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on Corrections Research

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FORUM on Corrections Research

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Contrecoups: A program of therapy for spousal and family violence

by ***Normand Aubertin*** *and* ***Paul-Robert Laporte***[1]
Federal Training Centre, Correctional Service of Canada[2]

Four years ago, the Quebec Region of the Correctional Service of Canada introduced a treatment program for offenders at risk for spousal or family abuse. This program, known as "Contrecoups" (which may be translated as "rebound" or "repercussions"), takes a holistic approach. Group sessions are offered to inmates who are motivated to work out their family violence problems. The program is run at the minimum-security Montée St-François Institution. There are 24 biweekly meetings for groups of 8 inmates. The meetings are scheduled before the offenders' release and we insist on continuing their therapy after release. This article reports on the achievements of Contrecoups after four years in operation.

To implement this program, the Service contracted with a community organization, Option, which specializes in group therapy with violent spouses. Option was given a mandate to implement the program in a penitentiary and provide training to a team of Service therapists who could eventually take over from the contract therapists.

The first therapy group was ready on April 21, 1993, under the guidance of a Service therapist and a contract therapist. Now, two "home-grown" therapists and one contract supervisor make up our team.

Consequences of the therapy

For our first report on Contrecoups, we focused on the consequences of this therapy in terms of the participants' parole experience and performance under supervision, as well as on their recidivism rate. When we can conduct more rigorous and detailed research, we will be able to draw more valuable conclusions.

Between April 1993 and May 1997, case management officers had referred 172 offenders to Contrecoups. One hundred and twenty-eight cases were assessed and we accepted 84 of them (65.6%). There were 11 therapy groups, from April 21, 1993, to December 20, 1996. We rejected the other 44 cases (34.4%) on the grounds of poor motivation, failure to admit their crimes, insufficient time remaining to be served, and transfer request denied. Among the cases accepted, 68 inmates (80.9%) completed the program and 51 (75%) have been released to date. Among those granted conditional release by the National Parole Board, 32 (62.7%) obtained day parole and 5 (9.8%) were given full parole. The other 14 (27.5%) were released on their statutory release date. Of the 51 inmates who have been released, 19 (37.3%) have finished their sentence.

Only 23 (45%) of these 51 released offenders continued group therapy for violent spouses in the community (see Table 1). If we compare outcomes in the two groups for crimes of spousal violence, we may observe that therapeutic counselling following release had a beneficial effect. Only 2 (8.6%) of the released inmates who followed a program of therapy in their community committed a further act of spousal abuse, compared with 6 (21.4%) who followed no community therapy program.

Table 1

Outcome: Cases and Rates

	Community therapy program (n = 23)	No community therapy program (n = 28)
Reoffended with spousal violence	2 (8.6%)	6 (21.1%)
Did not reoffend with spousal violence	21 (91.1%)	22 (78.6%)

As you can see, the recidivism rate among the offenders who followed the Contrecoups program is 15.7% (or 8 of 51 cases). Since most studies put the rate of reoffending for spousal abuse at 30% to 70%, it appears that the Contrecoups program has so far had a very positive impact on recidivism rates. It is possible, however, that community supervision also played a role in reducing the recidivism rate. Further study will permit us to isolate this variable and show the impact of the program itself on the recidivism rate.

Another consideration to be borne in mind is the effectiveness of the risk assessment conducted by the case management teams at Montée St-François Institution. Of the 8 inmates who reoffended for spousal abuse, 5 (62.5%) had been released on their statutory release date and one had been released on day parole just before his statutory release date. Of the 27.5% of inmates who were released on statutory release and who completed their participation in Contrecoups, 62.5% (5 out of 8) reoffended. This shows that the assessment of risk to reoffend was fairly accurate in most of these cases, although it must be admitted that risk assessment is still not an exact science, especially where spousal violence is concerned.

Table 2

Return Rates with Spousal Violence

	Offenders who completed Contrecoups (n = 51)	Offenders who did not participate in Contrecoups (n = 44)
Followed post-release treatment program	8.6%	0.0%
Did not follow post-release treatment program	21.6%	27.8%

We compared these data with those of a similar group of offenders. The files of the 88 cases that had been referred to Contrecoups were not accepted for a comparison group. We selected cases in which a pattern of spousal violence had been clearly identified and rejected cases that had followed any group therapy program on the outside (e.g., group therapy for sex offenders), to minimize the risk of interference between the impact of the therapy group for violent spouses and the risk of recidivism. We believe that some of the other problems that are treated through group therapy may also have an impact on spousal violence. We picked 44 cases that met these criteria for the comparison group.

We compared the return rates for the different groups with their participation in Contrecoups and in post-release treatment programs. Outcome data include all the offenders whose conditional release was suspended to prevent, or because of, further spousal violence. Table 2 shows the results of this comparison.

The 27.8% return rate among offenders who did not follow any post-release treatment program is comparable to the lower figure mentioned in the literature (30% to 70%).[3] It is likely that the supervision conducted by the Service also affected this result in a positive way.

This shows that the assessment of risk to reoffend was fairly accurate in most of these cases, although it must be admitted that risk assessment is still not an exact science, especially where spousal violence is concerned.

When we compare the return rates in Table 2 for the offenders who followed a treatment program after their release with the rates for those who followed no such programs, we see that following a program had a significant impact. This shows the importance of continuing treatment after completing Contrecoups.

What does the future hold in store?

Right from the start, the Contrecoups therapists informed the case management teams that they did not have any specific tool for assessing the risk presented by the offenders who were enrolled in the program.

We are in the process of studying research reports on risk assessment so that we can develop an instrument that would let us measure the risk presented by the participants in Contrecoups. But this also raises another question: what will be the impact of this instrument on the therapeutic environment? Although we always try to separate offenders who come to therapy because they truly want to change from those who come for reasons other than a genuine

motivation to change, the fact that an assessment is to be made on the risk that they represent might raise certain concerns or expectations on their part.

One of the strategies we are considering is to separate risk assessment from the therapeutic environment. A program officer who is not involved in Contrecoups could administer the tests while the therapists are delivering the program. This would keep the therapists from affecting the test results while still enabling them to obtain some idea of how the participants were progressing with their therapy.

Taken together, these data could constitute a body of valuable information for case management teams, who could use it to build a risk assessment that was much more specifically related and relevant to the theme of spousal violence.

We also wonder whether it is possible to adapt a treatment program similar to Contrecoups for offenders who are violent outside the family setting.

The Contrecoups program has been transferred to the Federal Training Centre, which also offers spousal violence awareness and pre-treatment programs. In view of the increasing demand, and need, for spousal/family abuse treatment, we want to target clients for Contrecoups more effectively, on the basis of these programs. With the help of caseworkers from the other programs, we would like to write a brochure that spells out the characteristics of the target clients of the various spousal/family violence programs. ■

[1] Therapy coordinator and therapist, respectively.

[2] 6096 Lévesque Blvd., Laval, Quebec H7C 1P1.

[3] D. G. Dutton, *The Domestic Assault of Women: Psychological and Criminal Justice Perspective* (Vancouver, BC: UBC Press, 1995).

See also L. K. Hamberger and J. E. Hastings, "Court-mandated treatment of men who assault their partner: Issues, controversies, and outcomes," in *Legal Responses to Wife Assault: Current Trends and Evaluation*, N. Z. Hilton, ed. (Newbury Park, CA, Sage Publications, 1993): 188–229.

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Evidence of the effectiveness of current treatments for sex offenders

by ***Roberto Di Fazio***[1]
Program for Violent Offenders, Collins Bay Institution

The degree to which any sexual behaviour is considered deviant depends on the ever-changing standards of society.[2] *What is considered sexually deviant and worthy of treatment is typically guided by the* Diagnostic and Statistical Manual of Mental Disorders.[3]

Incarceration, or any other penalty the criminal justice system can impose, has proven to be a largely ineffective deterrent and incapable of changing sex offenders' behaviour.[4] *What has been found to be effective, in concert with the role played by the criminal justice system, is treatment.*

The cost of treatment

A cost-benefit analysis on effective sex offender treatment[5] concluded that treatment saves taxpayer dollars. Their conclusion was based on a report that compared the cost of treatment with the straightforward cost of simple incarceration and the subsequent probabilities of recidivism.

Crime rates and prevalence

Although sex offences present a concern because they are high-profile crimes, they are infrequent when compared with other crimes. Nevertheless, the high cost of sexual victimization has made this type of crime a serious problem. Public reaction to media coverage is the dominant factor influencing policy decisions[6] and has led to heightened concern about sexual aggression, higher rates of reporting, more aggressive prosecution and longer sentences.

Physical treatments

Psychosurgery. A review of the procedure of brain ablation[7] points to some distressing findings. The unimpressive results, the overly invasive nature of the procedure, and the risk of intellectual and emotional side-effects are reasons why psychosurgery should not be further explored.

Castration. Difficulties have been noted with the use of this procedure. One study found that treatment was more successful for offenders who freely consented to the procedure and whose offences were limited to sexual ones.[8]

Pharmacological. The advantage of the pharmacological approach is that it achieves the same sex drive reduction as surgical castration, but with fewer ethical problems; surgery is not required and the effects are completely and quickly reversible.

Although sex offences present a concern because they are high-profile crimes, they are infrequent when compared with other crimes.

Sex offenders, however, have described pharmacological treatments as one of the least desired therapies. Rice and colleagues conclude that few offenders voluntarily accept treatment designed to reduce testosterone levels. Of those willing to participate, even fewer will continue to receive their dosage for significant periods of time. For those who do remain in treatment, the evidence suggests that rates of reoffending are low; however, there appears to be little convincing evidence that it is the drugs themselves that are responsible for reducing the rate of recidivism. Marshall and colleagues explain that some practitioners may discourage the use of pharmacological treatment because of its high dropout and refusal rates.

Psychological treatments

Most articles devoted to psychological treatment — in particular, those using behavioural or cognitive-behavioural treatment — share the common treatment component of behavioural techniques aimed at normalizing deviant sexual preferences. Other common components include training in social competence, sex education, anger management and relapse prevention.

Behavioural. Early psychological treatment for sex offenders was based on the idea that deviant sexual preferences motivated sexual offending. Behavioural therapy was well suited to this ideology, given its ability to restrict the focus of therapy. The use of aversion therapy has seen a loss in popularity because of its low efficacy and ethical problems.[9]

Covert sensitization has also proven to be not very effective. Its efficacy seems to improve when it is combined with other techniques such as olfactory aversion.[10]

Behavioural therapy for sex offenders has also focused on increasing nondeviant sexual arousal. A summary of research on this approach[11] concludes that the overall results are mixed; some studies found the method effective and others found no change in participants' sexual arousal patterns.

Cognitive-behavioural. Cognitive-behavioural treatment came into use when it was noted that sex offenders viewed themselves, along with the behaviours and feelings of their victims, in a distorted fashion.[12] This multifaceted treatment permits therapists to attend to a number of areas considered criminogenic needs among sex offenders, such as: denial and minimization, inappropriate attitudes, deviant sexual preferences, victim impact and empathy, social skills, anger control, substance abuse, relationship issues, and life skills.

Most treatment programs address the majority of these areas with group therapy. In a group format, therapists model supportive but firm challenges (based on the arresting officer's report and a transcript of the trial), all offenders are encouraged to participate fully in discussions, and participants achieve a full understanding of the relevant issues.[13] A group format encourages participants to put forward pro-social beliefs and to discuss the benefits of such beliefs.[14]

Relapse prevention provides a more realistic therapeutic goal of control, as opposed to cure. It relies on multiple rather than single sources of information concerning offender behaviour, integrates mental health, parole and probation professionals, and defines behavioural maintenance as a continuum rather than an abstinence-relapse dichotomy.

Relapse prevention. Relapse prevention is a theoretical treatment model based on the concept that offence precursors can be identified and addressed.[15] It also accepts the likelihood that precursors associated with sexual abuse will recur. The first element in the relapse prevention model asks offenders to identify their offence chain. In the next phase, offenders detail how they would deal with each risk factor identified in the offence chain. Relapse prevention provides a more realistic therapeutic goal of control, as opposed to cure. It relies on multiple rather than single sources of information concerning offender behaviour, integrates mental health, parole and probation professionals, and defines behavioural maintenance as a continuum rather than an abstinence-relapse dichotomy.

Cognitive-behavioural and relapse prevention. Adding relapse prevention to the cognitive treatment of sex offenders reduces their recidivism rate.[16] Marshall notes that work in this area has yet to systematically compare programs with and without relapse prevention. Nevertheless, work in this area has demonstrated impressive findings.[17]

Meta-analyses

One meta-analysis[18] concluded that there was no evidence that treatment effectively reduces the risk of sexual reoffending. Another[19] disagreed with this conclusion on a number of issues; its chief criticism was that many of the treatment models in the first meta-analysis were obsolete.

An even more recent meta-analysis[20] found that 19% of the treated offenders recidivated during an average follow-up period of 6.85 years compared with 27% of the untreated offenders. Hormonal (r = .31) and cognitive-behavioural (r = .28) treatment approaches yielded greater effect sizes than studies that used behavioural (r = -0.1)

treatments. The fact that one to two thirds of participants refuse hormonal therapy has influenced practitioners' choice of treatment.

Sexual arousal patterns as a factor in recidivism among sex offenders

Researchers can only speculate on the interaction between a sex offender's deviant desires and normal sexual arousal patterns. The rates of recidivism among sex offenders are distressing, especially over time after treatment. The assumption must remain that rates of recidivism would increase if sexual arousal did not decrease in the late middle-aged male. The mapping out of the male sexual arousal pattern in future research may point to the true effect of treatment.

Methodological and measurement issues

Most studies of sex offenders lack random sampling and control groups. Marshall and Pithers note that withholding treatment from sex offenders will likely result in the psychological and physical injury of human beings. Most sex offenders will not be paroled until they have effectively participated in a recognized program. Marshall and colleagues also emphasize their belief that the pursuit of scientific standards cannot be held in higher account than the protection of innocent children, women and men from victimization.

Difficulties result from relying on recidivism as the sole measure of outcome. Principal among them is the use of arrest and conviction records to measure reoffence, ignoring the fact that victims may not report all counts of victimization. In addition, many sex offenders are known to have committed two to five times as many sex crimes as those for which they were arrested.

Researchers have expressed concerns over the use of phallometric assessment because of offenders concealing the true nature of their response and the ease with which results can be falsified, for example, through not attending to the stimuli.[21] Phallometric assessment may yet prove useful to clinicians who are aware of its limitations and take steps to guard against faking.[22]

Offender typology

Knowledge of typology appears to reduce recidivism by ensuring the offender's treatment is the most efficacious for his or her prime sexual deviance. For example, a comprehensive review of cognitive-behavioural programs indicated that exhibitionists, male child molesters and female child molesters benefit from different approaches.

Measuring treatment effectiveness through proximal measures

Researchers have put forward a number of proximal measures. These include repeated measure of an offender's cognitions throughout treatment,[23] empathy for victims of sexual offences,[24] level of denial and minimization,[25] adult attachment styles,[26] time in treatment and treatment stage attained,[27] and other dynamic risk factors.

Most sex offenders will not be paroled until they have effectively participated in a recognized program.

Future directions

Barbaree and Cortoni, as well as Pithers, believe sex offender treatments can be improved by revising current approaches. They recommend that treatment be specific to sex offender issues and conducted in a designated sex offender treatment setting. They recommend group therapy with a peer group because it facilitates confrontation when denial or minimization are inevitable, while ensuring a controlled and supportive environment. Zamble and Quinsey[28] recommend focusing on psychologically meaningful variables (e.g., coping ability) and dynamic updating of the offender's progress in treatment and their risk of reoffending. Nicholaichuk and colleagues note that to detect treatment effects, treated and untreated offenders must be properly matched by need and risk levels rather than the past practice of relying on samples of convenience.

Mander and colleagues note that sex offenders are a heterogeneous group. Future treatment and research should acknowledge this by reporting outcome as defined by different typologies rather than overall rates of recidivism. Specifying the treatment program offenders enter would result in greater impact on an offender's rate of recidivism.[29]

Advancement in statistical analyses demonstrates that the Criminal Career Profile may prove efficient at predicting the occurrence of violent offences. In addition, given financial constraints and the large number of sexual offenders who would benefit from treatment, an objective criterion for determining when an offender has derived maximum treatment benefit would be useful. Such a measure may help identify offenders not likely to participate in or benefit from treatment. Money earmarked for their treatment would be better directed at implementing external monitoring.

In conclusion, Marshall claims the assessment of sex offenders is in its infancy. As such, he believes the area will only continue to improve once it begins to take into account the impact of treatment through the use of proximal measures. ■

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A descriptive profile of incarcerated sex offenders

by ***Jean Proulx, Luc Granger, Marc Ouimet*** *and* ***Jean-Pierre Guay***[1]
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Researchers have been collecting data on sex offenders at the Regional Reception Centre[4] (RRC) since March 1995. (An article based on this research was presented in a previous issue of Forum.*)[5] This article gives a brief profile of the sex offenders who were received at the RRC in the first 18 months of the research project. At the time of writing, 199 subjects had agreed to take part in the study, and fewer than 10 subjects had refused to participate or had withdrawn from the study.*

The collected data cover a diverse set of variables, including the personal characteristics of the offenders, their legal and correctional history, the circumstances of the offences and the characteristics of the victims. Each offender's personality profile is measured by a battery of psychometric tests, and the subjects' sexual preferences undergo phallometric evaluation. For the purposes of this article, however, a small number of variables that convey the general characteristics of the sex offenders and their offences have been selected.

Because a significant proportion of sex offenders are sentenced to less than two years in prison, this study represents a sample of offenders who have committed some of the most serious sex offences. Offenders sentenced to a term of imprisonment are likely to be those who caused serious injury to the victim and those whose criminal record indicates persistent criminal activity. A second methodological caution is required: the analysis focuses on offenders entering the correctional system (flow statistics). The results would probably be quite different if a sample of sex offenders already incarcerated (stock statistics) had been studied since, generally, stock statistics produce a much bleaker picture because the "best" cases leave the system faster than the rest.

Characteristics of offenders

Sex offenders are not a homogeneous group of individuals.[6] Table 1 gives the distribution of subjects in our sample for a set of variables.

The figures in Table 1 show that 21% of the subjects are between the ages of 18 and 29. There are also a significant number of offenders who are 50 or older. The average age of sex offenders is 39.3, which is substantially older than the general offender population. The data on ethnic backgrounds show that the sample comprises 176 Caucasians,

Table 1

General Characteristics of Sex Offenders

	Frequency	Percentage
Age		
18–29 years	42	21.3
30–39 years	69	35.0
40–49 years	48	24.4
50 years or older	38	19.3
Total	*197*	
Education		
Primary	60	30.5
Secondary	119	60.4
Post-secondary	18	9.1
Total	*197*	
Intellectual performance		
Superior (111+)	9	6.0
Average (90–110)	58	38.4
Low (85–89)	60	39.7
Limited (71–84)	16	10.6
Deficient (50–70)	8	5.3
Total	*151*	
Length of sentence		
2 years to less than 3 years	57	28.9
3 years to less than 5 years	85	43.2
5 years to less than 10 years	41	20.8
10 years or longer	14	7.1
Total	*197*	

13 Aboriginal people, 8 Blacks and 1 Asian. The subjects' highest level of education was evaluated by the institution's training consultant. The figures in Table 1 show that 30.5% of the subjects completed primary school, 60.4% secondary school and 9.1% post-secondary studies. With regard to intellectual performance as evaluated by the training consultant, 38.4% of the subjects are of average intelligence, 39.7% are considered as having weak cognitive performance and 11% have very limited cognitive ability. At the time of the offence, 34.5% of the subjects were employed. Some of the subjects were students at the time (3.2%), but the vast majority (61.4%) were unemployed or on welfare.[7]

Table 1 also shows that most of the sex offenders in the sample were given a sentence of two to five years in prison (72.1%). Only 7.1% of the subjects drew a sentence of 10 years or longer. Other data show that one third of the subjects (33.2%) had been previously convicted of a sex offence. The 66 repeat sex offenders together faced 219 sex-related charges prior to their current incarceration. Further, 66.3% of the subjects had previously committed non-sex-related offences, with a total of 2,125 charges. Overall, 75.1% of the subjects in the sample have an official record of at least one offence as an adult. In addition, 106 of the 193 subjects (54.9%) have previously served a provincial sentence, and 27 (14.0%) served a federal sentence. The data from Motiuk and Belcourt for sex offender admissions in Canada show similar percentages: 56.3% served provincial sentences and 21.2% served federal sentences.[8]

Characteristics of offences and victims

The 199 sex offenders in the sample were convicted of committing at least one offence against 339 different victims. Table 2 presents the characteristics of the offences against all the victims. It then gives the characteristics of the last offence committed by the sex offenders in the sample.

Table 2

Characteristics of Offences and Victims

	All assaults Number (%)	Last assault Number (%)
Sex of victim		
Male	87 (25.9)	32 (16.6)
Female	249 (74.1)	161 (83.4)
Total	*336*	*193*
Age of victim		
1–12	171 (51.4)	73 (37.8)
13–17	67 (20.1)	53 (27.5)
18 or older	95 (28.5)	67 (34.7)
Total	*333*	*193*
Relationship of offender to victim		
Father, stepfather	102 (30.4)	55 (27.8)
Spouse, ex-spouse	28 (8.3)	22 (11.1)
Friend, relative, guardian	69 (20.5)	34 (17.2)
Acquaintance, neighbour	91 (27.1)	57 (28.8)
No relationship	46 (13.7)	30 (15.2)
Total	*336*	*198*

Table 2 shows that 25.9% of the victims were male and that 16.6% of the offenders assaulted a male victim in their last sex offence. This last estimate is comparable to the finding by Motiuk and Belcourt,[9] who estimated that 16.3% of the sex offenders admitted to federal penitentiaries had male victims. The difference between the two percentages (the two columns) is attributable to the fact that sex offenders with male victims have more victims on average than sex offenders with female victims. The distribution of victims' ages shows that more than 50% of the victims were under 13 years of age, 20.1% were adolescents and 28.5% were adults. Motiuk and Belcourt's distribution of victims' ages is similar to the distribution in the sample under discussion.

A study of the distribution of the relationship between the offender and the victim shows that the offender was the victim's father (biological father, adoptive father, stepfather or mother's spouse) in 30.4% of the sex offences. The offender was an acquaintance of the victim (e.g., neighbour) in 27.1% of cases, a friend, relative or guardian in 20.5% of cases, and the victim's spouse or ex-spouse in 8.3% of all offences. The offender was a complete stranger in only 13.7% of the sex offences. These results confirm the view that sex offences are usually committed by someone close to or known by the victim. The family setting appears to be especially conducive to this type of crime.

Other results show that a weapon (firearm, knife or blunt object) was used in approximately 20% of offences. It appears that no force was used in 15.6% of the offences; minimal force was used in 48.8% of cases; and moderate or excessive force was used in 35.6% of the sex offences. Descriptions of the offences show that the offender drank alcohol in the hours preceding the crime in 61.6% of the offences. Use of soft drugs was mentioned in 11.5% of the cases and hard drugs in 18.6% of the cases.

These results confirm the view that sex offences are usually committed by someone close to or known by the victim. The family setting appears to be especially conducive to this type of crime.

Classification of offenders based on victims' characteristics

We focused on two main characteristics to classify the subjects: age and gender of the victim. These two variables, coupled with degree of violence and family relationship between the offender and the victim, formed the core set of variables used by Gebhard's research team to classify offenders.[10] Gebhard's classification is especially useful in this research for analysing the differing circumstances of the offences for each group of sex offenders.

Table 3 shows, for the last offence, the distribution of subjects by gender of the victim (the variable which defines heterosexual and homosexual offenders) and age of the victim (pedophiles assaulted victims under the age of 13, hebephiles assaulted victims between the ages of 13 and 17, and rapists assaulted adult victims). The table shows the relationship between the offender and the victim. It should be noted that this table pertains to the sample of subjects, not the offences. The percentages are thus based on 193 subjects (there are six missing values).

The data in Table 3 illustrate the relative size of each group of offenders. The two largest groups are heterosexual rapists and heterosexual pedophiles. The most interesting data describe the relationship between the offender and the victim for each subgroup. Homosexual pedophiles are evenly distributed between the three types of relationship, whereas homosexual hebephiles are more often strangers. The correlation is the same for female victims. Pedophile offenders are usually a member of the victim's family, whereas hebephiles and rapists are often strangers or acquaintances of the victim.

Table 3

Classification of Offenders by Characteristics of Victim and Relationship

		Relationship between offender and victim		
Classification of offender	**Number (%)**	**Family**	**Acquaintance**	**Stranger**
Pedophile-homosexual	15 (7.8)	6	4	5
Hebephile-homosexual	15 (7.8)	0	5	10
Rapist-homosexual	2 (1.0)	0	1	1
Pedophile-heterosexual	58 (30.1)	38	17	3
Hebephile-heterosexual	38 (19.7)	11	14	13
Rapist-heterosexual	65 (33.7)	24	16	25

Discussion

Generally, the sex offenders in this sample present a well-established criminal profile and deficient social

integration (education, employment, use of alcohol and drugs). Most offenders assaulted a person they knew, either a member of their family or an acquaintance. The results presented in this article tend to show that the sex offenders in the RRC sample are comparable with data from Motiuk and Belcourt that characterizes incarcerated offenders in Canada. An initial segment of the sample, roughly 275 subjects, will be the focus of numerous analyses. The subjects will be tracked upon release in order to identify the factors related to potential recidivism. ■

[1] P.O. Box 6128, Postal Station Centre Ville, Montreal, Quebec H3C 3J7. This study stems from the research project entitled *"Étude prospective de la récidive chez les agresseurs sexuels : Prédicteurs criminométriques, psychométriques et phallométriques"* [Prospective study of recidivism among sex offenders: criminometric, psychometric and phallometric predictors] conducted at the Regional Reception Centre.

[2] 10905 Henri-Bourassa Boulevard East, Montreal, Quebec H1C 1H8.

[3] 246 Montée Gagnon, Sainte-Anne-des-Plaines, Quebec J0N 1H0.

[4] The RRC is a federal penitentiary whose mission is to accommodate Quebec offenders sentenced to a prison term of two years or longer.

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Coming up in the May 1999 issue of *Forum on Corrections Research*

The May 1999 issue of FORUM will focus on "Youthful Offenders."

Suggested themes of upcoming issues include: "Managing Women Offenders" and "Aboriginal Offenders."

The impact of empathy training on offender treatment

by ***Rachel Mulloy***[1]
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A major goal of treatment for violent and sexual offenders is to increase the empathy felt by the offender for the victims of their crimes. However, it is very difficult to measure changes in empathy brought about by treatment.[2] *This issue is complicated by the fact that there are offenders deemed to be psychopaths, who characteristically lack empathy.*[3] *It is also unclear whether psychopaths are treatable at all.*[4] *Sixty-eight sex and violent offenders who had gone through treatment at the Regional Health Centre in Abbotsford, British Columbia, were examined. The post-treatment scores on the Interpersonal Reactivity Index*[5] *were compared with staff ratings of performance while in treatment, Psychopathy Checklist — Revised*[6] *scores and recidivism data to see if a relationship existed.*

Empathy and the successful treatment of psychopaths

Researchers in the forensic field have suggested that those who commit the most serious interpersonal crimes do so partly because of a profound lack of empathy.[7] Although this statement probably does not apply to all those convicted of assaultive crimes, it is plausible for those who commit many such offences. Psychopaths, for example, have been shown to be at high risk for violent reoffence[8] and, by definition, are profoundly callous.[9]

Increasing empathy is often seen as a key to reducing the likelihood of offending against others.[10] Some form of empathy training is, therefore, a common treatment component for those convicted of crimes such as assault, robbery, murder and sexual assault.[11] The Regional Health Centre (RHC) in Abbotsford, British Columbia, offers intensive treatment for sex and violent offenders with personality disorders (within the jurisdiction of the Correctional Service of Canada). Early follow-up research on program participants between 1990 and 1994 indicated that the sex offenders had a reduced incidence of overall and sexual recidivism,[12] and that the violent offenders showed a decrease in violent offending.[13] Empathy training is an important aspect of the treatment programs. Cognitive-behavioural therapy is part of the empathy training.[14] The emotional and cognitive awareness of the effects of interpersonal crimes on past victims is seen as a deterrent to future offending and the creation of new victims through such behaviour.

The emotional and cognitive awareness of the effects of interpersonal crimes on past victims is seen as a deterrent to future offending and the creation of new victims through such behaviour.

Given the clear theoretical relationship between increased empathic awareness and a reduction in reoffence, it is surprising that little research has been done on the effectiveness of empathy training.[15] One possible reason is that such training is commonly given within a larger multi-modal treatment program.[16] It is difficult to assess the impact of one treatment component within such a program.

One way to assess the effects of empathy training is to examine the results of psychometric tests measuring the understanding of empathy concepts. Although there are some difficulties with this approach,[17] it is the best possible given the available data. One test commonly used is the Interpersonal Reactivity Index (IRI). The IRI does not directly measure empathy, but it is reasonable to assume an indirect connection between knowledge of empathy concepts and empathy

itself. Post-treatment scores on the IRI were used to examine the impact of empathy training on participants. Because it is possible to know about empathy without being empathic, Psychopathy Checklist — Revised (PCL-R) scores were also examined; those with high scores on this scale are likely to be lacking in empathy. Staff ratings of offenders during treatment and the behaviour of offenders after treatment were also used to look at the effectiveness of empathy training, as was the impact of such training on the risk of post-treatment reoffence.

Profile of participants

The participants were 68 adult male inmates who participated in treatment at RHC in 1993 and 1994. Before and after completing treatment, program participants were required to complete a battery of psychometric tests, including the IRI. Thirty-one (46%) of the program participants in this sample were sex offenders. Thirty-seven (54%) were violent offenders.

The mean age of participants was 36 years. Most of the sample (75%) was Caucasian, with a significant minority (16%) of Aboriginal participants. The mean determinate sentence length for the group was 10.5 years: 38% were serving life sentences and 13% were designated as dangerous offenders. Of the 68 participants, 90% completed treatment. There were no major differences between the sex offenders and the violent offenders on any of these variables. The participants had been convicted of a median number of 11.5 crimes. Sex offenders had marginally fewer past convictions ($t = 1.93$, standard deviation 54.67; $p = .06$) than did violent offenders. None of the violent offenders had any sex crime convictions.

Procedure

Demographic and recidivism data were collected in early 1997 from National Parole Board files and the Offender Management System database. Psychometric test data were collected from RHC clinical files. The IRI is a 28-item scale with four subscales. These are:

- *perspective taking*, which measures the cognitive ability to appreciate others' point of view;
- *empathic concern*, which examines the affective ability to feel concern for others;
- *fantasy*, which assesses the ability to identify with fictitious characters; and
- *personal distress*, which assesses the extent to which the person shares the negative emotions of others.

Ratings of inmate performance while participating in treatment were also used to assess achievement during therapy. Each offender's performance was rated by an experienced coder using the qualitative final performance review by treatment staff. Three-point Likert scales were used, where 1 equals poor, 2 equals fair, and 3 equals good. Performance in each treatment module was rated using these scales, as was the staff assessment of overall performance in the treatment program and reduction in the risk of reoffence.

Two trained, independent raters scored the PCL-R by reviewing Correctional Service of Canada files, a procedure that has been shown to be reasonably valid.[18] The inter-rater reliability was excellent.[19] Forty-nine of the total sample of 68 (72%) were classified as non-psychopaths (PCL-R scores of less than 30). Nineteen (28%) of the treatment participants were classified as psychopaths (PCL-R scores of 30 or more). There were no significant differences between the sex offenders and the violent offenders in terms of PCL-R ratings.

Results

PCL-R scores

There was only one marginally significant difference between psychopaths and non-psychopaths on the IRI. This was on the empathic concern subscale: psychopaths scored marginally worse than non-psychopaths post-treatment ($t = 1.78$, standard deviation: 51; $p < .10$). There were no significant correlations between the IRI subscales and participants' total PCL-R scores.

Treatment Performance

Previous research on this sample[20] found that higher PCL-R scores were associated with poorer performance while in treatment, particularly in the empathy module.

Performance in the empathy module (participation and understanding of concepts) was not significantly associated with any of the post-treatment scores on the IRI.

Recidivism

The analysis did not include those who had received no form of release nor new charges.

Any recidivism (suspension or revocation of release, or new charges) was coded as 1.

Those who had been released and had not had any of the above problems were coded as 0, or no recidivism. PCL-R scores and staff ratings of performance while in treatment were not significantly associated with recidivism in this sample.

There were several significant differences on the IRI between those who recidivated and those who did not. However, the pattern of findings was not consistent.

Those who did not recidivate scored significantly better on the performance subscale of the IRI than those who recidivated. However, on the personal distress subscale, those who recidivated scored significantly better than those who did not.

Discussion

This study found no real connections between treatment and reoffending and the IRI, a scale aiming to measure empathic awareness.

There are several possible reasons for the lack of findings. The simplest is that the IRI does not measure empathic awareness. The lack of association between PCL-R scores and the IRI tends to support this hypothesis. However, this lack of association could result from the multifaceted nature of the PCL-R and few of the items may be directly connected to empathy.

There is also a lack of association between performance in the empathy module and the IRI, which also seems to support the hypothesis that the IRI does not measure empathy. But even if this scale does measure empathic awareness, such awareness does not necessarily mean that a person will actually be empathic. For a connection to be found between these scale scores and recidivism, empathic behaviors would have to be connected to empathic awareness and practised within the specific context of an opportunity to reoffend.

This series of connections suggests that it would only have been surprising if there had been significant associations between the IRI and recidivism data.

The limitations in the study's design and the relatively small sample may also have contributed to the general lack of findings. The results of this study indicate that scores on the IRI should not be used to make predictions about recidivism. The use of psychometric test data to measure a behaviour as specific as

Table 1

Differences Between Those Who Recidivated and Those Who Did Not on the Interpersonal Reactivity Index

Index subscales	Did not recidivate† (post-treatment scores (SD))+	Recidivated‡	*t* values (df)
Perspective taking	20.53 (3.50)	17.89 (4.56)	2.12 (44)**
Empathic concern	21.42 (3.95)	20.33 (3.90)	0.93 (44)
Fantasy	12.63 (4.13)	14.11 (4.88)	1.08 (44)
Personal distress	7.42 (4.67)	11.00 (5.46)	2.32 (44)**

** = p < .10; ** = p < .05; ***= p < .01; **** = p < .001.*
+ = Higher scores are "better" on this scale.
† = n ranges from 19 to 22.
‡ = n ranges from 27 to 32.

recidivism is generally inadvisable unless the scale has been specifically designed for the purposes of risk assessment.[21]

These findings do not discredit the connection between empathy and recidivism. Further work is clearly needed to test this hypothesis and to support or refute the use of empathy training within offender treatment programs. ■

[1] Please address all correspondence concerning this article to Rachel Mulloy, Department of Psychology, Queen's University, Kingston, Ontario K7L 3E9. An early version of this paper was presented at a meeting of the Canadian Psychological Association in Toronto, Ontario, in June 1997.

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Family violence risk assessment: Evaluating its importance

by ***Eunice Kim***[1] *and* ***Vince Roper***
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Research shows that only a small percentage of men who assault their spouses face criminal charges or punishment. Using empirical evidence from several studies, Dutton[2] *calculated conditional probabilities for the rate of report, detection, arrest and conviction of men who assault their wives: approximately 14% are reported, 7% are detected, 1% result in arrest, 0.75% result in conviction, and 0.38% result in punishment by fine or incarceration.*

That study suggests that more offenders have perpetrated spousal assault than have been identified. In a recent random file review of 935 offenders,[3] *33.7% of the sample had been violent toward a family member. Of all the offenders' files that contained evidence of family violence, 80.2% were charged for the offence. This is a high number, but remember that only a very small proportion of family violence and spousal assault offences lead to charges, and an even smaller percentage of those that were charged were punished with a fine or incarceration. Research suggests that the number of spousal assault offenders that are incarcerated is not an accurate representation of the actual number of offenders who have committed spousal assault.*

Further research indicates a high risk for male federal offenders to commit violence against their spouses and family members.[4] *A comparison between male federal offenders and men who assault their wives revealed many similarities. The researchers outlined four risk indicators for family violence specifically pertaining to federal offenders:*

1. *they have witnessed or experienced abusive family origins*
2. *they have committed past assaults against family members*
3. *they have a record of violence against strangers or acquaintances*
4. *they exhibit personality disorders with anger, impulsivity or behavioural instability (e.g., borderline, narcissistic, antisocial)*

Because these risk factors are prevalent in an incarcerated population, we likely underestimate the number of offenders that have actually committed family violence; we also probably underestimate the number of offenders at risk for committing family violence.

The Service must assess an offender's risk for family violence if psychologists, case management officers and institutional staff are to make informed decisions regarding private family visits and conditional release. Identifying an offender's risk as a case need also targets the offender's treatment needs.

Family Violence Risk Assessment pilot project

Concern with the likely under-identification of offenders at risk led a project team to recommend changes to existing assessment procedures. The team developed a simple, three-phase Family Violence Risk Assessment. The team also recommended training in the use of family violence assessment tools and workshops in family violence awareness. To evaluate this new approach, a pilot project was launched in October 1995. To narrow the focus of the pilot, the definition of family violence was restricted to spousal assault by men against their female partners.

Phase One: Case management officers assessed family violence risk during the assessment interview and reported their findings in the new Family Violence History section of the Criminal Risk Summary.

Phase Two: Psychologists assessed family violence risk during the assessement interview and reported their findings in the new Family Violence section of the Psychology Screening Report.

Phase Three: Parole officers assessed family violence risk based on information from the offender's family and reported their findings in the new Family Violence section of the Community Assessment.

Methodology

The pilot sample consisted of 210 male offenders who went through the Intake Assessment Unit of a federal correctional institution in Alberta; 108 were admissions from July to September 1995 and 102 were admissions from January to February 1996. Inmate consent was obtained by the signing of the Intake Assessment Unit Offender Contract.

Only the first two phases of the pilot project were evaluated. Frequency of positive identifications of family violence risk in the pre-pilot project sample were compared with the frequency of positive identifications for family violence risk in the post-pilot project sample. Four markers were used to measure the impact of the new procedures introduced by the pilot project (See Table 1).

Table 1

Variable	Pre-pilot	Post-pilot
Psychology Screening Report	• family violence risk assessment found most often in the Aggression Controls section	• family violence risk assessment found in the new Family Violence section
Offender Management System (OMS) Flag	• family violence risk assessment found in the flag status and flag description	• no change in family violence risk assessment procedures
OMS Criminal Risk Summary	• family violence risk assessment found anywhere in the report	• family violence risk assessment found in the Family Violence History section
OMS Case Needs	• family violence risk assessment found in the Marital/Family domain • the question under evaluation: Has he been a perpetrator of spousal assault	• no change in family violence risk assessment procedures

All four variables were coded to indicate the presence or absence of family violence risk. Positive identifications for family violence risk were scored as 1. An evaluator (case management psychologist) had to state that the offender was at risk to score the offender as a positive identification. If, for example, the evaluator mentioned that the offender was witness to spousal assault between his parents, but did not indicate the offender's risk to commit family violence, this could not be scored as 1.

Results

To test for differences between the pre-pilot and the post-pilot group, demographic variables that could confound results were analysed. The mean age of the subjects in the pre-pilot group was 36.5 years. The mean age of the subjects in the post-pilot group was 35.2 years. There was no significant difference ($t = 0.74$, $p < .05$). Chi-square analyses conducted on race, marital status and current convictions for spousal assault variables indicated that there was no association between these variables and group membership.

Discussion

OMS Flag: As seen in Figure 1, there was an extremely low frequency of flags in both the pre- and post-evaluations. Inconsistencies between case management officers were found. Some were unaware that the Family Violence Flag existed, while others did not recall being given instructions to fill in the Family Violence Flag. Retraining staff for consistent and reliable documentation of family violence risk on OMS seems to be needed.

Case Needs Marital/Family: Differences in the number of offenders identified for family violence risk in the pre-pilot project compared with the post-pilot project were not significant. Answers to Case Need questions were self-reported by the offender. However, reliance on self-reports could result in significant departures from the truth. It is possible this particular question did not evaluate risk, but only the presence or absence of a behaviour pattern. Assuming that the rate of family violence had not drastically increased over time, the number of positive identifications would not have increased for this variable because case management officers were simply tabulating the incidence of spousal assault.

Figure 1

Pre- and Post-Pilot Project Identifications of Family Violence Risk

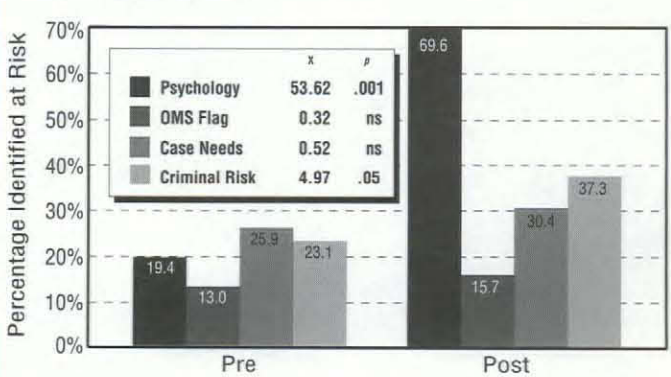
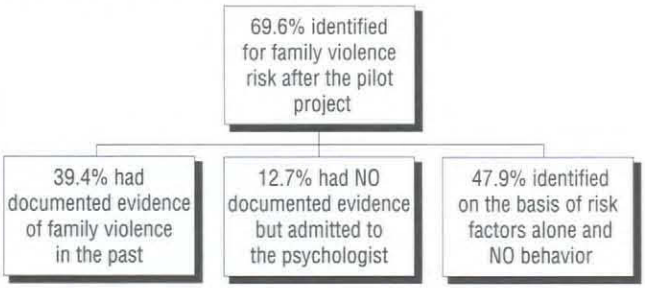


Figure 2

Psychology Screening Report



Criminal Risk Summary: Analysis of criminal risk showed that 37.3% of the post-pilot project sample were positively identified for family violence risk. It is likely that by adding a specific family violence assessment section to the summary, case management officers were forced to confront the issue. This finding is similar to Robinson's study[5] where 33.7% of the offender sample, in a national file review, had some history of perpetrating family violence.

Psychology Screening Report: Results of the Psychology Screening Report show that 69.6% of offenders in the post-pilot sample were identified for family violence risk. Of those positively identified for family violence risk, 52.1% were identified for family violence risk based on actual behavioural evidence (see Figure 2). Conversely, 47.9% of the sample identified for family violence risk were identified on the basis of two theoretical risk factors alone (history of child abuse, personality disorder) — not behavioural evidence.

Has family violence risk been over-identified? Should risk factors be eliminated from family violence risk assessment? One reason to keep theoretically excluded risk factors in family violence risk assessment is concern for possible victims. By identifying offenders likely to commit family violence, potential victims can be protected. Another reason to keep theoretical risk factors is to allow for refutability or testability. However, unless risk factors are empirically tested, we will never know whether they are predictive or not.

On the other hand, there is an important reason why we should consider removing theoretical risk factors from family violence risk assessment. Over-predicting violent behaviour results in false labelling, thereby violating the offender's rights (e.g., an offender may be wrongfully denied the privilege of private family visits). Over-estimating an offender's risk for family violence could also jeopardize his chances for release on parole.

Conclusion

Federal offenders are at high risk for committing family violence. Therefore, it is prudent to develop a comprehensive family violence risk assessment. Evaluation of this new risk assessment strategy reveals an overall increase in identifications of family violence risk, but the inclusion of theoretical risk factors dramatically increases the number of offenders identified for family violence risk. Follow-up studies may determine whether those offenders with only theoretical risk factors actually did commit violence against their spouses and family members, thereby validating the predictive power of such theoretical risk factors. ■

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[2] D. G. Dutton, "The criminal justice response to wife assault," *Law and Human Behaviour*, 11, 3 (1987): 189–206.

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Using psychological testing to predict institutional misconduct

by ***Brad Kelln,*** [1] ***David Dozois*** *and* ***Ian McKenzie*** [2]

Psychological assessment of offenders is important for efficient decision-making, prediction of institutional misconduct, treatment planning and parole.[3] *Assessment improved with the introduction of personality and psychopathology inventories, such as the Millon Clinic Multiaxial Inventory (MCMI-III).*[4]

The MCMI was originally developed for diagnostic decision-making and treatment planning for psychiatric populations.[5] *To date, no studies have examined the predictive use of the MCMI personality profiles in a general inmate population. One advantage of using the MCMI-III in predicting institutional misconduct is that the instrument is already in wide use within the forensic system,*[6] *and does not add significantly to staff workloads. Moreover, clinicians and case managers have been found to make unreliable and inaccurate predictions of serious inmate misconduct if they cannot base their predictions on objective assessment data.*[7] *The general assessment literature*[8] *also supports the need to use existing objective assessment devices.*

The current study used the MCMI-III on an inmate population to predict institutional misconduct. The incremental validity of the MCMI-III was then examined to test its predictive power beyond readily accessible data such as demographic information.

Methodology

The study assessed 142 male offenders incarcerated in a medium-security federal institution (Drumheller Institution). Their average age was 30.77 years (SD = 8.99; range 18–67). Their average sentence length was 60.68 months (SD = 60.78). The sample was 59% Caucasian, 27% Aboriginal, 5% Asian, 4% Hispanic, 4% Black and 1% other ethnic groups. These figures are comparable with demographic statistics from western Canadian institutions.[9] Just over one third (35%) of the sample were convicted of crimes against the person (i.e., sexual assault, physical assault and homicide), while 65% were convicted of other types of crimes (e.g., property, drug- and alcohol-related offences). The participants' age, ethnicity, type of offence and sentence length were included in the evaluation process.

Psychological assessment of offenders is important for efficient decision-making, prediction of institutional misconduct, treatment planning and parole.

The MCMI-III is a 175-item inventory, scored in a true-or-false format and designed to be consistent with the *Diagnostic and Statistical Manual of Mental Disorders — Fourth Edition* (DSM-IV).[10] The MCMI-III consists of 10 clinical scales, 11 basic personality scales and 3 severe personality scales.

Information on institutional misconduct was obtained from inmate records. Institutional misconduct was defined by five behaviours:

1. number of official reprimands;
2. number of days spent in segregation;
3. number of early lock-ups;
4. number of monetary penalties; and
5. number of days of program suspension.

MCMI-III data was collected during assessment, which was conducted shortly before the subjects' admission to Drumheller Institution, as most of the inmates were routed through other institutions (e.g., Edmonton Maximum Security). Demographic information and institutional misconduct data were gathered from administrative records. The average time from admission date to the collection of behavioural misconduct information was 9.28 months (SD = 4.24).

Results

Reprimands are given for less serious misconduct.[11] Reprimands are also a non-behavioural consequence of misconduct, whereas other penalties have behavioural ramifications (e.g., paying fines, going to segregation). Therefore, the reprimand records

of each inmate were analysed separately from more severe misconduct penalties. The results of this study are presented in two parts: individuals with only reprimands were compared with the rest of the sample (e.g., control group 1), and individuals with behavioural penalties were compared with the rest of the sample (e.g., control group 2).

Table 1

Predictive Accuracy of the MCMI-III in the Identification of Institutional Misconduct

	Reprimand		Misconduct	
	Demographics	Demographics + MCMI-III	Demographics	Demographics + MCMI-III
Correct Classification	50%	80%	69%	76%
Sensitivity	91%	67%	71%	76%
Specificity	43%	82%	68%	76%

Note: ***Sensitivity*** *is defined as the percentage of cases with the identified characteristics (i.e., reprimanded or misconduct) who are correctly identified as such by the instrument (e.g., of all the inmates who were reprimanded, how many are correctly identified as such by the procedure used?).*

Specificity *is defined as the percentage of cases without the identified characteristics (i.e., no reprimand or no misconduct) who are correctly identified as such by the instrument (e.g., of all the inmates who have received no behavioural penalties, how many were correctly identified as such by the procedure used?).*

In the prediction of reprimands, subjects were classified into two categories: reprimand (n = 21) and control group 1 (n = 121). In a discriminant function analysis (DFA),[12] the demographic variables of age, sentence length and type of offence produced a correct classification rate of 50% in the prediction of institutional reprimand (i.e., of the entire group, 50% were correctly identified as either receiving or not receiving an institutional reprimand). When the MCMI-III scales were added to the demographic variables, DFA correctly predicted the likelihood of reprimands for 80% of the inmates. MCMI-III scales that were strong predictors for the reprimand group (that is, for which the reprimand group scored significantly higher than the control group) were the Somatoform Clinical Syndrome scale, the Avoidant Personality scale and the Self-Defeating Personality scale.

To be included in the institutional misconduct group defined by behavioural penalties, subjects had to have received one or more of the following consequences: segregation, early lock-up, monetary penalty or suspension. Subjects were classified into two categories: the misconduct group (n = 41) and control group 2 (n = 101). The demographic variables alone predicted behavioural penalties for 69% of the inmates. This increased to 76% when the MCMI-III scales were included in the analysis. The results are summarized in Table 1.

In this analysis, 11 variables emerged as significant predictors of institutional misconduct. Those receiving behavioural penalties were younger and scored higher on the Narcissism, Aggressive-Sadistic, Schizoid, Antisocial, Aggressive, Passive-Aggressive and Borderline personality scales. Higher scores on the Compulsive personality scale are related to increased self-control and thus it is not surprising that those receiving behavioural consequences for misconduct were found to score lower on the Compulsive personality scale.

For the clinical scales, the misconduct group scored higher on the Alcohol Dependence and Thought Disorder scales than the control group. The misconduct group also obtained significantly higher scores on the Disclosure Modifying Index, indicating that they were more open and honest in responding to the MCMI-III. Such an unexpected finding may be a statistical artifact of elevated pathology in other clinical and personality scales (i.e., the Disclosure scale on the MCMI-III is composed entirely of other scales and thus having significantly higher scores on a large number of the individual scales would increase the overall score of the Disclosure index) or may be attributed to an impulsive response style.

Conclusion

The results of this study indicate that the MCMI-III strengthens the data forensic practitioners can use to predict misconduct in correctional facilities. This information, in turn, may be used to identify the individuals who

should be considered higher priorities for receiving appropriate psychological interventions (e.g., impulse control training, problem-solving skills training) to reduce the amount of behavioural misconduct in the prison system. Further research is necessary to establish cutoff scores for use within specific institutions based on the needs of the institution and the demographic representation of its population. ■

[1] The authors would like to thank the staff at Drumheller Institution for their support in the completion of this study. This research is supported by the Medical Research Council of Canada, the Killam Foundation and the Alberta Heritage Foundation for Medical Research. This support is gratefully acknowledged. The first two authors can be reached at Program in Clinical Psychology, EdB 292, University of Calgary, 2500 University Drive, N.W., Calgary, Alberta T2N 1N4.

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[3] R. Serin, "Psychological intake assessment: Contributing to contemporary offender classification," *Forum on Corrections Research*, 9,1 (1997): 51–54.

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[5] T. Millon, *Manual for the Millon Clinical Multiaxial Inventory* (Minneapolis, MN: National Computer Services, 1983); see also S. Wetzler, "The Millon Clinical Multiaxial Inventory (MCMI): A review," *Journal of Personality Assessment*, 55 (1990): 445–464.

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[10] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (Washington, DC: 1994).

[11] D. Lovell and R. Jemelka, "When inmates misbehave: The costs of discipline," *The Prison Journal*, 76 (1996): 165–179.

[12] Discriminant function analysis operates by finding the line of best fit for the data (i.e., the linear composites of the dependent variables are calculated so that they are successively maximized). Stepwise discriminant function analysis removes redundancy (or multicollinearity) among variables, and this yields information about the unique variance accounted for by the predictors. See E. J. Pedhazur, *Multiple Regression in Behavioral Research*, 2nd ed. (Fort Worth, TX: Harcourt Brace, 1982).

Just Released

R-73 ***Results of a Pilot Study of the Peer Support Programs for Women Offenders***
Date of Publication: August 1998
By: K. Blanchette and G. Eljdupovic-Guzina

R-74 ***Results of the Legal Service Client Satisfaction Survey March 1997 – March 1998***
Date of Publication: November 1998
By: R. L. Sinclair, C. A. Dell and R. Boe

Remarkable rarity of violence toward staff in prisons

by ***Marc Ouimet, Ph.D.***[1]
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Prisons are expected to fulfil a variety of functions: punishment, neutralization, rehabilitation and deterrence. One of the characteristics of prisons is that they bring together people with a high potential for violence. At first sight, then, we might think that it is risky or dangerous to work in a penal institution. But what do we actually know about violence against prison staff? In fact, we know very little. To our knowledge, no Canadian study has dealt specifically with the question of violence against staff in provincial prisons. This study therefore attempts to focus on this issue.

Some data

In 1982, a destructive riot broke out at the Archambault Institution. There were both guards and inmates among the dead. However, this tragic event must be seen as part of a larger picture.

In the network of provincial prisons in Quebec, there has not been one case of a homicide against a guard performing his duties inside the walls in the last 10 years. The recent killing of two correctional service employees outside the walls has nonetheless reminded us of the potential brutality of the criminal environment.

American data show that between 1984 and 1989 there were 21 murders of correctional officers.[2] We must remember that the total inmate population in the U.S. during this period was about one million, and the number of officers during the same period was about 120,000.[3] Calculated annually, if there are 3.5 murders a year (21 homicides/6 years), this makes an annual homicide rate of 2.91 per 100,000. In the United States, the annual homicide for the population as a whole is about 8 per 100,000 (or 20,000 murders a year).[4]

The scattered information available on homicides of correctional officers enables us to conclude that this occurrence is rare. Such an observation is all the more striking in that homicidal violence is relatively frequent among offenders. The Correctional Service of Canada counted 28 homicides behind federal bars from 1990–1991 to 1994–1995, a period of six years.[5] Since the federal population for this period was about 13,500, the annual rate is 41 per 100,000 inmates, which is 13 times higher than that in the civilian population, which annually is 3 per 100,000 inhabitants.[6] It is interesting to note that provincial prisons in Canada as a whole reported only six homicides during the five years under study, or a rate of 6 per 100,000 offenders, which is approximately equivalent to, if not less than, the rate for a comparable civilian population (the great majority being men between 18 and 40 years old). The feeling that there is a lack of safety in prisons may also be due to the high rate of suicide among inmates. From 1990–1991 to 1994–1995, Statistics Canada reported 76 suicides among federal inmates and 97 in Quebec prisons, or respective rates of 113 and 100 suicides per 100,000 offenders, which is about 10 times greater than the average for the civilian population.

Prisons are expected to fulfil a variety of functions: punishment, neutralization, rehabilitation and deterrence.

Light has published a study on the 694 cases of assault involving an inmate and a member of the staff in New York prisons in 1985.[7] He notes that 82.3% of the assaults occurred in maximum security prisons, against 15.3% in medium security prisons and 2.3% in minimum security prisons. The majority of the assaults did not cause any significant injury. There were 101 cases of moderate injuries and 19 cases of serious injuries (i.e., 2.8% of the assaults). This study highlighted the fact that serious violence against prison employees was rare (19 cases of serious violence for 24,300 guards), and this was in one of the toughest prison systems in the world, with a particularly aggressive inmate population (because of racial tensions, among other things).

In their study, McCorkle, Miethe and Drass review the general characteristics of 371 American prisons and the relationships with the rate of assaults against staff.[8] The results of a multiple regression analysis show that the following variables are not associated with the rate of aggression: occupancy rate, ratio of guards to inmates and size of institution. Two factors contribute significantly to an increase in violence against staff: the ratio of whites to blacks among guards and the security level of the institution (the higher security institutions have the most violence). One factor that relates to a drop in violence against guards is the level of involvement of inmates in programs. After an analysis of the results of research available on this question, Cooke indicates that the toughening of security measures in an institution may entail an increase in violent incidents between inmates and staff.[9] Cooke believes that a climate of relative security for everyone is dependent on the quality of the relationship between staff and inmates, as well as on the inmates' involvement in programs.

A climate of relative security for everyone is dependent on the quality of the relationship between staff and inmates, as well as on the inmates' involvement in programs.

Impact of Violence in Quebec prisons in 1996

In the Quebec correctional service, a disciplinary infraction requiring processing is automatically reported on a standard form that is then entered into the automated DACOR system. We queried the system to obtain information on all the disciplinary infractions that were entered in 1996 for all the institutions in Quebec. We may question the validity of indicators based on official reports of disciplinary infractions. Do they accurately reflect the inmates' behaviour or do they reflect rather the specific attention that the guards focus on rebellious prisoners?

Van Voorhis studied this question in an American prison and showed that the correlations between various indicators (infractions, evaluations of guards, questionnaire and interviews with inmates) were high enough to indicate good consistency among the various measures.[10] Furthermore, disciplinary infractions are the indicator that is most frequently used in research to gauge the offenders' institutional adjustment.

The two main types of clients in the Quebec correctional system are people who are awaiting trial (accused) and people who have been convicted (inmates). A study carried out on more than 300 people incarcerated at the Sherbrooke detention centre[11] showed that the accused had fewer disciplinary infractions than the inmates in all categories, with the exception of damage to property. The study also showed that classification according to the level of risk of the offenders was superior to classification according to legal status. Apart from legal status, it would appear that the age of the offenders has an inverse relation to the potential for committing an infraction. The youngest inmates are those most likely to flout the regulations.[12] Table 1 shows the number of infractions reported in 1996 for all Quebec prisons.

Table 1

Disciplinary Infractions in Quebec — 1996

Type of infraction	Number	Percentage
Non-compliance with regulations	2,634	30.79%
Disruption to order of institution	1,920	22.45%
Possession of prohibited item	1,166	13.63%
Threatening or offensive language	1,137	13.29%
Use of physical violence	792	9.26%
Damage to property	461	5.39%
Refusal to participate	297	3.47%
Gift of item	90	1.05%
Obscene actions	57	0.67%
Total	8,554	

Table 1 also shows that there were 8,554 reports of disciplinary infractions for 1996. The use of physical violence accounts for 9.26% of the total entered in the system. We then focused on cases of physical violence on people other than offenders, and this gave us a total of 162 violent infractions. These 162 cases included 154 guards, four members of the medical staff, one parole commissioner, one telephone repairman, one help cook and one psychologist. On the basis of the narrative description of the infractions, we coded the nature of the acts.

Table 2 shows the results (two cases of touching and three cases of unspecified violence did not make the chart.)

Table 2

Nature of Violent Acts Against Non-inmates

Type of Act	Number	Percentage
Use of force required to overpower offender	29	18.5%
Threats, hitting wall, aggressiveness, invitation to fight	29	18.5%
Threw himself toward....., attempted to....	25	15.9%
Blow, act likely to cause injury, bite, scuffle	25	15.9%
Push, shove, shoving object against victim	17	10.8%
Threw object on.... or toward....	15	9.6%
Spitting on non-offender	11	7.0%
Intervention in fight between offenders	6	3.8%
Scuffle between offender and non-offender (he jumped on me...)	5	3.2%
Total	162	

Infractions reported under "Use of violence" do not always correspond to the idea we have of what constitutes physical violence. In many cases, a violent infraction is listed because an offender had to be physically overcome. The data show that cases of physical violence that might be called assaults are in two categories: "Blow, act likely to cause injury, bite, scuffle," and "Threw object on...." The total for these is 40 for 1996. Still we could not conclude that all of the 40 cases could entail a police complaint. Here is an example: "X was coming back from court. I proceeded to search him. Afterward I told him to go into the room and wait for an escort. He wanted to go out again. I stood in front of him to prevent him from passing with my arms, he turned and planted a fist in my face. Several guards had to intervene to get him into confinement."

Here is another: "During the medication distribution, W began to swear at supervisor X. He threatened guards Y and Z. The unit manager told us to put him in segregation. Subject refused. We used the necessary force. Subject hit X with his fist. Subject was overpowered, restraints were placed on him, and he was put into a holding cell."

In a more serious case, an offender caught an officer's little finger between two pieces of metal. The officer was injured. In another case, an officer was bitten by an offender who claimed to have AIDS. In a single case in 1996, an employee who was not a guard was the victim of serious violence from an offender. This was a help cook who suffered a violent blow to the head from an inmate working in the institution's kitchen. There were incidents featuring aggressive or threatening language to a telephone repairman, a parole commissioner and on two occasions a member of the medical staff. An object was thrown at a psychologist, a medical person was shoved, and another one was spat upon.

Quebec correctional service regulations provide that when a crime is committed within an institution, a disciplinary infraction form need not always be completed, but rather the police should be called, and the police can then record the infraction and follow up with the legal proceedings. This being so, there may have been in 1996 some cases of violence toward an officer or another person that were not entered in DACOR. For 1996 we were able to consult all the files concerning assaults on officers that were submitted directly to the police. We found five cases of violence against an officer that were reported to the police. However, in none of the five cases were any serious injuries reported.

Discussion

After analyzing the incidents in the DACOR system and those that entailed a request for a police investigation, we were able to make a

number of observations. First, physical violence against officers is not very frequent. Our prisons daily house over 3,000 people and the number of violent incidents against officers was about 50. Moreover, employees of detention centres other than correctional officers do not appear to be targets for offenders. In 1996, not more than about 10 incidents against staff members other than guards resulted in disciplinary infraction reports or complaints to the police (most often these were for threats or aggressive language).

In his study of prisons, Lemire wrote that in the past the violence that occurred in prisons was mainly directed by guards against inmates.[13] Any confrontation of a guard by an inmate was severely punished. In the last few decades, things have changed. Guards have become more professional and no longer use violence in their relations with inmates. Violence in prison now is mainly by inmates against other inmates. Although the guard is still the formal enemy, inmates spend a great deal of time trying to avoid violence from other inmates. Lemire did find that there has been a recent increase in violence against guards, but that this is still quite marginal when compared with the violence inflicted by inmates on other inmates.

We must now ask what the reasons might be that could explain why violence against staff is so infrequent in our prisons. Lemire defends the idea that the prohibition against physically tackling guards is part of the inmate's informal code of conduct. There would appear to be some taboo against violence toward staff—a taboo justified by the fear that detention conditions might then deteriorate (withdrawal of common privileges, toughening of policies, coercion).

Another approach was adopted by Lusignan in his Ph.D. research dealing with the victimization of criminology workers.[14] Lusignan shows that prison guards have rates of victimization much lower than that of bailiffs, police officers and social workers. Death on the job for them is much lower than for miners, truck drivers, construction workers and police officers. Lusignan explains this situation by the fact that guards rarely leave themselves vulnerable in contacts with inmates. First, they are quite able to defend themselves bare-handed, and second, they make sure that another guard is never far away. The conditions required for a crime to occur are rarely all present.

We may also consider that an assault against an employee by an inmate will swiftly and immediately be met by some reaction from other employees. An offender has a great deal to lose if he tackles a guard. He may be roughed up, he may be confined to his cell for quite some time, he will have to answer to the Discipline committee, and he certainly risks having his release date postponed. If the assault is serious enough, it is quite likely that he will face new charges, and if he is convicted, the judge may be sickened by the incident and may hand down a severe sentence. It has often been said, in criminology, that the certainty of a sentence is a much stronger deterrent against criminal behaviour than its severity. In the case of aggression toward employees, the sentence would be both certain and severe. ■

[1] P.O. Box 6128, Postal Station Centre Ville, Montreal, Quebec H3C 3J7.

[2] National Institute of Justice, "Table 3.151: Prison staff killed by inmates," *Sourcebook of Criminal Justice Statistics* (1990): 402.

[3] National Institute of Justice, "Table 1.92: Correctional officers in adult correctional systems," *Sourcebook of Criminal Justice Statistics* (1990): 143.

[4] In Canada, between 1967 and 1981, six guards were killed by inmates. See C. H. S. Jayewardene and P. Doherty, "Individual violence in Canadian penitentiaries," *Canadian Journal of Criminology*, 27, 4 (1985): 429–439.

[5] Statistics Canada, *Adult Correctional Services in Canada*, 1994–95, Catalogue 85-211 (Ottawa, ON: Minister of Public Works and Government Services Canada, 1996).

[6] Nevertheless one should not necessarily conclude that the prison environment itself is a cause in this context. It is impossible to compare the homicide rate in society at large with the rate in a particularly problem-prone segment of it. Prisoners are mostly male and young, and they harbour a multitude of mutually conflicting problems in their adaptation to society. Moreover, during the same period the correctional service reported the murders of 20 parolees (killed after their release).

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The impact of violent acts on prison staff

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Prison staff members experience daily stresses that are, at least to some degree, an expected outcome of their work environment. However, traumatic events that occur infrequently, such as hostage-takings and forcible confinements, cause significant stress to staff members. As Herman[2] states, these events "are extraordinary, not because they occur rarely, but because they overwhelm the ordinary human adaptations to life. Unlike commonplace misfortunes, traumatic events generally involve threats to life or bodily integrity, or a close personal encounter with violence and death." Although the incidence of hostage-takings and forcible confinements is infrequent, averaging just under four per year, the implications can be extensive for those directly involved, including victims, medical staff, institutional emergency response team members, negotiators and crisis managers, and may be almost as severe for those who only experience the aftermath, such as colleagues, family and friends.

A recent study[3] on forcible confinements and hostage-takings that took place between 1993 and 1995 examined the characteristics of the perpetrators, but only focused peripherally on the survivors of these traumatic events. A literature review revealed that, to date, there were no studies focusing on victims of prison-based hostage-takings, in North America or elsewhere. The current study[4] was designed to investigate the impact of these violent acts on staff members of the Correctional Service of Canada. The study's main objectives were:

- to improve our understanding of survivors' experiences;
- to determine how the Correctional Service of Canada could intervene effectively and humanely;
- to help staff members cope with such incidents; and
- perhaps, to prevent them.

Sample

Using the Offender Management System, 52 survivors of national incidents from 1985 to 1995 were identified, and of these, 32 were successfully contacted, and 27 completed interviews. Of the 27 who completed interviews, 22 (81%) were still employed by the Service. Most expressed keen interest in the project and stated that it felt good to be "recognized." Others found that talking about their experiences was part of their healing process.

Demographics of victims

The greatest number of respondents were from the Ontario region (44%) at the time of the incident; of the rest, 26% were from Quebec, 19% from the Prairies, 7% from the Atlantic region and 4% from the Pacific region.

Most of the respondents in Ontario were female (63%). In Quebec, distribution was even for males and females. In the Prairies, males were over-represented (80%). The Atlantic region had one of each gender, and the lone respondent from the Pacific region was a female.

At the time of the incident, hostages ranged in age from 25 to 53, with a mean age of 38 years. There was no gender difference in mean age (female 35.2; males 39.6). The majority of the sample (70%) were married or in a common-law relationship at the time of the incident, while 15% were separated or divorced and 15% were single. Of those who were married, 21% reported that the incident led to the dissolution of their marriage.

Nine of the 27 respondents (33%) were correctional officers; the rest included psychologists, clerks, teachers and librarians. Years of service ranged from 1 to 25, with a mean of 6.41 years. Incidents lasted from a few moments to more than 60 hours.

Three quarters of the confinements were deliberately planned. This is supported by the fact that, in 85% of the incidents, a weapon was used. The most frequently cited weapon was a knife.

Force varied from psychological threats of force to physical and sexual assaults.

Physical injury was reported by one third of the sample and sexual assault was reported by 44% of the women in the sample (7 of 17). Almost all of the respondents reported varying degrees of emotional and psychological impact. The one respondent who did not report any distress was involved in a very brief incident. This finding is consistent with the post-traumatic stress disorder literature, which indicates that the more severe a traumatic event in intensity and duration, the greater the likelihood of psychological damage.[5]

During the incident

Respondents were asked to discuss their thoughts, feelings and behaviour during the hostage-taking and unlawful confinement. The most frequently reported thoughts were disbelief, fear of injury and death, and survival. Interestingly, many expressed the thought "I wasn't supposed to be there," as respondents said they were working a different shift, or in a different location from their normal workplace.

All respondents interviewed reported feeling surprised and threatened. Other feelings depended on the particulars of the incident (i.e., duration, severity and injury) and on the individual characteristics of the respondent (i.e., vulnerability, resiliency).

The following are the most frequently expressed emotions: shock, anxiety, terror, frustration, vulnerability, powerlessness, humiliation and isolation. Although several felt cool and calm throughout, others fluctuated between calmness and intense worry, and yet others were anxious and frightened throughout the event. Several described feelings of "wrongness" or danger, immediately before the incident.

During the incident, respondents' behaviour varied from physical resistance (32%) such as fighting, screaming or running, to verbal resistance (48%) such as talking, reasoning and negotiating, to submissiveness (25%), that is, complying with all demands. No gender differences were found in behaviour. Most respondents expressed satisfaction with their behaviour during their incidents.

After the incident

Immediately after the incident, 40% were debriefed, 56% received counselling and an additional 22% were offered assistance, but declined. Typically, contract employees were not offered debriefing or psychological assistance. Only two respondents were offered assistance during court proceedings, although it should be noted that court assistance to staff is an evolving process that has improved over the past decade.

Psychological impact

The changes in a person's life after a traumatic incident can have repercussions far beyond the time of the event. Therefore, both immediate and long-term reactions were surveyed. Respondents were presented with 24 symptoms associated with post-traumatic reactions[6] and asked to discuss which reactions were experienced during and/or after their incident. Table 1 lists their answers in order of prevalence.

Because being forcibly confined is, by its very nature, frightening and threatening, anxiety was the most commonly experienced symptom both during and following the incident (89%).

After a traumatic event, the human process of self-preservation can go on permanent alert, since it is believed that the danger can return at any time. Hypervigilance — or "hyperalertness" — is an acute state of sensitivity and awareness of one's surroundings. This was most commonly described as being felt in the workplace and was experienced by 81% of respondents.

Sleep disorders were also common, manifested as trouble falling asleep, frequent awakenings and nightmares. Most respondents experienced such problems immediately after the incident and for some, these difficulties lingered for months. Anger was experienced by respondents during and after the incident, and was directed primarily toward the perpetrator of the incident and the Service in general.

Other common experiences were an overwhelming sense of powerlessness, shock and fear (such as fear of strangers, fear of being alone, and fear of impending danger or of someone coming up behind them). Many

Table 1

Reactions to Hostage-Taking, Unlawful Confinement

		Percentage	Number (n=27)
1.	Anxiety	89	24
2.	Hypervigilance	81	22
3.	Anger, hostility	74	20
4.	Sleep disturbances	74	20
5.	Powerlessness	70	19
6.	Fears, phobias	67	18
7.	Shock	67	18
8.	Isolation	63	17
9.	Nightmares	63	17
10.	Flashbacks	59	16
11.	Embarrassment, shame, guilt	55	15
12.	Interpersonal difficulties	52	14
13.	Exaggerated startle response	48	13
14.	Increased crying or inability to cry	44	12
15.	Sense of detachment	41	11
16.	Paranoia	37	10
17.	Appetite change	33	9
18.	Depression	33	9
19.	Physical illness	33	9
20.	Change in alcohol, drugs, smoking	30	8
21.	Disoriented	30	8
22.	Impaired leisure activities	30	8
23.	Blunted affect	26	7
24.	Sexual difficulties	22	6

staff members felt isolated when they returned to work, because other staff members and offenders stared at them, avoided them or judged them critically. Flashbacks were frequently described as vivid memories of the event, recalled as if they were happening all over again. Flashbacks tended to occur at a variety of times after the incident, and sometimes continued for years.

Impact on work and personal or family life

The vast majority (89%) felt that their work life was affected by the incident. Many felt that other staff were critical or made judgmental comments. Lack of support from management, fear and avoidance of certain situations, and feelings of stress, fatigue or hypervigilance were also noted. Many (52%) found that their personal lives were negatively affected, especially their intimate relationships. Just over a fifth (21%) stated that their marriages ended as a result of the incident. Personal issues related to previous abuse tended to exacerbate the impact of the traumatic event. This occurred for 37% of the respondents (8 women and 2 men).

Coping strategies and positive adjustment

According to Meichenbaum,[7] it is important to assess both negative and positive adjustment in traumatized individuals. Therefore, respondents were asked which personal strengths they drew on to help them cope with their traumatic incidents. Many described adaptive coping behaviours that helped reduce anxiety and increased the probability of a positive outcome. Common themes included the ability to think clearly and remain calm; well-developed communication and interpersonal skills; inner character strengths such as determination, courage, stubbornness and pride; strength from religious or spiritual convictions; knowledge of institutional procedures; and thoughts of loved ones.

Respondents were also asked if they had benefited in any way from the traumatic experience and its aftermath. Common themes included: learning that they could cope with difficult situations, making positive changes related to survival, becoming more cautious and vigilant, enhancing their understanding of powerlessness and victimization, and having a greater appreciation for life.

Return to work

The leave taken before returning to work depended primarily on the duration and intensity of the incident. Generally, shorter incidents resulted in less psychological distress and an earlier return to work. For example, of the 10 respondents who returned to work immediately, eight experienced relatively short incidents (six were resolved within five

minutes and two within an hour), and all described less than 10 of the 24 symptoms in Table 1. However, of those same 10 who returned to work immediately, only three wished to do so. The remaining seven felt that they had no option but to return.

Of those taking leave, nine (approximately one third) returned within five months, four returned between 6 and 12 months, two took more than a year, and two did not return at all. Respondents who endured intense, prolonged incidents and suffered severe psychological distress required more time to recover. The two who were unable to return to work had prolonged incidents and were severely affected by their ordeals (see Table 2).

Ten respondents (37% of the sample) experienced severe psychological distress, defined as more than 16 of the 24 symptoms. This group's number of symptoms ranged from 17 to 23, with an average of 20. This group comprised seven women and three men. Eight (80%) were assaulted (three men were physically assaulted, four women were sexually assaulted, and one woman was physically and sexually assaulted). Although two of these incidents were resolved in less than an hour, the remaining eight incidents were prolonged, ranging from 4 hours to more than 60 hours. The two respondents who did not return to work were among this group. For the eight others, their return to work was delayed. MacWillson[8] found that uninterrupted exposure to the threat of violence or murder in confined conditions after such incidents would undoubtedly impose a heavy burden on the physical and mental well-being of hostages.

Respondents described mixed experiences in returning to work. Those who described positive experiences tended to have close, supportive co-workers and a good relationship with their manager. Others, however, reported more difficulties in interpersonal relationships and in adjustment after the incident. They tended to encounter unsupportive colleagues who made judgmental and disparaging comments.

Table 2

Respondents' Leave from Work After the Incident

Leave	Number (n=27)
No leave	10
1–3 weeks	6
1–5 months	3
6–12 months	4
More than 12 months	2
Never returned	2

Generally, respondents found managers to be insensitive or unsupportive, often ignoring or excluding the respondent from decisions relating to return to the workplace. The majority described being ignored or avoided by managers. Several felt disempowered and revictimized by the perceived lack of support.

Respondents' recommendations

Respondents described several areas where the Service should be commended as well as problem areas that require resolution. On the positive side, they expressed satisfaction with the help received from the Employee Assistance Program. For those whose incidents were terminated by force, a number expressed their satisfaction with the emergency response team's actions.

As a result of both this 1997 study and the previous study on unlawful confinement and sexual assault[9] a number of recommendations were submitted to the Service's Executive Committee for approval.

Training on hostage-takings and forcible confinement was recommended by most of the respondents. A half-day training module has been drafted, and focuses on preparation, prevention, motivation for forcible confinement and hostage-takings, behaviour during the confinement, crisis management model (e.g., roles of crisis manager, negotiators, emergency response team), post-traumatic stress disorder and return to the workplace. A 35-minute film, "Forcible Confinement: A Survivor's Story," is available in both official languages and is useful in encouraging group discussion. It is recommended that all staff (including contractors and managers) be provided with this training.

For survivors of such incidents, debriefing and psychological support was recommended and is already in place. It was also recommended that information flow to the survivor be improved

(e.g., documents, court dates). Better reintegration into the workplace was recommended, including greater consultation with the employee. A post-incident interview would focus on issues such as paid leave, work options and individual needs, and could be carried out by a designated employee such as a return-to-work coordinator. This individual could also coordinate individualized reintegration strategies such as redeployment, retraining and gradual transition to the workplace.

An improved reporting system for critical incidents, which focuses on improved classification, has already been addressed. This will clarify the total number of incidents and type of harm (e.g., physical, sexual, psychological).

The capacities of the respondents to live with, work with and surmount the trauma they suffered is remarkable, and a testament to their collective strength. This strength should be reinforced, by treating them with the fairness, dignity and respect they deserve: qualities that are entrenched in our Mission Statement and can only be enhanced by responding to the recommendations of this report. ■

[1] 440 King St. W., Kingston, Ontario K7L 4Y8.

[2] J. L. Herman, *Trauma and Recovery* (USA: Basic Books, 1992): 33.

[3] S. M. Williams, *Review of Sexual Assaults and Forcible Confinements* (Ottawa, ON: Correctional Service of Canada, 1995).

[4] B. T. Seidman and S. M. Williams, *Hostage-Takings of CSC Staff: Psychological Impact and Institutional Management* (Ottawa, ON: Correctional Service of Canada, 1997). The full report can be obtained from Sharon M. Williams at the address in Note 1.

[5] Herman, *Trauma and Recovery*.

[6] D. Meichenbaum, *A Clinical Handbook/Practical Therapists Manual for Assessing and Treating Adults with Post Traumatic Stress Disorder* (PTSD) (Waterloo, ON: Institute Press, 1994).

[7] Meichenbaum, *Clinical Handbook*.

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[9] Williams, *Review of Sexual Assaults and Forcible Confinements*.

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Victimization of case workers in corrections: Its extent and impact on clinical practice

by ***Richard Lusignan Ph.D.***[1]
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To date, academics studying victimization have taken little interest in the links between clinical practice and victimization rates or probabilities. This is surprising since several theories are relevant to this kind of analysis.[2]

The work of case workers in corrections reveals three factors that may lead to victimization: a contact with potential assailants who have already violated the *Criminal Code*; circumstances in which case workers may become targets; and finally the presence (or absence) of deterrents to an assailant's actions.

Therefore, the correctional workers in our study are exposed to the risk of victimization because of their daily professional association with individuals who have already displayed violent or socially unacceptable behaviour. Working with violent people or criminal offenders is a high-risk activity for victimization.[3]

These risks and the forms of victimization have changed as correctional facilities progressed from totalitarian institutions to custodial facilities that attempt to modify behaviour. Learning more about these situations can help the implementation of preventive measures such as changing their procedures and reducing the number of opportunities for assault.

Strategies and research techniques

Our descriptive, exploratory approach has two goals. The first is to measure and describe the victimization of case workers[4] when they are working with inmates or psychiatric patients. Our second objective is to determine whether there is a link between victimization (in the workplace or elsewhere) and changes in case workers' perceptions (whether clinical or professional) of their clients.

Assumptions

Case workers are indeed victimized in the course of their work, but the problem may be under-estimated and under-reported.

There is a link between a case worker being victimized and the development of a state of distress, even a post-traumatic stress. There are a number of ways of measuring the impact of victimization. We chose the concepts of disruption of habits and post-traumatic stress disorder, as defined in the DSM III-R.

If a case worker victimized, either once or on a number of occasions, his or her job performance will change. The changes take a number of forms, such as modified professional activities, different attitudes toward clients, and different expectations of support from the organization or from his or her peers.

Sample

We approached 271 staff working with adult federal inmates in the custody of the Correctional Service of Canada, Quebec Region. They work as case management officers, either within an institution or in the community.

We have also interviewed 15 case workers from the Institut Philippe Pinel de Montréal who work with a clientele considered violent within the forensic and psychiatric settings.

All participants were contacted personally or sent a letter. We tried to meet with the various groups of participants within their operational units. Those working in units more than 150 km from Montreal were sent letters and received follow-up telephone calls. The response rate to the questionnaires we distributed was 63% or 180 respondents.

Table 1

Distribution of the Participants Approached and Respondents, by Work Setting

Type of setting	Number of participants approached	% of total population	Number of respondents	Response rate
Maximum security	31	10.8	16	51.6
Medium security	63	22.0	40	63.5
Minimum security	12	4.1	10	83.3
CCC**	19	6.6	12	63.2
Working with parolees	146	51.0	89*	61.0
Institut Pinel	15	5.2	14	93.3
Total	286	100.0	181	63.3

** one incomplete questionnaire had to be discarded*
*** Community Correctional Centres*

Table 1 shows the distribution of the participants according to their work setting. Our sample included 180 clinical practitioners, of whom 89 were men (49.4%) and 91 were women (50.6%). Our respondents were between 22 and 57 years of age. The average age was 34.4 years.

The amount of time respondents had spent in their current job was between one month and 30 years. Their experience in their current position is a mean average of 6.7 years, with a standard deviation of 6 years. We should point out that nearly half of the respondents had less than 4 years' experience in their current position.

Instrument used and contribution of the qualitative method

We used a questionnaire with four main sections that the respondents filled out to identify themselves and to describe incidents they thought were serious. Each one of the participants was asked to describe two events that he or she had experienced directly, two incidents that had happened to co-workers and one event that he or she had witnessed.

The instrument we used also collected data about the criteria used to diagnose Post-Traumatic Stress Disorder (PTSD).

We could encounter psychological defence mechanisms such as denial and rationalization,[5] and not be able to correct for self-evaluation done in response to observations made by people close to the respondent. However, we must remember that the prevalences established for PTSD are still minimum prevalences.[6] Finally, it occurred to us that the case workers who were the most disturbed by their experience might stop their clinical practice, and would not be captured by our research protocol. To compensate for this, we used an additional qualitative approach and met with at least one person who had left the field of correctional case work.

When we designed the project, we thought this more qualitative approach was justified, given the polymorphous nature of the subject being studied. For one thing, it was impossible to identify at the outset all possible forms of victimization; second, we wanted to come to the best possible understanding of all the active factors among the victims. What leads workers to leave corrections after being victimized on the job? What happens after the assault, when the person goes back to working with violent clients and offenders?

To answer these questions, we interviewed 11 case workers (8 men and 3 women) who were currently practising at one of the two institutions. The professional experience of this small sub-group was quite impressive. Together, they had 170 years of experience as criminologists working for various employers.

Results

Using a quantitative approach, we measured nearly 200 variables for each participant. Using the qualitative approach we discovered situations and characters one would not have expected if one relied solely on deductive logic: projection, the extent of sexual intimidation that female workers had experienced, the kinds of support offered by the employer, and the support from clients after an assault. These methodological components had a synergetic effect, enriching our findings.

Recognition of victimization in the work setting

Our first assumption in this study was questioning the presence of victimization factors in the work setting of correctional case workers.

Victimization at work is foremost characterized by interpersonal violence. Violent incidents at work made up 64% (35 out of 55) of all the direct violent offences that victims reported on the questionnaire (n=122). If we disregard theft mischief (7) and threats (14), the incidents that occurred in the workplace included assault (13), assault with a weapon (9), assault causing bodily harm (1), forcible confinement (11) and attempted murder (1).

Despite the fact that a suspect was identified in 82% of the crimes that occurred in the workplace (compared with 22% in the case of incidents that occurred outside the workplace), a charge was laid in only 30% of the cases (41% outside the workplace) and a conviction resulted in 22% of the cases (34% outside the workplace).

The actions and attitudes of representatives of the organization revealed some variations, but tended to minimize the incidents. More generally, victims did not feel they were being listened to, but felt rather that their employers were trying to invalidate their comments or the intensity of their reactions. Thus, only two incidents described during the interviews resulted in legal proceedings. Consequently, victims had feelings of abandonment, solitude and insecurity.

The impact of victimization

The second assumption we wanted to verify was the possible link between victimization of a correctional case worker and the development, in that person, of a state of distress, or even PTSD.

After the incident there were feelings of loss and, at the same time, a change in the victim's perceptions and attitudes. These changes were characterized by a polarization of expectations and increased mistrust of other people. Many respondents mentioned certain phenomena associated with fear of the client and the development of self-protection mechanisms that appeared during the weeks and months immediately following the victimization. They described themselves as becoming more rigid and harsh, with a greater desire to control their clients, who were all seen as being potentially dangerous.

In addition, the empirical verification of our assumption led us to study the initial fear, the deferred fear and the prevalence of PTSD among the respondents.

The degrees of the fear were graded as follows: no fear, slight fear, average fear, severe fear and panic. The most intense initial fear was related to forcible confinements and hostage-taking incidents. Fear described as being between average and severe fear was caused by incidents involving threats (of death), robbery, armed robbery, sexual assault, assault and assault with a weapon. Crimes against property (theft and mischief) resulted in an initial fear that the respondents described as slight.

There was a significant difference between the fear experienced at the time of the offence and the feeling of fear experienced afterward. Only the victims of forcible confinement and sexual assault reported retaining a higher degree of fear. Incidents involving threats, robbery, armed robbery, and assault with or without a weapon seemed more likely to result in slight, ongoing fear than did incidents involving theft and mischief.

There was a strong statistical association between the degree of deferred fear felt by the victim and his or her participation at various stages of the criminal justice system. The degree of deferred fear increased according to the stage reached in the justice system (denunciation, indictment, conviction).

In addition to fear, we also measured the symptoms of PTSD. The general incidence of PTSD in our sample was 16% (29/180); this percentage includes a first sub-group indirectly victimized (5/58 or 9%) and an other sub-group directly victimized (24/122 or 20%).

In statistical terms, PTSD appears significantly linked to the many forms of victimization (direct and indirect) and to fear. Compared with victims as a whole, the participants with PTSD showed higher degrees of fear, both at the time of the crime and after. No statistical link could be drawn regarding the age of respondents who were victims. However,

among men, who on average were older than the women in our sample, the actual age of those with PTSD was statistically higher than that of their peers without the disorder. These results could indicate that the incidents reported by men were not necessarily recent and that as people age the trauma related to earlier events may appear.[7]

Changes in professional practice after victimization

The third assumption we studied concerned post-incident, concrete or observable changes in the participant's work. These changes occurred in different ways, including changes in professional activities, different attitudes toward clients and changed expectations of support from the organization and from peers.

The data collected during the interviews allowed us to sketch a picture of the case workers who were victimized and the way in which they continued their careers after the incident. The process of withdrawal followed by the return to work, or continuous delivery of professional services, almost inevitably led to a series of ethical, personal and professional questions that we explored in the interviews.

A change in habits may also be reflected in their professional duties, their availability and their ability to perform these duties. For example, a number of the workers we interviewed said that after the incident, they were concerned about being fair to all their clients: they wanted to avoid associating all of them with the person who had victimized them.

The data collected in the questionnaire show that a minority of victimized individuals change their work habits. This finding indicates the full significance of the practices of consulting colleagues to verify one's personal perceptions.

The victimization of correctional case workers results in varying consequences depending on the time at which it occurs in a person's career, the place where it occurs, the nature of the crime and the personality of the victim.

The victimization of correctional case workers results in varying consequences depending on the time at which it occurs in a person's career, the place where it occurs, the nature of the crime and the personality of the victim.

Despite the results we obtained, our study of the impact of victimization on workers' clinical practice suggested more avenues of research to explore than discoveries to announce.

Possible approaches

We are convinced that in all practice settings there should be preventive strategies based on the maintenance and development of the health and safety of case workers in corrections. In a general context, studies could look at the aging of correctional case workers and the fact that their jobs are becoming more unstable; within the specific context of victimization, studies could consider the identification and measurement of the consequences of victimization, particularly among the baby boomers who entered the corrections profession during the 1960s and 1970s.

What is the impact of part-time work on the introduction of safety standards, control of the organizational structures for communicating information or the dangers of injury on the job? Is the additional stress of employment instability a factor that could cause the premature physical or psychological aging of these workers? These are questions that all interested parties should study to establish more effective preventive strategies in clinical settings.

Studying the contents of criminological evaluations written by clinicians involved in victimization incidents could result in information about changes in their professional practice. One way of analysing this situation involves the theory of attribution.[8]

In that case, our working hypothesis would be based on what Jones and David called an error in perception linked to "personalism."[9] By definition, this is a personalized interpretation of observed acts. Because the information or actions that have an emotional impact on the evaluator are more likely linked to personality than to environmental factors, a harsher judgment of the offender may result.

In practical terms, replacing the concept of trauma with a broader view of the quality of working life and a study of the factors in the readjustment of victimized workers would be the first step in the long road to better understanding the interactions between the professional workplace and the victimization of case workers. ■

[1] 10905 Henri Bourassa East, Montreal, Quebec H1C 1H1.

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