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THE ASSOCIATION OF READINESS TO CHANGE AND MOTIVATIONAL INTERVIEWING WITH TREATMENT OUTCOMES IN MALES INVOLVED IN DOMESTIC VIOLENCE GROUP THERAPY

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THE ASSOCIATION OF READINESS TO CHANGE AND MOTIVATIONAL
INTERVIEWING WITH TREATMENT OUTCOMES IN MALES INVOLVED IN DOMESTIC
VIOLENCE GROUP THERAPY

(Spine title: Readiness to Change and MI in Male DV Group Therapy)

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by

Sharla Jessica Zalmanowitz

Graduate Program in Education

2

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

The School of Graduate and Postdoctoral Studies

The University of Western Ontario

London, Ontario, Canada

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THE UNIVERSITY OF WESTERN ONTARIO

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entitled:

The Association of Readiness to Change and Motivational Interviewing with Treatment

Outcomes in Males Involved in Domestic Violence Group Therapy

is accepted in partial fulfillment of the
requirements for the degree of
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Abstract

Readiness to change and motivation are significant areas of interest with males mandated to group therapy following a domestic abuse charge. Significant literature supports the theory that men who are motivated will benefit more from group therapy than those who are not. The present study investigated the impact of Motivational Interviewing (MI) and the stages-of-change on offender self-reported outcome measures. The sample consisted of 211 men who completed the *Responsible Choices for Men* group therapy program. Men entering the program after September 2008 received two sessions of MI, while those entering prior did not. Stage-of-change was assessed using the URICA- G and the URICA-DV. Global outcome scores were assessed using the OQ-45.2. Multi-level growth modeling indicated that stage-of-change has a statistically significant impact on outcomes, while MI was clinically meaningful. Discussion investigates the benefits of MI as a pre-group treatment, and the importance of accounting for individual readiness to change.

Keywords

Domestic Violence, Group therapy, Readiness for Change, Stage-of-change, Motivational Interviewing, Transtheoretical Model, Multi-level growth modeling, Mandated treatment

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List of Abbreviations

MI	Motivational Interviewing
URICA	University of Rhode Island Change Assessment
DV	Domestic Violence
OQ	Outcome Questionnaire

Introduction

The past twenty years has seen a rapid increase in research and interest in the perpetrators of domestic violence and the impact of psychological treatment following their arrest. Policymakers are interested in knowing whether counselling, be it mandated or voluntary, leads to lower rates of recidivism in contrast to competing approaches such as criminal sentencing or incarceration. There is a considerable literature addressing attendance, recidivism and attrition rates with males who are involved in such programs. As reflected in the literature, there is particular controversy regarding the impact of counselling with court-mandated, non-voluntary male violence perpetrators. In part, because of disappointing outcomes from treatment with this group, there has been a focus on methods to improve treatment responsiveness. Of particular interest to the current study, is the potential use of motivational interviewing (MI) techniques in improving treatment outcomes involving males who are mandated by the court to attend treatment programs. The current study investigated individual factors such as motivation and readiness to change with the possibility that these factors may influence offender improvement from therapy.

Literature Review

Terminology

Researchers and practitioners differ regarding the appropriate terminology used to refer to domestic violence. A feminist perspective favours the term “woman abuse”, as it identifies the gendered nature of the crime. The term domestic violence is most frequently used in research, and is more readily accepted within the justice system. Other

terms such as wife batterers, family violence, spousal abuse and intimate partner violence are also used in the literature. For purposes of this review, the term male domestic violence has been chosen, as it is important to acknowledge the gendered nature of the crime in using the term “male” in relation to domestic violence.

Domestic Violence

Alpert, Cohen, and Sege (1997) define adult intimate-partner violence or domestic violence as “intentional violent or controlling behaviour by a person who is currently, or was previously, in an intimate relationship with the victim”. Violence or abuse refers to specific behaviours intentionally used by one person to gain control over another. This includes physical aggression, threats, intimidation, neglect, sexual assault, social isolation, verbal attacks, and restriction to resources (Alpert, Cohen, & Sege, 1997). Statistics Canada reports that in 2002, approximately one-quarter (27%) of all victims of violent crimes were victims of family violence. Among all family violence victims, 62% were victims of violence at the hands of their spouse (Canadian Centre for Justice Statistics, 2004). Females accounted for 85% of all victims of spousal violence reported to the subset of police departments (Canadian Centre for Justice Statistics, 2004). The most common charge laid is common assault (64%), followed by major assault (12%). Other charges include uttering threats, sexual assault and criminal harassment (Canadian Centre for Justice Statistics, 2004). Data from the Homicide Survey indicate that between 1993 and 2002, women were more at risk than men of being killed by their spouse. Male spouses, both current and estranged, were responsible for the vast majority (62%) of family homicides against female victims (Canadian Centre for Justice Statistics, 2004). While these numbers are alarming, it is critical to note that the vast majority of

domestic violence goes unreported; actual numbers are estimated to be even higher (Huang and Gunn 2001; Gondolf, 2002).

Domestic Violence Therapy

Group therapy is the format of choice in 90% of male domestic violence interventions, with couple and individual therapy deemed inappropriate within the current standards (Austin & Dankwort 1999; Gondolf, 2002). The rationale for using group therapy for men is predicated in the belief that males learn to confront one another's denial and victim blaming, leading to greater personal growth (Murphy & Baxter, 1997). In a qualitative study investigating how male domestic violence intervention programs work, Silvergleid and Mankowski (2006) found that when men confronted one another in the context of group support, confrontation was accepted as therapeutic and tended not to be met with resistance to a lesser degree.

There are two models of male domestic violence group treatment. The first is the Feminist model, referred to as the Duluth Model (Pence & Paymar, 1993), and the second is the cognitive-behavioural (CBT) model. Less frequently utilized models of intervention include anger management, and couples therapy (Babcock, Green & Robie, 2004).

The Duluth psycho-educational/Feminist Model

The Duluth Feminist model is the most prominent approach used with male domestic violence offenders (Gondolf, 2002). According to this model, the roots of domestic violence are vested in patriarchal ideology and the implicit or explicit societal sanctioning of men's use of power over women (Babcock et al., 2004). Group facilitators

utilize consciousness-raising exercises in challenging a man's perceived right to control or dominate his partner (Babcock et al., 2004). A fundamental tool of the Duluth model is the "Power and Control Wheel" which illustrates that violence is part of a pattern of behaviour rather than consisting of isolated incidents of abuse or cyclical explosions of pent up anger or painful feelings (Pence & Paymar 1993). In this context, the pattern of behaviour includes intimidation, male privilege, isolation, emotional and economic abuse (Pence & Paymar 1993). The Duluth Feminist model requires men to face early confrontation regarding issues that relate to responsibility for violent actions and acknowledgment of a patriarchal power and control ideology (Eckhardt, Holtzworth-Munroe, Norlander, Sibley & Cahill, 2008). Research has shown that feminist based groups utilizing narrative techniques have encouraging rates of success (Jenkins, 1990; McGregor, Tutty, Babins-Wagner and Gill, 2002; Tutty, Babins-Wagner and Rothery, 2009).

Cognitive Behavioural Groups

Cognitive behavioural therapy (CBT) groups focus primarily on the act of violence itself (Babcock et al., 2004). According to the cognitive-behavioural model, violence is a learned behaviour, and therefore nonviolence can be similarly learned (Babcock et al., 2004). In the CBT model, violence continues because it is functional for the user, reduces bodily tension, achieves victim compliance and gives the abuser a sense of power and control (Sonkin, Martin & Walker 1985, in Babcock et al., 2004). CBT groups use skills training in communication, assertiveness and social skills, along with anger management techniques such as the use of time-outs, relaxation training and

changing negative attributions to promote awareness of the alternatives to violence (Babcock et al., 2004).

The Duluth and CBT models are considered theoretically distinct schools; however, numerous current male domestic violence programs utilize components of both therapies. Babcock et al., (2004) identified that, to the extent that CBT groups address patriarchal attitudes, and the Duluth model groups address the learned and reinforced aspects of violence, any distinction between CBT and Duluth group model are becoming increasingly less clear and differentiated. Additionally, most groups combine feminist theories of power and control with specific interventions to deal with anger control, stress management, and improved communication skills (Babcock et al., 2004).

Other empirically rejected models include those based on anger management and couples therapy. Anger management therapy teaches men to identify the warning signs of anger and replacing it with more appropriate non-violent behaviours (Gondolf, 2002, p. 14). Anger management models have been criticized because they imply that the victim provoked the anger. They try to provide a 'quick fix' and do not address the social reinforcements of violence and the control of women (Gondolf, 2002, p. 14). Couples therapy aims to address the communication patterns between individuals, and teaches techniques and skills together (Gondolf, 2002, p.14). Ethically, it may be dangerous or demeaning to have the victims and the perpetrators attend the counselling together (Gondolf, 2002). Not only do approaches differ in their theoretical orientation, but also the context within which the men are engaged in therapy is also different, with some programs requiring men to be court ordered or *mandated* to attend treatment, as opposed to volunteering to participate.

Mandated treatment

Domestic violence is a criminal offence, and it is commonplace in the judicial system to impose mandatory domestic violence therapy as a component of an individual's probation (Hoffart and Clarke, 2004; Canadian Centre for Justice Statistics, 2004). In 2002, a probation order occurred in 72% of spousal violence charges (Canadian Centre for Justice Statistics, 2004). The integration of prosecution, probation, shelters, counselling and other services is referred to as a coordinated community response to intimate partner violence (Pence and Shepard, 1999; Gondolf, 2002; Saunders, 2008). While therapy is intended to counsel and help participants, many men view it as part of their punishment (Gondolf, 2002).

There has been significant interest and research on the effectiveness of mandated treatment, which has yielded mixed findings. Over two decades ago DeMaris and Jackson (1987), found that self-referred men appeared to make better progress in decreasing their violence than court-referred men. More recently, Farabee, Prendergast and Anglin (1998) reviewed eleven compulsory drug abuse treatment studies and found that criminal justice referrals did as well as, or better than, voluntary participants in nine of the studies (Farabee et al., 1998). Other studies have found that self-referred men had higher rates of attrition when compared to court mandated men (60% vs. 33%) and therefore court referred men were more likely to benefit from treatment (Hamberger and Hastings, 1986; Bowen and Gilchrist, 2004; Scott and Wolfe, 2003; McMurrin, 2002). Gondolf (2002) notes that voluntary program participants tended to have more serious psychological problems and more likely to drop out and revictimize their partners. Still other studies

have found no significant differences between mandated and voluntary participants (Tutty, et al., 2009).

Outcomes of Male Domestic Violence Therapy

A significant body of literature has reviewed the effectiveness of domestic violence treatment. The outcomes from these reviews have been largely inconclusive (Gondolf, 2002). Most studies use reoffending rates as the measure of outcome, as it is objective, and of particular concern to the courts (Gondolf, 2002). In a review of the early studies on marital violence treatment programs, Rosenfeld (1992) concluded that men who are arrested and complete treatment have only slightly lower recidivism rates than men who are arrested but refuse treatment, dropout of treatment or remain untreated. They reported minimal decreases in recidivism rates between men who completed treatment (36%) and men who only received legal-system interventions such as court-ordered sanctions (39%) (Rosenfeld, 1992). When comparing treatment graduates to dropouts or comparing offenders randomly assigned to treatment or no treatment, the differences on recidivism rates and corresponding effect sizes are relatively small (Babcock and LaTaillade, 2000, in Eckhardt, Babcock & Homack, 2004).

Spousal reports are also troubling. A meta-analysis by Levesque and Gelles (1998) found when relying on partner reports of recidivism, there were no overall effects in reducing male domestic violence, however small effects were noted across studies that relied on police reports and court records (Levesque and Gelles, 1998 in Prochaska and Levesque, 2002). Women whose partners are involved in male domestic violence treatment report an increased sense of safety (Austin and Dankwort, 1999) and are optimistic that treatment will promote significant change in their partners (Gregory and

Erez, 2002). Among women whose partners were attending treatment, more than half intended to return to the relationship as compared to one-fifth whose partners were not in treatment (Gondolf 1988). Additionally, many women were afraid that the abuse would increase because of their partner's resentment and anger in being forced to attend treatment (Gregory and Erez, 2002). Other women reported that while physical abuse decreased, emotional and verbal abuse increased (Gregory and Erez, 2002).

These results may not tell the complete story. Babcock et al., (2004) conducted an important meta-analysis of 22 studies evaluating treatment efficacy for domestically violent males. They assessed the impact of treatment type, Feminist/Duluth (k=19), Cognitive Behavioural Therapy (k=11), or other (k=7), and treatment length (less than 16 weeks) to long (greater than 16 weeks) short term (less than 12 months) or long term (greater than 12 months), and assessed differences in member attrition and recidivism. There were no significant differences between the Duluth or CBT models. Based on partner reports of recidivism, they found that treated physical abusers have a 40% chance of being nonviolent compared to 35% without treatment. This suggests that treatment accounts for a 5% difference in the reduction of partner abuse (Babcock et al., 2004). The authors note that while this may seem insignificant, a 5% reduction of all reported cases of domestic violence in the United States would equate to approximately 42 000 women per year no longer being physically abused (Babcock et al., 2004).

Reports from *Homefront*, a collaborative, community domestic violence project in a Canadian city integrating the courts, probation, shelters, counselling agencies and other services found that individuals who completed treatment were significantly less likely to re-offend than those who did not complete the treatment, at both twelve month (5.7% vs.

13.2%) and eighteen month (9.4% vs. 21.4%) follow up intervals (Hoffart & Clarke, 2004).

Gondolf (2002) suggests that the inconclusive findings of previous studies may in part reflect the relatively short periods of follow-up. Gondolf (2002) reported the results of an extensive multisite evaluation of programs in four American cities. Follow-up interviews were conducted with program graduates and partners at three month intervals for a period of four years. At the 15 month follow-up, nearly one third (32%) of the partners had been revictimized, 37% at 30 months, and 42% at 48 months, with most of the assaults occurring in the first six months (Gondolf, 2002, p. 114). Nearly one quarter of the women reported calling the police during the 15 month follow-up. Gondolf (2002) notes that these figures may be actually be higher, due to the tendency of women to under report abuse. Arrest reports are consistent, with 11% arrested for a domestic violence crime, and 29% arrested for any violent crime at the four year mark (Gondolf, 2002, p. 116). Gondolf (2002) notes that classification of crime made it difficult to ascertain whether the arrests were actually incidences of domestic violence. Thus, the rates of any violent crime may include domestic violence crimes as well (Gondolf, 2002, p.116).

Despite these statistics, when assessed for overall quality of life, women reported significant improvements. Two-thirds of the women stated that they felt they were “better off” after men’s treatment (66% at 15 months, 69% at 30 months and 63% at 48 months), and a significant number stated they felt very safe (79% at 15 months, 83% at 30 months, and 85% in 48 months). At 15 months, 66% of women stated that they were very unlikely to be hit, and this number increased to 85% and 84% at the 30 and 48 month marks respectively.

Gondolf (2002) concludes that the intervention programs were successful. Though significant numbers of the participants did reoffend at points throughout the duration of the study, such reconvictions tended to be prior to the six-month follow-up. The trends showed a significant de-escalation of abuse over time, with the majority of men eventually becoming violence free (p. 129). By the 30 month follow up, over 80% had not assaulted a partner in the previous year, even if they had committed an abusive act in an earlier period of follow up. This is supported by the partner reports of “feeling very safe” at the 30 and 48 month follow-ups. Most previous follow up studies have been restricted to one year, and thus would not capture the cumulative success rate (Gondolf, 2002).

These results suggest the presence of a mediating variable that may distinguish the men who were successfully non-violent shortly following treatment, from those who were not. A particularly promising area of research is whether the offenders’ motivation to change and readiness for change prior to when the program was instituted may affect these outcomes.

Motivation to Change

Motivation to change has emerged as a critical component in all areas assessing the impact of therapy, and has received significant attention particularly in the area of male domestic violence therapy. An individual must be ready, willing and able to begin working on making a change (Lopez-Viets et al., 2002). “Ready” indicates that the person believes the change is important to make and has become a priority. “Willing” refers to whether the person is prepared to make the necessary changes, and “able” refers to whether the person has adequate self-efficacy to believe they have the ability to make

and sustain the changes (Lopez-Viets, et al., 2002). Motivation is often accompanied by ambivalence; the oscillation between the desire to make a change, and the desire to stay the same (Miller and Rollnick, 1991).

Motivation is considered an evolving construct, which can change over time (Lopez-Viets et al., 2002). Motivation to change and motivation to stay the same are both rational goal choices influenced by the individual's characteristics and circumstances (McMurran, 2002). An individual's decision to change or not to change depends on their perception of the benefits and drawbacks of each choice.

Arguably, most offenders are rational, and thus have a variety of reasons rationalizing their denial of harm and resistance to change (McMurran, 2002). They may desire to continue a rewarding behaviour, wish to avoid feeling ashamed, fear embarrassment or shame or be unable to see how they can lead a different life. They may be resistant to attending therapy because they experience therapy as aversive, confusing or incomprehensible, or because attendance is difficult (McMurran, 2002). One study reports that 20-30% of men admit that, despite being on probation, they are unwilling to change (Eckhardt et al., 2008).

Motivation to change may be understood in the same terms. Offenders want to avoid the sanctions and disapproval that are a consequence of being caught offending, reduce feelings of guilt and shame about their behaviour, or strive to significantly change their lives (McMurran, 2002). They may attend therapy because they agree with the treatment goals and/or understand the treatment process (McMurran, 2002).

Offenders who are the highest risk for serious recidivism are viewed as the least motivated to change (Stewart & Millson, 1995 in (McMurrin, 2002). Aggression is difficult to treat, and male domestic abusers are generally not seeking treatment voluntarily and do not expect the interventions to help (Gondolf, 2001 in Babcock et al., 2004). Thus, the small effect sizes seen in male domestic abuse interventions may in part be attributable to the perpetrator's non-investment in the therapeutic process and subsequent attrition from the programs (Babcock et al., 2004). Silvergleid and Mankowski (2006) cited one group participant who stated "Nobody can force you, really, to be somebody else, you have to desire to change".

Internal vs. external motivational factors

A distinction is made between internal and external motivation factors. External or extrinsic motivation arises from conditions outside the person such as from perceived social pressures, reinforcement and punishment (Lopez-Viets et al., 2002). Once the external control is perceived as gone, so too is the desire to change (Lopez-Viets et al., 2002). Typically, individuals become externally motivated in order to gain social acceptance and avoid punishment and disapproval (McMurrin, 2002).

Conversely, internal or intrinsic motivation arises from within the person (Lopez-Viets et al., 2002). It is not dependent upon external motivators, and is therefore more likely to persist in the absence of external controls (Lopez-Viets et al., 2002). Some individuals become internally motivated when they are pursuing the achievement of a valued goal, or the avoidance and escape from aversive emotions such as guilt and/or shame (McMurrin, 2002). It is generally assumed that motivation driven by internal

factors is a more reliable and salient predictor of change, particularly when considering long-term maintenance (McMurran, 2002).

A legal mandate may be an important external motivator for a client to enter treatment, but once in treatment, internal motivation can be enhanced as part of the explicit goals of the treatment program (McMurran, 2002; Jaffe, Wolfe, Telford & Austin, 1986). It is argued that even self-referred men are motivated by extrinsic rather than intrinsic motivational factors (McMurran 2002). Self-referred offenders attend treatment in the short term as a reaction to the possibility of losing their partner. Once they have gained from their partner that the relationship is assured, or their partner leaves, motivation to attend the program is gone. Court mandated men however have the added incentive of further legal action to keep them in the program (Bowen and Gilchrist, 2004).

The Transtheoretical Model and the Stages of Change

Early research on the transtheoretical model and stages-of-change focused on smoking cessation and addictive behaviours (Prochaska & DiClemente, 1982; Prochaska, DiClemente & Norcross, 1992). The theory suggests that individuals move through a sequence of stages before they successfully make and maintain a change in their behaviour. Each stage is characterized by an individual's perceived importance of making a change. The stages-of-change are referred to as: precontemplation, contemplation, preparation, action, maintenance and termination (Prochaska et al., 1992).

Precontemplation: In this stage, people are not intending to take action in the foreseeable future. Individuals may be in this stage because they are under-informed or in

denial about the consequences of their behaviour, or they may be demoralized because they have previously attempted change in the past and failed. Furthermore, they may blame their partner or their circumstances (Scott, 2004). They avoid learning and thinking about their high risk behaviours. They tend to underestimate the benefits of changing and overestimate the costs. Many people remain stuck in the precontemplation stage for years (Prochaska and Levesque, 2002). When precontemplaters present for psychotherapy, they often do so because of pressure from others (Prochaska et al., 1992). This may be pressure from friends, family, employers or even the law.

Contemplation: Individuals in this stage have the intention to take action in the next six months, but have not done so as of yet. It has been named “behavioural procrastination” (Prochaska and Levesque, 2002). Scott (2004) has labelled this stage “change crisis and exploration of change”. Individuals in this stage are more aware of the pros of changing but are also acutely aware of the cons. They may lack knowledge about what to change and how to do it. People can stay stuck in contemplation for years (Prochaska and Levesque, 2002).

Preparation: The preparation stage is characterized by the intent to take action in the immediate future. Individuals may be testing out different change strategies (Scott, 2004). They have usually taken significant steps in the past year and often have a plan of action (i.e. recovery group, counselling etc). These individuals are ready to engage in action-oriented rehabilitative programs (Prochaska and Levesque, 2002).

Action: In this stage, people have made specific overt modifications in their lifestyles within the past six months. Since action is observable, behaviour change often

is equated with action. With criminal offenders, zero tolerance is the official policy of the criminal justice system (Prochaska and Levesque, 2002).

Maintenance – Individuals are thought to be in the maintenance stage when they are working to prevent relapse and do not apply change processes as frequently as people in the action stage. They are less tempted to relapse and increasingly more confident that they can sustain their changes. The maintenance stage may last for a few months, or as long as a lifetime (Prochaska and Levesque, 2002).

Termination: In this stage individuals have zero temptation and 100% self-efficacy. They are confident they will not return to their old habits, no matter how much emotional distress they experience (Prochaska and Levesque, 2002). They may have adopted new principles and moral values (Scott, 2004). Not all individuals arrive at the termination stage.

In practice, individuals do not progress through these stages in a linear fashion. Rather, they can move forwards and backwards between stages through the course of their treatment. In the original research with smoking cessation, Prochaska and DiClemante (1982) hypothesized the stages-of-change to be a wheel or a revolving door, with most individuals going around and around several times before making an exit. Prochaska et al., (1992) modified this model to be a spiral pattern, with most individuals relapsing to an earlier stage at points throughout their treatment. When applied to the four-year follow-up study described in Gondolf, (2002), the fact that the majority of reoffending occurred during the first six months following treatment and then decreasing

as time went on can be viewed as an individual relapsing, before ultimately making the desired changes.

Levesque and Gelles and Velicer (2000) found that in a sample of 292 males involved in a domestic violence counselling group, 24% were in the precontemplative stage, 63% were in the contemplation/preparation stage, and only 13% were in the action stage. Thus, the lack of progress seen in many men in domestic violence groups may be attributable to their being in an earlier stage-of-change. Both the Duluth and CBT models utilize challenges and confrontations that assume individuals are in the action stage and ready to make changes (Eckhardt, et al., 2008). Eckhardt et al., (2008) reports that 30-40% of men in domestic violence programs will simply “go through the motions” with no real desire to make changes.

Several studies have applied the transtheoretical model to male domestic violence counselling. Williamson, Day, Howels, Bubner & Jauncey (2003) utilized the Anger Readiness to Change questionnaire, a 12-item questionnaire based on Prochaska and DiClemente's stages-of-change model. Participants were 414 adult male prisoners located in 16 prisons in Australia. The test found 14.3% were in the precontemplation stage, 28.7 % were in the contemplation stage and 57.0% were in the action stage (Williamson et al., 2003). The fact that the participants were already incarcerated and had much to gain from changing may account for the high proportion of individuals already in the action stage. The tests were administered to control and experimental participants at pre-treatment, post-treatment, 2-month and 6-month follow-up. They found that treatment was more beneficial in reducing anger when treatment readiness was initially high (Williamson et al., 2003). The authors note that there was no evidence that

the treatment itself was effective, rather, that those inclined to make changes prior to the treatment fared better than those who did not (Williamson et al., 2003).

Measures of Treatment Outcome

Several studies have utilized the University of Rhode Island Change Assessment (URICA) to assess an individual's stage-of-change (McConaughy, DiClemente, Prochaska, & Velicer 1989; McConaughy, Prochaska and Velicer, 1983). The URICA (formerly the Stages of Change Measure) is a 32 item rational scale questionnaire designed to assess an individual's stage-of-change. Eight statements identify precontemplation ($\alpha = .88$), contemplation ($\alpha = .88$), action ($\alpha = .89$) and maintenance ($\alpha = .88$) (McConaughy et al., 1983; 1989). The URICA-DV (domestic violence) is a modified version of the URICA that specifically addresses domestic abuse (Levesque, Gelles, & Velicer, 2000).

Scott and Wolfe (2003) assessed readiness to change as a predictor of outcome in male domestic abuse treatment. Participants were 119 men who completed treatment; dropouts were excluded from the study. Two thirds of the sample was mandated by probation (64%) and the remaining one third attended due to pressure from partners, friends, employers or child protective services. This study assessed cessation of abusive behaviour following treatment. Participants were additionally assessed for changes in empathy, communication skills and perceptions of personal responsibility for abusive behaviour; variables that are expected to promote and maintain changes in men's abusive behaviour. Stages-of-change were assessed using the URICA (McConaughy et al., 1983; 1989). This study deliberately did not use the URICA-DV, as many men initially reject the label "abuse" for their behaviours (Scott & Wolfe, 2003). Treatment reflected a

feminist-based treatment program comprised of 10 individual sessions followed by a 7 week closed group. Results provide some evidence that men in the contemplation and action stages show greater positive growth compared to men in the precontemplative stage. Men in the precontemplative stage reported less abuse than those in the contemplative and action stages. Partners of men in the precontemplative stage reported greater abuse than the men did (equal to those in the contemplative and action stages), indicating that denial may be playing a large role.

Alexander and Morris (2008) assessed stages-of-change and the response to treatment in male domestic abusers. They hypothesized that individuals in an earlier stage-of-change would report less distress as evidenced by anxiety, depression and alcohol abuse, fewer problems with anger and fewer internal motivators. Participants were 210 men in a 26-week group counselling program. Stage of change was assessed using the URICA (McConaughy et al., 1983;1989). Partner reports showed that individuals in both clusters perpetrated the same amount of violence; therefore the two groups differed only in the assessment of their own violence. They found that men in an earlier stage-of-change consistently reported fewer problems with anger and less abusive behaviour. This is consistent with the stages-of-change, as it is reflective of denial and minimization rather than an accurate description of their behaviour. Men in an earlier stage-of-change report fewer symptoms of distress than did men in a later stage-of-change. Thus, they may have had less internal motivation to change because their behaviour did not cause them any marked distress.

Stage Matched Intervention

Treatment programs that aim to have people immediately stop offending are usually designed for the population that are in the preparation or action stages. Research on health related behaviours estimates that only 20% of individuals are in preparation and therefore, the 40% in precontemplation, and 40% in contemplation are not maximizing their benefits from treatment (Laforge, Velicer, Richmond & Owen, 1999). Prochaska and Levesque, (2002) advocate for a stage matched intervention. Offenders are assessed for what stage-of-change they are at, and treatment is matched to their stage of preparation.

Levesque, Driskell, Prochaska, & Prochaska, (2008) designed and tested a computer program entitled "The Journey to Change". The program assesses each individual's stage-of-change and provides individualized information on their stage-of-change, decisional balance (pros and cons of ending violence), processes of change, self-efficacy and strategies. Ninety eight percent of users said they found the program to be useful or very useful, eighty eight percent said it gave them something new to think about, and ninety eight percent said it could probably or definitely help them change their attitudes or behaviours (Levesque et al., 2008).

The results from these studies suggest that in order for therapy to be successful, individuals must be in the contemplation, preparation or action stages. The next step is to assist offenders in increasing their readiness to change.

Motivational Interviewing (MI)

MI is a counselling strategy intended to help clients increase their readiness for change (Miller and Rollnick, 1991; Musser Semiatin, Taft, & Murphy, 2008). During MI, clients are assisted in utilizing and recognizing the above mentioned processes of change. The key components of MI are; the use of empathy, development of discrepancy, avoidance of argumentation, utilization of resistance and support of self-efficacy (Miller and Rollnick, 1991). Use of empathy involves creating a warm, supportive and understanding therapeutic relationship with the client (Miller and Rollnick, 1991; Hill, 2009). Development of discrepancy involves amplifying the dissonance between an individual's behaviour and their broader goals (Miller and Rollnick, 1991). Most abusive men do not believe in hitting women, yet their behaviour suggests otherwise (Kistenmacher and Weiss, 2008). Avoidance of argumentation involves avoiding situations where the client will become defensive. If the counsellor is arguing for the "good" non-violent side, the client will automatically defend the "bad" violent side (Miller and Rollnick, 1991). Utilization of resistance involves exploring what makes a client reluctant to change. Finally, developing self-efficacy involves increasing a client's own belief that they will be successful at making a change.

Taft et al., (2001) found that adding MI techniques to intake procedures improved both retention and recidivism rates among men attending group intervention programs. Motivational techniques have been used successfully with groups of sex offenders to enhance and maintain motivation prior to and throughout the duration of an offender program (Garland and Dougher, 1990).

Two studies in 2008 assessed the impact of MI as a pre-treatment for male domestic abuse therapy (Kistenmacher and Weiss, 2008; Musser et al., 2008). Abusive men were randomly assigned to either two sessions of MI or a no-treatment control condition prior to engaging in group therapy. Results showed that the MI group demonstrated a significant pre-to-post increase in self-reported action toward changing violent behaviour than the control (Kistenmacher and Weiss, 2008). Additionally, the MI group placed less blame on their victim, society and other external factors as a function of the intervention (Kistenmacher and Weiss, 2008). Participants completed more of the assigned CBT homework during the group than those who did not receive the MI sessions (Musser et al., 2008). More MI participants reported seeking additional sources of help (Musser et al., 2008). The authors postulate that MI facilitates motivation via increasing thoughts of readiness for change rather than decreasing thoughts related to resistance (Kistenmacher and Weiss, 2008; Musser et al., 2008).

Outcome Research

There has been increased pressure from third party payers and funders to see measurable forms of improvement in order to consider therapeutic interventions as being accountable and successful (Lambert (2010) in Duncan, Miller, Wampold and Hubble, 2010). This has lead to the concept of *Practice-based evidence*. Practice-based evidence refers to the use of evidence from real-time therapy interventions to evaluate effectiveness. It asks the question “was this therapy effective with this client today”. There is strong support in the literature that collecting ongoing feedback improves treatment outcomes (Lambert (2010) in Duncan, Miller, Wampold and Hubble, 2010).

The present study investigated whether there are measurable differences in outcome results of court-ordered men following group therapy. This study investigated whether the stage-of-change for men at the start of group therapy influenced their benefit from treatment outcomes, and additionally whether implementing MI with men who were at different stages-of-change influences the outcomes from therapy.

Method

Participants

Participants included all individuals who were mandated to complete the Calgary Counselling Centre's *Responsible Choices for Men* program as part of their probation order between June 2007 and November 2009, which reflected 282 men. Of this total, 71 participants had missing data regarding their stage-of-change at the first counselling session, and were excluded from this study. The present study examined the remaining 211 men for whom there was complete data.

In 2008, Calgary probation implemented the use of MI with participants prior to their referral for group counselling. Thus, the participants who completed the group between June 2007 and September 2008 ($n=106$) did not engage in MI, while those who completed the group between September 2008 and November 2009 ($n=105$) received two sessions of MI prior to their contact with the Calgary Counselling Centre (CCC). Participants had similar characteristics based on important demographic variables and received the same group-based treatment.

Data was collected from the participants at their first counselling session, and then again at the start and end of the group (pre-test and post-test). Summaries of the

demographic data collected are contained in Tables 1- 12. The MI and Non-MI groups differ only in terms of the years they received treatment. Men in both groups appear to be nearly identical in terms of age, number of individual sessions attended, number of group sessions attended, and number of children.

Table 1 (n=210)

Comparison of Participant Factors

		# Individual Sessions Before Group	# of group sessions attended	Age	Number of children	Partner's Age
Non MI Group	Mean	4.73	10.39	36.08	1.57	32.56
	N	105	106	106	84	90
	Std. Dev.	2.722	4.181	10.502	1.185	11.238
MI Group	Mean	4.24	11.41	33.10	1.45	31.35
	N	105	105	105	83	85
	Std. Dev	2.064	3.885	10.883	1.192	11.231
Total	Mean	4.49	10.90	34.60	1.51	31.97
	N	210	211	211	167	175
	Std. Dev	2.422	4.059	10.772	1.187	11.219

Demographic data on marital status, level of education, living arrangements, and income status was collected at the first counselling session. In terms of marital status, the men had a nearly equal distribution between being single, married, separated, divorced or living common law. For both groups, the majority of men currently identified as single. Level of education ranged from completing grades 5-8 to having a university degree. The MI and non-MI group had an almost identical distribution, with the vast majority of both groups completing grades 9-12. In terms of income, the men were closely matched, with the non-MI group earning slightly more than the overall average. Living arrangements

were strikingly similar as well, with the majority of both groups living primarily alone, with a roommate or in a nuclear family situation. Tables 2-5 summarize and compare each of these factors.

Table 2*Marital Status*

	Marital Status					Total
	Single	Married	Separated	Divorced	Common-law	
Non MI	41	22	18	6	18	105
MI	46	19	13	5	22	105
Total	87	41	31	11	40	210

Table 3*Level of Education*

	Level of Education				Total
	Grades 5-8	Grades 9-12	Technical/Vocational	University	
Non MI	1	60	26	16	103
MI	1	56	28	17	102
Total	2	116	54	33	205

Table 4*Income*

	Income (\$)								Total
	0 - 5,000	5,000 - 15,000	15,001 - 25,000	25,001 - 35,000	35,001 - 45,000	45,001 - 55,000	55,001 - 65,000	65,001 and higher	
Non- MI	8	7	9	16	16	9	10	15	90
MI	6	7	12	27	15	7	7	12	93
Total	14	14	21	43	31	16	17	27	183

Table 5*Living Arrangements*

	Current Living Arrangements									Total
	Alone	Room- mate	Couple	Nuclear / Immediate family	Extended Family	Blended Family	Special Family	Other	Single parent family	
Non MI	23	27	14	21	2	6	1	4	0	98
MI	20	22	17	23	4	5	3	6	2	102
Total	43	49	31	44	6	11	4	10	2	200

Detailed participant histories were collected on the first evening of group.

Participants were asked to identify any previous counselling, psychiatric history, substance abuse, medical problems or abuse in their family of origin. The participants were nearly identical in terms of having previous counselling, with the majority answering no. The overwhelming majority of both groups indicated that they did not have a psychiatric history, problem with substance abuse, or medical concern. The majority of both groups indicated no history of abuse in their family of origin; however the answers were not as severely skewed as the other questions in this category. This information is contained in tables 6-10.

Table 6*Previous counselling*

		Have you previously received counselling?		Total
		No	Yes	
	Non MI	60	44	104
	MI	60	40	100
Total		120	84	204

Table 7*Psychiatric History*

		Do you have a psychiatric history?		Total
		No	Yes	
	Non MI	94	9	103
	MI	93	6	99
Total		187	15	202

Table 8*Substance Abuse*

		Do you have a problem with substance abuse?		Total
		No	Yes	
	Non MI	91	14	105
	MI	92	12	104
Total		183	26	209

Table 9*Medical Problems*

		Do you have any medical problems?		Total
		No	Yes	
	Non MI	96	9	105
	MI	94	11	105
Total		190	20	210

Table 10*Abuse in Family of Origin*

		Did abuse occur in your family of origin?		Total
		No	Yes	
	Non MI	66	36	102
	MI	78	24	102
Total		144	60	204

Information was collected regarding their previous involvement with law enforcement, and whether there were any on-going legally-ordered interventions. The majority of men in both groups indicated that there had not been any previous police intervention, however near equal numbers of both groups indicated that there had been in the past. Both groups were identical in identifying whether a legal order intervention had been put in place. This information is contained in Tables 11-12.

Table 11*Previous Police Intervention*

		Has there been any previous Police Intervention?		Total
		No	Yes	
	Non MI	71	31	102
	MI	68	35	103
Total		139	66	205

Table 12*Legal Order intervention*

		Has there been any legal order(s) intervention?		Total
		No	Yes	
	Non MI	56	45	101
	MI	57	46	103
Total		113	91	204

Responsible Choices for Men

The Responsible Choices for Men program is a 14 week group therapy program designed for individuals who use violence and control in their intimate relationships (McGregor et al., 2002). The group is part of a coordinated community response in

Calgary to address male domestic violence. Each session is two hours in length, with the exception of the first and last sessions, which extend for three hours. Each group is comprised of 6-12 men, co-facilitated by a male and female therapeutic team. Prior to admission to the group, each individual is required to attend at least one session of individual therapy in which an individual counsellor assesses the client's fitness for group therapy. Individuals who are not expected to benefit from the group setting (i.e. cannot speak English, schedule does not permit them to commit to the group etc.) are not enrolled in the group and continue with individual counselling. Once the client is assessed as a good fit for the group, the primary therapist supports their motivation in preparing them for the group. Additionally, the primary therapist will also work with the participant's spouse and family to ensure safety and supports are in place (McGregor et al., 2002). The participants in the present study attended an average of 4.49 sessions of individual therapy prior to commencing group therapy (Non-MI group = 4.73, MI group = 4.24 sessions).

The Responsible Choices for Men group is based on feminist perspectives using narrative methods (Jenkins, 1991) and is focused on changing belief systems of men that are related to their use of violence (Tutty et al., 2009). Unlike most domestic violence programs in North America, the Responsible Choices for Men program uses a process-oriented, rather than psycho-educational approach (McGregor et al., 2002). The major objectives of the group are to decrease all forms of abusive behaviour, promote acceptance and responsibility for personal behaviour, increase self-esteem and assertiveness, improve family relations, decrease stress, and increase empathy to those who have been impacted by the violence (McGregor et al., 2002).

The group has four main components; challenging victim blaming, challenging belief systems, reconnecting with emotions, and experiencing empathy (McGregor et al., 2002). During the first phase, challenging victim blaming, the focus of the group is to help the men become more accountable for their actions. During the second phase, challenging belief systems, men discuss issues such as entitlement, locus of control, need for control and gender stereotyping. During this phase, the men are invited to explore and challenge their own belief systems. The third phase, reconnecting with emotions, identifies that many participants experience anger without identifying the underlying emotions. They are encouraged to explore these emotions. The final and most important phase, experiencing empathy, encourages the participants to connect to the emotional pain of their partner and plan for the future.

Measures

Outcome Questionnaire (OQ). The Outcome Questionnaire - 45.2, is a 45 item self-report instrument designed for the repeated measurement of client progress and overall global functioning through the course of therapy. The total score is calculated between 0-180, with higher scores indicating greater distress. A total score greater than 63 is considered to indicate significant distress (Lambert, Burlingame, Umphress, Hansen, Vermeersch, Clouse & Yanchar, 1996). It has three subscales which measure Symptom Distress, Interpersonal Relations, and Social Role. The Symptom Distress subscale consists of 25 items weighted with items reflecting psychological symptoms associated with the most prevalent types of mental health disorders among adults including anxiety, mood, and substance-related disorders. A score greater than 36 indicates significant symptom distress (Lambert et al., 1996). The Interpersonal Relations subscale consists of 11 items assessing an individual's current level of interpersonal

relationship functioning. A score greater than 15 indicates considerable interpersonal distress (Lambert et al., 1996). The Social Role subscale consists of 9 items that assess an individual's current level of performance at school or at work. A score greater than 12 on the social role scale indicates considerable concern (Lambert et al., 1996). Questions are answered on a 5-point Likert Scale with values of 0 (*never*), 1 (*rarely*), 2 (*sometimes*), 3 (*frequently*), and 4 (*almost always*) (Vermeersch et al., 2004). Research has indicated that the OQ is a psychometrically sound instrument, with adequate 3-week test-retest reliability (.84) and high internal consistency reliability coefficients (.93) (Lambert et al., 1996). Data from the OQ will reflect the participant's first individual session, and first and final group sessions.

University of Rhode Island Change Assessment (URICA). The URICA is a 32 item scale with eight items measuring each of four stages of stage; precontemplation, contemplation, action and maintenance (McConaughy et al., 1983; 1989). The precontemplation stage is characterized by the reluctance to change, or denial that a need to change exists (Prochaska and Levesque, 2002). Statements that endorse precontemplation include "As far as I'm concerned, I don't have any problems that need changing" or "I may be part of the problem, but I really don't think I am" (McConaughy et al, 1989). The contemplation stage is characterized by individuals who are ambivalent about change (Prochaska and Levesque, 2002). Statements such as "I think I might be ready for some self-improvement" or "I hope that someone here will have some good advice for me" endorse contemplation (McConaughy et al, 1989). The action stage typically includes a visible change in behaviour (Prochaska and Levesque, 2002). Statements describing the action stage include "I am really working hard to change" or "I

have started working on my problems, but I would like help” (McConaughy et al, 1989). Finally, the maintenance stage typically includes individuals who have made a change and are working to prevent relapse (Prochaska and Levesque, 2002). Statements indicative of the maintenance stage include “It worries me that I might slip back on a problem I have already changed, so I am here to seek help” or “It’s frustrating, but I feel I might be having a recurrence of a problem I had thought I had resolved (McConaughy et al, 1989). Participants respond to each statement with 1 (strongly disagree), 2 (disagree), 3 (undecided), 4 (agree) and 5 (strongly agree). Data from the URICA was collected at the client’s initial counselling session.

University of Rhode Island Change Assessment – Domestic Violence (URICA-DV). The URICA-DV is a 20 item scale developed from the URICA and adapted for an abusive male population (Levesque et al., 2000). The URICA-DV makes specific mention of violence in its questions and focuses only on men’s readiness to change their physical forms of abuse. Violence is defined in the scale as “physical aggression toward your partner” and lists a number of abusive behaviours that may cause physical pain or injury. The characteristics of each stage-of-change are the same as that in the original URICA, however, wording of the questions has been modified. Example statements include, Precontemplation; “The violence in my relationship isn’t a big deal”, Contemplation; “I’m beginning to see that the violence in my relationship is a problem”, Action; “I’m finally going to do something to end my violent behaviour”, and Maintenance; “Although I haven’t been violent in a while, I know it’s possible for me to be violent again”) (Eckhardt and Utschig, 2007). Data was collected from the URICA-DV on the first and final session of group.

The present study predicts that individuals in a later stage-of-change will have higher scores on the OQ, suggesting a greater recognition of distress in their lives and a desire to change. Past research in this area supports this hypothesis. The present study also predicts that the presence of MI prior to the group therapy program will have an influence on the OQ scores.

Data Analysis

Stages of change were grouped into five clusters, adapted from those described in Levesque et al., (2000), and Brodeur et al., (2008). The scores of the URICA and URICA-DV were converted into t-scores and then plotted on a graph. Clusters were determined based on the profile of the graph.

Precontemplation (n= 38) - The profile for this cluster scores high on the precontemplation scale, and low on the contemplation, action, and relapse scales.

Contemplation (n=56) – This profile scores above average in precontemplation, but average in all other levels.

Preparation (n=31) – This profile scores slightly below average for Precontemplation, and slightly above average in all other levels.

Action High-Relapse (n=25) – This profile scores below average for precontemplation, and above average and nearly equal for contemplation, action and relapse.

Action Low Relapse (n=50) – This Profile scores low on precontemplation, high on contemplation and action, and Low on relapse.

Table 13*URICA Stage of Change*

	Stage of Change Pre-Test					Total
	Precontemplation	Contemplation	Preparation	Action high relapse	Action low relapse	
Non-MI	18	24	17	13	26	98
MI	20	32	14	12	24	102
Total	38	56	31	25	50	200

Table 13 illustrates the stage-of-change distribution of the participants who had no MI, and those who did. Both groups are comparable.

This study utilized Multi-Level Growth modelling to assess group differences (Singer and Willett 2004). A multi-level growth model assesses growth and change over a series of time points. These models are ideal for event-level data because they allow for varying numbers of observations as well as missing observations. The computer program HLM 6.08 student (Raudenbush, Bryk, Cheong, & Congdon, 2004) was used to conduct the multi-level analyses. As Multi-Level Growth modelling is a type of regression analysis, it utilizes indicator or dummy variables to identify group membership for each individual belonging to a specific set of conditions (Willett & Singer, 2004). In the present study, the indicator variable identified the stage-of-change an individual was assigned to at the time of the group counselling pre-test, and whether they received the MI. A second set of indicator variables was created allowing the model to measure the strength of the interaction. Thus, the variables were centered on the pre-test (Time 2).

Level one assesses the individual changes or within-groups comparison, while Level 2 assesses the influence of pre-existing group factors, between groups changes

(Singer & Willett, 2004). For the first model measuring the effects of stage-of-change and MI separately, the level one equation used was:

Level -1

$$OQ = \pi_0 + \pi_1*(TIME) + \pi_2*(TIME_SQ) + E$$

Level one analyzes the change of each individual's OQ scores over the three time points, before group, pre-test and post-test.

Level two further explores individual OQ scores into groups corresponding to each stage-of-change, and then again for the MI condition. The first set of equations uses the precontemplation group as the comparison. The second set of equations uses the non-MI group as a comparison. The parameter π_0 analyzes the differences in the intercept at time 2, while the parameter π_1 measures the strength of the slope that measures change in MI over time. The parameter r identifies the mean measurement error associated with π .

Level-2

Stages of change equations:

$$\pi_0 = \beta_{00} + \beta_{01}*(contemplation) + \beta_{02}*(preparation) + \beta_{03}*(action\ high-relapse) + \beta_{04}*(action\ low-relapse) + r_0$$

$$\pi_1 = \beta_{10} + \beta_{11}*(contemplation) + \beta_{12}*(preparation) + \beta_{13}*(action\ high-relapse) + \beta_{14}*(action\ low-relapse) + r_1$$

Motivational Interview equations:

$$\pi_0 = \beta_{01}*(motivational\ interview) + r_0$$

$$\pi_i = \beta_{10} + \beta_{11}*(\text{motivational interview}) + r_i$$

For all models, Level 1 and Level 2 variables were centered on time two.

Results

The results of these analyses are reflected in Tables 14-20.

Table 14

Level 1 Analysis

Fixed Effect	Final Estimation of Fixed Effects			Approx DF	P-Value
	Coefficient	Standard Error	T-Ratio		
Intercept	35.953	1.830	19.637	194.000	0.000
Slope	-8.857	0.818	-10.835	539.000	0.000

The level 1 analysis shows that at time 2, the average OQ score was 35.95. The slope shows that there was an 8.86 point decrease at each time point (P=0.000).

Figure 1

OQ score changes over time

Table 15*Level 2 Analysis – Stages of Change π_0 (intercept)*

Fixed Effect	Final Estimation of Fixed Effects				
	Coefficient	Standard Error	T-Ratio	Approx DF	P-Value
For Intercept 1 π_0					
Intercept 2, β_{00} (precontemplation)	30.934	3.712	8.333	190	0.000
Contemplation, β_{01}	4.075	4.666	0.873	190	0.384
Preparation, β_{02}	19.6	5.326	3.679	190	0.001
Action High-Relapse, β_{03}	14.5	5.716	2.536	190	0.012
Action Low Relapse, β_{04}	-4.081	4.781	-0.854	190	0.395

The level-two analysis examined separately each stage-of-change. The mean for precontemplation is 30.93, with each subsequent stage compared to precontemplation.

Therefore the contemplation group has a 4.07 point increase ($P=0.384$), preparation has an increase of 19.60 points ($p=0.001$), action high = 14.50 ($P=0.012$), and action low = 4.08 decrease ($P=0.395$).

Table 16*Level 2 Analysis – Stages of Change π_1 (slope)*

Fixed Effect	Final Estimation of Fixed Effects			Approx DF	P-Value
	Coefficient	Standard Error	T-Ratio		
For Intercept 1 π_1					
Intercept 2, β_{10} (precontemplation)	-7.502	2.335	-3.213	190	0.002
Contemplation, β_{11}	0.276	2.957	0.093	190	0.926
Preparation, β_{12}	-0.327	3.36	-0.097	190	0.923
Action High-Relapse, β_{13}	-3.635	3.584	-1.014	190	0.312
Action Low Relapse, β_{14}	-3.608	3.01	-1.199	190	0.233

There was an average 7.5 point decrease at each time point for precontemplation ($P=0.002$). There were no significant differences in slope for the other stages.

Figure 2*Stage of Change Mean OQ scores at time 1, 2, 3*

Table 17*Level 2 Analysis – Motivational interview π_0 (Intercept)*

Fixed Effect	Final Estimation of Fixed Effects			Approx DF	P- Value
	Coefficient	Standard Error	T-Ratio		
For Intercept 1 π_0					
Intercept 2, β_{00} (Non-MI group)	38.966	2.427	16.052	193	0.000
Motivational Interview, β_{01}	-5.775	3.270	-1.766	193	0.078

The second level 2 analysis examined separately each group that received MI from those who did not. The individuals who did not receive MI had an average OQ score of 39.00. Individuals who received MI had an average 5.78 point decrease in their OQ score ($P=0.078$). This score fell short of statistical significance; however it approaches significance and may be important in a clinical population.

Table 18*Level 2 Analysis – Motivational interview π_1 (slope)*

Fixed Effect	Final Estimation of Fixed Effects				P-Value
	Coefficient	Standard Error	T-Ratio	Approx DF	
For Intercept1 π_1					
Intercept 2, β_{10} (Non-MI)	-7.776	1.418	-5.482	193	0.000
Motivational Interview, β_{11}	-1.944	1.937	-1.003	193	0.317

The non-MI group had an average decrease of 7.77 points between time points (P=0.000).

The MI group did not show statistically significant differences.

Figure 3

Non-MI vs. MI Mean OQ scores at time 1, 2, 3

The second model investigated the interaction between the stages-of-change and MI. Individuals were grouped by stage-of-change, and whether or not they received MI. For each stage-of-change, there was a MI condition and a no MI condition resulting in 10 different groups. Each group was compared to the precontemplation no-MI condition. The first equation examines the differences in scores at each time point, while the second equation examines the differences in slopes for each condition.

$$\begin{aligned} \pi_0 = & \beta_{00} + \beta_{01} * (\text{Precontemplation-MI}) + \beta_{02} * (\text{Contemplation - No MI}) + \\ & \beta_{03} * (\text{Contemplation- MI}) + \beta_{04} * (\text{Preparation - No MI}) + \beta_{05} * (\text{Preparation - MI}) + \beta_{06} * (\text{Action High Relapse - No MI}) + \beta_{07} * (\text{Action High Relapse- MI}) + \beta_{08} * (\text{Action Low Relapse - no MI}) + \beta_{09} * (\text{Action Low Relapse-MI}) + r_0 \end{aligned}$$

$$\pi_1 = \beta_{00} + \beta_{01}*(\text{Precontemplation-MI}) + \beta_{02}*(\text{Contemplation} - \text{No MI}) + \\ \beta_{03}*(\text{Contemplation- MI}) + \beta_{04}*(\text{Preparation} - \text{No MI}) + \beta_{05}*(\text{Preparation} - \text{MI}) + \\ \beta_{06}*(\text{Action High Relapse} - \text{No MI}) + \beta_{07}*(\text{Action High Relapse- MI}) + \beta_{08}*(\text{Action} \\ \text{Low Relapse} - \text{no MI}) + \beta_{09}*(\text{Action Low Relapse-MI}) + r_1$$

Table 19

Level 2 analysis: Interaction of Stages of Change and Motivational interview, π_0 (Intercept)

Fixed Effect	Final Estimation of Fixed Effects				P-Value
	Coefficient	Standard Error	T-Ratio	Approx DF	
For intercept1 π_0					
Intercept2, β_{00} (Precontemplation No MI)	37.817	5.347	7.072	185	0.000
Precontemplation – MI, β_{01}	-11.120	7.263	-1.531	185	0.127
Contemplation – No MI, β_{02}	1.406	6.933	0.203	185	0.840
Contemplation – MI, β_{03}	-5.090	6.576	-0.774	185	0.440
Preparation - No MI, β_{04}	11.064	7.449	1.485	185	0.139
Preparation – MI, β_{05}	14.713	7.853	1.874	185	0.062
Action High-relapse - No MI, β_{06}	11.729	8.191	1.432	185	0.154
Action High-relapse – MI, β_{07}	3.549	8.170	0.434	185	0.664
Action Low-relapse - No MI, β_{08}	-8.824	6.804	-1.297	185	0.197
Action Low-relapse –MI, β_{09}	-13.241	6.942	-1.907	185	0.058

All scores were compared to the Precontemplation – No MI group. This group had an average OQ score of 37.82. The results showed no significant effect of the interaction.

Table 20

Level 2 analysis: Interaction of Stages of Change and Motivational interview, π_0
(Intercept) – error variable removed

Fixed Effect	Final Estimation of Fixed Effects			Approx DF	P-Value
	Coefficient	Standard Error	T-Ratio		
For intercept1 π_0					
Intercept2, β_{00} (Precontemplation No MI)	33.709	3.850	8.756	520	0.000
Precontemplation – MI, β_{01}	-7.980	4.900	-1.629	520	0.104
Contemplation – No MI, β_{02}	4.910	4.723	1.035	520	0.301
Contemplation – MI, β_{03}	-1.310	4.465	-0.294	520	0.769
Preparation – No MI, β_{04}	16.154	5.001	3.225	520	0.002
Preparation – MI, β_{05}	17.896	5.349	3.345	520	0.001
Action High-relapse – No MI, β_{06}	16.066	5.559	2.890	520	0.004
Action High-relapse – MI, β_{07}	8.197	5.499	1.491	520	0.137
Action Low-relapse – No MI, β_{08}	-3.937	4.642	-0.848	520	0.397
Action Low-relapse – MI, β_{09}	-8.979	4.650	-1.929	520	0.054

These results were re-analyzed without the error parameter to investigate differences. This allows the means to vary along the intercept. Removing the error parameter allows for a more accurate understanding of the variability in the population. The variability represents individual differences and is more representative of the population. When the results were analyzed with no error variable on the intercept, the mean precontemplation – No MI score was 33.709. There was a significant effect of the Preparation-No MI (16.15, $P=0.002$), Preparation MI (17.90, $P=0.001$) Action High Relapse – No MI (16.01 $P=0.004$) and Action Low Relapse MI (-8.97 $P=0.054$). Additionally, several groups approached significance; Precontemplation- MI (-7.98 $P=0.104$), and Action High Relapse – MI (8.20, $P=0.137$).

Summary

Overall, these analyses reflect that there were statistically significant differences between the OQ scores of individuals based on their stage-of-change, and whether or not they received MI. The first analysis showed a significant difference between the preparation group ($P=0.001$), and the Action High-Relapse group ($P=0.012$). Being in a higher stage-of-change appears to reflect a higher OQ score. The effects of MI approach statistical significance ($P=0.078$) and may be important to consider in other clinical populations. Individuals who received MI scored lower on the OQ than those who did not. When the interaction was analyzed with no error variable on the intercept, there was a significant effect of the Preparation No-MI group (0.002) the Preparation MI group ($P=0.001$), the action High-Relapse No-MI group ($P=0.004$) and the action low-relapse MI group ($P=0.054$).

Discussion

The present study examined the effects of MI in enhancing treatment outcomes with violent men, all of whom presented for group therapy at different stages in their preparedness for change. In this study, treatment outcomes were reflected by scores on a self-report rating scale, the Outcome Questionnaire. The OQ is a tool used to examine an individual's perceived distress with their depressive symptoms, relationships and social roles. This information is important in establishing optimal conditions for success in domestic violence group counselling for men. Specifically, this study examined the individuals' readiness and motivation to change. Readiness to change was determined using the University of Rhode Island Change Assessment (URICA) (McConaughy et al., 1983; 1989), and the University of Rhode Island Change Assessment- Domestic

Violence (URICA-DV) (Levesque et al., 2000) questionnaires. These two assessments categorized each individual into a specific stage-of-change. Motivation to change was determined by whether or not the participants had received motivational interviewing sessions through the local probation office prior to commencing treatment at the agency.

The findings suggest that an individual's readiness to change, as evidenced by their stage-of-change at the beginning of therapy, is related to their treatment outcomes. Individuals in the later stages-of-change (preparation, and action high-relapse) scored significantly higher on the OQ, suggesting that they recognized areas in their lives that were related to their need for treatment. Individuals in the earlier stages-of-change (precontemplation and contemplation) scored significantly lower on the OQ, suggesting that they may not recognize the need to make changes in their lives. Individuals in the action low-relapse stage also scored lower on the OQ. This may indicate that these individuals may have already begun to make changes in their current adjustment, in the current context, to the role that violence plays in their life.

Impact of motivational interviewing

Though the MI condition did not make the cut-off for traditional statistical significance ($P=0.078$), it is likely to be important for a clinical population. Statistical significance refers to whether the effects of an analysis are strong enough to reject the null hypothesis. In this case the null hypothesis was $\alpha=0.05$ (Moore & McCabe, 2006). The clinical significance of a treatment refers to its ability to meet standards of efficacy set by consumers, clinicians, and researchers (Jacobson & Truax, 1991). Taking this into consideration, the impact of MI was clinically significant; individuals who had the two sessions of MI prior to their placement in group therapy scored slightly lower on the OQ

than those who did not. This finding suggests that they may have already begun to recognize distress in their lives, and started to make changes by virtue of their already being found guilty of an assault charge and placed on probation. An assault charge may be an effective external motivator (Jaffe et al., 1986)

The present study identified that a similar distribution of men across the stages-of-change dimension fell equally between the two conditions of MI. This finding may suggest that the presence or absence of MI did not affect the distribution of participants into the stages-of-change (see Table 13). Despite this, clear differences were seen between the MI and Non-MI groups in the area of self-reported outcomes.

Relevance of Stage-of-change

When the interaction of the stage-of-change and MI was examined, the group that received MI scored lower than the corresponding Non-MI group. This is consistent with the findings from the regression analysis of the MI condition alone, suggesting that MI sessions may help the individual address some of the distress in their lives prior to the commencement of group therapy specific to their violence. The regression analysis showed the Preparation no-MI, Preparation MI and Action High-relapse No-MI groups to have the greatest difference in score. This too is consistent with the first regression analysis on stage-of-change alone, suggesting individuals in the later stages-of-change recognize the most distress in their lives.

Relevance to previous research

The present study investigated whether pre-existing differences in regards to stage-of-change could predict treatment outcomes in male domestic violence group counselling. The present findings are consistent with previous research in the three major

areas of interest; stages-of-change, motivation for change/MI, and outcome reports from therapy.

The greatest challenge when conducting therapy with a mandated population is that they may be resistant to involvement and have low intrinsic motivation for engaging in the therapy. As motivation is considered an evolving construct which can change over time, (Lopez-Viets et al., 2002) it is reasonable to postulate that interventions designed to increase motivation would be beneficial with this population.

The present study hypothesized that the presence of MI prior to the group therapy program would have an influence on the OQ scores as suggested in past research by Kistenmacher and Weiss (2008) and Musser et al., (2008). The positive results of MI in the present study are consistent with these findings. Kistenmacher and Weiss (2008) found that men who had MI were more likely to show an increase in self-reported action towards changing their violent behaviour. Musser et al., (2008) found that more MI participants reported seeking additional sources of help. Both of these findings could account for some of the decrease in self-reported distress indicated by individuals who had MI in the present study. Campbell, Neil, Jaffe & Kelly (2010) found that in a sample of men enrolling in a men's group therapy program, the most common reasons cited for not seeking help are that men are not sure who to ask, are embarrassed, or did not want anybody to know. Men reported that if they were to ask for help, they would prefer to speak to a counsellor (60%), friend (49%) family member (49%) or doctor (33%) (Campbell et al., 2010). It is possible that in the present study, the men who received MI may have addressed some of these concerns prior to the group, thus encouraging them to seek additional sources of help.

Transtheoretical model

The transtheoretical model was designed to reflect that the desire to change exists along a continuum; not all individuals are at the same point in their desire to change. Men beginning group therapy may be in different places along the spectrum and this will influence the gains that they make through the therapy process. The original hypothesis predicted that individuals in a later stage-of-change will have higher scores on the OQ, suggesting a greater recognition of distress in their lives and an increased desire to change.

The findings of the present study are consistent with past research on the transtheoretical model and the stages-of-change. In a study similar in design with the current research, Alexander and Morris (2008) assessed stages-of-change and the response to treatment in male domestic abusers as evidenced by anxiety, depression, alcohol abuse and problems with anger, noting that men in an earlier stage-of-change reported fewer problems with anger and lower rates of abusive behaviour. This is consistent with the stages-of-change, as it is reflective of denial and minimization rather than an accurate description of their behaviour.

Research by Scott and Wolfe (2003) investigated the effects of stage-of-change and abuse on a post-therapy follow up study of abusive males. They found that individuals in the contemplation, and action stage had fewer incidents of abuse post-therapy than those in the precontemplative stage. Findings from the current study found that individuals in the precontemplative stage scored lower on the OQ than those in the higher stages, suggesting a certain extent of denial of their problems related to violence.

Individuals who deny there are problems are less likely to actively work on change, as they perceive less of a need.

The present study used outcome informed research to monitor change along the therapy process. Outcomes were assessed across three different time points. Duncan et al., (2010) advocates that collecting ongoing feedback is crucial for ensuring that therapy is effective and accountable. In terms of outcome research, the present study shows a measureable improvement for the participants. Individuals in each stage-of-change and in the MI condition had an overall improvement in self-reported outcomes scores on the OQ across the treatment period.

Implications for Clinicians

Research in the area of treatment outcomes for men who are abusive in their intimate relationships is crucial for clinicians. First, clinicians involved in this area of practice have a strong commitment towards increasing women's safety (Gregory & Erez, 2002; McGregor et al., 2002). It also requires significant time, money and resources for a man to proceed through a group therapy program. Thus it is important to ensure that programs and procedures are informed by research in order to create the conditions most optimal for success.

The present study identified that a man's readiness and motivation to change impacts his performance through the course of group therapy. This finding suggests that an assessment interview or a formal assessment with the URICA or URICA-DV gauging a man's readiness and motivation to change could be beneficial to the group facilitator. Furthermore, this raises the question of whether men should be included in a group

therapy program when they show only modest motivation or readiness to engage in therapy. It could be that improved outcomes could be achieved by providing individual counselling and MI as a pre-group treatment to individuals who are at a lower stage-of-change. Such interventions could improve the impact of the group intervention, resulting in an increased cessation of abusive behaviour over time.

In the present study, the men attended an average of 4.49 individual counselling sessions before beginning the group therapy process itself. During this time, the therapist assessed their perception of the individual's readiness and motivation to change. The time was also spent discussing and developing their personal motivations to change with the goal of increasing their readiness to change. Individuals were only enrolled in the group when the primary therapist perceived that they were ready to do the therapeutic work, and had the potential to succeed.

The present study additionally identified that MI appeared to reduce men's self-reported distress on the OQ, regardless of their stage-of-change. Perhaps access to one-on-one counselling helped the men deal with some of the distress in their lives prior to engaging in the group therapy experience. Clinicians may want to consider the benefits of MI as a pre-group intervention for men. All of the men included in the present study were mandated to attend counselling as part of a probation order. Mandated men represent a significant proportion of the population attending male domestic violence group therapy. They are likely to be resistant, defensive and in denial of their problems (Scott and King, 2007, Scott and Wolfe, 2003). They may also be minimizing their role in the violence and remain at the point of victim blaming. Their motivation for attending the program may be extrinsic, as it represents their attempt to avoid jail time in putting their conviction for

violence 'behind them'. MI may assist this group in developing their own intrinsic motivations for doing the therapeutic work. As stated previously, it is generally assumed that motivation driven by internal factors is a more reliable and salient predictor of change, particularly when considering long-term maintenance (McMurran, 2002).

Outcome Measures

The use of global outcome measures may provide valuable information to clinicians. It is important for clinicians to collect ongoing, continuous feedback from the group in order to ensure that they are being accountable to each member and considering each of their unique needs. In a group therapy situation, it is possible for some members to do all of the talking, and for others to remain passive, leaving the facilitator unaware of how the process is affecting each individual.

The present study utilized the Outcome Questionnaire 45.2 (Lambert et al., 1996). The administration of this questionnaire provided the group facilitators with substantial information about each group member that may not have been otherwise addressed during the therapy session. The data collected from the outcome questionnaire provides the clinician with immediate feedback on events and perceptions in each individual's life. It additionally identifies any critical information (i.e. suicidal ideation and substance use) that should be followed up by the therapist. Clinicians may want to consider the administration of such a tool, as it collects important information, while not taking away from valuable group process time.

Considerations for Future Research

Multi-Level Growth Modelling

The present study is among the first outcome studies in the area of domestic violence that uses multi-level growth modelling in reflecting the extent of pre-therapy conditions that can influence treatment outcomes. There is currently a wealth of valuable knowledge addressing the factors and conditions that can contribute to desirable outcomes in male domestic violence therapy. The use of the statistical multi-level growth modelling contributes to this body of research by improving researchers' ability to report on the specific factors that can predict specific outcomes over time. Knowing which circumstances predict desirable outcomes can help clinicians set up the conditions most conducive for success.

Multiple Outcome Time Points

The current study addressed the predictability of an individual's self-reported distress over three time periods through the course of a domestic violence therapy intervention. Distress was reflected in the areas of depressive and anxious symptoms, interpersonal relations, and social functioning. A valuable addition to the present study could have been to include a fourth time point, investigating distress at follow up.

Court Mandated Treatment

The inherent challenges related to offering court-mandated group domestic violence therapy is complex, and there are countless variables and factors to be considered when investigating the question "does it work"? Future research using multi-level growth modeling could address whether an individuals' stage-of-change or exposure to MI predicts the trajectory of other factors over time, aside from self-reported

outcomes. Among the more important areas to be addressed include treatment attrition, future offending and spouse-reported abuse.

A consistent problem in the area of court mandated male domestic violence group therapy is the high rate of treatment attrition. Past research has found numerous sociodemographic factors that predicted treatment dropout including marital status, childlessness, unemployment, low income and lower educational attainment (Daly & Pelowsky, 2000). As these factors are relatively fixed within any in clinical sample, other more malleable or dynamic factors need to be considered. A recent study by Brodeur et al., (2008) investigated whether the Transtheoretical model could predict treatment attrition in male domestic violence group therapy. This study analyzed five treatment programmes in the province of Quebec. They found that the transtheoretical model did not predict attrition; however a limitation in their study was that there were differences in rates of attrition depending on the treatment facility. Future research could use multilevel-growth modeling to assess whether the transtheoretical model can predict treatment attrition.

The benchmark measure of whether domestic violence intervention has been effective is reflected in the decline and ultimate cessation of violence following the intervention. The present study addressed within-treatment outcomes and did not address this factor. Future research should investigate the extent to which the Transtheoretical model and MI enhanced treatment effectiveness as evidenced by subsequent abuse at follow up. This could be reflected in future charges or breaches of probation, self-reported abuse, or spousal reports of abuse. Gondolf's groundbreaking study found that rates of re-offending decreased over time, suggesting that the long term effects of male

domestic violence group counselling were successful (Gondolf, 2002). Multilevel growth modeling could be used to measure the predictability of readiness to change, or motivational interviewing with rates of re-offence over time.

Limitations

The findings of the present study contribute to the growing body of research in the area of group therapy for male domestic violence. It is important to note however that there are several limitations in the current study that should be addressed through further research.

The present study drew on data collected in a clinical setting. As such, the methodology is limited as a result of the logistics associated with doing research in applied settings. The present study utilized a quasi-experimental, non-equivalent groups design. Such a design involves comparing two groups that are similar in most regards, but differ in terms of the manipulation of an independent variable. It does not utilize random assignment of participants to a specific condition as reflected in a true experimental design (Heppner et al., 2008). In the present study, the two conditions, MI or no-MI were formed as a result of a new policy implemented within the agency at a specific time point. The no-MI group consisted of all group participants entering the program prior to September 2008. In September 2008, Calgary probation implemented a policy whereby all individuals mandated to group therapy participated in two sessions of MI prior to the referral. Thus the MI group consisted of all program participants after September 2008. Demographic data suggest that the two groups were comparable across a large range of variables and experience. However, it does not account for events and circumstances that differed across the three year period. Most notably, the study timeline overlaps the 2008

economic recession. Unofficial reports from shelters and crisis hotlines suggest a link between financial distress and domestic violence. As this information has no empirical basis, conclusions cannot be drawn and it is unknown whether or not economic conditions had an impact on participants. It is however, an important detail to address. Further research in this area could use a randomized control trial, assigning individuals to the MI or no-MI condition to ensure greater control of confounding variables.

Procedures in the criminal justice system can be slow moving, and are vulnerable to delays. Significant time can and does elapse from the time an individual is arrested, charged in court to the point when they are mandated to attend group therapy. It may be longer still for them to meet with a probation officer, and be referred to the *Responsible Choices for Men* group therapy program. Finally, once referred to the program, each participant must wait for an opening in a group. Thus, there was no way to control for the time that elapsed between the individual receiving MI, to the time that they commenced the *Responsible Choices for Men* group. For some men, the process took weeks, for others, months, and for still others the process took over a year. The length of time it takes an individual to complete the process may have an impact on their motivation.

An additional limitation to the present study is that there was no control or monitoring for the impact of the individual therapist or motivational interviewer. It is unknown how many different people delivered MI through probation, or how many different therapists had initial sessions with the participants prior to their commencement in the group. Though the group is based on a manualized treatment with a specific outline, the facilitators differed from group to group and may have differentially impacted the participants.

The data for this study was collected from a specific intervention program from one counselling agency over a given time period. The sample size is relatively small. Thus, it may be difficult to generalize these results from this study to other mandated domestic violence programs. Additionally, the results may only generalize to individuals who complete the *Responsible Choices for Men* program. Future research should address the data from combining MI from probation with multiple different therapy programs.

The measures used in the present study were all participant self-report. This study is limited in that it did not consider reports from the women involved in the altercation, or to the police.

This study utilized both the URICA-G and the URICA-DV to assess readiness for change. It is standard procedure for the agency that took part in this study to give every client the URICA-G at reception prior to their first counselling session. Individuals with a presenting concern of domestic violence receive the URICA-DV as part of the group pre-test. Levesque, Gelles, & Velicer, (2000) advocate for the use of a tool that specifically identifies physical violence as the problem. Scott and Wolfe (2003) advocate against using the URICA-DV as an assessment of readiness to change because many men initially reject the label “abuse” for their behaviours. The authors of the present study would tend to agree with Levesque, Gelles & Velicer (2000) however the debate regarding the use of the URICA-DV remains a potential limitation.

A final significant limitation to the present study is that assessing the association between readiness to change and self-reported distress only measures the participant’s willingness to be accountable for behaviours that they have done, and that are the basis

for their engagement in the therapy work. It is not a measure of the extent to which they actually reduce or cease to commit subsequent acts of violence. From the results of this study, we can postulate that individuals who are accountable for their actions and ready to engage in the therapy process will make greater gains post-therapy, however empirical evidence is still needed to further support this claim. Further research will be necessary examine the degree to which MI and stages-of-change contributes to improving outcomes as reflected by a reduction of abusive behaviour.

Summary and Conclusion

Notwithstanding the above limitations, the current study indicates that there is a significant influence of MI and the stage-of-change, on self-reported outcomes in male domestic violence group therapy. The rehabilitation of such a population is complex and has generated significant controversy over the years.

Over the past decade, significant research has investigated the effectiveness of group therapy as an intervention for males who are violent with their intimate partners. Rehabilitation in the form of mandated treatment is intended to be a more productive means of intervention relative to incarceration. Nevertheless, early studies have shown disappointing results (Gondolf, 2002) which have reflected minimal decreases in recidivism rates between men who completed treatment (36%) and men who only received legal-system interventions such as court-ordered sanctions (39%) (Rosenfeld, 1992). Babcock et al., 2004 suggested that treatment accounts for only a 5% difference in the reduction of partner abuse.

There is strong evidence to support that a person has to want to change in order to make a change, and that an individual must be ready, willing and able to begin working on making a change (Lopez-Viets, 2002). However, there is the challenge that offenders who are the highest risk for serious recidivism are viewed as the least motivated to change (Stewart & Millson, 1995 in (McMurrin, 2002). The question that emerged is how to motivate an individual who has been forced into therapy against their will?

The present study built on the already strong foundation of MI and its potential benefits with an offending population. MI is a counselling strategy intended to help clients increase their readiness for change (Miller and Rollnick, 1991; Musser Semiatin, Taft, & Murphy, 2008). It utilizes specific techniques aimed at developing an individual's intrinsic motivation factors.

Motivation is not an all or nothing not all phenomena and exists along a continuum, i.e. an individual can be partially motivated and partially ambivalent. The transtheoretical model and understanding with respect to the stages-of-change has partially addressed this issue (Prochaska & DiClemente, 1982; Prochaska, DiClemente & Norcross, 1992). Originally theorized and applied to smoking cessation and addictions, the transtheoretical model suggests that individuals move through a sequence of stages before they successfully make and maintain a change in their behaviour. Each stage is characterized through the individual's perception regarding the importance of making a behavioural change.

The transtheoretical model has been effectively used with male perpetrating domestic violence populations (Scott and Wolfe 2003; Alexander and Morris 2008;

Levesque et al., 2008). The accompanying assessment tools the URICA-G and the URICA-DV are relevant means in determining how motivated an individual is to change (McConaughy et al., 1989; McConaughy et al., 1983; Levesque et al., 2000). The present study built upon this research and utilized the same assessment tools.

The current study merged elements of previous research by addressing the influence of MI and the stages-of-change on self-report outcome measures with a court-mandated male perpetrating domestic violence population. All the men in the study were required to complete the *Responsible Choices for Men* group therapy program as a component of their probation. Depending on the year of referral, half of the men took part in two sessions of MI prior to commencing the group, while the other half did not. Both groups of men were comparable reflected in demographics and past involvement with law-enforcement. Each individual completed the URICA-G and the OQ-45.2, an outcome questionnaire assessing global functioning prior to beginning the group. They additionally completed the URICA-DV and the OQ-45.2 again at group pre-test and group post-test.

Data was analyzed using Multi-Level Growth modelling to assess group differences (Singer and Willett, 2004). The indicator variable identified the stage-of-change an individual was assigned to at the time of the group counselling pre-test, and whether they received MI. A second set of indicator variables was created allowing the model to measure the strength of the interaction.

The results obtained reflect that there were statistically significant differences between the OQ scores of individuals based on their stage-of-change, and whether or not

they received MI. Individuals in the higher stages-of-change (preparation, and action high-relapse) scored significantly higher on the OQ, suggesting that they recognized areas in their lives that need improvements. Individuals in the earlier stages-of-change (precontemplation and contemplation) scored significantly lower on the OQ, suggesting that they may not recognize the need to make changes in their lives. The MI condition approached statistical significance ($P=0.078$). Though this does not make the cut-off for statistical significance, it is likely to be important for a clinical population. When the interaction of the stage-of-change and MI condition was examined, the group that received MI scored lower than the corresponding Non-MI group. This is consistent with the findings from the regression analysis of the motivational interview condition alone, suggesting that the motivational interview sessions may help the individual address some of the distress in their lives prior to the commencement of group therapy specific to their violence.

In conclusion, the present study supports previous research findings that MI helps improve treatment outcomes in male domestic violence group therapy. Results obtained showed that the presence of MI was linked to lower levels of reported personal distress. The results additionally suggest that the transtheoretical model and the stages-of-change can predict which individuals are most likely to succeed in therapy. Thus it is highly beneficial to assess individuals for their stage-of-change prior to the commencement of the group therapy program. The predictive ability of the transtheoretical model suggests that effort should be taken to ensure that offenders are in a later stage-of-change prior to beginning group therapy in order to have the most optimal outcomes. Individuals who are

still at an early stage-of-change may benefit from individual counselling sessions or additional MI to increase their motivation and progress them into a later stage-of-change.

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Appendices

Demographic Information

A. Personal Information:

Name: _____ Age: _____

Referral source:

☐ Probation [1]	☐ Self [2]	☐ Family/friend [3]
☐ Physician [4]	☐ Child Welfare [5]	☐ Lawyer [6]
☐ Counsellor [7]	☐ Psychologist [8]	☐ Police [9]
☐ Hospital [10]	☐ Advertisement [11]	☐ Psychiatrist [12]
☐ Pastor [13]	☐ Employer [14]	☐ Homefront [15]
☐ Other [17]		

Marital status:

☐ Single [1]	☐ Married [2]	☐ Separated [3]
☐ Divorced [4]	☐ Widowed [5]	☐ Common-law [6]

Level of education:

☐ None [0]	☐ Grades 1-4 [1]	☐ Grades 5-8 [2]
☐ Grades 9-12 [3]	☐ Technical/ vocational [4]	☐ University [5]

Employment status:

☐ Full-time [1]	☐ Part-time [2]	☐ Casual [3]
☐ Not employed [4]	☐ Retired [5]	☐ Student [6]
☐ Self-employed [7]	☐ Other [8](explain) _____	

Occupation: _____

Income (gross yearly):

☐ \$0 - \$5,000 [1]	☐ \$5,001 - \$15,000 [2]	☐ \$15,001 - \$25,000 [3]
☐ \$25,001 - \$35,000 [4]	☐ \$35,001 - \$45,000 [5]	☐ \$45,001 - \$55,000 [6]
☐ \$55,001 - \$65,000 [7]	☐ \$65,001 and higher [8]	

Language(s) spoken: _____

Current living arrangement:

☐ Alone [1]	☐ Roommate [2]	☐ Couple [3]
☐ Immediate family [4]	☐ Extended family [5]	☐ Blended family [6]
☐ Single parent family [7]	☐ Other [8](explain) _____	

B: Additional Information

Number of children: _____ Ages: _____

Have you previously received counselling?

☐ No [0] ☐ Yes [1] (If yes, please explain: _____)

Do you have a psychiatric history?

☐ No [0] ☐ Yes [1] (If yes, please explain: _____)

Demographic Information – continued

Is your use of alcohol and/or drugs causing you problems in your life?

☐ No [0] ☐ Yes [1] (If yes, please explain): _____

Do you have any medical problems?

☐ No [0] ☐ Yes [1] (If yes, please explain): _____

Did abuse occur in your family of origin?

☐ No [0] ☐ Yes [1] (If yes, please explain): _____

Has there been any previous police intervention?

☐ No [0] ☐ Yes [1] (If yes, please explain): _____

Has there been any legal order(s) intervention?

☐ No [0] ☐ Yes [1] (If yes, please explain): _____

Number of previous couple relationships you have had: _____

C. Other Information:

Please answer the questions in this section with regard to the person with whom there has been violence or abuse.

What is your current relationship with this person?

☐ Married [1]	☐ Living common-law [2]
☐ Girlfriend [3]	☐ Separated [4]
☐ Divorced [5]	☐ Ex-partner [6]
☐ Ex-girlfriend [7]	
☐ Other (please specify) [8] _____	

Do you still have contact with this person?

☐ Yes [1] ☐ No [2]

If this person is your current or former spouse/partner/girlfriend, please answer the following about him/her:

Name: _____ Age: _____

Sex: ☐ Male [1] ☐ Female [2]

Income (gross yearly): _____

Highest level of education:

- ☐ Less than grade 9 [1]
☐ Grade 9 to 11 [2]
☐ Grade 12 [3]
☐ Technical/vocational [4]
☐ University [5]

Behaviour occurring with partner during conflict: _____

Safety concerns for partner: ☐ No [0] ☐ Yes [1]

Length of relationship (years): _____

Name: _____ Age: ____ yrs Session # _____ Program Code _____
ID # _____ M ☐ F ☐ Date mm / dd / yyyy Problem Code _____

SD	IR	SR
	☐	
☐		
☐		
		☐
☐		
☐		
	☐	
☐		
☐		
☐		
		☐
☐		
		☐
☐		
	☐	
	☐	
	☐	
	☐	
	☐	
☐		

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	Never	Rarely	Sometimes	Frequently	Almost Always
1. I get along well with others.....	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
2. I tire quickly.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. I feel no interest in things.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. I feel stressed at work/school*.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. I blame myself for things.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6. I feel irritated.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7. I feel unhappy in my marriage/significant relationship.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8. I have thoughts of ending my life.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9. I feel weak.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10. I feel fearful.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
11. After heavy drinking, I need a drink the next morning to get going.
(if don't drink, mark "never")	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
12. I find my work/school* satisfying.....	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
13. I am a happy person.....	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
14. I work/study* too much.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
15. I feel worthless.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
16. I am concerned about family troubles.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
17. I have an unfulfilling sex life.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
18. I feel lonely.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
19. I have frequent arguments.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
20. I feel loved and wanted.....	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
21. I enjoy my spare time.....	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
22. I have difficulty concentrating.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Please continue on back

Page 1 Totals: _____

	Never	Rarely	Sometimes	Frequently	Almost Always	SD	IR	SR
23. I feel hopeless about the future.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
24. I like myself.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐		
25. Disturbing thoughts come into my mind that I cannot get rid of.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
26. I feel annoyed by people who criticize my drinking (or drug use). (if not applicable, mark "never")	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	☐	
27. I have an upset stomach.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
28. I am not working/studying* as well as I used to.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
29. My heart pounds too much.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
30. I have trouble getting along with friends and close acquaintances.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
31. I am satisfied with my life.....	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐		
32. I have trouble at work/school* because of drinking (if not applicable, mark "never")	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
33. I feel that something bad is going to happen.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
34. I have sore muscles.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
36. I feel nervous.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
37. I feel my love relationships are full and complete.....	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0		☐	
38. I feel that I am not doing well at work/school*.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
39. I have too many disagreements at work/school*.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
40. I feel something is wrong with my mind.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
41. I have trouble falling asleep or staying asleep.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
42. I feel blue.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
43. I am satisfied with my relationships with others.....	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0		☐	
44. I feel angry enough at work/school to do something I might regret.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
45. I have headaches.....	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		☐

SD total:	IR Total:	+ SR Total:	= Total OQ Score:
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Page 2 Totals: _____

Page 1 Totals: _____ 76

Totals: _____

*For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.
page 2 of 2

Revised: June 2007

When answering the questions below, think about the problem you have come to the Centre to work through. Please indicate how much you disagree or agree with each of the following statements. Base your responses on how you are feeling and acting NOW. Please do not mark the shaded areas.

Name: _____	Age: ____ yrs	Session # _____	Program Code _____
ID # _____	M ☐ F ☐	Date ____ / ____ / ____	Problem Code _____

	Strongly Disagree	Disagree	No opinion	Agree	Strongly Agree	P	C	A	R
1. As far as I'm concerned, I don't have any problems that need changing.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐			
2. I think I might be ready for some self-improvement.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5		☐		
3. I am doing something about the problems that had been bothering me.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5			☐	
4. It might be worthwhile to work on my problem.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5		☐		
5. I'm not the problem one. It doesn't make much sense for me to be here	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐			
6. It worries me that I might slip back on a problem I have already changed, so I am here to seek help	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5				☐
7. I am finally doing some work on my problem.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5			☐	
8. I've been thinking that I might want to change something about my self.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5		☐		
9. I have been successful in working on my problem but I'm not sure I can keep up the effort on my own.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5				☐
10. At times my problem is difficult, but I'm working on it.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5			☐	
11. Being here is pretty much a waste of time for me because the problem doesn't have to do with me.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐			
12. I'm hoping that this place will help me to better understand myself.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5		☐		
13. I guess I have faults, but there's nothing that I really need to change.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐			
14. I am really working hard to change.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5			☐	
15. I have a problem and I really think I should work at it.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5		☐		
16. I'm not following through with what I had already changed as well as I had hoped, and I'm here to prevent a relapse of the problem.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5				☐

	Strongly Disagree	Disagree	No opinion	Agree	Strongly Agree	P	C	A	R
17. Even though I'm not always successful in changing, I am at least working on my problem.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5			☐	
18. I thought once I had resolved my problem I would be free of it, but sometimes I still find my self struggling with it.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5				☐
19. I wish I had more ideas on how to solve the problem.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5		☐		
20. I have started working on my problems but I would like help.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5			☐	
21. Maybe this place will be able to help me.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5		☐		
22. I may need a boost right now to help me maintain the changes I've already made.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5				☐
23. I may be part of the problem, but I don't really think I am.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐			
24. I hope that someone here will have some good advice for me.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5		☐		
25. Anyone can talk about changing; I'm actually doing something about it.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5			☐	
26. All this talk about psychology is boring. Why can't people just forget about their problems?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐			
27. I'm here to prevent myself from having a relapse of my problem.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5				☐
28. It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5				☐
29. I have worries but so does the next guy. Why spend time thinking about them?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐			
30. I am actively working on my problem.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5			☐	
31. I would rather cope with my faults than try to change them.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐			
32. After all I had done to try to change my problem, every now and again it comes back to haunt me.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5				☐

Page 2 Totals: _____

Page 1 Totals: _____ 78

Totals: _____

Name: _____	Age: _____ yrs	Session # _____	Program Code _____
ID # _____	M ☐ F ☐	Date ____ / ____ / ____	Problem Code _____

Totals: _____

T-Score	Precontemplation	Contemplation	Action	Relapse / Risk
100+	40			
95	37-39			
90	35-36			
85	32-34			
80	30-31			
75	27-29			40
70	25-26		39-40	37-39
65	22-24	40	37-38	34-36
60	20-21	37-39	35-36	31-33
55	17-19	35-36	32-34	29-30
50	15-16	33-34	30-31	26-28
45	12-14	30-32	27-29	23-25
40	9-11	28-29	25-26	20-22
35	8	26-27	22-24	18-19
30		23-25	20-21	15-17
25		21-22	18-19	12-14
20		18-20	15-17	10-11
15		16-17	13-14	8-9
10		14-15	10-12	
5		11-13	8-9	

* T-scores based on 350 clients in the core counselling program at CCC, compiled May 2006

This survey asks a lot of questions about violence. By "violence," we mean physical aggression toward a partner or ex-partner, like a wife or girlfriend. This includes throwing objects, pushing, slapping, kicking, or choking, using a weapon, and other behaviors that can cause fear, pain, or injury.

If you did none of these things, think about "violence" as the thing you did that got you arrested or got you into a domestic violence program.

By "ending the violence," we mean using healthy strategies to improve your relationship and stay violence-free. Examples of healthy strategies include:

- Communicating with your partner clearly and respectfully
- Managing stress
- Controlling your anger
- Not abusing drugs or alcohol

Name: _____	Age: ____ yrs	Session # _____	Program Code _____
ID # _____	M ☐ F ☐	Date ____ / ____ / ____	Problem Code _____

	Strongly Disagree	Disagree	No opinion	Agree	Strongly Agree
1. I'm beginning to see that the violence in my relationship is a problem.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. I don't see the point of focusing on the violence in my relationship.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. Although I haven't been violent in a while, I know it's possible for me to be violent again.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. I'm actively working on ending the violence in my relationship.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. I wish I had more ideas about how to end the violence in my relationship.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. I'm actually doing something to stop my violent behavior not just thinking about it.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. The violence in my relationship isn't a big deal.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. I've ended the violence, but sometimes still struggle with the old urges that allowed the violence to happen in the first place.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9. It's O.K. to use violence as long as you don't hurt anyone.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
10. I'm at a point in my life where I'm beginning to feel the harmful impact of my violent behavior.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
11. I've made some changes and ended the violence, but I'm afraid of going back to the way I was before.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

P	C	A	R
Do Not Mark Below			

12. As far as I'm concerned, there's no need to change the way I treat my partner.
13. Although at times it's difficult, I'm working on ending my violent behavior in my relationship..
14. More and more, I'm seeing how my violence hurts my partner.
15. I'm finally doing something to end the violence.
16. I guess I have bad points, but there's nothing I really need to change.
17. I've been pretty successful in leading a violence-free life, but there are still times when I'm tempted to resort to violence.
18. I'm making important changes and ending the violence in my life.
19. More and more, I'm realizing that my violence is wrong.
20. Although I've made the changes necessary to lead a violence-free life, there are still times when I'm tempted to use violence.

Strongly Disagree	Disagree	No opinion	Agree	Strongly Agree
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

P	C	A	R
☐			
		☐	
	☐		
		☐	
☐			
			☐
		☐	
	☐		
			☐

Page 2 Totals: _____

Page 1 Totals: _____

Totals: _____

Name: _____	Age: ____ yrs	Session # _____	Program Code _____
ID # _____	M ☐ F ☐	Date ____ / ____ / ____	Problem Code _____

Totals: _____

T-Score	Precontemplation	Contemplation	Action	Relapse / Risk
100+				
95				
90				
85	25			
80	23-24			
75	21-22			
70	19-20			23-25
65	17-18	24-25		21-22
60	15-16	22-23	24-25	19-20
55	13-14	19-21	22-23	16-18
50	11-12	17-18	19-21	14-15
45	9-10	15-16	17-18	12-13
40	6-8	12-14	15-16	9-11
35	5	10-11	13-14	7-8
30		7-9	11-12	5-6
25		5-6	8-10	
20			6-7	
15			5	
10				
5

Appendix I – Calgary Counselling Centre letter of permission

July 26, 2010

RE: RESEARCH PROJECT: The Association of Readiness to Change with Treatment Outcomes in Domestic Violence Group Therapy

I am pleased to provide you with permission to conduct your research as outlined in your proposal. You may use the existing data set that has been collected from the Responsible Choices for Men group counselling program at the Calgary Counselling Centre.

You have our permission to take the data off-site once the names and identifiable information have been cleared from the database. Additionally, when the project has been completed, the database will be destroyed.

I look forward to reading your report upon its completion. We request that Calgary Counselling Centre be provided a copy of your completed thesis

Please feel free to contact me if you require any additional information or if I may be of further assistance.

Thank you for your interest in our center, and all the best in your research.

X

Robbie Babins-Wagner, CEO

Sharia Zalmanowitz, Researcher

Calgary Counselling Centre

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