finding suggests that the offenders in the Quebec region reported a more fearful attachment pattern than that reported by those offenders in the Pacific region. Third, there was a significant finding on the Pre-Occupied scale,  $F(4, 81)= 5.96, p= .001$ . The post hoc examination of the means found that the mean for the Quebec region ( $M= 12.88, SD= 3.31$ ) was significantly larger than the means for both the Prairie ( $M= 9.14, SD= 3.23$ ) and Pacific ( $M= 8.80, SD= 2.14$ ) regions. This finding suggests that the offenders in the Quebec region reported a stronger Pre-Occupied attachment pattern than did the offenders in both the Prairie and Pacific regions. The mean for the Atlantic region ( $M= 12.09, SD= 3.65$ ) was significantly larger than the mean for Pacific region ( $M= 8.80, SD= 2.14$ ). This finding indicates that the offenders in the Atlantic region reported a stronger Pre-occupied attachment style than did the offenders in the Pacific region.

**Table 10.12.** Correlation Between RSQ and Age and Comparing Mean Score Differences on Level of Security and Relationship Status

Scale	RSQ		Age	
	<i>M</i>	<i>SD</i>	<i>r</i>	<i>p</i>
Secure	16.00	3.25	.003	.98
Fearful	15.41	3.73	-.07	.67
Pre-Occupied	10.40	3.40	.15	.35
Dismissive	17.00	3.17	-.07	.67

Scale	Level of Security				<i>t</i>	<i>p</i>	Comparison
	Minimum		Medium				
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Secure	14.35	2.34	16.35	3.33	-2.33	.02	Med>Min
Fearful	17.29	3.22	14.99	3.74	2.34	.02	Min>Med
Pre-Occupied	12.88	3.31	9.79	3.16	3.57	.001	Min>Med
Dismissive	18.24	2.84	16.79	3.16	1.71	.09	

*Note: Degrees of freedom= 83. Min, n= 17; Med, n= 68.*

Scale	Relationship Status				<i>t</i>	<i>p</i>	Comparison
	In a Relationship		Not In a Relationship				
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Secure	16.78	3.32	15.67	2.97	1.39	.17	
Fearful	14.52	3.29	15.60	3.70	-1.16	.25	
Pre-Occupied	9.48	3.38	10.70	3.66	-1.31	.19	
Dismissive	15.52	3.31	17.80	3.19	-2.72	.01	Not In> In Relation.

*Note: Degrees of freedom= 63. Yes, n=23; No, n= 42.*

**Table 10.13.** Mean Score Differences on Relationship Style Questionnaire for Region

Scale	Region										<i>F</i>	<i>p</i>	Comparison
	Atlantic (n= 11)		Quebec (n= 17)		Ontario (n= 16)		Prairie (n= 22)		Pacific (n= 20)				
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Secure	15.00	1.84	14.35	2.34	15.44	3.08	17.27	3.33	17.00	3.88	3.05	.02	Prairie>Que
Fearful	17.36	3.04	17.29	3.22	15.00	3.95	14.73	3.41	13.80	3.85	3.32	.01	Que>Pac
Pre-occup.	12.09	3.65	12.88	3.31	10.25	3.09	9.14	3.23	8.80	2.14	5.96	.001	Que>Pr, Pac
Dismissive	16.09	2.02	18.24	2.84	16.38	3.69	17.00	3.89	17.05	2.52	1.03	.40	

*Note: Degrees of freedom for all groups= 4, 81.*

In summary, the offenders completed three self-report personality measures: Borderline Personality Organization (BPO), Antisocial Personality Disorder Checklist (APD), and Relationship Style Questionnaire (RSQ). The age of the offenders was not significantly

correlated with any of the measures. However, there was a significant regional effect for each of the subscales of the BPO as well as for the APD. For the RSQ, there was a significant Level of Security effect for three subscales. There was also a significant regional effect for three of the four subscales of the RSQ.

## **Part II. Psychometric Properties of Test Battery**

Part II consists of two sections. First, Cronbach's alpha was used to assess the internal consistency for the measures used in the present study. Although, by convention, an alpha of .90 and higher is considered excellent, an alpha of .70, while relatively low, is considered adequate for most research purposes (Nunnally, 1978). Second, The A and B versions of three measures are compared using a t-test ( $\alpha = .05$ ). The Relapse Prevention Test, Family Violence Vignettes, and Empathy Scale each consist of two versions – Version A and Version B. The administration of the tests are counterbalanced so that Version A is administered at pre-test and Version B at post-test or vice versa. Although the order, wording, and perspective of questions appear to be different, each of the two versions are considered to be alternative or parallel forms. In addition to assessing the internal consistency of the various measures, it is also helpful to compare versions A and B in order to determine whether or not each version is in fact an alternative but equivalent measures of the same variable or construct.

### **(a) Reliability Analysis**

#### **1. Abusive Relationships Inventory (ABI) (administered at pre- and post-treatment)**

The ABI consists of four scales: Rationales for Hitting, Need for Control, Legal Entitlement, Batterer's Myths. At pre-treatment: Rationales for Hitting,  $\alpha = .95$ ; Need for Control,  $\alpha = .92$ ; Legal Entitlement,  $\alpha = .80$ ; Batterer Myths,  $\alpha = .75$ . At post-treatment: Rationales for Hitting,

$\alpha = .60$ ; Need for Control,  $\alpha = .85$ ; Legal Entitlement,  $\alpha = .74$ ; Batterer's Myths,  $\alpha = .42$ . (For Batterer's Myth, Boer, Kroner, Wong, and Cadsky (undated) report  $\alpha = .71$ ).

## **2. Relationship Style Questionnaire (RSQ) (administered pre-treatment only)**

The RSQ measures four attachment patterns: Secure, Fearful, Pre-Occupied, and Dismissive. The reliability coefficients at pre-treatment were: Secure,  $\alpha = .30$  (For Secure, Bartholomew (1989) reports  $\alpha = .71$ ); Fearful,  $\alpha = .50$ ; Pre-Occupied,  $\alpha = .65$ ; Dismissive,  $\alpha = .30$ .

## **3. Paulhus Deception Scale (PDS) (administered pre-treatment only)**

The PDS measures two aspects of socially desirable responding: Self-Deceptive Enhancement, Impression Management. In the present study: Self-Deceptive Enhancement,  $\alpha = .63$ ; Impression Management,  $\alpha = .60$  (For Impression Management, Paulhus (1991) reports a reliability estimate of .85).

## **4. Borderline Personality Organization (BPO) (administered pre-treatment only)**

The BPO assesses components of a Borderline organization in three scales: Loss of Reality, Primitive Defences, Identity Diffusion. In the present study, alphas were: Loss of Reality,  $\alpha = .75$ ; Primitive Defences,  $\alpha = .85$ ; Identity Confusion,  $\alpha = .85$ .

## **5. Relapse Prevention Test (RPT) (administered at pre- and post-treatment)**

The RPT presents participants with four scenarios related to family violence. For the present study, the reliability estimates at pre-treatment were: Scenario 1,  $\alpha = .68$ ; Scenario 2,  $\alpha = .82$ ; Scenario 3,  $\alpha = .88$ ; Scenario 4,  $\alpha = .89$ ; Total scale score,  $\alpha = .92$ . At post-treatment: Scenario 1,  $\alpha = .83$ ; Scenario 2,  $\alpha = .82$ ; Scenario 3,  $\alpha = .85$ ; Scenario 4,  $\alpha = .88$ ; Total scale score,  $\alpha = .90$ .



## 6. Family Violence Vignettes (FVV) (administered at pre- and post-treatment)

The FVV consist of five vignettes that assess aspects of relationship violence: Jealousy, Employment and Finances, Rejection, Control Issues, Sexual Issues. Table 11.1 presents the reliability estimates for the various domains of the scale at both pre- and post-treatment. At pre-treatment, the reliability estimates ranged from .52 to .86. At post-treatment, Cronbach's alpha ranged from .60 to .95.

**Table 11.1.** Reliability Estimates for Family Violence Vignettes

Items <sup>1</sup>	Alpha Pre	Alpha Post
Positive/appropriate response (5 items)	.85	.70
Negative/hostile response (5 items)	.82	.60
Question 5. Responsibility (5 items)	.52	.57
Question 6. Total Attribution Score (5 items)	.68	.72
Question 7a. Internal/Self-control (5 items)	.80	.86
7b. External control (5 items)	.76	.85
Question 8. Effectiveness Rating (5 items)	.86	.95
Question 9. Risk score (5 items)	.86	.93

*Note:* <sup>1</sup> Across five scenarios: Jealousy, Employment and Finances, Rejection, Control Issues, Sexual Issues.

*Note:* Items per scale in brackets.

## 7. Empathy Scales-FV (ES) (administered at pre- and post-treatment)

The ES presents a number of situations related to family violence to the interviewee. The situations represent: four situations with one's partner in distress, four situations with a child in distress, and four situations where a person outside of the family is in distress. For the present study, the scale's reliability estimates are given in Table 11.2. At pre-treatment, Cronbach's alpha ranged from .75 to .89. At post-treatment, the reliability estimate ranged from .76 to .91.

**Table 11.2.** Reliability Estimates for Empathy Scale

Scenario	Alpha Pre	Alpha Post
Total for all 6 Scenarios (18 items)	.89	.91
Total for all Perspective Taking (6 items)	.82	.84
Total for all Affect (6 items)	.79	.76
Total for all Coping w/Distress (6 items)	.73	.79
Total for all Partner-centred (6 items)	.82	.78
Total for all Child-centred (6 items)	.85	.84
Total for Person Outside Family (6 items)	.82	.84

*Note: items per scale in brackets.*

### **8. Treatment Readiness (TRR) and Treatment Responsivity (RRS) Rating Scales (administered at pre- and post-treatment)**

These measures are designed to assess treatment readiness and responsivity factors that could affect offender's readiness for and response to treatment. Each scale consists of eleven domains. The reliability coefficients for the two scales at pre- and post-treatment are presented in Table 11.3. For the Treatment Readiness Scale, at pre-treatment, the reliability coefficient for the eleven domains ranged from .56 to .95. At post-treatment, the internal consistency estimates ranged from .70 to .89. Turning to the Treatment Responsivity Rating Scale, at pre-treatment, the reliability estimate for the scale ranges from .68 to .89. At post-treatment, the reliability coefficients for the eleven domains ranged from .74 to .90.

**Table 11.3.** Reliability Estimates for Treatment Readiness and Responsivity Rating Scales

Treatment Readiness	Alpha Pre	Alpha Post
1. Problem Recognition	.78	.89
2. Goal Setting	.82	.88
3. Motivation	.82	.87
4. Self-Appraisal	.81	.70
5. Expectations	.65	.85
6. Behavioural Consistency	.74	.84
7. Views About Treatment	.65	.81
8. Self-Efficacy	.63	.86
9. Dissonance	.68	.77
10. External Supports	.95	.88
11. Affective Component	.56	.71
Total	.93	.97
<i>Note: Number of items per domain= 2.</i>		
Treatment Responsivity	Alpha pre	Alpha post
1. Procriminal Views	.74	.76
2. Procriminal Associations	.88	.90
3. Grandiosity	.68	.74
4. Callousness	.74	.81
5. Neutralization	.89	.89
6. Impulsivity	.71	.80
7. Procrastination	.80	.79
8. Motivation for Anger	.79	.83
9. Power and Control	.81	.76
10. Problem-Solving	.77	.80
11. Victim Stance	.80	.82
Total	.94	.96
<i>Note: Number of items per domain= 2.</i>		

### 9. Treatment Participation and Gain Rating Scale (TPG) (administered only at post-treatment)

The scale is used to assess how much offenders benefited from treatment over the course of treatment. The Scale consists of fifteen domains. Cronbach's alpha for the Total scale score was .61.

### 10. University of Rhode Island Change Assessment (URICA) (administered at pre- and post-treatment)

The URICA is a generic measure of readiness consisting of four subscales: Pre-Contemplation, Contemplation, Action, Maintenance. The coefficient alphas for the present study are given in Table 11.4. At pre-treatment, Cronbach's alpha ranged from .39 to .79. At post-treatment, the reliability estimates ranged from .41 to .83. While these reliability estimates are, in the main, consistent with the reliability estimates reported by DiClemente and Hughes (1990), for the Pre-Contemplation scale, the researchers report alpha = .69.

**Table 11.4.** Reliability Estimates for URICA

Scale	Alpha Pre	Alpha Post
Pre-Contemplation (5 items)	.39	.41
Contemplation (5 items)	.68	.60
Action (5 items)	.79	.72
Maintenance (5 items)	.70	.83

*Note: Number of items per domain in brackets.*

### 11. Antisocial Personality Disorder Checklist (APD) (administered only at pre-treatment)

The APD consists of eleven items that are scored in a yes/no format. The items are summed to yield a total scale score. For the present study, Cronbach's alpha = .85.

#### (b) Comparing Versions A and B at Pre- and Post-Treatment

In addition to conducting an internal consistency analysis of the test battery, an t-test ( $\alpha = .05$ ) was performed in order to compare overall mean differences between versions A and B at pre- and post-treatment for three measures: RPT, FVV, ES. In addition, a multivariate Analysis of Variance (ANOVA) was performed to compare each version on: Age, Level of Security, Relationship Status, and Region. The findings for the ANOVA are found in the appendix.

## 1. Relapse Prevention Test (RPT)

The t-scores and p-values for versions A and B of the Relapse Prevention Test are given in Table 11.5. Turning first to pre-treatment, there were no significant overall differences between the versions for the four scenarios and the total score. At post-treatment, there was a significant overall difference between Versions A and B for Scenario 3 only,  $t(46) = 2.12$ ,  $p = .04$ . An examination of the means shows that the Version A mean of 6.80 ( $SD = 3.40$ ) is significantly larger than the Version B mean of 4.60 ( $SD = 3.16$ ).

**Table 11.5.** Comparing Overall Mean Scores Differences at Pre- and Post-Treatment: Relapse Prevention Test

Scenario	Pre-Treatment				<i>t</i>	<i>p</i>	Comparison
	A		B				
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Scenario 1	4.27	2.38	4.28	2.48	-.01	.10	
Scenario 2	3.50	2.77	4.59	3.05	-1.34	.18	
Scenario 3	3.50	3.34	4.93	2.71	-1.72	.09	
Scenario 4	3.33	3.42	4.90	2.91	-1.82	.07	
Total	14.60	10.25	18.70	8.95	-1.55	.13	
<i>Note: Degrees of freedom = 51, A, n = 24; B, n = 29.</i>							
Scenario	Post-Treatment				<i>t</i>	<i>p</i>	Comparison
	A		B				
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Scenario 1	6.48	2.94	5.80	3.32	.72	.48	
Scenario 2	5.76	2.98	5.33	3.04	.45	.65	
Scenario 3	6.80	3.40	4.60	3.16	2.12	.04	A>B
Scenario 4	6.88	3.50	6.20	2.96	.65	.52	
Total	25.91	10.36	21.93	9.25	1.27	.21	

*Note: Degrees of freedom = 46. A, n = 33; B, n = 15.*

## 2. Family Violence Vignettes (FVV)

A t-test was first performed in order to compare overall mean differences between versions A and B at pre- and post-treatment. The means, t-scores and p-values for the analysis are given in Table 11.6. At pre-treatment, there was a significant mean difference for versions A and B for five items. At post-treatment, there was a significant AB difference for two items.

**Table 11.6.** Comparing Overall Mean Score Differences at Pre- and Post-Treatment: Family Violence Vignettes

Item	Pre-Treatment						Comparison
	A			B			
	M	SD	n	M	SD	n	
Appropriate/Non-hostile response	15.16	4.15	19	18.00	2.49	19	-2.56 .01 B>A
Hostile/Inappropriate Response	2.61	3.70	18	1.39	2.25	18	1.19 .23
Responsibility for Situation	8.50	2.65	12	9.71	1.89	7	-1.06 .30
Attribution score	5.08	2.60	13	1.38	1.66	13	4.32 .001 A>B
Internal/Self-control	3.91	1.51	11	3.67	1.97	6	.28 .78
External Control	3.69	1.44	13	1.50	1.64	6	2.96 .01 A>B
Effectiveness Rating	38.48	10.62	25	45.47	6.46	19	-2.53 .01 B>A
Risk Rating	15.33	12.82	26	7.95	6.10	22	2.47 .02 A>B
<i>Note: Degrees of freedom = 34.</i>							
Item	Post-Treatment						Comparison
	A			B			
	M	SD	n	M	SD	n	
Appropriate/Non-hostile response	19.24	1.42	25	19.27	1.56	11	-0.06 .95
Hostile/Inappropriate Response	.40	1.04	25	.36	.67	11	.11 .92
Responsibility for Situation	7.17	2.41	12	7.00	2.45	9	.16 .87
Attribution score	1.38	1.66	13	5.18	2.82	11	-4.10 .001 B>A
Internal/Self-control	3.82	1.83	11	4.90	.32	10	-1.84 .08
External Control	2.75	1.91	12	.44	.53	9	3.50 .002 A>B
Effectiveness Rating	43.56	7.44	18	39.29	12.0	17	1.27 .21
Risk Rating	9.11	7.97	22	16.25	13.7	16	-2.02 .06*
<i>Note: Degrees of freedom = 34. * p = .06.</i>							

### 3. Empathy Scales (ES)

A t-test was performed in order to compare the overall mean differences between versions A and B at both pre- and post-treatment. As seen in Table 11.7, there were no significant overall differences between versions A and B of the ES at both pre- and post-treatment.

**Table 11.7.** Comparing Mean Score Differences at Pre- and Post-Treatment: Empathy Scale

Scenario	Pre-Treatment				<i>t</i>	<i>p</i>
	A		B			
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
All 6 Scenarios	19.87	8.50	21.38	7.66	-.76	.45
All Perspective Taking	4.87	2.80	5.47	2.30	-.94	.35
All Affect	5.16	2.70	5.13	2.37	.04	.97
All Coping w/Distress	7.47	2.82	8.63	2.75	-1.70	.10
All Partner-centred	6.47	3.13	7.52	3.05	-1.38	.17
All Child-centred	7.32	3.11	6.93	3.51	.47	.64
All Outside Family	6.08	3.11	6.93	3.07	-1.13	.26

*Note: Degrees of freedom = 66, A, n = 38; B, n = 30.*

Scenario	Post-Treatment				<i>t</i>	<i>p</i>
	A		B			
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
All 6 Scenarios	24.76	7.30	25.14	7.62	-.19	.85
All Perspective Taking	7.59	3.47	8.36	2.78	-.92	.36
All Affect	7.70	2.62	8.04	2.74	-.49	.63
All Coping w/Distress	9.48	1.92	8.75	2.91	1.12	.27
All Partner-centred	8.34	2.62	9.11	2.39	-1.14	.26
All Child-centred	8.66	2.94	8.00	3.04	.82	.41
All Outside Family	7.76	2.87	8.04	3.18	-.34	.73

*Note: Degrees of freedom = 55. A, n = 29; B, n = 28.*

In summary, most of the measures demonstrated adequate to excellent overall internal consistency. However, both the Relationship Style Questionnaire (RSQ) and the Paulhus Deception Scale (PDS) demonstrated low internal consistency. In addition to examining the internal consistency of the measures, the three measures which have an A and B version were compared using a t-test. Although versions A and B were comparable at pre- and post-treatment for both the Relapse Prevention Test (RPT) and Empathy Scale (ES), the Family Violence

Vignettes (FVV) showed several mean differences on versions A and B at pre- and post-treatment. The most obvious explanation is that the two versions differed too much in format and content to be considered proper parallel forms. Therefore, their uses as parallel forms may be questioned, and analysis of the FVV before and after treatment must consider these differences.

### **Part III. Intercorrelations of Measures at Pre- and Post-Treatment**

#### **1. Pre-treatment**

Correlational analysis (Pearson's  $r$ ) was performed in order to examine the relationship between the attitudinal/behavioural measures collected at both pre- and post-treatment. The results of the analysis at pre-treatment are given in Table 12.1. A pattern of correlation was found between three scales of the Relationship Style Questionnaire (RSQ) and the four scales of the Borderline Personality Organization (BPO) measure. There was a negative correlation between the Secure scale of the RSQ and the Loss of Reality, Primitive Defences, Identity Diffusion, and Total scale score of the BPO. Thus, offenders who reported a stronger secure attachment pattern were judged to experience: (a) lower levels of transient psychotic episodes that borderlines are believed to experience; (b) lower use of such defences as splitting, omnipotence, idealization, and projective identification, and; (c) lower levels of experiencing a poorly integrated sense of self or others. There was a pattern of significant positive correlations between the Fearful and Pre-Occupied subscales of the RSQ and the four subscales of the BPO. This pattern suggests that offenders who scored high on the Fearful and Dismissive domains were also more likely to score higher on the BPO.

The four subscales and Total scale score of the Relapse Prevention Test showed a pattern of positive correlations with the seven domains of the Empathy Scale. Offenders who were judged to have relatively strong relapse prevention skills (e.g., recognize how a situation could erupt



into violence, effective use of emotions management skills, ability to offer and evaluate the effectiveness of proposed solutions) were also judged to demonstrate a greater willingness to empathize with others; that is, they were judged to show a stronger ability or willingness to recognize and take into account the thoughts and feelings of others and to offer helpful responses to conflict situations. In addition, the five domains of the Relapse Prevention Test also showed a pattern of positive correlations with the Treatment Readiness and Treatment Responsivity Rating Scales. Offenders who were judged to have stronger problem-solving and conflict resolution skills were also judged to show greater overall treatment readiness and responsivity to treatment.

Six of the seven domains of the Empathy Scales showed a pattern of positive correlations with both the Treatment Readiness and Treatment Responsivity Rating Scales. Offenders who were judged to have a stronger ability to empathize with others were also judged to show greater overall treatment readiness and responsivity.

At pre-treatment, the Paulhus Deception Scale (PDS) showed a pattern of correlation with the four domains of the Relationship Style Questionnaire (RSQ). The Secure scale of the RSQ was negatively correlated with the Self-Deceptive Enhancement and Impression Management subscales as well as with the Total scale score for the PDS, suggesting that offenders who reported a strong secure attachment pattern also reported lower levels of the tendency to over-report desirable qualities or behaviours and to under-report undesirable qualities and behaviours. The Fearful, Pre-Occupied, and Dismissive domains of the RSQ were all positively correlated with the Impression Management subscale and the Total scale score of the PDS. This pattern of correlation suggests that offenders who scored high on the Fearful, Pre-Occupied, and Dismissive domains also reported a strong tendency to under-report their undesirable qualities to others.

There was a significant positive relationship between the Impression Management subscale

and Total score for the PDS and the Primitive Defences subscale of the BPO. This finding suggests that those offenders who score high on impression management also reported a high frequency of use of primitive defences. The Total score on the PDS was also positively related with the Primitive Defences and Identity Diffusion subscales as well as with the Total score for the BPO. Thus, offenders who reported a strong tendency to engage in socially desirable responding also tended to score high on the BPO.

## **2. Post-treatment**

The post-treatment correlations are given in Table 12.2. The Abusive Relationships Inventory (ABI) showed a pattern of correlation with the Pre-Contemplation, Contemplation, and Action scales of the University of Rhode Island Change Assessment (URICA). The Rationales for Hitting scale of the ABI was negatively correlated with the Action scale of the URICA. This finding suggests that offenders who showed a strong tendency to rationalize abusive behaviour were not at the point where they are prepared to take action to deal with their problems. The pattern of negative correlations between the Need for Control, Legal Entitlement, and Batterer's Myths domains of the ABI with the Contemplation and Action scales of the URICA suggest that offenders who reported: (a) a strong need to control their partner; (b) a tendency to believe that being a man grants one certain special privileges and exemptions (e.g., If a husband forces his wife to have sex, it is not rape), and; (c) a strong tendency to endorse certain myths (e.g., Many women secretly desire to be beaten) also tended not to be at the point where they are prepared to seriously consider the possibility of change.

The five domains of the Relapse Prevention Test were positively correlated with the seven domains of the Empathy Scale. This suggests that offenders who were judged to have stronger problem-solving and conflict resolution abilities were also judged to have a greater ability or

show more willingness to recognize, appreciate, and take into account the thoughts, perspective, feelings, and needs of others. The Relapse Prevention Test also showed a pattern of positive correlation with the Treatment Readiness and Treatment Responsivity Rating Scales as well as the Treatment Participation and Gain Rating Scale. This finding suggests that offenders who were judged to have stronger problem-solving skills (e.g., ability to recognize how situations could lead to violence, effective use of emotions management skills, and ability to rationally assess the usefulness of solutions) were also judged to be better prepared for treatment, to be more responsive to treatment, and to show greater treatment gain.

Six of the seven scales of the Empathy Scale showed a pattern of positive correlations with the Treatment Readiness Rating Scale and the Treatment Participation and Gain Rating Scale. This finding suggests that offenders who demonstrated a greater capacity for empathy after treatment were also judged to show greater treatment readiness and the largest treatment-related gains

Table 12.1. Intercorrelations Among Measures at Pre-Treatment

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
<b>RSQ</b>																	
1. Secure	--	-.50**	-.40**	-.30**	-.41**	-.53**	-.51**	-.51**	.05	-.22*	-.25*	-.31**	-.19	-.27**	-.13	.17	-.51**
2. Fearful	--	--	.58**	.28**	.44**	.55**	.63**	.58**	.09	.26	.32**	.37**	-.08	.11	-.10	.02	-.15
3. Pre-Occupied	--	--	--	.22*	.50*	.56**	.57**	.57**	-.03	.25*	.37**	.37**	-.02	.15	-.02	.11	-.10
4. Dismissing	--	--	--	--	.15	.12	.17	.15	-.24*	.15	.22*	.22*	-.01	.04	-.10	-.04	.08
<b>BPO</b>																	
5. Loss of Reality	--	--	--	--	--	.81**	.83**	.92**	-.03	.17	.14	.19	.15	.30**	.12	.06	-.04
6. Prim. Defences	--	--	--	--	--	--	.91**	.96**	-.03	.20	.25*	.28**	.001	.20	.002	-.03	-.20
7. Identity Diff.	--	--	--	--	--	--	--	.96**	-.02	.24*	.18	.26*	.07	.32**	.03	.10	-.16
8. T total	--	--	--	--	--	--	--	--	-.03	.22*	.20	.26*	.07	.28	.05	.04	-.15
<b>APD</b>																	
9. T total	--	--	--	--	--	--	--	--	--	-.11	-.17	-.14	-.12	-.15	-.01	-.003	-.36
<b>PDS</b>																	
10. Self-Deceptive	--	--	--	--	--	--	--	--	--	--	.66**	.62**	.15	.16	.13	.12	-.26
11. Imp. Mgt.	--	--	--	--	--	--	--	--	--	--	--	--	.02	.07	.04	-.05	-.31*
12. Total Scale	--	--	--	--	--	--	--	--	--	--	--	--	.11	.17	.10	.06	.05
<b>ABI</b>																	
13. Rationales	--	--	--	--	--	--	--	--	--	--	--	--	--	.84**	.78**	.75**	.14
14. Control	--	--	--	--	--	--	--	--	--	--	--	--	--	--	.70**	.80**	.003
15. Entitlement	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	.57**	.01
16. Myths	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	.06
<b>RPT</b>																	
17. Scenario 1	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
18. Scenario 2	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
19. Scenario 3	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
20. Scenario 4	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
21. Total	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
<b>ES</b>																	
22. All 6	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
23. All Persp.	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
24. All Affect	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
25. Coping	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
26. Partner-cent	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
27. Child-centred	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
28. Person Out.	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
<b>URICA</b>																	
29. Pre-Con.	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
30. Contemplation	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
31. Action	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
32. Maintenance	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
33. TRR	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
34. RRS	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Note: \* $p < .05$ , \*\* $p < .01$ .

Table 12.1. (Continued). Intercorrelations Among Measures at Pre-Treatment

Variable	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34
<b>RSQ</b>																	
1. Secure	.13	-.07	-.08	.02	.01	.04	.08	-.06	-.08	.09	.03	-.13	-.21	-.01	-.08	-.15	.02
2. Fearful	.03	-.01	.10	.002	-.12	-.12	-.21	-.02	-.02	-.14	-.15	.09	.04	-.14	.15	.04	-.12
3. Pre-Occupied	.11	.09	.15	.09	-.02	-.07	-.12	.12	.07	-.08	-.03	.09	.11	.04	.07	.08	-.07
4. Dismissing	.01	.15	.19	.13	-.03	.03	-.05	-.11	-.04	.03	-.06	.08	.25*	.06	-.03	.16	.11
<b>BPO</b>																	
5. Loss	.02	-.02	.05	-.01	-.04	-.07	-.10	.06	-.03	-.10	.05	.14	.07	-.12	.12	.09	-.04
6. Prim. Defences	-.07	-.21	-.08	-.17	-.18	-.17	-.26*	-.08	-.13	-.21	-.13	.11	.16	-.03	.25*	.02	-.09
7. Identity Diff.	-.07	-.19	-.01	-.12	-.08	-.12	-.19	.02	-.02	-.14	-.06	.16	.08	.10	.29*	.06	-.08
8. Total	-.06	-.15	-.02	-.11	-.11	-.13	-.20	-.003	-.07	-.16	-.05	.15	-.08	.23*	.15	.06	-.07
<b>APD</b>																	
9.	-.29*	-.22	-.25	-.33*	-.06	-.04	-.05	-.07	.02	-.08	-.10	-.19	-.07	-.15	.08	-.33	-.62
<b>PDS</b>																	
10. Self-Decept..	-.30*	.02	-.06	-.16	-.004	-.02	-.05	-.03	.02	-.10	-.02	.13	.05	.07	.04	.02	-.11
11. Impr. Mgt	-.18	.01	.06	-.11	-.01	.02	-.10	-.05	.07	-.06	-.03	.02	.19	.21	-.05	.04	-.09
12. Total	-.30*	-.26	.02	-.001	-.16	-.06	-.04	-.13	-.01	-.001	.27	.12	.18	.15	.18	.15	-.14
<b>ABI</b>																	
13. Rationales	-.16	.09	-.15	-.03	.10	.02	.05	.18	.10	.02	.13	.09	-.09	.01	-.06	.001	.19
14. Control	-.21	-.04	-.18	-.13	.005	-.07	-.07	.13	.02	-.01	.01	.23*	-.03	.002	.10	-.05	.08
15. Entitlement	-.13	-.05	-.13	-.10	.16	.12	.12	.16	.17	.15	.09	.16	-.14	-.01	-.11	-.10	.07
16. Myths	-.21	.05	-.18	-.10	.12	.02	.05	.20	.18	.03	.10	.07	-.12	-.06	-.01	-.08	.11
<b>RPT</b>																	
17. Scenario 1	.67**	.57**	.63**	.84**	.53**	.53**	.53**	.46**	.33**	.52**	.48**	.07	-.13	-.07	-.06	.47**	.63**
18. Scenario 2	--	.53**	.55**	.82**	.51**	.53**	.48**	.40**	.40**	.45**	.46**	-.01	-.19	.09	.17	.32*	.42**
19. Scenario 3	--	--	.64**	.85**	.51**	.51**	.48**	.41**	.37**	.51**	.40**	-.13	-.16	.19	-.22	.25	.35**
20. Scenario 4	--	--	--	.83**	.51**	.51**	.61**	.41**	.37**	.51**	.50**	-.02	-.17	-.03	-.09	.25	.35**
21. Total	--	--	--	--	.64**	.65**	.62**	.48**	.47**	.62**	.50**	.38**	.50*	.06	-.06	.50*	.38**
<b>ES</b>																	
22. All 6	--	--	--	--	--	.92**	.93**	.84**	.88**	.83**	.86**	-.16	-.10	.22	.05	.53**	.34**
23. Persp. Taking	--	--	--	--	--	--	.91**	.60**	.76**	.78**	.82**	.51**	-.10	.20	.05	.51**	.33**
24. All Affect	--	--	--	--	--	--	--	.65**	.74**	.81**	.83**	.56**	.40*	-.08	-.10	.17	-.01
25. Coping	--	--	--	--	--	--	--	--	.77**	.67**	.71**	-.25*	-.02	.17	.10	.43**	.20
26. Partner-cent	--	--	--	--	--	--	--	--	--	.58**	.68**	-.19	-.07	.25*	.03	.41**	.19
27. Child-centred	--	--	--	--	--	--	--	--	--	--	.53**	.35**	.30*	-.17	.09	.30**	.30**
28. Person Out.	--	--	--	--	--	--	--	--	--	--	--	-.18	-.01	.24*	.09	.60**	.36**
<b>URICA</b>																	
29. Pre-Contemp.	--	--	--	--	--	--	--	--	--	--	--	--	.27*	-.35**	-.04	-.08	.04
30. Contemplation	--	--	--	--	--	--	--	--	--	--	--	--	--	.54**	.20*	.22	.02
31. Action	--	--	--	--	--	--	--	--	--	--	--	--	--	--	.08	.22	.03
32. Maintenance	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	-.06	-.22
33. <b>TRR</b>	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	.72**
34. <b>RRS</b>	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Note: \*p&lt;.05. \*\*p&lt;.01.

**Table 12.2.** Intercorrelations Among Measures at Post-Treatment

Variable	1	2	3	4	5	6	7	8	9	10	11
<b>ABI</b>											
1. Rationales	--	.58**	.55**	.31**	.01	.40**	-.30*	.002	-.20	-.17	-.20
2. Control	--	--	.67**	.52**	-.16	-.44**	-.36*	-.05	-.31*	-.23	-.18
3. Entitlement	--	--	--	.40**	-.10	-.25	-.15	-.05	-.17	-.10	-.11
4. Myths	--	--	--	--	-.09	-.28	-.24	-.01	-.19	-.14	-.14
<b>RPT</b>											
5. Scenario 1	--	--	--	--	--	.46**	.53**	.54**	.80**	.47**	.46**
6. Scenario 2	--	--	--	--	--	--	.64**	.35*	.77**	.40**	.42**
7. Scenario 3	--	--	--	--	--	--	--	.41**	.83**	.44**	.45**
8. Scenario 4	--	--	--	--	--	--	--	--	.74**	.34*	.27
9. Total	--	--	--	--	--	--	--	--	--	.54**	.44**
<b>ES</b>											
10. All 6	--	--	--	--	--	--	--	--	--	--	.93**
11. All Persp.	--	--	--	--	--	--	--	--	--	--	--
12. All Affect	--	--	--	--	--	--	--	--	--	--	--
13. Coping	--	--	--	--	--	--	--	--	--	--	--
14. Partner-cent	--	--	--	--	--	--	--	--	--	--	--
15. Child-centred	--	--	--	--	--	--	--	--	--	--	--
16. Person Out.	--	--	--	--	--	--	--	--	--	--	--
<b>URICA</b>											
17. Pre-Cont.	--	--	--	--	--	--	--	--	--	--	--
18. Contemplation	--	--	--	--	--	--	--	--	--	--	--
19. Action	--	--	--	--	--	--	--	--	--	--	--
20. Maintenance	--	--	--	--	--	--	--	--	--	--	--
21. <b>TRR</b>	--	--	--	--	--	--	--	--	--	--	--
22. <b>RRS</b>	--	--	--	--	--	--	--	--	--	--	--
23. <b>TPG</b>	--	--	--	--	--	--	--	--	--	--	--

  

Variable	12	13	14	15	16	17	18	19	20	21	22	23
<b>ABI</b>												
1. Rationales	-.16	-.10	-.18	-.10	-.17	.18	-.32	-.53**	.20	-.17	-.04	-.11
2. Control	-.21	-.22	-.17	-.21	-.22	.34*	-.41**	-.65**	.06	-.31*	-.24	-.27*
3. Entitlement	-.13	-.05	-.03	-.08	-.16	.53**	-.48**	-.70**	.07	-.31*	-.24	-.05
4. Myths	-.14	-.12	.01	-.13	-.25	.22	-.31*	-.45**	.14	-.35*	-.35*	-.28*
<b>RPT</b>												
5. Scenario 1	.41**	.41**	.30**	.41**	.54**	.15	-.14	-.16	-.16	.36*	.40**	.31*
6. Scenario 2	.30*	.35*	.27	.43**	.35*	.08	.11	.25	-.19	.60**	.43**	.51**
7. Scenario 3	.31*	.44**	.33*	.44**	.40**	-.13	.14	-.15	.16	.60**	.50**	.50**
8. Scenario 4	.35*	.32*	.38**	.30*	.25	.23	-.15	-.15	.16	.25	.27	.22
9. Total Score	.50**	.50**	.42**	.51**	.50**	.10	-.01	.07	-.10	.60*	.50**	.50**
<b>ES</b>												
10. All 6	.90**	.85**	.84**	.80**	.90**	.06	.01	.22	-.03	.38**	.25	.36**
11. All Persp.	.81**	.67**	.80**	.84**	.80**	.10	.02	.27	-.11	.31*	.15	.33*
12. All Affect	--	.66**	.82**	.80**	.80**	.08	.001	.22	-.06	.30*	.24	.30*
13. Coping	--	--	.64**	.78**	.81**	-.03	-.003	.10	.09	.43**	.31*	.36**
14. Partner-cent	--	--	--	.63**	.60**	.22	-.15	.06	-.03	.26	.15	.30*
15. Child-centred	--	--	--	--	.72**	-.05	.12	.24	.09	.45**	.30*	.45**
16. Person Out.	--	--	--	--	--	.01	.03	.25	-.14	.30*	.21	.21
<b>URICA</b>												
17. Pre-Contemp.	--	--	--	--	--	--	-.45	-.45**	-.02	.06	.04	.04
18. Contemplation	--	--	--	--	--	--	--	.47**	.09	.09	-.82	.05
19. Action	--	--	--	--	--	--	--	--	-.03	.16	.05	.07
20. Maintenance	--	--	--	--	--	--	--	--	--	.05	.01	.08
21. <b>TRR</b>	--	--	--	--	--	--	--	--	--	--	.90**	.90**
22. <b>RRS</b>	--	--	--	--	--	--	--	--	--	--	--	.86**
23. <b>TPG</b>	--	--	--	--	--	--	--	--	--	--	--	--

Note: \* $p < .05$ , \*\* $p < .01$ .

#### **Part IV. Assessing Treatment-Related Change**

The present study involves a non-experimental pre- to post-treatment design. Although such a design does not allow for the drawing of unambiguous causal inferences, it is nevertheless helpful to explore the issue of treatment-related change.

Seven measures were administered at pre- and post-treatment: Abusive Relationships Inventory (ABI), Relapse Prevention Test (RPT), Family Violence Vignettes (FVV), Empathy Scale (ES), University of Rhode Island Change Assessment (URICA), Treatment Readiness Rating Scale (TRS), Treatment Responsivity Rating Scale (RRS). The Treatment Participation and Gain Rating Scale (TPG) was administered post-treatment only. The pre- to post-treatment comparisons involves three components: (1) A paired-samples t-test ( $\alpha = .05$ ) was first performed on those measures that were administered at both pre- and post-treatment in order to compare overall pre- and post-treatment performance by the program participants; (2) Using Pearson's  $r$ , the age of the offenders is correlated with the change scores for the various measures, and; (3) t-test or one-way ANOVA was performed on the change scores for the various measures in order to compare the scores on the three between-subject factors of Level of Security, Relationship Status, and Region. In computing change scores, pre- treatment scores were subtracted from post-treatment scores for each of the measures. A positive change score would indicate that the post-treatment mean score was larger than the pre-treatment mean score. On the other hand, a negative change score would indicate that the post-treatment mean score was smaller than the pre-treatment mean score. One can then interpret the meaning of the change by considering the meaning of the measure. For example, if an attribute or characteristic is desirable (e.g., empathy) and if the treatment was helpful in improving one's capacity for empathy, then one would expect that the change score would be positive indicating a post-treatment increase in mean score. On the other hand, if an attribute is undesirable (e.g., belief in batterer's myths), then if the treatment

were helpful in reducing one's tendency to endorse certain batterer myths, then one would expect the change score to be negative indicating a lower post-treatment mean score. Finally, the Treatment Participation and Gain Rating Scale was administered post-treatment only. The age of the offenders was correlated with each item of the scale. A t-test ( $\alpha = .05$ ) or one-way analysis of variance was subsequently performed in order to compare mean scores for each item of the scale on the between-subject factors of Level of Security, Relationship Status, and Region.

### **1. Abusive Relationships Inventory (ABI)**

The Abusive Relationships Inventory (ABI) consists of four subscales: Rationales for Hitting, Need for Control, Legal Entitlement, Batterer's Myths. Lower scores on an item reflect a more positive or favourable response.

First, a paired samples t-test was performed in order to compare overall pre- to post-treatment changes in score without regard to between-group comparisons. As seen in Table 13.1, there was a significant overall pre- to post-treatment difference in score for each subscale of the ABI. In each case, the post-treatment scores were lower than the pre-treatment scores, suggesting that, following treatment, the offenders had fewer negative attitudes about relationships. Following treatment, offenders were less likely to: (1) suggest that there are often sound, justifiable reasons for acting abusively (e.g., If my wife would do what I tell her to, I wouldn't have to hit her.); (2) report a strong need to control their partner (e.g., A woman should do what her husband tells her to.); (3) assert that being a man grants one special privileges (e.g., It is not against the law for a man to force his wife to have sex with him.); and (4) endorse certain myths that foster abuse (e.g., Sometimes after a fight, a husband and wife sometimes get along better.).



**Table 13.1.** Comparison of Abusive Relationships Inventory Pre- and Post-Treatment Mean Scores

Scale	Pre		Post		<i>t</i>	<i>p</i>	Comparison
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Rationales for Hitting	18.67	15.36	12.82	3.86	3.11	.003	Pre>Post
Need for Control	24.00	16.24	14.42	6.53	5.18	.001	Pre>Post
Legal Entitlement	13.24	9.74	10.39	6.49	2.47	.02	Pre>Post
Batterer's Myths	8.84	5.73	6.04	2.63	4.15	.001	Pre>Post

*Note: Degrees of freedom= 66. For each scale, n= 67. Lower scores reflect a more positive or favourable response.*

Change scores for each subscale were computed by subtracting the pre-treatment mean scores from the post-treatment mean scores. The age of the offenders (a continuous variable) was subsequently correlated (Pearson's *r*) with the change scores. As seen in Table 13.2, there were no significant correlations between the age of the offenders and the change scores for each of the subscales of the ABI, indicating that the pre- to post-treatment changes observed in Table 13.1 were unrelated to the age of the offenders.

**Table 13.2.** Correlations Between Change Scores for Abusive Relationships Inventory and Age

Subscales	Age (n= 38)	
	<i>r</i>	<i>p</i>
Rationales for Hitting	-.29	.13
Need for Control	-.16	.44
Legal Entitlement	-.27	.17
Batterer's Myths	-.24	.22

*Note: For each scale, n= 27. Pre-treatment scores subtracted from post-treatment scores.*

Third, a t-test or one-way ANOVA was performed in order to compare change scores on the between-group factors of Level of Security, Relationship Status, and Region. Turning first to Level of Security and Relationship Status, as seen in Table 13.3, there were no significant

between-group differences on the change scores for each of the four subscales of the ABI. This finding suggests that the amount of pre- to post-treatment change in score which did occur was not significantly different for those offenders who were in a minimum or medium security facility. Furthermore, the amount of change in score which did occur was not related to the relationship status of the offenders.

**Table 13.3.** Comparing Change Scores on Level of Security and Relationship Status: Abusive Relationships Inventory

Subscales	Level of Security				<i>t</i>	<i>p</i>
	Min		Med			
	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>		
Rationales for Hitting	-6.85	17.20	-5.72	15.25	-.23	.82
Need for Control	-12.46	19.00	-9.10	14.30	-.72	.47
Legal Entitlement	-1.69	5.53	-3.19	10.25	.51	.61
Batterer's Myths	-3.10	6.78	-2.78	5.32	-.17	.86

*Note: Degrees of freedom= 64. Min, n= 13; Med, n= 53. A negative mean change score indicates a post-treatment decrease in score.*

Subscales	Relationship Status				<i>t</i>	<i>p</i>
	In a Relationship		Not in a Relationship			
	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>		
Rationales for Hitting	-3.80	5.84	-7.45	19.10	.91	.37
Need for Control	-7.13	10.64	-12.85	18.65	1.14	.26
Legal Entitlement	-2.81	4.20	-3.88	11.15	.37	.71
Batterer's Myths	-2.38	4.73	-3.33	6.90	.50	.62

*Note: Degrees of freedom= 47. In a Relationship, n= 16; Not in a Relationship, n= 33. A negative mean change score indicates a post-treatment decrease in score.*

Turning to Region, as seen in Table 13.4, the amount of change in score which did occur from pre- to post-treatment was not significantly different across regions.

**Table 13.4.** Comparing Change Scores on Region: Abusive Relationships Inventory

Subscales	Region												F	p
	Atlantic (n= 7)		Quebec (n= 13)		Ontario (n= 16)		Prairie (n= 14)		Pacific (n= 17)		M <sub>ch</sub>	SD		
	M <sub>ch</sub>	SD	M <sub>ch</sub>	SD	M <sub>ch</sub>	SD	M <sub>ch</sub>	SD	M <sub>ch</sub>	SD				
Rationales for Hitting	-.29	5.56	-6.85	17.17	-10.38	21.00	-4.00	7.30	-4.65	15.90			.65	.63
Need for Control	-6.29	5.12	-12.46	19.00	-14.75	17.18	-7.14	10.0	-5.88	15.78			1.00	.41
Legal Entitlement	-3.00	6.03	-1.69	5.53	-3.56	14.11	-.71	0	-4.76	10.80			.41	.80
Batterer's Myths	-.71	4.57	-3.08	6.78	-5.44	6.22	-1.00	4.60	-2.44	5.61			1.60	.18
								2.48						

*Note: Degrees of freedom all groups= 4, 62. A negative mean change score indicates a post-treatment decrease in score.*

## **2. Relapse Prevention Test (RPT)**

The Relapse Prevention Test (RPT) consists of five scenarios and a total scale score all of which are intended to assess an offenders problem-solving ability (e.g., recognition of situations leading to violence, effective use of emotions management skills, evaluating effectiveness of proposed solutions). Higher scores reflect a more positive or favourable response.

Turning first to the paired samples t-test, as seen in Table 13.5, there was a significant overall pre- to post-treatment increase in mean score for each of the four subscales and the total scale score. Since higher scores reflect a more positive or favourable response, the higher post-treatment scores imply an improvement in performance. At post-treatment, offenders were judged to show an improvement in their relapse prevention skills; that is, following treatment, offenders showed an improved ability to: (1) recognize when a situation could lead to violence; (2) use effective problem-solving and emotions management skills in dealing with conflict, and; (3) evaluate the effectiveness of the those solutions (e.g., use of a cost/benefit analysis) the offenders offered that could constructively resolve the conflict contained in the scenario.

**Table 13.5.** Comparison of Relapse Prevention Test Pre- and Post-Treatment Mean Scores

Scenario	Pre		Post		<i>t</i>	<i>p</i>	Comparison
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Scenario 1	4.57	2.14	6.50	2.76	-4.96	.001	Post>Pre
Scenario 2	4.50	2.80	5.50	3.10	-2.12	.04	Post>Pre
Scenario 3	4.70	3.03	5.93	3.52	-2.50	.02	Post>Pre
Scenario 4	4.60	3.90	6.67	3.42	-3.26	.002	Post>Pre
Total score	18.30	8.60	24.62	10.20	-4.30	.001	Post>Pre

*Note: Degrees of freedom= 41. Higher scores reflect a more positive or favourable response.*

Second, change scores were computed by subtracting pre-treatment scores from post-treatment scores. Pearson's *r* was then used to correlate the age of the offenders with the change scores. As seen in Table 13.6, there were no significant correlations between age and the different scales of the RPT indicating that the pre- to post-treatment changes in score observed in Table 13.5 are unrelated to the age of the offenders.

**Table 13.6.** Correlations Between Change Scores for Relapse Prevention Test and Age

Subscales	Age ( <i>n</i> = 38)	
	<i>r</i>	<i>p</i>
Scenario 1	.32	.18
Scenario 2	.21	.38
Scenario 3	.01	.98
Scenario 4	.06	.80
Total	.20	.41

*Note: For each subscale, n= 19. Pre-treatment scores subtracted from post-treatment scores.*

Turning to the t-test, as seen in Table 13.7, the amount of change in score which occurred was not significantly different for the minimum and medium security facilities. Also, as seen in

Table 13.7, the change scores were not differentially influenced by the offender's relationship status.

**Table 13.7.** Comparing Change Scores on Level of Security and Relationship Status: Relapse Prevention Test

Subscales	Level of Security				<i>t</i>	<i>p</i>
	Min		Med			
	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>		
Scenario 1	2.18	2.40	1.84	2.60	.38	.70
Scenario 2	1.55	2.58	.87	4.15	.50	.62
Scenario 3	-.09	3.56	1.68	3.00	-1.60	.12
Scenario 4	-.09	3.36	2.87	4.20	-1.45	.04
Total	3.55	7.71	7.26	9.94	-1.12	.27

*Note: Degrees of freedom = 40. Min, n = 11; Med, n = 31.*

*Pre-treatment scores subtracted from post-treatment scores.*

Subscales	Relationship Status				<i>t</i>	<i>p</i>
	In a Relationship		Not in a Relationship			
	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>		
Scenario 1	2.17	3.38	1.77	2.10	.45	.66
Scenario 2	1.17	3.80	1.27	4.00	.07	.94
Scenario 3	1.33	2.84	.88	3.45	.40	.70
Scenario 4	2.08	5.00	2.42	3.73	.23	.82
Total	6.75	11.23	6.35	9.32	.12	.91

*Note: Degrees of freedom = 36. In Relationship, n = 12; Not in a Relationship, n = 26. Pre-treatment scores subtracted from post-treatment scores.*

Considering the one-way ANOVA next, as seen in Table 13.8, there were no regional differences on the pre- to post-treatment change scores of the program participants.

**Table 13.8.** Comparing Change Scores on Region: Relapse Prevention Test

Subscales	Region										<i>F</i>	<i>p</i>
	Atlantic (n= 8)		Quebec (n= 11)		Ontario (n= 0)		Prairie (n= 11)		Pacific (n= 11)			
	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>		
Scenario 1	1.13	2.10	2.18	2.40	--	--	2.09	2.30	1.91	2.30	.30	.83
Scenario 2	-.75	3.69	1.55	2.58	--	--	2.36	4.30	.00	3.79	1.48	.24
Scenario 3	1.50	2.14	-.09	3.56	--	--	2.09	3.45	1.09	3.27	.88	.46
Scenario 4	1.38	3.16	-.09	3.36	--	--	3.90	4.61	2.64	4.52	1.96	.14
Total	3.25	7.23	3.55	7.71	--	--	10.45	11.04	5.64	9.46	1.40	.26

*Note: Degrees of freedom all groups= 3, 37. Pre-treatment scores subtracted from post-treatment scores.*

### 3. Family Violence Vignettes (FVV)

The Family Violence Vignettes (FVV) are a series of five vignettes that measure responses to situations that involve: jealousy, employment and finances, rejection, control issues, and sexual issues. Items assess whether or not respondents demonstrate hostile/power and control attitudes in understanding and dealing with the scenario and whether or not the participant assesses partner with respect and as an equal. Except for Negative response items, higher scores reflect a more positive or favourable response.

First, a paired-samples t-test was performed in order to compare overall pre- to post-treatment change in score for the various items of the FVV. As seen in Table 13.9, there was a significant pre- to post-treatment change in mean score on the Positive response items (1b, 2b, 3b, 4b),  $t(26) = -3.10$ ,  $p = .01$ . At post-treatment,  $M = 19.19$  ( $SD = 1.52$ ); at pre-treatment  $M = 16.70$  ( $SD = 3.64$ ). Since higher scores reflect a more positive or favourable response, the finding suggests that, following treatment, the offenders assessment of the various scenarios were less hostile; the offenders also expressed more respect for their partner, and were judged to be less controlling or domineering. Although the t-score for the Effectiveness Rating was non-significant, the score does approach significance ( $p = .07$ ) suggesting that, at post-treatment, the

offenders judged that they were handling the situations more constructively and, therefore, more effectively.

**Table 13.9.** Comparison of Family Violence Vignettes Pre- and Post-Treatment Mean Scores

Items <sup>1</sup>	n	Pre		Post		df	t	p	Comparison
		M	SD	M	SD				
Positive response 1b, 2b, 3b, 4b	27	16.70	3.64	19.19	1.52	26	-3.10	.01	Post>Pre
Negative response 1a, 2a, 3a, 4a	25	1.36	2.30	.52	1.10	24	1.53	.14	
Question 5: Responsibility	13	8.85	2.27	8.31	2.30	12	.49	.63	
Question 6: Total Attribution Score	18	3.33	3.00	2.76	2.00	17	1.30	.28	
Question 7: a. Inter. control	12	4.17	1.10	4.42	1.50	11	-.43	.67	
b. Ext. control	12	2.42	1.55	2.83	.94	11	-.45	.65	
Question 8: Effectiveness Rating	32	40.53	10.30	42.70	12.25	31	-1.85	.07	
Question 9: Risk Score	35	12.24	11.10	10.94	10.00	34	1.13	.27	

Note: <sup>1</sup> Across five scenarios: jealousy, employment/finances, rejection, control issues, sexual issues. Except for Negative response items, higher scores reflect a more positive or favourable response.

Second, the age of the offenders was correlated (Pearson's *r*) with the pre- and post-treatment change scores for the various items. As seen in Table 13.10, there were no significant correlations between the age of the offenders and the change scores for the various items of the FVV.



**Table 13.10.** Correlations Between Change Scores for Family Violence Vignettes and Age

Items <sup>1</sup>	n	Age (n= 38)	
		r	p
Positive response 1b, 2b, 3b, 4b	12	-.15	.63
Negative response 1a, 2a, 3a, 4a	8	-.20	.61
Question 5: Responsibility	5	-.01	.98
Question 6: Total Attribution Score	7	.71	.08
Question 7: a. Internal Self- control	3	-.54	.62
b. External control	4	.33	.66
Question 8: Effectiveness Rating	11	-.30	.38
Question 9: Risk Score	14	.001	.99

*Note:* <sup>1</sup> Across five scenarios: jealousy, employment and finances, rejection, control issues, sexual issues. Pre-treatment scores subtracted from post-treatment scores.

Turning to Level of Security and Relationship Status, as seen in Table 13.11, the amount of change in score which occurred for those offenders in the minimum security facility was not significantly different from the amount of change which occurred for those offenders in the medium security facilities. Similarly, change scores were not related to the relationship status of the offenders.

**Table 13.11.** Comparing Change Scores on Level of Security and Relationship Status: Family Violence Vignettes

Items <sup>1</sup>	n	Level of Security						df	t	p	
		Min		Med		n	M <sub>ch</sub>				SD
		M <sub>ch</sub>	SD	M <sub>ch</sub>	SD						
Positive response 1b, 2b, 3b, 4b	3	-.33	3.50	24	2.83	4.22	25	1.24	.23		
Negative response 1a, 2a, 3a, 4a	2	.50	3.50	23	-.96	2.84	23	.71	.48		
Question 5: Responsibility	2	1.50	4.95	10	.00	2.71	10	.64	.53		
Question 6: Total Attribution	1	.00	.00	17	-.59	2.15	16	.27	.80		
Question 7a. Internal Self-control	0	--	--	11	.73	1.20	10	--	--		
7b. External control	0	--	--	12	-1.58	1.88	10	--	--		
Question 8: Effectiveness Rating	2	7.00	1.40	29	2.17	6.52	29	1.03	.31		
Question 9: Risk Score	5	.30	5.90	29	-1.45	7.10	32	.52	.61		

Note: <sup>1</sup> Across five scenarios: jealousy, employment and finances, rejection, control issues, sexual issues. Higher scores reflect a more positive or favourable response. Pre-treatment scores subtracted from post-treatment scores.

Items <sup>1</sup>	n	Relationship Status						df	t	p	
		In a Relationship		Not in a Relationship		n	M <sub>ch</sub>				SD
		M <sub>ch</sub>	SD	M <sub>ch</sub>	SD						
Positive response 1b, 2b, 3b, 4b	8	3.50	4.14	17	2.30	4.47	23	.64	.53		
Negative response 1a, 2a, 3a, 4a	7	.00	2.10	16	-1.31	3.11	21	1.01	.32		
Question 5: Responsibility	5	.40	3.05	6	.83	3.25	9	-.64	.54		
Question 6: Total Attribution	6	1.67	2.10	10	-.20	2.00	14	-1.38	.19		
Question 7a. Internal Self-control	4	1.25	1.90	7	-.30	2.14	9	1.19	.26		
7b. External control	5	-1.20	2.40	6	-2.00	1.67	9	.65	.53		
Question 8: Effectiveness Rating	8	4.00	8.43	19	3.42	4.43	25	.23	.82		
Question 9: Risk Score	8	2.88	7.62	22	2.48	6.54	28	1.90	.07		

Note: <sup>1</sup> Across five scenarios: jealousy, employment and finances, rejection, control issues, sexual issues. Higher scores reflect a more positive or favourable response. Pre-treatment scores subtracted from post-treatment scores.

Considering regional differences next, as seen in Table 13.12, there were no significant regional differences on the change scores of the RPT.

**Table 13.12.** Comparing Change Scores on Region: Family Violence Vignettes

Items <sup>1</sup>	Region										F	p	
	Atlantic		Quebec		Ontario		Prairie		Pacific				
	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>			
Positive													
1b, 2b, 3b, 4b	-1.25	2.12	-.33	3.51	--	--	5.00	4.24	4.82	3.25	1.97	.14	
Negative													
1a, 2a, 3a, 4a	1.00	1.77	.50	.70	--	--	-1.75	3.60	-2.10	2.63	2.75	.07	
Question 5: Responsibility	--	--	--	--	-10.00	--	--	--	.00	2.71	2.23	.16	
Question 6: Attribution	.80	1.90	--	--	--	--	.00	--	-1.27	2.10	.85	.52	
Question 7a: Internal Self-control	--	--	5.00	--	--	--	1.00	--	.70	1.25	3.74	.06	
Question 7b: External control	--	--	--	--	--	--	-4.00	.00	-1.10	1.65	.98	.47	
Question 8: Effectiveness Rating	4.50	3.45	7.00	1.40	-9.67	2.10	3.63	8.40	5.00	4.75	1.90	.15	
Question 9: Risk Score	.00	.00	.30	5.90	-.50	6.36	.56	11.68	-4.64	3.47	.97	.44	

Note: Degrees of freedom. Positive response= 4, 20; degrees of freedom Negative response= 3, 22; degrees of freedom Responsibility= 4, 8; degrees of freedom Attribution= 4, 13; degrees of freedom Internal Self-control= 4, 7; degrees of freedom External control= 4, 7; degrees of freedom Effectiveness Rating= 4, 27; degrees of freedom Risk Score= 4, 30.

Note: Positive response: Atlantic (n= 8), Quebec (n= 2), Ontario (n= 0), Prairie (n= 4), Pacific (n= 11).

Negative response: Atlantic (n= 8), Quebec (n= 3), Ontario (n= 0), Prairie (n= 5), Pacific (n= 11.)

Responsibility: Atlantic (n= 0), Quebec (n= 2), Ontario (n= 1), Prairie (n= 0), Pacific (n= 10.)

Attribution: Atlantic (n= 5), Quebec (n= 0), Ontario (n= 0), Prairie (n= 1), Pacific (n= 11).

Question 7a. Internal Self-control: Atlantic (n= 0), Quebec (n= 1), Ontario (n= 0), Prairie (n= 1), Pacific (n= 10).

Question 7b. External control: Atlantic (n= 0), Quebec (n= 0), Ontario (n= 0), Prairie (n= 2), Pacific (n= 10).

Effectiveness Rating: Atlantic (n= 8), Quebec (n= 2), Ontario (n= 3), Prairie (n= 8), Pacific (n= 11).

Risk Score: Atlantic (n= 8), Quebec (n= 5), Ontario (n= 2), Prairie (n= 9), Pacific (n= 11).

Note: Higher scores reflect a more positive or favourable response. Pre-treatment scores subtracted from post-treatment scores.

#### 4. Empathy Scale (ES)

The Empathy Scale (ES) consists of seven subscales designed to assess offender's willingness to recognize the thoughts and feelings of others. Higher scores reflect a more positive or favourable response.

The paired samples t-test revealed a significant pre- to post-treatment change in mean score for six of the seven subscales of the Scale (see Table 13.13). The findings imply that, following treatment, except for the Child-centred scenarios, offenders expressed a greater willingness to recognize and respect the thoughts and feelings of others as well as an improved ability to offer helpful, constructive solutions to the problems contained within the scenarios.

**Table 13.13.** Comparison of Empathy Scale Pre- and Post-Treatment Mean Scores

Scenario	Pre		Post		<i>t</i>	<i>p</i>	Comparison
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
All 6 Scenarios	20.42	7.36	24.24	7.83	-3.55	.001	Post>Pre
All Perspective Taking	5.11	2.29	7.44	3.25	-6.10	.001	Post>Pre
All Affect	5.07	2.38	7.61	2.78	-7.04	.001	Post>Pre
All Coping w/Distress	7.98	2.71	8.89	2.68	-2.43	.02	Post>Pre
All Partner-centred	6.92	2.96	8.43	2.71	-3.39	.001	Post>Pre
All Child-centred	7.22	3.10	8.17	3.12	-1.94	.06	
All Person Outside Family	6.28	2.88	7.65	3.04	-2.96	.005	Post>Pre

*Note: Degrees of freedom= 53. Higher scores reflect a more positive or favourable response.*

For the correlational analysis, t- and F-tests, change scores were computed by subtracting pre-treatment scores from post-treatment scores. Turning first to the correlational analysis, as seen in Table 13.14, there were no significant correlations between the age of the offenders and the seven subscales of the Empathy Scale.

**Table 13.14.** Correlations Between Change Scores for Empathy Scale and Age

Subscale	Age (n= 38)	
	<i>r</i>	<i>p</i>
All 6 Scenarios	-.03	.90
All Perspective Taking	-.07	.73
All Affect	-.33	.88
All Coping w/Distress	.15	.48
All Partner-centred	.06	.80
All Child-centred	-.03	.90
All Person Outside Family	.04	.86

*Note: For each subscale, n= 23. Pre-treatment scores subtracted from post-treatment scores.*

Turning to the t-test and Level of Security, as seen in Table 13.15, there was a significant difference in change score on the All Child-centred scenarios subscale,  $t(52)= 2.60$ ,  $p= .01$ . For the minimum security facility,  $M_{change}= 3.10$  ( $SD= 3.28$ ); for the medium security facilities,  $M_{change} = .27$  ( $SD= 3.42$ ). This finding indicates that the amount of pre- to post-treatment change in score or the improvement that occurred for the offenders in the minimum security facility was significantly larger than the amount of change which occurred for the offenders in the medium security facilities. There were no significant findings for Relationship Status.

**Table 13.15.** Comparing Change Scores on Level of Security and Relationship Status: Empathy Scale

Subscale	Level of Security				<i>t</i>	<i>p</i>	Comparison
	Min		Med				
	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>			
All 6 Scenarios	6.00	8.96	3.13	7.54	1.14	.26	
All Perspective Taking	3.70	2.87	2.30	3.22	1.40	.16	
All Affect	3.08	2.90	2.37	2.58	.84	.40	
All Coping w/Distress	1.54	3.25	.71	2.57	.95	.35	
All Partner-centred	1.77	3.88	1.43	3.10	.33	.74	
All Child-centred	3.10	3.28	.27	3.42	2.60	.01	Min > Med
All Person Outside Family	1.15	3.56	1.44	3.40	.26	.80	

*Note: Degrees of freedom = 52. Min, n = 12; Med, n = 41. Pre-treatment scores subtracted from post-treatment scores.*

Subscale	Relationship Status				<i>t</i>	<i>p</i>	Comparison
	In a Relationship		Not in a Relationship				
	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>			
All 6 Scenarios	1.71	7.12	4.95	9.10	-1.16	.25	
All Perspective Taking	1.50	3.13	2.93	3.53	-1.28	.21	
All Affect	2.07	2.53	2.86	3.04	-.83	.41	
All Coping w/Distress	.21	2.26	1.29	3.02	-1.17	.25	
All Partner-centred	1.21	3.31	1.88	3.54	-.58	.56	
All Child-centred	.29	3.97	1.14	3.90	-.66	.51	
All Person Outside Family	.21	3.96	1.93	3.55	-1.42	.16	

*Note: Degrees of freedom = 40. In a Relationship, n = 14, Not in a Relationship, n = 27. Pre-treatment scores subtracted from post-treatment scores.*

Turning to the regional comparisons, as seen in Table 13.16, there was a significant regional difference for the Child-Centred scenarios of the ES,  $F(3, 49) = 4.17, p = .01$ . The post hoc examination (Tukey's test,  $\alpha = .05$ ) of the mean change scores found that the change score for the Quebec region ( $M_{\text{change}} = 3.08, SD = 3.28$ ) was larger than the change scores for both the Atlantic region ( $M_{\text{change}} = -1.00, SD = 3.00$ ) and Prairie region ( $M_{\text{change}} = -.46, SD = 3.67$ ). The finding suggests that, following treatment, the offenders in the Quebec region were judged to show a larger improvement in their ability to recognize and appreciate the thoughts and feelings of the children in the stories than shown by the offenders in both the Atlantic and Prairie regions.

Table 13.16. Comparing Change Scores on Region: Empathy Scale

Subscales	Region												F	p	Comparison
	Atlantic (n= 8)		Quebec (n= 13)		Ontario (n= 1)		Prairie (n= 13)		Pacific (n= 19)						
	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>					
All 6 Scenarios	-1.56	5.15	6.00	8.95	-9.00	--	3.15	8.24	5.74	6.74	2.14	.11			
All Perspective Taking	.50	2.45	3.70	2.87	-1.00	--	1.62	3.70	3.68	2.67	2.03	.12			
All Affect	1.13	2.23	3.08	2.90	-2.00	--	2.15	2.60	3.25	2.38	1.60	.20			
All Coping w/Distress	-1.13	1.90	1.54	3.26	-3.00	--	1.00	2.52	1.47	2.48	2.13	.11			
All Partner-centred	-.94	1.60	1.77	3.88	-1.00	--	2.46	4.12	1.84	2.30	2.06	.10			
All Child-centred	-1.00	3.00	3.08	3.28	-7.00	--	-.46	3.67	1.68	2.70	4.17	.01	Que> At, Pr		
All Person Outside Family	.38	2.92	1.15	3.56	-1.00	--	1.15	3.21	2.21	3.74	.62	.60			

Note: Degrees of freedom all groups=3, 49. Pre-treatment scores subtracted from post-treatment scores.

## 5. University of Rhode Island Change Assessment (URICA)

The University of Rhode Island Change Assessment (URICA) assesses four stages of readiness to change: Pre-Contemplation, Contemplation, Action, and Maintenance. The scale is designed to be a continuous measure. Thus, respondents can score high or low on more than one of the four stages.

Considering the paired samples t-test first, as seen in Table 13.17, there was a significant pre- to post-treatment difference for two subscales. First there was a significant difference on the Action subscale,  $t(41) = -2.40, p = .02$ . Since the post-treatment mean ( $M = 23.50, SD = 2.66$ ) is significantly larger than the pre-treatment mean ( $M = 22.31, SD = 3.07$ ), this finding suggests that, following treatment, the offenders were more committed to change. Second, there was a significant finding on the Maintenance scale,  $t(41) = 2.22, p = .03$ . Since the pre-treatment mean ( $M = 15.83, SD = 4.10$ ) is significantly larger than the post-treatment mean ( $M = 13.75, SD = 5.40$ ), this finding suggests that, at post-treatment, the offenders, to the extent that they had taken steps to deal with their problems were, nevertheless, not strongly committed to maintaining their improvement.

**Table 13.17.** Comparison of URICA Pre- and Post-Treatment Mean Scores

Scale	Pre		Post		<i>t</i>	<i>p</i>	Comparison
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Pre-contemplation	7.50	3.16	6.74	2.42	1.47	.15	
Contemplation	22.21	3.20	22.00	3.40	.44	.66	
Action	22.31	3.07	23.50	2.66	-2.40	.02	Post>Pre
Maintenance	15.83	4.10	13.75	5.40	2.22	.03	Pre>Post

*Note: Degrees of freedom = 41.*

For the correlational analysis, t- and F-tests, change scores were computed by subtracting pre-treatment scores from post-treatment scores. Turning first to the correlational analysis, as seen in Table 13.18, there were no significant correlations between the age of the offenders and



any of the four subscales of the URICA.

**Table 13.18.** Correlations Between Change Scores for URICA and Age

Subscale	Age (n= 38)	
	<i>r</i>	<i>p</i>
Pre-contemplation	.17	.49
Contemplation	-.40	.10
Action	-.33	.18
Maintenance	-.32	.20

*Note: For each subscale, n= 18. Pre-treatment scores subtracted from post-treatment scores.*

Considering Level of Security and Relationship Status next, as seen in Table 13.19, there were no significant differences between each level of security or each relationship category. This finding indicates that any pre- to post-treatment improvement in score which did occur was unrelated to both Level of Security and Relationship Status.

**Table 13.19.** Comparing Change Scores on Level of Security and Relationship Status: URICA

Subscale	Level of Security				<i>t</i>	<i>p</i>
	Min		Med			
	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>		
Pre-contemplation	-2.20	4.30	-.31	2.90	-1.58	.12
Contemplation	.20	2.30	-.34	3.38	.47	.64
Action	.60	1.90	1.34	3.45	-.65	.52
Maintenance	-.40	7.15	-2.63	5.80	1.00	.32

*Note: Degrees of freedom= 40. Min, n= 10; Med, n= 32. Pre-treatment scores subtracted from post-treatment scores.*

Subscale	Relationship Status				<i>t</i>	<i>p</i>
	In a Relationship		Not in a Relationship			
	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>		
Pre-contemplation	-1.00	2.00	-.74	3.13	-.19	.84
Contemplation	1.40	3.13	-.89	3.10	1.90	.06
Action	1.50	3.10	1.04	3.40	.38	.71
Maintenance	-3.60	6.10	-1.44	6.47	-.91	.37

*Note: Degrees of freedom= 36. In a Relationship, n= 10; Not in a Relationship, n= 27. Pre-treatment scores subtracted from post-treatment scores.*

Turning to the regional comparisons, as seen in Table 13.20, there were no significant regional differences on the change scores for each of the four subscales of the URICA.

**Table 13.20.** Comparing Change Scores on Region: URICA

Subscales	Region										F	p
	Atlantic (n= 3)		Quebec (n= 10)		Ontario (n= 9)		Prairie (n= 9)		Pacific (n= 11)			
	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>		
Pre-contemp.	-.33	1.53	-2.20	4.30	.22	3.15	.33	3.00	-1.27	3.00	.97	.44
Contemplation	.00	4.00	.20	2.30	-.33	2.70	-1.67	2.30	.64	4.40	.71	.59
Action	2.67	3.06	.60	1.90	.78	2.68	.78	5.20	1.90	2.47	.45	.77
Maintenance	4.00	4.58	-.40	7.17	-3.78	5.00	-1.90	5.78	-4.10	5.95	1.46	.23

*Note: Degrees of freedom all groups= 4, 37. Pre-treatment scores subtracted from post-treatment scores.*

## 6. Treatment Readiness Rating Scale (TRR)

The Treatment Readiness Rating Scale (TRR) consists of 11 domains and a total scale score designed to assess treatment readiness factors (e.g., Problem Recognition, Goal Setting). Higher scores reflect a more positive or favourable response.

Turning to overall pre- to post-treatment score changes, as seen in Table 13.21, there were several significant differences between the pre- and post-treatment scores. Offenders were judged to show greater treatment readiness on the overall scale and 12 of 22 subscales. Presumably, following treatment, offenders showed a wide range of improvements including an improved ability to acknowledge their problems, set realistic treatment goals, and appreciate the benefits of treatment, as well as an improved ability to believe that change is possible and that others (e.g., family, friends, therapist) are important to their continued improvement.

**Table 13.21.** Comparison of Treatment Readiness Rating Scale Pre- and Post-Treatment Mean Scores

Domain	Pre		Post		<i>t</i>	<i>p</i>	Comparison
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
1. Problem Recognition							
Problem Severity	1.73	.76	2.26	.81	-4.54	.001	Post>Pre
Problem Understanding	1.35	.69	2.09	.80	-7.82	.001	Post>Pre
2. Goal Setting							
Realistic Goals	1.58	.80	2.08	.93	-4.14	.001	Post>Pre
Goal Importance	1.92	.98	2.21	.98	-2.23	.03	Post>Pre
3. Motivation							
Treatment Need	1.91	.82	2.05	.88	-1.27	.21	
Treatment Motivation	2.03	.70	2.15	.85	-1.27	.21	
4. Self-Appraisal							
Ownership	1.80	.79	2.20	.81	-3.81	.001	Post>Pre
Satisfaction	1.68	.81	1.77	.94	-.76	.45	
5. Expectations							
Consequences	1.56	.75	2.02	.75	-4.47	.001	Post>Pre
Benefits	1.67	.81	2.21	.85	-4.60	.001	Post>Pre
6. Behavioural Consistency							
Consistency	2.03	.80	2.08	.86	-.44	.66	
Meets Commitments	1.70	.82	1.95	.87	-3.05	.003	Post>Pre
7. Views About Treatment							
Treatment and Self	2.12	.98	2.45	.81	-2.71	.01	Post>Pre
Therapeutic Alliance	1.88	.95	2.14	.84	-2.42	.02	Post>Pre
8. Self-Efficacy							
Treatment Change	2.26	.64	2.38	.78	-1.27	.21	
Personal Change	2.50	.75	2.48	.80	.19	.85	
9. Dissonance							
Distress	1.89	.93	1.95	.99	-.51	.61	
Dissatisfaction	2.05	.77	2.11	.96	-.47	.64	
10. External Supports							
Support for Treatment	1.77	.91	1.92	.81	-1.80	.08	
Support for Change	1.76	.98	2.00	.84	-2.40	.02	Post>Pre
11. Affective Component							
Emotional Expression	1.24	.61	1.70	.80	-4.57	.001	Post>Pre
Emotional Demands	1.88	.99	2.02	1.00	-1.22	.23	
12. Total score	40.3	11.8	46.2	14.6	-4.10	.001	Post>Pre

*Note: Degrees of freedom= 65. Higher scores reflect a more positive or favourable response.*

For the correlational analysis, t- and F-tests, change scores were computed by subtracting pre-treatment scores from post-treatment scores. Turning to the correlational analysis, as seen in Table 13.22, there were no significant correlations between the age of the offenders and the various domains of the scale.

**Table 13.22.** Correlations Between Change Scores for Treatment Readiness and Age

Domain	Age (n= 38)	
	<i>r</i>	<i>p</i>
1. Problem Recognition		
Problem Severity	-.01	.93
Problem Understanding	-.19	.60
2. Goal Setting		
Realistic Goals	-.23	.24
Goal Importance	-.27	.15
3. Motivation		
Treatment Need	-.02	.90
Treatment Motivation	-.07	.70
4. Self-Appraisal		
Ownership	.04	.85
Satisfaction	.10	.59
5. Expectations		
Consequences	-.17	.36
Benefits	-.31	.10
6. Behavioural Consistency		
Consistency	-.09	.64
Meets Commitments	-.24	.21
7. Views About Treatment		
Treatment and Self	-.06	.76
Therapeutic Alliance	.05	.81
8. Self-Efficacy		
Treatment Change	-.06	.76
Personal Change	.04	.84
9. Dissonance		
Distress	-.12	.53
Dissatisfaction	.10	.65
10. External Supports		
Support for Treatment	-.11	.58
Support for Change	-.04	.84
11. Affective Component		
Emotional Expression	.05	.79
Emotional Demands	-.12	.53
12. Total score	-.11	.55

*Note: For each domains, n= 29. Pre-treatment scores subtracted from post-treatment scores.*

Turning to comparing change scores for both levels of security, as seen in Table 13.23, there was a significant difference in change score for two items of the Treatment Readiness Rating Scale. First, there was a significant difference between the minimum and medium security facilities for the Treatment Change item of the Self-Efficacy domain,  $t(64)= 2.11, p= .04$ . For the minimum security facility,  $M_{change}= .50 (SD= .65)$ ; for the medium security facility,  $M_{change} = .01 (SD= .78)$ . The finding implies that the offenders in the minimum security facility grew more optimistic about the possibility of change for themselves than did the offenders in the medium security facilities. Second, the change score for the offenders in the minimum security facility was significantly larger than the change score for the offenders in the medium security facilities on the Emotional Expression item of the Affective Component domain,  $t(64)= 2.16, p= .03$ . For the offenders in the minimum security facility,  $M_{change} = .86 (SD= .77)$ ; for the offenders in the medium security facilities,  $M_{change} = .35 (SD= .80)$ . This finding implies that the amount of change which the offenders in the minimum security facility experienced in their ability to accurately identify and label their emotions was larger than the amount of pre- to post-treatment change for the offenders in the medium security facilities.

**Table 13.23.** Comparing Change Scores on Level of Security: Treatment Readiness Rating Scale

Domain	Level of Security				<i>t</i>	<i>p</i>	Comparison
	Min		Med				
	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>			
1. Problem Recognition							
Problem Severity	.57	.85	.52	.98	.18	.86	
Problem Understanding	1.00	.55	.67	.81	1.42	.16	
2. Goal Setting							
Realistic Goals	.86	.77	.40	1.00	1.55	.13	
Goal Importance	.71	.99	.17	1.00	1.74	.09	
3. Motivation							
Treatment Need	.43	.76	.05	.90	1.42	.16	
Treatment Motivation	.29	.73	.07	.80	.90	.37	
4. Self-Appraisal							
Ownership	.50	.76	.37	.86	.53	.60	
Satisfaction	.14	1.17	.07	.93	.22	.82	
5. Expectations							
Consequences	.64	.74	.40	.85	.96	.34	
Benefits	.93	.92	.44	.96	1.70	.09	
6. Behavioural Consistency							
Consistency	.29	.61	-.02	.87	1.22	.23	
Meets Commitments	.36	.50	.23	.73	.60	.54	
7. Views About Treatment							
Treatment and Self	.70	1.07	.23	.96	1.63	.11	
Therapeutic Alliance	.57	.65	.17	.90	1.55	.13	
8. Self-Efficacy							
Treatment Change	.50	.65	.01	.78	2.11	.04	Min> Med
Personal Change	-.07	.73	.00	.63	-.36	.72	
9. Dissonance							
Distress	.30	.83	.00	.99	.99	.33	
Dissatisfaction	.00	.88	.07	1.10	-.24	.80	
10. External Supports							
Support for Treatment	.07	.47	.17	.73	-.50	.63	
Support for Change	.14	-.14	.27	.84	-.50	.60	
11. Affective Component							
Emotional Expression	.86	.77	.35	.80	2.16	.03	Min> Med
Emotional Demands	.29	.83	.09	.93	.70	.50	
12. Total score	10.97	12.03	4.80	11.57	1.50	.14	

*Note: Degrees of freedom= 64. Minimum, n= 14; Medium, n= 52. Pre-treatment scores subtracted from post-treatment scores.*

Turning to Relationship Status, as seen in Table 13.24, there was not a significant difference in mean change score between those offenders who were in a relationship at the time of testing

and those who were not indicating that the offender's relationship status at the time of testing was unrelated to any pre- to post-treatment changes which did occur.

**Table 13.24.** Comparing Change Scores on Relationship Status: Treatment Readiness

Domain	Relationship Status				<i>t</i>	<i>p</i>
	In a Relationship		Not In a Relationship			
	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>		
1. Problem Recognition						
Problem Severity	.47	.94	.55	1.06	.24	.80
Problem Understanding	.71	.70	.85	.76	.65	.52
2. Goal Setting						
Realistic Goals	.41	-.58	.58	.87	-.57	.57
Goal Importance	.29	-.45	.45	1.03	-.52	.61
3. Motivation						
Treatment Need	.29	-.24	.24	.94	.19	.85
Treatment Motivation	.12	-.12	.18	.88	.27	.80
4. Self-Appraisal						
Ownership	.41	-.40	.40	.86	.07	.94
Satisfaction	-.12	.12	.18	.92	-1.04	.30
5. Expectations						
Consequences	.88	.78	.45	.71	1.95	.06
Benefits	.85	.80	.60	1.03	.97	.34
6. Behavioural Consistency						
Consistency	.00	.94	.21	.74	-.87	.38
Meets Commitments	.12	.60	.40	.70	-1.38	.17
7. Views About Treatment						
Treatment and Self	.35	.93	.52	.97	-.57	.57
Therapeutic Alliance	.05	1.03	.36	.78	-1.17	.25
8. Self-Efficacy						
Treatment Change	.18	.64	.15	.76	.12	.90
Personal Change	.00	.80	-.03	.60	.15	.88
9. Dissonance						
Distress	.12	.99	.15	.97	-.12	.90
Dissatisfaction	-.24	1.30	.15	.83	-1.28	.21
10. External Supports						
Support for Treatment	.00	.50	.18	.77	-.88	.38
Support for Change	.05	.56	.30	.95	-.97	.33
11. Affective Component						
Emotional Expression	.41	.80	.64	.82	-.92	.36
Emotional Demands	.05	.56	.24	1.12	-.63	.53
12. Total score	5.47	9.60	7.76	12.50	-.66	.51

*Note:* Degrees of freedom = 48. In a Relationship, *n* = 17; Not in a Relationship, *n* = 33. Pre-treatment scores subtracted from post-treatment scores.

Considering regional comparisons next, as seen in Table 13.25, there were three significant regional differences in mean change score for the Treatment Readiness Rating Scale. First, there was a significant finding on the Realistic Goals item of the Goal Setting domain,  $F(4, 61) = 3.04$ ,



$p = .02$ . The post hoc examination (Tukey's test,  $\alpha = .05$ ) of the change scores found that the mean change scores for both the Quebec ( $M_{change} = .86, SD = .77$ ) and Prairie regions ( $M_{change} = .86, SD = 1.10$ ) were significantly larger than the mean change score for the Pacific region ( $M_{change} = -.11, SD = 1.13$ ). This finding suggests that the offenders in the Quebec and Prairie regions, from pre- to post-treatment, improved more in their ability to set realistic treatment goals than did the offenders in the Pacific region. Second, there was a significant finding on the Treatment Benefits item of the Expectations domain,  $F(4, 61) = 4.10, p = .01$ . The post-hoc examination of the means found that the mean score change for both the Quebec ( $M_{change} = .93, SD = .92$ ) and Prairie regions ( $M_{change} = 1.00, SD = 1.04$ ) were significantly larger than the mean change score for the Pacific region ( $M_{change} = -.11, SD = .96$ ). This finding suggests that, from pre- to post-treatment, the offenders in both the Quebec and Prairie regions improved more in their ability to identify the benefits of treatment than did the offenders in the Pacific region. Third, there was a significant finding on the Support for Treatment item of the External Supports domain,  $F(4, 61) = 2.96, p = .03$ . The post-hoc examination of the change scores found that the mean change scores in both the Ontario ( $M_{change} = .33, SD = .65$ ) and Prairie regions ( $M_{change} = .57, SD = .76$ ) were significantly larger than the change score for the Pacific region ( $M_{change} = -.17, SD = .80$ ). This finding implies that the offenders in both the Ontario and Prairie regions believed themselves to have more available social support (e.g., family, friends, employer, etc.) than did the offenders in the Pacific region.

Table 13.25. Comparing Change Scores on Region: Treatment Readiness Rating Scale

Domains	Region												F	p	Comparison	
	Atlantic (n=8)		Quebec (n=14)		Ontario (n=12)		Prairie (n=14)		Pacific (n=18)							
	M <sub>ch</sub>	SD	M <sub>ch</sub>	SD	M <sub>ch</sub>	SD	M <sub>ch</sub>	SD	M <sub>ch</sub>	SD						
1. Problem Recognition																
Problem Severity	.50	.53	.57	.85	.58	.80	.43	1.45	.56	.86	.06	.99				
Problem Understanding	.63	.52	1.00	.55	.75	.87	.57	.85	.72	.90	.60	.67				
2. Goal Setting																
Realistic Goals	.50	.53	.86	.77	.58	.67	.86	1.10	-.11	1.13	3.04	.02				Que.,Prairie> Pac
Goal Importance	.71	.76	.70	.99	.33	.65	.43	1.40	-.28	.96	2.19	.08				
3. Motivation																
Treatment Need	.50	.93	.43	.76	.08	.67	.30	1.10	-.33	.77	2.32	.07				
Treatment Motivation	.25	.70	.30	.73	.08	.80	.14	1.10	-.05	.54	.44	.78				
4. Self-Appraisal																
Ownership	.50	.53	.50	.76	.17	.72	.43	1.09	.40	.92	.30	.87				
Satisfaction	.13	.64	.14	1.15	.08	.67	.36	1.08	-.17	1.04	.57	.68				
5. Expectations																
Consequences	.38	.52	.64	.74	.50	.80	.79	.70	.05	1.00	1.92	.12				Que., Prairie> Pac
Benefits	.63	.52	.93	.92	.50	.67	1.00	1.04	-.11	.96	4.10	.01				
6. Behavioural Consistency																
Consistency	.00	-.53	.30	-.61	-.08	.80	.29	1.20	-.22	.73	1.14	.23				
Meets Commitments	.38	.52	.36	.50	.08	.90	.43	.85	.11	.58	1.98	.11				
Consistency	.00	.53	.61	.61	-.08	.80	.29	1.20	-.22	.73	1.14	.35				
Meets Commitments	.38	.52	-.36	.50	.08	.90	.43	.85	.11	.58	.74	.57				
7. Views About Treatment																
Treatment and Self	.38	.52	.70	1.10	.00	.60	.57	1.28	.05	1.00	1.43	.23				
Therapeutic Alliance	.63	.52	.57	.65	.25	.97	-.21	.97	.22	.88	1.98	.11				
8. Self-Efficacy																
Treatment Change	.00	.00	.50	.65	.00	.95	.21	.58	-.11	.96	1.45	.23				
Personal Change	.00	.00	-.07	.73	.25	.62	.00	.40	-.17	.86	.78	.54				
9. Dissonance																
Distress	.13	.64	.29	.83	.00	.95	.14	1.23	-.17	.99	.48	.75				
Dissatisfaction	.00	1.10	.00	.88	.00	.95	-.14	1.29	.33	1.03	.46	.76				
10. External Supports																
Support for Treatment	.00	.00	.07	.47	.33	.65	.57	.76	-.17	.80	2.96	.03				Ont, Prairie> Pac
Support for Change	.00	.00	.14	.77	.00	.85	.29	.94	.33	.90	1.10	.36				
11. Affective Component																
Emotional Expression	.13	.35	.86	.77	.17	.83	.50	.76	.44	.92	1.66	.17				
Emotional Demands	.38	.52	.29	.83	.08	.80	.30	1.38	-.17	.71	.83	.51				
12. Total score	6.50	7.03	10.10	12.03	4.75	9.70	8.50	15.00	1.17	11.04	1.40	.24				

Note: Degrees of freedom all groups=4, 61. Pre-treatment scores subtracted from post-treatment scores.

## **7. Treatment Responsivity Rating Scale (RRS)**

The RRS consists of 11 domains designed to assess those client-based qualities or characteristics that can either facilitate or inhibit treatment compliance or responsivity to treatment (e.g., Procriminal View, Grandiosity). Each scale consists of two subscales. Higher scores reflect a more positive or favourable response.

Beginning with the paired samples t-test, as seen in Table 13.26, there was a significant pre- to post-treatment improvement in score for eighteen of 22 items as well as the Total scale score. Except for their procriminal views, tendency to prefer procriminal peers, and their lack of concern for others, offenders were judged to show greater treatment responsivity after completing treatment. Following treatment, offenders had more a realistic view about themselves and more realistic expectations about their future; offenders were less likely to minimize their problems and more likely to consider the consequences of their actions; offenders were more likely to express their anger appropriately and more aware of how their anger affects others; participants were less likely to want to control others, and were less likely to portray themselves as a victim of circumstance.

**Table 13.26.** Comparison of Responsivity Rating Pre- and Post-Treatment Mean Scores

Domain	Pre		Post		<i>t</i>	<i>p</i>	Comparison
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
1. Procriminal Views							
Criminal Pride	2.18	.79	2.33	.91	-.52	.61	
Criminal Justification	1.88	.72	2.05	.81	-1.80	.08	
2. Procriminal Associations							
Procriminal Peers	2.05	.87	2.10	.95	-.52	.61	
Procriminal Activities	1.90	.88	2.23	.89	-3.34	.001	Post>Pre
3. Grandiosity							
Self-Image	1.76	.84	2.05	.94	-2.88	.005	Post>Pre
Expectations of Future	1.73	.89	2.10	.82	-3.75	.001	Post>Pre
4. Callousness							
Lacks Concerns for Others	1.93	.67	2.08	.84	-1.50	.14	
Exploitative	1.78	.88	2.14	.76	-3.40	.001	Post>Pre
5. Neutralization							
Minimization	1.59	.81	1.97	.81	-3.65	.001	Post>Pre
Denial	1.86	.86	2.22	.79	-3.40	.001	Post>Pre
6. Impulsivity							
Thinks of Consequences	1.40	.85	1.90	.71	-5.36	.001	Post>Pre
Delays Gratification	1.41	.85	1.76	.86	-3.50	.001	Post>Pre
7. Procrastination							
Commitment	2.10	.74	2.34	.82	-2.43	.02	Post>Pre
Aimlessness	1.81	.71	2.27	.78	-4.84	.001	Post>Pre
8. Motivation for Anger							
Volatility	1.37	.67	1.86	.78	-4.50	.001	Post>Pre
Instrumentality	1.39	.77	1.95	.92	-4.60	.001	Post>Pre
9. Power and Control							
Entitlement	1.75	.90	2.10	.92	-2.57	.01	Post>Pre
Respectfulness	1.51	.97	2.15	.78	-5.85	.001	Post>Pre
10. Problem-Solving							
Generates Alternatives	1.39	.70	1.85	.90	-5.19	.001	Post>Pre
Flexibility	1.34	.78	1.86	.90	-4.94	.001	Post>Pre
11. Victim Stance							
Self-Pity	1.36	.76	1.86	.94	-3.75	.001	Post>Pre
Suffering	1.71	.83	2.10	.90	-4.03	.001	Post>Pre
12. Total score	37.33	11.8	45.1	14.6	-5.73	.001	Post>Pre

Note: Degrees of freedom= 43.

For the correlational analysis, t- and F-tests, change scores were computed by subtracting pre-treatment scores from post-treatment scores. Turning to the correlation between the age of the offenders and the various items of the RRS, as seen in Table 13.27, there were no significant correlations.

**Table 13.27.** Correlations Between Change Scores for Responsivity Rating Scale and Age

Domain	Age (n= 38)	
	<i>r</i>	<i>p</i>
1. Procriminal Views		
Criminal Pride	-.15	.49
Criminal Justification	-.12	.60
2. Procriminal Associations		
Procriminal Peers	.10	.67
Procriminal Activities	.04	.84
3. Grandiosity		
Self-Image	.08	.70
Expectations of Future	-.12	.58
4. Callousness		
Lacks Concerns for Others	-.34	.10
Exploitative	-.13	.54
5. Neutralization		
Minimization	.05	.54
Denial	-.11	.60
6. Impulsivity		
Thinks of Consequences	-.26	.21
Delays Gratification	-.20	.33
7. Procrastination		
Commitment	-.32	.12
Aimlessness	-.01	.96
8. Motivation for Anger		
Volatility	-.32	.13
Instrumentality	-.28	.19
9. Power and Control		
Entitlement	-.14	.50
Respectfulness	-.16	.44
10. Problem-Solving		
Generates Alternatives	-.21	.31
Flexibility	-.06	.76
11. Victim Stance		
Self-Pity	-.03	.90
Suffering	.16	.45
12. Total score	-.22	.32

*Note: For all domains, n= 24. Pre-treatment scores subtracted from post-treatment scores.*

Turning to the between-group comparisons, as seen in Table 13.28, there were three significant differences in change score found between the minimum and medium security facilities. First, there was a significant finding on the Entitlement item of the Power and Control domain,  $t(58) = 2.60, p = .01$ . An examination of the means shows that the mean change score for the minimum security facility is 1.00 ( $SD = .90$ ); the mean change score for the medium security facilities is .17 ( $SD = 1.04$ ). This finding suggests that, from pre- to post-treatment, the offenders in the minimum security facility were less egocentric and showed a larger improvement in their willingness to be fair in resolving disputes than did the offenders in the medium security facilities. Second, there was a significant finding on the Generates Alternatives item of the Problem-solving domain,  $t(58) = 3.59, p = .001$ . Since the mean change score for the minimum security facility ( $M_{change} = 1.00, SD = .58$ ) is significantly larger than the score change for the medium security facilities ( $M_{change} = .30, SD = .68$ ), this finding suggests that, from pre- to post-treatment, the offenders in the minimum security facility showed a larger improvement than did the offenders in the medium security facilities in their ability to generate constructive, alternative solutions to problems. Third, there was a significant finding on the Flexibility item of the Problem-solving domain,  $t(58) = 2.93, p = .005$ . An examination of the means shows that the mean change score for the offenders in the minimum security facility ( $M_{change} = 1.10, SD = .64$ ) is significantly larger than the mean change score for the offenders in the medium security facilities ( $M_{change} = .37, SD = .80$ ). This finding suggests that the offenders in the minimum security facility showed a larger pre- to post-treatment improvement in their willingness to try new problem-solving strategies than did the offenders in the medium security facilities.

**Table 13.28.** Comparing Change Scores on Level of Security: Treatment Responsivity

Domain	Level of Security				<i>t</i>	<i>p</i>	Comparison
	Min		Med				
	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>			
1. Procriminal Views							
Criminal Pride	.21	.43	.00	.82	.94	.35	
Criminal Justification	.29	.47	.13	.78	.71	.48	
2. Procriminal Associations							
Procriminal Peers	.00	.00	.06	.85	-.28	.78	
Procriminal Activities	.29	.47	.35	.85	-.26	.79	
3. Grandiosity							
Self-Image	.54	.88	.22	.74	1.34	.18	
Expectations of Future	.46	.66	.35	.80	.47	.64	
4. Callousness							
Lacks Concerns for Others	.46	.66	.06	.80	1.63	.11	
Exploitative	.70	.75	.27	.80	1.70	.10	
5. Neutralization							
Minimization	.62	.65	.30	.80	1.27	.21	
Denial	.23	.60	.40	.86	-.63	.53	
6. Impulsivity							
Thinks of Consequences	.85	.55	.41	.75	1.93	.06*	
Delays Gratification	.31	.48	.37	.85	-.25	.80	
7. Procrastination							
Commitment	.31	.85	.22	.73	.38	.70	
Aimlessness	.54	.97	.43	.85	.45	.65	
8. Motivation for Anger							
Volatility	.77	.44	.40	.90	1.36	.18	
Instrumentality	.92	.76	.46	.96	1.61	.11	
9. Power and Control							
Entitlement	1.00	.90	.17	1.04	2.60	.01	Min> Med
Respectfulness	1.00	.58	.54	.90	1.75	.09	
10. Problem-Solving							
Generates Alternatives	1.00	.58	.30	.63	3.59	.001	Min> Med
Flexibility	1.10	.64	.37	.80	2.93	.005	Min> Med
11. Victim Stance							
Self-Pity	.54	.78	.54	1.11	.12	.91	
Suffering	.54	.78	.35	.74	.81	.42	
12. Total score	12.62	6.70	6.42	11.00	1.94	.06*	

Note: Degrees of freedom= 58. Min, *n*= 13, Post, *n*= 45. \**p*= .06. Pre-treatment scores subtracted from post-treatment scores.

Turning to the relationship status of the offenders, as seen in Table 13.29, there were no significant differences in mean change scores for those offenders who were in a relationship and those who were not.

**Table 13.29.** Comparing Change Scores on Relationship Status: Treatment Responsivity

Domain	Relationship Status				<i>t</i>	<i>p</i>
	In a Relationship		Not in a Relationship			
	<i>M<sub>ch</sub></i>	<i>SD</i>	<i>M<sub>ch</sub></i>	<i>SD</i>		
1. Procriminal Views						
Criminal Pride	.07	1.04	.03	.70	.17	.86
Criminal Justification	-.07	.76	.31	.64	-1.74	.09
2. Procriminal Associations						
Procriminal Peers	.00	1.00	.03	.65	-.12	.90
Procriminal Activities	.23	.93	.41	.76	-.66	.51
3. Grandiosity						
Self-Image	.23	.60	.35	.80	-.50	.62
Expectations of Future	.07	.76	.42	.67	-1.48	.14
4. Callousness						
Lacks Concerns for Others	-.15	.55	.32	.70	-1.75	.09
Exploitative	.07	.50	.47	.86	-1.52	.14
5. Neutralization						
Minimization	.46	.88	.35	.70	.42	.67
Denial	.31	.85	.55	.80	-.88	.38
6. Impulsivity						
Thinks of Consequences	.92	.76	.48	.72	1.80	.08
Delays Gratification	.46	.66	.32	.80	.56	.58
7. Procrastination						
Commitment	.07	.64	.30	.78	-.87	.40
Aimlessness	.46	.78	.52	.77	-.21	.83
8. Motivation for Anger						
Volatility	.77	.83	.52	.85	.91	.37
Instrumentality	.77	1.17	.55	.80	.72	.47
9. Power and Control						
Entitlement	.62	1.40	.35	1.02	.70	.50
Respectfulness	.77	.93	.71	.64	.24	.81
10. Problem-Solving						
Generates Alternatives	.46	.52	.60	.67	-.73	.47
Flexibility	.38	.65	.80	.83	-1.62	.11
11. Victim Stance						
Self-Pity	.92	1.04	.55	1.03	1.10	.28
Suffering	.62	.65	.45	.77	.67	.50
12. Total score	8.46	9.75	9.10	10.15	-5.19	.85

*Note: Degrees of freedom=44. In a Relationship, n= 13; Not in a Relationship, n= 32. Pre-treatment scores subtracted from post-treatment scores.*



Turning to the regional comparisons, as seen in Table 13.30, there were five significant findings. First, there was a significant finding on the Lacks Concern for Others item of the Callousness domain,  $F(4, 55) = 3.17, p = .02$ . The post hoc examination of the means (Tukey's test,  $\alpha = .05$ ) found that the mean change score for the Prairie region ( $M_{change} = .55, SD = .73$ ) was significantly larger than the mean change score for the Pacific region ( $M_{change} = -.30, SD = .85$ ). This finding suggests that, from pre- to post-treatment, the offenders in the Prairie region showed a larger improvement in their willingness to express concern for others than shown by offenders in the Pacific region. Second, there was a significant finding on the Respectfulness item of the Power and Control domain,  $F(4, 55) = 2.70, p = .04$ . The post hoc examination of the means found that the mean change score for the Quebec region ( $M_{change} = 1.00, SD = .58$ ) was significantly larger than mean change scores for both the Atlantic ( $M_{change} = .25, SD = .46$ ) and Pacific regions ( $M_{change} = .30, SD = .85$ ). The finding implies that, from pre- to post-treatment, the offenders in the Quebec region came to express more respectful attitudes toward others than did the offenders in both the Atlantic and Pacific regions. Third, there was a significant between-group difference on the Generates Alternatives item of the Problem-solving domain,  $F(4, 55) = 3.77, p = .01$ . The post hoc examination of the means found that the mean change score for the Quebec region ( $M_{change} = 1.00, SD = .58$ ) was significantly larger than the mean change scores for both the Ontario ( $M_{change} = .17, SD = .58$ ) and Pacific regions ( $M_{change} = .24, SD = .75$ ). This finding suggests that the offenders in the Quebec region improved more in their ability to offer constructive solutions to problems than did the offenders in the Ontario and Pacific regions. Fourth, there was a significant between-group difference on the Flexibility item of the Problem-Solving domain,  $F(4, 55) = 5.10, p = .001$ . The post hoc examination of the means found that the mean change score for the Quebec region ( $M_{change} = 1.08, SD = .64$ ) was significant larger than the mean change score for both the Ontario ( $M_{change} = .25, SD = .87$ ) and Pacific regions

( $M_{change} = .05$ ,  $SD = .75$ ). The finding suggests that, from pre- to post-treatment, the offenders in the Quebec region demonstrated a greater flexibility in their willingness to consider and evaluate solutions than did the offenders in both the Ontario and Pacific regions. Fifth, there was a significant finding on the Total scale score,  $F(4, 55) = 3.23$ ,  $p = .02$ . The post hoc examination of the means found that the mean change score for the Prairie region ( $M_{change} = 14.33$ ,  $SD = 9.95$ ) was significantly larger than the mean change score for the Pacific region ( $M_{change} = 2.63$ ,  $SD = 12.93$ ). The finding suggests that, across the various domains of the RRS, the offenders in the Prairie region showed a larger pre- to post-treatment improvement in overall treatment compliance and responsiveness than did the offenders in the Pacific region.

Table 13.30. Comparing Change Scores on Region: Treatment Responsivity

Domains	Region												F	p	Comparisons	
	Atlantic (n=8)		Quebec (n=14)		Ontario (n=12)		Prairie (n=9)		Pacific (n=17)							
	M <sub>ch</sub>	SD	M <sub>ch</sub>	SD	M <sub>ch</sub>	SD	M <sub>ch</sub>	SD	M <sub>ch</sub>	SD						
1. Procriminal Views																
Criminal Pride	.13	.35	.21	.43	-.25	.97	.22	.44	.00	1.00	.80	.53				
Justification	.13	.35	.29	.47	.00	.43	.44	.74	.05	1.10	.68	.60				
2. Procriminal Associations																
Procriminal Peers	.13	.35	.00	.00	-.08	.90	.56	.73	-.12	1.00	1.42	.24				
Procriminal Activities	.13	.35	.30	.47	.25	.62	.90	1.10	.24	1.00	1.47	.22				
3. Grandiosity																
Self-Image	.38	.52	.54	.88	.00	.60	.56	.73	.12	.86	1.30	.28				
Expectations of Future	.50	.76	.46	.66	.17	.83	.44	.53	.35	.93	.32	.86				
4. Callousness																
Lacks Concern for Others	.38	.52	.46	.66	.00	.74	.55	.73	-.30	.85	3.17	.02				Prairie> Pacific
Exploitative	.13	.35	.69	.75	.08	.80	.80	.65	.20	.98	1.97	.11				
5. Neutralization																
Minimization	.38	.74	.62	.65	.33	.78	.44	.88	-.88	.88	.58	.67				
Denial	.50	.76	.23	.60	.42	.50	.78	1.10	.12	.93	1.16	.34				
6. Impulsivity																
Thinks of Consequences	.25	.46	.85	.55	.25	.62	.78	.44	.40	1.00	1.80	.14				
Delays Gratification	.38	.52	.30	.48	.42	1.16	.56	.53	.24	.90	.26	.90				
7. Procrastination																
Commitment	.25	.46	.30	.85	.33	.90	.44	.53	.44	.80	.65	.62				
Aimlessness	.38	.52	.54	.97	.50	.67	.90	.78	.18	.53	1.56	.20				
8. Motivation for Anger																
Volatility	.50	.53	.77	.44	.17	.94	.56	.53	.47	1.20	.80	.52				
Instrumentality	.25	.46	.92	.76	.75	.99	.67	.50	.24	1.20	1.42	.24				
9. Power and Control																
Entitlement	.25	.46	1.00	.91	.25	.97	.33	.50	.33	1.46	1.82	.14				
Respectfulness	.25	.46	1.00	.58	.67	.90	1.10	1.05	.30	.85	2.70	.04				Que> Atlantic, Pacific
10. Problem-solving																
Generates Alternative	.38	.52	1.00	.58	.17	.58	.56	.53	.24	.75	3.77	.01				Que> Ontario, Pacific
Flexibility	.50	.53	1.08	.64	.25	.87	1.00	.70	.05	.75	5.10	.001				Que> Ontario, Pacific
11. Victim stance																
Self-Pity	.50	.53	.54	.78	.17	1.25	1.22	1.10	.35	1.10	1.54	.20				
Suffering	.38	.52	.54	.78	.33	.98	.56	.53	.24	.75	.43	.80				
12. Total score	7.00	5.50	12.62	6.70	5.17	8.95	14.33	9.95	2.63	12.93	3.23	.02				Prairie> Pacific

Note: Degrees of freedom all groups=4, 55. Pre-treatment scores subtracted from post-treatment scores.

## 8. Treatment Participation and Gain Rating Scale (TPG)

The Treatment Participation and Gain Rating Scale (TPG) consists of 15 domains and a Total scale score designed to assess how much offenders benefited from treatment. Higher scores reflect a more positive or favourable response. Since the TPG was administered post-treatment only, the present analysis does not involve a paired sample t-test. The analysis involves two major components: (1) A one-sample t-test ( $\alpha = .05$ ) is performed in order to determine whether or not the mean scores of the various items differ significantly from 0. The age of the offenders is then correlated (Pearson's  $r$ ) with the various items of the Scale. In addition, t-test ( $\alpha = .05$ ) or one-way analysis of variance (ANOVA) is performed on the various items of the scale in order to compare the mean scores on the between-group factors of Level of Security, Relationship Status, and Region; (2) The TPG Scale is correlated (Pearson's  $r$ ) with the change scores (pre-treatment scores subtracted from post-treatment scores) of the Treatment Readiness (TRR) and Treatment Responsivity (RRS) Rating Scales. The TPG, TRR, and RRS are all scored by facilitators. If the offenders have benefited from treatment (as measured by the TPG), and since, as shown earlier, the offenders demonstrated a number of improvements in terms of their readiness for and responsivity to treatment, one would expect there to be a positive correlation between the TPG and TRR and RSS. The TPG is also correlated with the change scores (post minus pre) for two self-report measures: Abusive Relationships Inventory (ABI), and University of Rhode Island Change Assessment (URICA). If the offenders did benefit from treatment (as measured by the TPG), then it is of interest to consider how their improvement relates to their scores on the ABI and URICA; that is, it is of interest to consider the extent to which the facilitators judgment about the offender's behaviour agrees with the offender's judgment of how much treatment improved their attitudes (as measured by the ABI and URICA).

Turning first to the one-sample t-test, as seen in Table 13.31, the mean scores for all of the

items of the TPG were significantly different from 0 indicating that the differences between the observed statistics and hypothesized parameters (Test Value= 0) are too large to be explained by mere sampling error, so that they may represent real differences that occur in the sample of offenders.

**Table 13.31.** One-Sample T-Test: Treatment Participation and Gain Rating Scale

Domain	TPG		<i>t</i>	<i>p</i>
	<i>M</i>	<i>SD</i>		
1. Increased Knowledge	2.15	.76	22.12	.001
2. Increased Skills	2.00	.84	18.67	.001
3. Disclosure				
Group	1.97	.80	19.32	.001
Individual	2.30	.67	26.87	.001
4. Offender Confidence				
Pre-treatment	1.44	.92	12.21	.001
Post-treatment	2.10	.87	18.84	.001
5. Application of Knowledge	1.80	.86	16.25	.001
6. Application of Skills	1.75	.91	15.11	.001
7. Understanding	1.97	.82	18.83	.001
8. Depth of Emotional				
Understanding of content	2.00	.94	16.75	.001
9. Motivation	2.10	.83	19.73	.001
10. Insight	1.86	.88	16.40	.001
11. Attendance	2.46	.67	28.55	.001
12. Disruptiveness	1.92	.92	16.31	.001
13. Appropriateness	2.00	.81	19.53	.001
14. Participation	2.13	.78	21.21	.001
15 Therapeutic Alliance	2.08	.84	19.30	.001
16. Total score	34.05	10.1	24.45	.001

*Note: Degrees of freedom= 60. For each domain, n= 61. Test value= 0.*

Turning to the correlational analysis, as seen in Table 13.32, there were two significant correlations between the age of offenders and the various items of the TPG. First, there was a significant negative correlation between the age of the offenders and the Individual item of the Disclosure domain,  $r = -.46$ ,  $p = .03$ . This finding implies that the younger offenders were judged to be more comfortable with discussing and sharing information during individual sessions than

were the older offenders. Second, there was a significant negative correlation between the age of the offenders and the Depth of Emotional Understanding of Program Content domain,  $r = -.42$ ,  $p = .04$ . The finding suggests that the younger offenders were judged to be more emotionally involved in or connected to the program than were the older offenders.

**Table 13.32.** Correlations Between Treatment Participation and Gain Ratings and Age

Domain	Age (n= 38)	
	<i>r</i>	<i>p</i>
1. Increased Knowledge	-.20	.35
2. Increased Skills	-.37	.08
3. Disclosure		
Group	-.19	.37
Individual	-.46	.03*
4. Offender Confidence		
Pre-treatment	-.08	.75
Post-treatment	-.37	.08
5. Application of Knowledge	-.37	.08
6. Application of Skills	-.40	.06
7. Understanding	-.19	.32
8. Depth of Emotional Understanding of Content	-.42	.04*
9. Motivation	-.34	.11
10. Insight	-.25	.24
11. Attendance	.38	.07
12. Disruptiveness	-.21	.34
13. Appropriateness	-.26	.23
14. Participation	-.15	.50
15 Therapeutic Alliance	-.30	.18
16. Total score	-.33	.13

Note: \* $p < .05$ . For each domain,  $n = 23$ .

Turning to the between-group comparisons, as seen in Table 13.33, there was a significant mean difference between the minimum and medium security facilities for three domains. First, there was a significant mean difference for the Motivation domain,  $t(59) = 2.53$ ,  $p = .01$ . An examination of the means shows that the mean for the minimum security facility ( $M = 2.57$ ,  $SD = .76$ ) is larger than the mean for the medium security facilities ( $M = 1.90$ ,  $SD = .80$ ). This finding suggests that, following treatment, the offenders in the minimum security facility were judged to

be more motivated to improve than were the offenders in the medium security facilities. Second, there was a significant mean difference for the Insight domain,  $t(59)= 2.90, p= .005$ . An examination of the means shows that the mean for the minimum security facility ( $M= 2.43, SD= .75$ ) is significantly larger than the mean for the medium security facilities ( $M= 1.70, SD= .85$ ). The finding suggests that the offenders in the minimum security facility were judged to demonstrate more insight and understanding into their various treatment needs than did the offenders in the medium security facilities. Third, there was a significant finding for the Attendance domain,  $t(59)= 2.64, p= .01$ . An examination of the means shows that the mean for the offenders in the minimum security facility ( $M= 2.86, SD= .36$ ) is significantly larger than the mean for the offenders in the medium security facilities ( $M= 2.34, SD= .70$ ). The finding suggests that the offenders in the minimum security facilities showed better program attendance than did the offenders in the medium security facilities.

**Table 13.33.** Mean Score Differences for Level of Security: Treatment Participation and Gain

Domain	Level of Security				<i>t</i>	<i>p</i>	Comparison
	Min		Med				
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
1. Increased Knowledge	2.30	.92	2.12	.72	.75	.47	
2. Increased Skills	2.07	1.00	1.98	.80	.36	.72	
3. Disclosure							
Group	2.14	.86	1.91	.80	.94	.35	
Individual	2.43	.76	2.26	.64	.85	.39	
4. Offender Confidence							
Pre-treatment	1.36	.63	1.47	1.00	-.40	.70	
Post-treatment	2.20	.90	2.10	.87	.56	.57	
5. Application of Knowledge	1.70	.83	1.80	.88	-.35	.72	
6. Application of Skills	2.00	.88	1.68	.90	1.16	.25	
7. Understanding	2.30	.73	1.87	.82	1.70	.10	
8. Depth of Emotional							
Understanding of Content	2.43	.94	1.96	.90	1.90	.06	
9. Motivation	2.57	.76	1.90	.80	2.53	.01	Min> Med
10. Insight	2.43	.75	1.70	.85	2.90	.005	Min> Med
11. Attendance	2.86	.36	2.34	.70	2.64	.01	Min> Med
12. Disruptiveness	1.86	.77	1.94	.95	-.28	.78	
13. Appropriateness	2.00	.88	2.00	.80	-.09	.93	
14. Participation	2.30	.73	2.10	.80	.84	.41	
15. Therapeutic Alliance	2.43	.94	1.98	.80	1.78	.08	
16. Total Score	37.40	10.75	33.10	11.00	1.30	.20	

*Note: Degrees of freedom=59. Minimum, n= 14; Medium, n= 47. Higher scores reflect a more positive or favourable response.*

Turning to the relationship status of the offenders, as seen in Table 13.34, there was a significant finding for the Disruptiveness domain,  $t(43) = -1.99, p = .05$ . Since the mean for those offenders who were *not* in a relationship ( $M = 2.03, SD = .88$ ) is significantly larger than the mean for those offenders who were in a relationship ( $M = 1.42, SD = 1.00$ ), the finding implies that those offenders who were not in a relationship at the time of testing were judged to be less disruptive and more attentive during treatment than were the offenders who were in a relationship.

**Table 13.34.** Mean Score Differences for Relationship Status: Treatment Participation and Gain

Domain	Relationship Status				<i>t</i>	<i>p</i>	Comparison
	In a Relationship		Not in a Relationship				
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
1. Increased Knowledge	2.17	.57	2.17	.77	.00	1.00	
2. Increased Skills	1.92	.51	2.10	.93	-.50	.62	
3. Disclosure							
Group	2.00	.60	1.97	.85	.11	.90	
Individual	2.10	.50	2.24	.75	-.67	.50	
4. Offender Confidence							
Pre-treatment	1.10	1.00	1.55	.87	-1.52	.14	
Post-treatment	1.83	.83	2.18	.88	-1.19	.24	
5. Application of Knowledge	1.50	.80	1.94	.80	-1.65	.11	
6. Application of Skills	1.75	.87	1.91	.88	-.54	.60	
7. Understanding	2.00	.85	2.00	.80	.00	1.00	
8. Depth of Emotional Understanding of Content	1.83	.83	2.15	.94	-1.03	.31	
9. Motivation	1.83	.58	2.21	.82	-1.47	.15	
10. Insight	1.62	.77	1.93	.86	-1.11	.27	
11. Attendance	2.42	.50	2.52	.76	-.42	.68	
12. Disruptiveness	1.42	1.00	2.03	.88	-1.99	.05	Not in > In
13. Appropriateness	1.67	.78	2.06	.83	-1.43	.16	
14. Participation	1.92	.80	2.21	.74	-1.16	.25	
15. Therapeutic Alliance	2.00	.74	2.09	.88	-.32	.75	
16. Total score	31.04	9.12	35.23	11.03	-1.17	.25	

*Note:* Degrees of freedom = 43. In a Relationship,  $n = 12$ ; Not in a Relationship,  $n = 33$ . Higher scores reflect a more positive or favourable response.

Turning to the regional comparisons, as seen in Table 13.35, there were three significant regional differences. First, there was a significant finding on the Motivation domain,  $F(4, 56) = 2.51, p = .05$ . The post hoc examination of the means (Tukey's test,  $\alpha = .05$ ) found that the mean



for the Quebec region ( $M= 2.57, SD= .76$ ) was significantly larger than the mean for the Pacific region ( $M= 1.74, SD= .80$ ). This finding suggests that the offenders in the Quebec region displayed more treatment motivation and desire to change than did the offenders in the Pacific region. Second, there was a significant regional difference on the Insight domain,  $F(4, 56)= 2.64, p= .04$ . The post hoc examination of the means found that the mean for the Quebec region ( $M= 2.42, SD= .75$ ) was significantly larger than the mean for the Pacific region ( $M= 1.47, SD= .84$ ). The finding suggests that the offenders in the Quebec region were judged to have more insight into their assorted treatment needs than did the offenders in the Pacific region. Third, there was a significant finding on the Attendance domain,  $F(4, 56)= 2.77, p= .04$ . The post hoc examination of the means found that the mean for the Quebec region ( $M= 2.86, SD= .36$ ) was significantly larger than the mean for the Atlantic region ( $M= 2.13, SD= .99$ ). This finding suggests that the offenders in the Quebec region showed better program attendance than did the offenders in the Atlantic region.

Table 13.35. Mean Score Difference for Region: Treatment Participation and Gain

Domains	Region												F	p	Comparison
	Atlantic (n= 8 )		Quebec (n= 14)		Ontario (n= 12)		Prairie (n= 8 )		Pacific (n= 19)						
	M	SD	M	SD	M	SD	M	SD	M	SD					
1. Increased Knowledge	2.00	.53	2.30	.91	1.95	.62	2.37	.74	2.15	.83	.54	.71			
2. Increased Skills	1.88	.64	2.10	1.00	1.92	.80	2.25	.85	1.95	.85	.28	.90			
3. Disclosure Group	1.88	.35	2.14	.86	1.83	.94	2.25	.70	1.84	.83	.63	.63			
Individual	2.00	.53	2.43	.76	2.33	.78	2.38	.74	2.25	.56	.56	.69			
4. Offender Confidence Pre-treatment	1.63	.92	1.36	.63	2.00	.95	1.25	.90	1.15	1.00	1.84	.13			
Post-treatment	2.25	1.00	2.20	.90	2.25	.87	2.25	.70	1.80	.85	.86	.49			
5. Application of Knowledge	1.88	.35	1.71	.83	1.67	.90	2.00	.75	1.80	1.10	.22	.93			
6. Application of Skills	2.00	.53	2.00	.88	1.67	.78	2.25	1.00	1.32	.95	2.33	.07			
7. Understanding	1.88	.35	2.30	.73	2.00	.60	1.88	1.00	1.80	1.00	.80	.53			
8. Depth of Emotional Understanding of Content	2.00	.53	2.43	.94	2.00	.85	2.13	1.13	1.70	1.00	1.32	.27			
9. Motivation	1.88	.64	2.57	.76	2.25	.87	2.13	.83	1.74	.80	2.51	.05	Que> Pac		
10. Insight	1.75	.46	2.42	.75	1.87	1.20	1.87	.65	1.47	.84	2.64	.04	Que> Pac		
11. Attendance	2.13	.99	2.86	.36	2.58	.50	2.50	.76	2.21	1.10	2.77	.04	Que> Atl		
12. Disruptiveness	2.00	.53	1.86	.77	1.83	1.00	2.50	.76	1.74	.63	1.05	.40			
13. Appropriateness	1.88	.83	2.00	.88	2.00	.74	2.40	.92	1.95	.80	.48	.75			
14. Participation	2.25	.46	2.30	.73	2.25	.75	2.40	.74	1.80	.92	1.38	.25			
15. Therapeutic Alliance	1.75	.90	2.43	.94	2.25	.87	1.90	.64	1.95	.80	1.29	.29			
16. Total score	33.0	7.00	37.36	11.00	34.67	10.72	36.63	11.00	30.58	12.00	.94	.44			

Note: Degrees of freedom all groups=4, 56. Higher scores reflect a more positive or favourable response.

The total score for the Treatment Participation and Gain Rating Scale (TPG) was next correlated with the total change scores (post minus pre) for four scales: Treatment Readiness Rating Scale (TRR), Treatment Responsivity Rating Scale (RRS), Abusive Relationships Inventory (ABI), and the University of Rhode Island Change Assessment (URICA). As seen in Table 13.36, there was a significant positive correlation between the TPG and both the TRR and RRS, suggesting that those offenders who were judged by facilitators to have benefited most from treatment were also judged to have shown larger pre- to post-treatment improvements in treatment readiness and responsivity than those offenders who demonstrated fewer or weaker treatment-related gains. The significant negative correlations between the TPG and the Need for Control and Batterer's Myths subscales of the ABI suggests that those offenders who were judged to have shown large treatment-related gains also (self) reported: (a) less of a need to exert power and control over their partner and; (b) less of a tendency to accept or endorse certain myths (e.g., Some women get turned on if they get slapped around a little before sex.) that can encourage abusive behaviour.

**Table 13.36.** Correlations Between TPG and TRR, RRS, ABI, and URICA

Scales	<i>n</i>	Treatment Part./Gain	
		<i>r</i>	<i>p</i>
Tr. Readiness Rating Scale	59	.60	.001**
Tr. Responsivity Rating Scale	56	.46	.001**
Abusive Relationships Inventory			
Rationales for Hitting	59	-.10	.42
Need for Control	59	-.26	.04*
Legal Entitlement	59	-.05	.70
Batterer's Myths	59	-.30	.03*
University of Rhode Island Change Assessment			
Pre-Contemplation	41	.07	.64
Contemplation	41	.01	.94
Action	41	.05	.73
Maintenance	41	.11	.48

*Note: \*  $p < .05$ . \*\*  $p < .001$ . Pre-treatment scores subtracted from post-treatment scores*

In summary, Part IV deals with the issue of treatment-related change. The paired samples *t*-test showed that there were several positive treatment-related changes for several of the measures. The Abusive Relationships Inventory, Relapse Prevention Test, Empathy Scale, University of Rhode Island Change Assessment, Treatment Readiness Rating Scale, and Treatment Responsivity Rating Scale all showed a number of significant pre- to post-treatment improvements in mean score. However, without a control group, it is not possible to unambiguously trace this apparent improvement to a treatment effect. Although the age of the offenders was correlated with the change scores for the various measures, there were only two significant correlations on the Treatment Participation and Gain Rating Scale. Similarly, although change scores were compared on the between-group factors of Level of Security, Relationship Status, and Region, there were relatively few significant between-group differences

indicating that when significant treatment gains did occur, they were not due to belonging to any particular group, but occurred across all offenders in the program. Turning to the Treatment Participation and Gain Rating Scale (TPG), the one-sample t-test found that the mean scores for each of the items of the Scale were significantly different from 0. The TPG was positively correlated with both the Treatment Readiness and Treatment Responsivity Rating Scales indicating substantial agreement between scales. The TPG was also negatively correlated with the Need for Control and Batterer's Myths subscales of the Abusive Relationships Inventory (ABI), suggesting that those offenders who were judged by facilitators to have shown substantial treatment-related gains also judged themselves, at post-treatment, to have less of a need to exert dominance over their partner as well as less of a tendency to believe certain myths that can support and encourage abusive behaviour.

#### PART V. THE STATISTICAL INFORMATION ON RECIDIVISM (SIR) SCALE: CONCURRENT AND PREDICTIVE VALIDITY

The SIR was completed pre-treatment only. The primary task of the SIR is to predict recidivism. The Scale consists of 15 items. The items are summed to yield a total score that clusters into one of five categories: Very Good, Good, Fair, Fair to Poor, Poor. Those offenders who receive a Very Good risk rating are judged to be the least likely to recidivate within three years of being released from a facility.

Part V consists of four sections: (1) A descriptive overview of the recidivism data made available by Correctional Services Canada for the present study; (2) The SIR is correlated with recidivism data; (3) The SIR is compared on the three between-subject variables of Level of Security, Relationship Status, and Region, and; (4) The SIR ratings are correlated with the mean scores from four measures that were also administered pre-treatment only. In addition, the SIR

ratings are correlated with the change scores of five measures that were administered pre- and post-treatment as well as with the total score for the Treatment Participation and Gain Rating Scale (post-treatment only).

### **1. Descriptive Statistics for the Statistical Information on Recidivism (SIR) Scale**

Recidivism information for the group of offenders in the present study was obtained from the Offender Management System (OMS) by authorized personnel with Correctional Services of Canada (CSC). Although the OMS contains comprehensive information about an offender's criminal history (e.g., initial intake information, charges, sentencing, property, medical information, etc.), the recidivism data provided to the researcher from CSC only includes release and re-admission date; that is, the data do not include information about the nature of the offence (e.g., commission of new offence, parole revocation for indictable offence, revocation for technical parole violation) that lead to re-admission. For present purposes, recidivism is defined as an arrest and re-conviction that resulted in re-admission to a federal facility.

To reiterate, 101 offenders completed the test battery. Thirty-eight (38) of these 101 offenders (37%) were released from a facility at the extraction date (end of follow-up period). The mean follow-up period for these 38 offenders was 1.6 years ( $SD = .70$  years). Eleven (11) of these 38 offenders (29%) recidivated and were returned to a federal facility within the follow-up period. For those who recidivated, the mean amount of time between release and re-admission was 224 days ( $SD = 97$  days). SIR ratings were available for 30 of the 38 offenders who were released. Nine (9) of these 30 offenders (30%) recidivated and were returned to a facility within the follow-up period.

As seen in Table 14.1, seven (7) of the 30 offenders for whom SIR ratings were available had received a "Very Good" risk rating; Five (5) had received a Good risk rating; eight (8) had

received a Fair risk rating; five (5) offenders had received a “Fair to Poor” risk rating, and; five (5) offenders had received a Poor risk rating. Considering the number and percentage of the those who recidivated and for whom SIR scores were available, as seen in Table 63, four (4) of the 7 offenders (43%) who had received a “Very Good” risk rating recidivated within the follow-up period of 1.6 years; While none of the offenders who had received a Good risk rating recidivated within the follow-up period, 4 of the 8 (50%) offenders who had received a Fair risk rating recidivated within the follow-up period; 1 of the 5 offenders (20%) who had received a “Fair to Poor” risk rating recidivated, and; 1 of the 5 offenders (20%) who had received a Poor risk rating recidivated within the follow-up period of 1.6 years.

**Table 14.1.** Recidivism by SIR Risk Groupings

Sir Risk Grouping	n <sup>1</sup>	Non-Recidivated (SIR scores available) Count	Recidivated <sup>2</sup> (SIR scores available) Count	Percent Recidivated (SIR scores available)
Very Good	7	4	3	43%
Good	5	5	0	0
Fair	8	4	4	50%
Fair to Poor	5	4	1	20%
Poor	5	4	1	20%
Total	30	21	9	

*Note:*<sup>1</sup> Although 38 offenders had been released, SIR scores were available for only 30 of the 38.

*Note:*<sup>2</sup> Although 11 offenders were returned to a facility within the follow-up period, SIR ratings were available for only 9 of these 11.

## 2. Correlating the SIR with Recidivism Data

Four factors were intercorrelated: (1) Age; (2) Length of Time between Release and Readmission Date ( $M= 224$  days,  $SD= 97$  days); (3) “Did Offenders Recidivate?” (No/Yes), and; (4) SIR scores. As seen in Table 14.2, there were two significant findings. First, Age was positively correlated with “Length of Time Between Release and Readmission,”  $r= .61$ ,  $p= .05$ .

This finding indicates that, once released, the older offenders took longer to re-offend and return to a facility than did the younger offenders. Second, the age of the offenders was positively correlated with the SIR,  $r = .48$ ,  $p = .001$ . Since higher scores on the SIR reflect a more favourable risk rating, this finding indicates that older offenders were judged to be less likely to recidivate than were the younger offenders; that is, SIR-based risk of recidivism decreases with age.

However, SIR score was not significantly related with recidivism.

**Table 14.2.** Correlation Matrix of SIR with Three Factors

	1	2	3	4
1. Age (n= 38)	--	.61*	-.23	.48**
2. Length of Time Between Release and Readmission (n= 11)	--	--	.24	.11
3. Did Offender Recidivate?(No/Yes) (n= 39)	--	--	--	-.19
4.SIR (n= 53)	--	--	--	--

Note: \*  $p < .05$ , \*\*  $p < .01$ .

### 3. Comparing the SIR on Three Between-Subject Variables

A t-test or one-way ANOVA was also performed in order to compare SIR mean scores on the three between-subject variables of Level of Security, Relationship Status, and Region. As seen in Table 14.3, there were no significant findings for both Level of Security, and Region. However, there was a significant finding for Relationship Status,  $t(51) = 2.17$ ,  $p = .03$ . An examination of the means indicates that those offenders who were not in a relationship ( $M = 4.31$ ,  $SD = 10.33$ ) at the time of testing scored more favourably on the SIR than did those who were in a relationship ( $M = -1.90$ ,  $SD = 8.80$ ).



**Table 14.3.** Comparing SIR Mean Score Differences for Level of Security, Relationship Status, and Region

SIR Mean Score						
Group	<i>n</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>	Comparison
Level of Security						
Minimum	13	.38	9.60			
Medium	40	2.80	10.43	-.74	.46	
<i>Note: Degrees of freedom= 51.</i>						
Relationship Status	<i>n</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>	Comparison
In a Relationship	18	-1.90	8.80			
Not in a Relationship	35	4.31	10.33	2.17	.03	Not In> In
<i>Note: Degrees of freedom= 51.</i>						
Region	<i>n</i>	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>	Comparison
Atlantic	8	.63	9.85			
Quebec	13	.38	9.60			
Ontario	6	4.67	12.90			
Prairie	15	5.33	10.15			
Pacific	11	-.90	10.25	.71	.59	
<i>Note: Degrees of freedom= 4, 48.</i>						

#### 4. Correlating the SIR with Pre-Treatment Only Scores and with Change Scores

The SIR was completed pre-treatment only. Four other measures were also completed pre-treatment only: Relationship Style Questionnaire (RSQ), Borderline Personality Organization (BPO), Anti-social Personality Disorder Checklist (APD), Paulhus Deception Scale (PDS). The anti-social and borderline personality are both implicated in high rates of domestic violence (Correctional Service of Canada, 2001). The RSQ measures four attachment patterns: Secure, Fearful, Pre-Occupied, Dismissive. Individuals with fearful and pre-occupied attachment patterns are prone to feelings of anxiety, jealousy, anger, and violence in their intimate relationships (Correctional Services of Canada, 2001). The Paulhus Deception Scale (PDS) measures self-deceptive enhancement and impression management. Self-report measures are particularly susceptible to socially desirable responding (Paulhus, 1984). In addition, family violent offenders are prone to downplaying both their violence and undesirable characteristics (Dutton & Hemphill, 1992). It is of interest to examine the relationship between the SIR and the tendency to engage in socially desirable responding.

As seen in Table 14.4, there was not a significant correlation between the SIR and any of the four measures that were also administered pre-treatment only. In other words, the SIR failed to demonstrate concurrent validity.

A correlational analysis was also performed between the Total SIR rating and the pre- to post-treatment change scores for the five measures that were administered pre- to post-treatment and which have a total score: Relapse Prevention Test (RPT), Empathy Scale (ES), Treatment Readiness Rating Scale (TRR), Treatment Responsivity Rating Scale (RRS), University of Rhode Island Change Assessment (URICA). Change scores were obtained by subtracting the pre-treatment mean scores from the post-treatment mean scores. In addition, the SIR was correlated with the Total score for the Treatment Participation and Gain Rating Scale which was administered post-treatment only. As seen in Table 14.5, the SIR was not significantly correlated with any of the measures. Since the correlation coefficient measures the extent to which two factors vary together, and thus how well either factor predicts the other, the nonsignificant findings suggest that, for the present sample at least, high risk of recidivism ratings could not be used to predict pre- to post-treatment changes in performance.

**Table 14.4.** Correlations Between SIR and Pre-Treatment Measures

Measure	Total SIR Score	
	<i>r</i>	<i>p</i>
Relationship Style Questionnaire		
Secure	.04	.80
Fearful	-.18	.23
Pre-Occupied	-.002	.99
Dismissing	-.13	.40
Borderline Personality Organization		
Loss of Reality	-.09	.53
Primitive Defences	.01	.95
Identity Diffusion	-.10	.55
Total BPO	-.06	.70
Antisocial Personality Disorder	.13	.46
Paulhus Deception Scale		
Self-Deceptive Enhancement	-.09	.56
Impression Management	-.04	.78
Total PDS	-.07	.64

**Table 14.5.** Correlations Between SIR and Change Scores and with Treatment Participation and Gain Rating Scale

Measure	SIR Total Score	
	<i>r</i>	<i>p</i>
Relapse Prevention Test	-.15	.52
Empathy Scale	.13	.53
Treatment Readiness Rating	-.24	.18
Treatment Responsivity Rating	-.12	.53
URICA	.20	.39
Participation and Gain (post-treatment only)	.02	.90

*Note: Except for the Treatment Participation and Gain Rating Scale (post-treatment only), pre-treatment scores subtracted from post-treatment scores.*

In summary, the SIR was not significantly related with recidivism. However, the age of the offenders was significantly correlated with both the SIR and “The Length of Time Between Release and Re-admission.” The SIR was not significantly correlated with the four measures that

were administered concurrently with the SIR. The SIR did not correlate with the change scores for those measures that were administered both pre- and post-treatment. Nor did the SIR significantly correlate with the Treatment Participation and Gain Rating Scale.

## PART VI. CORRELATIONS BETWEEN CRITERION AND PREDICTOR VARIABLES

The initial intention was to conduct a (hierarchical) regression analysis to examine the contribution of several independent (predictor) variables on several dependent (criterion) variables. The dependent variables chosen for analysis included six measures: Empathy Scale (ES), Relapse Prevention Test (RPT), Treatment Readiness Rating Scale (TRS), Treatment Responsivity Rating (RRS) Scale, Treatment Participation and Gain Rating Scale (TPG), and the University of Rhode Island Change Assessment (URICA). Except for the Treatment Participation and Gain Scale, each of these measures were administered pre- and post-treatment. All of the dependent variables were targets of treatment and have total scale scores. Change scores for the total scale score of each measure (except for the Treatment Participation and Gain Rating Scale) were calculated by subtracting pre-treatment total scale scores from post-treatment total scale scores. The initial intention was to regress the chosen predictor variables on the total change score for each of the dependent variables.

Seven measures/variables were to be used as independent/ predictor variables: Paulhus Deception Scale (PDS; administered pre- treatment only), Age, Relationship Status, Level of Security, Borderline Personality Organization (BPO; pre- treatment only), Antisocial Personality Disorder Checklist (APD; pre- treatment only), and the Statistical Information on Recidivism (SIR) Scale (pre-treatment only). Since the analysis was to involve hierarchical regression, the predictor variables were to be entered into separate blocks in order to examine any significant

incremental change in contribution to the prediction of the criterion from one block of variables to the next.

Prior to analysis, SPSS Descriptives was used to test the normality assumption for the five independent variables that are continuous variables. As seen in Table 15.1, positive skewness was identified for the Total score of the Borderline Personality Organization measure, negative kurtosis was identified for the Total score of the Antisocial Personality Disorder Checklist, and positive kurtosis was identified for Age. A logarithmic transformation was applied to the Borderline Personality Organization measure. Following transformation, the obtained skewness value for the BPO was .60 (kurtosis value= .70). A square root transformation was applied to the Total score of the APD. Following transformation, the obtained kurtosis value was 1.89 (skewness value= 1.38). A logarithmic transformation was applied to Age. Following transformation, the obtained kurtosis value was 1.85 (skewness value= -1.05). The analysis was to be performed on the transformed data.

**Table 15.1.** Normality of Predictors Prior to Transformation

Predictor	<i>Skewness</i>	<i>SE</i>	<i>z</i>	<i>Kurtosis</i>	<i>SE</i>	<i>z</i>
Paulhus Deception Scale	.37	.26	1.44	-.45	.52	-.09
Age	.65	.38	1.71	2.22	.75	2.96
Borderline Personality Org.	.88	.26	3.38	.68	.52	1.31
Antisocial Personality Disorder	-.11	.29	-.38	-.41	.57	-2.47
Statistical Info. on Recidivism	.24	.33	.73	-1.14	.64	-1.78

One of the preliminary steps to conducting a regression analysis is to examine the correlations between the predictor and criterion variables. According to Heiman (1999) and Howell (1997) regression should be performed only when the Pearson  $r$  is significant. Unfortunately, the preliminary correlational analysis revealed that too few of the selected predictors were significantly correlated with any of the criterion to warrant a regression analysis. Table 69 only reports the zero-order correlations between the various independent and dependent variables.

As seen in Table 15.2, there were only 3 significant correlations. First, there was a negative correlation between the APD and the Total change score for the TPG,  $r = -.49$ ,  $p = .001$ . This finding indicates that those offenders who scored high on the Anti-social Personality Disorder Checklist also tended to receive lower (therefore, less favourable) ratings on the Treatment Participation and Gain Rating Scale. Second, the age of the offenders was positively correlated with the Total change score for the URICA,  $r = .52$ ,  $p = .01$ . This finding suggests that the older offenders were more willing or prepared than the younger offenders to take action against their problems. Third, there was a significant negative correlation between the BPO and the Total change score for the URICA,  $r = -.27$ ,  $p = .04$ . This finding suggests that those offenders who displayed a strong tendency toward borderline personality also reported a weak overall desire to change and turn their lives around.

Table 15.2. Independent and Dependent Variable Correlations

Predictor	n	Criterion (change score)											
		Empathy		Relapse Prevention		Readiness Rating		Responsivity		Part. & Gain		URICA	
		r	p	r	p	r	p	r	p	r	p	r	p
Paulhus Deception	83	-.06	.33	-.02	.45	-.07	.28	.03	.40	-.06	.32	.16	.16
Age	38	.03	.45	.18	.23	-.12	.26	-.19	.19	.31	.07	.52	.01*
Borderline Personality	84	-.09	.25	-.05	.37	-.06	.32	.07	.29	.02	.44	-.27	.04*
Antisocial Personality	68	.11	.22	.19	.12	-.14	.16	-.16	.13	-.49	.001*	-.17	.18
SIR	53	.13	.53	-.15	.52	-.24	.18	-.12	.53	.02	.90	.20	.39

Note: \*  $p < .05$ , \*\*  $p < .001$ . Except for the Treatment Participation and Gain Rating Scale (post-treatment only), pre-treatment scores subtracted from post-treatment scores.

In summary, although the initial intention was to perform a (hierarchical) regression analysis, there were too few significant correlations between the selected predictor and criterion variables to warrant a regression analysis. However, three significant correlations were observed. First, the Anti-social Personality Checklist was negatively correlated with the Total score on the Treatment Participation and Gain Rating Scale suggesting that those offenders who scored high on the Checklist were also judged to have benefited less from the treatment program than those offenders who did not score high on the Checklist. Second, the age of the offenders was positively correlated with the Total change score of the University of Rhode Island Change Assessment. This finding suggests that the older offenders were better prepared than the younger offenders to take action against their problems and to maintain any positive changes that had been made. Third, the Borderline Personality Organization measure was negatively correlated with the URICA, suggesting that those offenders who showed a strong tendency toward Borderline Personality disorder also reported a relatively weak desire to change and improve their lives.

## DISCUSSION

### **The Present Study**

This study assessed the high intensity batterer intervention program offered to incarcerated male offenders by Correctional Services of Canada (CSC). The program emphasizes three main components: modification of cognitions, emotions management, social skills development. According to the theory of cognitive behaviourism, a person's emotional reactions are not directly caused by an event but by the person's thoughts in response to the event. Since abusive behaviour is largely the product of faulty thinking patterns, change the faulty thinking patterns and one's adverse emotional reactions and the tendency to act abusively should also change.



Thus, it is critical to make program participants keenly aware of their existing attitudes, beliefs, and values, and how these cognitions may be illogical and self-defeating. In addition to the cognitive and emotional parts of the equation, there is also the need to improve the participant's social skills so that they can better manage their relationships. This means improving their communication skills as well as their negotiation and conflict-resolution skills. Much of the present study was devoted to the question of whether or not participation in the treatment program changed the attitudes and beliefs of offenders, as well as improved their ability to effectively control their emotions and better manage their relationships.

In exploring the issue of treatment-related change, a series of paired sample t-tests were performed in order to compare overall pre- and post-treatment scores on seven measures. The seven measures showed a number of significant pre- to post-treatment improvements in mean score. As measured by the Abusive Relationships Inventory, following treatment, the offenders were less likely to report believing that there are often sound, justifiable reasons for acting abusively; they were less likely to report a strong need to control their partner or to claim that being a man grants one special privileges and exemptions; offenders were less likely to endorse certain myths that foster abuse. As measured by the Family Violence Vignettes and Relapse Prevention Test, offenders, following treatment, were judged to show strong improvement in their reasoning and conflict-resolution skills. As measured by the Empathy Scale, offenders, at post-treatment, were judged to show a greater willingness to recognize, appreciate, and respect the point of view and feelings of others.

However, even though the findings suggest that there was an improvement in the offender's way of thinking as well as in their ability to control their emotions and manage their relationships, the missing link involves whether or not there will be an actual change in their *behaviour* once they are released from a facility. As noted earlier in the introduction, following

treatment, abusers and their partner generally enjoy a “honeymoon” period were both work hard to improve their relationship (Rosenbaum, 1988). Unfortunately, with the passage of time, the likelihood of reverting to bad habits also increases. Follow-up studies are conducted precisely to monitor a program participant’s progress after completing treatment. Unfortunately, the present study does not involve a follow-up study per se. However, the present study opens up three paths that may be helpful in forecasting the participant’s possible post-release progress.

First, consider the University of Rhode Island Change Assessment (URICA) as well as the correlation between the Treatment Participation and Gain Rating Scale (TPG) and the Abusive Relationships Inventory (ABI) and URICA. The paired samples t-test on the URICA showed a significant pre- to post-treatment improvement on the Action subscale suggesting that, following treatment, the offenders showed greater enthusiasm about actually making the effort to change and turn their lives around. One can only hope that this apparent commitment would carry through into their lives once they are released. Unfortunately, this hope dims somewhat when one observes that, despite the offenders proclamations about their desire to change, the paired samples t-test of the Maintenance subscale of the URICA calls into question their willingness to work toward maintaining any improvements they might have made. This suggests that the group of participants might be vacillating between their desire to actually change and their willingness to work on maintaining any improvements they might have made.

Second, the TPG was correlated with two pre- to post-treatment measures that were completed by the offenders: Abusive Relationships Inventory (ABI), URICA. The findings from the TPG suggest that the participants had improved in many ways. Recall that the TPG was completed by facilitators. Correlating the TPG with the ABI and URICA provides some insight into whether or not the offenders believed that they had improved as much as the program facilitators believe they had. The results showed that the TPG was negatively correlated with the

Need for Control and Batterer's Myths subscales of the ABI suggesting that those offenders who were judged by facilitators to have shown large treatment-related gains, also self-reported: (a) less of a need to control and dominate their partner, and; (b) less of a tendency to accept or endorse certain myths that can encourage abusive behaviour. Unfortunately, the TPG was not significantly correlated with the Rationales for Hitting and Legal Entitlement subscales of the ABI; nor did the TPG significantly correlate with the four subscales (Pre-Contemplation, Contemplation, Action, Maintenance) of the URICA. Taken together these findings suggest that, despite facilitators' beliefs about the progress made by the participants, the offenders themselves might be more skeptical about whether the program changed their attitudes and beliefs; the absence of a correlation between the TPG and URICA suggests that the offenders might not share the facilitators' faith in their ability and willingness to turn their lives around.

Third, turning to recidivism rates, earlier, in the introduction, two evaluations of domestic violence programs offered by Correctional Services of Canada (CSC) in Quebec facilities were reviewed. In the Amoretti et al. (1997) evaluation, the post-release progress of 97 program participants was tracked. Although 97 offenders had participated in the institutional program, only 30 continued treatment following their release. The researchers found that 6 of the 30 (20%) who had both participated in the institutional program and continued treatment following their release had been returned to prison within one year following their release. On the other hand, 26 of the 67 offenders (39%) who had participated in an institutional program but did not participate in a post-release program were returned to prison within one year of being released. Aubertin and Laporte (1999) monitored the post-release progress of 51 offenders. Twenty-three of the 51 released offenders continued treatment following their release. Using reoffending with spousal violence as the outcome measure, the researchers observed that only 2 of the 23 offenders (9%) who had both received treatment in a facility and continued treatment upon release had

committed an act of spouse abuse compared with 6 of the 28 (21%) who had received institutional treatment but not post-release treatment. In the present study, 11 of 38 offenders (29%) who had been released were returned within the follow-up period of 1.6 years. Although no information was provided to the researcher about whether or not the participants in the present study continued treatment following their release, the two Quebec evaluations suggest that post-release treatment is imperative in helping offender's maintain any improvements gained from participating in an institutional program. It can be reasonably suggested that unless the offender sample for the present study receives post-release treatment, their chances of reoffending will be quite high.

## **Conclusion**

Although there were a number of positive findings, the present study is touched by numerous methodological shortcomings, three of the most obvious ones involving the absence of a comparison group, small sample sizes, and inadequate recidivism data.

The present study involved a non-experimental design. Although there were several positive pre- to post-treatment changes in scores on several of the measures administered to the offenders, since a control group was not available, it is still an open question whether any positive treatment effects are attributable to the program and not to any number of outside influences that could conceivably spur an apparent improvement in the offender's attitudes and behaviours. Any number of standard objections can be tabled. For example, offenders might show a post-treatment improvement in attitude because their test-taking skills have improved – that is, offenders performed better because, over the course of treatment, they may have grown more experienced and discriminating and therefore more sensitive about how to report their attitudes or properly present themselves to raters. Self-reports are particularly susceptible to socially

desirable responding (e.g., Dutton & Hemphill, 1992). Perhaps, as treatment progressed, participants grew more experienced and developed a better feel for how to present themselves in the most positive manner. Perhaps at post-treatment offenders were given more time to complete the self-report measures and therefore they were more careful in how they responded. Nor can the rater's expectation of outcomes be ignored. Facilitators and raters may have certain expectations about the benefits of treatment or a vested interest in wanting the program to succeed and unwittingly enhance their reports of an offender's behaviour.

Another possible source of invalidity involves the phenomenon of regression toward the mean (Howell, 1997). In the present study, there were numerous significant pre- to post-treatment changes in a positive direction suggesting a treatment-related improvement. However, one might wonder how much of the pre- to post-treatment difference in score is attributable to the phenomenon of regression toward the mean. Internal validity is threatened because what appears to be a significant positive change in score due to treatment may actually be nothing more than a change in random error producing an apparent improvement in score (regression toward the mean). Of course, since regression occurs in situations involving extreme scores, one needs to compare the sample mean to the mean of a reference group or population in order to determine whether or not the sample mean is unusually or extremely low. Unfortunately, no norms or reference groups were available for the present study. In addition, an untreated control group would be helpful because to the extent to which the control group's scores change will show the extent of all extraneous variables, including regression toward the mean. However, no such group was available and, as a result, the problem of regression toward the mean remains a possible explanation for at least some of the pre- to post-treatment improvement which was observed for many of the measures.

The present study was also hobbled by small sample sizes and insufficient or missing data.

Although approximately 1400 offenders have participated in the family violence programs offered by Correctional Service of Canada (CSC) since 1999, the amount of data made available for the present study only included 101 offenders. Further, it was not made known to the researcher how or why the data file received from CSC included this particular group of 101. As a result, there is no way to know how representative the present sample is to its corresponding population. In addition, information about the ethnic background of the offenders was too small to allow for comparisons between ethnic groups. Since Aboriginal peoples are considered to be a particularly high risk/need population for domestic violence (Johnston, 1997), it would have been helpful to CSC to compare Aboriginal with non-Aboriginal offenders.

Moreover, difficulties with the small sample size was compounded by the amount of missing data. In the present study, given the amount of missing data for some variables and analyzes, the decision was not to impute a value for the missing value; that is, the preferred approach was to use listwise deletion even though the approach often resulted in a substantial decrease in the available sample size. But, of course, the major problem with simply omitting data is to reduce the generalizability of the results (Tabachnick & Fidell, 1996), a problem which should be kept in mind for a number of the analyzes.

Staying with the issue of sample size, but turning to the Statistical Information on Recidivism (SIR) Scale, during the follow-up period, 38 offenders had been released from a facility. Eleven (11) of the 38 offenders (29%) had been returned to a facility within the follow-up period. Although 11 offenders were returned to a facility within the follow-up period, SIR ratings were available for only 9 of these 11. Three of the 7 offenders (43%) who had received a "Very Good" risk rating on the SIR were returned to a facility within the follow-up period; 4 of the 8 (50%) who had received a Fair risk rating were returned to a facility; 1 of the 5 (20%) who had received a Fair risk rating was returned to a facility, and 1 of the 5 offenders (20%) who had received a

Poor risk rating on the SIR was returned to a facility within the follow-up period. These rates and percentages can be compared with the success/failure rates observed by other studies. For example, Neufeld (1982) found that 20% of offenders classified as “Very Good” were returned to a facility within 3 years of their release (as opposed to 43% for the present study). As in the present study, Neufeld also found that 50% of his offender sample classified as Fair were unsuccessful (recidivated). In addition, Neufeld found that 60% of those classified as “Fair to Poor” were unsuccessful (as opposed to 20% for the present study) and 66% of those classified as Poor were unsuccessful (as opposed to 20% for the present study). For the present study, one would expect that the recidivism rates for those offenders classified as “Fair to Poor” or Poor would be higher. In other words, the domestic violent offenders for the present study did not recidivate at the rates that the SIR would predict.<sup>1</sup> Of course, this inconsistency may be due to the small sample size for the present study; that is, while Neufeld (1982) examined the post-release recidivism of 2475 offenders, the present study examines the post-release recidivism of 38 offenders. And while the follow-up period in the Neufeld study was 3 years, in the present study, the follow-up period was almost half of that (1.6 years). On the other hand, the relatively low recidivism rates observed in the present study also raises the issue of the applicability of the SIR to domestic violent offenders. The SIR was developed for general offenders and there may be something different about domestic violent offenders, differences which affect their recidivism rates. One possibility for a follow-up study would be to examine SIR ratings for a relatively large random sample of domestic violent offenders to determine whether or not their recidivism rates are in line with what the SIR would predict.

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<sup>1</sup> Hann and Harman (1988) examined SIR scores and post-release recidivism in a sample of 534 offenders released from federal facilities in 1983 and 1984. In their study, failure rates (recidivated within 3 years of release) were as follows: Very Good, 13%; Good, 26%; Fair, 38%; Fair to Poor, 53%; Poor, 63%.

The present study had a mean follow-up period of 585 days or 1.6 years (which is characteristic of the follow-up period for most offender recidivism studies). The problem is that the more time from treatment that passes, the more likely it is that the abuser will return to bad habits. However, the major shortcoming at this point is the lack of recidivism data. In the present study, while 11 (11%) offenders were returned to prison during the follow-up period, unfortunately, the only information made available was whether or not an offender was re-admitted to a facility within the follow-up period; no information was provided about why (e.g., revocation for indictable offence, revocation for technical violation) they were re-admitted. Furthermore, it is helpful to observe that only one type of recidivism data (i.e., re-admission rate) was made available for the present study. It is best for recidivism data to be drawn from several sources such as victim reports, self-reports, and official records (Tolman & Edleson, 1995). Although both battered women and abusive men often under-report abuse, victim and self-reports in conjunction with official records help increase the reliability of recidivism data. Although recidivism is a crucial indicator of treatment success, it is often observed that even though abusers might stop physical abuse, they may still engage in a broad range of psychologically abusive and controlling behaviours (Tolman & Edleson, 1995). Beyond providing information about physical abuse, victim reports can provide information about whether or not an abusive partner is still psychologically mistreating his partner.

The usefulness of the recidivism data in the present study is also limited by the absence of a control group. Although most of the offenders were not returned to a facility during the follow-up period, without a control group, their failure to recidivate cannot be traced to a treatment effect. Even though non-recidivists might have stopped being violent toward their partner, this post-release temperance can conceivably be influenced by any number of extraneous factors that can restrain an offender from acting abusively or engaging in criminal behaviour for reasons



quite apart from being treated. For example, an offender might know that others are watching out for his partner; an offender's partner might have contact with a support group or be in contact with a clinician, family counselor or clergyperson; in addition, the threat of re-arrest may temporarily constrain an offender and encourage him to be on his best behaviour. All of these factors and more have to be controlled for before one can have any confidence in tracing non-recidivism to a treatment effect.

Another point worth mentioning involves the Type I error rate per experiment; that is, with the alpha set at .05, it would be expected that five significant findings could be falsely obtained for every 100 t-tests conducted. In Section 4, dealing with treatment-related change, 89 paired sample t-tests were performed. Of the 89 t-tests, 65 resulted in the rejection of the null hypothesis. With an error rate per comparison of .05, it can be expected that, for the 89 comparisons, about 4% of the comparisons would result in a Type I error. This would mean that, of the 89 comparisons, one would expect that 3 or 4 comparisons would result in the incorrect rejection of the null hypothesis. Unfortunately, one does not know which of the 65 significant comparisons resulted from the incorrect rejection of the null hypothesis.

One other situation involves subject-experimenter effects. Six of the measures that were administered both pre- and post-treatment involve semi-structured interviews scored by facilitators. A number of routine points can be raised. From the point of view of the offenders, having participated in the program for a considerable period of time, they can be expected to develop a strong sense of what is expected of them and how they should respond. Some offenders may be overly cooperative and say what they think they are supposed to say; that is, some offenders can be expected to present themselves in the most favourable manner. On the other hand, offenders might be hostile toward their treatment and provide behaviours which are the opposite of those the facilitator expects. Regardless of whether or not the respondents act

cooperatively, the point is that their responses may not express what they really think and feel. From the point of view of the facilitator, they too can be expected to have their expectations about treatment outcomes and may have a vested interest in the success of the program. Of course, the major problem with subject-experimenter effects is that the reliability and validity of results are weakened; that is, not only might the facilitators enhance the ratings given to offenders, but to the extent this bias is systematic, it will roll into the systematic error of the raw scores making them appear more reliable than they might otherwise be. Unfortunately, in a face-to-face interview, the facilitator/researcher does not have the luxury of minimizing subject-experimenter expectancies by using such time-honoured experimental procedures as single- or double-blind procedures. In a face-to-face interview, the most obvious “cure” is for the facilitator to remain as neutral as possible (Heiman, 1999). This means interviewing the offenders without indicating what is “normal” or expected and not judging their responses. The goal, of course, is to make the interviewee feel safe enough to respond openly and honestly.

Quite apart from the present study, it is clear that most researchers hold mixed opinions on the usefulness of batterer intervention programs that are often compromised by a host of theoretical, political, and methodological issues and problems. Consider a list of some of the fundamental and methodological problems tabled by the Minnesota Centre Against Violence and Abuse. Although the list was compiled in 1995, the problems listed below continue unabated:

- (a) Most family violence providers have neither the time nor money to properly assess their program’s effectiveness.
- (b) No universal approach has yet to be identified. Although the family violence programs offered to offenders by CSC approach domestic violence from a perspective of individual attitudinal and behavioural changes as well as a pro-feminist perspective, a literature review finds program influences ranging from psycho-dynamic, social learning, humanistic to programs

that are hybrids which freely draw from the range of perspectives. Although variety is often a virtue, clashes between perspectives also raise questions about which perspective should take precedence (Although cognitive-behavioural techniques have been identified (e.g., Andrews et al., 1990) as the most effective form of treatment for general offenders, others (e.g., Hanson & Wallace-Capretta , 2000) have observed a lack of superiority for cognitive-behavioural treatment over other forms of treatment such as humanistic, pro-feminist, or eclectic.)

(c) Questions remain about the competency and training of program providers.

(d) Abuse of women cannot be understood solely by focusing on the individual; the economic, religious, and cultural context must inform theory and treatment.

(e) Attempts to develop a batterer typology have fallen short.

(f) Lack of theoretical coherence and appropriate measures prevents predicting recidivism.

(g) Small sample sizes; reliance on non-experimental and quasi-experimental studies.

(h) Too short follow-up periods.

(i) Little weight is often given to subject's self-reports.

(j) Programs are often insensitive to cultural differences among participants. For example, as suggested by the National Institute for Justice (2003), models based on white feminist theory (e.g., Duluth model) may not work well with minority populations.

(k) Recidivism data routinely ignores non-physical forms of abuse (e.g., psychological, economic).

(l) While some abusive men stop their violence, they may become more verbally and psychologically abusive; that is, abusive men may reformulate their power and control strategies.

(m) Overly optimistic program assessments gives society a mistaken impression about the effectiveness of intervention programs. Treatment can hold out the false hope that a man who underwent treatment is less dangerous than he was before.

(n) Court mandated treatment may allow an offender refuge from culpability and criminal sanction.

(o) References to economic, family, religious, and cultural antecedents may dilute an abuser's sense of personal responsibility. Similarly, the desire to develop distinct batterer profiles may obscure important differences between abusive men while obscuring those societal conditions that foster and tolerate abuse.

To this list can be appended the critical fact that offenders are a particularly high risk/need population. Although the list of challenges and problems faced by many offenders sometimes seems to stretch to the horizon, the following brief discussion will help the reader appreciate two points: (a) Why offenders are such a high risk/need population, and (b) Why one cannot think of a batterer intervention program for offenders (especially violent offenders) as a cure-all.

The literature review of the issues faced by many offenders has revealed histories of physical, psychological, and sexual victimization (Appleford, 1989). Even witnessing violence between parents has been associated with future violence against women (Statistics Canada, 1993); offenders have been observed having low verbal intelligence with little commitment to prosocial values while endorsing sexist attitudes that are tolerant of spouse abuse (Hanson & Wallace-Capretta, 2000); evidence supporting an association between alcohol abuse and domestic violence range from 20% (Coleman & Straus, 1983) to 80% (Leonard & Jacob, 1988); Saunders (1995) reports that a disproportionate number of offenders have antisocial or borderline personality disorder; the histories of offenders is often marred with explosive and violent behaviour (Robinson, 1995); offenders can be defensive and minimize their abuse (Myers, 1996). Although this list could easily be extended, it is long enough to remind us that, given the number of potential problems faced by many offenders, it is not surprising that efforts to change their attitudes and behaviour is particularly challenging. It seems clear that the legion of potential

problems faced by offenders can combine and interact in any number of mysterious ways to easily mitigate or cancel out any benefits gained from treatment. More generally, the sheer complexity of the problem of treating abusive men also becomes clearer when one considers the many sides to the issue. Integrating approaches, domestic violence can be seen as having a developmental side (learned aggression), a psychological side (perhaps the abuser has an anti-social or borderline personality disorder), a biological side (the relationship between testosterone and aggression), a cultural side (many cultures are patriarchal), and perhaps an evolutionary side (using aggression to stave off sexual rivals while asserting a monopoly over one's mate).

Undoubtedly, inconsistent findings has fostered discouragement about the effectiveness of batterer intervention programs. It is clear that evaluating batterer invention programs is beset with a host of challenges and, in the absence of theoretical consensus about the "causes" of spouse abuse and sound empirical evidence in general support of the efficacy of intervention programs, the disagreements among researchers, academics, and practitioners will continue unabated.

On the positive side, even though domestic violence research has traditionally been beset with a legion of challenges, positive treatment effects, albeit often modest, are routinely observed and a more mature, refined picture of domestic violence research and treatment seems to be gradually emerging, one which seems to offer promise in dealing with the complexity of the psychological, social, cultural, and legal aspects of domestic violence. When dealing with offenders, certain lessons have been learned, lessons which have met with general agreement among academics and service providers.

Regardless of the perspective taken (e.g., cognitive-behavioural, psychodynamic, humanistic), development of effective intervention strategies need to be informed by the pro-feminist perspective. Given women's vested interest in the issue of wife abuse, it is

imperative that their understanding of the problem be given a full hearing. The pro-feminist perspective provides a critical account of how male privilege and dominance at the societal level can translate into abuse at the individual level. Cognitive-behaviourism emphasizes one's cognitions (e.g., attitudes, beliefs, values) as well as the relationship between cognitions, feelings, and behaviour. Although some researchers (e.g., Dutton, 1988) caution against overstating the relationship between patriarchy and abusive behaviour (that is, that patriarchy is a direct and sufficient cause of abuse), the pro-feminist perspective forges a crucial connection between Culture and Individual, and helps to explain how the ideology of "the whole" influences the ideology of "the individual."

And, even though general family violence research is often criticized because no particular explanatory model stands supreme, at the same time, it seems clear that researchers and service providers must nevertheless adopt a "family violence worldview" or explanatory framework that is informed from many directions. The nested model provided by Dutton (1995) which distinguishes between the macrosystem, exosystem, microsystem, and ontogenic levels reminds us that we cannot be content to focus our etiological quest on only one strata of explanation; no single perspective has all the answers. What is required is a model that both recognizes that domestic violence is multi-determined while simultaneously considering the interactions between levels.

Researchers have moved from a monolithic "one size fits all" treatment approach that regards abusive men as forming a homogeneous group toward a "medical model" based on prevention, diagnosis and treatment, and which appreciates that different subtypes (e.g., Family Only Batterers, Generally Violent/Antisocial Batters, Power and Control Batterers, Reactive, Instrumental, etc.) of abusive men may respond to different types of treatment. The notion that abusive men do not form a homogeneous group is particularly true of offenders

who are recognized to be a particularly high risk/need population whose special needs must be accommodated.

Further, as has come to be routinely recommended (e.g., Serin & Kennedy, 1997), treatment for offenders should recognize the principles of Risk, Need, and Responsivity. The Risk Principle states that the intensity of treatment should correspond with level of risk; that is, high risk offenders require more intensive treatment than do low risk offenders. The Need Principle recommends that the focus of treatment should be on criminogenic (dynamic risk factors which, if changed reduce the likelihood of criminal conduct, e.g., alcohol and substance abuse, antisocial attitudes, low educational and social skills) rather than noncriminogenic needs (factors whose resolution does not have a significant impact on recidivism, e.g., anxiety, personality variables such as self-esteem, depression). The Responsivity Principle states that treatment must be sensitive to offender's interpersonal style or personality characteristics that can either facilitate or inhibit learning and improvement. Since the goal of the Responsivity Principle is to maximize offender's response to treatment, treating particular offenders must take into account how their interpersonal style (e.g., motivation, volatility, tendency to rationalize, grandiosity) affects how well they learn program content and change their attitudes and behaviour. We are again reminded that offenders do not form a homogeneous group whose individuality can be safely ignored.

It is also universally understood that cultural differences between individuals must be acknowledged. Interventions must be tailored to take into account sociocultural differences, such as poverty, race, nationality, gender, sexual orientation and so on (Healey et. al. 1998). For Aboriginal offenders, this involves exploring how Aboriginal practices, customs, and values can be incorporated into a program.

It is also understood that batterer intervention programs are just one piece in the overall puzzle of reducing domestic violence; that is, batterer intervention programs require a coordinated community response that must work along-side federal and provincial legislation that protects women, specialized courts that deal exclusively with family violence issues, police who are willing to arrest abusive men, judges willing to grant restraining orders, monitoring of batterers, victim services, public awareness, post-release treatment, and changes to social norms that inadvertently tolerate partner violence.

Although many are skeptical about the lasting benefits of batterer intervention programs, Gondolf (1997) observes that the effectiveness of batterer programs are generally at least comparable to other programs such as drunk driving, drug and alcohol, as well as sex offender programs. Further, as Gondolf (2000) observes, doubts about the effectiveness of treatment are often exaggerated because methodological problems often make it difficult to adopt any firm conclusion about a program let alone one that confidently denies the general efficacy of treatment. While many studies are plagued by methodological problems, Healy et al. (1998) suggests that, "Among evaluations considered methodologically sound, the majority have found modest but statistically significant reductions in recidivism among men participating in batterer interventions" (p. 8). The fact that theoretical and empirical advances are being made provides a basis for hoping and expecting that as spouse abuse becomes better understood and treatments more refined, diverse intervention programs will become more effective in reducing spouse abuse. But since the field of batterer intervention is still young and since many challenges remain to be resolved, it would seem that the most reasonable stand to take about the potential effectiveness of treatment is one of cautious optimism.



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## APPENDIX

MULTIVARIATE ANOVA COMPARING VERSIONS A AND B ON AGE,  
LEVEL OF SECURITY, RELATIONSHIP STATUS, AND REGION

### **1. Relapse Prevention Test (RPT)**

A multivariate analysis of variance (ANOVA) was performed in order to compare Versions A and B of the RPT on the four factors of Age (Median split,  $Md= 38$  years), Level of Security, Relationship Status, and Region. First, as seen in Table 18.1, there were no significant main effects for Age at both pre- and post-treatment for any of the four scenarios or Total scale score of the RPT. This finding indicates that the age of the offenders was not related to the scores of the examinees for Versions A and B at pre- and post-treatment. Nor did the analysis reveal any significant Age x AB interactions for any of the scenarios or the Total scale score at pre- and post-treatment.

**Table 18.1.** Main Effect for Age: Relapse Prevention Test Version A and B

Scenario	Form	Pre-Treatment						F	p
		Younger (<38)			Older (38>)				
		n	M	SD	n	M	SD		
Scenario 1	A	9	3.17	2.06	5	3.00	1.41	2.03	.17
	B	6	5.50	1.05	6	3.50	2.51		
Scenario 2	A	9	2.22	2.17	5	2.20	1.10	1.69	.21
	B	6	5.67	3.20	6	3.17	2.64		
Scenario 3	A	9	2.44	2.55	5	1.60	1.83	.04	.85
	B	6	5.00	1.67	6	5.50	2.59		
Scenario 4	A	9	2.11	2.71	5	1.60	1.95	.01	.93
	B	6	4.50	1.87	6	4.83	3.54		
Total	A	9	9.94	8.16	5	8.40	4.04	.80	.38
	B	6	20.67	5.01	6	17.00	9.44		

*Note: Degrees of freedom= 1, 22.*

Scenario	Form	Post-Treatment						F	p
		Younger (<38)			Older (38>)				
		n	M	SD	n	M	SD		
Scenario 1	A	7	6.43	4.20	6	7.50	1.87	.01	.92
	B	5	4.80	1.30	5	4.00	4.06		
Scenario 2	A	7	7.00	2.45	6	5.67	1.03	.07	.79
	B	5	5.20	1.30	5	6.00	3.81		
Scenario 3	A	7	7.29	2.81	6	5.67	3.44	.74	.40
	B	5	4.40	2.07	5	3.80	3.70		
Scenario 4	A	7	7.00	3.37	6	7.50	3.33	.23	.64
	B	5	5.40	1.14	5	7.50	4.10		
Total	A	7	27.70	7.55	6	26.33	7.39	.02	.89
	B	5	19.80	3.96	5	20.00	14.4		

*Note: Degrees of freedom= 1, 19.*

Second, as seen in Table 18.2, there were no significant differences between the two levels of security (minimum, medium) for any of the four scenarios or Total score of the RPT at either pre- and post-treatment. This finding indicates that Level of Security was not related to the scores of the examinees for Versions A and B at pre- and post-treatment.. Nor did the analysis reveal a significant Level of Security x AB interaction for any of the scenarios or the Total scale score at pre- and post-treatment.

**Table 18.2.** Main Effect for Level of Security: Relapse Prevention Test Version A and B

Scenario	Form	Pre-Treatment						F	p
		Minimum			Medium				
		n	M	SD	n	M	SD		
Scenario 1	A	5	2.80	2.39	19	4.66	2.29	2.00	.16
	B	8	4.00	2.45	21	4.38	2.54		
Scenario 2	A	5	2.20	1.48	19	3.84	2.95	.54	.46
	B	8	4.75	3.06	21	4.52	3.12		
Scenario 3	A	5	4.20	5.02	19	3.55	2.91	2.19	.14
	B	8	6.38	3.34	21	2.58	2.29		
Scenario 4	A	5	2.40	2.41	19	3.58	3.55	.18	.67
	B	8	6.38	3.38	21	4.33	2.58		
Total	A	5	11.60	10.41	19	15.39	10.35	.001	.98
	B	8	21.50	10.45	21	17.62	8.35		

*Note: Degrees of freedom= 1, 49.*

Scenario	Form	Post-Treatment						F	p
		Minimum			Medium				
		n	M	SD	n	M	SD		
Scenario 1	A	10	6.90	2.13	23	6.30	3.25	2.21	.14
	B	3	2.67	1.53	12	6.58	3.20		
Scenario 2	A	10	6.20	2.94	23	5.57	3.47	.07	.80
	B	3	4.33	3.32	12	5.58	3.12		
Scenario 3	A	10	7.90	3.45	23	6.30	3.32	.74	.39
	B	3	1.67	2.08	12	5.33	2.99		
Scenario 4	A	10	6.60	3.10	23	7.00	3.73	2.57	.12
	B	3	3.33	2.08	12	6.92	2.75		
Total	A	10	27.60	7.28	23	25.17	11.52	1.86	.18
	B	3	12.00	8.19	12	24.42	7.95		

*Note: Degrees of freedom= 1, 44.*



Third, the analysis did not reveal any significant Relationship Status differences on Versions A and B for the four scenarios or Total scale score at either pre- and post-treatment (see Table 18.3). This finding indicates that Relationship Status was not related to the scores of the examinees for Versions A and B at pre- and post-treatment. Nor did the analysis reveal any significant Relationship Status x AB interactions at pre- and post-treatment.

Fourth, turning to Region, as seen in Table 18.4, there were no significant regional differences on Versions A and B for any of the four scenarios or Total scale score. This finding indicates that Region was not related to the scores of the examinees for Versions A and B at pre- and post-treatment. Nor was a significant Region x AB interaction found for any of the scenarios or the Total scale score at either pre- and post-treatment.

**Table 18.3.** Main Effect for Relationship Status: Relapse Prevention Test Version A and B

Scenario	Form	Pre-Treatment						<i>F</i>	<i>p</i>
		In a Relationship			Not in a Relationship				
		<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>		
Scenario 1	A	7	3.86	1.77	15	4.30	2.70	.52	.47
	B	9	3.89	2.71	17	4.59	2.60		
Scenario 2	A	7	2.57	2.15	15	3.80	3.10	1.12	.30
	B	9	3.89	2.67	17	4.65	3.43		
Scenario 3	A	7	2.43	2.23	15	3.73	3.83	1.32	.26
	B	9	4.33	3.12	17	5.24	2.68		
Scenario 4	A	7	3.14	2.91	15	3.47	3.80	.14	.71
	B	9	4.33	3.24	17	4.76	2.77		
Total	A	7	12.00	6.81	15	15.30	11.9	.98	.33
	B	9	16.44	9.98	17	19.24	9.15		

*Note: Degrees of freedom= 1, 44.*

Scenario	Form	Post-Treatment						<i>F</i>	<i>p</i>
		In a Relationship			Not in a Relationship				
		<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>		
Scenario 1	A	10	5.90	3.70	4	6.74	2.73	.01	.92
	B	19	6.00	2.94	10	5.40	3.60		
Scenario 2	A	10	4.80	3.26	4	6.32	3.00	.17	.67
	B	19	5.75	3.10	10	5.20	3.33		
Scenario 3	A	10	5.30	3.71	4	7.21	3.24	.03	.87
	B	19	6.00	2.94	10	3.70	3.10		
Scenario 4	A	10	6.00	4.14	4	7.42	3.10	.14	.71
	B	19	8.00	2.71	10	5.70	2.98		
Total	A	10	22.00	13.0	4	27.68	9.14	.001	.99
	B	19	25.75	11.4	10	20.00	8.78		

*Note: Degrees of freedom= 1, 39.*

**Table 18.4.** Main Effect for Region: Relapse Prevention Test Version A and B

Scenario	Form	Pre-Treatment										F	p
		Region											
		Atlantic		Quebec		Ontario		Prairie		Pacific			
M	SD	M	SD	M	SD	M	SD	M	SD	M	SD		
Scenario 1	A	--	--	2.80	2.39	5.17	1.65	5.38	2.88	3.75	1.67	1.68	.20
	B	6.22	1.39	4.00	2.45	--	--	3.00	2.56	3.00	2.16		
Scenario 2	A	--	--	2.20	1.48	3.33	.58	5.25	3.49	2.63	2.45	1.22	.32
	B	6.33	1.41	4.75	3.06	--	--	2.50	3.02	2.50	4.50		
Scenario 3	A	--	--	4.20	5.02	4.67	1.20	3.75	3.33	2.38	2.33	1.26	.30
	B	5.67	1.41	6.38	3.34	--	--	2.63	2.20	5.00	2.16		
Scenario 4	A	--	--	2.40	2.40	3.00	1.00	5.25	4.10	2.13	1.04	.23	.92
	B	5.44	.88	6.38	3.38	--	--	2.88	2.90	4.75	3.60		
Total pre	A	--	--	11.60	10.4	16.2	3.00	19.6	12.88	10.88	8.10	1.06	.39
	B	23.6	2.74	17.39	11.2	--	--	11.0	7.87	17.25	8.58		

Note: Degrees of freedom = 4, 45. Atlantic, n = 9; Quebec, n = 8; Ontario, n = 3; Prairie, n = 8; Pacific, n = 12.

Scenario	Form	Post-Treatment										F	p
		Region											
		Atlantic		Quebec		Ontario		Prairie		Pacific			
M	SD	M	SD	M	SD	M	SD	M	SD	M	SD		
Scenario 1	A	7.25	2.12	6.90	2.13	11.00	--	5.67	4.24	5.00	2.00	1.52	.21
	B	--	--	2.67	1.53	9.00	--	6.90	5.10	6.00	.63		
Scenario 2	A	5.75	2.92	6.20	1.32	10.00	--	6.78	3.20	2.20	2.95	2.45	.06
	B	--	--	4.33	3.10	5.00	--	6.80	4.10	2.34	2.34		
Scenario 3	A	7.00	2.20	7.90	3.45	11.00	--	6.80	3.07	3.40	3.97	1.22	.32
	B	--	--	1.67	2.08	8.00	--	4.40	3.78	5.67	2.42		
Scenario 4	A	6.75	3.58	6.60	3.10	9.00	--	8.22	3.67	4.80	4.10	1.20	.33
	B	--	--	3.33	2.10	4.00	--	7.60	3.78	6.83	1.72		
Total post	A	26.7	7.10	27.66	7.28	41.00	--	27.44	12.83	15.50	9.9	1.80	.15
	B	--	--	12.00	8.19	26.00	--	25.60	11.63	23.17	5.20		

Note: Degrees of freedom = 4, 39. Atlantic, n = 8; Quebec, n = 10; Ontario, n = 1; Prairie, n = 14; Pacific, n = 5.

## **2. Family Violence Vignettes (FVV)**

A multivariate ANOVA was performed on the data in order to compare Versions A and B of the FVV on three independent variables: Age (see Table 18.5), Level of Security (see Table 18.6), and Relationship Status (see Table 18.7). However, insufficient data made testing difficult, if not impossible. As a result, the reliability of the findings is highly questionable. Furthermore, because of insufficient data, Versions A and B were not compared on Region.

**Table 18.5.** Main Effect for Age: Family Violence Vignettes Test Version A and B

	Form	Pre-Treatment						F	p
		Younger (<38)			Older (38>)				
		n	M	SD	n	M	SD		
Hostile/ Inappro. Response	A	3	.67	1.15	1	.00	--	.25	.67
	B	--	--	--	1	1.00	--		
Non-hostile/ Appro. response	A	3	10.67	1.15	1	20.00	--	49.0	.02
	B	--	--	--	1	19.00	--		
Responsibility for Situation Attribution Score	A	3	6.67	.58	1	5.00	--	6.25	.13
	B	--	--	--	1	7.00	--		
Internal/ Self-Control	A	3	3.33	2.08	1	5.00	--	.48	.56
	B	--	--	--	1	3.00	--		
External Control	A	3	2.33	2.53	1	5.00	--	.84	.46
	B	--	--	--	1	3.00	--		
Effectiveness Rating	A	3	37.00	9.54	1	50.00	--	1.39	.36
	B	--	--	--	1	37.00	--		
Risk Rating	A	3	15.00	7.93	1	5.00	--	1.19	.39
	B	--	--	--	1	21.00	--		

Note: Degrees of freedom= 1, 2.

Scenario	Form	Post-Treatment						F	p
		Younger (<38)			Older (38>)				
		n	M	SD	n	M	SD		
Hostile/ Inappro. Response	A	--	--	--	1	.00	--	--	--
	B	2	.00	.00	--	--	--		
Non-hostile/ Appro. response	A	--	--	--	1	20.00	--	--	--
	B	2	20.00	.00	--	--	--		
Responsibility for Situation Attribution Score	A	--	--	--	1	7.00	--	--	--
	B	2	6.50	3.54	--	--	--		
Internal/ Self-Control	A	--	--	--	1	3.00	--	--	--
	B	2	5.00	.00	--	--	--		
External Control	A	--	--	--	1	3.00	--	--	--
	B	2	.50	.71	--	--	--		
Effectiveness Rating	A	--	--	--	1	37.00	--	--	--
	B	2	39.50	12.00	--	--	--		
Risk Rating	A	--	--	--	1	21.00	--	--	--
	B	2	10.50	10.50	--	--	--		

Note: Degrees of freedom= 1, 1.

**Table 18.6.** Main Effect for Level of Security: Family Violence Vignettes Version A and B

Scenario	Form	Pre-Treatment						<i>F</i>	<i>p</i>
		Minimum			Medium				
		<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>		
Hostile/ Inappro. Response	A	--	--	--	7	1.43	1.90	1.21	.30
	B	1	.00	--	5	3.00	3.15		
Non-hostile/ Appro. response	A	--	--	--	7	14.29	3.73	.61	.45
	B	1	20.00	--	5	17.00	3.16		
Responsibility for Situation	A	--	--	--	7	7.43	1.99	.14	.72
	B	1	10.00	--	5	9.20	1.92		
Attribution Score	A	--	--	--	7	5.57	1.13	1.88	.20
	B	1	1.00	--	5	3.00	1.58		
Internal/ Self-Control	A	--	--	--	7	3.57	1.81	7.04	.02
	B	1	.00	--	5	4.40	.89		
External Control	A	--	--	--	7	3.14	1.77	.91	.36
	B	1	.00	--	5	1.80	1.64		
Effectiveness Rating	A	--	--	--	7	41.29	7.30	2.12	.18
	B	1	.00	--	5	43.40	5.13		
Risk Rating	A	--	--	--	7	11.71	6.05	.74	.41
	B	1	8.00	--	5	14.60	8.20		

Note: Degrees of freedom = 1, 10.

Scenario	Form	Post-Treatment						<i>F</i>	<i>p</i>
		Minimum			Medium				
		<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>		
Hostile/ Inappro. Response	A	--	--	--	5	.00	.00	--	--
	B	--	--	--	5	.00	.00		
Non-hostile/ Appro. response	A	--	--	--	5	20.00	.00	--	--
	B	--	--	--	4	20.00	.00		
Responsibility for Situation	A	--	--	--	5	6.60	1.14	--	--
	B	--	--	--	4	5.75	2.22		
Attribution Score	A	--	--	--	5	3.00	1.58	--	--
	B	--	--	--	4	6.00	1.41		
Internal/ Self-Control	A	--	--	--	5	4.60	.89	--	--
	B	--	--	--	4	5.00	.00		
External Control	A	--	--	--	5	1.40	1.14	--	--
	B	--	--	--	4	.75	.50		
Effectiveness Rating	A	--	--	--	5	43.40	5.13	--	--
	B	--	--	--	4	41.25	7.23		
Risk Rating	A	--	--	--	5	14.60	8.20	--	--
	B	--	--	--	4	10.50	2.38		

Note: Degrees of freedom = 1, 7.

**Table 18.7.** Main Effect for Relationship Status: Family Violence Vignettes Version A and B

Scenario	Form	Pre-Treatment						F	p
		In a Relationship			Not in a Relationship				
		n	M	SD	n	M	SD		
Hostile/ Inappro. Response	A	4	.00	.00	3	3.33	1.15	.45	.52
	B	1	4.00	--	4	2.75	3.59		
Non-hostile/ Appro. response	A	4	14.50	4.43	3	14.00	3.46	.02	.89
	B	1	16.00	--	4	17.25	3.59		
Responsibility or Situation Attribution Score	A	4	7.25	2.63	3	7.67	1.15	.01	.91
	B	1	10.00	--	4	9.25	2.22		
Internal/ Self-Control	A	4	6.00	1.41	3	5.00	.00	.27	.62
	B	1	1.00	--	4	3.00	1.83		
External Control	A	4	3.75	1.89	3	3.33	2.08	.76	.41
	B	1	5.00	--	4	3.00	2.16		
Effectiveness Rating	A	4	2.75	2.22	3	3.67	1.15	1.35	.27
	B	1	.00	--	4	2.00	1.83		
Risk Rating	A	4	43.00	8.52	3	39.00	6.08	1.12	.32
	B	1	46.00	--	4	39.50	6.81		
Risk Rating	A	4	8.50	2.90	3	16.00	7.00	2.36	.16
	B	1	8.00	--	4	15.00	9.42		

Note: Degrees of freedom = 1, 4.

Scenario	Form	Post-Treatment						F	p
		In a Relationship			Not in a Relationship				
		n	M	SD	n	M	SD		
Hostile/ Inappro. Response	A	1	.00	--	3	.00	.00	--	--
	B	3	.00	.00	4	.00	.00		
Non-hostile/ Appro. response	A	1	20.00	--	3	20.00	.00	--	--
	B	3	20.00	.00	4	20.00	--		
Responsibility for Situation Attribution Score	A	1	8.00	--	3	6.33	1.15	.64	.47
	B	3	6.00	2.65	4	5.00	--		
Internal/ Self-Control	A	1	1.00	--	3	3.67	1.53	.28	.63
	B	3	6.33	1.53	4	5.00	--		
External Control	A	1	5.00	--	3	4.33	1.15	.25	.64
	B	3	5.00	.00	4	5.00	--		
Effectiveness Rating	A	1	2.00	--	3	1.67	1.15	.001	1.00
	B	3	.67	.58	4	1.00	--		
Risk Rating	A	1	46.00	--	3	41.67	6.43	.02	.88
	B	3	40.67	8.74	4	43.00	--		
Risk Rating	A	1	8.00	--	3	17.33	5.30	1.15	.34
	B	3	9.67	2.08	4	13.00	--		

Note: Degrees of freedom = 3, 4.

### **3. Empathy Scales (ES)**

A multivariate ANOVA was subsequently performed in order to compare Versions A and B of the ES on the four factors of Age (Median split,  $Md= 38$  years), Level of Security, Relationship Status, and Region. First, as seen in Table 18.8, there were no significant age main effects at both pre- and post-treatment for any of the four scenarios. This finding indicates that the age of the offenders was not related to the scores of the examinees for Versions A and B at pre- and post-treatment. In addition, the analysis did not reveal any significant Age x AB interaction effects at both pre- and post-treatment.



**Table 18.8.** Main Effect for Age: Empathy Scale Version A and B

Scenario	Form	Pre-Treatment						F	p
		Younger (<38)			Older (38>)				
		n	M	SD	n	M	SD		
All 6 Scenarios	A	10	16.70	7.12	7	17.00	12.2	.07	.80
	B	6	18.33	9.48	8	19.81	8.10		
All Perspective Taking	A	10	3.20	2.39	7	4.29	3.68	1.65	.21
	B	6	4.00	2.19	8	5.38	2.00		
All Affect	A	10	4.00	2.16	7	4.14	3.89	.04	.83
	B	6	4.33	2.66	8	4.63	2.62		
All Coping w/Distress	A	10	7.80	2.53	7	6.43	3.55	.72	.40
	B	6	8.50	4.04	8	7.88	3.04		
All Partner-centred	A	10	5.00	2.71	7	5.29	4.23	.49	.49
	B	6	5.83	3.06	8	7.31	3.84		
All Child-centred	A	10	6.20	2.66	7	7.00	4.47	.23	.63
	B	6	7.33	3.27	8	5.25	4.13		
All Person Outside Family	A	10	5.50	2.64	7	4.71	4.42	.28	.60
	B	6	5.17	3.80	8	7.25	3.01		

Note: Degrees of freedom=1, 27.

Scenario	Form	Post-Treatment						F	p
		Younger (<38)			Older (38>)				
		n	M	SD	n	M	SD		
All 6 Scenarios	A	6	21.00	8.53	7	27.00	6.45	.46	.50
	B	6	26.67	6.22	4	16.00	11.9		
All Perspective Taking	A	6	5.17	3.66	7	8.71	3.35	.12	.73
	B	6	8.00	2.90	4	5.50	4.43		
All Affect	A	6	6.83	2.93	7	8.43	2.44	1.38	.25
	B	6	8.67	2.25	4	4.25	3.95		
All Coping w/Distress	A	6	9.00	2.28	7	9.86	1.57	1.86	.19
	B	6	10.00	2.28	4	6.25	4.11		
All Partner-centred	A	6	7.17	2.56	7	9.00	2.71	.001	.97
	B	6	8.67	1.97	4	6.75	3.69		
All Child-centred	A	6	7.67	3.50	7	9.43	2.70	2.40	.10
	B	6	9.33	1.51	4	3.50	3.32		
All Person Outside Family	A	6	6.17	3.49	7	8.57	2.51	.03	.87
	B	6	8.67	3.20	4	5.75	5.31		

Note: Degrees of freedom=1, 19.

Turning to Level of Security, as seen in Table 18.9, there were no significant Level of Security main effects for any of the subscales at both pre- and post-treatment. However, there were several interaction effects at both pre- and post-treatment.

#### **(a) Pre-treatment**

At pre-treatment, there were four significant interaction effects. First, there was a significant interaction effect for the Total Score for All 6 Scenarios,  $F(1, 64) = 8.00, p = .01$ . The subsequent simple effects analysis of the two levels of Factor 2 (Versions A and B) at the two levels of Factor 1 (minimum, medium) found a significant within-group effect for the minimum security facility,  $F(1, 13) = 6.23, p = .03$ . An examination of the means found that the mean for Version B ( $M = 23.56, SD = 8.90$ ) was significantly larger than the mean for Version A ( $M = 11.50, SD = 9.60$ ) for the minimum security facility. The simple effects analysis of the two levels of Factor 1 (minimum, medium) at each level of Factor 2 (Versions A and B) found a significant between-groups effect for Version A,  $F(1, 36) = 8.27, p = .01$ . An examination of the means found that the Version A mean for the medium security facilities ( $M = 21.44, SD = 7.44$ ) was significantly larger than the Version A mean for the minimum security facility ( $M = 11.50, SD = 9.57$ ).

Second, there was a significant interaction effect for the Total score for the All Perspective Taking domain,  $F(1, 64) = 16.18, p = .001$ . The simple effects analysis of Factor 2 (Versions A and B) at the two levels of Factor 1 (minimum, medium) found a significant within-group effect for the minimum security facility,  $F(1, 13) = 15.40, p = .002$ . An examination of the means for the minimum security facility found that the mean for Version B ( $M = 6.90, SD = 2.32$ ) was significantly larger than the mean for Version A ( $M = 1.83, SD = 2.65$ ). Turning to the simple effects analysis of Factor 1 (minimum, medium) at each level of Factor 2 (Versions A and B), the analysis found a significant between-groups effect for Version A. The subsequent

examination of the means found that the Version A mean for the medium security facilities ( $M= 5.44$ ,  $SD= 2.47$ ) was significantly larger than the Version A mean for the minimum security facility ( $M= 1.83$ ,  $SD= 2.64$ ).

Third, there was a significant interaction effect on the Total Score for All Affect domain,  $F(1, 64)= 13.60$ ,  $p= .001$ . The subsequent simple effects analysis of Factor 2 (Versions A and B) at each level of Factor 1 (minimum, medium) found a significant within-group effect for the minimum security facility,  $F(1, 13)= 9.32$ ,  $p= .01$ . The post hoc examination of the means for the minimum security facility found that the mean for Version B ( $M= 6.11$ ,  $SD= 2.52$ ) was significantly larger than the mean for Version A ( $M= 2.00$ ,  $SD= 2.60$ ). Turning to the simple effects of Factor 1 (minimum, medium) at both levels of Factor 2 (Versions A and B), a significant between-groups effect for Version A was found,  $F(1, 36)= 10.51$ ,  $p= .003$ . An examination of the means found that the Version A mean for the medium security facilities ( $M= 5.75$ ,  $SD= 2.30$ ) was significantly larger than the Version A mean for the minimum security facility ( $M= 1.83$ ,  $SD= 2.64$ ).

Fourth, there was a significant interaction effect on the Total Score for the All Partner-centred scenarios,  $F(1, 64)= 5.66$ ,  $p= .02$ . The analysis of the simple effects of Factor 2 (Versions A and B) at each level of Factor 1 (minimum, medium) found a significant within-group effect for the minimum security facility,  $F(1, 13)= 6.99$ ,  $p= .02$ . An examination of the means for the minimum security facility found that the mean for Version B ( $M= 8.44$ ,  $SD= 3.32$ ) was significantly larger than the mean for Version A ( $M= 4.00$ ,  $SD= 2.97$ ). Turning to the simple effects of Factor 1 (minimum, medium) at both levels of Factor 2 (Versions A and B), a significant between-groups effect for Version A was found,  $F(1, 36)= 4.94$ ,  $p= .03$ . An examination of the means found that the Version A mean for the medium security facilities ( $M= 6.95$ ,  $SD= 2.95$ ) was significantly larger than the Version A mean for the minimum security

facility ( $M= 4.00$ ,  $SD= 2.97$ ).

### **(b) Post-treatment**

At post-treatment, there was a significant interaction effect for five of the seven domains of the Empathy Scale. First, for Total Score for All 6 Scenarios, the interaction F-value is  $F(1, 53)= 11.47$ ,  $p= .001$ . The simple effects analysis of Factor 2 (Versions A and B) at both levels of Factor 1 (minimum, medium) found a significant within-groups effect for the minimum security facility,  $F(1, 11)= 10.00$ ,  $p= .01$ . An examination of the means found that the Version A mean ( $M= 28.40$ ,  $SD= 5.15$ ) was significantly larger than the Version B mean ( $M= 15.00$ ,  $SD= 10.40$ ). Turning to the simple effects of Factor 1 (minimum, medium) at each level of Factor 2 (Versions A and B), a significant between-groups effect was found for Version A,  $F(1, 36)= 8.27$ ,  $p= .01$ . An examination of the means found that the Version A mean for the medium security facilities ( $M= 21.44$ ,  $SD= 7.44$ ) was significantly larger than the Version A mean for the minimum security facility ( $M= 11.50$ ,  $SD= 9.57$ ).

Second, there was a significant interaction effect for the All Perspective Taking domain,  $F(1, 53)= 11.47$ ,  $p= .003$ . The subsequent simple effects analysis of Factor 2 (Versions A and B) at each level of Factor 1 (minimum, medium) found a significant within-group effect for the minimum security facility,  $F(1, 13)= 15.40$ ,  $p= .002$ . The subsequent examination of the means found that the Version B mean ( $M= 6.90$ ,  $SD= 2.32$ ) was significantly larger than the Version A mean ( $M= 1.83$ ,  $SD= 2.64$ ) for the minimum security facility.

Third, there was a significant interaction effect on the Total Score for the All Coping with Distress domain,  $F(1, 53)= 6.42$ ,  $p= .01$ . The subsequent simple effects analysis of Factor 2 (Versions A and B) at each level of Factor 1 (minimum, medium) found a significant within-group effect for the minimum security facility,  $F(1, 11)= 8.13$ ,  $p= .02$ . The subsequent

examination of the means found that the Version A mean ( $M= 9.80, SD= 1.93$ ) was significantly larger than the Version B mean ( $M= 5.33, SD= 3.80$ ) for the minimum security facility.

Fourth, there as also a significant interaction effect on the Total Score for the All Partner-centred domain,  $F(1, 53)= 9.05, p= .004$ . The subsequent simple effects analysis of Factor 2 (Versions A and B) at the two levels of Factor 1 (minimum, medium) found a significant within-group effect for the minimum security facility,  $F(1, 11)= 4.93, p= .05$ . An examination of the means found that the Version A mean ( $M= 9.20, SD= 2.20$ ) was significantly larger than the Version B mean ( $M= 5.67, SD= 3.21$ ) for the minimum security facility. The simple effects analysis of Factor 1 (minimum, medium) at the two levels of Factor 2 (Versions A and B) found a significant between-groups effects for Version B,  $F(1, 26)= 9.00, p= .01$ . An examination of the means found that the Version B mean for the medium security facilities ( $M= 9.52, SD= 1.98$ ) was significantly larger than the Version B mean for the minimum security facility ( $M= 5.67, SD= 3.20$ ).

Fifth, there was a significant interaction effect on the Total Score for the Person Outside Family domain,  $F(1, 53)= 10.85, p= .002$ . The subsequent simple effects analysis of Factor 2 (Versions A and B) at both levels of Factor 1 (minimum, medium) found a significant within-group effect for the minimum security facility,  $F(1, 11)= 10.00, p= .01$ . An examination of the means found that the Version A mean ( $M= 8.70, SD= 2.50$ ) was significantly larger than the Version B mean ( $M= 3.33, SD= 2.90$ ) for the minimum security facility. The simple effects test of Factor 1 (minimum, medium) at each level of Factor 2 (Versions A and B) found a significant between-groups effect for Version B,  $F(1, 26)= 9.72, p= .004$ . An examination of the means found that the Version B mean for the medium security facilities ( $M= 8.60, SD= 2.75$ ) was significantly larger than the Version B mean for the minimum security facility ( $M= 3.33, SD= 2.90$ ).

**Table 18.9.** Main Effect for Level of Security: Empathy Scale Version A and B

Scenario	Form	Pre-Treatment						<i>F</i>	<i>p</i>
		Minimum			Medium				
		<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>		
All 6 Scenarios	A	6	11.50	9.57	32	21.44	7.44	2.02	.16
	B	9	23.56	8.90	20	20.22	7.20		
All Perspective Taking	A	6	1.83	2.64	32	5.44	2.47	.98	.33
	B	9	6.89	2.32	20	4.65	1.87		
All Affect	A	6	2.00	2.61	32	5.75	2.30	.75	.10
	B	9	6.11	2.52	20	4.70	2.30		
All Coping w/Distress	A	6	5.67	3.56	32	7.81	2.58	3.24	.08
	B	9	8.11	3.18	20	8.95	2.63		
All Partner-centred	A	6	4.00	2.97	32	6.94	2.97	.75	.40
	B	9	8.44	3.32	20	7.08	2.98		
All Child-centred	A	6	4.33	3.39	32	7.87	2.77	3.32	.07
	B	9	6.89	4.57	20	6.85	3.13		
All Person Outside Family	A	6	3.17	3.66	32	6.63	2.73	.75	.39
	B	9	8.22	3.07	20	6.30	3.03		

*Note: Degrees of freedom= 1, 63.*

Scenario	Form	Post-Treatment						<i>F</i>	<i>p</i>
		Minimum			Medium				
		<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>		
All 6 Scenarios	A	10	28.40	5.15	19	22.84	7.65	1.35	.25
	B	3	15.00	10.4	25	26.36	6.45		
All Perspective Taking	A	10	10.10	1.80	19	6.26	3.43	.02	.88
	B	3	4.67	3.51	25	8.80	2.40		
All Affect	A	10	8.50	2.37	19	7.26	2.70	1.33	.25
	B	3	5.00	4.00	25	8.40	2.42		
All Coping w/Distress	A	10	9.80	1.93	19	9.32	1.95	3.85	.06
	B	3	5.33	3.80	25	9.16	2.60		
All Partner-centred	A	10	9.20	2.20	19	7.90	2.77	2.21	.14
	B	3	5.67	3.20	25	9.52	1.98		
All Child-centred	A	10	10.50	2.01	19	7.68	2.93	.10	.79
	B	3	6.00	4.35	25	8.24	2.88		
All Person Outside Family	A	10	8.70	2.50	19	7.26	3.00	3.54	.06
	B	3	3.33	2.90	25	8.60	2.75		

*Note: Degrees of freedom=1, 53.*

Turning to Relationship Status, the F- and p-values for the multivariate ANOVA at both pre- and post-treatment are presented in Table 18.10. As seen in the table, there were no significant Relationship Status main effects for any of the scenarios at either pre- and post-treatment. This finding indicates that Relationship Status was not related to the scores of the examinees for Versions A and B at pre- and post-treatment. Nor did the analysis reveal a significant Relationship Status x AB interaction effect for any of the subscales of the ES.

Lastly, a multivariate analysis for Region was performed on the seven domains of the Empathy Scale for Versions A and B at both pre- and post-treatment. The F- and p-values for the analysis are presented in Table 18.11. As seen in the table, there were no regional differences on Versions A and B for any of the seven scenarios. This finding indicates that the region in which the offenders were incarcerated was not related to the scores of the examinees for Versions A and B at pre- and post-treatment. Nor did the ANOVA reveal any significant interaction effects for the seven domains of the Empathy Scale.

**Table 18.10.** Main Effect for Relationship Status: Empathy Scale Version A and B

Scenario	Form	Pre-Treatment						<i>F</i>	<i>p</i>
		In a Relationship			Not in Relationship				
		<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>		
All 6 Scenarios	A	12	21.58	7.67	17	18.35	10.50	.07	.79
	B	8	19.25	6.41	18	21.14	8.20		
All Perspective Taking	A	12	5.25	2.80	17	4.35	3.43	.22	.64
	B	8	5.00	1.93	18	5.17	2.20		
All Affect	A	12	5.75	2.18	17	4.65	3.48	.08	.78
	B	8	4.50	2.56	18	5.17	2.28		
All Coping w/Distress	A	12	8.17	2.60	17	7.18	3.25	.03	.87
	B	8	8.00	1.77	18	8.72	3.20		
All Partner-centred	A	12	6.83	2.80	17	5.82	3.90	.05	.83
	B	8	6.88	2.80	18	7.47	3.35		
All Child-centred	A	12	7.50	3.21	17	7.06	3.50	.23	.63
	B	8	5.63	4.00	18	7.00	3.27		
All Person Outside Family	A	12	7.24	2.86	17	5.47	3.73	.99	.32
	B	8	6.58	3.50	18	6.67	3.22		

*Note: Degrees of freedom=1, 51.*

Scenario	Form	Post-Treatment						<i>F</i>	<i>p</i>
		In a Relationship			Not in Relationship				
		<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>		
All 6 Scenarios	A	8	20.88	7.30	18	25.83	7.33	1.90	.18
	B	6	23.50	9.90	12	25.80	8.60		
All Perspective Taking	A	8	6.13	3.76	18	7.90	3.45	1.60	.21
	B	6	7.33	3.50	12	8.42	3.15		
All Affect	A	8	6.63	2.67	18	7.83	2.62	.88	.35
	B	6	7.83	3.97	12	8.42	2.95		
All Coping w/Distress	A	8	8.13	1.55	18	10.11	1.88	2.57	.12
	B	6	8.33	4.03	12	9.00	2.95		
All Partner-centred	A	8	7.50	2.45	18	8.72	2.85	.74	.40
	B	6	9.00	2.37	12	9.33	2.93		
All Child-centred	A	8	7.25	2.74	18	8.94	2.84	2.80	.10
	B	6	6.33	2.70	12	8.00	2.60		
All Person Outside Family	A	8	6.13	3.04	18	8.17	8.17	1.22	.28
	B	6	8.17	3.92	12	8.50	8.50		

*Note: Degrees of freedom=1, 40.*



**Table 18.11.** Main Effect for Region: Empathy Scale Version A and B

Scenario	Form	Pre-Treatment										F	p
		Region											
		Atlantic		Quebec		Ontario		Prairie		Pacific			
M	SD	M	SD	M	SD	M	SD	M	SD				
All 6 Scenarios	A	--	--	11.50	9.57	28.50	.71	22.38	9.00	19.88	6.05		
	B	23.94	1.94	23.56	8.90	25.00	--	12.00	5.45	26.25	3.30	2.66	.08
All Persp. Taking	A	--	--	1.83	2.64	7.50	.71	5.77	3.14	4.94	1.90		
	B	5.44	.88	6.89	2.32	9.00	--	2.71	1.60	6.25	.96	1.46	.24
All Affect	A	--	--	2.00	2.60	8.00	.00	6.08	2.87	5.24	1.75		
	B	5.78	1.40	6.11	2.52	5.00	--	2.30	1.70	6.50	1.00	2.80	.07
All Coping w/Distress	A	--	--	5.67	3.55	10.50	2.12	8.10	2.84	7.30	2.31		
	B	10.67	.71	8.11	3.18	7.00	--	6.14	2.34	10.00	1.63	1.70	.20
All Partner-centred	A	--	--	4.00	2.97	8.50	.71	6.77	3.68	6.88	2.55		
	B	7.61	.50	8.44	3.32	8.00	--	4.43	3.10	10.50	1.90	4.10	.02
All Child-centred	A	--	--	4.33	3.40	10.50	.71	8.54	2.90	7.10	2.55		
	B	8.78	1.85	6.90	4.57	9.00	--	4.00	2.31	7.50	3.42	.96	.40
All Person	A	--	--	3.17	3.66	9.50	.71	7.10	3.30	5.95	2.14		
Out. Family	B	7.56	1.51	8.22	3.07	8.00	--	3.55	2.88	8.25	2.87	1.50	.23

Note: Degrees of freedom = 2, 50. Atlantic, n = 9; Quebec, n = 9; Ontario, n = 2; Prairie, n = 13; Pacific, n = 17.

Scenario	Form	Post-Treatment										F	p
		Region											
		Atlantic		Quebec		Ontario		Prairie		Pacific			
M	SD	M	SD	M	SD	M	SD	M	SD				
All 6 Scenarios	A	22.25	4.83	28.40	5.15	--	--	20.14	8.95	28.75	8.45		
	B	--	--	15.00	10.4	27.80	5.15	25.20	8.44	26.27	6.54	2.10	.14
All Persp. Taking	A	5.88	1.80	10.10	1.80	--	--	5.00	4.28	9.25	3.20		
	B	--	--	4.67	3.51	9.20	1.48	8.40	3.29	8.80	2.45	.04	.14
All Affect	A	6.75	1.83	8.50	2.37	--	--	6.57	3.10	9.50	2.90		
	B	--	--	5.00	4.00	9.00	1.87	7.70	3.85	8.47	2.10	2.23	.12
All Coping w/Distress	A	9.63	1.93	9.80	1.93	--	--	8.57	1.80	10.00	2.45		
	B	--	--	5.33	3.79	9.60	2.07	9.20	1.80	9.00	3.00	1.58	.22
All Partner-centred	A	6.75	1.67	9.20	2.20	--	--	7.86	3.48	10.25	2.05		
	B	--	--	5.67	3.21	10.00	2.00	9.80	1.80	9.27	2.12	2.43	.10
All Child-centred	A	7.63	1.92	10.50	2.00	--	--	6.70	3.73	9.50	2.90		
	B	--	--	6.00	4.36	8.20	2.60	6.60	3.36	8.80	2.80	2.16	.13
All Person	A	7.88	2.30	8.70	2.50	--	--	5.57	2.94	9.00	3.56		
Out. Family	B	--	--	3.33	2.90	9.60	2.30	8.80	3.83	8.20	2.60	2.20	.13

Note: Degrees of freedom = 2, 38. Atlantic, n = 8; Quebec, n = 10; Ontario, n = 5; Prairie, n = 7; Pacific, n = 15.