TREATMENT BEHAVIOUR OF MALE BATTERERS: AN EXPLORATION OF COUNSELLOR REPORTS

by

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A thesis submitted in conformity with the requirements
for the degree of Master of Arts
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TREATMENT BEHAVIOUR OF MALE BATTERERS: AN EXPLORATION OF COUNSELLOR REPORTS

Master of Arts (2007)
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Abstract

The current study explores the content of final progress reports written by counsellors of a batterer intervention program; specifically, the nature and frequency of counsellor documented in-treatment behaviours are explored. Results indicated that counsellors frequently reported on client attendance, accountability, and treatment engagement. Other treatment behaviours, however, were reported with moderate to minimal frequency, with some key behaviours never receiving mention. When accountability and treatment engagement were isolated as predictors of success, it was found that approximately 20% of clients were considered unsuccessful by counsellors at the completion of the batterer program. Success in Intervention Phase I was found to predict success in Intervention Phase II for unsuccessful- and successful-rated clients, but not for mixed-rated clients. Results also indicate that client motivation, but not working alliance score or individual-level characteristics, predict final counsellor-rated success. Research and clinical implications are discussed in the context of the current findings.

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Chapter 1

Introduction

Overview

Violence against women is a prevalent social problem in Canada. It is estimated that, over a lifetime, approximately 30% of women will experience some form of intimate partner violence in a relationship (Johnson & Sacco, 1995). Furthermore, although both men and women have been found to perpetrate more minor forms of spousal violence, such as slapping and pushing, at an approximate equal frequency, women are the predominant victims of more severe forms of intimate partner violence (Statistics Canada, 2006).

To address the serious concerns that have arisen from such high rates of intimate partner violence, mandated batterer intervention programs have become a standard legal sanction in Canada. When offenders cause 'non-significant' injuries to their partners, the courts mandate these men to attend a 16-week educational batterer intervention program. Unfortunately, although batterer programs have been accepted as standard protocol when addressing intimate partner violence, comprehensive reviews have suggested that as many as one-third of men in these programs will go on to re-assault their partners (Gondolf, 2002; Scott & Wolfe, 2003). Thus, significant concerns have been raised about the efficacy of batterer intervention programs at reducing rates of violent recidivism beyond that achieved by arrest and sentencing alone.

Researchers have suggested that one potential way to increase intervention effectiveness is to increase the accuracy of violence risk assessment (Douglas & Kroop, 2002). However, batterer programs are currently unrelated to treatment progress or perceived reoffense risk, with these programs relying almost exclusively on program attendance to determine client treatment outcome. Violence risk assessment and counsellor input does not play a role in batterer clients'

program outcome despite the fact that clinical judgement is generally a key component in the discharge of patients from other intervention programs, such as alcohol and mental health treatment (Shea, 1988), and despite some research suggesting that clinicians are often able to predict future violence with moderate accuracy (Johnson, 2000; Lidz et al., 1993). Specifically, recent research has begun to demonstrate that counsellors can predict future abuse with substantial sensitivity by using structured clinical ratings of key in-treatment behaviours of men in batterer programs (Gondolf, 1995; Taft, Murphy, King, Musser, & DeDeyn, 2003). Such research suggests that in order to improve discharge criteria and post-treatment planning, and in turn improve the future success of batterer intervention program participants, new attention should be directed towards the behaviour of clients throughout treatment and their success or failure in meeting key program goals for change.

This study attempts to examine the content of reports written by counsellors in a batterer intervention program in order to explore the potential utility of counsellor reported client treatment behaviours as future discharge criteria. To set the context for this research, the following sections review current research surrounding domestic violence, counsellor judgement, and client treatment behaviours.

Domestic Violence in Canada

Between the years of 1999 and 2004, the Canadian General Social Survey asked a random sample of Canadians about any physical violence that they had experienced in the context of family conflict, including minor forms of intimate partner violence, such as slapping and pushing. This survey found that an estimated 653,000 women and 546,000 men (7% and 6% of the population respectively) experienced at least one incident of violence by their intimate partner (Statistics Canada, 2005). This demonstrates two important points: primarily, that

domestic violence is a prevalent social problem within Canada, and secondly, that there is approximate gender symmetry in relatively minor forms of intimate partner violence.

When considering more severe forms of spousal violence, the significance of this problem is reaffirmed, as demonstrated by the fact that incidents of domestic violence account for approximately one quarter of all violent crimes reported to police services. However, when looking at these more serious cases of domestic violence, there is a drastic increase in the number of male perpetrators, with women becoming the predominant victims. Women suffer more severe and repeated forms of violence and are significantly more likely to be the victims in police-reported cases. For example, in 2004, there were nearly 28,000 incidents of spousal violence reported to police, and 84% of the victims in these cases were female (Statistics Canada, 2006).

Given that women are more likely to report more serious types and repeated episodes of violence by an intimate partner, it is not surprising that women are also more likely than are men to be the targets of more than ten violent incidents at the hands of their partner (21% versus 11%), to suffer injury (44% versus 18%), to seek medical attention (13% versus 2%), and to fear for their life (34% versus 10%) as a results of spousal violence. Furthermore, data from the Homicide Survey found that between the years of 1994 to 2003 approximately one in five solved homicides in Canada involved spouses and that approximately 80% of the victims of these homicides were women (Statistics Canada, 2005).

These concerning figures clearly demonstrate just how prevalent spousal violence continues to be within Canadian families and strongly suggests the need for focused efforts in order to ensure the reduction and prevention of violence against women.

Response to Domestic Violence in Ontario

Formal legal response to domestic violence is a relatively new social development. Prior to the women's movement, which began in the 1970's, Canadian society commonly viewed spousal violence as a private affair, and offered minimal intervention in these matters. However, driven by feminist demands for change, Canadian society has moved away from viewing spousal violence as a personal matter, and now advocates a multi-faceted public response to family violence. Given the prevalence of spousal violence within Canada, in addition to the vast and complex consequences that it entails, an effective response requires the ongoing commitment and collaboration of community members, practitioners and all levels of governments. Currently, both the provincial and territorial governments are working together with various non-governmental organizations and the private sector in an effort to protect the victims of domestic violence while holding the perpetrators of this crime accountable.

Canada's response to spousal violence now includes preventative public education around the nature of domestic violence, research, victim services, and batterer intervention programs (Department of Justice Canada, 2006). Today, women who are the victims of spousal violence have a variety of services available to them including emergency shelters, distress lines, and longer-term support through advocacy services for victims. There has also been an emphasis placed on offender accountability, which is seen through a system that includes mandatory charging whenever there is probable cause to believe that domestic violence has taken place. In addition to mandatory charge policies, legal reform surrounding domestic violence has also led to the creation and wide scale implementation of specialized courts for domestic violence offenders. Domestic Violence Courts (DVC) are an effort for a more holistic, multi-systemic approach to processing cases of domestic violence and promoting victim safety (Eley, 2005).

DVC programs provide a variety of services, including investigation by trained police, subsequent arrest and prosecution of the accused, fast tracking of cases, monitoring of offenders, victim support, and Partner Assault Response (PAR) programs (Eley, 2005; Victim Services Division, 2003).

In Ontario, the Domestic Violence Courts consist of two streams through which men may participate: the early intervention pathway or the coordinated prosecution pathway. The early intervention pathway is available to men who are first time offenders, who have pled guilty to the offence, and who have not used weapons or caused 'significant' injuries to their partners. In the early intervention pathway, men are mandated to attend PAR programs, which are batterer intervention programs that provide offenders with an opportunity to learn non-abusive behaviours, prior to sentencing. After completing the PAR program, judges proceed to determine the offenders' sentences; satisfactory completion of the PAR program will generally lead to a sentencing recommendation by the Crown Attorney of a Conditional Discharge (Victim Services Division, 2003). Men who are ineligible, who have pled not guilty to the charge, or who decline to participate in the early intervention pathway must participate in the coordinated prosecution pathway, where the emphasis is placed on prosecution. In the case of a conviction, sentencing options include incarceration and/or probation orders, which may include attendance at a PAR program as a condition of the order (Victim Services Division, 2003). Therefore, whether offenders participate in the early intervention pathway or the coordinated prosecution pathway, there is a good probability that they will be required to complete a PAR program before being able to exit the DVC system.

Partner Assault Response Programs. Partner Assault Response programs are specialized counselling and educational batterer intervention programs for individuals who have abused their

partners (Ministry of the Attorney General, 2000). Although PAR programs are generally delivered by various community-based, non-profit agencies, and are far from completely standardized, they are funded by and adhere to the standards of the Victim Services Unit of the Ministry of the Solicitor General (Ministry of the Attorney General, 2000). Similar to the overarching goals of the Ontario Domestic Violence Courts, the goals of PAR programs are to hold offenders accountable for their behaviour while enhancing victim safety. Today, PAR programs have increasingly become a common legal sanction in Ontario. In 2003 alone, over 7000 individuals were provided service for domestic violence offences across the province (Ministry of the Attorney General, 2004).

Ontario PAR programs consist of group sessions that are generally held weekly, for a minimum of 16 weeks. According to PAR guidelines, participants must attend 13 out of the 16 weekly sessions to successfully complete the program (Victim Services Division, 2003). Group sessions focus on holding men accountable for their use of abusive behaviour through the use of a pro-feminist, psychoeducational framework where men are provided with knowledge about the impact of their abuse (Austin & Dankwort, 1999). Moreover, PAR programs encourage men to examine the beliefs and attitudes that they have used to justify their abusive behaviour while giving them the tools to learn non-abusive ways of resolving conflict (Victim Services Division, 2003; Pence & Paymar, 1993).

The Efficacy of Batterer Programs

Despite the growth in popularity of batterer intervention programs, significant concerns have been raised about the efficacy of these programs. Studies generally find that approximately two thirds of men who complete treatment do not go on to reassault their partners (Gondolf, 2002; Scott & Wolfe, 2003). However, there are also a proportion of untreated men who do not

reassault their partners and thus one important question remains: Do men who complete treatment reassault their partners at a *lower rate* than untreated men? There have been over 50 empirical studies, at least 6 study based reviews, and numerous commentaries looking at batterer treatment (Scott, 2004a), and yet still no clear answer to this question has emerged. Some studies have found that batterer programs lead to a small decrease in future violent recidivism (e.g., Edelson & Grusznski, 1988; Gondolf, 2002) and others have found no significant difference in reassault rates between men assigned to batterer treatment programs and men on control waitlist groups (e.g. Davis, Taylor, & Maxwell, 2000; Dunford, 2000; Feder & Forde, 2000). A recent quasi-experimental study by Bennett, Stoops, Call, and Flett (2007) offers a more optimistic outlook for batterer programs, suggesting that men who complete batterer intervention programs are 39% to 61% less likely to be rearrested for future domestic violence than men who do not complete the program, even after controlling for differences in violence history, personality, demographics, and motivation. However, a quantitative meta-analysis by Babcock, Green and Robie (2004) examined 22 studies evaluating treatment efficacy for domestically violent males and found that effects due to treatment, although significant, were in the small range. Therefore, this comprehensive review suggests that batterer intervention programs are only minimally successful at reducing rates of violent recidivism beyond that achieved by arrest and sentencing alone.

In summary, reviews of batterer intervention programs have demonstrated mixed support for the effectiveness of these programs as a means of reducing domestic abuse. This is distressing when one considers the serious implications of failing to provide effective service to eliminate domestic violence. However, it is important not to lose hope in the potential for batterers' interventions to have an impact on spousal violence. Meta-analyses examining the

effectiveness of substance abuse programs yield similar small treatment effects (Agosti, 1995) and yet these programs help some people to overcome their addictions and are a widely accepted treatment for alcoholism. Further, it is important to remember that, since intimate partner violence is such a prevalent problem, even a small effect size translates into a large number of women who will no longer be battered. In light of this, rather than dismissing batterer intervention programs as ineffective, research should be directed towards determining how to improve batterer treatment. Treatment programs for men who have been the perpetrators of domestic violence are still young and have only recently became associated with the justice system, leaving much to be learned about how to improve the effectiveness of these programs.

Counsellor Judgement

It has been suggested that one possible way to increase the effectiveness of intervention programs for men who batterer is to increase the accuracy of violence risk assessment (Douglas & Kroop, 2002). If counsellors were able to identify those batterers who pose a higher risk of reoffending, it is possible that this information could be used to help inform discharge and post-intervention planning. Currently in Canada, satisfactory completion of a batterer intervention program, and a batterer client's subsequent discharge from the program, is unrelated to treatment progress or perceived re-offense risk. Rather, batterer programs rely almost exclusively on program attendance to determine client treatment outcome. Currently, in order to successfully complete the program, men in batterer programs need only attend 80%, or 13 out of the 16 weekly sessions (Victim Services Division, 2003); in addition, many programs require participants to fulfill homework and fee requirements. Studies have found that participants' failure to attend group sessions increases the probability of reassault (Dutton, Bodnarchuk, Kropp, Hart, & Ogloff, 1997; Gondolf, 1997) and continued psychological abuse (Gondolf,

1997), and thus attendance is a reasonable starting point for determining participant outcome. However, men are not required to meet any mandatory behavioural goals throughout treatment, with program participants generally being discharged after completing the program regardless of their actual performance in the group sessions. Thus, purely attendance based discharge is potentially misleading as men may attend the required number of sessions without being engaged in treatment or willing to integrate the program material into their daily lives. Moreover, attendance-based discharge eliminates violence risk assessment from the discharge process and enables batterer clients who have meet attendance requirements to be discharged from the program, despite potential counsellor concern regarding risk of re-assault.

Related to this point, a study by Taft, Murphy, King, Musser, and DeDeyn (2003) found that session attendance did not predict post treatment physical or emotional abuse. The authors suggest that the association between these variables may have been attenuated by limited variability in session attendance (88% of the participants attended at least 75% of the sessions), which may have been caused in part by fear of legal consequences for nonattendance. Such an argument may also be made for the basis of attendance of men currently in batterer programs, with clients perhaps attending group sessions more out of a fear of legal reprimand rather than a true desire to change abusive behaviours. These findings support the hypothesis that although session attendance is necessary in order for treatment to be successful, it is not sufficient in and of itself (Yalom, 1995), and thus efforts must be made to also identify other client therapeutic behaviours that can help predict lowered future relationship violence.

Although discharge is currently based on attendance, more information is available about men's progress while in group. Counsellors of batterer intervention programs typically complete final reports on the progress of each man in the group, including observations of critical in-

treatment behaviours that each man has or has not engaged in. Further, while the practice of including counsellor judgement in the discharge process has been noticeably absent in batterer intervention programs, the use of counsellor mediated discharge criteria is relatively common practice in other intervention programs, such as alcohol and mental health treatment. When a client has finished a treatment program and is ready to be discharged, counsellors use their clinical judgement regarding the client's success at meeting treatment goals and this helps to determine whether or not the patient should leave the program. At the very least, the counsellors record their judgements and pass them on to those involved in further treatment of, or decisions about, the client (Shea, 1988).

Clinician judgement is used, for example, in the discharge of patients in Assertive Community Treatment (ACT) programs, which facilitate community living, psychosocial rehabilitation, and recovery for persons who have serious mental illnesses. Each ACT discharge is carefully evaluated by the ACT team and occurs when both the client and the clinician(s) mutually agree that the client has met the individualized program goals and that there can be a termination of services (Ministry of Health and Long-Term Care, 2005). The Ministry of Health and Long-Term Care (2005) suggests that when clinical judgement is used in such a way, services can be delivered in a continuous rather than time-limited framework, allowing relapse to be addressed and treatment gains maintained and improved upon.

Clinical judgement also plays a role in the discharge of clients in addiction treatment services all across Ontario. Within the last decade, the Ministry of Health and the Ontario Addiction Services Advisory Council have worked together to develop standard discharge criteria that addiction staff across the province can use to help guide their practice. Discharge criteria are broad and clinicians are required, and encouraged, to use their clinical judgement

when applying the criteria (Ontario Substance Abuse Bureau, 2000). For example, when judging whether or not to maintain a client in community treatment services, a clinician would be required to assess some of the following questions: Has the client developed sufficient skills to problem solve, self manage or cope with life issues? Has the client developed, practiced, and have confidence in his/her relapse prevention strategies and skills? Is the client actively working on addressing longer-term goals for change?

Both of the aforementioned, provincially approved, clinician-mediated discharge criteria demonstrate how accepted clinician judgement is in other treatment sectors, and what a critical role clinician input plays in the discharge of clients from various intervention programs.

History of Clinician Prediction of Violence

In addition to being a well-used source of information in mental health and substance abuse treatment programs, research is beginning to support the idea that clinical judgement may also be an important tool for determinations of dangerousness. Recent research suggests that while there may be problems in predicting future violence with complete accuracy, clinicians can make conditional predictions of patient outcome, and even patient violence, in the short term which are better than chance (Johnson, 2000; Lidz et al., 1993). However, the violence risk assessment field has been riddled with controversy for over half a century and the effectiveness of clinical judgement as a predictor of violent recidivism has been an enduring issue in the field of mental health and clinical psychology.

In 1966, the Supreme Court of the United States ruled in *Baxstrom v. Herold* that a legal determination of dangerousness was required in order to continue to commit inmates in a corrections department mental hospital after their sentence had expired (Baxstrom v. Herold, 1966). This ruling ultimately lead to the release of nearly 1,000 mentally ill offenders who were

at the time being held in hospitals without judicial determinations of dangerousness. Although clinicians had previously deemed all of these offenders to be too dangerous to be released from maximum security hospitals, their rates of reoffending were quite low, leading to the general conclusion that mental health professionals were greatly overestimating risk (Steadman & Cocozza, 1974). Additionally, much subsequent research on violence risk assessment agreed that clinicians were not accurate in making predictions about patient violence (Steadman & Cocozza, 1974; Monahan, 1981). The influence of these early findings led many to conclude that accurate future violence predictions by mental health practitioners were not possible. In an extremely influential book, *The Clinical Prediction of Violent Behavior*, Monahan (1981) condemned clinical predictions of dangerousness, concluding that "psychiatrists and psychologists are accurate in no more than one out of three predictions of violent behavior" (p.47). Monahan's work had such a profound impact that it essentially eliminated research interest in the area for many subsequent years and caused an increased interest in statistical predictions of violence (Otto, 2001).

The statistical (or actuarial) model is based on the belief that clinicians are inaccurate predictors of violence, and instead advocates for a method in which client data are entered into formulas, tables, and/or charts that integrate client information (e.g., demographic information) with base rate and other empirical information to predict risk (Grove & Meehl, 1996). Many reviews, including a recent meta-analysis of the clinical versus statistical literature (Grove, Zald, Lebow, Snitz, & Nelson, 2000), supports the finding that statistical methods are more accurate than or, at minimum, equally as accurate as clinical prediction methods. Although these study results offer convincing support for the use of statistical prediction, recent studies in the broader field of violence risk assessment have shown that the predictive accuracy is not high enough to

guide treatment and intervention (Mossman, 2000). Furthermore, such prediction methods do not necessarily provide all of the information that may be required when predicting future violence. For example, although high scores might suggest an increased probability of violence, they do not address the level of violence. Predicted violence can range from verbal assault without physical contact to murder, and therefore statistical methods may not be fully informative to clinicians faced with making decisions about the discharge of patients from treatment programs. In addition, statistical methods do not allow any flexibility for clinicians to adjust results according to key behavioural observations that may not be incorporated into the statistical model. For example, does it matter if an offender scores below the specific cut off, and thus is considered a low violent recidivism risk according to the statistical method, if he also expresses genuine violent intent?

Structured Clinical Judgement. The idea that statistical predication does not allow for the observation and incorporation of key contextual variables, and other important information, is supported in a recent study by Doyle and Dolan (2006). In this study, the researchers examined the predictive accuracy of a series of statistical prediction measures and structured clinical judgement, a model that attempts to increase clinicians' accuracy in predicting violent recidivism by standardizing their clinical evaluations. Doyle and Dolan found that while historical measures of risk and measures of psychopathy, impulsiveness and anger were highly predictive of community violence, the more dynamic clinical factors derived from structured professional judgement (rated at discharge) added significant incremental validity to the historical factors in predicting community violence. Thus, these authors concluded that the heterogeneity of violence risk factors suggest that reliance on statistical measures, while still potentially helpful in clinical decision making, may be limited in their applicability to individual patients. Hart (1998) also

argued for the adoption of structured clinical judgement, suggesting that structured approaches are superior to clinical judgement as they standardize how evaluations are conducted and variables are weighed, and superior to statistical methods as the increased flexibility allows clinicians to consider other potentially important information when making decisions regarding risk. As such, structured clinical judgement is increasingly being proposed as a way to overcome the various difficulties that have been encountered with both unstructured clinical judgement and statistical prediction methods.

Treatment Behaviours in Batterer Intervention Programs

One way to help structure clinical judgement within many intervention contexts, including batterer treatment, is to supply clinicians with guidelines that enable them to provide structured clinical ratings on a fixed set of in-treatment occurring behaviours that are related to treatment goals. Research has suggested that in order for men to change from an abusive partner to a non-abusive partner, a change process, which is driven by several key treatment behaviours (such as acceptance of abuse, self-disclosure, participation, etc.), must occur (Silvergleid & Mankowski, 2006). Therefore, it can be hypothesized that the presence of such client treatment behaviours would indicate that this change process, and ultimately a decreased likelihood of future recidivism, has occurred.

This idea is explored in a significant study conducted by Gondolf (1995). In this study, the utility of structured clinical judgement in batterer programs is examined by developing an instrument of 10 clinically-based discharge criteria using focus groups of batterer counsellors and battered women advocates. Discharge criteria were based on client treatment behaviours that could be observed and documented by counsellors within batterer intervention programs and on which discharge might reasonably be based. Using these criteria, program counselors rated

participants in a 13-week court-mandated batterer program, first when the men entered the program and again when they left the program. These treatment behaviours included attendance, nonviolence, sobriety, accountability, technique usage, help-seeking, process consciousness, active engagement, self-disclosure, and sensitive language. The following sections provide a review of these treatment behaviours and the current empirical findings on their relationships to treatment success in perpetrators of domestic violence.

Attendance

It seems intuitive that in order for batterer intervention programs to be effective, individuals must remain in treatment. Poor attendance means that men do not obtain the information and counselling that is intended, thus they do not derive the full potential benefit from interventions and overall violence prevention must ultimately be reduced. Not surprisingly, a study by Taft, Murphy, Elliott, and Morrel (2001) found that increased session attendance was significantly associated with lower post-treatment relationship violence and criminal recidivism. Several other studies have mirrored these findings, once again demonstrating that those who drop out of domestic violence treatment programs have higher violence recidivism rates than those who complete treatment (Dutton, Bodnarchuk, Kropp, Hart, & Ogloff, 1997; Gondolf, 1997; Shepard, Falk, & Elliott, 2002). These consistent findings suggest that attendance should continue to be a key component in the determination of client treatment success and program outcome.

Nonviolence

Ensuring victim safety is one of the primary goals of batterer intervention programs and thus nonviolence throughout treatment is a vital and essential measure of a client's success. The presence of violence throughout the duration of treatment is perhaps the most self-evident

predictor of continued violence following treatment and therefore is an intuitive marker for post-intervention violent recidivism. Research has found that the frequency and severity of physical aggression is one of the most robust predictors of violence continuation across time in non-treatment samples (Lorber & O'Leary, 2004; Quigley & Leonard, 1996). Furthermore, a study by Woodin and O'Leary (2006) found that elevated levels of physical aggression before domestic violence treatment predicted the continuation and severity of physical aggression during treatment and in the following year. Thus it seems reasonable to assume that violence throughout treatment would also predict continued violence following treatment. Research supports this hypothesis, demonstrating that a significant proportion of men who reassault (37%) first do so within 3 months of program intake and that men who reoffend while in intervention are at substantially higher risk for repeated incidences of assault perpetration (Gondolf, 2002). Such findings suggest that any violence committed while attending treatment should be a significant marker for continued future violence.

Sobriety

Research has consistently demonstrated that alcohol use and abuse are strongly associated with partner violence in a wide variety of samples (see Leonard, 2001, for a review). Specifically, Leonard (1993, 2001) proposed that substance abuse patterns and marital discord, in combination with acute substance influences, produce physical aggression in the context of intimate partner conflicts. Research also strongly supports an association between illicit substance use and partner violence. For example, studies show that individuals who engaged in partner violence reported more frequent marijuana and cocaine use than nonviolent individuals (Chermack, Fuller, & Blow, 2000), and men who continued to engage in partner violence following substance abuse treatment used marijuana at a higher rate than men who reported no

violence following treatment (Walton, Chermack, & Blow, 2002).

A study by Moore and Stuart (2004), which investigates the effects of illicit substance and alcohol use on the occurrence of violence among men in batterer intervention programs, found that relative to non-substance users, substance users scored significantly higher on all measures of perpetration and receipt of intimate partner violence after controlling for alcohol use. Similarly, a study by Fals-Steweart (2003), which used daily self reports and partner reports to track alcohol use and physical aggression of men in treatment for wife assault, demonstrated that drinking was associated with a large increase in the risk of wife assault that same day, especially amongst alcoholics. Furthermore, many studies examining recidivism data have established that batterers are more likely to reassault if they have a history of substance abuse (Hanson & Wallace-Capretta, 2004; Hanson, Cadsky, Harris, & Lalonde, 1997). This is corroborated by Gondolf (1997), who found that a substantial portion of men (57%) who reassaulted their partners had been drinking within 3 hours prior to at least one of the reassaults.

Acceptance

Research has repeatedly demonstrated the importance of acceptance, and the detrimental effects of denial, in processes of change. Empirical investigations into the attributional processes of married couples demonstrate that discordant couples tend to attribute responsibility for negative partner behaviour to their spouse while excusing their own negative behaviour (Holtzworth-Munroe & Jacobson, 1985). Furthermore, in a study looking at the moderating effects of attributions on the relationship between marital satisfaction and marital violence, Bryne (1993) found that, among men, marital violence was significantly related to maladaptive responsibility attributions, which concern a spouse's accountability for an event. Such findings suggest that spousal conflict, and even spousal violence, is correlated with negative attribution

processes and a denial of responsibility.

In light of such research, it is commonly believed that batterers who minimize, deny, and/or blame their victim are more dangerous and are at a heightened risk of reoffending than men who accept responsibility for their actions. Although results have not always been consistent (Henning & Holdford, 2006), various studies have corroborated these beliefs, finding that men who are not willing to accept responsibility for their abusive behaviour make fewer gains throughout treatment (Daly & Pelowski, 2000; Scott & Wolfe, 2003; Scott, 2004b). Correspondingly, recent batterer research is suggesting that acts of accountability, such as admitting that abuse exists, and not blaming others, or minimizing the problem, is a key step in the processes of change that facilitates successful treatment. While examining personal accounts of batterer intervention program participators and facilitators, Silvergleid and Mankowski (2006) found that taking responsibility for past abusive behaviour was emphasized as one of the most important processes needed in order for men to be successful in treatment. Similarly, when analyzing the interviews of nine reformed batterers, Scott and Wolfe (2000) found that men who had successfully changed their abusive behaviour displayed a great deal of honesty about and responsibility for their past abuse. Out of 9 men, 8 stated that learning to recognize their own abusive behaviour was a critical step in their process of change.

Using Techniques

The importance of using techniques taught by batterer intervention programs, such as taking conscious steps to avoid violence, using time-outs, self-talk, and conflict resolution skills, has emerged as another behavioural indicator of change in men who have been the perpetrators of domestic violence. Using techniques is extremely important in treatment programs because the skills covered, such as anger management, communication, and conflict resolution require

generalization to the participants' real life environment. Successful batterer program completers themselves have emphasized the importance of using new skills, such as time-outs, identifying feelings, and positive self-talk, crediting the use of such techniques with a new level of awareness and commitment to change (Silvergleid & Mankowski, 2006). Batterer program facilitators have also emphasized the importance of the development of new skills. As one facilitator reported, "I do think that the [tools] that we use here contribute to men's changing because they offer men something really concrete that they can put into practice" (Silvergleid & Mankowski, 2006). In one qualitative study, Scott and Wolfe (2000) found that increased communication skills, which were taught throughout group sessions, contributed to change in more than 75% of the program participants. These communication skills included techniques for conflict management and resolution, learning to listen in difficult conversations, learning about warning signs of anger, and developing the ability to intervene at an early stage to prevent the escalation of angry feelings.

Homework Completion. Homework completion is another critical treatment behaviour as intervention programs typically involve time-limited sessions with a heterogeneous group of men, and the skills covered often involve thoughts and behaviours that are present only in relationship interactions. Homework completion is an opportunity for men to consolidate the information that has been taught in group sessions, and to apply newly acquired knowledge, skills, and techniques to their personal relationships. Homework compliance has been found to predict outcome in treatment for depression (Burns & Spangler, 2000), panic disorders (Schmidt & Woolaway-Bickel, 2000), and marital problems (Holtzworth-Munroe, Jacobson, Deklyen, & Whisman, 1989). Furthermore, when examining process and adherence factors as predictors of partner reported abuse following participation in a batterer treatment program, Taft et al. (2003)

found that homework compliance was significantly associated with future emotional abuse. Thus, it seems likely that a lack of willingness, or a lack of ability, to complete homework and/or put treatment techniques into practice is another plausible marker of poor treatment progress.

Help-seeking

Although it is common knowledge that help-seeking behaviour can result in a reduction of the gap between a person's skill and the demands of the environment so that functioning is maintained or improved, unfortunately, men are often characterized as unwilling to ask for help when they experience problems. Research has demonstrated that men are less likely than women to seek help for a wide range of difficulties, including depression, substance abuse, physical disabilities, and stressful life events (Husaini, More, & Cain, 1994; McKay, Rutherford, Cacciola, & Kabasakalian-McKay, 1996; Padesky & Hammen, 1981; Thom, 1986; Weissman & Klerman, 1977). In addition, it has also been found that men are less likely to seek out medical services (Griffiths, 1992; Gijsbers Van Wijk, Kolk, Van den Bosch, & Van den Hoogen, 1992) and mental health services, such as psychotherapy and counselling (Vessey & Howard, 1993). The chairperson of the Men's Clinic at the Ottawa Civic Hospital, expressed concern about this issue at a conference on health care for men, stating that this attitude - to avoid seeking help as long as possible - poses a serious threat and puts men at heightened risk for various negative outcomes (Rafuse, 1993).

Help-seeking behaviour in the context of batterer intervention programs involves the active seeking out of information about alternatives, discussing options with group counsellors and other group members, asking others for help, and being open to referrals and future support. Batterer counsellors have rated help-seeking behaviour as an important step in the change process, suggesting that help-seeking behaviour improves batterers' functioning; successful

batterer program participants also endorsed this belief by corroborating the importance of gathering helpful suggestions and strategies (Silvergleid & Mankowski, 2006). Clients who seek out help and information about alternatives ensure that they have the knowledge and skills needed to avoid future violence and thus help-seeking behaviour is a reasonable marker for treatment success. Considering that men frequently struggle with the ability to seek out help, a lack of help-seeking behaviour should be watched for and considered when working with men who have been the perpetrators of intimate partner violence.

Process Consciousness (i.e., Developing Group Cohesion)

Group cohesion is widely thought of as a critical process variable in group therapy. Members of a cohesive group frequently feel comfortable in the group and feel valued, accepted and supported by other members and it has been hypothesized that group cohesion results in the tendency for a group to become united in the pursuit of its goals and objectives (Carron, 1982). Group cohesion has been identified as a factor that lowers rates of dropout, in addition to helping group members to communicate, develop relationships, and take responsibility for their actions (Yalom, 1995). Furthermore, groups with higher levels of cohesion have shown increases in self-disclosure and overall superior levels of participation and performance throughout treatment (Yalom, 1995; Littlepage, Cowart, & Kerr, 1989; MacNair & Corazzini, 1994; Robbins, 2003).

The available evidence suggests that group cohesion is associated with greater treatment effectiveness, and one study has documented this association amongst a sample of men in sexual-offender treatment programs (Beech & Fordham, 1997). In addition, a number of studies have now documented a relationship between group cohesion and outcome in treatment programs for domestically violent men. For example, when Wangsgaard (2001) conducted four focus groups and 21 follow-up interviews with participants receiving counselling for their

abusive behaviour, participants suggested that the single most important factor in their change process was the emotionally safe treatment environment that was created through respect, talking, sharing, and support from the other group members and the facilitators. Similarly, Silvergleid and Mankowski (2006) also found that both group participants and facilitators reported the importance of process conscious behaviour and group cohesion; specifically noted was the importance of including a balance of group support and confrontation, sharing and hearing stories, and modeling and mentoring other members. Finally, Taft, et al. (2003) found that the influence of group cohesion was a significant predictor of post-treatment outcome for participants in a cognitive-behavioral group treatment program for partner violent men.

Indicators of group cohesion within a group treatment program include process conscious behaviours such as letting others speak one at a time, acknowledging others' contributions, asking questions of others without interrogating, and heeding the direction of counsellors (Gondolf, 1995). Thus the detection of such in-treatment behaviours could indicate higher levels of group cohesion and act as another possible marker for successful client outcome.

Active Engagement

It is widely accepted that to be effective, every kind of psychological treatment requires some level of engagement from the patient. If clients are actively engaged in treatment, levels of commitment to and compliance with the intervention should be enhanced, allowing clients to have a higher probability of successfully completing treatment and experiencing positive outcomes. Recent therapeutic work has suggested that the degree of engagement that a client displays in therapy is a factor directly related to treatment progress and outcome (Levenson & Macgowan, 2004). Moreover, behavioural indicators of treatment engagement, such as contributing and actively working on problems in therapy (Macgowan, 1997), have been shown

to be associated with lower levels of future partner violence (Gondolf, 1995). On the other hand, low treatment engagement and high client resistance has been conceptualized as impeding the successful achievement of therapeutic goals (Beutler, Rocco, Moleiro, & Talebi, 2001). A combination of clinical observations and empirical studies document that resistant men often fail to complete treatment, display disruptive behaviours in-group, and hinder progress being made by other group members (Daly & Pelowski, 2000; Augusta-Scott & Dankwort, 2002; Elliott, 2002). The combination of the aforementioned empirical evidence suggests that a client's level of participation and engagement in treatment is associated with ongoing treatment progress and thus would be a critical measure of batterer treatment success.

Self-Disclosure

There appears to be great consensus amongst group therapists about self-disclosure, with the majority agreeing that self-disclosure is essential to the group therapeutic process and that participants will not benefit from group therapy if they do not fully self-disclose (Yalom, 1995). This belief is also corroborated by batterer program group facilitators, who have suggested that just the act of sharing a secret or problem creates change in a way that a private confession cannot (Silvergleid & Mankowski, 2006). Additionally, batterer clients with high levels of responsibility have also been shown to indicate self-disclosure as an important therapeutic factor; indeed, the higher the clients' level of responsibility, the more importance he placed on self-disclosure (Roy, Turcotte, Montminy, & Lindsay, 2005).

In explaining his model of important therapeutic factors in group psychotherapy, Yalom (1995) suggests that even more important than the actual unburdening of oneself is the fact that self-disclosure results in a deeper, richer, and more complex relationship with others, leading to an increased therapeutic alliance between participant and counsellor and increased group

cohesion, both of which have been shown to be predictors of treatment outcome (Taft et al., 2003; Littlepage, Cowart, & Kerr, 1989; MacNair & Corazzini, 1994; Robbins, 2003). This tiered view is supported by successful completers of batterer intervention programs, who suggest that one of the reasons that they felt supported in the group was the sense of commonality that existed among them, which was largely built through various self-disclosures (Silvergleid & Mankowski, 2006).

Given the perceived importance of self-disclosure in typical group therapy, one might think it would be a prominent focus of clinical research. However, a review of the literature found that there was a drastic lack of attention paid to the empirical evaluation of self-disclosure. What limited empirical evidence is available, although not recent or within the context of batterer treatment, has supported the importance of self-disclosure in successful group therapy (Truax & Carkhuff, 1965; Liberman, Yalom, & Miles, 1973). For instance, Peres (1947) demonstrated that successfully treated patients in group therapy made almost twice as many self-disclosing personal statements throughout therapy as did unsuccessfully treated patients. Thus the available empirical evidence examining general group therapy, combined with the general clinical consensus, suggests that self-disclosure is another important treatment behaviour for men in batterer intervention programs.

Sensitive (non-sexist) language

Feminist theory suggests that men with patriarchal attitudes and beliefs are more likely to be abusive than men who do not hold these views (Mihalic & Elliott, 1997; Stith & Farley, 1993). Despite the fact that batterer programs are strongly influenced by feminist ideas, research has provided mixed evidence for the importance of men's patriarchal attitudes for predicting violence towards their partners. Some previous research has found that male batterers are in fact

more likely than non-abusive men to have attitudes tolerant of wife assault (Hanson, Cadsky, Harris, & Lalonde, 1997) and tend to adopt a sexist, adversarial approach to intimate relations (Hanson & Wallace-Capretta, 2004; Dobash & Dobash, 2000). However, when Sugarman and Frankel (1996) completed a meta-analysis to examine the relation between wife assault and the maintenance of patriarchal ideology, they concluded that adult batterers could not be differentiated from non-abusive men on the basis of traditional gender attitudes (i.e., sexism) or gender schemas (i.e., masculinity).

Despite these mixed literature findings, Silvergleid and Mankowski (2006) found that batterer program facilitators believe that a critical process of change in batterer intervention programs is essentially a "resocialization" into a new manhood, stating that one of the most significant areas of change is seen when "men in the group challenge other men's sexist beliefs and role model … nonsexist beliefs" (Silvergleid & Mankowski, 2006). Thus it seems reasonable that participant language, which is an observable marker of sexist and patriarchal beliefs, should be combined with the aforementioned measures to help predict batterer treatment success.

Treatment Behaviours as Predictors of Violent Recidivism

Although, as just reviewed, much research suggests that a variety of treatment behaviours are potentially good markers of batterer treatment success, one question remains: Can counsellor ratings of in-treatment behaviours actually predict client recidivism? A review of the literature demonstrates that documented treatment behaviours can often predict intervention outcome in diverse fields including behavioural marital therapy (Holtzworth-Munroe, Jacobson, & DeKlyen, 1989), treatment of problem drinkers (Bresling, Sobell, Sobell, Buchan, & Cunningham, 1997), cognitive-behavioural therapy of depression (Burns & Spangler, 2000) and panic disorder

(Schmidt & Woolaway-Bickel, 2000), and treatment of sexual offenders (Marques, Wiederanders, Day, Nelson, & Ommeren, 2005).

However, although there has been much research that demonstrates the ability of treatment behaviours to predict treatment outcomes in other intervention fields, very few studies of treatment behaviours have been conducted in the field of domestic violence. In a review of the literature, only three studies were found which examined the predictive utility of structured clinical ratings of in-treatment behaviours of male participants in batterer intervention programs. The most relevant study published to date is the one conducted by Gondolf (1995), as previously mentioned. In this study, program counsellors rated participants of a 13-week court-mandated batter program on 10 behavioural criteria (as previously reviewed) in order to test the utility of behaviourally-based discharge criteria for batterer programs. The 164 men that composed the batterer program were rated first when they entered the program and then again when they left the program. Although the initial ratings were not associated with program completion or dropout, the final ratings were. Results also demonstrated that counsellor observations of client treatment behaviours exhibited substantial sensitivity, with 78% of the follow-up abuse being correctly classified according to counsellor rating. However, despite these encouraging findings, a dissertation study conducted by Wernik (2005), which used these same discharge criteria, did not replicate these results, instead finding that counsellor report of treatment behaviours did not substantially relate to future reassaults or repeated reassaults.

The third identified study, conducted by Taft et al. (2003), once again suggests that treatment behaviours may be useful in determining batterer client success. This study assessed the relationship between treatment outcome and process (working alliance and group cohesion) and adherence (session attendance and homework compliance) factors during a treatment

program for men who had been violent to their intimate partner. Results of this study supported the use of treatment behaviours as markers of recidivism, with counsellor working alliance ratings significantly predicting both physical and emotional abuse, client rated group cohesion predicting physical and emotional abuse, and counsellor rated homework compliance predicting emotional abuse.

In conclusion, although researchers often posit the importance of incorporating dynamic, changing factors into violence risk assessment, counsellor report of client treatment behaviours remains an under researched area within the domestic violence context. Furthermore, despite some conflicting evidence within the field, the work of Taft et al. (2003) and Gondolf (1995) offers encouragement for the utility of treatment behaviours as predictors and, in such, suggests that behaviourally-based discharge criteria may warrant additional consideration within the field of domestic violence. Further research in this area may help to shed light on the ability of behaviourally-based discharge criteria to improve treatment outcomes for men who batter, to serve as guidelines for post-program planning, and as a way to inform and make recommendations to domestic violence courts, female partners, and the men themselves.

The Present Study

Although client in-treatment behaviours are potentially important predictors of treatment success, the question remains of whether or not counsellors can, and do, note these behavioural markers during their evaluation of clients throughout group. Therefore, an exploration of current counsellor reports would allow for the identification of the various types of information that counsellors report regarding men's treatment behaviours and is one way to begin to examine the possibility of behaviourally-based discharge criteria.

The present study examined the content of final progress reports written by counsellors in a

batterer intervention program. Specifically, this study developed a thematic coding scheme, the Treatment Behaviours in Batterer Intervention Program Activities Scale (TBBIPA), in order to examine the nature and frequency of counsellor post-intervention judgements of key rated client treatment behaviours. Guided by the behaviourally-based discharge criteria suggested by Gondolf (1995), coded treatment behaviours encompassed twelve behavioural domains including behaviours such as attendance, sobriety, accountability, and understanding of material. As such, the TBBIPA allowed for a preliminary examination of the type of in-treatment behaviours that are consistently being provided by counsellors.

In addition to this preliminary exploration, several hypotheses were generated. Firstly, it was expected that counsellors would observe and report on a variety of key-rated client treatment behaviours. Considerable variation in counsellors' judgements, with some clients deemed 'successful' across outcome domains and others as not having made progress throughout treatment, was also expected. Secondly, it was hypothesized that men who had lower levels of motivation coming into the program (i.e., overall motivation, perceived need for treatment, perceptions of treatment and staff, optimism towards outcome, and comfort regarding disclosure in group) would make less progress in treatment, as measured by counsellor reports. Finally, it was predicted that men who had higher levels of concerning attitudinal variables (e.g., higher levels of dominance, more difficulty managing their anger, greater hostility towards women) would also make more limited progress throughout treatment and thus be judged as unsuccessful at meeting behavioural goals.

Chapter 2

Method

Participants

Participants were drawn from a sample of 257 men who attended a batterer intervention program in London, Ontario, Canada between February 2005 and March 2006. From this, a sub-sample of 129 individuals whose files included final written counsellor reports documenting their progress through both Intervention Phase I (weeks 1-10 of treatment) and Intervention Phase II (weeks 11-16 of treatment) were included in this study. The selection of batterer clients for the current study sub-sample is illustrated in Figure 1.

On average, batterer clients were 37.19 years of age (SD = 10.49; range 18 to 68 years old). The majority of men were attending treatment on a court-mandated basis due to their involvement with the correctional system (n = 90; 69.8%). The remainder of clients attended treatment as an early intervention sentencing option through the courts (n = 23; 17.8%) or on a voluntary basis (n = 16; 12.4%). Over 34% of clients were living with their current partner at the beginning of treatment (n = 43), with the remaining men living with their family (n = 45; 36.0%), alone (n = 23; 18.4%), or with friends (n = 14; 11.2%). Thirty percent of the men were single at the beginning of treatment (n = 38), 27.3% were married (n = 35), 15.5% were in common-law unions (n = 20) and 5.5% were dating (n = 7). Over half of the clients were currently separated from their partners (n = 68; 52.7%), however, 52.2% of the men who were separated were also hoping to reconcile their relationships (n = 36).

As expected based on previous findings (Gondolf, 2002), a significant proportion of clients also displayed several lifestyle risk factors. The majority of men (n = 102; 79.1%) had a current or prior conviction for a criminal offence, and over half (n = 65; 51.2%) had a current

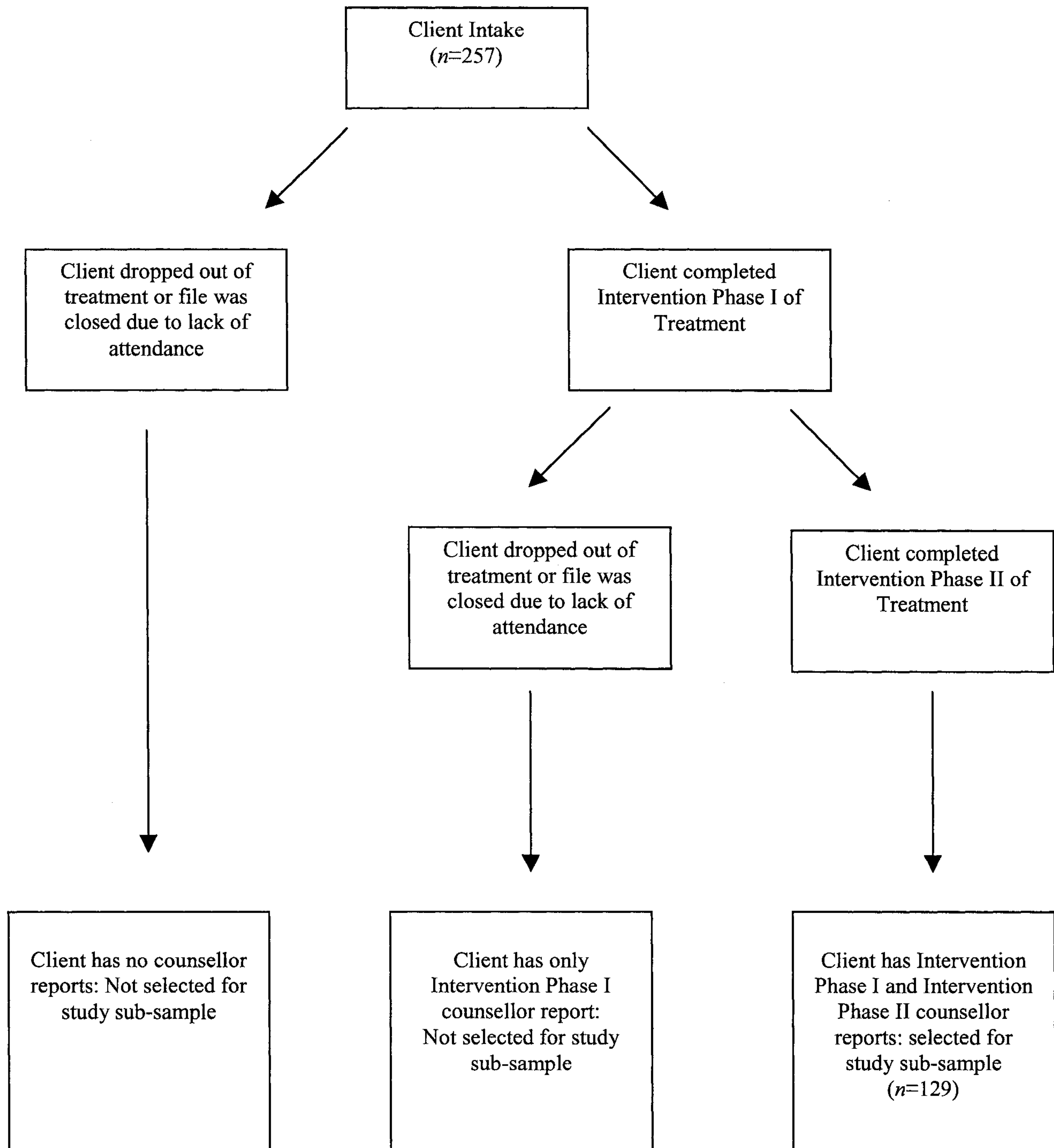

Figure 1. Selection of Study Sub-sample Following Batterer Program Completion.

restraining order in force. Almost half of the client sample ($n = 60$; 47.6%) had previously attended treatment services for anger management problems, drug and alcohol abuse, or mental health issues. In addition, 16.3% of the men ($n = 21$) had previously attended this same batterer intervention program for past abusive behaviour. Furthermore, one quarter of clients were unemployed or receiving government assistance ($n = 31$; 24.0%) and 10.3% of the men had either experienced suicidal ideation or had actually attempted suicide ($n = 13$).

Finally, over three-quarters of men in the sample had children ($n = 100$; 78.7%), with 39.8% of the men admitting that their children had witnessed domestic arguments within the home ($n = 51$). Additionally, 31.8% of these men had current or past involvement with child protection services ($n = 41$).

Program Description

Participants were recruited from a batterer intervention program that follows a similar format to other batter intervention programs across Canada and, specifically, to other Partner Assault Response programs in Ontario. As such, the program aims to hold men accountable for their use of abusive behaviour through the use of a pro-feminist, psychoeducational framework where men are taught about the impact of their abuse. Clients begin treatment by attending an information session where the goals and expectations of the program are shared. Following this information session, clients spend a total of 16 weeks attending weekly group sessions. Program requirements include attending a minimum of 14 out of 16 weekly sessions, completing all written assignments, and submitting all fees (which are determined on an individual basis according to a sliding scale).

All sessions are held once a week for two hours, with the 16 weeks being divided into two phases: Intervention Phase I and Intervention Phase II. The first 10 weeks of treatment

(Intervention Phase I) focus on understanding why abuse occurs in relationships and identifies the different types of abusive behaviour, including physical abuse, sexual abuse, emotional abuse and economic abuse. Clients are encouraged to examine their personal use of abuse within their relationships and the effects of such violence and abuse on their partners, their children, and their relationships. Finally, alternative ways to deal with problems in their relationships are explored.

The last 6 weeks of treatment (Intervention Phase II) focus on reinforcing the information covered in Intervention Phase I and concentrate on three main topics: accountability, responsibility, and safety planning. Men are required to make personal accountability statements regarding the abuse and violence they have used against their partners. Clients are also challenged to take full responsibility for their abusive behaviour and to develop personal safety strategies to prevent future incidents of violence.

Obtaining Consent and Collection of Data

Batterer clients were invited to participate in the research study after attending the initial information session with the batterer program. Men were informed that their participation in the research, or lack thereof, would not impact their experience or outcome in the treatment program or in the legal system (for a copy of the consent form see Appendix A). Men who consented to participate in the research project completed an intake package consisting of the Attitudes Towards Correctional Treatment scale (ACT) and Personal and Relationships Profile Inventory (PRP). In addition, clients completed the Working Alliance Inventory (WAI) at week 2; group counsellors also independently completed the WAI at week 2. Furthermore, according to program protocol, counsellors completed final written reports for those clients who met attendance requirements following Intervention Phase I and Intervention Phase II. As previously

stated, only men whose file contained final written counsellor reports for both Intervention Phase I and Intervention Phase II were included as participants in this research study.

Measures

Treatment Behaviours in Batterer Intervention Program Activities Scale. The Treatment Behaviours in Batterer Intervention Program Activities Scale (TBBIPA) is a thematic coding scheme developed for the use of this study. Based on the behaviourally-based discharge criteria suggested by Gondolf (1995; Appendix C), the TBBIPA allows for the classification of counsellor judgements of batterer client in-treatment behaviours, as reported in their final counsellor reports. Classifications are ranked on a 4 point-scale; although a small minority of items are simply rated for the presence or absence of a particular behaviour, the majority of items are based on a scale that demonstrates increasing success at meeting a behavioural treatment goal with increasing score (1 "very unsuccessful" to 4 "very successful"). Behavioural categories include men's attendance, nonviolence, sobriety, accountability, homework completion, engagement in treatment, help-seeking, group process (i.e., participation in development of group cohesion), self-disclosure about violent or abusive behaviours, use of sensitive and non-sexist language, and utilization of techniques taught in the program. Two additional categories were also included in the coding scheme based on recurrent counsellor documentation of these behaviours in the final reports. These additional behavioural categories include men's understanding of program material and men's apparent willingness to integrate program material into their daily lives. A brief outline of the behavioural categories included in the TBBIPA is provided in Table 1 with a complete copy of the TBBIPA and examples provided in Appendix B.

Table 1.

Category Classifications from the Treatment Behaviours in Batterer Intervention Program Activities Scale (TBBIPA)

Category	Rating Description
Attendance	Rate on a scale of 1 to 4, where 1 is missing 3 or more weekly sessions, 2 is missing 2 weekly sessions, 3 is missing 1 weekly session, and 4 is missing no weekly sessions
Nonviolence	Rate on a scale of 1 to 4, where 1 is an incident of spousal violence, 2 is an incident of non-spousal violence, 3 is a breach of probation, and 4 is no known incidents of violence
Sobriety	Rate on a scale of 1 to 4, where 1 is multiple incidents of alcohol and/or substance intoxication, 2 is a single incident of alcohol or substance intoxication, 3 is suspicion of alcohol or substance use, and 4 is no known incidents of alcohol or substance intoxication
Accountability	Rate on a scale of 1 to 4, where 1 is denial of abusive behaviour, 1.5 is no accountability for abusive behaviour, 2 is limited accountability for abusive behaviour, 2.5 is identifying use of abuse, but struggling to accept responsibility for behaviour, 3 is identifying use of abuse with no mention of accepting responsibility for behaviour, 3.5 is demonstration of higher levels of accountability by more repeated or advanced identification of abuse with no minimizing, blaming or excusing the problem, and 4 is identifying use of abuse with no minimizing, blaming or excusing the problem, **and** identifying the impact of the abuse on his partner
Using techniques	Rate on a scale of 1 to 4, where 1 is no reference to use of techniques taught in group, 2 is a single reference to use of techniques taught in group, 3 is occasional reference to use of techniques taught in group, and 4 is frequent reference to use of techniques taught in group
Homework	Rate on a scale of 2 to 4, where 2 is outstanding assignment(s), and 4 is all assignments completed
Help-seeking	Rate on a scale of 1 to 4, where 1 is no help-seeking behaviour, 2 is a single incident of help-seeking behaviour, 3 is two incidents of help-seeking behaviour, and 4 is frequent help-seeking behaviour

Group process	Rate on a scale of 1 to 4, where 1 is disruptive to the group process, 1.5 is no voluntary contribution to the group process **or** no contribution to the group process unless directly prompted by group facilitators, 2 is minimal contribution to the group process, 2.5 is minimal to moderate/appropriate contribution to the group process, 3 is moderate contribution to the group process, 3.5 is moderate to active contribution to the group process, and 4 is consistent active contribution to the group process
Active engagement	Rated on a scale of 1 to 4, where 1 is inappropriate participation, 1.5 is a mixture of inappropriate and appropriate participation, 2 is no or minimal participation, 2.5 is minimal to moderate participation, 3 is moderate/appropriate participation, 3.5 is moderate to active participation, and 4 is active participation
Self-disclosure	Rated on a scale of 1 to 4, where 1 is no self-disclosure, 2 is occasional self-disclosure with prompting from facilitators, 3 is occasional voluntary self disclosure, 4 is frequent voluntary self-disclosure
Sensitive language	Rated on a scale of 1 to 4, where 1 is has used sexist and/or pejorative slang more than once, 2 is has used sexist language and/or pejorative slang once, 3 is has not used sexist language and/or pejorative slang, and 4 is has not used sexist language and/or pejorative slang and checks others who use sexist and/or pejorative language
Understanding of Material	Rated on a scale of 1 to 4, where 1 is difficulty understanding the material, 2 is difficulty understanding some aspects of the material while demonstrating an understanding of other aspects of material, 3 is understanding of some aspects of the material, and 4 is understanding of multiple aspects of the material
Willingness to Integrate	Rated on a scale of 2 to 4, where 2 is an apparent lack of willingness or inability to integrate the material into their lives, and 4 is an apparent willingness to integrate material into their lives

Both Intervention Phase I and Intervention Phase II final reports were coded using the TBBIPA. Two trained raters (one graduate student and one undergraduate research assistant) scored all of the final counsellor reports. Twenty percent of the reports were independently rated by both raters and indicated a mean inter-rater reliability of 97% for coding of the Intervention

Phase I reports and a mean inter-rater reliability of 94% for coding of the Intervention Phase II reports.

Attitude Towards Correctional Treatment Scale (ACT). The ACT scale (Baxter & Tweedale, 1995) is a 33-item self-report assessing an offender's motivation for treatment. The scale's items are rated on a 5-point Likert scale (1 "strongly disagree" to 5 "strongly agree") and are summed, to produce a total motivation score and five subscale scores. These five subscale scores measure the clients' perceived need for treatment, perceptions of treatment, staff and the institution, treatment optimism, and disclosure comfort in groups. The ACT was originally developed to assess participant characteristics in correctional settings that may influence treatment. It has shown good internal consistency and adequate test-retest reliability (Baxter, Marion & Goguen, 1995) and was internally consistent in the current sample (Total motivation, $\alpha = .91$; Perceived need for treatment, $\alpha = .81$; Perceptions of treatment $\alpha = .72$; Perceptions of staff and the institution $\alpha = .81$; Treatment optimism $\alpha = .86$; Disclosure comfort in groups $\alpha = .73$).

Working Alliance Inventory (WAI) - Short Form. The Working Alliance Inventory (WAI) short-form is a 12-item self-report (client and counsellor versions) assessing the relationship between the batterer client and program facilitator. The WAI has been shown to have strong psychometric properties (Busseri & Tyler, 2003; Tracey & Kokotovic, 1989) and was internally consistent for most subscales within this sample for both counsellor and client ratings (Task, αs = .92 and .85, respectively; Goal, αs = .88 and .78, respectively; Bond, αs = .84 and .40, respectively). Furthermore, the importance of this measure was demonstrated by Taft et al. (2003), who found that WAI ratings were a significant predictor of recidivism for men in treatment for partner violence.

Personal and Relationships Profile Inventory (PRP). The PRP (Straus, Hamcy, Boney-McCoy & Sugarman, 1999) is a 186-item, self-report measure intended for clinical screening on variables related to the perpetration of intimate partner violence. The focus of the current analyses was on six subscales of this inventory – men's level of control, entitlement, anger management, preoccupation with own needs, superiority, and problem denial. In addition, the PRP includes a social desirability response set scale adapted from Reynolds (1982) that was used to adjust men's scores on all subtests of this measure. The PRP was developed with experts in the field of intimate partner abuse. All subscales have strong internal reliability and adequate construct validity. Ongoing research by multiple researchers continues to explore the psychometric properties of this instrument. In the current study, this scale demonstrated adequate internal consistency across most subscales, including social desirability, anger management, hostility towards women, dominance, relationship distress, and blaming others (αs = .74, .68, .77, .73, .82, and .87, respectively). However, two subscales measuring mistreatment of others and minimization indicated lower levels of internal consistency (αs = .42 and .40, respectively).

Demographic Information. In addition to these established measures, demographic information was collected and coded from each participant's file including the following variables: age, employment status, status of relationship with partner, number of children, basis of attendance to the program, criminal history, restraining order status, previous involvement with the batterer agency, and involvement with child protection. The collection of this information is important for controlling for variables known to moderate treatment outcomes (e.g., previous violence).

Chapter 3

Results

Evaluation encompassed several domains of inquiry, and attempted to answer the following research questions: (1) What behavioural observations are made most consistently in counsellor reports?; (2) What are the characteristics of these reports?; (3) Overall, how often do counsellors characterize clients as successful or unsuccessful?; and (4) Are counsellor final ratings (i.e., Intervention Phase II) predicted by demographic, attitudinal and motivational predictors of client outcome that have been established in past research? Results are grouped by research question, with additional exploratory analyses integrated within each domain.

The Presence of Behavioural Observations in Counsellor Reports

Intervention Phase I. Results, as illustrated in Table 2, found that counsellors did not frequently make observations on the majority of the rated behavioural categories in their Intervention Phase I reports, with approximately one-third of the behavioural categories never or very rarely mentioned. These categories included sobriety (n = 0; 0.00%), nonviolence (n = 1; 0.78%), help-seeking (n = 2; 1.55%), and sensitive language (n = 3; 2.33%). The majority of the behavioural categories, including using techniques (n = 12; 9.30%), self-disclosure (n = 13; 10.08%), group process (n = 22; 17.05%), willingness to integrate material (n = 26; 20.16%), homework completion (n = 61; 47.29%), and understanding of material (n = 80; 62.02%), were occasionally included in the written reports. Counsellors frequently included written observations on the remaining 3 behavioural categories, including active engagement (n = 104; 80.62%), accountability (n = 113; 87.60%), and attendance (n = 129; 100.00%).

Intervention Phase II. Similar to those results found from Intervention Phase I, results from Intervention Phase II demonstrated that counsellors did not make frequent behavioural

observations for many of the rated areas in Intervention Phase II final reports (see Table 2). Once again, nonviolence (*n* = 1; 0.78%), sobriety (*n* = 2; 1.55%), help-seeking (*n* = 3; 2.33%), and sensitive language (*n* = 4; 3.10%) were rarely mentioned in the reports. Approximately one-third of the behavioural categories were occasionally mentioned, including willingness to integrate material (*n* = 24; 18.60%), self-disclosure (*n* = 45; 34.88%), understanding of material (*n* = 46; 35.66%), group process (*n* = 61; 47.29%), and using techniques (*n* = 72; 55.81%). The behavioural themes that were frequently reported in Intervention Phase II counsellor reports were active engagement (*n* = 106; 82.17%), homework completion (*n* = 125; 96.90%), accountability (*n* = 127; 98.45%), and attendance (*n* = 129; 100.00%).

Table 2.

Behavioural Observations Made by Counsellors in Final Reports for Intervention Phase I and Intervention Phase II (Percent)

	Intervention Phase I (n=129)	Intervention Phase II (n=129)
	M	M
Attendance	100.00	100.00
Nonviolence	0.78	0.78
Sobriety	0.00	1.55
Accountability	87.60	98.45
Using Techniques	9.30	55.81
Homework Completion	47.29	96.90
Help-Seeking	1.55	2.33
Group Process	17.05	47.29
Active Engagement	80.62	82.17
Self-disclosure	10.08	34.88
Sensitive Language	2.33	3.10
Understanding	62.02	35.66
Willingness to Integrate Material	20.16	18.60

The Content of Behavioural Observations in Counsellor Reports

For this area of inquiry analyses were restricted to the behavioural categories of attendance, accountability, using techniques, homework completion, group process, active engagement, self-disclosure, understanding, and willingness to integrate program material, as an insufficient number of counsellors reported on the remaining behavioural categories (i.e., nonviolence, sobriety, help-seeking, and sensitive language; see Table 2).

Intervention Phase I. Intervention Phase I reports demonstrated that counsellors perceived a significant proportion of batterer clients as being unsuccessful at meeting behavioural expectations throughout these first ten weeks of treatment. Men were considered unsuccessful at meeting a behavioural expectation if their counsellor documented an observation that was coded as a 2.5 or less on the 4-point Treatment Behaviours in Batterer Intervention Program Activities Scale (TBBIPA; see Table 3). Such a rating demonstrated counsellor concern regarding the participant's ability to meet the expectations of that behavioural goal.

Thirty-eight percent of men were considered to be unsuccessful at meeting expectations for taking accountability for their abusive behaviour ($n = 43$). These men therefore would have been characterized as struggling with responsibility, having limited or no accountability, or completely denying their use of abusive behaviour. The remaining men were either classified as having a basic level of accountability, such as identifying their abuse ($n = 10$; 8.8%), or having higher levels of accountability ($n = 60$; 53.1%). Although self-disclosure was not frequently discussed in Intervention Phase I reports, those counsellors who did report on this behavioural domain noted that clients frequently avoided disclosing personal examples of abusive or violent behaviour, with one quarter of men never engaging in self-disclosure ($n = 3$; 23.1%).

Table 3.

Criteria for a Judgment of Unsuccessful or Successful on TBBIPA Behavioural Categories

Category	Unsuccessful Ratings (Score of ≤ 2.5)	Successful Ratings (Score of ≥ 3.5)
Attendance	Not Applicable (all men have met attendance requirements in order to have a written counsellor report).	Not Applicable (all men have met attendance requirements in order to have a written counsellor report).
Accountability	Denial of abusive behaviour, no accountability for abusive behaviour, limited accountability for abusive behaviour, or identifying use of abuse, but struggling to accept responsibility for behaviour.	Higher levels of accountability, demonstrated by more repeated or advanced identification of abuse with no minimizing, blaming or excusing the problem, with or without identifying the impact of the abuse on his partner.
Using Techniques	One or no references to use of the techniques taught in group.	Frequent reference to use of techniques taught in group.
Homework Completion	Outstanding assignment(s).	No outstanding assignment(s).
Group Process	Disruptive to the group process, no voluntary contribution to the group process or no contribution to the group process unless directly prompted by group facilitators, minimal contribution to the group process, or inconsistent (i.e., minimal to moderate) contribution to the group process.	Consistent active contribution to the group process, or moderate to active contribution to the group process.
Active Engagement	Inappropriate participation, a mixture of inappropriate and appropriate participation, no or minimal participation, or inconsistent (i.e., minimal to moderate) participation.	Active participation, or moderate to active participation.
Self-disclosure	No self-disclosure or occasional self-disclosure but only with direct prompting from facilitators	Frequent voluntary self-disclosure.
Understanding of Material	Difficulty understanding all or some of the material.	Understanding of multiple (i.e., most) aspects of the material.
Willingness to Integrate	An apparent lack of willingness or inability to integrate the material into their lives.	An apparent willingness to integrate the program material into their lives.

When examining various domains of participation within the group sessions, results also showed that counsellors frequently had concerns about men's engagement in treatment. This is demonstrated by the fact that counsellors reported that 30.8% of men ranged from having inconsistent (ranging from minimal to moderate) overall engagement in treatment at best and having disruptive, inappropriate participation at worst (*n* =32). Only 22.1% of men were noted to have consistent active engagement in treatment (*n* = 23). The remaining clients demonstrated varying levels of moderate participation (*n* = 49; 47.1%). Similar patterns were seen in men's participation in the group process, with over one-quarter of men being classified as unsuccessful at meeting expectations within this behavioural category (*n* = 6; 27.3%). Concerns about participation within the group sessions were also mirrored in concerns about participation outside of the group sessions (i.e., homework completion), with 39.3% of clients having outstanding assignments at the completion of Intervention Phase I (*n* = 24). It is important to note here that homework completion is not mandatory for completion of Intervention Phase I, and thus a lack of homework completion, while concerning, did not affect men's status in the program.

Finally, counsellor reports demonstrated that a significant proportion of men did not meet expectations for the use and understanding of the treatment material taught throughout the program. This is demonstrated through the finding that a significant proportion of men were characterized as having difficulty understanding at least some of the material (*n* = 18; 22.5%). Furthermore, although counsellors did not frequently comment on clients' use of techniques, the observations that were recorded demonstrated that the majority of men were not frequently making reference to any use of the techniques (e.g., time-out, identification of warning signs) that are taught throughout treatment (*n* = 9; 75.0%). Not surprisingly, given the aforementioned concerns, counsellors also reported that at this point in treatment they believed that 42.3% of

batterer clients were either unwilling or unable to integrate the program material into their daily lives in order to change their patterns of abusive behaviour.

Intervention Phase II. Examination of counsellor reports following Intervention Phase II demonstrated that many of the counsellor concerns that were reported following Intervention Phase I were still present at the completion of the batterer program (i.e., following Intervention Phase II). Moreover, concerns about participant accountability had increased by the completion of Intervention Phase II, with counsellors documenting that 52.0% of men either struggled to take responsibility for their abusive behaviour, had limited or no accountability, or completely denied their use of abusive behaviour (n = 66). Furthermore, counsellors reported that 15.6% of men never made self-disclosures (n = 7) and an additional 20.0% of clients only made occasional self-disclosures when they were directly prompted by group facilitators (n =9).

Similar to Intervention Phase I, according to counsellor reports, a significant proportion of batterer clients did not meet expectations for participation and engagement in treatment throughout Intervention Phase II. Reports demonstrated that over one third of clients had inconsistent (ranging from minimal to moderate) overall engagement in treatment at best and had disruptive, inappropriate participation at worst (n =36; 34.0%). For these final six weeks of the program, counsellors noted that only 11.3% of men demonstrated consistent active engagement in treatment (n = 12). When commenting on men's involvement in the group process, counsellors reported that, once again, 31.1% of men did not meet expectations within this domain (n = 19), with only 18.0% consistently and actively participating in the group process (n = 11).

Success of Batterer Clients

For analysis of the overall success of batterer clients, analyses were restricted to the behavioural categories of accountability and active engagement, due to the fact that an

insufficient number of counsellors reported on the remaining behavioural categories (see Table 2). Attendance was also not included in this analysis as attending a minimum of 14 of the 16 group sessions was a mandatory requirement of the program and therefore would have been a requirement that had been fulfilled by men who had final counsellor reports within their files. It was noted, however, that 9.3% of men missed 3 group sessions through the 16-week program ($n = 12$), and that one individual missed 4 group sessions. As final reports were still provided for these participants, it is assumed that group facilitators must have considered these individuals to have extenuating circumstances that were appropriate reasons for exceeding the allowable missed sessions.

A total of 92 participants (71.32% of the total sample) had Intervention Phase I reports which included counsellor observations of both accountability and active engagement. Analyses were conducted in order to compare this sub-sample of men to those participants who did not have counsellor observations of both accountability and active engagement in their Intervention Phase I final reports. Men who had complete Intervention Phase I ratings (i.e., accountability and active engagement ratings) tended to have a different counsellor write their report than those men without complete ratings, $F(7,115) = 6.17, p < .001$. However, as expected, these groups of men were generally equivalent in other domains. After correcting for multiple comparisons, no significant differences were noted between the two groups on measures of motivation (e.g., perceived need for treatment, comfort with disclosure), treatment-resistance, attitudinal measures (e.g., dominance, hostility towards women), or client characteristics (e.g., relationship status, arrest history, employment status). However, differences were noted on counsellor reported measures of self-disclosure and willingness to integrate material. According to counsellors, men without complete ratings were less likely to engage in self-disclosure ($M = 1.00$, $SD = 0.00$, $n =$

3), $t(11) = -7.97, p < .001$, than men with these ratings ($M = 3.50, SD = 0.53, n = 10$). Furthermore, men without complete ratings were also more likely to be considered unwilling to integrate program material into their life ($M = 2.44, SD = 0.88, n = 9$), $t(24) = -3.00, p < .01$, than were men with complete ratings ($M = 3.53, SD = 0.87, n = 17$).

The number of men who had reports that included counsellor observations of both accountability and active engagement increased to 106 participants (82.17% of the total sample) for Intervention Phase II reports. When comparing those men who had complete Intervention Phase II ratings (i.e., accountability and active engagement ratings) with those men did not, it was found that, once again, those men with complete ratings tended to have a different counsellor write their report than those men without complete ratings, $F(6,121) = 10.15, p < .001$. Otherwise, these groups of men were basically equivalent. No significant differences were noted between scores on motivational (e.g., perceived need for treatment, comfort with disclosure) or attitudinal measures (e.g., dominance, hostility towards women). Once again, after correcting for multiple comparisons, groups were also equivalent in terms of client characteristics (e.g., relationship status, arrest history, employment status). Finally, no differences were detected between the groups in terms of the other counsellor documented behavioural categories (e.g., self-disclosure, understanding).

Classification of Participants as Successful, Mixed, or Unsuccessful. Men were categorized as being successful, unsuccessful, or as having mixed success at meeting program goals according to counsellor reports. Men were considered to be successful if they received positive counsellor comments (i.e., receiving a rating of 3.5 or higher on the 4-point TBBIPA; see Table 3) for the areas of both accountability and active engagement. For example, one counsellor wrote of a client's accountability: *"[he] was able to identify his use of each type of*

abuse in his relationship. [He] accepted challenge well and was open to identifying and accepting responsibility for his use of violence in his relationship. [He] was also able to begin to identify his partner's experience of his abuse"; the counsellor also wrote of this client's engagement in treatment: *"[he] consistently and actively participated in all group discussions"*. Both of these counsellor comments received a rating of 3.5 or higher on the TBBIPA and thus this client was classified as successful.

Conversely, men were considered to be unsuccessful if they received poor counsellor ratings (i.e., receiving a rating of 2.5 or less on the 4-point TBBIPA; see Table 3) for both accountability and active engagement. For example, one counsellor wrote that his client was *"completely unwilling to identify any behaviour whatsoever as abusive in group sessions ... and was challenged by the facilitators multiple times on his inability to take accountability and responsibility for his behaviour and actions"*. The counsellor then commented on the client's engagement in treatment, stating that *"[the client] frequently did not participate in group discussions and at times was disruptive to the group"*. These comments, which demonstrate concern about both the client's accountability and his engagement in treatment, and which were both scored a 2.5 or less on the TBBIPA, resulted in this client being classified as unsuccessful.

If men received counsellor comments on the areas of accountability and active engagement that were more neutral in nature (i.e., receiving a rating of 3.0 on the 4-point TBBIPA; see Table 1) and/or they received a combination of poor, positive, or neutral comments, they were categorized as having mixed success. For example, the following more neutral counsellor comments resulted in the client being classified as having mixed success: *"[The client] identified his use of abuse in his relationship ... [The client] participated moderately in most group discussions"*. Similarly, the following counsellor comments, which

illustrate a combination of poor and positive comments, also illustrate a client who was categorized as having mixed success: *"[The client] was able to identify his use of emotional abuse, but seemed to struggle in accepting responsibility for his behaviour ... However, [the client] has participated regularly and appropriately in all group discussions".*

Success of Batterer Clients in Intervention Phase I. Results demonstrated that 14.13% of the 92 men with complete ratings were categorized as being unsuccessful at meeting program expectations following Intervention Phase I, based on receiving poor counsellor ratings on the measures of both accountability and active engagement ($n = 13$). Only 15.22% of men were considered to have been successful at meeting both of these behavioural expectations ($n = 14$), and the majority of men were considered to be inconsistent, with counsellors documenting a combination of both successful, unsuccessful, and neutral ratings ($n = 65$; 70.65%; see Figure 2).

Further analyses were conducted in order to determine if, according to counsellor report, men who were unsuccessful at meeting accountability and active engagement expectations were also more likely to be unsuccessful at meeting expectations in other behavioural domains. Completing a MANOVA was not possible due to the extremely low number of men with counsellor comments for all of the behavioural domains, and thus a series of one-way analysis of variance (ANOVA) comparisons were conducted to examine the relationships between client success level (based on success at meeting accountability and active engagement expectations) and success in other behavioural areas (i.e., homework completion, group process, understanding of material, and willingness to integrate material). Results, as presented in Table 4, indicated that the participants' success level was significantly related to counsellor rating of client willingness to integrate material, $F(2,14) = 5.98, p < .05$, and client understanding of material, $F(2,62) = 4.06, p < .05$. However, although the means for these groups were in the expected direction, with

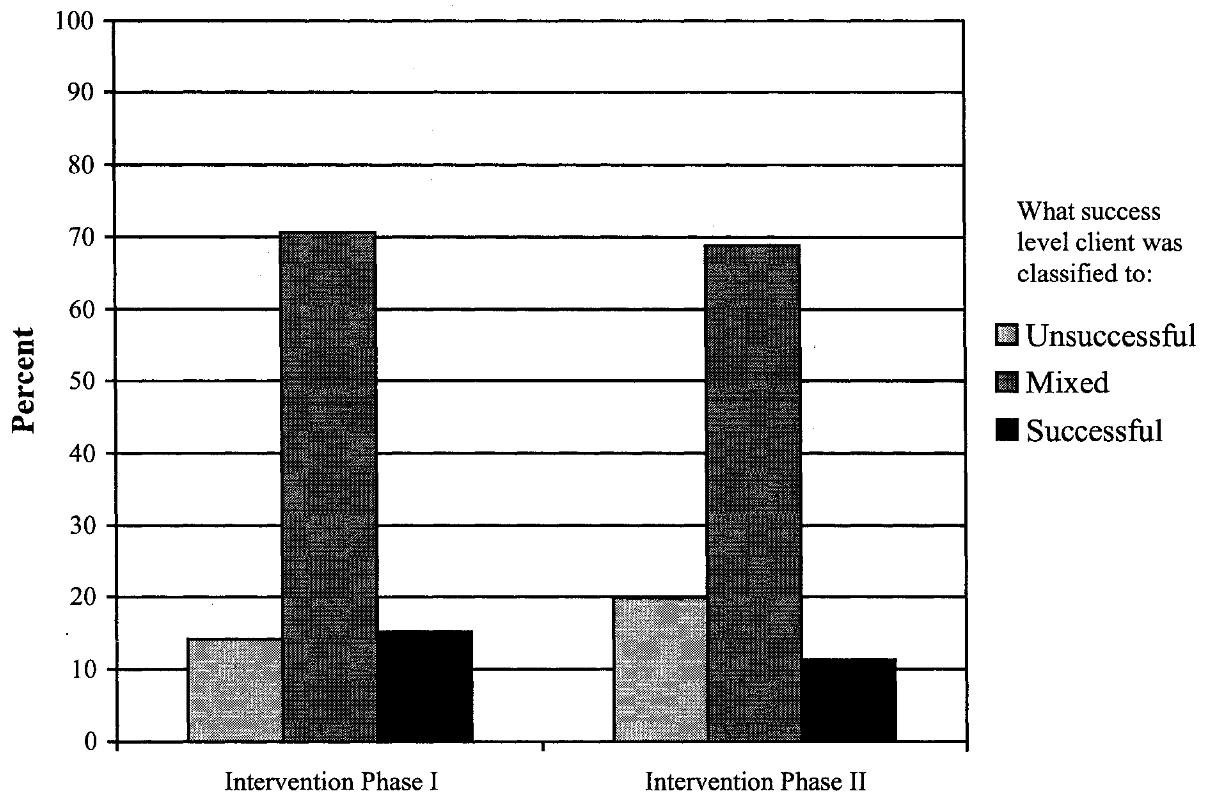

Figure 2. Percent of Counsellor Reported Unsuccessful, Mixed, and Successful Clients for Intervention Phase I and Intervention Phase II.

unsuccessful men having the lowest mean score and successful men having the highest, after correcting for multiple comparisons using Bonferroni, these findings became non-significant. Similarly, although no significant relationship was found between success level and the counsellor documented behavioural categories of group process and homework completion, once again, unsuccessful men received lower ratings than did successful men (see Table 4).

Table 4.

Additional Behavioural Observations across Success Levels for Intervention Phase I

	Unsuccessful (n=13)		Mixed (n=65)		Successful (n=14)		
	M	SD	M	SD	M	SD	Statistic
Homework Completion	3.20	1.10	3.14	1.00	4.00	0.00	$F(2,42) = 1.73$
Group Process	2.50	2.12	3.23	0.90	3.00	1.73	$F(2,13) = 0.32$
Understanding	2.40	1.26	3.09	0.84	3.56	0.73	$F(2,62) = 4.06$*
Willingness to Integrate	2.50	1.00	3.80	0.63	4.00	0.00	$F(2,14) = 5.98$*

* $p \leq .05$

Success of Batterer Clients in Intervention Phase II. Analyses of counsellor reports following Intervention Phase II demonstrate that at the completion of the program, counsellors considered 19.81% of the men to have been unsuccessful at meeting behavioural goals and expectations of the program ($n = 21$), 68.87% of the men to have had mixed success ($n = 73$), and only 11.32% of the men to have been successful ($n = 12$) (see Figure 2).

Similar to Intervention Phase I analyses, a series of one-way ANOVAs were conducted in order to determine if, according to counsellors, men who were unsuccessful at meeting Intervention Phase II accountability and active engagement expectations were also more likely to be unsuccessful at meeting expectations in other behavioural domains. After correcting for multiple comparisons, results indicated that there was a significant relationship between success level (i.e., unsuccessful, mixed, and successful) and group process score, $F(2,54) = 9.70$, $p <$

.001, and self-disclosure score, $F(2,37)=13.03, p<.001$. In both cases, follow-up tests were conducted to evaluate pairwise differences among the means and it was found that unsuccessful men received significantly lower counsellor ratings on both group process and self-disclosure than did mixed and successful men[1]. Thus, clients who were unsuccessful at meeting accountability and active engagement expectations were also significantly more likely to have lower group process scores and lower self-disclosure scores than mixed and successful-rated men (see Table 5).

Table 5.

Additional Behavioural Observations across Success Levels for Intervention Phase II

	Unsuccessful (n=21)		Mixed (n=73)		Successful (n=12)		
	M	SD	M	SD	M	SD	Statistic
Homework Completion	3.70	0.73	3.86	0.52	4.00	0.00	$F(2,100)= 1.26$
Use of Techniques	1.90	0.57	2.08	0.54	2.00	0.00	$F(2,53)= 0.52$
Group Process	2.17	0.78	3.05	0.83	3.71	0.39	$F(2,54)= 9.70$***
Self-disclosure	1.82	0.75	2.81	0.49	3.00	0.00	$F(2,37)=13.03$***
Understanding	3.00	1.41	3.12	1.09	3.50	0.55	$F(2,35)= 0.38$

***$p \leq .001$

Although no significant relationships were found between success level and counsellor documented homework completion, use of techniques, and/or understanding of material, a visual analysis of the means, as can be seen in Table 5, the pattern of mean ratings was in the expected direction.

[1] Levene's test of equality of error variances was not significant for group process, $F(2,54) = 1.17$, *n.s.*, or self disclosure, $F(2,37) = 3.75$, *n.s* indicating homogeneous variances across groups and thus Bonferonni test, which assumes equal variances, was used to conduct post hoc comparisons in both cases.

Predictors of Counsellor Final Ratings (i.e., Intervention Phase II)

Demographic Information. A series of ANOVAs and chi-square tests of independence were conducted in order to examine the relationship between client demographic information, collected at intake, and counsellor determined success level. This analysis was completed in order to determine if any demographic variables should be controlled for when completing subsequent analyses. After correcting for multiple comparisons, results indicated that the success of clients was not related to demographic information (see Table 6).

Table 6.

Client Characteristics across Success Levels for Intervention Phase II

	Unsuccessful (n=21)	Mixed (n=73)	Successful (n=12)	Statistic
Client Characteristics				
Age (mean)	37.81	38.25	36.83	$F(2,103) = 0.10$
Number of Children (mean)	1.88	1.78	2.67	$F(2,90) = 1.52$
Unemployed (percent)	0.00	24.66	41.67	$X^2(2) = 9.01$
Single (percent)	38.10	26.03	25.00	$X^2(2) = 1.24$
Living with Partner (percent)	23.81	36.99	25.00	$X^2(2) = 1.67$
Court-mandated to Attend Treatment (percent)	85.71	83.56	100.00	$X^2(2) = 2.29$
Charged and/or Convicted for Criminal Offence (percent)	85.71	75.34	91.67	$X^2(2) = 2.43$
Previous Involvement with Batterer Agency (percent)	14.29	16.44	16.67	$X^2(2) = 0.06$
Involved with Child Protection (percent)	28.57	27.40	25.00	$X^2(2) = 0.05$
Restraining Order in Force (percent)	55.00	47.95	50.00	$X^2(2) = 0.31$

Attitudinal Characteristics. Clients completed the Personal and Relationships Profile (PRP) at intake, and analyses were next completed in order to determine if these attitudinal variables were predictive of counsellor rated success. The PRP questionnaire yielded eight scales: social desirability total, anger management total, hostility towards women, dominance

total, mistreatment of others, relationship distress total, minimization, and blaming. The eight PRP scales were entered as dependent variables into a one-way multivariate analyses of variance (MANOVA) that compared men who were rated as unsuccessful, mixed, and successful by their counsellors. The effect of the outcome was non-significant, $F(16, 50) = 0.62$, *ns*, $\eta^2 = .17$. Furthermore, although unsuccessfully-rated clients seemed to have lower mean scores for relationship distress, and higher mean scores for hostility towards women, dominance, mistreatment of others, and minimization than did mixed and successfully-rated clients, no significant univariate effects were found, possibly due to the low *n* size of the unsuccessful and successful groups (see Table 7).

Table 7.

Personal Relationships Profile (PRP) Scores across Success Levels for Intervention Phase II

	Unsuccessful (n=21)		Mixed (n=73)		Successful (n=12)			
	M	SD	M	SD	M	SD	$F(2,32)$	η^2
Social Desirability Total	36.14	3.48	35.75	4.96	35.25	1.50	0.04	.002
Anger Management Total	24.71	2.50	25.17	4.27	25.00	4.24	0.27	.017
Hostility to Women	9.42	3.55	9.13	3.19	8.00	2.16	0.11	.007
Dominance Total	17.29	3.25	16.54	4.06	16.75	0.96	0.06	.004
Mistreatment of Others	6.14	1.35	6.04	1.90	5.75	1.71	0.05	.003
Relationship Distress Total	15.14	5.52	17.08	3.31	19.75	4.65	1.75	.098
Minimization	8.86	1.35	7.75	1.82	7.50	1.91	1.23	.071
Blaming	12.00	2.94	14.54	4.36	13.50	1.29	1.16	.067

Note: Overall MANOVA (Wilks' Lambda) $n = 35$, $F(16, 50) = 0.62$, *ns*, $\eta^2 = .17$ (overall model).

Treatment Motivation. Batterer clients also completed the Attitudes Towards Correctional Treatment Scale (ACT) at intake. Men's scores on the ACT questionnaire were compared using a MANOVA with counsellor-rated success level (unsuccessful, mixed, and successful) as the independent variable and each of the ACT scales (total motivation, perceived need for treatment, perceptions of treatment, perceptions of staff, optimism towards outcome, and comfort with

disclosure in group) as dependent variables. The results of the MANOVA yielded a significant effect of counsellors' ratings of success following Intervention Phase II, $F(12, 114) = 1.85$, $p<.05$, $\eta^2 = .16$. Significant univariate effects were found for overall total motivation, perceived need for treatment, perceptions of treatment, optimism towards outcome, and comfort with disclosure in group (see Table 8).

Table 8.

Attitudes Towards Correctional Treatment (ACT) scores across Success Levels for Intervention Phase II

	Unsuccessful (n=21)		Mixed (n=73)		Successful (n=12)			
	M	SD	M	SD	M	SD	$F(2,62)$	η^2
Total Motivation Score	109.40	13.66	126.20	14.58	129.00	21.65	5.39**	.148
Perceived Need for Tx	27.10	5.11	33.29	5.55	33.25	7.23	4.97**	.138
Perceptions of Tx	28.70	4.16	32.62	3.76	32.00	5.63	3.81*	.109
Perceptions of Staff	17.20	2.04	19.06	3.21	19.38	3.34	1.65	.051
Optimism toward Outcome	27.50	3.95	32.38	4.80	32.13	5.11	4.46*	.126
Comfort with Disclosure In Group	15.00	3.23	16.57	3.60	20.00	3.89	4.54*	.128

Note: Overall MANOVA (Wilks' Lambda) $n = 65$, $F(12, 114) = 1.85$, $p<.05$, $\eta^2 = .16$ (overall model).
$*p \leq .05$; $**p \leq .01$

Follow-up tests were conducted to evaluate pairwise differences among the means and it was found, as can be seen in Figure 3, that unsuccessful-rated men had significantly lower levels of overall motivation than both mixed and successful-rated clients. Similarly, unsuccessfully-rated clients had significantly lower scores on measures of perceived need for treatment, perceptions of treatment, and optimism towards outcome than mixed-rated clients; group differences between unsuccessful and successful-rated men, though not significant, showed the same pattern of results with unsuccessful men scoring lower than successful men. Finally, when examining clients' comfort with disclosure in group, it was found that unsuccessfully-rated men

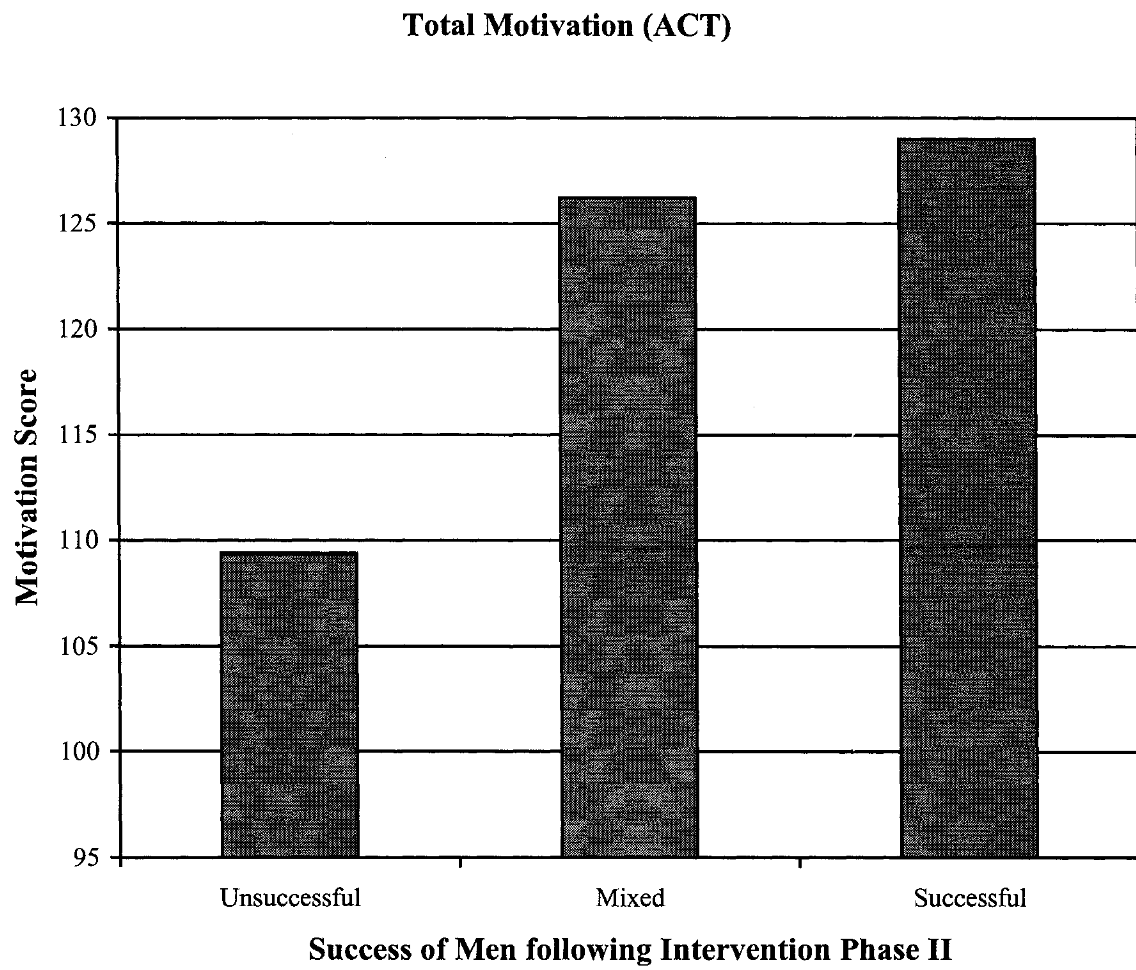

Figure 3. Total Motivation Score across Success Levels for Intervention Phase II.

had seemingly lower scores than men rated as having mixed success, and significantly lower scores than successfully-rated clients.

Therapeutic Alliance. Clients and counsellors both completed the Working Alliance Inventory (WAI) following the first two weeks of treatment. Two separate MANOVAs - one involving counsellor WAI scores and the other involving client WAI scores - were conducted to determine if week two WAI scores were predictive of the client's final success-rating by their counsellor. The dependent variables included each of the counsellor WAI scales (general alliance total, task subscale, goal subscale, and bond subscale); the independent variable was counsellor-rated success level (unsuccessful, mixed, and successful). Both the MANOVA involving counsellor WAI scores and the MANOVA involving client WAI scores were non-significant, $F(6, 92) = 1.44$, *ns*, $\eta^2 = .09$, and, $F(6, 68) = 0.67$, *ns*, $\eta^2 = .06$, respectively. Furthermore, in both cases, of the 4 possible univariate ANOVAs tested, none reached significance (see Table 9).

Table 9.

Working Alliance Inventory (WAI) Scores across Success Levels for Intervention Phase II

	Unsuccessful (n=21)		Mixed (n=73)		Successful (n=12)			
	M	SD	M	SD	M	SD	*F*	η^2
Counsellor WAI Ratings							$F(2, 48)$	
General Alliance Total	4.13	0.96	4.50	1.12	5.19	0.97	2.04	.078
Task Subscale	16.90	4.70	19.09	5.11	21.29	3.68	1.70	.066
Goal Subscale	16.30	3.47	16.91	4.73	19.29	4.89	1.00	.040
Bond Subscale	16.30	4.11	18.03	4.80	21.71	3.35	3.03	.112
Client WAI Ratings							$F(2, 36)$	
General Alliance Total	5.25	1.25	5.40	0.80	5.46	0.73	0.12	.006
Task Subscale	20.14	6.54	22.52	4.01	22.29	5.19	0.70	.038
Goal Subscale	22.29	6.70	22.28	3.89	22.57	3.10	0.01	.001
Bond Subscale	20.57	4.79	20.08	3.25	20.71	4.86	0.10	.005

Note: Overall Counsellor WAI MANOVA (Wilks' Lambda) $n = 51$, $F(6, 92) = 1.44$, *ns*, $\eta^2 = .09$ (overall model).
Overall Client WAI MANOVA (Wilks' Lambda) $n = 39$, $F(6, 68) = 0.67$, *ns*, $\eta^2 = .06$ (overall model).

Success in Intervention Phase I. A 3 (unsuccessful, mixed, or successful) x 2 (Intervention Phase I and Intervention Phase II) chi-square test of independence was conducted to determine the relationship between client counsellor-rated success in Intervention Phase I and Intervention Phase II. Results showed that there was no relationship between counsellor-rated success level (i.e., unsuccessful, mixed, or successful) in Phase I and counsellor rated success level (i.e., unsuccessful, mixed, or successful) in Phase II, $X^2(4) = 4.08$, *ns*, $\phi = .23$. However, upon visual examination of the results, it appeared that these null results may have been the result of movement of clients from the mixed category in Intervention Phase I into the unsuccessful or successful category in Intervention Phase II, and vice versa. Thus, a second 2 (unsuccessful or successful) x 2 (Intervention Phase I or Intervention Phase II) chi-square test of independence was conducted to examine the relationship between those men who were rated by their counsellors as either unsuccessful or successful in Intervention Phase I and Intervention Phase II. These results indicated a significant relationship between counsellor rated success (i.e., unsuccessful or successful) in Intervention Phase I and counsellor rated success (i.e., unsuccessful or successful) in Intervention Phase II, $X^2(1) = 3.94$, $p < .05$, $\phi = .75$. Twenty-two percent of successful-rated clients ($n = 3$) in Intervention Phase I were also considered successful in Intervention Phase II, with 71% rated as mixed ($n = 10$) and 7% rated as unsuccessful ($n = 1$). Similarly, 23% percent of men ($n = 3$) who were rated as unsuccessful in Intervention Phase I were also rated as unsuccessful in Intervention Phase II, with the remaining 77% of these clients rated as having mixed success ($n = 10$). Thus, success was consistent across time in the sense that while it was possible for an 'unsuccessful' client to have 'mixed success' in Intervention Phase II, it was unlikely for an 'unsuccessful' client to become 'successful'. These results suggest that success in Intervention Phase I is a good predictor of success in Intervention Phase II for

those participants who were categorized as successful or unsuccessful (but not for those participants who were categorized as having mixed success).

Chapter 4

Discussion

The current study aimed to explore the content and utility of counsellor reports on men attending a batterer intervention program. Batterer clients who had final written counsellor reports documenting their progress throughout treatment were selected following program completion. Analysis of the content of reports found that counsellors frequently reported on client attendance, accountability for abusive behaviour, and degree of engagement in treatment. Other domains of treatment-related behaviours (e.g., self-disclosure) were only reported on with moderate frequency, with some key behaviours, including sobriety and nonviolence, being rarely or never mentioned in counsellor reports. When the behavioural domains of accountability and active engagement were isolated as predictors of success, a subset of men was clearly identified as unsuccessful at making progress throughout treatment. Specifically, 14% of clients were considered unsuccessful at meeting in-treatment behavioural expectations following Intervention Phase I, with this number increasing to approximately 20% of clients at the completion of the program. Consistent with hypotheses, it was found that men who had lower levels of various facets of motivation coming into the program made less progress in treatment, and were more likely to be considered unsuccessful by their counsellors. Differences in demographic information, attitudinal variables, and the working alliance relationship were not apparent across success levels. Finally, an examination of the predictive ability of counsellor-determined success following Intervention Phase I revealed that success level in Intervention Phase I is a good predictor of success level in Intervention Phase II for both unsuccessful-rated and successful-rated clients, but not for mixed-rated clients. These results are discussed in terms of the utility of

counsellor reports, unsuccessful men in batterer treatment, predictors of client success, and limitations of the current findings.

Utility of Counsellor Reports

A primary objective of this study was to explore the content of counsellor reports in order to examine the potential utility of counsellor reported client treatment behaviours as future discharge criteria. It was expected that counsellors would report on a variety of key-rated client in-treatment behaviours, including those behaviours suggested as important markers of future recidivism. Mixed support, overall, was found for this hypothesis. Counsellors frequently reported on client attendance, client engagement in treatment, and client accountability for their abusive behaviour. Counsellor reporting of other in-treatment behaviours, however, was infrequently documented and occasionally completely non-existent, as was the case with counsellor report of client sobriety and nonviolence. The question then emerges: Are current counsellor reports useful as indicators of client treatment success?

One may argue that the information provided in these counsellor reports, although limited, has the potential to offer important insights into client future recidivism. Counsellors reported mainly on men's attendance, engagement in treatment (i.e., participation), and accountability, which can all be seen as broad indicators of engagement in the various aspects of treatment. Attendance and engagement (i.e., participation) have both been identified as encouraging markers of client treatment success. Firstly, although counsellor report of client attendance was expected, as attendance is a current requirement for completion of BIP programs, it remains an important marker of batterer success. Studies have found that participants' failure to attend group sessions increases the probability of both violent reoffense (Taft et al., 2001; Dutton, Bodnarchuk, Kropp, Hart, & Ogloff, 1997; Gondolf, 1997) and continued psychological

abuse (Gondolf, 1997). Secondly, recent therapeutic work has also suggested that the degree of engagement that a client displays in therapy is directly related to treatment outcome (Levenson & Macgowan, 2004).

The third domain, accountability, is also often emphasized as one of the most important processes in successful treatment (Silvergleid & Mankowski, 2006; Scott & Wolfe, 2000). However, research on the relationship of accountability to change is less consistent. A low level of accountability is common among perpetrators of violence against women (Pence & Paymar, 1993), and is commonly observed in the form of denial. There is some research to suggest that denial is strongly related to poor treatment progress with sex offenders (Levenson & Macgowan, 2004), and conversely, that admission of guilt and accepting personal responsibility are associated with positive treatment outcomes (Barrett, Wilson & Long, 2003). Moreover, several batterer studies have also found that men in the transtheoretical model's precontemplation stage of change (which includes denial in its definition and suggests low levels of accountability) show little positive change over the course of treatment (e.g., Levesque, Gelles, & Velicer, 2000; Scott & Wolfe, 2003). Despite these findings, results linking accountability to positive outcome are not always clear. In a meta-analysis of studies on re-assault among sexual offenders, Hanson and Bussiere (1998) found that denial was unrelated to sexual recidivism, but was weakly correlated with general recidivism. Furthermore, Henning and Holdford (2006) found that in a large sample of men arrested for assaulting their intimate partner, denial of the offense was unrelated to police reported violence 12 to 50 months later. However, it is also important to note that in this study counsellor rating of men's minimization (another indicator of low levels of accountability) *was* related to police reported recidivism. Thus, additional studies are needed to clarify these relationships.

Although counsellor report of engagement-related treatment behaviours does provide relevant information that may be useful in predicting client success, of great concern was counsellors' failure to report on client sobriety and violence. Indeed, several studies have documented a strong association between alcohol (and illicit substance) use and partner violence (Leonard, 2001). For example, Hanson, Cadsky, Harris, and Lalonde (1997) and Hanson and Wallace-Capretta (2004) have both established that batterers are more likely to reassault if they have a history of substance abuse. Moreover, Gondolf (1997) found that 57% of batterers who reassaulted their partners had been drinking within 3 hours prior to at least one of the reassaults. Another recent study by Gondolf (2002) examined the relationship between violence and future re-assault; findings from this study confirmed that men who reoffend while in intervention are at substantially higher risk for repeated incidences of assault perpetration. Thus the fact that counsellors almost never addressed sobriety and nonviolence throughout treatment within their final reports is highly relevant and concerning. This, in combination with the lack of frequent reporting on other key in-treatment behaviours, such as self-disclosure and understanding of material, undermines the usefulness of counsellor reports as a measure of client success.

There are differing implications of the sparseness of final reports provided by men's counsellors. Firstly, reports of men who participate in batterer intervention programs through the Domestic Violence Court (DVC) early intervention pathway are forwarded to judges who proceed to determine the offender's sentence. Satisfactory completion of the batterer intervention program will generally lead to a sentencing recommendation by the Crown Attorney of a Conditional Discharge, and counsellor reports are generally included in the sentencing decision. Thus, if current counsellor reports are not commenting on several important treatment behaviours that may be related to client success and future recidivism, they may be hindering

accurate sentencing and post-treatment programming for clients. Secondly, men who are participating in batterer programs through the DVC coordinated prosecution stream may also be affected by the lack of information in counsellor reports. Without detailed reports outlining the batterer clients' areas of strength and weakness, probation officers are not able to make well-educated decisions regarding future treatment planning. Follow-up studies are warranted on judges' and probation officers' perceptions of the usefulness of final reports and on the impact of final reports on sentencing decisions and post-treatment planning.

Finally, a lack of counsellor reported treatment behaviours has implications for the utility of any behaviourally based discharge criteria that may be developed in the future. Although key in-treatment behaviours may be potentially important markers that could be used as discharge criteria, if counsellors cannot, or do not, consistently note these behaviours in their written evaluation of clients, the usefulness of behaviourally based discharge criteria becomes negligible.

It is possible that implementing a structured protocol for counsellors to use while reporting on client in-treatment behaviours may increase the utility of behaviourally based discharge criteria. Structured clinical judgement could outline the treatment behaviours that should be attended to and offer guidance to the counsellor, while still allowing for the individual observation and incorporation of key contextual variables and other important information. However, before such a policy change is implemented, a careful examination of the predictive validity of in-treatment behaviours should be completed due to the fact that, as previously noted, the current literature demonstrates conflicting evidence regarding the predictive ability of batterer treatment behaviours. While the work of Gondolf (1995) and Taft et al. (2003) tends to support the belief that treatment behaviours in batterer treatment programs can predict outcome

net of other risk markers, Wernik (2005) challenged this conclusion, finding that counsellor report of treatment behaviours did not substantially relate to reassaults. Such patterns of mixed results are also found in other related fields of research, such as the sex-offender field. For example, when using treatment behaviours to predict outcome for sex-offender treatment, Barbaree (2005) did not find support for these items as predictors of recidivism, however, Marques et al. (2005) found that sexual offenders who met behavioural treatment goals did indeed reoffended at a significantly lower rate than did those who failed to exhibit those behaviours associated with treatment goals. As this study was unable to examine the relationship between counsellor report of client in-treatment behaviours and follow-up abuse, additional work is needed to clarify this relationship.

Unsuccessful Men in Batterer Treatment

A second area of investigation concerned the success of batterer clients. Considerable variation in counsellors' judgements was expected, with some clients deemed 'successful' across outcome domains and others as not having made progress throughout treatment. When counsellor reports of client treatment behaviours were compared, support was found for this hypothesis. Overall, at program completion, approximately 20% of clients ($n = 21$) were considered unsuccessful at meeting counsellor expectations for in-treatment behaviours, 11% were successful ($n = 12$), and the remaining 69% fell somewhere between these two extremes ($n = 73$). Thus, despite the fact that all participants had satisfactorily completed the program (i.e., had fulfilled attendance requirements), counsellors continued to consider one-fifth of these men to have made very little progress throughout treatment. In addition, the vast majority of the remaining clients had only mixed success, indicating that, according to counsellors, an alarmingly large portion of batterer program completers are not fully meeting behavioural

treatment goals. These results suggest that current discharge criteria cannot account for all of the factors associated with treatment success. Moreover, in combination with studies demonstrating that approximately one-third of men who complete batterer treatment go on to reassault their partners (Gondolf, 2002; Scott & Wolfe, 2003), these findings suggest that a significant portion of the variability associated with future violence may indeed be unaccounted for, leaving room for the use of treatment behaviours.

Predictors of Counsellor-Rated Success

A final objective of this study was to evaluate the ability of pre-intervention variables (i.e., individual-level characteristics and measures of the clients' motivation to change) to predict counsellor post-intervention report of treatment behaviours. Firstly, it was expected that men who had lower levels of motivation coming into the program would make less progress in treatment, as measured by counsellor reports. With the exception of batterer clients' perceptions of staff, consistent support was found for this hypothesis. Clients who showed lower overall levels of treatment motivation, in addition to a lower perceived need for treatment, poorer perceptions of treatment, less optimism towards outcome, and less comfort with group disclosure at program intake, were significantly more likely to be judged as unsuccessful by their counsellors at program completion. Client motivation was expected to predict counsellor-rated success, as client resistance has been conceptualized as impeding the successful achievement of therapeutic goals, with past research suggesting that men who are less prepared or motivated to change will make fewer gains over treatment compared to those men identified as 'more ready' (Prochaska, DiClemente, & Norcross, 1992). Clients' low levels of motivation may have resulted in their poor engagement in treatment and low levels of accountability, thus resulting in poor counsellor reports of these in-treatment behaviours.

Counter to study hypotheses, other individual-level (i.e., demographic and attitudinal) characteristics were found to be unrelated to client progress throughout treatment. Although individual characteristics have been found to be related to dropout rates (Daly & Pelowski, 2000; Daly, Power & Gondolf, 2001), the relationship between these variables and recidivism for program completers is much less clear. In a study by Gondolf (1996), it was shown that a clustering of personality and demographic characteristics was not predictive of violence severity in batterer clients. Furthermore, a comprehensive review conducted by Cattaneo and Goodman (2005) found that individual characteristics were poor predictors of reabuse, with study results often being too mixed and inconsistent to draw strong conclusions. These past findings suggest that while individual-level characteristics are good predictors of dropout, they may not be as robust at predicting treatment success (i.e., recidivism). Thus it is possible that our study design, which eliminated all dropout participants from its sample, and which used an outcome measure (i.e., counsellor report of in-treatment behaviours) hypothesized to be associated with treatment success, was responsible for the null results within this domain.

Finally, when the therapeutic relationship was examined across the three success levels, support was not found for the hypothesis that men with stronger relationships with their counsellors would be rated as more successful. No differences were found in either the client or counsellor working alliance scores at the beginning of treatment across success levels. These results are surprising since the degree of rapport between a counsellor and client has long been recognized as an important and highly influential factor related to treatment success in psychotherapy (Raue & Goldfried, 1994). More specifically, a positive therapeutic relationship between counsellor and client has been shown to predict outcome for men in treatment for domestic violence (Brown & O'Leary, 2000; Taft et al., 2003). Batterer clients who had a poor

therapeutic relationship with their counsellor, however, may have been largely eliminated from this sample along with the sub-sample of men who dropped out of the program or who were asked to leave the program. The lack of variability in working alliance scores may therefore have been due to a 'ceiling effect' caused by the counsellor-client relationship being adequately developed for all of those clients who completed the program. Indeed, when examining the data, it becomes apparent that batterer clients included in this sample appeared to have a sufficiently developed therapeutic relationship with their counsellor (i.e., mean score of 5.39 on a 7-point scale, corresponding with a moderate to high therapeutic alliance). It seems reasonable that while a positive therapeutic relationship is necessary for treatment success, it is not sufficient in and of itself. Thus unsuccessful-rated clients may have other barriers to changing their in-treatment behaviour but continue to have a sufficiently developed relationship with their counsellor, which may also potentially explain their continued attendance despite their lack of engagement in treatment. Finally, since therapeutic relationship was only measured at week two of treatment, it is also possible that potential differences in the working alliance scores may have appeared across success levels later in treatment, which this study was unable to compare. Additional work, therefore, is needed to define the development of the therapeutic relationship for clients who are considered unsuccessful by their counsellors.

Limitations of the Research and Suggestions for Future Research

Findings from this study must be interpreted within the context of several important limitations. Firstly, limitations may stem from possible procedural and methodological shortcomings. The implementation of the Treatment Behaviours in Batterer Intervention Program Activities (TBBIPA) Scale, in particular, may be one source of potential error. This measure, although largely based on the validated *Discharge Criteria* created by Gondolf (1995),

was specifically developed for this study and therefore has yet to be formally evaluated for its reliability and validity in identifying unsuccessful batterer clients. Additionally, due to low documentation levels for the majority of the behavioural categories, success classification was based solely on counsellor report of accountability and engagement in treatment. Thus, the concept of success (as measured by this study) may not have been adequately captured.

Related to this point, interpretation difficulties are compounded by the fact that, with the exception of Gondolf (1995), Taft et al. (2003), and Wernik (2005), a review of the literature in the field of domestic violence points to very little consideration of treatment behaviours as a possible predictor of recidivism. Moreover, as this study did not include any follow-up data, interpretations regarding recidivism could not be made. Thus, subsequent studies will be required to formally evaluate, not only the predictive validity of the TBBIPA, but also the validity of in-treatment behaviours more generally as predictors of future partner related violence.

Secondly, counsellor reports were collected and coded post-intervention, and thus counsellors were not provided with any guidance when completing client reports. Reviews of the prediction literature consistently point to several shortcomings involved in unstructured clinical judgment. These include exposure to skewed populations of individuals leading to misleading judgements, poor weighting of variables and limited ability to rule out irrelevant variables, limited cognitive capacity to account for heavy loads of information, and random fluctuations in judgement (Hart, 1998). Thus, the current study may have subsumed several of these shortcomings by coding reports consisting of unstructured counsellor observations. It is possible that counsellors may have documented more treatment behaviours, and had better accuracy in their observations, if they were provided with guidelines prior to implementing the treatment program and writing their client reports.

It is also possible that the low documentation of many treatment behaviours may have been the result of counsellor inability to observe specific behaviours. For example, behaviours such as sobriety and nonviolence, while an important marker of treatment success, may not be readily observable within group sessions. The difficulty with reporting on such behaviours suggests the potential importance of a holistic approach to violence prediction, which incorporates both counsellor report and other previously established predictors of recidivism (e.g., history of abuse, criminal history, history of drug and alcohol abuse).

Other limitations stem from the methodological and analytical design of this study. Specifically, the inability to directly compare motivation, attitudinal, and working alliance scores across success levels throughout the course of treatment and at program completion prevents the comparison of changes in motivation, attitudes, and the therapeutic relationship for these groups and further limits the conclusions which can be reached. Additionally, the client bond subscale from the WAI and two subscales from the PRP (i.e., mistreatment of others and minimization) were found to have lower levels of internal consistency (αs = .40, .42, and .40, respectively). These low alpha values indicate high levels of error variance, and in effect, decrease the likelihood of detecting effects across groups with these variables. Furthermore, it is important to note that the group samples obtained were relatively small in size, thus further limiting the power and confidence by which true differences could be detected. A final limitation of this study involves the analysis of data, which treated the data as independent. In actuality, data were nested, with one counsellor writing reports on multiple batterer clients. Due to the nested nature of the data, multi-level statistics, such as Hierarchical Linear Modeling (HLM), might have been a more appropriate mode of evaluation had group sizes permitted such analyses.

This study represents one possible methodology for exploring the content of reports written by counsellors of a batterer intervention program. Although the current study methodology allows for an important overview of unmodified, current counsellor reports, future studies should also examine the benefit of providing counsellors with structured guidelines for reporting on key treatment behaviours. As previously mentioned, unstructured clinical judgment has the potential to be inaccurate and unreliable. However, by adding structure to the process by which counsellors make clinical observations of client treatment behaviours, it is possible that the shortcomings associated with unstructured clinical judgement could be greatly diminished and counsellor reports could be incorporated into the assessment process. Additionally, future research will want to explore the predictive validity of in-treatment behaviours as markers of treatment success and reassault. Finally, other avenues of exploration, such as the use of in-treatment behaviours to improve post-treatment planning, are also likely relevant to improving treatment outcomes. Together, such future research will hopefully help to illustrate the multi-faceted process that facilitates change in men who have been the perpetrators of intimate partner violence, thus allowing for the identification of individuals who pose a high risk of continued harm to their partners and families.

Conclusions

The findings from this study provide an initial look into the extent and nature of counsellor post-intervention judgements of key rated client treatment behaviours. The finding that counsellors are deeming a significant proportion of batterer clients as 'unsuccessful' across behavioural outcome domains suggests that a significant portion of the variability associated with treatment success may be unaccounted for when using traditional attendance-based discharge criteria, which is standard practice in Canada. Although further empirical research is

needed to understand the relationship between batterer client treatment behaviours and future recidivism, counsellor report of in-treatment behaviours may be one way to improve post-treatment planning, and in turn improve the future success of batterer intervention program participants. An increased understanding of in-treatment behaviours has considerable potential for influencing current standards and design of discharge criteria for batter intervention programs in Ontario and across Canada, in the hopes of improving treatment outcomes for men who batter. At a minimum, behaviourally based discharge criteria might be used as a way to inform and make recommendations to Domestic Violence Courts, female partners, and the men themselves. It is through an increased appreciation and utilization of such an integrated approach to batterer intervention systems that we hold the hope of reducing the prevalence of violence in intimate partner relationships.

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Appendix A
Information and Consent Form

OISE Letterhead

Letter of Research Information

You have just become involved in the Changing Ways program, a program specifically for men who have been abusive towards their intimate partners. To try to improve the service it offers, Changing Ways has recently started a new group. Some of the men who come into the Changing Ways program will now be invited to attend this group, others will be invited to attend traditional groups. All groups at Changing Ways aim to help men examine their behaviour. They differ in the ways counsellors go about helping men in different groups, in the number of men in the group, and in the timing of group (i.e. some groups run for two hours with a break, others for 1 ½ hours without a break).

For this research project, we are examining men's progress through treatment in the different Changing Ways groups. Basically, we are looking at what is most helpful for men. If you choose to participate, you will be asked to complete a number of assessments as you progress through your program at Changing Ways.

Today you will receive one package of questionnaires to complete. You will receive similar packages to complete at the end of your time at Changing Ways and again six months later. Each one will take approximately 20 minutes to complete. Because this is a research project, you may choose not to answer any question that makes you feel uncomfortable or you may withdraw from the study at any time. Researchers will also look at information collected by the program staff at Changing Ways to help judge the success of this new group

Your partner will also be invited to participate in research, though her decision and yours will be completely independent.

Information collected for research purposes will be kept completely confidential with the important exceptions of reports of suicidality, homicidality, or child abuse. Information will be coded using a confidential ID number. Information will be pooled for statistical analysis and reporting so that an individual can, at no time, be identified.

There is no known risk to your participation or lack of participation in this study. It will not affect your progress at Changing Ways by either helping or hindering your chances of being invited to future groups at Changing Ways. It will also have no effect on any involvement that you may have with the legal system.

Results of this study will be used to make decisions about the future development of programs at Changing Ways. A formal report will be prepared for members of the London community and a research paper may be sent to a scholarly journal. A copy of results will be made available to all participants who are interested.

To indicate whether you do or do not consent to participate in this research, please fill in the form that is attached to this letter. Please keep a copy of this letter for your records.

If you have any questions, feel free to call me at the number listed below. Thank you very much for your time.

Katreena Scott, Ph.D.
Assistant Professor, 416-923-6641 ext. 2570

Consent for Research Participation

Your Name: ______________________________

I have read the letter of information provided by Katreena Scott and understand what is involved in this study. I also understand that I have the right to withdraw my consent at any time for no reason, and that all information obtained for this study will be kept strictly confidential.

Please check one of the following:

____ *I voluntarily consent to participating in the study described.*

____ *I do not consent to participating in the study described.*

________________________ ________________

Signature Date

Appendix B
Treatment Behaviours in Batterer Intervention Program
Activities (TBBIPA) Scale

Treatment Behaviours in Batterer Intervention Program Activities Scale (TBBIPA)

Please rate the following categories on a scale of 1 to 4 using the provided behavioural indicators.

1. **Attendance:** rate on a scale of 1 to 4, where 1 is missing 3 or more weekly sessions, 2 is missing 2 weekly sessions, 3 is missing 1 weekly session, and 4 is missing no weekly sessions.

   1 2 3 4

   _____ Behavioural category not mentioned in report

2. **Nonviolence:** rate on a scale of 1 to 4, where 1 is an incident of spousal violence, 2 is an incident of non-spousal violence, 3 is a breach of probation, and 4 is no known incidents of violence.

   1 2 3 4

   _____ Behavioural category not mentioned in report

3. **Sobriety:** rate on a scale of 1 to 4, where 1 is multiple incidents of alcohol and/or substance intoxication, 2 is a single incident of alcohol or substance intoxication, 3 is suspicion of alcohol or substance use, and 4 is no alcohol or substance intoxication.

   1 2 3 4

   _____ Behavioural category not mentioned in report

4. **Acceptance, Accountability and Responsibility:** rate on a scale of 1 to 4, where 1 is denial of abusive behaviour, 1.5 is no accountability for abusive behaviour (e.g., frequently minimizing, blaming or excusing the problem), 2 is limited accountability for abusive behaviour (e.g., occasional minimizing, blaming or excusing of the problem; rarely identifying contribution to problems or admitting that abuse exists), 2.5 is identifying use of abuse, but struggling to accept responsibility for behaviour (e.g., no minimizing, blaming or excusing the problem but struggling to identify partners experience of abuse; some counsellor reservation about participants acceptance despite meeting expectations), 3 is identifying use of abuse with no mention of accepting responsibility for behaviour (e.g., no mention of the *impact* of the abuse on his partner), 3.5 is demonstration of higher levels of accountability by more repeated or advanced identification of abuse with no minimizing, blaming or excusing the problem (but still no mention of the impact of the abuse on his partner), and 4 is identifying use of abuse with no minimizing, blaming or excusing the problem, **and** identifying the impact of the abuse on his partner.

1 1.5 2 2.5 3 3.5 4

_____ Behavioural category not mentioned in report

5a. **Using Techniques:** rate on a scale of 1 to 4, where 1 is a lack of use of techniques taught in group (e.g., time-outs, identification of warning signs, etc.), 2 is a single reference to use of techniques taught in group, 3 is occasional reference to use of techniques taught in group, and 4 is frequent reference to use of techniques taught in group (must be reference to use of more than one technique).

1 2 3 4

_____ Behavioural category not mentioned in report

5b. **Homework Completion:** rate on a scale of 2 to 4, where 2 is outstanding assignment(s), and 4 is all assignments completed (e.g., met all minimal requirements; has completed the requirements).

2 4

_____ Behavioural category not mentioned in report

6. **Help-seeking:** rate on a scale of 1 to 4, where 1 is no help-seeking behaviour, 2 is a single incident of help-seeking behaviour (e.g., seeking information about alternatives and discussing options with others in the group), 3 is two incidents of help-seeking behaviour (e.g., seeking information about alternatives and discussing options with others in the group), and 4 is frequent (3 or more incidents of or reference to frequent use of) help-seeking behaviour (e.g., seeking information about alternatives and discussing options with others in the group; open to referrals and future support).

1 2 3 4

_____ Behavioural category not mentioned in report

7. **Group Process (Being respectful and responding to group members):** rate on a scale of 1 to 4, where 1 is disruptive to the group process (e.g., prompting off topic or inappropriate discussions), 1.5 is no voluntary contribution to the group process (e.g., no feedback to other members) **or** no contribution to the group process unless directly prompted by group facilitators, 2 is minimal contribution to the group process, 2.5 is minimal (or no contribution) to moderate/appropriate contribution to the group process, 3 is moderate contribution to the group process (e.g., appropriate contribution to the group process; being respectful and responding appropriately to the other group members statements), 3.5 is moderate to active contribution to the group process, and 4 is consistent active contribution to the group process (e.g., being respectful and responding to the other group members and respectfully challenging group members and/or encouraging other men in group).

   1 1.5 2 2.5 3 3.5 4

   _____ Behavioural category not mentioned in report

8. **Active Engagement (Participation):** rated on a scale of 1 to 4, where 1 is inappropriate participation (e.g., disrupting group), 1.5 is a mixture of inappropriate and appropriate participation, 2 is no or minimal participation (e.g., participating in discussions when prompted by facilitators), 2.5 is minimal to moderate participation, 3 is moderate/appropriate participation (e.g., participating in discussions), 3.5 is moderate to active participation, and 4 is active participation (e.g., active participation in discussions, defining terms).

   1 1.5 2 2.5 3 3.5 4

   _____ Behavioural category not mentioned in report

9. **Self-disclosure:** rated on a scale of 1 to 4, where 1 is no self-disclosure, 2 is occasional self-disclosure with prompting from facilitators, 3 is occasional voluntary self-disclosure, 4 is frequent voluntary self-disclosure (e.g., provides appropriate examples from their life).

   Note: do not count self-disclosures made in the participant's accountability statement.

   1 2 3 4

   _____ Behavioural category not mentioned in report

10. **Sensitive Language (non-sexist language):** rated on a scale of 1 to 4, where 1 is has used sexist language and/or pejorative slang more than once, 2 is has used sexist language and/or pejorative slang once, 3 is has not used sexist language and/or pejorative slang, and 4 is has not used sexist language and/or pejorative slang and checks others who use sexist language.

    1 2 3 4

    _____ Behavioural category not mentioned in report

11a. **Understanding of Material:** rated on a scale of 1 to 4, where 1 is difficulty understanding the material (e.g., unable to generate workable alternative options to abusive behaviour), 2 is difficulty understanding some aspects of the material while demonstrating an understanding of other aspects of material, 3 is understanding of some aspects of the material (e.g., able to give alternative options to abusive behaviour), and 4 is understanding of multiple aspects of the material.

1 2 3 4

_____ Behavioural category not mentioned in report

11b. **Willingness to Integrate Material:** rated on a scale of 2 to 4, where 2 is an apparent lack of willingness or inability to integrate the material into their lives, and 4 is an apparent willingness to integrate the material into their lives (e.g. with a goal towards personal change).

2 4

_____ Behavioural category not mentioned in report

11. Please indicate if this was a Intervention Phase I (IPI) report or a Intervention Phase II (IPII) report:

IPI IPII

12. Please indicate any significant features of the counsellor report that you feel are important to note.

____

____

____

____

____

Appendix C
Overview of Gondolf (1995) Discharge Criteria Form

Table C1.

Criteria for a Judgment of Unsuccessful or Successful on TBBIPA Behavioural Categories.

Item	Operational definition
Attendance	Arrives at group session on time; socializes or lingers afterward; contacts program in advance about absence; has legitimate excuse for absences
Nonviolence	Has not recently physically abused partner, children, or others; no apparent threats, intimidation, or manipulation
Sobriety	Attends meetings sober; not high or drunk; no apparent abuse of alcohol or drugs during week; complying to ordered or referred drug and alcohol treatment
Acceptance	Admits that violence and abuse exists; not minimizing, blaming, or excusing the problem; realizes responsibility for abuse; identifies contribution to problems
Using techniques	Takes conscious steps to avoid violence; refers to time-outs, self-talk, conflict resolution skills, etc.; does homework assignments or recommendations
Help-seeking	Seeks information about alternatives; discusses options with others in the group; calls other participants for help; open to referrals and future support
Process conscious	Lets others speak one at a time; acknowledges others' contributions; asks questions of others without interrogating; heeds direction of counsellors
Actively engaged	Attentive body language and non-verbal response; maintains eye contact; speaks with feeling; follows topic of discussion in comments
Self-disclosure	reveals struggles, feelings, fears, and self-doubts; not withholding or evading issues; not sarcastic or defensive
Sensitive language	respectful of partner and women in general; non-sexist language and no pejorative slang; checks others who use sexist language

Source: Gondolf, E.W. (1995). Discharge criteria for batterer programs. *Minnesota Center Against Violence and Abuse.*