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The Relationship Between Male Batterers' Self-Disclosure and Treatment Outcome

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A thesis submitted in partial fulfillment of the requirements for the degree in Master of Education

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THE RELATIONSHIP BETWEEN MALE BATTERERS' SELF-DISCLOSURE
AND TREATMENT OUTCOME

by

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Graduate Program in Education (Counseling Psychology)

A thesis submitted in partial fulfillment
of the requirements for the degree of
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Abstract

The present study investigated self-report behaviours among male batterers. It was predicted that batterers who acknowledged their abusive behaviour would be more likely to benefit and progress in the batterer intervention program than men who used denial and minimization as reflected by the counselor reports. Furthermore, this study hypothesized that there may be a specific impact of batterers' acknowledgement of their children's witnessing of the domestic violence, with those who acknowledged child witnessing tending to have better program outcomes than men who deny their children's involvement. Results, based on a review of 101 DV cases provided by a community agency delivering treatment for domestic violence populations, indicated that batterers who acknowledged their abusive behaviour performed better in the intervention program than batterers who did not acknowledge the impact of DV. Similarly, men who acknowledged the presence of their child (ren) at the DV incident received significantly higher ratings of treatment outcomes than men who did not acknowledge. Implications for clinical practice and suggestions for future research are discussed.

Keywords: self-report, acknowledgment, male batterer, domestic violence, domestic violence treatment, treatment outcome, treatment progress, underreporting, denial, minimization

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The Relationship between Male Batterers Self-Disclosure and Treatment Outcome

Domestic violence (DV) is a serious societal problem that affects both adult victims and their children who are exposed to the violence. One of the key strategies to reduce the harm caused by DV is early detection and intervention. Amongst the critical interventions are programs for abusers to end their violent behavior and, although there has been considerable research and controversy on the effectiveness of these programs, little research has addressed the nature of self-reporting behaviour among men and its relationship to treatment outcome. This study explored this research gap by examining batterers' awareness of the impact of their behaviour on their victim and/or families at the point of the intake into a community intervention program. Two important issues with respect to self-report were of interest in this study: the relationship between men's level of acknowledgment upon program completion; and similarly, the acknowledgment of child witnessing domestic violence incident and program outcome as judged by their counselors. It was hypothesized that higher level of acknowledgement of the abusive behaviour would be strongly correlated with received higher ratings from their counselor. Furthermore, this study advanced the hypothesis that men who acknowledged the presence of their child (ren) at the DV incident, completed the program with higher outcome scores. As part of the methodology, self-reports of batterers were compared with the agency reports (mainly consisting of police reports) to account for any discrepancy between batterers' self-report and other available objective data.

In the first section of this thesis, I review the nature and prevalence of domestic violence, current definitions of batterer typology, impact of denial on child-(ren) of

batterers, risk assessment, understanding the change process and lastly, level of denial, minimization and blaming in self-reporting of abusive behavior by this population.

Following this review, I describe current study methodology and hypotheses.

The Definition and Prevalence of Domestic Violence

The definition of the term domestic violence (DV) has been evolving over time. O' Leary (2001) notes that in the early 1970s, DV and abuse was described as strictly physical harm to an intimate partner. Currently, DV represents a more holistic view that encompasses verbal, psychological, physical, sexual, and financial forms of abuse. For the purpose of this study, DV refers to its current definition and domestic partnership refers to a married, common law, dating, or intimate couple relationships. Moreover, it is important to clarify that the terms batterer and DV perpetrator will be used interchangeably in the present paper.

Prevalence of Domestic Violence. Domestic violence against women has been identified as a major public health issue (Alhabib, Nur & Jones, 2010). In a World Health Organization multi-country study of violence against women, Garcia-Moreno, Jansesn, Ellsberg, Hense and Watts (2005) reported a variation in the lifetime prevalence of physical or sexual violence, or both, from 15% to 71% among the countries studied. These findings suggest the global commonality of DV as it moves from one culture to another. Every five years, Statistics Canada captures the extent and prevalence of family violence using police statistics and victims surveys. This report serves as an initiative to educate policy makers and the public about issues of DV and violence. More specifically, the 2009 report focused on self-reports incidents of intimate partner abuse and victimization. Of the 19 million Canadians with an ex or current spouse, 6% reported

experiencing abuse from their partner in the preceding five years (Statistics Canada, 2009). Furthermore, from incidents of intimate partner violence reported, females were more likely than males to report multiple incidents of spousal violence at 57% and 40% respectively (Statistic Canada, 2009). According to police reports of 2009, female victims were about three times more likely than male victims to state that they had experienced a DV incident to police (23% versus 7%) and report serious forms of assault (34% versus 10%) compared to male victims (Statistic Canada, 2009). Although most assault incidents are underestimates of the incidents of DV due to the complex and private nature of this issue, this pattern suggests the difference in underreporting of abuse between male and female batterers.

The distinction between women and men perpetrators also manifests itself in the type of risks and characteristics presented by each group (Stanford & Lake, 2011). Several studies in the domestic violence literature have focused on treatment need of male and female batterers to understand how men differ from their female counterparts. Henning and Feder (2004) studied risk factors in a large sample of male (5,578) and female (1,126) batterers and found men to have higher risk factors for recidivism, assault and substance abuse history. Another study by Henning, Jones & Holford (2003) examined the mental health functioning of these two groups and concluded that women had more internalized problems whereas males presented with more substance abuse and conduct disorder issues. The two studies reviewed above suggest that there are gender differences in risk assessment and treatment needs of batterers. Similar conclusions were reached by other studies that emphasized on unique differences and needs in these two populations (Abel, 2001; Hamberger & Potente, 1994). An issue that was not extensively

addressed in these four studies was minimization, denial of risk factors and abusive behaviour among men and women batterers. Given the importance of gender differences in assessment and treatment of batterers, more specifically, the higher underreporting levels among males than females (Babcock et al., 2005), this study aims to exclusively examine self-disclosure/acknowledgment in male batterers.

With the prevalence of DV, legal, social and health services have outreached to the victims in order to provide specialized interventions for this population. This includes abused women's programs, family court services, assault help lines and range of other resources that serve affected families and children (Benki, 2011). Although this movement has progressed to enforce safety of women and children in abusive relationships, it has shifted the attention away from addressing the source of the problem: assessment of effective intervention for batterers (Benki, 2011).

Currently most domestic violence programs, also known as batterer intervention programs (BIPs), follow a specific treatment model and, although there are variations in the specific material reviewed in these programs, the common modes of therapy are cognitive behavioural, group and psycho-educational techniques that vary in length and intensity (Gregory & Erez, 2002). Specific conditions for completion of the program are often presented; for example, (Benki, 2011) noted that most programs agree that the male participants need to comply with program rules, complete homework and pay fees to graduate. One of the criticisms of such criteria is that successful completion is then based on compliance with these conditions, rather than more relevant treatment outcomes such as increasing their level of accountability for the ownership and negative effects of battering behaviour. Despite this problem, programs aim to assist batterers in

understanding abusive behaviour and ensure the offender accepts accountability for their behaviour (Gondolf, 1997). One of the widely used models of treatment is an intervention called the Duluth Domestic Abuse Model, a community response treatment that focuses on victims' safety and holding batterers accountable for their abusive behaviors (Pence & Paymar, 1993). Unfortunately, several studies have shown that this model lacks strong empirical support (e.g., Babcock, Green, & Robie, 2004; Feder & Wilson, 2005; Maiuro & Eberle, 2008). In a meta-analysis, Babcock and colleagues (2004) evaluated the impact of Cognitive Behavioural Therapy (CBT), along with other treatments that worked well on batterer recidivism and found no significant difference between treatments. More recently, Smedslund, Dalsbo, Steiro, Winsvold and Clench-Aas (2009) reviewed studies for current treatment of batterers and concluded that there are not enough randomized control trials that can make empirically supported conclusions about the effectiveness of DV interventions for batterers. Given these concerns, it is important that researchers, community, professionals and involved systems be mindful of investigation and implementation of appropriate treatment for this population. The next section will focus on current literature to highlight the need for insight into batterers' psychopathology, importance of assessing risk and current tailored risk assessments.

Risks and Assessment of Risk Factors: Understanding Risk

Battering leads to multiple physical and psychological consequences for both the victims and families involved. Nevertheless identifying the level of risk of domestic violence is critical in prevention of future violence. There are several clinical implications in improving the ability to predict risk of violence. Some of the important

implications for this assessment are assisting the victims of DV to make realistic safety plans, make appropriate decisions involving supervision by the judicial system, and lastly assist in better implementation of treatment planning for batterers (Weisz, Tolman, & Saunders, 2000). Despite the numerous literatures in the area of DV, there are variations on the types of characteristics, pre-dispositions and risk factors that account for motivation to commit an abusive act by a batterer (Mowat-Leger, 2002). Therefore a comprehensive understanding of male batterers behaviors as well as level of denial/minimization is crucial for several reasons: preventing future violence from the batterer (Andrewes & Bonta, 1998), as well as reducing risk of child witness of abuse or in unfortunate cases, becoming involved in abusive relationships in the future as adults (Mowat-Leger, 2002). Therefore, studying risk, and appropriately assessing violence will be helpful in identifying the needs of both perpetrators of violence and victims. More specifically, this paper examines the acknowledgment of DV relative to their treatment outcome as a preliminary step to understand risk relative to their self-disclosures.

Risk Factor Assessment. What has been considered practical and useful in the criminal justice field is the classification of factors that influence the likelihood of recidivism and treatment attrition rates among batterers (Benki, 2011). Risk assessment refers to

“personal attributes and circumstances that are assessable prior to service and are predictive of future criminal behaviour” (Andrews, Bonta & Hoge , 1990, p. 24).

This is important as the classification of perpetrators into different subtypes has been useful in labeling them in accordance with their level of risk for recidivism: “low”, “medium”, and “high” (Andrews et al., 2006; Healey et al., 1998; Marlowe, Festinger, Lee, Dugosh, & Benasutti, 2006). Essentially it has been argued that not all batterers

benefit from the same treatment program and the mismatch of treatment and level of risk may reduce the treatment effects (Ward, Melsner, & Yates, 2007). Furthermore, risk assessments allow professionals to identify persons at risk for perpetrating serious and/or lethal violence (Otto & Douglas, 2010). There are a variety of spousal assault risk assessment tools available. However in a meta-analysis of the validity of risk assessment tools for DV, the Danger Assessment (measures the level of danger an abused victim has of being killed by the perpetrator ;DA; Campbell, 1986), the Ontario Domestic Assault Risk Assessment (DV risk assessment to assess future assaults; ODARA; Hilton, Harris, Rice, Lang, Cormier, & Lines, 2004), and the Spousal Assault Risk Assessment (assesses the degree to which an individual poses a threat to his spouse; SARA; Kropp, Hart, Webster, & Eaves, 1998) were identified as notable tools currently being utilized in Canada (Hanson et al., 2007).

The validity of these assessment tools have been empirically tested and classify batterers into high, moderate and low level offenders (Dutton & Kropp, 2000). The accuracy of matching batterers into different risk levels is promising in the classification of offenders by the judicial system to appropriate probation time and supervision. Unfortunately, within the rehabilitation system, there is a gap in accurately matching individualized needs of batterers to appropriate treatment modules practices (Taxman & Malowe, 2006; Ward, Melsner, & Yates, 2007). This gap can be partially attributed to the fact that much of the data retrieved about a referred case to an intervention program is through self-reports of batterers (Fischer & Rose, 1995; Dankwort & Austin, 1995; Gondolf, 1997a). Only recently have collaborations been made to enhance more comprehensive data collection and risk assessment; for instance, the Province of Ontario

released the Domestic Violence Risk Management Guide (DVRM) report that includes a general outline of the most common risk factors that legal professionals need to account for and report in an incident of DV (Ministry of Community Safety and Correctional Services, 2013). A list of some of the common risk factors recorded include, but are not limited to: threats to violence, history of assault, severity of the injury, relationship status, community supervision, substance abuse, mental health status, unemployment and use of weapons (DVRM, 2013). These tools have implications for understanding the type of factors that are critical in assessment of risk to victims and subsequently, improvement of intervention programs for perpetrators. Moreover, the use of these tools has been instrumental in establishing batterers' heterogeneous nature. However, despite such agreement, fewer programs receive this risk assessment information from police or match batterers with tailored intervention based on assessment of individual risk factors and needs.

Another area that is a challenge to evaluate relative to men's assessment of risk is the reporting of child exposure to DV. One of the interesting questions that need to be explored in batterers' denial/minimization is the inclusion of child exposure to DV in assessment of risk for this population. This variable is relevant to be discussed as is often excluded on assessment instruments that measure risk of violence in men. This is concerning because men's acknowledgment of their children's exposure to DV may be or suggested on the basis of clinical experience is an important indicator of their level of risk and readiness for change (Crooks & Scott, 2004). Hence, the following section will focus on the prevalence and known effects of exposure of DV on children of batterers.

Prevalence and Impact of Child Exposure to Domestic Violence. Alongside the prevalence of domestic violence, is the concern that children in intimate partner violence households are exposed to violence and negatively impacted. The children's experience with DV can be understood by considering the direct and indirect ways in which a child experiences violence. For instance a child can face directly experience physical injuries in an attempt to interrupt an assault or indirectly imply passive ways to interpret and process violence in his/her environment (Cunningham & Baker, 2004). To date, numerous studies have looked at the prevalence of children's exposure to DV. For example, an important survey from the Second National Family Violence revealed an estimate of 10 million children exposed to marital violence each year (Straus, 1991). Moreover, based on interviews from national sampling in United States, an estimated 15.5 million children are reported living in DV households with at least one DV incident occurrence and approximately 7 million were exposed to severe DV (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006). More recently, the first Canadian national survey by The Canadian Incidence Study of Reported Child Abuse and Neglect found an estimated 49,994 child investigations by child welfare services involved children exposed to DV (Canadian Incidence Study of Reported Child Abuse and Neglect, 2001). In addition, this survey established that of those populations of children exposed to DV, "one third were categorized as a single incident, 13% involved multiple incidents over a period of less than 6 months, and 39 % involved multiple incidents over a period longer than 6 months" (Jaffe et. al, 2012, p. 9).

Although major sets of data have been collected in this area, there are significant discrepancies across studies due to the variability in research methodologies (Osofsky, 2003). Therefore, more children may be exposed to DV than those estimates indicate as

most studies rely on surveys and self-reports to understand the co-occurrence of DV and child exposure.

As mentioned previously, the statistic on prevalence of DV and children's exposure to DV is may be heavily underreported due to minimization of abuse by partners, parents, and children due to multiple reasons such as fear of consequences (Osofksy, 2003). In addition to the level of underreporting, there is considerable evidence on the negative impact of child exposure to this issue. A meta-analysis of studies related to impact of exposure of on children reported that this group has significantly more emotional, physical, and behavioural difficulties than non-exposed children (Wolfe, Crooks, et al., 2003). More specifically, children could be affected negatively in two ways: At risk for physical harm and become vulnerable to developmental/psychological strains due to violence (Arias & Pepe, 1999; Wolf, 2002). Although the severity of children's problems varies, internalizing and externalizing behaviors, more specifically, aggression and post-traumatic stress disorder (PTSD) are common reactions to difficulties of dealing with the trauma of DV (Cunningham & Baker, 2003).

Unfortunately, often the impact of exposure to DV can move beyond the childhood stages of development into adolescence and adulthood (Jaffe et al., 2012, p. 14). In fact, several studies have found connections between exposure to DV, as one of a number of adverse childhood events (e.g. child maltreatment, parent criminality) and range of mental and physical health issues including but not limited to: alcoholism, drug abuse, heart disease, self-esteem issues, coping difficulties and mood disorders onto adulthood Caetano, Field & Newton, 2003; Dube, Anda, Felitti, Edwards & Williamson, 2002; Whitfield, Anda, Dube & Felitti, 2003). This literature suggests that the impact of intimate partner violence

on children is not limited to one incident at hand and the negative outcomes often continue onto later stages of life. The integration of impact of children's exposure to DV into the work of self-disclosure of male batterers is important as it places emphasis on the acknowledgment of abusive behaviour with respect to their role as partners and parents. In addition, understanding child exposure as a risk factor in self-reports of male perpetrators is a useful framework for accurate assessments of this population.

To date, clinicians have used a variety of measures to assess children's exposure to DV. Some of the most common measures currently used are the Adult Conflict Tactics Scale (CTS), adopted for use of children named the Conflict Tactics Scale Parent-Child Version (CTS-PC) (Straus et al., 1996); Juvenile Victimization Questionnaire (JVQ) (Finklehor et al., 2005); and The Violence Exposure Scale for Children (VEX-R; Fox & Leavitt, 1996). As a group, these measures are useful in screening for general exposure to violence, yet they lack the ability to comprehensively measure elements of exposure to violence (Edelson, Ellerton, Seagren, Schmidt & Ambrose, 2007). For instance, the CTS PC measurement defines witnessing as "saw or heard" which is a "narrow definition of child exposure" (Edelson et. al, 2007) or the VEX-R (Fox & Leavitt, 1996) designed to assess exposure to neighborhood violence, which is not comprehensive as it doesn't account for violence in the home where most cases of DV incidents occur.

Although these tools are the most commonly used measures in evaluating child exposure to violence, one additional challenge is that they are readily available for testing in self-report formats (Feindler, Rathus, & Silver 2003). This can pose an issue as self-reports may not be the most accurate method in evaluating this issue. This challenge has been identified by few studies that have shown significant differences between the reports

of DV by children and their parents (O'Brien, John, Margolin, & Erel, 1994; Sternberg, Lamb, Guterman, & Abbott, 2006). These studies have observed lower reports of violence by parents in comparison to children's description of DV in their home. This level of underreporting can be due to several reasons: lack of awareness on part of the parents, the fear that children will be removed from the home or the perceived risk it may presents to children as compared to parents. Overall these studies suggest the need by clinicians to tap into children, perpetrators and other collateral sources in order to gather a more accurate picture of the degree of violence and risk factors present among batterers. Therefore, the current study examines denial/ minimization in order to gain insight into batterers' reporting pattern of acknowledgment of their behaviour on victims/child-(ren) and its relationship with treatment outcome. This knowledge is critical because it contributes to literature in establishing the necessity of this variable in effective assessment of batterers as both partners and parents.

Batterers as Parents

Other approaches to understanding change in male batterers involve their attitudes and parenting roles as fathers. Numerous studies have explored characteristics of batterers as fathers and their parenting practices. For example, Bancroft and Silverman (2002), found male batterers to present as authoritative and rigid parents. Moreover, this study found that this population accepts limited feedback, criticism and expects unquestionable obedience from family members. This raises concerns about batterers as fathers since control is an important clinical element in male perpetrators' attitudes. In fact, control can lead batterers to treat their children as "rightfully" theirs and feel justified in authoritative-abusive parenting and at times child maltreatment (Francis,

Scott, Crooks, & Kelly, 2002). In support of these findings, Crooks & Scott (2004) noted that one of the primary difficulties with maltreating fathers is their sense of entitlement towards their children. This literature emphasizes acknowledging the multi-dimensional role of batterers in order to fully addressing their needs. Hence, treating all fathers who batter as a homogenous group could be problematic in appropriately assessing their level of risk. The research of perpetrators as parents has clinical implications, including having men come to an awareness of their attitudes and the impact of these attitudes on their children, as this is an important motivator for change (Crooks, Scott, Francis, Kelly & Reid, 2004). For instance, Crooks and colleagues (2004) emphasized increasing men's awareness of abusive behavior and child-centered parenting as important goals in their treatment outcome. Hence, this literature of batterers as parents is an important step in understanding the variability among these men and the current study extends this work by examining denial and minimization in this population and its relationship with their treatment progress.

Although the research on classification of batterers, their parenting and risk assessment is important in understanding this population, there can't be enough emphasis put on the need to focus on accounts of perpetrators, victims, and examine other relevant sources to fully assess risk factors that impact treatment and progress. This study attempts to address such issues by examining patterns of self-reporting behaviour among batterers. The next section will focus on the Trans theoretical Model of Change and batterers' readiness for acknowledgment of DV as a mean of grasping the rationale for examining denial and minimization in their self-reports.

Theoretical Models in Understanding Change in Batterers

One of the important areas to review in the male batterer intervention research is the stages and models of change in this population. The main problem with examining the process of change in this area is that many of the men referred for treatment are court-ordered and may lack motivation or present as compliant to avoid further legal consequences (Gondolf & Wernik, 2009). Another possibility for unwillingness or lack of readiness to change is lack of behavioural and social skills in controlling abusive behaviour when 'triggered' by the victim (Farrell, 2011). As expected, distinguishing levels of change enhances our understanding of batterers' cognitive distortions and clinicians' ability to work with batterers more effectively.

The Trans theoretical Model of Change (TTM) was originally developed to address health promoting behaviour including smoking, safe sex, healthy diet, exercise and alcohol consumption (Prochaska, Velicer, Rossi, Goldstein, Marcus & Rakowski, 1994). This model was later integrated with the knowledge about batterers for its application in understanding stages of change in this population (Scott and Wolfe 2000, 2003). According to the TTM, there are four stages that categorize batterers' process of change and change-intervention: Pre-contemplation, Contemplation, Action and Maintenance (Scott & Wolfe, 2003). The Pre-contemplation stage involves denial and unawareness of abusive behaviour because the problem behaviour is not recognized yet. The second stage, Contemplation, corresponds to men's awareness of the problem behaviour but lack of resources about how to change or doubts about their readiness to do so. During Action stage, problem behaviour is fully identified and necessary steps are taken to alter it. Finally, Maintenance is followed, in which the behaviour change is stabilized and supported through lifestyle and social action.

In incorporating the TTM to treatment efficacy of Batterer Intervention Programs (BIPs), Scott (2004b) studied the dropout rates of batterers in relation to their stage of change and found nine times higher attrition rate for men who began intervention at the Pre-contemplation than in the Action stage. Further research indicated that incongruity between treatment goals and stage of change are significantly correlated with treatment dropout rates among batterers (Eckhardt & Babcock, 2004). These findings suggest that many batterers' may not be ready for the process of change upon enrollment into interventions programs. Clinically, this is expressed through cognitive distortions: minimization, denial and blaming (Pence & Paymar, 1993). On the other hand, Eckerle and colleagues (2011) studied the model of pre-therapeutic change process in first time offenders who engaged in self-reflection, insight, and self-improvements before enrollment into intervention programs. One of the strengths of this study's methodology was the use of both qualitative and quantitative data, which included self-reports of men, police reports and other relevant criminal justice system files. These findings suggest that the process of change may begin prior to treatment in some men as they internalize, evaluate and demonstrate commitment in reflecting on the impact of their behaviour. Hence, as moving from the Pre-contemplation to action stages focus on self-evaluation, reflection of behavioral change techniques may prove to be more successful than behavioral techniques only, as recommended by Scott (2010). Understanding this possible shift has implications such as enhancing treatment outcomes by increasing the clinician's ability to work with batterers in a more effective manner.

As much as it is difficult to provide effective treatment for men who are not demonstrating readiness for change, Daniels and Murphy (1997) suggest that one of the

ways is for treatments to meet clients where they are in their treatment stage in order to increase their chance of success. The TTM is beneficial in two ways that are rather interconnected: firstly, tailoring clients' readiness to change and secondly, providing stage appropriate interventions. Subsequently, this means enhancing motivation at the specific stage of change where the client stands.

Given that measuring readiness for change is often based on self-reported data (Babcock, Candy, Senior & Eckhardt, 2005; Scott, 2010), the implications for its precision have to be further investigated. Therefore, gathering multiple sources of data in DV incidents provides a solid methodology for effective assessment of the batterers' readiness for change and allows clinicians to plan treatments accordingly. The next segment will be dedicated to reviewing self-reporting behaviour among batterers while considering the link between cognitive distortions and readiness for change.

Self-Report of Batterers: Denial, Minimization and Blaming

In order to better understand the nature of underreporting among batterers, it is necessary to operationalize the terms denial, minimization and blaming. Although these terms are placed on a continuum, their constructs differ in a few ways. Denial refers to disclaiming an act and minimization is admission of an action while diminishing its impact or severity. An example of minimization can be a perpetrator reporting that he lightly slapped his partner, rather than disclosing that the injury inflicted resulted in a broken jaw. Furthermore, denial refers to dismissing the impact of a violent act, such as acknowledgment of verbal abuse with the assertion that the victim had no reason to feel hurt or upset. Blaming takes a distinct definition in that it attributes abusive behaviour to externalized or situational factors. For instance, a batterer may position the victim as at

fault for triggering his violent behavior, rather than taking responsibility for the violence himself. These three constructs are similar in the sense that they are utilized to avoid gull acknowledgment of abuse and its impact.

Investigating the acknowledgment of problem behaviour is a key component in understanding steps that lead to personal accountability. The extent of personal responsibility has been studied between both non-clinical and clinical samples. Scott and Straus (2007) evaluated gender comparisons of denial and blaming between female and male undergraduate students and reported greater evidence of blaming and denial among young men than young females in relationship disputes. To date, there have been a few studies that have examined the nature of self- reports of violence among male batterers, and several conclusions have emerged from past studies examining these three constructs. Dutton and Starzomski (1997), assessed 120 court-ordered , self-referred batterers and 45 community sample using the Minnesota Power and Control Wheel (MPCW) tool that included eight sections measuring: using intimidation; emotional abuse; isolation; minimizing, denying, and blaming; using children; male privilege; economic abuse; and using coercion and threats. Moreover, this assessment was conducted within the first three weeks of a 16-week treatment program and found that more serious levels of blaming and denial are associated with higher assaultive acts. Similarly, other studies reported higher blaming behaviour and relationship dissatisfaction among violent men compared to non-violent men (Schweinle, Ickes, & Bernstein, 2002; Tonizzo, Howells, Day, Reidpath, & Froyland, 2000).

An important study by Naraine (1996) evaluated the differential reporting and treatment completion in male batterers. It showed that in a sample of 60 men and their

female partners, men's self-report of verbal and physical abusive acts was significantly lower compared to accounts provided by their female partners. Furthermore, males had higher level of denial and lower ambivalence levels in intimacy, which was predicative of higher drop-out rates in court-mandated treatment (Naraine, 1996). In contrast of previous findings, more recent research has reported that male batterers frequently use externalization and victim blaming to justify their behavior; however, there was no significant relationship between use of cognitive distortions and re-offending (Henning & Holford, 2006). This study involved a sample of 2,824 male offenders convicted of DV who had undergone a comprehensive psychological assessment ordered by the Domestic Violence Assessment Centre (DVAC) following a 60 minute interview by a clinician prior to attending treatment. It is important to note that the lack of validity of scales to capture cognitive distortions and failure to discriminate between different types of responders were shortcomings of this study. Despite such limitations, Henning and Holford (2006) were able to highlight the need for a comprehensive assessment of severity and causes of these distortions. Moreover, other reviewed findings supported the recommendation for collection of additional data in increasing accuracy of men's reporting behaviour (Austin & Dankwort, 1999; Hamberger, 1997).

Based on review of numerous studies, there is an emphasis on gathering collaborate data in DV cases. However, research studies have identified some of the challenges involved in this strategy. For instance, Heckert and Gonfold (2000) listed insufficient historical information or underreporting of victim because of hesitancy to testify as the most common obstacles. Additionally, the fact that most batterers engage in minimization, denial and blaming, presents additional difficulties in assessment,

supervision and treatment planning respectively. Clinically, there is preliminary evidence for the existence of denial, minimization and blaming that interferes with treatment progress of abusive men and higher levels of denial may contribute to less progress in the programs (Scott & Wolfe, 2003). Given the nature of underreporting and the extensive use of self-reports by clinicians upon program enrollments, one might ponder about the appropriateness of treatments that are tailored around intake assessments. Clinically, additional formal measures should be included in order to provide a comprehensive picture of the extent of abuse and its impact on victims involved. Thus, understanding batterers' acknowledgment of DV towards their children and families guided the design of this study. The objective of the study was to investigate self-reporting of the act of violence and presence of risk factors among this population. Furthermore, it aimed to understand the effect of acknowledgement of abusive behavior by batterers on the quality of intervention program outcome. The following section will describe the specifics of the study and its methodology.

Purpose of Current Study

There is a large body of literature that focuses on developing effective support and interventions for batterers (Benki, 2011; Crooks & Scott, 2004; Gondolf, 1997a; Gregory & Erez, 2002; Hamberger, 1997; Healey & Smith, 1998). However, less effort has gone into understanding the degree of denial, minimization and blaming as an important starting point in assessment of batterers' self-reporting behaviour (Henning & Holford, 2006). Although it is imperative for agencies and communities to learn about treatment effectiveness, knowledge of underreporting behaviour of batterers contributes significantly to target the issue of acknowledgment that is essential to implement change.

One of the initial steps for promoting change is for researchers to examine factors that contribute to appropriate assessment and subsequently, interventions of batterers in order to end violence against women. Hence, the goal of the present study was to investigate male batterers' acknowledgment of their abusive behaviour, through their self-reports and measure this acknowledgment relative to their performance on intervention program outcome. Based on previous literature examining the evaluation of change in batterers, it was predicted that male perpetrators of DV would be more likely to benefit from intervention programs if they identified their abusive behavior and its impact on their children. The following hypotheses were proposed:

- 1- Men who present lower levels of discrepancy between their self-report and agency reports will complete the Batterer's Intervention Program with higher ratings on accountability, safety plan, responsibility and empathy for their children and/or victim as indicated on counselor report.
- 2- Men, who acknowledge presence /involvement of children during the incident at initial intake, will tend to complete the program with higher ratings on accountability, safety plan, responsibility and empathy for their children and/or victim as indicated on counselor report.

Methods

This study reviewed secondary data from completed cases at an intervention program and assessed each case based on two categories of measures: self-reports and agency reports. The self-reports comprised of measures that were based on the self-reporting of batterers themselves. This included a self-evaluation intake form (including history intake and a list of risk factors derived from the Danger Assessment tool (DA) maintained by the agency, and basic education exercise (worksheet exercise to encourage men to reflect on their abusive behaviour). The agency report included measures that are based on objective data and external (to the client) sources of information. Examples included the police report, client history, psychological and/or medical assessments, and other legal documents. It is important to note that in the majority of cases, police reports were the only consistent measure used in the coding of agency report category, as other documents were either missing or varied between files. The cases were coded in each of the measure in order to see if correlations between risk factors, program progress and acknowledgement exist. The present study examined the case files for the presence of the risk factors based on both self-reports and agency reports indicated in each risk assessment item.

Participants

The present study consisted of a retrospective case analysis of 101 files of men who participated and completed a community intervention program designed for male batterers from year 2009-2010, and 2010-2011. This study examined cases reviewed based on the inclusion criteria for DV that involve a partner and/or his child(-ren). As such, the 101 cases were selected according to the following criteria: the perpetrator was

male, the perpetrator and primary victim were between the ages of 18 to 65, the perpetrator was expecting, had biological, step and/or adopted children under the age of 18 or had no children, the perpetrator's file included both self-report and police report information and the perpetrator had completed the program. Among the files included, 17 of the cases did not have any children and one case involved a same-sex couple.

Materials

The present study utilized the community based intervention program's database, primarily self- evaluation intake form which included selected risk factors common to instruments such as DA, ODARA, DVDRC and SARA , counselor progress report, basic education exercise, and police reports to assess each case individually.

The self- evaluation intake form (See Appendix C) was the primary measure used to obtain self-reported information about the batterer and victims involved. This measure is a 164-item instrument developed by the agency that serves as a history intake and risk assessment evaluation tool. Furthermore, it includes demographic, past or current involvement with the agency, relationship history, law/court involvement, children, history of abuse, employment information and an informal risk-assessment. The risk assessment is a 17-item intake tool that screens for abusive behaviors men admit to using in their relationships. This intake has been used for a number of years with men who are mandated or voluntarily enrolled in the program.

The program intake form includes several risk factors common to current risk assessment tools being utilized in the field of DV. The researcher developed a 23 risk factor coding scheme that incorporated items from the ODVDRRC (See Appendix E) and

compared them against the 17 item risk factors assessment tool on the intake form and additional 6 risk factors found throughout the intake form questions (See Appendix C). The selected risk factors by the agency included: perpetrator's history of intimate and other violence, suicidality, attempt to isolate the victim, unemployment, child custody dispute, description of assault in order to code for minimization, witness of abuse growing up, prior suicide attempt, failure to comply with authorities, prior threats to kill the victim, jealousy, assault with a weapon, control over victim's daily activities, forced sexual acts, threatening or violence against family pets, availability/ threat to use weapons, victim leaving the house for fear of safety, substance use along with separation status and presence of stepchildren. An additional item (partner or victim left home for fear of safety) was added to the risk factor coding scheme based on the researcher's clinical observation that most victims reported fearing for their safety prior to the events leading to the DV incident. This item was compared against victim's accounts of feeling threatened prior to DV incident as found on the police reports. Additionally, an item specific to children's presence at the scene of DV at intake was compared with police reports to measure level of denial in this variable.

The counselor progress report focuses on the four categories that guide the work of counselors: responsibility, safety planning, accountability and empathy to evaluate men's advancement by the end of the program. Each category is assessed on subsets of recognition (the batterer recognizes the violence occurred, minimizes behavior and does not think the victims are impacted) comprehension (the batterer acknowledges behaviour, and its impact on victims but does not provide concrete examples or a realistic safety plan) and problem solving (the batterer recognizes the behaviour, its impact on victims

and himself, and provides detailed examples to acknowledge impact and develops realistic safety plans for the future), and a detailed summary of clients' participation during the course of the program is documented by the counselor. This grading is subjective and descriptive yet it provides a standardized format of report writing and ensures the consistency and accuracy of counselors' assessment within the agency. The researcher developed a coding scheme based on the four indices used by the counselors (see Appendix D) as it allows for more precise coding of narratives by the researcher.

The police reports were a detailed narrative of the DV incident as well as the history of any other previous charges/assaults. These reports included common elements such as: the details of the incident and list of batterers charges related to the incident. Victim's account of the incident was often included in these reports as well. It is important to note that the cases relied on police reports as an objective measure, as it was present in all the 101 cases studied. Police reports were coded for risk factors and presence of child by thoroughly reading the narratives and identifying presence or absence of risk factors. For instance, the presence of alcohol/drug use receives a score of 1 and its absence receives a score of 0. Police reports all included: history of charges/assaults, narrative of the incident that referred the batterer to the program, batterer and victim's testimony of the assault.

Other reports are not limited to, but can include, psychological or medical assessments, documents pertaining to the healthcare sector, social services, children's aid society and other public safety agencies. The extent of availability of other report information on each case varied and was dependent on the amount of prior agency involvement and the thoroughness of police investigations. In order to measure accuracy

of self-reports, male batterers' report of presence of risk factors (collected from intake form) was compared to risk factors reported by objective sources (police reports).

Procedures

The researcher took an oath of confidentiality, and was granted permission by the University of Western Ontario's Ethics Review Board and the batterer intervention program to examine the provided data. All cases were accessible to the researcher through hard copy files, which were located in a locked file room at the agency. Each case collected was labeled by an unidentifiable code and password protected on the computer to ensure confidentiality. All data were identified by a study code in order to enhance confidentiality.

Each case was reviewed and coded by the researcher based on relevant data for each measure. Police reports for the assault incident were coded based on the narrative portion describing the incident or relevant testimonies from informants, witnesses and the batterers. The presence of each risk factor on risk factor coding scheme and intake form risk assessment was coded using a three-point response format (*0= absent, 1=present, 99= missing*) on the police report. For instance, if the risk factor "threatened to kill victim" was present in the police report, a score of 1 would be given to the agency risk factor category. If the same risk factor was absent in the self-report of a batterer, a score of 0 would be used to code that self-report risk factor. If sufficient information was not available regarding a specific item, the item was scored as missing (99) and omitted from the total score. Moreover, risk factors that were absent from the police reports were coded as missing. The logic behind this coding scheme was to compare self-reports of batterers against agency reports including police reports/victim testimony, psychological

assessments and etc. This would allow for accurate measurement of acknowledgement levels of batterers when compared with external sources. It is important to note that the coding was based on the most recent DV incident. If a batterer had a long history of assaults and charges, the most recent incident that referred them to the intervention program would be coded. In fact, police reports documenting previous incidents were not included in coding of risk factors as the batterer was referred to the program for the most recent charges. Therefore this allowed for consistency between self-reports and police reports in coding as both examined the most recent incident at hand.

The researcher coded the counselor progress report on each category of accountability, safety plan, empathy and responsibility to assess batterers' level of acknowledgment, understanding of abusive behaviour, participation and program outcome. The researcher created a range of scores identified as low = 0-5, moderate = 6-7 and high = 8-13. A combined highest composite scoring was calculated in order to obtain a total for program outcome. Given this aggregate, the higher a batterer score was on counselor report, the better the program outcome would be. It is noteworthy that there is variability in scores that one can obtain. For example, a batterer can score high on empathy, low on safety planning, and moderate on accountability and responsibility; regardless of individual scores on each category, the total was used by the researcher to indicate outcome (See Appendix D).

As items on the intake form are solely based on self-reports, this comparison indicated how accurately the batterer has provided information relative to other independent tools (police reports). The total of agency report risk factors (ARRF) and the total of self-report risk factors (SRRF) were subtracted to determine any reporting

discrepancies (ARRF-SRRF) in relationship to treatment progress outcome. For instance, a batterer with a total score of 15 on ARRF and 10 on SRRF would receive a discrepancy score of five. Due to the exhaustive nature of data collection and thorough information on each case, any data missing in the file was excluded from the analyses.

Lastly, inter-rater reliability for the coding of all the measures (presence and absence of risk factors between intake and coding scheme; counselor reports; and child exposure measure) was established by having two raters independently score a random subsample of 15 cases. The inter-rater reliability analysis using the Kappa statistic averaged for each of the measures yielded Kappa = 0.84 with $p < 0.01$, 95% agreement for the coding of all the items.

Results

Characteristics of the Perpetrators

The cases reviewed in the present study involved male perpetrators ranging in age from 18 to 65 years old at the time of program enrollment with a mean of 32.61 (SD= 8.95) (see Table 1). During the time of the enrollment in the program, nearly half (45.5%) of the perpetrators with children were in common-law relationships, 34.6% were legally married, while 19.8% cases involved dating couples. The number of children parented by the perpetrator at the time of program enrollment ranged from 0 to 6 children, with a mean of 2.40 children (SD=1.34) and a median of 2.00 children (see Table 1). Of the perpetrators with children, approximately 18.8% of the perpetrators were living with their child(-ren). With regards to perpetrator's employment status at the time of program intake, roughly half (51.4%) of the men were unemployed. Regarding assault history, 9.9% presented no history, 31.6% with one time charge and 58.4% had two or more charges.

Table 1: *Batterers' Demographic Information: Age, Number of Children, Relationship Status, Employment Status, And Assault History*

Category	Sample (n=101)	
	Mean	SD
Age (18-65)	32.61	8.95

Number of Batterers' Children (0-6)	2.40	1.34
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Type of Relationship

Legal Spouse	35 (34.6%)
Common Law	46 (45.5%)
Boyfriend/Girlfriend	20 (19.8%)
Actual Separation (between victim and batterer)	21(20.7%)
Unemployed	52 (51.4%)
Currently Living with Child	19 (18.8%)
Assault History	
No History	10 (9.9%)
One Charge	32 (31.6%)
Two or More Charges	59 (58.4%)

Chi-Square Analyses of Risk Factors

The first hypothesis predicted that batterers with lower levels of acknowledgment received higher program outcome scores as indicated by the counselor ratings. This nature of underreporting was explored by analyses of separate chi-square between categories of (Self-report x Agency-report) on 23 risk factor variables (see Table 2). Self-reports referred to variables and risk factors that were reported by the perpetrators and agency reports encompassed identical risk factors and variables gathered from incident report and other objective data. Results indicated significant differences in 20 risk factors between these two categories, and an overall higher distribution of risk factors in ARRF

Present but SRRF Absent than ARRF present and SRRF absent (see Table 2); however, results indicated no significant difference among risk factors of history of domestic violence ($\chi^2 (1) = 2.3$, ns), access to or possession of firearms ($\chi^2 (1) = .13$, ns). On the other hand, six risk factors showed a significant discrepancy between men's self-report and police reports of risk factors present. There was a significant discrepancy between self-report and agency report (27.1%) for History of violence outside of the family; (54.0%) discrepancy for past/present partner left home for fear of safety; (31.2%) discrepancy for alcohol and drug use; (39.1%) discrepancy or prior attempt to isolate the victim; (38.0%) discrepancy for obsessive behavior and (18.3%) discrepancy for prior threat to kill victim; Furthermore, there were instances where the men self-reported a risk factor that the police did not assess and the highest percent was 6% in the history of DV category. The remaining 15 risk factors were mostly absent as confirmed by the high percentage in the self-report and agency report agreement category. Therefore even though these risk factors displayed significant difference in discrepancy, they were not statistically reliable due to their small comparable sample size. Lastly, prior hostage taking and/or forcible confinement were excluded from this calculation due to its low frequency of occurrence in the sample.

Table 2: Distribution of Risk Factors Present and Absent from Cases Reviewed

Risk Factors (N)	ARRF Present but SRRF Absent	ARRF Present and SRRF Present	ARRF Absent but SRRF Present	ARRF Absent and SRRF Absent	Chi-Square
History of violence outside of the family by perpetrator (n=96)	26(27.1%)	31(32.3%)	5(5.2%)	34(35.4%)	17.8*
Past/present partner left home for fear of safety (n=98)	53(54.0%)	21(21.4%)	1(1.0%)	23(23.4%)	6.1*
History of DV (n=98)	43(43.9%)	30(30.6%)	6(6.1%)	19(19.3%)	2.3
Excessive alcohol and/or drug use by the perpetrator (n=96)	30(31.2%)	39(40.6%)	2(2.0%)	25(26.0%)	19.1*
Prior attempt to isolate the victim (n=97)	38(39.1%)	28(29.0%)	5(5.1%)	26(26.8%)	6.5*
Obsessive Behaviour displayed by the perpetrator	38(38.0%)	39(39%)	0%	23(23%)	19.0*

(n=100)					
Perpetrator unemployed (n=100)	3(3%)	49(49%)	3(3%)	45(45%)	77.4*
Perpetrator was abused or witnessed abuse growing up (n= 87)	7(8.0%)	33(38%)	3(3.4%)	44(50.5%)	51.6*
Prior threats to kill victim (n=93)	17(18.3%)	16(17.2%)	4(4.30%)	56(60.2%)	22.0*
Actual or pending separation (n=101)	3(2.9%)	18(17.8%)	3(3%)	77(76.2%)	67.8*
Control most of or all of the victim's daily activities (n=90)	8(8.9%)	8(8.9%)	1(1.1%)	73(81.1%)	34.6*
Extreme minimization and/or denial of spousal abuse history (n=100)	14(14%)	2(2%)	2(2%)	82(82%)	3.6*
Prior threat to commit suicide by perpetrator (n=90)	4(4.4%)	11(12.2%)	0%	75(83.3%)	62.7*
Failure to comply with authority (n=101)	17(16.8%)	12(11.9%)	0%	72(71.2%)	33.8*
Presence of step-children in the home (n=101)	1(.99%)	12(11.8%)	0%	88(87.1%)	92.2*
Prior threats with a weapon (n=91)	7(7.7%)	3(3.3%)	1(1.0%)	80(87.9%)	17.5*
Child custody or access dispute (n=98)	2(2.0%)	7(7.1%)	0%	89(90.1%)	74.5*
Victim and perpetrator living common law (n=101)	0%	9(8.9%)	2(2%)	90(89.1%)	80.8*
Prior assault with a weapon (n=91)	3(3.3%)	4(4.4%)	0%	84(92.3%)	50.2*
Prior suicide attempt by perpetrator (n=96)	6(6.2%)	2(2.1%)	0%	89(92.7%)	26.0*
Access to or possession of firearms (n=98)	4(4.0%)	0%	3(3.0%)	91(93%)	.13
Prior violence against family pets (n=86)	1(1.1%)	1(1.1%)	0%	84(97.6%)	42.5*
Prior hostage taking and/or forcible confinement (n=52)	0%	0%	0%	52(100%)	Omitted

Frequency of Treatment Progress Outcome.

The progress of men in the program was rated based on the items of counselor progress report form (See Appendix D). Four indices of accountability, responsibility, safety and empathy were coded on a four-point scale with the exception of five-point ratings for the responsibility index (See Appendix D). The frequency of indices of counselor rating was examined to see the distribution categorized into the four groups. When examining the frequency for accountability, 40.6% were placed in the minimal participation range, 48% and 49.5% fell in the adequate level of participation for responsibility and safety, respectively, and 30.9% demonstrated satisfactory level of empathy for their partners. The frequency of counselor ratings is listed in the charts below (see Table 3).

Table 3: *Frequency of the four indices of accountability, responsibility, safety and empathy*

Scale Rating	Index of Counselor Rating			Safety Plan (n=101)
	Accountability (n=101)	Responsibility (n=100)	Empathy (n=97)	
Presents none (0)	18(17.8%)	4 (4%)	9 (8.9%)	1 (1%)
Minimal participation (1)	41(40.6%)	9 (8.9%)	29 (28.7%)	22 (21.8%)
Adequate participation (2)	20(19.80%)	16 (15.8 %)	30 (30.9%)	50 (49.5%)
Actively participated (3)	21(20.7%)	49 (48.5%)	29 (28.7%)	28 (27.7%)
Demonstrated full responsibility of abusive behaviour (4)	N/A	22(21.8%)	N/A	N/A

There is a 4% missing rate for Empathy, and 1% missing rate in Responsibility index.

In addition to the counselor rating of indices, it is important to discuss the distribution of progress outcome of this sample. The study involved perpetrators who completed batterer intervention program and their progress was evaluated by examining the level of acknowledgment of DV upon program completion. This progress was categorized into three groups of low, moderate and high outcomes based on combination of scores received on four counselor rating categories of accountability, responsibility, safety and empathy. It should be noted that the low outcome scores using cut-offs that ranged from one to five, with the lowest score being one, the moderate outcome scores were six and seven, and the high outcome scores were rated from 8 to 13 with 13 being the highest score achievable. It was predicted that greater acknowledgment on each index

would subsequently generate higher progress outcome. Essentially higher progress outcome refers to higher scores on counselor reports. The cut-off scores were determined based on the frequency of counselor outcome. The frequency of counselor outcomes was calculated by dividing the scores into 30th cumulative percentile. The three ratings of low, moderate and high were presented as 24.8%, 31.6% and 43.6%, respectively, in this sample. Thus, there was a relatively even spread among low, moderate and high outcome within this sample.

Acknowledgment of Child Witnessing DV and Counselor Progress Report.

The second hypothesis predicted that batterers' who acknowledged their children's presence at the DV incident would receive higher program outcome scores as rated by the counselor. This hypothesis examined whether there is a relationship between their acknowledgment of their children's involvement in the DV incident and program outcome scores by the time the program is completed. The specific item measuring denial (was the child present/witnessed the incident?) was compared against police report that indicated the discrepancy in presence of the child. As a result, independent samples *t*-tests were used to determine if men who denied their child-(ren) witness the DV incident, and men who acknowledged their child-(ren) witnessing the DV incident differentiated in their level of treatment outcome based on counselor progress report scores. Three separate *t*-tests were conducted to test the hypothesis that men who acknowledged the presence of their child-(ren) at the DV scene would score higher in their progress outcome than men who did not.

The Levene's test for equality of variances was found to be significant, and a t statistic, assuming homogeneity of variance was computed. Acknowledgment of child witnessing DV could be reported in two forms: a batterer acknowledging the presence of his child-(ren) that matched with the police report ($n=10$) or a batterer acknowledging the absence of his child-(ren) that was consistent with the police report ($n=40$). When t -test was computed between men who denied their children witnessing the incident ($M = 7.7$, $SD = 3.5$) and men who acknowledged the absence of their child-(ren) by self-report that was consistent with police report ($M= 8.8$, $SD= 2.8$), no significant difference was reported between these two groups $t(68) = .153$, $p < .05$, *ns*. This comparison is important as it provides a context for what acknowledgment means in reporting of both absence and presence of the child. There was a significant difference between men who denied child presence and men who acknowledged child presence at the scene [$t(38) = .23^*$, $p < .05$]. These results indicate that men in the acknowledgment group ($M = 10.8$, $SD = 1.7$) scored higher on treatment outcomes upon program completion than men who did not acknowledge their child-(ren) involvement ($M = 7.7$, $SD = 3.5$).

Table 4: *t*-tests for Acknowledgment of Child Witnessing Abuse and Treatment Outcome

Acknowledgment of Child Witnessing Incident	Mean	SD
Consistency in Acknowledgment ($n=10$) of child (ren) present	10.8	1.7
No Acknowledgment by self-report but in police report ($n=30$)	7.7	3.5

$t(68) = .153$, $p < .05$, *ns*, $t(38) = .023^*$, $p < .05$, *significant*

Correlations between Self-Report Risk Factors (SRRF), Agency Report Risk Factors (ARRF) and Their Discrepancy.

When examining the sample, the risk factors coded based on self-reports (SRRF) of perpetrators and the risk factors identified based on agency reports (ARRF) were individually totaled to determine the level of presented acknowledgment and risk. Furthermore, each ARRF was subtracted from SRRF in order to determine any existing discrepancy. The discrepancy was a measure used to represent the accuracy of perpetrators' self-reports. As shown in Table 5, the results indicate a higher Mean and SD for total of agency reports compared with total of self-reports suggesting underreporting in the self-report category of batterers (see Table 5).

Table 5: Frequency of Sum of Self-Report Risk Factors, Agency Report Risk Factors and discrepancy between the two

Category (n=101)	Mean	Standard Deviation(SD)	Range
Total of Agency Report Risk Factors (ARRF)	7.0	2.5	1-13
Total of Self-Report Risk Factors (SRRF)	3.8	2.6	0-11
Discrepancy between Total of Agency Report – Total of Self- Report (ARRF-SRRF Discrepancy)	3.3	2.3	-3-11

SRRF ($M = 3.8$, $SD = 2.6$), ARRF ($M = 7.0$, $SD = 2.5$) and ARRF-SRRF Discrepancy ($M = 3.3$, $SD = 2.3$)

Finally, the correlations between treatment progress outcome and total of agency report minus total of self-report (ARRF-SRRF) Discrepancy was conducted using *Pearson's* correlation to determine if there were significant relationships between these

two variables. A significant negative correlation was identified [$r(101) = -.610^{**}$, $p < .01$], suggesting that there is a strong association between underreporting DV and counselor's rating of treatment progress. Thus the first hypotheses were supported; batterers with lower discrepancies between self and police report at the beginning of intervention were rated by their counselors as having better treatment outcomes.

Discussion

The purpose of the present study was to investigate and better understand court-ordered male batterers' self-reporting behaviour (levels of denial/minimization) in a group batter intervention and their treatment progress relative to the acknowledgment of their abusive behaviour. Given the limited literature on self-reporting of abusive behavior among male perpetrators, this study aimed at gathering preliminary data on denial, minimization and underreporting of male batterers' abusive behavior. To achieve this, batterers' self-reported levels on 23 DV risk factors were used as an indicator to measure their program outcome. The study involved review of completed case files of men who participated in a community intervention program during 2009- 2011. The summaries provided details regarding the batterers' acknowledgment of DV, a population that is typically known for underreporting and minimization of history of abuse and other abusive behaviours. Based on the previous literature on denial and minimization among DV offenders (Henning, Jones & Holford, 2005), this study predicted that batterers who begin intervention with lower number of denial/minimization at intake, tend to receive higher program outcome scores as rated by the counselors. Furthermore, it was hypothesized that men who acknowledge the presence of their child (ren) at intake, also receiver better treatment progress outcomes upon program completion than men who deny/minimize this variable. Hence, both hypotheses were supported: men with higher acknowledgment levels at intake with respect to risk factors and child witnessing the DV incident received better treatment program outcomes. Overall, this study aimed at understanding acknowledgement of abusive behaviour and its relationship with mans' treatment progress.

Presenting Themes

The Difference between Self and Agency report Risk Factors. Common themes which surfaced when reviewing the present study findings, the data revealed some significant differences in the frequency of risk factors rated by self-reports and agency reports. The scores for the total of Agency Report Risk Factors (ARRF) were significantly higher than Self-Report Risk Factors (SRRF), indicating that most batterers tend to engage in more underreporting of abusive behaviour and DV risk factors. Similar findings have been reported in other studies (Henning et al, 2003), which highlight the importance of understanding self-reporting in batterers. Moreover, for the most common and subjective risk factors such as obsessive behaviour displayed by the perpetrator, isolation of the victim and violence outside of the family, about 30 to 40 percent of men were in denial. This percentage increased up to 55% denial of men in risk factors such as victim's fear of safety. It is interesting and relevant to think about these rates of underreporting with respect to men's readiness for change and that most men in "denial" could be at pre-contemplation stage of change. The present findings of this sample provide further support regarding the high levels of denial and minimization in this population and call for meticulous assessment of risk using reliable methods by clinicians.

Upon review of the study findings, several major themes related to general risk factors and batterers' reporting behaviour emerged from the data. For instance, additional patterns in the types of risk factors presented in each category of self and agency report were noticed that are critical to discuss. In conducting the chi-square analyses, most of the risk factors, with the exception of a few, revealed significant differences between self

and agency reports. Firstly, the top two risk factors gathered from agency reports were listed as “obsessive behaviour towards the victim” and “victim’s fear of safety”. One explanation for this pattern may be that “Obsessive behaviour towards the victim” and “victim’s fear of safety” endorsed the batterers’ acts as more proactively aggressive. Second, this pattern in reporting is expected as agency files report on the DV behaviour and incident without minimizing or denying any factual information. Aligned with this pattern, research has found stalking and obsessive behaviours to be one of the most prevalent components of DV (Hamel, 2001; McMahon and Rounsaville, 2001; Stephen and Laudet 1996). Other researchers have reported that victims of male abusers with higher assault histories are more likely to feel endangered by their partners than victims of male abusers with lower assault histories (Henning and Feder, 2004). This

The second pattern of reporting in the present study’s findings was related to risk factors presented by batterers. The top two frequent risk factors reported by men were “unemployment”, and “alcohol and/or drug use”. As discussed earlier, previous research has reported that male offenders have a higher tendency to suffer from anti-social behaviour and substance abuse issues (Henning et al, 2003). Another issue that arises from this pattern is that mental health-related problems that can interfere with treatment progress. For instance, if alcohol and/or drug use is reported as one of the most common risk factors by batterers, offering adjunct substance-related treatments may respond better to the intervention needs of the specific population. This suggestion is supported by previous research emphasizing on the importance of tailoring interventions for batterers with substance issues (Stuart, Moore, Kahler, & Ramsey, 2003). Hence, identifying risk

factors and their underreporting among men would potentially assist in classifying different levels of change and tailoring special treatments accordingly.

Four important explanations may account for the discrepancy between self and police reports of this study's sample. First, the variance in the stage of readiness to change can impact a batterer's justification of their abusive behaviour. In fact, minimization, denial and victim blaming are widely recognized among male offenders who present low motivation in change and high termination rates (Daly & Pelowski, 2000). Second, minimization or denial of DV can act as a defense mechanism to avoid the feelings of guilt towards the impact of abuse on the victim(s). Perhaps the guilt and shame associated with acknowledgment of DV is difficult to process for high risk batterers or those with higher levels of denial/minimization. Third, there may be predisposing traits that influence the level of acknowledgment or attitudes towards acknowledgment (age, education, support, ethnicity, occupation, cultural differences, etc.) as studied by Heckert and Gondolf (2000). More specifically, at the point of intake and follow up of batterers, predictors of underreporting were higher among men in the following categories: age (younger); ethnicity (white men) and men with children. Hence, it could be possible that the socio-demographic status can also contribute to batterers' level of underreporting as opposed to personality traits only. For instance, a batterer may weigh the cost and benefits of telling the truth about his abusive behavior and decide that denying will earn him less legal consequences than fully acknowledging his behavior. Finally, it is possible that lack of commitment or satisfaction with the relationship and/or family increases the likelihood to externalize and blame violence (Cantos, Neidig, & O'Leary, 1993). However, in the context of batterers who are motivated or mandated to

complete treatment programs, acknowledgment or lack of it may embody a different meaning. For instance, it may be easier to admit to abusive behaviour if the perpetrator is motivated to change while a mandated perpetrator may be obligated to acknowledge abusive behavior because of awaiting consequences. Thus, it is crucial for professionals to actively and effectively assess such self-reports, and identify and prepare these individuals for appropriate DV treatments. Furthermore, given these considerations, objective assessment of risk factor measures should be included in combination with self-reports in order to account for the level of underreporting by male batterers.

In addition to the reporting pattern of perpetrators, two risk factors worth mentioning are “access to or possession of firearms” and “history of DV”. In case of “access to or possession of firearms”, significant support for differences between the mentioned risk factors was not found due to infrequent occurring risk factors in both self and police reports. Nevertheless, it is important to recognize that this does not imply that batterers may not underreport in this area. Surprisingly, significant chi-square values were present in six risk factors including: prior violence against pets, prior suicide attempt, prior assault with a weapon, prior threat with a weapon, extreme minimization and denial, and failure to comply with authority due to the large discrepancies between the numbers of absent and present risk factors in each cell. Hence these factors are only numerically significant, as they were infrequently occurring in self and police reports; thus there was no solid basis in order to check the variable of acknowledgment in these risk factors. While the history of DV was one of the most frequent risk factors reported by batterers and the agency, no significant differences in reporting was found. One plausible explanation may be that since history of DV is the basis for which the men were

referred to the program, this risk factor would be difficult to deny and in another context, denial of this variable could be higher.

As a final note, historically, outside of the DV field, great emphasis has been placed on accounts of batterers to gather and assess information. Unfortunately, one of the major shortcomings in mental health system is it's disconnect from other social and legal systems. With respect to DV, although there has been a concerted effort to use other informants to gain information about men's abuse, this gap manifests itself in use of appropriate assessment measures to properly assess risks and potential treatments involved in this population. Given perpetrators' engagement in high levels of denial and minimization, as observed in this study, for the majority, continuing to evaluate DV cases heavily based on men's self-reports is a disservice to the victims and the community involved. Therefore, it is important for researchers to further investigate this issue and for practitioners to responsibly assess the level of presented risk by utilizing a multi-dimensional approach that includes the victim, child (ren), police reports and other sources.

Relationship between Reporting Discrepancy and Progress Outcome. With respect to the treatment outcome of batterers in this study sample, several interesting results are worth exploring. The most important finding was related to discrepancy between self-reporting, agency reporting and program outcome of male batterers throughout the program. There was a moderate to high negative correlation between ARRF-SRRF Discrepancy and program outcome, suggesting that men who have higher discrepancy in their reporting tend to receive lower ratings of progress from their

counselors. In addition, this relationship exists in batterers who have lower discrepancy in their reporting and higher treatment progress scores from the counselors.

As supported by the Trans theoretical Model (TTM) of change (Scott, 2001), this variation may be accounted for by batterers' stage-related readiness for change at the time of the intake. In fact, this model suggests that acknowledgment of abusive behavior is the first step towards the process of change (Scott, 2001). Previous research supports this relationship as men with higher readiness to change engaged in more self-reflection on their abusive behaviour and/or its impact (Eckerle et. al, 2011). Other explanations for this association could be that batterers with low discrepancies in reporting may be more motivated to progress in the program because of the fear of personal, social or legal consequences, whereas batterers with higher discrepancies who have been exposed to the judicial system longer, are less concerned about such penalties. Perhaps as perpetrators' acknowledgment of abusive behaviour increase, so does their performance and learning within the program and consequently, they achieve higher scores on accountability, responsibility, empathy and safety planning indices.

As predicted, men who acknowledge their abusive behaviour tend to benefit from BIP's according to counselor ratings in comparison to their counterparts who engage in high denial, minimization and blaming. Regardless, what is most critical to note from this correlation is the unique opportunity for systems to recognize and distinguish the nature of acknowledgement among perpetrators as it may bear different influences in treatment.

Presence of Child Acknowledgment and Program Outcome. The findings of this study suggest that men who acknowledge the presence of their children at the scene

of the incident and are consistent with the police reports, tend to receive higher program outcome ratings based on counselor reports. Although there are several ways that batterers can expose their children to violence, both directly and indirectly, this study asked the question of whether men's child-(ren) were physically present at the DV incident. The reporting of this issue has several implications in assessment of batterers' progress within the program. The relationship between underreporting of child presence and treatment progress expands on the previous literature that investigated reporting of DV in parents and children (Edelson et. al, 2007). It was also consistent with prior findings that emphasized on more effective assessment of children's exposure to violence (Hamby & Finkelhor, 2001). In addition, this finding opens opportunities for embracing multidimensional assessment of risk and protective factors present in batterers, their child-(ren) and victim's lives. Sadly, a large proportion of the sample of men denied the presence of children at the DV scene which makes one ponder about the extent of underreporting on the impact of DV on their child-(ren) and the victim. If men have difficulty admitting their children's witness of abuse, expecting reports on the impact of their action may be unrealistic and unlikely. Thus, it cannot be overemphasized that this calls for the importance for professionals to collect multiple sources of information to make accurate and well-informed decision about DV cases.

The knowledge of denial/minimization in batterers is critical in the issue of appropriate assessment of risk and underreporting. Effective assessment of batterers' level of denial towards their children's presence/impact also expands the issue of acknowledgment beyond their role as a partner. As general parenting programs do not address the needs of this population (Crooks and Scott, 2004), accounts of batterers' DV

behaviour in relation to their children can potentially be a significant indicator for their readiness for change and relevant program planning. Such discussions have both research and clinical implications that we will describe in the next section.

Clinical Implications

Data from the present study suggest that men who acknowledge the impact of DV on the victim and/or family tend to make better progress in intervention programs. Of the sample studied, with the exception of a few, most men acknowledged that an assault occurred. However, they were more likely to minimize and externalize the severity of assaults in comparison to victim and incident reports. It may be more difficult to deny that DV happened altogether than underestimate the extent of violence against police reports. This study has several important implications. Firstly, due to low levels of acknowledgment of batterers particularly during program intake, it is effective, if not necessary, for professionals to gather as many secondary sources of information as possible for accurate referral assessments. Given the minimization and denial of assaults at program intake, it is also recommended for practitioners to consult valid documents, informants and police reports to determine the degree of underreporting. This may be difficult as documenting varies among service agencies and some files on referred cases might be less comprehensive than others. Therefore, collaboration between involved service providers is imperative to ensure such consistency.

A unique and significant finding in this study was that men who acknowledge abusive behaviours tend to progress better in the program. Although we hope that accepting responsibility for DV and gaining insight into abusive behaviour will improve

victims' lives, we cannot assume that long lasting change in behaviour is the case for most batterers. Research has shown a high dropout rate among those who perceive a mismatch between their goals and treatment objectives (Eckhardt, Babcock & Homack, 2004). In understanding the elements and causes of minimization, denial/blaming and their impact on self-reporting behaviour, we are exploring ways to improve clinical practice. As self-reports are strong indicators of readiness to change, studying them will provide a solid groundwork for program implementation. Therefore, treatment programs may want to consider focusing on matching interventions with an individual's readiness to change based on underreporting levels in order to improve treatment outcomes.

With respect to batterers' assessment as parents there are several implications noteworthy to discuss. Batterers in treatment are more likely to benefit from intervention programs when they have been able to recognize to some extent the impact and/or involvement of their children and families. Other literature has reiterated this relationship by examining risk and parental involvement in batterers (Bancroft & Silverman, 2002; Rowbottom, 2003). This has implications for batterers' roles as parents and may suggest that those who are capable of acknowledging abuse will be more motivated and ready to change and/or improve their attitudes towards their children and partners. For example, understanding underreporting of child exposure to DV can be used as an important indicator by individuals involved in child custody assessment and/or supervision of perpetrators' suitability as parents. Given the high level of denial in reporting child witness of abuse, it is critical to examine different accounts of victims, children, legal documents, etc. to capture and assess this exposure precisely.

Finally, most studies that have examined denial, minimization and blaming have focused on the specific violent incident and not necessarily the whole constellation of risk factors. What is unique about the findings of this study is examining denial and minimization on the specific aspects of the incident as well as risk factors that may not be related to the specific event. This has significant clinical influences since it assesses underreporting in different layers. For instance, as previously mentioned, even though the treatment of male batterers is legislated, programs fall short of receiving a standardized assessment of risk factors that do not rely on self-reports. This is where the gap between the legal and health system interferes with administering formal, comprehensive assessment, thus hindering the ability of intervention programs to provide appropriate services that meet the needs of batterers with diverse issues. Specific assessments to identify risks and underreporting of this population can enhance clinician's understanding of batterers' psychological, substance-related issues, history of trauma, parenting-related issues and etc. in order to assist them at an individualistic level, and serve the larger family and communities involved.

Limitations

Although this research identified numerous important themes, there are several limitations that need to be acknowledged because of the exploratory nature of the study design. Firstly, with the use of secondary data in this study, there is the risk of distorting the original data or losing important detail when describing the set of indicators. For some men, due to the fear of consequences and involvement with Children's Aids, courts, police departments and community services, there is a risk that some batterers may not have reported the impact of abuse on the victims or their children in their lives on intake

forms. This limitation presents the possibility of missing information as a result of conducting file reviews from case summaries. Due to the fact that the researcher did not have the ability to question or speak to the perpetrators themselves, no clarification of any missed or wrongfully interpreted information was possible. If pertinent information related to the study focus had been neglected when putting together the summaries, there was no alternative way in which the researcher could have gained access to that information. Hence, gathering this information through clinical interviews will provide greater detail and insight into the presence of risk among batterers.

Despite this challenge, the summaries contained reports from police interviews with friends, family, and professionals, providing the researcher with a broad spectrum of information from various reliable sources to capture. For instance, although police reports are, to some degree, subjective to the discretion of the officer reporting, there are more objective than batterer accounts and future recall. Furthermore, they draw on direct observation, related information obtained from witnesses, dispatches, other contacts with the batterer and at times, immediate testimony of the victim.

While the researcher is confident to state that counselor reports were valid measures of batterers' progress, it is acknowledged that the assessment of outcome by counselors is the sole instrument for measurement of outcome. Although the quantitative coding of counselor narratives (coding the narratives based on a four point scale) and the ratings received a high inter-reliability, additional standardized instruments to measure treatment outcome would be useful to increase confidence in the findings. Furthermore, in terms of program outcome evaluation, it is critical to note that the court-ordered involvement of men, may present socially desirable responses for successful program

completion. For instance, a batterer may pretend to progress throughout the program to avoid legal/social consequences without thoughtfully understanding the impact of his behaviors on the victims. Therefore one has to be mindful of how the results are sum of scores on each index of accountability, safety planning, empathy and responsibility, a batterer could receive a low rating on one index and a higher one on another. This was one of the challenges of this study as a high score on certain indices does not guarantee full acknowledgment on other indices. Therefore program outcome needs to be interpreted according to this limitation. Despite the mentioned limitation, these templates were standardized in reporting, scoring and the counselors were equally trained to ensure internal consistency of write-ups/reports.

The sample size for some of the risk factors of the chi-square analyses was a less than expected. For instance prevalence of “use of firearms” risk factor was low in this sample and the small number of men who presented this risk limited the power of the difference in self and agency reporting. Even though the initial entry had a reasonable sample size of 101 men, future studies should account for a higher sample size in order to investigate larger variability and size in risk factors.

Finally, the sampling included all batterers limited to one treatment centre and geographic location. The sampling criteria selected men who had complete data (police report, self-report) and had completed the program. This is an important point for this study as the extent of information on uncompleted files was not sufficient to provide us with details on variables of acknowledgment (e.g. missing police reports). All the cases were court ordered and thus, did not include males who were not court ordered nor dropped out of treatment. In addition, all cases analyzed were from the Western Ontario,

City of London area. As a result, the sample doesn't take into account batterers from other geographical or cultural areas. That being said, the present study findings are important to consider given that the cases reviewed represented a sample of individuals in which multiple risk factors and underreporting were present, yet the existing systems failed to prevent the tragedy of domestic violence. This study provided an initial groundwork for analysis of future work in self-report and treatment outcomes among male batterers.

Directions for Future Research

Findings from this study provide further confirmation that self-reports made by male batterers are significantly influenced by minimization, victim blaming, denial and externalizing. These levels of underreporting require the need for additional investigation in this area, specifically the factors that take part in cognitive distortions. Due to the limited measures and details to examine denial/minimization, much of the information was derived from descriptive data. Future research with an emphasis on mixed methodology may be able to better capture insight into batterers' barriers in disclosure and reasons for underreporting.

Another important area for future research is the variability of denial and minimization among batterers with different risk levels. Different models including the Trans theoretical model that focuses on stages of change have been utilized to explain this process and men's "readiness" for accepting abusive behaviour (Scott, 2001). Although a broad topic, the variability of the extent to which batterers minimize abuse needs to be investigated in more detail. For instance, what are some of the factors that contribute to some offenders assuming more or less responsibility than their

counterparts? Are personality traits more heavily weighed than situational factors? Can social support and relationship satisfaction act as a protective factor in levels of denial? What are some of the predictor factors for each of these cognitive distortions? These answers have critical implications for researchers and clinicians in effective assessment and intervention of batterers as self-reports are heavily relied upon in the field of DV to collect information.

In addition to examining the prevalence of underreporting and denial in batterers, it would be crucial to investigate the difference in acknowledgment of absence of a risk factor versus acknowledgment of its presence. Future research should study how and whether these two variables impact reporting behaviour and treatment outcomes among perpetrators. This knowledge assists in effective assessment of denial, minimization and blaming, and can be utilized in stage-appropriate programming.

Finally, future research should also examine behavioural change in outcome variables. For example, studies should evaluate whether receiving higher treatment outcomes impact the safety of the victims and families involved. For instance men who completed the program with higher treatment outcomes Also, some of the visible attitude and behavioral changes (e.g. respect for women, education on DV, using power and control) that have improved the batterers' lifestyle after program completion need to be identified. Such follow-ups will improve our understanding of factors that influence self-reports and readiness for change among perpetrators.

Summary

In conclusion, although it is vital that agencies and communities support and provide resources for victims of DV, it is even more important to target the source of these tragic issues in order to witness real and lasting changes. As previous literature has suggested, up until recently, more research has focused on the victims of DV to promote their safety and well-being and issues of batterer treatment is often overlooked, even though men are the primary issue at hand. This study explored the relationship between acknowledgment of DV risk factors and treatment outcomes. It is the researcher's hope that this paper will pave the way for extensive future research in this important area. Thus, it serves as a stepping stone in understanding importance of denial/acknowledgment of abusive behavior in predicting treatment outcomes among male batterers. It is hoped that these research findings will stimulate more effective policies, intervention initiatives and practices by researchers and practitioners to not only protect victims of violence, but also help the perpetrators of DV.

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Appendix A



825 Bradley Ave., London, ON N6E 3C2 • Tel.: (519) 438-9869 • Fax: (519) 438-9780 • www.changingways.on.ca

December 16, 2011

Dear Peter

Further to our recent meeting and discussion of research with Changing Ways, I am pleased to allow both your M Ed students Carolyn Carrier and Armita Hosseini to access our agency intake forms in order to extract information related to their areas of interest (risk factors and information about children exposed to violence). Both students will be working under your supervision together with Dr. Katreena Scott from OISE on these projects. The students can use space here to code data and any information removed from here would be coded with non-identifying information in regards to our clients. Your students will sign an oath of confidentiality with Changing Ways that acknowledges their awareness of the sensitive and highly confidential nature of the information they will be reviewing. We look forward to working with you on these studies.



Trevor Hinds
Program Director

Appendix B

Western Education
WESTERN UNIVERSITY
FACULTY OF EDUCATION

USE OF HUMAN SUBJECTS - ETHICS APPROVAL NOTICE

Review Number: 1205-5
 Principal Investigator: Peter Jaffe
 Student Name: Armita Hosseini
 Title: *Male batterers' acknowledgement of the impact of DV on their children*
 Expiry Date: April 30, 2013
 Type: M. Ed. Thesis
 Ethics Approval Date: June 13, 2012
 Revision #:
 Documents Reviewed &
 Approved: Western Protocol

This is to notify you that the Faculty of Education Sub-Research Ethics Board (REB), which operates under the authority of the Western University Research Ethics Board for Non-Medical Research Involving Human Subjects, according to the Tri-Council Policy Statement and the applicable laws and regulations of Ontario has granted approval to the above named research study on the date noted above. The approval shall remain valid until the expiry date noted above assuming timely and acceptable responses to the REB's periodic requests for surveillance and monitoring information.

During the course of the research, no deviations from, or changes to, the study or information/consent documents may be initiated without prior written approval from the REB, except for minor administrative aspects. Participants must receive a copy of the signed information/consent documentation. Investigators must promptly report to the Chair of the Faculty Sub-REB any adverse or unexpected experiences or events that are both serious and unexpected, and any new information which may adversely affect the safety of the subjects or the conduct of the study. In the event that any changes require a change in the information/consent documentation and/or recruitment advertisement, newly revised documents must be submitted to the Sub-REB for approval.

Dr. Alan Edmunds (Chair)

2011-2012 Faculty of Education Sub-Research Ethics Board

Dr. Alan Edmunds:	Faculty of Education (Chair)
Dr. John Barnett	Faculty of Education
Dr. Farahnaz Faez	Faculty of Education
Dr. Wayne Martino	Faculty of Education
Dr. George Gadamidis	Faculty of Education
Dr. Elizabeth Nowicki	Faculty of Education
Dr. Immaculate Namukaza	Faculty of Education
Dr. Kari Veblen	Faculty of Music
Dr. Ruth Wright	Faculty of Music
Dr. Kevin Watson	Faculty of Music
Dr. Jason Brown	Faculty of Education
	Faculty of Education, Associate Dean, Research (<i>ex officio</i>)
Dr. Susan Rodger	Faculty of Education, Western Non-Medical Research Ethics Board (<i>ex officio</i>)

The Faculty of Education 1137 Western Rd. London, ON N6G 1G7	Research Officer Faculty of Education Building kueneman@wwo.ca 519-661-2111, ext.88561 FAX 519-661-3095
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Appendix C

Contact Information

(Please Print)

Date: _____

Name: _____

First

Middle

Last

Date of birth: _____ Age: _____

Address: _____

City: _____ Postal code: _____

Email Address: _____

Phone: Home: _____ Cell: _____

Other: _____

Best time to call? _____ Is it ok to leave a message? Yes No

Referral Source:

Voluntary ___ Domestic Violence Courts (EIP)___ Children's Aid Society ___

Parole order ___ Probation order ___

Probation / Parole Officer: _____

How often do you meet with them? _____ When does your order end? _____

Current Agency Involvement

Please list the counselling services that you are **currently** involved with: ie: CAS, drug or alcohol treatment, mental health issues, anger management, marriage counselling etc

Agency	Counsellor	Reason	How often do you meet?
---------------	-------------------	---------------	-----------------------------------

Have you **ever** been involved with Changing Ways in the past? Yes ___ No ___ # of times ___

When? _____ Did you complete the Program? _____

Do you have any difficulties with reading? Yes No

Do you have any difficulties with writing? Yes No

Do you have difficulties with speaking or understanding English? Yes No

Do you require the services of an interpreter? Yes No Language:

How often do you consume alcohol?

Not at all__Once per month__Once per week__Once per day__More than once Per day__

How often do you use drugs?

Not at all__Once per month__Once per week__Once per day__More than once Per day__

Do you struggle with any addictions? Yes No

What:_____

Law Enforcement / Court Involvement

<p>Any outstanding charges for violence? Yes ___ No ___</p> <p>Explain what they are: _____</p> <p>_____</p>
--

Have you ever been charged with **and or** convicted for violence related offences such as assault, confinement, stalking, harassment, uttering threats ? Yes_____ No_____

Charge:_____Date:_____Sentence:_____

Charge:_____Date:_____Sentence:_____

Charge:_____Date:_____Sentence:_____

How many times have you been charged with / convicted for charges against women?

How many times have you been charged with / convicted for charges against men? _____

Were weapons involved in any of these cases? Yes No

Explain:_____

Do you have access to weapons of any kind including, but not limited to: Guns, Knives
Yes No

If Yes: List type:

Location of weapons: _____Firearms Ban **Yes No** How Long

Have you ever been charged with a weapons related offence? Yes No

Describe: _____

Do you have a Firearms Possession and Acquisition License? Yes No

Is there a non-association/restraining order in force with your **current/past partner**?
Yes No

With who? _____ Expires When?

Conditions: _____

Have you ever been charged with breaching a court order? Yes No

If Yes,
explain: _____

Relationship Status / History

While you are involved in the Changing Ways Program our Women's Contact staff will contact your current partner. If you are in the program because you were abusive to past partner, she will also be contacted. The purpose of the contact is to inform her about the Changing Ways Program, discuss the impact of the abuse that she has experienced and to provide information about services that are available to her. **Sharing her contact information is mandatory and does not constitute a breach of your probation order.**

Do you have any concerns or objections to partner contacts? Yes No

If yes why?

Current Partner:_____ Age:_____

Address:_____ City:_____ Postal
Code:_____

Phone Number:_____ Best Time To Contact:_____

How long have you been in this relationship?_____ Married____ Common Law____
Dating____

Separated____ How long?_____ Planning to reconcile Yes No When

Have you and your partner been separated in the past? Yes No Why

Is this woman currently pregnant?_____ Due Date_____

Does this woman know you are becoming involved in the Changing Ways Program? Yes
No

Is this relationship the reason you are here? Yes No

If not, complete the following information for the victim of your abuse

Past Partner / Victim:_____ Age:_____

Address: _____ City: _____ Postal
Code: _____

Phone Number: _____ Best Time To Contact: _____

Were you Married ___ Common Law ___ Dating ___ How long were you
together? _____

Why did this relationship end?

How long have you been separated _____ Planning to divorce _____
When _____

Planning to reconcile _____
When _____

Is this woman currently pregnant? _____ Due Date _____

Does this woman know you are becoming involved in the Changing Ways Program? Yes
No

Children

Do you have children? Yes No

Name	Age	Sex	Biological	Does this	Do you
currently			Mom	child live	have
contact with				with you?	this child?

_____ Yes No Yes No

If you currently have contact with any of these children is it supervised? Yes No

Who supervises these visits: _____

Does your ex partner have any children? Yes No

with	Age	Sex	Does this child live with you?	Do you currently have contact this child?
_____	_____	_____	Yes No	Yes No
_____	_____	_____	Yes No	Yes No
_____	_____	_____	Yes No	Yes No

If you currently have contact with any of these children is it supervised? Yes No

Who supervises these visits: _____

Are you currently involved in any dispute about the custody/access regarding any of these children?

Yes No

Describe: _____

Have any of the children ever witnessed you and their mom fight? Yes
No

If yes describe ie: yelling, name calling, physical
etc _____

Was any of the abuse directed towards the children? Yes
No

If yes
describe: _____
—

Have you ever been involved with or have any current involvement with the Children's
Aid Society? Yes No

In what
city: _____ Worker: _____

Describe why you were / are
involved: _____

Do you currently have a Supervision Order / Service Agreement with CAS? Yes
No

Describe: _____

HISTORY OF ABUSE

The following information is being collected to provide an overview of you and the history of abuse that you have used in your relationships. *****This information is not being gathered to have charges laid against you. Please be as honest as you can.**

Why are you becoming involved in the Changing Ways Program? _____

What do you hope to gain from the program? _____

How do you handle stress or difficult times?

Do you feel that abuse is a problem in your relationship(s)? Yes No

If you answered yes how long has abuse been occurring in your **relationships**?

What do you and your present or past partner argue about?

Money ____ Jealousy ____ Friends ____ Drug / Alcohol use ____ Family ____ Work

Children ____ Other

(Describe): _____

What types of abuse have you used in your **relationships**?

Name calling _____

Pushing / Shoving _____

Slapping _____

Restraining _____

Kicking _____

Hair Pulling _____

Intimidation _____

Put Downs _____

Throwing Things

Threats _____

Hitting With Something _____

Controlled the Money

Grabbing _____

Monitoring Her Time _____

Harassing Phone

Calls _____

On average how often has the abuse occurred?

Once _____

Once a week _____

Once a month _____

Daily _____

2-3 times a week _____

2-3 times a month _____ Other

Has your present or past partner ever left home because of fear for her safety? Yes
 No

Describe: _____

Describe the incident of abuse that brought you to Changing Ways:

When did it happen: _____ Who did you
abuse: _____

Describe what **YOU** did: _____

Was your partner injured?

Describe: _____

Were the police called ? Yes No

If yes why do you think they were called? _____

How do you feel about what happened?

What is your attitude / feeling towards your (ex) partner and the relationship at this time?

Risk Assessment

The following are behaviours that many men admit to using in their relationships

- | | | | |
|-----|--|------------------------------|-----------------------------|
| 1. | Have you used suicide as a threat? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. | Have you ever thought of or attempted to commit suicide?
Describe: _____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. | | | |
| 4. | Have you threatened to use guns or other weapons against your (ex)partner or the children? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. | | | |
| 6. | Have you threatened to harm or kill your (ex)partner or the children? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. | Have you threatened to harm or kill anyone in your (ex)partner's family or her friends? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8. | Have you used violence against anyone other than your (ex)partner? (e.g., family, friends, strangers etc.) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 9. | Have you killed or injured a pet owned by your (ex)partner? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 10. | Have you tried to stop your partner from calling the police? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 11. | Do you feel sorry for your (ex)partner or her situation? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 10. | Do you feel you have a lot of anger? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 11. | Are you jealous or possessive? | | |
| 12. | Do you think that your abusive behaviour really isn't that bad? (Do others make it out to be worse than it actually is?) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 13. | Did your parents fight (verbally or physically) a lot when you were a child? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

14. Are there others who might assist you in using violence against your (ex)partner? (If you wanted to hurt her) Yes No
15. Have you ever prevented your (ex)partner from having contact with her children? Yes No
16. Do you think that the reason you are abusive is because your parent(s) were? Yes No
17. Have you ever stopped your partner or attempted to stop her from getting help or formal support? (e.g. police, shelter, hospital) Yes No

Employment / Income Information

Describe your present job situation:

Employed ____ Where do you work?

Employed days ____ Employed evenings ____ Employed nights ____ Employed shift work

Unemployed ____ When did you become unemployed?

What do you do for income? Ontario Works ____ ODSP ____ Student ____ CPP ____ WSIB

Other _____

Tuition Scale

GUIDELINES:

- * Indicate your personal level of earnings.
- * Tuition is paid prior to each session. You may pre-pay for all or part of the program.
- * Tuition paid will not be returned.

Adjustments may be granted for special circumstances. If you are requesting a reduced tuition, you must complete the "Application For Tuition Adjustment" form.

Annual Income	Tuition per meeting
Under \$ 10,000	\$ 10.00
10,000 – 14,999	\$ 15.00
15,000 – 19,999	\$ 20.00
20,000 – 24,999	\$ 25.00
25,000 – 29,999	\$ 30.00
30,000 – 34,999	\$ 35.00
35,000 – 39,999	\$ 40.00
40,000 – 44,999	\$ 45.00
45,000 and over	\$ 50.00

NAME: _____

SIGNATURE: _____

DATE: _____

TUITION PER SESSION: \$

Appendix D:

Date: _____

Participant Code: _____

Children Demographics

Number of Children (biological, expecting, adopted, stepchildren) : _____

Does this Child live with you ? 0-N/A

1-Yes

2-No

Do you currently have contact with your child(ren) ? 0-N/A

1-Yes

2-No

If yes :

1-Supervised

2-Unsupervised

Does your current partner have any children from past relationships? 0-N/A

1-Yes

2-No

If yes, do you have contact with them? 1- Supervised

2-

Unsupervised

Does your ex-partner have any children from past relationships? 0-N/A

1-Yes

2-No

If yes, do you have contact
with them? 1- Supervised

2-Unsupervised

Are you currently involved in any dispute about the custody/access regarding any of
these children? 0-N/A

1-Yes

2-No

Have you ever been involved with or have any current involvement with the Children's
Aid Society? 0-N/A

1-Yes

2-No

Do you currently have a supervision order or service agreement with Children's Aid Society?

0-N/A

1-Yes

2-No

Self-Report of Abusive Behaviour

Number of previous assault charges including recent incident ?

Have any of the children ever witnessed you and their mom fight?

0-N/A

1-Yes

2-No

If yes: Describe

Was any of the abuse directed towards the children ?

0-N/A

1-Yes

2-No

Do you feel that abuse is a problem in your relationship ?

1-Yes

2-No

Changing Ways Self-Evaluation Intake Form and Incident Report Comparison Items

Acknowledgment of Incident:

0- No Acknowledgment

1- States that assault occurred Minimizes assault and blames the victim

2- States that assault occurred, injury consistency, type of abuse , accurate of the time-duration

3- States that assault occurred, injury consistency, type of abuse , accuracy of the time-duration, acknowledges whether and/or how victim been impacted

Child(ren)'s direct and/or indirect involvement in incident based on incident report:

- 0- N/A
- 1- Yes
- 2- No

Missing Info

Perpetrator's acknowledgment of direct and/or indirect child(ren) involvement at intake:

- 0- N/A
- 1- No Acknowledgment
- 2- Acknowledges children witnessing/directly involved

Changing Ways Counsellor Progress Report Items

Accountability

- 0- Presents no accountability
- 1- Minimal participated in discussion
- 2- Adequately participated, minimizing abusive behaviour, victim blaming
- 3- Actively Participated, fully disclosed and demonstrated potential benefits and drawbacks of accountability, submitted all required assignments

Responsibility

- 0- Doesn't feel responsible to end abusive behaviour
- 1- Minimal participation
- 2- Participation, yet minimization and masking of abusive behaviour
- 3- Participated, demonstrated adequate level of responsibility to ending abusive behaviour
- 4- Participates actively, demonstrates full understanding of abusive behaviour and impact on relationship, submitted all required assignments

Safety

- 0- No safety plan set
- 1- Develops safety plans
- 2- Develops realistic safety plans, examine attitudes-feelings towards abuse
- 3- Develops realistic safety plans, examines attitudes-feelings towards abuse, self-aware of internal thoughts (shared personal experiences or warning signs)

Empathy

- 0- No empathy towards victim

- 1- Demonstrates minimal level of empathy
- 2- Demonstrates satisfactory level of empathy using feeling words
- 3- Demonstrates satisfactory level of empathy using feeling words, examples and reflections

Items on Worksheet for Basic Education Exercise (Using Children and/or others)

What was your intention with this action ? Describe

What were the effects of your action on you ?

- 0- None
- 1- Minimizing and/or blaming consequences on the victim
- 2- Adequate level of impact on self based on his own needs
- 3- Acknowledging the full effects of abusive behaviour, impact on relationship(s), disclosing personal feelings-attitudes about the impact

What were the effects of your actions on your partner, children or others?

- 0-None
- 1-Minimizing, masking ,victim blaming
- 2- minimal and/or satisfactory level of impact on children or others
- 3-Acknowledging the full psychological/physical impact on victims, children by disclosing personal feelings-attitudes and examples

Appendix E:

RISK FACTORS FOR ANALYSIS

(Comparison between Changing Ways Risk Assessment and O.D.V.D.R.C.)

A = Evidence suggests that the risk factor was not present

P = Evidence suggests that the risk factor was present

Risk Factors	Self-report	Incident Report/ Other Data
1. History of violence outside of the family by perpetrator		
2. History of domestic violence		
3. Prior threats to kill victim		
4. Prior threats with a weapon		
5. Prior assault with a weapon		
6. Prior threat to commit suicide by perpetrator		
7. Prior suicide attempt by perpetrator		
8. Prior attempt to isolate the victim		
9. Control most of or all of the victim's daily activities		
10. Prior hostage taking and/or forcible confinement		
11. Child custody or access dispute		
12. Prior violence against family pets		
13. Perpetrator was abused or witnessed abuse growing up		
14. Obsessive behaviour displayed by the perpetrator		
15. Perpetrator Unemployed		
16. Victim and perpetrator living common law		
17. Presence of step-children in the home		
18. Extreme minimization and/or denial of spousal abuse history		
19. Actual or pending separation		

20. Excessive alcohol and/or drug use by the perpetrator		
21. Access to or possession of firearms		
22. Failure to comply with authority – perpetrator		
23. Has you past or present partner ever left home because of fear for her safety		

Curriculum Vitae
Armita Hosseini

Education

1. B.A. (Hons.) in Psychology, York University, 2006-2010
2. M.Ed. in Counselling Psychology, University of Western Ontario, September 2011-Present

B. Related Counselling Experience

1. *East Metro Youth Services-Internship Placement*
Scarborough, ON

September 2012 – April 2013
2. *Dr. Nikkhou and Associates*
Toronto, ON

September 2009 – July 2011
3. *Centre for Addiction and Mental Health (CAMH)*
Toronto, ON
October 2012- April 2013

C. Awards and Achievements

1. York University Entrance Scholarship valued at \$6000 2013
2. Dean's Honours Roll Award 2010
3. Koenig Psychology Undergraduate Award valued at \$1000 2010
4. Psychology Undergraduate Book Prize 2008
5. Newton/Wilder Achievement Bursary valued at \$500 2007
6. York University Entrance Scholarship valued at \$2000 2006
7. Queen Elizabeth Entrance Scholarship valued at \$1000 2006

D1. Articles in Preparation

1. Jaffe, P.G., **Hosseini, A.**, Scott, K.& Kelly, T. The relationship between male batterers' self-disclosure and treatment outcome. Manuscript in preparation.

D2. Peer-Reviewed Publications

1. Hosseini, A., Debono, T., Toplak, M. E., Cairo, C., Ghelani, K., & Tannock, R. Written Expression Performance in Adolescents with Attention-Deficit/Hyperactivity Disorder (ADHD) (2011). *Reading and Writing: An Interdisciplinary Journal*, 1-24.

D3. Conference Presentations

1. Hosseini, A. (2010, April) Written Expression in Adolescence with ADHD: an Examination of Productivity and Self Correction in a Writing Sample. *Psychology Undergraduate Thesis Conference*, York University, Toronto, ON.
2. Hosseini, A. (2010, April) Written Expression in Adolescence with ADHD: an Examination of Productivity and Self Correction in a Writing Sample. *40th Annual Undergraduate Thesis Conference*, Psychology, University of Windsor, Windsor, ON.
3. Hosseini, A. (2011, June) Presence of Social Anxiety and Peer Relation Difficulties in Children with Attention Deficit Hyperactivity Disorder (ADHD). *Canadian Psychological Association 73rd Annual Convention*. Halifax, NS.
4. Hosseini, A. (2012, January) Male Batterers' Acknowledgment of the Impact of Domestic Violence on Their Children. *Graduate Thesis Conference*. The University of Western Ontario, London, ON.