CORRECTIONAL COUNSELLOR RELATIONAL COMPETENCY ASSESSMENT: DEVELOPMENT AND VALIDATION

by

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Abstract

While correctional psychology has gained substantial understanding in reference to treatment-to-client matching criteria, little is known about service providers' relational factors and their contribution to offender rehabilitation. As the first step in a systematic investigation of this topic, this study's purpose was to develop and initially validate the Correctional Counsellor Relational Competency (CCRC) measure as well as to present relational profiles of correctional service providers across Canada. Three studies were conducted to achieve these objectives. In the first study, based on the input of experts in the field of correctional rehabilitation and the extensive literature review, stimulus materials (vignettes) and the responses to the selected vignettes were developed and then rated by the experts. Those vignettes and responses that demonstrated acceptable content validity were selected for further validity investigation. In the second study, 310 Correctional Program Officers and Community Service Providers completed the CCRC and demographic survey to assess initial psychometric properties of the instrument and to compare the relational profiles of correctional services providers across a number of demographic factors (e.g., gender, age, and ethnicity). As well, 92 participants completed the CCRC for the second time to assess test-re-test reliability. Exploratory factor analysis revealed a 7-factor structure of CCRC that included the following relational factors, confidence, empathy, confrontation, neglect, blame/criticism, reinforcement of antisocial attitudes and behaviours, and self-disclosure. The seven scales of CCRC had high internal consistency and test-re-test reliability. Analysis of repeated measures revealed group differences on a number of demographic factors in blame/criticism and reinforcement of antisocial attitudes/behaviours scales. Some differences were also found in confidence, confrontation, and self-disclosure scales of CCRC. Finally, in the third study, 246 Correctional Program Officers and Community Service

Providers completed an on-line package with 9 measures selected for construct validation. CCRC demonstrated convergent and divergent validity, as well as criterion validity with Empathy predicting group cohesion and Confidence and Self-disclosure predicting working alliance.

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Correctional Counsellor Relational Competency Assessment: Development and Validation

Generally, the treatment process is rooted in the interaction between three main components: the type of intervention strategies, clients' factors, and therapists' factors. For decades, the focus of both general and correctional research has been on the development of evidence-based intervention strategies, investigation of the clients' factors such as level of treatment readiness or risk/need, and the match between the type and/or intensity of treatment and clients' characteristics (Andrews & Bonta, 2003; Dowden, Blanchette, & Serin, 1999; Lightfoot, 2001; Marshall & Burton, 2010; Norcross, Beutler, & Levant, 2005; Orlinsky & Ronnestad, 2005; Van Voorhis & Gentry-Sperber, 1999). The therapist as a contributor to the treatment process and outcome has been ruled out by the majority of researchers or at best argued to be controlled for through random assignment of the clients or accounted for through standardized training of the therapists (Marshall, 2005; Norcross, et al., 2005).

However, a growing body of empirical evidence has accumulated pointing to the importance of therapist-related factors. In the general (clinical, psychotherapy) literature, early research suggested that some therapists are consistently effective and some consistently ineffective even when the level of training, type of treatment, and variation in clients are controlled (Lafferty, Beutler, & Crago, 1989; Luborsky et al., 1986; Orlinsky & Howard, 1980). More recently, both general and correctional research have attested that even in the presence of optimal client-strategy match, the success of therapy, very often, depends on the factors related to therapists or counsellors who are the primary agents of change (e.g., Huppert et al., 2001; Marshall 2005; Marshall & Burton, 2010; Project MATCH Research Group, 1998; Washington

State Institute for Public Policy, 2004). In fact, in many cases the effects of therapists greatly exceed the effects of treatment techniques in terms of client outcomes (Wampold, 2001).

If we accept the importance of therapist contribution to the therapeutic process and outcomes, the question then becomes what makes a therapist effective or what contributes to his/her ability to be an effective agent of change? It seems that the answer to this question lies in therapist intra- and inter-personal relational skills. It has been reported in general literature that the highest percentage of variance (10%) in treatment outcomes[1], after the client's contribution, can be attributed to the therapeutic relationship, 9% to the therapist who plays a significant role in establishing therapeutic relationship, and only 5% to the therapeutic strategies (Norcross & Lambert, 2005). Similarly, in correctional literature, Marshall (2005) reported that 32 to 61% of variance in specific indices of change during the intervention with sex offenders can be attributed to a combination of counsellors' relational features.

In recognition of the importance of relational factors in the treatment process and outcomes, there has been a shift in clinical research from studying treatment techniques, strategies and promoting evidence-based interventions to investigating the therapist and client factors in the context of a therapeutic relationship. The landmark of this shift was the commissioning of a task force by the American Psychological Association to "identify, operationalize, and disseminate information on evidence-based therapeutic relationships" (Norcross, 2002, p.7).

In comparison with psychotherapy, correctional research regarding therapist or counsellor factors, particularly relational factors, has sadly lagged behind. Even though a number of authors in the field have acknowledged the importance of service providers' contribution in the process

[1] Treatment outcomes include symptom reduction or decrease in distress symptoms, treatment length or completion, treatment satisfaction, and self-reported progress in treatment.

of change (e.g., R. Alexander, 2000; Andrews & Kiessling, 1980; Bauman & Kopp, 2006; Corey, 1995; Marshall, 1996; Marshall, Anderson, & Fernandez, 1999; Walters, 1998), only a limited number of researchers have examined this issue empirically. In the past 30 years only two groups of researchers have emerged who have subjected therapist factors to empirical investigation. Andrews and colleagues (Andrews & Carvell, 1997; Andrews & Kiessling, 1980; Andrews, Kiessling, Russell, & Grant, 1979 as cited in Totter 2009; Bonta, Rugge, Scott, Buorgon, & Yessine, 2008; Dowden & Andrews, 2004; Trotter, 1999) have attempted to investigate service provider factors in the context of offender community services (probation or parole) and Marshall and colleagues (Marshall, Anderson, & Fernandez, 1999, Marshall, et al. 2002; Marshall, et al., 2003; Marshall, 2005; Marshall & Serran, 2004; Serran, Fernandez, Mrshall, & Mann, 2003) have studied therapist factors in the context of sex offender treatment.

Andrews and colleagues outlined five principles of core correctional practices (CCP) of community service providers. Their research findings emphasized the importance of quality of interpersonal relationships along with specific strategies of intervention (e.g., appropriate modeling and reinforcement, problem solving, and effective use of community resources). Marshall and colleagues demonstrated that effective therapists working with sex offenders should be warm, empathic, rewarding, and directive. These authors also showed that therapist non-confrontational style of interaction (i.e., firm and supportive challenging) with offenders is more effective than a confrontational style of interaction (i.e., harsh, perceived as denigrating, challenging).

Clearly, both groups of researchers highlighted the importance of service provider or therapist relational skills and the quality of interpersonal relationships in working with offender populations. However, difficulties in operational definitions and measurement seem to have

impeded a wide-spread investigation of this topic in corrections. Andrews and colleagues have mainly relied on meta-analytical methodology without clarifying relational constructs, operational definitions, and the issues of measurement in their sample of studies. Marshall and colleagues have used coding manuals and worked with archival data providing limited methodology for future research by resting solely on rating of observers in their investigations. Furthermore, both groups of researchers have listed a number of relational factors without addressing potential overlap and clarifying the unique contribution of each relational factor to different treatment outcomes.

More specifically, in their last meta-analysis, Dowden and Andrews (2004) included the following list of counsellor characteristics, warm, genuine, humourous, enthusiastic, self-confident, empathic, respectful, flexible, committed to helping the client, engaging, mature, or intelligent in a loosely defined "relationship factors" category and coded all of these characteristics under one rubric. This strategy produced a heterogeneous category, where the contribution of each characteristic to the reduction in recidivism could not be determined. Moreover, each of these characteristics is a complex phenomenon that requires clear theoretical conceptualization and operational definition. It is still an empirical question whether or not all of these characteristics contribute to one or several higher-order factors. Furthermore, the percentage of studies that reported presence of relational factors and other core correctional practice indicators was quite low, ranging from 3 to 16%, and the authors did not comment on the quality of included studies, which limited the conclusiveness of their findings.

In sum, it can be argued that the lack of assessment of correctional counsellors' relational skills is a serious limitation in the field of offender rehabilitation that leads to scarcity of research on this topic and potential rejection or minimization of the importance of the role that service

providers play in treatment outcomes. As noted by Marshall and Burton (2010), the assessment of service providers' characteristics, particularly correctional counsellors' relational skills, should be a priority and one of the main focuses of correctional research.

To address the above limitations, to bridge the gap between psychotherapy and correctional research, and to continue the systematic investigation of the relational factors in the correctional setting, the present study proposes to develop a measure of correctional counsellor relational competency (CCRC) and validate it across a number of correctional programs delivered by a variety of clinical staff and for a variety of offender populations. In the following section, an extensive review of both general[2] and correctional literature is provided to identify correctional counsellor relational factors, to discuss theoretical underpinnings and conceptualisations of each relational competency and to present operational definitions relevant to the correctional setting. The process of the development of CCRC is described and the results of the validation phase of this study are presented. In the following pages, the terms therapist, correctional counsellor, counsellor, and service provider are used interchangeably to cover the vast variety of titles front line staff are given depending on the level and type of education and the population with which they work.

Relational Competencies: Theory, Research, and Operational Definitions

Empathy

Empathy was defined by Rogers (1957) as a counsellor's ability "to sense the client's private world as if it were his/her own, but without ever loosing the *as if* quality" (p. 99). Rogers and his colleagues stressed that to have *accurate empathy*, it is not only important to sense or

[2] It is important to mention the reasons for the choice to rely on the investigation of clinical literature. First, there are limited published articles available that studied the effective therapists' and/or service-providers' relational factors in the correctional settings. Second, despite some differences, theoretical explanations and general principles of change are similar in both clinical and correctional populations. Therefore, it can be assumed that relational factors impacting the process of change in clinical populations will effect change similarly in correctional populations.

perceive the client's private world but also to "communicate, accurately and with sensitivity, the feelings of the patients and the meaning of those feelings" (Traux & Charkuff, 1967, p. 285). In a more recent meta-analytic review, Bohart, Elliot, Greenberg, and Watson (2002) suggested that in addition to sensing and responding to affective experiences (i.e. feelings) of their clients, therapists can also enter and understand their clients' frame of reference cognitively, on a moment-to moment basis, or by trying to grasp an overall sense of what is it like to be that person. In other words, an accurately empathic therapist demonstrates understanding of the cognitive and emotional aspects of clients' communication, which unfold moment-to-moment in each session, without losing the contextual connection between clients' background and present experience (Bohart, et al., 2002).

From this point of view, accurate empathy is a complex multi-level phenomenon, which nevertheless is considered to be a learnable clinical skill (Egan, 1975; Miller, Hedrick, & Orlofsky, 1991; Truax & Carkhuff, 1967). Constructs such as *stages of accurate empathy* (Truax & Carkhuff, 1967) *empathic rapport*, *process empathy* and *person empathy* (Bohart, et al., 2002), as well as simple and complex *reflective listening* (Miller & Rollnick, 2002) have emerged in an attempt to operationalize or measure empathy, reflecting its complexity and variations, as well as to offer an outline for enhancing counsellors' ability to be empathic with their clients.

Initially, Truax and Carkhuff (1967) differentiated between high and low levels of accurate empathy, identifying 9 stages that reflect different degrees of being empathic. In the beginning stages, counsellors are either unaware or aware of client's obvious feelings and their responses reflecting client's mood or content of communication are not very accurate. As counsellors learn to listen, understand and sensitively respond, as opposed to evaluate their

clients, their attunement to the deeper feelings and reflections of unspoken messages increases. At the last stages, counsellors' responses fit better with client's mood and content of communication. Counsellors also master the correct recognition and reflection of the intensity of client's deep feelings which allow counsellors to have greater precision and timeliness in their responses.

Although the Truax and Carkhuff differentiation offers useful guidelines for counsellor training, these guidelines are specific to non-directive client-central therapy and might not be applicable for counsellors with a different theoretical orientation. More specifically, a heavy emphasis on client's emotional exploration might not reflect the goals of cognitive-behavioural intervention or other directive approaches. Importantly, Bohart, et al., (2002) proposed three modes of empathy (i.e., empathic rapport, communicative attunement, and person empathy) that capture the complexity of this construct and can be generalized across a number of therapeutic interventions.

Yet another attempt to capture the complexity of empathy originated within a directive client-centered therapeutic technique, Motivational Interviewing. Initially designed to promote motivation to change in clients who suffer from addictive disorders (Miller & Rollnick, 2002), it has recently been adapted to offender populations (Ginsburg, Mann, Rotgers, & Weekes, 2002; L. E. Marshall, Marshall, Fernandez, Malcolm, & Moulden, 2008; McMurran 2002; Miller & Rollnick 2002). This work suggests that in order to enhance accurate empathy, counsellor should be trained to use *reflective listening*. The authors further suggested that counsellor should learn how to use both simple and complex reflections appropriately. Simple reflections involve accurately repeating or summarizing client's statements and are used to promote client/therapist

exchange. Simple reflections add little or no meaning to client's utterances and offer no direction for exploration.

Complex reflections, on the other hand, require therapist appreciation of the communication complexity. Each client's statement might have multiple meanings that are more often implied than communicated. A statement like "I wish I were more sociable" might mean a number of things including "I feel lonely and I want to have more friends", "I get very nervous when I have to talk to strangers" or " I would like to be popular" (Miller & Rollnick, 2002, p. 69-70). When using complex reflections, the counsellor not just merely repeats what the client said but often uses word substitutions or guesses an unspoken meaning. Complex reflections create a movement forward on the client's path of exploration of his/her ambivalences, promotes statements of concern and awareness as well as change talk (i.e., motivation to change).

In addition to providing clear guidelines to clarify what reflective listening is, Miller and Rollnick (2002) also specified what reflective listening is not. The authors cautioned counsellors to be aware of "roadblocks", responses that get in the way of the direct path of client's exploration. Adapted from the work of Gordon (1970), 12 roadblock were identified and they included: i) ordering or commanding, ii) warning or threatening, iii) giving advice or providing solutions, iv) arguing or lecturing, v) moralizing, vi) judging, criticizing, or blaming, vii) approving or praising, vii) ridiculing or labelling, ix) interpreting or analyzing, x) sympathizing or consoling, xi) questioning, and withdrawing, xii) distracting or changing the subject (cited in Miller & Rollnick, 2002). In this study, empathy is operationalized as simple and complex reflective listening. Non-empathic responses include confrontation, passive aggression, and over-involvement and will be defined in the following sections on feedback and counter-transference.

Empirical investigations from two sources have been accumulated demonstrating the relationship of empathy and therapeutic outcomes (Ginsburg, et al., 2002; Norcross, 2002; Orlinsky, Ronnestad & Willutzki, 2004; One source includes research on the effectiveness of client-centered therapies where empathy is a key element of intervention [e.g., Motivational Interviewing] (Burke, Arkowitz, & Dunn, 2002; Ginsburg, et al., 2002; Noonan & Moyers, 1997) and the second source involves research on the general effectiveness of empathy (Bachelor, 1988; Bohart & Tallman, 1999; Myers, 2000; Norcross, 2002; Orlinsky, et al., 2004; Patterson & Forgatch, 1985) measured directly, on different process and outcome variables.

A large body of evidence exists in support of client-centered therapies (Elliott, 2002) with the mean effect size (i.e., Pearson r) for pre-post differences equal to .97 and for controlled effects equal to .80. As well, a recent application of directive client-centered approach, Motivational Interviewing (MI), has been found to be effective with a number of addiction disorders (e.g., Burke, Arkowitz, & Dunn, 2002; Dunn, DeRoo, & Rivara, 2001; Noonan & Moyers, 1997). Since MI advocates for all three relational conditions, empathy, positive regard, and congruence, as well as other techniques (e.g., open-ended questioning), it cannot be concluded from these results that empathy uniquely had an effect on the outcomes, however, it is safe to assume that a combination of certain facilitative conditions, including empathy might produce more favourable outcomes.

An interesting line of research that emerged from investigating the effects of MI, involves comparing empathic and confrontational style of counselling in substance abuse treatment (Miller, Benefield, & Tonigan, 1993; Patterson & Forgatch, 1985; Valle, 1981) and sex offender rehabilitation (Marshall, 2005; Marshall, et al. 2002; L. E. Marshall, et al. 2008). The results generally support an empathic style of counselling as opposed to confrontational counselling. For

the latter, the goal is to break through client's resistance and to promote quick changes by direct confrontation, discomfort and punishment. As well, in correctional literature, it has been demonstrated that programs such as "boot camps" and "scared straight" that maximize the level of confrontation and external control not only do very little to reduce recidivism but often contribute to its increase (Andrews, et al., 1990).

In terms of the general effectiveness of empathic listening, it has been demonstrated it is a consistent and robust predictor of therapeutic outcomes, with medium effect size ranging from r=.26 to r=.32, accounting for 8% to 10% of the variance in outcomes (Norcross, 2002; Orlinsky, et al., 2004). The magnitude of empathy's effect size is comparable and slightly larger than that of therapeutic alliance (r=.26 estimated by Horvath & Symonds, 1991; or r=.22 estimated by Martin, Garske & Davis, 2002) and can explain more outcome variance than the specific intervention utilized (compared to 1% to 8% of outcome variance estimated by Wampold, 2001 for interventions).

More specifically, psychotherapy research shows that empathic understanding effects client satisfaction with therapy and by doing so increases their compliance with treatment (e.g., self-disclosure, desire for help, and treatment completion) (Altmann, 1973; Bachelor, 1988; Chafetz, et al., 1962, 1964; Landfield, 1971; Myers, 2000). Moreover, it provides "corrective relational experience" (Bachelor, 1988; Myers, 2000), raises the client's level of productive experiencing (Klein & Mathieu-Coughlan, 1986; Rice & Saperia, 1984), promotes client's involvement (Bohart & Tallman, 1999), reduces resistance to change (Patterson & Forgatch, 1985), as well as mobilizes client capacity for self-change (Bohart & Tallman, 1999). It has been also demonstrated by Andrews, et al. (1979) in correctional research that the use of reflective

listening along with pro-social modeling and reinforcement has a significant impact on the reduction of recidivism (as cited in Trotter, 2009).

In sum, there is sufficient evidence relating therapist empathic skills with treatment process and outcome variables. This relationship is so robust that some researchers have gone so as to consider empathy as a causal factor of therapeutic change (Burns & Nolen-Hoeksema, 1992; Miller, Taylor, & West, 1980). The APA Task Force on therapeutic relationships identified therapist empathy along with client-therapist interaction factors (therapeutic alliance, group cohesion, goal consensus and collaboration) to be the only therapist factor that has consensual agreement among clinicians and researchers regarding its effectiveness.

Regard and Feedback

Positive regard was defined by Rogers (1957) as the extent to which "the therapist finds himself experiencing a warm acceptance of each aspect of the client's experience as being a part of that client unconditionally" (p.98). In this definition positive regard encompasses friendliness, respect and non-possessive caring for the client. The client is perceived as a unique and special human being. Actions of the client are absorbed without criticism and judgment. Rogers believed that an effective therapist is able to provide a non-threatening, safe, trusting, and secure atmosphere for clients' psychological growth through his/her own acceptance, caring, respect, valuing, warmth, and interest for the client.

Building on Roger's work, Truax and Carkhuff (1967) introduced a construct of *non-possessive warmth*, placing an emphasis on unconditionality of regard or acceptance. In their definition:

> non-possessive warmth for the client means accepting him as a person with human potentialities. It involves a non-possessive caring for him as a separate person and, thus, a

> willingness to share equally his joys and aspirations or his depressions and failures. It involves valuing the patient as a person, separate from any evaluation of his behaviour or thought. Thus, a therapist can evaluate the patient's behaviour or thoughts but still rate high on warmth if it is quite clear that his valuing of the individual as a person is uncontaminated and unconditional. (pp. 59)

The relationship between unconditional acceptance or non-possessive warmth and therapeutic outcome was extensively investigated in the late 60's and 70's by Carl Rogers and his students and colleagues (see Truax, et al., 1966; Truax & Mitchell, 1971; Mitchell, Bozarth, & Krauf, 1977, for review of findings). Early reports usually looked at the presence of all three conditions (empathy, non-possessive warmth, and congruence) suggesting that the presence of at least two conditions to be predictive of favourable outcomes in the majority of cases. Later, when non-possessive warmth was investigated separately, it became apparent that even though there were no negative findings, a positive relationship of non-possessive warmth with a number of outcome measures only reached significance 31% (34/108) of the time (Truax & Mitchell, 1971).

These findings question the effectiveness of unconditional acceptance in the therapeutic process. They also question the possibility of a therapist achieving a level of complete unconditionality. Indeed, it has been argued that unconditional acceptance is impossible since all therapists, even those who are highly aware of their interaction with their client, tend to reinforce selectively (see Truax & Mitchell, 1971, for discussion). There is also a question whether or not unconditional acceptance is at all relevant to the therapeutic process in the context of cognitive-behavioural intervention where selective reinforcement is the central therapeutic technique. It

can be argued that positive regard should not be viewed just in terms of unconditional acceptance.

A movement from abstract conceptualizations of positive regard (e.g., non-possessive warmth or unconditional acceptance), to more observable expressions of therapist positive feelings, attitudes, and behaviours towards their clients such as affirmations and friendly behaviours was initiated by two different theoretical approaches. The first approach originated from the client-centered psychotherapy. Building on Rogers' work, Barrett-Lennard (1986) differentiated what he called "an awkward concept of unconditional positive regard" into two operationally clear constructs, the *level of regard,* which refers to the level of positive and negative emotional reactions to a particular client and *unconditionality of regard,* which refers to the constancy of positive regard. The second approach was rooted in the development and application of circumplex models of social interactions (Benjamin, 1974) and interpersonal behaviours (Leary, 1957) to the analysis of psychotherapy processes (e.g., Constantino, 2000; Najavits & Strupp, 1994; Orlinsky & Ronnested, 2005).

These models propose that social behaviours can be organized along two dimensions, affiliation-disaffiliation and control-autonomy. More specifically, Benjamin's (1974) structural analysis of social behaviour (SASB) model allows measuring the affiliation and control behaviours of a therapist and corresponding affiliation and interdependence behaviours of a client. For example, based on a social interaction theory, it is expected that friendly behaviours of a therapist will elicit friendly reactions of a client, while controlling behaviours of a therapist will elicit submissive behaviours. Interactions aside, these models can also tap into the construct of therapist regard. Behaviours such as affirming, nurturing, protecting, belittling, blaming, attacking, rejecting, and ignoring can all be considered as operational definitions of therapist

regard and provide a detailed account of behavioural representation of what Barrett-Lennard (1986) referred to as a single abstract dimension of positive and negative feeling reactions of one person to another or, more simply, the level of regard.

Considerable evidence has accumulated since the 1980s in support of the relationship between therapist's level of regard and therapy outcomes. Building on the findings from the Rogers' group, Orlinsky and colleagues (1978, 1986, 1994, and 2004) conducted comprehensive reviews of the literature and organized the process-outcome research under the rubric of *therapist affirmation versus negation.* Based on 73 studies, these authors found that positive regard, defined as affective attitudes or positive (e.g., liking, warmth, caring, respect) feelings towards a client serves as a facilitator of growth, healing, and therapeutic change in comparison to negative regard, defined as negative feelings towards a client (e.g., wariness, aloofness, resentment, hostility).

Affirmation, positive feedback, positive reinforcement, validation, and *rewardingness* are all conceptually similar and can be viewed as behavioural representation of therapist's regard, in this case, positive regard. Affirming and supporting the client during the therapeutic process is discussed as one of the strategies in Motivational Interviewing (Miller & Rollnick, 2002), an approach found to be effective with substance abuse clients and recommended as an adjunct to existing interventions with juvenile and adult offenders (Ginsburg, et al., 2002; Kistenmacher & Weiss, 2008; L. E. Marshall, et al., 2008; Musser, Semiatin, Taft, & Murphy, 2009; Preston 2001; Print & O'Callaghan, 2004). As well, affirming or reinforcing pro-social attitudes and behaviours have been argued to be an important component in correctional treatment (Andrews, et al., 1990; Andrews & Bonta, 2003; Bonta, et al., 2008; Dowden & Andrews, 2004; Preston 2001). Recently, affirming improvement in the quality of life in general as opposed to just

affirming changes in criminogenic factors (e.g., antisocial attitudes, behaviours, and/or associates, etc.) has been proposed as promising element in offender rehabilitation (Ward & Brown, 2004; Ward,Vess, Collie, & Gannon, 2006).

Positive feedback, defined as therapist communication directed towards praising, encouraging, and supporting the client or describing the client's behaviour as effective (Claiborn, Goodyear, & Horner, 2002) was found to significantly impact treatment outcomes with alcoholic clients (Miller, et al., 1993), sex offenders (Marshall, et al., 2002; Beech & Hamilton-Giachritsis, 2005), violent (non sexual) offenders (Taft, Murphy, Elliott, & Morrel, 2001), child protection clients (Shulman, 1991), youth (see Karver & Caparino, 2010 for review; Sukhodolsky, Kassinove, & Gorman, 2004), juvenile offenders (Alexander, Barton, Schiavo, & Parsons, 1976), as well as in working with groups of offenders and non offenders (Beech & Fordham, 1997; Morran, Robinson, & Stockton, 1985; Stockton & Morran, 1981).

In addition to positive feedback, a therapist can give negative or corrective feedback to clients, tapping into yet another aspect of therapist regard. In the clinical literature, negative or corrective feedback, defined as therapist communication reflecting ineffectiveness of certain client's behaviours (Claiborn, et al., 2002) has been consistently demonstrated as being less effective and less well received by clients in comparison to positive feedback (see Claiborn, et al., 2002, for discussion). More specifically, positive feedback is more effective in establishing working alliance, trust, and group cohesion than negative feedback (Rotheram, LaCour, & Jacobs, 1982). Nevertheless, negative feedback has been advocated as an important corrective strategy that, if delivered sensibly by a therapist, can be very effective. Alternatively, if the delivery of negative feedback is not managed properly, it can contribute to client's distortion and resistance (Claiborn, et al., 2002; Morran, et al., 1985). Notably, negative feedback was found

most effective in the later stages of therapy when therapist-client relationship has been established and the therapist is perceived as a credible source of information (Claiborn, et al., 2002; Rotheram, et al., 1982).

In contrast to the clinical literature, correctional researchers put equal, and sometimes greater, weight on the importance of negative feedback, confrontation, or anti-social discouragement as opposed to positive feedback (Bonta, et al. 2008). In fact, confrontation and negative feedback addressing anti-social attitudes and behaviours, which are used interchangeably in the correctional literature, are still believed to be the main agents of change with offenders (Andrews, Bonta, & Wormith, 2006; Bonta, et al., 2008; Gendreau, 1996; Trotter, 1999, 2002). Recently, however, the over-emphasis on confrontational approach in offender rehabilitation has come under attack. A number of authors (i.e. Kear-Colwell & Boer, 2000; Kear-Colwell & Pollock, 1997; Preston 2001) have argued against confronting clients in the beginning of treatment as it might prevent formation of group cohesion and/or establishment of therapeutic alliance, both necessary conditions for change. These authors also argued that confrontation might promote resistance to treatment and contribute to treatment attrition. Moreover, some authors suggested that an aggressive confrontational approach (i.e., harsh, and perceived as denigrating and challenging) should be avoided all together in offender rehabilitation (Marshall, et al., 2003; Marshall & Burton, 2010; Williams & Henley, 2005).

In this context, it is important to differentiate between therapist negative or corrective feedback and such counter- transferential behaviours as negating or negative regard, which can be considered as a third facet of therapist's regard. Corrective feedback if delivered appropriately is argued to be an effective strategy in rehabilitation. Confronting clients about their maladaptive behaviours does not just offer clients new information but also a new perspective on the self and

the world (Claiborn, 1982). Whereas, negating or negative regard, expressed in such negative therapists behaviours as criticism, non-acceptance, disrespect, misunderstanding, rejection, and distortion of clients statements, has been demonstrated to have detrimental effects on clients' improvement. It has contributed to clients getting worse and dropping out of treatment in the general literature (Henry, Schact & Strupp, 1990; Nejavits & Strupp, 1994) and to the avoidance of treatment (Drapeau, Körner, Granger, Brunet, & Caspar, 2005), lack of improvement in treatment (Marshall, et al., 2002; Marshall, et al., 2003), and increased rates of re-offending in the correctional literature (Trotter, 1990; 1993; 1995; 1996, cited in Trotter, 1999).

Clarifying the necessary conditions for the delivery of negative feedback, researchers in the general literature demonstrated that it can be helpful to deliver corrective feedback after or between offering positive feedback (Rose & Bednar, 1980; Schaible & Jacobs, 1975; Stockton & Morran, 1981). Similarly, correctional researchers have suggested, with some empirical support, that disapproval of anti-social attitudes and behaviours (delivery of negative feedback) should be done in the environment of respect, care, and active engagement in the process of client's rehabilitation, as opposed to hostility, blaming, control, and punishment (Dowden & Andrews, 2004; Ginsburg, et al., 2002; Trotter, 1999; 2002).

In sum, positive feedback, negative feedback, and negating can be considered as different behavioural facets of the therapist regard continuum. They can serve as operational definitions of this construct, as they appear to have differential influence on treatment outcomes. Affirmation, validation, rewardingness, positive reinforcement and feedback play an important role in the beginning of treatment while negative or corrective feedback, if delivered skilfully, can be beneficial towards the end of treatment. It is clear that negation, judgment, blame and criticism have a negative effect on offender rehabilitation and can be considered to be on the opposite end

of the therapist regard continuum. The summary of construct definitions and operational definitions is presented in Appendix A.

Self-Disclosure

Therapist self-disclosure as a strategy for intervention has been one of the most discussed and controversial topics of the last 15 years. Farber (2003) mentioned several reasons for such interest in the special issue of *Journal of Clinical Psychology* dedicated to the topic of self-disclosure. He believes that the research on this topic is timely and pressing since there has been an obvious shift from focusing on intra-psychic to interpersonal issues and from a single-person to a dyadic client-therapist relationship in psychotherapy; as well as a move from anonymous to a more open, revealing and self-disclosing culture in the world of high technology and isolation. Self-disclosure, defined generally as statements revealing something personal about the speaker (Hill & Knox 2002), has become an integral part of our lives and is advocated to promote authenticity, egalitarianism, and mega-experience of human interconnectedness.

Historically, self-disclosure as a therapeutic technique was proscribed mainly due to the influence of prevailing thinking at the time, a psychodynamic perspective (Farber, 2003; Hill & Knox, 2002). Even though alternative views existed (e.g., Ferenczi's mutual therapy), a majority of practitioners followed strict psychoanalytic guidelines of anonymity, neutrality, abstinence, and non-self-disclosure (Farber, 2003; Hill & Knox, 2002). These guidelines were established so that a patient can project their sexual and aggressive tendencies onto a therapist, whose goal is to uncover, interpret and resolve patient transference (Geller, 2003).

Psychodynamic authors have recognized, however, that the Freudian prescription of being completely objective and neutral is difficult to fulfill. Disclosure of therapist personal nonverbal information through appearances and office decor cannot be avoided (Lane & Hull,

1990). As well, the humanistic perspective revolutionized and liberated conservative views of the psychodynamic school of thought. Proponents of a humanistic approach advocate for therapist transparency, authenticity, realness, mutuality (Robitscheck & McCarthy, 1991) and demystification of the therapeutic process (Kaslow, Cooper, & Linsenberg, 1979). In fact, it is believed that through therapist genuine self-disclosure, the experience of therapy becomes less threatening, the power and control in the client-therapist relationship become equalized and the humanness and universality of clients' experiences are confirmed (Cornett, 1991; Jourard, 1971, cited in Hill & Knox, 2002).

Following this line, psychodynamic therapists have also changed their views on the appropriateness of therapist self-disclosure. Even though, it has been recommended that the decision to use self-disclosure should be carefully weighed and "less sometimes is more", the obvious advantages of self-disclosure for increasing client engagement and motivation for treatment and client awareness of the effects of their behaviours on others (therapist) have been recognized (Geller, 2003; Goldstein, 1997). Similarly, other theories including feminist, multicultural and cognitive-behavioural have fully embraced the strategy of self-disclosure (Constantine & Kwong-Liem, 2003; Enns, 1997; Goldfried, Burckell, & Eubanks-Carter, 2003; Mahalik, VanOrmer, & Simi, 2000).

Hill and O'Brien (1999) distinguished self-disclosure from immediacy. The notion of immediacy overlaps with a third "necessary condition" for effective psychotherapy brought forward by humanistic psychologists. Therapist's congruence, defined as an ability of the therapist to reveal his/her experiences to a client or being transparent (Rogers, 1957) is this necessary condition. Rogers draws a reference to an integrated therapist who "within the relationship is freely and deeply himself, with his actual experiences accurately represented by

his awareness of himself....which is the opposite of presenting a façade, either knowingly or unknowingly" (p. 97).

Even though attempts were made to operationalize and measure congruence (e.g., Barrett-Lennard, 1962), the complexity of the identified processes involved in being congruent (i.e., therapist total experience, awareness of this experience, and genuineness of communication) created barriers for further research. It is not surprising that the interest of researchers in therapist congruence has been replaced with theoretical and empirical activities around related constructs such as real relationship (Gelso & Carter, 1994; Gelso & Hayes, 1998; Gelso, et al., 2005), immediacy which is an aspect of self-disclosure (Hill & Knox, 2002; Goldfried, et al., 2003), counter-transference and its management (Gelso & Hayes, 2002; Heyes, Gelso, VanWagoner, & Diemer, 1991; Van Wagoner, Gelso, Hayes, & Diemer,1991), and the more general topic of therapist well-being (Beutler, Machado, & Neufeldt, 1994; Beutler, et al., 2004).

In this study disclosing immediate feelings (i.e., immediate self-disclosure) and disclosing personal information (i.e., personal self-disclosure) will be referred to as two types of self-disclosure. Immediate self-disclosure or immediacy is defined as disclosing "immediate feelings about self in relation to the client, about the client, or about therapeutic relationship" (Hill & O'Brien 1999, p. 369). Personal self-disclosure is defined as "revealing something personal about the helper's non-immediate experience or feelings" (Hill & O'Brien 1999, p.369), such as "I felt the same way when I was trying to quit smoking".

Hill and O'Brien (1999) also described a typology of personal self-disclosing statements which consisted of four categories: disclosure of facts, disclosure of feelings, disclosure of insight and disclosure of strategies. These four types of disclosure refer to the facts about a

therapist (e.g., credentials), feelings and insights the therapist experienced in similar situations to his/her client, and strategies a therapist might have used in the past when presented with similar circumstances.

In addition to immediate and nonimmediate therapist self-disclosures, several authors have suggested to differentiate self-disclosing statements according to their intent. For example, Hill, Mahalik, and Thompson (1989) argued that two intents, "to reassure" and "to challenge" can distinguish between positive or negative self-disclosure. In their view, "reassuring disclosure support, reinforce, or legitimize client's perspective, way of thinking, feeling, and behaving; whereas challenging disclosures challenge the client's perspective, way of thinking, feeling, or behaving" (cited in Hill & Knox, 2002, p.256).

It is important to mention in this context that the constructs of self-disclosure and feedback have some overlap. The purpose of reassuring disclosure is very similar to affirmation and positive feedback when communication of positive regard is the goal, while the purpose of challenging disclosure overlaps with that of negative feedback (for review see regard & feedback section). Immediate self-disclosure is very similar to feedback. In fact, it can be considered a type of feedback that a therapist offers to the client about the effect of a client's action on the therapist. Personal self-disclosure, however, is different from feedback in that the therapist offers information about him/her-self. Feedback is when the therapist gives information directly about the client's behaviours. Despite some overlap, it is the revealing of the therapist's personal world that might have a differential effect from that of affirmation, positive, or negative feedback on a clients' improvement.

In offender rehabilitation, modeling and reinforcing pro-social feeling, thinking, and behaving, teaching offenders problem solving skills, as well as challenging antisocial attitudes

and behaviours are central treatment strategies for effective intervention (Bonta, et al., 2008; Andrews & Bonta, 2003; Dowden & Andrews, 2004; Gendreau, 1996; Trotter, 1999). Moreover, immediate as well as non-immediate self-disclosing statements made by therapists might be instrumental in implementing such social learning/ cognitive-behavioural strategies. In fact, the evidence for usefulness of self-disclosure as a strategy can be found in the context of cognitive-behavioural therapy. Goldfried, et al. (2003) discussed self-disclosure as a useful strategy for providing feedback, modeling, enhancing motivation, and strengthening therapeutic alliance.

Providing immediate information or feedback to the client on interpersonal impact (i.e., immediacy) is suggested to be most effective with individuals diagnosed with personality disorders (Benjamin & Karpiack, 2002; Goldfried, et al., 2003; Linehan, 1993). The poor emotion regulation and impulsivity, disregard for consequences and aggression of these clients present numerous challenges for clinicians. For instance, it is difficult to maintain a therapeutic bond with these individuals, to overcome their resistance and defensiveness as well as to deal with therapists' own emotional or count-transference reactions to these patients (Kernberg, 2001; Linehan, 1993; Piper, Rosie, & Azim, 1996). Taking into account that a large percentage of offenders are diagnosed as having anti-social personality disorders and/or display similar characteristics to individuals diagnosed with personality disorders (Dahle, 1997; Lykken, 1995), immediate self-disclosures might be quite useful in dealing with some anti-social attitudes and behaviours in therapy.

It might be very instructive to immediately disclose the impact client's behaviours make on a therapist. This immediate feedback might show clients how other individuals in their lives might have been or will be affected by their behaviours. Linehan (1993) noted that her clients:

> ... were often raised in families where reactions to their behaviour were either not communicated or not normative. Thus, a patient is often unaware of how her behaviour affects others until it is too late to repair the damage. It is particularly important to give the patient feedback on her behaviour fairly early in the chain of detrimental interpersonal behaviours, rather than waiting until a reaction is so strong that the relationship will be difficult to repair. (p. 378)

This immediate self-disclosure or feedback is believed to explicate interpersonal consequences of clients' behaviours and opens the door for re-evaluation and change (Burckell & Eubanks-Carter, 2003; Benjamin & Karpiack, 2002; Linehan, 1993).

Working with offenders, as with patients with personality disorders, requires self-disclosing the negative impact a client makes on a therapist (Burckell & Eubanks-Carter, 2003; Linehan, 1993). However, this negative feedback often elicits defensive and angry reactions. Therefore, as was noted in the section on therapist's regard and feedback, the corrective negative personal responses should be done by the therapist in a context of therapeutic caring and trust. The balance between accepting the client and promoting change is considered to be a key component when working with individuals presenting personality disorder characteristics (Linehan, 1993).

Further, therapist personal self disclosure to model an effective way of functioning or to offer alternative ways of thinking and acting is recognized as an appropriate and helpful technique by cognitive-behaviour theorists (Burckell & Eubanks-Carter, 2003). Such disclosure is also embraced by a number of other approaches including humanistic/existential (Hill & Knox, 2002). Burckell and Eubanks-Carter (2003) wrote "...an important function of therapist self-disclosure is to help demonstrate behaviours that are novel for clients" (p.565). In the case of

offenders, there is a lack of experience with pro-social role models (Andrews & Bonta, 2003). Offenders are raised in families that often fail to demonstrate appropriate pro-social functioning. As well, their current environment (anti-social peers, family, jail /prison) fails to model what is appropriate (Glueck & Glueck, 1950). The role of the therapist might often involve demonstrating how therapists would act in similar situations to which their clients encounter. The demonstration might involve the therapist to expose his/her way of thinking and feeling, the steps he/she would make to problem-solve and make decision regarding what actions to take considering possible consequences. This process might in turn encourage alternative ways of thinking and acting in offenders.

Therapist self-disclosure does not necessarily have to involve demonstration of a particular strategy (problem-solving), it can also involve a disclosure of therapists' past insights or feelings relevant to the client's current situation (Hill & Knox, 2002). An insight type of self-disclosure is particularly relevant in practice by paraprofessionals who are recovering addicts or ex-offenders themselves. Self-disclosure of insights similar to those their clients are struggling to gain might be invaluable for increasing client's readiness for change and facilitating progress in general.

Motivation is an important factor in offender rehabilitation (McMurran, 2002) as it facilitates the movement of a client from a stage of denial and corresponding lack of motivation to change (i.e., pre-contemplation) through a stage where a client considers the importance and need to change (i.e., contemplation) to a stage of taking steps towards changing attitudes, thoughts, feelings and behaviours (i.e., action) (Prochaska & DiClemente, 1982). The self-disclosure of a therapist, colleague or former client success story that involves overcoming barriers to change might be particularly useful in enhancing client motivation. Burckell and

Eubanks-Carter (2003) argued that immediacy (immediate self-disclosure) related to a person's lack of desire to be in treatment might increase readiness and motivation for treatment.

Finally, therapist disclosure can strengthen the therapeutic alliance or working relationship between a client and a therapist. Therapeutic alliance has been argued to be an important building block for effective intervention across a wide range of treatment modalities including cognitive-behavioural in both clinical (Horvath & Bedi, 2002; Norcross, 2002) and correctional (Polascheck & Ross, 2010) settings. No matter how skilful the therapist is in adhering to the most effective strategies for intervention, he/she is unlikely to be successful without a strong therapeutic alliance (Burckell, & Eubanks-Carter, 2003; Horvath & Bedi, 2002). Immediacy or disclosure of therapist immediate feelings has been argued to promote the sense of realness, genuineness and congruence of the therapist, which in turn helps to establish trust and contributes to building a strong therapeutic bond (Burckell, & Eubanks-Carter, 2003).

Thus far, the types and therapeutic goals for therapist self-disclosure as well as the relevance of this strategy to interventions with offenders in the context of social learning and cognitive-behavioural approaches have been reviewed. Prior to moving to the empirical evidence for the effectiveness of this strategy, it is important to note the decision to self-disclose should be guided by the client's therapeutic needs at a particular moment. The therapist should consider the appropriateness, timing, and amount of personal information to be shared (Burckell, & Eubanks-Carter, 2003).

Hill and Knox (2002) warned therapists against using disclosure for their own needs, thus changing the focus from a client to the therapist by self-disclosing and interfering with the flow of the session, burdening, confusing, or over-stimulating the client, and blurring the client-therapist boundaries. These reasons for using self-disclosure may signal a therapist's internal

conflict and their inability to manage counter-transference (this topic will be discussed in greater detail in the next section). Moreover, the misuse of self-disclosure has been suggested to potentially lead to an adverse therapeutic process and outcome (Hill & Knox, 2002; 2003; Geller, 2003; Burckell, & Eubanks-Carter, 2003).

As noted earlier, the topic of self-disclosure is fairly new and the limited evidence that does exist is mixed and inconclusive in the general literature regarding its effectiveness. Hill and Knox (2002) criticized the methodology with which researchers have tried to investigate this topic. They stated that majority of studies have focused on the frequency of therapist self-disclosure as opposed to the type, timing, quality, and client readiness for disclosure. Frequency methodology used so far does not control for therapist misuse or inappropriate use of this strategy. In the present study a vignette approach is used to assess relational factors including self-disclosure. Through the vignette approach, it is possible to define appropriate situations for self-disclosure, which in turn will allow the evaluation of types and quality of self-disclosure.

Hill and Knox (2002) presented the results of five studies on four data sets using different methodology to reveal the effect of therapist self-disclosure on both intermediate and distal treatment outcomes. In terms of intermediate outcomes, Hill, et al. (1988, 1989) showed that in response to therapist self-disclosure, clients disclosed more and were more satisfied with treatment. These group of researchers also demonstrated that reassuring disclosures were more helpful from the client's point of view than challenging disclosures. Furthermore, Knox, Hess, Petersen, and Hill (1997) underscored the complexity of the effect of therapist self-disclosure on the therapeutic process. They reported that therapist self-disclosure made the therapist seem more human and real, which in turn strengthened the therapeutic relationship and helped the

client to feel reassured and normal, as well as providing the foundation for client self-exploration, honesty and positive change.

As for distal treatment outcomes, P.S. Ramsdell and Ramsdell (1993) found that after a number of treatment sessions, clients rated therapist self-disclosure as having beneficial effect on their progress in therapy. Similarly, Barrett and Berman (2001) found that therapist self-disclosure in response to client disclosure was rated as being beneficial and contributed to a decrease in distress symptoms after treatment.

In the correctional literature, the limited evidence that does exist on disclosure is quite consistent; disclosing yields positive client perceptions of service providers' helpfulness and their own improvement in treatment (Trotter, 1993; Shulman, 1991). Disclosure also results in lower rates of re-offending (Alexander, et al., 1976). In conclusion, although self-disclosure as a therapeutic factor or strategy has not been clearly defined and extensively studied, there is tentative support for its utility in the offender literature (e.g., Marshall, et al., 2003; Preston 2001). Building on the cognitive-behavioural approach, there seems to be a great potential for this technique to enhance motivation to change and the therapeutic bond, as well as to provide corrective experience, and model and reinforce pro-social behaviours.

Counter-Transference (CT)

In discussing the topic of self-disclosure, the importance of therapist judgement in terms of when, how, and for what purposes to use self-disclosures was noted. However, some unwelcome and potentially damaging self-disclosures might penetrate a therapeutic encounter when a therapist is not aware of his/her internal unresolved conflicts being projected onto a client. In these instances, therapists are using self-disclosure and feedback to satisfy their own unmet needs. This phenomenon refers to *counter-transference*, a term originated in

psychoanalytic tradition and first introduced by Sigmund Freud. Freud (1910/1957) wrote, "we have become aware of the 'counter-transference', which arises in him [therapist] as a result of patient's influence on his unconscious..." (p. 144). He further suggested that psychoanalysis is limited in the ability to help a client by the therapist's his own complexes and internal resistances. Therefore, Freud believed that a therapist should "begin his activity with a self-analysis and continually carry it deeper while he is making his observations on his patients" (p. 145).

The above conceptualization of counter-transference focusing mainly on the unconscious unresolved material of a therapist (therapist inappropriate reactions) has been referred to a *classic view* of counter-transference. According to this view, counter-transference is a negative and harmful factor in psychotherapy that has to be strictly dealt with and possibly eradicated (Reich, 1951; 1960). As psychodynamic theorists moved beyond classical drive and ego analytical theory to relational and interpersonal dynamic models, counter-transference became to be viewed as an important tool that a therapist should use to understand his/her client's internal world. In this view, which was termed *totalistic*, psychoanalytic theorists have put an end to looking at counter-transference as a hindrance to the therapeutic process and started regarding all of the therapist's emotional reactions, be it neurotic or non-neurotic as useful material for analysis (Heimann, 1950; Kernberg, 1965; Little, 1951). These theorists, however, did not offer a clear and meaningful differentiation between a myriad of emotional reactions and remained quite conservative in terms of sharing some of the therapists' emotional reactions with their patients.

Gelso and Hayes (2002) criticized a totalistic view of counter-transference and suggested that if all emotional reactions are meaningful, then there is no need for the term counter-transference. Based on this argument, it was proposed to narrow the totalistic definition of

counter-transference to the following; therapist defensive and irrational reactions to clients that are based on the therapist's own unresolved conflicts and anxieties (Hayes 2004). This definition refers to an *integrative conception of CT*. The integrative conception is very close to the classical perspective with the exception that, it does include conscious reactions and, similar to the totalistic perspective, it views CT as potentially helpful for the therapeutic process if a therapist explores and understands his/her CT reactions (Gelso & Hayes, 2002).

The integrative conception of CT is no longer a psychoanalytic but rather a transtheoretical construct. Indeed, theorists from different schools of thought agree on its common occurrence, definition, and potentially harmful effect on the therapeutic process and outcomes, if not managed effectively (for the discussion of CT in cognitive-behavioural therapy, self-psychology, feminist social constructivism, experiential therapy, family and systems therapy as well as interpersonal communications therapy, see Ellis, 2001, Guy & Brady, 2001, Brown, 2001, Mahrer, 2001, Kaslow, 2001 and Kiesler, 2001, respectively). Hayes, et al. (1998) offered empirical support for the universality of CT. Eight experienced therapists identified CT as being present in 80% of 127 sessions. Specifically, these defensive and irrational reactions and feelings towards their clients resulted from their own unresolved conflicts and anxieties (i.e., counter-transference).

Counter-transference was further differentiated by Gelso and Hayes (2002) who suggested that there is internal state and overt expression of counter-transference. This subdivision is quite helpful for operationalizing CT. Internal states include emotional (anxiety, feeling states ranging from highly negative to highly positive, varying degree of emotional intensity ranging from high to under intensity) and cognitive (failure to recall session events and material accurately). The overt expression of counter-transference is represented by CT

behaviours that can include withdrawal, under-involvement, or avoidance of patient material, as well as over-involvement (being overly engaged and concerned about the client). Counter-transference behaviours (i.e., external CT) are generally considered to hinder the therapeutic process and have a negative effect on outcomes. Alternatively, counter-transference internal states (i.e., internal CT) are considered to be helpful for understanding patient's inner world, and, when analyzed and managed successfully by the therapist, can enhance therapeutic process and outcomes.

The focus of this study was on external CT or counter-transferential behaviours. The external states of CT were operationally defined using a cognitive framework. Rudd and Joiner (1997) criticized the inclusion of unobserved and unconscious constellations in defining CT and proposed an operational definition that was consistent with a cognitive framework. In this definition, therapists' reactions to a patient vary from hostile aggressor, to receptive collaborator, to helpless victim. The hostile/aggressive and helpless/victim reactions behaviourally manifest in rejection / abandonment and overprotecting / caretaking, respectively. These behavioural reactions represent therapist overt states of counter-transference or external CT. In contrast, receptive and collaborating responses manifest in active treatment behaviours and indicate the absence of external CT.

More specifically, hostile aggressor behavioural responses might include termination of treatment, referral to another counsellor, and such provocative behaviours as being late for appointments, cancellation of sessions, negating, ignoring, rejecting, criticizing, and blaming a client. Helpless victim behaviours might include overly cautious monitoring, caretaking, frequent interventions, and sympathizing instead of empathizing with the client.

Both Gelso and Hayes (2002) and Rudd and Joiner (1997) had similar conceptualization of one aspect of counter-transference, over - involvement. All authors described caretaking, sympathizing, and overly engaged therapist. The authors differed, however, in the conceptualization of avoidance. In contrast to Gelso and Hayes (2002) who considered passive avoidance behaviours of therapists (e.g., withdrawal and avoidance of patient material), Rudd and Joiner (1997) believed that more direct, intentional, and aggressive dimensions are at play when a therapist withdraws and displays the negative behaviours towards a client (e.g., premature treatment termination, frequent cancellations, lateness, referral to another counsellor, abandoning neglecting or ignoring). Furthermore, Rudd and Joiner (1997) discussed other aggressive and hostile behaviours such as criticism, blame, negation, and rejection that have an aspect of attack, rather than withdrawal.

For clarity, the present study considers three counter-transference categories of behaviours: 1) passive aggression characterized by re-directing, neglecting or ignoring a client, 2) active hostility and aggression characterized by negation, blame and criticism, and 3) over-involvement characterized by caretaking, sympathizing, and being overly engaged. These aspects of counter-transference are germane to the correctional context where the power structure is more pronounced than in any other therapeutic setting. Furthermore, there is usually very little one-on-one interaction between a correctional counsellor and a client (offender) because most of the interventions are conducted in a group setting. The group setting makes it more difficult for a service provider to withdraw or avoid interaction but allow for ignoring, re-directing or neglecting.

The relational competencies of empathy, regard and feedback and self-disclosure involve therapist's behaviours that are counter-transferential in nature. In this study, non-empathic

responses include passive-aggressive behaviours such as ignoring and neglecting, and over-involved statements; regard and feedback include one counter-transferential aspect, active display of aggression characterized by blame, criticism, and negation; and self-disclosure includes inappropriate self-disclosures. Control of the therapeutic process (discussed in the following section) includes an aspect of dominance or over-control. Table 1 shows the distribution of counter-transferential behaviours across relational competencies and Appendix A contains definitions of these constructs.

Table 1.
Distribution of counter-transferential behaviours across relational competencies.

Empathy
- Empathic Responses
  - Simple and Complex Reflective Listening
- Non-Empathic Responses
  - Confrontation
  - *Passive Aggression (ignoring and neglect)*
  - *Over-Involvement*

Regard & Positive Feedback
- Positive Feedback
- Negative Feedback
- *Active Aggression (blame and criticism)*

Self-Disclosure
- Immediate Disclosure
- Appropriate Self-Disclosure
- *Inappropriate Self-Disclosure*

Control of Therapeutic Process
- Use of Authority
- *Dominance / Over-control*
- Directive Communication

Counter-transferential aspects are *italicized*

Rudd and Joiner (1977) also defined active treatment behaviours (receptive and collaborating responses) that are similar to what Kiesler (2001) referred to as "real responses". Behaviours that do not involve neglect, rejection, blame, criticism, or over-involvement can be considered as receptive and collaborating responses and are used in this study to represent a fourth category, namely absence of counter-transference.

Despite the volumes of clinical literature, the empirical research related to counter-transference has only recently accumulated significant evidence demonstrating that CT

behaviours have an inverse relationship with positive outcomes (Hayes, Riker, & Ingram, 1997). Importantly, the absence of CT feelings and behaviours is associated with patient improvement one-year post-treatment (Hoffart & Friis, 2000). In early correctional research, it has been demonstrated that pessimistic attitudes about the client's ability to change (internal CT), emphasis on what client is doing wrong (external CT), and failure to apply effective strategies of offender rehabilitation (external CT) all lead to poorer outcomes with involuntary clients (Andrews, et al., 1979 as cited in Trotter 1999; Masters, Thomas, Hollon, & Rimm 1987; Shulman 1991; Trotter, 1999). As well, several general psychotherapy studies found that therapists with a hostile self-image of their clients responded in a disaffiliative manner, which in turn had a negative impact on therapeutic outcomes, including client improvement and the length of stay in treatment (Henry, Schacht, & Strupp, 1986, 1990; Najavits & Strupp, 1994; Rudy, McLemore, & Gorsuch, 1985).

Moreover, empirical evidence accumulated in both the general and correctional literature suggests that therapists' active engagement in the therapeutic process, as well as a collaborative stance, is beneficial for both treatment process and outcomes regardless of therapeutic modality and the client's presenting problems (see Orlinsky, et al., 2004, for review; Trotter, 1999). More specifically, therapist involvement, which refers to the activity level, emotional involvement of the therapist in the session, interest in helping the client as well as the use of a collaborative versus either a passive or a prescriptive role in the process of therapy have been found to relate to patient's improvement (Hatcher, 1999; Luborsky, et al., 1985; Milne, Baker, Blackburn, James, & Reichelt, 1999; Smith & Grawe, 2005; Trotter, 1993, 1999, 2009; Smokowski & Wodarski, 1996).

Control of the Therapeutic Process

Control is an integral part of any correctional setting, be it prison or community supervision. The control is exercised to ensure institutional and community safety and compliance with rules. Control can be used for punitive or rehabilitation purposes. In the recent years, multiple investigations have confirmed that offender rehabilitation is the best path towards achieving community safety (Andrews & Bonta, 2010). Punishment not only has little impact on the reduction of recidivism but also contributes to greater amount of violations, institutional misconduct and post-release recidivism (Andrews & Bonta, 2003; Gendreau, Goggin, Cullin, & Andrews, 2000; Gendreau, Paparozzi, Little, & Goddard, 1993; McGuire, 2004). Therefore, it can be argued that the degree to which correctional service providers see themselves as rule enforcers versus agents of change might have a differential effect on the way they use control, thereby impacting recidivism outcomes.

The effective use of control could be quite challenging even for those service providers who are committed to the goals of rehabilitation and aspire to be the agents of change. Correctional counsellors are often required, on one hand, to ensure offenders' compliance with the conditions imposed by the courts, and the rules and regulations of a particular facility (i.e., jail, prison). On the other hand, they are tasked with creating an environment for personal change and growth (Skeem, Louden, Polascheck, & Camp, 2007). The challenges of the counsellor's dual roles and responsibilities are further reinforced by offenders' characteristics such as mistrust and hostility towards authority figures and resistance to comply with the imposed conditions. Those counsellors who are unable to deal with these challenges may revert to a punitive stance where punishment is the only strategy for conflict resolution, facilitation of program compliance and change.

Recognizing the inherent duality of competing agendas of control in offender rehabilitation, Andrews and Kiessling (1980) proposed an effective use of authority as a necessary strategy for a corrections counsellor to adopt for effective practice. In their view, the effective use of authority should consist of four elements: (1) explicating the formal use of rules associated with the correctional setting, (2) seeking compliance with these rules through positive reinforcement, while avoiding interpersonal domination and abuse, (3) focusing on the behaviour and not client's performance of it, and (4) being specific and direct concerning behavioural demands through specifying choices and consequences in an encouraging, supportive, and respectful manner.

Despite the recognition of its importance, counsellors' use of control and its effect on the intervention process and outcomes has rarely been studied in the correctional setting. Moreover, there is no operational definition exists that can clarify the level and types of counsellor control of the therapeutic process. This greatly impedes the measurement of this construct in a correctional setting. In contrast, such overlapping constructs as therapist *control*, *dominance*, and *directiveness* have been extensively studied in clinical setting. Two different approaches have been used to capture this construct: examining directive versus non-directive treatment strategies, representing two end-sides of control versus not-control continuum; and, measuring control as a separate construct regardless of the type of treatment strategy applied. The latter included measuring client's perception of therapists' directiveness and dominance as well as therapist self-ratings of dominance or observer's ratings of therapists' directive, controlling and dominating behaviours.

Cognitive-behavioural interventions are considered to be directive in nature. In comparison to therapists with other orientations, cognitive-behavioural therapists talk more in

sessions, ask more questions, direct and structure session content and interactions, as well as more frequently offer information and advice (see Keijsers, Schaap, & Hoogduin, 2000, for review). Practices such as setting a treatment agenda, homework assignment and giving feedback are at the heart of therapist competency evaluation (Young & Beck, 1980) and are part of many cognitive-behavioural treatment manuals including problem-solving training (D'Zurilla & Goldfried, 1971), aggression replacement training (Goldstein & Click, 1987), relapse prevention (Marlatt & Gordon, 1985), rational-emotive therapy (Ellis, 1955, cited in Dryden & Ellis, 1988), and dialectical behaviour therapy (Linehan, 1993).

Comparison of directive (cognitive-behavioural, CBT) versus non-directive (client-centered) modes of treatment produced no significant differences in terms of their ability to impact treatment outcomes in the general clinical literature (Elliott, 2002). More specifically, Elliott reported high effect sizes (.80 – 1.06) for non-directive treatment approaches and no significant difference in the treatment effectiveness between non-directive and cognitive-behavioural interventions, suggesting that directive treatment can be quite effective. It is also important to note that, in cognitive –behavioural practices, directive statements that involve providing advice (a form of dominance) are relatively rare in comparison to other directive strategies (see Keijsers, et al., 2000, for review) suggesting that the positive effects of CBT might be in part due to therapist directiveness and not dominance. However, in addition to directive statements, effective cognitive-behavioural therapists also use responses central to humanistic approaches such as empathic and acknowledging statements. Therefore, it is difficult to separate directive behaviours from a number of strategies used by the therapist and to make definitive conclusions regarding effectiveness of one manner of responding over another.

Outside of directive versus non-directive treatment comparison, a number of researchers define dominance as the manner of therapist response, measuring therapist activity and directiveness using client reports. The findings from these studies are mixed, suggesting that perceived therapist directiveness could have positive (Bennun, Hahlweg, Schindler, & Langlotz, 1986; Schindler, Revenstorf, Hahlweg, & Brengelmann, 1983) as well as negative effects (Emmelkamp & van der Hout, 1983) on client's improvement. Similarly, the results of studies that assessed a number of therapist attributes (behaviours) including the level of activity, directiveness, and expertness in the beginning stages of treatment produced mixed findings. Positive (Bennun & Schindler, 1988; Elliott, Barker, Caskey, & Pistrang, 1982; Williams & Chambless, 1990), null (Alexander et al., 1976; Blaauw & Emmelkamp, 1991; Keijsers, Schaap, Hoogduin, & Peters, 1991) and one negative (Keijsers, Schaap, Hoogduin, & Lammers, 1995) effect on therapeutic outcomes are reported.

A number of recent reviews that attempted to integrate research findings related to therapist control have suggested that no definitive conclusions can be drawn, mainly due to the inconsistency or ambiguity in defining, operationalizing and measuring this construct (Orlinsky, et al., 2004, Beutler, et al., 2004; Keijsers, et al., 2000). It can be hypothesized that the mixed evidence related to the effectiveness of control is due to unclear differentiation between directiveness as a positive factor and dominance as a negative factor. Furthermore, it is quite possible that the clients who perceived their therapist as active, directive and non-domineering could have had positive treatment outcomes whereas those clients who perceived their therapist as dominant, over-controlling, punitive and critical could have had no improvement in treatment or even poorer outcome, post-treatment. Similarly, therapist active, directive and non-domineering behaviours might have had positive effects whereas therapist dominant, over-

controlling, critical, and punitive behaviours could have had negative effects on treatment outcomes. Some empirical evidence exists to support these hypotheses (Chu, 2002; Elliott, 2002; Keijsers, et al., 2000; Orlinsky & Ronnested, 2005; Schulte & Kunzel, 1995; Serran et al., 2003; Teyber & McClure, 2000; Washton & Stone-Washton, 1990).

Researchers who looked at *therapist dominance* as a personality characteristic conceptually close to dogmatism and close-mindedness found that dominance has a negative effect on therapist flexibility and subsequent treatment outcomes (Chu, 2002; Henry, et al., 1990; Orlinsky & Ronnested, 2005; Serran et al., 2003; Teyber & McClure, 2000). Also, those researchers who looked at dominance as the therapists' desire to control his/her patient found that the low desire to control (e.g., low dominance) contributes to more effective therapeutic outcomes (Washton & Stone-Washton, 1990). Moreover, Schulte and Kunzel (1995) found that "controlling the other's behaviour by advice, instruction, criticism, or closed questions" (p. 171) had a negative relationship with treatment outcomes at the end of therapy and two years post-therapy.

Evidence also exists in support of the positive effect of therapist directiveness. As mentioned earlier, comparing directive versus non-directive approaches provides some support for the effectiveness of therapist directiveness, in the context of cognitive-behavioural interventions (Elliott, 2002; Keijsers, et al., 2000). Moreover, some types of therapist's controlling behaviours such as directing the "process" of therapy and directing the "topic" of sessions lead to more consistent positive results, in comparison to other types that include controlling the "client's behaviours". For example, Tracy (1985) found that counsellors who initiated the topic of discussion, which were followed by their patients more often had greater success in therapy in comparison to the counsellors who followed their patients more often.

Similarly, Schulte and Kunzel (1995) found that directing the topic of sessions by therapists had a significant positive effect on treatment outcomes in the context of cognitive-behavioural intervention.

In conclusion, unlike other relational factors (e.g., empathy) presented thus far, the evidence for the effectiveness of therapist control is mixed and inconclusive. Nevertheless, consistent with the inherent duality of counsellor's use of control in a correctional setting, the findings from general literature provide some initial support for the existence of both positive and negative aspects of therapist control, generally pointing to dominance, over-control, criticism, and advice giving being linked to negative outcomes while directing the process and content of therapeutic interactions, being linked to positive outcomes.

If we are to consider these two aspects of control in terms of counsellor behaviour or relational manner, it is possible that a counsellor can be simultaneously directive and not dominating or abusive. In other words, directiveness and dominance can represent two underlying aspects of control. Following this line of reasoning, the counsellor's control of therapeutic process in this study is defined as the counsellor's ability to direct the therapeutic session and guide the client without dominating the interaction. That is, counsellor's controlling behaviours can be either positive which involves open-ended questioning, suggesting a topic, and setting a meeting agenda or negative involving advice giving, use of close-ended questions, and direct criticism.

More specifically, counsellors' controlling behaviours include challenging client's way of thinking through Socratic dialogue (positive) versus demanding a change through advice giving or criticism (negative), as well as directing the content or the process of the session (positive) versus directing client's behaviours (negative). Directing the session content and process (e.g.,

suggesting a topic, setting agenda, assigning home work) can be done either in authoritative or authoritarian manner. Authoritative manner involves directing session activities in a rational, relatively flexible way, encouraging collaboration and dialogue, yet exercising authority when necessary. An authoritarian manner involves dominance and rigid control of activities, as well as stressing obedience without questioning and punishing for failure to obey. Also, exercising authority does not mean demanding obedience but rather using firm control in a respectful manner to handle conflicts if a reasoned approach fails. Most of the negative controlling behaviours (e.g., dominance, over-control, criticism, and punishment) can be categorized as aggressive/hostile and are counter-transferential in nature, thereby impeding the therapeutic process (for discussion, refer to Counter-transference section).

One empirical investigation in the correctional literature was found to provide support for the proposed conceptualization of use of control by correctional staff. Gillis, Getkate, Robinson, and Porporino (2003) examined two types of leadership styles of correction staff (work supervisors) who were supervising a group of inmates on a number of assigned work detail tasks - transactional and transformative. The authors defined transactional leadership as rewarding employees for attaining predetermined objectives and punishing them for failure to achieve such goals, which is conceptually similar to an authoritarian style of directiveness. Transformative leadership was defined as going beyond the transactional relationship by encouraging employees to strive for additional goals and interests – don't just meet goals, achieve your best. Transformative leadership involves trust building, encouragement, inspiration, and motivation for change as opposed to punishment for not achieving set objectives, (i.e., authoritative style of directiveness). The results indicated that correctional staff who employed transformative as

opposed to transactional leadership style were able to enhance offender productivity, skills development, work habits and personal growth.

Though limited, this initial evidence is encouraging and provides initial support for the proposed conceptualization of correctional counsellor use of control. Considering that relational factors in general have not been studied extensively in correctional settings, this finding highlights the importance of the ability of correctional counsellors to exercise control effectively.

Confidence

One of the main goals of any therapeutic process is to help clients to change. According to the theory developed by Strong (1968) who examined therapy or counselling as a social influence process, counsellor credibility plays a key role in this process. Strong (1968) proposed that counselling is a two stage process where therapists first establish themselves as a useful resource and then influence clients in a therapeutic manner. Clients' perception of their therapists as experts (e.g., proficient in their profession), attractive (e.g., dependable/faithful), and trustworthy (e.g., likable) serves as an indicator of how well a therapist is able to establish him/herself as a useful and credible source. Empirical investigation of this theory supported Strong's two stage model and demonstrated that the degree to which clients perceive their therapists as credible directly relates to therapists' potential to influence the therapeutic process and facilitate change (Heppner & Claiborn, 1989). It has been demonstrated that clients' perception of their counsellors as experts, attractive and trustworthy increased therapeutic alliance (Goldstein, 1986; Wei & Heppner, 2005) and positively affected treatment satisfaction ratings, as well as client improvement (see Heppner & Claiborn, 1989, for review; Hoyt, 1996).

Based on the initial empirical findings, Strong and Matross (1973) advanced the construct of "social power" which is based on an aspect of therapist credibility associated with therapist

knowledge and skills relevant to the client's need. Moreover, Strong and Claiborn (1982) believed that social power is instrumental in the effective delivery of change-promoting messages such as negative feedback. Also, Chang (1994) demonstrated that there is a reciprocal relationship between feedback and therapist credibility. That is, positive feedback reinforces the therapist's social power and promotes the client's view of the counsellor as credible. Similarly, counsellor's credibility allows for more effective delivery of corrective messages (Claiborn, et al., 2002).

In the attempt to understand what cues are important for building clients' perception of the therapist as credible, researchers looked at therapist, client, and therapist-client match variables (see Heppner & Claiborn, 1989, for review). In terms of therapist variables, general therapist characteristics such as ethnicity, sex role orientation, physical disability, and attire were not consistently predictive of clients' view of therapist credibility in comparison to specific therapist behaviours, such as self-disclosure, self-involvement-statement, or profanity (Heppner & Claiborn, 1989). Despite this initial investigation into therapists' characteristics that influence clients' view of their therapists as credible, little was said within this framework about therapists' perception of their own credibility and self-confidence in delivering interventions, or their ability to deal with specific client issues. In addition, there was no investigation of therapist's perception of clients' level of confidence in relation to therapeutic outcomes.

In contrast to social influence theory that places emphasis on client perceptions of therapist credibility for achieving therapeutic change, using factor analysis of two well-known scales of therapeutic alliance (Working Alliance Inventory, WAI: Horvath, 1981 in Horvath & Greenberg, 1986 and California Psychotherapy Alliance Scale, CALPAS: Marmar, Horowitz, Weiss, & Marziali, 1986), Hatcher (1999) identified a construct labelled *therapist's confident*

collaboration that combined both therapist confidence in treatment and therapist's perception of client's confidence and commitment. Items such as "My patient and I both feel confident about the usefulness of our current activity in therapy", "As a result of these sessions, my patient is clearer as to how he/she might be able to change", "My patient has confidence in therapy and therapist" and "My patient is confident that our efforts will lead to change" loaded on the therapist's confident collaboration scale.

Hatcher (1999) further reported that therapist confident collaboration had the strongest relation to therapist estimates of improvement and correlated significantly with patient-reported progress. Similar to Hatcher's scale of therapist's confident collaboration, the confidence scale of the Agnew Relationship Measure (ARM: Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998) contains both therapist confidence in treatment and therapist perception of patient's confidence in therapist expertise and the therapeutic process. Stiles, Agnew-Davies, Hardy, Barkbam, and Shapiro (1998) found that confidence reported by therapists on the ARM was found to have strong correlations with immediate counselling gains, as well as gains maintained at the 3 month and 1-year follow-up among clients treated for depression in both CBT and psychodynamic modalities.

In addition to the research on the constructs that can be gauged only in the context of therapist-client interaction (e.g., client's perception of therapist credibility or therapist confident collaboration), empirical evidence exists demonstrating there is a relationship between therapist confidence rated at the initiation of treatment (e.g., first session) and treatment outcomes. For example, McGuff, Gitlin, and Enderlin (1996) found that 85 out of 217 clients who reported that their intake therapist were confident in being helpful also reported cancelling and missing fewer follow-up sessions regardless of the length of treatment. Wei and Happner (2005) demonstrated

that those counsellors who perceived themselves to be efficacious problem solvers prior to therapeutic interaction were more likely to be efficacious in establishing counselling tasks and goals related to the working alliance.

Thus far, therapist confidence has been reviewed in the context of the therapeutic interaction and prior to treatment, as assessed by clients and therapists. Since the present study purports to assess therapist relational competency rated by the therapist prior to the actual therapist-client interaction, it might be useful to follow the logic of the latest investigation (i.e., Wei & Happner, 2005) and look at therapist confidence in his/her ability to deliver a specific intervention or therapist self-efficacy. Bandura (1977, 1982) defined self-efficacy as a set of beliefs related to individuals' abilities to organize and execute courses of actions required to attain desired goals or situation-specific tasks. In other words, self-efficacy is a set of beliefs in one's own capability, effectiveness, strength or power to attain situation specific goals. Bandura (1997) suggested that self-efficacy beliefs shape the goals and influence problem-solving abilities by impacting on an individual's self-regulation strategies and general functioning.

Using this definition, counsellor or therapist confidence in treatment can be conceptualized as a belief in his/her capability, effectiveness, or power to help a particular client with a specific problem in a given situation. According to social cognitive theory, context-specific beliefs as opposed to a general assessment of self-efficacy beliefs offer a more helpful way to index self-efficacy, particularly in relation to correspondingly specific performance conditions (Bandura, 1997). Consistent with this theoretical argument, therapist confidence in treatment in this study will be operationalized as therapist confidence in his ability to help resistant clients to undergo treatment, as well as therapist confidence in his/her abilities to handle

and help high-risk clients (e.g., angry, hostile, sexually seductive, or in open opposition to authorities).

Social cognitive theory also offers a number of pathways through which a sense of self-efficacy can be acquired. These include performance experience (experiences of successes and failures), vicarious experiences (observational learning and imitation), verbal persuasion (feedback), and emotional arousal (positive affect results in more self-efficacious beliefs than negative arousal) (Bandura, 1997). This suggests that therapist confidence in treatment can be viewed as a learnable skill and should be a target of training, supervision and quality assurance assessment.

Self-efficacy theory has been applied to mental health counselling in the past decade providing support for its applicability and relevance in terms of training, supervision, work environment, and counsellors' performance (Murdock, Wendler & Nilsson, 2005). More specifically, it has been demonstrated that higher levels of self- efficacy beliefs relate to lower levels of burn out and greater likelihood of service provider job retention across a number of helping professions (Capara, et al., 2003; Ellet, 2001; Evers, Tomic, & Brouwers, 2001; VanDick & Wagner, 2001; cited in Murdock, Wendler & Nilsson, 2005). Moreover, it has been demonstrated that both generalized and task-specific self-efficacy positively relate to job performance and job satisfaction (Judge & Bono, 2001; Stajkovic & Luthans, 1998).

In sum, therapist confidence in treatment has been demonstrated to positively affect treatment process and outcomes. Social cognitive theory, broadly and self-efficacy theory more specifically, can be used as a framework for defining and operationalizing therapist confidence. In this context, therapist confidence can be viewed as a learnable competency that can not only

affect therapist performance but also job satisfaction, and retention, as well as prevent therapist burn out.

Conclusion

Five high-level relational constructs or competencies were identified in this literature review: empathy, regard and feedback, self-disclosure, confidence, and control of therapeutic process. These relational constructs have been suggested to be significant and/or promising elements for effective intervention in the general and correctional literature. To adequately cover the content domain of each relational competency, both non counter-transferential and counter-transferential aspects and/or facets were defined within each construct. These facets included empathy, confrontation, passive aggression (i.e., neglecting or ignoring), over-involvement, positive feedback, negative feedback, active aggression (i.e., blame and criticism), immediate self-disclosure, appropriate personal self-disclosure, inappropriate personal self-disclosure, use of authority, dominance /over-control, directive communication, and context-specific confidence.

It is important to note that some of these constructs might have a content overlap. For example, the definitions of confrontation, negative feedback and use of authority are similar and all three constructs might measure the same latent variable. One of the hopes of this study is to clarify relational constructs, reduce overlap and identify latent variables that are captured by the above mentioned relational aspects. The summary of construct definitions and operational definitions of relational competencies and their facets are presented in Appendix A.

Measurement Issues and Study Overview

The majority of therapist assessment tools developed thus far are based on a complex procedure involving video or audio taping therapeutic sessions and having several independent observers rate therapists' performance based on the previously developed coding manuals (e.g.,

Cognitive Therapy Scale, Young & Beck, 1980). This methodology is quite cumbersome, especially if one is to assess the effectiveness of training which requires pre- and post-training testing of trainees' performance. At present, the counsellor competency assessment tools (e.g., Correctional Programs Quality Review of Facilitators) in corrections are usually not empirically based and lack demonstrated reliability and validity. The assessment procedures are based on subjective ratings of counsellors' performance by clinical supervisors, questioning the effectiveness of these procedures in quality assurance. Finally, content and number of relational competencies vary across various assessment frameworks, which in turn creates confusion in assessment application and difficulty in interpretation and comparison of findings. In fact, there is no measure that is based on an integrative theoretical model and able to capture important relational factors identified in this review, applicable to the correctional setting.

To address these issues, three studies were conducted with the overall goal of development (Study 1), refinement (Study 2) and initial validation (Study 3) of the vignette-based measure of Correctional Counsellor Relational Competency (CCRC). More specifically, the first goal of Study 1 was to develop vignettes or challenging situations that service providers frequently encounter in their work (i.e., stimulus). The vignette approach creates simulated situations equivalent or comparable to the real therapeutic session environment. This allows independent researchers to measure competencies of counsellors in a quick and efficient manner for application to correctional staff selection and training. In addition, a vignette methodology offers obvious advantages for researchers including variable manipulation, random assignment, and control for extraneous variables (Gliner, Haber, & Weise, 1999). The main question for this study was whether constructed vignettes are representative of real situations correctional counsellors encounter in their every day work.

The second goal of Study 1 was to develop responses to the challenging situations (vignettes) reflective of the five identified relational competencies: empathy, regard and feedback, self-disclosure, confidence, and control of therapeutic process. The question here was whether the generated responses can capture intended domain of content for each relational competency.

Study 2 had two objectives. The first objective was to refine the CCRC, reduce the content and conceptual overlap and explore internal structure. It was hypothesized that a refined CCRC would have acceptable psychometric properties: 1) internal consistency, 2) parsimonious and stable internal structure, and 3) temporal stability. The second objective of Study 2 was to begin compiling normative data for the refined CCRC. This was done through comparing relational competencies across a number of demographic markers (e.g., age, gender, ethnicity, years of experience, level of education, theoretical orientation, and affiliation).

Finally, the goal of Study 3 was to assess the construct validity of the refined CCRC (i.e., convergent, divergent, and criterion validity). Based on the CCRC's final 7-factor structure obtained in Study 2 and a comprehensive literature review, a number of validated measures/scales were selected to test the construct validity of each CCRC factors. CCRC factors included empathy, confrontation, blame and criticism, self-disclosure, confidence, reinforcement of antisocial attitudes and behaviours, and neglect. It was expected that each of the 7 CCRC factors obtained in Study 2 would moderately correlate with at least one independent measure/scale to support construct validity.

To demonstrate convergent validity, it was hypothesized that the CCRC factors would moderately correlate with measures of related constructs. To demonstrate discriminant validity, it was hypothesized that each factor would correlate poorly or have no relationship with the

measures not specifically selected for (or theoretically unrelated to) that factor. To support criterion validity, it was hypothesized that CCRC relational factors have significant relationship with group cohesion and/or therapeutic alliance. Since the factors were identified and defined in Study 2, the rationale for selection of independent measures to test CCRC validity as well as the detailed validity hypotheses are presented in the introduction to Study 3.

Study 1: CCRC Development and Content Validity

Method

Study 1 involved identifying learning moments from training manuals and trainers' input, creating vignettes or challenging situations, and selecting the most representative situations for the correctional setting. This study also involved developing a pool of response items that tap two aspects (i.e., non counter-transferential and counter-transferential) of the five high-level relational competencies identified and defined in the literature review: empathy, regard and feedback, self-disclosure, confidence, and control of therapeutic process.

Sample

For the vignette development, the sample consisted of 5 correctional experts. An expert was defined based on one of the following qualifications: 1) a clinician who specializes in offender rehabilitation and has at least 5 years of experience either in delivering offender interventions or training and supervising other correctional service providers, or 2) a researcher who has published in peer-reviewed journals on the issues related to offender treatment process and outcomes, or 3) a researcher who has 5 or more years of experience in the development and validation of treatment programs for offenders. Most of the selected experts were experienced clinicians, trainers, and supervisors of offender intervention programs.

For the response content and quality ratings or to test content validity of generated responses, the sample consisted of 11 participants: 5 correctional experts (Correctional Service of Canada (CSC) trainers and clinicians in the field of offender rehabilitation), 2 experts in the field of clinical psychology with more than 5 years of clinical experience, and 4 graduate students of Carleton University. Three of these individuals also took part in the development of stimuli materials (i.e., vignettes).

Procedure

Vignette Development. The experts were tasked to generate themes for learning moments in the correctional setting. The identified learning moments served as the base for the construction of context-appropriate vignettes. The experts were then asked to rate these generated vignettes regarding how representative and typical (frequently occurring) these situations were in the work of correctional treatment providers. Both questions had Likert type scale from 1 to 10, with 1 being "not representative or frequently occurring" and 10 "most representative or frequently occurring". The criterion for Vignette inclusion was set to an average rating of 7 or above. As well, 310 service providers who participated in Study 2 (see study 2 for sample details) were asked to rate each selected Vignette regarding how typical the situation was in the correctional setting and in their work on a 5-point Likert scale from 1 ("not at all") to 5 ("extremely").

Item Pool Development. To develop a response item pool for the selected vignettes, the recommendation of DeVellis (2003) was followed: a large pool of items was generated to tap into defined early multi-faceted relational competencies (i.e., empathy, feedback, self-disclosure, confidence, and control of therapeutic process). To obtain content validity of the items, 6 experts (i.e., trainers, clinicians, researchers, and graduate students) were recruited to review the content

validity package. One document contained operational definitions and examples for each relational competency. The other document contained generated responses for the selected vignettes, reflecting the competencies. The experts were asked to rate the items on a scale from 1 ("not at all") to 7 ("extremely") regarding how well each of the items (responses) reflect the corresponding relational factors (content validity).

The following criteria were used to assess content validity of items. The scores below 3 were considered low, the scores ranging from 3 to 5 were considered moderate, and the scores above 5 were considered high. The experts were given an opportunity to re-write or suggest an alternative response for the items for which they had given a low rating to (i.e., 1 or 2). After receiving the first wave of feedback, the items with low ratings were eliminated and items with moderate ratings were revised. Five additional experts were recruited to rate the initial and revised items using the same procedure.

Results

Content and Face Validity of Vignettes

Through interviews with experts, nine learning moments or challenging themes in working with offenders were suggested. These included non-compliance, challenging credibility of a facilitator or counsellor, challenging the system or staff, antisocial/inappropriate behaviours, antisocial attitudes/attributes, challenging program materials, lack of problem recognition or alternative thinking, stalling group process, and inappropriate disclosure. Based on these categories, forty-four vignettes were created to reflect the identified challenging theme/moments. Following vignette development, the nine most representative situations were selected for each identified category (see Table 2). All of the selected vignettes received high ratings (above set criterion of 7) on the representativeness scale. Of the selected vignettes all had frequency scores

above 7, with the exception of one, vignette number 9, which received the lowest average frequency of occurrence score (5 out of 10). Since the criterion was set to 7 for the final inclusion of vignettes, the decision was made to eliminate vignette 9 and use the remaining 8 vignettes for further instrument development.

The mean, standard deviation, and range of scores service providers gave to the question of how typical each selected vignette or situation was in their work is presented in Table 3. The means ranged from 3.64 to 4.34, supporting face validity of selected vignettes.

Content Validity of Responses

The eight vignettes were used as a base for creating an item pool of vignette - appropriate responses. One hundred and forty nine items were initially generated. The average item ratings received from the first group of experts ranged from 2.83 to 7.00 with the mean equal to 5.25. The majority of the items (116) received high scores (above 5) suggesting acceptable content validity. Twelve items with low ratings (below 3) were eliminated and twenty one items with moderate ratings (between 3 and 5) were re-written with the goal of clarifying, shortening, or simplifying the items. As well, all items were examined for being double barrelled or combining two or more content areas in a single item. Some double barrelled items were rewritten.

For example, the item, "I hear you Bianca [affirmation]; what do you think about the situation regarding my interaction with the police officer [changing the topic]" was changed to "OK Bianca but what do you think about the situation regarding my interaction with the police officer [changing the topic or re-directing]". Other double barrelled items were retained to preserve the natural flow of each situation. For example, the item "I remember myself feeling the same way you are right now. Then I realized that avoiding looking at my triggers led me to

Table 2.
Learning or challenging themes and corresponding situations

Challenging Theme	**Vignette (Situation)**
Non-compliance	**Vignette 1.** In a substance abuse program, one of the homework assignments required participants to identify and write down triggers as well as create a craving inventory. A number of participants including Pam, a 26 year-old female serving a sentence for drug trafficking, showed resistance to these assignments. Pam who initially was quite motivated to be a part of the treatment stated that she does not see a good reason for remembering past situations that can create cravings. "We are trying not to think about drugs; this is exactly what leads us to relapse".
Challenging Program Materials	**Vignette 6.** Peter, a 42 year old Aboriginal male has a history of violent convictions and had three fights in a medium security facility. Peter was scheduled to attend a high intensity violence prevention program. In the interview, Peter was sincere in expressing his desire to change and stated that he really does not want to spend more time in prison. In the middle of the program, however, Peter got into another fight. When CPO asked to describe what happened and how Peter tried to apply the skills taught in the program, he responded with agitation, "This stuff will never work out there when somebody breathes down your neck and is asking for it. All this stuff in your book is crap and will never work out there".
Challenging System/Staff	**Vignette 3.** Jack, a 32 year old male, is incarcerated for possession of illicit substances. Jack has no history of aggressive behaviours. It has been recommended that Jack participates in a cognitive restructuring program (e.g., AAA). Jack met this recommendation with enthusiasm and was accepted to the program. Jack has been cooperative throughout the program. He has been one of the few inmates who has always completed his homework assignments. Halfway through the program, Jack brought his HW describing an altercation with a correctional officer who refused to open gates for him. The altercation resulted in Jack receiving an infraction. When a facilitator asked Jack to describe his thoughts at the moment, Jack stated "They treat us like animals in a cage then expect us to roll over and do what they want".
Antisocial/Inappropriate Behaviours	**Vignette 4.** During a group session, a facilitator discloses a situation where she was stopped by a police officer for speeding in order to create a learning moment for the participants. The facilitator talked about her feelings and thoughts in the situation and how she was able to go through a decision making process before responding to the officer's sarcastic comments. The facilitator welcomed feedback after sharing her story. Bianca, a 34-year old woman serving time for break and entry, started asking the facilitator a series of personal questions, including her marital status, where she lived, etc.

(Table continues)

Challenging Theme	Vignette (Situation)
Antisocial Attitudes/Attributes	**Vignette 5.** Jean Pierre (J.P.) is a 25 year old male who has multiple convictions for shoplifting and burglaries. J.P. also has a number of convictions related to drug trafficking. As a result of the initial risk assessment, J.P. was mandated to participate in a cognitive restructuring program (e.g., AAA). When a facilitator asked J.P., how he believed his actions affected the owner of the store, J.P. responded "It was not a big deal. He had insurance and got all brand new stuff. I would not have even pressed charges if I were him."
Challenging Credibility of Facilitator/Counsellor	**Vignette 2.** During the first session of a substance abuse program, after the introductions a facilitator was about to discuss the topics to be covered in the group when she was interrupted by a 28 year old Aboriginal male who had been in and out of prison for initiating fights while intoxicated and selling drugs, "excuse me Miss, what is your background? Have you ever been addicted to something? It does not seem like you have an idea of what it is like to be an addict. You have to walk in my shoes to understand me."
Lack of Problem Recognition	**Vignette 7.** Keith, a 23-year old offender, has a long history of antisocial behaviour and peer-related criminal activities. All of his friends and associates are engaged in criminal activities. During the second group meeting of a mandatory program, Keith adamantly claims that he has everything figured out, stating that he knows he will not re-offend because he made up his mind.
Stalling Group Process	**Vignette 8.** Chris, a 44 years old male convicted for drug possession, attends AA meetings and believes that he can talk as much as he wants. Even after the facilitator specified the time for each participant, Chris continues to monopolize the group without letting other members talk. Chris interrupts other participants quite often and either changes the focus of the discussion to himself or gives advice to others. For example, when a facilitator attempted to respond to someone's question in the group, Chris turned it into a new opportunity to talk. "That is a good question. When I am in a situation like this, I usually take control but my life right now is under control. I am sleeping well, I get my visitations regularly, I come to class; it is hard but I am trying my best to survive; I take one day at a time and you should definitely try that; it works for me, it should work for you too".
Inappropriate disclosure	**Vignette 9.** In the initial interview, Mark, a 22 year old serving his first sentence for selling drugs, was asked to comment on how he was getting along with the guards and with other inmates in the institution. Mark hesitated a bit at first and then blurted out: "I can hardly take it; I am about to go insane; Just yesterday, I was muscled into bringing in some drugs from my UTA".

Table 3.
Means, standard deviations, and ranges of answers to "how typical is each situation?" rated by service providers (N=310)

	Mean	Standard Deviation	Range
Vignette 1	3.99	.85	1.00 – 5.00
Vignette 2	4.16	.87	2.00 – 5.00
Vignette 3	4.34	.77	2.00 – 5.00
Vignette 4	3.64	.94	2.00 – 5.00
Vignette 5	4.17	.78	2.00 – 5.00
Vignette 6	4.02	.83	2.00 – 5.00
Vignette 7	4.09	.80	2.00 – 5.00
Vignette 8	3.99	.83	2.00 – 5.00

relapse" contains both affirming and self-disclosing statement, which is to be expected in this context.

Prior to collecting feedback from the second sample of experts, an additional 19 items were created to replace previously eliminated responses and to further clarify the constructs, for a total of 156 items. In comparison to the first wave of feedback, the average ratings for the revised set of items were higher, ranging from 3.25 to 7.00 with the mean equal to 6.28, indicating improved and acceptable content validity. Hence, no further items were eliminated and seventeen items with moderate ratings were revised to better represent the constructs they were trying to measure and to improve long, double barrelled and/or unclear items. A sample of the item pool for Vignettes 1 and 2 after two revisions is presented in Table 4.

Discussion

The goal of Study 1 was to develop a vignette-based measure of the Correctional Counsellor Relational Competency (CCRC) and to assess face and content validity of the newly developed instrument. This study was done in two stages. The first stage involved developing stimulus materials or situations that are representative of challenging moments in correctional program delivery. The second stage involved developing item-responses for each Vignette

Table 4.

A sample of generated pool of responses (items) for the facets of the following relational factors: empathy, feedback, self-disclosure, external counter-transference, and control of therapeutic process, after two revisions

Vignette 1. In a substance abuse program, one of the home work assignments required participants to identify and write down triggers as well as create a craving inventory. A number of participants including Pam, a 26 year old female serving a sentence for drug trafficking, showed resistance to these assignments. Pam who initially was quite motivated to be a part of the treatment stated that she does not see a good reason for remembering past situations that can create cravings. "We are trying not to think about drugs; this is exactly what leads us to relapse".

Response (Item)	**Relational Facet**
- Pam, in our initial sessions you convinced me that working on your sobriety was very important for you. What has changed?	Directive
- You have mentioned that thinking about the times you have used drugs might make you relapse; has that happened to you before?	Directive
- Are you that weak to just bail out on a simple homework assignment?	Dominance
- Completing this homework assignment is a necessary part of this program and I believe it is in your best interest to do so.	Use of authority
- Not thinking about drugs will not make you drug free; you have to work through your triggers that lead you to relapse	Confrontation
- I know how scary it must be to even think about drugs, especially after you have been clean for some time	Empathy
- Do not respond to Pam and move on with the session's agenda	Passive aggression
- I am so sorry that you feel bad about doing this assignment; would you like to do it together after the class?	Over-involvement
- Pam, we can discuss this later as we have two more very important topics to cover	Passive aggression
- You are resisting this exercise and questioning its value without giving it a chance. This group is your support system and we can help you through it.	Negative feedback
- Pam, you have a legitimate concern; does anyone else have similar feelings about this assignment?	Positive feedback
- I knew you were not committed enough for this program	Active aggression-blame, criticism
- I remember myself feeling the same way you are right now. Then I realized that avoiding looking at my triggers led me to relapse.	Appr. Self-disclosure: insight
- I had a similar situation. After a while, I learned that looking at my behaviours directly helped me to tolerate and manage my cravings better	Appr. Self-disclosure: strategy

- I worked hard through all of these assignments to overcome my addictions and I cannot accept people who don't even want to try	Inappropriate self-disclosure

Vignette 2. During the first session of substance abuse program, after the introductions a facilitator was just about to move to the topics to be covered in the group when she was interrupted by a 28 year old Aboriginal male who has been in and out of prison for initiating fights while intoxicated and selling drugs, "excuse me Miss, what is your background please? Have you ever been addicted to something? It does not seem like you have an idea of what it is like to be an addict. You have to walk in my shoes to understand me."

- We'll get back to these questions; Right now, I'll do a brief overview of what will be covered in this program	Passive aggression
- It is a good point; your view about service providers makes sense	Positive feedback
- This attitude is not always correct and might get in the way of your recovery	Negative feedback
- Your attack on me is a clear indication of your inability to look at yourself and take responsibility for your own recovery	Active aggression-blame, criticism
- It is good that you speak out for yourself	Positive feedback
- The way you express your opinion is not correct and might get on the way of your recovery	Negative feedback
- How do you believe an ex-addict counsellor is different from a non-addict counsellor?	Active aggression-blame, criticism
- I do not believe this type of questioning is appropriate in this classroom	Use of authority
- You are attacking me for not being an addict; are you suggesting that I should become one in order to help you?	Dominance
- If one had high blood pressure, do you think that the doctor would need to have high blood pressure as well to know how to treat it?	Directive
- Your questioning has a negative effect on me and it is emotionally difficult for me to accept your oppositional attitude in the beginning of the program	Immediate Self-disclosure
- I think seeing my brother waste his life on drugs gives me the right to be here	Inappropriate self-disclosure
- When I was going through counselling, I remember myself mistrusting my counsellor in the beginning because I did not have trust in myself	Appr. Self-disclosure: insight
- Offer no answer and continue with the session.	Passive aggression
- I am sorry that I do not have everything you are looking for in a treatment provider but I can promise you that I do my best to understand you.	Over-involvement
- I don't believe that it's important for me to be an addict in order to help you; you can learn a lot from a non-addict	Confrontation
- You feel that only an addict can understand your situation	Empathy

representative of five content domains identified in the literature review: empathy, feedback, self- disclosure, confidence, and control of therapeutic process.

Experts in the field of offender rehabilitation identified the nine most frequently occurring challenging themes (e.g., challenging authority) in the practice of being a correctional program officer. Building on these themes, 44 situations were developed reflecting different program modalities (e.g., substance abuse, violence prevention, sex offender) and various offender characteristics (e.g., age, history of offending, motivation to change). The eight situations selected for further instrument development were judged as both representative by experts and typical by service providers of the correctional programming in Canada, suggesting content and face validity of the developed stimulus materials.

It is important to note that even though the content of the final set of vignettes did not include all possible program modalities in a correctional setting (e.g., sex offender programming), the sample of experts did include clinicians working with sex offenders and the challenging moments were deemed as representative of various program modalities, including programs designed for sex offenders. Furthermore, the vignettes can be tailored to each specific program modality in the future and can include both challenging or anti-social attitudes and behaviours along with positive or pro-social attitudes and behaviours of offenders.

The content of selected vignettes can be differentiated based on various offender demographics such as age, gender, ethnicity, and history of offending as well as characteristics such as criminogenic attitudes and behaviours, substance abuse problems, and motivation to change. This is compatible with the notion of static (e.g., age, offender history) and dynamic (e.g., criminogenic attitudes and behaviours) risk factors identified in offender risk-need assessment literature (Andrews & Bonta, 2003, 2010; Hanson, 2009). Furthermore, the dynamic

factors (i.e., criminogenic needs) represented in each Vignette theme elucidated by experts are consistent with the main targets for effective offender programming recognized in the correctional literature (e.g., Andrews, et al., 2006).

The variability in static and dynamic factors across CCRC Vignettes can potentially be used for variable manipulation, random assignment, and/or control for extraneous variables in the future research. This is compatible with Gliner's et al., (1999) recommendation for possible research application of vignette approach.

The responses for each vignette were generated in two waves. This created an opportunity for item revision and clarification. A total of 12 responses were dropped and 21 responses were re-written after the first wave of the expert feedback (i.e., low ratings) with the goal of eliminating double barrelled items as was suggested by DeVillis (2003). Due to the vignette-based methodology employed for the development of the instrument, it was not possible to eliminate all double barrelled items while preserving the natural flow of each situation. However, an effort was made to simplify and clarify each item as well as to have each item convey only one message or idea when possible.

The final set of responses consisted of 156 items. The mean rating score of how well each item tapped into the corresponding relational construct for this set of items was 6.28 (out of 7) suggesting acceptable construct validity. It is important to note that the first draft of the CCRC also contained items designed to assess face validity of the instrument but due to potential of over-burdening the respondents and avoiding test-fatigue these items were dropped. Future research might consider re-introducing the items into CCRC for service providers to assess how well each set of responses represent certain relational competencies.

Study 2: Refinement of CCRC, Psychometric Properties and Normative Data

The goal of Study 2 was two-fold. First, it was to refine the CCRC, reduce conceptual and content overlap, and obtain acceptable psychometric properties including internal consistency, a parsimonious, reliable and stable internal structure, and temporal stability. Second, it was to begin creating normative data for the refined CCRC.

Method

Sample

The national sample consisted of 310 service providers, 264 service providers employed by Correctional Service Canada (CSC) Reintegration Program Division and 46 front line workers from two correctional community organizations, the John Howard Society of Canada and Canadian Association of Elizabeth Fry Societies. The CSC service providers included Correctional Program Officers, Aborigional Program Officers, Program Managers, and Regional Program Managers from all 5 regions of the country. The sample composition based on the demographic survey is presented in Tables 5 and 6.

The test-re-test sample consisted of 94 service providers. The demographic composition of the re-test sample was similar to that of the main sample in terms of age, years of volunteer and paid counselling experience, years of employment in the capacity of service provider, and years under clinical supervision (see Table 6). The two samples did not differ significantly in terms of gender, marital status, level of education, and theoretical orientation (see Table 6). However, there were small difference (5-10%) between two samples in terms of work affiliation and ethnicity (see Table 5). For example, the participation of CSC service providers increased from 85% (test) to 90% (re-test) and the participation of community service providers decreased from 15% (test) to 10% (re-test) suggesting that more CSC service providers volunteered for the re-test stage of the study.

Table 5.
Demographic composition of samples in Studies 2 and 3: Percentages

	Study 2 *Internal Consist. & Normative Data*	**Study 2** *Test-retest Reliability*	**Study 3** *Validation*
Gender			
Male	31%	27%	30%
Female	69%	73%	70%
Ethnicity			
Caucasian	69%	78%	75%
Aboriginal	19%	14%	19%
Hispanic	3%	1%	3%
African	2%	0%	1%
Asian	1%	2%	1%
Preferred Language			
Anglophone	88%	83%	87%
Francophone	12%	17%	13%
Marital Status			
Single	17%	16%	17%
Married	51%	51%	51%
Living with partner	17%	18%	17%
Divorced or Separated	12%	15%	14%
Widowed	1%	0%	1%
Work Affiliation			
CSC	85%	90%	85%
Community Organizations	15%	10%	15%
Level of Education			
HS Diploma	11%	9%	10%
College Diploma	15%	13%	13%
B.A. / B.S.	61%	65%	64%
M.A. / M.S.	12%	13%	13%
Theoretical Orientation			
CBT	83%	84%	84%
Humanistic/Existential	6%	3%	7%
Cultural/Spiritual	3%	4%	3%
Psychodynamic	3%	1%	3%
Eclectic	2%	3%	3%

Additional sample descriptive included the focus area of participants' studies (major) and content area of program delivery. Of 310 participants, 21.6% reported study concentration

in Criminology or Criminal Justice, 13.9% in Sociology or Social Work, 10% in Adult Education (i.e., CSC training), and 9,4% in Counselling Psychology. Other majors included Forensic Psychology, Clinical Psychology, Addictions Counselling, Behavioural Studies and Technology, Education, and Pastoral Studies or Counselling but these were reported with lower frequency.

Table 6.
Demographic composition of samples in Studies 2 and 3: Means and standard deviations

	Study 2 *Internal Consist. & Normative Data*	**Study 2** *Test-retest Reliability*	**Study 3** *Validation*
Sample Size (N)	310	94	246
Age			
Mean	40.00	40.00	41.61
SD	12.19	12.61	9.65
Years of Paid Counselling Experience			
Mean	7.10	6.58	7.22
SD	7.51	6.66	7.54
Years of Volunteer Counselling Exp.			
Mean	2.89	3.54	2.96
SD	6.50	6.21	6.59
Years of Employment as SP*			
Mean	5.88	5.67	5.88
SD	5.65	5.08	5.44
Years under Clinical Supervision			
Mean	6.25	6.26	6.28
SD	6.93	6.87	7.04

*SP = Service Providers

In terms of the content of program delivery at the time of the study, 32 participants reported delivering general cognitive restructuring programs (e.g. AAA), 18 Aboriginal specific programs, 18 programs for female offenders, 30 substance abuse programs, 22 violence prevention programs, 18 family violence programs, 11 programs for sex offenders, and 104 programs in the community; 65 participants did not report this information. Forty-one participants reported holding positions in program management with 13 delivering client services 5 or more than 5 years ago.

Procedure

To reach the objectives of Study 2, CCRC was first checked for language clarity and submitted for French translation. Two professional translators were employed to ensure translation accuracy. CCRC had 8 Vignettes and a set of responses that were organized in four sections. Each section measured various aspects of empathy, feedback, self-disclosure, and control of therapeutic process. Participants were asked to rate each response on a 7-point Likert scale on how likely they are to use it in a given situation. The responses ranged from 1 "not at all" to 7 "extremely". Participants were also asked to rate their level of confidence in dealing with each situation on a 5-point Likert scale. The responses ranged from 1 "not at all" to 5 "extremely".

SNAP survey software was used to transfer the questionnaire package that included the CCRC into a web-based survey format. The web link to the survey was generated and distributed to all service providers employed at the time of the study, by Correctional Service Canada, the John Howard Society of Canada and Canadian Association of Elizabeth Fry Societies. Service providers were given an option to answer the survey either in French or English.

Participants were also given the following participation options: 1) to complete the CCRC only, 2) to complete the CCRC twice (test-re-test); 3) to complete the CCRC and validation measures; 4) to complete the CCRC twice (test-re-test) and validation measures; or 5) to complete demographic survey only. Those participants who choose options 2 and 4 received a link to the CCRC (re-test) through email approximately 24 days after the initial administration.

In addition to the CCRC (options 1 through 4), the demographic information was obtained from all of the participants in order to construct individual relational competency

profiles and compare them across service providers according to gender, ethnicity, professional background, age, years of experience, and other relevant variables.

Hypotheses and Data Analysis

Data screening and editing procedure was performed to deal with missing data prior to conducting the main analyses. One of the main objectives of this study was to refine the CCRC measure, to reduce content and conceptual overlap and to explore internal structure. It was hypothesized that the CCRC would have acceptable psychometric properties: 1) parsimonious, stable, and reliable internal structure, 2) internal consistency, and 3) temporal stability.

Using SPSS statistics package (version 17), Exploratory Factor Analysis (principal axis factoring) was conducted to empirically explore the underlying structure of the CCRC and to identify the most stable and reliable factor solution. Reliability analysis was used to examine internal consistency of the CCRC constructs. Pearson correlation coefficients were calculated between the same CCRC subscales in the test and re-test stages.

The other objective of this study was to explore normative data of the refined CCRC scales in various demographic groups. To reach this objective, frequency and descriptive procedures were used to provide normative statistics for the CCRC subscales. As well, Profile Analysis of Repeated Measures was employed to examine if CCRC profiles differed in two or more groups of service providers according to various demographic characteristics (e.g., gender, age, and ethnicity). The profile analysis of repeated measures tries to answer three major questions (i.e. hypotheses): 1) whether or not the overall differences among the demographic groups are significant (equal level hypothesis); 2) whether different demographic groups have parallel profiles or the same pattern of highs and lows on CCRC subscales (parallel hypothesis); and 3) whether the CCRC scales have the same average response (flatness of profiles hypothesis)

(Tabachnick & Fidell, 2007). Only the first and second questions are meaningful and will be considered for the purposes of this study.

Results

Data Screening and Assumptions

In the first step of data screening, univariate descriptive statistics were inspected for accuracy of input. The examination of the range of individual item scores of CCRC showed no items outside of the expected range. In the second step, the amount and distribution of missing data was evaluated. Missing Values Analysis revealed no variables with 5% or more missing values. The Little's MCAR test (an omnibus chi square testing to see if the probability of 'missingness' is related to any of the other variables in the dataset) was not significant ($p = .108$). It can therefore be inferred that the missing data is completely at random (MCAR). Since any procedure for handling missing values (e.g., deletion, value substitution, imputations) would lead to similar result when the percentage of missing data is less than 5% (Tabachnick & Fidell, 2007), it was decided to substitute the missing data at the item level using regression method in order to preserve all cases for the factor analyses. CCRC individual items were used for developing regression equation and estimating the missing values. The CCRC items were used as predicted and potential predictors. The maximum number of predictors was set to 8 to satisfy a case-to-independent variable (IV) ratio of 40 to 1 (Tabachnick & Fidell, 2007) and to reflect the minimum number of items for each construct in the study. After the substituting of missing values, the inter-items correlations were compared pre- and post-substitution. Since there was no noticeable difference in pattern and magnitude of correlations of these 2 datasets, the new dataset with missing value substitution was used for factor analysis.

In the third step of data screening, the performance of individual CCRC items was evaluated through examining histograms, box plots, item variance, item means and the pattern of correlations among items. Nineteen items were eliminated from the initial pool of 156 items based on the recommendation of DeVellis (2003). The items that had low variance (less than 1), a mean near one of the extremes of the range (1 or 7), high skewness, kurtosis, and low or non-significant inter-item correlations were eliminated.

Multivariate outliers. Mahalanobis distance was used to assess the presence of multivariate outliers. Since 137 items remained after the initial elimination, the corresponding $\chi 2$ value of 196.3 ($\alpha = .001$) was used as the critical value for Mahalanobis distance test (Tabachnick & Fidell, 2007, p.74). Inspection of extreme values of Mahalanobis distances revealed the presence of multivariate outliers. Sixteen items, with Mahalanobis distances ranging from 197.24 to 242.87, exceeded the critical value of 196.3. However, it has been suggested that Mahalanobis distance is "not perfectly reliable indicator of multivariate outliers" (Tabachnick & Fidell, 2007, p.74) and one needs to look at the Cook's distance (influence) to determine whether or not the identified cases of multivariate outliers are influential (Stevens, 2002, p.134). The Cook's distance revealed no influential multivariate outliers since the highest Cook's distance was equal to .09, which is less than the influence measure's critical value of 1.00. Therefore all of the 137 items were retained.

Multivariate normality. The sample did not meet the criteria for multivariate normality. Hence, principle axis factoring was used as a method of factor extraction where the satisfaction of multivariate normality assumption is not crucial (Fabrigar et al. 1999). In addition, no test of significance was planned to be employed in this stage of analysis. Most of the variables appeared to be skewed in one direction, indicating the specific nature of the current sample

(professional working in the field of correctional rehabilitation). In cases like this, the recommendation was not to employ transformation and to leave the variables as they are which also might be beneficial for interpretation purposes (Tabachnick & Fidell, 2007).

Multicollinearity and singularity. To evaluate multicollinearity and singularity, regression analysis revealed tolerance values above .1 and/or .2, respectively, demonstrating an absence of multicolliniarity and singularity. The tolerance values for 19 items, however, fell between values of .1 and .2 (i.e., .12 - .20). The decision was made to keep these items when Variance Inflation Factor (VIF) values were considered. VIF shows how much the variance of the coefficient estimate is being inflated by multicollinearity. Since VIF values associated with each tolerance level did not exceed 10, a rule of thumb VIF value for presence of multicollinearity and singularity (Stevens, 2002), the 19 items were kept.

Factorability of data (Matrix R). To determine factorability of the 137 items, several well-recognized criteria for the factorability of a correlation were used. Firstly, the majority of the items correlated at least .30 with at least one other variable, suggesting reasonable factorability. The significant correlations ranged from r = -/+.11, n=310, p<.05 to r =.79, n=310, p<.01. Secondly, the Kaiser-Meyer-Olkin measure of sampling adequacy was .81, above the recommended value of .6, and Bartlett's test of sphericity was significant (p < .000), indicating factorability of the matrix. The diagonals of the anti-image correlation matrix were all over .5, supporting the inclusion of each CCRC item. Finally, the communalities ranged from .37 to .86 with 86% being above .5, further confirming that each item shared some common variance with other items.

Exploratory Factor Analysis

Factor extraction. Principal Axis Factoring (PAF) was used to explore the factor structure underlying the CCRC. Several methods were considered to decide how many factors to retain including Kaiser's criterion, scree plot, and parallel analysis. Twenty two components had

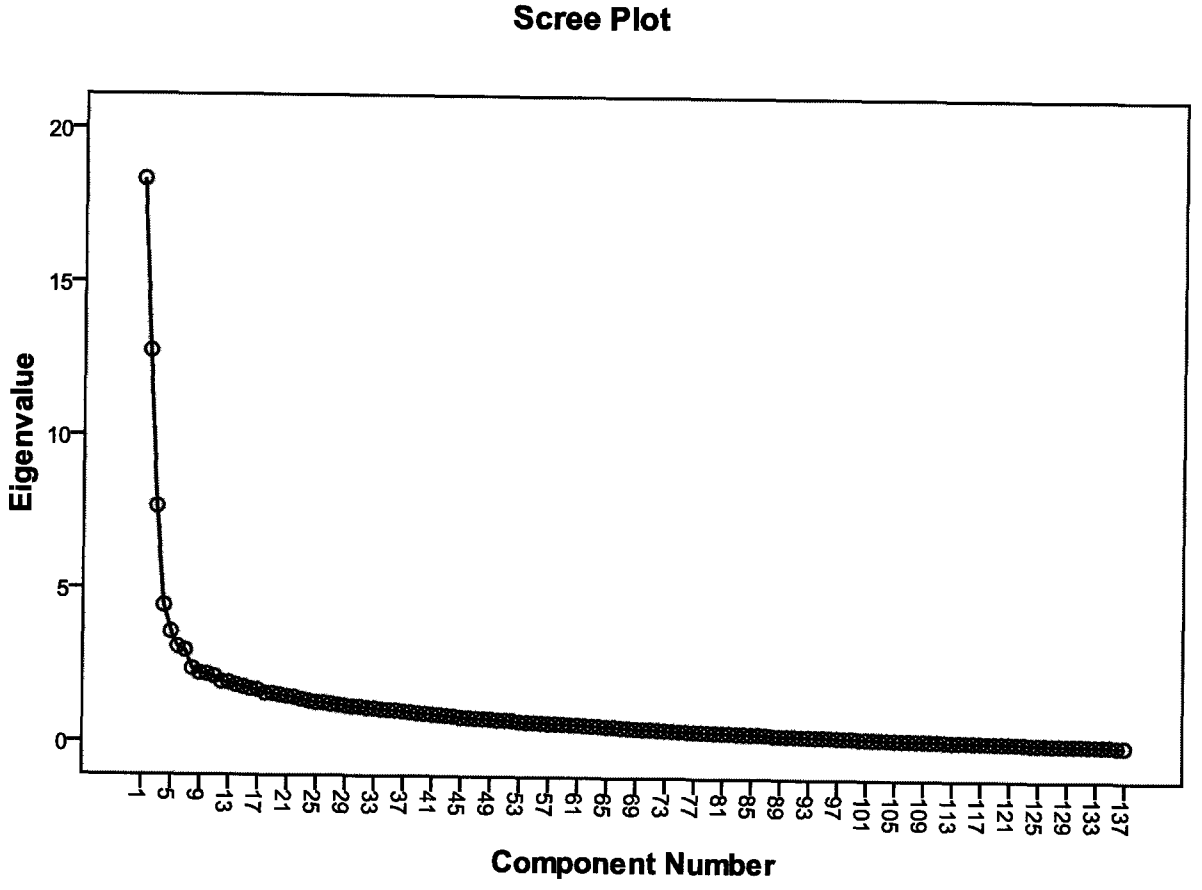

Figure 1. Scree plot obtained by Exploratory Factor Analysis of items in the item pool.

eigenvalues greater than 1 and should be retained according to Kaiser's criterion. It has been suggested that if the number of variables/items entered into the Exploratory Factor Analysis (EFA) is significantly greater than 30, in this case 137, it is safe to assume that Kaiser's criterion might overestimate the number of components to retain (Brown, 2010). Hence, other methods were considered.

The scree plot, shown in Figure 1 indicated the presence of 7 factors, while parallel analysis indicated the presence of 11 factors; since the observed eigenvalues corresponding to the first eleven factors exceeded randomly generated eigenvalues (see Table 7). Both seven- and eleven- factor solutions were examined. Forcing 7 factors in PAF led to a stable and theoretically meaningful solution. However, defining eleven factors in PAF with various rotations failed to result in a stable and statistically-defensible solution.

Table 7.
Parallel analysis

	Observed Eigenvalue		Randomly Generated Eigenvalue
Factor 1	17.93	>	2.24
Factor 2	12.50	>	2.12
Factor 3	7.27	>	2.03
Factor 4	4.02	>	1.96
Factor 5	3.17	>	1.90
Factor 6	2.67	>	1.84
Factor 7	2.58	>	1.79
Factor 8	1.97	>	1.75
Factor 9	1.86	>	1.70
Factor 10	1.83	>	1.66
Factor 11	1.75	>	1.61
Factor 12	1.55	<	1.58

Moreover, editing the eleven-factor solution (e.g., eliminating items with low loadings, low communalities, and/or cross loadings) eventually yielded a 7-factor solution. Therefore,

defining 7 factors in PAF was chosen for further analysis with the goal to determine the final factor solution. This decision is in line with the general recommendation whereby the scree plot is a reliable method for determining the number of factors when the sample size is greater than 300 [i.e., 310] (Brown, 2010).

Factor rotation. To improve component interpretability and to derive a parsimonious factor structure, both orthogonal (i.e., variamax) and oblique (i.e., oblimin and promax) rotations were employed. The factor structure solution in terms of item loadings was the same after varimax and promax rotations, indicating stability of the factor solution. However, according to Tabachnick & Fidell (2007), the oblique rotation methods are preferred for determining the final solution since more than one-third of the inter-factor correlations were above .30 (Table 8).

Table 8.
Factor Correlation Matrix

Factor	1	2	3	4	5	6	7
1	1.00						
2	-.08	1.00					
3	.18	.11	1.00				
4	-.06	.37	.37	1.00			
5	.02	.26	.34	.31	1.00		
6	-.03	.34	.11	.19	.11	1.00	
7	-.04	.12	.31	.14	.35	-.06	1.00

Extraction Method: Principal Axis Factoring.
Rotation Method: Promax with Kaiser Normalization.

Moreover, the oblimin rotation failed to converge and extract factors on a number of occasions while promax rotation generated results consistently, regardless of the composition or number of variables entered into the analysis. Hence the promax rotation was chosen as the main rotation method for the item refinement stage. All component loadings less than .32 were

suppressed for all analyses in this study as per Tabachnick & Fidell's (2007) recommendation to determine the appropriate cut-off for interpretation purposes.

As a rule of thumb, 60 to 80% of variance would have been explained if 27 to 47 factors were retained (Tabachnick & Fidell, 2007). However, this would not have constituted a parsimonious solution. Since the goal of this factor analysis was to explore the internal structure of 137 variables/items and to eliminate the items that performed poorly, it was not surprising to see 35% of total variance explained with the first extraction of 7 factors. All items were carefully examined and 53 items were eliminated based on the combination of the following reasons: poor factor loading (<.35), cross-loading, theoretical item-factor mismatch, and contribution to a lower internal consistency of a factor. To determine the latter, reliability analyses were performed for each factor to identify items that reduce/increase the total internal consistency. More specifically, the Cronbach's alpha scores for each scale were examined when item(s) were retained or deleted.

Table 9 presents eighty four items retained in the final factor solution, which explained 40% of total variance. The contribution of each factor (i.e., sums of squared loadings) to the total variance could not be obtained since the factors were correlated. The distribution of items after elimination was as follows: 7 responses to Vignette 1; 9 responses to Vignette 2; 10 responses to Vignettes 3; 11 responses to Vignette 4; 13 responses to Vignette 5; 14 responses to Vignette 6, and 10 responses to both Vignettes 7 and 8 (see Appendix B).

Factor interpretation. Table 10 shows construct distribution across 7 factors in the final factor solution. Twenty one items asking three similar questions across eight different situations, "How successful might you be in handling this situation?", "How effective might you be in

Table 9.
Final factor loadings and communalities based on PAF and Promax rotation with Kaiser Normalization for the remaining 84 CCRC items, (N=310)

CCRC Items	Factor*							Communality
	1	2	3	4	5	6	7	h^2
How successful might you be in handling this situation? (Vignette 5)	.79							.62
How successful might you be in handling this situation? (Vignette 7)	.77							.61
How confident are you to deal with this situation? (Vignette 6)	.77							.57
How successful might you be in handling this situation? (Vignette 6)	.75							.57
How successful might you be in handling this situation? (Vignette 3)	.74							.60
How effective might you be in handling this situation? (Vignette 6)	.74							.57
How confident are you to deal with this situation? (Vignette 5)	.73							.56
How effective might you be in handling this situation? (Vignette 7)	.72							.57
How effective might you be in handling this situation? (Vignette 5)	.72							.57
How confident are you to deal with this situation? (Vignette 7)	.71							.53
How successful might you be in handling this situation? (Vignette 2)	.70							.50
How effective might you be in handling this situation? (Vignette 2)	.70							.49
How confident are you to deal with this situation? (Vignette 2)	.70							.46
How confident are you to deal with this situation? (Vignette 3)	.68							.51
How successful might you be in handling this situation? (Vignette 8)	.66							.45
How effective might you be in handling this situation? (Vignette 3)	.65							.53
How effective might you be in handling this situation? (Vignette 8)	.65							.43
How confident are you to deal with this situation? (Vignette 8)	.65							.42
How effective might you be in handling this situation? (Vignette 1)	.64							.44
How successful might you be in handling this situation? (Vignette 1)	.63							.44
How successful might you be in handling this situation? (Vignette 4)	.60							.36

(Table continues)

CCRC Items	Factor*							Communality
	1	2	3	4	5	6	7	h^2
V5. This line of justification does not belong here; you are here to take responsibility for your behaviour.		.72						.44
V6. You are blaming the program for your relapse instead of looking at yourself.		.65						.60
V3. It is wrong to bash correctional officers. If you don't change your attitudes you will continue to get in trouble.		.63						.44
V5.You are minimizing the damage done to the owner; this line of thinking will lead you to committing more crimes.		.62						.48
V5.That is a criminal attitude; stealing is stealing.		.61						.49
V6.This attitude will not help you to keep away from fighting.		.61						.45
V6. Peter, how can you blame the program? Don't you think it is about you and not the material?		.61						.44
V2. I do not believe this type of questioning is appropriate in this classroom.		.59						.30
V2. The way you express your opinion is not correct and might get in the way of your recovery.		.54						.26
V7. It frustrates me to see somebody being so unrealistic and believing he can change overnight without much effort.		.52						.27
V6. We all agree to respect each other in the group. You've crossed the line.		.51						.30
V7. This is only our second session and I need you to realize the whole program is necessary in order to meet your plan to live crime-free.		.48						.48
V4. Bianca, you are crossing a personal boundary; it will be helpful if you focus on the question at hand and the activity in the group.		.45						.29
V4. We are not here to talk about me; we are here to deal with your issues.		.43						.23
V5. Regardless whether the owner has or does not have insurance, you cannot lawfully take what is not yours.		.43						.44
V3. You feel not having been treated fairly.			.66					.46
V5. You feel that your actions had no real impact on the owner.			.65					.50
V2. You feel that only an addict can understand your situation.			.61					.35
V3. Can you give us more information about the situation - your thoughts, feelings, your actions?			.57					.42

(Table continues)

CCRC Items	Factor*							Communality
	1	2	3	4	5	6	7	h^2
V1. Pam, you have a legitimate concern; does anyone else have similar feelings about this assignment?			.57					.35
V1. I know how scary it must be to even think about drugs, especially after you have been clean for some time.			.56					.32
V7. You are very determined about avoiding crime in the future.			.55					.46
V6. You must have felt horrible to find yourself in another fight again; I can see why you are disappointed.			.55					.48
V1. You have mentioned that thinking about the times you have used drugs might make you relapse; has that happened to you before?			.51					.29
V7. Keith, the group and I would like to learn more about your specific plans to remain crime-free.			.48					.31
V5. How do you believe these attitudes contributed to your decision to commit this crime?			.47					.33
V7. Your motivation towards crime-free lifestyle is encouraging.			.47					.39
V6. Your frustration shows me that you are really trying. These changes take time, so keep working on them.			.39					.36
V2. When I was going through counselling, I remember myself mistrusting my counsellor in the beginning because I did not have trust in myself.				.75				.56
V1. I had a similar situation. After a while, I learnt that looking at my behaviours directly helped me to tolerate and manage my cravings better.				.73				.50
V1. I remember myself feeling the same way you are right now. Then I realized that avoiding looking at my triggers led me to relapse.				.73				.49
V7. In the beginning of my healing journey, I also felt confident and enthusiastic that I could completely change my life; later I realized that I needed to be patient, set realistic goals and get the help of others in addition to being motivated.				.68				.52
V6. From my experience I found that every time I wanted to reject new material or strategies completely, I was dismissing very important things that helped me later to change my self-defeating behaviours.				.61				.50

(Table continues)

CCRC Items	Factor*							Communality
	1	2	3	4	5	6	7	h^2
V5. Through working on my own problems some time ago, I realized that I had to challenge my false beliefs; otherwise, I would repeat my old problem behaviours.				.61				.53
V8. From my experience every time I tried to dominate the group, I not only made other people dislike me but I also missed out on learning more about myself from others.				.41				.37
V3. When I come across somebody who I feel is disrespectful and in authority I try to take inventory of my thoughts and feelings, consider my actions and consequences and if necessary change my thinking process to avoid arguments.				.37				.26
V4. I would like to hear the group's feedback on the situation I just described.					.64			.46
V6. Does anyone else have a situation to discuss?					.58			.41
V5. Well, what about you (another participant), how do you think your actions affected the person you committed a crime against.					.49			.35
V4. OK Bianca, but what do you think about the situation regarding my interaction with the police officer?					.46			.41
V8. Shift your attention to the participant who asked the question and respond to the initial question.					.44			.26
V3. We've heard from Jack; I now would like to hear from others.					.39			.32
V5. Do not respond to JP's statement but ask him another question on the agenda.					.38			.15
V6. Well, I need to hear how others are progressing with their skill application.					.37			.20
V2. We'll get back to these questions; right now, I'll do a brief overview of what will be covered in this program.					.35			.17
V8. Chris, I should cut you off; I already specified the time frame, which you failed to follow; now it's the other participants' turn.						.69		.47
V8. Chris, you have the biggest mouth I have ever seen. You are not alone in this room and others should have an opportunity to talk.						.60		.33
V4. You cannot seriously think that knowing my personal information will help you in group?						.49		.27
V8. Chris, you tend to interrupt me and others and take over the group; everybody should have a chance to talk.						.49		.41

(Table continues)

CCRC Items	Factor*							Communality
	1	2	3	4	5	6	7	h^2
V8. Chris, I do not know whether or not you realize but you are monopolizing the group. You don't give people a chance to work through their situations.						.48		.37
V4. Bianca, you need to stop being nosey; I am not here to answer such personal questions.						.38		.31
V6. This fight shows me that you are just not getting it.						.37		.22
V2. You are attacking me for not being an addict; are you suggesting that I should become one in order to help you?						.35		.21
V4. You are really interested in getting to know me.							.59	.36
V3. I share your frustration; sometimes I want to yell at them myself.							.53	.30
V6. I am glad you were able to stand up for yourself.							.47	.22
V4. I appreciate your wanting to know me as a person.							.43	.32
V3. Unfortunately, it isn't the first time this has happened. I'll talk to the officer.							.43	.25
V8. Chris you always have great insights and you generously share with others							.42	.33
V7. This is really good, Keith; you can be a great example for others.							.39	.29
V5. It's good that the owner was able to have his merchandise replaced.							.38	.17
V4. I would like to know more about you as well; we can have a chat after the class.							.37	.20
V4. I am married/single and live not far from here in a beautiful place.							.37	.15

Note. Factor loadings < .30 are suppressed

*Factor 1 – Confidence
*Factor 2 – Confrontation
*Factor 3 – Empathy
*Factor 4 – Self Disclosure
*Factor 5 – Neglect
*Factor 6 – Blame/Criticism
*Factor 7 – Reinforcement of AA/AB

handling this situation?", and "How confident are you to deal with this situation?" loaded on the first factor. Hence, the first factor was labelled *Confidence.*

Fifteen items loaded on the second factor. These items were originally created to represent confrontation, use of authority, dominance, and discouraging antisocial attitudes and/or behaviours. The marker items include "This line of justification does not belong here; you are here to take responsibility for your behaviour", "You are blaming the program for your relapse instead of looking at yourself", and "This is a criminal attitude; stealing is stealing". Since most of the items that loaded on this factor are either corrective or confrontational in nature, this factor was defined as *Confrontation.*

Table 10.
Construct Distribution across 7 factors.

Factor 1 **Confidence**	Factor 2 **Confrontation**	Factor 3 **Empathy**	Factor 4 **Self-Disclosure**	Factor 5 **Neglect**	Factor 6 **Blame/Criticism**	Factor 7 **Reinforcement AA/B**
- Context-specific Confidence	- Non-empathic Confrontation - Use of Authority - Dominance - Negative Feedback – Discouraging Anti-social Attitudes and Behaviours	- Simple and Complex Reflective Listening - Directive Communication - Positive Feedback – Reinforcement of Pro-social Attitudes and Behaviours	Appropriate Self-Disclosure	Passive Aggression or Redirecting Providing No Feedback	- Active Aggression - Dominance / Over-control - Use of Authority	- Positive Feedback – Reinforcement of Antisocial Attitudes and Beaviours - Inappropriate Self-Disclosure - Over-Involvement

Thirteen items loaded on the third factor. These items were originally created to tap the constructs of empathy, directive and non-domineering approach to therapeutic interaction, and positive reinforcement of pro-social attitudes/behaviours. The marker items included "You feel that your actions had no real impact on the owner", "You feel not having been treated fairly", "You feel only an addict can understand your situation", and "Can you give us more information

about the situation – your thoughts, feelings, your actions, etc.?" Hence, the third factor was called *Empathy.*

Eight items loaded on the fourth factor tapping into the construct of appropriate self-disclosure. The items were originally designed to represent disclosure of insight and/or strategy. The marker items included "When I was going through counselling, I remember myself mistrusting my counsellor in the beginning because I did not have trust in myself" and "I had a similar situation. After a while, I learnt that looking at my behaviours directly helped me to tolerate and manage my cravings better". This factor was labelled *Self-disclosure.* The fifth factor had 9 items originally designed to tap the constructs of passive aggression where no feedback is given to a client. The highest loadings included items such as "I would like to hear group's feedback on the situation I just described", "Well, what about you (another participant), how do you think your actions affected the person you committed a crime against" and "OK Bianca, but what do you think about the situation regarding my interaction with the police officer?". What most of these items had in common was the action of ignoring or neglecting a participant by re-directing, shifting everyone's attention to another topic or addressing another participant. Hence, this factor was labelled *Neglect.*

Eight items loaded on the sixth factor. Five items were originally designed to represent the construct of criticism and blame (e.g., "Chris, you have the biggest mouth I have ever seen. You are not alone in this room and others should have an opportunity to talk" or "Bianca, you need to stop being nosey; I am not here to answer such personal questions") and the other three were designed to tap into the construct of either dominance or use of authority (e.g., "Chris, I should cut you off; I already specified the time frame, which you failed to follow; now it's the other participants' turn"). Even though there was some overlap with the items that loaded on the

Confrontation factor, this factor had items that were clearly more blaming and critical in nature. Hence, the sixth factor was labelled *Blame/Criticism.*

Finally, ten items loaded on the seventh factor. These items were pooled from the following categories, reinforcement of antisocial attitudes and behaviours (e.g., "It is good that the owner had his merchandise replaced"), inappropriate self-disclosure (e.g., "I share your frustration, sometimes I want to yell at them myself"), and over-involvement (e.g., "Chris you always have great insights and you generously share with others"). This factor had some overlap with Empathy but the majority of the items loading on this factor were more extreme and specific in reinforcing antisocial behaviours like stealing and fighting. Hence, the seventh factor was labelled *Reinforcement of Anti-social Attitudes and Behaviours (Reinforcement AA/AB).*

Stability of the solution and internal consistency. The sample size for the present analysis was 310, which is consistent with the general recommendation of 300 cases for a factor solution to be reliable and stable (Tabachnick & Fidell, 2007). Table 11 presents descriptive statistics, average inter-item correlations, and reliability coefficients for the 7 factors of CCRC. The inter-item correlations ranged from .21 to .49 and the Cronbach's alphas for all 7 factors were above .71, demonstrating acceptable internal consistency of CCRC scales.

Temporal Stability

The Pearson correlations between first and second testing scores on CCRC scales ranged between .69 and .87, demonstrating acceptable temporal stability or test-retest reliability. Table 11 presents test-retest reliability coefficients for each CCRC scale.

Profile Analysis of Repeated Measures

The process of refinement of CCRC through exploratory factor analysis yielded reliable and stable 7-factor structure. Each factor constitutes an independent scale of CCRC (e.g.,

Table 11.
Means, standard deviations, reliability coefficients, average inter-item correlations, and scale ranges for the factors of CCRC

CCRC scales	Mean	SD	*M* inter-item *r*	Reliability[a]	Reliability[b]	Range
Confidence	4.15	.46	.49	.95	.69	2.87 - 5.00
Confrontation	1.92	.75	.32	.86	.83	1.00 - 4.37
Empathy	4.52	1.01	.32	.86	.79	1.92 - 6.85
Self-Disclosure	3.50	1.36	.42	.86	.76	1.00 - 6.88
Neglect	2.92	.96	.25	.75	.74	1.00 - 5.78
Blame/Criticism	1.87	.73	.26	.71	.87	1.00 - 4.30
Reinforcement of AA/AB	1.56	.51	.21	.71	.81	1.00 - 3.20

[a] Cronbach's alpha
[b] Test-re-test reliability coefficient

empathy, self-disclosure, etc.) and can be considered as a dependent variable in the profile analysis. The profile analysis of repeated measures examined if the pattern of CCRC means on the subscales differ in two or more groups of service providers created in accordance with the following demographic characteristics: gender, ethnicity and ethno-linguistic group membership, age, level of education, years of experience, theoretical orientation, and organization/affiliation. The profile analyses in this study attempted to answer two main questions: 1) whether or not the overall differences among the demographic groups are significant (equal level hypothesis); 2) whether different demographic groups have parallel profiles or the same pattern of highs and lows on CCRC subscales (parallel hypothesis).

Assumptions. Before conducting the profile analyses, the required assumptions outlined in Tabachnick and Fidell (2007) were tested. The pairwise plots of the CCRC seven scales were checked for non-linearity and heteroscedasticity. Some of bivariate pairs presented a blop-type

arrangement indicating weak relationships which was expected. Some of the bivariate scatterplots, however, had an oval shape, indicating linearity. Both graphical method (box plot) and inspection of z-scores were employed to detect univariate outliers. The extreme values analysis revealed a total of 10 cases of univariate outliers in three variables, ZCCRC_Confront, ZCCRC_Reinf_AA_AB, and ZCCRC_Blame/Critic. Based on the recommendation of Tabachnick and Fidell's (2007), the offending cases were brought within the range by being assigned a value one unit larger than the next most extreme score. The new z-scores were generated and checked for their maximum values. All of the values were below critical value of 3.29. Conducting correlation analyses pre- and post- bringing univariate outliers within the range demonstrated no noticeable difference.

The inspection of extreme values of Mahalanobis distances revealed the presence of two cases of multivariate outliers, with Mahalanobis distance exceeding that of the critical value, χ^2 = 24.32 at $\alpha = .001$. However, the Cook's distance revealed no influential multivariate outliers since the highest value was .03, which is less than the influence measure's critical value of 1 (Stevens, 2002; Tabachnick & Fidell, 2007). The results of the latter test were adopted since it has been suggested that the Mahalanobis distance is "not a perfectly reliable indicator of multivariate outliers" (Tabachnick & Fidell, 2007, p.74). The Durbin-Watson statistic (d) was equal to 1.9, indicating no autocorrelation of errors. In other words, the independence of errors was established since only a $d < 1$ is problematic (Gujarati, 2003, p. 469). As well, the absence of multicollinearity and singularity was confirmed since the Variance Inflation Factor (VIF) was above 1 for all 7 variables and Tolerance values were close to 1.

CCRC profile by gender. Box's M test was not significant (p=.43), indicating that the homogeneity of variance co-variance matrices assumption for the profile analysis of CCRC

scales by gender was held (Tabachnick & Fiedel, 2007). The interaction between CCRC scales and gender was not significant, F (6, 302) = 1.05, p=.39, indicating the same pattern of highs and lows of relational competencies measured by CCRC in both male and female groups. The male and female profiles are presented in Figure 2. The test of between-subject effect demonstrated a significant gender difference, F (1, 307) = 6.79, p=.01, η^2=.02, implying an overall difference among the groups on the set of relational competencies measured by CCRC (i.e., rejection of equal-levels hypothesis). The independent t-test analyses demonstrated that this overall difference was related to the difference in the means of CCRC Blame and Criticism scale at

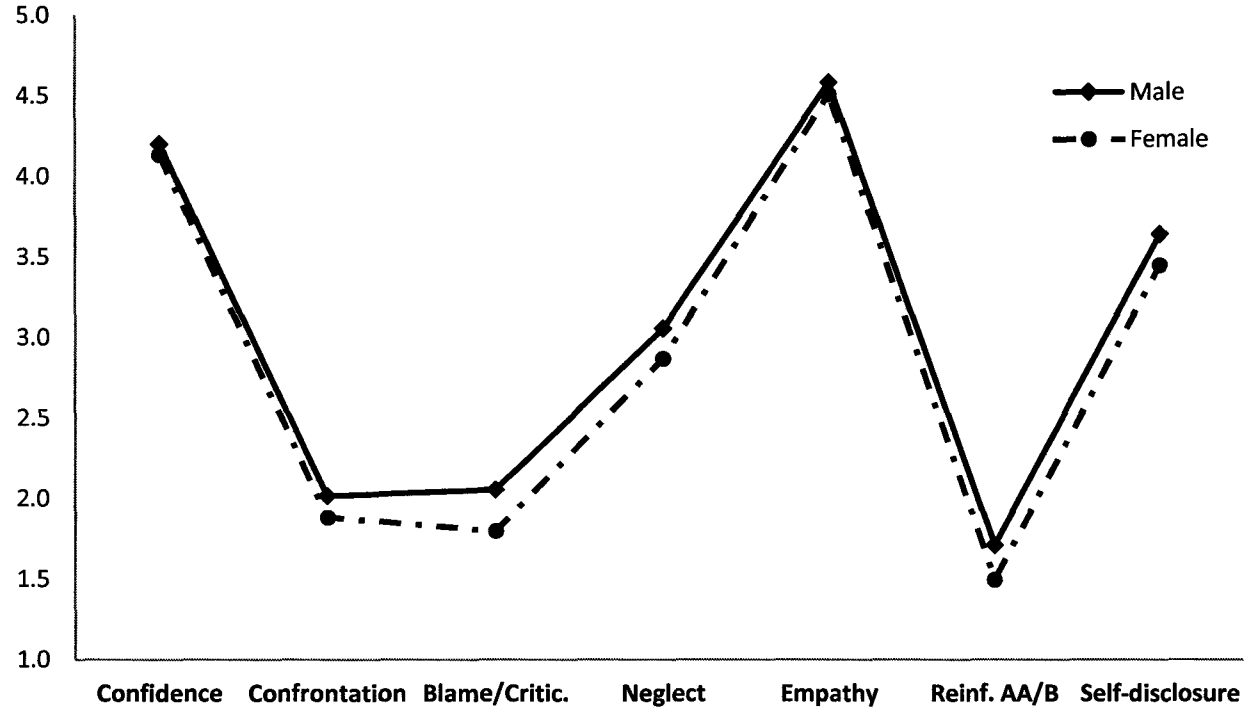

Figure 2. CCRC profile by gender.

p=.004, with males (M=2.05, SD=.74; n=95) using blame and criticism more often than females (M=1.80, SD=.72; n=216). Also, there was a difference in the means on CCRC Reinforcement of Antisocial Attitudes and Behaviours scale at p=.002 (adjusted for equal variance assumption),

with males (M=1.71, SD=.62) reinforcing antisocial attitudes and behaviours more often than females (M=1.49, SD=.45).

CCRC profile by ethnicity and ethno-linguistic group membership. The profiles of Aboriginal and non-Aboriginal (Caucasian) service providers were compared, since these two groups emerged as most prominent in this sample. However, given the fact that Box's M test was significant indicating the violation of homogeneity of variance assumption, the test of parallelism was not reliable. Hence, Figure 3 shows the profile of Aboriginal and non-Aboriginal (Caucasian) participants for descriptive purposes only.

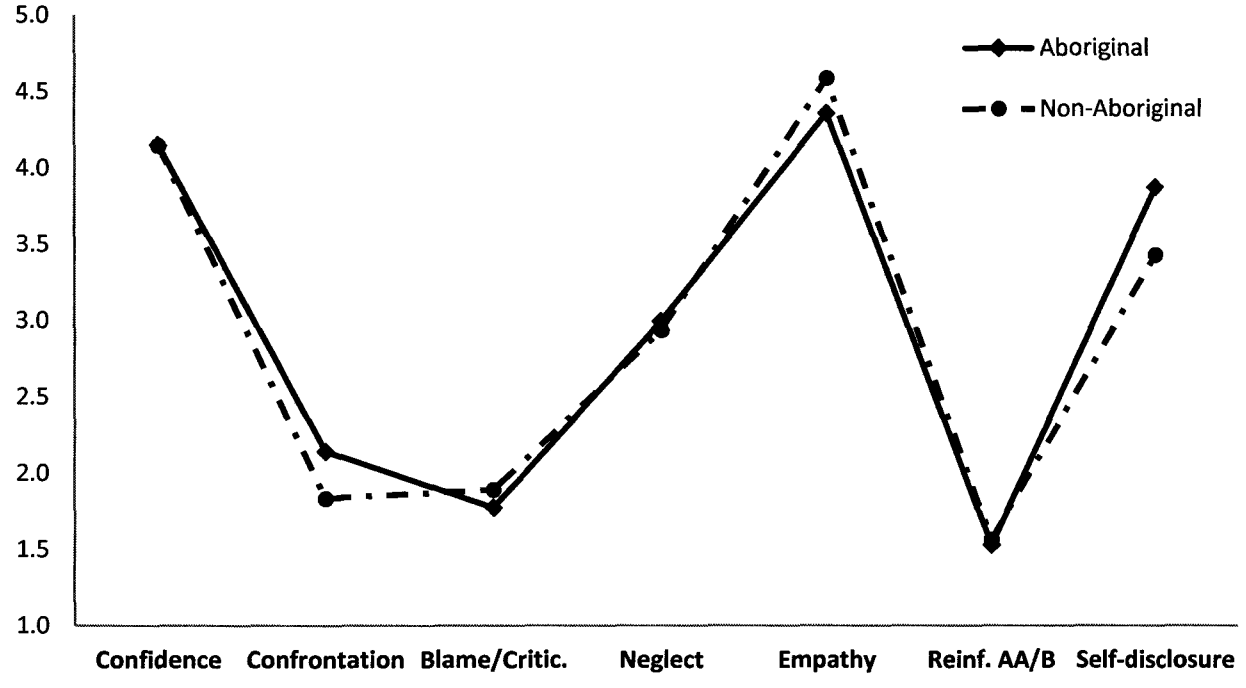

Figure 3. CCRC profile by ethnicity.

Both assumptions of homogeneity of variance co-variance matrices for the CCRC profile by ethno-linguistic group membership was held based on Box's M test, which was not significant at alpha equal to 0.001. The Wilks' criterion indicated significant deviation from

parallelism for Francophone and Anglophone profiles presented in Figure 4, [$F(6, 303) = 38.96$, $p=.000$; $\eta^2=.43$]. However, the test of level equality was not significant [$F(1, 308)=6.35$, $p=.06$]. To examine non-parallelism further, simple effects analyses were applied. When Bonferroni adjustment was considered, the only significant difference was between language groups on the Criticism and Blame [$F(1, 308) = 153.50$, $p=.001$] with Francophone service providers ($M=3.02$, $SD=.68$) using criticism and blame more often than Anglophone ($M=1.72$, $SD=.59$) service providers. The difference between these two groups was large, with eta squared equal to .33, indicating a large effect size (Cohen, 1988).

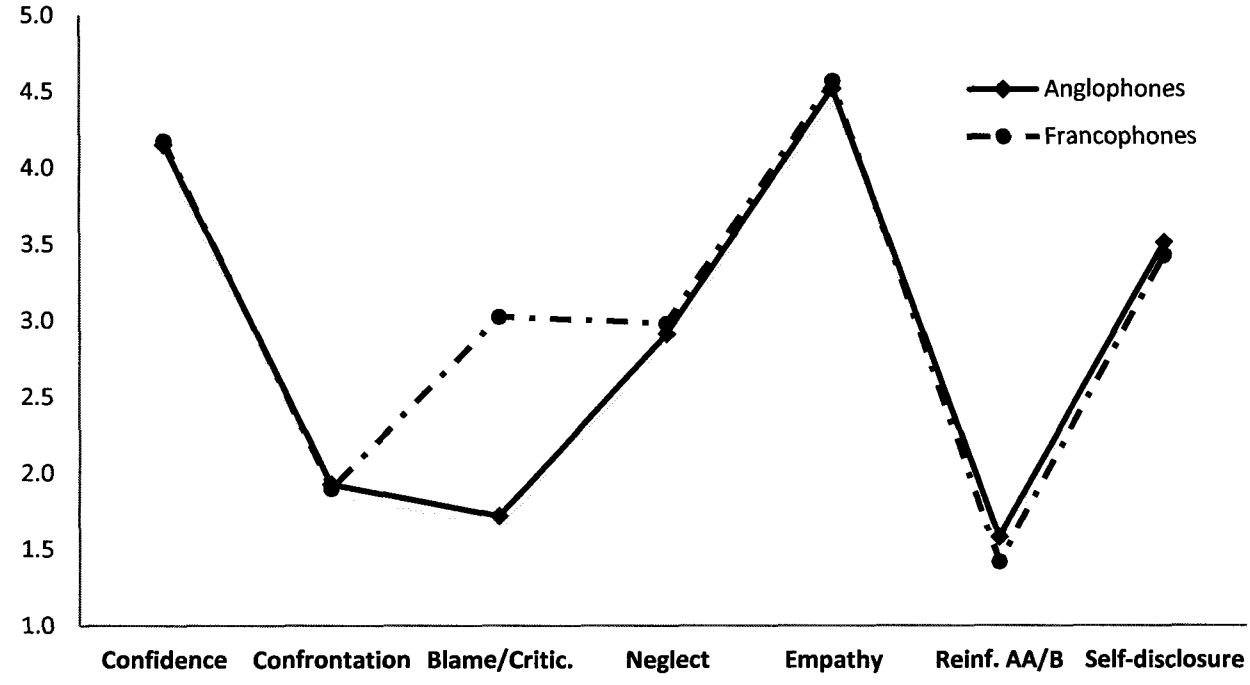

Figure 4. CCRC profile by ethno-linguistic group membership.

CCRC profile by age. The age variable was re-coded into three groups for further analyses: 1) less than or equal to 35, 2) between 36 and 45, and 3) equal or greater than 46. The participant profiles of CCRC scores by three age groups were compared and analysed (Fig. 5). The homogeneity of variance co-variance matrices assumption was held based on the result of Box's M test that was not significant at alpha equal to 0.001. However, the sphericity assumption

was violated based on the result of Mauchy's test. Therefore, Greenhouse-Geisser and Huynh-Feldt adjustments were employed instead of the Wilks' lambda statistics in order to test parallelism of the profiles, seen in Figure 5. The interaction was significant (p=.001), indicating different pattern of highs and lows of relational competencies measured by the CCRC in the three age groups (η^2=.06). The equality of levels test did not reach the level of significance, $F(2, 297) = .45$, p=.64, indicating no overall differences in the CCRC among the three age groups.

Simple effects analyses were employed to explore the significance of the interaction effect further. When the Bonferroni correction was considered, the only significant difference

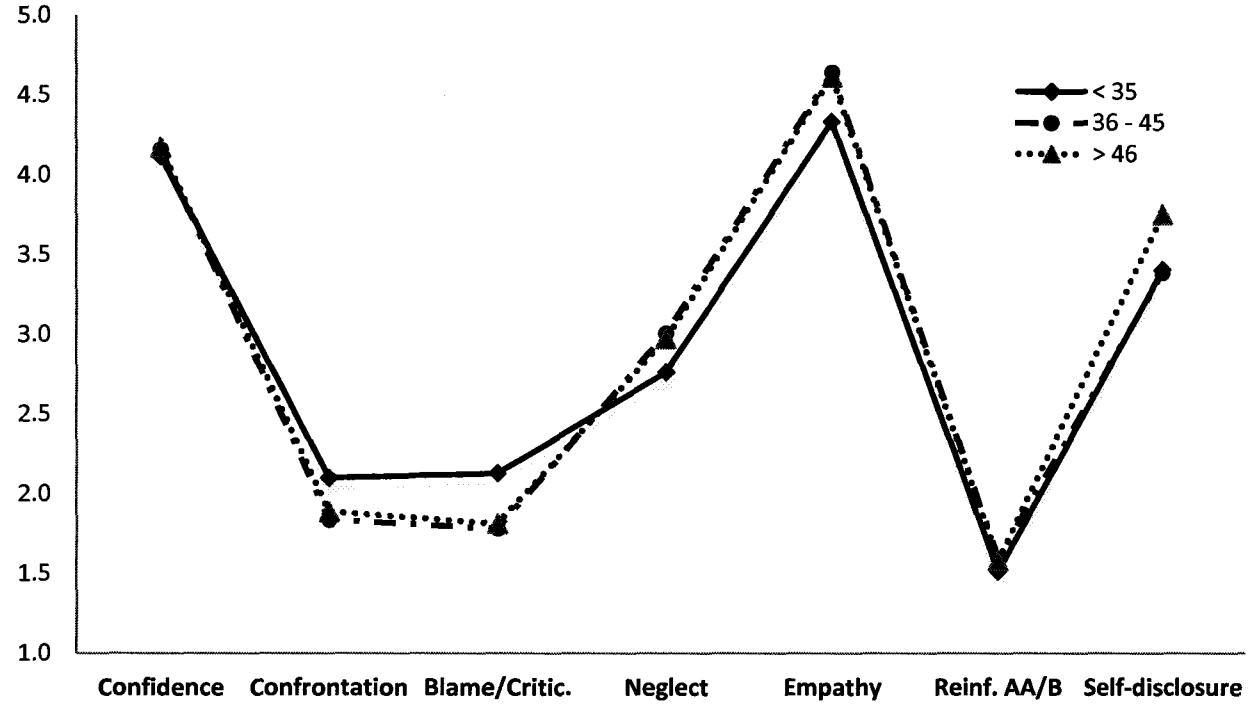

Figure 5. CCRC profile by age.

found between age groups was in terms of Criticism and Blame [F (2, 297) = 6.56, p=.002; η^2=.04]. The Games-Howell post-hoc test demonstrated that service providers who were 36 and older (M=1.84, SD=.66 for 36-45 age group; M=1.81, SD=.75 for +46 age group) used criticism and blamed less often than younger service providers (M=2.13, SD=.84).

CCRC profile by level of education. The participant profiles of CCRC scores by level of education were compared, analysed, and are presented in Figure 6.

The Box's M test was not significant (p=.16), indicating that the homogeneity of variance co-variance matrices assumption was held. However, the sphericity assumption was violated based on the result of Mauchy's test. Therefore, an alternative to Wilks' lambda statistics (i.e., Greenhouse-Geisser and Huynh-Feldt) was used. The interaction between CCRC scales and level of education was significant, based on the Greenhouse-Geisser statistic (p=.000; η^2=.05), indicating different pattern of highs and lows of relational competencies on the CCRC for the three levels of education (High School or College, Bachelor of Art or Science, and Master of Art or Ph.D.).

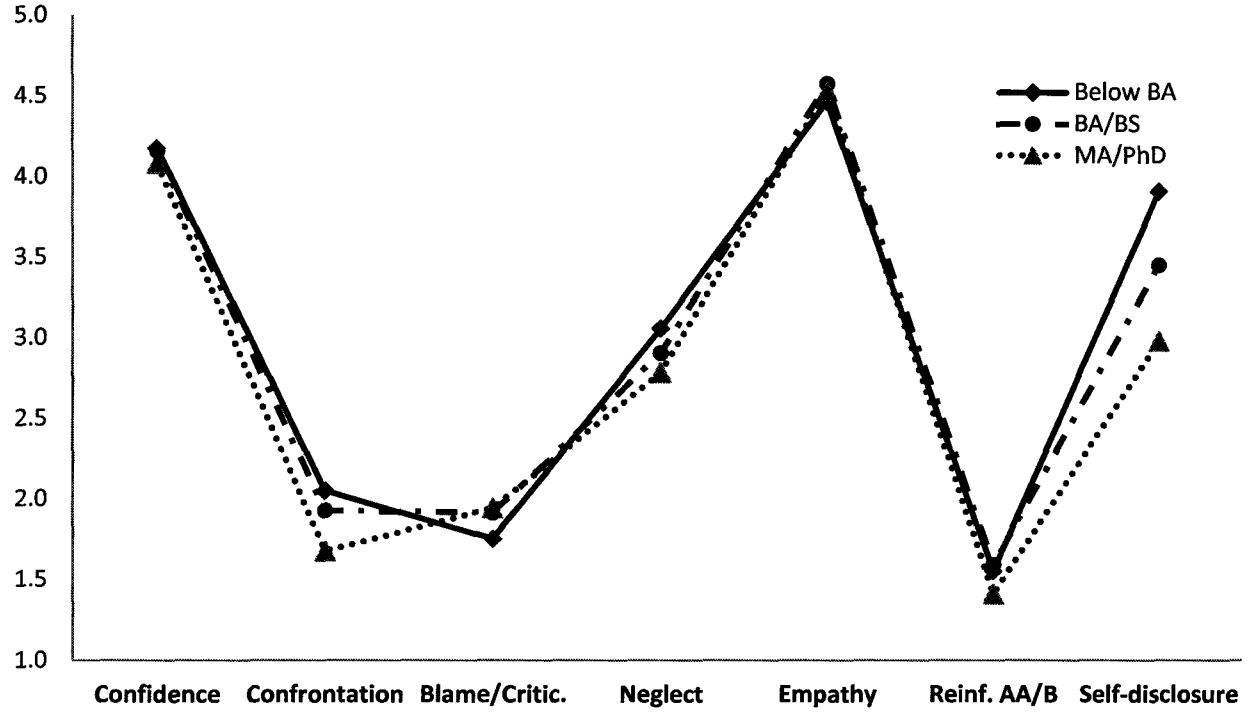

Figure 6. CCRC profile by level of education.

The equality of levels test did not reach statistical significance, $F(2, 303) = 2.51$, p=.08. Simple effects analyses were applied to explore the significance of the interaction effect (i.e.,

rejection of profile parallelism) further. A one-way ANOVA for each of the CCRC scales by level of education revealed the significant difference only in Confrontation [$F(2, 303) = 3.25$, p=.04; η^2=.02] and Self-disclosure [$F(2, 303) = 6.60$, p=.002; η^2=.04] scales.

The Games-Howell post-hoc test which does not rely on the assumption of homogeneity of variance indicated that service providers who had High school or College education (M=2.05, SD=.76; n=79) were higher on Confrontation in comparison to service providers with M.A./Ph.D (M=1.70, SD=.55, p=.009; n=38). Service providers with less formal education were also higher on Self-disclosure (M=3.91, SD=1.32; n=79) in comparison to service providers who had higher education (B.A./B.S. (M=3.45, SD=1.40, p=.03; n=189; M.A./Ph.D. (M=2.98, SD=1.09, p=.003; n=38).

CCRC profile by years of experience. Figure 7 illustrates profiles of participants in four groups of work experience in the capacity of a correctional service provider, "less than 1 year", "2-3 years", "4-9 years", and "10 and above". Using Greenhouse-Geisser and Huynh-Feldt adjustments, the profiles did not deviate significantly from parallelism (p=.19). Furthermore, the between-subject test was not significant, $F(3, 291) = .63$, p=.60, indicating no group differences in their overall CCRC scores.

CCRC profile by theoretical orientation. CCRC Figure 8 illustrates the profiles of service providers who have cognitive-behavioural orientation in comparison to those who reported other theoretical orientations including psychodynamic, humanistic, spiritual, and eclectic. The profiles did not deviate significantly from parallelism based on the Wilks' lambda statistic, $F(6,288) = .86$, p=.52. Furthermore, the test of between-subject was not significant, $F(1, 293) = .27$, p=.61, indicating no group differences in the overall CCRC scores.

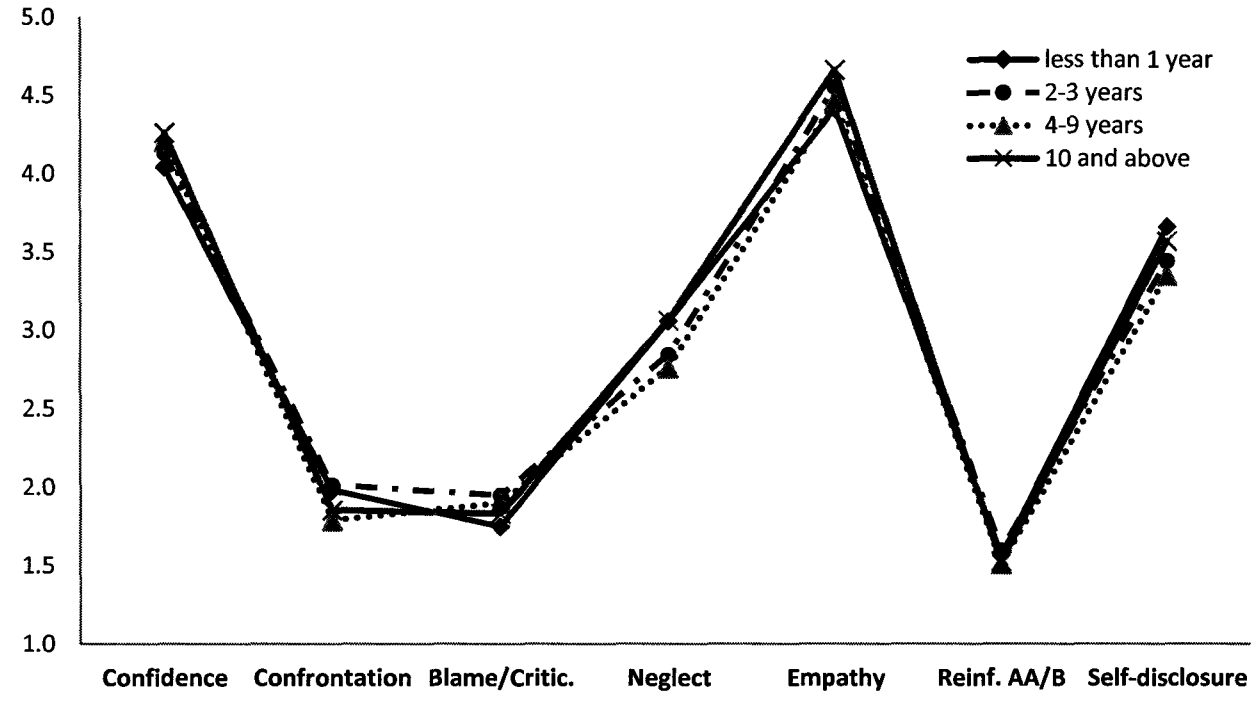

Figure 7. CCRC profile by years of experience.

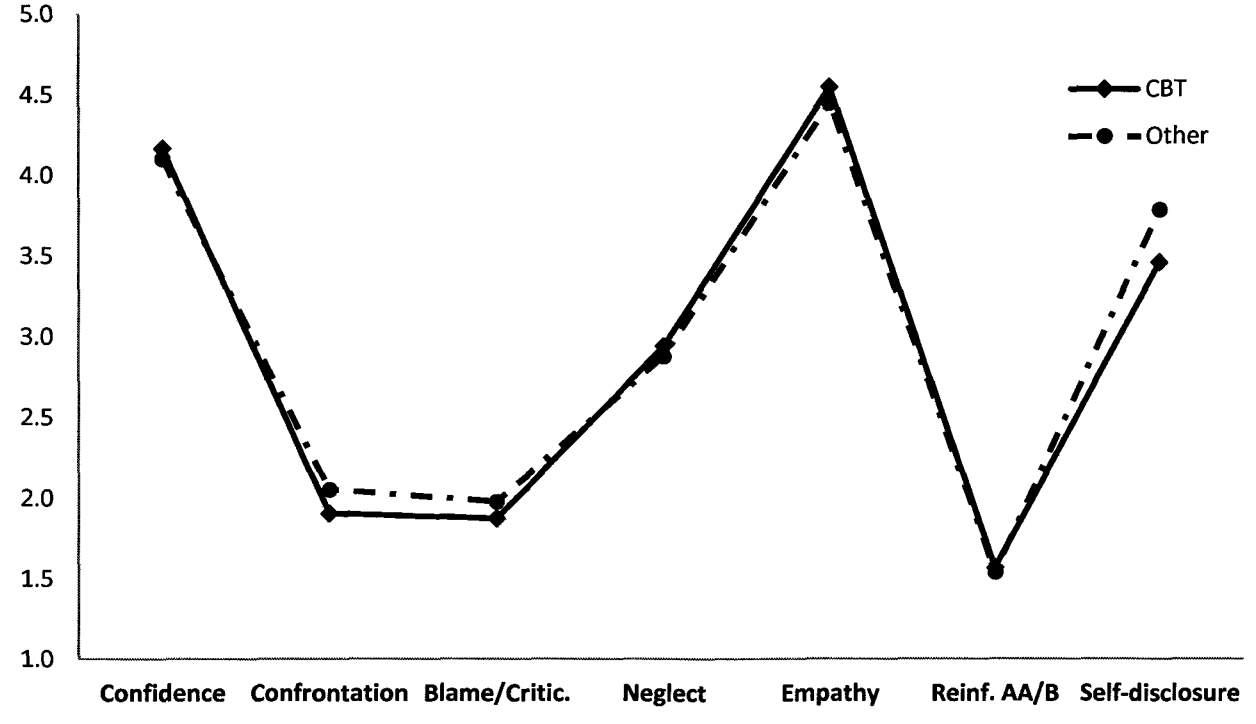

Figure 8. CCRC profile by theoretical orientation.

CCRC profile by organization/affiliation. Profiles of service providers from community organizations and those employed by CSC are presented in Figure 9. The profiles deviated significantly from parallelism based on the Wilks' lambda statistic, F (6,303) = 4.6, p=.00; η^2=.08. However, the test of between-subject was not significant, F(1, 308) = 1.9, p=.28, indicating no group differences in the overall CCRC scores between service providers from community organizations and those employed by CSC.

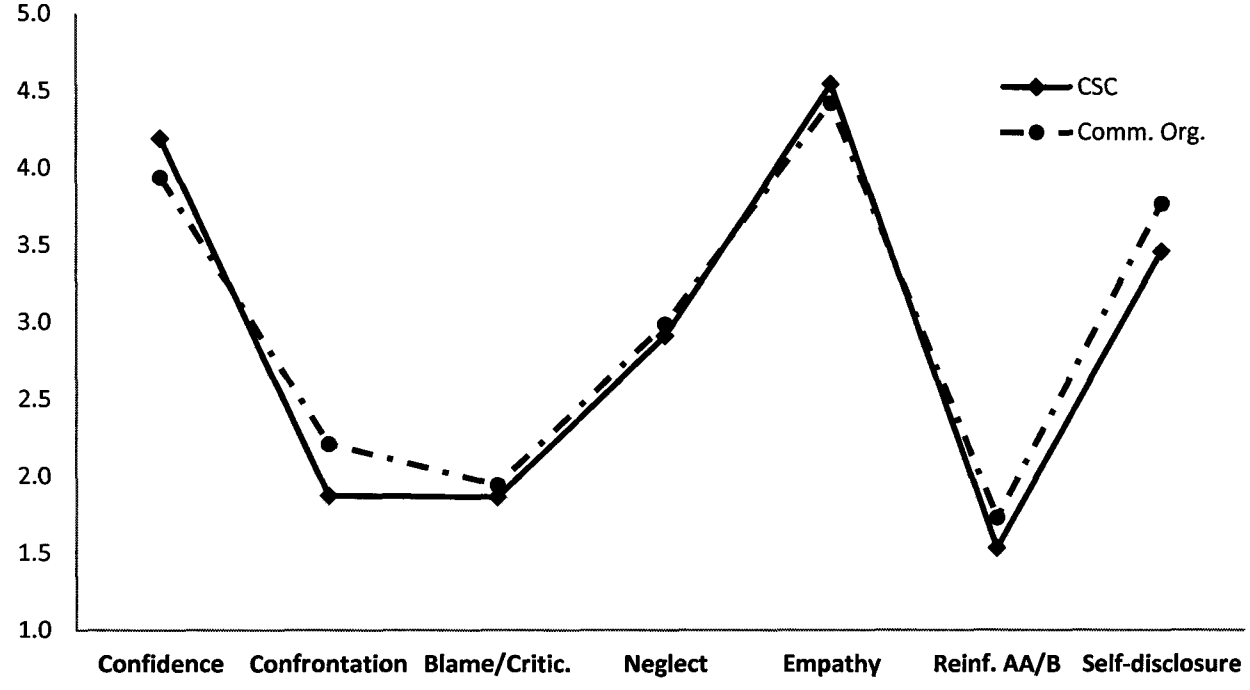

Figure 9. CCRC profile by organization/affiliation.

Simple effects analyses were applied to explore the significance of the interaction effect further. When Bonferroni adjustment was considered, the only significant difference was between groups in Confidence [F(1, 308) = 12.53, p=.000; η^2=.04] and Confrontation [F (1, 308) = 8.09, p=.005; η^2=.03]. Service providers employed by CSC were more confident (M=4.19, SD=.44; n=264) and confronted less (M=1.87, SD=.71; n=264) than those employed by community organizations such as John Howard Society or Elizabeth Fry Society.

The mean for confidence and confrontation in the latter group was 1.80 (*SD*=.51, n=46) and 2.21 (*SD*=.91, n=46), for CSC staff. Since the homogeneity of variance assumption was violated for Confrontation, an independent t-test was conducted to look at the adjusted t-test with equal variance not assumed. The results indicated no significant difference between groups in terms of confrontation, when the Bonferroni adjustment was considered, p=.02.

Discussion

In Study I, the vignette-based measure of correctional counsellor relational competency was developed based on the extensive literature review and experts' contribution. The content domain of the CCRC covered five high-level relational constructs or competencies: empathy, feedback, self-disclosure, confidence, and control of therapeutic process. These relational constructs have been suggested to be significant and/or promising elements for effective intervention in the general and correctional literature. The content domain of each relational competency included both non counter-transferential and counter-transferential aspects and/or facets. These fourteen facets included empathy, confrontation, passive aggression (i.e., neglecting or ignoring), over-involvement, positive feedback, negative feedback, active aggression (i.e., blame and criticism), immediate self-disclosure, appropriate personal self-disclosure, inappropriate personal self-disclosure, use of authority, dominance /over-control, directive communication, and context-specific confidence. Some of the above listed relational facets had both conceptual and content overlap. Hence, one of the objectives of Study 2 was to reduce content overlap through assessing CCRC dimensionality, and generating a parsimonious, stable and reliable internal structure.

CCRC Internal Structure

The Exploratory Factor Analysis (EFA) was employed to uncover CCRC internal structure and reduce content overlap. EFA produced the final factor solution consisting of seven factors, instead of the conceptually defined fourteen facets based on the literature review. This reduction in construct overlap is consistent with Norcross' (2002) recommendation to be cognizant of content overlap among effective and promising elements of therapeutic relationship. He wrote "We may have cut the "diamond" of the therapy relationship too thin at times, leading to profusion of highly related and probably redundant constructs" (p. 11). The factors after EFA were *confidence*, *confrontation*, *blame and criticism, neglect, empathy, reinforcement of antisocial attitudes and behaviours,* and *self-disclosure.* It is important to discuss differences between the initial conceptualization of relational aspects and the final CCRC factor structure.

One of the main differences between the conceptual and final factor solution was related to counter-transferential responses. Even though three counter-transference behaviours (passive aggression, active aggression, and over-involvement) were initially conceptualized as being facets or aspects of empathy, feedback, self-disclosure, and control of therapeutic process, EFA uncovered these three aspects of counter-transference as being stand-alone unidimensional phenomena. Hence three independent CCRC scales emerged, namely *neglect*, *blame and criticism*, and *reinforcement of antisocial attitudes and behaviours*. These scales reflected the counter-transferential aspects of passive aggression, active aggression, and over-involvement, respectively, based on the work of Gelso and Hayes (2002) and Rudd and Joiner (1997).

There is a subtle difference between various aspects of passive aggression, neglect as defined and measured in this study and avoidance as initially proposed and defined by Gelso and Hayes (2002). Neglect or ignoring is more active in comparison to avoidance since ignoring happens in the presence of others while avoidance is not necessarily occurs during a face-to-face

interaction or in the presence of others. Although both are aspects of the passive aggression, this study only considered ignoring, redirecting and shifting one's attention to a different topic or participant (i.e., CCRC neglect scale). Capturing avoidance was not possible due to a very specific context created by vignettes – situations. All 8 vignettes were bound to group facilitation and had no option outside of group sessions. As a result, the measure of avoidance response such as avoiding client's material in an individual session or cancelling a session was not possible.

The aspects of active aggression defined based on the literature review emerged in a factor capturing blame, criticism, and dominance. This is consistent with Rudd and Joiner's (1997) conceptualization of the hostile and aggressive aspect of external counter-transference. Finally, the aspects of initially defined over-involvement emerged in a factor capturing reinforcement of antisocial attitudes or behaviours, inappropriate self-disclosure, or statements of over-involvement. In these instances, a counsellor not only fails to address criminogenic behaviours or attitudes warranted by each situation, but also, in an attempt to sympathize or please a client, reinforces anti-social behaviours or attitudes. Since most (7 out of 8) vignettes presented situations in which an offender is to be addressed regarding antisocial attitudes, behaviours, or in-appropriate interactions, any expression of over-involvement would constitute reinforcement of antisocial attitudes and/or behaviours.

Another major difference between the initial conceptual framework and the final factor solution was related to the control of therapeutic process (CTP). CTP was the only construct that did not result in a separate dimension after EFA. The items from three aspects of CTP defined in this study, use of authority, dominance, and directive interaction were spread across three CCRC scales in the final solution, confrontation, criticism and blame, and empathy. More specifically, the items that were initially created to operationalize the use of authority and dominance loaded

equally on the confrontation and blame/criticism factors, whereas the items representing directive interaction loaded on the empathy factor.

Consistent with the literature on the control in the correctional setting (Andrews & Kissling, 1980; Andrews, et al., 1990; Gillis, et al., 2003; Skeem, Encandela, & Eno Louden, 2003; Skeem, et al., 2007; Trotter, 1999), the control of therapeutic process can be conceptually considered as either positive or negative. In fact, the allocation of CTP items between empathy, confrontation, and blame/criticism factors in the final solution was depended on the degree to which each item had negative connotation or whether it tapped into positive versus negative aspect of control. For example, those CTP items that loaded on the criticism and blame factor had a higher degree of negative connotation in comparison to those items that loaded on the confrontation factor (see Table 8). All of the CTP items that loaded on the empathy factor could be consider as positive control.

The emergence of both confrontation and blame/criticism factors clarifies and consolidates multiple definitions of confrontation in the correctional literature. Confrontation was defined as aggressive, hostile, and punitive interaction by Marshall, et al. (2002) and as effective use of authority and discouraging antisocial attitudes and behaviours by Andrews and Kissling (1980). Both aspects are represented in the final factor solution. Aggressive, hostile and punitive interactions characterize the blame/criticism scale and effective use of authority and discouraging antisocial attitudes and behaviours characterize the confrontation scale.

The loading of directive interaction—positive CTP items on the empathy factor implies the necessity of a new definition for empathy in the correctional setting; one that is supported by the literature on dual role of service providers working with involuntary (mandated treatment) clients (Andrews, et al., 1990, Trotter, 1999, Skeem, et al., 2007). In fact, Skeem et al. (2007)

found that an effective relationship quality in mandated treatment blends caring and affiliation with fairness and social control. Similarly, the final empathy scale has the aspects of empathic, affirmative interaction and control of therapeutic process.

Finally, EFA uncovered two separate factors of context-specific confidence and self-disclosure, as was initially defined and operationalized in this study. Even though the final factor solution explained only 40% of total variance, this was to be expected based on the existing item to number-of-participants ratio, the number of factors retained, possible variability between vignettes/situations, and the difference in the complexity of the item/responses.

Normative Data

Psychometric properties. As was hypothesized, all seven factors demonstrated acceptable psychometric properties including internal consistency and temporal stability. More specifically, all of the Cronbach's alphas, a measure of internal consistency, calculated for each CCRC scales were above .70, a lower acceptable bound for alpha suggested by Nunnaly (1978) (as cited in DeVillis, 2003) and an adequate alpha level; as recommended by Netemeyer, Bearden, and Sharma (2003).

The alphas for Blame/Criticism, Neglect, and Reinforcement of AA/B scales fell in the range between .70 and .80. Although these values are considered to be respectable according to DeVillis (2003), a much higher standard for internal consistency is suggested when the purpose of the measure is to provide an individual assessment with potentially important consequences (DeVillis, 2003). It was also recommended to have higher alphas in the development stage as alphas might drop when the measure is used in a new context. The Blame/Criticism, Neglect, and Reinforcement of AA/B scales also had a smaller number of items retained in comparison with subscales with higher internal consistency. Given the effect of item number on the value of

alpha, the future development efforts may need to consider creating additional items for these scales in order to increase internal consistency.

The alphas for Empathy, Confrontation, and Self-disclosure fell in the range between .80 and .90, considered to be very good (DeVillis, 2003) and the alpha for Confidence scale was .95. The items that loaded on Confidence scale are worded similarly despite asking about different situations, which might have inflated alpha (Netemeyer, Bearden, & Sharma, 2003). When alpha is much above .90, DeVillis recommends shortening the scale. It may therefore be beneficial to shorten the Confidence scale without jeopardizing its internal consistency.

Despite of the low response ranges for some of the scales (e.g., reinforcement of AA/B), the test-re-test reliability was quite high. The test-re-test correlation coefficients ranged from .69 to .87, implying acceptable temporal stability.

Frequency of CCRC factors occurrence. Service providers were relatively confident and reported using empathy and self-disclosure more often than neglect, confrontation, criticism/ blame, and/or reinforcement of antisocial attitudes and behaviours. In fact, reinforcement of AA/B responses were endorsed the least. Confrontation and criticism/blame were used with comparable frequency. Neglect (i.e., ignoring participant(s) by shifting attention to another participant or the topic of discussion) appeared to be used more frequently by service providers than reinforcement of AA/B, confrontation, and/or blame/criticism, but less frequently than empathy and self-disclosure.

The high endorsement of the responses on the neglect scale in comparison to other counter-transferential responses is consistent with studies done in community supervision where probation/parole officers have been observed to ignore or fail to address criminogenic needs (e.g., antisocial behaviours and attitudes). In fact, Bonta, et al. (2008) reported that majority

(74.1 to 81.5%) of probation officers in their study ignored addressing criminogenic needs such as antisocial attitudes and social supports.

The frequencies of endorsement of the responses on blame/criticism and reinforcement of antisocial attitudes/behaviours scales in this study were quite low, which is consistent with offender rehabilitation literature (Bonta, et al., 2008; Marshall, et al., 2002). Nevertheless these behaviours have been reported among service providers working with various groups of offenders and are important to be detected for supervision and training purposes. More specifically, both blame/criticism and reinforcement of antisocial attitudes/behaviours have been observed in probation officers (Bonta, et al., 2008), child protection workers (Trotter 2004, cited in Trotter 2009), and service providers working with sex offenders (Marshall, et al., 2002).

Confrontation, among the non-counter-transferential factors was endorsed the least. This is surprising finding since confrontation, negative feedback, or challenging ineffective or anti-social attitudes and behaviours have been encouraged in the correctional setting and advocated as a main agent of change with offenders (Andrews, et al., 2006; Andrews & Bonta, 2003; Bonta, et al., 2008; Dowden & Andrews, 2004; Gendreau, 1996; Trotter, 1999, 2002). Many correctional programs have been designed incorporating the importance of challenging anti-social and reinforcing pro-social attitudes and behaviours (e.g., Alternatives, Associates, and Attitudes; Violence Prevention Program, National Substance Abuse Program).

Encouragingly, service providers in this study appeared to use empathy or reinforcement of pro-social behaviours more often than discouraging or confronting anti-social attitudes or behaviours. This tendency in practice has been supported by research in the general literature (Claiborn, et al., 2002) as well as recent work in the field of sex offender rehabilitation (Marshall, et al., 2003; Marshall & Burton 2010; Williams & Henley, 2005; Trotter 2009).

It is yet to be determined when, if at all, confrontation is effective when working with offenders and/or ex-offenders. The recommendation in the general and correctional literature has been to use empathy or reinforcement in the beginning of an intervention and confrontation or negative feedback at the later stages of the intervention (Claiborn, et al., 2002; Kear-Colwell & Boer, 2000; Kear-Colwell & Pollock, 1997; Preston 2001; Rotheram, et al., 1982). Future research might not only determine the impact of confrontation and other relational factors on the treatment process and outcomes, but also examine the conditions necessary for effective confrontation in the correctional setting.

It is important to note that some of the scales, particularly counter-transferential (e.g., blame/criticism, reinforcement of AA/B) had low variability. The low variability of less frequently endorsed CCRC scales might be due to the fact that most of the service providers who volunteered for this study had received sufficient training to be able to avoid counter-transferential responses and to endorse non-counter-transferential responses (i.e., empathy and self-disclosure). This argument is supported by the fact that participants in this study had an average work experience in the capacity of a correctional counsellor of 6 years. In the future, it will be important to evaluate students or trainees and to compare CCRC performance across these groups.

Group differences in CCRC. Another purpose of this study was to explore and compare relational profiles of correctional counsellors across Canada on a number of demographic factors (e.g., gender, age, and ethnicity). Overall the findings indicated that there were no significant differences on empathy and neglect scales of the CCRC across various demographic groups. There were also no significant differences between four groups created to capture the level of experience, and theoretical orientation groups. Most of the significant

differences were detected in the counter-transferential factors, criticism/blame and reinforcement of AA/B. Some differences were also found in confidence, confrontation, and self-disclosure scales of CCRC.

More specifically, male counsellors endorsed criticism and blame as well as reinforcement of antisocial attitudes and behaviours more often in comparison to their female counterparts. The finding related to criticism and blame is consistent with the research on negative assertion. It has been demonstrated that male express more aggression, disagreement, and negative emotions towards others than females do (see Carli, 2002, for review).

On the one hand, the finding related to the reinforcement of antisocial behaviours or over-involvement may seem counter-intuitive, if one is to consider the research on the gender differences in mental and physical health. According to this research, females tend to internalize (depression or anxiety) while males externalize (impulsiveness, aggression, substance abuse) their emotional problems (Needham & Hill, 2010; Kessler et al., 2005; Rosenfield, Vertefuille, & McAlpine, 2000). Hence, one might expect female counsellors with counter-transferential feelings or internal conflict to overcompensate by becoming over-protective and revert to care-taking while male counsellors becoming more aggressive and revert to criticism and blame. Yet, the finding in this study showed that female counsellors become over-involved with offenders or reinforce their antisocial attitude and behaviours to a lesser degree than their male colleagues.

On the other hand, this finding is justifiable, if one is to consider the context of Vignettes. In each vignette, a correctional counsellor was expected to address criminogenic attitudes and behaviours. It can be argued that male counsellors in comparison to their female colleagues have higher level of antisocial attitudes that get expressed in their support of offenders' criminogenic attitudes and behaviours. This speculation is in line with the studies demonstrating that males

generally engage in risk-taking antisocial behaviours more often than females and for longer periods of time (e.g., Moffitt, Caspi, Rutter, & Silva, 2001). However, given the small effect size, the gender differences in reinforcement of antisocial attitudes and behaviours should be interpreted with caution and subjected to further empirical investigation. Future studies may clarify the above argument by measuring directly the antisocial attitudes and level of internal conflict of male and female correctional counsellors.

Two other groups endorsed criticism and blame significantly more than their counterparts: Francophone (in comparison to Anglophone) and younger service providers (35 years of age and younger in comparison to 36 years of age and older participants). The effect size for ethno-linguistic difference on criticism/blame factor was quite large (.33). The differences between two distinct Canadian cultural groups, French and English Canadians have been documented for over 5 decades, especially in organizational psychology concerning work force issues such as job satisfaction, employees burnout rates, work-related coping strategies, work motivation and cultural values (Baer & Curtis, 1984; Jain, Normand, & Kanungo, 1979; Kanungo, Gorn, & Dauderis, 1976; Kanungo & Bhatnagar, 1978; Mann-Feder & Savicki, 2003).

No previous studies have compared the styles of interaction in these cultural groups but some evidence exists in support of the current finding. French Canadians, as a distinct cultural group tend to use control rather than escape coping strategy characterized by action and cognitive reappraisals that are proactive and take-charge in tone (Mann-Feder & Savicki, 2003). As well, French Canadians have higher occurrence of introversion, sensation, thinking and judging while the English have a higher incidence of feeling, intuitiveness, and perceiving personality types (Stalikas, Casas, & Carson 1996). Briggs-Myers and Myers (1995) described thinking-judging types appearing to the world as logical and feeling-judging types as empathetic.

The fact that French Canadian service providers tend to revert to criticism and blame more frequently than English Canadian might also be a by-product of potential item bias resulting during translation. Even though two translations by two different professional translators were made and checked for equivalence, both of them were English to French, rather than English to French and back to English as suggested by Candell and Hulin (1986). As well, a direct question relating to primary language was not asked. There could have been individuals whose primary language was French but who chose to fill out the questionnaire package in English. Hence this finding needs to be interpreted with caution. Future research needs to test for item bias in French version of CCRC as well as introduce a primary language variable in order to make more conclusive statements in reference to ethno-linguistic differences in CCRC performance.

In terms of age differences, it was not surprising to see a trend of more counter-transferential responses and fewer non-countertransferential responses among younger participants (35 years old and younger) in comparison to their older counterparts (36 years of age and older). It has been argued that improvement in emotional functioning and well-being continues well past middle age (Carstensen & Charles, 1999; Kessler & Staudinger 2010). Life-span researchers showed that older adults have less anxiety and greater contentment (Lawton, Kleban, & Dean, 1993) as well as a higher balance of positive to negative affect than their younger counterparts (Ryff, 1989). A number of recent studies have demonstrated the presence of a curvilinear relationship between negative affect and age, with negative affect or emotions generally decreasing with age well into adulthood and increasing again after 60 (Carstensen, Pasupathi, Mayr, & Nesselroade, 2000; Kessler & Staudinger 2010; Turk-Charles, Reynolds & Gatz, 2001). Since most of the participants in this study fall in the range of 25 to 60 years of age,

it is reasonable to argue that service providers are able to cope and regulate their emotional states and internal conflicts better with age. Therefore they display less irrational or counter-transferential behaviours, supporting the findings of CCRC age profile analysis.

Differences were also detected in *CCRC confidence* when profiles were compared by organizational affiliation. The CCRC confidence was significantly higher in service providers employed by Correctional Services of Canada (CSC) in comparison to service providers working in the community non-for-profit organizations (i.e., John Howard Society, Elizabeth Fry Society). This finding might be associated with the level of management support, financial and professional development opportunities available to the government employees (CSC employees) in comparison to their counterparts in the community organizations. Community organizations generally have lower operating budgets and have to struggle for funding renewal and budgetary increases. The comparative analysis of funding allocations of Hospitals, Community Health Centers (CHC), and Aboriginal Health Access Centers (AHAC) in Ontario demonstrated this discrepancy, where Hospitals receive three times higher funding than CHCs and AHACs. As well, CHCs have a core budget three times that of AHACs (AOHC Aboriginal Health Access Centre Network, 2007). Future research should further test contextual differences of various correctional organizations and how those might impact the level of self-efficacy or confidence of employees.

Finally, the differences were found in CCRC *confrontation* and *self-disclosure* when level of education and ethnicity were examined. Service providers with High School or College education confronted and endorsed self-disclosure significantly more often than their counterparts with higher education (i.e., B.A., M.A., or Ph.D.). This finding is intriguing since both self-disclosure and confrontation are controversial in terms of their application in treatment

and have had more advocates against it than for it, in the past 20 years (Hill & Knox, 2002; Farber, 2003; Geller, 2003; Marshall, et al., 2003; Marshall & Burton 2010; Miller, et al., 1993; Williams & Henley, 2005). Considering this controversy, many counselling or psychology graduate programs might have veered on a side of caution, having taught students to stay away from confrontation and self-disclosure. Some evidence exists in support of this argument. Taft and Murphy (2007) suggested, with some empirical support, that paraprofessionals use confrontation more often than trained professionals. As well, most of the training programs, especially concerning working with offenders advocate for strict personal boundaries where little room is provided for revealing personal information (Lazur, 1996; Pollock & Stowell-Smith 2006).

The pattern of differences in confrontation and self-disclosure was also similar to the above finding when profiles were compared between Aboriginal and non-Aboriginal ethnic groups. Aboriginal service providers appeared to use confrontation and self-disclosure more often than their non-Aboriginal colleagues. The non-Aboriginal individuals are subjected to Western worldview and communication patterns in their homes and educational system. In contrast, Aboriginal individuals learn Aboriginal worldview and methods of communication in their homes and community before entering educational institutions. It can be assumed that Aboriginal service provider may maintain their traditional values and ways of communication with others throughout the education process. Consequently, it can be speculated that the difference between non-Aboriginal and Aboriginal service providers in the use of confrontation and self-disclosure can stem from traditional upbringing, worldview and cultural way of relating with others. In fact, some evidence exists supporting the above speculation. The oral, story-telling tradition of Aboriginal peoples and its role in transferring traditional values, beliefs and

ways towards conflict resolution have been widely documented (Duryea & Potts, 1993; McKeough, et al., 2008). Aboriginal service providers are comfortable in storytelling traditions and often share their personal stories to educate others and to pass along their traditional knowledge. Future studies might need to clarify not only the nature of the differences in the use of self-disclosure among Aboriginal and non-Aboriginal service providers but also look at the performance of other ethnic groups on the measure of CCRC.

In conclusion, the findings of Study 2 suggested that the CCRC has acceptable psychometric properties including inter-item correlations and reliability. In fact, the final internal structure and content of measure seemed theoretically and conceptually meaningful and empirically stable. The frequencies of endorsing each of the CCRC scales and the CCRC profiles for different demographic groups were consistent with the literature in both general and correctional settings. As well, the presence of group differences on some demographic variables can serve as a foundation for future research. For example, it could be beneficial to examine possible moderating effects of demographic characteristics such as gender, ethnicity, and age on the relationship between CCRC relational competencies and process (i.e., therapeutic alliance) as well as outcome variables (i.e., program completion, change in anti-social attitudes).

Although the evidence presented in Study 2 may be deemed as a considerable support for the construct validity of the measure, it was important to investigate validity of the measure further and in a more systematic way. This was accomplished by forming various validity hypotheses and/or questions for each CCRC factor as well as by studying the relation between CCRC scales and various validated measures. Three types of validity, convergent, divergent and criterion for each CCRC scale are investigated and discussed in the next section, Study 3.

Study 3: Construct Validity

The overall goal of Study 3 was to assess construct validity of the refined CCRC (i.e., convergent, divergent, and criterion validity). Based on the results of Study 2, the final structure of the CCRC consists of 7 relational factors/competencies: confidence, confrontation, blame/criticism, neglect, empathy, reinforcement of antisocial attitude and behaviours, and self-disclosure. The general hypotheses were as follows. It was expected that each of the 7 CCRC factors would have a moderate correlation with at least one independent measure/scale to support construct validity. To demonstrate convergent validity, it was hypothesized that the CCRC factors would moderately correlate with measures of theoretically related constructs. To demonstrate discriminant validity, it was hypothesized that each factor would correlate poorly or have no relationship with the measures not specifically selected for (or theoretically unrelated to) that factor. To support criterion validity, it was hypothesized that CCRC relational factors have significant relationship with group cohesion and/or therapeutic alliance. The rationale for the selection of independent measures to test the validity of the newly developed CCRC as well as the detailed validity hypotheses are presented below for each CCRC factor separately.

CCRC Confidence. The confidence scale of CCRC measures the level of confidence of service providers to handle challenging situations as presented in the 8 vignettes. The self-efficacy theory covers both aspects of self-efficacy, general (Chen, Gully, & Eden, 2001) and context-specific (Bandura, 1997). Hence, it is expected that CCRC Confidence will have a moderate positive relationship with the general self-efficacy, a construct similar to CCRC confidence but in a more general sense (Hypotheses 1). It is also expected that CCRC Confidence will have a positive relationship with specific self-efficacy related to such tasks as active listening, providing constructive feedback, and establishing boundaries in the correctional setting (Hypothesis 2). The latter relationship is expected to be stronger than with the general

self-efficacy, since CCRC Confidence measures context-specific self-efficacy. For summary of hypotheses related to CCRC Confidence, please refer to Table 12.

There is strong evidence demonstrating the relationship between anxiety or personal distress and low levels of self esteem (Davis, 1983), as well as between high level of neuroticism and low level of self-efficacy (Judge & Ilies, 2002; Srobel, Tumasjan, & Sporrle, 2011). It can be argued that the presence of counter-transferential anxiety in a therapeutic setting negatively effects service providers' confidence in dealing with difficult clients. Following this argument, it is hypothesized that the level of confidence will have a positive relation with one's ability to manage counter-transference, including anxiety management. More specifically, there should be a positive relationship between CCRC confidence and factors contributing to the successful management of counter-transference, defined and operationalized by VanWagoner, et al. (1991) and Latts (1996). These factors include empathy, anxiety management, self-insight, self-integration, and conceptualization skills (Hypothesis 3).

Furthermore, it has been demonstrated that level of experience is related to self-efficacy in various settings including high-school classrooms, which are similar to a correctional group facilitation setting (Klassen & Chiu, 2010). The profile analysis conducted in Study 2, however, yielded no difference in confidence scores in terms of years of experience. This finding might be due to the use of years of experience as a categorical (4 groups were created to conduct profile analysis), rather than continuous variable. Hence, a positive correlation between CCRC confidence and years of experience is hypothesized when this marker is treated as a continuous variable (Hypothesis 4).

Finally, there is evidence demonstrating the relationship between therapist's confidence and working alliance (Wei & Happner, 2005). The CCRC confidence is hypothesized to have a

small to moderate positive relationship with the working alliance measures (Hypothesis 5) such as the Therapist Confident Collaboration Scale (TCCS: Hatcher, 1999). In terms of divergent validity, CCRC confidence should have no association with fantasy and empathic concern subscales of trait empathy since these constructs have no theoretical relationship and measure a completely different phenomenon (Hypothesis 6).

Table 12.
Hypotheses related to CCRC Confidence

1. CCRC Confidence will be positively correlated with general self-efficacy
2. CCRC Confidence will be positively correlated with specific-to-correctional setting self-efficacy
3. CCRC Confidence will be positively correlated with factors contributing to management of counter-transference (i.e., empathy, anxiety management, self-insight, self-integration, conceptualization skills)
4. CCRC Confidence will be positively related to years of experience
5. CCRC Confidence will be positively correlated with therapeutic alliance
6. CCRC Confidence will have no relationship with fantasy and empathic concern

CCRC Confrontation. The final confrontation scale, from Study 2 covered aspects associated with explicating rules and giving negative feedback or discouraging antisocial attitudes and/or behaviours. It is important to look at the position of confrontation within the interpersonal circumplex model (Trobst, 2000). The proposed circumplex of interpersonal supportive actions (i.e., SAS-C) is organized along two orthogonal dimensions, one captures dominance or submissiveness of an individual in a helping situation, and another covers the nurturance along love-warm and hate-cold continuum (Trobst, 2000).

Most of the items comprising the CCRC confrontation scale have firm tone and might appear to be void of positive regard. However, the use of authority and negative feedback measured by this scale provide feedback to a client with respect and concern for him/her, which

is consistent with Andrews and Kiessling's (1980) recommendation. Having respect and concern does not necessarily mean that there is love, warmth, or positive regard towards another person (Truax & Carkhuff, 1967). This implies that the CCRC confrontation construct is conceptually similar to that of dominance and non-nurturance as opposed to submissiveness and nurturance (i.e., love-warmth). Therefore it is expected that the confrontation scale may overlap with one of the quadrants of the SAS circumplex that represent dominant and non-nurturing interpersonal behaviours.

More specifically, it is hypothesised that the confrontation scale of CCCR has significant positive relationship with three subscales of SAS-C, directive, arrogant, and critical, that fall under dominance and non-nurturance quadrant (Hypotheses 1, Table 13). Based on the above argument, it is also hypothesized that CCRC confrontation will have a positive correlation

Table 13.
Hypotheses related to CCRC Confrontation

1. CCRC Confrontation will be positively related to dominant and non-nurturant dimensions of the SAS-C measured by directive, arrogant, and critical social behaviours
2. CCRC Confrontation will be positively correlated with empathic concern
3. CCRC Confrontation will have no relationship with attachment related anxiety and avoidance

with empathic concern for others (Hypothesis 2, Table 13), which is different from positive regard and nurturance. In terms of divergent validity, CCRC confrontation should have no relationship with attachment-related anxiety and avoidance, since there is no theoretical or empirical link between confrontation and attachment (Hypothesis 3, Table 13).

CCRC Blame/Criticism. The blame and criticism scale, by definition, overlaps with CCRC confrontation. The items in both scales have a tone of firmness and lack of positive regard. However, blame/criticism also has its own unique characteristic in that it taps the

construct of a more extreme negative interaction that verges on inappropriate and harmful interpersonal communication in treatment. Hence, it is expected that the CCRC blame and criticism scale will positively correlate with non-nurturance dimension of SAS-C and cover a large spectrum of negative behaviours measured within the interpersonal circumplex model including distancing, avoidance, directiveness, arrogance, and criticism (Hypotheses 1, Table 14).

Based on the early conceptualization of counter-transference, blame and criticism are considered to be counter-transferential behaviours which result from an inability to manage counter-transference appropriately (Rudd & Joiner, 1997). Hence, the CCRC blame/criticism scale is expected to have a significant negative relationship with the factors contributing the effective management of counter-transference such as self-insight, self-integration, anxiety management, empathy, and conceptualizing skills (Hypothesis 2, Table 14).

Based on Bandura's social learning theory (1977), individuals learn from one another, via observation, imitation, and modeling. If a group leader or facilitator exhibits negative behaviours such as blame and criticism, it is possible that offenders, who are prone to aggression and violence in the first place, would use negative communication or behaviours towards their

Table 14.
Hypotheses related to CCRC Blame/Criticism

1. CCRC Blame/Criticism will be positively related to non-nurturant dimension of the SAS-C measured by directive, arrogant, critical, distancing, and avoidant social behaviours
2. CCRC Blame/Criticism will be negatively correlated with factors contributing to management of counter-transference (i.e., empathy, anxiety management, self-insight, self-integration, conceptualization skills)
3. CCRC Blame/Criticism will be positively correlated with conflict among group participants
4. CCRC Blame/Criticism should have no relationship with general and context-specific self-efficacy

group peers. Accordingly, it is hypothesized there will be a significant positive relationship between CCRC blame/criticism and interpersonal anger, distancing, distrust, and tension among group participants (Hypothesis 3). Since there is no theoretical or empirical evidence for the relationship between criticism and self-efficacy, it is hypothesized CCRC Blame/Criticism should have no relationship with both general and specific self-efficacy (Hypothesis 4).

CCRC Neglect. The scale of neglect measures the tendency to ignore, re-direct or shift one's attention to another topic or participant and to offer no feedback when the situation requires it. This tendency has an underlying aggression towards a client that gets expressed passively through a form of neglect. By changing the topic or re-directing, a counsellor controls or dominates the group process, which is not, necessarily, in the best interest or benefit of a client. Theoretically, this factor should overlap with the Supportive Actions Scale-Circumplex dominance and non-nurturance dimensions defined by Trobst (2000). Hence, it is expected that CCRC neglect has positive correlations with the directive, critical, and arrogant subscales of SAS-C that represent dominant and non-nurturance aspects of interpersonal interaction (Hypothesis 1).

Service provider neglect is a form of passive aggression displayed towards a client and represents a behavioural manifestation of counter-transference (Rudd & Joiner, 1997). The presence of neglect indicates a service providers' inability to manage their counter-transference effectively. Accordingly, a negative relationship is hypothesized with the factors contributing to the successful management of counter-transference, namely empathy, anxiety management, self-insight, self-integration, and conceptualization skills (Hypothesis 2).

Neglect, as defined in this study, is a form of control of a group process. That is, a counsellor through the act of redirecting clients' attention from the issues brought by the client to

another topic or participant controls the group process. According to the social interaction theory (Benjamin, 1974), controlling behaviours of a therapist elicit submissive behaviours by a client. Hence, it is hypothesized that CCRC neglect will have positive correlation with submissiveness of group participants to facilitator's direction and avoidance of group participants to look at the issues important for their recovery (Hypothesis 3). In term of divergent validity, it is hypothesized that CCRC neglect will have no significant relationship with attachment related anxiety (Hypothesis 4), since the anxiety and avoidance are two orthogonal dimensions in the attachment theory (Fraley, Waller, & Brennan, 2000). The hypotheses for CCRC Neglect are presented in Table 15.

Table 15.
Hypotheses related to CCRC Neglect

1. CCRC Neglect will be positively related to dominant and non-nurturant dimensions of the SAS-C measured by directive, arrogant, and critical social behaviours
2. CCRC Neglect will be negatively correlated with factors contributing to management of counter-transference (i.e., empathy, anxiety management, self-insight, self-integration, conceptualization skills)
3. CCRC Neglect will be positively correlated with avoidance among group participants
4. CCRC Neglect will have no relationship with attachment-related anxiety

CCRC Empathy. The classical definition of empathy refers to the counsellor's ability to sense the client's private world as if it were his/her own, but without ever losing the *as if* quality. The counsellor is not only able to accurately understand the client's world or figuratively speaking walk in the client's shoes but also to communicate this understanding to the client accurately and with sensitivity (Rogers, 1957; cited in Traux & Charkuff, 1967). Based on the results of the factor analysis in Study 2, the CCRC empathy scale consists of two main components, empathic-affirming and directiveness. That is, an empathic correctional counsellor

not only understands the client's world and communicates this understanding to the client but also reinforces pro-social behaviours and promotes exploration through open-ended questioning.

Empathic-affirming and directive aspects of empathy have conceptual overlap with nurturance and dominance dimensions of the supportive actions circumplex model (Trobst, 2002). It is hypothesized that CCRC empathy will be positively correlated with the nurturance and dominance domains of SAS-C represented by directive, engaging, and nurturant social behaviours (Hypothesis 1, Table 16). At the same time, it is hypothesized that the CCRC empathy scale will not be associated with the other 5 subscales of SAS-C that tap non-nurturance and submissive dimensions represented in deferential, avoidant, distancing, critical and arrogant behaviours (Hypothesis 2, Table 16).

Empathy has been defined and measured as a trait in personality psychology (e.g., Davis, 1980). Based on personality theories (Cattell, 1943; Winter, John, Stewart, Klohnen, & Duncan, 1998), it can be argued that individuals who have trait empathy will, more likely, be empathic in interaction with others. Therefore, a positive relationship between trait empathy and CCRC Empathy is hypothesized. More specifically CCRC empathy will correlate positively with three subscales of trait empathy, perspective taking, empathic concern, and fantasy (Hypothesis 3, Table 16).

Empathy has also been defined and measured as an important factor of the management of counter-transference (Bandura, 1956; Latts & Gelso, 1987; Peabody & Gelso, 1982; Robins & Jalkovski, 1987). The definition of empathy in this context is similar to the classical definition of empathy in a therapeutic setting. It refers to the ability of a therapist to identify with and put one's self in the other's shoes permitting the focus on client needs despite work difficulties and/or being pulled to attend to their own needs (VanWagoner, et al., 1991). Considering that

CCRC empathy measures empathy in a classical sense along with other aspects related to the correctional setting, it is hypothesized that there will be a small positive correlation between CCRC empathy and the empathy factor of the management of counter-transference (Hypothesis 4, Table 16).

Table 16.
Hypotheses related to CCRC Empathy

1. CCRC Empathy will be positively correlated with nurturance and dominance domains of SAS-C measured by directive, engaging, and nurturant social behaviours
2. CCRC Empathy will not be associated with non-nurturance and submissive dimensions of SAS-C measured by deferential, avoidant, distancing, critical and arrogant behaviours
3. CCRC Empathy will correlate positively with three subscales of trait empathy, perspective taking, empathic concern, and fantasy
4. CCRC Empathy will positively correlate with empathy, defined as a factor of management of counter-transference
5. CCRC Empathy will have negative correlation with attachment-related anxiety and avoidance
6. CCRC Empathy will positively correlate with group cohesion and working alliance

Being empathic towards others has been demonstrated to significantly relate to a secure attachment style in close relationships (Gillath, Shaver, & Mikulincer, 2005, Mikulincer & Shaver, 2005). Securely attached individuals are those who have low attachment related anxiety and low attachment-related avoidance (Fraley, Waller, & Brennan, 2000). Therefore, it can be hypothesized that CCRC Empathy will have negative correlation with attachment related anxiety and avoidance (Hypothesis 5, Table 16)

Finally, empathy has been extensively studied in various therapeutic settings (see Horvath & Bedi, 2002, for review). The research demonstrated that there is a strong relationship between empathic response and numerous treatment process and outcome variables including therapeutic alliance and group cohesion (Burlingame, Fuhriman, & Johnson, 2002; Horvath &

Bedi, 2002). Hence, it is hypothesized that CCRC empathy will have a significant and positive relation with group cohesion and working alliance (Hypothesis 6, Table 16).

CCRC Reinforcement of Antisocial Attitudes and Behaviours (Reinf_AA_AB). The items comprising this scale tap into the construct of over-involvement and reinforcement of antisocial attitudes and behaviours of participants / offenders by a service provider. Over-involvement refers to being overly engaged and concerned about the client (Gelso & Hayes, 2002) or being overprotecting and caretaking (Rudd & Joiner, 1997). This conceptual theme has an overlap with empathy. However the caretaking behaviours of a counsellor do not address client needs such as exploring a problem or understanding the consequence of his/her antisocial behaviours. These over-involvement behaviours are geared towards various counter-transferential needs of counsellor such as reducing his/her own anxiety and gaining approval and acceptance by a client. Therefore, it is hypothesised that the CCRC Reinf_AA_AB will have a small positive correlation with empathic concern (Hypothesis 1) and negative correlation with factors related to management of counter transference (i.e., anxiety management, self-insight, self-integration, and conceptualization skills) (Hypothesis 2).

CCRC Self Disclosure. The items that comprise the scale of self-disclosure involve supportive or challenging statements that use self as an example and disclose appropriate information about a service provider that can benefit a participant with a particular situation. Therefore, this factor should be considered a therapeutically appropriate self-disclosure as defined in Appendix A. An example of self-disclosure in a therapeutic context might be an insight or strategy that had previously helped a service provider to deal with his/her own anger.

Historically, self-disclosure by service providers has not been promoted in general or correctional setting because of the fear of boundaries violation (Farber, 2003; Geller, 2003; Hill

& Knox, 2002; Lazur, 1996; Marshall & Burton 2010; Pollock & Stowell-Smith 2006; Williams & Henley, 2005). It is safe to assume that only self-confident service providers can use self-disclosures with ease. Hence, it is hypothesised that there will be a positive relationship between CCRC self-disclosure and general self-efficacy (Hypothesis 1, Table 17). Conversely, individuals who are not secure in their interpersonal relationship may not be willing to disclose personal information. For example, people with fear of being close to others and who have a tendency to avoid relational involvement may not share their personal information. It is hypothesized that appropriate self-disclosure should be negatively related to attachment-related anxiety and avoidance (Hypothesis 2, Table 17).

Although confidence and secure attachment characteristics of a service provider are important for the use of self-disclosure, it is necessary that disclosure serves client's therapeutic needs as opposed to therapist self-needs in order to be considered appropriate (Hill & Knox, 2002). This requires a high level of self-awareness in the therapeutic situation (i.e., management of counter-transference), as well as an ability to understand the client's internal world and problem (i.e., empathy). Consequently, it is expected that CCRC self-disclosure will be positively related with self-insight, empathy, and perspective taking (Hypothesis 3 and 4, Table 17).

The oral, story-telling tradition of Aboriginal peoples has continued and is used today in healing and sharing circles where facilitators or Elders share their personal stories to educate others and to pass their traditional knowledge. This tradition has been incorporated into correctional programming for Aboriginal participants (e.g., Basic Healing, Circle of Change, In Search of Your Warrior, Strength of a Warrior, New Spirit of a Warrior and other programs) when facilitated by Aboriginal service providers. Even though, the profile analysis could not be

performed for Aboriginal vs. Non-Aboriginal groups due to sample sizes, there were some differences on the scale of Self-disclosure. Hence, it is hypothesized there will be cultural differences in the use of self-disclosure; Aboriginal service providers are hypothesized to disclose more often than non-Aboriginal service providers (Hypothesis 5, Table 17).

Table 17.
Hypotheses related to CCRC Self-Disclosure

1. CCRC Self-Disclosure will have a positive correlation with general self-efficacy
2. CCRC Self-Disclosure will be negatively related to attachment-related anxiety and avoidance
3. CCRC Self-Disclosure will be positively related with self-insight and empathy defined as factors of management of counter-transference
4. CCRC Self-Disclosure will be positively related with perspective taking, an aspect of trait empathy
5. Aboriginal service providers will self-disclose more often than non-Aboriginal service providers
6. CCRC Self-Disclosure will positively correlate with engagement scale of SAS-C
7. CCRC Self-Disclosure will positively correlate with group engagement and working alliance
8. Male service providers will not differ in the endorsement of self-disclosing responses in comparison to their female counterparts

There is a conceptual overlap between CCRC self-disclosure and "engaging supportive actions" defined within Interpersonal Circumplex Model (Trobst, 2002). Both constructs refer to providing useful information and active social involvement with others, as well as desire to help. Hence, it is hypothesized that there will be a positive correlation between engagement and self-disclosure (Hypothesis 6). Furthermore, self-disclosure has been demonstrated to improve therapeutic relationship (Knox, et al., 1997). Therefore, it is expected that CCRC self-disclosure will have a positive correlation with group engagement and confidence in the therapeutic relationship (i.e., working alliance) (Hypothesis 7). Finally, since there is no theoretical or empirical basis to assume that gender has an impact on the use of self-disclosure it is

hypothesized that male service providers will not differ from their female counterparts on self-disclosure variable (Hypothesis 8).

Additional Hypotheses. Confidence, empathy, and self-disclosure have been linked to positive therapeutic processes and outcomes, both theoretically and empirically in general clinical (Barrett & Berman, 2001; Bohart & Tallman, 1999; Hatcher, 1999; Knox, et al., 1997; Norcross, 2002; Orlinsky, et al., 2004; Patterson & Forgatch, 1985; Ramsdell & Ramsdell, 1993; Wei & Happner, 2005) and correctional (Bonta, et al., 2008; Linehan, 1993; Marshall, et al., 2002; Marshall, 2005; Marshall, et al., 2008) literature. Therefore, it is hypothesized that the combination of these three constructs, measured by the CCRC will have significant associations with the process and outcome variables in this study (i.e., group cohesion and working alliance).

Method

Sample

This study involved testing the convergent, divergent, and criterion validity of CCRC. The sample consisted of 246 service providers. The demographic composition of the validation sample was similar to that of the sample used for determining CCRC internal structure in Study 2 (see Table 5 and 6). The two samples did not differ in terms of work affiliation and years of employment and differed negligibly in terms of all other demographic markers such as age, gender, marital status, level of education, ethnic background, preferred language, years of volunteers and paid counselling experience, years under clinical supervision, and theoretical orientation.

Procedure

Participants for this study were recruited from the same pool of correctional service providers across Canada as for Study 2. Following the recommendations of Hinkin (1998), data

collection was combined for both the data reduction and validation stages. Hence, the on-line survey, in addition to CCRC and demographic questionnaire also offered an option for participants to complete the full package, which included a series of questionnaires selected for the validation stage. After participants had consented to take part in both stages, they first completed the demographic form, followed by the CCRC and then were presented with the questionnaires selected for the validation stage.

The following measures were administered to test construct validity: Interpersonal Reactivity Index, Supportive Action Scale – Circumplex, Counter-transference Factor Inventory-Revised, General Self-Efficacy Scale, Correctional Facilitator Self-Efficacy Measure, Experience in Close Relationship Inventory, and Marlowe-Crowne Social Desirability Scale. As well, two additional questionnaires (Therapist Confident Collaboration Scale and Group Climate Questionnaire) were included in the package to test criterion validity.

Measurement

The Interpersonal Reactivity Index (IRI: Davis, 1980, 1983) is a 28-item self-report measure of trait empathy. The items are rated on a 6-point Likert scale ranging from 0 – "does not describe me at all" to 5 – "describes me very well". The IRI has four subscales: Perspective Taking (PT) assesses as one's ability to see things from other's point of view (e.g., "I sometimes try to understand my friends better by imagining how things look from their perspective"); Fantasy (FS) assesses the ability of individual to identify with fiction characters in the movies, novels, or plays (e.g., "I really get involved with the feelings of the characters in a novel"); Empathic Concern (EC) taps into respondents' feelings of warmth, concern, and compassion for others (e.g., "I often have tender, concerned feelings for people less fortunate than me"); and Personal Distress (PD) measures the level of one's personal distress and discomfort in the face of

other's negative experience (e.g., "When I see someone who badly needs help in an emergency, I go to pieces"). All subscales demonstrated acceptable internal consistency, ranging from .71 to .77. Test-retest reliability was reported to range from .62 to .71 (Davis, 1980). As well, Davis (1980) reported positive correlations with other measures of empathy, demonstrating construct validity.

The Supportive Actions Scale – Circumplex (SAS-C: Trobst, Collins, & Embree, 1994; Trobst, 2000) is a 64 item self-report scale that assesses socially supportive behaviours when someone close has a problem, including both protective and harmful personal transactions. The items are rated on a Likert scale ranging from 1 – "never" to 7 – "always". The SAS-C was developed based on an interpersonal circumplex model and taps two dimensions of dominance and nurturance. There are eight subscales that were confirmed by factor analysis (Trobst, 2002): Directive (e.g., "I give advice"); Engaging (e.g., "I enthusiastically help out"); Nurturant (e.g., "I let them deal with things at their own pace"); Deferential (e.g., "I remain non-judgmental"); Avoidant (e.g., "I avoid challenging their point of view"); Distancing (e.g., "I try not to show too much concern"); Critical (e.g., "I remind them that people sometimes get what they deserve"); and Arrogant (e.g., "I advise them to pay attention to what I have to say"). The internal consistency of subscales was acceptable, ranging from .71 to .85. The SAS-C has demonstrated construct validity (Trobst, 2000) through correlations with extant social support subscales (e.g., social support behaviours - emotional support, socializing, practical assistance, financial assistance, advice/guidance, directive guidance, nondirective support, positive social interaction, and tangible assistance) and personality characteristics (e.g., trait empathy).

Countertransference Factor Inventory-Revised (CFI: VanWagoner, et al., 1991; CFI-R: Latts, 1996) is a 40-item self-report or observer rating system assessing therapist factors

contributing to the successful management of counter-transference, including self-integration, self-insight, management of anxiety, and empathy. In this study the CFI-R therapist self-report was used. Therapists rated themselves on each item using a 5 point rating system ranging from 1 (strongly disagree) to 5 (strongly agree). The CFI-R has high level of internal consistency with alpha coefficients of .86, .90, .86, .79, .85, and .96 for self-insight, self-integration, anxiety management, empathy, conceptualizing skills and CFI-R total, respectively. It has been demonstrated that both CFI and CFR-R have acceptable reliability and construct validity (see Gelso & Hayes, 2002 for review). For example, these authors reviewed studies demonstrating negative correlations of factors of management of counter-transference with actual counter-transference behaviours within a given session in both laboratory and field situations.

New General Self-Efficacy Scale (NGSE: Chen, Gully, & Eden, 2001) was developed to improve construct validity of the existing general self-efficacy measure (GSE) created by Sherer, et al., (1982). The NGSE assesses one's confidence in his/her ability to perform effectively across different tasks and situations. High scores on NGSE correspond to a high level of confidence. The NGSE is an 8-item Likert scale with item responses ranging from 1 – "Strongly Disagree" to 2 – "Strongly Agree". Internal consistency was high for NGSE was .86 and .90 when administered on two separate occasions (Chen, Gully, & Eden, 2001). Test-retest coefficient (r = .67) showed that the NGSE scale was stable. It was demonstrated that NSFE has construct validity and predicts self-efficacy related to specific tasks (Chen, Gully, & Eden, 2001).

Correctional Facilitator Self-Efficacy Inventory (CFEI: Shturman, 2007) is a 37-item self report questionnaire that assesses correctional service provider confidence in performing tasks required for their competency evaluation (i.e., Correctional Programs Quality Review of

Facilitators). The CFEI was developed based on the Correctional Service of Canada guidelines for program delivery (Commissioner's Directive D726-1) which are grouped into six categories: working alliance, program delivery techniques/skills, analytical thinking/judgment, planning and organizing, self management, and compliance with policy. The subjects are asked to rate each skill according to level of their confidence in performing it on a 5-point Likert scale ranging from "not at all confident" to "always confident". This newly developed measure demonstrated acceptable internal consistency (i.e., alpha coefficient = .94) in this study. As well, it had significant correlation with general self-efficacy (r = .48, p<.01), measured by New General Self-Efficacy Scale (NGSE: Chen, Gully, & Eden, 2001), indicating initial construct validity.

Experiences in Close Relationships-Revised (ECR-R: Fraley, Waller, & Brennan, 2000) assesses two main dimensions of attachment, anxiety and avoidance. The measure consists of 36 items and uses 7-point Likert scale ranging from "Disagree Strongly" to "Agree Strongly". Attachment-related anxiety consists of 18 items and assesses the extent to which, people experience fear of being abandoned and have an excessive need for reassurance in relationship with their partners. Attachment-related avoidance consists of 18 items assesses the extent to which people feel uncomfortable with closeness and self-disclosure to their partners. The ECR-R has repeatedly demonstrated high level of internal consistency (alpha = .90) (Fraley, 2010; Fraley, Waller, and Brennan, 2000) and temporal stability (86% shared variance over 6 week period) (Sibley & Liu, 2004). In terms of construct validity, Sibley, Fischer, and Liu (2005) showed that the ECR-R explained 30% to 40% of the between-person variation in social interaction diary ratings of attachment-related emotions experienced during interactions with a romantic partner and 5% to 15% of that in interactions with family and friends.

Group Climate Questionnaire – Short Form (GCQ-S: MacKenzie, 1983) is a 12 item self-report measure that assesses group process or individual group member's perceptions of the group's therapeutic environment. The items are rated on a 7-point Likert scale ranging from 0 - "not at all" to 6 - "extremely". The group cohesion assessment can be done by either therapists or clients. In this study, the ratings by correctional counsellors were used. The GCQ-S consists of 3 subscales, engagement, conflict, and avoidance. The Engagement scale reflects constructive therapeutic work including group cohesion. The Conflict scale measures interpersonal anger, distancing, distrust, and tension. The Avoidance scale reflects members' avoidance of constructive involvement. Engagement, conflict, and avoidance scales of GCQ-S have an acceptable internal consistency with alpha coefficients of .94, 92, and .88 respectively. As well, the construct validity of the GCQ-S has been demonstrated on a numerous occasions linking the scores to treatment process and outcomes (Kivlighan & Goldfine, 1991; MacKenzie et al., 1987).

Therapist Confident Collaboration Scale (TCCS: Hatcher, 1999) – assesses both therapist confidence in treatment and the therapist's perception of client's confidence and commitment. The TCCS was empirically derived through confirmatory factor analysis using two reliable and valid measures of therapeutic alliance, Working Alliance Inventory – Therapist Version (WAI-T; Horvath, 1981 as cited in Hatcher, 1999) and California Psychotherapy Alliance Scales-Therapist Version (CALPAS-T; Gaston & Marmar, 1991 as cited in Hatcher, 1999). This scale addresses two issues related to the construct of therapeutic alliance: 1) low predictive validity of therapist therapeutic alliance ratings, and 2) the often reported mismatch between therapist and client perspectives on therapeutic alliance (Horvath & Luborsky, 1993; Orlinsky, et al., 2004; Tichenor & Hill, 1989). The TCCS consists of six items including "My

patient and I both feel confident about the usefulness of our current activity in therapy", "As a result of these sessions, my patient is clearer as to how he/she might be able to change", "My patient has confidence in therapy and therapist" and "My patient is confident that our efforts will lead to change". The TCCS has been demonstrated to have high internal consistency (alpha coefficients of .88 and .89 in two independent samples) and significant correlations with both therapist and patient ratings of improvement (Hatcher, 1999).

Marlowe-Crowne Social Desirability Scale (SDS: Crowne & Marlowe, 1960; Raynolds, 1982) is a 13 item self-report which is a short version of the original 33-items developed by Reynolds (1982). The SDS aims to identify individuals who are high/low on seeking approval from others, which in turn assesses the level of social desirability as a response tendency to any questioners with a self-report format. Using a true-false answer key, the SDS produces either high or low scores where the high scores are indicative of socially desirable responding. The SDS-short version has an acceptable level of internal consistency (i.e., alpha equals to .80), a very strong relation with the longer version of the SDS (i.e., greater than .90), and convergent validity (O'Grady, 1988).

Data Analysis

Data screening and editing procedures were conducted to eliminate outliers and address missing data prior to conducting analyses. Psychometric analyses involved bivariate and/or multiple correlation analyses to determine the level of association between CCRC subscale scores and scores on the selected measures intended to be used for assessing convergent, divergent, and predictive validity. An independent t-test was used for univariate group comparison in order to determine the difference between Aboroginal and non-Aboriginal as well as male and female service providers in the use of self-disclosure. Finally, multiple regression

analysis was used to assess criterion validity of CCRC, the relation between CCRC subscales and counsellor ratings of working alliance and group climate (cohesion).

Results

Data Screening and Assumptions

The data containing 10 measures selected for validation was examined for accuracy of input. There were no items outside of the expected range in any of the measures. In total, 246 participants filled out questions related to convergent, divergent, and predictive validity. Twenty two of these participants did not fill out the *Climate Questionnaire Short Form (GRQ-S)*, group facilitation outcome measure and 65 participants did not complete the *Therapist Confident Collaboration Scale (TCCS),* a working alliance outcome measure which required additional information about a particular client. Since most of the Correctional Program Officers engage only in group facilitation and rarely in individual counselling, it was expected to see a decrease in the number of people who would answer questions related to a therapeutic encounter with a client.

The Missing Values Analysis (MVA) with all validation measures revealed less than 5% of missing values. An omnibus chi square test that examined whether or not the pattern of 'missingness' for all of the variables was related to any of the other variables in the dataset was not significant ($p = 1.00$) . Hence, it was concluded that the data is missing completely at random (MCAR). The regression method at the item level was used for data substitution in eight self-report measures, with the goal of preserving all of the cases. This method was similar to that used in study 2 of this study. The pre- and post-substitution correlation matrices showed no noticeable difference. For the scales that required information about group and individual clients,

the GCQ-S and TCCS, the participants who did not provide answers for the entire questionnaire or to the majority of the items were excluded from further analyses related to predictive validity.

The pairwise plots were checked for non-linearity and heteroscedasticity. Some of bi-variate pairs presented a blop-type arrangement indicating weak relationships, which was expected. No bi-variate scatterplots departed from linearity or had culvilinear arrangement. In terms of heteroscedasticity, a number of pairs that included the following variables, CCRC_Confront, CCRC_Reinf_AA_AB, CCRC_Blame/Critic, LM_Nurturant, DE_Critical, Anxiety, Avoidance, GCQ_Eng, GCQ_Conf, and TherRel_Total, appeared to have greater variability in the scores of one variable for low or high values of the other, indicating heteroscedasticity. It should be noted, however, the presence of heteroscedasticity might weaken the analysis of ungrouped variables but it does not invalidate it (Tabachnick & Fidell, 2007). The issue of the heteroscedasticity was considered by dealing with non-normal variables and univariate outliers.

The univariate normality was checked using Kolmogorov-Smirnov and Shapiro-Wilks Tests that indicated departure from normality for 28 out of 34 variables. Because these tests are overly sensitive to large sample sizes, histograms, box plots, probability and detrended normal probability plots were examined, as well as assessed standardized skewness and kurtosis based on the recommendations of Tabachnik and Fidell (2007). Eleven variables, CCRC_Confront, CCRC_Reinf_AA_AB, LM_Nurturant, DE_Critical, Anxiety, Avoidance, GSE_Total, GCQ_Eng, GCQ_Conf, and TherRel_Total were revealed as problematic with standardized skewness/kurtosis scores exceeding +/- 3.29 suggesting univariate non-normality. Prior to performing transformations on these variables, it has been suggested to deal with the univariate outliers first as they might be effecting the skewness and kurtosis (Tabachnick & Fidell, 2007).

To detect univariate outliers, both graphical method (box plot) and inspection of z-scores were employed. The box plot revealed several cases that fell far away from the box. Inspection of the standardized values of the variables revealed the presence of univariate outliers in twelve variables, ZCCRC_Confront, ZCCRC_Reinf_AA_AB, ZCCRC_Blame/Critic, ZLM_Nurturant, ZJK_Deferential, ZHI_Avoidant, ZFG_Distancing, ZDE_Critical, ZAnxiety, ZGSE_Total, ZGCQ_Conf, and ZTherRel_Total with z values exceeding +/- 3.29. Examining these variables further using extreme values analysis revealed a total of eighteen cases of outliers.

To deal with the outliers, the offending cases were assigned a value one unit larger than the next most extreme score. The new z-scores were generated and checked for their maximum values. All of the values were below 3.29. Correlation analyses conducted pre- and post-bringing univariate outliers within range demonstrated no noticeable difference.

To determine if adjusting the outliers reduced the problem of non-normality, Z values for skewness and kurtosis were re-calculated. Bringing outliers within range did reduce the size of skewness and kurtosis z-scores for most of the variables but did not eliminate the problem completely. Transformations were done for the most extremely skewed and kurtozed variables. Seven variables were positively skewed, CCRC_Confront, CCRC_Reinf_AA_AB, CCRC_Blame/Critic, DE_Critical, Anxiety, Avoidance, and GCQ_Conf, requiring either a square-root or logarithmic transformations. Three other variables, LM_Nurturant, GCQ_Eng, and TherRel_Total were negatively skewed, requiring reflection (i.e., subtracting scores from a constant that is larger than any other score on that variable) before performing a square-root transformation. Transformations succeeded in bringing standardized skewness and kurtosis into acceptable range for all of the variables.

The presence of multivariate outliers was examined for two planned regression analyses separately. The first analysis was planned for three IVs (CCRC Confidence, CCRC Empathy, CCRC Self-Disclosure) and one DV (Therapist Confident Collaboration). There were no multivariate outliers detected since Mahalanobis distance did not exceed the critical value of 16.27 (χ^2 at $\alpha = .001$ for 3 IVs) (Tabachnick & Fidell, 2007, p.74).

The second analysis was planned for three IVs (CCRC Confidence, CCRC Empathy, CCRC Self-Disclosure) and one DV (Engagement scale of GSQ). The same critical value as above was used since the same number of IVs was planned for this analysis. The inspection of extreme values of Mahalanobis distances revealed the presence of one case of a multivariate outlier, with Mahalanobis distance equals to 18.57 exceeding that of the critical value. However, it has been suggested that Mahalanobis distance is "not perfectly reliable indicator of multivariate outliers" (Tabachnick & Fidell, 2007, p.74) and one needs to look at the Cook's distance (influence) to determine whether or not the identified cases of multivariate outliers are influential (Stevens, 2002, p.134). The Cook's distance revealed no influential multivariate outliers since the highest Cook's distance was equal to .46, which is less than influence measure's critical value of 1.00. Durbin-Watson statistic (d) was equal to 1.9 and 1.8 for the first and second sets of variables respectively, indicating no autocorrelation of errors. In other words, the independence of errors was established since only $d < 1$ is problematic (Gujarati, 2003, p. 469). Finally, as per Tabachnick and Fidell's (2007) recommendation, the absence of multicollinearity and singularity was confirmed since Variance Inflation Factor (VIF) was 1 for 3 IVs and Tolerance values were 1 for Confidence and .8 (close to 1) for Empathy and Self-disclosure.

Construct Validity: Convergent, Divergent, and Criterion

The results of Pearson correlation analyses between each subscale of CCRC and validation variables are presented in Table 18.

All of the hypotheses related to *CCRC Confidence* were confirmed. As predicted CCRC confidence had higher in magnitude positive relationship with the specific-to-correctional-setting self-efficacy ($r = .56, p<.01$) than with general self-efficacy ($r = .39, p<.01$). It had significant positive relationship with all factors related to the management of counter-transference including anxiety management, empathy, conceptualization skills, self-insight, and self-integration. CCRC confidence had a significant positive relationship with the years of experience ($r=.19, p<.01$) showing that service providers with more experience in the field of correctional rehabilitation are more confident than their less experienced counterparts. In terms of the relationship of CCRC confidence and working alliance, as expected the correlation was positive and significant with the therapist's confidence collaboration scale ($r=.23, p<.01$) suggesting initial convergent validity. As for divergent validity, as predicted, confidence did not have a significant association with fantasy and empathic concern.

Two out of three hypotheses were confirmed for *CCRC Confrontation* scale. As was predicted, the confrontation scale of CCRC had significant positive relationships with directive ($r=.30, p<.01$), critical ($r=.26, p<.01$), and arrogant ($r=.21, p<.01$) subscales of the Supportive Actions Scale – Circumplex supporting the relationship with dominant and non-nurturant (void of positive regard) dimensions of interpersonal interactions. However, though in the correct direction, the relationship between CCRC confrontation and empathic concern did not reach the level of significance, questioning the presence of respect and empathic concern in confrontation responses of service providers. As predicted, there was no significant relationship between

Table 18.
Pearson Correlations of the Correctional Counsellor Relational Competency Inventory (CCRC) (Confidence, Confrontation, Blame/Criticism, Neglect, Empathy, Reinforcement of Antisocial Attitudes and Behaviours, and Self-Disclosure) and Validation Measures

	Confidence	Confrontation	Blame/Critic	Neglect	Empathy	Reinf_AA_AB	Self-Disclosure
Empathy_PT	.23**	.11	.08	.07	**.21****	.03	**.25****
Empathy_FS	-.05	.00	.08	.02	**.16***	**.12(.13*)**	.02
Empathy_PD	**-.32****	.04	.09	-.04	.01	-.02	-.09
Empathy_EC	.09	**.12**	.00	.05	**.23****	**.15***	.11
PA_Directive	-.00	**.27**(.30**)**	**.24****	**.22****	**.19****	**.27****	.25**
NO-Engaging	.14*	.03	.12	.08	**.26****	.03	**.22****
LM_Nurturant	.09(.13*)	-.01	-.08	.01	**.20****	.00	.11
JK_Deferential	.10	-.02	.16*	.06	.12	-.02	.13
HI_Avoidant	-.10	-.12	**.15***	-.10	.05	-.04	-.05
FG_Distancing	-.11	.06	**.37****	-.05	-.04	-.02	.07
DE_Critical	-.16*	**.26****	**.19**(.21**)**	**.12***	.02	**.14***	.13*
BC_Arrogant	-.10	**.21****	**.20**(.22**)**	**.16***	.03	**.26****	.10
Attachment-Anxiety	**-.14*(-.17**)**	.01	.10	-.04	**-.14*(-.16*)**	.01	**-.17****
Attachment-Avoidance	**-.16*(-.18**)**	.05	.05	-.04	**-.23****	-.04	**-.15***
CFI_AM	**.48****	-.08	**-.11**	.05	.10	.00	.06

(Table continues)

	Confidence	Confrontation	Blame/Critic	Neglect	Empathy	Reinf_AA_AB	Self-Disclosure
CFI_Emp	**.43****	-.01	-.03	.12	**.16***	.03	**.19****
CFI_CS	**.47****	-.00	.02	.04	.09	-.06	.11
CFI_S_Ins	**.32****	.01	.07	.07	**.13***	-.01	**.17****
CFI_S_Int	**.46****	-.03	-.08	-.08	.04	**-.10**	.05
CFI_Total	**.52****	-.02	-.01	.04	**.13***	-.04	.14*
GSE_Total	**.39****	.12	.04	.08	.12	-.07	**.21****
CFSE_Total	**.56****	.03	.06	.09	.15*	.02	.08
SocDes_Total	**.17***	**.18***	.02	.14*	-.01	.06	.28**
GCQ_Eng	**.11**	.04	.04	.09	**.21****	.12	**.16***
GCQ_Conf	-.09	.07	**.11 (.15*)**	.11	.11	.09	.00
GCQ_Avoid	.07	.11	.02	**.18****	.19**(.24**)	.04	.05
TherRel_Total	**.23****	-.01	.03	.14	.11	.04	**.23****

Note 1: CCRC = Correctional Counsellor Relational Competency Inventory; CCRC_Blame/Critic = Blame and Criticism scale of CCRC; CCRC_Reinf_AA_AB = Reinforcement of Antisocial Attitudes and Behaviours scale of CCRC; Empathy_PT = Perspective Taking subscale of the Interpersonal Reactivity Index (IRI); Empathy_FS = Fantasy subscale of IRI; Empathy_PD = Personal Distress subscale of IRI; Empathy_EC = Empathic Concern subscale of IRI; CFI-R = Counter-transference Factor Inventory Revised; CFI_AM = Anxiety Management subscale of CFI-R; CFI_Emp = Empathy subscale of CFI-R; CFI_CS = Conceptualization Skills subscale of CFI-R; CFI_S_Ins = Self-insight subscale of CFI-R; CFI_S_Int = Self-integration subscale of CFI_R; GSE_Total = General Self-Efficacy; CFSE_Total = Correctional Facilitator Self-Efficacy Total; SocDes_Total = Social Desirability Total; GCQ = Group Climate Questionnaire; GCQ_Eng = Engagement subscale of GCQ; GCQ_Conf = Conflict subscale of GCQ; GCQ_Avoid = Avoidance subscale of GCQ; TherRel_Total = Therapeutic Relationship Total.
Note 2: Correlations in bold are hypothesized to demonstrated concurrent and predictive validity; all other non-significant correlations point out to discriminant validity
Note 3: (Values in parenthesis) = correlations for transformed variables that are different from those of non-transformed variables
* $p < .05$ ** $p < .01$

CCRC confrontation with attachment-related anxiety and avoidance supporting divergent validity.

As expected, in comparison to the confrontation scale, the *CCRC Blame/Criticism* scale positively correlated with all of the subscales of SAS-C that fell within the non-nurturance hemisphere, marked by negative interpersonal communication or behaviours, including deferential, avoidant, distancing, directive, critical, and arrogant. The magnitude of correlations ranged from small (r=.15, p<.05) to medium (r= .37, p<.01). The largest relationship was with distancing subscale, defined as providers' negative interaction (i.e., avoiding expressions of concern and otherwise distancing themselves), followed by directive, critical, and arrogant subscales. The relationships with deferential, and avoidant subscales were the smallest.

Contrary to the second hypothesis where a negative significant relationship between blame/criticism and management of counter-transference was expected, the relationship with three out five factors (i.e., anxiety management, empathy, and self-integration) was in the predicted direction but did not reach the level of significance, questioning the counter-transferential nature of blame/criticism scale. However, when a one-tailed test of significance was used, the negative correlation between blame/criticism and anxiety management reached the level of significance (r=-.11, p<.05), which was consistent with a priori hypothesis, demonstrating that service providers who use criticism and blame in their interaction with clients are less able to manage their anxiety.

Furthermore, the positive relationship between the blame/criticism scale of CCRC and conflict scale of Group Climate Questionnaire was confirmed. Blame and criticism was the only scale of CCRC that contributed to interpersonal anger, distancing, distrust, and tension among group participants. Finally, as predicted there was no significant relationship between CCRC

blame/criticism and both general and context-specific self-efficacy supporting divergent validity of CCRC blame/criticism.

Three out of four a priori hypotheses related to *CCRC Neglect* scale were confirmed. As predicted, CCRC neglect had significant positive correlations with three subscales of the Supportive Actions Scale – Circumplex, namely directive, arrogant, and critical. These three subscales represent dominant and non-nurturing interpersonal interactions. As well, there was a significant positive relationship between neglect and the avoidance subscale of group cohesion, indicating that the more service providers ignore and neglect their clients in a group setting, the more group participants avoid looking at real issues and submit to the direction of the service provider.

The hypothesis predicting a negative relationship between neglect and management of counter-transference was not confirmed as only one relationship (neglect and self-integration) was in the predicted direction and none of the relationships were significant. In terms of divergent validity, as predicted CCRC neglect did not have a significant relationship with attachment-related anxiety.

Most of the hypotheses (5.5 out of 6) related to *CCRC Empathy* were confirmed. More specifically, as expected CCRC empathy had significant positive relationship with engaging (r=.26, p<.01), nurturant (r=.20, p<.01), and directive (r=.19, p<.01) subscales of the Supportive Actions Scale Circumplex and no relationship with all other subscales of SAS-C including, differential, avoidant, distancing, critical, and arrogant. This finding supports the predicted relationship of CCRC empathy with nurturant and dominant dimensions of interpersonal interaction.

The correlations between CCRC empathy and three subscales of trait empathy (perspective taking, fantasy, and empathic concern), were all significant and in the expected direction, further demonstrating construct validity. As well, there was a significant positive relationship with the empathy subscale of the Counter-transference Factor Inventory (r=.16, p<.05), indicating the relationship between classically defined empathy and CCRC empathy.

As expected, there were significant negative correlations between CCRC empathy and subscales of attachment, anxiety (r=-.16, p<.05) and avoidance (r=-.23, p<01) indicating that service providers who engage in more empathic interaction with clients are lower on attachment-related anxiety and avoidance. As well, there was a significant relationship between CCRC empathy and group engagement (r=.21, p<.01), indicating that higher level of service provider empathy may yield a higher level of participant engagement in a group setting. Although in the expected direction, the relationship between CCRC empathy and therapist confident collaboration, a measure of therapeutic alliance, was not significant.

In terms of the construct validity of *CCRC Reinforcement of Antisocial Attitudes and Behaviours* (CCRC Reinf_AA_AB), one out of the two hypotheses was confirmed. As predicted, there was a significant positive relationship between reinforcement of AA/B and empathic concern (r=.15, p<.05). Even though in the predicted direction, the relationship between CCRC Reinf_AA_AB and factors of management of counter-transference, self-insight, self-integration, and conceptualization skills, did not reach the level of significance. Contrary to a priori hypothesis, there was no relationship between CCRC Reinf_AA/B and anxiety management.

All of the hypotheses related to *CCRC Self-Disclosure* construct validity were confirmed. As predicted, CCRC self-disclosure had a positive correlation with general self-efficacy (r=.21, p<.01) demonstrating that service providers who use self-disclosure more often have a higher

level of perceived self-efficacy. There was a significant negative relationship with two subscales of attachment, anxiety and avoidance, indicating that those service providers who use self-disclosure more often are also lower on attachment related anxiety and avoidance in comparison with those who use self-disclosure less often.

As expected, CCRC self-disclosure had significant positive correlations with perspective taking (r=.25, p<.01), a marker of trait empathy and empathy subscale of factors of the management of counter-transference (r=.19, p<.01). As well, self disclosure had a significant positive relationship with self-insight (r=.17, p<.01), another factor contributing to the successful management of counter-transference.

Furthermore, CCRC self-disclosure had a significant correlation with the engaging subscale of SAS-C, indicating that service providers who have a high level of self-disclosure also have a high level of enthusiasm in helping, active social involvement, expression of concern, protectiveness, and provision of useful information. In terms of treatment process variables, CCRC self-disclosure had significant positive correlations with group cohesion (engagement subscale) and therapist confident collaboration, a measure of therapeutic alliance, suggesting initial convergent validity.

An independent-sample t-test was conducted to compare the difference in the level of use of self-disclosure between Aboriginal and non-Aboriginal as well as male and female services providers. The assumption of homogeneity of variance was held since the Levene's test for equality of variances was not significant. As hypothezised, there was a statistically significant difference in the level of self-disclosure by culture, with Aboriginals being more self-disclosing (M=31.20, SD=10.74) than non-Aboriginal service providers (M=26.69, SD=10.79; t (214) = 2.48, p=.01]. The eta square statistic (.03) indicated a small effect size. The hypothesis

concerning the differences between males and females on self-disclosure was also confirmed. There was no statistically significant difference in the level of self-disclosure by gender [t(243)=1.07, p=.29], supporting divergent validity of CCRC self-disclosure.

For a summary of all hypotheses and their confirmation, please refer to the Appendix C.

Testing additional hypotheses. To test how a set of CCRC scales was related to intermediate process or outcome variables, multiple regression analysis was used to examine the multiple correlations between CCRC confidence, empathy, and self-disclosure as a set of predictors for two separate outcome variables, group cohesion and working alliance. The multiple regression analysis of group cohesion on the CCRC scales was significant [F (3, 219) = 4.74, p<.01] with 6% of variance explained. Among the three predictors, CCRC empathy was the only factor that had a significant standardized coefficient, β =.16, p=.03, indicating that correctional counsellor empathy predicts the level of participant engagement and group cohesion.

The multiple regression analysis of working alliance (i.e., therapist confident collaboration) on the CCRC scales was also significant [F (3, 171) = 6.31, p<.001] with 10% of variance explained. Among the three predictors, CCRC confidence and CCRC self-disclosure had significant standardized coefficients, β =.22, p=.01 and β =.22, p=.01, respectively. These analyses indicate that both confidence and self-disclosure in treatment staff can predict the level of therapeutic alliance.

Discussion

The purpose of these three studies was to develop and begin the process of validation of the relational competency measure (i.e., CCRC) for counsellors or service providers in the criminal justice setting. Before the discussion of the results of study 3, it is important to provide

an overview of the validation model used for the purposes of development and initial validation of CCRC.

There are many forms and/or models of validity. Construct validity is considered to be the main type of validation of a newly developed measure when one of the following three conditions is held: 1) a valid criterion is not available, 2) the theoretical and/or causal explanation of the relationship between the measure and other variables is the main objective for the measure development, or 3) the underlying construct of the measure is, in itself, important (e.g., personality traits measured by Big Five) (DeVellis, 2003; Cronbach & Meehl, 1955, Kane, 2006).

Establishing construct validity generally requires conducting numerous studies and years of research. The model of validity used for this thesis included providing a chain of evidence for the construct of interest and an integrative argument about the findings, consistent with Cronbach and Meehl's (1955) and Kane's (2006) recommendations. Hence, multiple forms of evidence were used to build an argument for the construct validity for CCRC. These forms included substantive, structural and external components as specified by Loevinger (1957) and Kane (2006). The substantive component included evidence from existing literature related to the theoretical framework of the measure. The structural component included evaluating underlying structure of the measure. Lastly, the external component included testing the relationship of CCRC scales with observable behaviours or other variables. More specifically, the latter component included positioning the construct (e.g., empathy, confrontation) within a theory and testing a nomological net of hypotheses, as suggested by Cronbach and Meehl (1955).

Consistent with the above validity framework and the new approach to measurement validation (Kane, 2006), the validity in this thesis is considered as an argument in the attempt to

integrate evidence accumulated for the content and the relationships of the constructs measured by CCRC with other variables (content, convergent, divergent, and criterion validity).

Three studies were conducted to develop and provide initial validation evidence for the CCRC. In the first study, a vignette approach was used to develop an initial item pool for both non counter-transferential and counter- transferential aspects of the relational constructs that have been suggested to have significant or and/or promising effect on intervention according to the general and correctional literature. The underlying theories and empirical evidence for application and consideration of each scale were discussed. The expert feedback supported content validity of the instrument in terms of operational aspects of the measurement as well as adequacy and appropriateness of items, sampled to represent relational competencies (see discussion in study 1). The Exploratory Factor Analysis (EFA) produced the final factor solution consisting of seven factors, *confidence*, *confrontation*, *criticism and blame, neglect, empathy, reinforcement of antisocial attitudes and behaviours,* and *self-disclosure*. The initial support for the stability of a factor structure was presented. The frequencies, profile analyses as well as group differences were positioned within existing empirical and theoretical research related to each relational competency (see discussion in study 2).

All of the above evidence can be considered as initial support for the construct validity of the CCRC scales. In Study 3, the focus was on discussing the conceptual and theoretical themes underlying each of the CCRC scales and providing the rational for a possible relationship between different CCRC scales and other theoretical constructs and observed outcome variables. A priori validation hypotheses for each construct were tested. In the following, the findings and argument for the interpretation and usage of the scale as well as the recommendation for future research are presented.

CCRC Confrontation

The CCRC confrontation scale involves the effective use of authority and discouraging of antisocial attitudes and behaviours. The confrontational responses in this study are characterized by firmness, control, and respect. As well, confrontational responses lack the expression of positive regard or warmth. This definition is consistent with Andrews and Kissling's (1980) conceptualization of the use of authority and with Strong and Claiborn's (1982) view of feedback. The latter authors assert feedback is an influence process where a service provider has resources as well as expertise to establish a certain degree of social power to influence change (Claiborn, et al., 2002).

Directive confrontation or negative feedback are forms of negative control and are difficult to receive, even when done in the atmosphere of utmost respect. The confrontational statements by service providers can be perceived by the recipient as a form of criticism, contributing to participant resistance (Miller, et al., 1993). Hence, the relationship of CCRC Confrontation with the dominant and non-nurturant quadrant within the interpersonal circumplex model was hypothesized. As expected, the CCRC confrontation scale had a significant positive correlation with the dominant and non-nurturant quadrant of the SAS-C and had no relationship with nurturant and submissive dimensions of the circumplex. The highest correlation (r=.30) was with the directive subscale of SAS-C, followed by critical (r=.26), and arrogant (r=.21) subscales.

These results confirm the aspects of negative control underlying service provider confrontation as well as lack of warmth or positive regard. Positive regard and empathy, though correlated, have been differentiated theoretically and empirically (Truax & Carkhuff, 1967; Bohart, et al., 2002; Claiborn, et al., 2002). Hence, the second hypothesis was set to test whether

or not confrontational statements have an aspect of empathic concern for a client. The results did not show a significant relationship of confrontation with empathic concern suggesting the CCRC confrontation is characterized by both lack of warmth or positive regard and concern. It is yet to be determined whether CCRC confrontation has an underlying aspect of respect. Future research might look at measures of respect in interpersonal interactions and how respect relates to CCRC Confrontation.

CCRC Blame and Criticism

The CCRC confrontation scale moderately correlated with *CCRC Blame and Criticism* scale (r=.34), suggesting some overlap between these two factors. The CCRC blame and criticism scale can be defined as confrontation or attack on the whole person or personal characteristics rather than person's behaviours or attitudes. When endorsing criticism and blame items on the CCRC measure, service providers tend to belittle, blame, attack, reject, punish, and/or express aggression/hostility towards a client. Contrary to confrontation, the criticism and blame scale had the highest correlation (r=.37) with the distancing subscale of SAS-C, defined as avoiding expressions of concern by the provider, withholding love and status from both the self (provider) and the other (recipient), a tendency to reject the other and disregard the feelings of self and other (Trobst, 2000) implying concurrent validity.

Similar to confrontation, the blame and criticism scale correlated with directive, critical and arrogant subscales of SAS-C but had additional significant relationships with deferential and avoidant subscales indicating that blame and criticism measures a different construct from confrontation. In fact, as predicted, the blame and criticism scale overlapped with the non-nurturant hemisphere of the support actions circumplex, while confrontation had an overlap with dominant and non-nurturant quadrant only.

Within the interpersonal circumplex model, individuals who revert to blame and criticism when interacting with others, not only withhold granting of status and love to others but also deny giving status and love to themselves. Denying status and love to oneself has been linked to an unresolved internal conflict (Trobst, et al., 1994; Trobst, 2000). Similarly, when service providers struggle with unresolved internal conflict, they tend to use counter-transferential behaviours with their clients more often, according to theoretical framework of counter-transference (Gelso & Hayes, 2002; Hayes, 2004).

Since blaming and critical interaction with clients is considered to be counter-transferential, it was hypothesized that the management of counter-transference should have a negative relationship with blame/criticism. This hypothesis was largely unsupported, even though there was a small significant inverse relationship with management of anxiety ($r = -.11$)[3], one of the five factors contributing to successful management of counter-transference. This result might be due to the fact that management of counter-transference is not a direct measure of CT feelings and/or behaviours. In fact, the assumption that the presence of the five factors (e.g., self-insight) underlying management of CT is equivalent to the absence of CT behaviours might be wrong. Even though evidence exists demonstrating a relationship between factors underlying management of counter-transference and reduction in CT feelings (Gelso, Fassinger, Gomez, & Latts, 1995) and CT behaviours (Friedman & Gelso, 2000), the theoretical framework and measurement of counter-transference are different from that of management of counter-transference. Future research might consider supervisors' ratings or observation of CT during group facilitation to gather evidence for the counter-transferential nature of CCRC blame/criticism.

[3] One tail alpha was used for this analysis.

Finally, as hypothesized, CCRC blame and criticism had the highest significant correlation with the conflict subscale of group climate questionnaire (r=.15), in comparison to other CCRC scales (e.g., confrontation, neglect, and empathy). This suggests the possibility of a negative influence of service providers' critical and blaming behaviours on conflict (i.e., anger, rejection) among group participants. This finding is consistent with multiple findings in the general (Claiborn, et al., 2002; Henry, et at., 1990; Nejavits & Strupp, 1994; Rotheram, LaCour, & Jacobs, 1982) and correctional (Drapeau, et al. 2005; Marshall, et al., 2002; Marshall, et al., 2003; Dowden & Andrews, 2004; Ginsburg, et al., 2002; Trotter, 1999; 2002) literature linking blame and criticism with negative process (i.e., lack of group cohesion and therapeutic alliance) and treatment outcomes. Blame and criticism had greater contribution to negative therapeutic process than confrontation, further supporting the construct validity of both the confrontation and blame and criticism scales.

Despite clear negative effects of blame and criticism, the implications of confrontation are less clear. In early correctional research confrontation was endorsed as an effective intervention strategy (Bonta, et al., 2008; Andrews, et al., 2006; Genreau, 1996; Trotter, 1999, 2002), whereas recently, some correctional researchers have been advocating against it (Preston 2001, Kear-Colwell & Pollock, 1997; Kear-Colwell & Boer, 2000; Marshall & Burton 2010; Williams & Henley, 2005) suggesting a negative, rather than positive impact on the therapeutic process. In the present study, confrontation had no relationship with group engagement, conflict, or therapeutic alliance and a small positive relationship with participants' avoidance, thus supporting the latter group of researchers. Further research is needed to determine the effects of confrontation on treatment process and outcomes when clients' perceptions and ratings are considered.

CCRC Neglect

Initially, *CCRC Neglect* was defined as passive aggression towards a particular participant where the service provider, instead of active engagement with the client, ignores the client by re-directing or shifting attention to a different participant in the group or a different topic. Neglect is accompanied by service providers discounting the importance of the participant's situation, giving no direct feedback when the situation requires an intervention, and controlling the therapeutic process. Based on this conceptualization, it was hypothesized that the neglect scale would correlate with dominant dimension of Support Actions Scale Circumplex (SAS-C). This hypothesis was confirmed. The results showed a positive relationship between neglect and three subscales of dominant dimension, namely directive, critical and arrogant, supporting construct validity of the CCRC neglect scale.

Contrary to the initial hypothesis, neglect had a positive, albeit small relationship with empathy, one of the factors contributing to successful management of counter-transference (CFI-R; Latts, 1996). The correlations with other factors measured by CFI-R were not significant (i.e., self-insight, self-integration, conceptualization skills). As discussed in the section on blame and criticism, a better measure of counter-transference behaviours has to be selected to demonstrate validity of neglect as a counter-transference construct. Another explanation for non-significant results could lie in that ignoring anti-social attitudes or behaviours might be a successful intervention strategy, rather than counter-transferential behaviour. Ignoring one's anti-social attitudes and behaviours might have a positive impact on offenders' process of change and can potentially contribute to extinction of anti-social attitudes or behaviours over time. Future research should test this hypothesis by considering the impact of this intervention on outcome measures such as change in antisocial attitudes and recidivism.

CCRC neglect, as predicted, correlated significantly with the avoidance scale of the group cohesion questionnaire. It appears that service providers, who control the therapeutic process through re-directing, also influence participant engagement level and negatively influence participant personal responsibility for group work. This potentially leads to displays of anger and rejection among participants. This finding is consistent with social interaction theory (Benjamin, 1974), suggesting that controlling behaviours by service providers elicit submissive behaviours in clients (i.e., avoidance of group participants to look at the issues important for their recovery and submissiveness to facilitator's direction). As well, this finding is compatible with social learning theory (Bandura, 1977), suggesting that facilitator's passive aggression (i.e., neglect) might elicit avoidance, anger and rejection among group participants.

CCRC Reinforcement of Antisocial Attitudes and Behaviours (Reinf_AA/B).

Reinf_AA/B refers to service provider over-involving, overprotecting and caretaking behaviours in interaction with clients. By being overprotecting and caretaking, service providers by default reinforce antisocial attitudes and behaviours in the correctional context. This definition is consistent with Gelso and Hayes (2002) and Rudd and Joiner (1997) who conceptualize over-involvement as being overly engaged and concerned about the client or as being overprotecting and caretaking. Theoretically, reinforcement of AA/B has an overlap with empathy since both constructs capture active engagement with and concern for a client. As expected, there was a significant positive relationship between reinforcement of AA/B and empathic concern supporting construct validity hypothesis.

CCRC reinforcement of AA/B also correlated with other measures of empathy in this study. It is interesting that the correlation between CCRC reinforcement AA/B and CCRC empathy (r=.31) was greater than the correlations of CCRC reinforcement AA/B with fantasy

(r=.13) and with empathic concern (r=.15) subscales of trait empathy. One explanation for this finding is that a part of the covariation between the reinf_AA/B and empathy, measured by CCRC is due to similarity in the measurement method of these constructs. It is plausible that the magnitude of correlation between CCRC constructs and validation constructs would have increased if the measures had had similar or compatible measurement method (i.e., vignette methodology).

Over-involving behaviours are counter-transferential in nature since service providers who are overprotecting function from a place of helpless victim, indicative of internal conflict, insecurities, and low self-esteem (Gelso & Hayes, 2002; Rudd & Joiner, 1997). Hence, as in other instances of CT behaviours (e.g., neglect, blame/criticism), reinforcement of AA/B was expected to have a negative relationship with factors underlying management of counter-transference (CT). Once again, this hypothesis was not confirmed. A similar argument about the difference between CT and management of CT may explain the non-significant results. In addition, it is possible the effect of management of CT is situation-specific. That is, a service provider who is able to manage his/her over-involvement in some specific situations would not be able to overcome his/her CT in other situations. Although the measurement for over-involvement was situation-specific the measure of management of CT in this study was not. Therefore control for the effect of situation was not possible. Another explanation of the small correlation between these variable might lie in the low variation in scores of reinforcement of AA/B.

Future research may increase the range of CCRC counter-transferential responses (i.e., blame/criticism, neglect, and reinf_AA/B) through validation of CCRC in a student sample or

with individuals who are less experienced. As well, efforts should be made to find similar methods of measuring CT behaviours for future validation.

CCRC Confidence, Self-Disclosure and Empathy

The three CCRC scales, confrontation, blame/criticism and neglect, discussed thus far have been theoretically and empirically associated with poor treatment processes in previous research. These findings have been partially confirmed by the current study, supporting concurrent validity. On the other hand, the other three CCRC scales, *Self-disclosure*, *Confidence*, and *Empathy*, were expected to have a positive influence on therapeutic process and contribute to both group cohesion and therapeutic alliance, as was demonstrated in previous research (Knox, et al., 1997; Wei & Happner, 2005; Horvath & Bedi, 2002; Burlingame, Fuhriman, & Johnson, 2002). In this study, CCRC confidence and self-disclosure predicted therapeutic alliance and CCRC empathy predicted group engagement and cohesion, implying initial criterion validity of self-disclosure, confidence, and empathy.

Furthermore, these three CCRC scales, as predicted, had significant positive correlations with engaging and nurturant subscales of the supportive actions circumplex (Trobst, 2000). It is important to note that CCRC empathy had a stronger relationship with the nurturant subscale of the SAS-C than confidence and self-disclosure. This is to be expected since empathic responses directly communicate understanding of clients' internal world through active listening.

Both theoretical and empirical evidence suggest that service providers who have higher level of self-awareness, empathy, and self-esteem should have a secure attachment style where positive image of self and others in a relationship has a prominent role (Bartholmew & Horowitz, 1991; Cassidy & Shaver, 1999). As well, these service providers should have low level of internal (self) and external (other) conflict, reducing the chances of irrational or counter-

transferential interaction with individual clients or group participants (Henry, et al., 1986, 1990; Rudy, McLemore, & Gorsuch, 1985; Najavits & Strupp, 1994). Thus, the fact that CCRC self-disclosure, confidence, and empathy had negative significant correlations with attachment related anxiety and avoidance as well as positive significant relationships with CFI-R empathy, perspective taking and self insight (i.e., factors contributing to the successful management of counter-transference) is indicative of further construct validity of these CCRC scales.

In addition to the above evidence towards construct validity, it is important to note that self-disclosure, empathy but not confidence had a significant relationship with directive communication measured by SAS-C, indicating providers' active engagement in directing communication with participants. The directive component of empathy and self-disclosure makes sense in the correctional setting where a facilitator, rather than a client, has to be in control of the therapeutic processes. The cognitive-behavioural approach that serves as the basis in correctional rehabilitation is directive, where service providers talk more in sessions, ask more questions, direct and structure session content and interactions, as well as more frequently offer information and advice (see Keijsers, et al., 2000, for review). Hence, the fact that all, except for confidence, CCRC scales have a significant relationship with directive subscale of SAS-C adds to the establishment of CCRC construct validity.

Unlike confidence and empathy, self-disclosure had a small yet significant relationship with the critical subscale of SAS-C and a moderate relationship with the CCRC confrontation scale, indicating the presence of both nurturant and dominant dimensions. This seems reasonable since the original definition of self-disclosure included both affirming/reinforcing and challenging responses. The fact that self-disclosure loaded on its own factor, though sharing equal variance of 4% with CCRC confrontation and CCRC empathy scales, indicates the unique

contribution of self-disclosing statements above and beyond that of empathic or confrontational responses.

To provide further support for CCRC validity, the culture differences in the use of self disclosure were confirmed, with Aboriginal service providers disclosing more in a correctional group setting in comparison to their non-Aboriginal counterparts. This finding is consistent with the existence of oral, storytelling tradition, specific to Aboriginal peoples, and its role in transferring traditional beliefs, values, and ways towards conflict resolution (Duryea & Potts, 1993; McKeough, Bird, et al., 2008). As well, as expected, confidence had a significant positive relationship with the year of experience. This finding was consistent with the literature on self-efficacy in various settings (e.g., Klassen & Chiu, 2010).

Finally, confidence and empathy scales should have fairly strong, yet empirically distinguishable, relationship with validated measures of these or similar constructs. The correlation of CCRC confidence with confidence in a correctional setting (r=.56) and general self-efficacy (r=.39) reflects both overlap and distinguishability. CCRC empathy had a significant relationship with three subscales of trait empathy (i.e., perspective taking, fantasy, and empathic concern) as well as CFI-R empathy. The latter relationship was small, indicating that CCRC empathy measures a different type of empathy from that of trait empathy and empathy in individual therapy, yet has sufficient overlap with expected measures to imply convergent validity.

Evidence for divergent validity

In addition to initial convergent and criterion validity of the seven CCRC scales discussed above, the current study provided evidence of divergent validity of the CCRC. Further to a priori hypotheses related to divergent validity being confirmed, all seven scales did not

significantly correlate (post hoc comparisons) with additional constructs that were not selected for the convergent, concurrent or criterion validity of these construct (see correlation matrix, Table 18). For example, CCRC self-disclosure did not correlate with avoidant and distancing behaviours that are submissive and non-nurturant in nature, while blame/criticism did not correlate with trait empathy, engaging or nurturant behaviours that are supportive in nature.

Limitations and Future Research

A key limitation of the current study is that it exclusively relied on counsellors' ratings. The initial proposal to use clients' ratings of therapeutic alliance and other process or outcome variables as well as supervisors' ratings of relational competencies was excluded from this study due to the data collection limitations and time constraints associated with this project. In the future, it will be important to determine the extent to which service providers' ratings correlate with supervisors' ratings of the relational factors. It will also be worthwhile to examine the relationship between correctional counsellor relational competencies and clients' ratings of therapeutic alliance, as well as treatment outcomes such as change in antisocial attitudes and behaviours, motivation to change, program participation, treatment attrition and completion, and recidivism. Furthermore, since the CCRC presented service providers with simulated situations, it will be important to confirm that the counsellors actually do what they say, in real life situations.

Another limitation is that the current sample did not allow for an equal number of participants in the profile analyses of the CCRC. Even though the assumption of the homogeneity of variance was held for the most of the analyses, future research will benefit from further testing CCRC performance across selected demographic groups with comparable number of participants in each group. As well, it will be important to confirm the initial structure of

CCRC by using a different sample of participants for cross validation. The sample in this study is representative of Canadian correctional service providers but it will be worthwhile to test CCRC performance in other correctional settings and countries. Lastly, it is important to note that some of the scales in this study had low variability. This might be due to the fact that most of the service providers who volunteered for this study received sufficient training to be able to endorse similar responses. The average experience in the capacity of a correctional counsellor was 6 years. In the future, it will be important to test students or trainees and to compare CCRC performance across these groups.

Conclusion

Despite these limitations, this project was the first attempt to consolidate theoretical frameworks across different clinical areas and to create an efficient measure of counsellor's relational factors in the correctional setting. The model of validity used for this project provided a chain of evidence for the construct validity of CCRC. In addition to substantive and structural evidence presented in Study 1 and 2, where content and face validity of the instrument was established and theoretically meaningful and stable structure and acceptable psychometric properties of CCRC were obtained, Study 3 provided external information in support of construct validity. More specifically, most of the hypotheses related to convergent, divergent and criterion validity of CCRC were supported.

Although additional work is needed to provide further support for predictive validity of the CCRC, the existence of such a measure creates a foundation and starting point for the systematic investigation of practitioners' relational factors and their contribution to offender rehabilitation. Furthermore, the CCRC is the first self-report tool that provides a comprehensive view of relational factors and could be used for training and quality assurance purposes in a

correctional setting. The vignette approach used for the development of this measure improves cumbersome and time consuming methods of clinical observations and behavioural ratings, yet maintains the depth of client-counsellor interaction, as it simulates real situations that correctional counsellors encounter in their practice. Gelso and Hayes (1998) wrote "When a measure is at once reliable, valid, and convenient, it stirs the minds and hearts of researchers" (p. 27). It is hoped that CCRC will open the doors for future research and create excitement in learning more about the importance of human relationships in correctional counselling.

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Appendix A.

Definitions, Operationalizations & Examples

Empathy – refers to the counsellor's ability to sense the client's private world as if it were his/her own, but without ever loosing the *as if* quality. The counsellor is not only able to accurately understand the client's world or figuratively speaking walk in the client's shoes but also to communicate this understanding to the client accurately and with sensitivity *Empathic Response* is operationalized as simple and complex reflective listening

- Simple reflective listening – mirroring what client says
- Complex reflective listening – mirroring the affect behind client's words

Non-Empathic Reponses consist of confrontation, avoidance, and over-involved statements/behaviours. Aggressive/hostile confrontations, avoidance, and over-involvement are all counter-transferential responses/behaviours of counsellors that have little to do with a client but steam from counsellor's unresolved issues.

- Confrontation the goal of which is to break through client's resistance and to promote quick changes by addressing the problem directly without worrying about client's discomfort; Confrontation might include ordering or commanding, warning or threatening, arguing or lecturing, moralizing, labelling, interpreting, analyzing, or questioning.
- Passive aggression - neglecting, changing the subject or ignoring the client; this facet also includes ignoring either pro-social or anti-social statements/behaviours which in essence offers clients no feedback about their attitudes or behaviours.
- Over-involvement - sympathizing or consoling, over-approving or praising the client regardless of his/her problem attitudes or behaviours, giving advice, or taking responsibility for solving clients' problems.

Regard & Feedback – positive regard refers to the extent to which a counsellor finds himself or herself experiencing a warm acceptance of each aspect of the client's experience as being a part of that client. Positive regard is a necessary condition for effective delivery of both positive and negative feedback.

- Positive feedback is used to keep certain client's behaviours unaltered or reinforced. Affirmation, positive feedback, and positive reinforcement are all conceptually similar and can be viewed as behavioural representation of positive regard. This includes affirmation of clients' strengths and efforts for establishing rapport or working the program, affirming improvement in the quality of life in general. As well, specific changes in criminogenic factors (e.g., anti-social attitudes or behaviours, views on employment, education, and family) are to be reinforced. A counsellor can potentially affirm and encourage either pro-social or anti-social attitudes/behaviours.
- Negative feedback – corrective feedback defined as therapist communication (confrontation or negative feedback) reflecting ineffectiveness of certain client's behaviours; disapproval of anti-social attitudes and behaviours (delivery of negative feedback) should be done in the environment of respect, care, and active engagement in the process of client's rehabilitation, as opposed to hostility, blaming, control, and punishment. A counsellor can also discourage pro-social attitudes/behaviours by doubting

client's abilities such as educational aptitude, ability to focus and achieve a pro-social goal, etc.

- Active aggression - negating, criticizing or blaming (counter-transferential response) Active advice-giving or judgmental statements; the therapist communicates interest and concern for the patient but his/her caring is semi-possessive; therapist tends to belittle, blame, attack, reject, punish; and/or express aggression/hostility towards the client

Self-disclosure – refers the statements revealing something personal about the counsellor.

- Immediate self-disclosure - disclosing immediate feelings about self in relation to the client, about the client, or about therapeutic relationship; explicate interpersonal consequences of clients' behaviours and opens the door for re-evaluation and change (strengthens therapeutic bond, opens door for change)
- Appropriate personal self-disclosure - disclosing personal information such as facts, views, strategies, and personal insights with the goal of modeling pro-social attitudes and behaviours; moral statements, insights or personal stories that strongly support conventional norms, demonstrate pro-social behaviours, as well as challenge anti-social sentiments are included.
- Inappropriate personal self-disclosure (counter-transferential response) - using disclosure for therapist's own needs, changing the focus from a client to the therapist by self-disclosing and interfering with the flow of the session, burdening, confusing, or over-stimulating the client, and blurring the client-therapist boundaries; modeling anti-social attitudes and behaviours by rejecting institution or agencies that create ties to conventional norms (e.g., family, employment, non-criminal associates) or by expressing egocentric and short-term hedonistic values that rationalize criminal behaviour.

Control of Therapeutic Process –refers to the counsellor's ability to direct the therapeutic session and guide the client without exerting over-control or dominating the interaction. Counsellors' directive behaviours can be either positive which involves open-ended questioning, suggesting a topic, and setting a meeting agenda or negative involving advice giving, use of close-ended questions, and direct criticism.

- Use of Authority - explicating the formal use of rules associated with correctional setting and program delivery, seeking the compliance with the rules while avoiding interpersonal abuse and disrespectful communication.
- Dominance/Over-control (counter-transferential response) - reverting to a punitive stance where punishment is the only strategy for conflict resolution, facilitation of program compliance and change. This style is characterized by controlling the other's behaviour through punitive and critical advice giving, instruction, or close-ended questioning.
- Directive 1/2 - active, directive and non-domineering; directing topic and process: open-ended questioning, suggesting a topic, assigning home work, and setting a meeting agenda; challenge client's way of thinking through Socratic dialogue.

Confidence – service provider's belief in his/her capability, effectiveness, or power to help a particular client with a specific problem in a given situation; more specifically a belief in service provider's ability to help resistant clients to undergo treatment, as well as therapist confidence in his/her abilities to handle and help high-risk clients (e.g., angry, hostile, sexually seductive, or in open opposition to authorities).

Appendix B

Correctional Counsellor Relational Competency Inventory
(Final version of CCRC after Exploratory Factor Analysis)

Instructions:
In this questionnaire, you will find 8 situations (vignettes), each containing an encounter between an offender and a service provider while facilitating a correctional program. Under each vignette, you will find a number of items including hypothetical service provider responses and general questions related to the situation. Imagine yourself in the situation (even if you have never been in similar context) and rate each item based on your experience and intuition using the following scale:

1	2	3	4	5	6	7
not at all	a little bit	somewhat	moderately	quite a bit	a great deal	extremely

It is highly recommended that you re-read each vignette and refer to its content frequently. Please pay attention to *the specific instructions* as they will help you in completing this questionnaire.

Vignette 1

In a substance abuse program, one of the homework assignments required participants to identify and write down triggers as well as create a craving inventory. A number of participants including Pam, a 26 year-old female serving a sentence for drug trafficking, showed resistance to these assignments. Pam who initially was quite motivated to be a part of the treatment stated that she does not see a good reason for remembering past situations that can create cravings. "We are trying not to think about drugs; this is exactly what leads us to relapse".

Q1. Service Provider Responses to Pam

Specific Instructions: below you will find 5 hypothetical responses used by service providers in similar situations. Put yourself in place of the service provider who is to respond to Pam in this scenario and rate how likely you are to use each response.

___b. You have mentioned that thinking about the times you have used drugs might make you relapse; has that happened to you before?
___b. I know how scary it must be to even think about drugs, especially after you have been clean for some time
___c. Pam, you have a legitimate concern; does anyone else have similar feelings about this assignment?

Specific Instructions: For the following responses, it is assumed that the treatment provider experienced what Pam is going through. If you have never been addicted to any substances, please imagine either a close friend or a family member who has been addicted and rate each statement on how likely you would be to share these experiences in response to Pam.

___a. I remember myself feeling the same way you are right now. Then I realized that avoiding looking at my triggers led me to relapse.
___c. I had a similar situation. After a while, I learned that looking at my behaviours directly helped me to tolerate and manage my cravings better

Q2. How effective might you be in handling this situation?

1 (not at all) *2* *3 (somewhat)* *4* *5 (extremely)*

Q3. How successful might you be in handling this situation?

1 (not at all) *2* *3 (somewhat)* *4* *5 (extremely)*

Vignette 2

During the first session of a substance abuse program, after the introductions a facilitator was about to discuss the topics to be covered in the group when she was interrupted by a 28 year old Aboriginal male who had been in and out of prison for initiating fights while intoxicated and selling drugs, "excuse me Miss, what is your background? Have you ever been addicted to something? It does not seem like you have an idea of what it is like to be an addict. You have to walk in my shoes to understand me."

Q1. Service Provider Responses to this offender
Specific Instructions: below you will find 6 hypothetical responses used by treatment providers in similar situations. Put yourself in place of the treatment provider who is to respond to the client/offender in this scenario and rate how likely you are to use each response.

___f. The way you express your opinion is not correct and might get in the way of your recovery
___a. How do you believe an ex-addict counsellor is different from a non-addict counsellor?
___b. I do not believe this type of questioning is appropriate in this classroom
___c. You are attacking me for not being an addict; are you suggesting that I should become one in order to help you?
___d. You feel that only an addict can understand your situation

Specific Instructions: In order to rate the following response you might need to assume that you have gone through counselling. If you have never been through therapy, please imagine either a close friend or a family member who has had this experience and rate this statement on how likely you are to share it in a given response with the offender.

___d. When I was going through counselling, I remember myself mistrusting my counsellor in the beginning because I did not have trust in myself

Q2. How confident are you in dealing with this situation?

1 (not at all) 2 *3 (somewhat)* 4 *5 (extremely)*

Q3. How effective might you be in handling this situation?

1 (not at all) 2 *3 (somewhat)* 4 *5 (extremely)*

Q4. How successful might you be in handling this situation?

1 (not at all) 2 *3 (somewhat)* 4 *5 (extremely)*

Vignette 3

Jack, a 32 year old male, is incarcerated for possession of illicit substances. Jack has no history of aggressive behaviours. It has been recommended that Jack participates in a cognitive restructuring program (e.g., AAA). Jack met this recommendation with enthusiasm and was accepted to the program. Jack has been cooperative throughout the program. He has been one of the few inmates who has always completed his homework assignments. Halfway through the program, Jack brought his HW describing an altercation with a correctional officer who refused to open gates for him. The altercation resulted in Jack receiving an infraction. When a facilitator asked Jack to describe his thoughts at the moment, Jack stated "They treat us like animals in a cage then expect us to roll over and do what they want".

Q1. Service Provider Responses to Jack

Specific Instructions: below you will find 7 hypothetical responses used by treatment providers in similar situations. Put yourself in place of the treatment provider who is to respond to Jack in this scenario and rate how likely you are to use each response.

___a. I share your frustration; sometimes I want to yell at them myself
___c. When I come across somebody who I feel is disrespectful and in authority I try to take inventory of my thoughts and feelings, consider my actions and consequences and if necessary change my thinking process to avoid arguments.
___a. You feel not having been treated fairly
___b. Unfortunately, it isn't the first time this has happened. I'll talk to the officer
___d. We've heard from Jack; I now would like to hear from others
___a. Can you give us more information about the situation – your thoughts, feelings, your actions, etc.
___d. It is wrong to bash correctional officers. If you don't change your attitudes you will continue to get in trouble

Q2. How confident are you in dealing with this situation?

1 (not at all) *2* *3 (somewhat)* *4* *5 (extremely)*

Q3. How effective might you be in handling this situation?

1 (not at all) *2* *3 (somewhat)* *4* *5 (extremely)*

Q4. How successful might you be in handling this situation?

1 (not at all) *2* *3 (somewhat)* *4* *5 (extremely)*

Vignette 4

During a group session, a facilitator discloses a situation where she was stopped by a police officer for speeding in order to create a learning moment for the participants. The facilitator talked about her feelings and thoughts in the situation and how she was able to go through a decision making process before responding to the officer's sarcastic comments. The facilitator welcomed feedback after sharing her story. Bianca, a 34-year old woman serving time for break and entry, started asking the facilitator a series of personal questions, including her marital status, where she lived, etc.

Q1. Service Provider Responses to Bianca
Specific Instructions: below you will find 10 hypothetical responses used by treatment providers in similar situations. Put yourself in place of the treatment provider who is to respond to Bianca in this scenario and rate how likely you are to use each response.

___a. I appreciate your wanting to know me as a person
___c. Bianca, you need to stop being nosey; I am not here to answer such personal questions
___d. OK Bianca, but what do you think about the situation regarding my interaction with the police officer?
___a. Bianca, you are crossing a personal boundary; it will be helpful if you focus on the question at hand and the activity in the group
___b. I would like to hear the groups' feedback on the situation I just described
___c. I would like to know more about you as well; we can have a chat after class
___d. You are really interested in getting to know me
___a. We are not here to talk about me; we are here to deal with your issues
___c. You cannot seriously think that knowing my personal information will help you in group?

Specific Instructions:
The content of this response might not match with your personal information. Rate the statement on how likely you are to share similar information with the offender.

___f. I am married/single and live not far from here in a beautiful place

Q2. How confident are you in dealing with this situation?

1 (not at all) 2 *3 (somewhat)* 4 *5 (extremely)*

Vignette 5

Jean Pierre (J.P.) is a 25 year old male who has multiple convictions for shoplifting and burglaries. J.P. also has a number of convictions related to drug trafficking. As a result of the initial risk assessment, J.P. was mandated to participate in a cognitive restructuring program (e.g., AAA). When a facilitator asked J.P., how he believed his actions affected the owner of the store, J.P. responded "It was not a big deal. He had insurance and got all brand new stuff. I would not have even pressed charges if I were him."

Q1. Service Provider Responses to J.P.
Specific Instructions: below you will find 10 hypothetical responses used by treatment providers in similar situations. Put yourself in place of the treatment provider who is to respond to J.P. in this scenario and rate how likely you are to use each response.

___a. You are minimizing the damage done to the owner; this line of thinking will lead you to committing more crimes
___b. Well, what about you (another participant), how do you think your actions affected the person you committed a crime against
___c. You feel that your actions had no real impact on the owner
___e. Do not respond to J.P. and move onto to the next participant
___c. That is a criminal attitude; stealing is stealing
___d. It's good that the owner was able to have his merchandise replaced
___e. Regardless whether the owner has or does not have insurance, you cannot lawfully take what is not yours
___b. How do you believe these attitudes contributed to your decision to commit this crime?
___c. This line of justification does not belong here; you are here to take responsibility for your behaviours

Specific Instructions:
The content of the next response might not completely match with your personal experience. Rate the statements on how likely you are to share similar information with the offender.

___d. Through working on my own problems some time ago, I realized that I had to challenge my false beliefs; otherwise, I would repeat my old problem behaviours

Q2. How confident are you in dealing with this situation?

1 (not at all) 2 *3 (somewhat)* 4 *5 (extremely)*

Q3. How effective might you be in handling this situation?

1 (not at all) 2 *3 (somewhat)* 4 *5 (extremely)*

Q4. How successful might you be in handling this situation?

1 (not at all) 2 *3 (somewhat)* 4 *5 (extremely)*

Vignette 6

Peter, a 42 year old Aboriginal male has a history of violent convictions and had three fights in a medium security facility. Peter was scheduled to attend a high intensity violence prevention program. In the interview, Peter was sincere in expressing his desire to change and stated that he really does not want to spend more time in prison. In the middle of the program, however, Peter got into another fight. When CPO asked to describe what happened and how Peter tried to apply the skills taught in the program, he responded with agitation, "This stuff will never work out there when somebody breathes down your neck and is asking for it. All this stuff in your book is crap and will never work out there".

Q1. Service Provider Responses to Peter

Specific Instructions: below you will find 11 hypothetical responses used by treatment providers in similar situations. Put yourself in place of the treatment provider who is to respond to Peter in this scenario and rate how likely you are to use each response.

___c. Peter, how can you blame the program? Don't you think it is about you and not the material?
___d. We all agree to respect each other in the group. You've crossed the line.
___a. This fight shows me that you are just not getting it
___b. This attitude will not help you to keep away from fighting
___c. Well, I need to hear how others are progressing with their skill application
___d. I am glad you were able to stand up for yourself
___f. Your frustration shows me that you are really trying. These changes take time, so keep working on them
___a. You are blaming the program for your relapse instead of looking at yourself
___c. You must have felt horrible to find yourself in another fight again; I can see why you are disappointed
___d. Does anyone else have a situation to discuss?

Specific Instructions:
The content of the next response might not completely match with your personal experience. Rate the statements on how likely you are to share similar information with the offender.

___d. From my experience I found that every time I wanted to reject new material or strategies completely, I was dismissing very important things that helped me later to change my self-defeating behaviours

Q2. How confident are you in dealing with this situation?

1 (not at all) 2 *3 (somewhat)* 4 *5 (extremely)*

Q3. How effective might you be in handling this situation?

1 (not at all) 2 *3 (somewhat)* 4 *5 (extremely)*

Q4. How successful might you be in handling this situation?

1 (not at all) 2 *3 (somewhat)* 4 *5 (extremely)*

Vignette 7

Keith, a 23-year old offender, has a long history of antisocial behaviour and peer-related criminal activities. All of his friends and associates are engaged in criminal activities. During the second group meeting of a mandatory program, Keith adamantly claims that he has everything figured out, stating that he knows he will not re-offend because he made up his mind.

Q1. Service Provider Responses to Keith

Specific Instructions: below you will find 7 hypothetical responses used by treatment providers in similar situations. Put yourself in place of the treatment provider who is to respond to Keith in this scenario and rate how likely you are to use each response.

___a. Your motivation towards crime-free lifestyle is encouraging
___b. This is only our second session and I need you to realize the whole program is necessary in order to meet your plan to live crime-free
___c. Keith, the group and I would like to learn more about your specific plans to remain crime-free
___c. You are very determined about avoiding crime in the future
___d. This is really good Keith; you can be a great example for others

Specific Instructions: In order to rate some of the following responses you might need to assume that you have gone through counselling. If you have never been through therapy, please imagine either a close friend or a family member who has had this experience and rate each statement on how likely you are to share it in a given response with the offender.

___a. In the beginning of my healing journey, I also felt confident and enthusiastic that I could completely change my life; later I realized that I needed to be patient, set realistic goals and get the help of others in addition to being motivated
___d. It frustrates me to see somebody being so unrealistic and believing he can change overnight without much effort

Q2. How confident are you in dealing with this situation?

1 (not at all) *2* *3 (somewhat)* *4* *5 (extremely)*

Q3. How effective might you be in handling this situation?

1 (not at all) *2* *3 (somewhat)* *4* *5 (extremely)*

Q4. How successful might you be in handling this situation?

1 (not at all) *2* *3 (somewhat)* *4* *5 (extremely)*

Vignette 8

Chris, a 44 years old male convicted for drug possession, attends AA meetings and believes that he can talk as much as he wants. Even after the facilitator specified the time for each participant, Chris continues to monopolize the group without letting other members talk. Chris interrupts other participants quite often and either changes the focus of the discussion to himself or gives advice to others. For example, when a facilitator attempted to respond to someone's question in the group, Chris turned it into a new opportunity to talk. "That is a good question. When I am in a situation like this, I usually take control but my life right now is under control. I am sleeping well, I get my visitations regularly, I come to class; it is hard but I am trying my best to survive; I take one day at a time and you should definitely try that; it works for me, it should work for you too".

Q1. Service Provider Responses to Chris
Specific Instructions: below you will find 7 hypothetical responses used by treatment providers in similar situations. Put yourself in place of the treatment provider who is to respond to Chris in this scenario and rate how likely you are to use each response.

___b. Chris you always have great insights and you generously share with others
___c. Chris, you tend to interrupt me and others and take over the group; everybody should have a chance to talk.
___d. Shift your attention to the participant who asked the question and respond to the initial question
___a. Chris, you have the biggest mouth I have ever seen. You are not alone in this room and others should have an opportunity to talk
___b. Chris, I should cut you off; I already specified the time frame, which you failed to follow; now it's the other participants' turn
___b. Chris, I do not know whether or not you realize but you are monopolizing the group. You don't give people a chance to work through their situations

Specific Instructions: the content of the next response might not completely match with your personal information or experience. Rate the statement on how likely you are to share similar information with the offender.

___a. From my experience every time I tried to dominate the group, I not only made other people dislike me but I also missed out on learning more about myself from others

Q2. How confident are you in dealing with this situation?
1 (not at all) *2* *3 (somewhat)* *4* *5 (extremely)*

Q3. How effective might you be in handling this situation?
1 (not at all) *2* *3 (somewhat)* *4* *5 (extremely)*

Q4. How successful might you be in handling this situation?
1 (not at all) *2* *3 (somewhat)* *4* *5 (extremely)*

Appendix C

Hypotheses for Study 3

1. **CCRC Confidence will be positively correlated with general self-efficacy**
2. **CCRC Confidence will be positively correlated with specific-to-correctional setting self-efficacy**
3. **CCRC Confidence will be positively correlated with factors contributing to management of counter-transference (i.e., empathy, anxiety management, self-insight, self-integration, conceptualization skills)**
4. **CCRC Confidence will be positively related to years of experience**
5. **CCRC Confidence will be positively correlated with therapeutic alliance**
6. **CCRC Confidence will have no relationship with fantasy and empathic concern**
7. **CCRC Confrontation will be positively related to dominant and non-nurturant dimensions of the SAS-C measured by directive, arrogant, and critical social behaviours**
8. CCRC Confrontation will be positively correlated with empathic concern
9. **CCRC Confrontation will have no relationship with attachment related anxiety and avoidance**
10. **CCRC Blame/Criticsm will be positively related to non-nurturant dimension of the SAS-C measured by directive, arrogant, critical, distancing, and avoidant social behaviours**
11. CCRC Blame/Criticism will be negatively correlated with factors contributing to management of counter-transference (i.e., empathy, anxiety management, self-insight, self-integration, conceptualization skills)
12. *CCRC Blame/Criticism will be positively correlated with conflict among group participants*
13. **CCRC Blame/Criticism should have no relationship with general and context-specific self-efficacy**
14. **CCRC Neglect will be positively related to dominant and non-nurturant dimensions of the SAS-C measured by directive, arrogant, and critical social behaviours**
15. CCRC Neglect will be negatively correlated with factors contributing to management of counter-transference (i.e., empathy, anxiety management, self-insight, self-integration, conceptualization skills)
16. **CCRC Neglect will be positively correlated with avoidance among group participants**
17. **Neglect should have no relationship with attachment-related anxiety**
18. **CCRC Empathy will be positively correlated with nurturance and dominance domains of SAS-C measured by directive, engaging, and nurturant social behaviours**

19. **CCRC Empathy will not be associated with non-nurturance and submissive dimensions of SAS-C measured by deferential, avoidant, distancing, critical and arrogant behaviours**
20. **CCRC Empathy will correlate positively with three subscales of trait empathy, perspective taking, empathic concern, and fantasy**
21. **CCRC Empathy will positively correlate with empathy, defined as a factor of management of counter-transference**
22. **CCRC Empathy will have negative correlation with attachment-related anxiety and avoidance**
23. *CCRC Empathy will positively correlate with group cohesion and working alliance*
24. **CCRC Reinf_AA_AB will have a positive correlation with empathic concern**
25. CCRC Reinf_AA_AB will have a negative correlation with factors of management of counter transference (i.e., anxiety management, self-insight, self-integration, and conceptualization skills)
26. **CCRC Self-Disclosure will have a positive correlation with general self-efficacy**
27. **CCRC Self-Disclosure will be negatively related to attachment-related anxiety and avoidance**
28. **CCRC Self-Disclosure will be positively related with self-insight and empathy defined as factors of management of counter-transference**
29. **CCRC Self-Disclosure will be positively related with perspective taking, an aspect of trait empathy**
30. **Aboriginal service providers self-disclose more often than non-Aboriginal service providers**
31. **CCRC Self-Disclosure will positively correlate with engagement scale of SAS-C**
32. **CCRC Self-Disclosure will positively correlate with group engagement and working alliance**
33. **Male service providers will not differ in the endorsement of self-disclosing responses in comparison to their female counterparts**
34. **Three non-counter-transferential CCRC scales, Confidence, Empathy, and Self-Disclosure will predict group cohesion**
35. **Three non-counter-transferential CCRC scales, Confidence, Empathy, and Self-Disclosure will predict working alliance (i.e., confidence in the therapeutic relationship)**

Note 1: Hypotheses in bold were supported by the data in this study
Note 2: Hypotheses in italics were partially supported by the data in this study

Appendix D

Interpersonal Reactivity Index

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by selecting the appropriate response next to each item. READ EACH ITEM CAREFULLY BEFORE RESPONDING. Answer as honestly as you can.

ANSWER SCALE:

A	B	C	D	E
DOES NOT DESCRIBE ME WELL				DESCRIBES ME VERY WELL

1. I daydream and fantasize, with some regularity, about things that might happen to me.
2. I often have tender, concerned feelings for people less fortunate than me.
3. I sometimes find it difficult to see things from the "other guy's" point of view.
4. Sometimes I don't feel very sorry for other people when they are having problems.
5. I really get involved with the feelings of the characters in a novel.
6. In emergency situations, I feel apprehensive and ill-at-ease.
7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.
8. I try to look at everybody's side of a disagreement before I make a decision.
9. When I see someone being taken advantage of, I feel kind of protective towards them.
10. I sometimes feel helpless when I am in the middle of a very emotional situation.
11. I sometimes try to understand my friends better by imagining how things look from their perspective.
12. Becoming extremely involved in a good book or movie is somewhat rare for me.
13. When I see someone get hurt, I tend to remain calm.
14. Other people's misfortunes do not usually disturb me a great deal.
15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.
16. After seeing a play or movie, I have felt as though I were one of the characters.
17. Being in a tense emotional situation scares me.
18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them.
19. I am usually pretty effective in dealing with emergencies.
20. I am often quite touched by things that I see happen.
21. I believe that there are two sides to every question and try to look at them both.
22. I would describe myself as a pretty soft-hearted person.
23. When I watch a good movie, I can very easily put myself in the place of a leading character.
24. I tend to lose control during emergencies.
25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while.
26. When I am reading an interesting story or novel, I imagine how I would feel if the events in

the story were happening to me.
27. When I see someone who badly needs help in an emergency, I go to pieces.
28. Before criticizing somebody, I try to imagine how I would feel if I were in their place.

Appendix E

SAS-C
Support Actions Scale - Circumplex

Form PG

Instructions

We are interested in how people typically respond when a friend or family member is in need of help or support. In answering the questions that follow, please try to be as accurate as possible in assessing how you typically or characteristically respond when someone close to you has a problem. Please think about times when people in your life have encountered difficulties and the types of things you have said or done in such situations. For each of the items listed, please indicate your likelihood of performing this particular behaviour by clicking a circle that best corresponds to your answer.

Example:

1	2	3	4	5	6	7
Never	Almost never	Seldom	Sometimes	Frequently	Almost always	Always

1. Lent money. 1 2 3 4 5 6 7

Circle "1" if you never do something like this. 1 2 3 4 5 6 7
Circle "2" if you almost never do something like this. 1 2 3 4 5 6 7
Circle "3" if you seldom do something like this. 1 2 3 4 5 6 7
Circle "4" if you sometimes do something like this. 1 2 3 4 5 6 7
Circle "5" if you frequently do something like this. 1 2 3 4 5 6 7
Circle "6" if you almost always do something like this. 1 2 3 4 5 6 7
Circle "7" if you always do something like this. 1 2 3 4 5 6 7

I...

1. ...told them that their problem was my problem too. 1 2 3 4 5 6 7
2. ...advised them to pay attention to what I had to say. 1 2 3 4 5 6 7
3. ...told them that they had to learn to live with it. 1 2 3 4 5 6 7
4. ...tried to not show too much concern. 1 2 3 4 5 6 7
5. ...avoided giving any advice. 1 2 3 4 5 6 7
6. ...did not give my opinion unless asked. 1 2 3 4 5 6 7
7. ...did not put any demands on them. 1 2 3 4 5 6 7
8. ...attempted to keep in regular contact with them. 1 2 3 4 5 6 7
9. ...gave advice. 1 2 3 4 5 6 7
10. ...emphasized how well qualified I was to help. 1 2 3 4 5 6 7
11. ...reminded them that whining doesn't help. 1 2 3 4 5 6 7
12. ...distanced myself. 1 2 3 4 5 6 7
13. ...avoided making recommendations. 1 2 3 4 5 6 7
14. ...let them make all the decisions. 1 2 3 4 5 6 7
15. ...let them deal with things at their own pace. 1 2 3 4 5 6 7
16. ...tried to involve them in social activities. 1 2 3 4 5 6 7
17. ...advised them to take advantage of the resources I could provide. 1 2 3 4 5 6 7
18. ...told them explicitly what to do step-by-step. 1 2 3 4 5 6 7
19. ...reminded them that people sometimes get what they deserve. 1 2 3 4 5 6 7

20.	...tried to stay "at arms' length".	1 2 3 4 5 6 7
21	...shied away from making suggestions.	1 2 3 4 5 6 7
22.	...let them do all the talking.	1 2 3 4 5 6 7
23.	...was careful not to pressure them.	1 2 3 4 5 6 7
24.	...enthusiastically helped out.	1 2 3 4 5 6 7
25.	...told them they came to the right person.	1 2 3 4 5 6 7
26.	...made decisions for them.	1 2 3 4 5 6 7
27.	...told them that I'm not surprised that they have these problems.	1 2 3 4 5 6 7
28.	...told them that I didn't want to get involved.	1 2 3 4 5 6 7
29.	...avoided trying to change their view of the situation.	1 2 3 4 5 6 7
30.	...did not impose my values on them.	1 2 3 4 5 6 7
31.	...let them know I was listening.	1 2 3 4 5 6 7
32.	...checked up on them frequently	1 2 3 4 5 6 7
33.	...told them to let me help with their problem.	1 2 3 4 5 6 7
34.	...insisted that they let me take care of things.	1 2 3 4 5 6 7
35.	...told them that nobody likes a cry-baby.	1 2 3 4 5 6 7
36.	...tried to keep them from leaning on me too much.	1 2 3 4 5 6 7
37.	...kept from stating any opinions.	1 2 3 4 5 6 7
38.	...refrained from any criticism.	1 2 3 4 5 6 7
39.	...was patient with them.	1 2 3 4 5 6 7
40.	...told them that I was worried about them	1 2 3 4 5 6 7
41.	...told them what I would do.	1 2 3 4 5 6 7
42.	...persuaded them to change their behavior.	1 2 3 4 5 6 7
43.	...suggested that they not complain too much.	1 2 3 4 5 6 7
44.	...avoided getting too involved.	1 2 3 4 5 6 7
45.	...avoided intruding on their problem.	1 2 3 4 5 6 7
46.	...did not argue with them.	1 2 3 4 5 6 7
47.	...gave them a hug.	1 2 3 4 5 6 7
48.	...eagerly helped in any way they asked me to.	1 2 3 4 5 6 7
49.	...told them that I'm in a good position to help.	1 2 3 4 5 6 7
50.	...told them to let me take care of everything.	1 2 3 4 5 6 7
51.	...told them that I don't like discussing personal problems.	1 2 3 4 5 6 7
52.	...did not comment on their situation.	1 2 3 4 5 6 7
53.	...avoided challenging their point of view.	1 2 3 4 5 6 7
54.	...remained non-judgmental.	1 2 3 4 5 6 7
55.	...just tried to be there.	1 2 3 4 5 6 7
56.	...did my best to protect them.	1 2 3 4 5 6 7
57.	...took over any matters I felt they couldn't deal with.	1 2 3 4 5 6 7
58.	...took control of the situation.	1 2 3 4 5 6 7
59.	...told them that I have my own problems to deal with.	1 2 3 4 5 6 7
60.	...helped in any way that didn't get me personally involved.	1 2 3 4 5 6 7
61.	...avoided influencing their course of action.	1 2 3 4 5 6 7
62.	...just listened quietly.	1 2 3 4 5 6 7
63.	...provided them with emotional support.	1 2 3 4 5 6 7
64.	...learned whatever I could about the problem and passed this knowledge on to them.	1 2 3 4 5 6 7

Appendix F

Countertransference Factor Inventory-Revised

Instructions: the following list of statements describe different aspects of counsellors or therapists relationship with their clients

Imagine a scale that tells how well each statement applies to you. Respond to each statement by clicking a circle to indicate how much each statement is true of you. If the statement does not apply, enter "Not at all true of me". If the statement is very reflective of your relationship with your client, select "Always true of me". Please be completely honest. Your answers are entirely confidential and will be useful only if they accurately describe you.

Not at all true of me
Moderately true of me
Quite a bit true of me
Very true of me
Always true of me

1. I am comfortable in the presence of client's strong feelings
2. At the appropriate times, I stand back from a client's emotional experience and try to understand what is going on with the client
3. I often conceptualize my role in what transpires in the counselling relationship
4. I am often aware of feelings in me elicited by clients
5. I effectively distinguish between client's needs and my own needs
6. I am comfortable being close to clients
7. I am perceptive in my understanding of clients
8. I can usually identify dynamics of the counselling relationship
9. I am often aware of fantasies in me triggered by client material and affect
10. I effectively recognize the boundaries between self and clients
11. I am comfortable with self when working with clients
12. I can usually identify with client's inner experience
13. I am able to distinguish between reactions that are "pulled" from me by the client from those that stem from my areas of conflict
14. I am often aware of personal areas of unresolved conflict which may be touched upon while doing therapy
15. I usually restrain myself from excessively identifying with the client's conflicts
16. I am able to comfort myself when feeling anxious during sessions
17. I am able to identify with client's feelings and maintain the capacity to disengage from the identification
18. I am able to use my reactions to clients as clues to client's feelings or dynamics
19. I usually recognize my own negative feelings towards clients
20. I have the capacity to stand back from my own emotional experience and observe what is going on with myself with regard to clients
21. I am able to deal with my own anxiety effectively when seeing clients

22. I generally remain emotionally attuned with the client when otherwise feeling uncomfortable during sessions
23. I am generally able to step back and cognitively process my own reactions to clients
24. I lack a theoretical understanding of the therapeutic work to help guide my intervention with clients
25. I have a stable sense of identity which is reflected in my therapeutic work
26. I am able to contain my anxiety in the presence of client's strong emotions
27. I make an effort to emotionally identify with the client when the client discusses material that is uncomfortable for me
28. I generally fail to convert my feelings during sessions into conceptualizations that are useful in guiding the work
29. I usually comprehend how my feeling influence me in the therapy
30. I usually manage my need for approval with clients
31. I often become immobilized by anxiety when working with clients, not knowing how to respond or intervene
32. I tend to empathize so much with the client's feelings that he client is actually impeded from growing
33. I possess a conceptual understanding of the therapeutic work which enables me to make sense of my reactions to clients
34. I am often aware of my personal impact on clients
35. I possess psychological balance which is reflected in my therapeutic work
36. I understand the background factors in my life that have shaped my personality and use this understanding to help my work with clients
37. I tend to deal with my anxiety in the presence of strong client emotions by disengaging from the work
38. I am unable to alternate easily between emotional identification with the client and objective understanding
39. I am not usually aware of the motivation behind my behaviour with clients
40. I allow my own personal problems or conflicts to interfere with the therapeutic work

Appendix G

New General Self-Efficacy Scale

Instructions: general self-efficacy relates to "one's estimate of one's overall ability to perform successfully in a wide variety of achievement situations", or to how confident one is that she or he can perform effectively across different tasks and situations. Below are eight statements. Respond to each statement by clicking a circle to indicate how much you agree or disagree with the statement.

1. I will be able to achieve most of the goals that I have set for myself.

1	2	3	4	5
Strongly disagree				Strongly agree

2. When facing difficult tasks, I am certain that I will accomplish them.

1	2	3	4	5
Strongly disagree				Strongly agree

3. In general, I think that I can obtain outcomes that are important to me.

1	2	3	4	5
Strongly disagree				Strongly agree

4. I believe I can succeed at most any endeavour to which I set my mind.

1	2	3	4	5
Strongly disagree				Strongly agree

5. I will be able to successfully overcome many challenges.

1	2	3	4	5
Strongly disagree				Strongly agree

6. I am confident that I can perform effectively on many different tasks.

1	2	3	4	5
Strongly disagree				Strongly agree

7. Compared to other people, I can do most tasks very well.

1	2	3	4	5
Strongly disagree				Strongly agree

8. Even when things are tough, I can perform quite well.

1	2	3	4	5
Strongly disagree				Strongly agree

Appendix H

Correctional Facilitator Self-Efficacy Inventory

Instructions: The following are the skills that you are usually assessed on by your supervisors.

Imagine a scale ranging from 1 to 5 that tells how confident you are in performing these skills. In the space next to each skill, please enter a number from "1" (not at all confident) to "5" (very confident). If the skill does not apply to your practice, enter "1". Please be completely honest. Your answers are entirely confidential and will be useful only if they accurately describe you. Your answers will not be used for your evaluation and will not be reported to your colleagues or supervisors.

Not al all confident: 1
Moderately confident: 2
Quite a bit confident: 3
Very confident: 4
Always confident: 5

1. Empowering others, group members and co-facilitators
2. Promoting group cohesion
3. Individualizing treatment approach for each client according to his/her gender, education, culture, and personal interests
4. Responding to clients empathically, either in individual or group sessions
5. Managing group processes
6. Establishing boundaries with clients individually and in the group
7. Actively listening
8. Respecting others
9. Modeling skills and attitudes consistent with the program
10. Using demonstration and role plays
11. Using visual aids
12. Reinforcing desired behaviours and attitudes
13. Presenting information in an interesting and dynamic fashion
14. Providing constructive feedback
15. Using guided learning
16. Delivering program according to program delivery and training manuals
17. Challenging distorted/criminal thinking
18. Co-facilitating a group
19. Communicating analysis of client's assessment and progress clearly in a written format
20. Demonstrating knowledge and understanding of program in program delivery
21. Demonstrating knowledge and understanding of program in written report communication
22. Linking program targets with offender needs in program delivery
23. Linking program targets with offender needs in written report communication
24. Reporting on progress of each client against treatment targets
25. Writing recommendations of strategies to manage risk factors
26. Organizing reports and sessions according to a structured format

27. Organizing group room to promote learning
28. Preparing to deliver sessions
29. Managing time
30. Being receptive to feedback
31. Producing post-program reports for all participants
32. Finalizing program reports within required timeframes
33. Coordinating the post-program case conference with the offender and the Case management Team
34. Conducting pre-program interviews and assessments no earlier than 30 working days before the program starts
35. Ensuring the suitability of group members
36. Conducting and documenting make-up and individual sessions
37. Submitting assessment data

Appendix I

Experiences in Close Relationships Inventory

Instructions: The statements below concern how you generally feel in your relationship with your romantic partner (i.e., a girlfriend, boyfriend, or spouse). We are interested in how you *generally* experience relationships, not just in what is happening in a current relationship. Respond to each statement by clicking a circle to indicate how much you agree or disagree with the statement.

1	2	3	4	5	6	7
Disagree Strongly			Neutral/ Mixed			Agree Strongly

1. I prefer not to show a partner how I feel deep down.
2. I worry about being abandoned.
3. I am very comfortable being close to romantic partners.
4. I worry a lot about my relationships.
5. Just when my partner starts to get close to me I find myself pulling away.
6. I worry that romantic partners won't care about me as much as I care about them.
7. I get uncomfortable when a romantic partner wants to be very close.
8. I worry a fair amount about losing my partner.
9. I don't feel comfortable opening up to romantic partners.
10. I often wish that my partner's feelings for me were as strong as my feelings for him/her.
11. I want to get close to my partner, but I keep pulling back.
12. I often want to merge completely with romantic partners, and this sometimes scares them away.
13. I am nervous when partners get too close to me.
14. I worry about being alone.
15. I feel comfortable sharing my private thoughts and feelings with my partner.
16. My desire to be very close sometimes scares people away.
17. I try to avoid getting too close to my partner.
18. I need a lot of reassurance that I am loved by my partner.
19. I find it relatively easy to get close to my partner.
20. Sometimes I feel that I force my partners to show more feeling, more commitment.
21. I find it difficult to allow myself to depend on romantic partners.
22. I do not often worry about being abandoned.
23. I prefer not to be too close to romantic partners.
24. If I can't get my partner to show interest in me, I get upset or angry.
25. I tell my partner just about everything.
26. I find that my partner(s) don't want to get as close as I would like.
27. I usually discuss my problems and concerns with my partner.
28. When I'm not involved in a relationship, I feel somewhat anxious and insecure.
29. I feel comfortable depending on romantic partners.
30. I get frustrated when my partner is not around as much as I would like.
31. I don't mind asking romantic partners for comfort, advice, or help.
32. I get frustrated if romantic partners are not available when I need them.

33. It helps to turn to my romantic partner in times of need.
34. When romantic partners disapprove of me, I feel really bad about myself.
35. I turn to my partner for many things, including comfort and reassurance.
36. I resent it when my partner spends time away from me.

Appendix J

GCQ
Group Climate Questionnaire

- Read each statement carefully and try to think of the group you are currently running. Try to think of the whole group.
- Respond to each statement by clicking a circle that best describes the group during the last meeting
- Please mark only ONE answer for each statement.
- From a drop-down menu below, select the type of group your answers will be referring to (e.g., Emotion and Anger Management)

Rating Scale	
0	not at all
1	a little bit
2	somewhat
3	moderately
4	quite a bit
5	a great deal
6	extremely

1. The members liked and cared about each other.	0	1	2	3	4	5	6
2. The members tried to understand why they do the things they do, tried to reason it out.	0	1	2	3	4	5	6
3. The members avoided looking at important issues going on between themselves.	0	1	2	3	4	5	6
4. The members felt what was happening was important and there was a sense of participation.	0	1	2	3	4	5	6
5. The members depended on the group leader(s) for direction.	0	1	2	3	4	5	6
6. There was friction and anger between the members.	0	1	2	3	4	5	6
7. The members were distant and withdrawn from each other.	0	1	2	3	4	5	6
8. The members challenged and confronted each other in their efforts to sort things out.	0	1	2	3	4	5	6
9. The members appeared to do things the way they thought would be acceptable to the group.	0	1	2	3	4	5	6
10. The members rejected and distrusted each other.	0	1	2	3	4	5	6
11. The members revealed sensitive personal information or feelings.	0	1	2	3	4	5	6
12. The members appeared tense and anxious.	0	1	2	3	4	5	6

Appendix K

Therapist Confident Collaboration Scale

Specific Instructions:
The following sentences describe some of the different ways a person might think or feel about his or her client (offender). As you read the sentences mentally insert the name of your client (offender) in place of the blank in the text. Below each statement there is a seven point scale. If the statement describes the way you always feel (or think) select 7; if it never applies to you select 1. Use the numbers in between to describe the variations between these extremes.

1. _____and I both feel confident about the usefulness of our current activity in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. As a result of these sessions, _____ is clearer as to how he/she might be able to change.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. My client has confidence in therapy and therapist.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. My client is confident that our efforts will lead to change.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. My client is committed to go through the therapy process to completion.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

Appendix L

Marlowe-Crowne Social Desirability Scale
Short Form Items

Instruction: listed below are a number of statements concerning personal attitudes and traits. Read each item and decide how it pertains to you.

Please respond either TRUE (**T**) or FALSE (**F**) to each item. Indicate your response by clicking a circle with the appropriate letter next to the item. Be sure to answer all items.

1.	It is sometimes hard for me to go on with my work if I am not encouraged	**T F**
2.	I sometimes feel resentful when I don't get my way.	**T F**
3.	On a few occasions, I have given up doing something because I thought too little of my ability.	**T F**
4.	There have been times when I felt like rebelling against people in authority even though I knew they were right.	**T F**
5.	No matter who I'm talking to, I'm always a good listener.	**T F**
6.	There have been occasions when I took advantage of someone.	**T F**
7.	I'm always willing to admit to it when I make a mistake	**T F**
8.	I sometimes try to get even rather than forgive and forget.	**T F**
9.	I am always courteous, even to people who are disagreeable	**T F**
10.	I have never been irked when people expressed ideas very different from my own	**T F**
11.	There have been times when I was quite jealous of the good fortune of others	**T F**
12.	I am sometimes irritated by people who ask favors of me.	**T F**
13.	I have never deliberately said something that hurt someone's feelings.	**T F**