



## ADDICTIONS AND DOMESTIC VIOLENCE: WHAT CAN WE LEARN ABOUT CLIENTS IN TREATMENT?

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### Overview of the Presentation

- Who are we?
- An overview of theories and research on substances and IPV in men and women
- Research results from the "Responsible Choices for Men" program regarding substance use and abuse.
- Practice implications and questions

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### Guiding Questions

- While most clinicians recognize the relationship between substance use & partner violence (IPV), how should these be taken into account during treatment?
- Should adjunct treatment of serious substance abuse issues be pursued in separate programs or in a combined format?
- Psychoeducational treatment of SA issues likely does no harm. Does it contribute to resolving either IPV or SA problems?

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**Alcohol & IPV & Men: What the literature says**

- Alcohol and substances have long been implicated in IPV cases
- But the nature of the relationship has been much debated.
- Gelles & Straus (1979) identified 15 theoretical views that could explain domestic violence. The theories fall into three categories: Individual, Social-Psychological and Socio-Cultural.

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- Individual theories include masochism on the part of the women; mental illness on the part of the partner; neurobiological explanations such as head-injuries and; drug & alcohol dependency.
- Hotaling & Sugarman (1986) conducted a secondary analysis of the 1975 U.S. National Family Violence Survey data. Alcohol usage was identified as a risk marker in 7 of 9 studies.

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- Kantor & Straus' (1987) study on a 1985 nationally representative sample of 5,159 US families reported that IPV as almost 3 times higher for men who frequently binged on alcohol compared to men who were abstinent (labelled the "Drunken Bum" theory).

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### Kantor & Straus' conclusion

- "Alcohol use is not an immediate antecedent of violence in the majority of families. The combination of blue-collar status, drinking, and approval of violence is significantly associated with the highest rate of wife abuse. Cultural approval of violence by men against women has the strongest association with wife abuse. Although our results provide support for the drunken bum theory of wife beating, they also demythologize the stereotype because they show that alcohol is far from being a necessary or sufficient cause of wife abuse." (Kantor & Straus, p. 213)  
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### Why Alcohol Abuse could cause violence

- Galvani (2004) explored various theoretical approaches to how alcohol could contribute to violent behaviour.
- Physiologically, alcohol (and other substances) has biological effects that can lead to increased aggression; known as the 'disinhibition theory' that alcohol affects the brain mechanisms that control inhibitions.  
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### The Effects of Intoxication

- the "proximal effects model": men that excessively drink alcohol are more likely to abuse spouses because they are "often intoxicated and alcohol intoxication facilitates violence" (Leonard & Quigley, p. 537).
- Fals-Stewart's research (2003) with a group of men entering treatment for domestic violence found that the men were 8 times more likely to be physically aggressive to partners on days when they drank.  
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### **Drunkenness as a control mechanism**

- Intoxication can control partner's behaviours through increasing fear, and unpredictability. (Hutchinson, 1999)
- "Frequency of drunkenness increases likelihood of victim fear 3.85 times, controlling for amount of alcohol used, class, race, marital status and levels of prior abuse".

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### **Women's Views of IPV & Substances**

- Johnson (2000) conducted a secondary analysis of Statistics Canada's Violence Against Women Survey.
- About 1/3 of the women who had experienced violence reported that alcohol was a precipitating factor in the event.
- Many perceived their partner's drinking as the primary or sole cause of the violent incident.

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- However, the statistical analysis found that male attitudes in support of violence were more important in predicting violent events than alcohol usage.
- Thus, factors other than alcohol use/abuse may be more important influences on the male perpetration of intimate partner violence.

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### The Debate: Pro

- Considerable research since the 1980s correlates substance use with IPV.
- Men who engage in frequent binge drinking (defined as 5 or more standard drinks in a single drinking session) physically assault women partners 3 times more than men who abstain (Murphy, O'Farrell, Fals-Steward, & Feehan, 2001).
- Problem drinking significantly predicted IPV (N=1380), controlling for age, education, months married, affectivity etc. (White & Chen, 2002)

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### The Debate: Con

- Gil-Gonzalez et al. conducted a meta-analysis of 22 studies on alcohol consumption & IPV.
- They caution that: "The magnitude of the effect was inversely associated with the year of publication. The biggest odds ratios were obtained in the studies with the smallest sample sizes. Conclusions: The evidence about the relationship between alcohol consumption and intimate partner violence is of low quality in the study designs and may be biased by publication of positive results. " p. 278

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- O'Leary (2003) notes that in community samples the connection between substance and IPV has been consistently low.
- However in clinical samples (i.e. men diagnosed with substance dependency), the associations are much stronger.

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### Debate Resolution?

- Leonard (2005) writes: "When can we say that heavy drinking is a cause of violence?"
- "While there is broad agreement that partner violent men are often heavy drinkers and heavy drinking often accompanies the violence, there is substantial disagreement regarding whether alcohol consumption plays any **causal role** in IPV..."

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- "Some argue that ... alcohol simply serves as an 'excuse' for the aggression, and that the aggression does not stop with successful treatment of the problem drinking..."
- A different perspective argues that acute alcohol consumption is a **contributing cause** of marital aggression, and that successful resolution of heavy drinking will often lead to a reduction, and in some cases a cessation, of IPV." (Leonard, 2005, p. 422)

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### Practical Considerations

- A proportion of men mandated to treatment have both IPV and substance abuse problems.
- Men with substance abuse problems commonly found in BIP programs: About 40% in Fals Stewart (2003)
- Men who abuse their partners are commonly found in substance abuse treatment programs (60% in O'Farrell et al., 2004)

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- Further, substances have an important place in treatment decisions:
- Brown, Caplan, Werk & Seraganian (1999): small samples of dual-problem men in 2 settings: substance abuse treatment and batterer intervention programs.
- Men in substance-abuse treatment reported more serious substance abuse issues & more frequently sexually abused their partners.

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### Treatment Issues: Drop-out

- Gondolf (2002) conducted a multi-site BIP evaluation. Men with substance abuse and psychological problems were much more likely to drop out.
- Gondolf suggests that such offenders need a different approach as they did not seem to experience any change in behaviour regardless of the intervention.
- This also highlights the need for screening SA & mental health problems.

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### Treatment Considerations

- Assess for SA throughout, not only at intake.
- Integrate substance abuse information/ treatment into IPV groups & vice versa. The caution is whether brief psycho-education to address either issue can possibly be effective?
- Create new programs to address both.
- Bennett's (2005) "Different Door" hypothesis. If sequential treatment, no evidence which should be first.

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- It is important to distinguish serious substance abuse from normal use of alcohol & normally problematic use of substances.
- Develop an assessment strategy to assess SA.
- Few programs that address both substance abuse and IPV currently exist and/or have been evaluated.

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### Programs that address SA

- Behavioural Couple Therapy was not developed for IPV but for alcoholism.
- 60% of the 303 women partners had experienced IPV before treatment.
- After the program the violence decreased significantly, and more so for couples more involved in treatment (more sessions & application of skills).

(O'Farrell, Murphy, Stephan, Fals-Stewart & Murphy, 2004)  
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### Individual Treatment for SA

- O'Farrell, Fals-Stewart, Murphy, & Murphy (2003): individual outpatient alcoholism treatment for 301 men was relatively successful at reducing rates of violence compared to a non-alcoholic comparison group.
- The men participated in 8 individual and 16 group sessions over 12 weeks.

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- The rates of partner violence among the treatment group members were at 56% prior to treatment, compared to 14% in the matched comparison group. One year after treatment, the rate was 25%.
- Although it was still higher than the comparison group, the rates of violence had decreased significantly for the male alcoholics.

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- Fals-Stewart, O'Farrell, & Birchler (2004): violence decreased from 60% to 24% post-BCT compared to 12% in a no-abuse control group.
- As such, *successful* treatment of substance abuse likely has an impact on levels of intimate partner violence, whereas *unsuccessful* treatment likely has little effect.

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### Group Cognitive-Behavioural Therapy for SA & IPV Offenders

- Easton et al. (2007): 75 men who met the criteria for alcohol dependence & had been arrested for partner assault were randomized to a 12-step group or a 90-minute cognitive-behavioural therapy (CBT) group. Both groups were 12 weeks.
- The CBT group was delivered using a manual, focused on substance use, intimate partner violence & the relationship between the two.

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- The 12-step group: substance use only.
- Post treatment, CBT group members had more days abstinent, But no significant differences on breathalyser analyses.
- Over time, CBT group participants showed greater declines in violent behaviour.
- However, at 6 month follow-up, no significant differences between the groups on substance use or violent behaviour (Easton et al., 2007).

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### AMEND

- Although for male batterers, it assesses for other issues, including substance abuse.
- The program runs from 36 weeks to 5 years.
- Some AMEND chapters require sobriety during the 6-week orientation. If men cannot comply, they are placed in a specialized treatment group that addresses both IPV violence & substance abuse.

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- Alcohol education has been incorporated into the core curriculum for all participants.
- The AMEND philosophy is that men need to take control of their actions, learn new skills to manage their behaviour, & increase personal and contextual awareness to minimize abuse.
- Currently, no empirical studies have evaluated the effectiveness of AMEND.

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### Summary of Lit Review

- Attending to substance abuse issues in DV men and IPV issues in men in substance abuse treatment is recommended.
- Be cautious about assuming that SA treatment alone will result in decreased IPV.
- Too soon to say what programs or combination of programs are most effective.

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### Program Overview

- The Calgary Counselling Centre has offered group treatment for abusive men for over two decades.
- This presentation briefly describes:
  - key issues pertaining to family violence and addictions, and
  - June 2005 – June 2008 data, both mandated and voluntary clients.

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### Background

- In Canada in one year, 34,317 individuals were victims of assault at the hands of a spouse (Statistics Canada 2004)
- Females were victims: 85%; males 15%
- In 73% of assaults of a woman by a current partner, the charges were common assault
- The consequences are significant for the victim and children in the home as well as the abuser
- Men and women who abuse often have psychosocial problems that can be compounded by the consequences of being involved with the criminal justice system.

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### Voluntary Clients in Treatment

- There is a paucity of research about voluntary clients in treatment for violence
- Pence & Paymar (1993) suggest that men enter treatment voluntarily as they are concerned about the impact of their violence on their partner and children

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### The Responsible Choices for Men Program

- Responsible Choices for Men was developed in 1995 for men who use physical violence and control tactics in intimate relationships.
- Influenced by the work of Australian therapist Alan Jenkins (1991)

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### The Program

- Invites participants to review their beliefs about self in relation to the world,
- challenges those beliefs based on distorted perceptions and
- helps clients access their preferred or honourable selves

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### Entry Into the Group

- All men participate in counselling prior to beginning group.
- Entry into group occurs when the man has begun to accept responsibility for the abuse
- Men's readiness for change is assessed using the URICA-DV

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### Group Process

- Groups are 30 hours, conducted over 14-weeks.
- Groups typically comprise 10 to 12 men
- A mixed gender team facilitates the groups
- Many groups have a reflecting team comprised of 3 to 6 individuals who observe sessions from behind a one way mirror

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### Addictions and Domestic Abuse

- The relationship between addictions and relationship problems are well documented, complex and interact reciprocally
- Relationships where one of the partners uses substances:
  - High levels of relationship dissatisfaction
  - Instability
  - Desire for change in the relationship
  - Verbal and physical aggression and abuse

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### Addictions and Domestic Abuse

- There are few evidence based strategies to integrate the treatment of domestic violence and substance abuse.
- CCC is interested in this issue due to the vulnerability of offenders, victims and families in domestic abuse situations where there is co-occurring substance abuse.

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### Research Design

- The study employs a pre/post-test design
- The major analysis compares mandated clients to those who voluntarily participated in the program
- The measures reflect the previously identified objectives of the Responsible Choices program. They include:

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### Research Measures

- Abuse of Partner Scales: Physical and Non-physical (Hudson, 1992)
- Psychological Assessment Screener (Morey, 1991)
- Generalized Contentment Scale (Hudson, 1992)
- Index of Clinical Stress (Hudson, 1992)
- Trauma Symptom Checklist 40 (Briere, 1998)
- Outcome Questionnaire (Lambert, Burlingame)

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### Measures for Intervening Variables

- Marlowe Crowne Social Desirability
- URICA-DV (Levesque, Gelles, & Velicer, 2000)
  - Assesses readiness for change specific to violence in the relationship
  - Stages include Pre-contemplation, Contemplation, Action & Maintenance/Relapse

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### Data Analysis

- Compared voluntary to mandated clients, June 2005 to June 2008.

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### Research Participants

- A total of 337 men began the Responsible Choices program between June 2005 through June 2008
- 279 (82.8%) were mandated
- 58 (17.2 %) self-referred

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### Age & First Language

	Mandated	Voluntary	Total
Age	35.4 (272)	37.07 (58)	35.7 % n=330
Partners' Age	32.77 (207)	35.28 (54)	33.29% (n=261)
First Language English	84%	84.9%	84.3%

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### Income – RC Men (2005 – 2007)

	Mean	Median
RC Men (n=151)	\$36,478	\$26,000

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### Education

	Mandated n=267	Voluntary n=57	Total n=324
Grade 5-8	1.8%	1.1%	1.2%
Grades 9-12	17.5%	44.9%	40.1%
Technical Vocational	47.4%	30%	33%
University	33.3%	24%	25.6%

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### Employment

	Mandated	Voluntary	Total
Full Time	73.1	80.4	74.4%
Self-Employed	9.3	10.7	9.6%
Part-Time	3.7	1.8	3.4%
Casual	.7	0	.6%
Unemployed	8.2	5.4	7.7%
Retired	0.4	1.8	.6%
Student	2.6	0	2.6%

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### Marital Status RC Men

	Mandated	Voluntary	Total Men
Single	39%	17.2%	35.2 %
Separated	14.9%	27.6%	17.1 %
Married	24.2%	37.9%	26.6 %
Common-law	16.7%	15.5%	16.5%
Divorced/ Widowed	5.2%	1.7%	4.6 %

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### English Second Language – RC Men

	Mandated	Voluntary	RC Men
No	84.1%	84.9%	84.3 %
Yes	15.9%	15.1%	15.7 %

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### Police Intervention

	Voluntary	Mandated
RC Men	27.6 % (n=16 of 58)	37.3 % (n=97 of 260)

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	RC Men	Voluntary	Mandated
Previous Medical Problems n=327	11.6 % (38 of 327)	10.5% (6 of 57)	11.9% (32 of 270)
Self Reported Psychiatric History n=327	8.1 % (26 of 320)	13.8% (26 of 320)	6.9% (18 of 262)

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### Still have contact with the Victim

	Mandated N=88	Voluntary N=19	Total N=107
Yes	60% (63)	79% (15)	63.6%
No	40% (35)	21% (4)	36.4%

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### Personality Assessment Screener (PAS) - Pretest data

- 22 item screener, with items selected from the Personality Assessment Inventory (PAI)
- Intended to act as a screener to determine who should be assessed in more depth using the PAI

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### PAS Element scores

PAS Element	Mean p-score (RC Men) (n = 315)
Social Withdrawal**	63.9
Acting Out	56.2
Anger control***	54.79
Hostile control	52.55
Psychotic features	52.28
Alcohol problems**	51.22
Alienation	50.21
Negative affect (p=.019)***	45.37
Suicidal thinking	45.82
Health problems	44.98
<b>Total score</b>	<b>47.33</b>

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### RC Men PAS Elements

PAS Element	Mean p-scores	
	Voluntary clients (n = 58)	Mandated clients (n = 258)
Anger control** (p=.001)	61.6	53.3
Negative affect*** (p=.001)	57.8	42.6
Suicidal thinking** (p=.01)	51.9	44.2
Social withdrawal*** (p=.004)	70.3	62.4
<b>Total PAS score** (p=.001)</b>	<b>60.4</b>	<b>44.4</b>

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### PAS Total Raw Score (all clients)

- The average raw score on the PAS was 18.9 for men at pre-test (n=307) and 15.61 (n=122) at post-test
- Voluntary clients score at pretest was 22.54 (n=56, s.d.=8.78)
- Mandated clients score at pretest was 18.08 (n=251, s.d.=8.51)

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### PAS Total Raw Score (same clients)

- The average raw score on the PAS was 16.89 for men at pre-test (n=114) and 15.78 (n=114) at post-test (sig, p=.047\*)
- Voluntary clients score at pretest was 23.33 (n=18, s.d.=7.38) post test was 21.94 (s.d.=7.03)
- Mandated clients score at pretest was 15.68 (n=96, s.d.=8.20), post test 14.63 (s.d.=8.29)

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### PAS Total Raw Scores

- The manual suggests a cut-off of 19
- Alberta Mental Health Board research suggests 22 &
- Forensic Services suggests 25.

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**PAS Total Raw Score - standard cut off 19**

	Mandated	Voluntary	Total
Up to 19	(148) 59 %	(23) 41.1%	(171) 55.7%
20 +	(103) 41%	(33) 58.9 %	(136) 44.3%
Total	251	56	307

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**PAS Total Raw Score - cut off 22**

	Mandated	Voluntary	Total
Up to 22	(180) 71.7 %	(28) 50%	(208) 67.8 %
23+	(71) 28.3 %	(28) 50 %	(99) 32.2%
Total	251	56	307

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**PAS Alcohol Problem at Pre-Test**

	Mandated	Voluntary	Total
Normal (Raw Score 1)	(30) 12.1%	(4) 7.3%	(34) 11.3%
Mild (Raw Score 2)	(120) 48.6%	(27) 49.1%	(147) 48.7%
Moderate (Raw Score 2-3)	(76) 30.8%	(13) 23.6%	(89) 29.5%
Marked (Raw Score 4-6)	(21) 8.5%	(11) 20%	(32) 10.6%
Total	247	55	302

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### Associations Between PAS Elements

- 6 of 9 elements correlated with the PAS Alcohol Problem p-score:
  - Anger Control ( $p < .001^*$ )
  - Negative Affect ( $p < .001^*$ )
  - Acting Out ( $p < .001^*$ )
  - Health Problem ( $p = .021^*$ )
  - Suicidal Thinking ( $p = .015^*$ )
  - Alienation ( $p = .003^*$ )

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### There was no association between the PAS Alcohol p-score and the following elements:

- Psychotic features ( $p = .178$ )
- Hostile/Control ( $p = .282$ )
- Social Withdrawal ( $p = .156$ )

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### RC Men

	PAS Alcohol Problem Score	Sig. (2-tailed)	N
Physical Abuse of Partner Scale (Adjusted Pre)	$r = .038$	.557, n.s.	239
Non-Physical Abuse of Partner Scale (Adjusted Pre)	$r = .190$	.003*	239

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### Number of Sessions Attended RC Men

- The average number of sessions attended by the men was 10.57 (n= 298, s.d.=4.07)
- Voluntary Clients attended an average of 11.12 sessions (n=49, s.d.=3.64)
- Mandated clients attended an average of 10.46 sessions (n=249, s.d.=4.14)

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### Client Outcomes

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### The OQ Score

- The OQ scores provides both an outcome and a measure of distress.
- The clinical cut off for the OQ total score is 63
- Reliable change requires a 14 point change in score
- Recovery requires both a 14 point change and a move below the clinical cut-off.

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### Client Distress

- Distress was determined by the Total OQ score at the first session
- For each of these clients the level of distress was above 63 on the OQ
- First Session – 30%
- First night of group – 21.1%
- Final OQ (either group or individual) - 16.5%

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### Distress and Demographic Variables: no significant differences

- There was little difference between distressed and non-distressed clients (35.5 vs. 35.4) with the overall mean **age** being 35.4 years. NS, t-test,  $p=0.969$ .
- The greatest number of non-distressed clients had an income between \$35,001 – 45,000 while the greatest number of distressed clients had an **income** of \$25,001 – 35,000.
- Level of **education** was similar between distressed and non-distressed clients. NS, chi-square,  $p=0.522$ .

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### Distress and Demographic Variables: no significant differences

- Distressed clients were more likely to be **separated** than non-distressed clients (24% vs. 14%). NS, chi-square,  $p=.061$
- Non-distressed clients were slightly more likely to have **English as a second language** (11% vs. 9%). NS, chi-square,  $p=.426$

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**Distress and Demographic Variables:  
no significant differences**

- Distressed clients were slightly more likely to have experienced **police intervention** than non-distressed clients (38.9% vs. 33.5%).  $p=.222$ , n.s.
- There was little difference between distressed and non-distressed clients in terms of **legal orders** for intervention (43% vs. 55%).  $p= 0.057$ , n.s.

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**Significant Differences between distressed and non distressed clients**

- Non-Distressed clients were more likely to be **referred by probation** than distressed clients (84% vs. 53%)  $p<.001$
- Distressed clients were more likely to be **self referred** (13% vs. 2%) or referred by a counsellor (22% vs. 4%).  $p<.001$
- Distressed clients were much more likely to have received **previous counselling** than non-distressed clients (75% vs. 44%).  $p<.001$ .

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**Significant Differences between distressed and non distressed clients**

- Distressed clients were much more likely to have **experienced abuse in their family of origin** than non-distressed clients (52% vs. 24%).  $p<.001$
- Distressed clients were more likely to have **previous medical problems** than non-distressed clients (25% vs. 10%).  $p<.001$
- Distressed clients were more likely to have **self-reported psychiatric history** than non-distressed clients (21% vs. 4%).  $p<.001$

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### Distress and Substance (Significant Findings)

- Distressed clients were more likely than non-distressed clients to have self-reported a **problem with substances** as reported on their pre-test questionnaire at pre-test (27.6% (n=24) vs. 6.3% (n=13),  $p < .001^*$ ).
- Distressed clients were more likely to score in the **marked range on the PAS** at pre-test than non-distressed clients at pre-test (18.2% (n=16) vs. 6.7% (n=14)),  $p < .05$
- Voluntary clients were more likely to score in the **marked range** 20% (n=11) than mandated clients 8.5% (n=21),  $p = .153$ , n.s.

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### Non Distressed Clients

- Non distressed clients: 67% of those who scored in the **marked range of the alcohol problem** element of the PAS self reported no problems with substances on CCC questionnaire.
- Distressed clients: 56% of those who scored in the **marked range of the alcohol problem** element of the PAS reported no problem with substances.
- Both groups of clients are scoring in the **marked range** on the PAS, they are **self reporting no problem with substances**. *Alcohol may not be seen as a substance on this scale.*

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### Pre – Post Test Scores (PAS)

- Distressed clients had higher PAS scores (25.77) than non distressed clients (16.06) at **pre-test**,  $p < .001^*$
- At **post test**, distressed clients had higher PAS scores (21.59) than non distressed clients (13.29) at pre-test,  $p < .001^*$
- Comparing **distressed clients** from pre-test (24.05) to post test (21.62),  $n = 92$ ,  $p = .005^*$ .
- Comparing **non-distressed clients** from pre-test (14.82) to post-test (13.85),  $n = 39$ ,  $p = .125$ , n.s.

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### Stage of Change at Pre-test and Distress

p<.001*	Non - Distressed (mainly mandated)	Distressed (mainly voluntary)	Total
Pre-contemplation	32.4% ( 61)	15.6% ( 14)	25.7% (75)
Contemplation	26.7 (54)	16.7% (15)	23.6 (69)
Preparation	17.8% (34)	<b>31.1% (28)</b>	21.9% ( 64)
Action High Relapse	5% (10)	<b>20% (18)</b>	9.6% (28)
Action Low Relapse	20.3% (41)	16.7% (15)	19.2% (56)
	202	90	292

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### Stage of Change at Post-test and Distress

P=.007*	Non - Distressed	Distressed	Total
Pre-contemplation	14.2% ( 21)	9.4% ( 5)	12.9% (26)
Contemplation	31.8 (47)	15.1% (8)	27.4 (55)
Preparation	10.8% (16)	<b>30.2% (16)</b>	15.9% ( 32)
Action High Relapse	9.5% (14)	<b>11.3% (5)</b>	10% (20)
Action Low Relapse	33.8% (50)	34% (18)	33.8% (68)
	148	53	201

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### Stage Progression – All Clients

		Stage of change post - calculated					Total
		Precontemplation	Contemplation	Preparation	Action high relapse	Action low relapse	
Stage of change pre - calculated	Precontemplation	15	20	4	1	9	49
	Contemplation	6	20	6	2	16	50
	Preparation	1	8	19	4	14	46
	Action high relapse	2	1	2	13	4	22
	Action low relapse	2	7	2	0	25	36
		26	56	33	20	68	203

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### Clinical Stress - adjusted

	Mean - Pre	Mean Post
Non Distressed N=142	45.94	29.51
Distressed N=53	<b>55.70</b>	<b>37.05</b>

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### Clinical Stress

	Distressed (199)	SD
Pre	48.91	14.85
Post	31.79	12.28
	P=.000*	

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### Clinical Stress - adjusted

	Mean - Pre	Mean Post	
Non Distress (142)	45.94	29.51	p<.001*
Distressed (53)	<b>55.70</b>	<b>37.05</b>	p=.001*

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**Self Esteem**

	Pre	Post	
Non Distressed (n=142)	24.05	20.3	P<.001*
Distressed (n=53)	27.64	23.14	P<.001*

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**OQ Post Test**

- 316 clients completed an OQ (at any point)
- 222 were **non distressed at first session**, OQ score 35.2 (s.d. 15.7) at final session OQ score 29.61 (s.d. 20.08) non distressed
- 94 were **distressed at first session**, OQ score (80.4, s.d., 13.1). Final OQ score 57.36 (s.d. 24.67), non distressed
- Differences at final session between those who were distressed and non distressed at program start was significant, p<.001\*

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**All Men - Distress**

p<.001*	Distress Score	S.D.
First Session	48.68	25.48
Last Session	37.86	24.98
Change	10.82	

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**OQ – Outcomes**

	Non Distressed at First Session p=<001*	Distressed at Last Session p=<001*
First Session	35.24 (s.d. 20.08)	80.40 (s.d. 13.07)
Last Session	29.61 (s.d. 15.62)	57.35 (s.d. 24.67)
Change	5.63	23.04

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Change Category	Voluntary	Mandated	Total
Deteriorated	6.1 (3)	9.8(24)	9.2 (27)
No Change	46.9 (23)	50.8 (125)	50.2 (148)
<b>Improved</b>	20.4 (10)	24.8 (61)	<b>24.1 (71)</b>
<b>Recovered</b>	26.5 (13)	14.6 (36)	<b>16.6 (49)</b>
	49	246	295

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- 40.7 % of either improved or recovery is promising and takes a very high standard for change
- Of the 50.2 % no change, the majority of client scores decreased, but not enough to meet the 14 point change necessary for improvement
- 9.2 % deterioration is the standard expectation for outcome measurement.

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