THE VICTIM’S VOICE: A VICTIM-FOCUSED SAFETY PLANNING INTERVENTION FOR INTIMATE PARTNER VIOLENCE

by

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ABSTRACT

Risk assessment and safety planning are vital in preventing the damaging physical and psychological effects of intimate partner violence (IPV) on women. A potentially useful addition to these preventative tools is the victim’s voice - a woman’s self-appraisal of her abusive relationship. For this study, this voice was deconstructed into two components, risk as analysis and risk as feelings. This conceptualization was used as a basis for two interventions administered to a community-based sample of 60 IPV victims. Each woman participated in an in-depth interview that included formal risk assessment, random assignment to an intervention, generation of a safety plan, and feedback regarding the intervention. A follow-up interview was also completed to collect re-victimization data. The purpose of this study was to compare the two interventions of interest, exploring their impact on IPV victims’: (a) risk and fear appraisals, (b) safety plan quality, (c) satisfaction with the intervention, and (d) re-victimization status. Traditionally, the risk as analysis approach has prevailed. However, the results of this study are suggestive of the risk as feelings approach being at least equivalent to, if not more, beneficial to victims. Additionally, this study examined the correspondence between formal assessment of risk (i.e., conducted by a trained professional) and victim-appraised assessment of risk; modest correspondence was demonstrated. Implications regarding the dual-mode processing conceptualization of risk, the potential mechanism underlying the risk as feelings approach, and applications to risk assessment and safety planning are discussed. The results of this study are intended to stimulate research in the area of victim-focused contextualized risk assessment and safety planning for women who have been victimized by an intimate partner.

Keywords: Intimate partner violence; safety planning; risk assessment; dual-mode processing; re-victimization; experiential; analytical; risk as analysis; risk as feelings
DEDICATION

• Dave, my one and only, you got me here with your encouragement, understanding, caring, and gentle persistence. Always, thank you.

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I can no other answer make, but, thanks, and thanks. ~William Shakespeare
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INTRODUCTION

This introduction has been conceptualized along four different, although intertwined, parts. Part I (Intimate Partner Violence Background) provides foundational knowledge of a serious social pandemic – violence in intimate relationships. Defining and highlighting the scope of this problem is essential to facilitate understanding of the need for effective prevention. Part II (Prevention of Intimate Partner Violence Re-victimization) emphasizes the prevention of re-victimization by intimate partners through two key areas: risk assessment and safety planning. Part III (The Victim’s Voice and Re-victimization) highlights the potential value in using the victim’s voice, or the victim’s perspective of an abusive relationship and intimate partner, to inform risk for re-victimization. Lastly, Part IV (Exploring the Victim’s Voice - A Theoretical Framework) examines a framework adapted from cognitive psychology to deconstruct the victim’s voice, for the purpose of developing a comprehensive victim-focused intervention.

In defining the presence of violence within an intimate relationship, numerous terminologies have been adopted. Examples of such definitions include: domestic violence, partner abuse, spousal abuse or assault, intimate terrorism, intimate partner violence, or, more specific to female victims, violence against women or wife assault. For consistency, intimate partner violence (IPV) is the term used herein.

Part I: Intimate Partner Violence Background

I had left him and I was downtown getting on a train when I ran into him. He was trying to force me back... I kept saying it was over, but he grabbed me by my hair and pushed me down. It took six cops to get him off of me. (Research Participant)

The majority of past empirical research in the field of partner violence suggests that IPV is a gendered phenomenon (McCloskey & Grigsby, 2005; Tjaden & Thoennes, 2000). For instance, in one study, between 90% and 95% of victims in abusive intimate relationships were women (Pagelow, 1992). There is evidence to suggest that women-perpetuated violence primarily occurs within the context of a relationship already marked by violence committed by men (Benson, Wooldredge, Thistlethwaite, & Fox, 2004). More recently, these research findings have been disputed (Dutton & Nicholls, 2005; Nicholls & Dutton, 2001; Stets & Straus, 1992). For
example, similar IPV perpetration rates between men and women have been identified, although victimization rates remain higher for women.\(^1\) However, the consequences of IPV may differ between genders, whereby violence initiated by a woman may result in less severe physical injury of a male partner than vice versa (Benson et al., 2004; Cascardi, Langhinrichsen, & Vivian, 1992; Ross & Babcock, 2009). In addition, when couples report violence in their relationships, women demonstrate significantly more, and longer-term, fear of their partners than men (Cantos, Neidig, & O’Leary, 1994). Mutuality of violence in intimate relationships is acknowledged here, however this study will focus on the victimization of women.

**Defining Intimate Partner Violence**

Intimate partner violence manifests in multiple non-mutually exclusive ways in relationships, including physical, psychological, and sexual abuse (Coker et al., 2002). The most recognized form of abuse, *physical abuse*, comprises any “actual, attempted, or threatened physical harm of a current or former intimate partner” (Kropp, Hart, & Belfrage, 2005, p. 1). Resultant harm varies from minor to serious injury (Garcia-Morena, Jansen, Ellsberg, Heise, & Watts, 2006) to death (Campbell, Glass, Sharps, Laughon, & Bloom, 2007). *Psychological abuse* is defined by behaviour intended to denigrate, humiliate, or threaten an intimate partner (Coker et al., 2002; Flinck, Paavilainen, & Åstedt-Kurki, 2005). *Sexual abuse* occurs when sexual contact between intimate partners is non-consensual and/or forced (Coker et al., 2002). Non-physically assultive sexual acts are also a form of sexual abuse (e.g., contraception refusal; Campbell & Soeken, 1999a; Garcia-Morena et al., 2006). Additional evidence is emerging that abuse may extend beyond these categories; that is, other forms of abuse, including stalking/harassment, financial abuse, and spiritual abuse, may be present in violent relationships (Flinck et al., 2005; Kropp, Hart, & Lyon, 2008; Lambert & Firestone, 2000).

**Defining the Scope of the Problem**

Intimate partner violence has garnered the infamous distinction of being one of the “most universal and widespread forms of violence against women” (Dumont, Forte, Cohen, Hyman, & Romans, 2005; p. 2). Due to its significant prevalence, damaging consequences on victims, and unique relational dynamic conducive to re-victimization, IPV is under intensive empirical scrutiny.

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\(^1\) This may be attributable to under-reporting of abuse by male victims of IPV (Dutton & Nicholls, 2005).
Prevalence Estimates of Intimate Partner Violence

Worldwide, approximately one woman in every three will encounter IPV in her lifetime (Heise, Ellsberg, & Goettemoeller, 1999). Based on a review of 48 population-based studies through the World Health Organization (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002), victimization rates for physical abuse perpetrated by a male partner was estimated to be between 10% and 69%. Similarly troubling prevalence rates exist for developed (e.g., Norway, Sweden, Iceland, Finland, and Denmark, see Wijma et al., 2003; New Zealand, see Koziol-McLain et al., 2010; Britain, see Walby & Allen, 2004) and developing countries (e.g., Ethiopia and Samoa; Garcia-Moreno et al., 2006). Annually, 1.5 million women in the United States become victims of IPV (Tjaden & Thoennes, 2000).

In Canada, since the 1970s, the victimization of women by their intimate partners has been increasingly recognized as a pervasive societal problem (Clark & Du Mont, 2003). The first national attempt to assess the prevalence of IPV in the Canadian population occurred with the Statistics Canada General Social Survey on Victimization in 1999 (Besserer, Brzozowski, Hendrick, Ogg, & Trainor, 2001). Results of this survey indicated that Canadian women were 1.2 times more likely to report being victims of spousal assault than men. A more recent Canadian review (Clark & Du Mont, 2003), reported the annual prevalence of male-to-female perpetrated partner violence ranged from 0.4% to 18.3%\(^2\) for physical abuse and 13.1% to 23.0% for psychological abuse. Between 8% and 36% of Canadian women reported physical or sexual abuse by an intimate partner over a lifetime (Clark & Du Mont, 2003). Specific to British Columbia, women reported one of the greatest rates of IPV victimization in comparison to the majority of other Canadian provinces (9% in the preceding five-year period; Statistics Canada, 2005). Overall, a substantial proportion of women – Canadian or otherwise – are at risk for experiencing IPV in their lifetime.

Consequences of Intimate Partner Violence\(^3\)

The deleterious effects of IPV victimization on the overall physical and psychological welfare of women is widely recognized (for a comprehensive review see Campbell & Soeken, 1999b or Plichta, 2004). Physical and psychological abuse is both associated with health problems, generating acute and chronic adverse outcomes (Gillum, Sun, & Woods, 2009). Physical injury is the most obvious immediate consequence of abuse (e.g., cuts, scratches, broken

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\(^2\) The range of physical violence against women was variable, attributed by the authors to the varying severity of abuse required to meet a threshold for determination of physical violence.

\(^3\) A variation of this section written by this author was published in Desmarais, Gibas, & Nicholls, 2009.
bones). For women, one of the primary reasons for an emergency room visit is victimization by a male partner (Lass, 2007). Long-term physical health effects of IPV include chronic medical conditions (Coker et al., 2002; Gillum, Sun, & Woods, 2009; Humphreys, Lee, Neylan, & Marmar, 2001). Compared to the general population, victims of IPV experience significantly greater than average neurological, cardiopulmonary, and gastrointestinal symptoms or disorders (Coker et al., 2002). Additionally, the fear victims endure with IPV victimization may also contribute to stress-related health problems (e.g., hypertension) or increase in self-injurious lifestyle choices (e.g., substance abuse for coping; Campbell, 2004). In general, IPV is associated with poor health, injury, disability, and increased mortality for victims (Plichta, 2004).

The psychological sequela of abuse is also exceedingly damaging to victims (Coker et al., 2002). Victims of IPV are likely to meet diagnostic criteria for major psychiatric disorders including, but not limited to, depression, posttraumatic stress, eating disorders, and substance abuse (Coker et al., 2002; Kernic, Wolf, & Holt, 2000). Victimization is also a recognized risk factor for self-harm and suicide (Campbell, 2004). Psychological distress experienced by victims of IPV was at least comparable to the level of distress experienced by a sample of female outpatient psychiatric patients (Humphreys et al., 2001). In addition, the detrimental impact of the physical and psychological effects of abuse may result in a decline in occupational functioning (Tolman & Rosen, 2001). Financial hardship, welfare receipt, and poverty are associated with IPV victimization (Tolman & Rosen, 2001). Even once a woman leaves an abusive relationship, the effects of victimization persist (Plichta, 2004).

Aside from the direct impact IPV has on victims, there are well-established radiating effects on their children (Jaffe, Hurley, & Wolfe, 1990; Riger, Raja, & Camacho, 2002). Between 5% and 20% of children are witnesses of IPV perpetrated between adults (McCloskey & Walker, 2000; Tjaden & Thoennes, 2000). Psychological (i.e., internalizing) and behavioural (i.e., externalizing) problems are prevalent in this population (English, Marshall, & Stewart, 2003; Wolak & Finkelhor, 1998; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). Often, if IPV is present in the home, children may also become targets of abuse resulting in injury (Cohen, Mannarino, Murray, & Igelman, 2006) or death (Jaffe & Juodis, 2006). The intergenerational effects of witnessing IPV are significant - children witnesses are at increased risk of IPV perpetration or victimization as adults (Appel & Holden, 1998; Langhinrichsen-Rohling, Neidig, & Thorn, 1995). Overall, the robust body of empirical evidence regarding the significant detrimental effects of IPV strongly suggests the need for prevention (Nurius et al., 2003).
The Dynamics of Intimate Partner Violence

Intimate partner violence is characterized by a pattern of abuse (Campbell, 2004). Once a perpetrator abuses his partner, he is unlikely to refrain from using violence in the relationship, particularly if he found it to be an effective means of control (Bancroft, 2002; Campbell, 2004). This continual perpetuation of violence is referred to as the cycle of violence (Walker, 2000). Once initiated, the abuse in an intimate relationship may escalate in frequency and severity (Campbell, Rose, Kub, & Nedd, 1998) although, in some instances, it may cease (Bybee & Sullivan, 2005). Of women that acknowledged partner violence in a national survey, approximately two-thirds reported multiple physical assaults by an abusive partner, with the same type of assault recurring (Tjaden & Thoennes, 2000). If a woman successfully extricates herself from an abusive relationship, she continues to be at risk for victimization. This “separation period” may be when a woman is at most risk for physical harm from her partner, including increased risk of being murdered (known as femicide; Dobash, Dobash, Cavanagh, & Lewis, 2004). Significantly, IPV was present in the majority of relationships prior to intimate partner femicide (Campbell, Sharps, Sachs, & Yam, 2003). In general, the close relational connection between a perpetrator and his victim appears to increase the likelihood of re-victimization.

In identifying the cyclical nature of violence in IPV, estimates of re-victimization rates exist (Bybee & Sullivan, 2005) and, not surprisingly given the interpersonal nature of IPV, are considered high (Lass, 2007). For example, one study (Fleury, Sullivan, and Bybee, 2000) reported 36% of a sample of abused women were re-victimized (i.e., assaulted) by an ex-intimate partner within a two-year period. Similarly, Campbell and Soeken (1999b) estimated that 44% of their sample of abused women experienced re-victimization by an intimate partner over the course of 3.5 years. A seminal study (Sullivan & Bybee, 1999) found that approximately 48% of abused women recruited from a domestic violence shelter were subsequently physically abused post-shelter stay. Approximately 38% of women in their sample also reported re-victimization, despite being between 1.5 and 2.0 years post-shelter stay. In a national survey, Tjaden and Thoennes (2000) reported that, on average, victims of IPV were assaulted 6.9 times over a period of 4.5 years. Despite this chronic violence, IPV ranks highly as one of the most unreported violent crimes. Barrett and St. Pierre (2011) reported less than one third of their sample of abused women accessed police services.

The ubiquitous nature of violence in intimate relationships, the escalation of harm whereby the potential for death exists, and the likelihood of re-victimization, warrants formal intervention. Rather than continuing to evaluate the scope of the problem, an empirical shift
towards focusing on prevention efforts in research has been initiated (Bennett Cattaneo, Bell, Goodman, & Dutton, 2007).

**Part II: Prevention of IPV Re-victimization**

Intimate partner violence has been identified as a serious, albeit preventable, health problem (Iyengar & Sabik, 2009). One apparent solution to reduce the prevalence of IPV is to prevent the recurrence of victimization (Gunderson, 2002). Two key areas, relevant to the current study, exist to accomplish this goal: risk assessment and safety planning. Identifying risk, via risk assessment, is a critical first step in the process of risk management and safety planning (Dutton & Kropp, 2000).

**Risk Assessment**

A number of risk assessment tools have been developed over the past two decades to gauge risk for IPV re-victimization for actual or threatened physical harm and lethality (e.g., see Dutton & Kropp, 2000 for a review). These instruments rely on the identification of risk factors for IPV, derived from the empirical literature, clinical practice, and/or statistical analyses. Risk factors are comprised of maladaptive perpetrator characteristics (e.g., history of substance abuse and previous spousal violence) as well as specific IPV behaviours (e.g., choking, assaultive behaviours during pregnancy). Increasingly, victim vulnerability factors are being included in risk assessment instruments (e.g., inadequate access to formal resources; Kropp, et al., 2008). Typically, risk becomes elevated with an increasing number of risk factors identified within the intimate relationship.

For the purpose of description, IPV risk assessment instruments may be broadly categorized into two groups: actuarial and structured professional judgment (SPJ). The actuarial approach relies on specific mathematical algorithms to identify and select risk factors related to violent re-victimization. There is limited clinical judgment, or discretion, as the actuarial measures provide explicit and fixed rules for determining the presence or absence of risk factors (Bowen, 2011; Douglas & Kropp, 2002). A final probabilistic estimate of violence is provided based on, typically, summing the number of present risk factors (Bowen, 2011; Douglas & Kropp, 2002). In comparison, SPJ measures are guidelines based on best clinical practice and systematic research review (Kropp et al., 2005). SPJ guidelines use professional clinical judgment and discretion to assess for the presence or absence of empirically established risk factors and to determine an overall rating of violence risk. The emphasis of these measures is less on prediction of violence, but rather on management of risk (Belfrage & Strand, 2008; Kropp, 2004). A
contentious debate exists, concerning which approach – actuarial or SPJ – results in more accurate predictions of violence risk (Bowen, 2011). Irrespective of this debate, the various risk assessment tools, despite their categorization, have demonstrated predictive accuracy in determining risk for re-victimization (e.g., Goodman, Dutton, & Bennett, 2000; Kropp & Hart, 2000). In acknowledging that human behaviour is dynamic and unpredictable, the achievement of perfect predictive accuracy is improbable (Hart, 2008).

For the purpose of prevention, risk assessment may inform victim safety planning, the second type of IPV intervention. By involving an abused woman in an assessment of risk, it is presumed that she will examine the extent of the danger she faces. In doing so, she may be more likely to engage in developing, and adhering to, a comprehensive safety plan (Belfrage et al., in press; Campbell, 2004; Hart, 2008).

Safety Planning

Safety planning provides an opportunity for a victim to disclose information about her abusive intimate relationship, to determine how best to maximize her safety. Potential risks are identified and a safety plan is developed with the victim to help her anticipate, and cope with, future incidents of partner violence (Davies, Lyon, & Monti-Catania, 1998). The hope is to increase the probability that a woman may minimize, avoid, or escape violence perpetrated against her (Hamberger & Potente, 1996). Safety planning may address physical (e.g., an escape route when violence is imminent) and psychological elements (e.g., an assessment for suicidality; Lindhorst, Nurius & Macy, 2005).

Although a multitude of evidence exists regarding the prevalence, risk factors and consequences of IPV, there is limited corresponding research regarding safety planning. Of the available evidence, the importance of safety planning with victims of IPV is confirmed. For instance, McFarlane and colleagues (2006) compared two safety planning interventions: a wallet-sized card with referral numbers for support services and a 20-minute nurse case management protocol. Over the course of a two-year follow-up, a significant decrease in threats, assault, and femicide risk was found for both types of interventions (McFarlane, Groff, O’Brien, & Watson, 2006). There were no between group differences for intervention type (McFarlane et al., 2006). An oft-cited study by Sullivan and Bybee (1999), involved a 10-week community-based advocacy service for abused women, who were subsequently followed for a period of two years at six-month intervals. Women received intensive services (4 – 6 hours per week), which included safety planning, referrals to needed resources, and basic social support. Compared to a control group, women receiving intensive services reported fewer incidents of violence and higher quality
of life (Sullivan & Bybee, 1999). More specifically, 24% of women in the advocacy group experienced no physical abuse by the original or new partner, in contrast to the 10% of women in the control group, over the course of the two-year study period (Sullivan & Bybee, 1999).

Safety planning is most effective when conducted as an active partnership between an IPV victim and a trained professional (Campbell, 2004). Although recognized as an important service to provide (Bennett, Riger, Schewe, Howard, & Wasco, 2004; Chang et al., 2006), safety plans are not routinely identified as being needed (Agar & Read, 2002; McCloskey & Grigsby, 2005), or developed when victims seek formal IPV services (Weisz, 2005). For example, one study (Weisz, 2005), found that 7 of 21 severely abused women received help with safety planning, although 18 of the 21 women indicated that they desired this service. Similarly, approximately 50% of surveyed social workers assisting abused women did not routinely develop or encourage implementation of a safety plan (Danis, 2003). More significantly, in a 12-city femicide study, the majority of murdered women had interacted with formal services in the year prior to their murders - multiple missed opportunities for safety planning (Campbell et al., 2007). Additional research is consistent with this: in a qualitative study of women who had survived a femicide attempt, few recalled discussing their level of risk with helping professionals (Nicolaidis et al., 2003). In fact, the majority of women recognized their level of risk for victimization, but had no formal opportunity to systematically assess risk or access safety planning (Nicolaidis et al., 2003). Despite a need for safety planning, victims of IPV are often not able to access this service (Chang et al., 2005).

If safety planning interventions are employed in community agencies, traditional feminist-based safety planning is often provided. Some researchers have cautioned that traditional safety planning is necessary, but insufficient to account for the complexity of IPV (Lindhorst et al., 2005). For example, traditional safety planning presumes that a woman is permanently leaving her abusive relationship. However, terminating an abusive relationship is an arduous process for many victimized women, who repeatedly return to abusive partners for a variety of reasons (e.g., the welfare of children or homelessness; Zanville, 2009). Therefore, tailoring a safety plan in anticipation of an abusive relationship ending does not provide a woman with safety strategies if she chooses to return to her partner; thus, likely increasing her risk for future harm. As such, Lindhorst and colleagues (2005) have recommended the development of contextualized safety plans for victims of IPV. Their theoretical conceptualization of safety planning is comprised of a woman’s appraisal of the threat and identification of key risk factors (i.e., environmental, individual, and protective) that form the basis of her perception of risk.
An empowerment approach is endorsed, allowing a woman to strategically plan for her own safety. Women-centred advocacy, premised in a woman identifying her own wants and needs, has been identified as critical for effectual safety planning (Davies et al., 1998).

Few formalized safety planning tools are available to help professionals address IPV victims’ needs for safety planning. The Intimate Partner Violence Strategies Index (IPVSI; Goodman, Dutton, Weinfurt, & Cook, 2003) assesses the extent that women use a variety of safety strategies; no specific intervention is associated with the IPVSI measure. The Aid for Safety Assessment and Planning (ASAP) is a safety assessment manual, developed in British Columbia, for victim service workers to use in collaboration with justice agencies (BC Institute Against Family Violence, 2006). The ASAP incorporates established perpetrator risk factors and “safety support” factors, which help identify the supports that a woman may need to ensure her safety. The ASAP guides a service worker and victim to develop strategies for the supervision and intervention of the abuser, as well as ensure the physical security and well-being of the victim (BC Institute Against Family Violence, 2004). To date, there is no published empirical literature regarding the ASAP, although it appears to be used in practice within municipal police services in British Columbia and New Brunswick. More recently, the Decision-making in Abusive Relationships Interview (DIARI), a risk/needs assessment specifically for victims of IPV, has been developed (Nicholls, Hilterman, & Tengstrom, 2010) and preliminary validation research conducted (Desmarais, Nicholls, Koch, & Kropp, submitted). Research has also surfaced describing a “computerized safety decision aid” – a program that provides feedback to IPV victims about risk and generates a personalized safety plan based on priorities input by the user (Glass, Eden, Bloom, & Perrin, 2010); however, its effectiveness requires investigation. A secondary reason for the limited application of safety planning interventions in practice may be related to practical constraints. Resources are typically scarce for service providers to support the growing prevalence of IPV victims (Allen, Bybee, & Sullivan, 2004; Connor-Smith, Henning, Moore, & Holdford, 2010).

In summary, risk assessment and safety planning are used to prevent the recurrence of IPV victimization. Formalized risk assessment, although impressively researched and validated, are primarily perpetrator-oriented (Campbell, 2004). Safety planning is victim-centric, but is nascent in development – yet to become formalized and attain scientific validation. In close partnership with victims of IPV, by parsing and structuring their voices via a newly developed
intervention, it is postulated that a comprehensive evaluation of risk and safety planning will be undertaken; this is one of the objectives of this study.

Part III: The Victim’s Voice and Re-victimization

As posed by Campbell (2004), a critical question in the field of IPV is “How best [are we] to help women who are abused most accurately determine their own risk?” (p. 1466). The determination of risk is critical so that a woman may generate a comprehensive safety plan, to maximize her safety. Victims possess personal knowledge of their abusive partner and, correspondingly, may have intuition regarding potential future incidents of partner-related violence (Bennett Cattaneo, 2007). A current debate concerns whether the victim’s perspective of IPV risk in her relationship, or the so-called victim’s voice, may be used to inform risk assessment, in tandem with, or beyond that derived from traditional risk assessment. In essence, to what extent does a victim provide unique information relevant to her own risk and safety?

Some researchers (e.g., Campbell, 2004; Nicolaidis et al., 2003) have argued in favour of ascribing less weight to the victim’s voice, by suggesting that an abused woman may exhibit impairment in assessing her own risk. A victim may minimize or deny her intimate partners’ potential for violence in order to cope with the abuse, particularly if she is not prepared to terminate the relationship (Londt, 2004). Women may be reluctant to consider whether their partners may actually harm them seriously (Campbell, 1995). Traumatic responses, as a likely consequence of victimization, are theorized as hindering a victim’s accurate appraisal of future violence (Campbell, 1995). It is also postulated that, as a corollary of psychological abuse (i.e., being called disparaging names such as “stupid”), an abused woman may not trust her own decision-making capabilities (Lass, 2007). In addition, self-perceived low risk may not necessarily translate into actual low risk for future violence (Campbell, 2004). As evidence, in one study (Campbell, 2004), 50% of women who were femicide victims, or nearly femicide victims, had not perceived their partner to be capable of lethal violence. As a result, Nicolaidis and colleagues (2003) warn that, “clinicians should not be falsely assured by a woman’s sense of safety” (p. 788).

Empirical research has provided some substantiation that a woman’s appraisal of risk may not serve as the best predictor of re-victimization. General research findings suggest that humans are inaccurate in predicting negative outcomes (e.g., for medical conditions; Connor-Smith et al., 2010). Even despite the presence of glaring risk factors, estimates of personal risk are often consistently undervalued (e.g., Gidycz, McNamara, & Edwards, 2006). Specific to IPV
victimization, Hanson and colleagues (2007), via a meta-analysis of 18 studies, rank ordered the predictive accuracy of IPV risk assessments. Ranging from most to least accurate, the results were as follows: Ontario Domestic Assault Risk Assessment (ODARA; Hilton, Harris, & Rice, 2004), Spousal Assault Risk Assessment Guide (SARA; Kropp, Hart, Webster, & Eaves, 1995), the Danger Assessment Scale (DA; Campbell, Webster & Glass, 2009), and, lastly, victim self-assessment (Hanson, Helmus, & Bourgon, 2007). Of note, statistically significant differences were not identified across the varying assessment methods. However, based on this finding, victim self-appraisals of risk are claimed as potentially useful, but formal risk assessment instruments are still identified as the most accurate in predicting violence risk (Kercher, Weiss, & Rufino, 2010). Hanson and colleagues have also argued, more broadly, that unstructured opinions of risk have less predictive accuracy than actuarial or structured risk assessment (e.g., Hanson & Bourgon, 2007) An underlying implication is that a woman’s self-appraisal of risk for IPV victimization – as an unstructured opinion – could be inaccurate.

Hanson and colleagues (2007) moderated their stance regarding weight given to the victim’s voice in risk assessment. They noted that an abused woman’s predictions of risk might be a “special case” due to the dynamics of the intimate relationship (Hanson et al., 2007). This perspective supports a growing emphasis on an abused woman’s ability to potentially provide a valid assessment of risk of re-victimization, comparable at least to conventional risk assessment tools (Harding & Helweg-Larsen, 2009; Lewis et al., 2006). Proponents of this view argue that, by the mere virtue of being victimized within an intimate relationship, a victim’s determination of risk for future violence with that same partner will be accurate (Lass, 2007). As Dienemann and colleagues (2002) indicated, “the client’s perceptions are the reality in which she lives” (p. 228). Hamberger and Potente (1994) similarly suggest that women may be able to identify certain situations, behaviours, or themes in arguments, which resulted in violence in the past and may signify potential violence. This suggests that women have, and are willing to reflect on, insight regarding risk within their intimate relationship. A victim’s fear may serve as a “barometer” of her vulnerability to potential violence (De Maris & Swinford, 1996).

Research evidence exists to support the assertion that a victim’s intrinsic knowledge of her own abusive relationship may be useful in informing risk assessment. For example, risk assessments from 177 abused women significantly added to conventional risk factors to predict violence after four months, although not all women made accurate predictions (Weisz, Tolman, & Saunders, 2000). Similarly, additional research by Bennett Cattaneo and colleagues (2003; 2007) as well as Heckert and Gondolf (2004) have demonstrated that the assessment of risk by victims
was a significant predictor of IPV. Bennett Cattaneo and colleagues (2007) demonstrated in their study that women were mostly accurate in predicting re-victimization (i.e., 66% of women in their sample). In a similar study (Bell, Bennett Cattaneo, Goodman, & Dutton, 2008), women were more likely correct in their appraisals of risk than incorrect. In Heckert and Gondolf’s (2004) study, women’s assessments of future violence improved predictions of re-assault more so than risk factors alone, and were equivalent or better predictors than risk assessment measures (i.e., the Kingston Screening Instrument for Domestic Violence, Gelles & Tolman, 1998; the DA, Campbell et al., 1999; and the SARA, Kropp, et al., 1995). Victim assessment was the best predictor of whether a perpetrator was a “repeat assaulter” or a “one-time assaulter” (Heckert & Gondolf, 2004). Significant methodological problems have been identified in these studies, including the use of simulated risk assessment measures (e.g., coding only 50% of a standardized risk assessment tool; Heckert & Gondolf, 2004), secondary analyses of data (i.e., not prospective research; Heckert & Gondolf, 2004; Weisz et al., 2000), narrowed perpetrator sample with respect to violent risk (e.g., inclusion of perpetrators with only misdemeanour charges; Weisz et al. 2000), or lacked comparison with formalized risk assessment measures (Bennett Cattaneo et al., 2003; 2007). These methodological problems limit the validity of study findings, casting doubt on the inclusion of the victim’s voice in risk assessment.

Although there has been no firm resolution of the victim’s voice debate, most parties concede that at least assisting victims to understand their fear and risk may be beneficial in assessing risk for violence and subsequent safety planning. That is, formal risk assessments should be victim-informed (Whittemore & Kropp, 2002) and, to differing degrees, most include the victim’s voice. For example, existing risk measures include instructions regarding the merit of integrating victim experiences (e.g., the SARA; Kropp et al., 1995), include an item that directly asks a victim for her perception of risk (e.g., the ODARA; Hilton et al., 2004), or are fully victim informed (e.g., the DA; Campbell et al., 2009). As stated by Campbell (2004), “we must help women understand that their own perceptions of risk are extremely important, and if they are frightened for their lives and safety for whatever reason, they should pay attention to that fear” (p. 1474; also see De Becker, 1997).

**Part IV: Exploring the Victim’s Voice - A Theoretical Framework**

It has been acknowledged that the victim’s voice may be valuable in assessments of IPV re-victimization risk. Conceptually, it is important to elucidate what comprises the victim’s voice. As defined above, the victim’s voice consists of a woman’s self-appraisal of her abusive intimate
partner. However, more specifically, the terms risk and fear are used interchangeably in the literature regarding victim perceptions of re-victimization risk. The distinction between these two terms is particularly relevant to this research as it forms the basis for the developed interventions. Although the exact association between risk and fear is unclear, it is postulated that the two dimensions are, to some extent, distinct or separable (May, Rader, & Goodrum, 2010). Risk may be defined as a victim’s cognitive appraisal of the possibility that she will experience IPV – that is, her perception of the likelihood that she will be victimized (Jackson, 2006). In contrast, fear may be defined as a victim’s affective evaluation of the possibility she will experience IPV – that is, her emotional reaction to potential re-victimization.

For this study, research from the judgment and decision-making field was drawn upon to more concretely operationalize self-appraised risk (Slovic et al., 2004). Based on a theoretical conceptualization developed by Slovic and colleagues (2004), risk can be deconstructed into two componential systems, (1) risk as analysis (i.e., judgments of likelihood) and (2) risk as feelings (i.e., experiences of fear and concern). In other words, dual-modes of processing – cognition and affect – are potentially implicated when a victim appraises her risk for victimization. The dual-mode processing of risk is inherent in the distinction between actuarial and clinical risk assessment (Blumenthal, Huckle, Czorny, Craissati, & Richardson, 2010). Thus, in this study, the dual-modes of processing conceptualization serves as an analogue of the actuarial (risk as analysis) and SPJ (risk as feelings) approaches to risk assessment.

**Risk as Analysis**

The risk as analysis, or analytical, mode of processing is devoid of affect: it is logic-laden, driven by cautious reasoning and deliberation (Finucane, Alhakami, Slovic, & Johnson, 2000). A metaphor typically used to describe this approach is one of a computer (Greifeneder, Bless, & Tuan Pham, 2011). Experienced events are appraised in an objective and deliberate manner, based on available and concrete evidence (Lieberman, 2002). According to Maner and Gerend (2006), the analytical system may examine the risk-benefit ratio based on the utility and likelihood of specific outcomes. It responds to probabilities (Slovic et al., 2004), algebraic assessments that inform decisions (Loewenstein, Weber, Hsee, & Welch, 2001) and are acquired through formal learning. A victim of IPV, for example, may deliberate about the potential for violence within her own relationship (e.g., “He has hit me before, he hit me today, and so he will

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4 Also see literature by Finucane and Loewenstein and colleagues (e.g., Finucane et al., 2000; Loewenstein et al., 2001).

5 “Clinical” was defined as being either “systematic” or “impressionistic, subjective” assessment (Blumenthal, Huckle, Czorny, Craissati, & Richardson, 2010, p. 445).
likely hit me tomorrow”). As conceptualized in the literature, the prevailing perspective is that rational processing is highly effortful, but results in accurate judgment (Epstein et al., 1996). This traditional perspective claims that deliberation, or decision-making, is solely a cognitive activity; it, therefore, is the purview of the rational system (Usher, Zohar, Weyers, Brauner, & Zakay, 2011). As a corollary, the inference is that judgments derived from emotional processing are flawed. Thus, cognition is often considered to be superior to affect (Epstein, 2010), with some asserting that people, generally, should be taught to engage more in this mode of processing (Hogarth, Portell, Cuxart, & Kolev, 2011).

**Risk as Feelings**

Risk as feelings is an experiential system that is guided primarily by affect. It is described as a “very gut-level” intuitive system, which provides a subjective appraisal of events (Epstein, 2010; Epstein, Pacini, Denes-Raj, & Heier, 1996; Lieberman, 2002, p. 2527). It is hypothesized to be the default mode in which humans primarily operate (Lieberman, 2002), based on past personal experience (Epstein, 2010). For example, when an IPV victim experiences fear as an emotional reaction to potential physical victimization and injury, the experiential system may be responsible for gauging this fear to determine her perceived risk (e.g., “I feel afraid for my safety” or “I just have this feeling he is going to hurt me today”). It is an imagistic system, with the vividness of visualized potential outcomes used as a determinant in judgments and decisions (Loewenstein et al., 2001).

Reliance on initial feelings to determine risk is often characterized as an affect heuristic because “reliance on affect and emotion is quicker, easier, and a more efficient way to navigate in a complex, uncertain, and sometimes dangerous world” (Slovic et al., 2004, p. 313). Especially when a decision is complicated or mental resources are constrained, which may occur with IPV victimization, the reliance on affect may be preferable. However, by circumventing deliberative analysis, it is proposed that the affective “short-cut” may, at times, be misguided (Slovic et al., 2004) and prone to errors in logic (Lieberman, 2002). Research findings suggest that when individuals experience negative affect, like fear, this affective response may inflate risk appraisals - which may not necessarily correspond to the actual “real-world” degree of risk (Wiener, Bornstein, & Voss, 2006). The risk as feelings system does not respond to logical probability estimates (Slovic et al., 2004), and ignores foundational statistical concepts (e.g., regression to the mean or base rates; Denes-Raj & Epstein, 1994). Somewhat facetiously, Epstein (2010) stated that affective processing, “can solve problems with a level of intelligence probably slightly more advanced than that of a chimpanzee” (p. 309). Despite this, the dominance of rationality may be
in question (e.g., Lieberman, 2002), with recent claims that the power of affect in quality decision-making has been underestimated (Usher et al., 2011).

Risk as Analysis and Risk as Feelings: Applications

Although the formulation and supportive evidence regarding the dual-modes of processing conceptualization is grounded in cognitive psychology, research exists that has applied this conceptualization to forensic psychology. The majority of research comprising the literature in this area are jury studies, based primarily on lawyers capitalizing on the rational-experiential dichotomy to best serve their clients in civil complaints. For example, studies assess the potential success of lawyers in using emotional processing to influence jurors ability to imagine pain and suffering a client has endured, thus resulting in greater compensation (Sannito & McGovern, 1993 cited from Lieberman, 2002). Using this dual-mode of processing framework, Krauss, Lieberman, and Olson (2004) examined how expert testimony may influence juror decision-making. Jurors operating within a rational mode of processing were influenced by actuarial expert testimony, whereas jurors in an experiential mode were more heavily influenced by clinical expert testimony (Krauss et al., 2004). This result was subsequently replicated in an additional study (Lieberman, Krauss, Kyger, & Lehoux, 2007). In addition, the dual-mode processing concept was examined with mental health professionals (psychologists and psychiatrists) and their assessment of violence risk in a scenario involving the release of a mental health patient from a hospital (Slovic, Monahan, & MacGregor, 2000). The results demonstrated that experts were less likely to release the patient when risk was framed in a manner that produced frightening images (i.e., an experiential mode) in contrast to relative, non-affect-laden risk probabilities (i.e., an analytical mode; Slovic et al., 2000). Thus, to a limited degree, the risk as analysis and risk as feelings framework has been applied to, and appears valid to use, within forensic psychology. To date, this conceptualization has not been applied to victims of IPV.

Bowen (2011) recently noted a need to focus on understanding how victims of IPV formulate assessments of risk. For this study, the victim’s voice is conceptualized as involving the dual-modes of processing theory identified above. That is, victims of IPV have the potential to evaluate the same event – risk of re-victimization – cognitively or emotionally. The next section describes how this framework will be used in this present study.

The Current Study

This current study examines a real-world application of the dual-mode processing of risk as analysis (i.e., referred to as cognitive or analytical) and risk as feelings (i.e., referred to as
affective or experiential) with IPV victims. This framework was used as a basis for the development of two victim-focused risk assessment and safety planning interventions. The overarching purpose of this study is to determine whether this application can be made successfully; that is, whether this model may provide a frame to understand IPV victim appraisals of risk, determine their influence on comprehensive safety planning and preventing re-victimization. More specifically, the following five research questions were under examination for this study:

**Research Question One**

*Do cognitive or affective interventions influence the association between expert and victim appraisals of risk?*

Premised in the victim’s voice debate, this question concerns whether there is correspondence between *other-rated* assessments of risk (i.e., by a trained individual, relying on formal training in risk assessment; referred herein as “expert”) and *self-rated* assessments of risk (i.e., by a victim, relying on lived experience; referred herein as “victim”). Results of previous research (Campbell, 1995; Lass, 2007) suggest that correspondence between professional and victim ratings of risk are modest, with victims conforming to professional assessments of risk. Specific to the dual-mode processing conceptualization, previous research has suggested that the experiential system would be less responsive to probabilistic outcomes than the analytical system (Epstein, 2010).

_Hypothesis:_ Similar to past research, it was hypothesized that the correspondence between expert and victim ratings of risk overall will be moderate in this study. Additionally, risk ratings for participants manipulated to operate within the risk as analysis framework may correspond more to actuarial ratings of risk than participants in the risk as feelings framework. Conversely, ratings by participants in the risk as feelings framework may correspond more to SPJ risk ratings than participants in the risk as analysis framework.

**Research Question Two**

*Do cognitive or affective interventions influence perceptions of risk or experiences of fear?*

The second question to be answered is whether one (or both) of the approaches will assist women victimized by their partners to quantify their risk and fear, thus identifying when they

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6 By convention, a trained professional is referred to as an “expert” or “professional;” the term “expert” will be used here. However, it will become evident that the focus in this study is in demonstrating the equivalence of both perspectives: both trained professionals and victims are “experts” in their respective domains (i.e., formal risk assessment versus lived experience).
may be in peril. Previous research, albeit not within an IPV population, suggests that experiential processing produces reactive and biased judgments in a variety of situations, as emotional arousal is used as information in judging risk (Peters, Västfjäll, Gärling, & Slovic, 2006; Lieberman, 2002). When feelings are experienced as unfavourable, individuals tend to judge risk as high (Slovic et al., 2004). Affect-laden imagery increases perception of risk for those induced into an experiential mode, more so than those in a rational mode of processing (Berndsen & Van der Pligt, 2005; Slovic et al., 2000). Furthermore, individuals manipulated into an experiential mode of processing do not alter their risk ratings, even when provided with information that diminishes risk (Johnson, 2005). The underlying emotion involved in a particular decision does not change and, therefore, is unaffected when confronted with probabilities; thus, this mode of processing would be insensitive to changes in risk (Lowenstein et al., 2001). Contrarily, individuals that favour rational processing are more likely to observe and integrate cues meant to reduce risk (Berger & Lee, 2011).

**Hypothesis:** Based on the research cited above, it is hypothesized that participants operating within the risk as feelings framework, in which unfavourable emotions are induced via highly-personalized affect-laden imagery, will perceive their level of risk and fear to be higher than participants in the risk as analysis framework. Due to the apparent resistance to change (Jackson, 2005), involvement in the risk as feelings framework may produce sustained risk and fear appraisals over time as influenced by emotional reactivity, whereas involvement in the risk as analysis framework may not.

**Research Question Three**

*Do cognitive or affective interventions influence the quality of the developed safety plans?*

A third objective of this study was to determine whether quality of the developed safety plans were influenced by the two different approaches, cognitive or affective. Although there is no specific empirical evidence regarding this comparison with victims of IPV, generally individuals require careful, logical analysis to understand and address a complex issue (Arvai, Gregory, & McDaniels, 2001). Therefore, the implication is that thoughtful, emotionally-neutral, analyses will result in better quality risk management decisions (Arvai et al., 2001). In contrast, it is a possibility that elevated emotions may hinder the development of a comprehensive safety plan. Generating fear, via the risk as feelings approach, may equate to being “scared out of your wits” and, thus, interfering with the development of a comprehensive safety plan.
Hypothesis: It is predicted that the risk as analysis approach, by virtue of deliberative analysis unencumbered by the influence of emotion, will generate better quality safety plans than participants in the other mode of processing.

Research Question Four

Do cognitive or affective interventions influence satisfaction with safety planning?

A fourth objective of this research is premised in “consumer satisfaction.” That is, from the perspective of the IPV victims, whether participants would be satisfied with their involvement in either safety planning intervention. It is a common result in the research literature whereby informal supports (e.g., friends or family) were utilized more for victims coping with partner violence than formal supports (Barrett & St. Pierre, 2011). Victims of IPV may therefore prefer informal assistance, more so than formalized support. However, there are noted exceptions, with recent studies showing that formal intervention were appreciated by victims (e.g., Sullivan & Bybee, 1999). Additionally, evidence exists to suggest that degree of satisfaction is inversely associated with negative affect (e.g., Brief, Bucher, & Roberson, 1995; Burns & Bowling, 2009). Even if satisfied, the experience of negative affect may temper consumer satisfaction ratings (Brief et al., 1995).

Hypothesis: In combining the findings from the above research, it is hypothesized that overall satisfaction with the administered safety planning interventions will be moderate. Regarding specific intervention comparisons, it is hypothesized that generating negative affect in participants may diminish satisfaction with the risk as feelings approach. Thus, participants in the risk as analysis approach may express greater satisfaction after involvement in their intervention than risk as feelings participants.

Research Question Five

Do cognitive or affective interventions influence re-victimization risk?

The extant literature for IPV suggests that, once an intimate partner has victimized a woman, repeated victimization is common (Langan & Innes, 1986). Similarly, it is hypothesized that participant re-victimization subsequent to participation in this research is an unfortunate possibility. Thus, a final objective was to explore the re-victimization status of participants at follow-up.

Hypothesis: The benefits of a deliberative (i.e., risk as analysis) examination of risk for future violence may increase the likelihood that IPV victims are motivated to implement and
comply with appropriate safety measures. In contrast, the higher degree of reported risk and fear by risk as feelings participants may increase their vulnerability to re-victimization. There is evidence to suggest that feelings of fear and helplessness may interfere with the use of self-protective actions (Davies, Lyon, & Monti-Catania, 1998) In addition, with a reduction in satisfaction hypothesized for the risk as feelings group, participants may be less inclined to follow their developed safety plan, resulting in increased opportunity for victimization to recur. Thus, it is hypothesized that the risk as feelings participants will report a higher rate of re-victimization than the risk as analysis participants.
METHODS

This section describes the participants, measures, and procedures used in this research. Additionally, this section reviews the statistical analyses performed for the purpose of exploring the five hypotheses under investigation.

Overview

The research described herein was designed to investigate the effects of two safety planning interventions for women who have experienced IPV. This research was conducted with a community-based sample of 60 women from the Metro Vancouver area, British Columbia, Canada. Each woman participated in an extensive interview. The interview consisted of collecting background information, completing self-report measures, developing a safety plan, and assessing satisfaction with the safety planning intervention. Participants also provided appraisals of risk and fear of violence at four key intervals: pre-intervention, post-intervention, and post-safety planning in Phase I and at follow-up in Phase II, if available. Two validated measures specific to assessing IPV risk were completed by the researcher (AG) during the pre-intervention interview. This was a single-blind study; each woman received one of the two manualized interventions based on research by Slovic and colleagues (2004) regarding the dual-mode of processing approach to risk assessment - risk as analysis, henceforth referred to as the Analytical Intervention, and risk as feelings, henceforth referred to as the Experiential Intervention. Lastly, at least one month after the initial interview, participants were contacted for a follow-up structured telephone interview to assess use of the developed safety plan and the prevalence of additional incidents of IPV. Independent raters also conducted an evaluation of the quality of the safety plans.

Participants

For this research, female victims of IPV were recruited from relevant community service agencies in the greater Vancouver area. Study advertisements were provided to these community services for recruitment of participants (see Appendix A). Upon initial contact with the
researcher, potential participants were screened for the requisite inclusion and exclusion criteria, as outlined below.

Inclusion Criteria

Women who experienced recent abuse by a male intimate partner were included in this study. The term *abuse* was consistent with the definition of spousal assault posited in the risk assessment instruments used in this study. More specifically, the ODARA (Hilton et al., 2004) defines abuse as a physical assault, or a threat to harm or kill thevictim while the perpetrator holds “a weapon in hand.” The B-SAFER (Kropp et al., 2005) defines abuse as, “the actual, attempted, or threatened physical harm of a current or former intimate partner” (p. 1). The ODARA definition has been identified as more stringent than the B-SAFER definition. Thus, to be inclusive, the B-SAFER definition of abuse was adopted for this study.

Recent violence was operationalized differently in the manuals of the two risk assessment instruments in use. For the ODARA (Hilton et al., 2004), recent was identified as the most recent assault. For the B-SAFER (Kropp et al., 2005), recent was defined as an incident occurring between one and two months prior to completion of the risk assessment instrument. For consistency, the most recent assault must have occurred within one month, but no longer than 12 months prior to participation in the study.

An intimate partner was operationalized by the ODARA as a current or former married or common-law male spouse (Hilton et al., 2004). It has been identified that a high proportion of IPV also occurs in casual relationships (e.g., dating relationships; Leaman & Gee, 2006; Wathen et al., 2007). The B-SAFER has a broader definition, also identifying dating as an intimate relationship (Kropp et al., 2005). For the purpose of inclusivity, this study adhered to the B-SAFER definition of an intimate partner. The intimate partner will be referred herein as the *index partner*. Women reporting more than one abusive intimate relationship across the course of their lives were cautioned to reflect on the index partner and incident only. In summary, each participant identified one intimate partner who had perpetrated an act of violence, or a serious threat of violence, against her within the designated timeframe.

Exclusion Criteria

Victims of violence perpetuated by an intimate female partner or a non-intimate male or female perpetrator (e.g., stranger assault or familial violence) were excluded from this study. An additional criterion excluded women who reported an incident of partner violence less than one month prior to contacting the researcher. This criterion was mandatory, to ensure the participant
may access appropriate services, as per ethical considerations. Additional exclusion criteria included: women who experienced a violent incident that exceeded a year since its occurrence, were non-English speaking or evidenced a limited ability to communicate in English, or were less than 19 years of age. Due to difficulty in obtaining informed consent, women who were unable to participate in a coherent interview were also excluded from participation (e.g., due to intoxication).

Between February and August 2009, 151 women contacted the primary researcher for potential inclusion in this study. Of those 151 women, 21 were immediately disqualified, as they did not meet the pre-determined inclusion criteria. These women were excluded for the following reasons: (a) the most recent incident of partner violence exceeded a year ($n = 19$), (b) the most recent incident did not meet the operational definition of IPV (i.e., no physical violence or threat of violence; $n = 1$), or (c) failed to meet both inclusion criteria ($n = 1$). Another 57 potential participants were inaccessible due to: (a) repeated failed contact with the provided contact information ($n = 36$), (b) no longer being available at the contact information provided (e.g., the woman had moved out of a shelter and forwarding contact information could not be provided; $n = 12$), or (c) the provision of incorrect, vague, or inaudible contact information ($n = 9$). In addition, upon contact, one potential participant indicated that she could not complete the study due to an illness. Eight potential participants did not attend the initial interview and, despite repeated attempts to engage, were unavailable to participate in the study. Four participants began the initial interview but did not complete it, due to scheduling constraints or illness.

Sample Description

The final sample of 60 participants was obtained from IPV specific resources (e.g., transition shelters; 55%), general community-based resources (e.g., addictions programs or community justice resources; 27%) or peer referral (e.g., either from a participant or another individual who observed the study advertisement in the community; 18%). The 60 participants were mostly concentrated in Vancouver (67%), followed by Surrey (28%) and Burnaby (5%). Relevant demographic, relationship, and victimization characteristics are described below.

Demographic Characteristics

Table 1 highlights the general sample characteristics of the 60 participants. Participants ranged in age from 20 to 62 years with a mean age of 43.48 years ($SD = 10.26$). The majority of participants self-identified as Caucasian (47%), with the remaining sample endorsing First Nations/Aboriginal or other ethnic origins (e.g., Latin/ Spanish). A majority of the sample (67%)
had at least obtained a high school education, although only a small proportion (17%) was employed at the time of the interview. Over 50% of the sample indicated that their partners interfered with their ability to gain or maintain employment. Self-reported difficulties with mental health problems (e.g., depression or anxiety; 81%) and addictions problems (73%) were highly prevalent in this sample. The majority of participants had children, who ranged in age from 5 months to 45 years; two participants were pregnant with an index partner’s child. For one-third of the sample, the abusive intimate partners were biologically related to at least one of the participants’ children. For approximately 68% of the women, children were not present in the home for the duration of the abusive relationship.

Participants also reported on the demographic characteristics of their index partner. Refer to Table 1 to compare demographic characteristics for the participants and their index partners. From the participants’ report, partners ranged in age between 23 and 71 years, with a mean age of 43.74 years ($SD = 10.41$). Ethnicity of the partners was primarily reported as Caucasian. In contrast to the female participants, fewer of the male partners had obtained a high school education although a higher proportion was employed at the time of the relationship. From the perspective of the participants, substance abuse issues (95%) and mental health issues (80%) appeared to be highly prevalent for the index partners.

**Index Abusive Relationship Characteristics**

Female participants were typically in common-law relationships with their partners (58%), rather than dating/casual (32%) or marital relationships (10%). The average duration of the intimate relationship was almost six years ($SD = 6.94$ years; Range = 1 month – 27 years). Separations were prevalent in these relationships, with approximately 70% reporting at least one prior abuse-related separation (Range = 1 – 5 separations). Seventy-eight percent of women had separated from their partners since the identified recent abusive incident. The length of time that had elapsed between the index incident of physical violence and participation in this current study was approximately 4.50 months ($SD = 3.22$; Range = 1 – 12 months). A similar time elapsed for participants in both interventions: Analytical Intervention ($M = 4.61$ months, $SD = 3.56$) and Experiential Intervention ($M = 4.32$, $SD = 3.12$), $t(58) = .35$, $p = .729$, $d = .08$.

**Index Victimization Characteristics**

In order of prevalence, the most recent incident of violence experienced by the participants consisted of being: pushed or shoved (16%), seriously threatened (11%), grabbed or restrained, punched, beaten up (i.e., significantly assaulted), hit with an object (8% each), slapped
Table 1. *General Descriptive Statistics of the Victims and their Index Partners*

<table>
<thead>
<tr>
<th></th>
<th>Victims</th>
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<th>Partners&lt;sup&gt;a&lt;/sup&gt;</th>
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<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
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<tr>
<td><strong>Age</strong></td>
<td></td>
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<tr>
<td>18 – 24 years</td>
<td>4</td>
<td>7%</td>
<td>1</td>
<td>2%</td>
<td></td>
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<tr>
<td>25 – 34 years</td>
<td>10</td>
<td>17%</td>
<td>10</td>
<td>17%</td>
<td></td>
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<tr>
<td>35 – 44 years</td>
<td>17</td>
<td>28%</td>
<td>24</td>
<td>41%</td>
<td></td>
</tr>
<tr>
<td>45 – 54 years</td>
<td>19</td>
<td>31%</td>
<td>15</td>
<td>25%</td>
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</tr>
<tr>
<td>55 – 64 years</td>
<td>10</td>
<td>17%</td>
<td>9</td>
<td>15%</td>
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<td><strong>Race and/or Ethnicity</strong></td>
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<tr>
<td>Caucasian</td>
<td>28</td>
<td>47%</td>
<td>33</td>
<td>55%</td>
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<tr>
<td>First Nations/Aboriginal</td>
<td>21</td>
<td>35%</td>
<td>10</td>
<td>17%</td>
<td></td>
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<tr>
<td>Other</td>
<td>11</td>
<td>18%</td>
<td>17</td>
<td>28%</td>
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<td><strong>Education</strong></td>
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<tr>
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<td>20</td>
<td>33%</td>
<td>20</td>
<td>44%</td>
<td></td>
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<tr>
<td>High school diploma</td>
<td>13</td>
<td>22%</td>
<td>15</td>
<td>33%</td>
<td></td>
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<tr>
<td>Post-high school education</td>
<td>27</td>
<td>45%</td>
<td>10</td>
<td>22%</td>
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<tr>
<td>Full-time, part-time, or student</td>
<td>10</td>
<td>17%</td>
<td>43</td>
<td>72%</td>
<td></td>
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<tr>
<td>Disability</td>
<td>18</td>
<td>31%</td>
<td>13</td>
<td>22%</td>
<td></td>
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<tr>
<td>Unemployed</td>
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<td>6%</td>
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<td></td>
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<td>Yes</td>
<td>48</td>
<td>80%</td>
<td>-</td>
<td>-</td>
<td></td>
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<tr>
<td>No</td>
<td>12</td>
<td>20%</td>
<td>-</td>
<td>-</td>
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<tr>
<td><strong>Index Partner – Biological Father</strong></td>
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<td></td>
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<tr>
<td>Yes</td>
<td>16</td>
<td>33%</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>32</td>
<td>67%</td>
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<td></td>
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<td></td>
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<tr>
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<td>44</td>
<td>73%</td>
<td>57</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td>27%</td>
<td>3</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health Issues</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>48</td>
<td>81%</td>
<td>43</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>11</td>
<td>19%</td>
<td>11</td>
<td>20%</td>
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</tbody>
</table>

<sup>a</sup>As reported by the victim.
or choked (5% each), or thrown (e.g., against a wall; 3%). One-third of the sample experienced more than one of the identified types of physical abuse. The prevalence of other forms of abuse committed by the index partner during the course of the intimate relationship included: psychological abuse (97%), stalking/harassment (72%), and/or sexual abuse (28%). For the index incident, women relied on multiple resources, including domestic violence resources (e.g., shelter; 60%), mental health resources (e.g., counselling, addictions treatment; 41%), police (39%), medical (28%) and/or legal (17%) services.

Statistical analyses were conducted to determine whether between-group intervention differences existed in demographic, index relationship, or index victimization characteristics. Between-group differences for the Analytical Intervention and Experiential Intervention were not significant on any reported variables, with the exception of (a) marital status at the time of the index incident, \( \chi^2(1, N = 60) = 6.24, p = 0.012, \) Cramer’s \( V = .32, \) and (b) prevalence of stalking in the intimate relationships, \( \chi^2(1, N = 60) = 4.02, p = 0.045, \) Cramer’s \( V = .26. \) The proportion of participants in a marriage or common-law relationship (rather than casual or dating relationship) with their abusive intimate partners was 53% and 83% for the Analytical and Experiential Interventions, respectively. Additionally, Experiential Intervention participants were more likely to report being stalked/harassed (83%) than Analytical Intervention participants (60%).

Overall, the demographic characteristics of this sample were generally similar to those identified in the research literature (e.g., Allen et al., 2004; Constantino, Yookyung, & Crane, 2005; Humphreys et al., 2001).

**Attrition and Follow-up Sample**

Of the original 60 participants, 60% \( (n = 36) \) participated in the follow-up survey; this equates to a 40% attrition rate. Reasons for attrition included: (a) participants were no longer accessible despite multiple attempts at contact (e.g., phone out of service, non-accessible via other contacts provided, and/or non-responsive to e-mail contact; \( n = 17 \)), (b) contact was made with participants, but could not be completed within the predetermined follow-up time frame \( (n = 7) \), and (c) one participant declined to complete the follow-up due to a scheduling problem. The level of attrition in this study was comparable to several studies (e.g., 45% attrition rate; Bennett, Goodman, & Dutton, 2000), although it was higher than others in the published research literature (e.g., 5% attrition rate; Sullivan & Bybee, 1999).

For participants who completed the study, the length of time since initial participation in the first phase of the study ranged between 1.00 and 5.70 months \( (M = 2.70, SD = .23) \). The
participants were originally recruited from intimate partner violence or women specific resources (58%), general community-based resources (25%) or through peer referral (17%). These participants were distributed across Vancouver (69%), Surrey (25%) and Burnaby (6%). Participants ranged in age from 22 to 62 years, with a mean age of 44.92 years ($SD = 10.28$). The majority of participants self-identified as Caucasian (47%), First Nations/Aboriginal (39%) or of another ethnic origin (14%). Approximately 60% of the participants had attained at least a high school education; only 17% of the participants were employed at the time of the relationship with the index partner. Self-reported difficulties with mental health and addictions problems were 81% and 69%, respectively. Approximately 86% had children, with 71% reporting that no offspring were living in the home at the time of the abusive intimate relationship. Between-group comparisons were conducted to determine if those participants who successfully completed both components of this study (i.e., Phase I and Phase II) varied from those who completed only the first phase. There were no statistically significant differences between the two groups with respect to the demographic variables of referral source, age, ethnicity, level of education, work status, or mental health or addictions issues, $p > .191$.

Comparisons were also conducted using the results of the two risk assessment measures. The purpose of this analysis was to ensure that risk level, as identified in the first phase of this study, did not influence availability for the follow-up interview. It is common for attrition to be higher for Moderate and High risk participants, due to the nature of recurring victimization. The inclusion of Low risk participants is therefore more likely, as these participants are theoretically more accessible and amenable to follow-up due to limited exposure to continued violence or to the ensuing consequences of violence (e.g., moving around to access services or changing phone numbers). Analyses indicated that there were no statistically significant group differences in ODARA total score, the actuarial equivalent of the B-SAFER (total score), $t(58) < 1.69, p < .096$, $d < .16$, and the summary risk judgments of Imminent Risk or Long-Term Risk, $\chi^2(2, N = 60) < .88, p > .642$, Cramer’s $V < .12$. With these measures, attrition rates did not differ systematically by risk. However, there was one exception: a statistically significant difference was identified on the final summary risk judgment rating of Serious Risk, $\chi^2(2, N = 60) = 7.73, p = 0.021$, Cramer’s $V = .34$. A greater proportion of follow-ups were completed with participants who were designated in Phase I of this research as Low risk (87%) with respect to the degree of severity of potential violence than non-completers (13%). This relationship did not hold with Moderate and High risk participants, where attrition and participation in the follow-up sample sizes were close to equivalent. This suggests that the follow-up sample was biased towards Low risk participants.
on a rating of Serious Risk; although, equivalent sample sizes were attained for Moderate and High risk completers and non-completers.

**Protection of Human Participants**

Ethical approval for this study was obtained from the Simon Fraser University Research Ethics Board. It is recognized that it is critically important to take precautions to minimize risk for violence as a result of participation in research (Sullivan & Cain, 2004). Thus, when seeking assent to participate in this study, potential participants were asked to consider carefully whether their participation would create difficulties within their relationship to the abuser (e.g., cause disagreements that may lead to violence). During the initial telephone screening process, participants provided their assent to attend the structured in-person interview. At the interview, informed consent was obtained from each participant (see Appendix B). The informed consent form outlined the procedure of the study, any potential risks or benefits, and mandatory reporting provisions. The informed consent form also explicitly stated that participation in the research was voluntary and withdrawal from the research would not affect the receipt of any community services. The participants were reassured that they may decline to answer any question if they felt uncomfortable. The informed consent form provided an assurance of confidentiality and anonymity. The resultant interview materials were anonymized, whereby each participant was assigned a study number. Participants were asked permission to audiotape \( n = 59 \) or videotape \( n = 1 \) the initial interview; informed consent for recording was obtained (see Appendix C). Consent to contact participants for the follow-up was also secured at this time. Participants received monetary compensation ($40) for their participation in the first interview component of the study; this was not contingent on the full completion of the interview. Participants were also provided with snacks and beverages. For the follow-up interview, participants were mailed a $10 gift certificate compensation for a retail store of their choice.

**Procedure**

This study employed a between-groups design, comparing participants receiving the Analytical Intervention or Experiential Intervention. Across the participating research sites, the IPV victims were randomly assigned to one of the two groups. To ensure that both groups had a final equitable sample size, blocking was employed. This reduced threats to internal validity (Kazdin, 2002), although this procedure does not guarantee group equivalence. The research was conducted with the recruited female victims in two phases, (a) Initial Intervention and (b) Follow-
up. A final phase, (c) Evaluation, was completed separately (i.e., without participants) once data collection was completed.

**Phase One: Initial Intervention**

The initial intervention phase included three steps: (a) Pre-intervention, (b) Intervention, and (c) Post-Intervention. Steps one and three were identical for both the Analytical and Experiential Interventions. The three steps occurred in one session with each participant. The average duration of administration was almost three hours \(M = 2.86, SD = 1.03\).

**Pre-intervention**

Upon contact with this researcher (AG), female victims of IPV were screened for inclusion in the study. Once deemed appropriate and assenting to participate, an interview time was determined. On initially meeting the participant, a consent form was provided and reviewed. The participant was then randomly assigned to either the Analytical Intervention or Experiential Intervention. The participant completed the structured interview to obtain general demographic and relationship information, in addition to self-assessments of risk and fear. The Index of Spouse Abuse (ISA; Hudson & McIntosh, 1981) was also self-administered. The researcher, independent of the participant, completed both risk assessment measures, the ODARA (Hilton et al., 2004) and the B-SAFER (Kropp et al., 2005).

**Intervention**

Based on random assignment, each participant was guided by the researcher through the appropriate intervention. At the conclusion of the intervention, each participant received a brief manipulation check to ensure that the interventions were distinct. This manipulation check involved completing a standardized measure of affect, the Russell Affect Grid (Russell, Weiss, & Mendelsohn, 1989). The Russell Affect Grid has been used as a manipulation check in prior mood induction research (Eich & Metcalfe, 1989).

Guided by the researcher, participants in both interventions developed their own safety plan. Participants received one generic prompt at the end of each section (e.g., “Any more safety strategies for this section?”). To refrain from influencing the quality of the safety plans, strategies were not provided to participants. Interference was deemed necessary only if a developed safety strategy had a reasonable probability of causing undue harm to the participant (e.g., a participant stated that, if she sees her former partner on the street, she would approach and hit him). In addition, the participants completed a card-sort based on the safety strategies from the IPVSI
(Goodman et al., 2003). Subsequently, participants were asked to reiterate their level of risk and fear of IPV re-victimization.

**Post-intervention**

For this final step, participants were asked questions to assess their level of satisfaction with the intervention. A written survey was also provided. Participants were allowed privacy, encouraged not to provide identifying personal information, and asked to place the completed written survey in a sealed envelope. Lastly, participants were debriefed regarding the purpose of the study and provided an opportunity to ask questions. This debriefing also included information regarding resources within the local community for IPV-related services (e.g., violence against women counselling or shelters), general counselling or mental health services (e.g., substance abuse treatment), and emergency distress lines. For completing this phase, each participant received a token monetary ($40) compensation.

**Phase Two: Follow-up**

Participants were asked for permission in Phase I to follow-up with a telephone survey on one occasion. The follow-up took place at least one month after the initial session, but no longer than six months. The follow-up typically occurred within three months ($M = 2.69, SD = 1.34$), which did not vary by intervention, $t(31) = .076$, $p = .940$, $d = .07$. The average duration of the phone interview was approximately half hour ($M = 33.94, SD = 28.49$).

**Phase Three: Evaluation**

This final phase was conducted independent of participant involvement. At the conclusion of the study, two evaluators (AG and JS) reviewed and evaluated the safety plans for the purpose of interrater reliability. Safety planning strategies were also coded, qualitatively, by one evaluator (AG) and interrater reliability was assessed with an independent evaluator (KR). The evaluators, AG, JS, and KR, are doctoral-level students in forensic psychology and have training and practical experience in IPV risk assessment and management.

**Materials and Measures**

**Initial Screen and Interview**

Each participant met individually with the researcher to complete an in-depth structured interview (for the full interview schedule, see Appendix D). The interview developed by the researcher encompassed general demographic information and relationship history of the
participant with the index partner. Questions involved, for example, queries regarding the status of the relationship with the index intimate partner, the duration of the relationship, the number of previous separations, and the number of previous encounters with community services for partner violence. Abuse history and information pertaining to IPV risk factors, required to complete both the risk assessment instruments, was also collected in the interview.

Self-reported Risk and Fear

Each participant identified her perceived level of risk and fear of IPV re-victimization with the index partner. These assessments were collected at three key points through the initial interview process—pre-intervention, post-intervention, and post-safety-planning. The follow-up also involved reiterating these risk and fear re-victimization questions.

As risk is a complex construct, participants were asked to assess risk for IPV re-victimization based on the following facets: severity, frequency, imminence and likelihood. These facets were derived from the literature specific to IPV risk assessment (Kropp et al., 2005). The participants provided their assessment of risk using a 10-point Likert scale, from 0 (Low) to 10 (High). Participants were asked to provide summary risk ratings that corresponded to the risk assessment instruments in use: a scaled estimate (i.e., from 0 – 10; analytical) and a summary judgment (i.e., Low, Moderate, or High; experiential). Risk ratings were solicited in a counterbalanced manner with each administration. Additionally, all participants provided a multi-componential assessment of their fear of their index partner. Participants assessed the following: overall fear, fear that the partner will generally become violent, fear of life-threatening violence, and fear of harassment (of her and of others). The participants provided their assessment of fear using a 10-point Likert scale, from 0 (Low) to 10 (High).

Index of Spouse Abuse (ISA)

In addition to the background interview, the Index of Spouse Abuse (ISA; Hudson & McIntosh, 1981) was provided to each participant. The ISA is a self-report instrument developed to measure the severity of abuse perpetrated by a male against a female intimate partner (Hudson & McIntosh, 1981). This measure is documented as “most user-friendly” due its ease of use, concrete content, and accessibility to low literacy populations (Cook, Conrad, Bender, & Kaslow, 2003, p. 655). It is a short-form measure, completed in a maximum of five minutes (Hudson & McIntosh, 1981). The ISA consists of 30 items divided into 11 types of physical and 19 types of non-physical abuse, including an assessment of psychological, emotional, sexual, and physical aggression. Regarding scoring, items are weighted differentially dependent on the severity of the
abuse as rated on a five-point Likert scale; the scale ranges from *Never* (0) to *Very Frequently* (5). Overall scores, ranging from 0 – 100, are calculated individually for physical and non-physical abuse, with a higher score indicative of the increasing magnitude of abuse in a relationship.

The ISA (Hudson & McIntosh, 1981) was validated through detailed independent evaluations by experienced therapists, to determine whether a woman was victimized (Punukollu, 2003). The instrument has documented adequate reliability and validity, used with a diversity of women (Riddell, Ford-Gilboe, & Leipert, 2009). Reliability coefficients were reported to be above .90 for the two subscales, physical and non-physical abuse, in both student and clinical population samples (Hudson & McIntosh, 1981). Other studies have reported internal consistency values of .83 and .89 for physical and non-physical abuse, respectively (Ridell et al., 2009). Exploratory factor analysis determined that the two subscales were measuring distinct components (Hudson & McIntosh, 1981). The ISA discriminates between abused and non-abused samples and exhibits convergent validity with an IPV lethality measure (Hudson & McIntosh, 1981). For this study, the ISA results exhibited internal consistency: Cronbach’s alpha was .87 for the physical abuse scale and .90 for the non-physical abuse scale. Coefficients greater than .70 are considered indicative of internal consistency (reliability; Nunnally, 1978). The magnitude of physical and non-physical violence in the index intimate relationship was similar for the Analytical Intervention participants (physical: \( M = 43.09, SD = 4.73 \); non-physical: \( M = 51.25, SD = 3.84 \)) and Experiential Intervention participants (physical: \( M = 44.87, SD = 4.66 \); non-physical: \( M = 53.47, SD = 4.25 \)), \( t(58) > .26, p > .701, d < .10 \).

**Risk Assessment Instruments**

The purpose of the in-depth structured interview was to extract background information from the participants in order to complete two validated risk assessment instruments, the ODARA (Hilton et al., 2004) and the B-SAFER with added victim vulnerability factors (Kropp et al., 2005). Both measures were completed independently by the researcher during the course of the interview and while participants were completing self-report measures. However, the participant — dependent on the intervention condition — was exposed to only one of the two risk assessment instruments. The risk assessment instruments were the foundation for the two interventions. In using the dual-mode processing conceptualization of risk, the ODARA is the analogue of the analytical mode of processing and the B-SAFER is the analogue of the experiential mode of processing.

Two distinctive risk assessment tools were used with participants. This was intentional, because this research utilizes a comparative treatment design (Kazdin, 2002); that is, two different
forms of treatments – analytical and experiential – are being compared to determine their respective impact on risk assessment and safety planning for victims of IPV. A comparative treatment design determines whether the interventions facilitate change and whether one is more effective than the other in creating change (Kazdin, 2002). The examination of the theoretical underpinning of risk, via the aforementioned Slovic dual-mode of processing approach (2004), requires two distinct interventions.

**Ontario Domestic Assault Risk Assessment (ODARA)**

The ODARA (Hilton et al., 2004) is an actuarial instrument, developed using historical information collected from approximately 600 males accused of assaulting a female partner or ex-partner and investigated by the Ontario Peel Police. The ODARA consists of 13 items scored 0 or 1, indicating the absence or presence of a risk factor, which are summed to obtain a total score. The total score places a male perpetrator into one of seven risk categories. Each category specifies the likelihood that a male will re-victimize his female partner within five years (Hilton et al., 2004). The ODARA has demonstrated concurrent validity with several IPV risk assessments, has been successfully cross-validated, and has discriminated between recidivists and non-recidivists for partner violence (Hilton, Harris, & Rice, 2010). It has evidenced sufficient interrater reliability in coding (Hilton et al., 2010).

For the purpose of determining interrater reliability for this study, a sub-sample \((n = 20)\) divided equally between the two interventions, of the completed ODARA risk assessment (Hilton et al., 2004) were evaluated by an independent rater (JS). This rater has extensive expertise with IPV risk assessment instruments, in general, and received specific training with the ODARA. Interrater reliability for independent ratings of the ODARA was assessed using intra-class correlation coefficients (ICC) for single raters, calculated using a mixed effects (absolute agreement) model. The intraclass correlation for the ODARA overall total score was .93, considered *excellent* reliability (Cicchetti & Sparrow, 1981).\(^7\) The average total score on the ODARA was 7.37 \((SD = 2.70)\) for the Analytical Intervention and 6.93 \((SD = 2.16)\) for the Experiential Intervention, \(t(58) = .69, p = .495, d = .17\). For both interventions, the average scores correspond to a risk category in the top one or two potential risk categories (Hilton et al., 2004).

**Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER)**

The B-SAFER (Kropp et al., 2005) is a SPJ measure designed specifically for police officers or other criminal justice professionals to assess and manage IPV risk. The B-SAFER is

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\(^7\) Following Cicchetti and Sparrow (1981), ICC values were interpreted as follows: <.40 is *poor* reliability; .41-.49 is *fair* reliability; .50-.74 is *good* reliability; and >.74 is *excellent* reliability.
an abbreviated version of the SARA (Kropp et al., 1995). The B-SAFER was developed through a systematic review of research regarding IPV, existing practice standards, ethical codes, and law (Kropp et al., 2005). The guide is comprised of a checklist of 10 risk factors divided into two sections: Section I, Intimate Partner Violence, and Section II, Psychosocial Adjustment. Section I assesses factors related to the IPV history of the perpetrator (e.g., previous spousal assault history). Section II assesses the psychological and social functioning of the perpetrator (e.g., substance abuse problems). Each item is scored as one of the following: No (i.e., the risk factor is definitely absent), Maybe (i.e., the risk factor may be partially or possibly present) or Yes (i.e., the risk factor is definitely present). Subsequently, final risk judgments are identified regarding case prioritization, risk for life-threatening or imminent violence, and likely future IPV victimization (rated as High/Urgent, Moderate/Elevated and Low/Routine) based on developed hypothetical scenarios (e.g., a worst-case scenario). Unlike the ODARA (Hilton et al., 2004), the B-SAFER items are not summed and a total “risk score” is intentionally not provided. The intent of the B-SAFER is to guide judgments of risk and subsequent management decisions, rather than designate a specific probabilistic prediction of risk.

For the purpose of this study, a third section was added to the B-SAFER (Section III; Kropp et al., 2005). Five additional risk factors were included pertaining to victim vulnerability factors (e.g., extreme fear of the perpetrator). The addition of Section III is a proposed addendum to the B-SAFER and is presently included in the Swedish version of the risk assessment instrument (referred to as the Spousal Assault Risk Assessment: Screening Version; Belfrage & Strand, 2008). The B-SAFER victim vulnerability factors have been identified as useful in providing a more fully comprehensive assessment of risk and, importantly, in contributing significantly to final risk ratings (Belfrage & Strand, 2008).8

Despite the recent development of the B-SAFER (Kropp et al., 2005), preliminary research is indicative of the validity of the tool. The B-SAFER has evidenced “very good” validity, particularly in highlighting a significant correlation between risk factors and final assessed risk (Belfrage & Strand, 2008). The B-SAFER also has documented predictive validity, cross-population validity (Au et al., 2008; Thijssen & de Ruiter, 2010), and its use contributed to a reduction in partner violence recidivism in a sample of offenders from Sweden (Kropp, 2004).

In addition, as previously noted, the B-SAFER is a summary version of the SARA (Kropp et al., 1995).

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8 The identification of victim vulnerability factors is not victim-blaming, but rather a means to appreciate the victim’s circumstance and identify management strategies to further enhance her safety (Belfrage & Strand, 2008; Kropp et al., 2005).
1995) that has been empirically validated in multiple studies (for a comprehensive review see Kropp & Gibas, 2010).

To assess interrater reliability, 33% of the completed B-SAFER risk assessments (Kropp et al., 2005) were evaluated by an independent rater (JS). The independent rater, JS, has extensive training and experience with the B-SAFER. Reliability was assessed using intra-class correlation coefficients for single raters using a two-way mixed effects model with absolute agreement (Shrout & Fleiss, 1979). For the B-SAFER, the result for the actuarial equivalent of a total score was ICC = .89; this is considered by convention to be excellent reliability (Cicchetti & Sparrow, 1981). The three subscale ICC values were .83 (Psychosocial Adjustment) and .87 (for both Intimate Partner Violence and Victim Vulnerability). Similarly, these ICC values are considered excellent (Cicchetti & Sparrow, 1981). Lastly, summary risk ratings, were also examined using a two-way random effects model, which is mathematically equivalent to a weighted kappa (i.e., a similar statistic used with ordinal data; Kropp & Hart, 2000). Results of the ICC analysis indicate that the reliability of the summary risk judgments were fair (.49 for Serious Risk), moderate (.56 for Imminent Risk) and good (.73 for Long-Term Risk; Cicchetti & Sparrow, 1981). Notably, of the 60 clinical judgments made (three risk summaries by 20 cases), only two individual ratings exhibited extreme disagreement (i.e., a rating difference of Low and High; Kropp & Hart, 2000). The mean total score on the B-SAFER was 14.93 (SD = 4.09) and 14.87 (SD = 4.25) for the Analytical Intervention and Experiential Intervention participants, respectively, \( t(58) = .06, p = .951, d = .01 \) (for B-SAFER subscale totals see Appendix, Table A1).

### Rational-Experiential Inventory (REI)

To assess for individual style of processing, each participant was administered the revised Rational-Experiential Inventory (REI; Epstein, Pacini, & Norris, 1998). The original REI was developed through amalgamating two existing scales, the Need for Cognition and Faith in Intuition scales (Epstein et al., 1998). The revised self-report consists of 40 items, divided equitably into two general categories of styles of processing, rational and experiential. Per Epstein and colleagues (1998), individuals may also be assigned to one of four quadrants, based on individual scores on the two major subscales: Rational and Experiential. The four quadrants are designated as low rationality/low experientiality (Poor), high rationality/high experientiality (Complementary), high rationality/low experientiality (Rational) and low rationality/high experientiality (Intuitive; Emond & Marmurek, 2010). For Analytical Intervention participants, the distribution was: Poor, 27% (n = 8), Complementary, 36% (n = 11), Rational, 27% (n = 8), and Intuitive, 10% (n = 3). For the Experiential Intervention, the distribution was as follows:
Poor, 40\% (n = 12), Complementary, 33\% (n = 10), Rational, 6\% (n = 2), and Intuitive, 20\% (n = 6). Differences between the two groups was not statistically significant, $\chi^2(3, N = 60) = 5.45, p = .142$, although a measure of association would suggest otherwise, Cramer’s $V = .30$. However, the difference is in the direction of the intended intervention (e.g., 6\% classified as Rational for the Experiential Intervention versus 27\% Rational for the Analytical Intervention).

The reliability and validity of the REI has been empirically supported (Epstein et al., 1998). Regarding internal reliability, Cronbach’s alpha coefficients of .90 and .87 were reported for the Rational and Experiential scales, respectively (Epstein et al., 1998). Notably, there were no identified significant correlations between the two main scales, thus suggestive of independent modes of information processing. Construct validity of the revised REI has been verified with established measures (e.g., the NEO-PI-R; Epstein et al., 1998). Discriminant validity was also established for the REI (Epstein et al., 1998). Using the study sample, the Cronbach’s alpha coefficient was calculated as .73 for the Rational scale and .84 for the Experiential scale.

**Intervention Manuals**

Dependent on random assignment, participants were guided through one of the two intervention manuals developed by the researcher. The two intervention manuals were similarly structured to include an introductory component to orient a participant to the respective intervention (see Appendix E). The main body of the manuals helped the researcher guide the participants in identifying the applicable risk factors for intimate partner re-victimization, while maintaining the fidelity of each risk assessment measure. Each intervention guided the victims to ascertain their own level of risk of re-victimization either via analytical or experiential means (see Appendix F).

The Analytical Intervention was based on the concept of risk as analysis. To help facilitate the adoption of an analytical approach, previous research provided guidance. Included techniques were: direct instruction (e.g., directed to think analytically; Krauss et al., 2004), mathematical calculation or manipulation (e.g., counting items; Epstein, 1994; Krauss et al., 2004), use of specific language (e.g., “calculate,” “thinking;” Berndsen and Van der Pligt, 2004; van Gelder, de Vries, & van der Pligt, 2009), emphasizing statistical information (Lieberman, 2002), and the adoption of a third person perspective (in this study, a lawyer). In addition, participants assigned to this condition were guided through the completion of the ODARA (Hilton et al., 2004). This included the participant reviewing the risk factors and identifying their level of risk based on the ODARA (Hilton et al., 2010).
In contrast to the Analytical Intervention, participants in the Experiential Intervention were guided through an experiential approach (i.e., risk as feelings), based on the SPJ tool. To adopt an experiential perspective, participants were guided through relevant B-SAFER risk factors and then asked to generate a worst-case scenario (Kropp et al., 2005). Previous research has indicated that narrative formats, including vivid scenarios, are successful in producing affect-laden imagery (Slovic et al., 2000). To help facilitate the adoption of the experiential approach, additional techniques involved the use of direct instruction (e.g., “go with gut-level feelings”; Krauss et al., 2004), specific language or cues (e.g., “emotions,” “intuition,” or “feelings;” Berndsen and Van der Pligt, 2004; Lieberman, 2002; van Gelder et al., 2009) and self-reflection. Previous studies have documented success in independently manipulating both cognition and affective processing modes in research participants (e.g., van Gelder et al., 2009).

**Safety Plans**

After the designated intervention, each participant was guided through developing a safety plan (see Appendix G). The structure of the safety plans was adopted from relevant research literature, which highlighted critical components of a safety plan (BC Institute Against Family Violence, 2006; Lindhorst et al., 2005). The safety plan was comprised of multiple components. First, participants were broadly asked to generate safety strategies. Subsequently, participants were directed to develop strategies that encompassed three major areas related to: (a) potential re-victimization (i.e., strategies for before, during, and after a violent incident), (b) specific strategies (i.e., strategies for the participants’ environment, support network, and personal well-being), and (c) risk factors identified in the completed risk assessment. Participants were also asked to identify barriers in using their safety plan and were encouraged to change their safety plan, if required.

All of the strategies ($N = 1826$) originating from the 60 developed safety plans were compiled and a coding scheme was developed. The protocol used to develop the coding scheme was based on literature outlining descriptive qualitative analysis (Miles & Huberman, 1994) and, in part, Ridell and colleagues (2009) who used the IPVSI (Goodman et al., 2003) as a basis for coding. The final coding scheme was comprised of 176 safety strategies organized into 34 subcategories and 11 overarching themes (see Appendix, Table A2 for the finalized coding). Every strategy was coded both individually (i.e., to determine overall total number of strategies) and categorically (i.e., to determine total number of categories endorsed). A form of reliability in qualitative analysis is stability or the extent to which the results of categorizing are invariant.
(Krippendorf, 1980). The data was coded on three separate occasions to ensure a finalized coding scheme that was representative of the safety strategies provided by participants.

Interrater reliability was also examined by having a second rater (KR) code a subset of the data (25%, $n = 16$). The second rater (KR) is a doctoral student, with practical experience in IPV risk assessment and management, as well as qualitative coding. Cohen’s kappa coefficient was calculated on the eleven categories. For six of the themes, kappa coefficients ranged from .63 to 1.00, with a mean kappa of .80. Due to a lack of variability (i.e., perfect agreement), kappa coefficients could not be calculated for three themes (see Table 2). These results indicate that interrater reliability in coding of the safety plans was adequate, evidencing at least substantial agreement (Viera & Garrett, 2005).

**Intimate Partner Violence Strategies Index (IPVSI)**

The IPVSI (Goodman et al., 2003) is a 39-item measure developed to determine a woman’s use of strategies to stop or evade partner violence. The items were generated from multiple resources, including a literature review, expert clinical and forensic experience, and focus groups involving abused women and advocates; this ensures the instrument has sufficient ecological validity (Goodman et al., 2003). The strategies are divided into six categories: Placating (five items), Resistance (seven items), Safety Planning (ten items), Legal (four items), Formal Network (nine items), and Informal Network (four items). Coding is binary, whereby women rate *Yes* or *No* for each item to stipulate whether they have used the strategy in their abusive intimate relationship. A total score is calculated by summing affirmative responses (Goodman et al., 2003). The IPVSI was administered to participants as a card-sort in this study. This measure controls for strategies already employed by participants prior to study involvement. For this study, the mean number of strategies used by Analytical Intervention participants was 19.75 ($SD = 7.98$) and 19.93 ($SD = 6.72$) for the Experiential Intervention participants, $t(55) = .09, p = .926, d = .02$.

The IPVSI has documented reliability and validity (Riddell et al., 2009). Interrater reliability was identified as adequate with 85% absolute agreement among five independent raters (Goodman et al., 2003). Strong content and convergent validity has been demonstrated with this instrument (e.g., correlation between categories endorsed and measures of abuse; Goodman et al., 2003), with moderate divergent validity (Bliss, Cook, & Kaslow, 2006). The nature of the scale obviates the need for a measure of internal consistency (Goodman et al., 2003; Lass, 2007).
Table 2. Interrater Reliability, Overall Safety Planning Categories

<table>
<thead>
<tr>
<th>Theme</th>
<th>Kappa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal Network</td>
<td>1.00</td>
</tr>
<tr>
<td>Relationship Changes</td>
<td>-</td>
</tr>
<tr>
<td>Resistance</td>
<td>.63</td>
</tr>
<tr>
<td>Safety Measures</td>
<td>-</td>
</tr>
<tr>
<td>Coping/Vulnerability</td>
<td>-</td>
</tr>
<tr>
<td>Formal Network: Self</td>
<td>.63</td>
</tr>
<tr>
<td>Empowerment</td>
<td>.76</td>
</tr>
<tr>
<td>Avoid/Ignore</td>
<td>.76</td>
</tr>
<tr>
<td>Legal</td>
<td>1.00</td>
</tr>
<tr>
<td>Information</td>
<td>.76</td>
</tr>
<tr>
<td>Placating</td>
<td>1.00</td>
</tr>
</tbody>
</table>
Consumer Satisfaction

Lastly, the conclusion of the intervention manual directed the researcher to ask consumer satisfaction questions (see Appendix H). In total, 13 different qualities were assessed with questions included, for example, to gauge the utility of the completed safety planning intervention. The consumer satisfaction questions were primarily derived from research literature regarding satisfaction with medical services (e.g., Chow, Mayer, Darzi, & Athanasious, 2009) and general measures of consumer satisfaction (for a review, see McMurty & Hudson, 2000; World Health Organization, 2000). A second component involved evaluating characteristics of the administrator (AG). These questions were adapted from research specific to satisfaction within clinical realms (e.g., the Working Alliance Inventory; Horvath & Greenberg, 1989). A written consumer satisfaction survey was also provided to participants (see Appendix I).

Manipulation Check

The purpose of the manipulation check was to provide substantiation that the two interventions were distinct; that is, that the Experiential Intervention elicited emotional reactivity and the Analytical Intervention did not. To assess for this difference, the manipulation check involved a standardized measure of affect, the Affect Grid (Russell et al., 1989). The Affect Grid is a single-item scale, providing a pictorial representation of the two dimensions of pleasure-displeasure and arousal-sleepiness. A participant places a single mark within a 9x9 matrix, representing her response to an instruction (e.g., “Please rate your mood as it is right now”; Russell et al., 1989, p. 493). The fifth row and column represents neutral affect (Timmermans, van Mechelen & Kuppens, 2010). Two scores, pleasure-displeasure and arousal-sleepiness, are made on a 9-point scale by identifying the placement of the participant’s mark on the grid. The Affect Grid has demonstrated adequate evidence of reliability, convergent, discriminant, and construct validity (Russell et al., 1989). A recognized advantage of the Affect Grid is that it does not produce user fatigue and, thus, is suited for repeated measures designs (Timmermans et al., 2010). The Affect Grid was provided initially to teach participants to use the measure (i.e., participants reflected on experienced affect prior to interview onset); this score was not included in subsequent analyses. The measure was subsequently administered on two occasions: pre-intervention and post-intervention.

Follow-up Interview

Subsequent to their initial participation, in Phase II, participants were contacted via telephone for follow-up. A structured interview was administered (see Appendix J). Precautions
were taken to minimize risks to participants by following guidelines outlined by Bennett and colleagues (2000) for telephone contact with victims of IPV. The interview included questions related to details of the safety plan and risk factors, use of safety plan strategies, and re-victimization status.

**Safety Plan Evaluation**

Each safety plan \( N = 60 \) was individually evaluated on a number of criteria, including an overall assessment of quality (see Appendix K for the evaluation form). Interrater reliability of the safety plan evaluations by the two raters (AG and JS) was calculated using intraclass correlation coefficients. Using McGraw and Wong (1996) and Shrout and Fleiss (1979) for guidance, it was determined that an appropriate ICC calculation for the purpose of this research was a two-way mixed effects model with absolute agreement. The evaluations were examined for 14 individual quality ratings and a global rating of safety plan quality. The 14 quality ratings were categorized into three areas: (a) safety plan strategy characteristics (e.g., diversity and feasibility of strategies), (b) participation characteristics (e.g., engagement in the safety planning process), and (c) predicted utilization characteristics (e.g., potential use of the safety plan in the long-term). Regarding interrater reliability, the ICC for the global rating was .85. Individual item ICC values were at least fair (i.e., ICC ratings were greater than .48).

**Data Analysis**

All analyses were conducted using Predictive Analytics SoftWare (PASW), version 18; formerly known as the Statistical Package for the Social Sciences (SPSS). The designated level of statistical significance used in this study was \( p < .05 \).

**Univariate and Multivariate Analyses**

Analyses were conducted for all relevant study demographic variables using statistics applicable to the level of measurement. Categorical data are reported as percentages and continuous data are reported as means or medians, dependent on the nature of the data. For the five research questions of interest, a combination of exploratory, descriptive, and inferential statistical analyses were conducted. Univariate between-group comparisons were conducted using chi-square test for categorical variables, relying on Fisher’s Exact Test if a cell in a two-way contingency table contained less than five subjects. Dependent on the distribution of the data, continuous variables of interest were compared by independent samples Student’s \( t \)-test or Mann-Whitney \( U \) test. Multivariate analyses were conducted using applicable analysis of variance
(ANOVA) or regression. Due to potential low power, because of a small comparative sample, relevant effect size statistics were also calculated. Effect sizes quantify the size of the difference between two intervention groups (Coe, 2002). Moderate to large effect sizes will be highlighted as representing a meaningful difference (e.g., Cohen, 1988).

Hierarchical Linear Modelling (HLM)

To examine whether intervention type, controlling for additional relevant variables, influenced victim risk and fear appraisals, a specific type of statistical modelling was used: Hierarchical Linear Modelling (HLM). Also known interchangeably as multilevel linear models, mixed-effects or random-effects models, or covariance components models (Nich & Carroll, 1997), HLM was used in this study to analyze the longitudinal data. By convention, “longitudinal” is defined as observing a unit (or individual) measured over at least two time points (van der Kamp & Bijleveld, 1998). HLM is an increasingly popular method to employ with longitudinal research (Wooldredge, Griffin, & Pratt, 2001) compared to traditional General Linear Models (GLM) analyses (e.g., repeated-measures ANOVA or MANOVA designs; Roberts, 2004). This is due, in part, to what is perceived to be the “severe limitations” of the traditional statistical methods (O’Connell & McCoach, 2004, p. 120). Among the purported limitations of the GLM methods are the requirements that (a) the data be balanced resulting in the removal of missing observations, thus reducing the overall sample size or requiring imputation which may increase the risk of biased data (Nich & Carroll, 1997), (b) time is a fixed effect (i.e., data collection points must be equivalent for all participants; Nich & Carroll, 1997), and (c) the data must meet critical assumptions to achieve validity in the analyses (e.g., homogeneity of variance across groups; O’Connell & McCoach, 2004). Missing data and varying data collection periods are synonymous with longitudinal research. HLM procedures addresses the impediments associated with the other approaches (O’Connell & McCoach, 2004).

Of significant import to this research study, HLM procedures are recognized for their usefulness in exploring change (O’Connell & McCoach, 2004). According to Nich and Carroll (1997), “these [HLM] models make more realistic assumptions about the nature and availability of data, and therefore, about the nature of how people change” (p. 10). Traditional repeated measures ANOVA, for instance, only investigate group changes for complete data, thus limiting the understanding of individual-level change (O’Connell & McCoach, 2004). In contrast, HLM procedures provide insight into patterns of change for all groups and individual participants and,

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9 For Cohen’s d, an effect size of < .10 is a trivial effect, .10 - .30 is a small effect, .30 - .50 is a moderate effect and .50 upwards is considered a large effect (Cohen, 1988).
also, allows for the investigation of the influence of specific variables (group or individual characteristics) on the rate of change (O’Connell & McCoach, 2004). Of particular interest to this research study, HLM procedures can identify whether change can be attributed to the effects of an intervention (O’Connell & McCoach, 2004). These procedures are identified as being most useful for small to moderate intervention studies (O’Connell & McCoach, 2004).

HLM is a two-step procedure in which lower level predictors (referred to as Level 1 or micro-level) are modelled first, then increasingly aggregate variables are analyzed (referred to as Level 2 or macro-level; Wooldredge et al., 2001). These designations reflect the hierarchical structure of longitudinal data (Roberts, 2004). Without acknowledging the hierarchical structure of data, erroneous conclusions may likely be made (i.e., increased risk of Type I errors; Roberts, 2004).

With application to the current study, for analysis of longitudinal data, research that includes three or more data collection points are preferred, as each participant’s growth trajectory can be modelled more comprehensively (O’Connell & McCoach, 2004). This study included four intervals of data collection: pre-intervention, post-intervention, post-safety planning, and follow-up; time was included as a Level-1 variable. Outcome variables (i.e., risk and fear appraisals) were also identified as Level-1 variables. With the hierarchical structure, Level-2 represented each individual participant (N = 60). Essentially, the repeated measures are nested within each participant. Intervention type was a Level-2 predictor variable. For control purposes, additional predictor variables that were attributes of each participant and measured once were also designated Level-2 variables. Level-2 variables were treated as fixed effects in the model, with participants treated as a random effect in which the dependent variable changed over time.

Due to sample size restrictions, a limited number of predictor variables were included in the final HLM analyses. The variables identified to have importance were the following: risk assessment measures (the ODARA and B-SAFER; Hilton et al., 2004; Kropp et al., 2005), the REI subtypes (Epstein et al., 1998), time interval and intervention type. Analyses indicated that several variables initially hypothesized to influence participants’ risk or fear levels were not statistically significant. Thus, the following predictor variables were excluded from the final model: ethnicity, age, and marital status. The results of the ISA (Hudson & McIntosh, 1981) were determined to be collinear with the risk assessment measures and, as such, redundant. Due to the nature of the research questions and the model selection process, the ISA was excluded. Additionally, time since the index abuse incident was excluded from the final model; that is, the number of months from the initial incident to participation in Phase I and Phase II of this
research. This result is important, suggesting that any alterations in appraised risk or fear were not influenced by time since the originating event. Lastly, possible interactions between treatment and time were tested and included in the final model, only if statistically significant at $p < .05$. 
RESULTS: MANIPULATION CHECK

A manipulation check was conducted to ascertain whether affect varied by intervention. Due to its emphasis on affect, Experiential Intervention participants were anticipated to exhibit the most pronounced change, in contrast to Analytical Intervention participants. The Affect Grid (Russell et al., 1989) was used to identify potential affective change. It is comprised of two dimensions, pleasure-displeasure and arousal-sleepiness, which are individually rated from 1 (extremely unpleasant feelings or extreme sleepiness) to 9 (extremely pleasant feelings or extreme arousal/excitement), with a mid-score (5) indicative of neutral affect. See Figure 1 for a graphical representation of both dimensions of interest for pre-intervention and post-intervention intervals.

To determine whether affect varied between interventions, the Affect Grid results were examined using an analysis of covariance (ANCOVA), controlling for pre-intervention ratings, with intervention (Analytical Intervention and Experiential Intervention) as the between-subjects factor. Results of the ANCOVA were examined individually for the two dimensions of the Affect Grid.

Pleasure-Displeasure Dimension

Paired sample t-tests indicated that significant differences in Affect Grid scores on the pleasure-displeasure dimension were present for Analytical Intervention participants, \( t(26) = 3.50, p = .002, d = .67 \); that is, ratings of pleasure were higher pre-intervention (\( M = 6.20, SD = 2.36 \)) than post-intervention (\( M = 4.81, SD = 2.53 \)). Participants in the Experiential Intervention exhibited a smaller change in affect, which was not statistically significant when compared across the assessed intervals: pre-intervention (\( M = 5.53, SD = 2.73 \)) and post-intervention (\( M = 4.81, SD = 2.69 \)), \( t(27) = 1.14, p = .266, d = .21 \). Thus, contrary to the initial hypothesis, participants in the Analytical Intervention exhibited a statistically significant change in affect, declining from experiencing positive affect pre-intervention to neutral or slightly negative affect post-intervention. When controlling for pre-intervention ratings in an ANCOVA, analysis of the pleasure-displeasure dimension intervention effect was not significant, \( F(1, 51) = .096, p = .758, \eta^2 = .002 \). It is noted that power may have been insufficient to detect a statistically significant effect.

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10 Analyses were also performed using both the results of the practice administration and pre-intervention ratings as covariates; results were consistent with those reported here.
Figure 1. Mean Ratings at Pre-Intervention, and Post-Intervention by Intervention Type, Pleasure-Displeasure and Arousal-Sleepiness Dimensions

Figure 1. Russell Affect Grid (Russell, Weiss, & Mendelsohn, 1989), ratings between 1 (extremely unpleasant feelings or extreme sleepiness) to 9 (extremely pleasant feelings or extreme arousal/excitement), with 5 indicative of neutral affect. Error bars represent standard error.
Arousal-Sleepiness Dimension

When controlling for pre-intervention ratings on the arousal-sleepiness dimension, no significant intervention effect was identified, $F(1, 51) = 2.19, p = .145, \eta^2 = .04$. Paired sample $t$-tests indicated statistically differences in Affect Grid scores on this dimension were present for those in the Analytical Intervention, $t(26) = 2.37, p = .026, d = .48$. Lower arousal ratings were reported pre-intervention ($M = 4.23, SD = 2.45$) than post-intervention ($M = 5.44, SD = 2.58$). A statistically significant result was not identified for participants in the Experiential Intervention: pre-intervention ($M = 4.63, SD = 2.45$), and post-intervention ($M = 4.44, SD = 2.56$), $t(26) = .37, p = .713, d = .08$. Contrary to expectation, Analytical Intervention participants reported experiencing a higher degree of arousal (i.e., excitement or anxiety) post-intervention. In contrast, Experiential Intervention participants did not report a significant change in arousal post-intervention, appearing to remain mostly neutral in affect.

Missirlian and colleagues (2005) indicated in their affect manipulation study that the use of mean values might contribute to an averaging effect; that is, fluctuations in affect may average to neutral. Thus, to examine potential individual-level change in affect, pre-post intervention difference scores were calculated and analysed using an independent samples $t$-test. For both Affect Grid dimensions, results were not statistically significant between intervention groups, $t(52) < 1.42, p > .163$. Although non-statistically significant, but consistent with the previous findings, effect size calculations revealed a moderate effect ($d = .38$) suggestive of the Analytical Intervention participants ($M = 1.18, SD = 2.60$) reporting a greater change in arousal than Experiential Intervention participants ($M = .18, SD = 2.59$). This further confirms a change in affect was exhibited by Analytical Intervention participants as a result of their participation in the intervention.

Additional analyses were performed to control for another measure of individual variability: the match between rational-emotional status and intervention type. Correspondence between intervention and REI subtype (Epstein et al., 1998) may have facilitated or hindered emotional reactivity. For example, an individual that was high on the Experiential subscale of the REI may react differently (i.e., express more affect) than an individual who was low on the same scale, although both were randomly assigned to the Experiential Intervention. Analyses accounting for the match between intervention and rational-emotional status were performed. Total scores on the Experiential and Rational subscales were used, separately, as covariates, with intervention type. Post-intervention scores on the Affect Grid were the outcome variables of interest. Results of the ANCOVA for the pleasure-displeasure dimension of the Affect Grid
indicated non-significant findings for both subscales, $F(2, 51) < 2.60, p > .062, \eta^2 < .13$. For the arousal-sleepiness dimension of the Affect Grid, similar non-significant findings were found for both subscales, $F(2, 51) < .30, p > .825, \eta^2 < .02$. In general, individual mode of processing did not appear to influence responding on the Affect Grid.

Summary. The results support the hypothesis that affect may vary by intervention, although the direction of the effect was not as anticipated. The Analytical Intervention participants exhibited a shift in affect with participation in the intervention while the Experiential Intervention participants did not. Participation in the Analytical Intervention appeared to influence participants’ degree of arousal, exhibiting an increase on completion of the intervention. It is possible that the Analytical Intervention participants also experienced an alteration in pleasure, declining to neutral. In contrast, the Experiential Intervention participants did not exhibit any statistically significant change in affect, appearing to remain predominantly neutral pre-intervention and post-intervention on both pleasure-displeasure and arousal-sleepiness dimensions. There were no between-group differences in affect post-intervention, when controlling for pre-intervention scores. Individual variation, via difference scores and the REI measure, did not appear to account for differences in processing of affect. The results of this section are partially indicative of a manipulation effect.
RESULTS: MAIN ANALYSES

Research Question One

Do cognitive or affective interventions influence the association between expert and victim appraisals of risk?

As the a priori hypothesis, moderate correspondence was anticipated between expert-rated and victim-rated risk ratings. In addition, it was also hypothesized that a higher degree of correspondence would exist between an intervention and its presumed risk assessment complement (e.g., Analytical Intervention participant ratings would exhibit a stronger correlation with actuarial measures of risk).

From a risk as analysis framework, expert ratings of risk were represented by the ODARA total score ($M = 7.15, SD = 2.43$), an actuarial measure, and the B-SAFER total score ($M = 14.90, SD = 4.14$), an actuarial analogue. Victim ratings included participants’ self-appraised pre-intervention and post-intervention overall risk ratings. Victim risk ratings were non-normally distributed (i.e., a bi-modal distribution). First, analyses were performed to determine whether there was an association between expert and victim risk assessments overall, irrespective of intervention type. A moderate significant association existed between expert and victim assessments of risk at pre-intervention, ODARA, $r_s = .31$, and B-SAFER, $r_s = .32$, $p < .016$.

The strength of the association between victim and expert risk assessments declined post-intervention for the ODARA, $r_s = .22$, and B-SAFER, $r_s = .24$, although this was not a statistically significant decrease, $z < .32, p > .719$. In general, the results of this section suggest a moderate correspondence between overall expert and victim risk assessments that decreased, but did not alter significantly, with involvement in the study interventions. Potential intervention type differences may influence this finding.

To examine the second stated hypothesis, expert and victim risk ratings were examined by intervention. Analyses were conducted to determine whether a stronger association was present between the Analytical Intervention participant risk ratings and expert-rated actuarial measures of risk than the Experiential Intervention participant risk ratings. At pre-intervention,

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11 Analyses were repeated excluding participants ($n = 20$) that did not meet the inclusion criteria of the ODARA, pre-intervention, $r_s = .20$, and post-intervention, $r_s = .29$. 
Analytical Intervention participant risk ratings exhibited a moderate correlation with the ODARA, $r_s = .41$, and strong correlation with the B-SAFER, $r_s = .55$. The strength of this association increased post-intervention for the ODARA, $r_s = .45$, and remained the same for the B-SAFER, $r_s = .55$; the increase for the ODARA was not statistically significant, $z = .18, p = .857$. For the Experiential Intervention, a weak or inverse relationship existed between participant risk ratings and the expert-rated actuarial measures, both pre-intervention for the ODARA, $r_s = .08$, and B-SAFER, $r_s = .10$, and post-intervention for the ODARA, $r_s = -.06$, and B-SAFER, $r_s = -.01$; the decline was not significant for either intervention, $z < .52, p > .601$. Between-group intervention differences in the strength of the association between expert and victim risk ratings for the ODARA and B-SAFER was non-significant pre-intervention, $z < 1.31, p > .190$, but significant post-intervention, $z > 1.42, p < .045$. Analytical Intervention participants’ risk ratings corresponded more strongly with actuarial assessments of risk than Experiential Intervention participants, particularly post-intervention.

From a risk as feelings framework, expert ratings of risk were represented by the B-SAFER summary risk ratings (Low, Moderate, or High). Victims also provided summary risk ratings for re-victimization. An overall summary risk rating was provided by participants both pre-intervention and post-intervention; this was matched with expert ratings (i.e., an overall summary risk rating based on the three B-SAFER summary risk ratings of Imminent, Long-Term, and Serious Risk). Due to insufficient variation across the summary risk ratings, the three categories collapsed to two: Low versus Moderate-High. Overall, expert and victim summary risk ratings corresponded moderately pre-intervention, $\chi^2(1, N = 60) = 1.93, p = .165$, Cramer’s $V = .20$, and post-intervention, $\chi^2(1, N = 60) = 3.12, p = .077$, Cramer’s $V = .23$. There was 59% agreement in summary risk ratings provided by the expert and victims at both time intervals. In comparison to expert-rated risk, disagreements ($n = 25$) in the summary risk ratings were biased towards participants underestimating risk (72%). For the summary risk ratings, overall, moderate correspondence was present.

Furthermore, to examine the second hypothesis, expert and victim summary risk ratings were examined by intervention. It was hypothesized that Experiential Intervention participants and expert summary risk ratings would exhibit greater correspondence than the Analytical Intervention participants’ summary risk ratings. This was not apparent with this data. At pre-intervention, Experiential Intervention participants’ summary risk ratings did not correspond with the expert evaluation of risk, $\chi^2(1, N = 30) = 0, p = 1$, Cramer’s $V = 0$. There was 50% disagreement; that is, 15 of 30 risk ratings were discrepant, with the majority (67% or $n =10$) of
these disagreements the result of an underestimation of risk. At post-intervention, the
correspondence between expert and victim summary risk ratings improved, but not significantly,
$\chi^2(1, N = 30) = .27, p = .709$, Cramer’s $V = .09$. Analytical Intervention participants’ and expert
summary risk ratings varied, although to less of a degree than for the Experiential Intervention
participants. The moderate correspondence between expert and victim summary risk ratings
remained unchanged from pre- to post-intervention for Analytical Intervention participants, $\chi^2(1,
N = 30) = 3.97, p = .046$, Cramer’s $V = .36$. Approximately 30% disagreement was identified,
with Analytical Intervention participants biased towards underestimating risk (80% or $n = 8$). No
statistically significant difference was identified when comparing proportion of disagreement
between the two interventions (i.e., 50% vs. 30%), $z = 1.05, p = .353$. In general, these findings
suggest that there is some degree of correspondence between expert and victim overall risk as
feelings appraisals of risk. Analytical Intervention participants exhibited moderate
correspondence, whereas this was not evident for Experiential Intervention participants. There did
not appear to be concordance between the Experiential Intervention participants summary risk
ratings and its analogue, the expert-rated SPJ summary risk ratings.

As an alternate method to determine if there was an influence of intervention type on
summary risk ratings, a method employed by Lass (2007) was used. Lass trichotomized risk into
three groups based on pre- and post-intervention ratings: (a) no change in risk perception, (b)
decrease in risk perception (i.e., from Moderate-High to Low risk), and (c) increase in risk
perception (i.e., from Low to Moderate-High risk). The data in this study were similarly
categorized, with the proportion of participants overall as follows: unchanged (75%, $n = 45$),
decreased risk appraisal (13%, $n = 8$), and increased risk appraisal (12%, $n = 7$). There were no
between-group intervention differences in the alteration of risk, $\chi^2(1, N = 60) = .84, p = .656$, Cramer’s $V = .12$. Confirming the previous findings, the majority of participants did not alter their
risk appraisals after participation in their respective intervention and there were no between-group
intervention differences in alterations of risk.

Summary. Consistent with the hypothesis, the results of this section suggest that, overall,
a moderate association exists between expert and victim assessments of risk. Participants’ risk
ratings remained fairly consistent pre- and post-intervention, irrespective of involvement in a
particular intervention. Incongruence between expert and victim risk ratings was biased towards
participants underestimating the degree of risk for future violence. As expected, Analytical

\[\text{Replicating these analyses with expert and victim post-intervention comparisons of the individual summary risk ratings of Imminent Risk, Serious Risk, and Long-Term Risk did not produce differing results.}\]
Intervention participants’ ratings corresponded more strongly with actuarial risk ratings than Experiential Intervention participants’ ratings, as initially hypothesized, although statistical significance was not achieved. The converse association was not evident with SPJ summary risk ratings; the Analytical Intervention participants unexpectedly exhibited a moderate association with expert ratings. Experiential Intervention participants’ ratings appeared minimally consistent with expert ratings for both actuarial and SPJ measures.

Research Question Two

Do cognitive or affective interventions influence perceptions of risk or experiences of fear?

For this research question, the original hypothesis was two-fold, (a) risk and fear would be appraised as higher for participants in the Experiential Intervention than the Analytical Intervention and, (b) risk and fear ratings would not change for participants after involvement in the Experiential Intervention, whereas ratings may change for participants in the Analytical Intervention.

Prior to answering the specific research question, it was important to identify whether risk and fear could be examined as separate constructs. Previous research (e.g., Chadee, Austen, & Ditton, 2007) identified risk and fear as discrete dimensions, which supports the dual-mode processing conceptualization of risk (Slovic et al., 2004). Based on the results of bivariate correlations of the victim-appraised risk and fear ratings, multicollinearity was not identified (see Table 3). Values above .75 are a marker of multicollinearity (Healey, 2009). Therefore, self-appraised risk and fear data was examined individually.

To examine the first hypothesis, basic descriptive statistics were initially analyzed to examine participants’ perceptions of (a) overall risk and fear and, (b) individual risk and fear characteristics. Non-normality was an issue with the risk and fear variables of interest, typically due to a bi-modal distribution of responses. For example, the majority of participants rated their overall level of fear either as low (i.e., 0 – 1, 26%) or high (i.e., 9 – 10, 23%), on a 10-point scale. The majority of participants rated their overall level of risk as low (0 – 1, 32%) or moderate (i.e., 5, 22%). Participants’ perceptions of overall risk and fear and individual risk and fear characteristics were examined employing the Mann-Whitney U test. Across the four time intervals under examination, there were no statistically significant intervention differences in overall ratings of risk, $z < .71, p > .479, r < .14$, or fear, $z < .99, p > .321, r < .13$, see Figure 2. Similarly, analyses of the individual risk characteristics, $z < .63, p > .532, r < .08$, and fear characteristics, $z < 1.37, p > .170, r < .23$, were also not statistically significant, see Table 4 and
Table 3. Correlations Between Victim Appraised Risk and Fear Assessments at Pre-Intervention, Post-Intervention, Post-Safety Planning and Follow-up

<table>
<thead>
<tr>
<th></th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
<th>Post-Safety Planning</th>
<th>Follow-Up</th>
</tr>
</thead>
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<td></td>
<td>Risk</td>
<td>Fear</td>
<td>Risk</td>
<td>Fear</td>
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<tr>
<td>Pre-Intervention</td>
<td>- .60**</td>
<td>.59** .34**</td>
<td>.69** .34** .52**</td>
<td>.22</td>
</tr>
<tr>
<td>Risk</td>
<td>- .43** .65**</td>
<td>.52** .63** .45**</td>
<td>.29</td>
<td></td>
</tr>
<tr>
<td>Fear</td>
<td>.43** .65**</td>
<td>.52** .63** .45**</td>
<td>.29</td>
<td></td>
</tr>
<tr>
<td>Post-Intervention</td>
<td>- .51**</td>
<td>- .66** .44**</td>
<td>.57 .31</td>
<td></td>
</tr>
<tr>
<td>Risk</td>
<td>- .43** .78**</td>
<td>- .27 .29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fear</td>
<td>.43** .78**</td>
<td>.27 .29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-Safety Planning</td>
<td>- .41**</td>
<td>.51** .18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk</td>
<td>- .41** .38**</td>
<td>.31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fear</td>
<td>.43**</td>
<td>.31</td>
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</tr>
<tr>
<td>Follow-Up</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Fear</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Note. Scale measured on a 10-point Likert scale (0 – 10; 0 = Low and 10 = High). Spearman’s rho correlations.

a N = 57 – 60.
b N = 31 – 34.
*p < .05. ** p < .01
Figure 2. *Overall Victim Appraised Risk and Fear Ratings at Pre-Intervention, Post-Intervention, Post-Safety Planning and Follow-up*

![Bar chart showing appraised risk and fear ratings](image)

*Figure 2.* Overall victim appraised risk and fear ratings, between 0 (*Low*) and 10 (*High*). Error bars represent standard error. *N* = 60, with *n* = 30 for both interventions.
Table 4. Descriptive Statistics for the Four Parameter Subjective Risk Ratings at Pre-Intervention, Post-Intervention, Post-Safety Planning and Follow-up

<table>
<thead>
<tr>
<th></th>
<th>Analytical Intervention</th>
<th>Experiential Intervention</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>M (SD)</td>
<td>Mdn</td>
</tr>
<tr>
<td>Imminence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1</td>
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<td>4.23 (4.04)</td>
<td>4.5</td>
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<tr>
<td>T2</td>
<td>29</td>
<td>3.58 (3.85)</td>
<td>2</td>
</tr>
<tr>
<td>T3</td>
<td>30</td>
<td>3.48 (3.75)</td>
<td>2</td>
</tr>
<tr>
<td>T4</td>
<td>16</td>
<td>1.62 (2.44)</td>
<td>0</td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1</td>
<td>30</td>
<td>4.20 (4.36)</td>
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<td>T2</td>
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<td>2</td>
</tr>
<tr>
<td>T3</td>
<td>30</td>
<td>3.63 (4.12)</td>
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</tr>
<tr>
<td>T4</td>
<td>16</td>
<td>1.75 (3.25)</td>
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<tr>
<td>Severity</td>
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<tr>
<td>T1</td>
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</tr>
<tr>
<td>T2</td>
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<td>4.05 (4.29)</td>
<td>2</td>
</tr>
<tr>
<td>T3</td>
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<td>1.5</td>
</tr>
<tr>
<td>T4</td>
<td>16</td>
<td>1.67 (2.98)</td>
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</tr>
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<td>Nature</td>
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</tr>
<tr>
<td>T1</td>
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<td>7</td>
</tr>
<tr>
<td>T2</td>
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<td>T3</td>
<td>30</td>
<td>3.48 (4.12)</td>
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<tr>
<td>T4</td>
<td>14</td>
<td>1.46 (2.60)</td>
<td>0</td>
</tr>
</tbody>
</table>

Note. Scale measured on a Likert scale (0 – 10; 0 = Low and 10 = High). T1 = Pre-intervention, T2 = Post-intervention, T3 = Post-safety planning, T4 = Follow-up. Range for all was 0 – 10, with the exception of T4, where range was 0 – 9.
Table 5. However, at follow-up, fear of harassment by the index partner exhibited a trend towards significance, $z = 1.94, p = .053, r = .33$, with a higher mean rank (20.18) for participants in the Analytical Intervention compared to participants in the Experiential Intervention (14.58). Based on this sample and these basic group-level inferential statistics, the original hypothesis that Experiential Intervention participants will appraise their level of risk or fear as higher than participants in the Analytical Intervention was not supported.

To examine the second hypothesis, generalized linear mixed model (random intercept) analyses were conducted. Two separate analyses were performed with self-appraised level of risk or fear as the outcome measure of interest, using a dichotomous composite variable. For risk, the composite score was based on scaled variables measured over the four study time intervals: overall risk assessment and the estimated imminence, severity, frequency, and nature of future violence. For fear, the composite score was based on five scaled variables also measured at key intervals: overall experience of fear of the index partner and fear of the index partner becoming violent, using life-threatening violence, harassing the participant, and harassing others (e.g., family members). However, with this composite score, insufficient variation remained an issue and could not be successfully corrected via transformation. The composite risk and fear scores were subsequently dichotomously coded (High or Low). Participants were categorized as assessing risk as High, if the composite score was equal to, or greater than, 4.0 (median split). Participants were categorized as experiencing a High degree of fear if the composite score was equal to, or greater than, 4.5 (median split). Participants were categorized as Low, if the composite scores for risk and fear were less than those identified values. The Level-1 covariate variable included in the final model was Time (pre-intervention, post-intervention, post-safety planning, and follow-up). Level-2 variables in the final model included: REI Subtypes, B-SAFER (total score), ODARA (total score), Intervention Type (Analytical Intervention and Experiential Intervention), and an Intervention Type x Time interaction. Results indicated that, when controlling for variables of interest, participants’ assessment of risk and fear changed as a function of involvement in the interventions. Specifically for participant risk assessments, a main effect of Time, Wald $\chi^2(7, N = 211) = 9.68, p < .001$, and an interaction effect (Time x Intervention Type) were both statistically significant, Wald $\chi^2(7, N = 211) = 20.36, p < .01$. Figure 3 provides a graphical representation of these results.

Specifically for participant risk assessments, a main effect of Time, Wald $\chi^2(7, N = 211) = 9.68, p < .001$, and an interaction effect (Time x Intervention Type) were both statistically significant, Wald $\chi^2(7, N = 211) = 20.36, p < .01$. Figure 3 provides a graphical representation of these results.

In both models, the B-SAFER total score also exhibited a moderately significant relationship: risk, Wald $\chi^2(1, N = 211) = 5.12, p = .024$, and fear, Wald $\chi^2(1, N = 211) = 5.20, p = .023$. Participants evaluated as having low B-SAFER scores were more likely to appraise their own level of risk and fear as low.

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13 In both models, the B-SAFER total score also exhibited a moderately significant relationship: risk, Wald $\chi^2(1, N = 211) = 5.12, p = .024$, and fear, Wald $\chi^2(1, N = 211) = 5.20, p = .023$. Participants evaluated as having low B-SAFER scores were more likely to appraise their own level of risk and fear as low.
<table>
<thead>
<tr>
<th></th>
<th>Analytical Intervention</th>
<th>Experiential Intervention</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>M (SD)</td>
<td>Mdn</td>
</tr>
<tr>
<td>Violence</td>
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<td>4.27 (4.19)</td>
<td>3</td>
</tr>
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<td>T3</td>
<td>30</td>
<td>4.32 (4.16)</td>
<td>3</td>
</tr>
<tr>
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<td>T1</td>
<td>30</td>
<td>4.07 (4.43)</td>
<td>2</td>
</tr>
<tr>
<td>T2</td>
<td>29</td>
<td>3.81 (3.96)</td>
<td>2</td>
</tr>
<tr>
<td>T3</td>
<td>30</td>
<td>3.75 (3.86)</td>
<td>2</td>
</tr>
<tr>
<td>T4</td>
<td>16</td>
<td>2.68 (3.85)</td>
<td>.5</td>
</tr>
</tbody>
</table>

*Note.* Scale measured on a Likert scale (0 – 10; 0 = Low and 10 = High). T1 = Pre-intervention, T2 = Post-intervention, T3 = Post-safety planning, T4 = Follow-up. Range for all was 0 – 10.
Table 6. Summary of Generalized Linear Mixed Model Analysis with Victim Appraised Risk and Fear Ratings, Across Time

<table>
<thead>
<tr>
<th>Risk</th>
<th>$B$</th>
<th>$SE$</th>
<th>$\chi^2$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>-.73</td>
<td>.15</td>
<td>9.68</td>
<td>.00***</td>
</tr>
<tr>
<td>Intervention</td>
<td>-2.02</td>
<td>1.56</td>
<td>1.97</td>
<td>.20</td>
</tr>
<tr>
<td>Time x Intervention</td>
<td>-20.36</td>
<td>.005**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1 x AI</td>
<td>-.19</td>
<td>.56</td>
<td>.12</td>
<td>.73</td>
</tr>
<tr>
<td>T1 x EI</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>T2 x AI</td>
<td>.68</td>
<td>.56</td>
<td>1.45</td>
<td>.23</td>
</tr>
<tr>
<td>T2 x EI</td>
<td>.13</td>
<td>.32</td>
<td>.17</td>
<td>.68</td>
</tr>
<tr>
<td>T3 x AI</td>
<td>.45</td>
<td>.54</td>
<td>.69</td>
<td>.41</td>
</tr>
<tr>
<td>T3 x EI</td>
<td>.63</td>
<td>.38</td>
<td>2.82</td>
<td>.09</td>
</tr>
<tr>
<td>T4 x EI</td>
<td>1.61</td>
<td>.63</td>
<td>6.49</td>
<td>.01*</td>
</tr>
<tr>
<td>T4 x AI</td>
<td>1.76</td>
<td>.82</td>
<td>4.57</td>
<td>.03*</td>
</tr>
<tr>
<td>REI Subtypes</td>
<td>-</td>
<td>-</td>
<td>1.53</td>
<td>.68</td>
</tr>
<tr>
<td>Poor</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Rational</td>
<td>.14</td>
<td>.77</td>
<td>.036</td>
<td>.85</td>
</tr>
<tr>
<td>Intuitive</td>
<td>.56</td>
<td>.75</td>
<td>.55</td>
<td>.46</td>
</tr>
<tr>
<td>Complimentary</td>
<td>-.36</td>
<td>.54</td>
<td>.45</td>
<td>.50</td>
</tr>
<tr>
<td>B-SAFER</td>
<td>-.13</td>
<td>.06</td>
<td>5.12</td>
<td>.02*</td>
</tr>
<tr>
<td>ODARA</td>
<td>-.20</td>
<td>.12</td>
<td>3.11</td>
<td>.08</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fear</th>
<th>$B$</th>
<th>$SE$</th>
<th>$\chi^2$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>-2.84</td>
<td>.15</td>
<td>12.33</td>
<td>.00***</td>
</tr>
<tr>
<td>Intervention</td>
<td>-3.43</td>
<td>1.35</td>
<td>5.97</td>
<td>.01**</td>
</tr>
<tr>
<td>Time x Intervention</td>
<td>-</td>
<td>-</td>
<td>24.84</td>
<td>.00***</td>
</tr>
<tr>
<td>T1 x AI</td>
<td>.52</td>
<td>.60</td>
<td>.77</td>
<td>.39</td>
</tr>
<tr>
<td>T1 x EI</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>T2 x AI</td>
<td>1.26</td>
<td>.60</td>
<td>4.42</td>
<td>.04*</td>
</tr>
<tr>
<td>T2 x EI</td>
<td>.97</td>
<td>.57</td>
<td>2.86</td>
<td>.09</td>
</tr>
<tr>
<td>T3 x AI</td>
<td>1.40</td>
<td>.59</td>
<td>5.63</td>
<td>.02*</td>
</tr>
<tr>
<td>T3 x EI</td>
<td>1.39</td>
<td>.58</td>
<td>5.77</td>
<td>.02*</td>
</tr>
<tr>
<td>T4 x AI</td>
<td>1.67</td>
<td>.75</td>
<td>4.98</td>
<td>.03*</td>
</tr>
<tr>
<td>T4 x EI</td>
<td>2.74</td>
<td>.71</td>
<td>15.09</td>
<td>.00***</td>
</tr>
<tr>
<td>REI Subtypes</td>
<td>-</td>
<td>-</td>
<td>7.48</td>
<td>.06</td>
</tr>
<tr>
<td>Poor</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Rational</td>
<td>-1.41</td>
<td>.89</td>
<td>1.64</td>
<td>.20</td>
</tr>
<tr>
<td>Intuitive</td>
<td>.66</td>
<td>.79</td>
<td>.69</td>
<td>.41</td>
</tr>
<tr>
<td>Complimentary</td>
<td>-1.33</td>
<td>.50</td>
<td>7.16</td>
<td>.01**</td>
</tr>
<tr>
<td>B-SAFER</td>
<td>-.15</td>
<td>.06</td>
<td>5.20</td>
<td>.02*</td>
</tr>
<tr>
<td>ODARA</td>
<td>-.24</td>
<td>.14</td>
<td>3.10</td>
<td>.08</td>
</tr>
</tbody>
</table>

Note. Fear and risk are dichotomously coded. Rational-Experiential Inventory (REI; Epstein, Pacini, & Norris, 1998), Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER; Kropp, Hart, & Belfrage, 2005), and Ontario Domestic Assault Risk Assessment (ODARA; Hilton, Harris, & Rice, 2004). T1 = Pre-intervention, T2 = Post-intervention, T3 = Post-safety planning, T4 = Follow-up. AI = Analytical Intervention, EI = Experiential Intervention.

*p < .05, **p < .01, ***p < .001
Figure 3. *Estimated Marginal Means for Intervention Type Across Time for Victim Appraised Risk and Fear Ratings*

*Figure 3.* Overall victim appraised risk and fear ratings (composite). Continuous predictors were fixed at the following values: B-SAFER total score = 14.78 (Brief Spousal Assault Form for the Evaluation of Risk; Kropp, Hart, & Belfrage, 2005) and ODARA total score = 7.04 (Ontario Domestic Assault Risk Assessment; Hilton, Harris, & Rice, 2004). Error bars representing standard error were omitted for clarity. *N* = 211.
the alteration in risk as participants proceeded through the four time intervals. Experiential Intervention participants exhibited a consistent decline in risk ratings, whereas participants in the Analytical Intervention did not. An increase in the number of participants in the Analytical Intervention who evaluated their risk as high was identified during the post-safety planning interval. In addition, participants’ assessment of fear also exhibited a change, over time and as a function of involvement in the interventions. Both main effects (Time and Intervention Type), \( \chi^2(7, N = 211) > 5.97, \ p < .010 \), and an intervention effect were significant, \( \chi^2(7, N = 211) = 24.84, \ p < .001 \), refer again to Figure 3. For both interventions, appraisals of fear declined consistently across the four time intervals. Although the Experiential Intervention participants exhibited higher ratings of fear initially (i.e., pre-intervention), the rate of decline was greater than exhibited for Analytical Intervention participants.

Overall, the results of the two generalized linear mixed models suggest that participation in the interventions had an effect on participants’ ratings of risk and fear. The results also suggest that intervention type served as a moderating effect, in that it appeared to influence the strength of the association between time and participant self-appraisals.

**Summary.** These findings were not consistent with the hypothesis for this research question, albeit intriguing results were identified. Self-appraised risk or fear levels did not significantly differ between Experiential Intervention and Analytical Intervention participants. At least no statistically significant between-group differences were identified at each discrete interval. This result is tentatively proffered due to the use of non-parametric statistics, small sample size, and low power of this study. Additionally, for this sample, risk and fear appraisals were not static and appeared to be influenced by participation in an intervention. When controlling for individual variation and confounding factors, results indicated that intervention type moderated the association between time and, independently, risk and fear. Generally, both risk and fear ratings declined with participation in the interventions.

**Research Question Three**

*Do cognitive or affective interventions influence the quality of the developed safety plans?*

The primary objective of this research question was to analyze and compare the safety plans for participants in each intervention group. Expert-rated evaluations of safety plan quality and specific features of the developed safety plans were examined. It was hypothesized that Experiential Intervention participants would produce lower quality safety plans than Analytical Intervention participants.
Safety Plan Evaluations

Refer to Table 7 for descriptive statistics for the global rating of safety plan quality (one score; Likert-scaled from 1 – 10) and the three main components of the safety plan evaluation: (a) safety plan strategy characteristics (e.g., diversity and feasibility of strategies), (b) participation characteristics (e.g., engagement in the safety planning process), and (c) predicted utilization characteristics (e.g., potential use of the safety plan in the long-term). For each of the three areas, expert ratings (Likert-scaled from 0 – 2) on the individual items were averaged to provide a final score.

Overall quality of the safety plans was comparable between the Analytical Intervention ($M = 6.57$, $SD = 1.98$) and Experiential Intervention ($M = 6.70$, $SD = 2.15$), $t(58) = .25$, $p = .804$, $d = .06$. Subsequent analyses of the three characteristic components of the safety plan evaluations was indicative of comparable quality, $t(49 - 58) < .51$, $p > .607$, $d < .21$. However, within participation characteristics, the assessed level of participant emotional lability was statistically significant, $t(36.71) = 2.70$, $p = 0.010$, $d = .81$. Participants in the Experiential Intervention were evaluated as more likely to display emotions during safety plan development, $M = .46$, $SD = .52$, than those participants in the Analytical Intervention, $M = .17$, $SD = .24$. One moderate effect, but non-statistically significant result, was identified with the Analytical Intervention participants, $M = 1.66$, $SD = .44$, evaluated as generating a safety plan tailored more to their needs than participants in the Experiential Intervention, $M = 1.50$, $SD = .51$; $t(58) = 1.36$, $p = .181$, $d = .34$. The remaining characteristics did not exhibit statistically significant between-group differences, with effect sizes ranging from small to negligible, $t(52 - 58) < .97$, $p > .283$, $d < .17$. In general, within this sample, the safety plans did not appear to differentiate between interventions with respect to overall quality. Minimal differences were identified, with no particular intervention favoured.

Additional Safety Plan Features

To continue to explore whether differences existed in the safety plans themselves between the interventions, two additional features were examined: (a) total number of safety strategies and (b) total number of safety strategy categories. These features were considered to represent facets of safety plan quality. Potential confounds including past safety planning experience, perceived degree of risk, and tried strategies as endorsed on the IPVSI (Goodman et al., 2003) were also explored.
Table 7. *Descriptive Statistics to Assess the Quality of Developed Safety Plans, Individual Characteristics*

<table>
<thead>
<tr>
<th></th>
<th>Analytical Intervention</th>
<th>Experiential Intervention</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M (SD)</td>
<td>M (SD)</td>
<td>M (SD)</td>
</tr>
<tr>
<td>Safety Plan Strategy Characteristics(^a)</td>
<td>8.00 (2.46)</td>
<td>8.26 (2.85)</td>
<td>8.13 (2.65)</td>
</tr>
<tr>
<td>Diverse strategies</td>
<td>1.23 (.60)</td>
<td>1.33 (.72)</td>
<td>1.28 (.66)</td>
</tr>
<tr>
<td>Specific strategies</td>
<td>1.25 (.50)</td>
<td>1.40 (.59)</td>
<td>1.33 (.55)</td>
</tr>
<tr>
<td>Feasible strategies</td>
<td>1.53 (.47)</td>
<td>1.60 (.42)</td>
<td>1.57 (.45)</td>
</tr>
<tr>
<td>Tailored strategies</td>
<td>1.67 (.44)</td>
<td>1.50 (.51)</td>
<td>1.58 (.48)</td>
</tr>
<tr>
<td>Effective strategies</td>
<td>1.25 (.58)</td>
<td>1.28 (.58)</td>
<td>1.27 (.58)</td>
</tr>
<tr>
<td>Comprehensive strategies</td>
<td>1.07 (.54)</td>
<td>1.15 (.63)</td>
<td>1.11 (.58)</td>
</tr>
<tr>
<td>Participation Characteristics(^b)</td>
<td>5.52 (2.01)</td>
<td>5.81 (2.05)</td>
<td>5.67 (2.01)</td>
</tr>
<tr>
<td>Participation in process</td>
<td>1.43 (.62)</td>
<td>1.57 (.49)</td>
<td>1.50 (.56)</td>
</tr>
<tr>
<td>Satisfaction in process</td>
<td>1.15 (.43)</td>
<td>1.09 (.54)</td>
<td>1.12 (.49)</td>
</tr>
<tr>
<td>Emotion exhibited</td>
<td>.17 (.24)**</td>
<td>.46 (.52)**</td>
<td>.31 (43)</td>
</tr>
<tr>
<td>Thoughtfulness exhibited</td>
<td>1.22 (.59)</td>
<td>1.33 (.65)</td>
<td>1.28 (.62)</td>
</tr>
<tr>
<td>Established rapport</td>
<td>1.56 (.54)</td>
<td>1.48 (.55)</td>
<td>1.52 (.54)</td>
</tr>
<tr>
<td>Predicted Utilization Characteristics(^c)</td>
<td>3.86 (1.74)</td>
<td>3.74 (1.63)</td>
<td>3.80 (1.67)</td>
</tr>
<tr>
<td>Short-term use</td>
<td>1.50 (.55)</td>
<td>1.50 (.55)</td>
<td>1.50 (.55)</td>
</tr>
<tr>
<td>Long-term use</td>
<td>1.09 (.66)</td>
<td>1.06 (.59)</td>
<td>1.07 (.62)</td>
</tr>
<tr>
<td>Implement alterations</td>
<td>1.17 (.70)</td>
<td>1.19 (.61)</td>
<td>1.18 (.65)</td>
</tr>
</tbody>
</table>

*Note. Average of expert ratings, 0 (Low) – 2 (High).*

\(^a\) Sum of averaged expert ratings, 0 – 12, N = 60, both interventions \( n = 30 \)

\(^b\) Sum of averaged expert ratings, 0 – 10, N = 54, both interventions \( n = 27 \)

\(^c\) Sum of averaged expert ratings, 0 – 6, N = 56, Analytical Intervention \( n = 29 \), Experiential Intervention \( n = 27 \)

\(^**\) \( p < .01 \)
**Total Number of Safety Strategies**

An independent samples *t*-test was conducted to evaluate the association between total number of strategies generated throughout the entire safety plan. Participants in the Analytical Intervention (*M* = 34.33, *SD* = 13.10) and the Experiential Intervention (*M* = 33.07, *SD* = 11.11) provided a large, and similar, amount of safety strategies, *t*(58) = .40, *p* = .688, *d* = .10.\(^{14}\) Additionally, study participants were requested to develop strategies across four areas: (a) overall safety strategies (i.e., an initial brainstorming attempt at providing strategies), (b) safety strategies to use in a potential re-victimization incident (i.e., before, during, and after a violent incident), (c) specific safety strategies (i.e., targeting the participants’ environment, support network, and personal well-being), and (d) safety strategies to address the impact of three risk factors identified by the participant as particularly relevant to risk (see Table 8 for descriptive statistics). Non-normality was present, due to a positive skew in this data. Therefore, between-group differences were analyzed using the Mann-Whitney *U* test. There were no statistically significant group differences across the first three sections of interest, *z* < .70, *p* > .482, *r* < .09. However, there was a trend toward significance for the number of strategies developed to address specific risk factors between the two intervention groups, *z* = 1.92, *p* = .054, *r* = .25. Participants in the Experiential Intervention group had a mean average rank of 34.80, in contrast to an average rank of 26.20 for participants involved in the Analytical Intervention. In general, however, safety plan quality, as assessed by the number of developed safety strategies, did not significantly differ between the two interventions.

**Total Number of Safety Strategy Categories**

As an additional method to examine safety plan quality, all safety strategies were catalogued into broader categories. Eleven categories were identified, see Table 9, and for a complete list of the strategies generated by participants refer to the Appendix, Table A2. To determine whether safety plan quality differed between the interventions, the total number of categories was analyzed using an independent samples *t*-test. The two intervention groups did not differ significantly, *t*(58) = .77, *p* = .444, *d* = .19, with both generating safety strategies across the multiple categories: Analytical Intervention (*M* = 8.90, *SD* = 1.58) and Experiential Intervention (*M* = 8.60, *SD* = 1.43). Across both interventions, in examining each individual category, no significant differences were identified, *χ*²(1, *N* = 60) < 2.07, *p* > .150, Cramer’s *V* < .18. One category, related to information (e.g., surveillance of partner and maintaining self-anonymity)

\(^{14}\) Analyses repeated removing maladaptive coping strategies duplicated this result, *t*(58) = .24, *p* = .812, *d* = .06. On average, participants provided one maladaptive strategy (*M* = 1.40, *SD* = 1.48, Range = 0 – 11).
Table 8. Descriptive Statistics to Assess the Quality of Developed Safety Plans, Total Number of Safety Strategies

<table>
<thead>
<tr>
<th></th>
<th>Analytical Intervention</th>
<th>Experiential Intervention</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M (SD)</td>
<td>Mdn</td>
<td>Range</td>
</tr>
<tr>
<td>Part 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>5.10 (2.98)</td>
<td>4</td>
<td>1 – 12</td>
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<tr>
<td>Part 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before</td>
<td>13.00 (5.87)</td>
<td>11</td>
<td>5 – 29</td>
</tr>
<tr>
<td>During</td>
<td>4.37 (2.04)</td>
<td>4</td>
<td>0 – 14</td>
</tr>
<tr>
<td>After</td>
<td>5.67 (4.02)</td>
<td>2</td>
<td>1 – 10</td>
</tr>
<tr>
<td></td>
<td>2.97 (1.77)</td>
<td>2.5</td>
<td>1 – 8</td>
</tr>
<tr>
<td>Part 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment</td>
<td>11.07 (6.01)</td>
<td>10</td>
<td>3 – 27</td>
</tr>
<tr>
<td>Support</td>
<td>4.37 (2.76)</td>
<td>4</td>
<td>0 – 14</td>
</tr>
<tr>
<td>Well-Being</td>
<td>2.77 (2.14)</td>
<td>2</td>
<td>1 – 10</td>
</tr>
<tr>
<td></td>
<td>3.93 (2.92)</td>
<td>3</td>
<td>0 – 12</td>
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<tr>
<td>Part 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Factors</td>
<td>5.17 (2.33)</td>
<td>5.5</td>
<td>2 – 10</td>
</tr>
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</table>

*Note.* Total N = 60, n = 30 for each intervention.
<table>
<thead>
<tr>
<th>Category</th>
<th>Analytical Intervention</th>
<th>Experiential Intervention</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Informal Network</td>
<td>28</td>
<td>93%</td>
<td>30</td>
</tr>
<tr>
<td>Relationship Changes</td>
<td>26</td>
<td>87%</td>
<td>28</td>
</tr>
<tr>
<td>Resistance</td>
<td>28</td>
<td>93%</td>
<td>25</td>
</tr>
<tr>
<td>Safety Measures</td>
<td>27</td>
<td>90%</td>
<td>26</td>
</tr>
<tr>
<td>Coping/Vulnerability</td>
<td>27</td>
<td>90%</td>
<td>26</td>
</tr>
<tr>
<td>Formal Network: Self</td>
<td>25</td>
<td>83%</td>
<td>26</td>
</tr>
<tr>
<td>Empowerment</td>
<td>24</td>
<td>80%</td>
<td>23</td>
</tr>
<tr>
<td>Avoid/Ignore</td>
<td>22</td>
<td>73%</td>
<td>21</td>
</tr>
<tr>
<td>Legal</td>
<td>21</td>
<td>70%</td>
<td>20</td>
</tr>
<tr>
<td>Information</td>
<td>22</td>
<td>73%</td>
<td>15</td>
</tr>
<tr>
<td>Placating</td>
<td>17</td>
<td>57%</td>
<td>18</td>
</tr>
</tbody>
</table>

*Note. Total sample size, N = 60, with n = 30 for each intervention.*
exhibited a moderate effect size, Cramer’s $V = .24$. Participants in the Analytical Intervention (73%, $n = 22$) provided more safety strategies for this category than Experiential Intervention participants (50%, $n = 15$). Generally, however, safety plan quality, as assessed by this feature of the safety plans, did not discriminate between participants involved in the two interventions.

Equivalency in safety plan quality between the two study interventions was not expected. Therefore, to ensure the validity of this finding, additional analyses were performed to eliminate other explanations (i.e., confounding variables). First, past safety planning experience was hypothesized to potentially influence quality of the current safety plan. With this sample, past safety planning experience did not confer an advantage to participants ($n = 20$) in terms of evaluated safety plan quality, $t(58) = 1.215$, $p = .231$, total number of safety strategies, $t(58) = 1.35$, $p = .182$, or categories generated, $t(58) = 1.69$, $p = .063$. Effect size calculations ($d = .33 - .51$) seem to suggest otherwise. However, controlling for previous safety planning experience (binary coded) with intervention type as an independent variable, did not produce differing results for the three safety plan quality outcomes in separate ANCOVAs, $F(1, 56) < 1.43$, $p > .244$, $\eta^2 < .07$.

As a second potential confound, participants who perceived themselves at high risk for re-victimization could develop more comprehensive safety plans, irrespective of intervention. This was not identified through the use of ANCOVA, with victim self-appraised risk (post-intervention, but pre-safety planning) entered as a covariate and intervention type entered as an independent variable in the analysis, $F(1, 55) = .003$, $p > .954$, $\eta^2 = .04$. In controlling for victim-rated level of risk, safety plan quality also did not appear to vary significantly between the two interventions.

Lastly, as a third confound, the IPVSI (Goodman et al., 2003) was used to identify safety strategies employed by participants prior to their participation in this study. A similar number of safety strategies had been tried by participants in both the Analytical Intervention, $M = 19.75$, $SD = 7.98$, and Experiential Intervention, $M = 19.93$, $SD = 6.74$; $t(55) = .093$, $p > .926$, $d = .03$. The IPVSI also consists of six subscales: Resistance, Placating, Legal, Informal Network, Formal Network, and Safety Planning (Goodman et al., 2003; see Table 10). No statistically significant differences were found between the two interventions in the number of tried strategies within

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15 The number of strategies within each category was also analyzed, similarly demonstrating no statistically significant between-group differences, $t(58) < 1.63$, $p > .109$, $d < .19$, with the exception of the information category: Analytical Intervention, $M = 1.63$, $SD = 2.12$, and Experiential Intervention, $M = .73$, $SD = .86$, $t(58) = 2.15$, $p = .036$, $d = .60$. 

65
Table 10. *Descriptive Statistics for the Intimate Partner Violence Strategies Index*

<table>
<thead>
<tr>
<th></th>
<th>Analytical Intervention</th>
<th>Experiential Intervention</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M (SD)</td>
<td>Mdn</td>
<td>Range</td>
</tr>
<tr>
<td>Resistance</td>
<td>3.73 (2.09)</td>
<td>4</td>
<td>0 – 7</td>
</tr>
<tr>
<td>Placating</td>
<td>3.33 (1.54)</td>
<td>3</td>
<td>0 – 5</td>
</tr>
<tr>
<td>Legal</td>
<td>1.57 (1.30)</td>
<td>1.5</td>
<td>0 – 4</td>
</tr>
<tr>
<td>Informal Network</td>
<td>1.80 (1.35)</td>
<td>2</td>
<td>0 – 4</td>
</tr>
<tr>
<td>Formal Network</td>
<td>4.20 (2.45)</td>
<td>2</td>
<td>0 – 9</td>
</tr>
<tr>
<td>Safety Planning</td>
<td>3.81 (2.88)</td>
<td>3.5</td>
<td>0 – 9</td>
</tr>
</tbody>
</table>

*Note.* The Intimate Partner Violence Strategies Index (IPVSI; Goodman, Dutton, Weinfurt, & Cook, 2003). Scores are a summed total of the number of strategies endorsed that the participant had tried in her abusive relationship, maximum of 39. Total sample size, N = 59, with n = 30 and n = 29 for the Analytical and Experiential interventions, respectively.
each of the six subscales, Mann-Whitney U test, \( z < 1.87, p > 0.061, r < 0.20 \). Controlling for the total number of tried safety strategies, with intervention type as an independent variable, did not produce differing results for the three safety plan quality outcomes in separate ANCOVAs, \( F(3, 53) < 0.358, p > 0.783, \eta^2 < 0.02 \). The analyses were not repeated with each subscale, due to limitations in sample size. Although other potential confounds exist, these findings provide some assurance that the finding of equivalence in safety plan quality across the two interventions may be robust.

Summary. Quality of safety plans was examined using three different representations of quality with potential confounds also explored. Safety plan quality appeared comparable across both interventions. Thus, the a priori hypothesis that Experiential Intervention participants would produce lower quality safety plans, when compared to Analytical Intervention participants, was not supported by this data.

Research Question Four

Do cognitive or affective interventions influence satisfaction with safety planning?

Participants completed a written survey involving two sections, the first of which is referred henceforth as consumer satisfaction characteristics. Thirteen attributes were assessed by each participant (e.g., confidence in, and satisfaction with, the developed safety plan). The second section included participants’ evaluation of the administrator (AG) of the safety planning intervention - referred henceforth as administrator characteristics. This component included eight attributes and involved, for example, an evaluation of the level of respect and empathy provided by the administrator (see Table 11 for descriptive statistics). For this research question, it was hypothesized that, overall, satisfaction with the safety planning interventions would be moderate, with Experiential Intervention participants experiencing less satisfaction than Analytical Intervention participants.

Comparing Safety Planning Interventions by Intervention Type

Overall ratings for both consumer satisfaction and administrator characteristics were calculated by averaging scores across the applicable domains. The majority of data fell within the upper range of the 0 – 10 scale; thus, a ceiling effect was observed. Notably, a substantive

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16 For the consumer satisfaction section, three items were reverse scored: level of vulnerability, fear, and anxiety experienced.
Table 11. Descriptive Statistics for Participant Evaluations of the Safety Planning Interventions: Consumer Satisfaction Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Analytical Intervention</th>
<th>Experiential Intervention</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( n = 26 )</td>
<td>( n = 23 )</td>
<td>( N = 49 )</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>8.29 (1.96)</td>
<td>9.00 (1.54)</td>
<td>8.61 (1.79)</td>
</tr>
<tr>
<td>Usefulness</td>
<td>8.33 (2.18)</td>
<td>9.00 (1.76)</td>
<td>8.64 (2.00)</td>
</tr>
<tr>
<td>Comprehensiveness</td>
<td>8.33 (2.06)</td>
<td>8.39 (1.85)</td>
<td>8.35 (1.95)</td>
</tr>
<tr>
<td>Tailored</td>
<td>8.00 (2.58)</td>
<td>8.96 (1.80)</td>
<td>8.45 (2.27)</td>
</tr>
<tr>
<td>Confidence</td>
<td>8.00 (2.58)</td>
<td>8.70 (1.82)</td>
<td>8.58 (1.94)</td>
</tr>
<tr>
<td>Comfort</td>
<td>8.21 (2.19)</td>
<td>8.67 (1.81)</td>
<td>8.43 (2.01)</td>
</tr>
<tr>
<td>Empowerment felt</td>
<td>8.34 (1.95)</td>
<td>8.52 (1.95)</td>
<td>8.43 (1.93)</td>
</tr>
<tr>
<td>Vulnerability felt</td>
<td>4.73 (3.41)</td>
<td>5.39 (2.98)</td>
<td>5.04 (3.20)</td>
</tr>
<tr>
<td>Anxiety felt</td>
<td>5.19 (3.59)</td>
<td>5.13 (2.63)</td>
<td>5.16 (3.14)</td>
</tr>
<tr>
<td>Fear felt</td>
<td>3.83 (3.41)</td>
<td>4.61 (3.07)</td>
<td>4.28 (3.23)</td>
</tr>
<tr>
<td>Competency felt</td>
<td>7.31 (3.07)</td>
<td>7.72 (2.46)</td>
<td>7.50 (2.78)</td>
</tr>
<tr>
<td>New information learnt</td>
<td>7.23 (2.52)</td>
<td>8.43 (2.21)</td>
<td>7.78 (2.43)</td>
</tr>
<tr>
<td>Potential for improving safety</td>
<td>7.53 (3.06)</td>
<td>7.04 (2.96)</td>
<td>7.30 (2.99)</td>
</tr>
</tbody>
</table>

Note. Rated 0 – 10 on a Likert Scale (0 = Low and 10 = High).
proportion of participants (98%, n = 54) reported they would recommend the safety planning intervention to other victims of IPV.

Consumer Satisfaction Characteristics

Considering the ceiling effect, not surprisingly, overall ratings of consumer satisfaction was similar between the Analytical Intervention (M = 7.56, SD = 1.71) and Experiential Intervention (M = 7.68, SD = 1.18) participants. To address the ceiling effect, the data was examined using a median split (Mdn = 7.69). No intervention was particularly favoured by participants, χ²(1, N = 57) = .02, p = .889, Cramer’s V = .018. In addition, the individual parameters that comprise the consumer satisfaction component were examined using the Mann-Whitney U test. Results of these analyses indicated there were no between group intervention type differences for all thirteen parameters, z < 1.58, p > .115, r < .20. In general, participants in both interventions appeared satisfied with the content of the safety planning intervention.

Administrator Characteristics

Means for the summed administrator characteristic ratings were 9.36 (SD = .90) and 9.54 (SD = 1.10) for the Analytical Intervention and Experiential Intervention participants, respectively. Consistent with the analysis of the consumer satisfaction data, a median split of the administrator characteristic ratings was used for comparison (refer to Table 12 for descriptive statistics). In examining the data in this manner, the median score was 10 (i.e., the highest rating), reinforcing the need for non-parametric analyses. Satisfaction with the administrator varied by intervention, χ²(1, N = 57) = 4.03, p = .045, Cramer’s V = .27. Approximately 68% of Experiential Intervention participants were placed in the high median group, compared to 41% of Analytical Intervention participants. In further examining the individual administrator characteristics, Experiential Intervention participants (Mean Rank = 33) reported greater satisfaction in the rapport established with the administrator of the safety planning intervention than Analytical Intervention participants (Mean Rank = 24), z = 2.35, p = .019, r = .31. No other significant differences between the interventions were identified for the remainder of the individual administrator characteristics, Mann-Whitney U test, z < 1.77, p > .077. Small to moderate effect sizes (r < .24) were evident, that favoured the Experiential Intervention. Overall, characteristics of the administrator were favoured more by Experiential Intervention than Analytical Intervention participants. This finding was likely driven by the result demonstrating greater satisfaction in rapport established between the Experiential Intervention participants and the administrator, compared to satisfaction ratings by Analytical Intervention participants.
Table 12. Descriptive Statistics for Participant Evaluations of the Safety Planning Interventions; Administrator Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Analytical Intervention</th>
<th>Experiential Intervention</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n = 26$</td>
<td>$n = 28$</td>
<td>$N = 54$</td>
</tr>
<tr>
<td>Rapport established</td>
<td>8.65 (1.60)* Mdn 9.75 Range 6 – 10</td>
<td>9.27 (1.81)* Mdn 10 Range 2.5 – 10</td>
<td>8.97 (1.72) Mdn 10 Range 2.5 – 10</td>
</tr>
<tr>
<td>Listening abilities</td>
<td>9.59 (0.75) Mdn 10 Range 8 – 10</td>
<td>9.54 (1.35) Mdn 10 Range 5 – 10</td>
<td>9.56 (1.09) Mdn 10 Range 5 – 10</td>
</tr>
<tr>
<td>Confidence in her safety planning skills</td>
<td>9.21 (1.20) Mdn 10 Range 6 – 10</td>
<td>9.50 (1.23) Mdn 10 Range 5 – 10</td>
<td>9.36 (1.21) Mdn 10 Range 5 – 10</td>
</tr>
<tr>
<td>Respect provided</td>
<td>9.69 (0.77) Mdn 10 Range 7 – 10</td>
<td>9.71 (1.01) Mdn 10 Range 5 – 10</td>
<td>9.70 (0.90) Mdn 10 Range 5 – 10</td>
</tr>
<tr>
<td>Overall quality of service provided</td>
<td>9.57 (0.86) Mdn 10 Range 7 – 10</td>
<td>9.57 (1.10) Mdn 10 Range 5 – 10</td>
<td>9.57 (0.98) Mdn 10 Range 5 – 10</td>
</tr>
</tbody>
</table>

*Note. Rated 0 – 10 on a Likert Scale (0 = Low and 10 = High). *p < .05
Comparing Current Versus Previous Safety Planning Interventions

Participants with past safety planning experience evaluated both the current and previous interventions on consumer satisfaction and administrator characteristics. One third of the sample reported previously developing a safety plan prior to their participation in this study. The majority (73%) of the previous safety plans were developed through participants accessing formal services, including shelters (56%), counselling programs (31%), or in conjunction with the criminal justice system (e.g., victim services; 13%). Approximately 90% of participants reported developing one plan in total, an average of 24 months prior to participation in the research (SD = 41.25; Range = .5 – 144 months). Sixty percent (n = 12) of participants reported currently relying on their safety plan. Participants recalled between one and four specific safety strategies, with the majority (50%, n = 6) recalling one strategy. Participants with past safety plan experience were found in both interventions: Analytical Intervention (n = 11) and Experiential Intervention (n = 9), $\chi^2(1, N = 60) = .30, p = .584$, Cramer’s $V = .07$.

Consumer Satisfaction Characteristics

Current and past safety planning interventions were compared on overall consumer satisfaction (see Figure 4). The results indicated a significant difference, Wilcoxon Matched Pairs Signed Ranks test, $z = 3.36, p < .001, r = .84$. The majority of participants (88%) reported greater consumer satisfaction with the current intervention ($Mdn = 7.69$) than the past intervention ($Mdn = 5.68$). Nine of the thirteen consumer satisfaction characteristics evidenced statistically significant differences, Wilcoxon Matched Pairs Signed Ranks test, $z > 1.96, p < .050, r > .52$, consistently favouring the current safety planning intervention. Analyses comparing consumer satisfaction ratings between interventions were not performed as the sample size was prohibitive. Overall, participants with past safety planning experience exhibited greater consumer satisfaction with the current than previous safety planning intervention.

Administrator Characteristics

Data for the administrator characteristics were limited (see Figure 5),\(^\text{17}\) although the sample size was sufficient to produce a reliable result (Lowry, 2011). Within-group differences on the summed administrator characteristics ratings was statistically significant, Wilcoxon Matched Pairs Signed Ranks test, $z = 2.52, p = .012, r = .80$. The majority of participants (80%) reported greater satisfaction with the current intervention than the past intervention; twenty

\(^{17}\)This small sample may be due participants overlooking these questions on the written survey and/or related to participant fatigue.
Figure 4. Overall Differences in Satisfaction between Current and Past Safety Planning Interventions, Consumer Satisfaction Characteristics

*Figure 4. Satisfaction ratings between 0 (Low) and 10 (High). Error bars represent standard error. n = 13 - 17. * p < .05, ** p < .01.*
**Figure 5. Overall Differences in Satisfaction between Current and Past Safety Planning Interventions, Administrator Characteristics**

*Figure 5. Satisfaction ratings between 0 (Low) and 10 (High). Error bars represent standard error. \( n = 8 - 11. \) \( * p < .05. \)
percent had tied ratings. Statistically significant differences were identified on seven of the eight individual administrator characteristics traits, Wilcoxon Matched Pairs Signed Ranks test, \( z > 2.03, p < .042, r > .68 \). Although not statistically significant, a large effect size \( (r = .62) \) was present for one trait, confidence in the administrator’s safety planning capability. Analyses were not performed to compare individual traits by intervention as the small sample would not produce reliable results. In general, participants appeared to exhibit greater satisfaction with their current than past safety planning intervention on key administrator characteristics.

**Summary.** The results of this section highlight that participants were satisfied, at least moderately, with the content of the current safety planning intervention. However, contrary to the initial hypothesis, Experiential Intervention participants expressed more satisfaction with administrator characteristics than Analytical Intervention participants. This may be attributed to the degree of satisfaction expressed by Experiential Intervention participants with the administrator in establishing rapport. Notably, when current experiences with a safety planning intervention were contrasted with past safety planning experiences, participants favoured the study intervention. However, a more in-depth analysis (i.e., to identify intervention differences) was not permitted, due to a limited sample size.

**Research Question Five**

*Do cognitive or affective interventions influence re-victimization risk?*

For this final question, it was hypothesized that Experiential Intervention participants may be vulnerable to re-victimization, more so than Analytical Intervention participants. Sixty percent of participants completed the follow-up wherein re-victimization status was determined. Re-victimization rates were solicited from participants for physical abuse, psychological abuse, stalking/harassment, or other forms of victimization not captured by the previous categories (e.g., stalking/harassment of a family member). Re-victimized \( (n = 12) \) and non re-victimized participants \( (n = 24) \) did not differ on relevant demographic characteristics or partner-relationship variables, \( p > .071 \).\(^{18}\)

To explore whether re-victimization status was influenced by intervention type, two separate analyses were conducted: (a) yes/no for any re-victimization and (b) the number of incidents of re-victimization. Twelve participants reported re-victimization, with 19 incidents

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\(^{18}\) Education status differed significantly between the two groups, Fisher’s Exact Test, \( \chi^2(1, N = 36) = 7.07, p = .011 \), Cramer’s \( V = .44 \), with re-victimized woman reporting higher education. This likely was an extraneous relationship and not one that influenced vulnerability to re-victimization.
reported. For the first analyses, seven Analytical Intervention participants and five Experiential Intervention participants reported re-victimization. This was not statistically significant, $\chi^2(1, N = 36) = 1.41, p = .236$, with a weak association, Cramer’s $V = .20$. However, in examining incident rates employing a z-test for proportions, a statistically significant difference was observed, $z = 1.90, p = .050, r = .44$. Analytical Intervention participants were more likely involved in a re-victimization incident (68%; 13 incidents including the incident of physical violence) than Experiential Intervention participants (32%; 6 incidents); this equates to an odds ratio of 2.13. The reported incidents were as follows: psychological abuse (Analytical Intervention, $n = 5$, and Experiential Intervention, $n = 4$), stalking (Analytical Intervention, $n = 5$, and Experiential Intervention, $n = 1$) and other (Analytical Intervention, $n = 2$, and Experiential Intervention, $n = 1$). Only one incident of physical abuse and no incidents of sexual abuse were reported. Accessibility was not a factor; only one participant maintained an intimate relationship with her abusive partner. The participant who experienced physical violence had terminated her relationship with the index partner. In examining re-victimization status, Analytical Intervention participants were involved in more encounters with the index partner than Experiential Intervention participants.

To discount the possibility that re-victimization status was related to degree of risk - not a true intervention effect - subsequent analyses were attempted. That is, participants at higher risk may account for vulnerability to re-victimization in general, regardless of intervention. Furthermore, more high risk participants may have been included in the Analytical Intervention, thus accounting for the findings. To also address participants’ propensity to undervalue risk, an expert evaluation of risk was used (i.e., B-SAFER summary risk rating). Choice of statistical analysis was limited by the small sample size. A cursory examination, using z-test for proportions ($n = 19$), revealed that vulnerability to re-victimization may be biased towards high risk participants, $z = 1.96, p = .050$. However, in both interventions, high risk participants were as likely to be re-victimized as not: Analytical Intervention, $z = 1.35, p = .177$, and Experiential Intervention, $z = 1.17, p = .242$. An almost equal number of participants were designated high risk in the Analytical ($n = 6$) and Experiential ($n = 5$) Interventions. This confound did not appear to be applicable to this study data. However, due to the low base rate of re-victimization in this sample, this may not be an entirely reliable finding.

Another potential factor influencing re-victimization risk concerns whether participants implemented the developed safety plan. For example, a participant that used fewer safety strategies may be more vulnerable to re-victimization. The majority of participants (87%) recalled
specific details of their safety plan, reporting employing between one and ten safety strategies in the month prior to the follow-up, $M = 3.64$, $SD = 2.43$. Overall, the number of strategies used by participants was associated with re-victimization status, $t(34) = 2.78$, $p = .009$, $d = .82$, with more strategies employed by re-victimized, $M = 5.25$, $SD = 3.10$, than non re-victimized participants, $M = 2.92$, $SD = 1.93$. No statistically significant differences were identified for Experiential Intervention participants, Mann-Whitney $U$ test, $z = .76$, $p = .447$, $r = .17$. However, in the Analytical Intervention, re-victimized participants reported employing a greater number of strategies (Mean Rank = 12) than non re-victimized participants (Mean Rank = 5), $z = 2.73$, $p = .006$, $r = .68$. Contrary to expectation, participants relying on a greater number of strategies were re-victimized, particularly for the Analytical Intervention participants.

Lastly, related to the developed safety plan, it was also posited that a safety plan independently evaluated as low quality could be associated with victim re-victimization status. Safety plan quality was independently evaluated as comparable between re-victimized and non re-victimized participants, Mann-Whitney $U$ test, $z = .25$, $p = .265$, $r = .04$. Thus, a quality safety plan may not fully protect a victim from re-victimization. In sum, these results suggest that, despite participants’ use of multiple strategies and a better quality safety plan, victimization may still recur.

**Summary.** The original hypothesis, that Experiential Intervention participants may be vulnerable to re-victimization, was not supported with the data in the current study. In contrast to Analytical Intervention participants, Experiential Intervention participants were less likely to be involved in re-victimization incidents. Degree of risk, number of employed safety strategies, and quality safety plan did not account for the differential rate of re-victimization between interventions. However, this interpretation is proffered with the caveat that sample sizes for analyses were small.

**Victim’s Voice: Revisited**

To revisit the original victim’s voice debate, it was questioned whether a victim or an expert would be more accurate in predicting victimization status. One method to approach this question was through logistic regression analyses. Victim overall evaluations of risk (post-intervention) with intervention type, as predictors of re-victimization status in a logistic regression model, produced statistically significant results, $\chi^2(2, N = 34) = 8.18$, $p = .017$. This model was able to correctly classify 91% of non re-victimized participants and 58% of re-victimized participants, for an overall success rate of 79%. Table 13 includes the logistic regression coefficient, Wald $\chi^2$ test, and odds ratio for each of the predictor variables. Partial
effects were identified for the victim appraisal of risk; participants assessed as high risk were more likely to be re-victimized (i.e., odds ratio of 1.39) than low self-appraised risk participants.

To determine whether expert evaluations of risk could predict re-victimization status, the B-SAFER and ODARA were examined. Actuarial assessments of risk with intervention type as predictor variables in a logistic regression (B-SAFER and ODARA total scores) were unable to predict re-victimization status, $\chi^2(2, N = 34) > 1.63, p > .283$. However, similar analyses using the summary risk ratings of the B-SAFER, a SPJ measure, produced significant results, $\chi^2(4, N = 34) = 12.31, p = .015$. This model was able to correctly classify 83% of non re-victimized participants and 67% of re-victimized participants, for an overall success rate of 78%. Table 13 shows the logistic regression coefficient, Wald $\chi^2$ test, and odds ratio for each of the predictor variables, none of which had significant partial effects. Participants were less able to accurately predict re-victimization than non re-victimization, whereas this was not evident for expert evaluations of risk. This is not an entirely unexpected result, given that participants underestimated risk in contrast to expert opinion and the low base rate of re-victimization in this sample. The SPJ measure demonstrated better predictive accuracy than the actuarial measures.

An alternative methodology to examine this research question uses accuracy categories (Bell, Bennett Cattaneo, Goodman, & Dutton, 2008). Participants were categorized into four groups: (a) true positive (high risk and re-victimization), (b) false positive (high risk and no re-victimization), (c) true negative (low risk and no re-victimization), and (c) false negative (low risk and re-victimization). Both true positive and true negative are accurate predictions. This method is purported to be more informative than other techniques, as it provides values for both correct and incorrect predictions (Bell et al., 2008). Using victim ratings of overall risk, accuracy was 66% (pre-intervention) and 64% (post-intervention). When accurate, participants were better at predicting true negatives (57%; post-intervention) than true positives (10%). When inaccurate, participants were more likely to predict false negatives (27%) than false positives (6%). Comparably, accuracy for expert assessments, based on the B-SAFER overall summary risk rating, was 64%. Dichotomizing the B-SAFER (median split) and ODARA total score (using a score of seven and above, per Connor-Smith et al., 2011), accuracy was 65% and 42%, respectively. Fisher’s Exact Tests, used to determine whether victim and expert appraisals differed significantly regarding accuracy categories, were not statistically significant for all comparisons, $\chi^2(1, N = 33) > 1.05, p > .305$, Cramer’s $V < .27$. Although not significant, a moderate effect size (Cramer’s $V = .27$) was evident for the ODARA and victim risk appraisal,
Table 13. Logistic Regressions Predicting Re-victimization Status from Victim Appraised Ratings of Risk (Model 1), ODARA Total Score (Model 2), B-SAFER Total Score (Model 3), or B-SAFER Summary Risk (Model 4), with Intervention Type

<table>
<thead>
<tr>
<th>Model</th>
<th>B</th>
<th>SE</th>
<th>Wald $\chi^2$</th>
<th>p</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victim Appraised Risk</td>
<td>.32</td>
<td>.15</td>
<td>4.76</td>
<td>.029*</td>
<td>1.39</td>
</tr>
<tr>
<td>Intervention$^b$</td>
<td>-1.55</td>
<td>.87</td>
<td>3.13</td>
<td>.077</td>
<td>.21</td>
</tr>
<tr>
<td>ODARA Total Score</td>
<td>.07</td>
<td>.15</td>
<td>.23</td>
<td>.633</td>
<td>1.07</td>
</tr>
<tr>
<td>Intervention$^b$</td>
<td>-.89</td>
<td>.73</td>
<td>1.48</td>
<td>.224</td>
<td>.41</td>
</tr>
<tr>
<td>B-SAFER Total Score</td>
<td>.10</td>
<td>.10</td>
<td>1.05</td>
<td>.305</td>
<td>1.10</td>
</tr>
<tr>
<td>Intervention$^b$</td>
<td>-.96</td>
<td>.75</td>
<td>1.65</td>
<td>.199</td>
<td>.38</td>
</tr>
<tr>
<td>B-SAFER Summary Risk$^a$</td>
<td>2.55</td>
<td>1.15</td>
<td>4.88</td>
<td>.027*</td>
<td>12.81</td>
</tr>
<tr>
<td>Intervention$^b$</td>
<td>-1.10</td>
<td>.81</td>
<td>1.82</td>
<td>.177</td>
<td>.33</td>
</tr>
</tbody>
</table>

Note. Ontario Domestic Assault Risk Assessment (ODARA; Hilton, Harris, & Rice, 2004) and Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER; Kropp, Hart, & Belfrage, 2005). Victim appraised risk rated as either Low or Moderate-High.

$^a$ High risk as the comparison group.

$^b$ Experiential intervention as the comparison group.

*p < .05
indicative of a potentially meaningful difference in accuracy. Although, this result is likely influenced by the questioned fidelity of the instrument in this study.\textsuperscript{19} In general, excluding the results of the ODARA, accuracy was similar pre-intervention and post-intervention with at least equivalent rates of accuracy in prediction between victim and expert-rated risk.

To examine whether differences in accuracy were influenced by participation in a particular intervention, subsequent analyses were conducted. It is noted that sample sizes for the between group comparisons were small. Between-group intervention differences were not identified in accuracy at pre-intervention, $\chi^2(1, N = 36) = 1.41, p = .236$, Cramer’s $V = .19$, with accuracy rated at 75% ($n = 20$) and 56% ($n = 16$) for the Experiential and Analytical Intervention, respectively. Experiential Intervention participants exhibited greater accuracy post-intervention (68%, $n = 19$) compared to the Analytical Intervention participants (57%, $n = 14$), although this was not statistically significant, $\chi^2(1, N = 35) = .44, p = .506$, Cramer’s $V = .11$. No pre- and post-intervention changes in accuracy were identified for either intervention, $z$-test for proportions, $z > .32, p > .126$. These results suggest that accuracy was not significantly influenced by intervention, although a slight bias may be present towards the Experiential Intervention in providing more accurate risk assessments.

**Summary.** In contrast to expert ratings of risk, accuracy in prediction was comparable, if not better, for victim-based risk ratings. Differences in accuracy were identified when assessments were made with actuarial, SPI, or victim assessment. Accuracy rates were similar after involvement in either intervention, although participation in the Experiential Intervention appeared to potentially confer some benefit.

\textsuperscript{19} Accuracy decreased to 39% if participants were excluded from the analyses that violated the rules of the ODARA; however, a small sample ($n = 13$) was used.
DISCUSSION

Intimate partner violence is a global problem, adversely affecting a disproportionate number of women. The unique nature of IPV, by virtue of the interpersonal and cyclical dynamic, ensures that once victimized women may likely experience repeated victimization (Langan & Innes, 1986). However, these features also confer an advantage – the more-or-less predictable nature of IPV serves as a potential basis for prevention. Risk assessment and safety planning have both been developed for the purpose of preventing IPV re-victimization. Few studies have consolidated IPV risk assessment and safety planning in one intervention (e.g., Niolon et al., 2009), particularly when collaborating with victims. The study described herein was designed to examine the victim’s voice as conceptualized from a dual-mode processing of risk: risk as analysis and risk as feelings. This study represents an initial investigation into the effects of analytical and experiential processing on IPV victim appraisals of risk and fear, and subsequent influence on safety plan quality, consumer satisfaction, and re-victimization status. This study also demonstrates how victim risk and fear appraisals may change after involvement in an intervention. It provides some of the first empirical data on how victim appraisals correspond to expert assessments. Below provides a summary and discussion of the five research questions under examination. Explanations for the results of these findings are restricted in their definitiveness by the limits acknowledged in this study (see Limitations section).

Research Question One

Do cognitive or affective interventions influence the association between expert and victim appraisals of risk?

Recent attention has focused on the validity and utility of victim appraisals in risk for IPV re-victimization (Bowen, 2011). Rather than recapitulate the debate here, one question is whether expert-rated and victim-rated assessments of risk are comparable. In the present study, overall correspondence between expert and victim assessments of risk was modest. This is consistent with previous research by Lass (2007), and Connor-Smith and colleagues (2010), where a modest association was reported between victim-rated and expert-rated risk assessments with the DA and (simulated) ODARA, respectively. The sum of these studies including this one suggests that, although expert and victim assessments of risk may not align, correspondence does exist. Despite
the reliance on different sources (i.e., information compiled to complete a formal risk assessment versus personal lived experience), similar information may be extracted to form the basis of both expert and victim risk assessments. Connor-Smith and colleagues (2010) suggest that victims of IPV are likely to reflect on perpetrator characteristics in their risk appraisals; risk factors that are also an element of formal risk assessment. Continued exploration, and potential collaboration between expert qua trained professional and expert qua victim appears warranted in understanding assessments of IPV re-victimization risk (Whittemore & Kropp, 2002).

There are several potential explanations for divergence in correspondence between expert and victim ratings of risk. First, in the present study, this discrepancy may be attributable to participants’ underestimation of risk. This deflation in risk is potentially explained by various phenomena including: habituation (i.e., the presence of constant risk may generate less concern than is warranted; Nicolaidis et al., 2003), optimistic bias (i.e., one’s belief that a lower risk for negative outcomes exists for oneself than is objectively present; Martin et al., 2000), or relative bias (i.e., one’s belief that other people are at greater risk of harm than oneself; Nicolaidis et al., 2003). Generally, individuals perceive their risk of likely events (e.g., interpersonal violence) lower than unlikely events (e.g., airplane crash; Loewenstein et al., 2001). This devaluation of risk has been previously identified specific to victims of IPV (e.g., Kropp, 2004). As an alternative explanation, risk assessments may be conditional on relationship status. For instance, in one study (Harding & Helweg-Larsen, 2009), women rated their personal risk of IPV re-victimization as low if their relationship had terminated. This may be particularly relevant to this study sample, as a large proportion had terminated the relationship with the index partner. As a final explanation, the discrepancy in correspondence may reflect the interactional nature of intimate relationships not captured in traditional risk assessment measures (e.g., the degree of emotional attachment to a partner despite abuse or hope that a partner may improve or change with treatment). Victim vulnerability factors are increasingly being included in IPV risk assessment (Kropp et al., 2008). These factors have evidenced predictive capability in assessing recidivism risk independent of perpetrator-focused risk factors (Belfrage & Strand, 2008). The demonstration of both convergence and divergence from expert opinion in this study likely reflects the aggregate nature of data (i.e., macro-level). Each woman’s personal experiences of IPV (i.e., micro-level) may influence whether her risk assessment corresponds with an expert assessment.

Relevant to the victim’s voice debate is whether victim appraisals of risk were influenced by involvement in an intervention; that is, whether guiding participants in identifying risk factors
would result in an alteration in self-appraised risk. Lass (2007) employed a similar methodology as this study: participants completed the DA on their own, the results were reviewed with an expert, and the participants’ again completed the DA on their own. With the Lass intervention, 50% of participants increased their estimates of risk for re-victimization after being provided expert feedback. This is consistent with the opinion that a woman’s perception of risk could be “subjected and shaped” by expert guidance in completing formal risk assessments (Walklate & Mythen, 2011, p. 108). This was not observed in the present study – for example, the majority (75%) of participants’ ratings of risk were consistent pre- and post-intervention. On further examining the results of the Lass study (2007), it appears that participants re-evaluated their “high” risk as “extremely high.” Whether this is a clinically significant change is debatable - high risk is high risk, requiring intensive safety planning and risk management, despite use of varying descriptors. In adopting this perspective, the results of the Lass study and the present study coincide: victims of IPV may not alter their initial appraisal drastically (e.g., changing one’s appraisal from high to low risk). Whether this consistency in risk rating in this study is due to victim’s relying upon other sources of information than the expert, ignoring or misunderstanding the guidance of the expert, denying the present risk, expressing confidence in one’s own prediction, or is simply an accurate assessment of risk, requires further study.

Regarding the dual-mode processing conceptualization of risk, another component of this research question concerned whether each mode of processing would correspond with its proxy risk assessment instrument. For instance, Analytical Intervention participant risk ratings were expected to correspond with the actuarial IPV risk assessment measures, as both are conceptually similar (i.e., do not rely on discretion or affect). Conversely, the Experiential Intervention participant risk ratings were expected to align more with the SPJ measure. In the present study, the expected pattern was demonstrated with the actuarial measures (i.e., greater correspondence for the Analytical Intervention than Experiential Intervention). This result replicates past research manipulating processing mode to examine whether there is an impact on judgments and decision-making (e.g., Krauss et al., 2004; Lieberman et al., 2007). This further confirms that assessments of risk with actuarial measures may involve analytical processing.

For the SPJ approach, the expected pattern was not identified in this study. Analytical Intervention participants risk ratings exhibited a stronger correspondence with the SPJ measure than Experiential Intervention participants’ risk ratings. Although contrary to expectation and inconsistent with past research (Krauss et al., 2004; Lieberman et al., 2007), this result is potentially understandable. First, this finding could reflect greater success in inducting Analytical
Intervention participants into the appropriate processing mode, compared to Experiential Intervention participants. This would be consistent with the results of the manipulation check of this study. Difficulty in manipulating emotion, particularly in inducing negative affect, is acknowledged in previous research (Clapham, 2001). To also account for these findings, it is possible that SPJ summary risk ratings may be accessible – or at least influenced – by both modes of processing, whereas this may not be true for actuarial-based risk ratings. Walklate and Mythen (2011) discussed the concept of “risk imperialism,” in which a rigid focus on risk factors – synonymous with the actuarial approach – neglects the relational and contextual nature of risk assessment. This is akin to masking what a victim intuitively knows about her own intimate relationship. As a final explanation, it is noteworthy that despite the minimal correspondence between the Experiential Intervention and the SPJ measure, comparable accuracy in risk prediction was demonstrated (see further discussion in Research Question Five). This suggests that, potentially, experts and victims may draw upon different aspects of affect generated through the process of appraising risk in forming a final risk judgment.

In general, the results of this question are informative, although far from decisive, in terms of the ongoing debate regarding whose evaluation of risk should be considered – a trained professional or a victim – when conducting risk and safety assessments for IPV. The findings suggest that rather than choosing one over the other, it may be beneficial to have both “experts” collaborate on risk assessment.

**Research Question Two**

*Do cognitive or affective interventions influence perceptions of risk or experiences of fear?*

Based on previous research, it was hypothesized that participants in the Experiential Intervention would perceive their level of risk and fear to be greater than participants in the Analytical Intervention. It was also postulated that participants in the Experiential Intervention would remain inflexible in their risk and fear ratings, providing sustained ratings over time, in contrast to Analytical Intervention participants. Neither hypothesis was supported by the present research. The first finding is contrary to past research (e.g., Slovic et al., 2004) whereby manipulation of the dual-modes of processing resulted in elevated risk and fear appraisals for risk as feelings participants. In this study, however, ratings by participants in the Experiential Intervention were similar to ratings by participants in the Analytical Intervention. Regarding the second hypothesis, appraised risk and fear ratings exhibited change over time: ratings decreased significantly and the rate of decrease was moderated by intervention type. Potential explanations for these results are elucidated below.
The results of this study may deviate from previous research on the mere basis that the dual-mode of processing conceptualization has not, to date, been empirically examined within an IPV population. Threats to safety, in particular, may influence the dual-modes of processing differently than found with other research applications of this concept. This is due to the highly interpersonal, affectively laden, and complicated nature of IPV, which has serious personal consequences. This contrasts with past research whereby the outcome was impersonal (i.e., relevant to a complainant in a civil court case), abstract (i.e., reading a vignette developed by researchers), or had minimal consequences (i.e., winning one dollar for drawing a correctly coloured bean; Denes-Raj, & Epstein, 1994; Epstein, Lipson, Holstein, & Huh, 1992; Lieberman, 2002).

Another potential explanation for the current findings of similarity in risk and fear ratings across interventions is premised in Cognitive Experiential Self-Theory (CEST; Epstein, 2010). This theory posits that the two systems of processing may operate in a coordinated manner (“both/and”; Kelso, 2005). This interplay has been characterized as the “dance of affect and reason” (Finucane et al., 2003). Even though an attempt to develop distinctive interventions was made in this study, the possibility exists that manipulating participants to utilize one mode of processing did not fully, or automatically, exclude the second mode of processing. The processes may be linked dynamically; if one process is influenced, it is likely that the other may be influenced as well – the dance of affect and reason, so to speak. The activation of both modes of processing could nullify an attempted manipulation, thus potentially accounting for the results of the manipulation check of this study.

Empirical and theoretical evidence provides support of this dance, explicating factors that may affect the relative influence of each system. Situational demands, extent of emotional involvement, ambiguity of outcomes, and individual differences may be implicated (Berger & Lee, 2011; van Gelder et al., 2009). For participants operating predominantly within an experiential mode, the rational system may also be triggered as the perceived threat has significant rather than benign consequences, to correct the output of the experiential system (akin to a “system check”), and/or to mollify the emotional intensity of a threat (Berger & Lee, 2011; Stanovich & West, 2008). Alternatively, when induced to operate within an analytical framework, experiential processing may not be fully disregarded as it is the default for humans (i.e., affect “bleeds” through), is particularly activated in interpersonal and/or emotionally intense contexts, and is better able to respond to ambiguous outcomes (Betsch & Glöckner, 2010; Epstein, 1994; Epstein, 2010). Greenberg and van Balen (1998) postulate that human experience is integrative,
the synthesis of multiple sources of information – both cognitive and affective – to construct one’s reality; both systems may thus be integral in judgment and decision-making (Betsch & Glöckner, 2010).

An alternative to this dance of affect and reason hypothesis, which also accounts for the similar results between interventions, is that the two modes of processing may operate in parallel (“either/or”; Kelso, 2005). Both modes of processing may influence risk and fear appraisals independently, relying on different sources of information to reach similar final judgments – the “solo dance.” In this study, the rational system perceived a threat and had sufficient time to analyze the threat as valid. Separately, the experiential system focused on generated affect to perceive a comparable valid threat. Thus, statistically significant differences in risk or fear appraisals may not be found when individuals are manipulated to operate within either processing mode; both are equally effective. This implies that the two interventions in this study were distinctive, but this was not fully captured by the manipulation check.

Past literature has promulgated the dominance of the analytical approach (Dawes, 1998; West & Stanovich, 2003). Based on this tradition, it was expected in this study that the cognitive mode of processing would prevail in risk and fear appraisals (i.e., appraisals would be grounded, not inflated). However, this was not the case, at least with this limited sample: risk and fear appraisals were similar. Rather than placing affect in an inferior position (Usher et al., 2011), these findings suggest that it may be at least equal to cognition in judgment and decision-making. The strength of this mode of processing may be in affect providing a common currency for complex decisions (e.g., feeling more uneasy about one solution compared to another), providing credible sources of information (e.g., “How do I feel about this?”), or acting as a spotlight (e.g., the intensity of feelings may highlight important information; Peters et al., 2006). Neurological research has provided evidence that localized brain damage, which hinders the ability to attach emotion to action, impairs decision-making abilities (Damasio, 1994). There is even evidence to suggest that this mode of processing may examine probabilistic outcomes, typically reserved for the cognitive mode of processing (Lieberman, 2002). Despite a different approach, but similar to the cognitive mode of processing, an inclusive valuation of risk may be undertaken with affective processing.

Although the dance metaphor highlights the similarity between the two processes in evaluating risk and fear, it does not fully account for the decline in ratings over time. This result contradicts previous research, which specifies that risk appraisals are relatively stable (Johnson, 2005), with a potential “belief perseverance effect” particularly adhered to by experiential
participants (Anderson, Lepper, & Ross, 1980). For individuals primed in an experiential mode, exposure to risk-discounting information did not influence evaluations of risk (Johnson, 2005). In contrast, individuals primed to process information analytically are more sensitive to risk-discounting information, which becomes integrated into their assessments of risk (Berger & Lee, 2011), thus ensuring better accuracy in judgment.

The differential decline in risk and fear ratings with intervention exposure is suggestive of a mechanism of change. Participants in the Experiential Intervention were encouraged to evaluate risk and fear from a self-perspective, whereas Analytical Intervention participants were asked to adopt a “third-person,” emotionally neutral perspective. Even if a potential interplay exists between the dual-modes of processing, a primary factor differentiating the intervention groups is the degree to which participants focused on emotion. A potentially causal explanation for this finding is premised in the processing of emotion over time (i.e., the concept of “experiencing;” Paivio & Carriere, 2006). Literature from experiential psychotherapies such as emotion-focused (e.g., Greenberg, 2002) and trauma-based exposure therapies (e.g., Foa & Jaycox, 1999) may further illuminate this hypothesis. Similar to the Experiential Intervention used here, both therapies direct clients to attend to their internal emotional experience (Safran & Greenberg, 1991) and allow for the amplification of emotion through imaginal representation (Greenberg, 2002).

A central tenet of experiential-based therapies is that emotional experience and expression should be encouraged (Littrell, 1998). Proponents indicate that “feeling the feeling” in awareness is a principle of change (Greenberg, 2002). Direct activation of emotion is necessary to access and explore unpleasant feelings (Safran & Greenberg, 1991). Through activating affect, and drawing it into conscious awareness, an individual may reprocess these emotions and recognize that their expression is legitimate, can be expressed without harm, and can support the construction of new meaning (Paivio & Carriere, 2006). In contrast, individuals who remain detached in therapy benefit less and, specifically, intellectual appraisal may inhibit change (Greenberg, 2002). Insufficient emotional arousal may result in only cursory, externally focused, or abstract exploration in therapy (Paivio & Carriere, 2006). Trauma-based research has also investigated the concept of emotional processing of traumatic experiences (e.g., Pennebaker, 1997; Segal & Murray, 1994). Hunt (1998) has demonstrated that in order to facilitate recovery, one must endure the emotional experience – “the only way out, is through” (p. 361). In writing about traumatic experiences, participants benefited more in explicating the facts and feelings regarding the trauma, than just limiting to facts (Pennebaker, 1997).
Experiential-based theories do not malign the role of cognition. In fact, cognition is integrated in the theories, mirroring the dance of affect and reason described above. Experiencing emotions is necessary, but not sufficient, for change. Reflecting on, and making meaning, after an emotional experience is important (Missirlian, Toukmanian, Warwar, & Greenberg, 2005). The traumatic event becomes assimilated into a more coherent narrative, which may promote understanding of the experience, the self, and the world (Greenberg & Pascual-Leone, 1997). A greater reduction in psychopathological symptoms has been identified (Greenberg & Pascual-Leone, 1997) when emotions are processed in a reflective manner, more so than when attending to only one process (Missirlian et al., 2005). However, emotional awareness is a required predecessor of this type of meaning making.

To apply these concepts to the results of this study, it is possible that participants in the Experiential Intervention experienced a reduction in fear – and, likely, associated risk – through processing and integrating felt emotions, consistent with experiential-based principles. More specifically, in generating a corresponding narrative (i.e., worst-case scenario) and encouraging emotional awareness (i.e., focusing on the feelings generated by the scenario), participants experienced greater reduction in the level of appraised fear. On the contrary, in inhibiting emotional awareness or expression, via the Analytical Intervention, a slower decline in fear was evidenced. The eventual decline in fear may be related to the interplay (or “bleeding”) of affect with cognitive appraisals, as described in the previous section. Post-safety planning risk assessments exhibited an elevation, but only for Analytical Intervention participants. As fear was not actively processed, transformed, or alleviated in this intervention, safety planning may have reignited or heightened one’s sense of risk. Perhaps adopting a neutral “third-person” perspective assisted in reducing risk appraisals temporarily; yet, without a sufficient reduction in fear, risk appraisals exhibited a rebound effect to correspond with the sustained and elevated self-appraisals of fear. In addition, being directed back to the self again, after adopting the neutral perspective, to develop safety strategies may have further accentuated the presence of fear and, correspondingly, risk.

Overall, the results of this study potentially suggest that, when examining discrete ratings of risk and fear, the interplay of cognition and affect may be evident. The possibility exists that both modes of processing are triggered in IPV contexts, due to its highly personal nature (e.g., involving an intimate relationship and threat to self). Alternatively, each mode of processing may operate in parallel with both equally effective in judgment and decision-making; this is despite the theoretical dominance of cognition. Over time, and controlling for confounding variables, a
pattern emerges: the elicitation, awareness, and processing of fear through the Experiential Intervention, which has a corresponding influence on risk, may be responsible for effecting change in victim’s perceptions of risk and fear. The impact of this differential response on the quality of safety planning is examined next.

**Research Question Three**

*Do cognitive or affective interventions influence quality of the developed safety plans?*

For IPV victims, the issue of personal safety is paramount. No universal strategy exists that deters all men from perpetrating violence against women. In fact, a strategy that may be beneficial for one woman may result in victimization when implemented by another (Goodkind, Sullivan, & Bybee, 2004). Thus, importantly, the results of this study support the contention that women actively protect themselves from further victimization through multiple means. Participants in this study did not typically exhibit passiveness or learned helplessness (Barrett & St. Pierre, 2011; Goodkind et al., 2004; Sullivan & Bybee, 1999). On average, participants in the Analytical Intervention generated 34 safety strategies, while participants in the Experiential Intervention developed 33 safety strategies. It is noted that the number of strategies provided by participants was greater than what has been identified in other research studies (e.g., average of five out of nine possible strategies; Glass et al., 2010). Participants in this study were not restricted to selecting safety strategies from a predefined list, but were guided to generate strategies freely with none, or minimal, intrusion by the researcher.

Specific to this research question, the a priori hypothesis was safety plan quality would be enhanced for participants in the Analytical Intervention, rather than Experiential Intervention participants. Through rational and thoughtful analyses, it was postulated that individuals would generate higher quality and more comprehensive risk management strategies. The arousal of fear, via the Experiential Intervention, was conjectured as inhibiting the development of a comprehensive safety plan – essentially, akin to being “scared out of your wits.” However, no statistically significant differences in safety plan quality were found between intervention groups using three methods of evaluation. The equivalency in safety plans is intriguing, and suggests that affective arousal does not necessarily translate into an inability to develop a plan to protect oneself. Potential explanations for this finding are consistent with the two explanations provided in the previous section (i.e., of the dance of affect and reason and solo dance), while an additional, third, hypothesis is also provided.
First, consistent with CEST theory (Epstein, 2010), it is plausible that the dual-modes of processing may operate in tandem in safety planning, in order to serve the best interest of the IPV victim. The reliance on one mode alone may not adequately address the high degree of risk inherent in IPV – of harm or death. Specific to the results of this study, for Analytical Intervention participants, the incorporation of affect may be useful in focusing attention on areas of perceived vulnerability (Epstein, 1994). For Experiential Intervention participants, after the initial experience of affect, rational appraisal may have been triggered to ensure comprehensiveness in safety strategies (Epstein, 1994; Stanovich & West, 2008). Alternatively, the structured nature of the safety plans themselves may have also triggered a rational mode of processing. This explanation suggests that neither intervention could produce a better safety plan than the other (“both/and” processing; Kelso, 2005), as both modes of processing were implicitly activated in either intervention. Hammond (2010) refers to this as “quasi-rationality” – an ideal balance of both modes of processing. Whether occurring sequentially or dynamically, the dance of affect and reason could have been in effect (Epstein, 1994).

As a second explanation, it is speculated that an affective response may not, as the colloquialism suggests, promote a loss of wits. The use of emotions may be as efficient as the use of cognition in safety planning. The accessing of emotions facilitates active problem solving (Greenberg, 2002) and may cause the emergence of adaptive responses (Safran & Greenberg, 1991). Emotion has been identified as a strong motivator in influencing risk-reducing behaviours (Lindhorst et al., 2005). Emotions are construed as “fundamentally adaptive” producing actions that meet primitive human needs, one of which is self-protection (Greenberg, Elliott, & Pos, 2007). Potentially, an optimal level of arousal may exist (e.g., the Yerkes-Dodson Law) in which the experience of emotion may serve as a motivator, but too much (i.e., incapacitated) or too little (i.e., unmotivated) may hamper an individual in coping (Yerkes & Dodson, 1908). Fear, in particular, has also been shown to focus study participants to attend to protective information, resulting in the controlled and complete processing of information (Loewenstein & Lerner, 2003; Mosier & Fischer, 2010). Specific to the results of this study, this explanation suggests that participants in the Analytical Intervention developed a number of appropriate safety strategies to address their level of perceived risk. Through thoughtful and deliberative analysis, quality safety strategies were generated (Arvai et al., 2001). This may account for the tailored nature of the safety plans developed by the Analytical Intervention participants (e.g., weighing the pros and cons of a safety strategy and choosing it if deemed relevant in assuring safety). Rather than being hindered by emotional reactivity and providing poor or fewer safety strategies as expected, the Experiential Intervention participants’ enhanced emotional awareness similarly led to the
generation of protective strategies to modify or reduce risk (Harding & Helweg-Larsen, 2009). In particular, these participants were likely to develop more strategies to address specific risk factors; this may relate to their use of imagery (i.e., worst-case scenario) in identifying particular outcomes and areas of vulnerability. In summary, “either/or” processing could have been present, with the effect of both being separately beneficial in producing quality safety plans (Kelso, 2005).

Lastly, as a final proposition, the resultant safety plans were equivalent because of the process itself, irrespective of intervention type. The majority of participants in this study had not previously received formal assistance in developing a safety plan. This is despite research indicating that victims of IPV desire safety planning services; the need is often unmet (Chang et al., 2005). Participation in the safety planning process, and encouragement to concretize a plan, may have motivated participants to expound a comprehensive safety plan. When asked to provide strategies for each component of the safety plan, participants simply complied. Inherent in the guided and structured format of the safety plan (i.e., having multiple components), numerous opportunities existed to generate safety strategies. Thus, regardless of intervention, high quality safety plans would have been developed by participants. Previous research (Gillum et al., 2009) indicates that more safety promoting behaviours are generated when women participate in an intervention, than when placed in a control group. Perception of personal safety also exhibited a corresponding increase (Gillum et al., 2009).

Overall, the results of this study indicate that women generated comprehensive safety plans. According to Hamby (2009), the characterization or typology of safety strategies does not ensure the quality of a safety plan. Rather, a “smart” strategy involves using any strategy, continuing to adopt and strategize (Hamby, 2009). The use of more and diverse strategies thus may be crucial to protecting oneself, regardless of the means in which safety planning is facilitated. In addition, the need for contextualized and individualized safety planning was reinforced with this study. Participants appeared to continue to tell their story when creating their safety plan, tailoring it to their own situation. In addressing individuality with safety planning, it is surmised that women will be more likely to employ the developed strategies to minimize, or eliminate, future victimization (Goodkind et al., 2004; refer to Research Question Five).

**Research Question Four**

*Do cognitive or affective interventions influence satisfaction with safety planning?*

It was initially proposed that, overall, participant satisfaction with the safety planning intervention would be average. It was further hypothesized that, due to provoking emotional
reactivity, the participants in the Experiential Intervention may rate their satisfaction lower than participants in the Analytical Intervention. Both of these hypotheses were not supported in this study. Participants, on average, appeared satisfied with both interventions (i.e., a ceiling effect was present). Degree of satisfaction mostly did not vary by intervention, with both groups expressing at least moderate levels of consumer satisfaction.

Victim satisfaction with formal IPV interventions is consistent with previous research. For instance, in Sullivan and Bybee (1999), 87% of participants reported being “very satisfied” with advocacy services received. Positive consumer experience predicts intention to return to the service in the future (Bennett Cattaneo & Goodman, 2010) or, generally, to seek further formal assistance (Hamilton & Coates, 1993). The field of trauma research is also informative when examining victim satisfaction of an intervention. Previous research has examined whether participating in studies focused on trauma, including IPV victimization, would have a detrimental effects on survivors (e.g., Griffin, Resick, Waldrop, & Mechanic, 2003; Hlavka, Kruttschnitt, & Carbone-López, 2007). Rather than finding their involvement in such research distressing, the majority of participants viewed it as interesting and valuable (Griffin et al., 2003) and identified it as a helpful experience (Newman, Walker, & Gefland, 1999). Specific to a sample of women victimized by IPV, the process of disclosing their experiences – a re-telling of their story – may provide reassurance that the right choices had been made (i.e., to “re-story” or “re-author,” similar to narrative therapy; Lee, 1997).

An additional explanation for the high degree of satisfaction with the developed intervention may be attributable to the “common factors” identified in psychotherapy outcome research. The warmth, acceptance, and empathy of a therapist are examples of such factors (Luborsky et al., 2002). That is, in this present study, participants may have been responding well to, and expressing satisfaction with, common factors. Research specific to the field of IPV support this assertion; Hamilton and Coates (1993) identified fundamental counselling skills as being valued by victims of IPV. Specifically, victims acknowledged that “listening respectfully” and “believing my story” – traits that reflect therapeutic qualities of non-judgment and empathy – were appreciated. Additionally, a qualitative study by Gerbert and colleagues (1999) found that validation by a health care provider elicited comfort and relief in IPV victims. This validation was apparently pivotal in aiding victims to acknowledge the seriousness of the violence in their intimate relationships and, most importantly, to effect personal change (Gerbert, Abercrombie, Caspers, Love, & Bronstone, 1999). An inappropriate or invalidating response by a helping professional is hypothesized to result in a woman “losing what may be a very loose foothold on
her ability to take action on her own behalf” (Hamilton & Coates, 1993, p. 322). Perceived support improves IPV victims’ mental health, help-seeking capability, and overall safety (Constantino et al., 2005; Liang, Goodman, Tummala-Nara, & Weintraub, 2005).

Another significant result of this study was related to between-group differences in satisfaction with the safety planning intervention. Although levels of satisfaction were similar between groups, one exception was found - participants in the Experiential Intervention reported a higher level of rapport with the administrator of the intervention than Analytical Intervention participants. This is in contrast to the initial hypothesis that stated that the emotional reactivity sanctioned by the administrator might be viewed unfavourably by Experiential Intervention participants. A potential explanation for this finding is that, by definition, rapport is the establishment of an emotional connection between two individuals (Carich & Spilman, 2004). Rapport is designated as an experiential, rather than behavioural or cognitive phenomenon (Hardy, Cahill, & Barkham, 2007). Through emotional disclosure, the possibility exists that Experiential Intervention participants experienced a degree of vulnerability, which created a sense of intimacy and closeness with the researcher. The revealing of one’s worst fears to another, which was a component unique to the Experiential Intervention, may have facilitated rapport-building or, at least, one’s perception of a stronger rapport in order to disclose such significant details. Research has indicated that emotional expressiveness facilitates closeness (Simpson, Gangestad, & Nations, 1996) and stimulates rapport (Tickle-Degnen & Rosenthal, 1990). Emotional arousal, perceptual processing, and rapport are the trifecta required to effect change (Missirlian et al., 2005). Without a sense of safety and acceptance, individuals typically will not explore their own feelings (Safran & Greenberg, 1991). The possibility also exists that the elicitation of emotion during the Experiential Intervention influenced the researcher to respond with empathy to participants, therefore building rapport; the cause-effect relationship of this finding remains to be determined. In general, however, the level of satisfaction reported by participants suggests that the interventions may be well received within an IPV population.

Further support for the potential use of the developed interventions in practice is inferred from the data comparing current and past experiences with safety planning. Approximately one third of the study sample engaged in safety planning with other formalized services. In contrast to past safety planning interventions, participants rated the current intervention highly on the majority of assessed characteristics. One potential explanation for this result involves the highly contextualized nature of the current safety plan, as recommended by Lindhorst (2005) and Davies (1998). Both theoretical conceptualizations are women-centric, supporting women who are
victims of IPV in voicing their own feelings, opinions, needs and assessment of risk with respect to their own circumstances (Davies et al., 1998; Lindhorst et al., 2005). Robinson and Stroshine (2005) found increased satisfaction with an IPV intervention when women were provided opportunities to voice their own concerns. In the intervention used in this study, women were guided to develop safety strategies based on their own lives, rather than employing traditional (i.e., presumption of relationship termination) or cursory methods (i.e., a safety planning checklist or brochure). Traditional methods have been deemed sufficient, but not necessarily helpful to all women who experience IPV (Lindhorst et al., 2005). In this study, each woman was provided with an opportunity to develop a safety plan that reflected her own perspective of her situation; this may have been reflected in each woman’s comparison ratings of satisfaction with the current and past safety plans.

The high degree of victim satisfaction with the interventions is promising, although some skepticism remains. In assuring anonymity, it was hoped that participants would provide an unbiased opinion regarding the safety planning interventions. However, alternative explanations for the degree of expressed satisfaction with the safety planning intervention focus less on the intervention itself under study and, instead, reflect common psychological phenomenon. For instance, the recency effect may have been present, whereby participants base satisfaction judgments on what they can easily remember – in this case, the most recent intervention (Miller & Campbell, 1959). Past experiences are typically more difficult to recall, particularly the further one is temporally removed from the experience, thus satisfaction ratings of past interventions could, by default, be less. The ceiling effect present with the satisfaction data may have precluded participants from assessing past experiences as highly; this positivity bias is recognized to occur in satisfaction surveys (Peterson & Wilson, 1992). It is also possible that participants played the “good participant role” by reporting high satisfaction ratings (i.e., the Hawthorne effect; Leonard, 2008). Lastly, one could hypothesize that cognitive dissonance was present. To further extrapolate, victimized women likely feel a need to be safe from their abusive partners, which justifies their participation in this study and need for a safety plan. However, if a woman was not satisfied with the intervention, but highly valued the idea of having a safety plan, she may readjust her degree of satisfaction to be in alignment with her values.

As previous research has indicated, victims of IPV have expressed a desire to receive safety planning services, although there appears to be a discrepancy between women’s needs and actual service provision (Chang et al., 2005). These results suggest that women would be receptive to collaborating with formal help-seeking professionals who use this developed
intervention. Significantly, a large proportion of participants indicated they would refer other victims of IPV for safety planning assistance using the developed study interventions.

**Research Question Five**

*Do cognitive or affective interventions influence re-victimization risk?*

The development of a safety plan is not an automatic guarantee that a victim will be safe from harm (McClosky & Grigsby, 2005). However, it is anticipated that there could be a reduction in re-victimization. For Experiential Intervention participants, it was proposed that they might report a higher rate of re-victimization than Analytical Intervention participants. This was based on previous research that suggested a relationship existed between perceived fear and re-victimization status; that is, higher levels of fear were associated with higher re-victimization rates (Stith et al., 2004). It was postulated that, as Experiential Intervention participants would generate greater fear through participation in their designated intervention and develop less comprehensive safety plans, their vulnerability to re-victimization might increase in comparison to Analytical Intervention participants. Excessive or extreme fear has been identified as a victim vulnerability factor on IPV-specific risk assessment instruments (Belfrage & Strand, 2008). With the current data, this research hypothesis was unsupported. Although, additional findings of interest were identified, including: (a) a low physical re-victimization rate overall, (b) a higher re-victimization incident rate for Analytical Intervention than Experiential Intervention participants, and (c) accuracy in risk assessment for both victim and expert ratings.

The overall re-victimization rate in the study sample was low, with one occurrence of physical violence committed by an index partner reported amongst 36 participants. This equates to a physical abuse re-victimization rate of 3%. If this rate of re-victimization is valid (refer to the Limitations section for additional concerns), then this is lower than published literature. For example, from a meta-analysis of 14 studies, the physical assault recidivism rate was 28% (14 study meta-analysis; Hanson, Helmus, & Bourgon, 2007). Reported recidivism rates for treatment as usual, or control groups, range between 43% and 89%, dependent on follow-up interval (Sullivan & Bybee, 1999). The length of follow-up in this study was limited to six months, which may partially explain the lower re-victimization rate. However, in studies with a follow-up interval that was similar to this study, reported physical abuse re-victimization rates were 9.8% (Walton-Moss, Manganello, Frye, & Campbell, 2005), 12.8% (Koziol-Mcclain et al., 2010) and between 18% and 30% (Stover, Meadows, & Kaufman, 2009). Sample size differences may also account for this disparity (e.g., an overall sample of $N = 36$ in this study versus $N = 141$ for
Sullivan, Campbell, Angelique, Eby, & Davidson, 1994). Nevertheless, short-term reductions in victimization rates are typically observable after the implementation of an intervention (Bybee & Sullivan, 1999; Stover et al., 2009).

With this data, victims at greater risk for re-victimization had better quality safety plans when originally generated and were implementing safety strategies after their participation in Phase I of this study. However, despite these potential precautions, victimization recurred – manifesting as physical abuse or, predominantly, psychological abuse or harassment. This suggests that women may try their best to protect themselves, but their partners’ recidivate against them anyways. As indicated by Lass (2007), “randomness and unpredictability of the violent man’s behaviours are his chief powers over his victim” (p. 10), therefore, there is a need to have a safety plan in place. This result does not suggest that safety plans have no value in protecting women. Rather, risk management of the perpetrator, through deterrence, monitoring, and/or therapeutic intervention, may not have been successful. It is readily acknowledged that appropriate risk management of offenders is a necessity (Kropp, 2004 and 2008; Storey & Hart, 2011), with some areas (e.g., Batterer Intervention Programs) exhibiting lower efficacy in preventing recidivism than hoped (Babcock, Green, & Robie, 2004). Collaboration between all parties involved in an IPV incident – offender, victim, formal agencies for both parties – is necessitated, to ensure ongoing awareness, monitoring, and correction of fluctuating risk in an (once) intimate relationship (Kropp, 2008).

Contrary to the original hypotheses for this research question, a greater proportion of re-victimization incidents were reported by Analytical Intervention than Experiential Intervention participants. This effect appeared to exist independent of degree of risk (i.e., high risk participants were distributed across both interventions), safety plan quality, implementation of a safety plan, or accessibility (e.g., not remaining in an abusive relationship). This suggests, albeit very tentatively, an advantage to the Experiential Intervention in providing an insular effect from re-victimization. At present, it is not clear what mechanism may explain this, although potential explanations are provided below.

The focus of the Experiential Intervention was in attending to affect, particularly when describing a worst-case scenario of re-victimization. Perhaps, when confronted by the index partner again, the generated emotional arousal triggered memory of the safety plan that was encoded in a similar context. Research suggests that context-dependent memory may improve the

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20 Clarity is required regarding whether the safety strategies were implemented prior to, or after, the re-victimization incident.
recall of information (LaBar & Cabeza, 2006; Mayer, McCormick, & Strong, 1995). Participants in the Analytical Intervention would not have benefited from this effect, as encoding (emotionally neutral, creation of the safety plan) and retrieval (emotionally intense, IPV incident of re-victimization) contexts were incongruent.

As Experiential Intervention participants described a worst-case scenario, the possibility also exists that these participants were better prepared for the re-victimization incident (i.e., a better “fit” between strategies developed based on the scenario and the actual event). These safety strategies may have also been related more to coping with dynamic risk factors (e.g., substance abuse) than static risk factors; this has been identified in previous research (Connor-Smith et al., 2010). These hypotheses may both account for the finding that Experiential Intervention participants developed more safety strategies specific to risk factors, which likely formed the basis for the worst-case scenario, than Analytical Intervention participants. Analytical Intervention participants, although providing a number of comprehensive strategies tailored to their needs, may not have appropriately matched strategies to a likely outcome (i.e., a “mismatch” between strategies developed and the actual re-victimization incident as a specific outcome was not visualized or identified). This may account for the higher number of information-based strategies provided by Analytical Intervention participants. Albeit practical and useful, these strategies are hardly protective when a victim is confronted by an abusive partner. Alternatively, the Analytical Intervention participants may have focused more on safety strategies that address static risk factors. This dynamic-static distinction requires additional exploration.

Another explanation is premised in the research literature involves degree of perceived control over future abuse (e.g., Clements, Sabourin, & Spiby, 2004). In adopting a rational perspective and systematically analyzing ones’ situation, participants may have perceived a greater sense of ability to control or change the outcome of future abusive episodes (Clements et al., 2004). With this sense of control, participants may have refrained from using caution and implementing appropriate safety strategies. For participants in the experiential mode of processing, where the worst-case scenario was imagined, less control may have been perceived over future events and vulnerability to an aversive outcome was exposed (Martin et al., 2000). Participants may have had to confront their optimistic bias (i.e., “This will never happen to me again”) or denial (“This does not pertain to me, I am not an abused woman”). As a result, these participants may have been motivated to proceed with caution, adhering more closely to the developed safety plan.
A final potential explanation is founded in experiential-based therapies. A prominent principle of these therapies is that the processing of one emotion allows another, more adaptive, response to surface (Greenberg, 2002). Greenberg (2002) provides an example of an abused individual who reprocesses the emotion of fear, a maladaptive feeling, into one of anger, an adaptive feeling. Premised in trauma-based therapies, the mastery of long-feared emotions can often be experienced as empowering (Fosha, 2000). For this study, the feelings of fear Experiential Intervention participants may have experienced related to IPV victimization were potentially replaced with feelings of empowerment. Combined with developing a safety plan, which in itself may be implicitly empowering, feelings of fear and associated vulnerability may have been reduced (Briere & Jordan, 2004), replaced with adaptive coping. From Hamburger and Potente’s (1996) perspective, the aim of safety planning is to empower a woman sufficiently so that she will initiate positive safety behaviours and adopt responsibility for her own safety.

Unequivocally asserting that one intervention was superior than the other in preventing re-victimization is premature, due to the limited sample size for this result ($n = 12$). Additionally, the bias towards the Experiential Intervention could also be an artefact of other confounding factors (e.g., opportunity or availability of the index partner, differential change in dynamic risk factors or risk affecting more Analytical Intervention participants than Experiential Intervention participants), rather than an intervention effect. It is also unclear whether the intervention effect would sustain an influence after a time delay to engender the use of safety-promoting behaviours in the “real-world.” Thus, this result is not indicative of a concrete finding, but rather suggestive of a potential trend that requires further replication, clarification, and exploration.

To revisit the victim’s voice debate, assessing accuracy in risk assessment was examined comparing expert and victim risk appraisals. The purpose of this examination was not to determine who was “right” per se, but how much weight to apportion each type of assessment. Based on this study, it appears that equal weighting may be allocated to both expert and victim appraisals of risk. That is, accuracy in predicting risk of re-victimization was at least equivalent between expert and victim ratings.\(^{21}\) This result coincides with past research (Bowen, 2011; Lindhorst et al., 2005) that indicated that the predictive accuracy of victims’ appraisals were on par with risk assessment measures. For instance, Bell and colleagues (2008) reported that victim’s appraisals were accurate in 66% of cases, similar to the rate identified in this study. Additional

\(^{21}\) The ODARA had a lower rating of accuracy. This could be attributable to the use of this instrument with participants whom did not meet the inclusion criteria to use this measure (e.g., dating partners only and/or threat without a weapon in hand) or due to predicting non-physical forms of violence with respect to the low base rate of physical violence in this study sample.
research (Hanson, Helmus, & Bourgon, 2007) reported similar effect sizes for expert and victim assessments of risk. The degree of accuracy evidenced here provides reassurance that women (mostly) perceive their risk accurately and, thus, can implement necessary safety strategies and precautions (Lass, 2007). As a caveat, it is noted that the risk assessment measures used in this study were developed to determine physical abuse re-victimization risk, whereas participants in this study most often reported emotional abuse and harassment.

In contrast to an expert, victims were more likely to predict non re-victimization (i.e., cessation of abuse) than re-victimization; this result has been previously highlighted in the literature (Bowen, 2011). Although this finding may only reflect the low base rate of repeated victimization found in this sample, caution is still warranted. In this sample, approximately one-third of women provided inaccurate predictions. These women might experience fear unnecessarily (i.e., as a false positive) or, potentially more likely, would be victimized without having an appreciable understanding of their risk (i.e., as a false negative). Reliance on victim appraisal alone is not advocated here, as accuracy in victim risk assessment does not appear sufficient to wholly disregard the utility of formal risk assessment.

Involvement in either intervention did not appear to influence accuracy ratings, although a potential trend may be identified favouring the Experiential Intervention. With this current study, the results suggest that appealing to either cognitive or emotional mode of processing had no significant effect in altering risk appraisal accuracy. To some degree, this result adds to the mounting evidence that the experiential mode of processing is not inferior to the analytical mode. Focusing on the affective experience of risk (i.e., the experience of fear) may provide as accurate an assessment of risk as a deliberative review. Within the broader actuarial versus SPJ risk assessment context, this result appears to duplicate recent evidence of at least the comparability of the two approaches in assessing violence risk (e.g., weighted AUC was .67 for actuarial measures and .68 for SPJ measures, Guy, 2008; Douglas, Yoemans, & Boer, 2005).

In closing, the cumulative results of this study suggest that the conventional view of cognitive superiority in judgment and decision-making may no longer be valid. Experiential processing appeared to have at least the same benefits, if not more, than cognitive processing in risk assessment, safety planning, consumer satisfaction, and prevention of re-victimization. It is clear that the victim’s voice, in whatever form it may take, is at least comparable to expert assessments and should continue to play an integral role in risk assessment and management in IPV.
LIMITATIONS

This is the first study of its kind to examine a dual-mode processing conceptualization of risk in a sample of women who have experienced IPV victimization. Although the results of the research presented here require replication, they are unquestionably informative. As with most empirical research, several limitations exist that prohibit definitive and causal statements regarding the results. Limitations to this study are outlined below and are related to the (a) sample, (b) study design, and, (c) outcome data and measures used.

Sample

A limited sample was used in this research (N = 60). This is acknowledged to be a small sample size. A meta-analysis conducted by Kazdin and Bass (1989) of treatment outcome research revealed that the typical sample size, per treatment condition, was 12. Nonetheless, concerns are raised whether there was sufficient power to detect statistically significant differences. Based on this study, given power within the 80% – 90% range and a significance level of 0.05, detected effect sizes would be large (Cohen, 1988). As such, it is possible that significant results may have been overlooked and/or several trends identified in this data may be significant with a larger sample. However, for several key analyses, it is countered that with two groups, random assignment to intervention, and repeated measures, power likely was sufficient.

Generalization of these study results must be made with caution as the sample may not be wholly representative of all women who experience partner violence. Although the sample was distributed across a variety of local community resources, the majority of participants were recruited from IPV shelters. These individuals could be distinct from IPV victims in general as they are already actively implementing safety strategies, as evidenced by their shelter stay. Yet, it has also been acknowledged that women who access shelter services typically may have the fewest resources and may be in the worst of circumstances of victimized women (Hamby, 2009). Thus, targeting such a population – and implementing an intervention with positive results – may suggest that the repetition of this study with women accessing alternative resources might be equally successful. Other potential sources of sample biases include the high proportion of (a) women in dating or casual relationships with the index partner and/or (b) women who had
terminated the intimate relationship after the index incident. This neglects women who continue their involvement in abusive intimate relationships where the recurrence of re-victimization, particularly without intervention (i.e., victim safety planning or perpetrator involvement in treatment), is probable. With respect to the growing evidence of the mutuality of violence in intimate relationships (Dutton & Nicholls, 2005), it is unknown how the results of this study would apply. It would be important to extend this research to include a larger and more representative sample in reiterations of this study.

**Study Design**

Limitations in the current study design may have also influenced the validity of the present results. There were several limitations identified for this study related to the inclusion criteria, manipulation check, and comparative treatment approach.

**Inclusion Criteria**

A number of limitations centre on the inclusion criteria related to (a) the timing of participation in the study and (b) the operational definition of IPV. First, participation in this research was permissible after a minimum of four weeks had transpired since the index violent incident. Although this moratorium was mandated ethically, it raises the question whether the four-week delay may have subverted the crises and, thus, the immediate urgency for safety planning. Risk and fear self-appraisals may have reflected this time lag. For women who experienced a violent incident closer to the 12-month limit, it is hypothesized that the motivation or need for safety planning would not be present, or less so than a women with more recent victimization. Due to the dynamic and unpredictable nature of IPV, however, it could be argued that safety planning for victims is always needed. Lastly, the time lag may also influence the validity of the risk assessment measures used, as their intended purpose is for assessing risk for violence in close temporal proximity to a violent incident (e.g., 1 – 2 months; Kropp et al., 2005).

Difficulty in accessing a victimized sample required the implementation of a less stringent operational definition of IPV as the basis for the inclusion criteria. This resulted in victims participating in the study who met the B-SAFER, but not the ODARA, definition of IPV victimization. Yet, it is also recognized that an alarming prevalence of IPV occurs in young (i.e., ages 20 – 24 years) and/or non-cohabitating relationships (Klaus, 2007). Also, although likely not that common, one safety strategy for several women in this study was to purposively reside separately from their partners. Restriction in the ODARA definition of violence has been recognized, and the measure is being cross-validated with other populations (i.e., non-
cohabitating couples; Nova Scotia Public Prosecution Service, 2009). It is recognized that this may limit results reliant on the ODARA, as the fidelity of the instrument was not fully maintained.

Manipulation Check

The manipulation check did not provide a statistically significant result for both intervention groups; that is, the Analytical Intervention participants appeared to vary in affect, whereas the Experiential Intervention participants did not. The Analytical Intervention participants exhibited increased arousal with a likely trend towards decreased pleasure to neutral. Consistent with the explanations offered here (i.e., the dance metaphor), this finding may be suggestive of participants in the Analytical Intervention successfully adopting a “third-person” perspective (i.e., to become neutral) and not adequately addressing their emotional experience (i.e., an increase in anxiety post-intervention). The Experiential Intervention participants may have been actively processing their emotions, thereby not registering any statistically significant fluctuations in affect. This is partially conclusive of an intervention effect, but not entirely convincing.

As an alternative explanation, the lack of statistical significance between groups has been documented in other published research using similar experimental manipulations (e.g., Lieberman, 2002). Mitigating factors identified in this research are also likely present here, including demand characteristics or manipulation decay. The possibility also exists that the manipulation check was accurate (i.e., in not identifying statistically significant differences), but the interventions themselves were not sufficiently distinct. Perhaps the study materials intended for one intervention triggered the other mode of processing. For example, the Analytical Intervention participants reviewed a graphical representation of risk (see Appendix F). The image provided may have been sufficient to activate an experiential response. Conversely, research exists (e.g., Lieberman, 2002) to suggest that humans, in general, do not adequately comprehend risk assessment information. Discerning the meaning of probabilities is often difficult for the average layperson (Lieberman, 2002). Thus, in not being able to understand fully the risk materials, participants in the Analytical Intervention may have been “forced” to adopt an experiential mode of processing. Berger and Lee (2011) further state that “merely activating a system does not guarantee that the system so activated will necessarily perform optimally or even relatively effectively” (p. 21). Regardless, to quell doubts regarding the efficacy of the manipulation used, suggestions for alteration in methods include using a priming task before
introducing the manipulation (see van Gelder et al., 2009) and/or utilizing multiple “doses” of the manipulation to reinforce the effect (Lieberman, 2002).

Lastly, the findings from this study indicated that an external observer could identify differences in emotional reactivity between interventions, which appeared to have been overlooked by the Affect Grid (Russell et al., 1989). Several potential explanations are provided for this discrepancy. First, this lack of finding could be related to timing; this observation took place during the safety planning component, although the Affect Grid was not administered at that time. The possibility exists that emotional reactivity became pronounced during the safety plan, rather than during the intervention as predicted. The lack of finding could also be related to the measure itself; the Affect Grid, as a generic measure of affect may not have had adequate sensitivity and specificity to measure the principle emotion of interest, fear. Additionally, the lack of finding could be related to the nature of emotion; in occurring outside of conscious awareness, in general, the use of a self-report measure may not accurately reflect internal affective experiences (Killgore, 1998). Lastly, this lack of finding could be related to the population of interest, IPV victims. There is literature to suggest that with repeated affective exposure (e.g., to fear), this becomes a normative experience. Thus, a victim’s assessment of neutral emotion may be experienced as high emotional arousal by a non-victim (Leventhal, Martin, Seals, Tapia & Rehm, 2007; Melde, 2009). These hypotheses are all possible. To eliminate this issue in future studies of this nature, the evaluation of affect, via a third-person measure, may be indicated (e.g., the Client Emotional Arousal Scale; Warwar & Greenberg, 1999).

Comparative Treatment Approach

Finally, without the presence of a control group, it remains unclear the extent to which the interventions influenced the quality of the safety plans or re-victimization status. The use of a control group would aid in establishing whether one, or both, interventions are effective as a preventative tool against IPV. On the other hand, the use of the control group may indicate there is no beneficial effect to either intervention. The omission of a control group may be further compounded as the researcher was not blind to condition and biases may have been present when administering the interventions. Efficacy of an intervention is best determined through the use of randomized clinical trials (Chambless & Hollon, 1998). Although, it may not be ethically appropriate or practically feasible to apply research within a highly vulnerable and difficult to access population, like victims of IPV.
Outcome Data and Measurement

The primary outcome data – risk and fear perception – were self-reported and required the distillation of complex constructs into a scaled item. To enhance the validity of this study in future replications, the use of standardized measures of these critical constructs might be necessary. For instance, the Women’s Experiences of Battering instrument (WEB; Smith, Smith, & Earp, 1999) contains fear items. For victim appraised risk assessments, as of yet, there does not appear to be a standardized method to use with victims to assess their own degree of risk. The research literature varies in its approach, with studies often adopting one item to investigate this construct (Bowen, 2011). Specifying a timeframe for assessing future risk has also been debated (e.g., risk for violence in a month or a year; Bowen, 2011). Additionally, participant appraisals were limited to perceptions of risk and fear of the index partner. Exploration of experiences with past abusive partners was not included due to time constraints. The possibility exists that risk and fear appraisals are cumulative with repeated re-victimization with different and/or multiple partners.

A second outcome of importance for this study was re-victimization status. Similar to risk and fear appraisals, re-victimization data was also collected from participants through self-report. Dependent on perspective (see debate in Hilton et al., 2010), this method may underestimate the rate of re-victimization. Social desirability, denial, and/or minimization may have deterred participants from reporting repeated victimization. Additionally, the unfortunate possibility exists that participants who were inaccessible for follow-up, wherein re-victimization status was determined, were victims of another violent incident. Inaccessibility may also be related to a participant’s continued effort to be safe and not located by an abusive partner (e.g., through changing telephone numbers, moving to another shelter, etc.). Participants were not aware that re-victimization status was a component of the follow-up; therefore, it is unlikely that re-victimized participants refrained from completing the follow-up due to this foreknowledge.

Additionally, the follow-up interval for participants in this study was not consistent, nor of a lengthy duration. Participants were assessed once for re-victimization, but that assessment could occur at any point (i.e., between 1 – 6 months) after initial participation in the study. It was also not clarified when the re-victimization incident occurred in relation to the follow-up, which has implications for findings regarding the implementation of the safety plan (i.e., before or after a new incident of violence). Lastly, re-victimization status may have been underestimated due to limits on data collection. Participants were asked to specify repeated incidents perpetrated by the index partner only, in which the safety plan was originally developed. Victimization by a non-
index partner was not included in data collection. However, it is noted that, in the open-ended questions in the follow-up survey, no participant indicated that a different partner had been abusive. The status of the index partner was also not requested, in terms of availability of the partner to recidivate (e.g., under formal sanctions like jail).

Overall, the limitations presented here should be contemplated and future research may be valuable in addressing them. Nevertheless, the presence of these limitations should not undervalue the contribution of this study to the current body of research on risk assessment and safety planning in the context of IPV.
IMPLICATIONS

At the nucleus of this research is the victim’s voice, or victim-based risk assessment. The conceptual basis of the victim’s voice is premised in characterizing a woman’s appraisal of her own risk for re-victimization, based on her knowledge of her abusive relationship. The aforementioned victim’s voice debate – regarding what weight victims risk appraisals should bear in risk assessment – is not resolved completely with the results of this study. However, the findings here suggest that women’s risk appraisals of IPV re-victimization may exhibit consistency and, when compared to an expert, accuracy in risk assessment. The results of this research contribute to a small – but growing – mass of literature emphasizing the merit of soliciting women’s personal risk assessments for future violence in intimate relationships (Connor-Smith et al., 2010). Rather than simply using victims to authenticate perpetrator accounts, victims own knowledge of the intimate relationship may be valuable in risk assessment (Campbell, 2004). Thus, it may be imprudent to distinguish between “experts” (i.e., professionals trained in risk assessment) and “non-experts” (i.e., the victim); both are “experts” within their own respective domains. In creating an equal playing field, so to speak, a collaborative dialogue between professionals and victims may occur that will likely enhance risk assessment and, subsequently, appropriate risk management.

Similar to the application of learned helplessness theory to victims of IPV (Walker, 2000), the conception that victims become too “emotional” or “scared out of their wits” to protect themselves may likely also be discarded. In facilitating experiential processing, women were able to provide comprehensive safety plans. Thus, regardless of intervention type, women in this study were active participants in their own safety; all women provided a breadth and depth of safety strategies to minimize their risk for re-victimization. This coincides with previous research (Campbell, 2004; Lindhorst et al., 2005) which stresses that women who are victimized by an intimate partner should be involved in safety planning. Involvement in a formalized safety planning process is critical in shifting the focus on identifying the presence of abuse in an intimate relationship to managing it. Safety planning does not absolutely assure a woman’s safety – perpetrator risk factors also influence risk for re-victimization (Lass, 2007). However, arming women with safety strategies is empowering (McDermott & Garofalo, 2004), particularly as helplessness and loss of power may be a consequence of abuse. As Hamberger and Potente
In a remark, a woman “does not have control over her partner’s violence – nor can she expect always to predict it” (p. 66), but she can have a plan that she may draw upon when required to protect herself.

Traditionally, cognition has been placed on a pedestal (Hogarth, et al., 2011). Logical examination, through a balancing of pros and cons or comparison of probabilities, was proposed to produce accurate decisions. In providing affective appraisals, it was surmised that emotions biased and hindered accurate judgment. This conventional stance was the basis for the a priori hypotheses of this study. However, contrary to expectation, the results described herein provide substantiation of a potential beneficial influence of emotions. The overarching implication is rather than viewing all emotional reactions automatically as suspect, emotion may also serve an important role in judgment and decision-making.

Despite a potential dance between affect and reason, the utility of emotion was identified in this study. The adoption of an experiential mode of processing appeared to instigate greater and consistent reductions in victim appraised risk and fear than an analytical mode of processing. This is not a carte blanche to ask emotionally-laden questions of victims of IPV, but rather to probe in a supportive (therapeutic) manner, so that a natural narrative may unfold and emotions can be expressed, examined, and, potentially, transformed. Although continued research is required to decisively establish the benefits of this decline in risk and fear for the risk as feeling approach, the equivalence in safety plan quality, the high degree of satisfaction, greater perceived rapport, and, potential reduction in re-victimization in comparison to the analytical mode of processing is convincing starting evidence. Undoubtedly, living in fear negatively affects individuals (e.g., the stress response; Lambert & Kinsley, 2005), although a degree of fear is likely beneficial to ensure appropriate precautions are taken (Lindhorst et al., 2005). Thus, the inference is that processing fear may make it more manageable and, as a result, may promote the safety of victims.

Although the actuarial versus SPJ debate was not the central focus of this study, it is implicated through the use of the IPV risk assessment measures as the basis for the competing interventions. In providing flexibility, allowing each individual to reflect on and weigh risk factors and drawing upon visual imagery, via generating worst-case scenarios of re-victimization, the experiential system was involved. The actuarial approach, like analytical processing, with its emphasis on probabilistic outcomes and rigidity in discretion is obviously limited in these respects. The culmination of the findings of this study suggests that utilizing an SPJ approach may be a better complement to risk assessment and safety planning with victims of IPV than an actuarial approach.
FUTURE DIRECTIONS

Although it may appear that this study has generated more questions than answers, this is an advantageous position as additional potentially fruitful avenues of research are identified. Three directions for future studies are tendered, including (a) risk and fear appraisals, (b) safety planning, and (c) expert and victim evaluations of risk. Lastly, general alterations to the current study design – as highlighted by the previous Limitations section – will be proffered.

Risk and Fear Appraisals

Based on the current data, it is theorized that a relationship exists between risk and fear (i.e., ratings jointly declined). Although outside of the scope of this study, use of this data to determine the nature of the relationship between risk and fear may be indicated. This clarification may be important, to understand the relative influence of these appraisals on safety plan quality, accuracy in risk assessment, and re-victimization status. Cluster analyses (e.g., see Allen et al., 2004) to classify victims by risk and fear self-appraisals (e.g., “high risk and low fear” cluster or “high risk and high fear” cluster) may be informative in this exploration. Alternatively, examination of this data within a moderating or mediating framework may confirm what has been implied by this study: fear may exhibit a greater influence over risk than vice versa.

The concept of “optimal arousal” was raised in this study with the inference that fear was generated, but not to the degree that it served as an impediment for participants. This raises the question of whether the results of this study would duplicate, continuing to assert the utility of experiential processing, when fear may be pronounced or minimized. This could include victims in an acute crisis, with a recent incident of violence (i.e., unlike the one-month moratorium with this study). Similarly, recurrent and excessive fear is a hallmark of post-traumatic stress disorder. Within an IPV population, incidence rates of this disorder are high, ranging between 33% and 60% (Humphreys et al., 2001). Alternatively, fear appraisals, like risk appraisals in this study, may be underestimated by victims. Whether levels of assessed fear were appropriate was not evaluated in this study. This direction of research may be valuable as excessive, but not lack of, fear has been identified as a victim vulnerability factor on formal risk assessment measures (e.g., Hilton et al., 2004).
The main affective focus in this study was fear. Undoubtedly, women who have experienced IPV victimization feel an array of intense emotions. Thus, the full complement of a participant’s affective experience was not assessed in this study. It has been theorized that multiple emotions may exert an important influence on risk perception. One study (Lerner & Keltner, 2000), for example, reported that anger may influence risk perception in a manner that is opposite to the influence of fear. Anger may induce optimism (Lerner & Keltner, 2000) and constructive behaviour (Hamberger & Potente, 1994), unlike fear. Similarly, feelings of sadness, shame, or guilt may also manifest with victims, with varying degrees dependent on the individual and the context of the IPV victimization. It may be interesting to extend this research to understand and discriminate between the different affective responses to IPV victimization and their impact on risk assessment.

Participants appraised their own degree of perceived risk and fear at critical intervals throughout this study. Although required to determine whether the intervention influenced change, this repeated valuation of risk and fear may not reflect reality. That is, it is queried how often a victimized woman may actually evaluate her own level of risk and fear. Does this occur on an ongoing basis and, if so, how frequently and what triggers such an assessment? Using computer-based technology (e.g., handheld personal devices) to monitor victim risk and fear appraisals may be a logical next step (see for example, Hogarth et al., 2011). This research may have implications in examining and understanding risk management from a victim’s perspective.

As a technical detail, rather than random assignment to an intervention, it may be interesting to screen future study candidates first using the REI (Epstein et al., 1998). For this study, for instance, a greater proportion of Poor subtypes (i.e., low rationality and experientiality) participated in the Experiential Intervention; this may have nullified the effect of the intervention for those participants. Previous research (Lieberman, 2002) has used a similar design, albeit not with an IPV population. Matching participants to their designated intervention (e.g., a categorized Rational individual on the REI with the Analytical Intervention) may highlight further how risk as feelings and risk as analysis may influence risk and fear assessments, safety planning quality, and re-victimization status. As a potential additional outcome, it may address the issue of individuality: whether some women may benefit more from one intervention than the other, dependent on predominant mode of processing. Clearly, the dual-mode processing conceptualization of risk is applicable to IPV, has stimulated intriguing research findings, and serves as an impetus for further exploration.
Safety Planning

The safety plans developed by both intervention groups appeared to be comprehensive. Interestingly, however, in comparing the number of strategies developed in Phase I and recollected or implemented in Phase II, there was evidence of a substantive decrement. Although this is not particularly surprising, due to the limitations of memory, it does provoke thought regarding why specific strategies were recalled, what strategies were implemented with or without success in an acute crisis, whether the decay of strategies continues over time, and what factors promote this decay. Once participants left after participating in Phase I of the study, what did they do, if anything, with their safety plan? Similar to risk assessment, safety plans are dynamic, changing as the context of an intimate relationship changes (Dienemann, Campbell, Landenburger, & Curry, 2002). It may be important to identify when safety plans change and under what conditions.

Expert Versus Victim Risk Assessment

This study compared expert and victim assessments of risk and fear. Future research regarding what factors influence victims’ formulations of risk and fear, their consistency and accuracy, are indicated (Bowen, 2011). Research by Connor-Smith and colleagues (2010) appears to be the beginning of this type of research. The benefit of mapping correspondence between an expert and a victim is in identifying factors that enhance appraisals of risk, promoting appropriate safety planning and risk management, thus offsetting the aversive consequences of IPV on victims. It would also be interesting to explore the effect of equitable collaboration between expert and victim (i.e., a “risk dialogue”) and/or whether consensus in risk ratings can be reached; if so, it is questioned whether there would be a benefit to achieving consensus (e.g., greater predictive accuracy, reduced re-victimization, increased use of formal helping agencies). A formal qualitative study may also be informative, in terms of allowing victims an opportunity to reflect on the formulation of their self-appraisal, to provide insight into the process. Anecdotally, in this study, participants would typically provide a rationale for their risk appraisals. For example, one participant lowered her risk rating because in her perspective, “others have it worse” than she did, while another participant increased her risk rating to “not get too cocky.”

Lastly, participants were asked to identify their level of risk, but the degree of confidence in which that appraisal was provided was not assessed. Previous research with expert raters (e.g., Douglas & Ogloff, 2003) has shown that confidence may mediate accuracy in risk assessment. Although, other studies do not show such a relationship (e.g., Desmarias, Nicholls, Read, &
Whether victim confidence in risk appraisals alter with participation in an intervention and influences accuracy in risk assessment may merit examination.

Study Design Adjustments

Direct services to IPV victims are always a priority for the prevention of re-victimization. Furthermore, the provision of an empirically validated service to IPV victims is indicated. To reach the threshold identified by Wathen and MacMillan (2003) for “good” empirical research, alterations to the methodology of this study would be advocated. The use of a control group is suggested in future research. To fulfil moral and ethical obligations (i.e., by not mitigating risk through refraining from safety planning), the control group could be defined as “treatment as usual.” This could involve accessing victims at community services and acquiring their developed safety plans or, at least, discussing the developed plan with the professional assisting the victims. A larger and diverse sample of women, who were in acute crisis who needed and desired safety planning, across multiple sites, would also augment the validity of this research. To determine more formally whether the interventions applied had a significant impact on re-victimization rates, further investigation is required in this area. Potential adjustments include a longer and consistent duration for follow-up, an exploration of collateral resources for recidivism rates and management strategies implemented, and improved methods to minimize victim attrition. Lastly, due to the dynamic nature of IPV, future research may involve gathering sufficient information to complete risk assessment measures a second time (i.e., at follow-up) to determine whether risk has actually reduced, victim vulnerability factors have changed (if were present originally), and to again assess the correspondence between expert and victim assessments of risk.

Finally, as is generally indicated for novel interventions, continued replication and evaluation is mandatory (Chambless & Hollon, 1998). If the validity and effectiveness of the safety planning intervention is established, future research may utilize a dismantling approach (Kazdin, 2002) and target areas that have been highlighted by this research (e.g., the role of the therapeutic alliance, the underlying mechanism of emotional processing in the Experiential Intervention, timing of the intervention, etc.). Until there is successful replication of the above study results, no specific recommendations are offered explicitly about which intervention, if any, should be implemented in practice. It is recommended, as it is in past research (Lindhorst et al., 2005), that women who have been victimized by a partner should become involved in a contextualized, collaborative risk assessment and safety planning process.
CONCLUSIONS

Intimate partner violence is a complex phenomenon, comprised of a multitude of factors that influences its prevalence, frequency, and nature in the lives of the women it impacts. Every woman in this study provided her own narrative, with each being unique. Intimate partner violence is, as Park (2005) suggests, “subjectively experienced by each woman” (p. 16). A woman, within her own relationship, possess information pertinent to her personal dynamic level of risk for re-victimization (Bowen, 2011) – warranting the inclusion of the victim’s voice in risk assessment. The findings outlined in this study have provided evidence of the consistency and accuracy of victim appraisals of risk, particularly in comparison with formalized assessments of risk. Whether relying on risk as analysis or risk as feelings approaches, women generate adequate risk appraisals and comprehensive safety plans. Experiential processing may confer benefits equivalent to, if not better than, the conventionally idealized cognitive processing. In response to the proposed question “How best [are we] to help women who are abused most accurately determine their risk?” (Campbell, 2004, p. 1466), the answer may lie in victim-focused contextualized and collaborative risk assessment and safety planning. Each woman’s perspective, her own voice, is crucial to assure her own safety from future IPV victimization.
REFERENCES

Agar, K., & Read, J. (2002). What happens when people disclose sexual or physical abuse to staff at a community mental health centre? *International Journal of Mental Health Nursing, 11*(2), 70 – 79.


APPENDICES

Appendix A: Study Advertisement

SAFETY PLANNING

TO: WHOM IT MAY CONCERN
SUBJECT: ASSISTANCE IN RECRUITMENT OF WOMEN
FROM: ANDREA GIBAS
       Phone (study phone line – private and confidential): 778-785-7451

My name is Andrea and I am a doctoral student studying Clinical Forensic Psychology at Simon Fraser University. I am currently in the initial stages of my dissertation research which will focus on safety planning with women who have experienced intimate partner violence.

The purpose of my study is to implement a safety planning intervention with women who have experienced violence by an intimate partner within the past year. It is important to note that this research includes all the same components to help develop a safety plan as is typically done in practice. This means that the developed safety plan should be similar to what an agency will develop with an individual – only the process will be different (i.e., getting the same ‘answer’ but following different paths). Women will also be asked to evaluate the usefulness and helpfulness of the safety plan. I want this research to directly serve women; and as such, women who participate in this study will be able to help guide and refine the safety planning interventions in a way that best serves them and, potentially, other future victims of intimate partner violence.

I would like to invite women who have experienced partner abuse within the past year (preferably the last six months) to participate in this research. Each woman will be guided through a clinical intervention designed to help create a comprehensive safety plan. I am hoping that we could work together on recruiting women in getting your help with:

Placing copies of the attached poster in places that are visible and accessible to women that attend your service. I also have brochures that I can send to you.

As is your mandate, both the privacy and safety of women is my priority. I have a generic email address and voicemail, so that it is not obvious what research I am doing if curious partners attempt to contact me.

I really believe that this project is valuable. For women, the benefit is the potential to increase their safety and the safety of future victims. Please contact me if you have any additional questions, comments, or suggestions. Thank you in advance for your help!
Want to Help Other Women in Your Situation?
then join me in the study

*A Woman’s Voice: Safety Planning for Intimate Partner Violence*

If you have been hurt by your husband, partner, or boyfriend within the past year – then join me in making a better way to keep women safe!

I would like to meet with you for about 2 - 3 hours at a SFU campus (Burnaby, Surrey, or Vancouver) to:

- Hear your story
- Develop a safety plan with you
- Talk about the plan we made

With your help, I hope to figure out how safety plans can be made better to help other women like you that will need to make a safety plan.

In thanks for your time, I would like to offer you:

- $40
- 2 bus tickets (or equal amount of money)
- Drinks/snacks
- Child friendly room or small child care reimbursement

For more information or to volunteer for this study, please contact

778-785-7451 (private voicemail)

or

women.health.study@gmail.com

This study has been reviewed by, and received ethics clearance through, the Office of Research Ethics, Simon Fraser University.
Appendix B: Informed Consent Form

SIMON FRASER UNIVERSITY

Informed Consent By Participants In a Research Study

The University and those conducting this research study subscribe to the ethical conduct of research and to the protection at all times of the interests, comfort, and safety of participants. This research is being conducted under permission of the Simon Fraser Research Ethics Board. The chief concern of the Board is for the health, safety and psychological well-being of research participants.

Should you wish to obtain information about your rights as a participant in research, or about the responsibilities of researchers, or if you have any questions, concerns or complaints about the manner in which you were treated in this study, please contact the Director, Office of Research Ethics by email at hweinber@sfu.ca or phone at 778-782-6593.

Your signature on this form will signify that you have received a document which describes the procedures, whether there are possible risks, and benefits of this research study, that you have received an adequate opportunity to consider the information in the documents describing the study, and that you voluntarily agree to participate in the study.

Title: The victim's voice: A victim-focused safety planning intervention for intimate partner violence
Investigator Name: Andrea Gibas
Investigator Department: Department of Psychology

Having been asked to participate in the research study named above, I certify that I have read the procedures specified in the Study Information Document describing the study. I understand the procedures to be used in this study and the personal risks to me in taking part in the study as described below:

Purpose and goals of this study: This study is designed to investigate two interventions that have been developed to assist individuals who have experienced partner violence with safety planning. The goal is to implement and compare the two interventions with participants who have had experiences with partner violence. The purpose of this part of the study is to implement the interventions via an in-depth interview.

What the participants will be required to do: You are being invited to take part in the first phase of a study that is being conducted at domestic violence services across British Columbia. If you agree to participate in this portion of this study you will be required to take part in a structured interview lasting approximately 2 hours. The interview is intended to collect
information about you, your intimate relationship where abuse was involved, and to go through one safety planning intervention. With your permission, this session will be videotaped or audiotaped (or videotaped and then transcribed).

**Risks to the participant, third parties or society:** Due to the sensitivity of topics and nature of the interview questions, it is possible participants may become more emotionally distressed during the interview and/or following its completion. We encourage you to share those feelings with the researcher and/or with the staff at the service agency you are attending. The researcher will provide you with referrals to appropriate resources to assist you. It is important for you to know that participation in this study is entirely voluntary. You may decline to answer any study questions posed to you. You may also withdraw from the study at any time. Declining to answer study questions or withdrawing completely from the study will have no consequences on the services or treatment you receive. Additionally, research has found that men who abuse their partners may also monitor their partner's phone calls and social contacts. As you may be aware, there is a risk that your (ex) partner could become angry and/or abusive if he finds out that you are taking part in this study, thereby increasing your risk of being abused and/or assaulted. However, precautions will be taken to ensure your safety.

**Benefits of study to the development of new knowledge:** It is anticipated that the results of this study will be used to standardize a safety planning intervention for individuals who have been affected by partner violence. This may, in turn, lead to improved safety for future victims of partner violence.

**Statement of confidentiality:** The data of this study will maintain confidentiality of your name and the contributions you have made to the extent allowed by the law. The interview conducted by the researcher may uncover information that is subject to mandatory reporting provisions. These mandatory reporting provisions include: any disclosure of current child abuse or neglect, or any disclosure of information that leads the researcher to believe that the participant poses a high risk of violence to herself or to an identifiable person or group of persons. This information would have to be disclosed to the appropriate authorities. Additionally – and this is very important – the researcher must report any unreported abuse by your partner against you, whether ongoing or not, to the appropriate authorities. If you tell the researcher that your partner has assaulted you recently or in the past and this has not been reported to anyone else, the researcher is obligated to report it to the authorities on your behalf.

**Inclusion of names of participants in reports of the study:** Any information (e.g., your name and the contributions that you have made to this research) that is obtained during this study will be kept confidential to the full extent allowed by the law.

**Contact of participants at a future time or use of the data in other studies:** The second phase of this study includes following participants at regular intervals after this first interview phase (e.g., at 1 month, 2 months, and 3 months post initial interview). This follow-up will involve a phone contact and another shorter interview. For each successive follow-up interview that you participate in you will receive monetary compensation. At the end of the study, the researcher will provide you with more details about what this will involve. If you agree to future contact, please initial the box on the signature form.

I understand that I may withdraw my participation at any time. I also understand that I may register any complaint with the Director of the Office of Research Ethics.
Dr. Hal Weinberg  
Director, Office of Research Ethics  
Office of Research Ethics, Simon Fraser University  
8888 University Drive  
Multi-Tenant Facility  
Burnaby, B.C. V5A 1S6  
ahal_weinberg@sfu.ca

I may obtain copies of the results of this study, upon its completion by contacting:

Andrea L. Gibas, Simon Fraser University, Department of Psychology, 8888 University Drive,  
Burnaby, B.C., Canada V5A 1S6

I understand the risks and contributions of my participation in this study and agree to participate:

Participant and witness shall fill in this area. Please print legibly

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<th>Participant Last Name:</th>
<th>Participant First Name:</th>
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<th>Participant Signature:</th>
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Appendix C: Informed Consent for Audiotaping

I understand that this study involves the audiotaping of my, ________________________ (Participant Name), interview with the researcher. Neither my name nor any other identifying information will be associated with the audiotape or the transcript (if needed). I also understand the following:

- I am not required to be audiotaped and I am under no obligation to have this session recorded.
- I can withdraw my permission to be audiotaped at any time during or after the session. My access to services will not be affected by my decision not to be audiotaped.
- The audiotape will not be used for any other purposes than this research project; confidentiality will be ensured.
- I have the right to review this recording at the end of the interview.
- The audiotape will be erased and destroyed upon completion of the research study.

I understand that the audiotapes may be transcribed by the researcher and erased once the transcriptions are checked for accuracy. Transcripts of my interview may be reproduced in part for use in further research related to this study. Neither my name nor any other identifying information will be used on any of the materials.

**Please check one of each pair of options.**

A. ___ I consent to have my interview audiotaped.  
   ___ I do not consent to have my interview audiotaped.

B. ___ I consent to have my audiotaped interview transcribed into written form.  
   ___ I do not consent to have my audiotaped interview transcribed.

The above permissions are in effect until the recordings are no longer required in this research project or will be approximately 6 months after signing this form. At that time, the recordings will be permanently erased and destroyed.

________________________   ____________________  
Participant Signature     Date

_________________________   ____________________  
Witness Signature      Date

Destruction date: _________________________

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Appendix D: Initial Screen and Interview

PART 1: DEMOGRAPHIC AND INTRODUCTORY SURVEY

Date Completed: __________________
Time of Day: __________________
Location: ______________________
Referred from:__________________
Form: A or B

After getting assent from participant to participate in the research

Inclusion/Exclusion criteria
“Hello, my name is Andrea and I’m a graduate student from Simon Fraser University. Before we actually begin the study, I just need to ask you a few yes/no questions to ensure you are the right fit for my study. Thanks for your patience!”

If ‘N’ marked on any item, discontinue with thanks:
a. Have you experienced abuse from an intimate partner: Y N
Abuse = actual, attempted, or threatened physical harm perpetrated by a man or woman against someone with whom he or she has, or has had, an intimate, sexual relationship
Intimate partner = current or former spouse - married or common law
b. Have you experienced recent abuse by an intimate partner: Y N
Recent = in the past 4 weeks - 1 year
c. Your intimate partner is/was male: Y N
d. You are nineteen years of age or older: Y N
e. Able to communicate in English (do not need to ask): Y N
Provide with Informed Consent Form
f. Informed consent obtained (verbal and/or written): Y N

Notes:__________________________________________________________

“Just to orient you to what we’re doing today – first I’ll ask you general background questions about yourself and your relationship history, then we’ll discuss different aspects about your relationship that included violence, we will work together to develop a plan or strategy to help you cope with this, and then we’ll talk about how the process went for you. This will take about 2 hours of your time. Does this sound ok to you? Please stop me at anytime to ask questions or if you need a break.”

If participant indicates can proceed, continue

“I am now going to ask you some general background questions about who you are and about your relationship with your (ex-) partner. As noted in the consent form, and I’ll reiterate it again, if you do not feel comfortable in answering any of the following questions, please let me know. If you feel that you no longer want to participate in this study, I understand completely – it’s not a problem - but please let me know. Your withdrawal from the study will not affect the services you are currently receiving or would like to receive in the future.”

General Demographic Information
1. How old are you: _______ years
2. What is your ethnic background: ________________________________

3. What is the highest level of education that you obtained:
   a. Elementary/Junior High
   b. Some high school
   c. Completed high school
   d. Some college/university
   e. Completed college/university degree (undergraduate)
   f. Some graduate school
   g. Completed graduate degree

4. Are you currently employed: Y  N
   a. Part-time, Full-Time,
      Other:__________________________________________________
   b. If yes, general job description:____________________________
   c. If no, describe circumstances:
      ________________________________________________________________________
   d. Do you have any current employment problems/issues (e.g., difficulty finding a job)?  Y  N
      ________________________________________________________________________
   e. When with your partner, did you have any employment issues/problems?  Y  N
      ________________________________________________________________________

(B-SAFER #15)

5. Do you have children: Y  N
   a. Total number of children: _____
   b. Number currently in the home/with participant: _____
   c. Ages of the children at home with participant:____________________
   d. The recent (ex-) intimate partner is the biological father: Y (#____)  N (#____)
   e. If separated, who has primary custody of the children:____________________
   f. If separated, does the non-custodial parent have visitation: Y  N
   g. Has your (ex-) partner ever assaulted you when you were pregnant?  Y  N
      ____________________________

(ODARA #8, 9, 12)

6. What is your current living arrangement like:
      ________________________________________________________________________
   a. Do you think where you live you are safe from your (ex-) partner? Y  N
      ____________________________

(B-SAFER #14)
b. Do you live in a home with no phone? Y  N
   (ODARA #13)

c. Do you live where there is no access to transportation? Y  N
   (ODARA #13)

d. Do people live close by? Y  N
   (ODARA #13)

7. Do you have, or did you have, any health or mental health problems/issues? Y  N
   (B-SAFER #15)

Do you have, or did you have, any substance abuse issues (including drugs - prescribed or illegal - or alcohol)? Y  N
   (ODARA #13)

Details about (Ex-) Intimate Partner
“I am going to ask you a few questions about your (ex-) partner to get an idea of what he was like and what your relationship with him was like.”

8. What is the age of your (ex-) partner: _______years

9. What is the ethnicity of your (ex-) partner: ________________________________

10. What is the highest level of education that he obtained:
    a. Elementary/Junior high
    b. Some high school
    c. Completed high school
    d. Some college/university
    e. Completed college/university degree (undergraduate)
    f. Some graduate school
    g. Completed graduate degree

11. Was he mostly employed during your relationship with him: Y  N
    a. Part-time, Full-Time, Other,
       Unknown:________________________________________________________
    b. If yes, general job description:______________________________
    c. If no, describe circumstances:
       ____________________________________________________________
    d. Has your (ex-) partner ever had employment/education problems (e.g., problems keeping a job or finding a job, having problems dealing with management)? Y  N
       ________________________________

   (B-SAFER #8)
12. What is his current living arrangement (if differs from that of the participant): ________________

13. While together, did your (ex-) partner ever have problems with his mental health, such as problems with his nerves or mental or emotional problems?  Y  N

(B-SAFER #10)

14. Has your partner ever attempted suicide or talked about suicide?  Y  N

15. While together, did he use substances like drugs or alcohol that caused difficulties between you and him?
   a. Drug abuse (illegal or legal/prescribed):  Y  N
      Description: ______________________________________________________________

   b. Alcohol:  Y  N
      Description: ______________________________________________________________

   c. If yes, does he become more angry or violent when he uses substances?  Y  N

   d. If yes, has he gotten in trouble with the police (e.g., charged with a crime) when drinking?  Y  N

         Has he had a drug or alcohol problem at any time since he was 18?  
         Y  N;  D  A  both

   e. Did he abuse alcohol or drugs just before or during your most recent assault?  Y  N

   f. What about a few days/weeks before?  Y  N

   g. If yes to ‘e’ or ‘f’, was his substance use more than usual the few days/weeks before?  Y  N

   h. Was there alcohol use by you when this last assault occurred?  Y  N

(B-SAFER #9, ODARA #13, 11)

16. Does your (ex-) partner have a criminal record:  Y  N  Unknown
   a. If yes, describe: __________________________________________________________

   b. Is he violent with other people, aside from you and your children?  Y  N

   (ODARA #10)

   c. Have the police ever had to deal with him before for any other kind of physical violence, aside from intimate partner violence?  Y  N

   (ODARA #2)
d. Has he been to prison for 30 days or more, even if he did not serve the whole time? Y N
   i. If yes, what was the length of time: ___________
   ii. Describe: __________________________________________________________________________

   (ODARA #3; B-SAFER #6)

**Relationship History**
“Ok, so now we’re going to talk more specifically about your most recent relationship with your (ex-) intimate partner that involved some degree of physical violence.”

17. What was the length of your most recent intimate relationship with your (ex-) partner:
   • _____years
   • _____months

18. What was the marital status of the intimate relationship:
   1. Marriage
   2. Common-law
   3. Dating
   4. Other: ____________________________________________

19. What is the current status of the relationship:
   1. Together
   2. Separated
   3. Divorced
   4. Other: ____________________________________________

20. New Partner? Y N

21. When was the last time had interaction/communication with partner:

   a. Since last incident of intimate partner violence? Y N
   b. Was the contact by choice? Y N
   c. What type of contact was it?
      ____________________________________________________________________________________

   d. Typically, how often do you have contact with your (ex-) partner?
      ____________________________________________________________________________________

22. Were there any serious problems in your relationship with your (ex-) partner (e.g., issues regarding money, child-rearing, cheating/infidelities)? Y N

   i. Had these issues been going on in the past month or two prior to the physical assault? Y N

   (B-SAFER #7)
23. Has there ever been any relationship separations: Y N
   a. Due to the abuse in relationship: Y N
   b. If ‘yes’, number of abuse-related separations: ______
   c. Number of non-abuse related separations: ______
   d. Longest length of time separated because of abuse: ______months ______years

24. Approximately how long after the relationship began did the physical abuse start?
   (Definition of physical abuse: “actual, attempted, or threatened physical harm
   perpetrated by a man or woman against someone with whom he or she has, or has had,
   an intimate, sexual relationship”)
   • ______years into the relationship
   • ______months into the relationship

25. Could you briefly describe the most recent incident of physical abuse (e.g., what kind of
   things did he do): _____________________________________________
   Injured/hospitalized?
   _____________________________________________________________
   Most significant injury:
   _____________________________________________________________
   (B-SAFER #1)

26. Has there been a domestic incident in your relationship, where your partner assaulted you
    and there was police involvement? Y N
    _____________________________________________________________
    (ODARA #1)

27. Has your (ex-) partner ever assaulted you with a weapon or attempted to assault you with
    a weapon? Y N
    _____________________________________________________________
    (B-SAFER #1)

28. Has he ever done anything to prevent you from leaving the location (e.g., lock the doors,
    take your car keys, hold on to you)? Y N ___________________________
    Was this during the most recent incident? Y N
    (ODARA #6)

29. Do you think your (ex-) partner’s violent acts, threats or thoughts of violence escalated or
    became more frequent with time? Y N
    _____________________________________________________________
    (B-SAFER #3)

30. What is or would be your (ex-) partner’s reaction to being called an abuser?
    _____________________________________________________________
    (B-SAFER #5)
31. Does your (ex-) partner minimize or deny his history of intimate partner violence? Y N
   In what way? ____________________________________________________________
   (B-SAFER #5)

(PART 1 RATINGS)

32. Was there ever any sexual abuse or attempted sexual abuse in the intimate relationship: Y N
   (Definition of sexual abuse: any sexual act without the willing consent/participation of the
   victim – includes physical sexual acts or humiliation/degradation or control)
   If answer is NO, skip to question #33
   a. How long was it after the relationship began did the sexual abuse or attempted
      sexual abuse start:
         • _______ years into the relationship
         • _______ months into the relationship
   b. Describe circumstances (if wants to discuss):

   (B-SAFER #1)

33. Was there ever any psychological abuse present in the relationship: Y N
   (Definition of psychological abuse: threats or coercive acts that seek to overpower
   and control the victim; ridiculing, shouting, swearing, and name-calling)
   If answer is NO, skip to question #35
   a. If yes, how long after the relationship began did it start:
      1. _______ years into the relationship
      2. _______ months into the relationship
   b. Describe circumstances (if wants to discuss):

34. Do you, or others close to you, consider your (ex-) partner to be a controlling, possessive,
    or jealous person? Y N
   (B-SAFER #5)

35. Did your (ex-) partner ever threaten to hurt you or someone else you know (e.g., family
    member; e.g., death threats, explicit plans)? Y N (at index offence – Y N)
   (ODARA #5)

36. Did your (ex-) partner ever tell you about him having violent thoughts, such things as
    images, fantasies, urges or plans about hurting you or someone you know? Y N
   (B-SAFER #2)
37. Was there any stalking of you/your children: Y  N

(Definition of stalking: stalking is the wilful, repeated, and malicious following of another individual)

If answer is NO, skip to question #40

a. If yes, how long after the relationship began did the stalking start:
   1. _______years into the relationship
   2. _______months into the relationship

b. Describe circumstances (if wants to discuss):

38. Were there any other behaviours or actions of your partner that you felt were abusive and have not been covered yet (e.g., financial, spiritual)?

39. Aside from this most recent incident, was there any previous involvement with any of the following services because of your relationship with your (ex-) partner:
   a. Police services Y N
   b. Lawyer/legal services Y N
   c. Domestic violence shelters Y N
   d. Domestic violence advocates Y N
   e. Mental health services Y N
   f. Medical health services Y N
   g. Other Y N

Describe:

40. For this most recent incident, what other services are you currently accessing?
   a. Police services Y N
   b. Lawyer/legal services Y N
   c. Domestic violence shelters Y N
   d. Domestic violence advocates Y N
   e. Mental health services Y N
   f. Medical health services Y N
   g. Other Y N

Describe:

41. What is your support network comprised of (e.g., people to turn to – family/friends?)

   a) Do they know about the abuse?

   b) Do they support the abuser?
42. Do you believe you have adequate access to resources (i.e., informal and formal services) to help you overcome this situation with your (ex-) partner? Y N
What are they?________________________

(B-SAFER #13)

43. Has there ever been any violations of a “no contact” order by your (ex-) partner: Y N N/A
   a. During most recent incident of physical abuse: Y N
   b. Past incidents (with same partner): Y N
   c. Total number of times that happened: ______
   d. Total number of times with police or corrections involvement: ______
   e. Describe circumstances:

   f. Has he violated probation, parole, bail or any other criminal court requirement (e.g., failed to attend an appointment, drinking when prohibited, etc.)? Y N
   g. Or, charged for an offence while on conditional release? (BSAHER #4, ODARA #4)

44. Has there ever been any violations of a “no go” order by your (ex-) partner: Y N N/A
   a. During most recent incident of physical abuse: Y N
   b. Past incidents (with same partner): Y N
   c. Number of times that happened: ______
   d. Number of times with police or corrections intervention: ______
   e. Describe circumstances:

   (BSAHER #4, ODARA #4)

45. Are you concerned that he will assault you or your children again? Y N

   (ODARA #7)

46. Do you feel you are at immediate risk of serious harm from your (ex-) partner (i.e., so, like today or upon your arrival back at home)? Y N
   ‖ If YES, use protocol in place to deal with this situation‖

47. On a scale of 0 – 10, what is your overall level of risk of being harmed by your partner in the future: _____

48. Or, said in another way, what is your overall level of risk of being harmed by your partner in the future: Low or Moderate or High

49. On a scale of 0 – 10, how likely in the next month will your partner:
   a. Hurt you physically (including sexually): _____
   b. Hurt you emotionally: ______
   c. Threaten you with harm: ______
   d. Destroy any of your property: ______
   e. Stalk you: ______
   f. Other: __________________________
Fear and Safety Planning

50. Do you blame yourself for your (ex-) partner’s violent actions or think his actions were justified (e.g., because you did something wrong to annoy him)? Y N

(B-SAFER #11)

51. Are you afraid of your partner? Could you describe that feeling?: Y N

(B-SAFER #12)

52. What is a “safety plan”:

53. Have you ever developed a safety plan: Y N
   a. Number of developed safety plans: _____
   b. When (most recent plan):

   c. With who:

   d. What did the plan include:

   e. Are you currently relying on the whole safety plan or parts of the safety plan?

Thank you for that information! Just to take a break from talking about your relationship, I would like you to complete this mini-survey for me.

|| Provide participant with the REI inventory||

||Insert either intervention here – see other files for interventions||
Appendix E: Interventions

~FORM A: AFFECTIVE/EXPERIENTIAL INTERVENTION~

“Ok, so we’ve really looked closely at your most recent relationship, which has given us a lot of information about it. Oftentimes when people are facing a big stressor like you’ve faced, people feel numb, confused, and/or in turmoil because there is so much information coming at them from all different directions. It makes it hard to figure out what is important and what information you should pay attention to, to ensure your own safety. When this happens, it is important to pause and slow down, and really take the time to examine all those bits of information, learn from them, and figure out what you should pay attention to.”

“How do you do that? Well, by using emotions and feelings. Our emotions and feelings often guide us and tell us what is important information that we should attend to. Some people talk about “going with your instinct” or “going with your gut” when they talk about this. That’s what I want you to do here, I want you to listen to what your feelings or emotions are telling you about this relationship. This can be based in your past experiences with your (ex-) partner. By reflecting on your feelings, we’ll be able to sense what is important for your safety. Do you feel you can do that?”  ||Once participant agrees…||

“Ok, let’s get started! Now, it is common practice in this field to take all the information about a relationship and look through it for factors – we call them risk factors- that are present in relationships and influence people to act in aggressive ways towards their partners. Risk factors help us figure out what is the risk for future violence in an intimate or once intimate relationship. Here is a list of risk factors that are commonly referred to in the field.”  ||Researcher writes down the B-SAFER risk factors on a wipe board or piece of paper and go through what they each mean||

“How do you do that? Well, by using emotions and feelings. Our emotions and feelings often guide us and tell us what is important information that we should attend to. Some people talk about “going with your instinct” or “going with your gut” when they talk about this. That’s what I want you to do here, I want you to listen to what your feelings or emotions are telling you about this relationship. This can be based in your past experiences with your (ex-) partner. By reflecting on your feelings, we’ll be able to sense what is important for your safety. Do you feel you can do that?”  ||Once participant agrees…||

“From what you have told me about your relationship with your (ex-) partner, these are the risk factors that seem to be present and relevant for you.”  ||Researcher circles the risk factors that are present in the relationship as based on information from the previous section||

“Now, this next part really requires you to rely on what your feelings or gut instincts are telling you… I want you to take a moment and really reflect on what you feel about this situation with your ex-partner – reflect on what feelings you have in your gut or in your stomach right now, as we talk about this.”

1. According to this information I just showed you, what is the total number of risk factors that are present in your relationship with your (ex-) partner? _____

2. When you see these risk factors as evidence of risk, what do you feel?

3. Does that feel right to you? What feels right and what doesn’t feel right?

4. Which of these risk factors are you afraid of the most with regards to your (ex-) partner? What makes your stomach go in knots or keeps you awake at night?

5. Which of these risk factors are you afraid of the least with regards to your (ex-) partner?
6. Can you order the risk factors in terms of what makes you feel the most afraid to least afraid?

________________________________________________________________________

7. Looking at these risk factors, what kind of feeling do you get about how dangerous your partner is?

________________________________________________________________________

“Ok, so now what I would like you to do is to use those risk factors and tell me a story about the ways that these risk factors could make you more at risk for harm from your (ex-) partner in the future. So, for instance, if you told me that you really felt that substance abuse issues is a problem for your (ex-) partner, one story could include your (ex-) partner going out for a night on the town with his buddies, getting extremely drunk, and coming home and being aggressive towards you. You can tell me stories that include the best case and worst case scenario, and if things stay the same as they are now. Remember to incorporate what your emotions/feelings or gut is telling you about your (ex-) partner’s risk for future violence.”

What do you feel is the “best case” story/scenario for you?
Scenario #1 (best case):

________________________________________________________________________

What do you feel is the “worst case” story/scenario for you?
Scenario #2 (worst case):

________________________________________________________________________

1. Keeping in mind the stories that you just developed, do you feel:
   a. That the level of concern that your (ex-) partner will commit spousal violence in the future if no intervention is taken is Low, Moderate, or High? L  M  H
   b. That the level of concern that any future spousal violence will involve life-threatening physical harm if no intervention is taken is Low, Moderate, or High? L  M  H
   c. That the level of concern that your (ex-) partner is at an imminent/immediate risk to commit spousal violence if no intervention is taken is Low, Moderate, or High? L  M  H

2. So, overall, you feel that your level of risk for being victimized in the future by your (ex-) partner is: L  M  H

Do you feel that what we just did reflects that level of risk? Y  N
Why or why not:
________________________________________________________________________

3. Overall, in terms of a proportion or percent, what is the likelihood of being victimized by a male partner within the next month? _______ (Cognitive Appraisal)

4. On a scale of 0 – 10, what is your overall level of risk of being harmed by your partner in the future: _______
MANIPULATION CHECK
“Now that we are getting to the end of what we have to do today, I just want to take a few minutes to see how you are feeling – to take your emotional temperature so to speak.”

||Administer Russell Affect Grid||
1. Can you describe what you are feeling to me at this moment?
   ____________________________________________________________________
   Can you rate the intensity on a scale of 0 – 10: _____
2. Can you describe what you felt during the entire process?
   ____________________________________________________________________
   Can you rate the intensity on a scale of 0 – 10: _____
3. Can you describe the moment that you felt the worst or the highest level of anxiety or worry?
   ____________________________________________________________________
   Can you rate the intensity on a scale of 0 – 10: _____
4. Did you experience any flashes or images during this process today?
   ____________________________________________________________________
   Can you rate the intensity on a scale of 0 – 10: _____
5. Did you have to have to suppress any flashes or images during this process today?
   ____________________________________________________________________
   Can you rate the effort required to suppress these flashes or images on a scale of 1 – 10: _____
6. On a scale of 0 – 10, how much would you say that this process provoked feelings and a reliance on your gut or instincts? _____
7. On a scale of 0 – 10, how much would you say that this process provoked thoughts and judgments about facts? _____
8. On a scale of 0 – 10, how much would you say that you were experiencing both at the same time? _____
9. You were told to think about your situation in an (*insert intervention here*) way, can you describe to me how you were able to do that? Was it easy/hard for you?
   ____________________________________________________________________

|| Go to Post-Intervention Survey ||
“Ok, so we’ve really looked closely at your most recent relationship, which has given us a lot of information about it. Oftentimes when people are facing a big stressor like you’ve faced, people feel numb, confused, and/or in turmoil because there is so much information coming at them from all different directions. It makes it hard to figure out what is important and what information you should pay attention to, to ensure your safety. When this happens, it is important to pause and slow down, and really take the time to examine all those bits of information, learn from them, and figure out what you should pay attention to.”

“How do you do that? Well, by thinking things through logically and rationally. Logic and common sense guides us and tells us what important information we should attend to. Some people talk about “being Spock-like” or “thinking like a computer” when talking about thinking this way. I want you to take the perspective of a lawyer: be cold, distant and neutral about your case. That’s what I want you to do here. This will allow a neutral examination of the facts and evidence presented here. By thinking about the facts and evidence in a systematic way, we’ll be able to figure out what is important for your safety. Do you think you can do that?”

“Ok, let’s get started! It is common practice in the domestic violence field to take all the information about a relationship and look through it for specific factors – we call them risk factors - that are present in the relationship and may influence a person to act in aggressive ways towards his partner. Risk factors help us figure out what is the aggressive person’s risk for future violence in an intimate or once intimate relationship. Here is a list of risk factors that are commonly referred to in the field, that have been shown by to be generally common to people who are abusive in their relationships. These risk factors were drawn from a group of 600 men that were accused of assaulting a female partner or ex-partner and were being investigated by the police. Averaged across all of those men, these are the risk factors that were found to optimize or best predict future domestic violence.”

“As compared to the risk factors found for the 600 men or, in other words, as compared to the average, these are the risk factors that are present.”

“Now this next part really requires you to rely on thinking logically and rationally…It might be helpful to separate yourself from the situation and think about what the average person – like a next door neighbour or dentist or random stranger on the street - might think about these risk factors.”

1. According to this information, what is the total number of risk factors that appear to be present? ______

2. When see these risk factors, what do you think a lawyer would think?

3. From the lawyer’s perspective, does that seem logical/make common sense? What makes common sense/what doesn’t make common sense?
4. Which of these risk factors do you think that a lawyer would say weigh the most? What would logic or common sense dictate?

5. Which of these risk factors do you think that a lawyer would say weigh the least?

6. Can you order the risk factors in terms of what you think that a lawyer would say weighs the most to the least?

7. What do you think the lawyer would say about how dangerous your partner is? (provide rating)

“Ok, now let’s total or sum the number of factors that are present. What is the number? Participant provides value from 0 – 13. This total number is important because there is a booklet that computes and translates what this score means in terms of risk for future violence. This total score places a male perpetrator into one of seven ascending risk categories, which indicates the likelihood that a male partner will re-victimize his female partner within the next 5 years. Let’s see, can you tell me what is the risk category for the total score of ___? ___

1. When see this %, what would a lawyer think?

2. Keeping that total score/risk category in mind, do you think that a lawyer will think:
   a. That the level of concern that your (ex-) partner will commit spousal violence in the future if no intervention is taken is Low, Moderate, or High? L M H
   b. That the level of concern that any future spousal violence will involve life-threatening physical harm if no intervention is taken is Low, Moderate, or High? L M H
   c. That the level of concern that your (ex-) partner is at an imminent/immediate risk to commit spousal violence if no intervention is taken is Low, Moderate, or High? L M H

3. Overall, in terms of a proportion or percent, what is the likelihood of being victimized by a male partner within the next month? ___ (*if discrepancy with ODARA ask why?)

Do you think that what we just did reflects that level of risk? Y N
Why or why not:

4. Just to reiterate, overall, you feel that your level of risk for being victimized in the future by your (ex-) partner is: L M H
   (Affective appraisal)

5. On a scale of 1 – 10, what is your overall level of risk of being harmed by your partner in the future: _____
MANIPULATION CHECK
“I just want to take a few minutes to see how you are feeling – to take your emotional temperature so to speak.”

||Administer Russell Affect Grid||

10. Can you describe what you are feeling to me at this moment?
    Can you rate the intensity on a scale of 0 – 10: _____

11. Can you describe the moment that you felt the worst or the highest level of anxiety or worry?
    Can you rate the intensity on a scale of 0 – 10: _____

12. Did you experience any flashes or images during this process today?
    Can you rate the intensity on a scale of 0 – 10: _____

13. Did you have to have to suppress any flashes or images during this process today?
    Can you rate the effort required to suppress these flashes or images on a scale of 1 – 10: _____

14. On a scale of 0 – 10, how much would you say that this process provoked feelings and a reliance on your gut or instincts? _____

15. On a scale of 0 – 10, how much would you say that this process provoked thoughts and judgements about facts? _____

16. On a scale of 0 – 10, how much would you say that you were experiencing both at the same time? _____

17. You were told to think about your situation in an (*insert intervention here*) way, can you describe to me how you were able to do that? Was it easy/hard for you?
    ________________________________

|| Go to Post-Intervention Survey||
Appendix F: Risk Factors

Experiential Intervention

<table>
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<tr>
<th>Risk Factors</th>
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</thead>
<tbody>
<tr>
<td>1. □ Violent acts</td>
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<tr>
<td>2. □ Violent threats or thoughts</td>
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<tr>
<td>3. □ Escalation</td>
</tr>
<tr>
<td>4. □ Violation of court orders</td>
</tr>
<tr>
<td>5. □ Violent attitudes</td>
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<td>6. □ General criminality</td>
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<td>7. □ Intimate relationship problems</td>
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<td>9. □ Substance use problems</td>
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<td>10. □ Mental health problems</td>
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<td>11. □ Inconsistent behaviour and/or attitudes</td>
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<td>12. □ Extreme fear</td>
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<tr>
<td>13. □ Inadequate access to resources</td>
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<tr>
<td>14. □ Unsafe living situation</td>
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<tr>
<td>15. □ Personal difficulties</td>
</tr>
<tr>
<td>16. □ Other Considerations</td>
</tr>
</tbody>
</table>

Analytical Intervention

Risk Factors

1. □ Prior Domestic Incident
2. □ Prior Non-Domestic Incident
3. □ Prior Correctional Sentence of 30 days or more
4. □ Conditional Release Failures
5. □ Threat to Harm or Kill at the Index Offence
6. □ Confinement at the Index Incident
7. □ Victim Concern
8. □ More than One Child
9. □ Victim’s Biological Child From A Previous Partner
10. □ Violence Against Others
11. □ Substance Abuse
12. □ Assault on a Victim when Pregnant
13. □ Barriers to Victim Support

Total Score: _____

Score

0 = 10%; One out of ten known wife assaulters score 0.

1 = 25%; One quarter of known wife assaulters score 1 or lower.

2 = 50%; Half of known wife assaulters score 2 or lower.

3 = 70%; Seven out of 10 known wife assaulters score 3 or lower.
4 = 80%; Eight out of 10 known wife assaulters score 4 or lower.

5 – 6 = 90%; Nine out of 10 known wife assaulters score 6 or lower.

7 – 13 = 95%; Fewer than 1 of 10 known wife assaulters score in this category.

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Appendix G: Safety Plan

PART 3: POST-INTERVENTION SURVEY
Form: A  or  B

SAFETY PLANNING
"Now we’ve established what the risk factors are, and your level of risk for the future in being hurt by your (ex-) partner. Although it’s difficult to talk about your relationship, this is all really valuable information that we can use to make a safety plan. As we talked about before, you said that a safety plan was [insert participant’s definition here]. That’s right – A safety plan is a plan that is made of strategies or actions to help ensure your safety against an (ex-) partner that has been abusive. We’ll work together right now to create a safety plan. Do you have any questions about safety plans?"

(Broad – asking participant to come up with own plan, without reference to risk factors)
1. Broadly, what will you do to stay safe? [*with prompting: Can you list 5 strategies or actions you can do that could become part of your safety plan?]

______________________________________________________________________________
______________________________________________________________________________

“Oftentimes it is best to create a plan that includes strategies that you can take before, during, and after a violent incident. With that in mind:”

2. What strategies or actions could you do right now or before an incident to ensure your (and your children’s) safety?

______________________________________________________________________________
______________________________________________________________________________

3. What strategies or actions could you do during an incident to ensure your (and your children’s) safety?

______________________________________________________________________________
______________________________________________________________________________

4. What strategies or actions could you do afterwards to ensure your (and your children’s) safety?

______________________________________________________________________________
______________________________________________________________________________

“Also, a good plan includes multiple areas of your life – how about considering strategies or actions that focus on 3 key areas: (1) your physical environment, including your home, work, or any other interactions with the environment (like dropping your kids off at school or going grocery shopping), (2) your support network (including friends, families, coworkers), and (3) your own well-being (like what can you do to help cope with the stress of this situation). It’s ok if you’ve already talked about some ideas in the previous section, because we’re just brainstorming ideas here!”
5. What strategies or actions could you put in place in your physical environment to help ensure your (and your children’s) safety?
______________________________________________________________________________
______________________________________________________________________________

6. What strategies or actions could you put in place with your support network to help ensure your (and your children’s) safety?
______________________________________________________________________________
______________________________________________________________________________

7. What strategies or actions could you put in place for your own well-being to help ensure your (and your children’s) safety?
______________________________________________________________________________
______________________________________________________________________________

“Now, let’s look at those risk factors that we came up with before and how they can be used to your advantage in coping with future threats of violence by your (ex-) partner. Let’s look at the top 3 that you ranked before.”

Listing of Risk Factors \(\text{from previous section}\)

1. Risk Factor #1:
2. Risk Factor #2:
3. Risk Factor #3

8. For the #1 risk factor, what strategies/actions could be put into place to manage (or reduce the impact of?) this risk factor?
______________________________________________________________________________
______________________________________________________________________________

For the #2 risk factor, what strategies/actions could be put into place to manage (or reduce the impact of?) this risk factor?
______________________________________________________________________________
______________________________________________________________________________

9. For the #3 risk factor, what strategies/actions could be put into place to manage (or reduce the impact of?) this risk factor?
______________________________________________________________________________
______________________________________________________________________________

“So, let’s summarize your safety plan so far”

\(\text{Reiterate details that have decided – both generally and specific to the risk factors}\)

“Now that you’ve let me know what type of safety planning strategies that is helpful, I’m going to give you a few more ideas. What I have here is a stack of cards. As you can see, each card has a safety planning strategy or action written on it that people commonly use when in a similar situation as yours \(\text{Note: the items for the cards are derived from the Intimate Partner Violence Strategies Index}\). What I’d like you to do is to look at each card and sort them into piles from “used” to “not used” for each key area. Please let me know if you’re unsure what the specific strategy is or if you have any questions!”
a. Of these strategies, what would be the most important safety measure you will use? Why?

b. What strategy or strategies would make things worse for you? Why?

c. What strategy or strategies would simply not work? Why?

“So, again, let’s just summarize your final safety plan so far to include everything”

10. Are there any barriers/problems you can foresee in implementing this safety plan?

a. Barriers to using this safety plan posed by the abuser:

b. Barriers putting the strategies you described for support now, during, or after a violent incident in jeopardy:

c. Barriers to safety in own environment, support network, or personal well-being:

d. Barriers posed by the system:

“There are a few things to remember about safety planning. The first thing is that safety plans can change, depending on circumstances – so a safety plan might change if a person who has stayed with her partner later decides to leave her partner, and vice versa. It’s ok to review and change a safety plan as much as necessary. In fact, it’s better if you do change it – because you’re in the best position to know if things are changing in your life and relationship that requires your plan to also change. I encourage you to review your plan on a regular basis.”
11. What could happen (i.e., what circumstances) that would make you review and/or update your safety plan?
______________________________________________________________________________
______________________________________________________________________________

12. Do you want to have a written copy of the safety plan?
- Provided copy to participant
- Participant wanted copy kept on file at domestic services agency
- Participant wanted both options

Other: ________________________________________________________________

a. If wants a copy, how will you keep it safe from your (ex-) partner?
______________________________________________________________________________
______________________________________________________________________________

“Another thing to remember is that if you are in immediate danger, call 911 or your local police. That will always be the first step if you are in immediate danger, rather than reviewing your safety plan!”

“Well, there we go! It seems like we have a complete safety plan here. Do you have any questions about the safety plan?”

Clarify any questions

Note: counterbalance question #19 and #20 for each individual within each intervention

19. Overall, in terms of a proportion or percent, what is the likelihood of being victimized by a male partner within the next month? ____

20. Just to reiterate, overall, you feel that your level of risk for being victimized in the future by your (ex-) partner is:       L   M   H

21. On a scale of 1 – 10, what is your overall level of risk of being harmed by your partner in the future: ____

Complete consumer satisfaction

DEBRIEFING
“We covered a lot today…and I’m sure it was very difficult for you to talk about all this. I definitely appreciate you taking the time and huge effort to do this. Are you feeling ok about what we did today? To make sure you can access as many resources as you need, I can provide you a list of telephone numbers for various services that may be of use to you. Would this be handy for you?”

If yes, provide numbers for counseling/DV services/other associated services that may be useful to participant – have on piece of paper and printed onto small business cards AND, if consent given, indicate to domestic violence service staff that participant is distressed
“The information that you have given to me today will be helpful in figuring out what is the best way to assist women in similar situations as yours with safety planning. Do you have any additional questions about this? Do you have any questions for me?”

Future Contact

We worked on developing a safety plan together today; this is a tool that is commonly used to help women in circumstances like yours to ensure their safety with an abusive (ex-) partner. As part of this research, I’m interested in contacting you on a regular basis (once every month for 3 months) to see how things are going with you. The contact will take place by phone, unless you desire otherwise. You can decide how it would be best for me to contact you, so that it is not obvious that you are participating in this type of research. You will receive $10 for the first follow-up, $10 for the next follow-up.

Do you give me permission to contact you again in 1 month? Y N
   No – Thank you for your time. I wish you the best of luck.
   Yes- Thank you! I really appreciate it ….and, just some questions to figure out what is the best way to contact you...

1. Is there a phone number that I may contact you directly (e.g., a work phone number), that is unlikely to change in the next month or so? Y N
   - How would you prefer I introduce myself? “I am Andrea from SFU”?
   _______________________________________________________________________
   - If someone else answers the phone what would you like me to do? I can say “I’m calling on behalf of the Women’s Health Study” and provide no additional details or,
   _______________________________________________________________________
   - Once I reach you my first question will always be, “are you free to speak, yes or no”; if the answer is ‘no’ the call will be disconnected and will be tried again later

2. If I contact you at this number, would I be able to leave a voicemail message? Y N

3. Could I get the names, phone numbers, and addresses of two people whom you trust, know you well, and you will stay in contact with them over the next few months? This is your safe contact list. Y N

   “Would you give me permission to contact these individuals if I am unable to contact you at the number you first gave me?” Y N

   “For your information, my message to these people will be “Hello, I’m Andrea, Ms. *insert participant’s name* and I met a month ago when she participated in a study called the Women’s Health Study. She gave me permission to contact persons that may know of her current address and/or phone number.”

   “Is there anything else you would like me to say so that these people know who I am and that it is alright for me to leave a message with them (e.g., a code word)?”
FOLLOW-UP INFORMATION

Study ID#:___________
(*This form will be kept separate from the interview material*)

Contact Information:
Name:  ____________________________________________
Address: __________________________________________
Phone #: __________________________________________
-------------
 Home Work
-------------
Cell phone (circle preferred phone #)
E-mail: __________________________________________

If a voicemail answers: Leave a message  Do Not Leave a message

Please list times/locations for future contact (*it is understood that these may change with time*)

List of Times/Locations that are safe: ________________________________

List of Times/Locations that are NOT safe for future contact: ____________________________

Please list the contact information of two close relatives or friends which the researcher may contact in case we are unable to directly reach you at the above provided information. They will not be told the nature of the research.

Contact Person #1:
Name:  ____________________________________________
Address: __________________________________________
Phone #: __________________________________________
-------------
 Home Work Cellphone
E-mail: __________________________________________
Relationship: _____________________________________

Contact Person #2:
Name:  ____________________________________________
Address: __________________________________________
Phone #: __________________________________________
-------------
 Home Work Cellphone
E-mail: __________________________________________
Relationship: _____________________________________

Follow-up contact (primarily by phone) will occur 1 month from now: _______ (Date).
Appendix H: Consumer Satisfaction (Verbal)

CONSUMER SATISFACTION

“Alright, we’ve figured out a safety plan together and now I would like your opinion and/or views on the process we used to get here and the final product – the safety plan. I’m going to ask you just broad questions about what you liked or didn’t like and then I’ll get you to fill out a form that has some more questions about what you liked or didn’t like about today. I want you to be as honest as possible for this next section. To help with this, when you are filling out the written survey, I’m going to leave the room. When you’re done, you can place the survey in the envelope here and seal it, if you like.”

“What we’re doing in this study is a work in progress - we’re trying to come up with the best way to help women in similar situations as you to develop safety plans. This means that the best source of information about how to make things better is from you. So, before we do the written part, let’s talk a bit more about what we did here today.”

VERBAL CONSUMER SATISFACTION QUESTIONS:

“At a broad/general level,”

1. How did you feel about what we did today?

____________________________________________________________________

____________________________________________________________________

2. Can you describe for me how fear/worry played a role in what we did today?

____________________________________________________________________

____________________________________________________________________

3. Was your fear/worry addressed by what we did today? Why/why not?

____________________________________________________________________

____________________________________________________________________

4. Can you describe anything else that you are afraid/worried about beyond what we did here today?

____________________________________________________________________

____________________________________________________________________

5. In what way has this process changed the way you feel about your level of risk for future harm by your (ex-) partner?

____________________________________________________________________

____________________________________________________________________

6. What did you find useful about:
   a. In going through the risk factors?

____________________________________________________________________

____________________________________________________________________

b. In creating the safety plan?

____________________________________________________________________

____________________________________________________________________
7. What did you not find useful about:
   a. In going through the risk factors?
      ________________________________________________________________
      ________________________________________________________________
   b. In creating the safety plan?
      ________________________________________________________________
      ________________________________________________________________

8. Can you tell me what risk factors were missing for you?
   ________________________________________________________________
   ________________________________________________________________

9. Can you tell me what safety planning steps/strategies were missing for you?
   ________________________________________________________________
   ________________________________________________________________

10. Can you describe the type of person you would want to help you with safety planning?
    ________________________________________________________________
    ________________________________________________________________

11. What else do you feel you need to do to make sure you’re safe?
    ________________________________________________________________
    ________________________________________________________________

12. What haven’t we spent enough time on today?
    ________________________________________________________________
    ________________________________________________________________

13. If we were to go through this process again right now, what would you want us to focus on? Not focus on?
    ________________________________________________________________
    ________________________________________________________________
    a. Risk factors
    b. Safety plan

14. If we were to go through this process in 6 months time, what would you do again? Not do again?
    ________________________________________________________________
    ________________________________________________________________

15. What “take home message” will you take with you?
    ________________________________________________________________
    ________________________________________________________________

“Ok, thanks for your feedback! Now, I’ll give you this written survey that basically asks for more detail about what you liked and did not like about today. I’m going to leave the room to give you more privacy. Once you’re finished, if you prefer, you can put the survey in the envelope and seal it and hand it to the receptionist.”
Appendix I: Consumer Satisfaction (Written)

Thank you for taking the time and effort to participate in this study today! As a final component of this study, please take the time to fill out the following questions below. This is a private survey – that means you are not required to put your name or any other identifying information on this form. The researcher has or will leave the room so that you may have privacy. When you are finished you can place this survey in the empty envelope, seal it, if you wish. This privacy is given to you so that you can be completely honest about what you did here today – particularly about what you liked and did not like. Honesty is good, because your comments and suggestions will help shape the future development of safety planning!

1. On a scale of 0 – 10 (0 = Low and 10 = High), how confident would you feel that the safety plan you’ve just created would help ensure your overall safety? ____
   Why?________________________________________________________

2. On a scale of 0 – 10 (0 = Low and 10 = High), how likely would you implement the safety plan you created?____
   Why?________________________________________________________

3. On scale from 0 – 10 (0 = Low and 10 = High), how likely would you to use the safety plan you just created in the short–term (within the month)? ____
   Why?________________________________________________________

4. On scale from 0 – 10 (0 = Low and 10 = High), how likely would you use the safety plan you just created in the long–term (greater than a month)? ____
   Why?________________________________________________________

5. In addition to what you’ve already discussed with the researcher, is there anything else you would like to comment on regarding:

   What you liked about going through the risk factors:

   What you liked about creating the safety plan:

   What you would like changed/removed from the risk factors:

   What you would like changed/removed from creating the safety plan:

   What you would like to see added to the risk factors:

   What you would like to see added to the creation of the safety plan:

6. If a friend were in need of similar help, would you recommend this safety planning process to her?

________________________________________________________________________

________________________________________________________________________
Please complete the following table regarding your experience with the safety plan and the safety planning process we did today – please complete the “today’s safety plan” column. If you have had previous safety planning experience(s), please also complete the “past safety plan” column with those past experiences in mind.

<table>
<thead>
<tr>
<th>Please rate the following items regarding the safety plan and safety planning process. Rate on a scale from: 0 (Low) – 10 (High)</th>
<th>Today’s Safety Plan Ratings (0 – 10)</th>
<th>Past Safety Plan(s) Ratings (0 – 10)</th>
<th>Comments (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of satisfaction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of usefulness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of comprehensiveness (or completeness)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of individualization (or tailored to your needs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of confidence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of comfort</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of empowerment felt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of vulnerability felt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of anxiety felt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of fear felt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of competency felt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of new information learnt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of potential for improvement in protecting safety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: _____________________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Also, please complete the following items regarding the person/researcher providing the safety planning service to you, both for “today’s” and any “past” safety planning experiences, if applicable.
Please rate the following items regarding the person/researcher providing the safety planning service to you.

Rate on a scale from: 0 (Low) – 10 (High)

<table>
<thead>
<tr>
<th>Metric</th>
<th>Today’s Safety Plan Ratings (0 – 10)</th>
<th>Past Safety Plan(s) Ratings (0 – 10)</th>
<th>Comments (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of her empathy (e.g., understanding)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of rapport established</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of kindness shown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of her listening abilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of open communication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of confidence in her safety planning skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of respect provided</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall quality of service provided</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:__________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Any other additional comments?

________________________________________________________________________

Thanks for completing this – we appreciate you taking the time!
Appendix J: Follow-up Phone Interview

FOLLOW-UP SURVEY (ADMINISTER AT POST-INTERVIEW AT 1, 2, AND 3 MONTHS)

<table>
<thead>
<tr>
<th>Study ID#</th>
<th>Date Completed</th>
<th>Time of Day</th>
<th>Follow-Up Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1mos. 2 mos. 3 mos.</td>
</tr>
</tbody>
</table>

PHONE CONTACT:
“Hello, could I please talk to *insert participant’s name here*?”

When person answers the phone, confirm that speaking to the appropriate participant

“Hello, its Andrea calling from Simon Fraser University. I’m calling about the Women’s Health Study and whether you would like to participate in it again. Because of the nature of the topic, it’s best if you can talk about this subject openly, without anyone around. Are you alone at the moment and able to speak freely?

(Say once person says free to speak) If it’s okay for you talk to me for a few minutes, say ‘Yes’. If it is not, meaning that you are not alone or not able to speak freely, please say ‘No’ and I will call back another time.”

If participant says ‘No’ or there are uncomfortable silences, background noises, or speech hesitations (indicating she may not be alone or safe to talk freely) – disconnect call, stating the following

“It’s important for this research that we can have an open conversation about emotions and relationships. I get the sense that maybe this isn’t the best time for us to talk right now and that’s ok – I’m used to catching people off guard about this and it’s not a problem for me to call you back at another time, if that is ok? |

If participant says ‘Yes’ Thanks for your time!

If participant says ‘Yes’ – continue below

“Great! I’m calling because about a month ago you participated in a research project at *insert name of location*. At that time you signed a form indicating that it was ok for us to contact you a month later to follow-up with you. It has now been a month. Is it possible for me to talk to you for about 30 minutes about how things are going for you?”

If participant says ‘No’ – disconnect call, with thanks

If participant says ‘Yes’ – continue below

“Before we start with any of the questions, I just want to remind you of a few important things. First, the content of this call will be kept confidential to the full extent of the law. However, if you disclose to me information about a child currently at risk for harm or neglect, or that you are at risk to harm yourself or others, then that is information I must disclose to the appropriate authorities. Do you understand this?”
“Also, it is important for you to know that your participation in this is entirely voluntary. You can withdraw from this study at any time. You may also refuse to answer any question that you do not wish to answer. Your withdrawal or refusal to answer questions will not have any effect on this study or on any future care or treatment at any domestic violence service agencies. Do you understand this?”

“For your participation today in this brief interview, you will be compensated for your time and effort by receiving $10. In addition, I encourage you to let me know if you feel any discomfort or distress during this interview so that I may direct you towards any assistance. I will also provide you with contact numbers for a variety of helpful resources if you would like to access resources after we have finished speaking. With all of this information in mind, do you consent to participate in this part of the study?”

“I will be taking some notes during this, so please bear with me. If at any time, you feel it is unsafe for you to continue to answer questions, let’s think of a secret code that can be used so that I know to hang up – or you can hang up after saying the phrase. I will then contact you two days from today at around the same time. The secret code can be something that is related to your daily routine so that it does not raise suspicions like, “my child doesn’t attend that school” or “I am not interested in getting a subscription to that newspaper.” What would you like this phrase to be?

“Alright, now we’re ready to get started!”

1. Could you remind me about the details of the safety plan you developed X (i.e., 1, 2 or 3) month(s) ago?

2. Do you recall any of the specific risk factors that were talked about in the interview X month(s) ago? If yes, can you tell me what they are and why you remembered them?

3. From your safety plan, what safety planning strategies have you implemented or used in the past month? Why?

4. From your safety plan, what safety planning strategies have you not used and do not anticipate using? Why?
5. In terms of each of the following areas – how to assure your safety right now, during a violent incident, after a violent incident, your physical environment, support network and personal well-being - can you tell me safety planning strategies you have found useful or not useful?

Right now:

__________________________________________________________________________

During: ___________________________________________________________________

After: ____________________________________________________________________

Physical Environment:

___________________________________________________________________________

Support: __________________________________________________________________

Personal Well-Being:

___________________________________________________________________________

6. I would like you to reflect on the process that you went through to develop your safety plan – do you have any particular likes or dislikes about the process that stand out for you?

___________________________________________________________________________

7. Has this safety plan process changed the way you feel about your level of risk for future harm by your (ex-) partner? In what way?

___________________________________________________________________________

8. You were asked to think about things using *insert intervention* approach while we worked together – do you think that had an impact on the way you:

Viewed your risk?___________________________________________________________

Viewed the risk factors?____________________________________________________

Created your safety plan?___________________________________________________

9. Have there been any barriers/problems you encountered in implementing this safety plan?

____________________________________________________________________________

10. Have you had to make changes to your safety plan? Could you tell me what those changes are and why?

___________________________________________________________________________

11. On a scale of 0 – 10 (0 = Low and 10 = High), how confident do you feel that the safety plan will help ensure your overall safety? _____

Why/Why not?

___________________________________________________________________________

12. On a scale of 0 – 10 (0 = Low and 10 = High), how likely will you be to continue to implement the safety plan? _____

Why/Why not?

___________________________________________________________________________
13. On scale from 0 – 10 (0 = Low and 10 = High), how likely will you use the developed safety plan (or modified due to changes in circumstances) in the short-term (within the month)? ____
   Why/Why not?

14. On scale from 0 – 10 (0 = Low and 10 = High), how likely will you use the developed safety plan (or modified due to changes in circumstances) in the long-term (greater than a month)? ____
   Why/Why not?

15. If we were to go through this process again right now, what would you want us to focus on? Not focus on?

16. In reflecting on what we did a * month ago*, what else do you feel you need to do to make sure you’re safe?

17. What is the current status of the relationship with your (ex-) partner:
   i. Together
   ii. Separated
   iii. Divorced
   iv. Other: __________________________

18. With the (ex-) partner that created the safety plan with, in the past month has there been any incidents of:
   a. Physical violence   Y       N
      The severity of the physical abuse: _____
      The physical impact of the abuse: _____
      The frequency of the physical abuse: _____
      The emotional impact of the physical abuse: ______
         i. Safety plan/strategies employed? If yes, what part of safety plan worked/did not work?

   b. Sexual Violence    Y       N
      The severity of the sexual abuse: ______
      The physical impact of the sexual abuse: ______
      The frequency of the sexual abuse: ______
      The emotional impact of the sexual abuse: ______
         i. Safety plan/strategies employed? If yes, what part of safety plan worked/did not work?
c. **Psychological/emotional abuse**  Y  N
   The severity of the psychological abuse: ______
   The frequency of the psychological abuse: ______
   The emotional impact of the psychological abuse: ______
   
   i. Safety plan/strategies employed? If yes, what part of safety plan worked/did not work?
   ______________________________________________________

   d. **Stalking**  Y  N
   The severity of the stalking: ______
   The frequency of the stalking: ______
   The emotional impact of the stalking: ______
   
   i. Safety plan/strategies employed? If yes, what part of safety plan worked/did not work?
   ______________________________________________________

   e. **Any other type of domestic violence**
   (financial/spiritual)  Y N (rate severity 0 – 10: ___)
   i. Safety plan/strategies employed? If yes, what part of safety plan worked/did not work?
   ______________________________________________________

19. On a scale from 0 – 10, how likely do you think that:
   a. Another incident with your (ex-) partner will occur in the near future: ______
   b. A similar incident, like the most recent one, will occur: ______
   c. The abuse will happen as often as before: ______
   d. Another incident will be more severe: ______
   e. What is your current overall level of fear of your partner: ______
   f. What is your level of fear specific to him:
      1. Becoming violent: ______
      2. Using life-threatening violence: ______
      3. Harassing you: ______
      4. Harassing others close to you: ______

   ‖ Note: counterbalance question #23 and #24 for each individual within each intervention‖

20. Overall, in terms of a proportion or percent, what is the likelihood of being victimized by a male partner within the next month? ______

21. Just to reiterate, overall, you feel that your level of risk for being victimized in the future by your (ex-) partner is:     L    M    H

22. On a scale of 1 – 10, what is your overall level of risk of being harmed by your partner in the future: ______
23. Have you had any assistance in developing a new safety plan or altering your safety plan in the past month? If so, please describe the extent of the assistance:
____________________________________________________________________

24. Any other additional comments?
____________________________________________________________________

“Great! Those are all of the questions I have for you for now. Do you have any questions for me?”

|| Answer questions, as appropriate||

||End of Follow-Up Survey  #_____ ||

*******
**NOTE: IF PARTICIPANT REQUESTED WRITTEN FOLLOW-UP CONTACT**
-If requested by the participant, rather than a phone contact, a written version of this script will be sent to a mailing address, with a self-addressed and stamped envelope
Appendix K: Safety Plan Evaluation Form

<table>
<thead>
<tr>
<th>Safety Plan Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID #: ___________  Rater: _______  Date: ___________</td>
</tr>
</tbody>
</table>

*Except when noted, use the following scale: 0 = low/no to 2 = high/yes

**Developed Safety Plan**

<table>
<thead>
<tr>
<th>RATING</th>
</tr>
</thead>
</table>
| Breadth of strategies provided (i.e., not just repeated items, offers variety of actions; **diversity**)
| |
| Depth of strategies provided (i.e., not just naming, but providing details and/or rationale; **specificity**)
| |
| Realistic strategies provided (i.e., possible for participant or a reasonable person to do; **feasible**)
| |
| Tailored to participants needs (i.e., not just generic strategies but tailored to the relationship needs and she applies it to her situation; **tailored**)
| |
| Degree of usefulness (i.e., could potentially offset any future incidents of violence; **effectiveness**)
| |
| Overall level of completeness of the safety plan (i.e., seems to meet or would meet the safety planning needs of the participant; **comprehensive**)
| |
| Rational or Emotional intervention? (R = Rational, E = Emotional)
| |
| **Perceived Participant Characteristics While Safety Planning**
| Level of participant engagement/participation in the process
| Level of participant confidence/satisfaction with the process
| Level of participant emotional lability (i.e., became emotional?)
| Level of participant thoughtfulness (i.e., reflective of her situation, giving it thought?)
| Level of rapport established with researcher
| **Safety Planning In the Future...**
| Participant would likely follow the plan in the short term (i.e., within 1 month)
| Participant would likely follow the plan in the long term (i.e., after 6 months)
| Participant would likely alter the plan if/when necessary
| **Overall...**
| **What is your overall grade for this safety plan (how good is it)? (0 - 10)** |
Appendix: Table A1

Table A1. Means and Standard Deviations for the Brief Spousal Assault Form for the Evaluation of Risk with Victim Added Vulnerability Factors

<table>
<thead>
<tr>
<th></th>
<th>Section I</th>
<th></th>
<th>Section II</th>
<th></th>
<th>Section III</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Range</td>
<td>Mean (SD)</td>
<td>Range</td>
<td>Mean (SD)</td>
<td>Range</td>
<td>Mean (SD)</td>
<td>Range</td>
</tr>
<tr>
<td>Analytical Intervention</td>
<td>5.73 (1.76)</td>
<td>3 – 9</td>
<td>6.23 (1.94)</td>
<td>2 – 9</td>
<td>2.97 (2.37)</td>
<td>0 – 8</td>
<td>14.93 (4.09)</td>
<td>7 – 24</td>
</tr>
<tr>
<td>Experiential Intervention</td>
<td>5.70 (2.20)</td>
<td>1 – 9</td>
<td>6.30 (2.10)</td>
<td>2 – 10</td>
<td>2.90 (2.32)</td>
<td>0 – 7</td>
<td>14.87 (4.25)</td>
<td>7 – 21</td>
</tr>
<tr>
<td>Total</td>
<td>5.72 (1.98)</td>
<td>1 – 9</td>
<td>6.27 (2.01)</td>
<td>2 – 10</td>
<td>2.93 (2.33)</td>
<td>0 – 8</td>
<td>14.90 (4.14)</td>
<td>7 – 24</td>
</tr>
</tbody>
</table>

*Note.* The Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER; Kropp, Hart, & Belfrage, 2005) with five added victim vulnerability factors. The B-SAFER is not typically summed as it is not intended to be used as an actuarial measure; however, if summed for descriptive purposes, the total scores of the B-SAFER range from 0 – 30, and 0 - 10 for the individual scales. Section I = Intimate Partner Violence, Section II = Psychosocial Adjustment, Section III = Victim Vulnerability
### Table A2. Category Counts, Overall Safety Planning Themes and Strategies

<table>
<thead>
<tr>
<th>Theme 1: Informal Network</th>
<th>Analytical Intervention</th>
<th>Experiential Intervention</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( n ) (%), ( \text{n} ) (%)</td>
<td>( n ) (%), ( \text{n} ) (%)</td>
<td>( N ) (%), ( \text{N} ) (%)</td>
</tr>
<tr>
<td><strong>Informal: Protection, Known Others</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have support aware of the situation/up to date on the situation</td>
<td>12 (40%)</td>
<td>11 (37%)</td>
<td>23 (38%)</td>
</tr>
<tr>
<td>Have individuals that will call for back-up/assistance/intimidation (e.g., probably guy friends, brothers), rather than call police</td>
<td>6 (20%)</td>
<td>6 (20%)</td>
<td>12 (20%)</td>
</tr>
<tr>
<td>Have support when meet with him (buddy system)</td>
<td>4 (13%)</td>
<td>7 (23%)</td>
<td>11 (18%)</td>
</tr>
<tr>
<td>Have helping strategies/signal devised in case of emergency (e.g., texting, if don’t answer phone; code words; towel in the window)</td>
<td>5 (17%)</td>
<td>5 (17%)</td>
<td>10 (17%)</td>
</tr>
<tr>
<td>Have support check up on her</td>
<td>5 (17%)</td>
<td>5 (17%)</td>
<td>10 (17%)</td>
</tr>
<tr>
<td>Have support communicate with him (rather than her)</td>
<td>3 (10%)</td>
<td>1 (3%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Have others witness him/observe him and/or what he is doing</td>
<td>3 (10%)</td>
<td>0 (0%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Have support ensure he cannot enter her space (e.g., friend say she’s not home)</td>
<td>2 (7%)</td>
<td>1 (3%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Have support also reduce/cut contact with him and reduce personal disclosure</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td><strong>Informal: Safe Place</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term (e.g., move to another building/apartment)</td>
<td>8 (27%)</td>
<td>13 (43%)</td>
<td>21 (35%)</td>
</tr>
<tr>
<td>Short-Term (e.g., coffee shop, stay with a friend)</td>
<td>8 (27%)</td>
<td>9 (30%)</td>
<td>17 (28%)</td>
</tr>
<tr>
<td>Relocate/move - greater distance (e.g., leave city, province)</td>
<td>7 (23%)</td>
<td>2 (7%)</td>
<td>9 (15%)</td>
</tr>
<tr>
<td>Keep/maintain separate residences</td>
<td>1 (3%)</td>
<td>2 (7%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Continual moves - no settling</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td><strong>Informal: Resources</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use current support system (e.g., friends, family)</td>
<td>13 (43%)</td>
<td>18 (60%)</td>
<td>31 (52%)</td>
</tr>
<tr>
<td>Acquire/obtain new support system (e.g., new friends)</td>
<td>4 (13%)</td>
<td>4 (13%)</td>
<td>8 (13%)</td>
</tr>
</tbody>
</table>
Table A2 continued.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Analytical</th>
<th>Experiential</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Informal: Protection, Unknown Others</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stay around people/public</td>
<td>8 (27%)</td>
<td>5 (17%)</td>
<td>13 (22%)</td>
</tr>
<tr>
<td>Meet him only in public</td>
<td>4 (13%)</td>
<td>5 (17%)</td>
<td>9 (15%)</td>
</tr>
<tr>
<td>Ask stranger(s) to call police/911 on her behalf</td>
<td>1 (3%)</td>
<td>6 (20%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>Let strangers know about her partner/situation (e.g., storekeeper, security guard, cab driver)</td>
<td>2 (7%)</td>
<td>4 (13%)</td>
<td>6 (10%)</td>
</tr>
<tr>
<td><strong>Theme 2: Relationship Changes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Relationship Status - No More Cycle</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-determined that remaining away from the relationship (i.e., not re-engaging with him despite loneliness, refusing to re-engage in cycle; stay away from him, best not to be with him or talk to him)</td>
<td>18 (60%)</td>
<td>22 (73%)</td>
<td>40 (67%)</td>
</tr>
<tr>
<td>Self-determined that she is not responsible for him and his violence and/or that he will likely not change</td>
<td>9 (30%)</td>
<td>14 (47%)</td>
<td>23 (38%)</td>
</tr>
<tr>
<td>Self-determined and imposed ending of relationship (i.e., she acknowledges the relationship has ended: break up with him, divorce)</td>
<td>5 (17%)</td>
<td>5 (17%)</td>
<td>10 (17%)</td>
</tr>
<tr>
<td><strong>Relationship Status - Continuation with Him, With Improvements to Relationship</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Want perpetrator/partner to access support services (e.g., housing, management)</td>
<td>6 (20%)</td>
<td>6 (20%)</td>
<td>12 (20%)</td>
</tr>
<tr>
<td>Seek changes/assistance together</td>
<td>2 (7%)</td>
<td>2 (7%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Improve on their relationship together (e.g., enhance communication)</td>
<td>2 (7%)</td>
<td>1 (3%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Make his place safe for her</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td><strong>Theme 3: Resistance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Escape</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leave area/walk away</td>
<td>16 (53%)</td>
<td>18 (60%)</td>
<td>34 (57%)</td>
</tr>
<tr>
<td>Run away</td>
<td>5 (17%)</td>
<td>7 (23%)</td>
<td>12 (20%)</td>
</tr>
<tr>
<td>Ensure have an exit/escape plan</td>
<td>5 (17%)</td>
<td>5 (17%)</td>
<td>10 (17%)</td>
</tr>
<tr>
<td>Use transportation (transit, cab) to leave</td>
<td>4 (13%)</td>
<td>4 (13%)</td>
<td>8 (13%)</td>
</tr>
<tr>
<td>Enter shop/store/business</td>
<td>5 (17%)</td>
<td>2 (7%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>Trust instincts about level of danger</td>
<td>3 (10%)</td>
<td>3 (10%)</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>Scream 'fire' or pull fire alarm</td>
<td>1 (3%)</td>
<td>2 (7%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Go to separate residence</td>
<td>2 (7%)</td>
<td>1 (3%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td><strong>Active Resistance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scream/yell/make a scene</td>
<td>22 (73%)</td>
<td>18 (60%)</td>
<td>40 (67%)</td>
</tr>
<tr>
<td>Scream/yell/make a scene</td>
<td>11 (37%)</td>
<td>6 (20%)</td>
<td>17 (28%)</td>
</tr>
</tbody>
</table>
Table A2 continued.

<table>
<thead>
<tr>
<th>Theme 4: Safety Measures</th>
<th>Analytical</th>
<th>Experiential</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inform him that abuse will not happen again in their relationship (e.g., take control back in relationship, be firm)</td>
<td>7 (23%)</td>
<td>5 (17%)</td>
<td>12 (20%)</td>
</tr>
<tr>
<td>Physically defend self</td>
<td>6 (20%)</td>
<td>5 (17%)</td>
<td>11 (18%)</td>
</tr>
<tr>
<td>Physically defend self</td>
<td>6 (20%)</td>
<td>5 (17%)</td>
<td>11 (18%)</td>
</tr>
<tr>
<td>Threaten with consequences if he does not leave (e.g., will call police)</td>
<td>4 (13%)</td>
<td>3 (10%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>Verbally defend self</td>
<td>2 (7%)</td>
<td>4 (13%)</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>Verbally defend self</td>
<td>2 (7%)</td>
<td>4 (13%)</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>Impose additional rules on him/the relationship</td>
<td>2 (7%)</td>
<td>3 (10%)</td>
<td>5 (8%)</td>
</tr>
<tr>
<td>Barricade/lock self in safe place (washroom in restaurant, washroom in home)</td>
<td>2 (7%)</td>
<td>3 (10%)</td>
<td>5 (8%)</td>
</tr>
<tr>
<td>Ignore his demands</td>
<td>3 (10%)</td>
<td>1 (3%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td><strong>Home</strong></td>
<td><strong>27 (90%)</strong></td>
<td><strong>26 (87%)</strong></td>
<td><strong>53 (88%)</strong></td>
</tr>
<tr>
<td>Lock doors and windows</td>
<td>13 (43%)</td>
<td>9 (30%)</td>
<td>22 (37%)</td>
</tr>
<tr>
<td>Make staff/landlord/neighbors aware of partner</td>
<td>14 (47%)</td>
<td>7 (23%)</td>
<td>21 (35%)</td>
</tr>
<tr>
<td>Monitor who is entering her personal space (e.g., her building or apartment; use peephole/ caution at front door, chain on door)</td>
<td>6 (20%)</td>
<td>6 (20%)</td>
<td>12 (20%)</td>
</tr>
<tr>
<td>Alarm system/camera/surveillance</td>
<td>3 (10%)</td>
<td>7 (23%)</td>
<td>10 (17%)</td>
</tr>
<tr>
<td>Have a friend stay/roommate</td>
<td>3 (10%)</td>
<td>4 (13%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>Know location of phone within house/have within reach</td>
<td>3 (10%)</td>
<td>3 (10%)</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>Secure building (i.e., live in a secure building)</td>
<td>4 (13%)</td>
<td>1 (3%)</td>
<td>5 (8%)</td>
</tr>
<tr>
<td>Safe or safety deposit box</td>
<td>2 (7%)</td>
<td>1 (3%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Have/get a dog</td>
<td>1 (3%)</td>
<td>2 (7%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>No easy access to her apartment (e.g., no spare key/take back key/change buzzer number)</td>
<td>0 (0%)</td>
<td>2 (7%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Lights/lighting as a deterrent</td>
<td>0 (0%)</td>
<td>1 (3%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Change mailing address to a P.O. box</td>
<td>1 (3%)</td>
<td>0 (0%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td><strong>Restrictions/Changes in Normal Routine</strong></td>
<td><strong>17 (57%)</strong></td>
<td><strong>17 (57%)</strong></td>
<td><strong>34 (57%)</strong></td>
</tr>
<tr>
<td>Vigilance or increased awareness of surroundings</td>
<td>10 (33%)</td>
<td>8 (27%)</td>
<td>18 (30%)</td>
</tr>
<tr>
<td>Constant companionship (safety in numbers)</td>
<td>7 (23%)</td>
<td>6 (20%)</td>
<td>13 (22%)</td>
</tr>
<tr>
<td>Provide information to others about whereabouts etc., so know if missing/injured (check-ins)</td>
<td>5 (17%)</td>
<td>6 (20%)</td>
<td>11 (18%)</td>
</tr>
<tr>
<td>Change in routes/areas no longer go (e.g., alleys)</td>
<td>4 (14%)</td>
<td>4 (13%)</td>
<td>8 (13%)</td>
</tr>
<tr>
<td>Isolate self/stay at home - Night time restrictions</td>
<td>3 (10%)</td>
<td>3 (10%)</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>Isolate self/stay at home - Generally</td>
<td>3 (10%)</td>
<td>2 (7%)</td>
<td>5 (8%)</td>
</tr>
<tr>
<td>Feature</td>
<td>Analytical</td>
<td>Experiential</td>
<td>Total</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>--------------</td>
<td>--------</td>
</tr>
<tr>
<td><strong>Phone</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have/acquire a cell phone or emergency phone - on person when out</td>
<td>11 (37%)</td>
<td>8 (27%)</td>
<td>19 (32%)</td>
</tr>
<tr>
<td>Change phone number or put in another person's name</td>
<td>3 (10%)</td>
<td>5 (17%)</td>
<td>8 (13%)</td>
</tr>
<tr>
<td>Security features (e.g., call block, GPS)</td>
<td>2 (7%)</td>
<td>2 (7%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Vigilance of unknown/blocked phone numbers</td>
<td>2 (7%)</td>
<td>1 (3%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Locate a public phone</td>
<td>1 (3%)</td>
<td>2 (7%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td><strong>Emergency Preparedness Supplies</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency deterents/weapons/personal alarms</td>
<td>5 (17%)</td>
<td>5 (17%)</td>
<td>10 (17%)</td>
</tr>
<tr>
<td>Emergency phone - paid for, have minutes, charged</td>
<td>2 (7%)</td>
<td>6 (20%)</td>
<td>8 (13%)</td>
</tr>
<tr>
<td>Emergency documents (e.g., copies, contact list)</td>
<td>2 (7%)</td>
<td>4 (13%)</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>Emergency money (e.g., bus fare, save up money on the side)</td>
<td>2 (7%)</td>
<td>2 (7%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Emergency supplies (e.g., clothes/baggage)</td>
<td>1 (3%)</td>
<td>2 (7%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td><strong>Protecting Children and Family (e.g., mother)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular check-ins with them to ensure their safety</td>
<td>5 (17%)</td>
<td>2 (7%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>Supervised visits</td>
<td>1 (3%)</td>
<td>4 (13%)</td>
<td>5 (8%)</td>
</tr>
<tr>
<td>Ensure are protected/not present/do not interfere when partner becomes violent/Impose rules to ensure their safety</td>
<td>0 (0%)</td>
<td>4 (13%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan trips (e.g., know when bus arrives, where)</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Utilize public transit more than walking</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Awareness of suspicious cars</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Do not share/enter vehicle with him</td>
<td>0 (0%)</td>
<td>1 (3%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Have a cab wait for her</td>
<td>1 (3%)</td>
<td>0 (0%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td><strong>Computer</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change/block old means of communication (e.g., change email)</td>
<td>2 (7%)</td>
<td>0 (0%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Communicate only through e-mail</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Learn about computers</td>
<td>1 (3%)</td>
<td>0 (0%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td><strong>School</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness of school of the situation</td>
<td>2 (7%)</td>
<td>1 (3%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Plan for pick-up of children at school</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Change schools</td>
<td>0 (0%)</td>
<td>1 (3%)</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>
### Table A2 continued.

<table>
<thead>
<tr>
<th>Theme 5: Coping/Vulnerability</th>
<th>Analytical</th>
<th>Experiential</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>2 (7%)</td>
<td>0 (0%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Make colleagues/boss aware of the situation</td>
<td>2 (7%)</td>
<td>0 (0%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td><strong>Maladaptive Coping: General</strong></td>
<td>26 (87%)</td>
<td>26 (87%)</td>
<td>52 (86%)</td>
</tr>
<tr>
<td>General defiance or generally angry</td>
<td>5 (17%)</td>
<td>9 (30%)</td>
<td>14 (23%)</td>
</tr>
<tr>
<td>Hopeful of him changing/ Denial of his past behaviour(s)/confidence he will not do anything further (e.g., he'll walk away/dismissive)</td>
<td>6 (20%)</td>
<td>6 (20%)</td>
<td>12 (20%)</td>
</tr>
<tr>
<td>Helplessness/inaction (e.g., just let him get it over with)</td>
<td>9 (30%)</td>
<td>2 (7%)</td>
<td>11 (18%)</td>
</tr>
<tr>
<td>Continue to refrain from using resources/seeking resources to help her</td>
<td>4 (13%)</td>
<td>5 (17%)</td>
<td>9 (15%)</td>
</tr>
<tr>
<td>Ambivalence (e.g., think about calling the police, if he persists…)</td>
<td>3 (10%)</td>
<td>3 (10%)</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>Continue to contact him/provide him with favours (e.g., inconsistent message)</td>
<td>2 (7%)</td>
<td>2 (7%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Continue to use substances</td>
<td>3 (10%)</td>
<td>0 (0%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Continue to isolate herself</td>
<td>2 (7%)</td>
<td>0 (0%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td><strong>Adaptive Coping/Decreasing Vulnerability: General</strong></td>
<td>17 (57%)</td>
<td>14 (47%)</td>
<td>31 (52%)</td>
</tr>
<tr>
<td>Avoid substances</td>
<td>11 (37%)</td>
<td>6 (20%)</td>
<td>17 (28%)</td>
</tr>
<tr>
<td>Avoid isolation</td>
<td>5 (17%)</td>
<td>6 (20%)</td>
<td>11 (18%)</td>
</tr>
<tr>
<td>Avoid victim stance or minimizing violence (e.g., “poor me”)</td>
<td>3 (10%)</td>
<td>7 (23%)</td>
<td>10 (17%)</td>
</tr>
<tr>
<td>Awareness in future/new relationships (e.g., avoid future abusive relationships)</td>
<td>3 (10%)</td>
<td>4 (13%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>Avoid bad people/bad support system</td>
<td>2 (7%)</td>
<td>1 (3%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Avoid having money on her when meet with him</td>
<td>2 (7%)</td>
<td>0 (0%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td><strong>Adaptive Coping/Decreasing Vulnerability: Emotions</strong></td>
<td>16 (53%)</td>
<td>12 (40%)</td>
<td>28 (47%)</td>
</tr>
<tr>
<td>Have script/comments planned out (e.g., “I don’t want trouble, I'm glad you’ve moved on)</td>
<td>7 (23%)</td>
<td>9 (30%)</td>
<td>16 (27%)</td>
</tr>
<tr>
<td>Deep breathing or other relaxation methods in the moment</td>
<td>5 (17%)</td>
<td>2 (7%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>Use bravado/ façade</td>
<td>4 (13%)</td>
<td>2 (7%)</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>Use of pharmacological medications or other substances (cigarettes; not abuse)</td>
<td>2 (7%)</td>
<td>2 (7%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Self-talk in the moment</td>
<td>2 (7%)</td>
<td>1 (3%)</td>
<td>3 (5%)</td>
</tr>
</tbody>
</table>
## Table A2 continued.

<table>
<thead>
<tr>
<th>Theme 6: Formal Network: Self</th>
<th>Analytical</th>
<th>Experiential</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Formal: Counselling/Therapy/Healing</strong></td>
<td>21 (70%)</td>
<td>25 (83%)</td>
<td>46 (78%)</td>
</tr>
<tr>
<td>Therapy/Counselling</td>
<td>10 (33%)*</td>
<td>21 (70%)*</td>
<td>31 (52%)</td>
</tr>
<tr>
<td>Specialized IPV services</td>
<td>14 (47%)</td>
<td>7 (23%)</td>
<td>21 (35%)</td>
</tr>
<tr>
<td>Addictions support</td>
<td>6 (20%)</td>
<td>7 (23%)</td>
<td>13 (22%)</td>
</tr>
<tr>
<td>Community social services (e.g., low income housing)</td>
<td>3 (10%)</td>
<td>7 (23%)</td>
<td>10 (17%)</td>
</tr>
<tr>
<td>Acquire/Obtain new services</td>
<td>3 (10%)</td>
<td>7 (23%)</td>
<td>10 (17%)</td>
</tr>
<tr>
<td>Renew/be consistent with attending services</td>
<td>2 (7%)</td>
<td>5 (17%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>Victim services</td>
<td>4 (13%)</td>
<td>1 (3%)</td>
<td>5 (8%)</td>
</tr>
<tr>
<td>Distress line</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td><strong>Formal: Safe Place</strong></td>
<td>12 (40%)</td>
<td>12 (40%)</td>
<td>24 (40%)</td>
</tr>
<tr>
<td>Short-term (e.g., shelter)</td>
<td>8 (27%)</td>
<td>8 (27%)</td>
<td>16 (27%)</td>
</tr>
<tr>
<td>Long-term (e.g., transition home)</td>
<td>4 (13%)</td>
<td>5 (17%)</td>
<td>9 (15%)</td>
</tr>
<tr>
<td><strong>Formal: Medical</strong></td>
<td>2 (7%)</td>
<td>4 (13%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>Go to medical clinic</td>
<td>1 (3%)</td>
<td>2 (7%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Go to hospital</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td><strong>Theme 7: Empowerment</strong></td>
<td>22 (73%)</td>
<td>21 (70%)</td>
<td>43 (72%)</td>
</tr>
<tr>
<td>Create Life Stability/General Life Enhancements</td>
<td>20 (67%)</td>
<td>19 (63%)</td>
<td>39 (65%)</td>
</tr>
<tr>
<td>Involvement in physical activities to heal/cope and distract (e.g., bath, walk on beach, journal)</td>
<td>6 (20%)</td>
<td>7 (23%)</td>
<td>13 (22%)</td>
</tr>
<tr>
<td>Life stability aspirations (e.g., keep it calm, build a life, start fresh)</td>
<td>6 (20%)</td>
<td>6 (20%)</td>
<td>12 (20%)</td>
</tr>
<tr>
<td>Start/complete schooling/education/courses</td>
<td>5 (17%)</td>
<td>5 (17%)</td>
<td>10 (17%)</td>
</tr>
<tr>
<td>Find employment/be financially independent</td>
<td>4 (13%)</td>
<td>4 (13%)</td>
<td>8 (13%)</td>
</tr>
<tr>
<td>Involvement in community (volunteer)</td>
<td>3 (10%)</td>
<td>4 (13%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>Reclaim her identity (e.g., that not crazy)</td>
<td>3 (10%)</td>
<td>4 (13%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>Optimism</td>
<td>2 (7%)</td>
<td>4 (13%)</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>Involvement in spiritual activities (e.g., prayer, solitude)</td>
<td>4 (13%)</td>
<td>2 (7%)</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>Find/seek help for children</td>
<td>3 (10%)</td>
<td>1 (3%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Obtain personal belongings from him</td>
<td>3 (10%)</td>
<td>0 (0%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Involvement in more self-care (physically - e.g., make-up/clothes)</td>
<td>0 (0%)</td>
<td>1 (3%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Table A2 continued.</td>
<td>Analytical</td>
<td>Experiential</td>
<td>Total</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------</td>
<td>--------------</td>
<td>-------</td>
</tr>
<tr>
<td><strong>Personal Growth/Strength</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength aspirations/aspirational (e.g., stay strong)</td>
<td>16 (53%)</td>
<td>14 (47%)</td>
<td>30 (50%)</td>
</tr>
<tr>
<td>Improve/strengthen emotional health/self-esteem (e.g., love self)</td>
<td>11 (37%)*</td>
<td>3 (10%)*</td>
<td>14 (23%)</td>
</tr>
<tr>
<td>Improve/strengthen physical health/condition (e.g., go to gym)</td>
<td>8 (27%)</td>
<td>3 (10%)</td>
<td>11 (18%)</td>
</tr>
<tr>
<td>Improve/strengthen social support (e.g., stay connected)</td>
<td>4 (13%)</td>
<td>5 (17%)</td>
<td>9 (15%)</td>
</tr>
<tr>
<td>Improve/strengthen mental health (e.g., deal with depression)</td>
<td>5 (17%)</td>
<td>3 (10%)</td>
<td>8 (13%)</td>
</tr>
<tr>
<td><strong>Diminishing the After Effects of Violence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocate around IPV violence (e.g., speak out, tell story)</td>
<td>2 (7%)</td>
<td>5 (17%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>Acceptance of violence/forgive herself for being in relationship</td>
<td>3 (10%)</td>
<td>2 (7%)</td>
<td>5 (8%)</td>
</tr>
<tr>
<td><strong>Theme 8: Avoid/Ignore</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance - of Him</td>
<td>15 (50%)</td>
<td>14 (47%)</td>
<td>29 (48%)</td>
</tr>
<tr>
<td>Avoidance of him when he is intoxicated (drugs or alcohol)</td>
<td>7 (23%)</td>
<td>6 (20%)</td>
<td>13 (22%)</td>
</tr>
<tr>
<td>Avoidance if observe him only and he has not seen her</td>
<td>7 (23%)</td>
<td>6 (20%)</td>
<td>13 (22%)</td>
</tr>
<tr>
<td>Avoidance if observe him and he has observed her</td>
<td>3 (10%)</td>
<td>4 (13%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>Avoidance of him based on his schedule (e.g., knowing where he is when and then avoiding him)</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Avoidance- Related to Him</td>
<td>9 (30%)</td>
<td>14 (47%)</td>
<td>23 (38%)</td>
</tr>
<tr>
<td>Avoidance of general areas or locations (e.g., neighbourhood)</td>
<td>1 (3%)*</td>
<td>10 (33%)*</td>
<td>11 (18%)</td>
</tr>
<tr>
<td>Avoidance of his support network (e.g., friends, family)</td>
<td>4 (13%)</td>
<td>4 (13%)</td>
<td>8 (13%)</td>
</tr>
<tr>
<td>Avoidance of his home or favourite/specific locations (e.g., bar)</td>
<td>2 (7%)</td>
<td>6 (20%)</td>
<td>8 (13%)</td>
</tr>
<tr>
<td>Avoidance of shared locations</td>
<td>2 (7%)</td>
<td>3 (10%)</td>
<td>5 (8%)</td>
</tr>
<tr>
<td>Avoidance of shared friends</td>
<td>2 (7%)</td>
<td>2 (7%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Ignore Attempts at Personal Contact</td>
<td>8 (27%)</td>
<td>4 (13%)</td>
<td>12 (20%)</td>
</tr>
<tr>
<td>Ignore his attempts to contact her at her home (e.g., do not answer door, pretend not at home)</td>
<td>4 (13%)</td>
<td>2 (7%)</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>Ignore his phone contacts</td>
<td>4 (13%)</td>
<td>1 (3%)</td>
<td>5 (8%)</td>
</tr>
<tr>
<td><strong>Theme 9: Legal</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police</td>
<td>20 (67%)</td>
<td>18 (60%)</td>
<td>38 (63%)</td>
</tr>
<tr>
<td>Call in crisis to obtain immediate help/assistance</td>
<td>18 (60%)</td>
<td>18 (60%)</td>
<td>36 (60%)</td>
</tr>
<tr>
<td>Check-in/staying in touch/appraisal of current situation</td>
<td>5 (16%)</td>
<td>2 (7%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>Assistance to retrieve belongings</td>
<td>2 (7%)</td>
<td>0 (0%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Table A2 continued.</td>
<td><strong>Analytical</strong></td>
<td><strong>Experiential</strong></td>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------</td>
<td>-----------------</td>
<td>-----------</td>
</tr>
<tr>
<td><strong>Criminal Justice System</strong></td>
<td>13 (43%)</td>
<td>11 (37%)</td>
<td>24 (40%)</td>
</tr>
<tr>
<td>Perpetrator accountability (attend court, press charges, ensure he goes to jail, talk to probation)</td>
<td>6 (20%)</td>
<td>6 (20%)</td>
<td>12 (20%)</td>
</tr>
<tr>
<td>Personal protection (peace bond, no go, restraining order)</td>
<td>8 (27%)</td>
<td>4 (13%)</td>
<td>11 (18%)</td>
</tr>
<tr>
<td>Personal legal matters: other (divorce, custody arrangements, change name, will)</td>
<td>4 (13%)</td>
<td>3 (10%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td><strong>Theme 10: Information</strong></td>
<td>22 (73%)</td>
<td>15 (50%)</td>
<td>37 (62%)</td>
</tr>
<tr>
<td><strong>Maintain Personal Information</strong></td>
<td>15 (50%)</td>
<td>15 (50%)</td>
<td>30 (50%)</td>
</tr>
<tr>
<td>No disclosure of location/address</td>
<td>10 (33%)</td>
<td>9 (30%)</td>
<td>19 (32%)</td>
</tr>
<tr>
<td>No disclosure to others unless trusted (vigilance)</td>
<td>5 (17%)</td>
<td>2 (7%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>No disclosure of information that may bring him back into her life (e.g., pregnancy)</td>
<td>2 (7%)</td>
<td>4 (13%)</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>No disclosure of other contact information (e.g., phone, email)</td>
<td>2 (7%)</td>
<td>2 (7%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Disguise self/identity (e.g., change name, not use real name)</td>
<td>4 (13%)</td>
<td>0 (0%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Protect/change banking information</td>
<td>1 (3%)</td>
<td>0 (0%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td><strong>Surveillance/Information Gathering (Partner)</strong></td>
<td>10 (33%)*</td>
<td>2 (7%)*</td>
<td>12 (20%)*</td>
</tr>
<tr>
<td>Documentation/Gather Evidence</td>
<td>7 (23%)</td>
<td>1 (3%)</td>
<td>8 (13%)</td>
</tr>
<tr>
<td>Fact-finding/investigating him (e.g., where he's living, whether he has a weapon)</td>
<td>5 (17%)</td>
<td>1 (3%)</td>
<td>6 (10%)</td>
</tr>
<tr>
<td><strong>Theme 11: Placating</strong></td>
<td>17 (57%)</td>
<td>18 (60%)</td>
<td>35 (58%)</td>
</tr>
<tr>
<td>Do not verbally defend self/avoid arguing</td>
<td>7 (23%)</td>
<td>12 (40%)</td>
<td>19 (32%)</td>
</tr>
<tr>
<td>Awareness/observation of his level of anger (e.g., body language, tone)</td>
<td>4 (13%)</td>
<td>8 (27%)</td>
<td>12 (20%)</td>
</tr>
<tr>
<td>Placate him (e.g., compliment, do what he demands)</td>
<td>5 (17%)</td>
<td>6 (20%)</td>
<td>11 (18%)</td>
</tr>
<tr>
<td>Give him space/cooling down period/time to get sober</td>
<td>7 (23%)</td>
<td>4 (13%)</td>
<td>11 (18%)</td>
</tr>
<tr>
<td>Lie or omit information to avoid conflict</td>
<td>4 (13%)</td>
<td>5 (17%)</td>
<td>9 (15%)</td>
</tr>
<tr>
<td>Talk to him without aggression/conflict (e.g., with empathy/compassion)</td>
<td>3 (10%)</td>
<td>6 (20%)</td>
<td>9 (15%)</td>
</tr>
<tr>
<td>Self-distraction (e.g., block him out, distract self)</td>
<td>4 (13%)</td>
<td>3 (10%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>Do not be alone with him</td>
<td>3 (10%)</td>
<td>4 (13%)</td>
<td>7 (12%)</td>
</tr>
<tr>
<td>Distract him (e.g., give treat, bring another beer)</td>
<td>4 (13%)</td>
<td>2 (10%)*</td>
<td>6 (10%)</td>
</tr>
<tr>
<td>Listen to him without responding</td>
<td>1 (3%)</td>
<td>4 (13%)</td>
<td>5 (8%)</td>
</tr>
<tr>
<td>Do not physically defend self</td>
<td>1 (3%)</td>
<td>3 (10%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Submit to abuse to get it over with</td>
<td>1 (3%)</td>
<td>2 (7%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Plead/beg/talk him out of it</td>
<td>0 (0%)</td>
<td>2 (7%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Bring him outside/into public</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>2 (3%)</td>
</tr>
</tbody>
</table>

*p < .05