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APPENDIX

Resource and Guide to Terms and Concepts of the
Pre-Sentence or Post-Sentence Evaluation Standards

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I. **Accountability**

A. Definition

Accountability can be defined as “taking full responsibility for the effects of one’s actions.” In domestic violence intervention, there are many aspects of accountability to consider, and there are many ways to assess or measure it at various points of treatment. Accountability is often linked to sincere apology, and full responsibility always must be individual and unilateral (i.e., taking full unilateral responsibility for the effects of one’s own words or actions regardless of the influence of anyone else’s words or actions). Accountability usually precedes genuine empathy, and it is often inhibited by unhealthy and self-limiting shame as differentiated from appropriate guilt. Low or limited levels of offender accountability can be correlated with high or extensive risks of offender reoffense. Low levels of empathy for the victim can also be correlated with high incidence of recidivism by the offender. (Bancroft, 2002).

B. Assessment

Accountability can be assessed by considering:

1. Does the offender take responsibility for his/her abusive actions in the police report of the incident? In the victim report? In the other witness report(s)?
2. Does the offender take responsibility for his/her own actions regardless of the actions for the victim or of witness(es)?
3. Does the offender take responsibility for any other reports of abuse in the relationship? In other relationships?
4. Is the offender willing to talk in treatment about his/her acts of abuse?
Patterns of abuse?
5. Is the offender willing to write about his/her abusiveness?
6. Is the offender willing to receive input/feedback/confrontations from the therapist about the abuse? From the group?
7. Is the offender able to identify personal deficiencies/challenges/struggles which have played a role in his/her abusiveness?
8. Is the offender able to identify and describe personal tools/strategies/interventions to be used to prevent future abusiveness?
9. Is the offender willing to commit to not abuse again?

C. Measurement

Accountability can be measured by:

1. Offender verbal statement of accountability

2. Offender written statement of accountability
3. Offender written “as-if” letter of accountability (addressed to the victim but not to be shared with the victim unless requested by and helpful to the victim, based on approval of victim advocate)

Accountability should be assessed repeatedly:

1. At intake
2. Prior to any change in level of treatment
3. Following any change in risk of reoffense
4. Prior to discharge from treatment

II. Motivation for Treatment

A. Definition

Motivation or “readiness” for treatment refers to the degree to which an offender engages in the process of change. It includes considerations of how receptive the offender is to learning new information and receiving feedback about his/her behavior. Utilizing concepts from the Stages of Change model (Prochaska *et al.*, 1994) the process of change may be understood to occur through several “stages” involving different thought processes, emotional responses, and behaviors. Though originally applied to substance abuse treatment, the stages of change model has since been applied to domestic violence treatment (Levesque *et al.*, 2000); Eckhardt *et al.*, 2004).

In models of domestic violence interventions, motivation for treatment or change refers to an individual’s “contemplation” of problematic or abusive behaviors, his or her receptivity toward this self-reflection, and the acknowledgement of the rationale or the benefits of changing behaviors, such as a reduction in the negative impact on themselves, others, or society in general. Thus, self-awareness and empathy will increase motivation to change. Additionally, a tendency to blame others for one’s actions will decrease motivation for change, as others are seen as the “real” problem.

B. Assessment and Measurement

The following can be considered in assessing an offender’s level of motivation:

1. What is the offender’s attitude toward treatment? Is he/she compliant? Resistant? Open? Defensive? Dismissing?
2. How receptive is he/she to learning new information and receiving feedback about his/her behavior?
3. How willing is he/she to acknowledge and examine the effects of his/her behavior on others?
4. What is his/her level of personal insight?
5. Does he/she tend to externalize or blame others for his/her behavior?

6. Are there factors, such as a significant lack of empathy, which might interfere with a treatment alliance or engagement in the treatment process?

Consider the following for assessing motivation for change:

1. The Transtheoretical Model (TTM) and the Stages of Change (DiClemente, 1992).
2. Another resource that may be of assistance is the work of Levesque who developed the URICA-DV that utilized the stages of change with domestic violence offenders. (Levesque *et al.*, 2000).

C. Treatment Considerations

1. Providers may want to utilize the Motivational Interviewing model (Rollnick, 1995) that has shown utility with resistant clients.
2. The resource (Eckhardt *et al.*, 2004) may be of assistance in the use of the Stages of Change and domestic violence offenders:

III. Amenability to Treatment

A. Definition

Amenability to domestic violence treatment refers to the offender's capacity to effectively participate, function, and understand treatment concepts. Significant cognitive (e.g. thinking) impairments can preclude an individual's ability to sufficiently pay attention during treatment sessions, learn new information, and/or self-reflect. Similarly, some cases of acute mental illness may interfere with participation due to the presence of impaired reality testing (e.g. delusions or hallucinations).

While some impairments may be the transient effects of medications or some other treatable physiological condition or disease process, including mental illness, other conditions may be more longstanding or permanent deficits, such as in the case of mental retardation, dementia (, severe learning disabilities, or acquired brain dysfunction (e.g. traumatic brain injury). The question then arises as to whether the individual has the current capacity to effectively participate in and benefit from treatment in light of these deficits.

The role of the treatment provider is to identify what limitations exist and distinguish those that require accommodation and those that would indicate a lack of amenability. If the treatment provider can accommodate, or refer to a treatment provider who can accommodate limitations, the offender is expected to participate in treatment.

B. Assessment

Amenability to treatment may be assessed as part of the mental health assessment, though a more in depth and specific evaluation may be warranted in some cases.

Various cognitive abilities should be assessed and accommodated (where appropriate) relative to the ability to effectively participation in treatment, including:

1. attention
2. memory (e.g. the ability to learn new information and/or to recall previously learned information)
3. language comprehension
4. reading comprehension
5. verbal reasoning, and abstract thinking or the ability to understand similarities between events and to learn from past experience)
6. executive functioning (e.g. planning, organizing, sequencing)

Conditions that should be assessed and accommodated (where appropriate) relative to effective offender participation due to associated cognitive impairments include, but are not limited to:

1. Mental retardation (significantly sub-average intellectual functioning with concurrent deficits in present adaptive functioning)
2. Dementia (a progressive decline in cognitive functioning)
3. Acquired brain dysfunction (e.g. traumatic brain injury)
4. Effects of medications and/or other physical conditions and treatments

Acute untreated or poorly managed mental disorders may also interfere with an individual's capacity to participate in domestic violence treatment, particularly in a group setting. Providers will need to assess whether these can be accommodated in treatment. This might include but are not limited to:

1. schizophrenia with prominent symptoms of hallucinations, delusions, or disorganization;
2. bipolar disorder with acute mania;
3. major depressive disorders with the significant suicidal ideation;
4. social phobias which interfere with group treatment;
5. post traumatic stress disorder (PTSD) with severe symptoms of dissociation and/or intrusive re-experiencing;
6. Significant psychopathy or antisocial personality features

Though research has varied on the effectiveness of treatment of psychopathy (Gacono, 2000; Skeem *et al*, 2003; Vien and Beech, 2006), a number of studies have identified various nonspecific treatments that are considered inappropriate

with psychopathic offenders, and may even contribute to an increase in violent recidivism following treatment (Hare *et al.*, 2000; Rice *et al.*, 1992). Generally, many psychopathic offenders may be considered inappropriate for domestic violence interventions as they tend to be disruptive during the treatment process in the absence of very highly structured treatment settings, and may be more likely to learn more effective ways to manipulate, deceive, and use others rather than change their violence-prone behaviors.

Regarding offenders with disabilities, please refer to Standard 10.10 Offender with Disabilities or Special Needs.

C. Measurement

Cognitive screenings may be conducted as part of a mental health evaluation using common assessment instruments including but not limited to:

- The Mini Mental Status Examination (MMSE)
- The Galveston Orientation Assessment Test (GOAT)

The more detailed assessment of cognitive status often involves neuropsychological tests, IQ tests, and/or achievement tests which evaluate specific clinical questions and abilities. Such evaluations are typically completed only by professionals with specialized training in the assessment of cognition, such as neuropsychologists, developmental or educational psychologist, and/or speech-language pathologists.

Mental disorders may be measured using the same instruments used during a mental health status assessment (e.g. Beck Depression Inventory, MMPI-2, MCMI-3), though psychopathy is commonly measured using the Hare Psychopathy Checklist (PCL-R) which requires specialized training.

D. Treatment Considerations

1. Accommodations for illiterate, hearing or visually impaired offenders
2. Mental health and/or monitoring of medication management
3. In cases where the provider determines that an offender is not amenable to treatment, according to these guidelines, then the provider shall refer the offender back to court with an alternative recommendation for treatment. The provider shall provide verifiable documentation to support the findings.

IV. Criminogenic Needs

A. Definition

Criminogenic needs is a term used to reference offender dynamic factors such as substance (alcohol and other drugs) abuse, antisocial attitudes, personality traits, associates, employment, marital and family relationships and other theoretically items that were statistically shown to be correlated with criminal conduct and amenability to change. (Andrews and Bonta, 1994). Criminogenic needs are aspects of a person or his/her situation that when changed, are associated with changes in criminal behavior (Bonta, 2002). As dynamic risk factors, criminogenic needs may be understood as contributing towards criminal behavior (e.g. domestic violence), and if effectively addressed, should decrease level of risk. (Andrews, 1989, Andrews and Bonta, 1994; Bonta, 2002).

Non-criminogenic needs are factors that may change but are not empirically related to a reduction in recidivism. Some examples are weight problems, self esteem issues, or witness to domestic violence as a child.

B. Assessment

Assessment instruments exist that capture information about these dynamic factors. Examples are the Level of Service Inventory (LSI) that is often utilized by probation. The Spousal Assault Risk Assessment (SARA) is another example of a validated reliable instrument that is designed to be used as a clinical guide.

Various areas may be assessed to identify an offender's criminogenic needs, including:

1. substance abuse
2. antisocial attitudes (e.g. minimization, denial, or blaming)
3. low levels of satisfaction in marital and family relationships
4. antisocial peer associations
5. identification and association with antisocial role models
6. poor self-control and self-management
7. poor problem solving skills
8. poor social skills
9. unstable living environments
10. financial problems
11. unemployment
12. social isolation
13. mental health

C. Measurement

A variety of measures have been created to assess criminogenic needs. Some are more broad (e.g. risk-needs classification instruments such as the LSI-R), while others are more specific (e.g. measures of substance abuse, anger and hostility, antisocial attitudes). Examples of more specific measures include:

1. the Addiction Severity Index
2. the Simple Screening Inventory (SSI)
3. the Aggression Questionnaire
4. the Criminal Sentiments Scale (CSS)

D. Treatment Considerations

1. Substance abuse assessment and treatment
2. Development of pro-social attitudes
3. Development of pro-social support system
4. Monitoring of employment status in collaboration with probation
5. Mental health assessment and treatment

V. Risk Principle and Needs Principle

A. Definition

The risk principle is an endorsement of the premise that criminal behavior is predictable and that treatment services need to be matched to an offender's level of risk. Thus, offenders who present a high risk are those who are targeted for the greatest number of interventions. When offenders are properly screened and matched to appropriate levels of treatment, recidivism is reduced by an average of 25 to 50 percent (Carey, 1997).

The needs principle pertains to the importance of targeting criminogenic needs and providing treatment to reduce recidivism. Criminogenic needs/dynamics risk factors are rehabilitative targets for treatment (Andrews and Bonta, 1994).

B. Treatment Considerations

Under treatment high-risk offenders is not effective and over treatment low risk offenders is not effective. Therefore the offender risk needs to be matched to the level of treatment interventions. Additionally, when criminogenic needs are addressed in treatment, there is likelihood of a reduction in recidivism.

VI. Responsivity Principle and Factors

A. Definition

Responsivity factors are those factors that may influence an individual's responsiveness to efforts that help them change their attitudes, thoughts and behaviors. These factors may or may not be offender risk factors or criminogenic needs. These factors play an important role in choosing the type and style of treatment that would be most effective in bringing about change for offenders (Andrews and Bonta, 1994).

B. Assessment (Bonta, 2000)

Thinking Style: It will be helpful to gather information regarding the offender's thinking style. Consider the following questions in your assessment:

1. Are they more verbally skilled and quick to grasp complex ideas or are they more concrete and simple in their thought processes?
2. Will they be more responsive to treatment that requires abstract reasoning skills, or will they be more responsive to more simple and direct treatment modalities?

Anxiety regarding treatment: Evaluate whether the offender is anxious about treatment. Consider the following questions:

1. Are they likely to respond better initially to individualized versus group treatment?
2. Is there some type of acute mental disorder such as delusions or a thought disorder, which may need to be managed in order for the offender to respond to treatment?

Personality dynamics: Consider whether there are personality dynamics that might influence the offender's response to treatment.

1. For example, many individuals with antisocial personality features tend to be more responsive to treatment that is highly structured as opposed to a more process-oriented style. Given a chronic level of low stimulation, such individuals may need a treatment style that is more active and stimulating as opposed to open discussion and quiet readings.
2. For offenders with various personality clusters, how can these features be utilized in treatment to assist the offender in engaging in treatment? For example, can reinforcement of changes be emphasized with the narcissistic offender to focus on his/her successes in treatment? Can the dependent offender learn to depend more on strategies learned in treatment and depend less on the victim?

Learning style: Consider the offender's learning style:

1. Is the offender an auditory or visual or kinesthetic (experiential) learner?
2. Would the offender learn better in a role play exercise or a reading assignment?

Personal and demographic: Consider whether the offender will respond better to treatment when other personal and demographic factors are considered and addressed. This might include geography, gender, ethnicity, language, sexual orientation, age, and/or other cultural factors.

VII. Lethality Assessment

Cite one or two of the studies that identify that women and men kill for different reasons.

Assessment of dangerousness or lethality risk of the offender is recommended by most experts. (Ganley, 1989; Hart, 1988, Campbell, 2001).

A. Assessment, Measurement

Information should be gathered from multiple sources. Specifically for female victims, consider the Danger Assessment Instrument. (Campbell, 2003) or Barbara Hart (1990).

B. Treatment Considerations

1. Safety planning and education regarding risk factors and lethality factors with victims
2. Ongoing risk assessment from multiple sources
3. Monitoring of high risk offense for indicators that offender is escalating/de-escalating, becoming more stable or decompensating

VIII. Mental Health Assessment

A. Definition

In the context of domestic violence offender treatment, mental health “assessment” refers to the process of assessing an offender’s current mental health status and identifying any factors that might directly impact level of risk for future violence or re-offense. Some mental health conditions may also indirectly increase risk by interfering with effective involvement in interventions (e.g. social anxiety).

Whereas a mental health assessment tends to cover a fairly broad domain, a mental health “evaluation” refers to a more formal procedure, commonly requested by the court or other referral source, that typically targets a specific clinical question or issue (e.g. capacity to participate in treatment). A mental health evaluation may incorporate various sources of information, including psychological testing, into a written report that details significant findings.

B. Assessment

Consideration should be given to whether or not there are contributing factors of the offender’s mental health history or current status that may increase level of risk. Various aspects of an offender’s mental health history or current status that should be assessed include, but are not limited to:

1. Psychotic disorders (e.g. schizophrenia, schizoaffective disorder, delusional disorder)
2. Mood disorders (e.g. bipolar disorder, major depression)
3. Anxiety disorders (e.g. post-traumatic stress disorder, panic disorder, obsessive compulsive disorder)
4. Personality disorders with anger, impulsivity, and poor behavioral controls? (e.g. DSM Cluster B personality disorders, or psychopathic/antisocial, borderline, narcissistic, or histrionic personality features). Personality disorder has also been identified as a risk factor for spousal assault (Magdol, et al, 1997). Further, personality disorders have been associated with increased risk for criminal behavior, including violence and violent recidivism (Hare, 1991; Harris *et al.*, 1993; Sonkin, 1987), and recidivistic spousal assault (Bodnarchuk *et al.*, 1997; Gondolf, 1998).
5. Past neurological trauma and/or current neurological symptoms

When mental health factors are identified in the assessment, a variety of issues should be considered:

1. What is the severity of the mental health condition?
2. Are symptoms current or historical?

3. Have symptoms ever resulted in psychiatric hospitalization?
4. Has an aspect of the mental disorder (ie, a delusion or hallucination) motivated or triggered past violence toward others?
5. Has an aspect of the mental disorder (ie, a delusion or hallucination) motivated or triggered past suicide attempts or threats?
6. To what extent do symptoms disrupt or interfere with aspects of the offender's everyday life? (e.g. work, relationships)
7. Is there a concurrent substance abuse disorder that contributes toward an increase or worsening of symptoms?
8. Is the offender actively compliant with medication management?

The empirical literature suggests a positive correlation between psychosis and past violence (Swanson, Holzer, Ganju, and Jono, 1990; Monahan, 1992), and that treated psychosis is associated with a decreased risk for violent recidivism (Rice, Harris, and Cormier, 1992). Psychotic and/or manic symptoms are associated with an increased short-term risk for violence (Binder and McNeil, 1988; Link & Stueve, 1994), and that these symptoms may be associated specifically with spousal assault (Magdol *et al.*, 1997). Additionally, certain anxiety disorders may interfere with effective participation in treatment (see Amenability to Treatment).

As most, if not all DSM IV Axis I disorders can now be effectively treated with medication, some method of psychotherapy, or both, treatment becomes a significant mediating factor for whether or not the disorder contributes toward ongoing risk of future violence or re-offense. Intervention is likely to work, though in some cases long-term treatment is the only intervention that will work. Assessment questions related to mental health treatment may include:

1. Is the offender currently in treatment? (e.g. medications, psychotherapy)
2. How long has the offender been in treatment?
3. Is the offender compliant with treatment?
4. Has treatment been effective or helpful?
5. Has the offender been involved in any violent or abusive behavior while the offender was in treatment?
6. Are offender symptoms currently being managed?

C. Measurement

Use of psychometric instruments:

All providers should be able to screen and/or do a preliminary assessment. When further assessment is needed the provider will perform this if qualified or refer to a provider who is qualified.

A variety of psychometric instruments or tests may be useful to help in the assessment an offender's mental health status. Some advanced and lengthy instruments, such as the MMPI-2, are restricted in their use based upon clinical

training qualifications or specific coursework involving a given instrument. Other briefer instruments, such as the Beck Depression Inventory, have less specialized training requirements. Such instruments are typically used to supplement or augment collateral information, such as the clinical interview.

A few possible instruments that may be used to assess mental health status include, but are not limited to:

1. MMPI-2 (Minnesota Multiphasic Personality Inventory)
2. MCMI-3 (Millon Clinical Multiaxial Inventory)
3. PAI-2 (Personality Assessment Inventory)
4. Mini Mental Status Exam (MMSE)
5. Beck Depression Inventory (BDI-2)
6. Beck Anxiety Inventory (BAI)

D. Other Considerations:

1. Personality Clusters

Since studies by Hamburger and Hastings in 1986, research has indicated that domestic violence offenders tend to possess several types of personality clusters when tested with the Millon Clinical Multiaxial Inventory (MCMI). The main clusters exhibited by domestic violence offenders are:

- a) Dependent, which constitutes about 35% of the offender population
- b) Narcissistic, which constitutes about 50% of the offender population
- c) Antisocial, which involves a multitude of various associated personality elevations, and constitutes about 15% of the offender population

Though research has suggested that personality disorders are not correlated with risk of reoffense, clinical expertise shows that offenders with certain personality elevations respond better to treatment when the clinical interventions are presented in a manner consistent with their specific personality.

2. A history of significant central nervous system trauma (e.g. traumatic brain injury, Seizures or epilepsy, brain disease) has been identified as another factor that can contribute toward impulsive violence or aggressive behavior (Meloy, 2000). More specifically, frontal and/or temporal lobe dysfunction has been shown to be associated with various types of violent offending (Raine 1993; Raine, Raine & Buchsbaum, 1996).

IX. Principles for Differentiating Treatment (Bitten)

A. Theories and Examples

There are a variety of constructs described below that can be used for differentiating offender treatment. The following principles may be applied to more broadly differentiated groups of offenders (e.g. offenders differentiated by language, male or female GLBT offenders, or male or female heterosexual offenders.)

1. The first principle for differentiating treatment, repeatedly found to be valid in criminal justice interventions, is that higher and lower risk offenders should not be treated together. (Lowencamp and Latessa, 2004).
 - a. Note that “lower risk offenders” can be more reliably identified with the use of researched risk assessment procedures (e.g. SARA) than by clinical judgment alone.
 - b. Efforts should be made to accentuate the natural strengths of lower risk offenders group. This includes avoiding overly intensive and costly intervention, and avoiding exposure to more anti-social or violent associates, or utilizing overly remedial programming. It is also important promote and strengthen natural pro-social networks.
2. A second principle for differentiating treatment is that anti-social offenders need different programming than other high and medium risk offenders.
 - a. Anti-social offenders should be treated in a separate group because they will contaminate other more pro-social members by interfering with group process.
 - b. Anti-social offenders need a different treatment approach that focuses on their self-interest. Treatment should be more didactic and less process-oriented than other groups. Treatment needs to continue to be as strongly oriented towards a containment model as possible (and which endeavors to disrupt anti-social support networks). Treatment should not include victim empathy content that may be used against victims by these offenders.
3. A third principle for differentiating treatment for other medium and high-risk offenders involves the differentiation of offender treatment based on criminogenic needs. Offenders with severe substance abuse problems, problematic personality traits, entrenched power and control issues, mental health disorders, etc. can be placed in different programming based on the resources and/or numbers of offenders in any given district. Examples are:
 - a. A domestic violence/substance abuse program for people with prominent substance abuse involvement and resulting lifestyle instability.
 - b. An “enhanced domestic violence treatment program” which is a catch-all group for medium and high risk offenders who are not highly anti-social.

- c. Criminogenic needs will also guide decision-making regarding ancillary or conjunctive programming. For example, an offender with Bipolar Disorder may need to be medically stabilized prior to participating in domestic violence treatment. An unemployed offender may need vocational assistance in addition to domestic violence treatment.
- 4. While offender responsivity issues should be considered in regard to making decisions about programming at all of the above levels, when possible responsivity can also guide differentiation in treatment programs.
 - a. A cognitive/behavioral approach should be utilized regardless of other responsivity factors.
 - b. Staff expertise, strengths, and/or approach can be matched with client needs. For example, anxious clients do poorly with highly confrontive therapists; less experienced therapists may be more easily manipulated by anti-social offenders.
 - c. Intellectual levels/learning styles can be further accommodated.

X. Multi-disciplinary Treatment Team (MTT)

A. Definition

The Multi-disciplinary Treatment Team (MTT) includes, at a minimum, three members: the supervising criminal justice agency (e.g. probation officer), the approved provider, and the treatment victim advocate. Initial placement into an identified level of treatment is determined at the initial evaluation and must be approved by consensus of the Multi-disciplinary Treatment Team (MTT). Other professionals relevant to a particular case may be also be a part of the MTT.

Team management of offenders through the MTT is purposefully strengthened in these Standards. The goal is consensus for all decisions. The DVOMB understands that the supervising agent for the court will have the ability to impact the decision of the team. In these cases, the other team members shall justify in writing, utilizing offender competencies and risk markers, the reason for their recommendations for treatment that may be submitted to the probation officer or the court. If there is a conflict within the MTT, it is recommended that the following decision process be utilized:

1. First discussing among MTT members
2. Second, by contacting the probation supervisor and requesting a meeting to review the recommendations of all members of the MTT
3. Third, requesting the court to review the recommendations of all MTT members.

The treatment victim advocate role:

The victim advocate working with the treatment provider is a critical member of the MTT. This includes cases in which the victim cannot be contacted. Whether or not the victim has been contacted, the victim advocate still has expertise and perspectives that are valuable to the MTT related to offender treatment planning and management.

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