EFFECTS OF A SHOPLIFTERS COUNSELLING PROGRAM ON
HARDINESS, DEPRESSION AND SELF-CONCEPT

by

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B.A., University of British Columbia, 1983

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS

in

THE FACULTY OF GRADUATE STUDIES
Department of Counselling Psychology

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA
April 1989

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Abstract

This study was concerned with evaluating the effectiveness of the Shoplifters Counselling Program (SCP) operated by the Elizabeth Fry Society of British Columbia. The concept of hardiness was used as a theoretical framework with which to assess treatment outcome. It was expected that the SCP would be more effective in reducing depression, and in increasing self-concept, commitment and internal control, from pre- to posttreatment, for first offenders (FO) compared to repeat offenders (RO).

Subjects were 42 females and 7 males, aged 19-77 (M=39.1) referred to the SCP for treatment and asked to volunteer as participants in the research. Treatment consisted of 6 weekly 2-hour sessions. Prior to the first session subjects were assessed on measures of self-concept, depression, commitment, and control. Participants were assessed again at post-treatment and at 6-week follow-up.

Repeated measures, multivariate analysis of variance, with preplanned contrasts, indicated that the FO and RO groups changed differentially from pre- to post-treatment on measures of depression ($F(1,24)=7.64, p<.01$), but not on measures of self-concept, commitment, and control. From posttest to follow-up, regardless of the number of prior offences, subjects had significantly changed on all dependent measures. Results suggest that, with the exception of depression scores, the SCP is equally
effective for FO's and RO's in achieving the desired changes. Due to the fact that only 2 men remained in the study at follow-up, generalizability of results is limited to women. Implications of these results and recommendations for future studies are discussed.
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Acknowledgements

Several people must be acknowledged for their valuable contributions towards the completion of this thesis.

First, I owe my deepest gratitude to Dr. Bonita Long, who I admire and respect greatly. Throughout this research project Dr. Long was my motivating force, guiding, supporting and encouraging me along the often lonely road. I am most thankful for her unending commitment to me and my project and I know that I will never be capable of truly expressing the depth of my appreciation.

I would also like to thank my other committee members, Dr. Lynn Alden, Department of Psychology (UBC) and Dr. Doug Cousineau, School of Criminology (SFU) for their valuable input at the proposal stage and for their insights and contributions on the manuscript.

I would like to extend my gratitude to the Elizabeth Fry Society and to the staff and clients of the Shoplifters Counselling Program for their cooperation and participation in this project.

Finally, I want to thank my family and friends for their continued support, interest, and patience over the course of this project.
Introduction

Research supporting the effectiveness of offender rehabilitation programs such as individual psychotherapy, group counselling and intensive supervision has increased over the years, providing a valid counter-argument for the notion that "nothing works" (Gendreau & Ross, in press; Martinson & Wilks, 1977). The notable increase in crimes such as shoplifting has led to a more concerted effort to develop and implement strategies that will be most effective in deterring and preventing the recurrence of such crimes.

The purpose of this study is to evaluate and compare the effectiveness of two interventions, Group Counselling and Community Work Service, within a specific theoretical framework. Researchers support the notion that the majority of shoplifters are not professional criminals, but individuals dealing with a variety of psychological and emotional stressors (Arboleda-Florez, Durie, & Costello, 1977; Bradford & Balmaceda, 1983; Moore, 1983, 1984). Within the stress literature, the personality construct, hardiness, has emerged. Given that hardiness is related to an individual's ability to effectively cope with stressful situations (Kobasa, Maddi, & Kahn, 1982), it was used in this study as a framework with which to compare the two intervention programs.

The question of prevention of crimes such as shoplifting has been approached and analyzed from many
different perspectives. Some have concentrated on the role of the mass media in developing anti-shoplifting information programs (Sacco, 1985). Others have focused on the responsibility of the store keepers (the direct victims) who can reduce the number of shoplifting incidents by increasing security (Kallis & Vanier, 1985) and changing the actual format of the store from self-service to counter-service (Walsh, 1978). It is assumed that if the victim is less vulnerable there will be fewer obstacles to block the "rational" process by which an individual performs the criminal act of shoplifting. However, these authors ignore the fact that not all shoplifters make a rational decision to steal based on the availability of the merchandise, or the existence of a "foolproof" means of escaping from the store. Many shoplifters do not take the time to consider whether or not they "appear" like obvious thieves, or whether anything could "link" them to the theft after it has occurred (Arboleda-Florez et al., 1977; Cupchik & Atcheson, 1983; Moore, 1984; Yates, 1986).

Increasing the number of staff and security guards, introducing sophisticated electronic devices, securing merchandise behind locked cabinets and mounting anti-shoplifting campaigns are useful strategies to deter some people from stealing. However, what is proposed throughout the literature is that reasons other than criminal intent play a powerful role in motivating shoplifting behavior.
Psychosocial stress has been identified by a number of researchers as one such motivating factor. Moore (1984) found that the most frequent stressors were a result of family factors, such as child abuse, neglect and alcoholic parents, and from interpersonal problems, including divorce and separation. Other stressors associated with a major illness or financial difficulties were found among some shoplifters (Arboleda-Florez et al., 1977; Moore, 1983, 1984). Bradford and Balmaceda (1983) concluded that 78% of their sample of shoplifters experienced mild to severe levels of psychosocial stress prior to the theft incident.

Experiencing a significant personal loss, be it the loss of a person through death, divorce or separation, or loss of a job, country or home, has also been associated with shoplifting (Cupchik & Atcheson, 1983; Moore, 1984; Ordway, 1962). Cupchik and Atcheson (1983) postulated a hypothesis they define as "loss-substitution-by-shoplifting", which states that people may try to replace or substitute a significant loss by unfairly taking another object. Other factors repeatedly found to be associated with a sub-group of shoplifters were depression (Bradford & Balmaceda, 1983; Cupchik & Atcheson, 1983; Moore, 1984; Ordway, 1962; Ray, Solomon, Doncaster, & Melina, 1983) and low self-esteem (Beers, 1974; Ray et al., 1983; Solomon &
Given that researchers have consistently found that a large sub-group of shoplifters are afflicted by a significant level of stress, it was important to support this study within a "stress" theoretical framework. For several years, researchers have been interested in the relationship between life stress, health and psychological adjustment (Johnson & Sarason, 1979). A personality construct, hardiness, has evolved from this literature (Kobasa, 1979; Kobasa et al., 1982).

Specifically, hardy individuals are described as possessing three general characteristics. First, they believe that they can "control" or influence the events of their experience. Second, they are able to feel deeply involved in or "committed" to the activities of their lives and to themselves. Lastly, they view change as an exciting "challenge", rather than as a threat to their own sense of security. In early research, Kobasa and others (Ganellen & Blaney, 1984; Kobasa, 1979; Kobasa et al., 1982; Kobasa, Maddi, & Puccetti, 1982) found that individuals high in hardiness were better able to cope with stress and consequently reported fewer cases of physical illness. These results seem to suggest that hardiness plays a "buffering" role, reducing the illness-related effects of stress, and that hardiness is a good predictor of health.
The theory, research methods and instrument developed to measure hardiness have all received recent criticism (Funk & Houston, 1987; Hull, Van Treuren, & Propsom, 1988; Hull, Van Treuren, & Virnelli, 1987). Findings suggest that, although hardiness is associated with lower levels of illness, it does not necessarily buffer the effects of stressful life events (Funk & Houston, 1987; Schmied & Lauler, 1986). More relevant to this study, authors also found that hardiness is more strongly related to psychological health compared to physical health. Furthermore, Hull et al. (1987) concluded that hardiness is not a unidimensional construct and that it is best conceptualized as three separate characteristics: commitment, control and challenge. It has been strongly recommended that the sub-scales of the hardiness scale be used separately (Funk & Houston, 1987; Hull et al., 1987; Hull et al., 1988), and specifically, that researchers should investigate the independent contributions of commitment and control only. Challenge was repeatedly found to be unrelated to both physiological and psychological health outcomes (Hull et al., 1987).

Despite these criticisms, the commitment and control components were found to be significantly related to such variables as depression, self-esteem, burnout and general maladjustment (Funk & Houston, 1987; Ganellen & Blaney, 1984; Holt, Fine, & Tollefson, 1987; Hull et al., 1987, 1988; McCranie, Lambert, & Lambert, 1987). These findings were based on samples...
of males and females, students and employed. This implies that individuals who have a strong sense of commitment to self and an internal locus of control are less depressed, have higher self-esteem and are more sociable and optimistic. It is therefore possible to suggest that the control and commitment components of the hardiness construct can be related to the group of shoplifters who are afflicted by high levels of psychosocial stress, and who are depressed and low in self-esteem. Interventions designed to increase self-commitment, internal locus of control and self-esteem, while decreasing symptoms of depression may, therefore, be effective in dealing with shoplifters.

A number of studies have attempted to evaluate the effectiveness of group counselling interventions for shoplifters on such variables as ego strength (Edwards & Roundtree, 1981), irrational beliefs (Ray et al., 1983; Solomon & Ray, 1984), self-concept (Ray et al., 1983; Semchuk, 1981; Solomon & Ray, 1984), self-image, coping ability and depression (Russell, 1976), ego strength and recidivism (Edwards & Roundtree, 1981; Ordway, 1962). Although most of these studies reported positive changes in the abovementioned variables, certain limitations in design should be mentioned. These include lack of (a) comparison groups, (b) pre- and post measures, and (c) valid and reliable instruments to measure change. Furthermore, most interventions were designed to treat first offenders
only (Edwards & Roundtree, 1982; Ray et al., 1983; Solomon & Ray, 1984).

In 1972, the Elizabeth Fry Society of British Columbia implemented a counselling program specifically designed to help those individuals who shoplift as a reaction to psychological and emotional stress. Over the past 15 years, the Shoplifters Counselling Program (SCP) has offered group, individual, marital and family counselling to people of all ages and socioeconomic backgrounds across the Vancouver lower mainland. Approximately 90% of the clients assessed as suitable for the SCP are referred to the group counselling setting.

A 6-week, 12-hour group program was designed in 1987 to meet specific goals: (a) to increase participants' understanding of their criminal behavior (i.e., what are the underlying issues linked to or motivating the behavior), (b) to decrease symptoms of depression, (c) to increase participants' level of self-esteem and commitment to self, and (d) to stimulate a stronger sense of internal control. The program operates on the premise that in meeting these goals participants will begin to deal with life's stressors and problems in a more productive manner, thus decreasing the likelihood that they will reoffend.

The purpose of this study was to evaluate the effectiveness of the SCP compared to another form of intervention adopted by the courts, Community Work Service (CWS). It was expected that SCP participants
would change significantly over a 6-week program compared to the CWS group, and that the changes would be maintained at a 6-week follow-up assessment. That is, they would show less depression, and greater self-esteem, commitment to self, and internal control.
Modifications in Design

Following the proposed research design, a comparison group was to be generated consisting of individuals who were ordered by the courts to report to a probation officer, and who were subsequently ordered to perform a specified number of Community Work Service (CWS) hours. Over a 6-month period repeated attempts were made to generate a sample of subjects for the comparison group. The researcher received written consent from the office of The Attorney General to solicit aid from any and all probation offices in the Province of British Columbia. Four such offices were approached by the researcher and on each occasion a presentation was made at a staff meeting outlining the research project and the role of the probation officer in referring subjects. A total of 80 Consent Forms (see Appendix A) were distributed. Probation officers were to inform their clients of the study and ask for volunteers. Those interested in participating were to sign the consent form and contact the researcher to set a time for an assessment interview. The researcher received no response whatsoever, and therefore was unable to generate a comparison group.

Upon consultation with individual committee members changes in the proposed research design were made. It was decided to replicate the treatment group and to use individual differences within the groups to compare and evaluate the effectiveness of treatment. It was expected that the short-term treatment would be
more effective for subjects with only one offence compared to those with two or more offences, in significantly decreasing depressive symptoms, and in enhancing self-concept, sense of personal commitment and internal locus of control. It was expected that since the former group had been processed through the Criminal Justice System repeatedly, the impact of this cycle would only increase their resistance to change. Although difficult to confirm, one could further speculate that a first offender is less likely to be a habitual shoplifter than a repeat offender. The negative behavior would therefore be a less integral part of his or her coping mechanism.
Literature Review

In the present chapter, the body of literature concerned with the prevention and deterrence of shoplifting will be examined. Of particular interest are the relatively few studies that evaluate the outcome of intervention programs for a group of non-professional shoplifters. The relationship between the concept of hardiness and stress, will be examined and conceptually linked to the group of shoplifters studied.

The Etiology of Shoplifting

Crime prevention and deterrence has been approached on a number of different levels: through public education, security measures, punishment and rehabilitative interventions. Researchers have long been interested in evaluating the policies and programs advocated by various government and community groups. Of particular interest is the body of literature that focuses on the etiology and prevention of shoplifting, an offence labelled under the Criminal Code of Canada as Theft Under $1,000.00. According to Statistics Canada, 792,626 "actual" arrests were recorded for theft under offences in 1987, and of those, 103,652 were for shoplifting. Conventional estimates state that only 1 in 35 shoplifters are ever caught (Owczar, personal communication, January, 1989). This means that over 3.5 million incidents of shoplifting are likely to have occurred in that year. In Canada, the standard loss reported for shoplifting is of
$1,000,000.00 per day (Bradford & Balmaceda, 1983). Even this figure is likely low, since it was cited in a 1978 report of the Solicitor General of Canada (Rawlins, 1978).

Although statistics pertaining to the cost and occurrence of shoplifting are not completely reliable, the cumulative effect of what is generally considered a "petty" crime is enormous. It is not surprising then that the pressure to clearly define the nature of shoplifting and in turn establish effective means of deterring it is ever increasing (Bradford & Balmaceda, 1983).

Our knowledge of who shoplifts and why has certainly broadened. The typical shoplifter is no longer described as a middle-aged, depressed woman attempting, for instance, to symbolically replace the lost role of mother or wife (Cupchik & Atcheson, 1983). In fact, it has become increasingly difficult to create a profile of a typical shoplifter. On demographic variables such as age, gender, education level, employment and marital status there are more significant differences between shoplifters and other criminals than between shoplifters and the general population (Arboleda-Florez et al., 1977; Bradford & Balmaceda, 1983; Sohier, 1969).

Arboleda-Florez et al. (1977) suggest that the problem of widely differing explanations for shoplifting stems from the paradox that it is such an "ordinary" crime committed by people of all ages and
socioeconomic backgrounds. Similarly, Ray (1987) says that shoplifting is best viewed as a crime that anyone can commit for a variety of reasons. She suggests that in order to gain a better perspective on the problem, we should consider the social, economic and societal variables as well as the individual factors that are involved.

From his sample of 78 college students who had been charged with shoplifting, Moore (1983) challenged previous findings (Beck & McIntyre, 1977) that labelled chronic shoplifters as anti-social and psychopathic, as measured by the MMPI. Using the same scale, he found that shoplifters scored high on passive-aggressiveness. He suggests that shoplifting is a result of this character disorder coupled with the experience of situational stress. These results are consistent with those of Arboled-Florez et al. (1977) whose sample was more representative, consisting of men and women between the ages of 16-68, from different backgrounds. In their 1983 study, Cupchik and Atcheson classified the psychodynamics of shoplifting based on a sample of 24 shoplifters referred to a forensic service for psychiatric evaluation. They concluded that shoplifting can be motivated by either one or a combination of the following factors: (a) a reaction to psychosocial stress, (b) a regressive, symbolic act, (c) an unconscious retribution, (d) either a conscious or unconscious manipulation (i.e., to effect some change; a cry for help), (e) a response to actual, anticipated
or perceived loss, and (f) a reaction to the occurrence of carcinoma.

In general, despite differences in labelling and classifying the motivational factors of shoplifting, the literature strongly supports the idea that a large proportion of shoplifters are not simply professional thieves who steal for financial gain. Researchers who have studied representative samples of shoplifters have repeatedly found common presenting factors. Most frequent are the presence of depressive symptoms and low self-esteem (Arboleda-Florez et al., 1977; Bradford & Balmaceda, 1983; Cupchik & Atcheson, 1983; Gibbens, 1981; Moore, 1984; Pratt, 1988; Ray, 1987; Ray et al., 1983; Russell, 1976; Townsend, 1972; Yates, 1986). Also highly represented is the presence of psychosocial stress due to (a) marital, relationship and family conflict (Arboleda-Florez et al., 1977; Moore 1984; Ray, 1987; Russell, 1976; Yates, 1986), (b) financial and occupational difficulties (Arboleda-Florez et al., 1977; Ray, 1987; Yates, 1986), (c) the anticipation or experience of a significant loss of person, place or object (Cupchik & Atcheson, 1983; Ordway, 1962), and (d) medical problems (Arboleda-Florez et al., 1977; Gibbens, 1981; Yates, 1986).

**Prevention and Deterrence**

What then is the approach that would best prevent and deter people from shoplifting? Sacco (1985) reviewed the empirical research relevant to the feasibility and effectiveness of anti-shoplifting
information programming. He concludes by stating that "mass media is not a magic bullet...It is... a costly and difficult social undertaking which has limited applicability and only a moderate capacity for problem amelioration" (pp. 26-27). This, he adds is particularly pertinent to the communication intervention strategies designed to reduce incidents of shoplifting.

With regard to punitive measures, although Gibbens (1981) and Sohier (1969) feel that a simple system of "deterrent fines", as for traffic violations, would be sufficient in eliminating the problem of recidivism, Walsh (1978) feels that fining only reduces the reaction to shoplifting to a monetary issue. He advocates increasing measures of security, and places most of the responsibility for crime prevention on the direct victim, the merchant. The process that seems to emerge then is one of shifting the responsibility from the general public, to the courts, to the merchant and so on. Education programs do exist, high tech security is implemented, mild to severe sentences are passed (from minor fines to incarceration) and yet the rate of shoplifting is not decreasing.

Interventions designed to deal directly with the individuals who shoplift, and "convert them into honest consumers" (Conner, 1981) are also strongly advocated (Cupchik & Atcheson, 1983; Gibbens, 1981; Moore, 1984; Yates, 1986). Based on her assessment of 101 shoplifters, Yates (1986) suggests that treatment
programs that address the issue of stress and depression management and assertiveness training should be developed. Moore (1984) proposed a two-phased treatment plan. First, he sees the need for short-term crisis intervention to assist offenders in coping through prosecution and sentencing. Second, operating on the assumption that shoplifters tend to minimize the seriousness of their crime, he suggests the implementation of an educational program that is "firm confrontational and reality-oriented" in order to change the offender's "distorted" view of shoplifting. Moore does add, however, that this type of program should not be a substitute for professional psychotherapy.

Gibbens (1981) also sees an obvious need for psychiatric or social treatment, but feels that behavioral, and not psychoanalytic treatment would be more effective. The latter, he states, may only "reveal the psychopathology without effecting a cure" (p. 347).

Treatment Programs

Only a relatively small number of treatment studies have been documented. According to Kurlychek & Morganstern (1978), the behavioral literature has provided few treatment suggestions for the management of compulsive shoplifting. They also see limitations in previous studies which rely on punishment (electric shock, breatholding, response cost) as the only or major therapeutic technique (Kellam, 1969; Keutzer,
1972; Kraft, 1970). Kurlychek and Morganstern (1978) offer a "multimodal" program based on a number of behavioral self-control principles. Their study, however, relies on a single case history. Although they incorporate a system of positive reinforcement as well as punishment in the treatment plan, the consequences of either "good" or "bad" behavior seem far from logical or meaningful. For instance, the subject was to reward positive behavior (not shoplifting, carrying a small handbag, etc.) by purchasing a magazine. Negative behavior was to be punished by donating $1.00 to an organization that the subject found "extremely aversive". What is limiting in this purely behavioral intervention is that the shoplifting is removed from its general context. What becomes important is the fear of losing $1.00 or the anticipation of receiving a magazine. The much broader implications of the criminal act, both for the individual and society as a whole, are forgotten or ignored.

Others have felt the need to implement programs designed to "educate" the offender about shoplifting and its consequences. Davis (1983) reports on one such program which consists of 5 lessons in a classroom environment, with a final exam on "Why do I shoplift?". The lessons review the shoplifting problem from the perspective of the victim and the community, offers information about the existing statutes against shoplifting and discusses the consequences of the
criminal act. Similarly, Conner (1981) devised a program which even offers the opportunity for particularly "gifted students" to take the course by correspondence! This form of intervention is evidently limited by the belief that once offenders are informed of the consequences of their behavior they will promptly cease to engage in this anti-social act.

Solomon and Ray (1984) go one step further in the development and evaluation of the Shoplifter Offender Program (SOP). The SOP is an 8-hour psychoeducational group counselling program based on the concepts and theory of Rational-Emotive Therapy (RET; Ellis, 1962). The goals are to teach the A-B-C's of RET in order to change irrational beliefs, prevent further shoplifting behavior and provide a "basic tool" for learning to effect life-style changes. Subjects for the study consisted of 94 court-ordered first offender shoplifters. Seventy-five percent of the sample were women, and the mean age for both men and women was 25.7 (SD=9.3). In testing the 94 participants of the SOP, the researchers found that shoplifters did not differ significantly on irrational beliefs, as measured by the Irrational Beliefs Test (IBT; Ray & Bak, 1980) from the normal population. In turn, they developed a 20-item Shoplifters Irrational Beliefs Scale (SIBS) which has not, however, been statistically validated. Further, there are limitations both in the program itself and in the method of evaluating its effectiveness. First, the authors recommend that future treatment address not
only cognitive aspects of shoplifters' behavior, but that it also pay attention to the affective aspects. These considerations stem from the MMPI and self-concept scores they derived from their sample which indicated that the shoplifters were high in depression and anxiety and low in self-esteem (Ray et al., 1983). Second, the researchers assumed that treatment was successful because only one reoffence was recorded, and because "97.37% of the SOP participants reported that the A-B-C model and the RET approach [had] been helpful" (p. 1077). Given that arrest statistics are not representative of the actual crime rate, and that self-reports are subject to various biases, the reliability of these results remains questionable.

The shoplifter's counselling program developed and operated by the Elizabeth Fry Society of British Columbia has been the subject of two separate evaluations (Russell, 1976; Semchuk, 1981). At the time of Russell's (1976) study, the program was designed for middle-aged, depressed, non-professional shoplifters. The clients met on a weekly basis, in a group setting, for approximately six months. According to the author, there was considerable variation between groups in terms of focus and content. The common goals of treatment, however, were to improve communication and assertiveness skills, and to motivate clients toward direct and positive action. Two methods were used to evaluate the groups' outcome. First the
researcher reviewed the files of 47 women, who had completed the 6-month program. The women ranged in age from their early twenties to mid-seventies, and 53% were first offenders. The group counsellors assessed their clients' progress along three dimensions: (a) change in interpersonal relation, (b) change in self-image, and (c) change in coping ability. Based on the counsellors' case notes and summaries, the researcher estimated that 80% of the subjects had made "positive gains" along each of the dimensions, and no one was seen as having regressed. Second, 14 women who had completed the program agreed to a follow-up interview with the researcher. All the subjects rated the experience as "highly beneficial". Three aspects of the program were reported as having had the most positive impact: (a) the opportunity to openly communicate their feelings about the shoplifting experience, (b) the opportunity to share ideas and suggestions, and discuss alternate courses of action, and (c) the sense of belonging to an empathetic and supportive group. Furthermore, the subjects reported increased feelings of self-control and decreased feelings of depression following their participation in group. The author admits that these methods of assessment are highly subjective, and therefore "only begin to serve as an indication of group effectiveness" (p. 9). Despite these limitations, however, the author feels that the results warrant attention, and recommends that more objective data be generated.
through the use of standardized pre- and posttreatment measures in future studies.

Semchuk (1981) also evaluated the Elizabeth Fry Society's counselling program for shoplifters, at that time known as the Court Referral Program. Demographic data were compiled from a sample of 80 cases referred to the program. The average age was 38.2 years, ranging from 17 to 76 years. Females made up 92.5% of this sample. Based on scores of the Tennessee Self Concept Scale (TSCS), 55.4% were selected for intensive counselling service. A total of 39 clients were monitored from initial intake to program completion. Type of treatment varied, where subjects were involved in either group or individual sessions (69% and 23%, respectively), or a combination of both (59%). The average length of treatment was 21 weeks, ranging from 5 to 63 weeks. Pre- and posttest scores on the TSCS were the only standardized outcome measures. Other measures used were subjective reports from counsellors, clients, judges and probation officers. The TSCS yields 11 separate scores, from a Total Positive score to a General Maladjustment index. Ten of the 11 measures showed significant change in a positive direction.

Although the researchers felt that these results were "remarkable" and provided "considerable and substantive evidence of the beneficial effects of treatment" (p. 69), serious limitations in design must be noted. First, the fact that length and type of
treatment differed from one subject to the next, makes it very difficult to attribute positive change to treatment alone. Furthermore, the content of treatment is not described. The researcher outlines the main objective of the group program; specifically, "to assist participating clients in improving their personal/social sense of well-being and actual behavioral functioning, including reducing the probability of a repetition of criminal offences" (p. 53). However, there is no clear indication as to what the participants were exposed to during their counselling sessions in order to achieve this objective. Finally, the researcher also notes that the lack of a comparison or control group further limits the conclusions that can be drawn from such positive results.

Edwards and Roundtree (1981) evaluated a short-term treatment program for first offender shoplifters using a control group, pre- and posttest outcome measures, and a standardized instrument to measure change. They hypothesized that (a) there would be significant differences between the shoplifters who received treatment and the waiting list control group on pre to post scores of the ego strength scale of the MMPI, and (b) there would be significant differences between those two groups on re-arrest statistics, gathered by local police departments, at a 90-day follow-up. Treatment consisted of 8 weekly 1 and 1/2 hour sessions that covered information on personality
and communication skills from reality therapy, transactional analysis, parent effectiveness training, gestalt, behavior modification and assertiveness training. Both hypotheses were rejected. Neither group changed over time on measures of ego strength, and no incidents of re-arrest were recorded for either group. The researchers attribute the latter findings to the fact that all subjects were court-ordered, and therefore reacting to "legal pressure". The authors, however, do not offer any explanation for the first finding. One could speculate that these nonsignificant results are attributed to the fact that the MMPI does not accurately measure the changes that treatment is attempting to effect, or, that treatment itself, with its variety of skills and therapeutic orientations, is not effective in increasing ego strength.

The goals of treatment must be clearly defined before choosing an instrument that will measure those changes due to treatment. Furthermore, these goals must be based on an understanding of the presenting problem, in this case shoplifting, and of the individuals seeking treatment. It is obvious that the primary goal of an intervention program for shoplifters is to reduce the recidivism rate. Official arrest statistics, as stated earlier, are not representative of the actual incidents of shoplifting. Self-reports of re-offences are equally unreliable. There are, on the other hand, secondary goals of treatment which are just as important and instrumental in attaining the
first. By measuring the outcome of these secondary goals we can make further inferences on the success, or failure of the first.

**Hardiness, Stress, and Coping**

The task of identifying a theoretical construct and reliable instrument that match the secondary goals of the SCP studied here, has led this researcher to examine the literature on stress and coping, since, as mentioned earlier, a particular subgroup of shoplifters is afflicted by high levels of stress. In a further attempt to study the individual differences between highly stressed subjects who remain healthy (adaptive coping ability) and those who show illness along with high stress (maladaptive coping ability), Kobasa (1979) identified a specific personality construct she termed hardiness. Hardy people are described as possessing three characteristics: commitment, control, and challenge. First, they tend to be committed to or involved in the many aspects of their lives, and have a general sense of purpose and self-awareness which allows them to find meaning and value in who they are and what they do. Second, they tend to believe and behave as if they have control or influence over events and outcomes through their use of personal choice, knowledge and skill. Finally, hardy individuals view change as a challenge and an opportunity for growth rather than as a threat to their own sense of security. The concept of hardiness, and in particular commitment and control, seemed to be theoretically associated with
the shoplifters that were to be studied.

In early research, the need for a large and highly stressed pool of subjects led Kobasa and others (Kobasa, 1979; Kobasa, Maddi, & Khan, 1982; Kobasa, Maddi, & Puccetti, 1982) to base their findings exclusively on a sample of middle and upper management males working for a large public utility company. They hypothesized that among the subjects that reported experiencing high levels of stress, those who had internal locus of control, a sense of commitment, and viewed change as a challenge would report fewer and less serious cases of illness than those who had external control, a sense of alienation, and saw change as a threat. First, Kobasa (1979) found a weak, but significant positive correlation, .24 (p<.025), between stress and illness. Second, using a discriminant function analysis on 16 personality variables used to measure hardiness, results showed that high stress/low illness executives could in fact be distinguished from high stress/high illness executives. That is, the first group was found to be more in control, more committed and more oriented toward challenge compared to the second group. From these results Kobasa inferred that hardiness can act as "insulation" or a "buffer" against illness.

Certain limitations are evident in the manner in which hardiness has been measured. From the initial 16 scales that were theoretically believed to be associated with one of the three hardiness
subcomponents (control, challenge, and commitment), only six were found to significantly distinguish between groups (for control, the Powerlessness, Nihilism and External Locus of Control scales; for challenge, the Vegetativeness and Adventurousness scales; and for commitment, the Alienation from Self scale). Confusion arises in later research when Kobasa and her colleagues (Kobasa, Maddi, & Courington, 1981; Kobasa, Maddi, & Puccetti, 1982; Kobasa & Puccetti, 1983) adopt a different method for measuring hardiness and its subcomponents. The Alienation from Self and Alienation from Work scales were used to measure commitment, the Powerlessness and External Locus of Control scales for control, and the Security scale for challenge. The scores on these 5 scales are combined to form a composite hardiness score. However, only 3 of these scales had previously been found to significantly distinguish between high and low illness subjects, and of these, the Powerlessness scale had yielded a small discriminant coefficient. To add to the confusion, Kobasa's (1982) study on commitment and stress resistance used the Powerlessness and Vegetativeness scales to measure commitment, although they had previously been identified as measures of control and challenge, respectively.

Despite these limitations and inconsistencies, the concept of hardiness as a healthy coping attribute has interested many researchers. Recent studies have broadened the sample pool of predominantly male
executives and professionals used by Kobasa and her colleagues, to include males and females, adolescents (Hannah & Morrissey, 1987), university undergraduates (Funk & Houston, 1987; Ganellen & Blaney, 1984; Hull et al., 1987, 1988; Rhodewalt & Agustsdottir, 1984; Wiebe & McCallum, 1986), university post-graduate students (Parkes & Rendall, 1988), teachers (Holt et al., 1987), nurses (McCraine et al., 1987), and secretaries (Schmied & Lawler, 1986). The hardiness measure has also received attention and criticism (Funk & Houston, 1987; Hull et al., 1987; Okun, Zautra, & Robinson, 1988; Parkes & Rendall, 1988) which has undoubtedly encouraged the original researchers to refine and standardize their instrument (The Hardiness Institute, Inc., 1985). Finally, in addition to physical illness, the effects of hardiness have been associated with measures of psychological well-being including lower levels of burnout (Holt et al., 1987; McCraine et al., 1987), of depression (Funk & Houston, 1987; Ganellen & Blaney, 1984; Hull et al., 1987), and higher self-esteem (Hull et al., 1987).

These points are of particular importance to the present research, since the Elizabeth Fry program participants include men and women of varying ages and employment status, and since indices of psychological well-being, depression and self-esteem, are important outcomes of treatment. Thus, the broader scope taken by recent researchers in studying hardiness, will allow for greater generalizability of results.
In an attempt to study the relationship of hardiness and social support and their role in moderating the effects of life stress, Ganellen and Blaney (1984) conducted a cross sectional study using 83 female undergraduate students. As expected, they found that those who reported greater levels of social support were also higher in hardiness. Given that these two factors were correlated, the researchers addressed a second question: whether hardiness and social support act as buffers in life stress. A series of 3-way (Social Support by Hardiness by Stress) ANOVA's were computed using scores on the Beck Depression Inventory as the dependent variable. Significant main effects were obtained for stress, social support and two of the six measures of hardiness, Alienation from self (commitment) and Vegetativeness (challenge). These results indicate that individuals low in stress, high in social support, commitment, and challenge, are least likely to be depressed. Concerning the buffering effect of social support and hardiness, the only significant interaction found was between stress and commitment. Social support and other aspects of hardiness were not found to have a buffering effect for stress.

Funk and Houston (1987) challenged previous researchers, including Ganellen and Blaney (1984), for relying on analysis of variance (ANOVA), and analysis of covariance (ANCOVA) designs to study the effects of hardiness, stress and other concepts such as social
support and exercise on health and illness. Since hardiness has been found to significantly correlate with these variables, using ANOVA "violates the assumption of independence among factors and dimensions" (p. 574). They suggest the use of multiple regression because this technique assesses "the effects of each factor while controlling for the influence of others" (p. 574). In their design, Funk and Houston compare findings from both retrospective and prospective analyses using ANOVA and ANCOVA, and repeat the analyses for retrospective and prospective data using multiple regression. Their sample was made up of 120 male undergraduate students. One measure of physical illness and one of depression were used as dependent measures. Their results show that the main effects of hardiness on physical illness and depression, found when retrospective data were analyzed with ANOVA and ANCOVA, were not reproduced when data were reanalyzed by multiple regression. For the prospective data, the main effects of hardiness on depression alone were obtained by both statistical techniques. The authors concluded that hardiness is more strongly related to depression than to physical illness, and suggest that future studies place more emphasis on the relationship between hardiness and depression rather than physical symptoms.

In their 1987 study, McCraine et al. examined the relationship between hardiness, job stress and burnout among registered staff nurses. The sample consisted of
95% females with an average age of 30.3 (SD=6.9).

Burnout was measured by the Tedium Scale (Pines & Aronson, 1981) which in turn measures three components of burnout syndrome: (a) physical exhaustion, (b) emotional exhaustion (e.g. depression), and (c) mental exhaustion (e.g., low self-esteem). A significant correlation was found between composite hardiness and burnout. In order to test the moderating effects of hardiness on stress and burnout, the researchers used a hierarchical multiple regression analysis. Contrary to findings reported by Kobasa and her colleagues (Kobasa, 1979; Kobasa et al., 1981, 1982) no moderating effects for hardiness were observed. Perceived job stress and levels of hardiness were found to be significant "additive" rather than "interactive" predictors of burnout. Although hardiness was seen as having beneficial main effects on reducing burnout, it did not appear to prevent high stress levels from leading to high burnout.

Another study investigating hardiness and its relationship to stress and burnout was conducted by Holt et al. (1987). Their sample of 192 elementary school teachers, 70% of which were at least 31 years old, completed a stress inventory, a burnout inventory yielding a score of emotional exhaustion, and two scales to measure hardiness components, commitment and control (Alienation Test and Locus of Control, respectively). The authors hypothesized that teachers in the high stress/high burnout group would be more
alienated (less committed) and have external versus internal locus of control compared to those in the high stress/low burnout group. Results of F-tests showed that mean scores for commitment and control were in the predicted direction. However, significant group differences were found for commitment scores \( F(1,63)=5.58, p<.05 \) and not for locus of control.

Although both studies are limited by their retrospective nature, in that low levels of hardiness could be a consequence of burnout rather than a cause, they do lend strength to the argument that certain aspects of hardiness are significantly related to psychological health. Hull et al. (1987) contribute to this argument in their study which examines the psychometric properties of the hardiness measure and its subcomponents. Results of convergent validation show that composite hardiness scores, and commitment, and control subscales were significantly related \( (p<.01) \) to depression and self-esteem. Challenge was found to be unrelated to these two measures of psychological health.

The Hardiness Measure (PVS)

In 1984, The Hardiness Institute, Inc., developed the third generation Hardiness Test, or, The Personal Views Survey (PVS). According to the fact sheet distributed by the Institute, the new instrument has been carefully constructed both conceptually and empirically. Item and factor analyses have led to discarding or revising certain items. The final result
is a stable and reliable rating scale, yielding high Alpha coefficients (in the .90s for composite hardiness, and .70s for its subscales), suggesting strong internal consistency. The test was standardized on a population of 223 women and 1511 men, professionals, non-professionals and students.

Two studies that utilize the PVS have recently been reported. Parkes and Rendall (1988) examined the PVS's psychometric properties using a sample of 87 post-graduate students, averaging 23.7 years in age (SD=3.5), 67.8% of whom were female. As there were no significant gender differences on hardiness scores, the two groups were combined to measure the instrument's reliability. Alpha values for hardiness, challenge, commitment, and control were in the moderate to high range (.89, .76, .85, .68, respectively). Composite hardiness, and in particular commitment, were significantly related to age, in that younger subjects had higher overall hardiness scores than older ones. The authors do outline some limitations of the PVS. The assumption that the respondents are married and employed is evident through the wording of certain items. In this respect, the PVS may not be "well-suited" for studies on stress and illness within the general population. Moreover, the predominance of negatively keyed items may influence scores for certain individuals. This imbalance may result in lower hardiness scores for people with "acquiescent response tendencies". The authors suggest that minor revisions
of wording, and a balance between positive and negative items would increase the value and application of the PVS within research.

Okun et al. (1988) used the PVS to measure hardiness and its relationship to objective and perceived health among 33 women with rheumatoid arthritis (RA). Subjects were tested at three monthly intervals. The authors predicted that first, hardiness would be positively related to objective health, and second, that RA patients high in hardiness would perceive themselves as healthier than would RA patients low in hardiness, in relation to same age peers and compared to the previous month. Results showed that (a) only the control component of hardiness was positively related to objective health, and (b) hardiness, control and commitment were significantly related to perceived health when compared to same age peers, but not in relation to the past month. Consistent with previous findings (Hull et al., 1987), challenge was not found to be related to measures of health. Perhaps, even in the latest version of the Hardiness Test, the challenge subscale warrants revision.

Summary

In conclusion, after having reviewed the relevant research on shoplifting, it has become apparent that there is still a need for researchers to systematically evaluate treatment programs. The existing intervention studies are generally based on a poor conceptual
framework. As a result, the concept of hardiness, and its relationship to stress and psychological health, has been explored and adopted as the theoretical framework from which to assess the effectiveness of a counselling program for a group of shoplifters who are afflicted by high levels of psychosocial stress. Despite the limitations of the instrument designed to measure hardiness, at least two of its subscales, commitment and control, have been found to be both reliable and valid measures, worthy of future research.
Method

Subjects

The original subject sample consisted of 49 individuals (42 women and 7 men) who had been charged with a Theft Under $1000.00 offense (shoplifting), and referred to the Elizabeth Fry Society's SCP for treatment. Clients had been referred to the SCP by a Judge or a probation officer as a condition of probation or as a Diversion agreement (non-voluntary clients), or, had been referred by a number of sources, including defence counsel, social workers, court workers, psychiatrists, physicians and self (voluntary clients). By the start of the SCP, or shortly after its commencement, all subjects had either received a sentence in court or had agreed to a diversion contract, both of which included mandatory completion of SCP, and therefore had become non-voluntary clients.

Specific criteria for acceptance to the SCP are as follows: (a) admit guilt to criminal offense, (b) demonstrate functional reading and oral comprehension of the English language, (c) present no signs of severe psychiatric disorders, (d) present no signs of mental handicap, (e) not presently substance abusers, and (f) be 18 years of age or over. Individuals who do not meet all of the above criteria are not accepted into the SCP and are referred to an appropriate service in the community.

Of the 120 clients who were assessed during the months of November, 1987 to April, 1988 and June to
September, 1988, 93 met the above criteria and were accepted into the group SCP. Of those, 49 agreed to participate in the research and completed the pretest questionnaires. Forty-two complete sets of data were collected at posttest (1 subject was incarcerated, 2 dropped out of SCP, 2 were not present for testing, and 2 sets of data were incomplete), and 26 subjects were available for testing at follow-up (1 additional subject was incarcerated, 5 were not present for testing, and 10 failed to return completed questionnaires).

The sample was predominantly female (85.7%), both male and female subjects ranged in age from 19 to 77 (M=39.1, SD=15.1). First offenders made up for 45% of the sample, while 55% were repeat offenders, with a criminal record ranging from 1 to 5 previous offences. Of the total sample, 35% were married or living common-law, and the remaining 65% were not married, and were either separated, divorced, widowed or single. Fifty-five percent were employed at some level (full or parttime), and 45% were not employed (unemployed, retired, students, housewives).

**Design**

A total of 10 SCP groups were completed (6 groups in the spring and 4 in the fall). The size of the groups ranged from 4 to 9 members, and the number of subjects in each group ranged from 3 to 7. For the purpose of analysis, groups 1 to 6 (n=26) are treated as the Treatment Group (Spring group), and groups 7 to
10 (n=23) are treated as the Replication Group (Fall group). For further breakdown of individual groups see Appendix B. Five groups were led by an SCP contract counsellor who received inservice training in group counselling through the Elizabeth Fry Society. The remaining five groups were led by the researcher, who is an SCP staff counsellor trained at the university graduate level in Counselling Psychology. All subjects were assessed at three time intervals: pre-intervention, 6-week posttest, and 6-week follow-up.

Dependent Measures

The Personal Views Survey (PVS; The Hardiness Institute, Inc., 1985) which measures Kobasa's construct, hardiness, is a 50-item questionnaire containing three subscales: commitment, control, and challenge. For the purpose of this study, only the first two scales were used to measure (a) subjects' level of commitment to self, or, the degree to which they possess a general sense of meaningfulness and purpose in life, and become actively involved in life events rather than remaining passively uninvolved; (b) subjects' locus of control, where individuals with an internal control disposition feel and behave as though they are influential, and not helpless over the events of their lives. The commitment scale consists of 16 items, 12 of which are negatively keyed for hardiness. The control scale consists of 17 items, 14 of which are negatively keyed for hardiness. Participants were to
indicate the extent to which each statement was true for them on a 4-point Likert-type scale ranging from "not at all" (0), to "completely true" (3). Scores were calculated in terms of the mean item scores for the commitment and control scales (range 0 to 3). High scores represent low levels of commitment and control. Recent support for convergent and discriminant validity and adequate internal consistency has been reported. Alpha values for internal consistency of the Commitment and Control scales range from .70 to .85, and .68 to .72, respectively (Hull et al., 1987; Okun et al., 1988; Parkes & Rendall, 1988).

The Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1979) has been identified as an effective measure of depression symptomology (Kendall, Hollon, Beck, Hammn, & Ingram, 1987; Shaefer et al., 1985) and is one of the widely accepted instruments for measuring changes in depression associated with psychotherapy (Steer, Beck, Riskind, & Brown, 1987). The authors conclude that if a therapist is using cognitive therapy to "change sets of dysfunctional attitudes and beliefs, then the BDI, with its more refined cognitive dimension, might be the instrument of choice" (Steer et al., 1987, p. 338).

The BDI is a self-report measure with 20 items composed of four alternative statements that rate the severity of depressive symptoms (e.g., sadness, pessimism, sense of failure, dissatisfaction, guilt, etc.). Total scores range from 0 to 63. According to
Kendall et al.'s (1987) cutoff score criteria, the range of scores from 0-9 can be seen as "normal", 10-16 as "mild" depression, 17-30 as more "moderate" depression and scores greater than 30 as "severe" depression. Recent studies (Schaefer et al., 1985; Steer et al., 1987) have reported evidence for strong internal consistency (Chronbach Alphas=.94 and .87).

The **Tennessee Self Concept Scale** (TSCS; Fitts, 1965) is one of the most widely used scales to measure self-concept and self-esteem. The instrument yields a "Total Positive" score ranging from 0 to 450 which reflects the individual's overall level of self-esteem (Fitts, 1965). The "Clinical and Research" form was used for this study, and contains 100 items that measure a person's self perception on five dimensions: the physical, moral/ethical, personal, family and social self. Individuals rated themselves according to how they are (identity), how they accept themselves (self-satisfaction), and how they act (behavior) in relation to those five dimensions of the self. The measure of self-concept was chosen because it is well standardized and multi-dimensional in its description of self-concept. Furthermore, a previous study (Semchuk, 1981) evaluating the SCP also made use of the TSCS as an outcome measure, and reported that 84% of subjects (n=31) registered a significant increase in "Total Positive" scores (p<.01) after completion of the counselling program. As in Semchuk's (1981) study, only the "Total Positive" scores were calculated in the
present research.

Ancillary Measures

Expectancy for Change (see Appendix C). In order to interpret the specific effects of treatment more accurately it was essential to assess for non-specific treatment effects such as treatment groups generating different demand conditions (Kazdin, 1980). The measure used is a self-report questionnaire comprised of 3 items asking subjects to rate the extent to which they feel treatment appears to be logical, will be successful and would be recommended to others on a 7-point Likert scale. The scale yields one score ranging from 0 to 21.

The Life Experience Survey (LES; Johnson & Sarason, 1979) is a self-report measure of life changes designed to assess (a) the "desirability" (positive or negative) of events experienced in the previous year, and (b) the perceived "impact" of these events (rated on a 7-point interval scale ranging from extremely positive, +3, to extremely negative, -3). The scale yields both a positive and a negative change score. A significant relationship between LES negative scores, depression (as measured by the BDI) and external locus of control (as measured by the I-E Locus of Control Scale) has been reported (Johnson & Sarason, 1979). Individuals who reported experiencing high levels of negative change displayed more depressive symptoms and appeared to be more externally oriented. For the purpose of this study the frequency of events and the
sum of negative scores were calculated and used for descriptive purposes.

Treatment

The SCP is a 6-week, 12-hour psychoeducational group counselling program designed to increase self-awareness, self-esteem, internal control and a sense of commitment to self. Clients were presented with a theoretical framework from which they could begin to understand the possible factors motivating the criminal behavior. The shoplifting is seen as an unproductive attempt to take control of life when dealing with unresolved emotional issues and stressful life events, and a way of satisfying some basic psychological need (i.e., love, power, freedom, fun). Sessions were two hours in length and were structured with didactic components, group discussion, experiential activities and paper pencil exercises (a detailed treatment Manual is available upon request).

At the end of the 6-week SCP, clients in the treatment group were given the option of either terminating counselling or continuing with the therapy component, an unstructured 6-week, 12-hour group counselling program. However, clients in the replication group were not given the same option. As a result of changes in agency policy, the 6-week psychoeducational component and the 6-week therapy component were combined to form one 12-week group program which all subjects were required to attend. The various effects and implications of this difference
will be discussed later.

Procedure

A one-hour personal interview was conducted with all clients referred to the Elizabeth Fry Society's SCP. A standard intake form was used (see Appendix D) to gather demographic data. An unstructured interview followed where: (a) clients were asked to describe the particulars of the criminal incident, (b) clients' emotional and cognitive state at the time of the incident was examined, (c) clients disclosed information about their family, employment, financial, medical and social history.

Having deemed the client as suitable for the SCP, the counsellor drew up a contract (see Appendix D) which specified dates, times and fees of group sessions. Clients were then informed of the present research project and asked to volunteer as participants. Having agreed to be a subject in the study, the client signed the consent form (see Appendix D). The LES was then administered. Participants were asked to appear one hour prior to the beginning of the first group for the purpose of completing the following questionnaires: (a) TSCS, (b) PVS, and (c) BDI. At the end of the first session they completed the Expectancy for Change Scale.

At the end of the 6-week SCP, participants completed (a) a self-evaluation form (see Appendix E), (b) a program evaluation (see Appendix E), (c) the TSCS, (d) the PVS, (e) the BDI, (f) the Expectancy for
Change Scale, and (g) an anonymous recidivism rate record (see Appendix E). This required an additional 1-1 1/2 hours. Those who did not choose to continue with the 6-week therapy group were asked to sign up for a 6-week follow-up meeting. The following questionnaires were administered to each participant, either at the end of the 6-week therapy group or at the scheduled 6-week follow-up meeting: (a) TSCS, (b) PVS, (c) BDI, and (d) recidivism rate record. Participants were thanked and informed that research findings would be made available to them upon written request.

Data Analysis

A one-way multivariate analysis of variance (MANOVA) was used to test for pretreatment differences between the Treatment (T) and Replication (R) groups on the four dependent variables and LES scores. A two-way (Group x Time) MANOVA with two preplanned nonorthogonal contrasts using Dunn's test for significance at .025 (pre- to posttest; posttest to follow-up) was performed for all dependent measures (commitment, control, depression and self-concept) to test the hypotheses. A two-way repeated measures ANOVA was calculated for pre- and postmeasures on expectancy for change. T and R groups were collapsed and a 2-way (Group X Time) MANOVA with two pre-planned nonorthogonal contrasts using Dunn's test for significance at .025 was performed to examine the individual differences on all dependent measures for T and R groups: First Offender (FO, n=22) and Repeat Offender (RO, n=27) group. Chi-squares were
calculated in order to determine how similar the two groups were on such variables as age, gender, education, criminal record, marital and employment status. Descriptive statistics including a Pearson product-moment correlation were also calculated.
Results

Group Comparability on Demographics

Chi-square tests of independence were computed to test for differences between the Treatment (T) and Replication (R) groups (n=26, n=23, respectively), and between the First Offender (FO) and Repeat Offender (RO) groups (n=22, n=27, respectively). No significant differences were found on the demographic variables of employment status, marital status, education, and criminal record for any of the groups. However, differences in age approached significance (Chi-square(2, N=49)= 5.81, p<.06) for the T and R groups, where 68.8% of subjects between the ages of 31 and 50 were in the T group, and 68.4% of subjects under 30 years of age were in the R group. These differences were not found for the FO and RO groups. Since the correlation between age and all the dependent measures did not exceed .30, it is not likely that this between group difference would influence the effects of treatment. Although there were more women than men in the total sample (n= 42, n=7, respectively), this disproportion is similar to other treatment studies of shoplifters (Semchuk, 1981; Solomon & Ray, 1983). A summary of subject characteristics is presented in Table 1.

Subject Attrition

Of the original 49 subjects, 7 were lost at posttest (dropouts). Two dropped out of the SCP, one
Table 1

Subject Characteristics—Demographics (N=49)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Age (mean, range)</td>
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<tr>
<td>Gender</td>
<td></td>
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<tr>
<td>Females</td>
<td>86%</td>
</tr>
<tr>
<td>Males</td>
<td>14%</td>
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<tr>
<td>Marital Status</td>
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<tr>
<td>Married/Common-law</td>
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<tr>
<td>Single/Divorced/Widowed</td>
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<td>Dependents</td>
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<tr>
<td>None</td>
<td>57%</td>
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<tr>
<td>1 or more</td>
<td>43%</td>
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<tr>
<td>Education</td>
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<td>Less than High School</td>
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</tr>
<tr>
<td>Canada</td>
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<tr>
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</tr>
<tr>
<td>Criminal Record</td>
<td></td>
</tr>
<tr>
<td>1 Offence</td>
<td>45%</td>
</tr>
<tr>
<td>2 or more</td>
<td>55%</td>
</tr>
</tbody>
</table>
was incarcerated, two were not present for testing, and two sets of data were incomplete. A further 16 subjects were lost at follow-up (dropouts). One other subject was incarcerated, 5 were not present for testing, and 10 failed to return completed questionnaires (see Table 2 for summary of attrition by groups).

A one-way multivariate analysis of variance (MANOVA) was used to test for pretreatment differences between the dropout group (n=23) and those who remained in treatment or were available for testing (n=26) on the dependent measures of self-concept, depression, commitment, and control, and on the ancillary measures of stress and expectancy for change. The overall MANOVA for the group effect was nonsignificant, F<1. However, an examination of the means (see Table 3) indicates that, prior to treatment, the dropouts tended to have a higher self-concept, were more committed, felt more in control, less depressed and reported experiencing slightly fewer and less stressful life events. Attrition was similar for the FO and RO groups in that 10 were lost in the first and 13 in the latter.

Pretreatment Dependent and Ancillary Measures: Descriptive Data

Prior to treatment, subjects in the FO and RO groups could be classified as "moderately" depressed, according to the BDI cutoff score criteria reported by Kendall et al. (1987) (see Table 4 for means and
### Table 2

**Summary of Attrition by Groups**

<table>
<thead>
<tr>
<th>Time</th>
<th>Treatment</th>
<th>Replication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretest</td>
<td>26</td>
<td>23</td>
</tr>
<tr>
<td>Posttest</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td>Follow-up</td>
<td>14</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Offender</th>
<th>Repeat Offender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretest</td>
<td>22</td>
</tr>
<tr>
<td>Posttest</td>
<td>19</td>
</tr>
<tr>
<td>Follow-up</td>
<td>12</td>
</tr>
</tbody>
</table>
### Table 3

**Pretest Means and Standard Deviations of Outcome and Ancillary Measures by Dropout and Retained Subjects**

<table>
<thead>
<tr>
<th>Groups</th>
<th>Dropout (n=23)</th>
<th>Retained (n=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>TSCS</td>
<td>325.7</td>
<td>36.8</td>
</tr>
<tr>
<td>BDI</td>
<td>14.0</td>
<td>9.0</td>
</tr>
<tr>
<td>COMM</td>
<td>.80</td>
<td>.4</td>
</tr>
<tr>
<td>CONT</td>
<td>.90</td>
<td>.4</td>
</tr>
<tr>
<td>LES</td>
<td>13.0</td>
<td>11.2</td>
</tr>
<tr>
<td>EXPT</td>
<td>18.4</td>
<td>2.2</td>
</tr>
</tbody>
</table>

**Note.** TSCS=Tennessee Self-Concept Scale, BDI=Beck Depression Inventory, COMM=Commitment, CONT=Control, LES=Life Experience Survey, EXPT=Expectancy for Change. The higher the score the higher the self-concept, stress, and expectancy. The lower the score, the lower the depression, and the higher the commitment and control.
Table 4

Pretest Means and Standard Deviations of Outcome and Ancillary Measures by Groups

<table>
<thead>
<tr>
<th>Measures</th>
<th>T (n=26)</th>
<th>R (n=23)</th>
<th>FO (n=22)</th>
<th>RO (n=27)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>TSCS</td>
<td>314.2</td>
<td>39.6</td>
<td>317.4</td>
<td>32.4</td>
</tr>
<tr>
<td>BDI</td>
<td>17.5</td>
<td>9.7</td>
<td>16.0</td>
<td>11.0</td>
</tr>
<tr>
<td>COMM</td>
<td>.80</td>
<td>.5</td>
<td>.90</td>
<td>.4</td>
</tr>
<tr>
<td>CONT</td>
<td>.90</td>
<td>.4</td>
<td>1.2</td>
<td>.4</td>
</tr>
<tr>
<td>LES</td>
<td>14.1</td>
<td>12.7</td>
<td>13.3</td>
<td>9.6</td>
</tr>
<tr>
<td>EXPT</td>
<td>18.5</td>
<td>2.7</td>
<td>18.4</td>
<td>2.5</td>
</tr>
</tbody>
</table>

(a) See Table 3

(b) T=treatment, R=replication, FO=first offender, RO=repeat offender
standard deviations). Similarly, mean BDI scores for both groups were close to those that Steer et al. (1987) derived from a sample of 300 outpatients diagnosed with DSM III major depression disorder.

For both FO and RO groups, mean self-concept scores were one standard deviation below the normal population (Fitts, 1965), but comparable to pretreatment TSCS means derived from the group of shoplifters in Semchuk's (1981) study.

It is difficult to relate mean commitment and control scores directly to earlier research on hardiness, as most studies used several different versions of the Hardiness test. However, in their 1988 study, Parkes and Kendall used the PVS and obtained means similar to those reported by Kobasa in a personal communication. In comparison the FO and RO pretreatment means for commitment and control were slightly higher, indicating that the shoplifters were less committed and felt less in control than Parkes and Kendall's sample of graduate students. Finally, with respect to stress levels, Zuckerman, Oliver, Hollingsworth, and Austrin (1986) report a mean LES score (i.e., mean number of events reported) of 4.46, based on a sample of 250 adults who were similar to the sample of shoplifters in this study on demographic variables such as age (mean, range), gender, education level, and marital and employment status. Compared to their sample, the shoplifters were more highly stressed, with a mean LES frequency of 8.71 (SD=5.40).
Correlation Matrix

An examination of the correlations among the outcome measures (see Table 5) revealed that the two hardiness subcomponents, commitment and control, were moderately correlated with measures of depression and self-concept, such that low commitment scores (i.e., strong sense of commitment) and low control scores (i.e., internal locus of control) were associated with fewer depressive symptoms, and higher self-concept. Furthermore, as expected, commitment and control were positively correlated with each other, while self-concept and depression yielded a strong negative correlation. These results are consistent with other studies (Ganellen & Blaney, 1984; Hull et al., 1987).

As mentioned earlier, age did not correlate with any of the measures above .30. Stress was moderately correlated with self-concept and depression on pretest scores, indicating that higher levels of stress were associated with lower levels of self-concept and higher depression. Only posttest scores of commitment and control yielded a moderate correlation with stress, where higher stress was associated with a higher commitment and control score (i.e., greater alienation and external locus of control).

Pretreatment Differences on Dependent and Ancillary Measures

A one-way MANOVA was used to test for pretreatment differences between the T and R groups, and between the FO and RO groups, on the dependent measures of
Table 5

**Intercorrelations Between Age and Outcome Measures Pre- and Posttest**

<table>
<thead>
<tr>
<th>Measures</th>
<th>Pretest</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AGE</td>
<td>LES</td>
<td>TSCS</td>
<td>BDI</td>
<td>COMM</td>
</tr>
<tr>
<td>AGE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LES</td>
<td>-.14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TSCS</td>
<td>.13</td>
<td>-.46</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BDI</td>
<td>.03</td>
<td>.51</td>
<td>-.76</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COMM</td>
<td>.16</td>
<td>.12</td>
<td>-.68</td>
<td>.62</td>
<td></td>
</tr>
<tr>
<td>CONT</td>
<td>.18</td>
<td>.02</td>
<td>-.43</td>
<td>.35</td>
<td>.71</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Posttest</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LES</td>
<td>-.15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TSCS</td>
<td>.30</td>
<td>-.26</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BDI</td>
<td>.02</td>
<td>.14</td>
<td>-.60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COMM</td>
<td>.16</td>
<td>.36</td>
<td>-.72</td>
<td>.60</td>
<td></td>
</tr>
<tr>
<td>CONT</td>
<td>.18</td>
<td>.41</td>
<td>-.63</td>
<td>.49</td>
<td>.77</td>
</tr>
</tbody>
</table>

*a* See Table 3
self-concept, depression, commitment and control, and the ancillary measures of stress and expectancy for change. The overall MANOVA for the T and R groups was nonsignificant, $F(6,42)=1.94$, $p<.10$, as was the overall MANOVA for the FO and RO groups, $F<1$. The results indicate that prior to treatment, subjects in the T and R, and FO and RO groups were similar in levels of self-concept, depression, commitment, and control orientation. Furthermore, these groups did not differ in the extent to which they reported stressful events of the past year as having had a negative impact on their lives; nor did they have different expectations for the effectiveness of treatment. Therefore, differential treatment effects could not be attributed to factors associated with either dependent or ancillary measures (see Table 4 for means and standard deviations).

**Treatment Effects**

Two-way (group by time) MANOVA's with two preplanned nonorthogonal contrasts using Dunn's test for significance at .025 (pre to post; post to follow-up), were performed on the dependent measures of self-concept, depression, commitment, and control. Only the preplanned contrasts are presented when discussing the time effect.

**Treatment vs. replication group.** A repeated measures, 2 x 3 (group by time) MANOVA with preplanned contrasts was performed to evaluate possible differential effectiveness of treatment for the T and R
groups, on the dependent measures: self-concept, depression, commitment, and control. The overall MANOVA group main effect was nonsignificant, $F<1$, as was the time (pre to post) effect, $F(4,21)=1.94, p<.14$. There was no significant group by time interaction for the pre- to posttreatment contrast, $F(4,21)=1.92, p<.15$, indicating that the groups did not change differentially over time.

To assess maintenance of change over the 6-week follow-up period, a post to follow-up contrast was used. The time effect was significant, $F(4,21)=5.60, p<.003$, and all univariate tests were significant (self-concept, $F(1,24)=13.63, p<.001$, depression, $F(1,24)=20.26, p<.001$, commitment, $F(1,24)=8.95, p<.01$, and control, $F(1,24)=10.98, p<.003$). The group by time interaction was not significant, $F<1$. For a summary of the MANOVA and univariate ANOVA's, see Table 6.

An examination of the means (see Table 7) indicated that from post to follow-up all dependent measures changed significantly in the expected direction (i.e., self-concept increased, depressive symptoms decreased, and commitment and internal control increased). Furthermore, there is no evidence to suggest that the groups changed differentially from pre-to posttreatment or at 6-week follow-up. Given these results, the T and R groups were collapsed for the purpose of examining within group differences: number of offences.
Table 6

Summary of Multivariate and Univariate Analysis for Outcome Measures by Treatment and Replication Group

<table>
<thead>
<tr>
<th>Effects</th>
<th>Multivariate</th>
<th>Univariate (p&lt;)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>p</td>
</tr>
<tr>
<td>Time (pre to post)</td>
<td>1.94</td>
<td>.14</td>
</tr>
<tr>
<td>Group by Time</td>
<td>1.92</td>
<td>.16</td>
</tr>
<tr>
<td>Time (post to follow-up)</td>
<td>5.60</td>
<td>.003</td>
</tr>
<tr>
<td>Group by Time</td>
<td>&lt;1</td>
<td>.66</td>
</tr>
</tbody>
</table>
Table 7
Means and Standard Deviations of Outcome Measures by Treatment and Replication Group

<table>
<thead>
<tr>
<th>Measures</th>
<th>TSCS</th>
<th>BDI</th>
<th>COMM</th>
<th>CONT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Treatment (n=14)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pretest</td>
<td>308.0</td>
<td>32.8</td>
<td>18.4</td>
<td>9.8</td>
</tr>
<tr>
<td>Posttest</td>
<td>320.3</td>
<td>34.9</td>
<td>13.4</td>
<td>7.9</td>
</tr>
<tr>
<td>Follow-up</td>
<td>331.1</td>
<td>35.5</td>
<td>8.1</td>
<td>6.8</td>
</tr>
<tr>
<td>Replication (n=12)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pretest</td>
<td>305.7</td>
<td>36.1</td>
<td>20.2</td>
<td>12.2</td>
</tr>
<tr>
<td>Post</td>
<td>307.2</td>
<td>39.2</td>
<td>17.9</td>
<td>11.1</td>
</tr>
<tr>
<td>Follow-up</td>
<td>332.2</td>
<td>40.4</td>
<td>9.8</td>
<td>8.8</td>
</tr>
</tbody>
</table>

See Table 3
First offender vs. repeat offender. To evaluate differential effectiveness of treatment for FO and RO subjects, a 2 x 3 (group by time) repeated measures MANOVA was computed for the dependent measures: self-concept, depression, commitment, and control. The time (pre to post) effect only approached significance, $F(4,21)=2.57, p<.07$. The group by time (pre to post) interaction approached significance, $F(4,21)=2.82, p<.05$. Although the usual procedure is to examine univariate Fs only if the multivariate $F$ is significant, in this case it was felt that an examination of the univariate Fs would be theoretically relevant as research in this area is new and exploratory. On the pre- to posttreatment contrast the univariate test for depression was significant, $F(1,24)=7.64, p<.01$, and the same test for self concept approached significance, $F(1,24)=2.51, p<.12$. Means on these two measures reveal a decrease in depression and an increase in self concept (see Table 8). Univariate $F$'s for commitment and control were nonsignificant From these analyses and Figure 1, it appears that subjects with only one offence showed significantly more improvement from pre- to posttreatment on measures of depression compared to subjects with two or more offences. Although not statistically significant, the group differences on measures of self-concept also warrant attention (see Figure 2). For a summary of the MANOVA and univariate ANOVA's, see Table 9.
Table 8

Means and Standard Deviations of Outcome Measures by First Offender and Repeat Offender Group

<table>
<thead>
<tr>
<th>Groups</th>
<th>TSCS</th>
<th>BDI</th>
<th>COMM</th>
<th>CONT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>First Offender (n=12)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pretest</td>
<td>307.9</td>
<td>37.6</td>
<td>19.6</td>
<td>10.9</td>
</tr>
<tr>
<td>Posttest</td>
<td>321.9</td>
<td>37.9</td>
<td>11.8</td>
<td>7.4</td>
</tr>
<tr>
<td>Follow-Up</td>
<td>336.2</td>
<td>33.4</td>
<td>6.0</td>
<td>4.8</td>
</tr>
<tr>
<td>Repeat Offender (n=14)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pretest</td>
<td>306.1</td>
<td>31.3</td>
<td>18.9</td>
<td>11.1</td>
</tr>
<tr>
<td>Posttest</td>
<td>307.6</td>
<td>35.9</td>
<td>18.6</td>
<td>10.4</td>
</tr>
<tr>
<td>Follow-up</td>
<td>327.8</td>
<td>40.9</td>
<td>11.4</td>
<td>8.9</td>
</tr>
</tbody>
</table>

See Table 3
Figure 1: Pre, post and follow-up means
Beck Depression Inventory
Figure 2: Pre, post and follow-up means
Tennessee Self Concept Scale

- 1st offenders
- repeat offenders
Table 9

**Summary of Multivariate and Univariate Analysis for Outcome Measures by First Offender and Repeat Offender Group**

<table>
<thead>
<tr>
<th>Effects</th>
<th>Multivariate</th>
<th>Univariate (p&lt;)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>p&lt;</td>
</tr>
<tr>
<td>Time (pre to post)</td>
<td>2.57</td>
<td>.07</td>
</tr>
<tr>
<td>Group by Time</td>
<td>2.82</td>
<td>.05</td>
</tr>
<tr>
<td>Time (post to follow-up)</td>
<td>5.09</td>
<td>.005</td>
</tr>
<tr>
<td>Group by Time</td>
<td>&lt;1</td>
<td>.87</td>
</tr>
</tbody>
</table>
To determine whether these changes were maintained over the 6-week follow-up, a post to follow-up contrast was used. The overall time effect was significant, $F(4,21)=5.09, p<.005$, as were the univariate $F$s for time (self-concept, $F(1,24)=11.62, p<.002$, depression, $F(1,24)=18.71, p<.001$, commitment, $F(1,24)=8.57, p<.01$, control, $F(1,24)=10.93, p<.003$). No significant group by time interaction was found, $F<1$, indicating that regardless of the number of prior offences, subjects continued to change similarly (i.e., increase self-concept, level of commitment and internal control, and reduce depressive symptoms) from post to follow-up (see Table 9 for means and standard deviations).

**Ancillary Measures**

**Posttreatment questionnaire.** In response to the posttreatment question "To what extent do you understand the reasons for your shoplifting?", the average overall rating on a scale from 1 to 5 ("very clear understanding" to "no understanding at all") was 1.7 for the FO group and 2.4 for the RO group. In response to the posttreatment statement "Overall, I would rate the program as poor, fair, good, or excellent", none of the 40 subjects who responded rated the SCP as poor, one rated it as fair, 13 as good and 26 felt the program was excellent.
Discussion

The purpose of this study was to evaluate the effectiveness of a group counselling program for shoplifters, in decreasing depressive symptoms, and in increasing self-concept, commitment to self, and internal locus of control. In general, it can be concluded that participation in the program resulted in significant and positive changes on all the outcome measures over the 12-week testing period. Unexpectedly, the most significant changes occurred from posttest to follow-up, suggesting that participants continued to benefit from the intervention following completion of the 6-week counselling program.

Group Differences for FO and RO

It was hypothesized that treatment would be more effective in enhancing hardiness, depression, and self-concept for those individuals with only one offence, compared to those with two or more offences. Specifically, it was predicted that first offenders would show a greater increase in level of self-concept, sense of personal commitment, and internal control, and a greater decrease in depressive symptoms, compared to repeat offenders, after having participated in the 6-week SCP. Contrary to what was expected, the multivariate analysis of variance for pre- to posttest measures revealed that the first offender (FO) and repeat offender (RO) groups did not change differentially over time. However, analysis of univariate F's indicate that treatment was more
effective for FO's, compared to RO's, on pre- to posttest measures of depression. Following six weeks of counselling, subjects with only one offence reported experiencing fewer depressive symptoms than did those with more than one offence. In fact, the mean depression score for the RO group did not change at all over the 6-week period (see Table 8). In accordance with Kendall et al.'s (1987) cutoff score criteria for the Beck Depression Inventory, both the FO and RO groups initiated treatment with a "moderate" level of depression ($M=17-30$). By posttest, the FO group had decreased their level of depression to "mild" ($M=10-16$), while the RO group did not change. At follow-up, the FO group fell within the "normal" range ($M=0-9$), and the RO group had dropped to "mild" depression.

The univariate $F$ test for group differences on measures of self-concept at posttest did not reach statistical significance. Compared to normative data reported by Fitts (1965), subjects in both the RO and FO groups fell well below normal ($M=345.57, SD=30.70$) prior to treatment intervention. By follow-up, the FO group displayed a level of self-concept that was closer to the normal population than did the RO group.

Semchuk (1981) reported a significant increase mean Total Positive scores from pre- ($M=313.3, SD=30.9$) to post intervention ($M=335.3, SD=35.2$) for a group of shoplifters exposed to an average of 21 weeks of groups counselling. Compared to Semchuk's results, the FO's
and RO's were lower in self-concept. By follow-up, the mean self-concept scores for FO's were comparable to Semchuk's posttest means. While the RO's improved by follow-up, they still remained lower in self-concept.

Calculations of Jacobson, Follette, and Revenstorff's (1984) conservative two-fold criteria for clinical significance revealed that a greater proportion of the FO group improved on measures of depression, compared with the RO group (66.7% vs. 42.9%), from pretest to follow-up. With regard to self-concept scores, no differences were found for the RO and FO groups (26.8% vs. 25%, respectively).

The univariate F tests for group differences from pre- to posttest on commitment and control did not reach statistical significance, thus the hypothesis that FO's would show greater improvement on these two measures from pre- to postintervention than would the RO's was not supported.

No significant differences were found between the RO and FO groups on pretreatment commitment and control scores indicating that RO's were not less hardy than FO's. Compared to Parkes and Rendall's (1988) results, both groups (FO and RO) of shoplifters displayed higher levels of alienation (less commitment) and appeared to be more externally controlled than a group of university students. By follow-up, the mean commitment and control scores for both groups were more comparable to those reported by Parkes and Rendall (1988). This unexpected similarity between the FO's and the RO's is
cause for speculation. One might question, for example, the authenticity of the classification for a first offender. In other words, is a shoplifter with only one criminal offence truly a first time offender? For some, this is certainly not the case. However, with the exception of self-reports, there is no reliable method of verifying or controlling for this variable.

Research on hardiness has focused on the relationship between a hardy personality, the experience of stress, and the presence of illness, both physical and psychological. Studies have not investigated the likelihood that this personality construct, and its three subcomponents, could change as a result of treatment intervention. However, evidence that short-term treatment can precipitate personality change has been documented (Goldmeier, 1976). The present study found that from pre- to postintervention, neither the FO nor the RO groups changed significantly on measures of commitment and control. However, both groups did show a significant decrease on the two measures from posttest to 6-week follow-up. That is, regardless of the number of prior offences, subjects significantly decreased their level of alienation (i.e., increased their sense of personal commitment) and external locus of control (i.e., increased internal locus of control) over the 12-week period from pretest to follow-up.
The lack of initial change on pre to post measures of hardiness could possibly be attributed to limitations in the PVS. For example, the wording of certain items makes an assumption that respondents are married and employed. Of the total sample of shoplifters, only 35% were married and 55% were employed.

Consistent with previous studies (Ganellan & Blaney, 1984; Hull et al. 1987), commitment and control were shown to be moderately correlated to depression and self-concept. However, the correlations between the hardiness components and stress, as measured by the LES, were low. Perhaps the LES does not accurately tap the notion that a particular subgroup of shoplifters are highly stressed. This may be explained in part by the fact that the LES asks subjects to identify those events which occurred over the past year, and to what extent those events were perceived as negative. The psychosocial stress experienced by shoplifters is often related to past experiences (i.e., from childhood) which have led to unproductive coping mechanisms. In this case, it might be limiting to simply examine a list of negative events, rather than focusing on ineffective coping strategies.

Although only one of the hypotheses was supported — that treatment was more effective in reducing depression scores for FO's compared to RO's — an important pattern was revealed regarding the overall beneficial effects of treatment. All subjects,
regardless of their criminal record, showed significant improvement on the four variables measured during the posttest to follow-up period. One possible explanation is that the effects of treatment had a delayed reaction time. Another, more likely explanation is that, of the 26 subjects who were tested at all three time intervals, 19 were involved in weekly group therapy sessions with the Elizabeth Fry's SCP during the post to follow-up period. As stated earlier, unlike subjects in the treatment (T) group, subjects in the replication (R) group were not given the option of terminating counselling after the initial 6-week program. All 12 were required to continue with a further six weeks of therapy. Of the 14 subjects in the T group, 7 continued for an additional six weeks of group therapy.

Given the small sample size, it was not possible to evaluate the differences between subjects who were exposed to 6 weeks of counselling compared to those who completed 12 weeks. One can only speculate that, although the 6-week SCP did, in fact, have positive effects on decreasing depression, the benefits of the program were greater when participation in group was extended to include an additional six weeks of therapy.

Some consideration must be given to the high dropout rate in this study. Of the total number of clients accepted into the SCP, only 50% agreed to participate in the study, and of those, 50% dropped out of the research by follow-up. Results were, therefore
based on 25% of the total client population. Although no statistical differences were found between subjects who dropped out and those who were available for testing, there was some evidence to suggest that the dropouts were more highly functioning initially. One could speculate that, if subjects who remained in the study were at extreme ends, a possible explanation for improvement on the dependent measures could be a regression to the mean.

The difficulty in initiating client participation in research might be a reflection of the highly sensitive nature of shoplifting. When jobs, family stability and reputations are at stake, the issue of confidentiality is of major importance. For some, no amount of assurance that results will be kept in the strictest confidence seems to suffice in alleviating the fears. Given that results were based on such a small percentage of the population, there is a degree of uncertainty as to the generalizability of the results.

It is well documented in the literature that this particular group of shoplifters is heterogeneous in nature. Although there may be some therapeutic advantages to creating homogeneous groups where clients are similar on such characteristics as age, gender, socioeconomic status, criminal record, for example, there are certain distinct benefits to treating shoplifters in one heterogeneous group. When participants are exposed to a vast pool of experiences,
this allows for greater understanding of the complexities of the behavior. A first offender can see the potential addictive nature of shoplifting, when confronted with the experiences of a habitual, repeat offender. The Welfare recipient, or uneducated, can realize that low income, or lack of formal education, are not the sole motivators for stealing, when the wealthy and professionals have been charged with the same offence. The 18 year olds may be less inclined to dismiss their behavior as simply a stage they will grow out of, when the 70 year olds have been sentenced by a Judge to attend the same shoplifting program.

**Program Evaluations**

From the self-evaluations completed at the conclusion of the 6-week SCP, it is evident that, in general, subjects gained a clear understanding of the factors motivating their criminal behavior. Comments suggest that many were able to recognize their shoplifting behavior as (a) an indirect and destructive way of coping with and expressing negative feelings (e.g., anger, guilt, helplessness, low self-esteem, powerlessness), (b) an unproductive way of meeting emotional and psychological needs such as love (sense of belonging, acceptance, community), freedom (having options, choices, control), power (a sense of competence, accomplishment, self-esteem), and fun (ability to experience pleasure, excitement, enjoyment), (c) similar in nature to other compulsive behaviors they engaged in -- overeating, drug/alcohol
abuse, overspending, sexual promiscuity, etc., and (d) having originated in a dysfunctional family system, where negative, often traumatic incidents were experienced. Subjects reported having learned to be more compassionate towards themselves and others, more assertive with their needs, and more direct in expressing their feelings.

The majority of subjects (97.5%) rated the program as either good or excellent. In general, subjects felt that the group offered a safe, supportive, non-judgmental environment, where a deep level of self-discovery and honest sharing could take place. They were appreciative of the counsellors' caring yet direct approach to confrontation, and in their ability to offer guidance without giving advice. Several suggestions for improvement were made: (a) to increase the length of each session by one or two hours, (b) to increase the length of the program itself, (c) to include one-to-one counselling, (d) to decrease the size of group to a maximum of 5 or 6 participants, and (e) to offer the program in other areas of the Vancouver lower mainland. A selection of subjects' comments derived from the program evaluations, can be found in Appendix E.

**Recidivism**

In an attempt to generate a measure that would most accurately reflect the true recidivism rate of this sample of shoplifters, all SCP participants (subjects and non-subjects) were asked to respond
anonymously to the following question, at posttest and follow-up: "Over the past six weeks, have you reoffended? If so, how many times?". At posttest, 75% (n=51) stated that they had not reoffended, and 25% (n=17) admitted to having shoplifted between 1 and 10 times. The total shoplifting incidents were 50, and only one resulted in an arrest by the police. By follow-up, 88.4% (n=38) said they had not reoffended, and 11.6% (n=5) reported having shoplifted between one and four times, with a total of 13 incidents. No re-arrests were reported.

Compared to other treatment studies which have reported recidivism measures of 0 to 2.5% (Conner, 1981; Edwards & Roundtree, 1982; Ordway, 1962; Semchuk, 1981; Solomon & Ray, 1984) the 11.6% recidivism rate reported at follow-up appears disproportionately high. It must be noted, however, that all the studies mentioned have relied solely on official arrest statistics, which are not representative of the actual number of shoplifting incidents (Gibbens, 1981; Kallis & Vanier, 1985; Kraut, 1976; Ray, 1987). A comparison with previously reported findings is, therefore, misleading. What is important to note is the decline in reoffences from posttest to follow-up. Given the anonymous nature of the recidivism questionnaire, it was not possible to distinguish between the FO and RO groups on number of reoffences. Future studies might include an item which addresses the question of prior convictions.
Conclusions, Limitations and Recommendations

In summary, the results showed that the SCP was more effective in decreasing depressive symptoms for individuals with no prior criminal record, compared to those with previous convictions. This distinction between first offenders and repeat offenders was not found for increased levels of self-concept, commitment, and control. These measures changed significantly, and in the expected direction, for both groups from posttest to follow-up. There are limitations in the ability to attribute these changes to treatment alone. Future studies should include a control group receiving no form of intervention, or a comparison group exposed to a different form of intervention. Moreover, there is a need to control the length of treatment subjects will be expected to complete. Certainly, there are ethical issues which must be taken into consideration, namely, delaying necessary treatment, and limiting the extent of counselling an individual can receive. Two limitations associated with the method of collecting data, should be mentioned. First, all measures were of a self-report nature. Second, the researcher's role included administering the questionnaires and conducting half of the treatment groups. This dual role could have affected the way in which subjects responded on the questionnaires (i.e., to appear better/worse, to please the researcher, or sabotage the research). Future studies should consider using counsellors who are not familiar with the specific
research hypotheses to administer treatment.

Limitations with respect to the generalizability of results include the high dropout rate and the reluctance shown by half the client population to participate in the research. Given that the majority of clients referred to the SCP are women, generalizability of treatment effects to men is limited. Future studies should generate a male sample size large enough to investigate the response of men to treatment.

In addition to contributing knowledge to the scarce body of studies on shoplifting, this study has contributed to the literature on hardiness. Although past researchers have identified shoplifters as experiencing considerable stress (Arboleda-Florez et al, 1977; Bradford & Balmaceda, 1983; Moore, 1983, 1984), the correlation between hardiness and LES scores was unexpectedly low. Future studies should include measures of coping strategies in lieu of, or in addition to measures of situational stress.

Furthermore, as suggested by Parkes and Rendall (1988), minor revisions in wording on the PVS would increase its value and application within research. Despite these limitations, it was shown that the hardiness construct can change over time following exposure to a treatment program. This particular focus, to the researcher's knowledge, is unique within the hardiness
literature. Finally, the hardiness construct is still viewed as conceptually related to a subgroup of shoplifters and worthy of future investigation.
References


Hardiness Institute, Inc. (1985). **Personal views survey**. Chicago: The Hardiness Institute, Inc.


APPENDIX A

Comparison Group Consent Form
APPENDIX B

Treatment and Replication Groups
### Treatment and Replication Groups

<table>
<thead>
<tr>
<th>Groups</th>
<th>n</th>
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<th>Non-subjects</th>
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</tr>
<tr>
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<td>11</td>
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<td>8</td>
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<td>3</td>
</tr>
<tr>
<td>9</td>
<td>9</td>
<td>7</td>
<td>2</td>
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<tr>
<td>10</td>
<td>9</td>
<td>6</td>
<td>3</td>
</tr>
</tbody>
</table>
APPENDIX C

Expectancy for Change Scale
1. "How confident are you that this program will be or has been successful in helping you deal with the shoplifting problem?"

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>Very much</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. How logical does this type of program seem to you as a way of dealing with a shoplifting problem?"

<table>
<thead>
<tr>
<th></th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>Very much</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. How confident are you in recommending this program to others who are dealing with the same problem?"

<table>
<thead>
<tr>
<th></th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>Very much</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX D

Intake Form
Counselling Contract
Subject Informed Consent Form
<table>
<thead>
<tr>
<th><strong>NAME:</strong></th>
<th><strong>DATE:</strong></th>
<th><strong>BIRTHPLACE:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>(PRINT SURNAME)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(FIRST NAME)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BIRTHDATE:**

**PERMANENT ADDRESS**

(OR NEAREST FRIEND OR FAMILY)

**PRESENT ADDRESS**

**SOURCE OF CURRENT REFERRAL**

**PLACE OF EMPLOYMENT**

**OCCUPATION**

**EDUCATION**

**MARRITAL STATUS**

**CITIZENSHIP**

**CURRENT CHARGE**

**DATE AND COURT OF IMPENDING CHARGES**

**SENTENCE(S) RECEIVED**

**PREVIOUS RECORD AND DISPOSITION**

**LAWYER**

**ADDRESS**

**PHONE**

**POSTAL CODE**

**PROBATION OFFICER**

**ADDRESS**

**PHONE**

**POSTAL CODE**

**OTHERS**

**OTHER INFORMATION**

---

2.86
COUNSELLING CONTRACT

Group Counselling:
  Registration Fee $__________
  Orientation Session Fee $__________
  Fee per Group Session $__________

Total Group Sessions (________ X $________) $________

Total Cost $________

Workshop $________

Individual Counselling per session $________

Marital/Family Counselling:
  per client per session $________
  per additional person $________

Written Reports:
  Assessment $________
  Progress $________

* FEES ARE NON-REFUNDABLE *

Payment of fees must be made weekly before the counselling session begins or monthly in advance.

A place is kept for each member until group completion. We do not accept new members to fill absences. Therefore, your commitment to a weekly fee is essential and adjustments in fees will not be made.

Group Participants please note: Regular attendance is essential in order for an individual to make good progress and for the group to function effectively. It is also essential that group members be on time for each session.

ORIENTATION TIME: ________________________________

GROUP TIME: ________________________________

NUMBER OF GROUP SESSIONS: ______

GROUP COUNSELLOR: ________________________________

I have reviewed this contract and agree to the above conditions.

CLIENT _____________________ DATE __________

COUNSELLOR _____________________ DATE __________
APPENDIX E

Self-evaluation

Program Evaluation

Anonymous Recidivism Rate Record

Social Support Questionnaire
THE ELIZABETH FRY SOCIETY OF BRITISH COLUMBIA
VANCOUVER

SELF-EVALUATION

CODE # ___________________ DATE ___________________

1. What have I learned about myself in this counselling program?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. What changes have I made?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3. What effects did these changes have on my family/others?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4. Did I meet my goal? If not, why not?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

5. To what extent do I understand the reasons for my shoplifting?

1  2  3  4  5
Very clear  somewhat  no understanding
understanding  at all

6. To what extent is it likely that I will re-offend?

1  2  3  4  5
Not at all  somewhat  Very likely
likely

7. During the course of the program, what has my progress been?

1  2  3  4  5
No progress  somewhat  Very high degree
at all  of progress
SELF-EVALUATION

1. What have I learned about myself in this counselling program?

Frequency

23 increased awareness of self and feelings (e.g., self-critical, guilt, low self-esteem, helplessness, abandonment, low self-confidence, anger)

18 recognizing the need to take control and responsibility in life versus withdrawing, avoiding, being a victim

9 shoplifting is one way of coping with negative feelings, problems, stress

5 shoplifting is one way of meeting emotional and psychological needs

4 need for more self-awareness

3 shoplifting is a symptom of emotional problems

2. What changes have I made?

Behavioral

Frequency

9 more assertive with needs

8 increased support system (professional and non-professional)

6 increased meaningful activities

5 stopped shoplifting

4 increased communication with others

Cognitive

19 increased self-acceptance and understanding

11 taking responsibility and control

6 changing negative/destructive self-talk

4 no conscious changes

3. What effects did these changes have on my family and others?

Frequency

15 none

10 more positive relations

9 more supportive attitude

7 greater acceptance, respect, understanding

5 happier

2 more tension, anger

1 less dependent

4. Did I meet my goal? If not, why not?
<table>
<thead>
<tr>
<th>Frequency</th>
<th>Goals</th>
<th>Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>no goals set</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>no, still working on goals—need more time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>control shoplifting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>reduce stress/guilt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>less dependent</td>
<td></td>
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</tbody>
</table>
THE ELIZABETH FRY SOCIETY OF BRITISH COLUMBIA
VANCOUVER

GROUP COUNSELLING PROGRAM EVALUATION

1. OVERALL, I WOULD RATE THE PROGRAM AS
   - POOR
   - FAIR
   - GOOD
   - EXCELLENT

2. DESCRIBE THE MOST POSITIVE ASPECTS OF THE PROGRAM.

3. DESCRIBE THE MOST NEGATIVE ASPECTS OF THE PROGRAM.

4. HOW DID YOU FEEL ABOUT THE COUNSELLOR/GROUP LEADER?

5. SUGGESTIONS FOR IMPROVEMENT IN TERMS OF PROGRAM CONTENT AND LEADERSHIP.

6. OTHER COMMENTS
Group Program Counselling Evaluation

1. Describe the most positive aspect of the program.

Frequency

- 23 sharing feelings, honesty and trust
- 21 supportive, non-judgemental group
- 13 increased self-awareness/raised consciousness
- 10 feeling accepted
- 7 understanding shoplifting behavior
- 5 professional help
- 4 alternate coping strategies

2. Describe the most negative aspects of the program.

Frequency

- 13 none
- 9 structural (i.e., too short, too large, too distant)
- 6 talking about personal/painful experiences
- 5 other group members (i.e., monopolizers, drop-outs)

3. How did you feel about the counsellor/group leader?

Frequency

- 18 supportive, empathetic, warm, understanding
- 12 skilled, professional (e.g., probing, feedback, insights, listening, guiding; clear)
- 7 non-judgemental, genuine
- 4 too probing

4. Suggestions for improvement in terms of program content and leadership.

Frequency

- 23 none
- 5 more sessions
- 3 longer sessions
- 2 smaller group
- 2 follow-up
- 2 more "homework", handout material
- 2 more "fun" activities
- 2 more on self-esteem, goal setting
1. Over the past six weeks, have you re-offended?
   
   _No
   
   _Yes    How many times? ______

2. Were you apprehended?
   
   _No
   
   _Yes    How many times? ______
1. Over the past six weeks, to what extent do you feel you have received emotional support from:
   a) Family
      1 2 3 4 5
      not at all somewhat very much
   b) Friends
      1 2 3 4 5
      not at all somewhat very much
   c) Church
      1 2 3 4 5
      not at all somewhat very much
   d) Other (specify)
      1 2 3 4 5
      not at all somewhat very much

2. Over the past six weeks, how often have you engaged in the following forms of professional counselling (e.g. psychiatrist, psychologist, counsellor, social worker):
   a) Individual
      __never
      __less than once a week
      __once a week
      __more than once a week
   b) Marital/Relationship
      __never
      __less than once a week
      __once a week
      __more than once a week
   c) Family
      __never
      __less than once a week
      __once a week
      __more than once a week
   d) Group
      __never
      __less than once a week
      __once a week
      __more than once a week
APPENDIX F

Clinical Significance for BDI Scores
Clinical Significance for TSCS Scores
### Clinical Significance for BDI Scores

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<th>RO</th>
<th>FO</th>
<th>RO</th>
<th>FO</th>
<th>RO</th>
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<tbody>
<tr>
<td>Improved</td>
<td>6</td>
<td>31.6%</td>
<td>6</td>
<td>26.1%</td>
<td>5</td>
<td>41.7%</td>
</tr>
<tr>
<td>No Change</td>
<td>10</td>
<td>52.6%</td>
<td>12</td>
<td>52.2%</td>
<td>7</td>
<td>58.3%</td>
</tr>
<tr>
<td>Deteriorated</td>
<td>3</td>
<td>15.8%</td>
<td>5</td>
<td>21.7%</td>
<td>0</td>
<td>0.0%</td>
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</table>

freq % freq % freq % freq % freq % freq %
### Clinical Significance for TSCS Scores

<table>
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<th>Pre-Followup</th>
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<td>freq %</td>
<td>freq %</td>
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<td></td>
<td>2 10.5</td>
<td>2 8.7</td>
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<td>15 79.0</td>
<td>20 87.0</td>
<td>9 75.0</td>
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