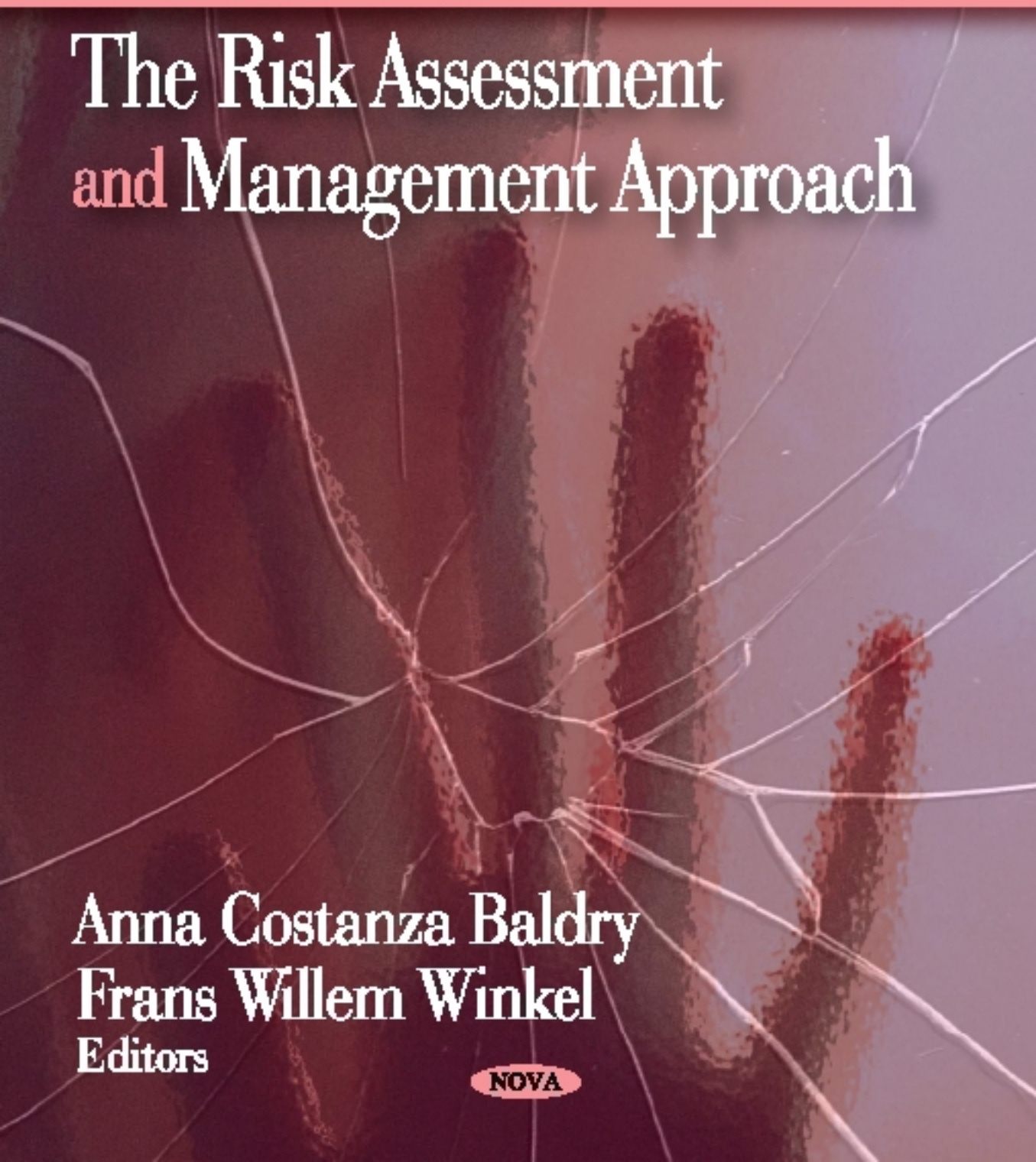
Intimate Partner Violence Prevention and Intervention

The Risk Assessment and Management Approach



Anna Costanza Baldry
Frans Willem Winkel
Editors

NOVA

INTIMATE PARTNER VIOLENCE PREVENTION AND INTERVENTION: THE RISK ASSESSMENT AND MANAGEMENT APPROACH

INTIMATE PARTNER VIOLENCE PREVENTION AND INTERVENTION: THE RISK ASSESSMENT AND MANAGEMENT APPROACH

ANNA C. BALDRY
AND
FRANS W. WINKEL
EDITORS

Nova Science Publishers, Inc.
New York

LIBRARY OF CONGRESS CATALOGING-IN-PUBLICATION DATA

Assessing risk of spousal assault : an international approach to reduce domestic violence and prevent recidivism / Anna C. Baldry, Chatzifotiou Sevastan, and Belfrage Henrik.
p. cm.
Includes index.
ISBN-13: 978-1-60692-695-6
1. Spousal abuse. 2. Family violence--Prevention. I. Baldry, Anna C. II. Sevastan, Chatzifotiou. III. Henrik, Belfrage.
HV6626.A87 2007
362.82'922--dc22
2007024658

Published by Nova Science Publishers, Inc. ✣ New York

CONTENTS

In: Intimate Partner Violence Prevention and Intervention ISBN: 978-1-60456-039-8
Editors: A. C. Baldry and F. W.Winkel, pp. 1-6

INTRODUCTION

Anna Costanza Baldry[1] and Frans Willem Winkel [2]

[1.] Department of Psychology, Second University of Naples, Italy
International Victimological Institute (INTERVICT), Tilburg University, Netherlands
[2.] International Victimological Institute (INTERVICT), Tilburg University, Netherlands

This book is about risk assessment in intimate partner violence contexts. The perspective utilized is based on the professional risk assessment approach exemplified in the Spousal Assault Risk Assessment (SARA) developed by Hart and Kropp (2000) and its screening version, the B-SAFER (Brief Spousal Assault Form for the Evaluation of Risk; Kropp, Hart, and Belfrage, 2005). This instrument was developed in Canada and implemented there and in Sweden, Italy, and Greece, and is currently being validated also in Portugal, the Netherlands, and Lithuania.

The process of identifying risk and protective factors for violence is referred to as *violence risk assessment*; the process of preventing violence by influencing risk and protective factors is referred to as *risk management*. Both risk assessment and risk management have become routine and integral in most contemporary criminal justice and public health responses to violence, at least in some countries. It is evident that increasing numbers of different types of violence have been the subjects of specialized instruments. This is not surprising given that different variables or patterns of variables predict different types of violence. In turn, risk management decisions differ as well. Intimate partner violence has long posed difficult policy challenges to criminal justice administrators and to related agency officials from other ministries and NGOs responsible for reacting to family violence. It is important, therefore, to discuss the general issue of risk assessment before narrowing the focus to intimate partner violence.

This book examines the main scope of risk assessment of violence and concentrates on the "risk factors" of the perpetrator, as well as those of the victim, especially the "vulnerability factors." Most risk assessment instruments are concerned with responding to the act of violence by reducing the likelihood of another violent act: in other words, reducing violent recidivism. The key assumption underlying the identification of the risk factors of recidivism of repeated victimisation is that, once identified, they can be managed and thus mitigated or reduced, hopefully, decreasing recidivism itself. One of the predominant policy responses to risk assessment is risk management meaning intervening with the abuser and the

victim to reduce risk. However, the efficacy of treatment and best treatment programs historically have been subjected to intense validity debates. The chapters in this book, therefore, will concentrate on linking risk assessment instruments to intervention programs which have been subject to valid evaluations establishing positive outcome effects.

It is only during the last three decades that risk assessment and risk management have become the subject of extensive research and instrument development and, consequently, a subject of intense controversy among practitioners and researchers. Proponents claim risk assessment is the most valid and useful technique in predicting a wide range of phenomena, ranging from general violence to sex offending, stalking, child abuse, suicide, and drunk driving, as well as other forms of antisocial behaviour. In contrast, antagonists and sceptics argue that such risk and management instruments have questionable validity and, too often, unfairly label offenders and contribute to punitive criminal justice responses, coercive health and mental health measures, or both. Although this debate is beyond the scope of this book, it has informed the scholarship of the research material presented in the all of the following chapters.

Theoretically, it is evident that there is a consensus that the onset, persistency, and escalation of the risk for violent behaviors are not determined or caused by any identified series of factors, but rather are, at best, correlates. In effect, negative risk factors and protective factors might have an influence on the violence outcome but they can not be referred to as causing the outcome. The correlates generally are considered either as static (i.e., they do not change in time) or dynamic (i.e., they change in time, place, or intensity). Identifying the presence or absence of both types of risk factors is seen as essential in assessing whether certain behaviors and victimisation outcome are likely to recur. In effect, the violence risk assessment approach is related to risk assessment of recidivism; once we know a person has been violent or committed a certain act, how likely is it that he or she will be violent again? This approach derives from the classic medical model of risk prediction. In predicting pathologies or illness, doctors identify known symptoms and the risk factors related to a specific disease or illness, and then predict the likelihood that a patient will develop it. They also estimate the likelihood of a physical condition's worsening if no medicative actions are taken to reduce the risk factors. However, the medical risk assessment model also is utilized to prevent or reduce the onset of an illness not just its recurrence or deterioration.

A general principle of risk assessment is that prediction of an outcome should exceed the 50% chance figure which would be no different than the odds of simply guessing correctly what might happen. However in real life, police officers, judges or forensic practitioners are not guessing when deciding which sentence give to the offender or whether to release or not the person. Their judgment is based on the legislation and experience but also to some factors that can not be easily measured. To reduce as much as possible this discretionarily variable, risk assessment methods can be of use. Similarly, this criterion applies to the risk assessment of the recurrence of an event after its onset. Another principle is the cumulative effect of multiple risk factors on an event's recurring. For example, a person who had a heart attack and has a history of heart attack in his or her family, and has a "risky" life style (e.g. smoking, poor nutrition habits, and no exercise) is at higher risk for a recurrence of the attack and subsequent relapses than one who has none or few of these risk factors. Another principle is that risk factors need to be weighed against protective factors. Even though a person may be at high risk to have cardiology problems, or to relapse after it has been treated (because of a

family history to the severity of the disease), his or her risk may be reduced by several other (protective) factors such as a change to healthy lifestyle habits and special medical treatment In effect, the level of risk, therefore, is dynamic; it *can* change over time, because risk and protective factors also *can* change over time.

Similarly, it is accepted that violence risk assessment is not a static assessment, and, consequently, that each time a decision is taken about the management of an offender and or the assistance and protection of the victim (e.g., release from prison, renewal of protective or restraining order, leaving a shelter for battered women) or each time there is a significant change in his or her life that might affect behavior and reasoning (e.g., the partner goes to lives somewhere else, loss of job, the victim has a new relationship), another risk assessment would be needed.

Several risk assessment approaches exist; among the most common is the *actuarial approach* which is based on the presence or absence of multiple risk factors. Typically, risk is assessed by establishing a minimum score. This approach, though extensively used, has limitations, among which that violence is dynamic, rarely static; individual and social factors can change even over a short period, as well as over longer development stages. Risk factors need to be assessed dynamically and systematically, not simply adding them up. A major advantage of the actuarial approach, as compared to the *clinical approach*, which arrives at an assessment based mainly on the assessor's practical and clinical experience, is that standardized measure and cut-off scores are utilized for both static and dynamic risk factors. On the other hand, because risk is dynamic, it can not be assessed solely on the resulting numbers of present risk factors. In this regard, the *structural professional judgement* approach tries to overcome the limitations of both approaches, providing an assessment method that is based on rigorous validated empirically based studies, but also allows the assessor to make sense of the presence or absence of the factors in a dynamic way, according to the possible scenarios that are considered as possible outcomes according to the factors identified.

The structured professional approach facilitates formal predictive validity studies of risk assessment and risk management instruments. In turn, this research allows for a more empirically rigorous policy assessment of specific intervention programs designed to reduce risk factors for violence. Such assessments are vitally important given the tragedies associated with intimate partner violence which might even lead to femicide.

Given that the development of instruments concerned with intimate partner violence risk assessment is rather recent, the leading schools in the development of the main instrument, the SARA and its companion police version B-SAFER (or SARA-S, in the Italian version), contributed the chapters in this book. The authors have been immersed in all the challenges briefly discussed above concerning risk assessment instruments, in general, and in the extremely sensitive area of intimate partner violence.

In addition, they have extensive experience in not only the theoretical, conceptual, and methodological issues but also in the training and administration of several renowned risk assessment instruments concerning violence-related phenomena. Finally, these authors are involved in ongoing comparative, cross-national, validated studies in various countries in North America and Europe. In fact, they are the leading scholars whose practical insights are invaluable to understanding the inherently complex theoretical and policy issues concerning intimate partner violence and providing innovative risk management instruments.

This book is novel since it is the first one that examines the development of spousal risk assessment on intimate partner violence, useful not only for researchers, scholars in the field

but also for all practitioners who are in charge with these cases, need to take decisions, treat, intervene.

Several themes are discussed, but one of the most critical is the victimological approach to risk assessment, meaning understanding what helps victims reduce their risk of being re-victimized or even victimized in the first place. How can femicide cases be addressed to aid understanding of what has happened in a victim's life prior to a murder? What can the police or any other professionals in contact with victims of intimate partner violence do both in terms of intervention and reducing the chance of any repeated victimization? Is the psychological reaction of the victim to the victimisation of any influence on the risk of recidivism? Which are the vulnerability factors that put a woman at higher risk of being (re)victimised?

A more general theme dealt with in the book is intervention and treatment programs for offenders and related evidence-based studies particularly referred to the impact of controversial criminal justice polices such as mandatory arrest, automatic incarceration, sentencing criteria, restraining orders and mandatory attendance of treatment programs.

In chapter one, Stephen D. Hart discusses the nature and goals of violence risk assessment in general, as well as the limits and benefits of the two primary approaches to assessing violence risk, the professional judgment and the actuarial procedures. He provides considerable insight into and support for the proposition that the risk assessment approach is efficient and useful, despite its limitations. The primary subject of this chapter, however, is violence in general, while the subsequent chapters examine, more specifically, risk assessment and management regarding intimate partner violence.

In chapter 2, Randall Kropp describes the development of two instruments designed specifically for the risk assessment and management of spousal assaulters, the Spousal Assault Risk Assessment guide (SARA) and the Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER). Both instruments illustrate the Structured Professional Judgment (SPJ) approach to risk assessment, described in the first chapter. How the SARA and the brief version of the SARA were developed, their structure, and how each risk factor is related to intimate partner violence and its recidivism are discussed.

In chapter 3, Henrik Belfrage explains how the clinical risk assessment tool, the SARA, was transformed into an instrument utilized by the police (the B-SAFER). Results from the Swedish project concerning how this transformation occurred are presented.

In chapter 4, Kelly Watt examines the ultimate consequence of intimate partner violence, femicide. She reviews the risk factors related to the perpetrator, the victim, and the community. Equally important, one of the most promising programs in response to femicide, fatality review teams, is described. These fatality review teams consist of different representatives of the community and various institutions (police, social services, victim services, politicians) and were developed first in the U.S. and, recently, have started in Canada and, possibly, in Italy and Lithuania. The teams analyze femicide cases to understand both interpersonal and multiagency dynamics that are related to femicide with policy goals to prevent it. The risk assessment based on the SARA is also discussed as a method for assessing risk of lethal violence.

In chapter 5, Frans Willem Winkel addresses the important issue of victim-related characteristics and coping strategies that occur after victimization, which then can be used for the identification of those victims most in need of support to reduce the potential risk resulting from posttraumatic stress disorder. The SCANNER, basically an actuarial

assessment instrument, is presented as a possible tool for police in conjunction with the B-SAFER to provide victims with specialized and tailored services. The Scanner identifies both the victims' protective factors and those vulnerability factors that can place the victim at higher risk. Results from a study of the impact of repeat victimization on measures of psychological functioning, such as psychological well-being and fear of crime, are also presented. Another critical issue discussed is the differential responses in cases of repeated victimization and single victimization. This distinction is often ignored in studies on risk assessment in intimate partner violence cases. Winkel argues that prevention and managing strategies should identify the vulnerability factors of the female victim and the subsequent support need to reduce the risk of re-victimization.

In chapter 6, Anna C. Baldry discusses the history of how the short screening version of the SARA was employed in Italy. She also reviews existing legislation related to domestic violence and the police role in Italy, and describes how the SARA in its screening version was set up and implemented experimentally in Italy. Preliminary validation evidence concerning both the efficacy of such an approach in predicting recidivism and the usefulness of adopting protective measures for the victim and other measures to restrain the perpetrator from using violence again are discussed. Finally, Baldry asserts the importance of adopting the SARA approach at a national level, within the Italian police force, rather than just on an experimental basis, as it is currently, taking the Swedish model as an example. The police could perform court-ordered risk assessments as a screening tool for all cases of intimate partner violence.

Similarly, in chapter 7, Sevasti Chatzifotiou describes the use of SARA at an experimental level in Greece. She reviews the current procedures for police response to domestic violence cases, as well as the national legislation dealing with these cases. The prevalence and characteristics of intimate partner victims and offenders are presented. Finally, the possible implementation and use of the SARA both at a police level and also within victim services, such as shelters for battered women, is discussed.

In chapter 8, Donald Dutton reviews the caveats about risk assessment generally and the limits of a risk assessment approach by advising those using an approach such as the SARA. He argues that risk assessment mainly based on risk factors could actually lead to false positives (i.e., assessing someone as at risk to recidivate when he does not). Conversely, Dutton states that risk assessment can result in false negatives, where someone is considered not at risk, based on the absence of most risk factors when, in fact, that person recidivates. Dutton's concerns are central to the theme that simply adding up the number of risk factors when performing risk assessment (as it is done with the actuarial approach) is not sufficient; it is equally important to assess the dynamics in the history of violence in terms of changes over time, as well to search for critical (or any other) factors that might be relevant in one case that might not be in others. The assessor needs to be aware that even some intimate partner homicides did not apparently show any precursor factor that might have helped prevent the ultimate outcome.

In chapter 9, Donald Dutton presents his perspective on dealing with abusers and mitigating victim impact. He presents findings from research on perpetrators of domestic violence indicating several treatable components of intimate abusiveness (attachment anxiety, borderline personality traits, substance abuse, and trauma reactions) that are not addressed by current cognitive-behavioral treatment models. Cognitive behavioral treatment modes are reviewed. A summary "blended" model is also presented; it focuses on each new aspect of

abusiveness as well as on the original targets of intervention. The model does not require an additive curriculum as redundancy exists for treatment across target behaviors. It is argued that this model is theoretically promising and may enhance current cognitive-behavioral treatment with court-mandated spouse abusers. The applicability of such an approach with psychopaths is also discussed.

In the last chapter, Jane Katz explores one of the most significant external factors involved in treatment and its efficacy in reducing recidivism; that is, the therapist's response to client responsivity issues. In other words, therapists need to distinguish reluctance to undergo treatment from resistance to it and learn how to effectively manage that reluctance. This is an important concept when dealing with intimate offenders at risk of recidivism because it stresses a different type of intervention and benefits.

We hope that this book will be of value for those working with perpetrators or with victims, in the law enforcement, in the criminal and civil justice system, in victim advocacy services, as well as for researchers interested in the field, as well as for policy makers. The applied, research driven approach used in this book makes it a useful book also for students in the law, psychology and medical sector who want to develop their knowledge in this field.

To reduce violence, the most efficient response is its prevention; ideally prevention of its occurrence all together, but also the prevention of repeated victimisation. This type of approach would allow not only to save lives of those directly and indirectly affected but also to reduce the cost associated to intimate partner violence. Just to be crude and materialistic, investing 1 dollar in crime prevention, saves 7 dollars in a ten year period. Worth while trying.

In: Intimate Partner Violence Prevention and Intervention ISBN: 978-1-60456-039-8
Editors: A. C. Baldry and F. W.Winkel, pp. 7- 18

Chapter 1

PREVENTING VIOLENCE: THE ROLE OF RISK ASSESSMENT AND MANAGEMENT

Stephen D. Hart [1]
Department of Psychology, Simon Fraser University, Canada, and
Faculty of Psychology, University of Bergen, Norway

Violence, and in particular violence against women and children, is recognized worldwide as a major public health problem. The response of the criminal justice and health care systems to violence relies on two related processes: *risk assessment*, the process of identifying risk and protective factors for violence; and *risk management*, the process of preventing violence by influencing risk and protective factors. The first part of this chapter discusses the nature and goals of violence risk assessment, compares the the professional judgement and actuarial approaches to assessing violence risk, and identifies some major limitations of existing procedures for violence risk assessment. The second part of the chapter focuses on violence risk management. It presents general principles that should guide the development of risk management strategies, as well as a comprehensive model of risk management tactics.

Violence is the actual, attempted, or threatened physical injury of another person that is deliberate and nonconsensual (Webster, Douglas, Eaves, and Hart, 1997). Violence is a major determinant of physical and psychological well-being. In 1996, the Forty-Ninth World Health Assembly resolved that violence – and, in particular, violence against women and children – is "a leading worldwide public health problem" (Resolution WHA49.25; see Krug et al., 2002, pp. xx-xxi) and urged its member states to take steps to deal with the problem, including the implementation of violence prevention programs.

According to Dahlberg and Krug (2002), the view that "violence can be prevented and its impact reduced…is not an article of faith, but a statement based on evidence" (p. 3). They discuss various prevention programs, noting that their efficacy depends in part upon the systematic identification of risk and protective factors. This is true regardless of whether the

[1] Address correspondence to hart@sfu.ca or Professor Stephen D. Hart, Department of Psychology, Simon Fraser University, Burnaby, British Columbia, Canada, V5A 1S6.

programs are designed to prevent victimization among people who have never been exposed to violence (i.e., primary or "true" prevention), those who appear to be at elevated risk (i.e., secondary prevention), or those who have already been victimized in the past (i.e., tertiary prevention).

The process of identifying risk and protective factors for violence is sometimes referred to as *violence risk assessment*. Similarly, the process of preventing violence by influencing risk and protective factors is sometimes referred to as *risk management*. Risk assessment and risk management are integral parts of the contemporary criminal justice and public health responses to violence (e.g., Andrews and Bonta, 2003; Kraemer et al., 1997). The goals of this chapter are twofold: first, to discuss the nature and goals of violence risk assessment, as well as the two primary approaches to assessing violence risk; and second, to present some general principles for violence risk management, including a comprehensive model of risk management tactics. The focus of the chapter is on violence in general; several chapters in the rest of this volume focus on risk assessment and management specifically in the context of intimate partner violence.

VIOLENCE RISK ASSESSMENT

The Nature of Violence Risk

A risk is a hazard that is incompletely understood and thus whose occurrence can be forecast only with uncertainty (Bernstein, 1996). The hazard we are concerned with in this chapter is violence, and violence clearly is a complex phenomenon. Violent acts can vary greatly with respect to such things as motivations, acquaintanceship with the victim, severity of physical or psychological harm, and so forth. Accordingly, violence risk is multi-faceted and cannot be conceptualized or quantified simply, for example, in terms of the probability that someone will engage in violence. Instead, one must also consider the nature, seriousness, frequency or duration, and imminence of any future violence (Hart, 1998, 2001; Janus and Meehl, 1997; but cf. Kapur, 2000; Kraemer et al., 1997). Also, violence risk is inherently dynamic and contextual (Hart, 1998, 2001; Kapur, 2000). For example, the violence risk posed by patients depends on where they will reside, what kinds of clinical services they will receive, their future motivation to establish a pro-social adjustment, whether they will experience adverse life events, and so forth. In essence, then, violence risk is not a characteristic of the physical world that can be evaluated objectively, but a subjective perception – something that exists not in fact, but in the eye of the beholder. These opinions regarding the nature and degree or quantum of risk in a given case, as well as the selection of risk management strategies and tactics, are based, in turn, on judgments regarding the collective influence of myriad individual things or elements, referred to as *risk factors*.

But what exactly is a risk factor? It is relatively easy to demonstrate using a wide range of research designs that a thing is, on average, correlated with violence. But things that are correlated with violence may be causes, features, concomitants, or even consequences of violence. A risk factor is a correlate that also precedes the occurrence of the hazard and therefore may play a causal role (Kraemer et al., 1997). Demonstrating that something is a risk factor requires longitudinal research or well-substantiated theory. Risk factors may be

further subdivided into three types (Kraemer et al., 1997). *Fixed risk markers* do not change over time in status. *Variable risk markers* change status over time, but these changes do not influence the outcome. *Causal risk factors* change status over time, and these changes influence the outcome. Differentiating among these three types of risk factors also requires longitudinal designs, and, ideally, experimental or quasi-experimental longitudinal designs.

Considerable attention has been devoted to the identification of (putative) risk factors for violence. There have been several excellent summaries of the research literature in recent years (e.g., Litwack and Schlesinger, 1999; Monahan and Steadman, 1994; Otto, 2002; Webster and Douglas, 1999). Unfortunately, there is no good research or theory that helps us to determine the nature of risk factors, ascertain their potency, understand how they are associated with each other, or specify what causal role they may play with respect to violence.

The Nature of Assessment

Assessment is the process of gathering information for use in decision making. The specific assessment procedures used are determined by what is being assessed and the nature of the decisions to be made. In the case of violence risk assessment, we must assess what people have done in the past, how they are functioning currently, and what they might do in the future. The decisions to be made are strategic in nature, including what should be done in clinical and legal settings to cope with or manage the violence risks posed by a person (Hart, 2001; Heilbrun, 1997; Monahan, 1981/1995; Monahan and Steadman, 1994). This means that violence risk assessment can be defined as the process of evaluating individuals to (a) characterize the risk they will commit violence in the future, and (b) develop interventions to manage or reduce that risk (Hart, 2001). Put differently, the task is to understand how and why a person chose to act violently in the past and then to determine what could be done to discourage the person from choosing to act violently in the future. The specific procedures used to gather relevant information typically include interviews with and observations of the person being evaluated; direct psychological or medical testing of the person; careful review of available documentary records; and interviews with collateral informants such as family members, friends, and service providers (Webster et al., 1997).

Goals of Violence Risk Assessment

The ultimate goal of violence risk assessment is violence prevention, or the minimization of the likelihood of and negative consequences stemming from any future violence. But violence risk assessment should achieve a number of goals in addition to the protection of public safety (Hart, 2001). A “good” risk assessment procedure should also yield consistent or replicable results. That is, mental health professionals should reach similar findings when evaluating the same patient at about the same time. It is highly unlikely that inconsistent or unreliable decisions can be of any practical use. Furthermore, a good risk assessment procedure should be prescriptive; it should identify, evaluate, and prioritize the mental health, social service, and criminal justice interventions that could be used to manage a patient’s violence risk. Finally, a good risk assessment procedure should be open or transparent. Put another way, we mental health professionals are accountable for the decisions we make, and it

is therefore important for us to make explicit, as much as is possible, the basis for our professional opinions. A transparent risk assessment procedure allows patients and the public a chance to scrutinize our opinions. The transparency should protect mental health professionals when a patient commits violence despite the fact that a good risk assessment was conducted, as it can be demonstrated easily that standard or proper procedures were followed. Transparency should also protect patients and the public by making it obvious when an improper risk assessment is conducted.

It is impossible for any single risk assessment procedure to achieve all these goals with maximum efficiency. Similarly, it is impossible for the various parties interested in violence risk assessment (mental health professionals, hospital administrators, patients, lawyers, judges, victims, etc.) to reach a consensus regarding which procedure is "best" for all purposes and in all contexts (Hart, 2001). Instead, mental health professionals should choose the best procedure or set of procedures for a particular assessment of a particular patient after considering explicitly the legal context of the evaluation.

APPROACHES TO VIOLENCE RISK ASSESSMENT

Mental health professionals use two basic approaches to reach opinions about violence risk: professional judgment and actuarial decision making (e.g., Menzies, Webster, and Hart, 1995; Monahan, 1981/1995). These terms refer to how information is weighted and combined to reach a final decision, regardless of the information that is considered and how it was collected (Meehl, 1954/1996). The hallmark of professional judgment procedures is that the evaluator exercises some degree of discretion in the decision-making process, although it is also generally the case that evaluators have wide discretion concerning how assessment information is gathered and which information is considered. It comes as no surprise that unstructured clinical judgment is also described as "informal, subjective, [and] impressionistic" (Grove and Meehl, 1996; p. 293). In contrast, the hallmark of the actuarial approach is that, based on the information available to them, evaluators make an ultimate decision according to fixed and explicit rules (Meehl, 1954/1996). It is also generally the case that actuarial decisions are based on specific assessment data, selected because they have been demonstrated empirically to be associated with violence and coded in a pre-determined manner. The actuarial approach also has been described as "mechanical" and "algorithmic" (Grove and Meehl, 1996; p. 293).

Professional Judgment Procedures

The professional judgment approach comprises at least three different procedures. The first is unstructured professional judgment. This is decision making in the complete absence of structure, a process that could be characterized as "intuitive" or "experiential." Historically, it is the most commonly used procedure for assessing violence risk and therefore is very familiar to mental health professionals, as well as to courts and tribunals. It has the advantage of being highly adaptable and efficient; it is possible to use intuition in any context, with minimal cost in terms of time and other resources. It is also very person-centered,

focusing on the unique aspects of the case at hand, and thus can be of great assistance in planning interventions to manage violence risk. The major problem is that there is little empirical evidence that intuitive decisions are consistent across professionals or, indeed, that they are helpful in preventing violence. As well, intuitive decisions are unimpeachable; it is difficult even for the people who make them to explain how they were made. This means that the credibility of the decision often rests on charismatic authority — that is, the credibility of the person who made the decision. Finally, intuitive decisions tend to be broad or general in scope, so that they become dispositional statements about the patient ("Patient X is a very dangerous person") rather than a series of speculative statements about what the patient might do in the future assuming various release conditions.

The second professional judgment procedure is sometimes referred to as *anamnestic* risk assessment (e.g., Melton, Petrila, Poythress, and Slobogin, 1997; Otto, 2000). This procedure imposes a limited degree of structure on the assessment as the evaluator must, at a minimum, identify the personal and situational factors that resulted in violence in the past. The assumption here is that a series of events and circumstances, a kind of behavioral chain, led up to the patient's violent act. The professional's task, therefore, is to understand the links in this chain and suggest ways in which the chain could be broken. (In this way, anamnestic assessment has much in common with relapse prevention or harm reduction approaches to treating violent offenders.) However, there is no empirical evidence supporting the consistency or usefulness of anamnestic risk assessments. Anamnestic risk assessment also seems to assume that history will repeat itself — that violent people are static over time, so the only thing they are at risk to do in the future is what they have done in the past. Nothing could be further from the truth, of course; there are many different "trajectories" of violence. Some patients or prisoners will escalate in terms of the frequency or severity of violence over time, some change the types of violence they commit, and some will de-escalate or even desist altogether.

The third procedure is *structured professional judgment*. Here, decision making is assisted by guidelines that have been developed to reflect the "state of the discipline" with respect to scientific knowledge and professional practice (Borum, 1996). Such guidelines — sometimes referred to as clinical guidelines, consensus guidelines, or clinical practice parameters — are quite common in medicine, although used less frequently in psychiatric and psychological assessment (Kapp and Mossman, 1996). The guidelines attempt to define the risk being considered; discuss necessary qualifications for conducting an assessment; recommend what information should be considered as part of the evaluation and how it should be gathered; and identify a set of core risk factors that, according to the scientific and professional literature, should be considered as part of any reasonably comprehensive assessment. Structured professional guidelines help to improve the consistency and usefulness of decisions, and certainly improve the transparency of decision making. They may, however, require considerable time or resources to develop and implement. Also, some evaluators dislike this "middle ground" or compromise approach, either because it lacks the freedom of intuitive decision making or because it lacks the objectivity of actuarial procedures.

Actuarial Procedures

There are at least two types of actuarial decision making. The first is the actuarial use of psychological tests. Classically, psychological tests are structured samples of behavior designed to measure a personal disposition, that is, an attempt to quantify an individual's standing on some trait dimension. Research indicates that some dispositions — such as psychopathy (Hart, 1998), major mental illness (Hodgins, 1992), and impulsivity (Barratt, 1994; Webster and Jackson, 1997) — are associated with violence risk in a meaningful way. On the basis of research results, one can identify cutoff scores on the test that maximize some aspect of predictive accuracy. This procedure has several strengths, most importantly its transparency and the demonstrated consistency and utility of decisions made using tests. One major problem is that the use of psychological tests requires considerable discretion: Mental health professionals must decide which tests are appropriate in a given case, and judgment also may be required in test scoring and interpretation. Another problem is that reliance on a single test does not constitute a comprehensive evaluation and will provide only limited information for use in developing management strategies and tactics. More generally, the actuarial use of psychological tests focuses professional efforts on passive violence prediction rather than violence prevention.

The second type of procedure is the use of actuarial risk assessment instruments. In contrast to psychological tests, actuarial instruments are designed not to measure anything but solely to predict the future. Typically, they are high fidelity, optimized to predict a specific outcome in a specific population over a specific period of time. The items in the scale are selected either rationally (on the basis of theory or experience) or empirically (on the basis of their association with the outcome in test construction research). The items are weighted and combined according to some algorithm to yield a decision. In violence risk assessment, the "decision" generally is the estimated likelihood of future violence (e.g., re-arrest for a crime against persons) over some period of time. Like psychological tests, actuarial instruments have the advantage of transparency and direct empirical support; they also suffer many of the same weaknesses, including the need for discretion in selecting a test, interpreting findings, and the limitations of the test findings for use in planning interventions. There are additional problems with actuarial instruments that estimate the absolute likelihood or probability of recidivism. One is that they require tremendous time and effort to construct and validate. In cases where the time frame of the prediction is long, true cross-validation may require decades. Also, when constructing actuarial tests, there is a classic bandwidth-fidelity trade-off between precision of estimated recidivism rates and generalizability: The same statistical procedures that optimize predictive accuracy in one setting will decrease that test's accuracy in others. Finally, it is easy to accord too much weight to information concerning the estimated likelihood of recidivism provided by actuarial tests. Most actuarial tests of violence risk yield very precise likelihood estimates, proportions with 2 or 3 decimal places, but they do not provide the information necessary to understand the error inherent in these estimates. When one considers the fact that many of these estimates were derived from relatively small construction samples and have not been validated in independent samples, it is clear that the actuarial test results are only pseudo-precise. It is important for any professional who uses actuarial tests to understand and explain to others the limitations of absolute likelihood estimates of recidivism.

LIMITATIONS COMMON TO PROFESSIONAL JUDGMENT AND ACTUARIAL PROCEDURES

Existing risk assessment procedures tend to suffer from important limitations. One is that they tend to focus on negative characteristics or features — factors associated with increased risk — rather than personal strengths, resources, and protective or "buffer" factors. A comprehensive risk assessment designed to assist in the development of interventions must take into account these positive features. A second problem is that few existing risk assessment procedures are tied to the development of interventions in a systematic or prescriptive manner. This is, in part, because most risk assessment procedures focus on identifying the presence of risk factors, rather than their functional relevance. In any given case, decisions about which interventions to use require evaluators to determine which risk factors are most important and why they are important (i.e., the nature of their causal influence). A third problem is one of quality assurance. Basic research to develop risk assessment procedures is important, but it is naïve to assume that any procedure will function similarly in the field. Evaluative research is required to monitor the implementation of risk assessment procedures and to determine whether they are functioning optimally and what could be done to improve their use.

VIOLENCE RISK MANAGEMENT

A comprehensive risk management strategy should be developed according to several principles (Hart, 2001; Kropp, Hart, Lyon, and LePard, 2002; see also Andrews and Bonta, 2003). First, the strategy should reflect overall judgments regarding the risks posed by the individual. Second, it should focus on risk management activities or tactics on factors that are relevant in the case at hand, so each relevant risk factor is addressed (i.e., neutralized or contained) by one or more activities. Third, it should be personalized in a way that maximizes its robustness and effectiveness for the individual. Let us discuss each of these principles in turn.

The Management Strategy Should Reflect Risks Posed

The risk management strategy should reflect both the nature and degree or quantum of risk in the case at hand. With respect to the nature of the risks posed, evaluators must speculate about the types or kinds of violence the individual may perpetrate in the future. The evaluator must ask the question, what exactly is it that I am worried this person might do? The answers are based on an analysis of what the individual has done in the distant and recent past, as well as what the individual is thinking about doing or planning to do at the present time. These descriptions of "possible futures" may be referred to as *scenarios*, short narratives designed to simplify complex issues in a way that facilitates communication and planning (Hart et al., 2003; more generally, see Chermack and Lynham, 2002; Ringland, 1998; Schwartz, 1990; van der Heijden, 1997). The scenarios are not predictions about what will happen, but rather projections about what could happen. Although the number of possible

scenarios is almost limitless, in any given case, only a few distinct scenarios seem plausible, credible, or internally consistent to evaluators in light of theory, research, experience, and the facts of the case (e.g., Chermack and van der Merwe, 2003; Pomerol, 2001).

With respect to the quantum or degree of risk posed by the individual, evaluators should think in both absolute and relative terms. In absolute terms, risk is the probability or likelihood that the person will perpetrate a specific type of violence. Although it is impossible to predict the future with any reasonable degree of scientific or professional certainty, evaluators can meaningfully or plausibly rank-order the different types of violence that a person might commit in terms of the probability or likelihood of occurrence. For example, the likelihood a person will commit sexual homicide is generally much lower than the probability he will commit a non-lethal sexual assault. In relative terms, risk is the level of effort or attention that should be devoted to the management of this person vis-à-vis other people. For example, it may be useful to classify cases as low or routine priority, moderate or elevated priority, and high or urgent priority (e.g., Hart et al., 2003).

It is only after evaluators have identified what types of violence a person might perpetrate and how worried they are the person might do so that they can take rational steps to prevent the violence from occurring.

The Management Strategy Should Reflect Relevant Risk Factors

There are several ways in which a risk factor may be relevant to risk management. First, it may be a *motivator* of violence. A motivator is a risk factor that makes violence an attractive or rewarding option for the person. For example, serious employment problems may lead someone to perceive armed robbery as a viable means of getting money; and relationship problems may lead someone to perceive intimate partner violence as a good way of expressing one's anger or frustration. Second, the factor may be a *disinhibitor* of violence. A disinhibitor is a risk factor that makes the person less likely to be influenced by restraints, prohibitions, or proscriptions against violence, regardless of whether these are intrinsic or extrinsic in nature. For example, alcohol intoxication, extreme anger, or lack of empathy associated with personal disorder may lessen the person's experience of anticipatory anxiety when he considers the possibility of perpetrating armed robbery or intimate partner violence. Finally, even when it is not causally related to violence, a risk factor may play a role as an *impeder* of risk management. An impeder is a risk factor that decreases the effectiveness of the various tactics that are or could be used to prevent future violence. For example, anti-authority attitudes may lead the person to reject the assistance offered by a probation or parole officer; and impulsivity associated with personality disorder may impair the person's ability to make, implement, and revise plans regarding psychological or psychiatric treatment.

But how do evaluators determine which risk factors are relevant in a given case, and how they are relevant? Unfortunately, there is a simple or objective test for measuring relevance. Neither is it possible to use the results of scientific research, as what is true in general may not be true in a specific case. This means that judgments about relevance – like scenarios of future violence – are hypotheses based on scientific theory, scientific research, personal experience, and the facts of the case. Although it is not possible to test directly the scientific validity of these hypotheses, it is possible to evaluate the plausibility or reasonableness of their underlying rationale.

It is sometimes assumed that risk factors are less relevant if they are fixed in nature or if they are "static" or "stable" (i.e., appear to change little or slowly over time). Very few risk factors, however, are truly fixed. Age, criminal history, marital history, and visible tattoos are examples of risk factors that are often characterized as static, yet clearly all of these can and do change over time. Even factors that are truly fixed may change status over time due to new information or re-consideration of old information. For example, a person may decide to disclose personal information, or other people may provide collateral information that had not previously been reported. Even when a factor is truly fixed and unchanged in status, it may change in relevance. A change in the relevance may reflect differences over time in the judgment of the evaluator or in the psychological meaning of the risk factor for the person being evaluated. For example, date of birth may not change, but a person may become more reflective about his lifestyle as he ages, leading to an increase in the perceived costs of perpetrating violence; or chromosomal sex may not change, but a person may develop a gender identity disorder that leads him to become resentful of and angry at people of the opposite sex. For a more detailed discussion of the role of fixed, static, or stable factors in the management of violence risk, see Hart, Douglas, and Webster (2001).

The Management Strategy Should be Personalized

A risk management strategy should be *personalized* for the case at hand. It may be useful to think of risk management in terms of building fence or wall designed to contain the risks posed by an individual (e.g., English, Jones, and Patrick, 2003). Building the fence requires a plan (the risk management strategy) that reflects the lay of the land (the risks posed by the individual). The plan should specify landmarks for placement of the fence (relevant risk factors) as well as the fencing materials to be used (the risk management tactics).

To ensure that a risk management strategy is robust and maximally effective, each relevant risk factor should be targeted by multiple tactics. To continue with the fence metaphor, some parts of a fence are more critical than others, and, in these parts, it may be necessary to place more fence posts or a stronger foundation. Also, a risk management strategy that relies on a number of different professionals working in different agencies and clinics may require coordination activities such as regular interdisciplinary meetings or a detailed policy and procedure document (Kropp et al., 2002). Metaphorically, it may be important for someone to travel the perimeter of the fence, making sure that all the posts remain upright and the fencing material is intact.

More on Risk Management Tactics

Risk management tactics can be divided into four basic categories: monitoring, treatment, supervision, and victim safety planning (Hart et al., 2001; Kropp et al., 2002).

Monitoring. Monitoring, or repeated assessment, is always a part of good risk management. The goal of monitoring is to evaluate changes in risk over time so that risk management strategies and tactics can be revised as appropriate. Monitoring services may be delivered by a diverse range of mental health, social service, law enforcement, corrections, and private security professionals. Monitoring, unlike supervision, focuses on surveillance

rather than control or restriction of liberties; it is therefore minimally intrusive. Monitoring tactics may include contacts with the client, as well as with potential victims and other relevant people (e.g., therapists, correctional officers, family members, co-workers) in the form of face-to-face or telephonic meetings. Where appropriate, they may also include field visits (e.g., at home or work), electronic surveillance, polygraphic interviews, drug testing (urine, blood, or hair analysis), and inspection of mail or telecommunications (telephone records, fax logs, e-mail, etc.). Frequent contacts by the client with health care and social service professionals are an excellent form of monitoring; missed appointments with treatment providers are a warning sign that the client's compliance with treatment and supervision may be deteriorating. Plans for monitoring should include specification of the kind and frequency of contacts required (e.g., weekly face-to-face visits, daily phone contacts, monthly assessments). They also should specify any "triggers" or "red flags" that might warn that the individual's risk of violence is imminent or escalating.

Treatment. Treatment involves the provision of (re-)habilitative services. The goal of treatment is to improve deficits in the individual's psychosocial adjustment. Treatment services typically are delivered by health care and social service professionals working at inpatient or outpatient clinics or agencies. In many cases, treatment is involuntary, that is, the individual is civilly committed to inpatient or outpatient care under a mental health act; is being treated in a correctional or forensic psychiatric facility; is ordered to attend treatment as a condition of bail, probation, or parole; or is required to attend assessment or treatment as part of an employee assistance program (Kropp et al., 2002). One important form of treatment is directed at mental disorder that is causally related to the individual's history of violence. Although there is as yet no direct evidence that various treatments for mental disorder decrease violence, it is possible — and even likely — that they will have a beneficial impact. Treatments may include individual or group psychotherapy; psychoeducational programs designed to change attitudes toward violence; training programs designed to improve interpersonal, anger management, and vocational skills; psychoactive medications, such as antipsychotics or mood stabilizers; and chemical dependency programs. Another important form of treatment is the reduction of acute life stresses, such as physical illness, interpersonal conflict, unemployment, legal problems, and so forth. Life stress can trigger or exacerbate mental disorder, but it can also lead to transient symptoms of psychopathology even in people who are otherwise mentally healthy. The most effective way to reduce psychological stress is to eliminate the stressor (i.e., stressful circumstance or event). To this end, dispute resolution mechanisms may be helpful. These might include referral to crisis management services or legal counseling and even, when comprehensive assessment indicates it is likely to be helpful for both parties, a recommendation for the individual to participate in arbitration, mediation, or conferencing processes.

Supervision. Supervision involves the restriction of the individual's rights or freedoms. The goal of supervision is to make it (more) difficult for the individual to engage in further violence. Supervision services typically are delivered by law enforcement, corrections, legal, and security professionals working in institutions or in the community. An extreme form of supervision is incapacitation; that is, involuntary institutionalization of the individual in a correctional or health care facility. Incapacitation clearly is an effective means of reducing the individual's access to potential victims. It is, however, by no means perfectly effective: The individual may escape or elope from the institution and also may commit violence against staff or other people while institutionalized. Incapacitation also has other disadvantages: It is

expensive; it restricts accessibility to treatment services; and it may promote the development of antisocial attitudes by increasing contact with antisocial peers and by creating a sense of powerlessness or frustration. Community supervision is much more common than institutionalization. Typically, it involves allowing the individual to reside in the community with restrictions on activity, movement, association, and communication. Restrictions on activity may include requirements to attend vocational or educational programs, not to use alcohol or drugs, and so forth. Restrictions on movement may include house arrest, travel bans, "no go" orders (i.e., orders not to visit specific geographic areas), and travel only with identified chaperones. Restrictions on association may include orders not to socialize or communicate with specific people or groups of people who may encourage antisocial acts or with past or potential victims. In general, supervision should be implemented at an intensity commensurate with the risks posed by the individual. This helps to protect the individual's civil rights and also helps to reduce the liability of people involved in providing supervision services.

Victim safety planning. Victim safety planning involves improving the victim's dynamic and static security resources, a process sometimes referred to as "target hardening." The goal is to ensure that, if violence recurs — despite all monitoring, treatment, and supervision efforts — any negative impact on the victims' psychological and physical well being is minimized. Victim safety planning services may be delivered by a wide range of social service, human resource, law enforcement, and private security professionals. These services can be delivered regardless of whether the individual is in an institution or the community. Victim safety planning is most relevant in situations that involve "targeted violence," that is, where the identity of the likely victims of any future violence is known. Dynamic security is a function of the social environment. It is provided by people — the victim and others — who can respond rapidly to changing conditions. The ability of these people to respond effectively depends, critically, on the extent to which they have accurate and complete information concerning the risks posed to victims. This means that good victim liaison is the cornerstone of victim safety planning. Counseling with victims to increase their awareness and vigilance may be helpful. Treatment designed to address deficits in adjustment or coping skills that impair the ability of victims to protect themselves (e.g., psychotherapy to relieve anxiety or depression) may be indicated. Training in self-protection should be considered, such as protocols for handling telephone calls and mail or classes in physical self-defense. Finally, information concerning the individual (including a recent photograph), the risks posed to victims, and the steps to be taken if the individual attempts to approach the victims should be provided to people close to the victims and those responsible for their safety. This information will allow law enforcement and private security professionals to develop proper security plans. Static security is a function of the physical environment. It is effective when it improves the ability of victims to monitor their environment and impedes individuals from engaging in violence. The risk management plan should consider whether it is possible to improve the static security where victims live, work, and travel. Visibility can be improved by adding lights, altering gardens or landscapes, and installing video cameras. Access can be restricted by adding or improving door locks and security checkpoints. Alarms can be installed, or victims can be provided with personal alarms. In some cases, it is impossible to ensure the safety of victims in a particular site, and the case management team may recommend extreme measures such as relocation of the victims' residences or workplaces.

CONCLUSION

Although brief, this chapter hopefully has illustrated both the potential importance and the daunting complexity of violence risk assessment and management. The state of scientific knowledge may be crude or primitive in many respects, yet it is sufficient to offer at least some guidance for professionals, policy makers, and other people who are responsible for preventing violence.

ACKNOWLEDGEMENT

Thanks to the usual suspects and, in particular, Kelly Watt, P. Randall Kropp, and Henrik Belfrage.

In: Intimate Partner Violence Prevention and Intervention ISBN: 978-1-60456-039-8
Editors: A. C. Baldry and F. W.Winkel, pp. 19-31

Chapter 2

DEVELOPMENT OF THE SPOUSAL ASSAULT RISK ASSESSMENT GUIDE (SARA) AND THE BRIEF SPOUSAL ASSAULT FORM FOR THE EVALUATION OF RISK (B-SAFER)

P. Randall Kropp
Forensic Psychiatric Services Commission
of British Columbia, Canada

Although there are very few risk assessment instruments that have been validated for assessing and managing risk in spousal assaulters, there are reasons to be optimistic. There is now a significant body of literature that documents factors known to be associated with spousal violence. By assessing risk in a systematic and comprehensive manner, more informed decisions regarding risk management can be offered. The SARA and B-SAFER are designed to assist in this process. They both reflect the empirical and professional literatures on spousal violence risk factors, and they both include recommendations for performing risk assessments and designing risk management strategies. More reliability and validity research is desirable, but, for now, these instruments are useful aids for those working with spousal assaulters and their victims.

INTRODUCTION

Spousal violence is a criminal act that takes significant social and economic tolls on society. There is an emerging literature that illustrates the complexities of assessing and managing risk in perpetrators of this form of violence (Dutton and Kropp, 2000; Hilton and Harris, 2004; Kropp, 2004). Effective case management of offenders should focus on identifying, assessing, and containing risk. *Violence risk management* is the process of speculating in an informed way about the aggressive acts a person might commit and determining the steps that should be taken to prevent those acts and minimize their negative consequences (Hart, 1998). *Risk assessment* involves evaluating an individual to determine which factors are present that might increase or enhance risk, typically referred to simply as

risk factors. *Risk management* involves developing a set of intervention strategies targeted at specific risk factors and designed to prevent the feared outcomes. This chapter describes the development of two instruments designed specifically for the risk assessment and management of spousal assaulters: The Spousal Assault Risk Assessment guide (SARA) and the Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER). Both are examples of the Structured Professional Judgment (SPJ) approach to risk assessment, which is described elsewhere in this volume.

ASSESSING RISK FOR SPOUSAL ASSAULT

For the purposes of this chapter, my definition of *spousal assault* is any actual, attempted, or threatened physical harm perpetrated by a man or woman against someone with whom he or she has, or has had, an intimate, sexual relationship. This definition is inclusive: It is not limited to acts that result in physical injury; it is not limited to relationships where the partners are or have been legally married; and it is not limited by the gender of the victim or perpetrator. Also, it is consistent with the observation that violence between intimate partners is pandemic in our societies regardless of the nature of their relationship (Gelles and Straus, 1988; Kurz, 1993). Having said this, it is recognized that husband-to-wife assault can be considered the most serious form of spousal assault, due to its prevalence, its repetitive nature, and its high risk of morbidity and mortality.

Risk Factors for Spousal Assault

The physical and psychological damage resulting from violence in intimate relationships has been well documented in recent years. Numerous studies have attempted to identify factors associated with spousal violence. Many studies have identified risk factors that discriminated those who were violent towards spouses from those who were not (e.g., Hotaling and Sugarman, 1986; Tolman and Bennet, 1990). Other studies have highlighted factors associated with risk for recidivistic violence among known spousal assaulters — those arrested, convicted, or in treatment (e.g., Gondolf, 1988; Hilton et al., 2004; Saunders, 1993). Many of these studies intersect with those discussing risk for violence in general, with many of the same factors emerging (e.g., Monahan and Steadman, 1994; Quinsey, Rice, Harris, and Cormier, 1998). There are also several important works that have discussed the assessment of risk for future violence in spousal assaulters, sometimes described as a “lethality” or “need to warn” assessment (e.g., Saunders, 1992). Finally, there have been some extremely useful studies on factors associated with the more specific act of domestic homicide (Campbell, Sharps, and Glass, 2001; Campbell et al., 2003; Dobash, Dobash, Cavanaugh, and Lewis, 2001).

There is considerable consensus amongst these studies regarding the important factors to consider when assessing risk for spousal assault. Many risk assessment “lists” have been published. Most of these include factors related to a history of assaultive behavior, generally antisocial behaviors and attitudes, stability of relationships, stability of employment, mental health and personality disorder, childhood abuse, motivation for treatment, and attitudes

towards women (see, for example, Dutton and Kropp, 2000; Hilton and Harris, 2004; Kropp, 2004; Riggs, Caulfield, and Street, 2000; Schumacher, Feldbau-Kohn, Slep, and Heyman, 2001). It is important to remember that these risk markers are not necessarily causal predictors, but, rather, factors that consistently co-occur with abusiveness .

Although there are now several risk assessment instruments in circulation, four tools have received considerable attention because their authors have published validity data. They are the Danger Assessment (DA: Campbell, 1995), the Domestic Violence Screening Inventory (DVSI: Williams and Houghton, 2004), the Ontario Domestic Assault Risk Assessment (ODARA: Hilton et al., 2004), and the Spousal Assault Risk Assessment Guide, or SARA (Kropp, Hart, Webster, and Eaves, 1999; Kropp and Hart, 2000). The remainder of this chapter shall focus on the SARA and introduce the B-SAFER, a recently developed brief risk assessment tool which was influenced by the SARA .

Spousal Assault Risk Assessment Guide (Sara)

The large number of spousal assaulters being formally processed by the criminal justice system has resulted in growing demand for assessments of risk for future violence. In North America, these risk assessments typically are conducted in one of following four contexts:

1) Pretrial**.** When someone is arrested for offenses related to spousal assault, the nature of the alleged acts or the defendant's history may raise the question of whether he should be denied pretrial release on the grounds that he poses an imminent risk of harm to identifiable persons (i.e., his spouse, his children) or whether he should have pretrial release conditions that include no-contact orders.
2) Presentence**.** Risk assessments are sometimes requested when a defendant's case has proceeded to trial. If he has not yet been convicted, the results may assist judges who are considering the diversion or the conditional or unconditional discharge of the defendant. If he already has been convicted, the findings may help judges to decide between alternative sentences (e.g., probation vs. incarceration) and to set or recommend conditions for community supervision (e.g., no-contact orders).
3) Correctional Intake**.** After conviction, risk assessments can be helpful to corrections staff who conduct "front-end" assessments in institutional or community settings. They can be used in the development of treatment plans, as well as to determine suitability or set conditions for conjugal visits, family visits, and temporary absences.
4) Correctional Discharge**.** In the case of an offender who has been incarcerated, risk assessments prior to discharge can help corrections officials or parole boards to determine suitability or set conditions for conditional release, as well to assist in the development of a post-release treatment or management plan. For a community-resident offender who is nearing the end of his supervisory period, a final risk assessment may indicate that correctional staff should communicate formal warnings to at-risk individuals in an effort to discharge any ethical and legal obligations before the case file is officially closed.

A major problem in conducting these risk assessments has been the lack of a systematic, standardized, clinically useful, and empirically-based framework for collecting, weighting,

and reporting background data and professional judgments. Considering the importance of the matter, it is rather odd that, until very recently, there have been no guidelines concerning how to conduct spousal assault risk assessments: what factors need to be considered, what type of information is helpful in making decisions, and where and how to get information. As part of a coordinated effort by the British Columbia Institute on Family Violence, the British Columbia Forensic Psychiatric Services Commission, the British Columbia Ministry of Women's Equality, and other government and community agencies, we decided to develop such a framework, which we have called the Spousal Assault Risk Assessment guide, or SARA.

DEVELOPMENT OF THE SARA

Our first step was to undertake a careful review of the clinical and empirical literatures on risk for violence, with particular emphasis on spousal assault (Cooper, 1993). Many of the studies reviewed have been included in subsequent literature reviews (Dutton and Kropp, 2000; Hilton and Harris, 2004; Riggs et al., 2002; Schumacher et al., 2001). We attempted to keep our list of factors relatively short and to aim at a moderate level of specificity (i.e., at the level of traits, characteristics, or incidents, rather than the level of isolated or specific behavioral acts). The result was a list of 20 factors, referred to on the SARA as *items*, grouped into the five content areas described below.

Criminal History Variables. Numerous studies indicated that a prior criminal record for offenses unrelated to spousal assault was associated with an increased risk for violence in general and also, more specifically, for recidivistic spousal assault. The factors here cover past history of violence, as well as failure to abide by conditions imposed by the courts or criminal justice agencies. We included three specific factors of past criminal record. *Past assault of family members* refers to violence directed against members of the individual's family of origin or against his own children. It does not cover past spousal assaults, which are coded in a different section. *Past assault of strangers or acquaintances* refers to violence directed against people who are not biological or legal family members. *Past violation of conditional release or community supervision* refers to past failures to abide by the conditions of bail, recognizances, court orders, probation, and parole or mandatory supervision. It is irrelevant whether the conditions were imposed following an incident or allegation of spousal assault; any failure is considered a poor prognostic indicator.

Psychosocial Adjustment Variables. Two SARA items reflect the observation that recent or continuing social maladjustment is linked with violence. *Recent relationship problems* refers to separation from an intimate partner or severe conflict in the relationship within the past year. *Recent employment problems* refers to unemployment and/or extremely unstable employment in the past year. It is unclear, although perhaps unimportant for the purpose of risk assessment, whether social maladjustment is the result of more chronic psychopathology or the cause of acute situational financial and interpersonal stress; regardless, these factors appear to be important predictors.

One item in this section, *victim of and/or witness to family violence as a child or adolescent*, is historical in nature and refers to maladjustment in the individual's family of origin. This is one of the most robust risk factors for spousal assault identified in the

literature. Why this factor is associated with violence so strongly is unclear, although some research suggests that social learning mechanisms may be involved (Widom, 1989).

There is now a considerable body of evidence supporting the link between certain forms or symptoms of mental disorder and violent behavior (e.g., Monahan and Steadman, 1994). This evidence was the basis for four SARA items related to psychological adjustment: *recent substance abuse/dependence, recent suicidal or homicidal ideation/intent, recent psychotic and/or manic symptoms, and personality disorder with anger, impulsivity, or behavioral instability.* Please note that we do not make any assumptions here that the mental disorder is responsible for or "causes" violent behavior. Rather, mental disorder is assumed to be associated with poor coping skills and increased social-interpersonal stress; thus, individuals with mental disorders may be prone to making and acting on bad decisions.

Spousal Assault History Variables. This section comprises seven items related to spousal assaults in the past. Risk factors based on the alleged or current offense are included in a different section, so that evaluators can more easily separate the quantum of perceived risk attributed to formally documented events (which are likely to be accepted as factual) versus that attributed to alleged events (which are likely to be contended).

The first four items concern the nature and extent of past assaults. *Past physical assault* is an obvious risk factor, based on the axiom (supported by research) that past behavior predicts future behavior (e.g., Monahan and Steadman, 1994; Quinsey et al., 1998). *Past sexual assault/sexual jealousy* refers to physical assaults that are of a sexual nature or occur in the context of extreme sexual jealousy. *Past use of weapons and/or credible threats of death* refers to behavior that explicitly or implicitly threatens serious physical harm or death. *Recent escalation in frequency or severity of assault* refers to situations where the "trajectory" of violence seems to be escalating over time.

The next three items concern behavior or attitudes that accompany assaultive behavior. *Past violation of "no contact" orders* covers situations where the individual has failed to comply with the orders of a court or criminal justice agency that prohibit contact with victims of past spousal assaults. Although it overlaps to some extent with the third item in the Criminal History section, we felt that such a violation is so directly relevant to spousal assault risk assessment that it deserved special attention. *Extreme minimization or denial of spousal assault history* may occur as part of a more general pattern of deflection of personal responsibility for criminal behavior, or it may be specific to past spousal assaults. *Attitudes that support or condone wife_assault* covers a wide range of beliefs or values -- personal, social, religious, political, and cultural -- that encourage patriarchy (i.e., male prerogative), misogyny, and the use of physical violence or intimidation to resolve conflicts and enforce control.

Alleged (Current) Offense Variables. This section comprises three items, similar in content to those appearing in the previous section, that are scored solely on the basis of the alleged or current offense: *severe and/or sexual assault, use of weapons and/or credible threats_of death*, and *violation of "no contact" order*.

Other Considerations. The final section does not contain any specific items. It allows the evaluator to note risk factors not included in the SARA that are present in a particular case and that lead the evaluator to decide the individual is at high risk for violence. Examples of rare but important risk factors include a history of stalking behavior (e.g., Burgess et al., 1997); a history of disfiguring, torturing, or maiming intimate partners; a history or sexual sadism; and so forth.

ASSESSMENT PROCEDURE

The authors of the SARA suggest an assessment procedure based on multiple sources of information and multiple methods of data collection. This is based on the recognition that victims, offenders, and other collateral sources (e.g., children, neighbors) may tend to underreport violence (albeit for different reasons), but that their reports often provide crucial information that is otherwise difficult or impossible to obtain. Also, we recognized that, in many cases, structured assessment procedures (self-report inventories, semi-structured interviews) are useful adjuncts to unstructured procedures ("clinical" interviews, reviews of police reports, or other case history information). In general, the assessment should include (a) interviews with the accused and victims; (b) standardized measures of physical and emotional abuse; (c) standardized measures of drug and alcohol abuse; (d) review of collateral records, including police reports, victim statements, criminal records, and so forth; and (e) other assessments, as required. If the information is incomplete, the evaluator should postpone undertaking or completing the risk assessment until the missing information becomes available. If it is impossible to track down the missing information, the evaluator should proceed with the risk assessment and emphasize in the final report the ways in which conclusory opinions need to be limited.

CODING JUDGMENTS

The SARA is not "scored" in the manner of most psychological tests. Rather, the evaluator is called upon to make three kinds of judgments, which are coded on a summary form.

Presence of Individual Items. The presence of individual items is coded using a 3-point response format: 0 = *absent*, 1 = *subthreshold*, and 2 = *present*. The SARA manual presents detailed criteria for defining and coding each item.

The presence of individual items is a relatively objective indicator of risk: In general, and especially in the absence of critical items (see below), risk can be expected to increase with the number of items coded present. Of course, completing the SARA does require some degree of professional, subjective judgment on the part of the evaluator; however, it is important to remember that the items were selected on the basis of their demonstrated validity and that considerable pains have been taken to ensure that the coding of items is simple and clear.

Presence of Critical Items. Critical items are those that, given the circumstances in the case at hand, are sufficient on their own to compel the evaluator to conclude that the individual poses an imminent risk of harm. They are included in recognition of the fact that risk, as perceived by the evaluator, is not a simple linear function of the number of risk factors present in a case. This is why we do not simply sum the numerical scores on individual SARA items to yield a total "score": It is conceivable that an evaluator could judge an individual to be at high risk for violence on the basis of a single critical item. Critical items are coded using a 2-point format: 0 = *absent*, 1 = *present*.

Summary Risk Judgments. Evaluators frequently are required to address two separate issues: imminent risk of harm to spouse (which generally is the issue that prompted the risk

assessment) and imminent risk of harm to some other identifiable person (for example, the individual's children, other family members, or the new partner of an ex-spouse). With the SARA, such risk is coded using a 3-point response format: 1 = *low*, 2 = *moderate*, and 3 = *high*. If the individual is deemed to be at risk for harming "others," the evaluator must identify the potential victims. These summary risk judgments capture the evaluator's overall professional opinion in a straightforward manner that permits comparison with other evaluators.

Research on the SARA

The authors have evaluated the reliability and validity of judgments concerning risk for violence made using the Spousal Assault Risk Assessment Guide (Kropp and Hart, 2000). SARA ratings were analyzed in six samples of adult male offenders (total N = 2,681). The distribution of ratings indicated that offenders were quite heterogeneous with respect to the presence of individual risk factors and to overall perceived risk. Structural analyses of the risk factors indicated moderate levels of internal consistency and item homogeneity. Inter-rater reliability was high for judgments concerning the presence of individual risk factors and for overall perceived risk. SARA ratings significantly discriminated between offenders with and without a history of spousal violence in one sample and between recidivistic and non-recidivistic spousal assaulters in another. Finally, SARA ratings showed good convergent and discriminant validity with respect to other measures related to risk for general and violent criminality (Kropp and Hart, 2000).

Williams and Houghton (2004) conducted a predictive validity study on the SARA using 434 male spousal assaulters on probation in Colorado. SARA assessments were completed on offenders when they were released into the community and re-offense rates were examined 18 months later. The authors computed Receiver Operator Curves (ROCs) to estimate the predictive accuracy of the SARA total scores and "weighted" SARA score which combined the total score and the overall (subjective) risk rating. Both methods showed statistically significant predictive validity for the SARA. The Areas Under the Curve (AUC) for the SARA and weighted SARA measures for predicting domestic violence reoffending were both .65 ($p < .001$). The AUCs for any reoffending were .70 and .71, respectively (also $p < .001$). Similarly, Hilton et al. (2004) reported an AUC of .64 for the SARA on a sample of 589 offenders. This result was achieved despite the SARA risk factors being approximated from archival files and thus not administered as recommended in the SARA manual. Overall, these two studies add support for the predictive validity of the SARA. Such information is desirable despite the fact the stated goal of the SARA is to prevent violence rather than to predict it.

Development of the B-SAFER

Recently, there has been an increased focus in the field on the need for brief risk assessments by police officers and other criminal justice professionals who work with offenders and victims (Hilton et al., 2004; Kropp, 2004). The SARA may not be an optimal tool for use by police and others in this context because it is relatively long, and it requires specific judgments regarding mental health, such as major mental illness and personality

disorder. Thus, completion of the SARA places a relatively heavy burden on users in terms of the availability of time, technical expertise, and case history information. We therefore decided to develop a new tool, which we called the Brief Spousal Assault Form for the Evaluation of Risk, or B-SAFER (Kropp, Hart, and Belfrage, 2005). This section outlines the steps taken in the development of the B-SAFER and describes the tool itself.

LITERATURE REVIEW

Our first step in developing the B-SAFER was to conduct a comprehensive review of the literature regarding spousal violence and spousal violence risk assessment. We also updated this review continuously during the project to keep abreast of new developments in the field.

Overall, the literature review indicated that there have been relatively few advances in our understanding of risk factors for spousal assault since the development of the SARA in the early 1990s. There has been further research supporting the utility of some risk factors previously identified (for example, see reviews by Dutton and Kropp, 2000; Riggs, Caulfield, and Street, 2000; Schumacher, Feldbau-Kohn, Slep, and Heyman, 2001), but no important new risk factors have been identified.

The literature review also suggested that there have been few advances in the development of specific tools or procedures for spousal violence risk assessment. One exception was the ODARA, a tool developed for use by the Ontario Provincial Police. As the ODARA is based on the actuarial approach, it is intended to estimate the likelihood of future violence rather than to provide information about risk management. This means that professionals who use the ODARA still need assistance making final decisions that reflect the totality of circumstances in the case at hand and that guide case management.

Another development was an increased focus on victims. Both the ODARA and the Stalking Assessment and Management Guide (SAM), a structured professional judgment tool currently being developed by the British Columbia Institute Against Family Violence (BCIFV), include consideration of factors that increase a victim's vulnerability to violence. One potential problem with this advance is that including victim vulnerability factors in a new tool increases the complexity (i.e., length and scope) of the assessment.

In sum, the literature review indicated to us that it would be possible to use the SARA as a basis or starting point for the development of the B-SAFER. It also indicated that the B-SAFER might benefit from consideration of victim vulnerability factors, providing their inclusion did not make the use of the tool unduly complex or resource-intensive.

Empirical Analyses

Statistical Analysis of SARA Ratings. We asked colleagues in Scotland to conduct statistical analyses of existing data sets to identify possible redundancy among the 20 SARA risk factors. The data sets comprised 2,796 adult male offenders from Canada: 1,786 were offenders on probation in British Columbia, and 1,010 were offenders from federal penitentiaries. The probationers were serving sentences for offenses related to spousal assault,

whereas the federal offenders were serving sentences for a variety of offenses but had a known, documented, or suspected history of spousal assault

Briefly, Exploratory and Confirmatory Factor Analyses suggested that the statistical association among the ratings of the 20 SARA items could be modeled adequately using 7 factors, with each factor comprising multiple items. The factors were interpreted as follows: History of Spousal Violence; Life-threatening Spousal Violence; Escalation of Spousal Violence; Attitudes Supportive of Spousal Violence; General Antisocial Behaviour; Failure to Obey Court Orders; and Mental Disorder. The factors themselves appeared to be non-redundant. Most of the factors had unique predictive power with respect to global judgments of risk for spousal violence or, in a small subsample of 102 offenders, with respect to actual spousal violence recidivism. Item Response Theory analyses of the same data yielded similar findings regarding redundancy.

Pilot Testing of the SARA-PV in Sweden. We pilot tested a modified version of the SARA, which we called the SARA-Police Version (SARA-PV), for use by the Swedish National Police. In the SARA-PV, each of the 20 SARA risk factors was revised and shortened to simplify coding decisions. Patrol officers attended 1-day training sessions conducted by one of the authors and then used the SARA-PV when responding to spousal violence incidents. Patrol officers reviewed the completed SARA-PV coding forms with shift supervisors prior to making case management decisions. A more detailed description of the Swedish project can be found in the chapter by Henrik Belfrage in this volume.

In total, we received 584 completed SARA-PV coding forms for 430 adult males suspected of perpetrating spousal violence. (Some people had multiple contacts with police and thus multiple SARA-PV ratings.) Analysis of the SARA-PV ratings indicated that it was sometimes difficult for patrol officers to gather the information required to rate some risk factors as part of their usual investigation procedures. In particular, they found it difficult to make specific judgments about the perpetrator's mental disorder and about his history of childhood victimization experiences. In addition, feedback received from police officers revealed two major concerns regarding the use of the SARA-PV. First, they wanted the scheme used to code the presence of individual risk factors to more closely resemble their usual operational procedures and language. Second, they expressed a desire for clarified and simplified coding of overall or summary judgments regarding risk.

The results of these empirical analyses indicated the following:

1) Some SARA items may have redundant or overlapping content.
2) Some SARA items may be difficult to code when used by police as part of routine investigations, due to specificity of content.
3) The schemes used in the SARA to code judgments regarding the presence of individual risk factors and overall risk may not be a good fit for use by law-enforcement.

Overall, these findings were consistent with our anecdotal observations and with informal feedback received when conducting SARA training with police in the past. The findings also suggested that it was both necessary and feasible to shorten, simplify, and revise the SARA for use by police.

Format of the Draft B-SAFER and Related Materials

The draft of the B-SAFER that we developed for pilot testing comprised 10 risk factors. The 10 risk factors were divided into two sections. The first section, Spousal Assault, contained 5 factors related to the perpetrator's history of spousal violence: (1) Serious Physical/sexual Violence; (2) Serious Violent Threats, Ideation, or Intent; (3) Escalation of Physical/sexual Violence or Threats/ideations/intent; (4) Violations of Criminal or Civil Court Orders; and (5) Negative Attitudes about Spousal Assault. The second section, Psychosocial Adjustment, contained 5 factors related to the perpetrator's history of psychological and social functioning: (6) Other Serious Criminality; (7) Relationship Problems; (8) Employment and/or Financial Problems; (9) Substance Abuse; and (10) Mental Disorder. The risk factors in the latter section are associated with risk for violence in general, in addition to risk for spousal violence. After considering these risk factors, the evaluator is asked to provide a judgment of risk level and recommendations for managing that risk (e.g., specific strategies for monitoring, treatment, supervision, and safety planning).

A coding form and user manual are now available. The manual includes an overview of the B-SAFER, as well as sections on user qualifications, confidentiality and informed consent, applications, and administration procedures. We have also included a comprehensive section entitled, "Definition of Risk Factors," which includes item definitions, rationales for including items (including references to supporting literature), specific coding instructions for each B-SAFER item, and a detailed reference list. The manual and coding form also include considerable information regarding the development of case management plans. Finally, we developed a semi-structured interview for victims, which we circulated among a small number of police officers and victim service workers for feedback. The interview includes suggested questions that can be asked for each risk factor. The format is semi-structured to allow the interviewers flexibility and discretion.

Quantitative Analyses

Six police agencies in Canada, representing five cities, volunteered to pilot the B-SAFER. One of the B-SAFER developers (Kropp) delivered half-day training sessions to selected officers at all of the agencies. Each officer was then provided with a draft B-SAFER manual and asked to complete the B-SAFER coding form and a checklist of recommended risk management strategies on current and recent spousal violence cases.

Training on the B-SAFER was also conducted for the Swedish National Police. Pilot testing in the counties of Kalmar, Växjö, and Blekinge was supervised by Professor Henrik Belfrage, a co-author of the B-SAFER (see chapter in this volume by Belfrage). The Swedish National Police subsequently forwarded data for 283 cases to BCIFV for analysis. We deemed this data to be directly relevant to this report because (a) the Swedish criminal justice system is similar to Canada's with the presence of a proactive spousal assault policy; (b) as in Canada, police officers in Sweden are required to make recommendations regarding detention and supervision prior to trial; (c) the B-SAFER was developed in collaboration with academics and police agencies in Sweden, so the risk factors were considered directly applicable; and (d) previous research on the SARA-PV (Police Version) in Sweden indicated that the structural professional judgment approach could be successfully applied.

Quantitative analysis of the pilot data forwarded to BCIFV by police in Canada and Sweden are summarized in Tables 1 through 3. All of the B-SAFER items were present in at least some cases from both countries, and many were present in a large percentage of cases. Table 1 reports the average number of risk factors, current and past, present in each country. In general, the cases from Canada had more risk factors than did those from Sweden, suggesting that the Canadian cases were higher risk. This interpretation is supported by the distribution of risk ratings made using the B-SAFER in Canada and Sweden, as reported in Table 2. The higher risk of the Canadian cases probably reflects the fact that they came primarily from a specialized investigative unit, whereas those from Sweden came from regular patrol officers.

Table 1. Total Risk Factors Ratings (*M, SD*)

	Canada	*Sweden*
Current risk factors	10.14 (3.94)	7.15 (4.15)
Past risk factors	10.34 (5.26)	6.09 (4.87)

Note. Items recoded: *No, Omit* = 0; *Possible* = 1; *Yes* = 2.

Table 2. Distribution of B-SAFER Risk Ratings

	Canada	Sweden
Long-term risk of assault		
Low	27%	38%
Moderate	29%	55%
High	45%	8%
Risk of imminent assault		
Low	35%	44%
Moderate	27%	47%
High	39%	9%
Risk for severe assault		
Low	47%	83%
Moderate	29%	17%
High	25%	1%

Perhaps the most important finding is reported in Table 3. Table 3 presents the associations (correlations) among the total number of risk factors present on the B-SAFER, current and recent; risk ratings made using the B-SAFER, and the management strategies recommended in the cases. The correlations suggest that B-SAFER risk factors and risk ratings were substantially associated with the number of management strategies recommended by police, as well as recommendations for detention made in Canada. (No recommendations for detention were made by the Swedish police.) Simply put, more intervention was recommended in cases perceived to be high risk than in cases perceived to be low risk.

Table 3. Correlations among B-SAFER Risk Factors, Risk Ratings, and Management Strategies

	1	2	3	4	5	6
1. Current risk factors, total	--	.74	.59	.56	.39	**.39**
2. Past risk factors, total	.64	--	.56	.45	.32	**.35**
3. Long-term risk of assault	.37	.54	--	.73	.45	**.41**
4. Risk for imminent assault	.34	.49	.80	--	.34	**.38**
5. Risk for severe assault	.49	.64	.73	.75	--	**.26**
6. Management strategies, total	**.07**	**.29**	**.35**	**.38**	**.20**	--
7. Detention	**.05**	**.27**	**.41**	**.38**	**.39**	--

Note. Ratings for Sweden appear above the diagonal; ratings for Canada, below. Detention was not recommended as a management strategy in any of the Swedish cases. One rater from Canada was excluded for analyses with management strategies.

Overall, the findings of these quantitative analyses indicated the following:

1) All of the risk factors were coded as present in a substantial proportion of cases, and there was a low rate of coding items as omitted or unable to be evaluated due to missing information. This suggests that the B-SAFER risk factors were defined clearly and coded easily by police officers in the course of routine investigations.
2) Overall or summary ratings of risk were diverse, distributed almost normally in the Canadian samples. This suggests that police officers were able to use the B-SAFER coding instructions to make discriminations among perpetrators.
3) There was a limited association between B-SAFER ratings and recommended management strategies, and there was substantial variability both within and among officers in their recommendations regarding management. This suggests that police officers' recommendations regarding case management were influenced by their judgments of risk (both the presence of individual risk factors and overall level of risk), but also that B-SAFER ratings were not highly "prescriptive" with respect to management recommendations.

Qualitative Feedback

Following the pilot testing, we asked officers from each agency to answer six questions (below) regarding the content and process of the B-SAFER. Overall, the feedback was positive. Officers said that they found the B-SAFER to be simple and easy to use. Some noted that it encouraged investigators to think about risks in specific and identifiable areas that might otherwise have been overlooked. Others appreciated the item indicators and examples listed on the coding form. Others said that the B-SAFER caused investigators to do more standardized and formalized risk assessments. Of note, was the following comment: "The B-SAFER provided us with a consistent tool to use in each case, which improved our service to victims."

There was some concern that police officers may have limited knowledge about some of the risk categories, such as those referring to mental disorder. Some officers indicated that they were uncomfortable completing the risk ratings section of the B-SAFER, indicating that it was difficult to make these determinations. Certain officers were particularly concerned that they would be required to disclose in court the B-SAFER information. The same officer thought the process required him to make "judgments and assumptions" about the offender and victim that went beyond his role as a police officer.

Most officers indicated that the B-SAFER was comprehensive and the risk factors appropriate. One respondent indicated that the indicators for item 5 (Negative Attitudes about Spousal Assault) could be expanded to include additional controlling behaviors, such as financial control, verbal and emotional abuse, and manipulative behavior. We received several suggestions that software to assist administration and report writing would greatly facilitate routine use of the B-SAFER, as well as quality assurance.

CONCLUSIONS REGARDING THE B-SAFER

We developed a tool that criminal justice professionals can use to assess risk for spousal violence, called the B-SAFER. The B-SAFER was based on the SARA and shares two important strengths. First, the B-SAFER uses a structured professional judgment or structured discretion approach that is appropriate for criminal justice contexts. Second, the content of the B-SAFER is firmly grounded in the professional and scientific literatures on spousal violence. But the B-SAFER also has two important advantages over the SARA when used in some criminal justice contexts. First, the B-SAFER is shorter than the SARA and thus is less resource-intensive to administer. Second, the content of the B-SAFER includes fewer items and less technical jargon related to mental disorder and therefore requires less expertise to use.

Based on our development work and on the results of pilot testing, we believe that the B-SAFER can be used by criminal justice professionals. Police officers found the B-SAFER helpful and easy to use in routine investigations of spousal assault complaints. In addition to helping them assess risks, the B-SAFER helped police to make risk management decisions. However, further evaluation of the B-SAFER should be undertaken. Evaluation should examine the inter-rater and test-retest reliability of the B-SAFER, as well as the impact of the B-SAFER on the safety of victims of spousal violence.

In: Intimate Partner Violence Prevention and Intervention ISBN: 978-1-60456-039-8
Editors: A. C. Baldry and F. W.Winkel, pp. 33-44

Chapter 3

POLICE-BASED STRUCTURED SPOUSAL VIOLENCE RISK ASSESSMENT: THE PROCESS OF DEVELOPING A POLICE VERSION OF THE SARA

Henrik Belfrage
Mid Sweden University, Sweden

This chapter describes a developmental project with the Swedish police that had as its objective the revision of an originally clinical risk assessment tool (the SARA) into a tool better suited for practical police work. Three of Sweden's 21 police counties participated in the project, and the study yielded a total of 651 SARA assessments administered to 484 individuals during one year (2001). The result was that a number of modifications in the original SARA were made, resulting in a new abbreviated version of the SARA, called the B-SAFER. The modifications made are described and discussed in detail.

In recent years, spousal violence has been given more attention than it had received in the past. It has been identified as a huge problem in our society, where estimates indicate that between 3% and 14% of women in North America report assaults by their male partners every year (Johnson and Sacco, 1995). In the United States, the 1992 National Crime Victimization Survey indicated that more than a million women were victimized by their intimates (Healey and Smith, 1998). In Canada, spousal violence accounts for approximately 80% of all violence reported to the police, and 20% to 40% of all adult male offenders have a documented history of spousal assault (Kropp and Hart, 2000). In Sweden, where this study was conducted, approximately 22,000 cases of assault against women are reported to the police every year. (Sweden has approximately 9 million inhabitants.). Close to 80% of all violence against women in Sweden is carried out by a perpetrator known to the victim (Rying, 2001). The dark figures related to this type of violence are expected to be high, and thus the costs to society are immense. The effects of spousal violence include physical and psychological damage to the victims, deaths, increased health care costs, prenatal injury to infants, physical and psychological damage to children exposed to violence in their homes, and increased demands for social, medical, and criminal justice services. New legislation,

batterer intervention programs, and victim protection programs are some of the strategies that society is implementing to address this problem.

One of the most essential tasks in this field must be better identification than has hitherto been possible of women at high risk and the development of strategies to reduce that risk. This implies a focus on the potential perpetrators. Who are they? What are their characteristics? What risk factors are of particular importance when assessing risk for spousal violence?

The most validated and research-based structured risk instrument in the field has, for many years, been the Spousal Assault Risk Assessment Guide (SARA) (Kropp, Hart, Webster, and Eaves, 1995). As shown in previous chapters in this book, the SARA contains 20 risk factors that appear to be important to consider when performing risk assessments in the context of spousal assault.

Originally, the SARA was developed by clinicians, to be used by clinicians. However, in recent years, there has been a growing awareness that other, non-clinician, professional groups could benefit from structured checklists when performing risk assessments. This is probably particularly the case among police all over the world, who, every day, perform risk assessments and make decisions about what protective actions to take in cases of spousal assault. The majority of those assessments and decisions are not based on any evidence-based and structured checklists. Even if it is probable that, in a majority of these cases, the police are doing a very good job, the extremely high incidence and prevalence of spousal assault in our society suggests that there is still room for improvement in this area.

This chapter describes a developmental project with the Swedish police that had as its objective the revision of an originally clinical risk assessment tool (the SARA) into a tool better suited for practical police work (the police version of the SARA, the SARA:PV).

THE STUDY

Background

Three of Sweden's 21 police counties participated in the project. All investigative police officers in these counties were trained in using the SARA and then given the task of using these guidelines as a base for their risk assessments in all cases of spousal assault for one year. The original 20-item version of the SARA was used, with the only modification being that the three items in the SARA that can be considered to be clinical in nature (items 8, 9, and 10) could be coded as "provisional" instead of "definite" for the obvious reason that the police lack clinical training. Most of the training in use of the SARA was done during the year 2000 by this author, but some of the police officers also attended lectures given by Professor Randall Kropp before the project was launched in 2001.

The three participating counties were Kalmar, Växjö, and Blekinge, all located in the south of Sweden, and the expected number of SARA assessments was estimated to be approximately 600. In order to ensure that the assessments were carried out and distributed to the research group, two police officers in each of the three counties were given the task of being controllers.

Procedure

In every case of spousal violence reported to the police in these three counties in 2001, (a) data on certain background factors were noted, (b) a SARA rating was completed, and (c) the legal proceedings and proposed protective actions were described. The procedure can be described as in Figure 1.

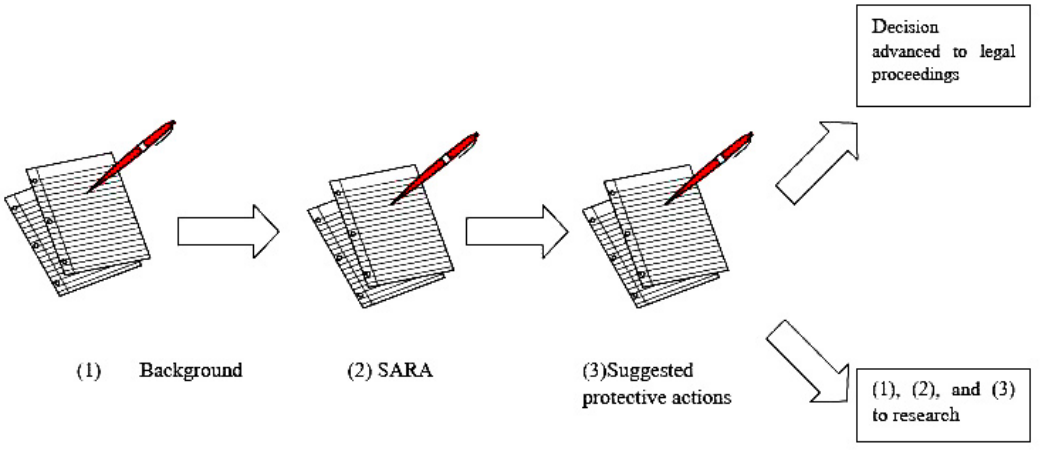


Figure 1. The procedure in the Swedish police-based SARA project.

The Sample

The project yielded a total of 651 SARA assessments administered to 484 individuals. Of these 484 alleged perpetrators, 54 (11%) were women. At first glance, this appeared to be a high number of women. However, a possible explanation for this seemingly high number is the fact that, at the time of their arrests, many of the male alleged perpetrators accused their female partners and ex-partners of spousal assault. Thus, it is likely that a substantial proportion of the female perpetrators might have been falsely accused by their own perpetrators. This uncertainty, together with the differences in other respects between men and women, led to our eliminating the women from the project study group. Thus, the final totals from the project were 584 assessments carried out on 430 adult males.

EMPIRICAL RESULTS OF THE STUDY

Background factors. Among the 430 men in the study group, the mean age was 39.46, with a range of 17 to 92 years of age. No less than 27% (114) had immigrant backgrounds, the definition being "foreign citizen, born abroad, or both parents born abroad." Among the victims, 106 (25%) had immigrant backgrounds. In 72 (17%) of the cases, both the alleged perpetrators and the victims had immigrant backgrounds (this was, to a certain extent, an

overrepresentation -- 3 times -- and a within-group phenomenon). Most immigrant perpetrators had their roots in the former Yugoslavia (32) or in the Middle East (29).

In half of the cases (215), the alleged perpetrator and the victim had an ongoing relationship, whereas in the other half, the relationships had ended. In 42% of the cases, there were children involved. The total number of children was 474 (i.e., larger than the number of adult victims). Sweden still, to a great extent, lacks programs for these children.

Criminal History. Table 1 presents findings on the type of offenses the men were charged with. Some men in the sample were charged with two or more crimes, so the most serious offense was coded first. This was defined as the offense that had the harshest sanction in the Swedish Penal Code. Additional offenses, if any, are listed in the next column.

Table 1. Alleged Offenses, including Attempted Crimes

Alleged offense	Most serious offense *n* = 430		Additional offenses *n* = 147	Total number of alleged offenses *N* = 577	
Murder/manslaughter	2	(0.5)	0	2	(0.5)
Assault	283	(65.8)	2	285	(66.3)
Illegal threat	92	(21.4)	88	180	(41.2)
Arson	1	(0.2)	0	1	(0.2)
Other violent crimes	2	(0.5)	8	10	(2.3)
Rape	2	(0.5)	7	9	(2.1)
Other sexual crimes	0		2	2	(0.5)
Other crimes	1	(0.2)	28	29	(6.7)
Gross violation of a woman's integrity	12	(2.8)	9	21	(4.9)
Violation of no contact order	7	(1.6)	2	9	(2.1)
Molesting	16	(3.7)	26	42	(9.7)
Breach of domiciliary peace	10	(2.3)	10	20	(4.7)
Missing information	2	(0.5)	0	2	(0.5)

Note: Percentages are indicated in parentheses.

As can be seen from Table 1, assault is the most commonly alleged offense in the study group. Gross violation of a woman's integrity is a comparatively new offense in Sweden (1998); under this offense, a perpetrator can be prosecuted for a number of crimes that together have a high penal value. The cases of murder were both attempted crimes. However, during the project period, one case appeared that tragically ended in a murder. The perpetrator relapsed several times during the project period, and several SARA risk assessments were made, the last being high risk, with suggestions for extensive protective actions. The victim, however, chose not to cooperate with the police and thus no actions were taken.

Risk Factors. The 430 men in this study group displayed, on average, 5 risk factors (*R* = 0-16). As risk factors, we consider all ratings of *partly* (1) and *yes* (2) in the SARA. The distribution of risk factors in the study group is shown in Table 2.

As Table 2 shows, the very large number of omitted items for most of the SARA risk factors was striking. Several causes for this high frequency can be identified.

Table 2. Distribution of Risk Factors, including Omitted Items and Critical Items

	SARA risk factors	0	1	2	Omitted items		Critical items	
	Criminal history							
1	Past assault of family members	227	29	105	69	(16)	20	(5)
2	Past assault of strangers or acquaintances	233	22	79	96	(22)	5	(1)
3	Past violation of conditional release or community supervision	335	3	11	81	(19)	0	(0)
	Psychosocial adjustment							
4	Recent relationship problems	61	67	275	27	(6)	24	(6)
5	Recent employment problems	243	26	86	75	(17)	2	(1)
6	Victim of and/or witness to family violence as a child	248	4	11	167	(39)	3	(1)
7	Recent substance abuse/dependence	176	44	146	64	(15)	28	(7)
8	Recent suicidal or homicidal ideation/intent	263	12	41	114	(27)	7	(2)
9	Recent psychotic and/or manic symptoms	244	10	54	122	(28)	8	(2)
10	Personality disorder with anger, impulsivity, or behavioral instability	165	53	110	102	(24)	11	(3)
	Spousal assault history							
11	Past physical assault	148	36	199	47	(11)	26	(6)
12	Past sexual assault/sexual jealousy	285	17	29	99	(23)	7	(2)
13	Past use of weapons and/or credible threats of death	250	62	35	83	(19)	5	(1)
14	Recent escalation in frequency or severity of assault	204	71	91	64	(15)	10	(2)
15	Past violation of “no contact” orders	381	6	10	33	(8)	2	(1)
16	Extreme minimization or denial of spousal assault history	225	21	94	90	(21)	8	(2)
17	Attitudes that support or condone spousal assault	260	15	44	111	(26)	3	(1)
	Alleged offense							
18	Severe and/or sexual assault	166	177	80	7	(2)	4	(1)
19	Use of weapons and/or credible threats of death	229	94	94	13	(3)	10	(2)
20	Violation of “no contact” order	403	8	7	12	(3)	0	(0)

Note: Percentages indicated in parentheses.

a) Unusual Risk Factors in a Police Context

It was clear to this author, before the project started, that it would be difficult, if not impossible, for the police to get sufficient information for several of the SARA risk factors, particularly those pertaining to the perpetrator’s psychosocial situation, which police in Sweden are neither used to nor, in many cases, allowed to gather about suspects. Consequently, it had been discussed, before the project was launched, whether or not to shorten the SARA by removing a number of the risk factors. We decided, however, to keep the SARA intact; the 20 risk factors in the SARA are evidently important and, therefore, any reduction of risk factors should be done first after a possible finding that the police for various reasons could not code some of the risk factors because of lack of information. We also

wanted to keep the instrument intact to ensure the possibility of comparison with other research.

b) Unclear Coding Information

During the first part of the project, the coding "insufficient information" appeared frequently. The reason for this was that the police felt that if they were not certain about a risk factor, no coding should be done. This was particularly true in the case of the psychosocial risk factors. Because the police officers were not perfectly sure about the presence or absence of such factors, the number of omitted items quickly became extremely high. This cautiousness might have been increased by the fact that it had been decided originally that there would be two police assessments for each case: one by an officer in the acute phase, making the initial assessment at the time of the arrest, and one, more comprehensive assessment, later by an investigating officer after having interviewed the victim and/or the alleged perpetrator. In practice, this meant that the latter officer completed a SARA assessment that the first officer had already begun. Given this approach, it was, of course, very important that the officer making the initial assessment not score items when he or she did not have sufficient information to do so. If that officer, for example, scored a *no* when he was not really sure that it should be a *no*, then it could lead to the investigating officer taking that scoring for granted and not making further inquiries -- inquiries that might, with more information, have resulted in a *yes*.

Because this approach became too confusing and difficult to implement in practice, we relatively soon abandoned it and, instead, focused on one risk assessment, namely, the one performed by the investigating officer. The scoring then became clearer, and the officer was to score items using the criterion "as far as known." Using this second approach, the number of omitted items was greatly reduced.

c) Change of the Coding Routine

During the project period, it soon became clear that the coding routine had to be changed in some respects. The order for coding the items according to the SARA, which seemed very logical to us before we started the project, proved to be difficult and sometimes even impossible to follow in practice. To code the SARA, the assessor began with background items and worked his way through items about the current alleged offense. In practice, it turned out that following this order very easily led to the assessor's not being able to separate what had happened in the past from what had happened in the current offense. Consequently, we had to change the order in which to code the items, so that the police officers started with coding the current offense (items 18, 19, and 20) and then scored items 1 to 17. This definitely made it clearer for the police, which we could see from the fact that the number of assessments with "conflicting" coding decreased. In total, the number of omitted items was too high to be acceptable and the consequences of this are discussed below.

Regarding the critical items, their use was very limited and the range was high. In other studies of the SARA, applied to other populations, the system with critical items had showed limited usefulness (Kropp and Hart, 2000). Consequently, we decided to leave those out in the revision of the SARA.

Summary risk ratings. Using the SARA implies that a summary risk rating is done in terms of low, moderate, or high risk. In this study, these ratings were distributed as shown in Table 3.

Table 3. Summary Risk Ratings

Risk	Total		Kalmar County		Kronoberg County		Blekinge County	
	N = 429	%	*n* = 219	%	*n* = 133	%	*n* = 77	%
Low	201	(46.9)	80	(36)	88	(66)	33	(43)
Moderate	169	(39.4)	107	(49)	36	(27)	26	(34)
High	59	(13.8)	32	(15)	9	(7)	18	(23)

Note. One case is missing from Blekinge County.

From Table 3, it can be seen that the most common summary risk ratings were *moderate* or *low*. The summary risk rating was *high* in only 14% of the cases. This was somewhat surprising because spousal assault is often characterized as a serial crime. It is also a different result from what Kropp and Hart (2000) found in their sample of men *sentenced* for spousal assault. In their material, *moderate* and *high* were the most common summary risk ratings, with only 22% rating low. One explanation for this difference is probably the fact that, in the Canadian sample, all men had been *convicted* for spousal assault. In this study, the sample consisted of men who were only *alleged* to have committed spousal assault; a substantial proportion of them probably not would be convicted, and some might even have been falsely accused.

However, there is another probable explanation to this somewhat contradictory and surprising result. The summary risk rating in SARA might be too vague and undefined to be reliable in a police context and thus creates a certain degree of uncertainty among the police. It might be seen as a "one-dimensional" risk rating, where a judgment of either low, moderate, or high is the only choice the rater has in the face of what might be very complicated and different contexts. The difficulty with one-dimensional summary risk ratings became evident when we noted a case where the alleged perpetrator recidivated repeatedly. Despite that, in repeatedly performed SARA assessments, his summary risk rating remained *moderate*. When asked about this, the assessing officer said that he had believed that the suspect would recidivate, but that it would not be a *severe* spousal assault. He thus interpreted *high risk* as high risk for *severe* violence instead of high risk for *any* violence. In another case, where a suspect had received a substantial number of risk factors in the SARA, the assessing officer explained that he truly believed the suspect to be a very high risk, but not *now*, because he was in custody.

The "unclearness" described above might explain why we found one of very few differences between the counties in this respect (Table 3). Kronoberg County had assessed only 7% as high risks, whereas Blekinge had assessed 23% as high risks.

Because of the problems with one-dimensional summary risk ratings described above, we decided to suggest a future revision of the SARA into a "three-dimensional" risk rating, where a rating would include not only the risk for recidivism, but also the severity of a possible relapse and what time perspective the risk should be put into.

Table 4. Distribution of Risk Factors in Relation to the Summary Risk Ratings

Number of risk factors	Low	Moderate	High	Total
0	8			8
1	30	1		31
2	40	2		42
3	30	9		39
4	35	29	4	68
5	16	21	6	43
6	15	26	5	46
7	13	20	2	35
8	9	19	4	32
9	4	19	10	33
10		11	10	21
11		6	8	14
12	1	2	4	7
13		2	3	5
14		2	2	4
16			1	1
Total	201	169	59	429

Note. One case is missing from Blekinge County.

As Table 4 shows, there is a relationship between the number of risk factors assessed and the summary risk ratings of *low*, *moderate*, or *high*. The mean of risk factors was 3.59 in the low-risk group, 6.67 in the moderate-risk group, and 9.00 in the high-risk group. The differences between the groups are statistically significant (ANOVA $df = 2$, $F = 136.8$***), and there is a significant correlation between number of risk factors and the outcome in the summary risk ratings (Pearson $r = 0.63$**). This supports the validity of the SARA in the sense that the risk factors in the instrument seem to be well correlated to risk for recidivism among men who are suspected for spousal violence.

An important objective of this study was to investigate what protective actions the police implemented after their risk assessments. In particular, we were interested in seeing what the relationship would be between the protective actions the police took and their risk ratings (see Table 5).

Table 5. Distribution of Protective Actions in Relation to Summary Risk Ratings

Protective actions $N = 430$		Low $n = 201$	Moderate $n = 169$	High $n = 59$
1	Further examination	67%	65%	58%
2	Register search	68%	70%	73%
3	Contact prosecutor	81%	88%	88%
4	Contact chief of police on duty	2%	2%	5%
5	Security discussion	28%	47%	63%
6	Improved home protection	1%	2%	0%
7	Initiating no contact order	12%	43%	53%

8	Initiating alarm package	2%	10%	19%
9	Initiating a contact person at the police	0%	1%	3%
10	Initiating support person	6%	24%	51%
11	Protected home	1%	4%	10%
12	Initiating risk/threat assessment	2%	2%	15%
13	Initiating life guard protection	0%	0%	0%
14	Protection of identity	0%	1%	0%
15	Contact safehouse	7%	12%	22%
16	Contact victims organization	18%	22%	22%
17	Other actions	16%	21%	20%
18	No actions	18%	8%	3%

The results shown in Table 5 indicate that, to a great extent, there was a correlation between the protective actions initiated and the summary risk ratings (marked with bold). Generally, the higher the summary risk rating, the more common the initiation of protective actions (i.e., 5, 7, 8, 10, 11, 12, and 15). Additionally, the lower the risk, the greater the number of cases in which no action was taken.

Recidivism. During the project period, there were instances of alleged perpetrators in the study group being reported for further spousal assault. These cases were, of course, of great interest, even if a follow-up of these cases was not unproblematic from a scientific point of view. The time-at-risk among the alleged perpetrators varied from 1 to 11 months, which is why the rate of recidivism could not be seen as a relevant and reliable measure. However, even though, in this study, we were primarily interested in the risk assessments performed by the police and what protective actions were made as a result of those assessments (rather than how many recidivated), we decided to analyze this recidivism group further.

We found that 92 (21%) of the 430 men in the study group were reported for at least one more incident, after the original reported offense. This figure must be regarded as a minimum figure, for the reasons discussed above. There were no trends in the recidivism group, at least not according to background factors. Thus, there were no differences between those who recidivated and the others related to history of crime, children in the relationships, immigrant background, or what county they were living in. There were, however, differences related to the number of risk factors the men were assessed as having. The recidivism group had more risk factors (M = 6.41) compared to those who did not recidivate (M = 5.31, t-test df = 427, t = -2,99**). However, no particular risk factors were more linked to recidivism than others.

It was of interest, of course, to analyze the relationship between summary risk ratings done by the police and the rates of recidivism. As seen in Table 6, recidivism was low among those assessed as high risk. At first glance, this might look surprising and even be regarded as a very negative result indicating that the police were wrong in their prediction of recidivists. Such an interpretation of the results is, however, incorrect for many reasons. In particular, for example, as a direct consequence of their risk assessments, the police initiated more and more comprehensive protective actions, as shown in Table 5. The result should, therefore, be seen as positive; that is, because of the protective actions they took, which were prompted by their SARA risk assessments, the police probably, to a great extent, managed to prevent a certain amount of spousal assault.

Table 6. Recidivism in Relation to Summary Risk Ratings

Summary risk rating	No recidivism *N* = 338		Recidivism *n* = 92	
Low	168	(50)	33	(36)
Medium	124	(37)	45	(49)
High	45	(13)	14	(15)

Note. Percentages indicated in parentheses.

When the recidivism rate within each of the risk categories was analyzed, the rates in the high-risk and moderate-risk groups were approximately the same (24% and 26%), whereas the rate was lower in the low-risk group (16%). An expected result would have been that the high-risk group would have recidivated to a greater extent than the others, according to previous research (Kropp and Hart, 2000). However, one must bear in mind the uncertainty and the various praxes that evolved during the project period regarding the summary risk ratings (discussed above). One must also keep in mind the relatively high recidivism rate during the study period (21%), which, in itself, must be seen as something of a failure, even if a plausible interpretation of the results of this study is that, over the course of the project, the police became more professional in the area of risk assessments of spousal assault.

CONCLUSIONS AND SUGGESTED REVISIONS OF THE SARA FOR USE BY THE POLICE

The first year of the project can be said to have been very successful in some respects, but less successful in others. From a strict *scientific* point of view, it was less successful in that the experimental approach -- to first implement and then evaluate -- was quickly abandoned. There was a constant process of improving the SARA in a variety of ways during the project. The order of rating the SARA was changed, because it turned out to be easier for the police to start with scoring the last, instead of the first, part of the SARA. An interview guide was developed, and the language in the SARA was slightly revised to better suit the police context. In practice, the process described above must be seen as something of a success. The SARA was constantly improved, and, thus, the police were becoming more and more professional in the area of risk assessment.

From the results in this study, along with the results of an extensive Item Response Theory analysis of the 2,681 SARA ratings presented in Kropp and Hart (2000) and performed by Cooke and Michie (2003), the following modifications to the SARA were made, resulting in the B-SAFER (Kropp, Hart, and Belfrage, 2004):

1) The system with critical risk factors was abandoned. In this study, as in previous studies (see Kropp and Hart, 2000), there was a wide range in the use of these factors. An acceptable reliability, as well as validity, seems to be hard to accomplish with the critical item approach.

2) The sequence of scoring the SARA was changed. The previous method of scoring the SARA, starting with the background and ending with the previous current offense situation, was changed to an approach where both the background factors and the present situation are considered for every item. One consequence of this is that the four sections in the SARA (Background, Psychosocial Adjustment, Spousal Assault History, and Current Offense), were replaced by two (Spousal Assault and Psychosocial Adjustment).
3) The number of risk factors was reduced from 20 to 10, with the following changes (the number of the items in the respective SARA versions in parenthesis):
    a) The two items (1, 2) on violence towards other family members and violence toward strangers have been collapsed into one item, Other Violence (6).
    b) The three items concerning no-contact orders and other forms of supervision (3, 15, 20) have been collapsed into one, Violation of Conditional Release or Community Supervision (4).
    c) The three items that could considered to be "clinical" (8, 9, 10) have been collapsed into one, Mental Disorder (10). The possibility of making the rating "provisional" or "definite" remains.
    d) Sexual Jealousy (12) has been included in item 5 in the B-SAFER, Negative Attitudes about Spousal Assault. More emphasis than before has also been put into "controlling" and "possessiveness" in this item.
    e) Use of Weapons (13, 19) has been included in item one, Physical/Sexual Violence, while Threats of Violence has become an item of its own: Violent Threats, Ideation, or Intent (2).
    f) Victim of and/or Witness to Family Violence as a Child or Adolescent (6) has been deleted as a risk factor in the B-SAFER because of the extensive number of times it wasn't coded in this study. The police generally have great difficulty in getting relevant and reliable information in order to code this item. However, this risk factor will, of course, still be present in the SARA, which is recommended when a more comprehensive risk assessment is needed.
    g) Non-violent Criminality has been added as a risk factor on scientific grounds. There is an evident overrepresentation of non-violent criminality in perpetrators of spousal assault (6).
    h) The summary risk rating was more clearly defined and modified from one-dimensional to three-dimensional. It is now clarified that the risk should be rated *if no intervention* is taken. Furthermore, instead of only making a rating of either low-, moderate-, or high-risk, the rater would now also consider a time perspective (imminent and long-term risk) and the level of severity of possible violence.

The above modifications aim at making the coding of the B-SAFER easier in the police context. Thus, the number of items has been reduced, and the definitions of the items have been better adapted to fit the police. However, it is important to stress that this revision does not mean that less training is needed to use the B-SAFER. It may even be that more training than was previously provided is needed. One reason for this is that because the items have been reduced from 20 to 10, every item now includes a more comprehensive consideration than before. Additionally, because all 10 risk factors are to be considered both in the present

situation and in the past, the B-SAFER can be said to still include 20 items. Finally, the summary risk rating has to be done three dimensionally instead of using the previous one-dimensional approach.

The B-SAFER is translated into Swedish (Belfrage, 2004) and Norwegian (Alfarnes, 2004) and is currently being implemented nationally in Sweden. It will be subject to continual follow-up studies.

In: Intimate Partner Violence Prevention and Intervention ISBN: 978-1-60456-039-8
Editors: A. C. Baldry and F. W.Winkel, pp. 45-60

Chapter 4

UNDERSTANDING RISK FACTORS FOR INTIMATE PARTNER FEMICIDE: THE ROLE OF DOMESTIC VIOLENCE FATALITY REVIEW TEAMS

Kelly Watt
Clinical/Community Division of the Department of Psychology
at the University of Illinois at Urbana-Champaign, USA

Intimate partner femicide, the killing of women by their current or former partners, is a serious international problem resulting in immense personal, social, medical, and legal costs to society. Until recently, little attention has been paid to the widespread occurrence of intimate partner femicide and few resources have been devoted to its understanding and prevention. In many cases intimate partner femicides are preventable occurrences given that family members, friends, co-workers, neighbors, or agencies were aware of or suspected serious problems in the victim-perpetrator relationship prior to the killings. This chapter aims to provide an overview of the factors associated with intimate partner femicide and to discuss a number of approaches that have been used for reviewing incidents that have occurred. Special emphasis will be placed on domestic violence fatality review teams as a promising means of understanding, intervening, and preventing intimate partner femicides.

Intimate partner femicide (IPF), the killing of women by their current or former intimate partners, is a serious problem worldwide, and one that is often associated with a previous history of non-lethal intimate partner violence (Krug, Dahlberg, Mercy, Zwi, and Lozano, 2002). IPF is the single most common form of homicide perpetrated against women (Brown, 1987; Campbell, 1986; Daly and Wilson, 1988; Mouzos, 2000; Polk, 1994; Wilson and Daly, 1992). For example, in the United States, Canada, and Great Britain, IPF accounts for 30-60% of all culpable homicides of females annually (Bureau of Justice Statistics, 2004; Dobash, Dobash, Cavanagh, and Lewis, 2004; Statistics Canada, 2003). These are likely underestimates of the true rate of IPF, due to the lack of a clear definition and inconsistent procedures for recording victim-perpetrator relationship in official crime statistics (Dobash et al., 2004; Pampel and Williams, 2000; Websdale, 1999). Furthermore, in some regions,

while overall homicide rates are decreasing, the rate of IPF is stable or even increasing (Aldridge and Browne, 2003; Campbell et al., 2003; Frye and Wilt, 2001). Tragically, many cases of IPF may be preventable, given that family members, friends, co-workers, neighbors, or agencies were aware of or suspected serious problems in the victim-perpetrator relationship prior to the killings (Abrams, Belkap, and Melton, 2000; Websdale, 2003). As a result of the immense personal, social, medical, and legal costs to society resulting from IPF, it is important to identify means to prevent or reduce its occurrence (Frye and Wilt, 2001; Venis and Horton, 2002; Websdale, Town, and Johnson, 1999).

Until recently, little attention has been paid to the widespread occurrence of IPF and few resources have been devoted to its understanding and prevention. During the past 15 years, however, domestic violence fatality review teams have emerged in the United States and Canada (Websdale, 1999, 2003). Domestic violence fatality review teams are a form of community partnership in which an alliance is made among people and organizations from multiple sectors to achieve a common goal (Roussos and Fawcett, 2000) – in this case, the prevention of IPF. Generally, domestic violence fatality review teams bring stakeholders together to systematically analyze the events leading to IPF in a given jurisdiction and to determine what could have been done differently to prevent their occurrence (Websdale, 1999). Stakeholders work collaboratively to prevent future IPF by developing ideas about how to change policies and procedures of participating agencies, how to better coordinate existing responses to domestic violence, and how to develop new services (Websdale, 1999).

This chapter aims to provide an overview of the factors associated with IPF and to discuss domestic violence fatality review teams as a means of understanding, intervening, and preventing these events. We start by reviewing the risk factors associated with IPF, including characteristics of the perpetrator, the victim, their relationship, and the community in which they lived. Next, we summarize what we have learned from previous research on IPF and what important gaps exist in our knowledge. Following this we briefly introduce a number of approaches for reviewing IPF and discuss their strengths and limitations. Finally, we focus on domestic violence fatality review teams as a promising means of increasing our understanding of IPF and contributing to the prevention of future deaths.

REVIEW OF RESEARCH ON RISK FACTORS FOR INTIMATE PARTNER FEMICIDE

Research on IPF has focused on the identification of risk factors for perpetration or victimization. Research of this sort is critical for guiding prevention efforts, including offender risk assessment and victim safety planning (Bourget, Gagne, and Moamai, 2000; Campbell, Sharps, and Glass, 2001; Healey and Smith, 1998; Kropp and Hart, 2000); legal decision making with respect to protection orders, penal sentencing, and conditions for community supervision (Websdale, et al., 1999); and the response of various community agencies to actual, suspected, or potential domestic violence. Information regarding risk factors for IPF comes from official criminal justice statistics in various jurisdictions (e.g., Browne, Williams, and Dutton, 1999, Bureau of Justice Statistics, 1998, Daly and Wilson, 1988), government reports for specific counties or states (e.g., Websdale, Sheeran, and Johnson, 2001), studies of convicted perpetrators, victims' coroner's files, or interviews with

proxies (e.g., Bourget et al., 2000; Campbell et al., 2003; Dutton and Kerry, 1999; Morton, Runyan, Moracco, and Butts, 1998), and reports by domestic violence fatality review teams (e.g., Abrams et al., 2000). Some studies have focused on describing cases of IPF (e.g., Dawson and Gartner, 1998; Johnson and Hotton, 2003; Moracco, Runyan, and Butts, 2003), whereas other studies compared IPFs to cases of non-lethal intimate partner violence (e.g., Campbell et al., 2003; Kellerman, Rivara, and Rushforth, 1993) or to other types of homicide (e.g., Belfrage and Rying, 2004; Dobash et al., 2004).

In general, risk factors associated with IPF can be divided into four categories: characteristics of the perpetrator, the victim, their relationship, and the community in which they lived. Below, we summarize research concerning each of these categories. Our review is limited to studies published in the English language.

Characteristics of the Perpetrator

Perpetrator risk factors include historical events, developmental experiences, personality characteristics, and life circumstances that increase a perpetrator's risk of committing IPF. These factors typically increase risk of IPF in one of two ways: by increasing the perpetrator's thoughts, desires, or ability to cause serious harm to his partner; or by decreasing a perpetrator's inhibitions once he experiences thoughts or desires of harming his partner.

Socially disadvantaged. Similar to men who perpetrate either non-lethal intimate partner violence or other forms of homicide, men who commit IPF are likely to be socially disadvantaged in that they often are young, poor, unemployed, and members of ethnic minorities (Campbell et al., 2001; Campbell et al., 2003; Dobash et al., 2004).

Victim of child abuse. Similar to perpetrators of non-lethal intimate partner violence, accumulating evidence suggests that perpetrators of IPF experienced or witnessed physical abuse in childhood (Aldridge and Browne, 2003; Browne et al., 1999; Showalter, Bonnie, and Roddy, 1980). For instance, Stout (1993) found that almost 40% of perpetrators of IPF witnessed spousal violence, and Dobash et al. (2004) found that almost 20% of perpetrators of IPF had been physically abused in as children. This is consistent with theories about the intergenerational transmission of violence, in which individuals replicate the violence they witnessed when they were children (Dobash et al., 2004).

Previous intimate partner violence. Research indicates that perpetrators have commonly been violent towards other intimate partners in the past (Abrams et al., 2000). For instance, Dobash et al. (2004) found perpetrators of IPF had more intimate relationship problems than men who killed in other contexts. The perpetrators of IPF had a greater number of failed relationships, were more likely to have perpetrated violence in intimate relationships, and appeared to "specialize" in committing violence directed specifically towards women (Dobash et al., 2004). This history may reveal important information about the general attitudes, emotions, and behavior towards intimate relationships that perpetrators bring into their current relationship.

Proprietariness. Proprietariness refers to a desire for exclusive control of women and a feeling of entitlement of that control (Wilson and Daly, 1992). Daly and Wilson (1988) suggest that proprietariness is an underlying dynamic of IPF. Perpetrators may express proprietary attitudes in behaviors such as restricting an intimate partner from engaging in

activities, preventing her from forming or maintaining relationships with others, or becoming sexually jealous in reaction to actual or perceived sexual attention directed by others toward her. Research suggests that proprietariness is evident in many cases of IPF (Block, 2003; Dobash et al., 2004; Easteal, 1993; Polk, 1994; Serran and Firestone, 2004; Websdale, 1999). Wilson, Johnson, and Daly (1995) found that the majority of cases of IPF they reviewed were precipitated by the man accusing his partner of sexual infidelity. In addition, Campbell et al., (2003) found that batterers were particularly likely to perpetrate IPF following separation when victims left them to start new relationships. It has been theorized that the use of violence may escalate when the woman leaves her partner because separation would be a direct challenge to male partners who believe they ''own'' their female partners (Serran and Firestone, 2004).

Possession of firearms. Campbell et al. (2003) suggested that the availability of a gun increases the likelihood that a perpetrator will use it during incidents of domestic violence (see also Bailey et al., 1997; Kellerman et al., 1993). However, this finding may be specific to the United States; in other countries, such as Canada, Britain, and Sweden, victims are most likely to be stabbed to death (Aldridge and Browne, 2003; Belfrage and Rying, 2004).

Criminal history. Many perpetrators of IPF have prior histories of criminal behavior. Research suggests that over half of perpetrators have prior arrests, most commonly related to domestic violence, non-domestic violent crime, and possession of narcotics (Belfrage and Rying, 2004; Campbell and Wolf, 2001; Dobash et al., 2004; McFarlane et al, 1999). However, in a smaller number of cases (e.g., 30%) perpetrators have no known violent or criminal behavior prior to the homicide (Ryan, Bensinger, and Kane, 2000; Abrams et al., 2000). This suggests that, at least in some cases, IPF may be associated with a more general pattern of antisocial attitudes and behavior.

Mental health problems. Perpetrators of IPF often have history of mental illness or a diagnosis of personality disorder (Campbell et. al., 2001; Dobash et al., 2004; Morton et al., 1998; Zawitz, 1994). In their review of all cases of spousal homicide in Sweden between 1990 and 1999, Belfrage and Rying (2004) found that 95% of perpetrators were diagnosed with at least one mental disorder. Specific mental health problems that have been associated with perpetrators include depression, sleeplessness, suicidal ideation or attempts, and threats of homicide (Campbell et al., 2001; McFarlane et al., 1999). Dutton and Kerry (1999) suggested that men who killed their partners during the course of a separation often had dependent, passive-aggressive, or borderline personality disorders; in contrast, men who killed their partners for instrumental reasons were more likely to have anti-social personality disorder.

Substance use problems. Perpetrators of IPF commonly have substance use problems. Research suggests that approximately 50% of perpetrators have a history of alcohol abuse or problem drinking, while approximately 15% have a history or drug abuse (Dobash et al., 2004; Belfrage and Rying, 2004, Sharps, Campbell, Campbell, Gary, and Webster, 2001, 2003; Stout, 1993). Similarly, between 20% and 50% are under the influence of alcohol and between 8% and 11% are under the influence of drugs at the time of the IPF (Dobash et al., 2004; Sharps et al., 2003; Stout, 1993). However, there may be differential risk for IPF depending on the substance used, the context in which it is consumed, and the amount ingested (Campbell et al., 2001, Dobash et al., 2004).

Characteristics of the Victim

Understanding IPF also requires understanding characteristics associated with victims, including historical events, developmental experiences, personality characteristics, and life circumstances that are associated with increased risk of IPF. Typically, these factors – which may be termed *victim vulnerability factors* (Fitzgerald, Drasgow, Hulin, Gelfand, and Magley, 1997; Fitzgerald, Hulin, and Drasgow, 1994) – may increase the victim's risk of IPF in one of three ways: by increasing the likelihood that she will establish a relationship with an individual who is at risk of perpetrating IPF, by preventing her from perceiving risks while in the relationship, or by decreasing the likelihood that she will take protective action once the risks are apparent.

Socially disadvantaged. In the United States, ethnic minorities tend to be over-represented among victims of IPF (Sharps et al., 2001, Campbell et al., 2003). These women may be in relationships with men who are also from ethnic minorities, which is a known risk factor for perpetrators (see above). However, research also suggests that ethnic minority communities are not as well informed about the dangers of domestic violence, the importance of reporting domestic violence to the police, and the acceptability of going for help from agencies outside the community (Santa Clara County Domestic Violence Council Death Review Committee, 2000). Over-representation of ethnic minorities may also reflect that historically community resources have been less available to communities of color and that women of color may be reluctant to report their partners to criminal justice systems that are known for inequitable practices (Richie and Kanuha, 1997).

Previous intimate partner violence. In addition to experiencing violence in their current relationship, research indicates that victims have often been abused in previous relationships (Abrams et al., 2000). Similar to perpetrators, relationship history may reveal important things about the general attitudes, emotions, and behavior towards intimate relationships that victims bring to their current relationship. Riggs, Caulfield, and Street (2000) suggested that experiencing violence in previous intimate partner relationships may lead to the development of behavioral patterns and expectations, including violence, which develop during earlier intimate partner relationships and tend to carry over and become foundations for future relationships.

Mental health problems. In many cases of IPF, victims show signs of increasing mental health problems prior to their death, as evidenced by stress-related physical and mental health problems such as sleeplessness and deterioration in social functioning (Abrams et al., 2000; Santa Clara County Domestic Violence Council Death Review Committee, 2000). In many cases, these symptoms may be a direct result of an escalation in intimate partner violence experienced by the victim.

Substance use problems. Similar to perpetrators of IPF, many victims of IPF have substance use problems. Sharps et al. (2003) found that approximately 30% victims of IPF have sought treatment for alcohol use problems and approximately 20% have sought treatment for drug use problems in the past. Within the year preceding the IPF, approximately 10% of victims were characterized as problem drinkers, compared to 1% of the general population (Sharps et al., 2001, 2003). Previous research also suggests that approximately 25% of victims are under the influence of alcohol at the time of the IPF (Sharps et al., 2001, 2003).

Characteristics of the Victim-Perpetrator Relationship

Relationship risk factors comprise such things as the feelings, attitudes, and behavior of the partners (current or former) toward each other, including the nature and quality of their emotional bonds, their views regarding actual and preferred relationship roles, and the way that they interact with each other.

Relationship status. Research indicates that women in common law relationships are at greater risk for IPF than are married women (Wilson et al., 1995; Shackelford, 2001). In addition, women's risk of IPF tends to decrease as they become older and to increase with the disparity between partner's ages (Wilson et al., 1995; Wilson, Daly and Wright, 1993). These findings have been interpreted to suggest that males experience greater proprietariness in common law unions, when their female partners are young, and when the age discrepancy between partners is large (Daly and Wilson, 1988).

Intimate partner violence. Prior violence in the relationship is one of the strongest and most consistent risk factors associated with IPF (Aldridge and Browne, 2003; Campbell et al., 2003). Studies indicate that between 50% and 75% of cases involve battering of the victim by the partner in the time prior to her death (Bailey et al., 1997; Campbell, 1992; Campbell et al., 2001, 2003; Dobash et al., 2004; McFarlane, et al., 1999; Moracco, Runyan, and Butts, 1998). In addition, intimate partner violence tends to escalate prior to the IPF. Studies document increases in the severity and frequency of violence, including threats to kill, threats with a weapon, strangling, beating while pregnant, forced sex, emotional abuse, and controlling behaviors. (Block, 2003; Campbell, 1995; Campbell et al., 2003; Websdale, 1999).

Separation. A history of actual or planned separation is strongly associated with IPF (Aldridge and Browne, 2003; Campbell et al., 2001; Daly, Wiseman, and Wilson, 1997). Research suggests that between 30% and 75% of victims had separated from their partners or were in the process of separating at the time of the IPF (Belfrage and Rying, 2004; Block, 2003; Dobash et al., 2004; Wallace, 1986). In many cases, women are at the highest risk in the period immediately following estrangement (Stout, 1993; Wilson and Daly, 1993), particularly if the perpetrator is highly controlling (Campbell et al., 2004). It has been theorized that when women announce their desire to leave the relationship, male partners commit IPF due their inability to cope with a loss of control over the relationship (Campbell, 2001; Johnson and Hotton, 2003) or a sense of abandonment (Dutton, 2002). Although it is clear that the period after separation is a time of increased risk, it is important to recognize that a large proportion of women are in intact relationships at the time they are killed (Dawson and Gartner, 1998; Moracco et al., 2003; Smith, Moracco, and Butts, 1998).

Stalking. In cases where the victim and perpetrator separate, many perpetrators engage in stalking or controlling behavior, such as threats of harm, following the victim, and unwanted communication (Aldridge and Browne, 2003; Campbell, 1995). McFarlane et al. (1999) found that during the 12 months prior to an actual or attempted IPF, more than 75% of women were stalked. Stalking behavior within the context of IPF has been associated with extreme jealousy, perceptions of betrayal, obsessive thinking, possessiveness, and proprietariness on the part of the perpetrator (Campbell and Wolf, 2001; Daly and Wilson, 1988). The occurrence of stalking in conjunction with a history of intimate partner violence may be a particularly important risk factor for lethal or near lethal violence (Campbell and Wolf, 2001; McFarlane et al., 1999).

Children. The presence of children in a relationship may be associated with increased risk for IPF. For example, studies indicate that approximately half of IPF victims have children from previous relationships (Brewer and Paulsen, 1999; Daly, Wiseman and Wilson, 1997). In addition, abuse during pregnancy has been associated with IPF (Campbell et al., 2001; 2003). Evolutionary theories have attempted to explain these findings, by suggesting that the presence of children represent a drain on the attention and resources that the mother can devote to the new partner, which in turn increases the risk of jealousy, proprietariness, and ultimately IPF (Brewer and Paulsen, 1999).

Characteristics of the Community

Community responsiveness factors are characteristics of the social support network, neighborhood, and community that may contribute to the occurrence of IPF. Norms, laws, policies, procedures, services, and support may be inadequate to prevent a perpetrator from committing violence or to assist a victim in increasing their safety. In some cases, helping agencies may actually condone violence by minimizing and denying the effects of violence and blaming the women for the abuse (Ptacek, 1999).

Problems with response of the social support network. In the majority of cases of IPF, family, friends, co-workers, or neighbors were aware of or suspected serious problems in the victim-perpetrator relationship prior to the killings (Abrams et al., 2000; Websdale, 2003). For instance, threats to kill the victim were often communicated to others prior to the homicide (Florida Domestic Violence Fatality Review Team, 1994). However, in many cases those who were aware that something was wrong either did nothing to intervene or provided assistance that was inadequate to prevent IPF (Santa Clara County Domestic Violence Death Review Committee, 2000; Abrams et al., 2000).

Problems with availability of community resources. Victims and perpetrators often seek help from community resources to deal with problems affecting their relationship, including intimate partner violence, prior to the IPF (Abrams et al., 2001; Block, 2003; Sharps et al., 2001). Most commonly, victims and perpetrators seek help from the health care or criminal justice system (Block, 2003). However, there may be limited or no availability of community resources due to things such as geographical location, government cutbacks, and inadequate funding or staffing for services. For instance, reductions in welfare payments have been associated with an increase in IPF (Dugan, Nagin, and Rosenfeld, 2003a). This finding suggests that government cutbacks may limit opportunities women have to live independent of their abusers (Dugan, Nagin, and Rosenfeld, 2003b).

Problems with accessibility of community resources. In addition to limited availability of community resources, there may also be limited or no accessibility to existing community resources for some victims or perpetrators due to things such as cost of services, lack of transportation, or lack of culturally appropriate services. Research suggests that victims of different ethnic backgrounds utilize shelter and criminal justice services at different rates (Block, 2003; Websdale et al., 1999). This is not surprising, given Richie and Kanuha's (1997) findings regarding the inaccessibility of community services for women of color due to racist and sexist institutional responses.

Problems with appropriateness of community resources. When victims and perpetrators seek help to deal with problems affecting their relationship, they may be faced with poor or

inappropriate responses by community resources including failure to provide services, lack of knowledge about intimate partner violence, and victim blaming. Research suggests that when policies and procedures were inconsistently applied and interpreted they lead to increased risk of harm to victims of domestic violence (Michigan Domestic Violence Homicide Prevention Task Force, 2001). Alternatively, services that are designed to increase safety may unintentionally increase the risk of IPF by angering or threatening the abuser without effectively reducing contact with the victim (Dugan et al., 2003a).

Problems with coordination of community resources. Despite the fact that both victims and perpetrators commonly seek assistance from community resources, research has highlighted deficits in coordination and communication of various agencies involved in domestic violence cases (Michigan Domestic Violence Homicide Prevention Task Force, 2001). Problems with coordination of community resources may be due to things such as lack of information sharing protocols, gaps in the policies and procedures for coordination between services, and strained relationships among service providers. Research suggests that criminal justice agencies often do not have access to complete and accurate information regarding the criminal histories and personal protection order histories of abusers (Michigan Domestic Violence Homicide Prevention Task Force, 2001).

GAPS IN THE EXISTING RESEARCH ON IPF

Previous research has advanced our understanding of IPF significantly. It has allowed us to identify general characteristics associated with the perpetrator, the victim, their relationship, and the community response that may contribute to the occurrence of IPF (see Table 1). For example, perpetrators of IPF often have a history of child abuse, relationship difficulties, proprietary attitudes, violent and non-violent criminality, mental health problems, and substance abuse. Victims of IPF often have a history of experiencing intimate partner violence, stress-related physical and mental health problems, and substance abuse. The perpetrator-victim relationship frequently includes a history of intimate partner violence -- such as physical assault, threats, and stalking -- as well as actual or attempted separation. Finally, the communities in which the perpetrator and victim live may be characterized by problems with the response of the social support network and an inadequate or poorly coordinated community response. This research has allowed us to identify multiple levels of factors that may be important targets of intervention and prevention strategies.

However, this body of research typically has suffered from one or more weaknesses. First, much of it was not guided by theory. With few exceptions (e.g., Daly and Wilson, 1988; Dobash et al., 2000), researchers studied risk factors that were identified easily from health or criminal justice records, rather than factors believed to be specifically or causally related to IPF. Therefore, most research has identified risk factors that were frequent or common across cases, but very little theory has been developed about how or why these factors are important.

Second, most research examined risk factors from only a single level of analysis, such as the individual (e.g., perpetrator) or relationship level. By failing to consider the victim or the community response, researchers have ignored additional factors that may increase the risk of IPF and potential interactions among factors across levels of analysis (e.g., Blalock, 1984). In

other words, previous research has often neglected to examine the interactive context in which IPF occurs. The ecological transactional approach is an example of a model that examines multiple levels of analysis and how factors at different levels may interact with each other (see Altman and Rogoff, 1987; Bronfrenbrenner, 1979; Felner, Felner, and Silverman, 2000; Linney, 2000). This model has been effectively employed for studying domestic violence in general (e.g., Carlson, 1984; Dutton, 1995; Edleson and Tolman, 1992; Heise, 1998) and IPF specifically (Watt, 2003).

Table 1. Risk Factors for Intimate Partner Femicide

Category	Risk factor
Perpetrator	
	Socially disadvantaged
	Victim of child abuse
	Previous intimate partner violence
	Proprietariness
	Possession of Firearms
	Criminal history
	Mental health problems
	Substance use problems
Victim	
	Socially disadvantaged
	Previous intimate partner violence
	Mental health problems
	Substance use problems
Victim-Perpetrator relationship	
	Relationship status
	Intimate partner violence
	Separation
	Stalking
	Children
Community	
	Problems with the response of the social support network
	Problems with of availability of community resources
	Problems with accessibility of community resources
	Problems with appropriateness of community resources
	Problems with coordination of community resources

Third, most research has treated risk factors as static in nature, making it difficult or impossible to identify dynamic or developmental processes leading to IPF. As opposed to focusing on IPF as an outcome or endpoint, it may be more accurately portrayed as a process that unfolds over time. For example, in many cases of femicide there is a lengthy escalation of violence with many interventions considered and attempted by multiple people and agencies. An understanding of developmental processes is critically important for the identification of risk factors that may be relevant only at specific times in or stages of a relationship, as well as for planning the delivery of services designed to prevent IPF.

Without in-depth knowledge of the context and processes of IPF, research is limited in the extent to which it can explain why IPF occurs and what strategies should be taken to prevent future occurrences. However, violence against women occurs within diverse contexts, with differences in the patterns of violence used by batterers and differences in the experiences and responses of victims (Piispa, 2002). Therefore, future research needs to embrace strategies that provide rich information about the diverse context and processes of IPF.

STRATEGIES FOR REVIEWING INTIMATE PARTNER FEMICIDE

Several strategies have been used to gain further insight into the context and processes underlying cases of IPF. These strategies include agency reviews, judicial reviews, public inquests, and domestic violence fatality review teams (see Watt, Hart, Kropp, and Bain, 2004, for a more detailed review). Although the primary goal of each of these approaches is to reduce the occurrence of future IPF, they differ with respect to the degree that they contribute to understanding and preventing IPF. This section will discuss the different strategies for reviewing IPF and the strengths and limitations of each. We will devote the majority of the section to domestic violence fatality review teams and discuss how they are a promising means of addressing the gaps in our understanding of IPF and contributing to the prevention of future deaths.

Agency Reviews

Structure. Many people who subsequently become perpetrators or victims of IPF have received services from governmental and non-governmental agencies in the social service, criminal justice, and health care sectors. If an agency becomes aware that a former client was involved in an IPF, the agency may undertake a review to determine whether staff followed organizational policies and procedures with respect to delivery of services in a particular case.

Goals. The primary goal of an agency review is to determine whether the actions of members may have contributed to the occurrence of the IPF, thus exposing the agency to liability. A secondary goal may be to review the delivery of services, including organizational policies and procedures.

Procedures. Agency reviews typically are ordered or requested by local managers or administrators. The review itself is conducted by agency members according to internal guidelines. The most common method of review is inspection of agency records; agency members may also be interviewed, usually informally (i.e., without representation).

Outcomes. The most common outcome of an agency review is a brief report for internal distribution that describes the agency's contact with the clients and identifies any breaches of policies and procedures, as well as the members responsible for the breaches. The report may be used to determine and justify sanctions for agency members who breached policies and procedures (e.g., warning, suspension, dismissal), and to take steps designed to minimize the agency's exposure to legal liability (e.g., preparation of public statements, consultation with corporate counsel, referral of the matter to police).

Strengths. An important strength of agency reviews is their accuracy. Because they are usually conducted by people familiar with the agency's policies and procedures, members, and day-to-day operations, agency reviews are likely to be based on information that is correct. Another strength is their relevance. Agency reviews typically form opinions and reach conclusions that are directly related to the agency's primary mission. This increases the chances that recommendations will be accepted, implemented, and enforced.

Limitations. A major weakness of agency reviews is their narrow focus on single events. The issues arising may not be representative of the problems that occur in "typical" cases of intimate partner violence or femicide. Also, agency reviews tend to focus on a single organization; information, problems, and concerns external to the agency may be ignored altogether. A second weakness is that agency reviews are reactive in nature. The focus on determination of facts and assignation of blame diverts attention away from prevention of future incidents. A third weakness is the private nature of agency reviews. They are rarely distributed publicly, so others cannot benefit from the findings or recommendations.

Judicial Reviews

Structure. Most jurisdictions have statutory provisions for the review of sudden deaths, when circumstances indicate that the cause of death is unclear or the findings may have broader implications for public safety. The presiding judge may be a member of the regular criminal or civil courts, or specially appointed to coroner's court; in some jurisdictions, a jury may assist the judge.

Goals. The primary goal of a judicial review is to determine cause of death. A secondary goal may be to make recommendations that may prevent further injury or death.

Procedures. The criteria for determining when judicial reviews are convened typically are set out in statute. Most criteria are narrow in scope, stipulating cases in which reviews must be done. The review is conducted by the court according to rules of administrative law. Information considered as part of the review is legal evidence in the form of witness testimony and documents, typically requested by the court or submitted to it by interested parties. The court itself and other interested parties may be represented by legal counsel.

Outcomes. The most common outcome of a judicial review is a report that summarizes findings of fact, reaches conclusions regarding cause of death, and presents recommendations designed to prevent future injury or death. Reports range in length from a few to hundreds of pages and are available to the public and sometimes distributed widely. Most judicial reviews have limited authority, insofar as their findings are not binding on others, they do not determine culpability for death, and they do not have the authority to enforce recommendations.

Strengths. An important strength of judicial reviews is their neutrality. The judges presiding over the reviews are disinterested in the case under review, which increases their objectivity when reviewing evidence, reaching conclusions, and making recommendations. A second strength is their broad scope and comprehensiveness. Judicial reviews have the ability to consider and receive into evidence virtually anything they deem relevant, and may also have powers to compel witnesses to testify and order the production of documents. Third, judicial reviews often are well resourced. They have both the time and the financial resources necessary to conduct an adequate review. Finally, judicial reviews may be influential in

promoting positive change given their findings are public and wrapped in a mantle of moral authority.

Limitations. A major weakness of judicial reviews is their focus on cause of death. The facts in a given case may be quite unusual, and thus any subsequent recommendations may lack more general relevance. Also, focusing on the proximal circumstances surrounding a death draws attention away from more distal processes that may play a contributory role. A second weakness is their lack of specific expertise. As a consequence of being at arm's length, judges and juries usually lack personal knowledge of the people and agencies involved in the case. Consequently, the conclusions and recommendations may lack impact on or relevance to interested parties.

Public Inquests/Inquiries

Structure. Most governments have the statutory authority to order public inquests or inquiries into critical incidents when circumstances indicate that the common good will be served by a full and open investigation. Government officials typically have very broad discretion with respect to determining terms of reference, including issues to be analyzed, who will preside, and the deadline for submission of a final report.

Goals. The goals of a public inquest are set out in its terms of reference. These typically involve finding fact, determining culpability, and making recommendations that may prevent further injury or death.

Procedures. Although public inquests have explicit terms of reference, the person(s) presiding over them may have considerable discretion in interpreting the terms of reference and determining the nature and scope of the proceedings. Public inquests are conducted according to rules of administrative law. Information considered as part of the review is legal evidence in the form of witness testimony and documents, typically requested by the court or submitted to it by interested parties. Because a public inquest has the power to determine culpability, the person or persons who preside and other interested parties often are represented by legal counsel. Compared to judicial reviews, public inquests often are much more comprehensive, time consuming, and costly to complete.

Outcomes. The most common outcome of a public inquest is a report that summarizes findings of fact, determines culpability, and presents recommendations designed to prevent future injury or death. Such reports often may range in length from a few to hundreds of pages. The report is available to the public and sometimes distributed widely. Most inquests do not have the authority to enforce recommendations.

Strengths. The primary strengths of public inquests are the same as those of judicial reviews: neutrality, scope, comprehensiveness, resources, and influence. The resources allocated to public inquests typically are much greater than those allocated to judicial reviews, and their influence also may be greater.

Limitations. Like judicial reviews, most inquests are focused on a single event and often presided over by people who lack specific expertise. Thus, their recommendations may lack general relevance, pay relatively little attention to contributory processes, and couch recommendations in terms that decrease their impact on or relevance to interested parties.

Domestic Violence Fatality Reviews

Structure. Approximately 15 years ago, practitioners developed domestic violence fatality review teams as a new approach for increasing understanding of the complex processes leading to IPF and for developing intervention or prevention strategies. This approach was heavily influenced by child death review teams and routine maternity= and delivery-related death review panels that have occurred in hospitals for decades (see Durfee, Tilton Durfee, and West, 2002; Rimsza, Schackner, Bowen, and Marshall, 2002; Webster, Schnitzer, Jenny, Ewigman, and Alario, 2003). Currently, approximately 27 states in the United States and 1 province in Canada conduct or plan to conduct some form of a domestic violence fatality review team (Websdale, 2003). Although some domestic violence fatality review teams are established as a result of an agreement among agencies to collaboratively review domestic violence related deaths, the majority of teams have been authorized by legislature or established under executive orders. Formal authorization has been sought due to concerns about confidentiality, liability, and immunity. Legislature and executive orders allow the teams to have access to confidential information related to review of a death, prevent information reviewed from being subject to subpoena or discovery, and provide immunity for each member of the team from civil or criminal liability for an activity related to the review of the death. Typically, legislation and executive orders allow for local discretion regarding the convening agency and the membership of the team (Websdale et al., 2001).

The structure of teams varies depending on available resources, committee membership and participation, legal or legislative direction, geographical or political location, and local preferences. Generally, members of intimate partner fatality reviews teams are recruited from multiple disciplines and agencies that have access to information and expertise concerning IPF (i.e., public health, criminal justice, and advocacy/social services). Some recommend including members of the public in order to guard against cover-ups, while others suggest including advocates for battered women or victims of domestic violence to assure that the perspectives of victims are incorporated into social policy. The structure of domestic violence fatality review teams relies on the consistent participation of members to ensure confidentiality, and guidelines are often developed to keep committees to a workable size. However, teams tend to be inclusive rather than exclusive, and additional members or "guests" may be invited to meetings to provide case-specific or policy-related information. Members meet on a regular basis to review cases of IPF and develop recommendations for changes to policies and practices on the basis of their review (Websdale et al., 2001; Websdale et al., 1999).

Some teams have a two-tiered organizational structure, where one or two members assume responsibility for leading the team, planning and coordinating meetings, facilitating the case review process, collecting information, and maintaining the databases of cases reviewed. Other teams have a single-tiered organizational structure, where a small group carries out administrative and case review tasks. Members are often responsible for acting as a liaison for their agency by sharing relevant information, by explaining agency policies, by identifying areas for improved response, and by implementing and evaluating changes to service delivery (Websdale et al., 2001; Websdale et al., 1999; Websdale, Moss, and Johnson, 2001).

Goals. Domestic violence fatality review teams have multiple goals. For instance, they aim to identify homicides resulting from domestic violence, examine the events leading up to the deaths, identify gaps in service delivery, and change the overall community response to domestic violence. The central goal of most domestic violence fatality review teams is to prevent future fatalities through system level change (Websdale, 1999). However, how they go about reaching this goal varies widely across committees. In general, while traditional strategies for reviewing IPF tend to promote a culture of blame, domestic violence fatality review teams strive to emphasize a culture of safety. This model values honesty and accountability and seeks to identify breakdowns or gaps in service delivery, focusing less on individual accountability and more on system-wide coordination. As opposed to placing blame on agencies for IPF, risk and error are viewed as inevitable aspects of coordinated delivery of complex services and perpetrators are ultimately held responsible for the deaths of their victims (Websdale et al., 1999; Websdale 2003).

Processes. As previously mentioned, many teams have immunity legislation that protects the deliberations of domestic violence fatality reviews and have developed protocols about how to share information and conduct reviews. The process by which cases are reviewed varies widely, depending on the availability of resources, the commitment of different agencies, and the experience of members. For instance, domestic violence fatality reviews teams differ in the types of cases they review. Some teams only review deaths perpetrated by a current or former intimate partner, whereas other teams review any death that occurs in the context of domestic violence (i.e., suicides of perpetrators, as well as homicides of children, new intimate partners, intervening parties, or responding law enforcement officers). Teams may review closed cases, in which the perpetrator has been convicted, or open cases, in which the case is pending (Websdale, Moss, and Johnson, 2001;Websdale et al., 1999). However, the former is much more common because prosecutors are often unwilling or unable to share information that might compromise a conviction.

The information collected by domestic violence fatality review teams differs in content, method, and breadth. Existing teams have varying powers regarding the acquisition of information. A few teams have the power and authority to administer oaths and to compel the attendance of witnesses whose testimony is related to the death under review. However, in general, data are collected concerning the incident, indications of past abuse, and the psychosocial, relationship, and criminal history of the individuals involved. Data sources reviewed may include police records, coroner's files, autopsy reports, court documents, medical records, mental health records, social service reports, or newspaper accounts. In some cases, family members or professionals are also interviewed.

The process by which the cases are reviewed also varies extensively between domestic violence fatality review teams. For instance, some reviews collect in-depth information for a small number of IPFs (case specific approach or systems approach), while others collect broad information about the role of domestic violence for a large number of deaths (wide angle approach or investigative model). The goal of the case specific approach is to identify system breakdowns and to change policies and procedures of agencies. Alternatively, the goal of the wide angle approach is to accurately identify the prevalence of domestic violence related deaths. Either way, team members often review the deaths in their respective agencies and bring those findings to the domestic violence fatality review team (Websdale et al., 1999, 2001).

Outcomes. Many domestic violence fatality review teams prepare reports that document the team's activities, summarize relevant facts based on a series of cases, and make recommendations for the improvement of service delivery. In addition to submitting the reports to government officials and domestic violence coordinating councils, these documents are often made available to the public via the Internet. An important feature of domestic violence fatality review teams is that members are often responsible for implementing and evaluating changes to service delivery in their respective agencies based on the recommendations. Anecdotal evidence suggests that domestic violence fatality reviews could reveal patterns contributing to fatalities that may lead to system-wide accountability, greater community collaboration, improvements to intervention programs, and prevention of future deaths (Websdale, 2003).

Strengths. Perhaps the most important strength of fatality reviews is their focus on prevention. The committees do not simply make recommendations, but work to implement and evaluate them. A second strength of fatality reviews is their expertise. Domestic violence fatality review teams are staffed by people who are very familiar with their respective agencies; this maximizes the relevance of recommendations made and the likelihood that changes will be made. A third strength is that fatality reviews typically consider a series of cases, rather than focusing on single cases. This increases the general relevance of their recommendations. A fourth strength is their focus on contributory processes. Intimate partner femicides are not treated as isolated events, but rather as part of processes that unfold in specific contexts.

Limitations. Although the primary purpose of domestic violence fatality review teams is to understand the processes leading to femicide in order to inform prevention efforts, this strategy for reviewing IPF typically suffered from several weaknesses. First, they lacked conceptual clarity regarding what constitutes a domestic violence fatality, resulting in inconsistent reporting by law enforcement agencies, inaccurate estimations of the prevalence of intimate partner fatalities, and erroneously informed policy and legislative recommendations (Abrams et al., 2000). Second, they used inconsistent data collection and coding procedures across committees. For instance, some committees focused on interviews with service providers or review of records from specific agencies whereas others used comprehensive archival sources (e.g., police or coroners' reports). Furthermore, each review selected variables for inclusion in a rather haphazard or idiosyncratic manner. For example, some case studies have focused primarily on the victim or perpetrator as individuals or a couple, but have ignored broader contextual factors including community services. Fourth, their methods of data analysis tended to rely on frequency counts of static variables. This resulted in a lack of attention being paid to contextual influences and dynamic processes contributing to IPF that could be the focus of future interventions.

THE ROLE OF DOMESTIC VIOLENCE FATALITY REVIEW TEAMS

Agency reviews, judicial review, and public inquests have serious limitations as strategies for reviewing IPF due to their focus on single cases; their reactive emphasis on cause of death, determination of facts, or assignment of blame; and their lack of personal knowledge of the people and agencies involved in the case or specific expertise regarding

IPF. In contrast, domestic violence fatality review teams make up for the limitations of these strategies by their review of multiple cases; their proactive emphasis on accountability and systems change; and their involvement of multiple disciplines and agencies with expertise and familiarity with their respective agencies.

Domestic violence fatality review teams may help to address the limitations of previous research on IPF by increasing our understanding of the diverse contexts and complex processes leading to IPF. First, domestic violence fatality review teams have access to many sources of information and can investigate factors from multiple levels of analysis that are considered causally relevant to IPF. Second, domestic violence fatality review teams collect in-depth information about cases of IPF, which allows for an identification of how factors interact and change over time. Third, domestic violence fatality review teams embed the investigation of IPF within context and develop intervention and prevention strategies that are relevant for informing the local community response. Due to the unique goals, structures, and processes of domestic violence fatality review teams, they hold a great deal of promise for informing future research, intervention, and prevention of IPF.

However, many domestic violence fatality review teams do not have the time, resources, or specific expertise to conduct sophisticated research on IPF. As previously mentioned, they often have different views about what constitutes a domestic violence fatality, use inconsistent data collection and coding procedures, and report their findings in the form of simple frequency counts. Similarly, many researchers do not have access to the depth and quality of information that they would need to conduct research that would significantly increase our understanding of the diverse contexts and complex processes contributing to IPF. However, research that increases our understanding of IPF has the potential for greatly improving both practice and theory. Therefore, domestic violence fatality review teams and researchers would mutually benefit by forming partnerships in their investigation of intimate partner femicide. These partnerships could lead to improvements in research that could further our empirical understanding of IPF and, even more importantly, further our efforts to change policy and practices that aim to decrease the occurrence of IPF.

CONCLUSION

We have learned much about IPF, but we still have much more to learn. It is time for us to move beyond single-factor analyses of IPF and develop theoretical frameworks that recognize the dynamic nature of these risk factors, the complex ways in which way they interact, and the influence of the physical and social environment on the lives and decision making of perpetrators and victims. Only then will we be able to develop rational policies and procedures designed to prevent IPF. Domestic violence fatality review teams deserve serious consideration as a means of addressing the gaps in our understanding of IPF and the deterrence of future deaths.

In: Intimate Partner Violence Prevention and Intervention ISBN: 978-1-60456-039-8
Editors: A. C. Baldry and F. W.Winkel, pp. 61-81

Chapter 5

IDENTIFYING DOMESTIC VIOLENCE VICTIMS AT RISK OF HYPER-ACCESSIBLE TRAUMATIC MEMORIES AND/OR RE-VICTIMIZATION THROUGH VALIDATED SCREENING: THE PREDICTIVE PERFORMANCE OF THE SCANNER AND THE B-SAFER[1]

Frans Willem Winkel
INTERVICT, International Victimology Institute, Tilburg University, Netherlands

The focus of this chapter is on the relation between (chronic) post traumatic stress symptomatology (PTSS) and repeat victimization. It illustrates that PTSS has the features of a Janus face: PTSS is both a repercussion and a precursor of re-victimization. In the first section, prospective evidence is reported that suggests that prior victimization is a unique risk factor that contributes to developing PTSS. No evidence was found for the inoculation perspective on re-victimization suggested by some psychologists. The focus of the second section is on the predictive validity of various risk assessment tools (e.g. the Scanner and the TSQ) aimed at early identifying crime victims at risk of developing chronic PTSS. The third section presents prospective evidence highlighting the validity of the B-SAFER and the Scanner to identify victims of intimate partner violence at risk of repeat victimization. Findings suggest that in a victim support context the B-SAFER may also serve as a tool to raise re-victimization awareness and to facilitate preventive behavior.

Victims who, months following their victimization, present with psychological symptoms that indicate chronic coping failure are obviously in need of emotional support provided by professional or volunteer mental health counsellors. To identify victims at risk of developing and maintaining hyper-accessible traumatic memories early, the Scanner was developed. The Scanner was originally designed as a decision aid for police officers in their initial contacts

1 Writing this chapter was facilitated by a grant from the Achmea Foundation Victim and Society.

with crime victims reporting their victimization to them. The police are currently generally seen as important gatekeepers to victim support facilities. For this reason, European law[2] requires these officers to actively refer victims to victim support. The Scanner– SR, the self-report version, consists of a limited number of items representing risk factors for chronic coping failure. Items can be answered in terms of a simple *yes* or *no* response format. The sum score of these items thus yields an index of risk.

One of the items included in the Scanner refers to prior victimization. In some theories, it is argued that victimization prior to the target incident should be conceptualized as a protective factor; in other theories, the focus is on the role of prior exposure as a risk factor for chronic coping failure. In the first section of this chapter, we will review these conflicting theories and then offer prospective evidence regarding the conditions under which prior victimizations constitute a risk factor for coping failure. Our focus on this particular risk factor was driven by the fact that repeat victimizations constitute a core theme of this volume.

In the second section, we will briefly outline the theoretical underpinnings of the Scanner and present some data on its predictive performance. In the final section, we will argue, using the Negative Emotionality Model (NEM) of domestic abuse perpetration and victimization developed by Moffitt, Robins, and Caspi (2001), that the Scanner also has potential for predicting domestic violence re-victimization. We will assess the predictive performance of the Scanner relative to other more commonly used risk assessment instruments in this domain, particularly the SARA–PV, or B-SAFER.[3]

REPEAT VICTIMIZATION

Introduction

The prevailing method to assess the prevalence of repeat victimization (Ellingworth, Farrell, and Pease, 1995; Skogan, 1999; Sparks, Genn, and Dodd, 1977) is to use victimization surveys. Typically, such surveys are retrospective in nature: Participants are questioned about the types and frequency of criminal exposure during, for example, the past 6 or 12 months. If one wants to test the differential impact of repeat versus singular victimization on the emergence of victimization-related "psychological damage," retrospective designs may have major disadvantages. These designs may erroneously suggest a strong relationship between multiple victimization and coping failure (e.g., that repeat victims are much more likely than singular victims to report higher levels of fear of crime and lower levels of psychological well-being). The emerging associations are spurious if they are predominantly the result of retrospective biases associated with mood-congruence effects. There is strong empirical evidence (Gilligan and Bower, 1984) suggesting that people who are in a negative mood -- or, more generally, are in a state of relatively low well-being -- will more easily retrieve prior negative life events (which are congruent with their current mood) than participants, who, for whatever reason, are in a more optimistic psychological state. In a

2 Referral guidelines exist not only in European law (e.g., the European Council Framework Decision on the Standing of Crime Victims), but also in North American legal provisions and in international soft law (e.g., the UN Declaration on Victims of Crime and Abuse of Power).

3 Brief spousal assault form to evaluate risk (of re-victimization).

victimization survey, the former participants are much more likely to "emerge" and to be classified as repeat victims, whereas the latter participants are much more likely to emerge as controls or singular victims. Thus, due to memory biases, victimization surveys have a built-in tendency to produce spurious correlations between coping problems and repeated exposure. A more fruitful approach in examining the precise nature of repeat victimization as a risk factor -- a variable reinforcing trauma susceptibility -- or as a potential protective factor lowering trauma susceptibility is to engage in prospective analyses in which victims are systematically followed up over time, after reporting their "first" victimization.

There are two conflicting theoretical perspectives on the victimological significance of repeat victimization (Fattah, 1999; Solomon, 1995; Winkel and Vrij, 1998). The *resilience/ inoculation perspective* suggests that a prior victimization offers an opportunity for learning and for developing coping strategies, on the basis of which one is better able to cope with, and better prepared for, a new victimization (Petrosino, Fellow, and Brensilber, 1997). The *vulnerability perspective* considers repeated exposure to stressful events as a risk factor. It holds that every stressful life-event depletes available coping resources and thereby increases vulnerability to subsequent stress. Both perspectives may be conceived of as representing two sides of the same coin and can be integrated in a "coping consistency model" (Winkel, 1999), which suggests that coping problems with a prior victimization will result in reporting more psychological problems in relation to a new victimization, whereas prior coping success is a good predictor of future coping success.

Critical elements in this model are (a) the presence of stress-residuals due to a prior victimization and (b) the time interval between the two victimizations. The shorter this interval, the more likely it is that repeated exposure will result in the retrieval of one or more prior criminal episodes in which the victim was involved. Stress-residuals, moreover, appear to be much more likely if (prior) toxic exposure interacts with high trauma susceptibility. This latter concept highlights the role of individual differences in responses to adversity: "In summing up the effects of life events on individuals, the grand old man of personality theory, Gordon Allport, is reported to have said: "The same fire that melts the butter, hardens the egg'" (Bowman, 1997, p. 53).

Highly susceptible victims exhibit a relatively unfavorable (psychosocial) risk profile. Empirically validated (intrapersonal) risk factors comprising such a profile include perceptions of external control (as opposed to perceptions of internal control as a protective factor), perceptions of unique vulnerability, and high levels of prior (previctimization) life stress (Winkel and Vrij, 1998). Social (inter-individual) risk factors, which tend to slow down the recovery process, include lacking a supportive environment (e.g., a spouse), receiving inadequate social support, and encountering "victim blaming" responses from that environment, for example, in terms of character attributions (Winkel and Denkers, 1995).

The potential negative impact of re-exposure -- the idea that repeat victims are more at risk for developing psychological problems relative to singular victims -- may be mediated, either fully or partly, by these "other" risk factors or by the specific features of the criminal episode. Repeat victims may, for example, be more heavily involved in crimes with specific features: The total amount of financial or physical damage is likely to be higher than for singular victims. Repeat victims are likely to be over-represented in specific categories of crime, such as personal contact crimes with a known perpetrator. The likelihood of getting involved in a fight with a known perpetrator is obviously higher than if the perpetrator is a total stranger; a more wealthy burglary victim is more likely to get re-visited, and so forth.

More serious crimes, in terms of the amount of damage caused or the involvement of a personal contact or not with the perpetrator, are also more likely to elicit psychological damage. In terms of psychological risk factors, repeat victims, relative to singular victims, are more likely to report (previctimization) perceptions of unique vulnerability or high prior life stress. They are more likely to score “unfavorably” on such dimensions than singular victims. Moreover, also in terms of social risk factors, repeat victims are more likely to encounter secondary victimization: Explanations of the cause of the crime from members of the victim's social environment are more likely to involve references to the victim's character or personality (character attributions; Winkel, Denkers, and Vrij, 1994). As a final example, repeat victims are more likely to find themselves in a situation where their support needs are not adequately met. Important support providers may have become less sensitive and receptive to the victim's problems.

The major aims of the present prospective exploration (the study was not specifically designed to examine the role of repeat victimization) were to address the following issues:

1) What is the precise impact, if any, of repeat victimization (RV) on measures of psychological functioning, such as psychological well-being and fear of crime? As a risk factor, RV will negatively influence these post-victimization outcomes.
2) Are the (psycho-social) risk profile and the episodic profile (in terms of specific features of the victimization) of RVs more unfavorable than those of singular victims (SVs) and controls, and, if so, what aspects in particular are influenced negatively?
3) What is the relative strength of various risk factors in explaining differential responding between RVs and SVs, or to what extent is the potential negative impact of re-exposure “unique” or mediated by differences in the episodic and psycho-social risk profiles of RVs and SVs?

Method

Sample. Analyses were based on a data set, gathered as part of the Amsterdam Prospective and Longitudinal Study on the Psychological Impact of Criminal Victimization, which was conducted with the financial support of the Dutch Justice Department and the Achmea Foundation Victim and Society (see Denkers and Winkel, 1998a, 1998b). Analyses relate to a sample of 298 controls (no victimization reported), 275 SVs and 29 RVs. Victimizations involved both property and person-directed crimes: 39% were burglaries; 27%, robberies; 31%, threats; 10%, assaults; and 5%, sex-related crimes. All contacts with subjects were conducted electronically and related to a panel of 5,218 subjects (previctimization: T1) to whom questionnaires were sent out. This panel was followed up over a 2.5-year period, in which the emergence of a criminal victimization (using a list of labels describing various crimes) was checked weekly. After a victimization was reported, post-victimization (T2) questionnaires were sent out.

Controls, who did not report victimization, were recruited from the panel on the basis of their matching the victims in the sample. Matching criteria were gender, age, degree of urbanization, and household composition. Victims and controls were followed up over a 10-month period. During this period, almost 10% of the victims reported a re-victimization. On average, these victims were confronted with two more crimes: 7 victims were re-victimized

once; 16, twice; 5, three times; and 1, four and 1, five times. Within 1 week after the first victimization, 28 extra crimes were reported; within 2 weeks, another 5; within 1 month, another 7; within 2 months, 12; within 4 months, 5; and within 10 months, still 5 more, which totals up to a rather high incidence rate of 62 re-victimization cases. Due to missing data, 4 RVs were deleted from the analyses. The remaining 25 RVs were all re-victimized within 2 weeks after their first victimization.

Measures

Outcome measures. The study entailed a series of cognitive, emotional, and behavioral outcome measures. The present focus is on general psychological functioning, indexed by fear of crime and psychological well-being. Only for these outcome measures, both pre- (or T1) and post-victimization (or T2) scores were available. The fear measure was based on Winkel (1987, 1998; Winkel and Vrij, 1993). Psychological well-being was measured via a Dutch translation of Diener et al.'s Satisfaction with Life Scale (Diener, 1984; Diener, Emmons, Larsen, and Griffin, 1985).

Predictor measures. Apart from biographical data (gender, living situation, partner, children, age, urban/rural, and income), the predictor set can be categorized in terms of (a) personal risk factors, measured at T1, (b) social risk factors, measured at T2, and (3) episodic features. Episodic features included the amount of financial damage, the seriousness of physical damage, needs for financial restitution/compensation, costs covered by insurance, reporting to the police, and personal contact with the perpetrator ("has seen" or "can give a full description" of the perpetrator). Personal risks included perceptions of "comparative" vulnerability (unique in vulnerability, universal vulnerability; Perloff, 1983), prior life stress (Cook, Smith, and Harrell, 1987), and perceptions of internal/external control (I/E scale - short version; Den Hertog, 1992).

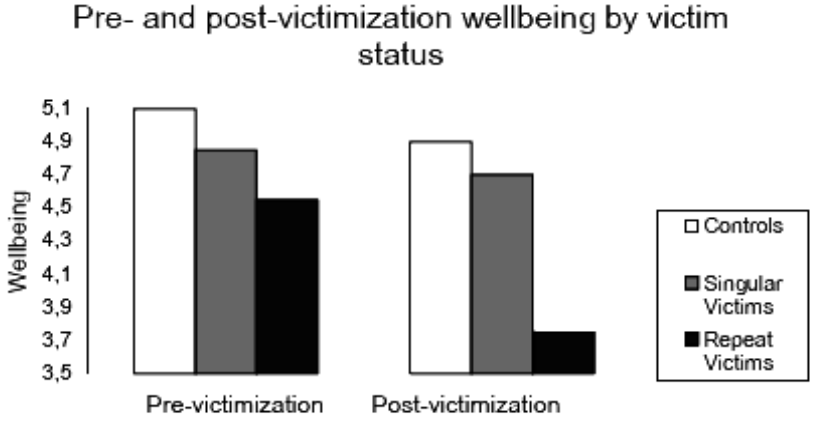
Social risk factors were measured in terms of discrepancies between needs for support and received support from the partner; from more "distant" support providers, such as family, relatives, and friends; and from social institutions, such as victim support (Denkers and Winkel, 1998a, 1998b). Other measures tapped various other types of responses received from the social environment, including empathic responses and causal "internal" attributions, which relate the occurrence of the episode to either the behavior or the character of the victim (Winkel and Denkers, 1995). Some biographical data, such as the fact that the victim does not have a partner (Winkel, 1995) were also considered in terms of social risk factors.

Results

To examine the impact of RV on psychological functioning after the victimization, various analyses of variance were conducted on fear of crime and psychological well-being. No significant differences emerged in previctimization levels of fear of crime.[4] Analyses did reveal (borderline) significant differences between controls, RVs, and SVs in post-victimization fear of crime $F(2, 500) = 2.86$, $p = .06$; see Figure 1). RVs reported the highest levels of

4 Differences in degrees of freedom relate to type of analysis conducted, e.g., including or excluding controls.

fear, controls the lowest, and SVs took an intermediate position. However, these differences did not show up, after controlling for previctimization differences in fear of crime, $F(2, 499) = 2.11$, $p > .10$). Figure 1 reveals that the patterning of means relating to psychological well-being is identical. Significant differences between controls, SVs, and Rs emerged, both at T1, $F(2, 5000) = 3.84$, $p < .05$, and at T2, $F(2, 500) = 8.13$, $p < .001$. These T2 differences remained significant after controlling for previctimization well-being, $F(2, 499) = 5.58$, $p < .005$. Again, controls reported the highest levels of well-being at T2, RVs reported the lowest levels of post-victimization well-being, and SVs took an intermediate position. Together, these analyses suggest that RV functions as a risk factor, in particular with regard to psychological well-being.



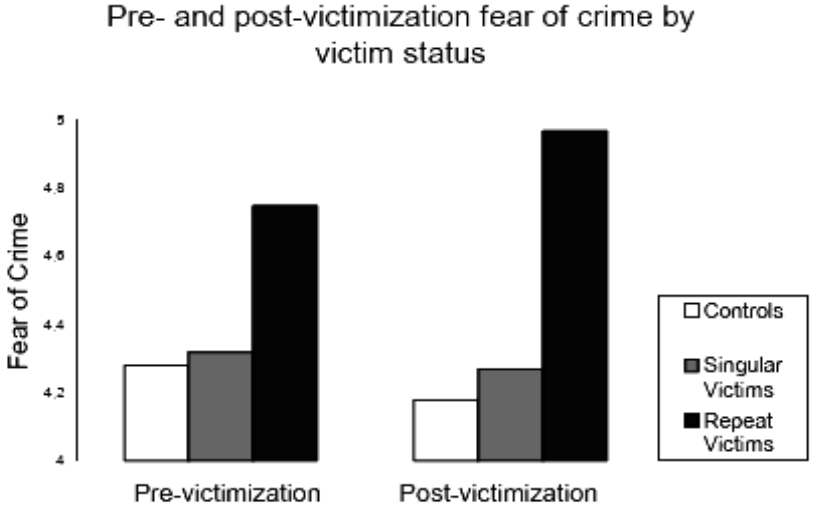


Figure 1. Wellbeing and fear of crime prior and post victimisation

Analyses further revealed that RV was related to type of exposure. RV was significantly more prevalent among victims of a threat, $X^2_{(300)}= 3.86$, $p = .05$), and among victims of a sex-related crime ($X^2_{(300)}= 12.92$; $p < .001$). About a third of these latter victims were re-victimized (once or more) within a 10-month period; for victims of assault and threats this rate was 12.5%, and for victims of property crimes (burglary and robbery), 7.5%. These outcomes are in line with previous findings suggesting that person-directed violence is associated with a relatively high re-victimization risk (Winkel, 1999). This suggestion is further underscored if RVs and SVs are compared in terms of other episodic features. RVs were significantly more likely to have seen the perpetrator or to be able to give a description of the suspect (see Table 1). No other episodic features resulted in significant differences. As to biographical data, re-victimizations were particularly reported by males, living on their own, in urban areas (Table 1). Age and income differences were not significant.

Table 1. Risk-Profile and "Other" Differences between Singular Victims and Repeat Victims (Significant Differences Only)

	Victimization			
	Controls	Singular victims	Repeat victims	X^2 / F
Episodic features:				
Has seen perpetrator ("personal contact")	n.a.	45.1%	68%	4.83*
Can give description of perpetrator ("personal contact")	n.a.	43.3%	72.0%	7.62**
Biographical data:				
Gender: male	51.1%	56.8%	65.5%	6.77*
Urban area	36.8%	48.2%	80%	30.71***
Is living with a partner	63.6%	56.8%	31%	19.51***
Personal risk factors:				
Pre-victimization perceptions of "unique vulnerability"	15.3%	19.7%	29.2%	9.20*
Prior (to victimization) life stress	12.2%	25.2%	42.7%	22.61***
Social risk factors:				
Character attributions from social environment	n.a.	1.95	2.99	10.69***
Insufficient support from partner living on his/her own	n.a. 15.6%	4.0% 29.8%	28.6% 40.0%	14.07** 48.11***

*** $p < .001$; ** $p < .01$; * $p < .05$

Significant differences also emerged in the psycho-social risk profiles of RVs and SVs. For personal risk factors, there were no differences in perceptions of external control. External control was reported by 18% of the controls and by 17% of RVs and SVs. Vulnerability perceptions were significantly related to victimization status (see Table 1). Perceptions of universal vulnerability -- the idea that one is as vulnerable as others in comparable circumstances -- were reported by about 30% of the RVs and SVs and by 42% of the controls. Marked differences emerged in perceptions of unique vulnerability: RVs felt the

most vulnerable, controls the least, and SVs took an intermediate position. Also, prior life stress was significantly more often reported by RVs than by SVs and controls (see Table 1). Thus, high prior life stress and perceptions of unique vulnerability were substantially more prevalent among RVs relative to both controls and SVs.

Significant differences also emerged in social risk factors. RVs more frequently met with reactions in which their character was blamed for the occurrence of the incident. A substantial number of RVs indicated discrepancies between needed and provided external support, resulting in a significantly higher proportion of RVs exhibiting insufficient support from their partners. Finally, RVs were significantly more often living without a partner.

Table 2. Risk Factors Differentiating Post-Victimization Well-being of Repeat Victims and Singular Victims

Risk factors	β (standardized regression coefficient)	*p* level
Pre-victimization well-being	.36	$p < .001$
Prior life stress	.23	$p < .001$
Re-exposure effect	.14	$p < .01$
Character attributions from social environment	.13	$p < .05$
Insufficient partner support	.10	$p = .07$
Living without a partner	.09	$p = .09$

To further clarify the re-exposure effect, the various blocks of predictors were stepwise regressed on post-victimization well-being, including repeat victimization in the first step ($\beta = .22$; $p < .001$). Adding blocks of personal risk factors, episodic features, and social risk factors generally resulted in a better fitting model, explaining more variance: The size of the regression due to re-exposure shrank to some extent, but remained significant at all steps. After removing insignificant paths, the predictors outlined in Table 2 were kept, explaining 40% of the variance. Table 2 reveals that repeat victimization offered a unique contribution to a reduction in well-being, which is not mediated by other risk factors. In general, social risk factors (e.g., the last three entries in Table 2) played a much less significant role in explaining post-victimization well-being than previctimization personal factors, such as prior life stress or the presence of a prior victimization.

SCANNER PREDICTIVE PERFORMANCE

Under-utilization of Victim Support

Victims' issues rather recently again became a more prominent concern on the agenda of the criminal justice system. The parallel increase in available victim support facilities, which work in close cooperation with this system, was, moreover, phenomenal. Despite these favorable "victim-focused" developments, the under-utilization of such services by victims who appear to be in need of such support still poses a major threat to the quality of victim assistance.

There is extensive evidence suggesting that a sizeable number of individuals exposed to crime will develop persistent, and sometimes chronic, psychological problems in response to their victimization, including complaints of depression, anxiety, fear of crime, and posttraumatic stress symptoms (Carlson and Dutton, 2003; Kilpatrick and Acierno, 2003). These victims appear not to cope on their own or with the assistance of significant others and thus are particularly in need of victim support. However, the majority of these victims do not engage in contacts with victim support. Analyzing data from the U.S., New and Berliner (2000) concluded that the psychological consequences of crime victimization are by now well established. Studies of nonclinical populations and clinical samples have documented elevated symptom levels and psychiatric disorders in adult and child crime victims. However, research on adult crime victims finds that only a minority seeks treatment, even though they may be suffering from crime-related psychological conditions. (pp. 693 – 695). Similarly, Wohlfarth, Winkel, and Van den Brink (2002, p. 456) revealed that out of the 23 cases with posttraumatic stress disorder (PTSD) at 1 month after the index victimization, only 10 (45%) sought help from the Dutch victim assistance organization: 6 (27%) received emotional help and 4 (18%) received only practical help. An additional 6 (26%) victims sought help from other sources (psychologist, psychiatrist, etc.), leaving a total of 7 (30%) cases without any support and 11 (48%) without any emotional support. A similar picture emerged at the 3-month follow-up. These findings underscore the need for early detection that could enable the preventive support or treatment of vulnerable victims (p. 456).

Even more alarming outcomes were recently reported by Winkel (2003) who found that 70% of the female victims and 80% of the male victims who exhibited elevated levels of depression and anxiety 6 months after reporting their victimization to the police did not engage in contacts with victim support.

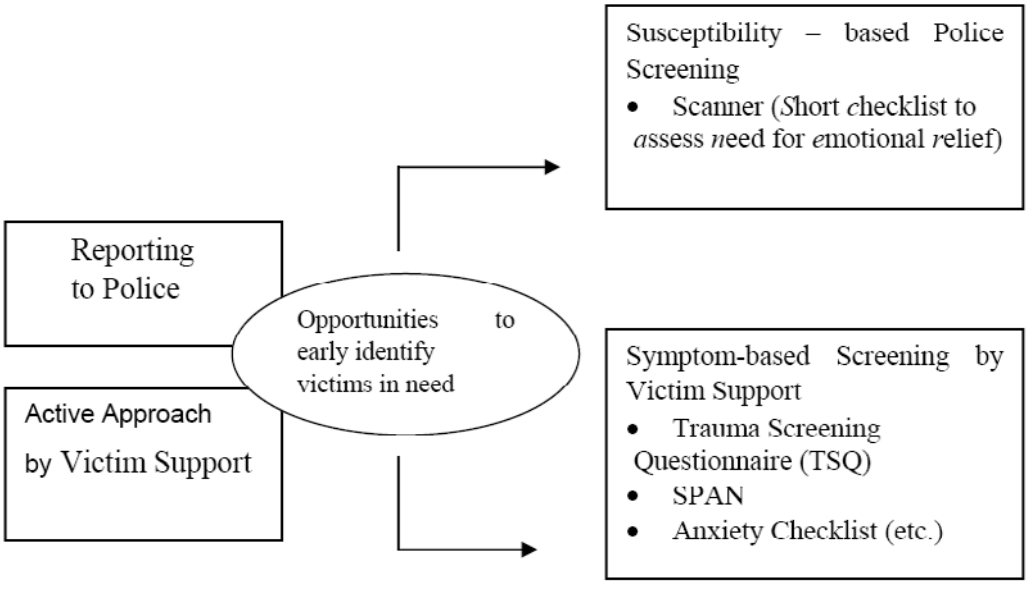


Figure 2. Identifying needy victims through early screening: opportunities and instruments.

At present, no attempts are made to identify victims at risk for persistent coping problems early. Structured risk assessment, on the basis of brief, empirically validated screening instruments, obviously provides a potential tool to reduce the gap between needed and received support. Figure 2 suggests that both initial contacts with the police and follow-up contacts with victim support may be utilized as opportunities for active screening. Various screening instruments were recently suggested in the trauma literature, including the Scanner (Wohlfarth, Winkel, and Van den Brink, 2002), the SPAN (Meltzer-Brody, Churchill, and Davidson, 1999), the Trauma Screening Questionnaire (TSQ) (Brewin, et al., 2002), and the Anxiety Checklist-Short Version (AC-SV) (Winkel, 2003). Conceptually, these instruments are based on different perspectives. The Scanner exemplifies a susceptibility-based procedure and is guided by the theoretical, empirically validated notion that particularly susceptible individuals involved in a criminal victimization are at risk for a broad range of persistent coping problems. The other instruments form part of a complaint or symptom-based procedure. The basic (atheoretical) notion underlying this procedure is that victims exhibiting elevated levels of symptoms a few weeks post-victimization are also at risk for longer term coping problems.

Screening

A toxic exposure by susceptibility (resilience) model. Quantitative meta-analyses of risk factors for PTSD (Brewin, Andrews, and Valentine, 2000; Ozer, Best, Lipsey, and Weiss, 2003); narrative reviews of more recent cognitive models of PTSD (Brewin and Holmes, 2003), including the influential Ehlers and Clark (2000) model; and findings from the Amsterdam Prospective - Longitudinal Study (AP-LS; Denkers,1996), *inter alia*, inspired by the Sales, Baum, and Shore model (1984) of psychological adaptation to criminal victimization consistently provide evidence for a toxic dose by resilience/susceptibility model of persistent coping problems (see Figure 3).

Resilience, entailing both previctimization intrapersonal and post-victimization interpersonal (e.g., perceived social support) resources, functions as a buffer against deleterious outcomes from victimization, whereas such outcomes are magnified by susceptibility. Brewin et al. (2000), for example, regarded their data as consistent with a model "in which the impact of pretrauma factors on later PTSD is mediated by the responses to the trauma, or, alternatively, with a model in which pretrauma factors interact with trauma severity or trauma responses to increase the risk of PTSD" (p. 756). Ozer et al. (2003) made an analogy to the flu or infectious disease: "Those whose immune systems are compromised are at greater risk of contracting a subsequent illness" (p. 68). Similarly, the cluster of risk factors they studied "may all be pointing to a single source of vulnerability for the development of PTSD or enduring symptoms of PTSD – a lack of psychological resilience." Brewin and Holmes (2003) recently concluded that "there now is good evidence in support of the various aspects of the Ehlers and Clark model. In particular, there is evidence about the relationship of various cognitive variables with persistent PTSD symptoms months later" (p. 363), including mental defeat (the perceived loss of autonomy), negative interpretations of the trauma, negative interpretations of initial PTSD symptoms, negative interpretations of other people's responses, a perception of permanent change in self or life goals, and rumination.

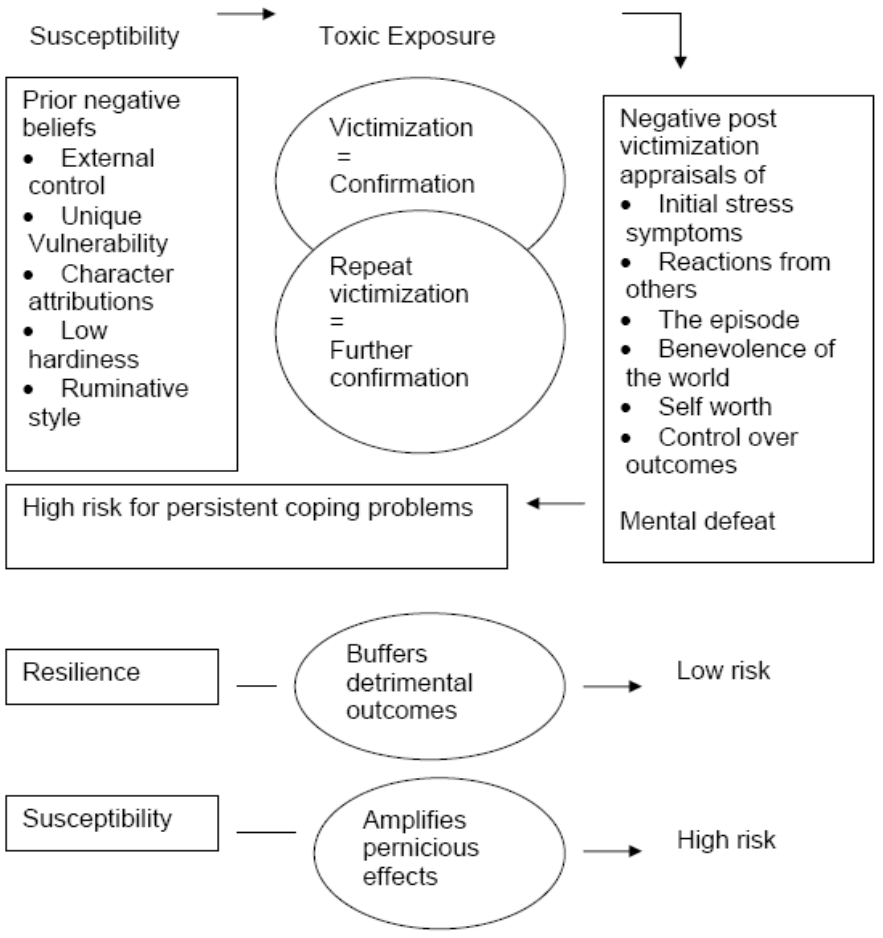


Figure 3. A cognitive and general version of the toxic exposure by susceptibility model.

The AP-LS linked victimization status (crime victims vs. controls) to a broad range of deleterious outcomes, including perceptions of physical and psychological health, fear of crime, satisfaction with life, the Symptom Checklist 90-R, and perceptions of the benevolence of the world, control over outcomes, luck, and self-worth. Links were generally weak for crime victims exhibiting prior positive beliefs (e.g., perceptions of internal control, perceptions of universal vulnerability, and favorable appraisals of current psycho-social functioning; Denkers, 1996) and for victims exhibiting prior hardiness (Denkers, 1996). Links were generally strong for victims with a deficit in previctimization positive beliefs or poor mental health status (Winkel, 1999); who were unemployed (Wohlfarth, Winkel, Ybema, and Van den Brink, 2001); who were repeatedly victimized (Winkel, Blaauw, Sheridan, and Baldry, 2003); for whom partner support was not available (Denkers and Winkel, 1998a, 1998b); and exhibiting a ruminative/anxious response style, a factorial dimension underlying a high need for affiliation, an anxious style of information processing, and perceptions of unique vulnerability (Denkers and Winkel, 1997).

Figure 4, adapted from Denkers (1996), which replicated previous, cross-sectional findings from Winkel and Denkers (1995), clearly reveals significant differences between resilient and susceptible victims in terms of post-victimization appraisals. Resilient victims

included victims exhibiting at least two (or three) positive beliefs, particularly perceptions of internal control (Rotter, 1966), perceptions of universal vulnerability (Perloff, 1983), and favorable appraisals of psycho-social functioning in the previous year (Cook, Smith, and Harrell, 1987). Victims were defined as susceptible, if they exhibited at least two (or three) negative beliefs, also assessed prior to victimization, particularly perceptions of external control, perceptions of unique vulnerability, or unfavorable appraisals of previous functioning. Post-victimization appraisals, considered to be key moderators of persistent coping problems in the Ehlers and Clark model, thus appear themselves to be substantially moderated by beliefs and appraisal processes, which were already present prior to victimization. Patterns similar to that depicted in Figure 4 also emerged for post-victimization appraisals of the meaningfulness of the world and worthiness of self (Janoff-Bulman, 1989).

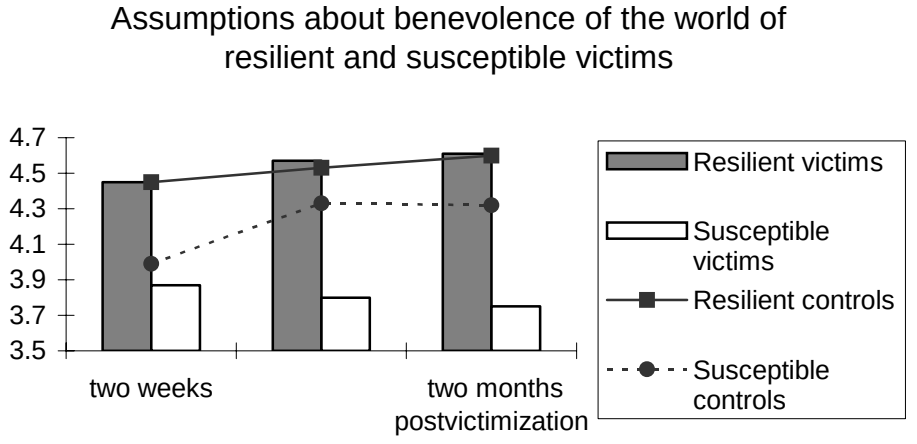


Figure 4. Assumptions about benevolence of the world of resilient and susceptible victims.

Instruments

Due to spontaneous recovery, emerging in terms of diminished severity (e.g., intensity or frequency) of symptoms with the passage of time, symptom-based screening can only be reliably conducted a few weeks after the victimization. Susceptibility-based screening can be conducted immediately post-victimization, for example, as part of, or directly following, the police interview. Both types of instruments may be considered more useful if they satisfy the criteria suggested by Brewin et al. (2002).

To be useful, screening instruments ideally should be short and contain the minimum number of items necessary for accurate case identification. They should be simple and preferably not require respondents to ponder over large numbers of alternative scale points. They should be written in a language that is easy to understand. Their purpose should be plain and they should be acceptable to respondents. For ease of administration, self-report questionnaires would appear to be the most flexible solution. If they are to be scored by non-specialists, which would widen their applicability, simple decision rules for determining who passes and fails the screen would be at a premium. Also highly desirable for successful

instruments is that they be accurate at detecting both current PTSD (or other coping problems) and the risk of future PTSD, and that they should work well with different traumas, with different periods of time elapsed post-trauma and with varying prevalence of PTSD (p. 161).

TSQ and Other Symptom-Screeners

Symptom screeners are similar in content and present victims with a list of potential symptoms, with a request for them to indicate if a given symptom was present during the last one or two weeks (see overview 1). Most of these screeners present symptoms directly derived from the DSM-IV definition of PTSD. The AC-SV was derived from the Symptom Checklist 90.

Overview 1. Symptom screeners: psychological complaints forming part of the TSQ (Trauma Screening Questionnaire), the SPAN (Startle, Physical symptoms, Anger, and Numbness), the FFS (Fight-Flight Simulator), and the AC-SV (Anxiety Checklist-Short Version)

1. Upsetting thoughts/painful memories about event. (TSQ)
2. Unpleasant dreams/nightmares about crime. (TSQ)
3. Re-experiencing feelings/acts during crime. (TSQ)
4. Emotionally upset by reminders. (FFS and TSQ).
5. Bodily reactions (sweatiness, fast heartbeat) when reminded. (SPAN; FFS, and TSQ).
6. Difficulty falling or staying asleep. (TSQ)
7. Irritability/anger outbursts. (SPAN; FFS and TSQ).
8. Difficulty concentrating. (TSQ)
9. Heightened alertness for potential dangers. (FFS and TSQ).
10. Easily startled/scared. (SPAN; FFS and TSQ).
11. Feeling numb. (SPAN)
12. Nervousness/shakiness inside. (AC-SV)
13. Being jumpy/suddenly scared for no reason. (AC-SV)
14. Feeling fearful. (AC-SV)

For example, TSQ items are presented with the following instruction:

Please consider the following reactions which sometimes occur after a traumatic event. This questionnaire is concerned with your personal reactions to the traumatic event which happened to you. Please indicate (Yes/No) whether or not you have experienced any of the following at least twice in the past week.

Scanner

Different 9- and 10-item versions (Winkel, 2000, 2003; Winkel, Wohlfarth, and Blaauw, 2003, 2004) and a 4-item short version (Wohlfarth, Winkel, and Van den Brink, 2002) of the

Scanner were specifically developed, as part of an AP-LS follow-up study, by the Achmea team, associated with the VUA-department of Clinical Psychology. The Scanner consists of a brief number of short statements, focusing on current responses to and interpretations of the episode, which to a large extent are assumed to assess prior susceptibility (see overviews 2a and b).

Overview 2 (a). Risk markers forming part of the Scanner (version 1)

Coping Residuals
1(a) Were you recently victimized before?
1(b) Do you still have problems with that victimization?
(1(a) + 1(b): *yes* response → Risk 1)
Upward Expectancies
2. The consequences were worse than I expected (*yes* response → Risk 2)
Character Attributions
3. This typically had to happen to *me* (*yes* response → Risk 3)
Unique Vulnerability
4. In comparison to others, do you run a higher risk of getting re-involved in such an incident? (*yes* response → Risk 4)
Insufficient Protection
5. I generally feel insufficiently protected against crime. (*yes* response → Risk 5)
Upward Coping
6. In comparison to others, I feel I am coping worse. (*yes* response → Risk 6)
Support Expectancies
7. If needed, can you fall back on a supportive environment (partner, friends, relatives)? (*no* response → Risk 7)
Previctimization Psychological Well-being
8. Are you generally (apart from what happened to you now) satisfied with your life situation? (*no* response → Risk 8)
Mental Burden / Life Threat
9. Did you experience the event as life threatening or as a mental burden? (*yes* response → Risk 9)
Physical Damage
10. Did you suffer physical damage? (*yes* response → Risk 10)

Overview 2 (b). Risk markers forming part of the Scanner (version 2: revised version 1)

Risk Factor 1: *Known perpetrator*

- Do you know (one of) the perpetrator(s)?
- Risk Factor 2: *Upward expectancies*
- Consequences were worse than previously expected or assumed.
- Risk Factor 3: *Character attribution*
- This typically had to happen to *me.*
- Risk Factor 4: *Prior trauma*

- Did you recently experience a traumatic episode?
- Risk Factor 5: *Life threatening episode*
- Did you experience the event as life threatening?
- Risk Factor 6: *Support expectancies* (*no* = risk)
- If needed, can you fall back on a supportive environment?
- Risk Factor 7: *Paid job* (no = risk)
- Do you currently have a paid job?
- Risk Factor 8: *Emotional style*
- I often respond emotionally.
- Risk Factor 9: *Initial reactivity*
- I currently feel quite upset.

Predictive Accuracy

Two independent studies, which were financially supported by the Achmea Foundation and the Ministry of Justice for the last 4 years and examined the predictive validity and diagnostic accuracy of these various screening instruments, were conducted among samples of crime victims who reported their victimization to the police. Detailed accounts are available in various recent articles, including Winkel (2003), Winkel, Blaauw, and Wiseman (2003), Winkel, Wohlfarth, and Blaauw (2003), Winkel et al. (2004), and Wohlfarth et al. (2002, 2003). Our focus here is on a number of analyses that were conducted specifically for this volume, relating to the second study, which at the outset involved more than 500 victims. The main findings are summarized in Tables 3, 4, and 5.

Table 3. Associations of Four Brief Symptom Screeners and the Scanner with Various Psychological Complaints, Assessed 6 Months Post-victimization

Screener	Anxiety	Depression	Posttraumatic stress symptoms	Disturbed coping (= sum score)
Symptom-based:				
Trauma Screening Questionnaire (TSQ)	73**	59**	.76**	.71**
SPAN	.68**	.60**	.67**	.67**
Fight-Flight Simulator (*FFS*)	.72**	.61**	.73**	.70**
Anxiety Checklist – Short Version (AC-SV)	.74**	.61**	.69**	.68**
Susceptibility-based: Scanner	.57**	.52**	.57**	.56**

** p <.001

Victims filled out the Scanner at the police station, subsequent to reporting the crime. Symptom screeners were filled out, as part of a mailed questionnaire, 4 weeks post-reporting.

Coping problems were assessed, again as part of a mailed questionnaire, 6 months after reporting. Assessments were made of anxiety, depression (SCL 90 R), and posttraumatic stress symptoms (PSS-SR[5]). The sum score of these measures yielded a general index of disturbed coping. Table 3 reveals substantial associations between the screeners and the severity of longer term complaints. Correlations were not affected by the length of a screening instrument: The performance of the shortest symptom-screener (the AC-SV) was equivalent to the longest one (the TSQ). Correlations with the Scanner were slightly lower on all domains, which is not surprising, given the longer time interval between measurements and a stronger dissimilarity of measures in terms of content. However, Table 4 clearly suggests that the total amount of variance explained in severity of symptoms is substantially higher if both types of instruments are combined. A substantial amount of additional variance is uniquely explained through the AC-SV. Additional analyses, moreover, revealed that true cases, identified by the Scanner, scored a significantly higher number of serious anxiety complaints than false alarms, that is, positively identified cases without subsequent coping problems.

Table 4. Performance of the Scanner Separately or Combined with the Anxiety Checklist (AC-SV) in Terms of (Additional) Variance Explained in Outcomes

	Anxiety	Depression	Posttraumatic stress	Disturbed coping
Scanner	.35	.28	.36	.31
Scanner + AC-SV (R^2 added by AC)	.29	.18	.19	.24
R^2 (total)	.64	.46	.55	.55

Diagnostic accuracy was assessed in terms of sensitivity, specificity, and positive and negative predictive power. For these analyses, screeners were dichotomized, using the thresholds depicted in Table 5. For the Scanner, for example, individuals were considered high risk if they reported three or more risk markers; they were considered low risk cases if they reported less than three risk markers. Moreover, in terms of the criterion, participants scoring above the 80th percentile on the sum score of outcomes were defined as victims with severe coping problems. Table 5 shows the sensitivity of various screeners (i.e., the probability that someone with a diagnosis of severe coping problems 6 months post-victimization will have earlier reported at least the specified number of serious symptoms or risk markers) and its specificity (i.e., the probability that someone without a later diagnosis will not have reported that cluster). Table 3 also shows the positive predictive power of each cluster (i.e., the probability that someone with that cluster will later report a diagnosis of severe coping problems) and its negative predictive power (i.e., the probability that someone without that cluster will not subsequently receive a diagnosis). Zimmerman and Mattia (2001, p. 792) suggested that “from a clinical perspective it is most important that the diagnostic aid have good sensitivity and corresponding high negative predictive value” (preferably at least .90). Table 5 reveals that the Scanner comes closest to these recommendations, and the AC-SV outperforms the TSQ as a potential follow-up screener.

[5] PSS-SR: PTSD Symptoms Scale – Self Report version (Foa et al., 1993).

Table 5. Sensitivity, Specificity, Positive and Negative Power to Predict Serious (> 80th percentile) Coping Problems 6 Months Post-victimization

Screener			Predictive power	
	Sensitivity	Specificity	Positive	Negative
Anxiety Checklist Short Version (AC-SV; cut-off = 1)	.69	.69	.37	.89
Trauma Screening Questionnaire (TSQ) (cut-off = 5)	.44	.95	.70	.86
Scanner (cut-off = 3)	.85	.62	.37	.94
Scanner – Short Version (cut-off =2)	.75	.74	.45	.91

DOMESTIC VIOLENCE: RE-VICTIMIZATION

High Negative Emotionality: A Linking Pin?

A recent review conducted by Miller (2003) provides an overview of research on the influence of personality on the development, course, and behavioral expression of posttraumatic stress disorder (PTSD). The existing literature is discussed in relation to three broad personality traits that have been emphasized in personality and psychopathology research: negative emotionality (NEM)[6], positive emotionality (PEM)[7], and constraint/inhibition (CON)[8]. The primary conclusion derived from this review is that high NEM is the primary personality risk factor for the development of PTSD, whereas low CON and low PEM serve as moderating factors that influence the form and expression of the disorder through their interaction with NEM. From this standpoint, a premorbid personality characterized by high NEM combined with low PEM is thought to predispose the trauma-exposed individual towards an *internalizing* form of posttraumatic response characterized by marked social avoidance, anxiety, and depression. In line with this perspective, Wohlfarth et

[6] *NEM* is orthogonal to PEM and refers to dispositions toward negative mood and emotion and a tendency towards adversarial interactions with others. According to Miller (2003), it is synonymous "with Neuroticism (Costa & McCrae, 1985; Eysenck & Eysenck, 1975), Emotionality (Buss & Plomin, 1975), and (negative) Adjustment (Hogan, 1986). It is ubiquitous in the field of personality assessment and "has emerged in every model of personality based on questionnaire measurement" (Zuckerman, 1999, p. 68)."

[7] *PEM* refers to individual differences in the capacity to experience positive emotions and tendencies towards active involvement in the social and work environments. According to Miller (2003), PEM is represented with subtle definitional variations in other models of personality as Extraversion (Costa & McCrae, 1985; Gough, 1987; Eysenck & Eysenck, 1975), Activity (Buss & Plomin, 1975), and Ambition/Sociability (Hogan, 1986)

[8] Many models of personality also posit the existence of a separate disinhibition-constraint dimension -- referred to here as CON -- that involves tendencies anchored by planfulness vs. spontaneity, restraint vs. recklessness, and harm-avoidance vs. risk-taking. CON has, according to Miller (2003), been referred to by other theorists as psychoticism (Eysenck & Eysenck, 1975), novelty-seeking (Cloninger, 1987), impulsivity (Buss & Plomin, 1975), control (Gough, 1987), and prudence (Hogan, 1986).

al. (2002) provided evidence for a substantial correlation between the Scanner (short version) and neuroticism (negative emotionality).

On the other hand, high NEM combined with low CON is hypothesized to predict an *externalizing* form of posttraumatic reaction characterized by marked impulsivity, aggression, and a propensity towards antisociality and substance abuse. In line with this hypothesis, Moffitt et al. (2001) provided empirical support for the NEM model of domestic violence (female and male) victimization and (female and male) perpetration. In view of these observations, high negative emotionality thus appears to be implicated both in the risk of persistent coping failure and in the risk of re-victimization. Given the substantial correlation between the Scanner–SV (short version) and neuroticism (negative emotionality), a plausible hypothesis is that the Scanner is not only predictive of coping failure, but also of domestic violence re-victimization. This hypothesis was further examined in a recently conducted Italian study.

Prediction Instruments

As part of a validation study of the SARA–PV conducted in Italy,[9] SARA-based interviews were conducted with close to 100 victims involved in domestic violence. The SARA interview yielded a summary rating of imminent and longer term re-victimization risk, the risk of future severe violence, and the risk of future escalation. Prior to this interview, two other risk assessment instruments, namely the Scanner[10] and the CTS (Straus, Hamby, Boney-McCoy, and Sugarman, 1996) were administered. Moreover, following the suggestions offered by Campbell (1995, 2004), Heckert and Gondolf (2004), Stith, Smith, Penn, Ward, and Tritt (2004), and Weisz, Tolman, and Saunders. (2000), two self-ratings of imminent, longer term, severe violence and escalation risks were requested, namely *before and after* the SARA interview was conducted by a trained psychologist. Table 6 provides a summary of the predictive performance of these various measures.

Table 6. Predictive Performance of Assessment Tools and Self Ratings of Risk: Associations with Repeat Victimization (2 Months Follow-up)

Assessment tool:	Repeat victimization
Scanner – SV (immediate assessment)	.32*
Scanner – SV (2 weeks follow-up)	.39**
Conflict Tactics Scale (victimization history during last half year)	.22*
Self-rated risk (victim perception before SARA interview)	.14 (*)
Self-rated risk (after SARA interview)	.17*
SARA-based Summary Risk Rating	.11

(*):$p < .10$; * $p < .05$; ** $p < .01$

9 See chapter by Dr. Baldry.

10 SV, including four items: initial distress, perceived unsafety, coping inefficacy, and optimistic appraisal (reverse coded) was used.

Table 6 reveals that SARA-based ratings and self-ratings by the victim were not at all or were weakly associated with repeat victimization. The CTS was moderately associated, and the Scanner, in particular, when administered 2 weeks after the initial interview, was strongly associated with repeat victimization. Apparently, self-ratings were differentially associated with outcome. Self-ratings significantly predicted repeat victimization, only after a SARA interview was conducted. This finding suggests that conducting a SARA interview is a reactive endeavor that has implications for the way in which victims perceive themselves. One might argue that a SARA interview with a victim is more than a pure risk assessment procedure: It also appears to constitute a particular form of *risk communication*, in which the sender (assessor) and the receiver (victim) exchange beliefs about future risks and potential hazards. Framed in terms of risk communication, the SARA interview raises the victim's awareness of future risk, which, in turn, may lead to taking additional steps to prevent a re-victimization by actively engaging in preventive behaviors. From this perspective, the low predictive performance of the SARA may be due to suppression effects, in particular, if high-risk victims were more strongly stimulated by the interview to take preventive measures. Therefore, the role of preventive behavior[11] following the interview was further studied in terms of suppression effects. A summary of these analyses is provided in Table 7.

The pattern emerging in Table 7 provides empirical support for the suppression hypothesis. SARA ratings were weakly associated with re-victimization for victims who engaged in preventive behavior afterwards. However, correlations were substantially higher for victims who did not engage in preventive behavior. For these victims, long-term risk ratings were strongly associated with re-victimization: These outcomes provide independent *support for the predictive accuracy of SARA* summary risk ratings.

Table 7. Predictive Performance of SARA Ratings: Suppression due to Prevention

	Repeat victimization	
SARA risk rating:	No follow-up prevention	Follow-up prevention
Imminent risk	.24*	.10
Long term risk	.42**	.03
Risk of serious violence	.32*	.11
Escalation risk	.28*	.22*

$p < .05$; ** $p < .01$

DISCUSSION

The main findings presented in this chapter can be summarized in a few points:

- Resilient victims of crime and domestic violence who were incidentally victimized are generally *not* in need of mental health interventions. These singular victims are at

[11] All SARA summary risk ratings were significantly associated with preventive behavior (correlations ranged from .23 to .40.) The Scanner, however, was not associated with preventive behavior.

very low risk of developing and maintaining hyper-accessible traumatic memories, and they are at low risk of repeat victimization.

- A significant number of crime victims, including victims involved in domestic violence, is, however, obviously in need of mental health support. Need for support is substantial if individuals are (a) at sustained risk of repeat victimization, (b) at risk of maintained hyper-accessible traumatic memories, and (c) if both risk conditions are simultaneously present (risk – comorbidity).
- Risk – comorbidity is the rule rather than the exception:
  - In the first section of this chapter, prospective evidence was presented that suggests that repeat victims reported less well-being and higher fear of crime, prior to the first incident.
  - Moreover, evidence revealed that repeat victims were more likely to report previctimization perceptions of unique vulnerability and high prior life stress. Repeat victims were, moreover, more likely to encounter character attributions from their environment and to receive insufficient support from partners.
  - In the second section of this chapter, the Scanner was presented. Repeat victimization was included in this risk assessment tool because of prospective evidence that suggests that repeat victimization depleted available intrapersonal coping resources (reduced resilience) and evidence that suggests that *both* repeat and singular victimizations in combination with high susceptibility yielded a substantial risk of persistent coping failure.
- Risk – comorbidity also appeared to be implicated in the third section of this chapter. The evidence presented revealed that the Scanner (short version) performed adequately in predicting domestic violence re-victimization.
- Most victims in need of support remain "forgotten victims." In the context of mental health intervention, there is a substantial discrepancy between support needed and received. To bridge this gap, and to curtail under-utilization of services, support facilities should become more sensitive and responsive to victims' needs. The arguments presented in this chapter suggest that building bridges includes the implementation of active approaches that are *risk guided* and thus utilize assessment tools to identify victims at risk in the sense described above.
- The studies presented in this chapter expand the evidence base for using the Scanner and the B-SAFER as instruments to identify, at an early stage, (e.g., during reporting to the police) victims involved in domestic violence who are particularly in need of support. An intriguing outcome of the study reported in the third section of this chapter was that the *underperformance* of the B-SAFER could be attributed to suppression. From a more positive angle, this outcome suggests that SARA-based interviews with domestic violence victims can be *therapeutic*, in the sense that victims become more aware of the potential dangers and hazards they are facing and are thus motivated to engage in preventive behaviors.
- To assist police officers responding to domestic violence crisis calls, new and broad tools need to be developed and validated. The evidence reviewed in this chapter suggests that valid quickscan procedures can be developed through combining items derived from the Scanner and the B-SAFER. Studies examining the predictive

performance of a thus constructed new SABRA tool, focusing on spousal assault broad risk assessment, are urgently needed.

In: Intimate Partner Violence Prevention and Intervention ISBN: 978-1-60456-039-8
Editors: A. C. Baldry and F. W.Winkel, pp. 83-105

Chapter 6

INTIMATE PARTNER VIOLENCE AND RISK ASSESSMENT: THE IMPLEMENTATION OF THE SARA, SCREENING VERSION IN ITALY

Anna Costanza Baldry
Department of Psychology, Second University of Naples, Italy
INTERVICT, Tilburg University, Netherlands

Violence against women is a widespread phenomenon also in Italy where provisions and legislations to combat violence against women are not always sufficient to prevent domestic violence. This chapter looks into domestic violence in Italy, the laws available and the police responses. It then looks at the way the Spousal Assault Risk Assessment method in its screening version (SARA-S) was implemented by providing the first longitudinal data based on a follow-up study of victims of domestic violence to which the SARA method has been applied to assess the risk of recidivism.

DEFINITION OF THE PROBLEM: STUDIES ON PREVALENCE RATES

In Italy, domestic violence was not considered a serious crime until quite recently. Despite its having been in the criminal code for decades, it has been treated, by both society and the authorities, as a matter that should be dealt with privately, within the family. Changes in the culture and in the criminal procedures, as well as the influence of the United Nations' and the European Union's declarations, recommendations, and framework decisions have all led to the development of new approaches to protecting women and children victims of crimes.

In 1997, the European Commission launched the Daphne program for the development of preventive measures to fight violence against children, young people, and women. European Union member states were encouraged to develop projects for the prevention and reduction of violence against women and children. This initiative gave rise to several projects put forward by different non-governmental organizations (NGOs) dealing with victims of domestic violence and other forms of victimization.

In March, 2001, the Council of the European Union adopted the Framework Decision regarding the standing of victims in criminal proceedings (2001/220/JHA), to which all member states should comply by adopting new laws, changing existing ones, and supporting projects and initiatives for the protection and support of victims. A victim was defined as a "natural person who has suffered harm, including physical or mental injury, emotional suffering or economic loss, directly caused by acts or omissions that are in violation of the criminal law in a Member State (art. 1). The Framework states, in article 13 (specialist services and victim support organizations), that Member States shall, in the context of the (criminal) proceedings, "promote the involvement of victim support systems responsible for organizing the initial reception of victims and victim support and assistance thereafter, whether through the provision of specially trained personnel within its public services or through recognition and funding of victim support organizations. Each Member State shall encourage actions taken in proceedings by such personnel or by victim support organizations, in particular: providing victims with information; assisting victims according to their immediate needs; accompanying victims during criminal proceedings, and assisting them after the criminal proceedings".

According to this Act, within a 5-year period, all member states should implement the Framework Decision. To this end, the states should promote activities and projects for the protection of victims of crime.

More specifically addressing violence against women, on April 30, 2002, the Committee of Ministers of the European Union developed the Recommendation Rec(2002)5 for member states on the protection of women against violence. This recommendation advised that there is a serious need for member states to develop new practices and take actions for the prevention and elimination of any forms of violence against women. In particular, the recommendations indicated that member states should take actions to prevent, combat, and reduce violence against women.

Official statistics worldwide under represent the prevalence rate of domestic violence because only 7 per cent of women reports to the police. In Italy, the first survey to examine violence against women -- in particular intimate partner violence -- has been conducted by the National Institute of Statistics (ISTAT) together with the Department of Equal Opportunities, with a representative sample of 25,000 women drawn from the entire Italian female population aged 16 to 70 (Istat, 2007). Women were interviewed by phone about their experiences in their current and past relationships and in the previous 12 months. Lifetime course data show that 14.3% of women have been victims of intimate partner or ex partner violence during their life, corresponding to almost 3 millions of women and 2.4% have been victimized in the last year. The prevalence of victims of ex partner's violence only is even higher corresponding to 17.4% of all women aged 16-70 who had a former partner (see Table 1). Data show that 96.4% of all women victims of current partner and 90.2% of women victimized by their previous partner violence did not report to the police, showing that IPV is perceived as a private matter to be dealt accordingly but also that victims are afraid of possible retaliation from the perpetrator.

Table 1. Women aged 16 – 70 years victims of physical or sexual violence by a partner or former partner, in the life course (percentage of all victims of physical or sexual violence)

	Current or former partner	Current partner	Ex partner	Husband/ cohabitant	Boyfriend	Former partner/ husband	Ex boyfriend
Type Of Physical Violence							
Pushed, grabbed, twisted arm, hair pulled	63,4	59	65,5	56,4	71,2	66,4	63,3
Threatned of hitting physically	48,6	38	53,5	40	24	60,5	47,5
Slap, kicked, punched and bit	47,8	40	50,4	43,8	19,1	56,3	45,5
Hit with an object or thrown something against	25,2	24	24,3	23,4	30,1	33,1	17,9
Used or threatened to use an fire arm or a knife	6,8	2,8	8,8	3,3	/	14,6	4,6
Tried to strangle, choked, burn	6,6	3,6	8	4,2	/	12,9	4,4
Other type of physical violence	3,9	1,7	4,9	1,7	2,3	7,6	3
Total *	100	100	100	100	100	100	100
Type Of Sexual Violence							
Unwanted sexual intercourse because scared of consequences	70,5	80	65,9	80,1	81,7	78,2	58,1
Rape	26,6	17	30	19,9	0,1	39,6	23,9
Forced to humiliating sexual activities	24	18	26	18,1	16,5	27,6	25
Attempted rape	21,1	10	25,3	11,7	2,8	22,8	26,7
Other type of sexual violence	5,2	1,4	6,8	1,5	0,5	5,2	7,8
Forced to sexual activities with other people	3,1	0,8	4,1	0,9	/	3,9	4,2
Total *	100	100	100	100	100	100	100

Source: Adopted and translated from Istat (2007)

When looking at police records, meaning those based on victims reporting, it emerges that in a 1-year period, approximately 2,500 to 3,000 cases of “maltreatment” are reported in the country, although this is clearly an underestimation of the actual number of cases.

The Italian government has made some changes in the civil and criminal law (see below for a discussion of the law on restraining and protection orders) and has implemented a national program called “Urban” aimed at studying attitudes towards domestic violence and its prevalence in the most disadvantaged areas or cities in the country. The original project

was set up in 8 different cities and was later expanded to twenty-four cities, with a total sample of over 8,000 women (Bruno, 2004, table note, p.4). From that study, it emerged that 12% of all women interviewed reported having been victimized by their partners or former partners. Within the previous two years only, 8.6% of the women interviewed reported being victims of intimate partner violence: 49% had been victims of psychological abuse that had been perpetrated by the partner or former partner in 39% of the cases; 27% had been victims of sexual harassment that had been perpetrated by the partner in 10% of the cases; 22% had been victims of physical violence that had been perpetrated by the partner or former partner in 47% of all cases; and, finally, 2% reported having been raped by the partner or former partner, which had been perpetrated in 36% of the cases.

Table 2. Socio-demographic Variables of Women Contacting Shelters in Italy

Characteristics	*1999*	*2000*	*2001*	*Total*
Average number of children	1.4	1.5	1.5	1.5
Mean number of years of abuse	9.3	7.3	6.3	7.6
Mean age	34.2	35	37.1	35.4
Marital status				
Unmarried	630 (13.6)	816 (15.2)	820 (16)	2,268 (15)
Married	2,621 (56.6)	2,909 (54.2)	2,710 (52.9)	8,256 (54.6)
Common Law				1,346
	375 (8.1)	478 (8.9)	492 (9.6)	(8.9)
Divorced	810 (17.5)	1,036 (19.3)	881 (17.2)	2,691 (17.8)
Widow	69 (1.5)	48 (0.9)	72 (1.4)	196 (1.3)
Unknown	125 (2.7)	80 (1.5)	148 (2.9)	363 (2.4)
Total	4,630 (100)	5,367 (100)	5,123 (100)	15,120 (100)
Education				
Elementary	838 (18.1)	907 (16.9)	799 (15.6)	2,540 (16.8)
Middle school	2,949 (63.7)	3,805 (70.9)	3,484 (68.0)	10,206 (67.5)
BA/Master	366 (7.9)	467 (8.7)	497 (9.7)	1,331 (8.8)
Unknown	477 (10.3)	179 (3.5)	343 (6.7)	1,043 (6.9)
Total	4,630 (100)	5,367 (100)	5,123 (100)	15,120 (100)
Nationality				
Italian	4,037 (87.2)	4,567 (85.1)	4,206 (82.1)	12,822 (84.8)
Foreign (UE and extra-UE)	547 (11.8)	757 (14.1)	840 (16.4)	2,132 (14.1)
Unknown	46 (1.0)	43 (0.8)	77 (1.5)	166 (1.1)
Total	4,630 (100)	5,367 (100)	5,123 (100)	15,120 (100)
Employment status				
Employed	1,963 (42.4)	2,759 (51.4)	2,920 (57.0)	7,605 (50.3)
Unemployed	2,255 (48.7)	2,361 (44.0)	1,993 (38.9)	6,623 (43.8)
Unknown	412 (8.9)	247 4.6)	210 (4.1)	892 (5.9)
Total	4,630 (100)	5,367 (100)	5,123 (100)	15,120 (100)

Note. Data refer to all women who contacted shelters in the north, n = 2,404 (1999), n = 3,129 (2000), n = 2,785 (2001); center, n = 1,857 (1999), n = 1,868 (2000), n = 1,991 (2001), and south (Palermo), n = 369 (1999), n = 370 (2000), n = 347 (2001) of the country. Percentages indicated in parentheses. Table adapted from Bruno (2003).

Table 3. Characteristics of the Perpetrator, the Relationship, and the Type of Violence of Women Contacting Shelters in Italy

Characteristics of the violence	*1999*	*2000*	*2001*	*Total*
Type of violence (multiple answer)				
Physical	2,834 (61.2)	3,274 (61.0)	3,125 (61.0)	9,238 (61.1)
Psychological	1,801 (38.9)	2,131 (39.7)	2,075 (40.5)	6,003 (39.7)
Economic	2,190 (47.3)	1,830 (34.1)	1,988 (38.8)	6,063 (40.1)
Sexual	1,320 (28.5)	1,669 (31.1)	1,506 (29.4)	4,521 (29.9)
Women who reported to the police	875 (18.9)	1,089 (20.3)	1,019 (19.9)	2,979 (19.7)
Characteristics of the perpetrator				
Partner	3,542 (76.5)	4,283 (79.8)	3,909 (76.3)	11,718 (77.5)
Ex-partner	607 (13.1)	655 (12.2)	748 (14.6)	2,011 (13.3)
Other (family member, friend, stranger)	542 (11.7)	585 (10.9)	482 (9.4)	1,648 (10.9)
Unknown	102 (2.2)	0	0	106 (0.7)
Marital status				
Unmarried	296 (6.4)	3,001 (5.6)	349 (7.7)	998 (6.6)
Married	2,500 (54.0)	2,828 (52.7)	2,459 (48.0)	7,787 (51.5)
Co-habitant	1,176 (25.4)	1,132 (21.1)	1,081 (21.1)	3,402 (22.5)
Divorced	449 (9.7)	741 (13.8)	589 (11.5)	1,769 (11.7)
Widow	19 (0.4)	16 (0.3)	36 (0.7)	76 (0.5)
Unknown	190 (4.1)	349 (6.5)	564 (11.0)	1,089 (7.2)
Employment status				
Employed	2,641 (62.0)	3,633 (72.7)	3,506 (73.4)	9,726 (69.3)
Unemployed	729 (17.1)	959 (19.2)	778 (16.3)	2,470 (17.6)
Unknown	891 (20.9)	405 (8.1)	492 (10.3)	1,838 (13.1)
Total	4,261 (100)	4,997 (100)	4,776 (100)	14,034 (100)
Problems of abuser (multiple answer)				
Alcoholic and substance abuser	499 (11.7)	859 (17.2)	826 (17..3)	2,161 (15.4)
Mental disorder	239 (5.6)	350 (7.0)	224 (4.7)	814 (5.8)
Prior criminal record	311 (7.3)	605 (12.1)	287 (6.0)	1,193 (8.5)
Childhood abuse	447 (10.5)	800 (16.0)	478 (10.0)	1,712 (12.2)
Other (drugs, gambling, psychiatric problems)	136 (3.2)	120 (2.4)	172 (3.6)	435 (3.1)
None revealed	3,149 (73.9)	3,293 (65.9)	3,262 (68.3)	9,782 (69.7)
Problems of the woman (multiple answer)				
None revealed	3,093 (72.6)	3,528 (70.6)	3,291 (68.9)	9,964 (71.0)
Alcoholic and substance abuser	64 (1.5)	110 (2.2)	110 (2.3)	281 (2.0)
Childhood abuse	780 (18.3)	1,044 (20.9)	855 (17.9)	2,680 (19.1)
Other (drugs, depression, psychiatric problems)	758 (17.8)	1,079 (21.6)	1,098 (23.0)	2,919 (20.8)

Note. Data refer to all women who contacted shelters in the north, n = 2,404 (1999), n = 3,129 (2000), n = 2,785 (2001); center, n = 1,857 (1999), n = 1,868 (2000), n = 1,991 (2001), and south (Palermo), n = 369 (1999), n = 370 (2000), n = 347 (2001) of the country. Table adapted from Bruno (2003). Percentages indicated in parentheses.

The numbers of cases reported from shelters show a much higher proportion of victims of intimate partner violence. Tables 2 and 3 refer to the characteristics of those involved in these incidents over a 3-year period. According to these data, there is no real profile of the "typical" victim, confirming, once more, that victims can be anyone, though a significant proportion of the women contacting a shelter were, in fact, unemployed and from a low socio-economic status. The men do not show significant problems (e.g., drug abuse, mental health problems), though these characteristics are found in the sample under investigation (see Table 3).

VULNERABILITY FACTORS OF VICTIMS OF INTIMATE PARTNER VIOLENCE

Kelly Watt in her chapter of this book, takes into account risk factors of homicide within an intimate relationship, showing how the risk factors of the SARA (for preventing recidivism of intimate partner violence) are often similar to those of homicide, as shown also by Campbell (2003).

One of the most significant problems existing in Italy with regard to domestic violence is getting the victims themselves to acknowledge that they are victims of intimate partner violence and to find a way to leave the abusive partner and seek assistance. Women stay in violent relationships, on average, about 5 to 6 years, but even as long as 30 years, before seeking help from a specialized service or even contacting the Police (Baldry, 2003). This is partly related to their fear of retaliation or an escalation of the violence, death threats, blackmail over the children, religious and cultural conditioning, economic dependence on the partner, social isolation, and, sometimes, stereotyped attitudes about gender roles in the family sometimes held by people in charge of protection and intervention. All of these fears can be referred to as "vulnerability factors of the victim." A woman's decision to leave a violent relationship might be affected by these vulnerability factors, which, when coupled with the risk of violence on the part of the perpetrator, increase the obstacles she faces. Though it goes without saying that the only one responsible for the violent behavior is the person who commits it, women are sometimes blamed for not leaving the relationship and, thus, held, at least in part, responsible for the violence they suffer; however, a woman's vulnerability factors render her decision to leave more difficult, if not nearly impossible. These factors, which have been extensively studied in the literature, should be taken into account when assessing risk because recidivism is more likely to be high if the woman exhibits vulnerability factors.

According to the study conducted by Riggs, Caulfield, and Street (2000) and other relevant studies focusing on victim vulnerability, risk factors for being a victim of domestic violence and of repeated violence (see also Watt this book) can include the following:

- Difficulties in getting access to services because they are not available or not known, because the perpetrator prevents the victim from doing so, because the victim is an immigrant and neither knows the language nor what services are available, or because she is afraid that her children will be taken away.
- Lack of trust in services, institutions, the police, and the judicial system, and fear of stigmatization.

- Insufficient coordination among services; no network, exchange of information.
- Masculine gender role stereotypes, strong religious beliefs, cultural and religious conservative beliefs.
- Small children, a desire for children to grow up with a father, fear that children might be removed to a foster home.
- Depression, low levels of stress management skills, inadequate coping strategies and problem-solving skills, low self-esteem, low assertiveness.
- Physical or mental impairment.
- Posttraumatic stress disorder symptoms, anxiety.
- Low levels of anger, low resiliency, learned helplessness.
- Alcohol and drug abuse.
- Isolation, inadequate social and friendship support, never talked to anyone about the violence because of preconceived ideas.
- No work/residence permit.
- High social/economic status to protect.
- Relational problems within the relationship, man from another country, culture.

From Domestic Violence to Femicide

Every year in Italy, on average, 100 women are killed by their partners or former partners. It is not known in how many of these victims were previously abused by their partners. A recent fatality review study conducted by the author within a EU Daphne Project reveald that up to 70% of all cases had prior history of violence.

Data collected on homicides committed in 2003 (Eu.r.e.s, 2004) indicate that of the 95 women killed in an intimate relationship, 64.2% were killed by their husbands or common law partners, 24.2% were killed by their former husbands or common law partners, and 11.6% were killed by their boyfriends or lovers. The mean age of the victims was 46.4 years (SD = 17.97), with the youngest victim aged 18 and the oldest one, 80 years. Femicides in intimate relationships are equally distributed in the country, though there is a higher proportion in the northwest (Lombardia and Piemonte; 18.9% and 10.5%, respectively). These latter data seem to be related to women with a higher economic status and a concomitant greater desire for independence, which, in some cases, they may have paid for with their lives. It has to be considered, however, that, in these regions, there is a higher proportion of people living in these areas.

The women were mainly killed with guns (43.2%). They were also killed with knives (25.3%), by strangulation (12.6%), with sharp objects (5.3%), by being beaten (4.2%), by being thrown out of windows (3.2%), by being run over by a car (2.1%), and, finally, in 2.1% of the cases, they were killed with a non-identified object. In one case, the victim was suffocated.

The Italian Legislation in Cases of Domestic Violence

The Italian criminal code contains only a few provisions specifically dealing with family violence (and therefore with domestic violence); even fewer provisions refer specifically to domestic violence (Baldry, 2001, 2003). However, there are numerous crimes identified by the law that can be applied to cases of domestic violence. In addition, there is also a new legal provision for issuing restraining orders in cases where violence is committed within the family. It is worth mentioning that all types of violence constituting "domestic violence" (physical, psychological, and sexual) are covered by the Italian criminal code, which means that a woman who has fallen victim to one of these types of violence can report this to the police, who may send the case to the prosecution. Some crimes must be reported by victims themselves in order to be prosecuted. Others, however, once they are known to the legal authorities, can be directly referred to the public prosecutor without the victim's having to file a complaint. The following are the different types of family violence that can be prosecuted under Italian law.

Psychological violence. In Italian law, psychological violence can be divided into three categories. The first is termed *private violence*. A person may be convicted of psychological violence if he or she forces someone else, with violence or threat, to endure unwanted actions. In these cases, the perpetrator is punishable with imprisonment up to 4 years. The second is *threat*, which refers to threatening physical injury to another. The third category is *insult*, which entails insulting the honor or the dignity of another person.

Physical violence. Physical violence is also divided into three categories. *Assault* refers to cases where an individual hits another person but there are no severe physical or mental consequences. In these cases, the perpetrator can be imprisoned for up to 6 months. Assaults are regarded as isolated events, and a legal action is started only if the victim reports the crime to the police. *Personal injury* is more serious than assault; in these cases, the assault has resulted in physical or mental impairment, and the perpetrator can be imprisoned from 3 months to a maximum of 3 years. If the victim reports an injury that will require up to 40 days to heal, the case can be prosecuted, but only if the victim reports the crime. When the injury is considered to be highly serious and will require more than 40 days to heal, the legal authorities (police or public prosecutors) are required to initiate legal action. *Personal injuries*, the third category, can be "serious" or "very serious." A serious case is punishable with 3 to 7 years imprisonment, in the first offense; a "very serious" case may be punishable with up to 12 years, if, as a consequence of the "very serious injury," the damage inflicted will impair the victim from leading a normal life.

Article 572 of the criminal code refers directly to family violence and is identified as *maltreatment within the family*. According to this provision, when somebody maltreats a member of the family, the punishment is imprisonment from 1 to 5 years. The article specifies that in order to proceed for a crime of maltreatment, the violence committed must include a set of violent acts (psychological as well as physical or sexual) committed repeatedly over an extended period of time, even if, in the interim from one event to the other, there is no violence taking place. Legal action by the authorities is mandatory. This means that the case is always prosecuted, whether the victim is willing to report to the police or not. Maltreatment can apply both to married couples and to common law relationships. In order to prosecute someone for maltreatment, there must be evidence that the physical and psychological violence has been inflicted repeatedly over an extended period of time.

Under Italian law, a suspect can also be charged with the crime of sexual violence taking place within the family. In 1996, a new law was introduced into the Italian penal code that encompasses all forms of sexual violence. According to this law, "whoever forces someone to do or suffer from a *sexual action* is punishable with imprisonment from 5 to 10 years" (emphasis added). All forms of sexual violence are included, ranging from sexual harassment to rape. These sexual crimes are punishable *only* if the alleged victim reports the crime. If a victim does file a complaint of sexual violence, she or he can not withdraw it at a later time. This is done to prevent victims from withdrawing complaints later because they have been threatened by the perpetrator. When a victim is under age, legal action is officially initiated by the prosecutor.

Obstacles to Collecting Evidence

When a woman suffers from domestic violence, there are different possible steps she can take to protect herself and to get help and assistance, such as going to the police to report the crime or seeking help in a hospital for injuries suffered. For instigating criminal proceedings, it is important to collect sufficient evidence of the violence that has been perpetrated. Discussed below are a number of obstacles that may impede the gathering of evidence in domestic violence crimes.

If a victim reports more than one incident of violence to the police, each report may go to a different prosecutor, which hinders effective evidence collection. It is, therefore, important that the public prosecutors, the police, and the victim's attorney assemble all reports of violence concerning the same victim in order to have sufficient evidence of the multiple violent events that took place within a certain period of time. This evidence of multiple incidents will demonstrate that a single act reported by the victim is only one of a series of several violent acts. This kind of evidence makes it possible to proceed with a charge of maltreatment.

Another important piece of evidence is medical reports of injuries suffered by victims of violence, which are drawn up by doctors, emergency rooms, or hospitals and can be collected. Such reports will assist victims to prove both the incidence and severity of assaults when reporting the cases to the police. Sometimes, however, women who have been beaten do not seek medical help because they are scared of retaliation or have actually been prevented from doing so by their abusive partners. In addition, some victims, when seeking medical treatment for their injuries, will provide other explanations for their bruises and wounds (e.g., fell from the stairs, hit the cupboard). The collection of evidence is impeded in such situations.

Obtaining corroborating witness evidence can be another obstacle in the criminal prosecution of this type of violence. Most domestic violence takes place behind closed doors, in a private setting, or with only the children present. Witnesses are important to support women's claims, especially in cases where there is no other evidence available than the word of the victim against that of the alleged perpetrator. Nonetheless, when violent acts are repeated over time, some individuals (e.g., relatives, friends, neighbors) may be aware of what is happening. They may have seen the bruises or heard the woman crying. The victim herself might even have talked to someone about what has happened. In some cases, witnesses are, therefore, available.

In summary, women often do not have sufficient evidence to legally prove what has happened to them (no medical reports, no witnesses, no corroborating evidence) and therefore the charge of maltreatment might fail. This is particularly significant because women's reports of domestic violence are often not taken seriously. The probability of this happening increases when victims make reports to the police and later drop the charges. In cases where divorce proceedings are involved, there is a tendency to believe that women make up such stories, hoping thereby to win custody of their children. Domestic violence is, to a certain extent, still considered both by public opinion and by those working in the criminal justice system as a private matter that needs to be solved within the family. This is still an attitude found rather frequently among many people, even those working for the protection of victims. This suggests that there is an underestimation of family violence, which is often not considered a "real" crime but, rather, a private matter.

As mentioned before, some women, after reporting the violence to the police, withdraw the report. This may occur either because the woman is afraid of what might happen if the man is arrested or because she has been threatened by her partner. Some victims might even feel guilty because of what may happen to their partners as a consequence of their reporting the violence to the police (e.g., be sentenced, go to prison, and lose a job).

Protection and Restraining Orders

In March, 2001, a new law was passed (law nr. 154, 05/04/2001: *Measures against violence within intimate relationships*) that deals with cases of family violence. This law specifically addresses the problem of victims' protection from violent partners by providing the court with the possibility of applying a protection order or restraining order (depending on whether it is issued by the civil or criminal court) when a person is accused of the crime of maltreatment. In the criminal code, the restraining order allows three types of prescriptions: (a) an order to live in a particular place or area, (b) a prohibition from living in the home, and (c) a prohibition from living in a certain community. This law applies to married couples, as well as to common law relationships, as long as the two partners are living together, though the recent jurisprudence has also recognized the possibility of making use of these orders when a relationship is over (due to violence), and the two no longer live together. In these cases, the judge can forbid the abuser to come close to the house of the former partner, her place of work, or to the children's school. These restrictions can, of course, also be applied when the individuals are still living together, and the judge first orders that the perpetrator leaves the residence and then complies with certain restrictions.

A victim of abuse can ask a civil judge to issue a protection order that requires the partner to leave the house without filing a criminal charge. A civil judge can issue an order for up to six months, renewable for another six. A judge can also order that, during this period, the violent partner may not approach the places where the victim or her parents, children or friends live or work. The order can also indicate that the violent partner has to provide financial maintenance. Along with a protection order, a judge may order intervention by special services, agencies, family mediation centers, or NGOs for the protection of an abused woman.

The same restrictions can be applied in criminal proceedings, with the aim of protecting the women's safety. Such orders are valid alternatives to imprisonment and are referred to as

restraining orders. In these cases, as well, a judge may also order that the perpetrator has to provide financial support for the family.

It is important to emphasize that this law is producing positive effects for victims because it allows them to continue to live in their homes without having to escape and find another place to live with their children. Although new legislation does not solve the problem of family violence, it constitutes an efficient first-aid measure to reduce the risk of re-victimization of women and their children.

Unfortunately, these orders are not always respected. In many cases, the men disobey the orders and approach the home or the women's working places or the children's schools. Another problem arises from the fact that not all judges in every part of Italy make use of this law. This, unfortunately, seems to be a problem related to attitudes toward these issues held by the judges themselves. It is not known for certain why this happens, but it appears that some judges do not apply this law because it would mean acknowledging the problem of domestic violence and being culturally prepared to change the usual procedure of dealing with these cases as private matters. This is especially true in some regions of Italy (see Baldry, 2003).

The new law is an important achievement, attained through the concerted efforts of some politicians together with NGOs working for the protection of women victims of violence. For example, the Association Differenza Donna, an association of women against violence against women, lobbied for the implementation of this law and currently provides assistance to victims who invoke it. In the city of Rome, in a 4-year period since the law's implementation, there have been sixty requests for protection orders in the civil courts and fourty for restraining orders in the criminal ones. The level of satisfaction reported by the victims who benefit from this procedure is high. Six months is not a long period for a restraining order, but it is, in many cases, enough for a woman to organize her life and that of her children and seek alternative solutions (Baldry, 2003). Unfortunately, there is not yet any study that examines how many of these orders have been issued, in which cases they have been violated, and what the significant risk factors are for those offenders who obey the orders and those who do not. In this regard, the SARA procedure can be helpful in providing indicators for public prosecutors and judges of increased risk of recidivism and where this has been reduced by the use of restraining or protection orders.

The Police Role

After a case of domestic violence has been reported to the police, there are different paths that can be followed, depending on the severity of the case. Most cases of this sort, nowadays, are dealt with by a so-called peace judge, whose role is to try to resolve conflicts. Reconciling the partners keeps less serious cases out of court and likely reduces the work load of the courts. However because domestic violence tends to be downplayed as a crime already, attention should be paid to insuring that the severity of these cases is not underestimated by having them dealt by the peace judge. When a violent act is considered to be more severe, then it is transferred to the criminal court where it will proceed as a maltreatment case.

Once a case is brought forward for trial and before it is heard, the public prosecutor may ask the judge for a restraining order if the accused person is considered to be dangerous to the victim or society. In domestic violence cases, this order is not always issued, due to a general

underestimation of the severity of the circumstances. Often it is difficult to prove that the suspect *is* dangerous. With the new restraining order legislation previously discussed, it is possible that the defendant will receive an order to leave the residence, while the victim and the children are allowed to stay in the home.

There are other precautionary measures that can be used in these cases as well, and they vary according to the seriousness of the crime and the risk of re-offending. The "obligation to sign" at a police station is one of them. This implies that the offender has to present himself to the police station and sign a register. This measure is intended to prevent the offender from leaving either the city where he is resident or the country. "House arrest" is another possible measure that can be adopted. In the most severe cases, where the victim and the society are considered to be in danger, "preventive custody" can be imposed.

In several cities in the country there are special units (Anti-violent Unit, Family Section) of public prosecutors (equivalent to the Crown Court in the United Kingdom) that have special duties and training for dealing with cases of violence within the family. These special units were created to facilitate faster procedures for such cases, in view of the danger they may present if not dealt with in quickly. Once a case is his or her responsibility, the public prosecutor working in one of these units focuses on shortening the time span between the preliminary hearings and the trial. In addition, the same public prosecutor hears all parties involved in the case, which aids a quick and efficient processing of the case.

Fast processing of this type of case is essential for the protection of the victims. However, the number of domestic violence case convictions, though increasing, is still relatively small because professionals are not specifically trained in these issues and can, as a consequence, underestimate the seriousness of the case, even though it appears that, in some jurisdictions, the second highest number of cases dealt with by the court are domestic violence cases. It needs to be emphasized, however, that once a crime has been reported to the authorities, it is mandatory for them to proceed with it; no diversion (such as mediation outside the criminal justice system) may take place. Thus, all such alleged crimes, once they are known to the legal authorities, have to be dealt with by the criminal justice system.

Police Actions in Domestic Violence Cases

Most domestic violence cases go unreported. In Italy, only 17.3% of the battered women who were admitted to shelters in 1993 reported the crime to the police; in a 10-year period, the rate increased to 23% (Baldry, 2006). The percentage of reported crimes has risen slightly due to the increased sensitivity of the police in dealing with these cases and heightened social awareness of the problem. Of those battered women who report the violence to the police, an unknown percentage subsequently withdraw the report because of their fear of retaliation or their reconciliation with the batterer. Children and economical restraints are often reasons for women to decide not to leave their partners.

In the Italian police forces, there are not yet any special units for dealing with domestic violence cases. However, there are so-called *ufficio minori* (youth offices) of the so called Divisione Anticrimine that deal with minors who have been victims of crime and are also in charge of child abuse cases within the family. Within the Squadra Mobile (investigation Squad) there are the *sezioni minori* who are in charge of the most complicated cases of child

abuse and sometimes domestic violence. These units receive special training, and they are usually directed by a female chief inspector.

In 1994, the police department in Milan, Region Lombardia, developed a protocol to deal with domestic violence cases and to prevent the escalation of violence. In most places, the police do not keep track of emergency phone calls coming from homes. The Milan project recommends that data on all phone calls requesting police intervention for conflicts in the home be recorded. This recommendation covers all cases, whether or not the police go to the site, arrest the man, or do nothing, and whether or not the victim files a complaint.

According to this protocol, the tasks of the police are as follows:

- To keep track of escalating conflicts and to monitor them.
- Upon receiving the third phone call from the same household for the same type of problem, regardless of whether the phone call has been made by the neighbors or by someone living in the house, the police have the power to intervene. In the case of multiple requests for help, there can be evidence of maltreatment. In this way, the victim is waived from the burden of having to report her partner, and the case would be prosecuted without her official complaint being needed.
- To protect the victim and her children from any escalating violence.

The special unit for the family of the office of public prosecution gathers all information, including the data gathered from phone calls indicating family disputes, and uses it as evidence in case of a trial. Keeping records of all the calls is essential for proving that the violence occurred within the household. Unfortunately, there are, as yet, no data available on the results of these police interventions.

Police should be given more training concerning domestic violence cases. Training components should include topics such as the cycle of violence, consequences for battered women, risk assessment of recidivism, safety issues, and the needs of battered women and their children. In Italy, there are no specific intervention programs for batterers.

To provide police and people working in the judicial system with the most up-to-date and efficient approaches to deal with domestic violence and adopt strategic measures to reduce the risk of recidivism and recidivism per se, the NGO Differenza Donna and Department of Psychology of the Second University of Naples started, in 2003, to implement the Spousal Assault Risk Assessment (SARA) in Italy.

THE IMPLEMENTATION OF THE SARA IN ITALY

Violence in intimate relationships is a crime with a high prevalence rate of recidivism. The challenge is to try to identify those cases most at risk of immediate, severe, and probable re-offending (Hart, 2001) in order to provide victims with the most efficient protection. The risk assessment approach provides a means of establishing the level of risk or recidivism, depending on the assessment procedure conducted. Once the possible scenarios resulting from the level of risk assessed and the possible outcomes if no intervention takes place are identified, strategies for management of the case can be devised to reduce the possibility of further violence.

In Italy, the screening version (SARA-S) of the SARA was introduced at an experimental level, thanks to the European Daphne program, which supports European projects for the prevention and reduction of violence against women and children. The project was organized with Italy as the coordinator and with other European countries as partners: Sweden and Greece, the first year; Portugal, the Netherlands, and Lithuania, during the second year of the project.

The implementation of the SARA-S in Italy comprised a number of different tasks. It included translating and adapting the SARA and its manual to the Italian context; training police forces, social workers, and victims' shelters in the risk assessment procedure; and validating the procedure by prospectively collecting data with a sample of abused women who contacted shelters for battered women or the police and following them up for (a) a period of over 2 months to assess short-term recidivism rates and (b) after six to twelve months to assess long-term rates.

PROCEDURE FOR RISK ASSESSMENT OF RECIDIVISM IN CASES OF DOMESTIC VIOLENCE IN ITALY

The risk assessment procedure is not officially implemented in the Italian judicial system yet. This means that the SARA-S is used only on an experimental basis and only by those who have undergone the training. Once a victim gets in touch with the police, a shelter, or a social worker, the assessment of risk of recidivism can be conducted by using the risk assessment approach of the SARA-S. This means that the service agencies and institutions that are aware of the SARA can decide whether to use it and benefit from that assessment. The implementation of the SARA within the police force, in fact, has helped them address the problem of domestic violence in a more accurate way, by asking the relevant questions.

The SARA helps not only in the assessment of risk, but also in providing police officers with a framework to use for each case they come across. The police force in Italy has no power to make decisions about whether to arrest a suspect unless found while committing the crime or to apply a restraining order, as this is the responsibility of the judge, at the request of the public prosecutor. However, the police provides the prosecutor with a report of the victim and any information they have gathered about the crime. It is at this stage that the SARA format can assist the officer to gather information that has been shown to be relevant to understanding the case and can assist in determining whether a suspect is at risk of recidivism. In this way, the police can indicate in the *informativa* (the letter accompanying the report) supplied to the public prosecutor how risky he or she thinks the case is for recidivism.

The following steps are currently taken in Italy for each case in which an assessment is done by using the SARA.

(a) *Letter of consent*. A letter of consent is signed by the victim in cases where the assessment is done by someone outside the judicial system (social workers and psychologists working in shelters). This allows those doing the assessment to collect and deal with personal data in accordance with Italian laws about privacy of identity.
(b) *Socio-demographic variable*. This is a form that is filled in by the evaluator (e.g., police, judge, social worker, and psychologist) to record all the information that can

be gathered from different sources: the victim, the perpetrator, and other reports. These socio-demographic data (e.g., age, place of birth, occupation, number and age of children) are usually gathered at the beginning of the interview, before the assessment of risk takes place.

(c) *CTS Scale (Straus, 1979)*. This slightly modified version of the CTS Scale, which has been adapted to the Italian context and is called the ICV (Baldry, 2006), is filled in by the victim. This instrument measures different levels of violence, from the psychological to different degrees of severity of physical violence and sexual coercion. In the procedure used in Italy, even though the ICV records both past and current (during the past 2 months) incidences and types of violence, it is the data for the previous 2 months only that is used to compare the amount and type of violence that took place during that time to the 2 months following the SARA assessment, when recidivism is measured. The respondent indicates whether the behaviors she reports were present or not in the last 2 months. In this assessment, it is important to start the evaluation by including a least the last episode for which the woman has contacted the shelter or the police. Administering this scale also can have a secondary benefit for the police. When victims report, they are sometimes afraid or embarrassed to describe what has happened; they also may have forgotten past incidences. Beginning by filling out this self-administered list of items describing various violent behaviors can reduce victims' embarrassment and also help their recall memory, thus facilitating the process for the police, who can use the information recorded as a starting place for asking more detailed questions.

(d) The SARA-S screening version. The SARA-S, consisting of 10 items, does not have to be filled in during the interview with the victim, but only after all relevant information about the case is gathered. It is useful, however, to scroll through all questions with the victim in order to insure that the assessor takes all relevant information into account. In the Italian version of the SARA-S, we have included a question, which comes before the risk factors are addressed, that asks the victim herself to rate her perception of risk (in the short- and long-term, risk of escalation of violence, and the risk of severe and lethal violence). Once all 10 risk factors are then addressed, and information regarding their presence or absence, currently or in the past, are taken into account, the assessor will establish the level of risk (low, medium, or high), in the short- and long-term; the risk of escalation of violence; and the risk of lethal violence. Following the interview with the victim to establish risk factors, she is asked again to rate, on a 3-level scale (*low*, *medium*, and *high*), her perception of the risk of recidivism. There were several reasons why we included this double, victim-based procedure. First, we wanted to see how the victims themselves perceived their risk, which might or might not be accurate. Victims might, in fact, underestimate the risk they run of being victims of violence, as stated by Campbell (2004), because they have become used to it and have a need to convince themselves that the risk is not too serious so that they can survive in the relationship. On the other hand, the criteria used by a woman to assess whether a man is going to be violent again might be related to factors other than those used by the evaluator who uses the SARA procedure. For management of risk purposes, it is essential to take into consideration what the victim herself perceives as the level of risk of future violence, especially when she states that the risk is high or medium. That is to say

that if victims do make errors in the estimation of their risk, it tends to be towards underestimating it; thus, if a victim says the risk of being beaten again is high, then this evaluation must be seriously taken into account. Gondolf (2004), in fact, showed that victims' assessments of risk are the most reliable predictors of actual further recidivism, more accurate than any actuarial or professional assessments. Though we think that a structured professional assessment is contributing significantly to providing a prediction that is better than chance, victims' accounts should be seriously considered (and therefore known), especially when there is no tendency on behalf of the victim to minimize what has happened to her. A second reason for the double, victim-based procedure is to determine whether a victim, after she has reviewed her entire relationship, the problems, and the types and severity of violence taking place, might decide that the risk is more serious than she previously had thought. In the last part of the original form of the SARA, we also added, in the Italian version, another assessment section that refers to possible risk of abuse of the children, with no further specification of what type of abuse. Again, two types of assessment are required: by the victim herself and by the evaluator. The aim of this further assessment part is to establish a well-known finding in psychology that a man who is violent and abusive towards his partner or former partner is at higher risk of being abusive also towards his children (at the least, psychologically abusive by exposing them to the violence). It is important to remember, too, that the children might not be the man's own children, but only those of the woman; in these cases, the risk of abusive behavior might even be higher.

(e) *The SARA-S guidelines*. For beginners in SARA-S assessment, the guidelines are very useful because, for each factor, they have a list of relevant questions that measure and identify that factor. Police officers, social workers, and judges might find these guidelines useful in order to pose the relevant questions to the victim or other people informed about the events and to become knowledgeable about the risk factors. After a certain amount of practice using the guidelines questions, the assessor should have learned them and no longer need to read them.

(f) *CTS follow-up (ICV follow-up).* For research and monitoring purposes, after 2 months, the modified CTS follow-up (ICV follow-up) is administered to the victim to establish the recidivism rate in the short term. The measure refers to the previous 2 months (since the SARA-S assessment was done). The same questions as in ICV are asked. If a follow-up in the long term were to take place, then the reference period should be adjusted accordingly. To establish the recidivism rate, it is not enough to check whether the victim has reported again to the police. Even though these women reported to the police once, it does not mean that they will report the case again. They could be afraid, could have experienced retaliation, could be hoping he will change, or could even now be ashamed. In the ICV follow-up, there are questions asking the woman whether in the last 2 months (or the relevant period the follow-up covers) her partner has been arrested, she has moved out of home, he has received a restraining order or she has gotten a protective order, and even whether he has died. This additional information is essential because when establishing whether there is a significant relationship between assessment of high risk of recidivism and actual recidivism, one has to control whether the two were living under the same conditions as before or not, or, in fact, the living conditions are different in such a way that the

measure taken per se reduced the risk of recidivism. The SARA assessment should have this aim: to provide professionals with the whole picture of a case so that they can determine if protective measures are needed and, if so, which would be the most effective in reducing the risk of recidivism assessed. Risk assessment with the screening version of the SARA (SARA-S), as well as with the full version, can be undertaken by anyone who has met the minimum standard requirements: knowledge about violence in intimate partner relationships and the relevant legislation, experience in dealing with cases of intimate partner violence, and risk assessment experience. Anyone dealing with these cases will have to follow and conform to his or her own country's legislation covering the privacy rights of victims.

The SARA-S is not a psychometric test, nor a clinical one; therefore, there are no specific psychological skills required to conduct a risk assessment. However to code item 9 (substance abuse problems) and 10 (mental health problems), professional evaluation might be required. The screening version, consisting of 10 factors, addresses this problem because it gives the assessor the opportunity to provide a provisional coding. Coding this risk factor does not require the evaluator to make a diagnosis. It can be coded based on diagnoses made in the course of psychiatric or psychological evaluations conducted by others. Alternatively, it can be coded *present* on the basis of the person's self-reports or the observations of the evaluator or collateral informants.

Each time an assessment takes place, besides guaranteeing the privacy of those involved, the assessor needs also to make sure that the information that he or she gathers from the victim does not put the victim at higher risk. If the assessment is done by the police, these privacy issues do not apply, though only with reference to the judicial system.

With regard to training in the SARA procedure, there are different possible paths. According to the authors (Kropp, Hart, and Belfrage, 2005), the potential assessors can train themselves by studying the manual and then be supervised in the assessment by the authors. In Italy, in order to be qualified in the risk assessment method of the SARA-S, it is essential to undergo a training module. For those who want to learn about the procedure and use it for research purposes, they can start by reading the Italian manual, inclusive of the case studies presented and their assessments. The length of training needed depends upon the trainee's knowledge of the field of intimate partner violence and the amount of experience he or she has in dealing with these types of victims and perpetrators.

The training modules conducted in Italy vary according to the professions of those being trained:

- Whole module consisting of 3 days (total 24 hr.), which includes training in interviewing techniques with victims, or its standard version, consisting of 2 days (16 hr) on basic training on SARA. These types of modules have been developed for the police and professional working in the judicial system (lawyers, judges).
- Short module of 1 day (8 hr.) for social workers working in social services, hospitals, clinical sectors, and shelters for battered women who already have skills to approach victims and in understanding the dynamics of IPV.

As illustrated below, different themes are dealt with during the training. The training modules must include, on the one hand, the psycho-social and criminological aspects of

domestic violence, legal norms and procedures (this part of the module is usually undertaken by a judge or public prosecutor), information and study outcomes on the impact of violence and trauma, and reference to the risk factors of the abuser and the vulnerability factors of the victim. On the other hand, the training must be practical and focused on case-study presentation, role-playing, and presentation of real cases in person or by video. Besides training on how to do risk assessment, attention is given to the risk management approach (Hart, this book); that is, once the risk is identified, it is important that possible solutions are identified.

Training Module for Police Officers, Civil and Criminal Court Personnel, and Social Workers in the Risk Assessment of Recidivism in Intimate Partner Violence Cases

Theoretical part:

- Intimate partner violence and family violence. Psychological and criminological aspects.
- Trauma and its consequences for the victims and on children.
- Assessment of risk of violence and of recidivism. Methods and approaches.
- Risk management and monitoring. Data presentation of efficiency of the risk assessment approach.
- From domestic violence to stalking and femicide, sociological and psychological aspects.
- Victim's vulnerability factors. Victim's safety planning.
- The SARA (Spousal Assault Risk Assessment) and risk factors.
- The screening version of SARA: B-Safer or SARA-PV for police officers.
- The legislation in cases of domestic violence: its application and limits.

Practical part:

- Sample case and identification of risk factors and their coding.
- Methods for filling in the screening version of the SARA .
- Kit-SARA. First step: guidelines for interview with the victims, socio-demographic variables, victim's risk assessment, scale to measure indicators of violence (ICV), SARA-S.
- ICV follow-up after 2 months for the short-term recidivism rate; after 6, 12 months for the long-term rate.
- Presentation of a real case and role playing and risk assessment.

THE STUDY

As mentioned before, in Italy the SARA procedure has been used, so far, on an experimental basis, to validate the procedure and to have an extra tool available for dealing

with women who got in touch with shelters or social services. The data that will be presented here are, therefore, preliminary and were gathered on 124 women, 76 of whom got in touch with a pubic service for medical, psychological, or economic support in Caserta, a town of in southern Italy, close to Naples, and 48 of whom got in touch with shelters for battered women in Rome.

Overall results show a correlation between high and medium levels of risk assessed and recidivism rate after 2 months, whereas the opposite, low recidivism after 2 months, was found for those cases assessed as low risk. It is interesting to note that the results go in the opposite direction when the assessment was medium to high risk and precautionary measures were taken for the protection of the victim (mainly the victim went to stay in a shelter and/or the man got a restraining order). The prevalence rate of recidivism in these cases is significantly lower, indicating that it is possible and effective to intervene to reduce the risk of recidivism. Preventing recidivism is, in fact, a scope of the SARA: predicting without intervening is not of much use. Unfortunately, decisions about which protective measures for victims or restrictions on offenders are to be applied are determined primarily by how the courts apply the laws, without regard to information gleaned from the results of structured, scientific assessments of risk that have the benefit of tailoring the measures to the level of risk involved.

Ideally, the training should be done in groups of not more that twenty to twentyfive to guarantee interaction with all participants.

Participants

The participants in the study were 124 women aged 16 to 65, with an average age of 37.26 years (SD = 11.23). In 22.6% of the cases, the women were foreigners (mainly from Eastern Europe, 13.7%); the rest were Italian (77.4%). Of the Italian women, the majority (66.7%) were from Caserta (South of Italy), and the rest, from Rome (33.3%). Most of the women were married (42.3%); the rest were single (30.9%), divorced (23.6%), or widowed (3.3%). In 34.2% of the cases, the women were white collars workers; 19.7% were housewives; 18.8%, unemployed; 15.4%, blue collar workers; 8.5%, working in several sectors with unspecified jobs; and the remaining 3.4% were professionals.

With regard to the perpetrators, the average age was 41.78 years (SD = 12.21), the youngest being 19 years old, and the oldest, 76. Most were Italian (85.2%); some from Eastern Europe (7.4%), and the rest, from other foreign countries.

Most of women in the sample (27.6%) had one child; 26% had two; 11.4%, three; 17.6%, none; and the remaining 17.4% had more than 4. The age of the children is correlated with that of the mother, so children's ages ranged from 2 months to a maximum of 40 years for the first (and sometimes only) child.

In risk assessment, the ages of the children living at home is an important factor. Women with children living at home are generally in a more vulnerable position if they want to leave the relationship, especially if their children are very young and are also the children of the abusive partner. If the woman is already living without the partner, having children under age can increase her vulnerability because of issues of custody and visitation, which, in intimate partner relationships, can increase the potential of threats and even violent attacks.

Results

As Table 4 (which refers to the type of relationship between the man and the woman when data were collected and the first evaluation was done) shows, in 35.8% of the cases, it was the ex-partner (ex-husband or former cohabitant partner) who committed the violence. These cases can be referred to as stalking cases within an intimate relationship.

Table 4. Type of Relationship between Victim and Offender

Type of relationship with the partner	*Absolute values*	*Percentage*
Married	53	43.1
Formerly married	28	22.8
Living together	11	8.9
Previously living together	10	8.1
Engaged	14	11.4
Previously engaged	6	4.9
Lover	1	.8
Total	123	100

Note. In one case, data are missing.

At the time of the first assessment, in 40.4% of all cases, victims were living at home with their partners; in 28.9%, they were living at home without their partners; in 14.9%, they were staying at friends' or relatives' houses; in 7.7%, they were living in a shelter for battered women; and, finally, in 8.8%, they were living somewhere else not specified.

Table 4 shows the percentages related to the type of violence the victims suffered in the 2 months prior to the assessment (Time 1) and that happened in the following 2 months (Time 2). The scale used to measure indicators of violence (ICV) had been structured in such a way that the same reference period was subsequently analyzed in order to be able to compare type of data collected and to determine whether there had been an increase, decrease, or no change in the amount of violence at Time 1 and Time 2.

As shown from data reported, the overall prevalence rate for any type of violence taking place in a 2-month period was very high. This high proportion was still reported after the following 2 months, even if it decreased for several types of violence.

Types of violence reported have been classified as psychological and verbal violence (items 1, 2, 3, 4, 5, 7) and physical violence (items 6, 8, 9, 10, 11, 12, 13, 14, 15). These items were added together to produce two single new measures that were then compared with the risk assessment done by the evaluator and by the victims. Due to the high proportion of psychological and verbal violence reported by the sample under investigation both at T1 and T2, this type of violence was not used to measure the relationship between recidivism and the assessment of risk of recidivism because it could not discriminate between victims.

To determine the relationship between the risk assessment established by the assessor (Figure 1) and by the victim (Figure 2) with the recidivism rate of physical violence after two months, categorical data were crossed by using the chi-square test. Results do not show significant differences, indicating that there are *false negatives* (cases that were assessed as low risk where there has been recidivism) and *false positives* (cases assessed as high risk that did not report any recidivism after the two month's assessment).

Table 5. Percentage of Women Reporting at Least One Violent Incident in the 2 Months Pre- and Post-Assessment

Type of violence reported	*Time 1*	*Time 2*
1. Has he shouted at you, called you names?	89.5	79.8
2. Has he been sulky, refused to talk to you?	75	66.7
3. Has he humiliated you, told you were stupid, ugly?	75	71.5
4. Has he followed you, constantly checked on where you were, with whom you were talking?	61.3	43.1
5. Has he been very jealous and suspicious towards you?	75.8	63.9
6. Has he thrown objects at you, without hitting you, broken your personal belongings?	59.7	36.9
7. Has he threatened to throw objects against you?	54.8	34.4
8. Has he thrown objects at you even if did not hit you?	47.1	23.0
9. Has he pushed you, grabbed or pulled you?	73.2	46.3
10. Has he hit you with his hands or fists?	67.5	30.9
11. Has he hit you with a sharp object?	20.2	11.4
12. Has he kicked you, bit you?	38.7	14.6
13. Has he been physically violent in a more serious way (e.g., tried to choke, strangle, or burn you, or has he threatened to use a gun or knife against you)?	37.2	19.7
14. Has he tried to force you, without succeeding, to have sexual intercourse with him against your will?	63.7	49.2
15. Has he had sexual intercourse with you against your will?	52.0	31.1
Total psychological violence (items 1,2,3,4,5,7)	98.4	90.1
Total physical violence (items 6,8,9,10,11,12,13,14,15)	89.7	70.8

Note. Total percentage adds to more than 100 because respondents could check more than one behavior.

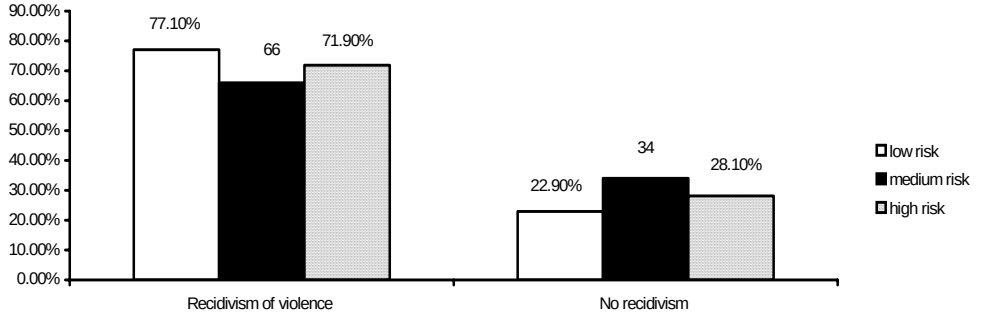


Figure 1. Percentages regarding risk assessment of short-term recidivism (within two months) done by the assessor at Time 1 and recidivism rate measured at Time 2 (after two months). Note: Recidivism is for any physical violence.

From the analysis of the data, it is possible to conclude that the most efficient risk assessment in terms of predicting short-term (within two months) recidivism was the one done by the assessor, rather than the one by the victim. The victims tended to underestimate the cases where recidivism took place and overestimate, as high risk, cases where there was no recidivism. This result is not surprising because the assessment done by the victim was not structured but, rather, based mainly on emotional state and past experience, whereas the evaluator's assessment was done following the SARA's structured, professional method.

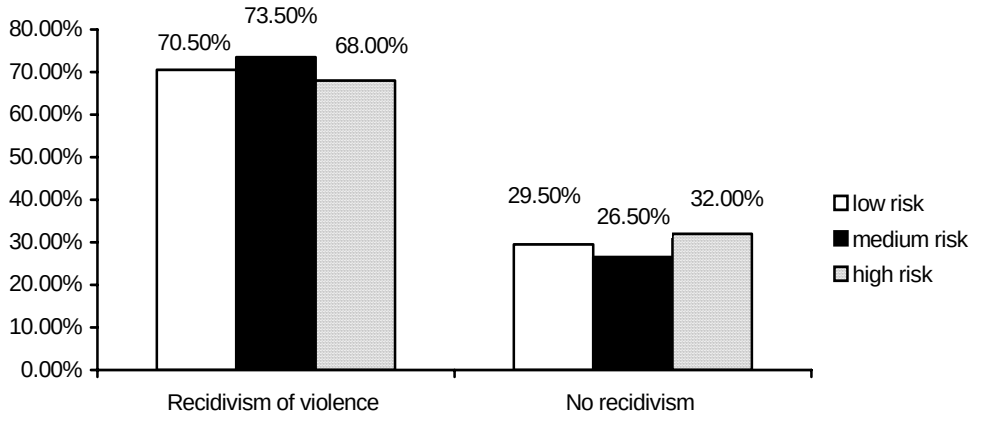


Figure 2. Risk assessment of short-term recidivism (within two months) done by the victim at Time 1 and recidivism rate measured at Time 2 (after two months). Note: Recidivism is for any physical violence.

In trying to provide an explanation for why there are false positive cases (i.e., high risk for recidivism was found, but no actual recidivism took place), we decided to take into account what had happened in the two months following the risk assessment done at Time 1. It is useful to recall that when recidivism is measured at Time 2 with the ICV scale (measuring the perpetrator's behavior in the previous two months), the victim is also asked about any changes in the relationship and living conditions that have occurred (e.g. whether they divorced, one of them moved out, a restraining order was issued, she went to live somewhere else, with a friend or relative, or in a shelter). Any protective measures undertaken, intended as a "victim safety planning response," should be in response to an assessment of at least a high risk rating, to *prevent* recidivism. This means that those men assessed as medium and high risk did not recidivate not because the assessment was incorrect but because effective measures were adopted to prevent recidivism.

The next stage in the use of the SARA in Italy, or elsewhere where it is more widely implemented, is to establish *which* measures for prevention of recidivism are most effective for which levels of risk (low, medium, and high). For example, when an assessor determines the risk is low, is it enough to monitor the case and do a follow-up after six months? What about when the risk is assessed as medium? Is supervision a good enough measure to prevent recidivism in these cases? And a restraining order? Will the offender comply with it? Which type of man and what circumstances increase the risk of violation of the order? Is there a misuse of such orders? Not all of these questions can be answered unless specific studies are conducted in this field; however, the SARA-S procedure can also assist also in this direction.

Figure 3 shows some of the measures that were taken in some of the cases addressed in the sample.

If we add together all possible measures undertaken for the protection of the victims or restraint of the perpetrator from further violence and cross tabulate this new variable with the recidivism rate after 2 months (present or absent), referring to any type of physical violence, we find an interesting significant result that indicates that, in cases where any restrictive or protective measures were undertaken, the level of recidivism decreased significantly (84.4%

recidivism rate when no measure was adopted vs. 55.6% recidivism rate when at least one measure was adopted, $\chi^2 = 11.86$, $df = 1$, $p < .001$).

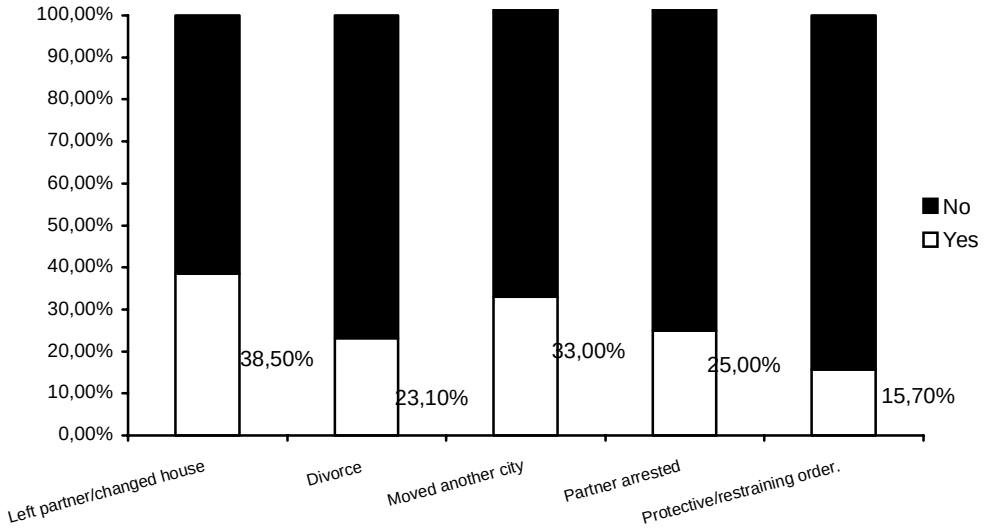


Figure 3. Percentages regarding actions adopted directly by the victim or by the judicial system to protect the victim.

The results presented so far regarding the SARA and its implementation do not provide significant enough amounts of data to be able to generalize from them, given the small sample size. They do constitute, however, a valid starting point to show the possible use of such methods in distinguishing types of cases and their severity in terms of risk of recidivism. Several steps still need to be taken in Italy to address the problem related to victims of intimate partner crime, especially with regard to risk of recidivism and prevention of such risk. Once risk is assessed, it is important to manage that risk in the most appropriate way to prevent further violence. Professionals working in the judicial system, as well as in the social sector, would benefit from the SARA procedure because it assists in creating a common "language" and, thus, a common understanding about the severity and risk of violence.

The SARA has been implemented in different degrees in different countries in Europe. Currently it is also being validated in Portugal and Lithuania. Though the implementation of such a procedure needs to be undertaken in every country in accordance with each country's legislation, criminal procedures, and roles the police have in the decision-making process about what to do with abusers when they are not caught while committing the crime, an approach like that of the SARA provides a framework, guidelines, and uniform methods for creating a clear understanding of the problems under investigation. Victims benefit when professionals adopt this method, not only because their cases can be scientifically and reliably assessed, but also because the approach that the SARA takes is that once risk is assessed, the relevant measures for monitoring, supervising, and treating offenders and planning for victims' safety (see Hart, this book) are implemented. This approach will give victims the confidence to rely on and collaborate with the appropriate institutions in order to find for themselves and for their children lives free from violence.

In: Intimate Partner Violence Prevention and Intervention ISBN: 978-1-60456-039-8
Editors: A. C. Baldry and F. W.Winkel, pp. 107-124

Chapter 7

SPOUSAL ASSAULT RISK ASSESSMENT: THE CASE OF GREECE

Sevasti Chatzifotiou
Department of Social Administration, at the Democritus University of Thrace, Greece

This chapter discusses the issue of domestic violence against women as it relates to Greek women, particularly, and analyzes the implementation of the Spousal Assault Risk Assessment Guide (SARA), which was first implemented in Greece in 2004, thanks to the European Commission Daphne Programme. The chapter is divided into three parts: (a) a discussion of general issues related to domestic violence against women, including a brief historical review of the women's movement and its influence on bringing about change; (b) a discussion of the Greek context, including cultural influences and attitudes and the present state of legal and social responses to this problem, and (c) the implementation and results of a research project using the SARA in a city in Crete. At the end of the chapter, recommendations about domestic violence in Greece and the SARA are presented.

DOMESTIC VIOLENCE AGAINST WOMEN

The myth of the family as a harbour of safety has now long been shattered. Prior to the 1970s, this myth had been kept alive by the historical and traditional view that what happens within a marriage is private and not open to public scrutiny. It is now well known and established that "women are more likely to be assaulted in their own homes and by people they know than outdoors by strangers" (Home Office Statistical Findings, 1996, p. 2).

Despite the increasing research on the subject of domestic violence over the last couple of decades (Dobash and Dobash, 1979,1992; Hague and Malos, 1993; Hanmer and Maynard, 1987; McWilliams and McKiernan, 1993), the degree to which this problem existed in most societies had not been established for a variety of reasons. The main reasons fell into two broad categories. First, violence against wives had been passively accepted within society and supported by its socio-cultural, structural, and political norms and had, therefore, remained largely underreported. Second, the social, legal, and medical professions had avoided getting

involved in what they considered a private matter, or they had been concerned mainly with the preservation of the family institution. As a result, the problem of violence against women was defined as a "dark figure," and many women remained silent for many years because they were discouraged from seeking help from others, such as family, friends, or social agencies. In the last two decades, however, considerable changes have been made in many societies, both in raising public awareness about the issue[1] and in the policies of the agencies themselves (Hoyle, 1998; Plotnikoff and Woolfson, 1998).

Historical Review

The phenomenon of wife abuse may be traced back to well before the Biblical role assigned to women, but the point of departure taken here dates back to the 18th century and has been chosen because of its important influence on subsequent Western attitudes towards the issue. Around the beginning of the 18th century, patriarchal norms became institutionalized in widely influential laws with widespread impact. As late as the 18th and 19th centuries, family laws upheld men's right to abuse their wives (Scheider, 1994, p.36). Napoleon's Civil Code, for example, relegated a woman's lifetime position to that of an "irresponsible minor" who was the property of her father and, later, her husband. This Code influenced many of the nations of Europe.

British Common Law had a section regulating the instruments allowed to chastise a wife. In the 18th century, this section was revised to limit the instrument to a rod not thicker than the husband's thumb (Dobash and Dobash, 1979). In the same vein, in the 19th century, British law textbooks stated that "the husband had by law 'power and dominion over his wife' and could 'beat her, but not in a cruel or violent manner'" (Davis 1988, p. 348). Because the colonies were greatly influenced by British common law, America also inherited these attitudes toward women. In its American modification, the law distinguished "correction" of a wife's behavior from abuse causing permanent injury and granted permission to a husband to inflict violence, characterized as "discipline" or "correction," upon his wife (Marcus, 1994). In this way, the American version of the common-law doctrine served to "naturalise" violence against women in that sphere to which they were assigned: the home (p.21). In the late 1800s, several states, such as Maryland, Alabama, Massachusetts, and Oregon, enacted legislation authorizing the whipping of abusive husbands, but it was not until 1920 (2 years after the passage of the women's suffrage amendment) that the beating of a wife became illegal in all states (Pleck,1987, pp. 108-121, cited in Marcus 1994, p.22). Overall, women's unequal status, subordinate role, and abuse had, historically, become legitimized in the religious and political institutions of Western societies, and the preservation of the marriage and the family is, even today, legally reinforced and promoted.

1 See for example, the "Domestic Violence - Don't Stand For It" awareness campaign on domestic violence launched in England and Wales in October 1994; the "Domestic Abuse - There's no Excuse" campaign launched in Scotland in December 1998; and the "Breaking the Chain" campaign launched in England and Wales in January 1999.

The Battered Women's Movement

The problem of violence against wives received intensive examination after the establishment of a women's centre in Chiswick, England, in 1972. The centre was established by a group of feminists as a place where women could go to discuss and share concerns and problems. Large numbers of abused women went to the centre and, as a result of a split in the organization, the National Women's Aid Federation (WAFE) was formed. By 1975, it had established 25 shelters for abused women and their children. Today, over 250 exist throughout the country (WAFE, October 1998, p.13). Through the efforts of this organization, the plight of battered women was brought to the attention of various groups around the world. WAFE adopted a number of values and principles that articulated their approach to the problem of domestic violence: to believe women and children and prioritize their safety; to support women to take control of their own lives; to recognize and care for the needs of children affected by violence; and to promote equal opportunities and anti-discrimination in all their work and services (p.1).

In its most recent publication, "Families Without Fear," (WAFE, 1998), WAFE attempted to offer key recommendations for the development of an effective, multi-agency, strategic response to create a future where all female members of society could live without fear. Accordingly, they suggested that a national strategy to end violence and abuse in personal relationships and to achieve true equality in all aspects of family life must do the following:

> Promote the PROTECTION of women and children at risk of violence and harm through beneficial changes to law, policy and practice, and hold violent men accountable for their abusive behaviour; ensure the PREVENTION of interpersonal and gender-based violence in the short and long-term through public awareness and education of children and the general public, as well as through an effective legal framework; and develop the PROVISION of effective services to meet the needs of all abused women and children. (p. 2)

In the United States, the battered women's movement began a few years after its birth in Britain. Its first real beginnings were in 1973 and 1974 with the opening of Women's Advocates, in Minnesota, and Transition House, in Boston, but it did not receive wider public recognition and achieve greater activity, similar to that in Britain, until later (Dobash and Dobash, 1992, p.26). Domestic violence shelters, established and staffed by feminists and by women who themselves had been battered, provided refuge for victims and focused public attention on their plight. A primary goal of shelter organizers was to relieve victimized women of self-blame for their roles in "provoking" abuse (Ferraro and Johnson, 1983). By 1982, more than 300 shelters and 48 state coalitions had been established in the United States (Schechter, 1983), and the "battered women syndrome" had been recognized by the International Classification of Diseases (Schillinger, 1988, p.469). The early activists advocated an ideology of empowerment, offering women psychological counselling combined with communal support and material assistance. Grassroots groups, in their very structure and in the nature of their services, said clearly to battered women: "It is not you that is sick. It is our society which is responsible in its structure of sexual domination, for condoning and perpetuating this behaviour and the institutions that sustain it" (p. 470).

The battered women's movement was the outcome of a successful merger of organized feminists, formerly beaten women, social services reformers, and social advocates (Pahl, 1979, pp. 25-35). The movement catalyzed public attention because it focused on the problem of physical assault on helpless victims and systematically portrayed images of women escaping violence (e.g., films such as "The Burning Bed"). This approach proved strategic in securing public money for shelter services, which are of crucial importance and stand at the heart of the battered women's movement. As a consequence of the attention this movement received, the belief that battered women faced unjust brutality from their partners and hostility or indifference from institutions became commonly held. The family as a sacred private place was now open for public inspection and attack, and social scientists led the way to a critical reassessment of the traditional family as the primary source of the violence problem. As Schechter (1982) put it,

> Although many political, strategic and ideological differences were evident...women agreed that men held power and privilege over women in personal life. Domination was uncovered, operating not only in the public political world but also in the private political sphere of the family. (p.32)

Both the battered women's movement and the women's movement, in general (with gender-specific points and mandates in its agenda), constantly challenged the traditional gender structure and the privatization of patriarchal authority, demanding an end to the invisibility and inaction that surrounded male violence against women (Currie, 1990, p.89). The goal of transforming the problem from a private problem to a public issue of social and national concern was about to be achieved with the help and combination of the following developments: the "explosion" of academic and break-through works addressing all aspects of domestic violence (Pizzey, 1974); the growth of social scientific explanations of family violence based on data about the frequency and distribution of wife assault; the exploration of technical avenues for the achievement of justice for women by legal researchers; and the holding of numerous conferences on family violence that brought police, social scientists, and other professionals together.

The Nature and Components of Marital Violence Against Women

Wife abuse has been defined as "physical assault," "acts of violence," "physical attack," "savage abuse," "a pattern of physical abuse," (Loseke, 1987, p. 232) and "real and serious physical assault" (Maynard, 1985, p. 131). It has also been defined as the use of "persistent, systematic, severe and intimidating force" (Dobash and Dobash, 1979), which yields "severe, repeated and demonstrable injury" and which produces "paralysing terror" (Loseke, 1987, p.232) or "terrifying intimidation" (Schechter, 1983, p. 87). It has also been characterized as "purposeful behavior" (Schechter, p. 91) and as an act which intends to physically harm and inflict pain on a woman. The violence can range from slaps and kicks, to black eyes, to broken bones, sadistic mutilation, torture, and attempted murder and murder itself. Evason (1982) quoted one of the respondents in her study as describing her experience in these words:

> For most of my married life I have been periodically beaten by my husband. What do I mean by "beaten"? I mean that parts of my body have been hit violently, and that painful bruises, swelling, bleeding wounds, unconsciousness, and combinations of these things have resulted. (p. 32)

The violence may or may not necessarily *only* include battery and rape, be related to sex or refusal of sex, or be related to drunkenness; it may also be emotional or psychological violence. Leonore Walker (1979), in her book, *The Battered Woman*, defined a battered woman as any woman who is coerced into doing what a man desires, whether the coercion be physical or psychological. In her book, she discusses psychological abuse fully when she describes the atmosphere of terror that envelopes the family of a batterer. She states that the environment is a tense and emotional one, even when no violence is being perpetrated, because the possibility of violence is always present. Thus, even when the violence does not reach the level of physical force, constant *fear* is still engendered by living in a relationship with serious threats of violence. In this way, some men effectively keep their wives as prisoners,[2] insisting on controlling their every movement and knowing every detail of their lives. In addition, some women, although not being physically attacked, feel constantly threatened.

To sum up, Loseke (1987) summarized five features of wife abuse events that characterize the nature of the problem. First, wife abuse pertains particularly to events including *extreme* forms of violence, and, second, it is characterized by *repetition* (i.e., it is not an event per se but, rather, a series of events). The third feature of wife abuse is that it produces *physical injuries*; the fourth, that it produces *psychological injuries* because the events involved are subjectively experienced by women as devastating; and, finally, the fifth is that the husband *intends* his behavior to be extreme, controlling, and consequential.

Dominant ideologies governing the roles of men and women, established institutions and structures, as well as economic, social, and emotional factors are the parameters that embody the oppressed situation of women and make the process of help-seeking look more difficult and more distanced, and the prospects of help-giving, less promising. Lack of financial support, accommodation (with its great difficulties of obtaining and paying for), child care, and effective help from institutions and agencies, together with an interplay of personal and social factors, are all issues related to domestic violence that have been addressed by many authors (Binney, Markell, and Nixon, 1988; Homer et al., 1984; Mullender, 1996) and are briefly discussed next.

Economic Dependency

Domestic violence against women is undoubtedly linked to the position of women in the socio-economic system, a position that is greatly characterized by their economic dependency. Lack of economic resources has long been seen as playing a major role in a battered woman's tolerance of abuse and not seeking help (Strube and Barbour, 1983).

[2] Psychologists in the U.S.A. have found parallels between the effects of domestic violence on women and the impact of torture and imprisonment on hostages. See more on this in Graham, Rawling, & Rimini (1988), "Survivors of Terror: Battered Women, Hostages and the Stockholm Syndrome," in Yllo, K., & Bogard, M. (Eds) *Feminist Perspectives on Wife Abuse*, London: Sage.

Feminists argue that the use of violence for control in marriage is perpetuated not only by norms about a man's rights in marriage but also by women's continued economic dependence on their husbands, which makes it difficult for them to leave violent relationships (Binney et al., 1988; Homer et al., 1984; Mahoney, 1994). This dependence is increased by the lack of adequate child care and job training, which would enable women to get jobs with which they could support themselves, or by the inequality of income distribution in the family.

Furthermore, women's economic dependency is an institutionalized and fundamental feature of our society. As Freeman (1987) states, women's attempts to leave violent relationships or to find different alternatives continue to be constrained by this basic inequality. The dependency of women on men for resources within marriage consolidates that inequality and, at the same time, establishes it through many different sets of relationships and institutions. Marriage, for example, takes its toll on women primarily through their position as wives. As Pahl (1985) claims, housework is menial and isolating, promising no future for the women, no promotion, and no raise in pay; in general, the services wives may provide are considered as natural and expected. The wages earned by the husband are tangible, and they belong only to him. Consequently, whatever money he decides to give her is not hers, but his. However, if a woman decides to look for a job outside the home, either for money, self-expression, or just something to do, she often finds herself having to fight against social pressures designed to put her back home.

Psychological Factors

Touching upon the psychological factor that influences women's decisions to seek help, questions like "Why do women stay with their batterers?" or "Why do they go back to them?" pervade the literature. A woman who stays with or returns to her violent husband risks being labeled a masochist; those who leave, of not giving the marriage a chance to work or of not being prepared to give the husband an opportunity to change. According to Evason (1982), the main practical difficulty that women face and that results in their staying at home is that they have nowhere to go. Another reason they stay is that they hope the marriage can still be saved; they feel they should stay and keep the home together for the sake of the children. Some hope that their husbands will leave. In some cases, women return under pressure from relatives and husbands. Moreover, as the study conducted by Evason (1982) in Northern Ireland reveals, other reasons appear to be fear of being unable to manage alone, of being socially stigmatized or socially isolated, and of being found by the husband and beaten more severely than ever.

Furthermore, Borkowski, Murch, and Walker (1983) report that practitioners have described a number of reasons why women find it difficult to leave violent husbands. As they state, women do so because they face the problem of finding somewhere else to live, they feel it's worth staying for the children's sake, and they change their minds once the crisis is over and they have calmed down. In addition, they feel demoralised and blame themselves for the violence they have suffered, they lose their self-confidence and feel unable to cope alone, they are afraid of their husbands' intimidation, they do not want to carry the stigma of being a battered wife, and, despite the violence, they continue to be emotionally attached to their husbands. Finally, practitioners commented that some women need the stimulus of violence

because it makes them feel fully alive, heightening their emotions. A small percentage of women find in violence itself some kind of emotional security.

In her book, *Policing Domestic Violence*, Edwards (1989, p.169) reports findings about the most frequently cited reasons women gave for staying in their violent relationships that were similar to those of Borkowski et al. (1983). The most striking ones refer to the fact that they had nowhere else to go, and the second most important was the fear of further violence to themselves and their children. Other women in the same study said that they stayed on because they wanted to "give it another try;" because "it was not bad all the time," and for financial reasons or fear of losing custody. It is obvious that structural imperatives are the main reasons that make women stay with or return to their violent husbands (such as the weakness of the law and the police response as well as the inadequate statutory provision of the shelters).

Generally, as the literature shows, making the decision to leave a violent husband is certainly not the easiest thing for a woman to do (Kirkwood, 1993). Dobash and Dobash (1979), for example, describe such a decision as a complex and difficult one, involving both personal concerns, and social, material, or structural factors, all of which affect women's decisions to leave or seek help or prevent them from implementing their decisions. Indeed, women's personal fears, like their doubts about their ability to be successful on their own, their fears of loneliness, fears about the emotional and material welfare of their children and of losing self-confidence and self-esteem, as well as their ambivalent feelings about themselves and their husbands, are very strong reasons why women fail to leave a violent relationship (Binney et al., 1988; Homer et al., 1984).

The importance of social and cultural influences that force women to consider their decisions to seek external help and/or leave their violent husbands needs also to be stressed (Dobash and Dobash, 1979; Kirkwood, 1993; Mahoney, 1994, p.60; McWilliams and McKiernan, 1993). Traditional values suggest that being a wife and mother are the most important roles for a woman and that she cannot be a complete woman unless she is married. Not surprisingly, society places the burden of family harmony on the woman, with the implication that a failed marriage is her fault. This suggests that “commitment” to the relationship constitutes a salient factor in the decision to keep silent, suffer the violence, and not seek help for a long time (Strube and Barbour, 1983, p.786). Thus, the deeply ingrained ideas both that marriages should be preserved at almost any cost for the sake of families and that a wife takes on the stigmatized status of a divorcee are combined with the notion that she is the one to blame for the break-up of marriage. All these arguments are urged upon her by friends, relatives, and representatives of social agencies and constitute significant deterrents to seeking external help and leaving a violent relationship.

Social and Structural Factors

Many authors have treated violence in the context of power and control and place women’s experiences in the context of their lives in an oppressive patriarchal society (Dobash and Dobash, 1979; Schechter, 1983). As these authors assert, it is in the institution of the family that the patriarchal legacy persists through the continuation of a hierarchical relationship between men and women. Mythology, ideology, and social institutions still protect male authority, and this is reinforced and, at the same time, perpetuated through the

socialization of the children in the family. In this way, the dominant ideology and social expectations place the husband as head of the household, responsible for the support of the family (breadwinner), and the wife as responsible for the housework, reproduction, and child care (Hanmer and Maynard, 1987; Kelly, 1988; Pagelow, 1981; Pahl, 1985). These roles of "wife" and "husband" did not simply grow out of biological realities, but also developed with the patriarchal nuclear family. The concepts of masculinity and femininity, which define these roles, create powerful expectations as to how women and men should behave, and these expectations, in turn, reinforce the values upon which our culture is based. Men are seen as dominant (and thus strong, active, rational, authoritarian, aggressive, and stable) and women as dependent (and thus submissive, passive, and non-rational). It is these stereotypes and definitions, which reflect social attitudes, that permit the expression of male violence as "natural" and justified (Mahoney, 1994: p.63).

Wife battering is characterized in our society as a social problem of vast proportions with its roots in historical attitudes toward women and the institution of marriage. The socialization of women and men and the assignment of inferior roles to women, which victimize and keep them economically dependent, make them vulnerable to abuse by the men with whom they live (Dobash and Dobash, 1992; Edwards, 1989).

The Silence of Violence

Domestic violence against women is recognized as an issue of “silence,” which prevents women from acknowledging the real "size" of the problem, and, thus, as mentioned before, it is impossible to know exactly how widespread it is and difficult to learn about the actual details of violent episodes and the marriages in which they occur (Dobash and Dobash, 1979; Evanson, 1982; Hanmer and Saunders, 1984; Homer et al., 1984). Research reveals that many wives endure violence for years without telling anyone and some never share their problems with an outsider before seeking refuge from women's aid groups. For example, it is estimated that up to 98% of the domestic violence against women is not reported to police and that two out of three women tell no one at first (Women’s Aid Federation of England, 1998). In another study, Dominy and Radford (1996) studied the violent experiences of 484 women in Surrey, England. The study found that two out of three women who defined themselves as victims of domestic violence said they had not told family, friends, or agencies about the violence. Consequently, men's violence against their wives continues to be a hidden and underreported problem.

Moreover, this silence can stem from the shame, horror, or the fear of retaliation that these women feel or from the “ideology of privacy” (Schneider, 1994, p.37) and their need for self-respect, which means that they must hide their failure to produce a happy family. This has been used against the victim by society and by the law as evidence of women’s "collusion," their "acquiescence," -- even of their desire for punishment and pain. The social stigma attached to being a battered wife is great and is also an important reason that women keep silent and are deterred from seeking assistance (Mahoney, 1994). This experience of silence is directly related to the isolation that battered women experience (Homer et al., 1984, p.21). Johnson (1998) defines *isolation* as “a function of weak social bonding that reduces the extent to which both victims of assault and violent partners are able to sustain attachments to friendship and community networks and receive social support to end the violence” (p.43)

and asserts that keeping a woman socially and physically isolated is one way for the violent man to assert dominance and control over her life.

THE GREEK CONTEXT

In Greece, the question of violence against women has been raised by the women's movement since 1978. It is due to the existence of this movement that the issue has become public, consciousness has been raised, and public authorities have become more sensitive and responsive. According to the National Report for the Physical and Sexual Violence Against Women in Greece (Ministry to the Presidency, December 1990, p.5), in spite of the fact that the number of publications on this and similar matters (mainly from women scientists) has increased during the last years (Antonopoulou, 1999; Chatzifotiou, 2005, 2001, 2000; Hadjiynni and Kamoutsi, 2005; Tsigris, 2000), the amount of scientific research continues to remain small.

As a result, there are many difficulties in the development of an official estimate of the extent, nature, importance, and consequences of the phenomenon in Greece. Moreover, there is an agreement among the practitioners that although the research data may be limited, the extent of the phenomenon is much greater and much more acute. For example, according to the director of the centre for battered women in Athens, the number of women who visit the centre for assistance is around 120 a year, whereas they receive almost four times the same number in phone calls, which are not presented anywhere in official statistics or papers as cases.

Existing Services to Date

In Greece, there is a substantial lack of specialized services where battered women may seek help. The only service dealing with the issue of domestic violence in Athens is the centre for battered women that was established by the initiative of the General Secretariat to Equality (GSE) and has been in operation since October, 1988. There are two services operating under its care: the Reception Office for battered women, which offers free legal advice, psychological support, and information on other available services, and a home for battered women, which has operated since 1993 in cooperation with the GSE and the Municipality of Athens. The shelter offers hospitality to women and their children, as well as psychological support and information on other available services. In addition, battered women can also go to the state hospitals, the health centres, and the mental health centres which, however, are not adequately staffed to handle such cases (Bouri, 1998).

Additionally, there is one more shelter for battered women on the island of Crete, in the city of Heraklion, which has one social worker running the place with the help of an NGO women's organization also based in Heraklion. The shelter has a capacity of about five women, and there is an active helpline with funding for about a year.

In Thessaloniki, (in the north of Greece), the only specialized agency in operation is the Office for Women's Issues. It has been in operation since 1994 and was established by the initiative of the Municipality of Thessaloniki. Also, an SOS call-service for battered or raped

women, operated by an autonomous women's group, has been in operation since October, 1990. This service was in operation until 1996, and it provided free legal advice, psychological support, and general information. In December, 1998, having received a year's funding jointly from the European Union and the Greek Department of Employment, the SOS service is operating again, offering the same services to women as in the past.

It is a great relief that there is a National Centre for Research on Women's Equality Issues (KETHI), with five branches in five large Greek cities. The centre provides free legal information and psychological support to women who ask for it and conducts research on women's issues, domestic violence included.

The Woman in Greek Marriage and Culture

Greek culture strongly encourages women to follow the one and only idea of what is appropriate to their sex: marriage and family life. *Familism* (Loizos, 1991, p. 8) (the idea and notion of family) has been described by investigators as the most important orientation in Greek life because it leads to the production and reproduction of kinship, a fundamental principle of "relatedness" in Greek culture, and to the creation of one's own "household" (*nikokirio*). The notion of *nikokirio* refers to an "economic and politically autonomous, corporate and conjugal household" (Loizos, 1991, p.6), which defines its members' status in the society and their identities of maleness and femaleness (*nikokiris* and *nikokira*) as the man/husband (who embodies the *logos* or intelligent reasoning, rationality*)* and the woman/wife (who is the queen of the domestic responsibilities and the producer of children, or the producer of a "household of procreation") (Daraki, 1995, p.168; du Boulay, 1974, pp.101-102; Hart, 1992, p.158; Loizos, 1991, pp.6 and12).

The family acts as the primary unit of socialization into class and gender identities. The solidarity of the family and its social and economic independence from other families has always been greatly valued by the Greeks (Campbell,1964; du Boulay, 1974; Friedl, 1962; Hart, 1992). The family's structure and context reflect broader social relations and power structures. Women may occupy subservient positions in the family in relation to the men, and this is reflected in the wider community institutions, where religious laws, customs, and practices keep women subjugated. Although their position in the family can shift within various groups according to class, age, and ethnicity, most women are expected to serve their families, bear children, and preserve Greek cultural traditions (Hart, 1992). These practices are challenged by many Greek women who struggle for equality, self-determination, and preservation.

Greece has been described by anthropologists and ethnographers as a society largely based on kinship (Loizos, 1991). Kinship is also expressed by the term *ikogenia*, a term which derives from *ikos*, meaning house, and *genia*, meaning birth, or generation and race. It is a term resembling the English word *family*. Also, kinship can be expressed with the term *syngenia* (*syn* + *genia*), similar to the English notion of relatedness, meaning "of common stock, generation, or lineage" (Loizos, 1991, pp.137-138). Kinship as *syngenia* is used to define relations through blood and marriage ties. It also defines the ways a person in a particular relationship is expected to behave, that is, his and her behaviors and actions must be based on specific "codes of conduct" that inform every kinship and every group of relatives (*syngenis)* that constitute it (Loizos, 1991, p.139). Although the concept of *syngenia*

primarily defines blood relations (*syngenis)* as the most important ones, because they are considered closer to the couple than relatives by marriage (Loizos, 1991, p.138), relations with the latter (spiritual kin/ relatives by marriage) may be as important or more important in a woman's life than those with actual (blood ties) relatives (Hart, 1992, p.177). This depends on whether or not the woman develops a special friendship with a spiritual kin (e.g., the bridesmaids -- *koumbari)* or others who can be of mutual assistance (e.g., neighbours). The *koumbara* (for female) or *koumbaros* (for male) technically is a person chosen as a "marriage sponsor" (arranges and finances the marriage ceremony) and who, consequently, has the right to baptize the first-born baby (in some places all babies) of the marriage (Hart, 1992, p.177). They are considered as "people of the house" and are treated as such by both the husband and the wife. The wife may even decide to confess her personal problems to her *koumbara,* as she considers her a friend, a spiritual relative, and she may keep a *koumbara's* secrets in return.

Marriage is often the only solution for most women to get away from the "dynasty of the father to that of the husband" (Daraki, 1995, pp.140, 163). Marriage, in Greece, has always been considered to be of supreme value. It is considered as a social necessity for both men and women (women in particular), and women gain their social status through the marital one. As long as she remains unmarried, whatever the reason, she must observe the "inferior status" in which the lack of a man automatically places her (du Boulay, 1974, p.121), and she is regarded as a "social handicap" and a "burden to the family" (Daraki, 1995, p.122). A marriage should always be a successful one (i.e., good, socially respectful, and long-lasting), and it is mostly expected that the wife is the one who will ensure its success (Loizos, 1991, p. 35). In other words, if anything should go wrong in the marriage, the woman knows that everybody (community and kin) will blame her for not being able to keep her marriage together and, consequently, for dishonouring her husband, her children, her in-laws, and her own family. No wonder that the old Greek proverb, "It's better to have my eye taken away, than to 'take away' my good name" (*Kallio na mou vgi to mati, para to onoma*), is still very much alive (Daraki, 1995, p. 153).

Marriage in Greece also informs the complex values of the family's "honor" (*timi*), "shame" (*dropi*), "dignity" (*aksioprepia*), "pride" (*perifania*), and all values related to prestige (Campbell 1964; Daraki, 1995; du Boulay, 1974; Hart, 1992; Loizos, 1991). All these notions play a pivotal role in policing, controlling, and containing women's lifestyle, behavior, and, in particular, their sexuality. Such concepts of honor, shame, and dignity prevail among Greek families (much as in other cultures, like Italian) regardless of religion, caste, and class. Honor is integral to maintaining patriarchy, and thus it has been repeatedly described in many traditional patriarchal societies (Baker, Gregware, and Cassidy, 1999, p.165). It can mean respectability, status, and reputation. Women are considered to be the upholders of the honor of the family. This cultural norm can be used as a powerful ideological weapon to control women's sexuality, freedom, and behavior. In the past, virginity, for example, was a strict requirement for women, to be kept until marriage had taken place. This no longer seems to be the prevailing norm (or practice), although, in small Greek villages, it seems to be still alive. *Shame* has several contradictory meanings: It can be conceived of as maintaining a woman's modesty -- a highly prized virtue -- or, in another context, it can mean a woman's state of disgrace. No matter what the women do, they are expected to always keep these concepts foremost. For example, if they should complain about anything in their home (or, even worse, about the "master of the household"), they should be aware of the personal

and familial costs that the consequent social disapproval of their actions would bring (Loizos, 1991, p.3).

The Role of Law and the Police

Although domestic violence against women is well recognized and reported as a social problem in Greece, there is evidence that it still remains a "common secret," well kept within Greek families. It should be stressed that there is no specific legislation for domestic violence that would take into account the marital and inter-familial relationships (Hadjiyanni and Kamoutsi, 2005). Instead, there are only broad constitutional and legal protections for women in Greece (Greece: Human Rights Practices, 1995 report, section 5) and the various types of violence against women in the family do not constitute a separate offense under Greek criminal law (Spinellis, 1997, p.242).

The latest information on law reform in relation to the issue of domestic violence refers to a general proposal made by Greek women ministers of the Greek parliament who put forward specific points that the Greek state should establish in order to protect victims of violence and punish the perpetrators, such as (a) legally restraining the perpetrator from the house where the victim lives, (b) requiring him to pay a large sum of money to the victim, and, in cases where there are children, taking away his custody rights, but requiring him to maintain the family financially. Such orders are already in effect in other countries like Austria or Canada, and it would be thrilling should they be implemented in Greek society too.

In Greece, as in other countries, police have been sharply criticized for their indifference to the problem of battered wives, for their lack of preparation in handling victims of family violence, for not taking seriously women's complaints and needs, and for tending to regard incidents of family violence as not real police work (Fragoudaki, 1987; Tsikris, 1996). The General Secretariat for Equality of the Sexes (GSES) asserts that police tend to discourage women from pursuing domestic violence charges and, instead, undertake reconciliation efforts, although they are neither qualified for nor charged with this task. The GSES also claims that the courts are lenient when dealing with domestic violence cases (Greece: Human Rights Practices, 1995 report, section 5).

Although there are not yet many national statistics on domestic violence in Greece, the results of the first national survey of a representative sample of 1,200 Greek women from urban and semi-rural areas were recently announced. The survey was supported by the General Secretarial of Equality of the Sexes, a governmental body under the auspices of the Ministry of the Internal Affairs and Decentralization, and was conducted by a scientific team from the centre for research on women's issues (K.E.TH.I., 2003). According to the survey's findings, out of 1,200 women, 3.6% reported physical violence by their partners, 56% suffered psychological and verbal abuse, and 3.5% of the sample experienced at least one episode of sexual abuse by their partners. This was an important report, and it gives us hope that there will be more surveys like this in the future.

Despite this promising development, it should be stressed that governmental actions and policies, unfortunately, are still not doing enough to prevent female victimization, to ensure that women's status is not defined relative to men, to ensure that women's rights are respected in everyday practice, and to protect women legally when they are assaulted by their husbands in their own homes.

SETTING THE SCENE FOR THE GREEK SARA

Introducing SARA to the Research Team

The initial contact of the project manager with the research team was made in January, 2004, in Rome, where all the team partners were introduced to each other and underwent a 3-day intensive training in the SARA in order to familiarize themselves with the research instrument. The project's deadlines were determined and the year's agenda was set up. The research teams exchanged all the useful information they had about the project's goals, as well as information about the issue of spousal violence in each one's country. The participants went through the forms to be used and had the opportunity to make comments, ask questions, raise issues that concerned them, and attempt to predict possible problems or difficulties that they might encounter when implementing the instrument in the fieldwork.

Collaborations

As the Greek partner to the project, I was very concerned about the possible difficulties to be faced in Greece regarding having people involved in the project and helping us out with the work at hand. From my personal experience from research conducted in Greece, I knew how rigid people in various services were, particularly the police and the staff from some of the social services. My part of the project mainly involved gaining access and working with staff from the shelter for battered women at Heraklion and the respective police departments in the city.

As expected, the social worker from the refuge was very cooperative and had no problem in participating in the work that had to be done regarding the project. We set dates for the necessary training of the staff on the SARA, and everything ran according to schedule and as expected. In contrast, we had no response from the police stations that we approached about their participation in the project. That did not discourage us at the beginning, and we decided to leave more time for further contacts with them.

While translating the SARA into Greek, we did not encounter any particular problems. The issue of legal responses to partner violence by the Greek state and the legal definitions of *violence*, *domestic violence*, *partner abuse*, and *assault* were made clear in the search of the relevant literature, limited as it was, and, accordingly, the necessary changes were made and explained to the rest of the colleagues. Relevant literature was also collected, and, after a few months, everything seemed ready to start the actual fieldwork.

As in every highly organized research project, the implementation of the SARA project in Greece was faced with a few difficulties that are more or less common to many research studies. To name but a few in our case, the shortage of the staff in the shelter for battered women in Heraklion made things difficult for both the researcher and the social worker. The social worker had to find extra time, outside of her formal working hours, to receive training on the SARA and to attend meetings with the police. She had not been paid for a few months (she is not under temporary contract in her job and, in cases like hers, the money is not always paid regularly). Worst of all, she lacked any specialized training on issues of violence (she was a graduate social worker with only few months of working experience in the shelter and

no previous familiarization or experience with domestic violence and its dynamics). In addition, because of her lack of research experience, we lost valuable time spent in many hours discussing with her the research and what she needed to do, mainly focusing on practical as well as theoretical issues related to the project's needs. Despite all of this, she was always willing to provide what she could for the project, and our collaboration proved to be a very successful one.

The other major problem we encountered was the uncooperative attitudes of the police toward participating in the project. As mentioned previously, the police in Greece have been one of the main agencies to have been sharply criticized by women victims of violence and abuse as having been very unhelpful, not knowing what to do, and avoiding any involvement when "domestic affairs" were at issue. It was unfortunate that these attitudes changed little throughout the project.

IMPLEMENTING THE SARA

Sample Description

The study started in April, 2004, and ran till November of the same year, during which 38 Greek women voluntarily participated and were interviewed by the social worker. The average age of the women was 35 years and all of them had a secondary education and were born and grew up in Heraklion. It was not particularly difficult to elicit the women's stories about their experiences with their partners' violence after the SARA was filled in by the social worker. For most of them, talking about the violence they experienced was cathartic, bringing them some relief and helping them come to terms with themselves and their experiences. Data were analyzed by the social worker and myself and constitute a mainly descriptive set of information.

SARA: 10 Items

Serious physical/ sexual violence. All women in the Greek study experienced physical violence and some (partial) sexual violence. Women stated that the violent partners used weapons against them and tried to make them comply with their demands and wills. Women experienced those behaviors as life threatening and, most of the time, were forced to obey in order to make their partners calm down and behave more peacefully. In cases where there were children, women were trying to protect them from being hit and that usually made the partners even more dangerous and violent towards them.

Serious violent threats, ideation, or intent. Again, this item was filled in by all the women in the study. All the women experienced aggressive behavior from the partner, as well as aggressive threats and thoughts that made them frightened and desperate. The women said they were not able to help their partners think clearly and sometimes felt that they were to blame because, otherwise, their partners would not have reacted as they did. Nonetheless, when the threats and violence became very serious, the women tried to get away from the house in order to save their lives.

Escalation of physical/sexual violence or threats/ideation/intent. All the women experienced physical violence from their partner and 8 stated that they experienced threats. In the latter cases, the women revealed that threats sometimes felt worse than the actual act of physical violence and that they would have preferred to deal with physical rather than psychological, emotional, and verbal abuse that hurt them more.

Violation of conditional release or community supervision. All the women in the sample stated that their partners had not been under community supervision or violated any conditional release.

Negative attitudes about spousal assault. All 38 women in the sample stated that their partners had strong patriarchal views about gender equality issues, regarding women as being inferior to men. The men also tended to minimize their violent behavior towards women and often made excuses for it, transferring the blame to the women or to other members of the family instead taking responsibility for it themselves. The women revealed that they could not put up with their situations any longer and they wanted it to end. Still, structural as well as societal problems had caused them to endure the situation and not leave the relationships.

Other serious criminality. The majority of the women in the sample (28) stated that their partners had not been sentenced or accused of any other kind of criminality, whereas 10 women revealed that their partners exercised violence towards other members of the family due to heavy alcohol use. None of the violent partners was ever charged by the police or went to court.

Relationship problems. All the women stated that they suffered long-standing abuse by the partner, especially verbal abuse. The main problems the women referred to were in relation to gender roles and their inferior status in the relationship. Physical and sexual violence were also presented in this item, but the emotional and verbal abuse prevailed constantly in their relationships.

Employment and/or financial problems. Thirteen women from the sample reported no such problems. On the contrary, their partners had stable, well-paid jobs. Twenty women reported that their partners had significant financial difficulties and were usually unemployed and bringing no money to the household. Five women reported that they faced many financial problems because their partners' work patterns were unstable (i.e., they were in and out of work for long periods of time). Most women believed that their financial problems were usually the primary reason for the conflicts that took place between the couple.

Substance abuse. Thirty women from the sample stated that their partners were neither using substances nor were heavy drinkers, whereas 8 of them said their partners were using illicit drugs but that they did not believe this caused their partners' social dysfunction. The women attributed their reasoning to the fact that their partners did not have any legal problems and, therefore, had their drug use under control.

Mental disorder. There were no reports of partners' mental illness or personality disorder files.

Risk to Intimate Partner if no Intervention was Taken

Moving on to the next stage of the SARA, we needed to evaluate the situation of each woman participant and come up with a list of the next steps to be taken. The SARA tool informs us of three types of evaluating the potential risk to intimate partner. Accordingly, for

8 women of the sample, the risk for extremely serious assault was evaluated as moderate and the long-term risk high, as these were cases where the partners' alcohol problems (e.g., heavy drinking) did not cause them to become impaired in social functioning or become extremely violent towards women. Similarly, for another 10 women with partners with substance abuse problems, the risk for extremely serious assault to women was also characterized as moderate, but the long-term risk high, and for the last 20 women experiencing mainly verbal and psychological abuse, the risk for extremely serious assault or death was rated low.

Suggesting Protective Actions

For all 38 women in the study, an action plan was prepared and suggested to them. Among other things, this involved individual and/or couple counselling, victims' reinforcement and empowerment towards redefining and supporting their rights, referrals to the police and social and legal services, and personal meetings with the shelter social worker and/or the researcher. The women were also made aware of a safety plan in order for them to be able to protect themselves and their children in cases of emergency and unexpected extremely serious violence from the perpetrators.

Women in the study accepted very positively the above suggested interventions despite the fact that, in most cases, they wanted to believe that their partners would become less violent, and they would be able to continue their relationships in peace.

The SARA: Follow up Stage (September – December 2004)

The second round of interviews and filling in of the SARA forms took place from September to December 2004. Results from interviews of 10 of the women who, in the first interview, had reported some physical, but mainly emotional and verbal abuse, from their partners were similar to those from the initial interview. Their situation was more or less the same, with violence still at the same level and with no changes in frequency or severity of episodes. Women in those cases were remaining in the violent relationships and had not asked for shelter or police help as yet.

In contrast, when the social worker contacted the 8 women with partners with alcohol problems, she found that the women had been beaten more severely than was the case in the initial contact with them and that the women had called the police, asked for restraining orders, and, at the same time, filed for divorce. Apparently the men's alcohol problems led to an escalation to more serious violence, and the women, who could not stand it any longer, decided to do something to change their lives and free themselves of the violence. This situation called for the cooperation of both the social worker and police, providing another opportunity for the SARA to be re-introduced and re-evaluated by the police.

Finally, in the follow-up stage with the rest of the 10 women with partners with substance abuse problems, it was found that 6 of them were still being assaulted by their partners, with the same frequency, but with no more severity than before. The women asked for the shelter and police help, and, again, the research team was thereby able to re-introduce the SARA to the police and allow them to see the practical usefulness of its implementation in their work.

CONCLUSIONS AND SUGGESTIONS

The SARA project was an ambitious and scientifically planned project, and Greece had a wonderful opportunity to participate in it. The work on training for the SARA, the implementation of the tool, the contacts with services in Greece, and the reading of the relevant literature and the actual research in the fieldwork put us in a position where we could initiate an evaluation of the project and the research tool as a whole.

The SARA proved to be a very useful tool for assessing and predicting recidivism of spousal assault. Spousal assault -- the actual, attempted, or threatened violence against a past or current intimate partner -- is one of the most difficult areas to explore and research. The SARA., which was originally developed by a team of researchers, namely, Kropp, Hart, Belgrade, Webster, and Eaves, is gaining increasing attention in more European countries and is a valuable tool for collecting scientific knowledge about domestic violence. The tool needs to become better known in countries like Greece, and service agencies, as well as the police, in particular, in these countries, need to become aware of its existence and accustomed to using it.

One main recommendation from this project is that the SARA needs to be incorporated into the agenda of the police and used every time police deal with a case of domestic violence. Naturally, this also implies that the police would need to be willing to cooperate with other services dealing with domestic violence such as social, legal, and health services.

One finding from this study is that women victims of spousal abuse value social workers more that police, but still want help from both. This was made obvious particularly in the cases where alcohol and substance abuse problems were at issue. Women decided to do something more about their situation and called the police, but were happy to have support from social services as well. All professionals working in the area of domestic violence need to be able to cooperate in order to provide the appropriate support asked for by victims of abuse.

Finally, it is obvious that we need to conduct more research with the SARA, as the sample of 38 women we used was not representative, and, consequently, the results of the study cannot be generalized. Still, the current study provides us with an important picture of the usefulness of the SARA as a successful tool for identifying risk of recidivism of spousal abuse.

All in all, it can be said that Greece, like most European countries, is slowly but steadily gathering scientific data regarding the recognition and nature of the problem of spousal assault. It is now more than certain that the problem is acute and that the public services are not ready yet to deal with it in the most effective and adequate ways. This is not to say that the professionals who work in those services are indifferent to this new reality. Instead, they can be very committed and effective as long as they know what they need to do and how. The recognition of the magnitude of the problem in Greek society is the main step which must lead to systematic agendas for best dealing with and combating the problem. The SARA project, as it was used in the case of Crete and could be expanded to other cities of the country, is a definite step in this direction.

ACKNOWLEDGEMENT

The author wishes to thank Ms Maria Mavraki and Mairi Pahiadaki, social workers from the shelter for battered women and the women's organization at Heraklion in Crete, for their participation in the project, help, and support throughout the research journey.

In: Intimate Partner Violence Prevention and Intervention ISBN: 978-1-60456-039-8
Editors: A. C. Baldry and F. W.Winkel, pp. 125-131

Chapter 8

CAVEAT ASSESSOR: POTENTIAL PITFALLS OF GENERIC ASSESSMENT FOR INTIMATE PARTNER VIOLENCE

Donald G. Dutton
University of British Columbia,Canada

In the current chapter I argue that current risk assessment for spousal homicide is poor. There are three chief reasons for this. The first is that spousal homicide is a rare event and psychology does not do well at predicting rare events. In North American the rate for severe battering of women is far higher than the spousal homicide rate (which is calculated in rates per hundred thousand marriages) . Hence, the presence of severe battering, by itself will not lead to spousal homicide but will more typically reamin at the severe level or drop. The best we can do from a perspective of current research is to predict severe battering. The second issue is that many spousal homicides are reactions to abandonment and our current scales do not assess or give sufficient weight to severe emotional reactivity to abandonment. Some case histories demonstrating this issue are given. Finally, the cultural context of prediction is important. In patriarchal cultures beliefs about the woman as chattel should be included in prediction. In North American culture, the woman's own use of violence may contribute to eventual lethality.

Risk assessment is essential as part of an overall strategy for intervening in intimate partner violence. Police and post-arrest assessors need to know whether they are dealing with a person who is at risk for re-offending. Decisions about incarceration and type of treatment both depend on a successful assessment of risk.

I have been working in the domestic violence field for 35 years and have seen the effects of both false positives and false negatives. False positives typically come when judges, despite a perpetrator's history of violence, focus on the current crime and underweight the "track record." The legal system in North America fiercely debates the extent to which a perpetrator's past should enter into findings of guilt on the current offense. Judges weigh what they call the "probative weight" of the past information against its being "prejudicial" (i.e., tending to make someone look guilty for a current event, in the absence of other

evidence, because of an assumed propensity). This is one way that psychological and legal thinking diverge; to a psychologist, that past behavior is immensely informative about the likelihood of the commission of the current crime. In fact, this is the basis of risk assessment.

Other chapters in this volume will describe the basis and success of the risk assessment instruments currently in use -- the SARA, the PCL-R, the HCL-20, the DVAI. My position, in this brief chapter, will be to caution against over-reliance on these instruments. Randall Kropp and Stephen Hart (Kropp and Hart, 2000) have always wisely emphasized that the SARA is a tool to help make assessments but that the final decision lies with the assessor. This is because situational and special features of a particular case can influence the final decision.

Here are three ways that risk assessments can fail. First, they tend to over-emphasize past criminal justice misconduct. Hence when "catastrophic" first offenses occur, it appears to be "coming out of the blue." Catastrophic first offenses do occur, typically in the context of relationship abandonment or workplace mistreatment. That is, people (typically men) who are "abandoned" (i.e., their wife or girlfriend leaves them) are at risk for spousal homicide (Daly and Wilson, 1988). The risk factor for males is about 5 (Wilson and Daly, 1993), although two caveats are in order.

To begin with, rates vary with culture (and, hence, baseline incidence). In the U.S., (Chicago), the risk factor is 5; in Canada, it is 9 (that is, the increase in the total number of homicides immediately after separation). Hence, risk instruments developed in one culture may not apply to other cultures where baseline incidence rates for a crime of violence are higher or lower. In addition, for homicide, at least, the incidence rate is so low that prediction is impossible. Wilson and Daly (1993) cite their rates at homicides per million couples.

This problem can be highlighted using one of the few risk prediction studies to assess actual homicide. Campbell et al. (2003) finally used the Danger Assessment, rather than perceptions, to predict femicide. Because this, as we have mentioned, is a low-likelihood event, it is difficult to predict. Campbell et al. used an ingenious "case control" design where proxies (women who knew a femicide victim well were cases; n = 220) and randomly identified abused women residing in the same metropolitan area served as control women (n = 343). This is not, strictly speaking, "prediction" but, rather, an after-the-fact construction of differentiating items between cases and controls. (For obvious reasons, including a duty-to-warn, a femicide prediction study could not be carried out.) Data on the femicide victims was gathered by proxy, and police and medical records from 1994 to 2000 were used to assess victim-perpetrator relationships. Pre-incident risk factors associated with risk of intimate partner femicide included unemployment (for the perpetrator), drug abuse, the victim having left for another partner, and the perpetrator having access to a gun (a risk factor of 8). (If the victim did not live with the perpetrator, her having a gun decreased risk.). In addition, bivariate analyses indicated the following risks: stalking, forced sex, and abuse during pregnancy. Prior arrests for domestic violence lowered risk for femicide. Inspection of the authors' Table 2, which lists bivariate risk factors, indicates that virtually all forms of violence and threats differ significantly between femicide and control groups. The final summary snapshot is of a perpetrator who has no job and abuses drugs, by inference, no meaning to life, and for whom the relationship which he has destroyed is his last hope. The irrational action, of course, does not alter this situation; he will not have the relationship with the victim dead. There is, unfortunately, a design problem with this study. The abuse-controls, according to the authors' data tables were minimally abusive. The criterion was one incident

of physical assault or threat with a weapon by a current or former lover in the past 2 years. However, the abuse-controls report no verbal abuse in 52% of cases, that their partner was not controlling in 75% of the cases, and that their partner had not threatened to kill them in 85% of the cases. These low rates on normally abusive behavior account for the numerous significant "risk factors," but raise the question of whether the prediction is really of femicide or extreme abuse versus low-level abuse. What one would like to see is a more focused analysis using serious abuse cases that were not lethal with the proxy cases.

One of the reasons we do not do a good job of prediction in these cases is that the prediction depends not so much on past criminality but on an ego deficit that only becomes active during relationship dissolution. I have described this identity disorder in some detail (Dutton, 2002a and b) as a type of "borderline trait" approaching, but not necessarily qualifying, as a full-blown Borderline Personality Disorder. I make the same critique here that Hare (Hare, 1996) made of the Antisocial Personality Disorder as defined in the DSM-1V: It relies too heavily on past behaviors and misses crucial psychological variables. In the present case, these would be reactivity to abandonment that translates into rage and violence. The following two case studies illustrate the point.

Note that there was minimal prior violence in Brodie Waldradt's case, and no escalation in substance abuse or use of weapons. Most of the risk factors seen as predictive of spousal homicide were not present. He would have scored low risk on the SARA except for one thing; he had been abandoned. Of course, this does not mean that the SARA should not be used. No prediction instrument is 100% accurate. It simply means that those using it must be cognizant of this other basis for risk.

This case, too, was a horrible double infanticide by a man who had no prior violence and who, in fact, had been voted father of the year at his children's school. In Mr. White's case, there was horrible childhood abuse directed toward him by his father and verified by his sisters. In Mr. Waldrat's case, he left home at age 5. This seems to me to be a risk marker for Mr. Waldrat being abused (although it is not definitive evidence). The point should be clear by now. Some psychological factors are untapped on assessment scales and need further clinical probing. Reaction to abandonment is one of these. Risk scales often contain an item on jealousy and both cases above were jealous. This one item unfortunately doesn't tap the depth of the problem.

Another caveat: Risk assessment instruments have been developed on males in North America. There are reasons to believe that there is a gender X culture effect on incidence rates and risk factors. I was reminded of this on a recent speaking engagement in Rome, where a therapist from Sardinia informed me of an uxoricide that occurred because the man believed his wife was having an affair and had a "duty" to uphold his family's honor. Obviously, these types of archaic practices pretty much circumvent prediction of violence based on past criminality. They also point out the cultural relativity of risk assessment instruments.

Archer (2006) has shown that gender equality impacts on the expression of intimate partner violence. Specifically, in countries where women have relatively low socioeconomic power, male violence rates are relatively high, and female violence rates are low. In countries where there is roughly gender equality of socioeconomic power (North America, New Zealand, Northern Europe), male and female rates of intimate partner violence are roughly equal (see also Archer, 2000). In these countries, there are some similar risk factors for intimate partner violence (Moffitt, Caspi, Rutter, and Silva, 2003) and some differences

(Henning and Feder, 2004). Their similar factors include a generic "negative emotionality" that Moffitt et al. described.

The 425 women and 436 men who were in intimate relationships from the Magdol et al. (1997) cohort indicated that both minor and severe physical violence rates were higher for women whether self- or partner-reported. The female severe physical violence rate was more than triple that of males (18.6% vs. 5.7%). Based on this same sample, Moffitt et al. (2001) reported that pre-existing characteristics of the women (at age 15) predicted their (a) choice of an abusive male partner at age 21 and (b) their own use of violence at age 21, apart from the male's violence (see below). As Magdol et al. put it, "Early studies of partner violence assumed that men's perpetration rates exceeded those of women, in part because these studies relied almost exclusively on clinical samples of women who sought assistance or of men in court-mandated counselling programs" (p. 69).

BRODIE WALDRAT (D.O.B. 4/23/71) Port Orchard, Washington

- murdered pregnant girlfriend, foetus also died.
- girlfriend had obtained restraining order restricting him from seeing her or child (when born).
- left Washington state for Idaho, turned car around, drove to Port Orchard, WA, on Olympic Peninsula.
- slept in car, waited for victim's mother to leave for work.
- knocked on door, tried to convince victim to give relationship another try.
- she said NO.

Pre-Homicide

- vaguely remembers hitting victim, did not remember rape.
- victim had been bound with duct tape, vaguely remembered doing this to stop "sickening sound."
- victim had been dragged onto parents bed, where rape occurred.

Post-Homicide

- changed shirt, left victim on bed.
- took cell phone and money.
- drove from Port Orchard to Eureka, CA. (600 miles).
- still wearing bloody jeans.
- fell asleep in motel parking lot, awakened by police.
- asked police "is she alright?"

Brodie's Background:

- ran away from home at 5, lived in as series of foster homes.
- had no prior involvement with the law.
- only prior violence was a fist fight (over a girl) at a navy cadet dance.
- there had been some low level abuse with his current girlfriend, no injuries but enough to make her want out of the relationship.

Jury Decision: Guilty, Second Degree Murder

Henry White, Long Beach, California.

- had no prior violence record.
- had been voted "father of the year" for carefully attending to his two children.
- had even washed and pressed their school clothes.
- had also brought them to school every day.
- he was trying unsuccessfully to reconcile (on the telephone) with his wife who was leaving him.
- the children were in the bath.
- he hung up the phone, went to the bathroom and drowned both children.

Post–Homicide

- seemed to be unable to realize what he had done.
- wandered around, had lunch, turned himself into police.

Background

- his sisters described him being beaten by his father while hanging upside down from a beam: Lisa Coulter, Mr. White's half-sister, described that Henry Sr. used to hang the defendant in the air by one leg and whip him with a belt. Sometimes this occurred as frequently as four times a week**.**
- Michelle Coulter, another half sister, "described that the defendant's physical beatings at the hands of his father started when he was two years old and may have started when he was six months old."
- he was, in effect, tortured and had no safe refuge within his family.

The psychiatrists' report described this as follows: Mr. White's childhood was "characterized by parental instability/abandonment."

Female Perpetration

The largest differences were for the items "kick/bite/hit with fist" (14.4% for females, 4.4% for males) and "hit with object" (8.3% for females, 1.1% for males).

Women were more likely to threaten with a weapon (.5% vs. 0), to use a weapon (.2% vs. 0), and to use verbal aggression (94% for females, 86% for males). Stranger violence was also more prevalent by women (36% vs. 25%).

Male Perpetration

Men were more likely to beat up (but only by .2%) and choke/strangle (1.4% more). Morse (1995) found the same result in the U.S. Youth Survey.

A comprehensive analysis of the Dunedin data was done by Moffitt et al. (2001). Based on the data from the other measures, these authors reported that the following characteristics predicted intimate violence in females: approval of the use of aggression, excessive jealousy

and suspiciousness, a tendency to experience intense and rapid emotions, and poor self-control (p. 65).

Moffitt et al. (2001) found that antisocial traits measured in females at age 15 (a) made them more likely to become involved in a relationship with an abusive man at age 21 and (b) even after controlling for their partners' physical abuse, "women with a juvenile history of conduct problems were still more likely to commit violence against their partners" (pp. 64 - 65). With a longitudinal study, earlier data can be used to forecast later behavior. Antisocial behavior in women through their teens made them more likely to be assaultive to intimate partners at age 21. A similar design was used in the U.S. and found the same results with respect to gender equality of violence (Morse, 1995).

Pre-existing characteristics in the woman, such as approval of violence, excessive jealousy and suspiciousness, a tendency to experience rapid negative emotions, and poor self-control predicted whether Dunedin women would engage in violence towards their partners (and non-intimates, too) 3 years later. (Moffitt et al, 2001, p. 65). In chapter 9 of this book, we will examine an in-depth study done on male perpetrators that describes an "abusive personality." The abusive personality has the same profile as what Moffitt et al. described: jealousy, impulsivity, rapidly fluctuating emotions, and poor self-control. With the men, these were related to borderline traits independently assessed. These psychological aspects, in fact, are central to definitions of borderline personality, which, unfortunately, was not formally assessed in the Dunedin women. From the descriptors given by Moffitt et al., however, it sounds like an identical "abusive personality" exists for female intimate abuse perpetrators.

In sum, antisocial behavior measured in females at age 15 predicted their use of intimate aggression against male intimates at age 21. A woman's conduct problems correlated +.44 with her later use of violence against her partner (with his violence partialled out). It also correlated +.36 with this use of violence towards her. The antisocial female sample had earlier puberty, earlier initiation of intercourse, and more older and delinquent friends (Moffitt et al., 2001, p. 50). Essentially, the pattern of correlations between early conduct problems correlating with later intimate violence and partners' use of violence was found for both sexes. The correlations were roughly similar, certainly not significantly different. The authors emphasize the importance of puberty as a developmental crossroads for these girls. The authors also make the provocative argument, based on their impressive data set, that males form two kinds of antisocial behavior types: one against strangers (that may be neurologically based) and one against intimate females. Females form one type: against intimate males. The sophisticated path analyses (statistical method of differentiating independent, moderator, and dependent variables) used by the authors on this huge and representative sample gives added weight to their findings.

Ehrensaft, Moffitt, and Caspi (2004) studied the Dunedin birth cohort of 980 individuals, finding 9% to be in "clinically abusive relationships," defined as those that required intervention by any professional (e.g., hospital, police, lawyers). The authors found comparable rates of violence, 68% of women and 60% of men self-reporting injury. Both male and female perpetrators evidenced signs of personality disturbance. The authors noted, for instance, the women had "aggressive personalities and/or adolescent conduct disorder" (p. 267). These findings, based on large and representative samples and followed over time in a longitudinal design, suggest that personality disorder is the major risk factor in gender equal societies.

Henning and his colleagues (Henning and Feder, 2004; Henning, Jones, and Holford, 2003) compared female to male domestic violence offenders. Rising numbers of women arrested for domestic violence present many theoretical and practical challenges. At the theoretical level, there is ongoing debate about whether women are equally as aggressive as men. At the practical level, little research is available to guide how female cases are handled in the criminal justice system. In this study, data were obtained regarding demographic characteristics, mental health functioning, and childhood familial dysfunction for a large sample of male (n = 2,254) and female (n = 281) domestic violence offenders. The women were demographically similar to the men, and few differences were noted in their childhood experiences. Women were more likely than men to have previously attempted suicide, whereas more men had conduct problems in childhood and substance abuse in adulthood. Compared to the male offenders, women reported more symptoms of personality dysfunction and mood disorder. Ninety-five percent of the women offenders had one or more personality disorders above 75 on the MCMI-111 compared to 70% of the male offenders. Females were six times more likely to have borderline scores above 75**,** although it's treated as a severe personality pathology on the MCMI.

Hence, when assessments are done of females arrested for intimate partner violence, personality disorder still presents as a central variable. Borderline personality, the central feature found in male perpetrator populations by Dutton (2002a) was even more prominent in female offender populations. This psychological variable is not assessed on current risk scales, although some of its manifestations (such as extreme jealousy) may be assessed.

One final caveat: Risk assessments for intimate partner violence are typically based on an assumption of unilateral violence. However, as Stets and Straus (1992) found, the most common form of violence is bilateral. This throws another wrinkle into risk assessment: Do we ever assess the volatility of a potential perpetrator's partner? It may be that future risk assessment will need to assess both partners. Moffitt, Robins, and Caspi (2001) found that when both partners had personality disturbances, risk for intimate partner violence was greatly enhanced.

CONCLUSION

I understand that, in patriarchal cultures, wife assault is a greater problem than husband assault (Archer, 2006). However, risk assessment instruments have been developed in egalitarian countries where gender equality and intimate partner violence are close to equivalent by gender. Hence, we cannot generalize about the risk factors in these societies to more patriarchal societies. More individual factors emerge in egalitarian societies as risk factors for assaultiveness than may not be required in patriarchal cultures.

Secondly, even in egalitarian cultures, risk assessment instruments rely too heavily on past criminal records. Hence, "out of the blue" killings or violent eruptions triggered by immanent abandonment or a perceived workplace injustice remain unforeseeable. Finally, although it is hard to imagine in a patriarchal culture, increasing egalitarianism will produce increases in female violence, as it did in North America, and this may require entirely separate assessment of risk.

In: Intimate Partner Violence Prevention and Intervention ISBN: 978-1-60456-039-8
Editors: A. C. Baldry and F. W.Winkel, pp. 133-146

Chapter 9

BLENDED BEHAVIOR THERAPY FOR INTIMATE VIOLENCE

Donald G. Dutton
University of British Columbia, Canada

Psychological research over the past twenty years has revealled an infrastructure of abusivness in male perpetrators. This includes attachment insecuirity, abandonment reactivity, trauma symptoms, and a history of being shamed and exposed to abuse. Current Cognititive Behavioral Treatment (CBT) offers the best outcome in reducing recidivism after court mandated treatment. This approach could be further stengthened by broadening the target foci of treatment to include these infrastructure aspects of abusiveness. Also, since the same personality disorder features are now appearing in convicted female perpetrators of domestic violence, the treatment could easily be adapted to treat this group.

CURRENT PRACTICE IN COURT-MANDATED THERAPY FOR SPOUSE ASSAULT: THE "DULUTH INTERVENTION"

Victim surveys have assessed annual incidence rates of domestic violence as around 11-12% for husband-to-wife violence and a similar rate for wife-to-husband violence (Dutton, 1995b; Straus and Gelles, 1990). In North America, a typical result of arrest and conviction for a domestic violence conviction involves court-mandated treatment as a requirement of probation. Initially, two forms of treatment were available: cognitive behavioral therapy (CBT: Dutton, 2003b) and "psychoeducational" groups, sometimes referred to as the Duluth Model (Pence and Paymar, 1993). The latter did not call itself therapy because it did not want to imply that there was a psychological component in the make-up of abusive men who were seen as playing out a socially determined and "normal" male role, preoccupied with power and control (e.g., Bograd,1988; Dobash and Dobash, 1979). As Bograd (1988) put it, "Feminists take it as a given that male domination influences everything" (p.15). Hence, "intervention," as the Duluth Model calls it, can only educate, not treat. Female violence was not considered by Pence and Paymar as anything but defensive, although subsequent studies

indicate this view is wrong (Archer, 2000; Dutton, 2004). Only a small (11%) subgroup of men are abusive, so "male socialization" cannot be the main factor behind male abusiveness. Women initiate intimate violence more frequently than men do, and they do so for a variety of reasons (many having nothing to do with self-defense), such as getting more control or punishing the other person (the male). Furthermore, many women use violence against non-violent men (see Dutton, 2004, for a review).

Nevertheless, the Duluth Model psychoeducational groups were legislated as mandatory in many U.S. states, and a state "domestic violence council" was put in place to "oversee" that treatment groups adhered to the model, including making group leaders "accountable" to victim advocates. In California, the policy gave leeway to therapists to add onto the essential components of the Duluth model that all abuse was a male-generated need for "power and control." In other locations, service providers became disenchanted with the Duluth program to the point that, when a recent treatment outcome study sought to compare Duluth with CBT models, only one "pure" Duluth model could be found. The others had reverted to using CBT techniques blended with Duluth perspectives in order to satisfy state requirements (Babcock, Green, and Robie, 2004).

Dutton (2003b) argued that Duluth models had two major flaws that were contraindicative of effective treatment: They attempted to shame clients, and, in taking a strong adversarial stance to clients (based on a feminist view of male sex role conditioning as a major issue in domestic violence), they failed to establish a therapeutic bond with their clientele. In two treatment outcome studies done on Duluth models, Shepard (1987, 1992) found a 40% recidivism rate in a 6-month follow-up of Duluth clients, higher than most control recidivism levels (Babcock et al., 2004), and Feder and Forde (1999) found no significant differences in either police reports or victim reports on a follow-up of men attending a "feminist-psychoeducational program or no treatment" (p. 9). Sixty percent of the men assigned to the Duluth program dropped out. It's hard to imagine a therapeutic case for a positive treatment result in groups where no therapeutic bond is developed.

TREATMENT IMPLICATIONS OF A TRAUMA MODEL OF ABUSIVENESS

Cognitive Behavioral Treatment for Assaultiveness

Court-mandated treatment models arose in a number of locations in the early 1980s and ranged in length from 8 to 52 weeks. The criminal justice system needed an effective way for judges to settle wife assault cases before them, and treatment was developed to meet that need. Maiuro and Avery (1996) defined the treatment foci of such groups as shown in Figure 1.

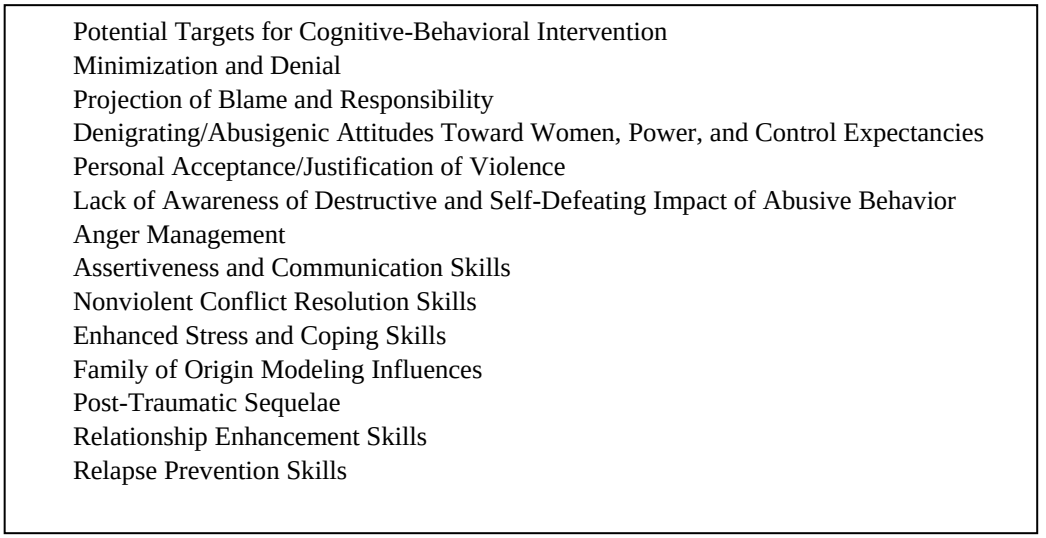


Figure 1. Standard Treatment Targets for Cognitive Behavioral Treatment (from Maiuro and Avery, 1996).

At intake, men are given a “time out “card, instructing them to leave high-risk situations and to walk away until calm, not to return until calm, and to leave again if they become re-angered. They must inform their wife of the procedure. At this point, no training is yet done in thought substitution to lower anger. Typically, CBT is done in a group format (see Dutton, 2003a, for a detailed description). As outlined in Figure 1, current CBT focuses on responsibility for abusiveness, cognitive reframing of abusogenic thoughts, assertiveness, and awareness of anger. Most men who are sent by the courts for wife assault treatment have had no experience with psychotherapy. Wallace and Nosko (1993) have described the opening-night ritual (in which men are asked to describe the “event that led to your being here”) in such groups as a "vicarious detoxification" of shame. Most men who come to these groups (assuming they are “normally” socialized) experience high levels of shame as a result of their violent behavior (as evidenced by their denial and minimization of the assaultive events; see Dutton, 1998, 2002b). Hearing other men in the group discuss their own violence allows the man to “vicariously detoxify”; that is, to face his own sense of shame. This sense of shame, were it not detoxified, would maintain the man’s anger at a high level and preclude his being open to treatment. The anger is maintained to keep the shame at bay. Anger allows blame to be directed outwardly, preventing shame-induced internalized blame. This is one reason why Duluth psychoeducational models have a counter-productive orientation. They enhance shame instead of reducing it, precluding further work.

Figure 2 shows a sample didactic and group process structure for a short (16-week) CBT group. Note that in week five, a “violence policy” is established. This asks men to complete the sentence “I think the use of violence is justified when….”. Most men will respond with self-defense or defense of family as an answer. From that point on, the therapist can portray all therapy as an attempt to allow the man to learn to live up to his own violence policy. This serves to undercut resistance to the imposed aspect of the treatment.

Treatment Outline

	Didactic Exercise	Group Process Goals
Week 1	Describe the assault that led to your being here. Participation Agreement	Shame Detoxification
Week 2	Conflict issues > Emotions > Actions	Group Cohesiveness
Week 3	What is “abuse"? Definitions, power wheel	Assessment of denial levels
Week 4	Explanation of confrontation. First group check in	Authority issues
Week 5	Violence policy	Group cohesiveness
Week 6	Anger Diaries	Shame detoxification
Week 7	Stress Management: Reichian Breathing	Hierarchy in group
Week 8	Abuse Cycle	Authority issues
Week 9	DESC Scripts	Attitude confrontation
Week 10	Family of Origin: How did your Mom / Dad show their anger?	Authority issues
Week 11	Continuation: How did you / your siblings feel?	Personal responsibility
Week 12	DESC Scripts – role play	Emotion detection
Week 13	Detection of other prevalent emotion: shame, resentment, guilt, etc.	
Week 14	Consolidation of communication skills	
Week 15	Preparation for the end: Relapse prevention	
Week 16	What did you learn? What continues to be a problem? What other therapies are available?	

Figure 2. Treatment Outline for CBT with Court-Mandated Spouse Abusers.

The anger diary (week six) is a basic tool to improve the men’s ability to detect and manage their anger. It requires them to specifically state what triggered their anger as objectively as possible (under the trigger column), to list how they knew they were angry (what physical or cognitive cues told them so?), to rate their anger severity on a scale where 10 is their own personal extreme, and to describe their "talk up" (their thoughts as their anger escalates) and their "talk down" thoughts (their thoughts as their anger diminishes). Most clients have some initial difficulty with the latter.

Comparison of the “trigger” and the talk-up columns of the anger diary will assist the therapist in identifying the interpretations and assumptions that generate and sustain anger as a consequence of the client's perception of the trigger. (see also Ellis, 1992). Assumptions of malevolent intent or what Beck (1976) called “hostile attributions” (that the action of the other person was done intentionally, to hurt them) are frequent with angry clients. Eckhart, Barbour, and Davidson (1998) and Eckhard, Barbour, and Stuart (1997) found that the cognitive factors from Beck’s analysis most predictive of abusiveness were (in order of importance) hostile attributions, magnification, dichotomous thinking (which is also a borderline trait), and arbitrary inference (see Figure 3).

Group discussion should clarify to the client that alternative interpretations of his spouse’s actions are both possible and probable. This exercise can also be used to evaluate the client’s ability to empathize with the other person. Lack of empathy itself sustains an anger response (Miller and Eisenberg, 1988) and has been therapeutically handled by “compassion workshops” for spousal abuse (Stosny, 1995).

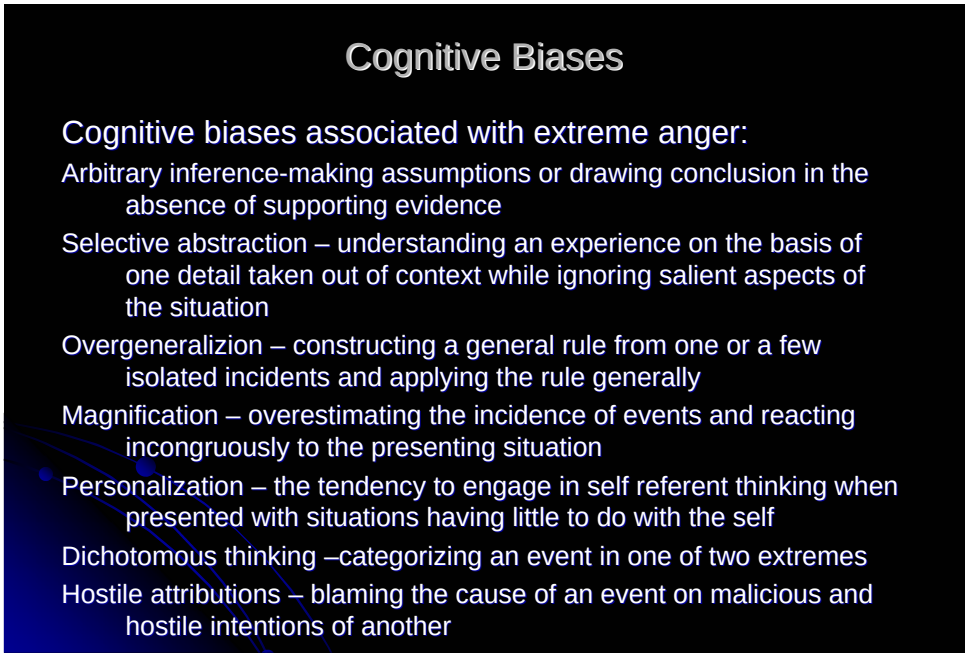


Figure 3. Cognitive Therapy and the Emotional Disorders (from Beck, A.T., 1976).

Later sessions address "self soothing" as a stress reduction technique that also serves to lower anger arousal. Wilhelm Reich (1945/1972) describes character armor as the result of storing tension in the fascia or connective tissue of the body. Since many assaultive men react to a build-up of internal tension, it is important to teach them how to maintain tension within acceptable levels through daily routines of breathing and stretching. A variety of useful stretching programs exist that can be combined with breathing and breath-control exercises to develop useful tension self-management techniques (see, for example, Kabat-Zinn, 1990). The didactic goal here is to teach effective tension management so that the reliance on abusive outbursts to diminish tension is lessened. Borderline clients can benefit from this aspect of the group as cyclical tension build-ups are a major part of their abusiveness. In working with cyclical or borderline clients, it is also important to ensure that the therapist is consistent from week to week. Any alterations in the therapist's relationship with the client can then be pointed out as part of the client's changeability, and cues can be elicited to help the client track his changes (see also Dutton and Winters, 1999). Once anger (or other relevant emotions) is recognized and charted, it can then be expressed to the partner in an assertive way. We use a DESC script (Describe, Express, Specify Positive Consequences) for an assertiveness exercise and role play it with the men, inviting them to tell us how their assertiveness might be sabotaged by their spouse. This exercise is presented as a negotiation, not a control, tool. When empathic listening, anger control, and assertiveness skills are acceptable, men are prepared for group completion. Some men are asked to repeat the group. Relapse prevention includes listing high-risk situations and having a clear plan for management, staying in touch with "24/7 support buddies" (chosen during group), and returning to group voluntarily when anger or stress levels begin to increase. Some excellent program guides for CBT with abuse groups exist (Sonkin and Durphy, 1989; Wexler, 2000). The Wexler book is aimed more at the therapist; the Sonkin and Durphy book, at the client.

This treatment and similar forms have tended to produce acceptable results. Dutton, Bodnarchuk, Kropp, Hart, and Ogloff, (1997a and b), using Canadian Police Information Centre records, followed group completers and dropouts for up to 11 years, looking for recidivism. Group completers had a 23% recidivism rate for up to 11 years after group (non-completers had a 50% rate). Presence of personality disorder in clients reduced treatment success (Dutton et al., 1995b). Babcock et al. (2004) established a *d'* of .34 in quasi-experimental designs for 22 treatment groups they studied. These were mainly hybrids of Duluth and CBT, however. Babcock et al. concluded that one could not make a case for one type of treatment over another (since few "pure forms" were found). Techniques that enhance treatment retention increased the effect size for a CBT group (Taft et al., 2001), which Babcock et al. indicated "could be viewed as a harbinger of potentially powerful intervention" (p. 24).

There are several ways to increase the treatment success of court-mandated therapy. All rely on established CBT techniques used for other problem areas and simply recognize the relevance of these techniques for batterer treatment. A rich psychology of intimate violence perpetrators has developed since the first wave of treatment was developed. Essentially, this research has unearthed what emotions, cognitions, and situational interactions interact to generate and support abusive behavior. They constitute the infrastructure of abuse.

BORDERLINE PERSONALITY ORGANIZATION AND ASSAULTIVENESS: THE THEORETICAL CONNECTION

Dutton (1998, 2002a and b) has shown empirically a strong relationship between borderline traits in male perpetrators and intimate abusiveness. In a series of studies, Dutton and his colleagues (for a review, see Dutton, 1995a or b; 1998; 2002b) have examined personality profiles of assaultive males. The overall strategy of this work has been based on self-report scales filled out by abusive men as part of an assessment procedure for treatment and corroborated through the female partners' reports of the men's abusiveness. Both self-referred and court-referred men have been compared to demographically matched controls. Extensive analyses of the men's reporting tendencies have been made through the use of both the Marlowe-Crown scale, the Balanced Inventory of Social Responding (Dutton and Hemphill, 1992) and the Disclosure, Debasement and Desirability Scales of the Millon Clinical Multiaxial Inventory-II and 111 (MCMI-II, 111). Self-reports of the man's anger, jealousy, experience of trauma symptoms, and abusiveness, and of the man's abusiveness (both physical and psychological) made by his female partner have constituted the dependent variables in these studies. Dutton and Starzomski (1993; 1994) argued that self-referred assaulters constituted a more "pure" group of abusive personality (defined as high scores of fearful attachment style, trauma symptoms, and borderline traits), whereas court-referred samples were more heterogeneous. Consistent with this view was the finding that 45% of self-referred but only 27.5% of court-referred wife assaulters reached the 85th percentile on the borderline scale of the MCMI- II.

Using the scale developed by Oldham et al. (1985), Dutton and Starzomski (1993) found Borderline Personality Organization (BPO) scores to be similar to those for diagnosed borderlines. The mean BPO score for the sample of wife assaulters was 71.3 (*SD* = 17.1),

whereas the score for diagnosed borderlines was 74.8. By comparison, Oldham et al. reported a mean score of 61.3 for a non-borderline sample, and our controls scored 60.0 (*SD* = 17.0) on the BPO scale. Furthermore, BPO scores were significantly related to chronic anger, jealousy, wives' reports of clients' use of violence, and experience of adult trauma symptoms in the wife assault group. High BPO scorers reported significantly more anger, of greater frequency, magnitude, and duration. They also reported greater jealousy and more trauma symptoms: dissociation, anxiety, sleep disturbance, depression, and post-sexual abuse trauma. Finally, they reported significantly more abuse towards their wives: both verbal-symbolic and physical as measured on the Conflict Tactics Scale (CTS: Straus, 1979). Analysis of response styles indicated that these associations were not mere disclosure or social desirability effects. It is important to note that BPO is a continuum of borderline traits and does not require a formal diagnosis of Borderline Personality Disorder.

Dutton and Starzomski (1993; 1994) corroborated these findings by focusing on wives' reports of abusive treatment by their husbands through assessment of both physical abuse using the CTS and emotional abuse using the Psychological Maltreatment of Women Inventory (PMWI: Tolman, 1989). Strong associations of men's BPO scores with women's reports of male abusiveness were found. A multiple regression indicated that BPO scale scores combined with scores from a self-report for anger (the MAI: Siegel, 1986) accounted for 50% of women's reports of Dominance/Isolation (Factor 1: PMWI) and 35% of Emotional Abuse scores (Factor 2).

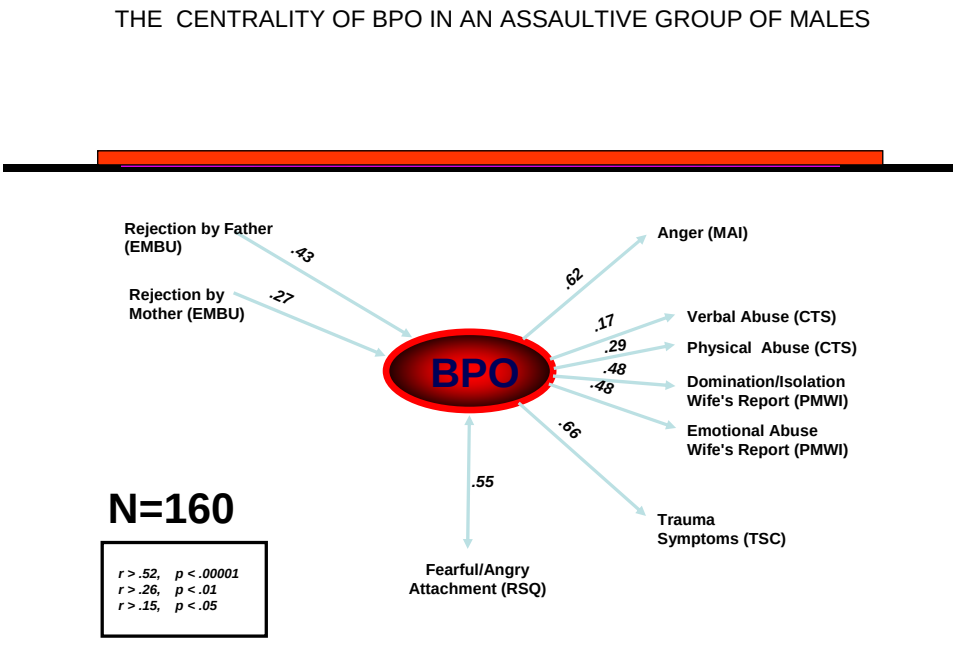


Figure 4. Schemata for Correlations of Borderline Personality Organization, Anger, Fearful Attachment, Trauma Symptoms, Parental Rejection, and Spouses' Reports of Verbal and Physical Abusiveness .

In effect, a constellation of personality features (BPO, high anger, fearful attachment, chronic trauma symptoms, and recollections of paternal rejection) accounted for reports of abusiveness by one's intimate partner in all of the above groups. Each of these features of abusiveness is a potential target for treatment. The correlations are represented in Figure 1 above. With minor variations, this constellation was replicated with blue collar controls, college students, psychiatric outpatients, and gay couples (Dutton, 1998; 2002b).

ATTACHMENT AND ABUSIVENESS

If early experiences influenced adult abusiveness, attachment theory might provide a valuable perspective in the etiology of abusiveness. Bowlby (1969) viewed interpersonal anger as arising from frustrated attachment needs and functioning as a form of "protest behavior" directed at regaining contact with an attachment figure. He viewed dysfunctional anger as anger expressions that increased the distance from the attachment object.

In turn, chronic childhood frustration of attachment needs may lead to adult proneness to react with extreme anger (which I refer to as "intimacy-anger") when relevant attachment cues are present. Thus, attachment theory suggests that an assaultive male's violent outbursts may be a form of protest behavior directed at his attachment figure (in this case, a sexual partner) and precipitated by perceived threats of separation or abandonment. A "fearful" attachment pattern may be most strongly associated with intimacy-anger. Fearful individuals desire social contact and intimacy but experience pervasive interpersonal distrust and fear of rejection. This style manifests itself in hypersensitivity to rejection (rejection-sensitivity) and active avoidance of close relationships where vulnerability to rejection exists. While the fearful share anxiety over abandonment with another insecurely attached group (called Preoccupied), their avoidance orientation may lead to more chronic frustration of attachment needs.

Dutton, Starzomski, Saunders, and Bartholomew (1994) assessed attachment styles in abusive men using the Relationship Style Questionnaire (RSQ: Griffin and Bartholomew, 1994), a 30-item, self-report measure. Fearfully attached men experience high degrees of both chronic anxiety (as measured by the TSC-33) and anger (as measured by the MAI). In addition, both trauma scores, in general, and dissociation scores, in particular, were highest for the fearful group. Fearful attachment alone accounted for significant proportions of variance in both emotional abuse criterion factors completed by female partners. Fearful attachment was also strongly correlated with borderline personality organization. Because anxiety (+ .42) and anger (+ .48) are both strongly associated with fearful attachment, one could argue that an emotional template of intimacy-anxiety/anger is the central affective feature of the fearful attachment pattern. These correlations maintain in the control sample (fearful-anxiety + .53, fearful-anger + .52), suggesting that this emotional template does not only reside within physically abusive men. Using the Adult Attachment Interview (Main and Goldwyn, 1994), Babcock et al. (2000) also found insecure attachment styles to be related to abusiveness. Mikulincer (1998) found, as had Starzomski, Saunders and Bartholomew (1994), that attachment style related to dysregulation of negative emotions in intimate relationships.

A prominent feature of Borderline Personality Organization (BPO) is intimacy-anger. The correlation of fearful attachment to BPO is so strong (+ .62) that one could argue BPO is a personality representation of this particular attachment style (Dutton et al., 1994). Dutton and Starzomski (1993; 1994), Maiuro et al. (1988), Eckhardt et al. (1997) (*inter alia*) have found abusers to have high scores on state-trait anger.

EARLY TRAUMA FROM SHAMING AND EXPOSURE TO VIOLENCE

In abused boys, a prominent sequela of abuse victimization is hyperaggression. Carmen, Rieker, and Mills (1984) suggested that abused boys are more likely than girls to identify with the original aggressor and to eventually perpetuate the abuse on their spouse and children. In their view, an effect of physical maltreatment by a parent is to exaggerate sex role characteristics, possibly as a means attempting to strengthen the damaged self. Van der Kolk (1987) noted that traumatized (including physically abused) children had trouble modulating aggression and included being physically abused as a child as a trauma source.

Herman and van der Kolk (1987) noted how PTSD included poor affect tolerance, heightened aggression, irritability, chronic dysphoric mood, emptiness, and recurrent depression and was "described in patients who have been subjected to repeated trauma over a considerable period of time" (p. 114). This profile also described spouse abusers. Hence, the possibility was presented that PTSD may be another link or mediating variable between childhood abuse victimization and adult perpetration of intimate abuse.

In order to test this notion, wife assaulters were compared to two groups of diagnosed PTSD men from independent studies (Dutton, 1995d). In the wife assault sample, 45% of all men met criteria for PTSD (75th percentile or above on the "82C profile" [avoidant-passive-aggressive-borderline] of the Millon Clinical Multiaxial Inventory – 11; MCMI-II: Millon, 1997). On the MCMI-II, wife assaulters and diagnosed PTSD men were similar on all 82C profile peaks. Finally, assaultive men exhibited elevated levels of trauma symptoms assessed using the Trauma Symptom Checklist -33 (Briere and Runtz, 1989) without having adult trauma exposure.

The source of trauma, as revealed in this work, was physical abuse combined with shaming by the father and with a lack of secure attachment to the mother. Consequently, the latter could not provide buffering against the former (Dutton, 1998; 2002b). Tangney, Wagner, Fletcher, and Gramzow (1992) have presented a more focused analysis of the potential role of shame as a mediator between the early experiences of assaultive men and their adult experience of anger and abusiveness. Tangney et al. differentiate shame-proneness and guilt-proneness as two moral affective styles where the former has to do with "global, painful, and devastating experience in which the self, not just behavior, is painfully scrutinized and negatively evaluated" (op. cit., p. 599). In this sense, shame-inducing experiences that generate a shame-prone style may be viewed as attacks on the global self and should produce disturbances in self-identity. Shame-prone individuals have been found to demonstrate a limited empathic ability, a high propensity for anger, and self-reports of aggression (Wallace and Nosko, 2003). Dutton, Starzomski, and van Ginkel (1995) found recollections of shame-inducing experiences by parents of assaultive men to be significantly related to the men's self-reports of both anger and physical abuse and to their wives' reports

of the men's use of Dominance/Isolation. These authors found three recalled sources of shame in assaultive males. These were public scolding, random punishment, and generic criticism. All three were recalled as generating experiences of shame. These, in turn, were correlated with adult anger and tendencies to project blame. Not surprisingly, given these tendencies, abusive actions also correlated with recalled shame experiences. Partial correlations revealed that parental shaming still correlated significantly with measures of abusive personality after physical abuse by the parents had been partialed out. The converse, however, was not true. With parental shaming partialed out, physical abuse by parents did not correlate significantly with abusive personality measures. Hence, experience of being shamed seemed to interact with exposure to violence to produce assaultiveness. It is for this reason, above all, that shaming clients in Duluth groups, based on their being male, is contraindicated.

Surprisingly, until now, these features of an abusive personality -- insecure attachment, borderline traits, and trauma reactions -- have not been a focus of CBT for spouse assault.

CBT-DBT

Currently, there is no focus on borderline issues in standard CBT treatment for assaultiveness. Dialectical Behavior Therapy for borderlines (DBT: Linehan, 1993a) has traditionally been used with clients having problems with suicidality. Hence, a well-developed behavioral therapy treatment for borderlines exists (Linehan, 1993a), although it has two different foci from CBT for batterers; it focuses on self-directed aggression and adopts “radical acceptance” as a starting point. According to Linehan, radical acceptance is an acceptance of the clients’ essential self, used to mitigate an assumed lifetime of non-validation within the family of origin. In the case of abusive clients, a lifetime of shaming may constitute the form of invalidation. Nevertheless, it is a behavioral therapy with many processes similar to CBT. Both teach skills: emotion regulation, interpersonal communication, arousal management, stress tolerance (called “core mindfulness” and involving self-soothing). The integration of CBT-DBT requires simultaneous acceptance of the clients’ non-abusive selfhood, while contracting with the client to sustain an effort to change abusive behaviors. It does not, however, require a doubling of the didactic content of the treatment; there is much overlap between DBT and CBT. One particular strength of the DBT program is the careful pre-planning to circumvent obstacles to program completion. DBT requires daily skill practice and diary keeping.

CBT for Trauma

Abusive men in the Dutton (1998, 2002b) studies had elevated levels of trauma symptom as described above. Foa, Keane, and Friedman (2000) have outlined a variety of treatments for PTSD, including psychopharmacological treatment and CBT. (Maiuro and Avery, 1996, had also suggested that psychopharmacological adjuncts to CBT with abusive clients had promise.) Rothbaum, Meadows, Resick, and Foy (2000) review CBT for trauma, outlining eight different approaches: exposure therapy, systematic desensitization, stress inoculation training, cognitive processing therapy, cognitive therapy, assertiveness training, biofeedback, relaxation training, and various combinations of the above. From the above outline of CBT

with abusive men, it can be seen that assertiveness training, relaxation training, and some forms of stress inoculation training are already in use for abusiveness. Nevertheless, little is done to address specific anxiety sources (e.g., abandonment fears, jealousy) that Dutton (1998, 2002b) stresses are the motivational basis of the interpersonal controlling behaviors in these clients. Identifying anxiety sources in treatment and then using systematic desensitization, relaxation, and stress inoculation to enable the client to control the anxiety would be the recommended strategy in CBT for PTSD. This would involve construction of anxiety gradients, relaxation practice to mastery at each increasing level (including breathing retraining). Potential anxiety sources include childhood exposure to physical abuse, lack of a safe haven, and abandonment. Skills would be developed in group with an expectation of their being used in real-world situations. Use of a "24/7 buddy system" (with clients co-contracting to provide haven/support for each other on an around-the-clock basis) as fallback is a safety device that is recommended. Again, adding a focus on trauma symptoms to treatment of abusers does not require extensive additional content because many issues are already covered by CBT and/or DBT. It simply requires a specific focus on the trauma symptoms, their identification, and stress tolerance skills (which are part of DBT training).

CBT for Attachment Anxiety

Dutton and Browning (1984) and Dutton et al.(1994) identified attachment anxiety or an attachment style labeled fearful/angry attachment as being related to abusiveness. Bowlby (1988) had identified several therapeutic tasks for insecure attachment: creation of a safe place, or secure base, for the client to explore thoughts, feelings and experiences regarding self and attachment figures, current relationships with attachment figures, and the relationship with psychotherapist as an attachment figure. What is essential for attachment therapy (and, we might add, success of CBT with other foci) is the establishment of a therapeutic bond between the therapist and client. Not until this bond is established will veridical descriptions of threat stimuli by the client be forthcoming. In a recent editorial in the American Journal of Psychiatry, Gold (1998) argued, in referring to borderlines, that "*in no other disorder is the therapist's ability to establish a therapeutic alliance so tested*" (p. 750). Given the borderline traits in spouse abusers and the unconvinced "precontemplation" phase in which many of them arrive in mandated treatment (Prochaska, DiClemente, and Norcross, 1992), this dictum is of utmost importance. Specific identification of attachment-generated phenomena and concomitant management techniques form another part of attachment therapy. For example, difficulties in reacting to separation (even daily separations and intolerance of lateness) should be chronicled and addressed in group. Abuse cycles, whether addressed as a borderline trait or as an aspect of ambivalent attachment, need to be addressed. What thoughts does the client have on a daily basis regarding his or her partner and the relationship? Does he or she cognitively express concern over the partner leaving or dissatisfactions with the partner's closeness? Figure 5 below shows similarities in CBT applications to four targets.

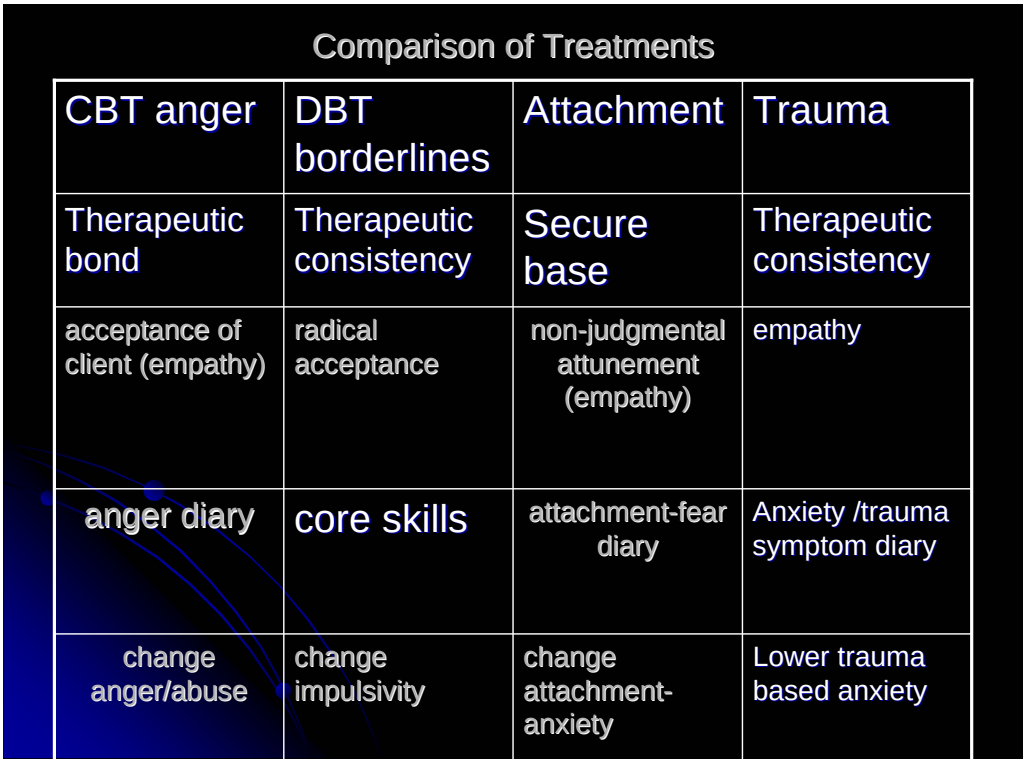


Figure 5. Similarities of CBT Approaches for Aspects/Traits of Abusiveness.

CBT for Substance Abuse

Marlatt (Larimer and Marlatt, 1994; Marlatt, 2002; Witkiewitz and Marlatt, 2004) has developed a cognitive-behavioral treatment for addictive behaviors, especially substance abuse. Substance abuse is so closely connected to spouse abuse (Kantor and Straus, 2002) that many programs require contemporary treatment for substance abuse before beginning treatment of men for spouse abuse. In Dutton's model, substance abuse is connected to borderline personality organization because it provides medication for aversive arousal in a population that cannot self-soothe and both drinks and batters to dissipate tension (Dutton, Swihart, Clift, and Thomas, 2001). Hence, substance abuse problems are frequent in spouse abuse populations and require modification.

Marlatt's CBT model (Marlatt, 2002) includes mediation, covert sensitization involving negative imagery, and contingency management (which restructures the addicted individual's environment in such a way that positive behaviors are reinforced and negative behaviors receive negative or neutral consequences). As described above, CBT for spouse abuse also uses contingency management techniques, including the establishment of the "24/7 buddy triads" for emergency support. These supporters can also supply positive social support for alcohol cessation. Larimer and Marlatt (1994) reported success of these operant procedures in a small sample outcome study. Skills training includes training in "drinking skills" (monitoring and cessation), blood alcohol discrimination, interpersonal skills, and vocational skills. Skills training is part of both CBT and DBT and, hence, the concept of skill acquisition

is already established in a blended CBT program. In addition, assertiveness and interpersonal skills are part of the core curriculum of both CBT and DBT. Also, as alcohol abuse is often a dysfunctional form of stress reduction, the stress management skills used in a CBT program (relaxation, stretching-breathing exercises) already aids this aspect of substance management.

One of the stronger aspects of the substance management program is relapse prevention, again an aspect of both CBT and DBT. For substance abuse, as with anger management, individuals are trained to identify high-risk situations and the discriminative stimuli that signal the approach of a high-risk situation, as well as coping skills (assertiveness, alternative behaviors, leaving the situation). CBT for spouse abuse also contains all these coping skills, the latter being covered by "time out" cards that list instructions to be followed when the client is angered (tell your spouse you are taking a time out, leave the house, do not drive or drink, walk until negative thoughts subside, remind yourself that you are angry, replace the negative thoughts with positive thoughts, repeat until calm, if unable to calm the self, call a 24/7 buddy). Substance abuse treatment also involves cue exposure where the client is exposed to a sight or smell of a substance without consumption. This is parallel to the role-playing of conflicted argument with the client's spouse in CBT for spouse abuse. Marlatt's outcome studies found that relapse was most likely in clients who lacked effective responses to high-risk situations (Marlatt, 1985). Recidivism is an obvious concern for spouse abuse treatment, with recidivism rates of about 21%, according to police statistics for an 11-year, nationwide follow-up (Dutton et al.,1997). The substance abuse treatment literature suggests that increasing role-play practice of conflict skills may be an effective method of reducing recidivism.

CBT for Psychopathy

No area of treatment outcome is more controversial than whether psychopaths are treatable, yet men with antisocial tendencies (some of whom may be psychopathic) are frequently mandated for spouse assault treatment (see Dutton, 1998). As Hare and Wong (2003) put it,

> The prevailing view is that the attitudes and behaviors of psychopaths are difficult or impossible to modify with traditional forms of treatment, intervention, and management. Indeed, many clinicians will not even attempt to treat psychopaths, and an increasing number of forensic institutions take the position that it is cost-effective to exclude psychopaths from their treatment programs. The reasons for the recalcitrance of psychopaths are not hard to find. Unlike other individuals, including most offenders, psychopaths often appear to suffer little personal distress, seem perfectly satisfied with themselves, see little wrong with their attitudes and behavior, and seek treatment only when it is in their best interests to do so, such as when attempting to avoid prison or when seeking probation or parole. It is, therefore, not surprising that they appear to derive little benefit from traditional correctional programs, particularly those aimed at the reduction of intrapsychic turmoil and the development of self-esteem, empathy, and conscience. (p. 3)

Several early studies suggested that psychopaths did worse after treatment (e.g., Ogloff, Wong, and Greenwood, 1990; Harris, Rice, and Cormier, 1991). However, Wong (2001) concluded that we actually know very little about the treatment of psychopaths. He noted that

most available studies were deficient in one or more of the criteria considered necessary for a methodologically sound outcome study: (a) The valid and reliable assessment of psychopathy based on clinical tradition and the work of Cleckley (1976) and operationalized in the Hare Psychopathy Checklist-Revised (PCL–R; Hare, 1991, 2003); (b) an adequate description of the treatment program; (c) an appropriate treatment evaluation with an adequate follow-up period; and (d) a suitable control group. Out of 74 empirical studies of the treatment of psychopathy, sociopathy, and antisocial personality disorder, only two met all criteria.

Losel (1998) believed some therapeutic success could be achieved with psychopaths in a highly structured "token economy" environment where acting according to the rules was in self-interest. However, most court-mandated treatment programs meet once a week and cannot provide this type of 24/7 structure. Mulloy et al. (2000) argued that these prior studies were unduly pessimistic as definitions of psychopathy varied from study to study and no longitudinal follow-up was done. They used a "multi-modal; CBT" program where the predominant treatment modality was CBT (Beck, 1996; Ellis, 1992) and emphasis was placed on the creation of a pro-social group norm and negotiation. Recent developments in discovering sub-categories of psychopath (Herve, 2003) also suggest differential treatability amongst the subtypes, with a category called a "pseudo-psychopath" emulating psychopathic indifference but retaining empathic capabilities.

How might assessed psychopaths (using the Psychopathy Checklist- Revised, PCL-R:Hare, 1991) be dealt with in court-mandated treatment? Hare and Wong (2004) have recently written a manual for correctional treatment of psychopaths. They stress focusing on (a) client's responsibility for own behavior, (b) necessity to learn more pro-social ways to function or (c) consequences of breaking the law (i.e., self-interest), and (d) that the client has strengths and needs to apply them to a lawful enterprise . Hare and Wong do not attempt to increase empathy/conscience, just to diminish violence and antisocial acts through therapy directed at showing the clients that it is in their self-interest to learn to behave in a more pro-social fashion. Also, the Hare and Wong model was designed for institutional treatment. It is not known whether this treatment would work effectively with an outpatient population treated for a few hours each week.

Treatment Effectiveness

The *d'* of .34 reported by Babcock, Green, and Robie (2004) is less than optimal for most therapeutic outcomes. The average effect size in psychotherapy studies is *d'* = .85, but it is substantially lower for court-mandated treatment. By comparison, the effect size of aspirin on heart attacks is *d'* = .41 (Davis and Taylor, 1999). By standards of court-mandated client populations, however, this is an average result. By expanding the focus of treatment in the blended model described above this outcome may improve.

In: Intimate Partner Violence Prevention and Intervention ISBN: 978-1-60456-039-8
Editors: A. C. Baldry and F. W.Winkel, pp. 147-176

Chapter 10

THE RESPONSE FACTOR: A PRACTITIONER'S TALE

Jane Katz
Registered Clinical Counsellor in British Columbia, Canada.

It has been well documented that a coordinated response which includes arrest, support for the victim, and mandated treatment for the offender is more effective than arrest alone at reducing relationship violence (Dobash, Dobash, Cavanagh, and Lewis, 2000; Pence, 1989; Steinman, 1990; Syers and Edleson, 1992). This is consistent with the general criminology literature that points to the important role that well-developed and implemented programs play in reducing criminal recidivism as opposed to punitive measures alone (McGuire, 1995). External sanctions and controls assist in the management of risk, whereas treatment programs help offenders develop an internalized set of sustainable risk management practices. The task for treatment providers, then, is to effectively address all three factors of the rehabilitation triumvirate: risk, needs, and responsivity.

Much has been learned over the past 20 years about assessing risk and identifying the needs of men who use violence in relationships. Responsivity, arguably the most critical factor for effective treatment outcomes, is increasingly gaining the attention it warrants. It encompasses both internal and external factors that impact a client's ability to benefit from, or respond to, treatment. This chapter will explore one of the most significant external factors: The therapist's response to client responsivity issues, or, put another way, therapist skills to see reluctance rather than resistance and to effectively manage that reluctance.

SOME HISTORY

In the mid 1980s, I was the supervisor of the only community counseling service in our small city. We occasionally received requests for counseling from men who were abusive in their relationships. Sometimes this was the result of an arrest and charge. More frequently, it was because the partner had left and refused to return unless the man received counseling. It was not unusual for the women to initiate the request. As the end of the 1980s approached, an increasing number of men were requesting counseling as a result of more rigorous arrest and charge policies in the province. What occurred in our community was paralleled throughout

the province and led to government funding of treatment programs for men on probation for spousal violence. In 1990, Dr. Zender Katz and I received funding from the British Columbia Ministry of Attorney General to develop and deliver a program in the Fraser Valley. The implementation of a zero tolerance "must-charge" policy in B.C. resulted in tremendous growth in the number of court-mandated men attending programs. Between 1990 and 2003, over 1600 men completed our program.

Our program had the following characteristics: psycho-educational, cognitive-behavioral, male/female co-facilitators in the men's group, intake interviews with the men, intake interviews with the partners, 24-hour crisis intervention (pager service), sixteen 3-hour sessions with the men, ten 2-hour sessions with the women, and follow-up interviews and follow-up sessions (once a month for 6 months.) Referrals came primarily from probation services, though we did have some "voluntary" participants. (The nature of "voluntary" will be discussed later in the chapter.) We were very involved in community coordination efforts with police, probation, crown counsel, victim services, women's shelters, and other agencies that dealt with victims or offenders. We also offered a Phase 2 program which was entirely voluntary and more attentive to the individual needs of those attending. Some individual work was also provided, although this was limited more to crisis intervention. We were one of the more fortunate contractors in that we also received funding to provide a concurrent program for the women partners. Occasionally we also provided couple counseling in the latter part of the program or post group.

In addition to the provincial work, between 1992 and 2005, I co-facilitated a 26-session family relationships program for federally incarcerated men, many of whom were violent in their relationships and a significant number of whom were convicted of spousal homicide.[1] Over 500 men completed this program. In recent years, I have been providing training for those who facilitate non-violent relationship programs for offenders in Canada and in Asia. As will become evident in this chapter, a significant focus of my interest is in engagement: getting people in the room, keeping people in the room, and finding ways to increase their receptiveness to learning and change.

During the1990s, British Columbia was an exciting place to be developing and delivering programs. Provincial government policies and funding not only supported the development of programs for men but also the implementation of Violence Against Women in Relationships (VAWIR) community coordinating committees. In addition, in 1989, a group of counsellors who were passionate about finding effective, ethical approaches in this relatively new field of practice came together to form the B.C. Association of Counsellors of Abusive Men (ACAM).[2] Guiding principles, based on existing knowledge of best practices, were developed. These principles endorsed cognitive-behavioral approaches, group work, male/female co-facilitation, victim contact, and coordination with criminal justice and victim services. These principles also reflected some important beliefs held by those present: Safety is paramount, violence is a choice for which there is no excuse, adults can learn and change, relationship violence is not simply an anger problem, modeling of respect and kindness is critical, and vilification of the man is not helpful.[3] In recent years, the organization's focus has extended to all relationship violence, not just that perpetrated by men in heterosexual

1 My work has also extended to the development and delivery of programs for women who have used violence in relationships.

2 Now called the Ending Relationship Abuse Society of B.C. (ERA).

3 These Guiding Principles are available through ERA's website www.bcera.ca.

relationships. An annual conference and annual general meeting continues to provide opportunities for facilitators and researchers from around the world to share their knowledge and skills.[4] It is in this environment of community and provincial support, shared learning, and passionate interest in effective, ethical treatment that we and others in the province developed and nurtured our programs.

The core elements of most programs for men who use violence in relationships were determined in the mid to late 1980s largely through the identification of common behaviors engaged in by these men and speculation about root causes. Through consultation with victims, the Domestic Violence program in Duluth, Minnesota, identified a constellation of common behaviors that seemed to precede or occur concurrently with physical violence, for example, threats and intimidation, verbal abuse that degrades or humiliates, control of finances, blame, use of the children, selective property damage, sexual coercion, attempts to isolate, harassment, and stalking behaviors. These behaviors suggested domestic violence was not simply the result of a man getting angry and lashing out with violence, but rather part of a systematic and deliberate attempt to maintain a sense of power and control in the relationship. This meant that simply helping a man manage his anger was not sufficient.

The Power and Control Wheel developed by the Duluth Program was a seminal piece of work that formed the basis of both risk assessment and the content of programs. Root cause theories tended to focus on social learning within a patriarchal family/society, resulting in a perceived need for programs to address attitudes and beliefs about roles in relationships. Skills deficits in communication, emotions management, empathy, conflict resolution, and problem-solving were identified as critical areas for attention. Awareness of the types of abuse, the effect of abuse, and the impact on children who witness abuse was considered to be lacking in offenders. Research suggested a cognitive-behavioral psycho-educational approach was most appropriate for offender treatment, and, thus, this approached was adopted for spousal violence as well (Gendreau and Andrews, 1990; Losel, 1996). All of these factors certainly influenced the initial development of most programs; however, over time, it became clear that these factors did not address everything that was required for program effectiveness.

In the early days, there tended to be a belief that most men who used violence in relationships fit a profile based on similarities in behavior. The power and control wheel, rather than being used as initially intended to help victims talk about their experiences, was instead used to stereotype the behavior of men and define program content. The assumption that followed was that treatment needs would be similar for all but a few rare exceptions. At the International Family Violence Research Conference in New Hampshire in the late 1990s, there was a marked uniformity of treatment approaches.[5] Despite this uniformity, and despite the fact that treatment appeared to have an impact, significant differences in the completion rates and outcomes of programs were, and continue to be, evident (Dutton, 1995; Edelson and

4 It is of note that the most popular session at the ACAM/ERA conferences was (and continues to be) the "Show and Tell" session where counsellors share their most effective strategies for engagement -- a reflection of the similar challenges practitioners face when doing this work and the desire on the part of those doing it to address responsivity. Much could be learned about responsivity from a qualitative review of these sessions.

5 There was also uniformity in research methodology which tended to be quantitative in nature, focus on recidivism, and provide little information about what was having the greatest impact in programs. In general, the research was of little assistance to a practitioner looking for more effective ways to engage the clients. It is this author's belief that increasing client responsivity in our program resulted from qualitative observations of responses to the material and ongoing qualitative inquiries with the men, their partners, and the probation officers.

Syers, 1991; Edelson, 1995; Gondolf and Jones, 2001; Gondolf, 2004; Healey, Smith, and O'Sullivan, 1998; Kropp and Bodnarchuk, 2001.) In addition, there is no treatment that stands out as most effective (Hanson and Wallace-Capretta, 2000). A focus on understanding differences in treatment outcomes resulted in the exploration of different typologies and differences in offender risk and needs. What is notably missing in much of the discussion is an emphasis on therapist skills and abilities.

Andrews and Bonta (1994) reported that for offenders in general "it appears that some approaches to treatment are better than others, and to some extent, the effectiveness of treatment depends on the type of client" (p. 286) -- an observation supported anecdotally by many practitioners of domestic violence treatment. This understanding resulted in a greater focus on matching offender risk and need to the appropriate treatment (responsivity). Despite the increased understanding of differing treatment needs, most court-mandated programs in B.C. (and throughout North America) were (and still are) subject to funding that dictates a "one-size-fits-all" approach. There is an expectation that these standardized programs will provide treatment for all men who are referred through the courts. Overlaid on this expectation is program accountability which is determined by completion rates and the impact on recidivism.

These conflicting realities (i.e., one-size-fits-all and accountability) have created stress for program providers. Some programs have responded by screening out clients who are identified as "resistant" based on denial and number and severity of incidences, often the ones most in need of treatment. Some have responded by increasing group size beyond what would allow for engagement of individuals in the room, in order to satisfy the funder's focus on numbers. Others have dealt with growing referrals, limited resources, and expectations of accountability by attempting to find creative ways to engage as many men as possible within a one-size-fits-all framework -- to become more responsive to the individual challenges presented by the clients. Given the realities of funding and time, the latter is where we need to focus our energies.

RESPONSIVITY: WHAT ARE WE TALKING ABOUT?

The term *responsivity* is relatively new in the field of offender treatment, in fact, it is not a word that can be found in dictionaries and frequently is highlighted as an error in documents.

> The responsivity principle is used to refer to the use of a style and mode of intervention that engages the interest of the client group and takes into account their relevant characteristics, such as cognitive ability, learning style, and values. In other words, responsivity refers to the extent to which offenders are able to absorb the content of the program and subsequently change their behaviour….Responsivity …is primarily concerned with therapist and therapy features, and is therefore essentially concerned with adjusting treatment delivery in a way that maximizes learning. (Ward, Day, Howells, and Birgden, 2004, p. ?)

As a concept for treatment, responsivity appears to encompass all of the external and internal factors that impact the offender's ability to "respond" to the program. There is a

lengthy list of items that have been identified as responsivity issues, all well known to program facilitators. These include the following:

- Cognitive abilities
- Learning styles/ disabilities
- Attitudes and beliefs
- Values
- Minimization, denial, and blame
- Lack of transportation
- Conflict with work schedule
- Substance abuse
- Transience
- Lack of motivation
- Literacy problems
- Disruptive or argumentative behavior
- Discomfort with behavior of others in the room
- Uncomfortable group space
- Unwilling to speak or participate in a group setting
- Personality
- Mental health issues
- Physical health issues
- Partner factors (e.g., her awareness, resolve, mental health, dependency)
- Limited or inconsistent enforcement by probation or the courts

In general, responsivity involves an interactive process between factors that challenge the client's ability to be present in mind and body and receptive to learning and the therapist's ability to address these factors. Since a client's responsivity is the reality of what he brings with him, responsivity then appears to pertain more to program factors (what, where, and when) and therapist qualities (who and how). Research suggests there are significant differences in the treatment needs of men referred to programs (Bodnarchuk, 2002; Dutton, 2003; Gondolf, 2002). Unfortunately, it is not uncommon for program therapists to ignore these realities and refer to men who are not complying or benefiting as "resistant" to treatment, a characterization that hinders creative approaches to engagement. Programs may screen people out or suspend them from a program once they have started, citing lack of motivation to change and asserting that the men cannot possibly benefit from attending.[6] Referring to a man as resistant suggests the program and/or therapist do not need to change their approach; it ignores the interactive nature of responsivity.

Screening out "resistant" clients is a logical response to anxiety. This is difficult work and the needs of the men are varied. It is also frightening work; therapists can't help but feel a sense of responsibility for the safety of others. The groups run in the community. The men have access to their partners. Many program therapists have had the experience of hearing that a man in the community has killed his partner and thinking, "Please, don't let it be one of my participants." For many therapists, the anxiety is reduced by only working with those who

6 This likely accounts for a considerable amount of variation in program outcomes.

will be most likely to benefit; whose responsivity issues are minimal. Anxiety and preserving a sense of competence can cause some therapists to "resist" certain clients in much the same way anxiety and preserving a sense of competence is also typical of participants who appear to "resist" the program. Anxiety is a critical factor in responsivity; attending to it is necessary for both clients and therapists.

While treatment effect has been demonstrated, albeit with varying results, there is emerging evidence that men who drop out of programs may be at higher risk of recidivism than those who never start a program (Jones, D'Agostino, Gondolf, and Heckert, 2004).[7] For this reason, it is particularly important to find ways to not only get men into the room, but also to keep them there. Rondeau, Brodeur, Brochu, and Lemire (2001) have noted that, among treatment variables, therapeutic alliance is the most significant factor in promoting program completion. A conceptual shift that can help therapists deal with responsivity issues and their own anxiety is simply to see the client as "reluctant" rather than "resistant." Focusing on reluctance allows for increased awareness of the emotional context (often anxiety) and leads to greater responsivity on the part of both therapist and client and increased therapeutic alliance.

MANAGING RELUCTANCE

It is very apparent that few men seek out programs of their own volition, likely for a variety of reasons: lack of awareness, feeling justified, a belief in their expressed conviction to "never do it again," and shame. In fact, it is often said that men who attend relationship violence programs are either court-mandated or partner-mandated to attend.[8] For this reason, program compliance and completion are challenges all therapists face. The term *voluntary* doesn't really apply to the majority of participants, and if one is looking to find resistance, it is easy to find.

When training facilitators, I always start by asking what concerns them most about working in these programs. The word *resistance* is quick to appear. When asked what resistance looks like, a long list of challenging behaviors is generated, in addition to the previous list of responsivity issues. A simple question is then posed: How would it change your interactions with the participant if you viewed this as reluctance rather than resistance? Very quickly people are able to identify differences in approach. The term *resistance* leads us to view people as concrete, aggressive, and stubborn. It often elicits a sense of defeat and concomitant defenses in the therapist. *Reluctance*, however, invites us to look at emotion, to see the anxiety behind the behavior. Resistance is associated with protection from something that the individual perceives to be negative and harmful. Resistance is wilful and concrete. *Reluctance*, in fact, is a more accurate and helpful term for the way most effective therapists think about clinical resistance.

7 There is much more research that needs to occur about these findings and what they mean. It seems to makes sense and one can easily speculate on the causes. Those who drop out are pushing away from the relationship with the therapist, the program, and all that represents.

8 We also occasionally received referrals from Child and Family Services. These men were typically parents of children who had been apprehended. Domestic violence was suspected or known to have occurred, but there were no outstanding charges or convictions. Attending the program was one of the requirements for access to the children.

There are four underlying principles of working with reluctance:

- Reluctance is rooted in anxiety and, as such, is a normal part of the change process. Expect it!
- Reluctance is not a participant shortcoming; it is a therapist challenge. It means that the therapist may not yet have found a way to engage the participant. The therapist may never find a way, but must at least be committed to trying. Embrace it! Learn from it!
- Coaching those who are reluctant requires skills we are trying to teach our clients -- empathy, respect, compassion, trustworthiness, responsibility.
- Therapists need to be aware of and manage their own reluctance.

People are not resistant to improving their lives. They are, however, often reluctant to engage in a process of change. When children are asked who they want to be when they grow up, they don't say "I want to be violent towards my wife. I want to push away the people I love. I want to be a criminal. I want my relationships to fail. I want to hurt my children. I want to feel shame. I want to go to jail." They want to be happy, and even children know this type of behavior does not make people happy. Men who use violence in relationships are not happy people. Therapists are attempting to provide something that would make their lives better; make them happier. There are few reasons a person would resist an opportunity to be happier. There are, however, many reasons someone might be reluctant to engage in the process for getting there.

What does reluctance look like? It can be loud. It can be aggressive. It can be sarcastic. It can be manipulative. It can be obsequious. It can be adamant. It can be pathetic. It can be logical. It can also be hidden. It is almost always fed by anxiety and four questions:

- How is this relevant to me?
- How will this help me?
- How is it possible for me to accomplish this?
- How can I stay safe?

Risk, needs, and responsivity all require an appropriate content and treatment model, but responsivity primarily requires the managing of reluctance. When a therapist sees or hears reluctance to engage, it signals one or all of the following is happening: The participant cannot relate to the material, cannot see how this will be helpful, is not confident about his ability to change, does not feel safe. The therapist must help the participant to find relevance in the material, recognize how change will be helpful, find ways to accomplish the goals of the program, and, most importantly, have a sense of personal safety in the room. Safety must also be recognized as a complex, multi-faceted concept. *Safety* refers to emotional safety, comfort, acceptance, and self-worth, as well as physical safety. The men in our programs act out in relationships when they feel powerless, out of control, and diminished -- unsafe. It makes sense that if therapists provide an environment where the men feel powerless, out of control, misunderstood, and/or diminished, the men will not move towards it with great relish, but rather put effort into finding a way to push away from it.

Every man is different. The men who are referred to programs range from those with wealth and status in the community to those who are homeless; those who have criminal histories to those for whom this is the first encounter with the law; those whose only use of violence is towards their partner to those who use it against others; those who have very pro-social attitudes to those who are very antisocial; those with no mental health issues to those with significant mental health issues; those who use drugs and alcohol to excess to those who don't use them at all; those who engage in frequent acts of violence to those for whom it has been an isolated event; those who have partners with significant issues to those whose partners present no confounding issues;[9] those with a great deal of self-awareness about the problem and a strong desire to change to those with no self-awareness about the problem and no sense of a need to change; those willing to accept responsibility to those who accept none; those with significant cognitive abilities which allow ease of learning to those very limited in these skills; those with pro-social skills to those with very few pro-social skills; those who pose little risk for future violence to those who pose significant risk. In addition, the person's place on any of these continuums may change during the program. Therefore, each man has the potential to feel and express reluctance uniquely at various stages throughout his change process. Regardless of how this reluctance is expressed, strategies must continue to be grounded in the modeling of appropriate skills that help the participant overcome anxiety and barriers to attending, feel accepted (the person, not the behavior), recognize relevance, identify benefit, and increase motivation and a sense of competence to engage effectively in the process.

Over time, it has been possible to predict some of the more common demonstrations of reluctance and incorporate exercises and interventions into programs to pre-empt some of its expression. In the space allowed, it would be very difficult to describe all of these strategies, but the remainder of this chapter will attempt to provide some examples of strategies and an approach that makes the generation of creative strategies easier. Addressing responsivity and building engagement requires curiosity about the individual and his story. Impersonal writing makes it difficult if not impossible to reflect the flavour of interactions between the therapist and the client which lie at the base of engagement and change, and, therefore, the remainder of this chapter will continue in a more narrative style.

THREE MEN: THREE STORIES

Max and the Lucky Question

Max (not his real name) was a man who attended the third program we delivered. This was a first charge, and, although he denied that he needed the program, he complied with the order to attend, primarily because he respected authority. He was Caucasian and of European descent. Max had been married 18 years to Lisa (not her real name) with whom he had four

[9] It is not uncommon for partners to have significant personal issues which, while not an excuse for the man's violence, can impact the man's responsivity. The women may have substance abuse problems, mental health problems, antisocial values, limited relationship skills, dependency, jealousy, low self-worth, verbally abusive and physically violent behaviors, and a lack of resolve about insisting on their own safety. This is not an insignificant issue and must be responded to in a way that does not diminish the man's responsibility for his actions, but recognizes the reality of the barriers to change.

daughters. He was very outspoken about his belief that the man is the head of the household. He was proud of his role as breadwinner and very clear that his wife's job was the cooking and cleaning and his was the making of the money. Over the years, his wife had begun to challenge the roles, and he had resorted to threats and grabbing and pushing to intimidate her. On one occasion, he had been drinking heavily and his violence escalated to hitting. His youngest daughter called the police. This was the incident that resulted in his referral to the program.

Max was living with his wife and daughters when he came into the program. He admitted the violence but minimized it and blamed it on the alcohol and the stress caused by his wife's behavior. He saw himself as a good guy and a good citizen who provided well for his family and the community, not a "wife beater." He said the arrest was sufficient, and he would not be physically violent again. By session four, Max was still quite vocal about his inability to find relevance in the material and was continuing to blame his wife for the difficulties, which appeared to be escalating again. That evening he wanted to prove to us how his wife's behavior had caused problems in the home. He told the group that he had just kicked his 15-year-old daughter out of the home because she was pregnant. He blamed his wife for the pregnancy, stating that it was evidence she had not done a good job of parenting and was too permissive. He wanted to set an example for his younger daughters and his wife that this behavior wouldn't be tolerated. During the conversation, I was feeling dismayed at the thought of what his daughter and wife were experiencing while, at the same time, attempting to engage him in some way. I asked him how he felt about the young man involved. He said, "Well, that's what teenage boys do. They try to have sex with girls. It was up to my daughter to say no." I responded with a simple question, "How have you taught the women in your house to say no to men?" He sat back and said nothing. The next week, his daughter was back home, and Max was clearly more engaged in the program. His wife indicated he was not complaining about attending and, over time, reported significant changes in his behavior.

Max was one of our true success stories -- probably the best story. As frequently happens in therapy, the story Max told remained in my memory, as did my emotional reaction to what he said, but the intervention did not. It was Max who later recounted that this was the turning point for him, the point where the program became relevant. Max's wife went back to school (something she had wanted to do for many years). His daughter had her baby, finished high school, and went on to college. She and the baby lived at home all that time. He voluntarily came into the Phase 2 group where he talked at length about his parents' and grandparents' messages about men being the "boss in the home" and how they had not served him or his family well. In the Phase 2 group, he was also able to deal with the feelings of regret he had over some of the choices he had made in his life.

I still run into Max and Lisa often. He looks much more relaxed than when I first met him, and he says that despite ups and downs, he is very happy and getting what he wants from life. This was a man with pro-social attitudes who loved his wife, loved his daughters, wanted to feel good about himself and that he mattered in the world and thought he was doing the right thing. He needed to see relevance in the program and to understand how change could help him. He also needed to be able to continue to feel good about himself. The question asked that evening helped with relevance. The program's philosophy of treating people with dignity helped him to deal with his embarrassment, and, once engaged, as with all things in his life, he wanted to do this well. He internalized all the beliefs and practices sufficient for maintenance: Violence had absolutely no place in his life.

It would be nice to believe we had 2,000 Maxes. Of course we didn't. When telling this story, it is interesting to speculate whether we would have been able to engage Max if his daughter had not become pregnant or if he had not been asked the question asked in that moment. Happily, with his permission, we are able to tell this story in groups to other men when talking about male privilege. It is amazing how often Max's story helps to engage others.

Jim and the Colored Shoes

Another story that is worthy of telling is about Jim (not his real name) who had a criminal history, difficulty maintaining employment, grade nine education, limited job skills, a history of fighting with other men, a history of violence with more than one girlfriend, and a pattern of drinking to excess. At intake, he said he had replaced his drinking with smoking marijuana because it kept him calm (not an uncommon admission by many of the men who attended our programs). He was separated from his girlfriend (who according to him had been unfaithful) and stated he didn't want anything to do with her. She had reported that he was following her and had threatened her new boyfriend. Jim denied this. He said he just needed to stay away from her and from alcohol and all would be well. He had started a new part-time job. He tried a number of things to get out of attending, including saying it would interfere with his employment, but ultimately he showed up the first night of group. He was clearly reluctant to engage in change. To our amazement, he not only became engaged but he also completed the program.[10] He was very positive about his experience and his learning but it was difficult to know how he had benefited because we had no feedback from a partner.

A chance encounter with Jim in the grocery store a few years later provided some fascinating information. He said he was in a new relationship that had lots of ups and downs but that he had been able to avoid any violence and tried to use the skills taught in the program. He also described an interesting risk management practice. Just prior to the first night of Jim's group, my co-therapist received a pair of bright yellow running shoes as a gift, and he wore them to the group. The men got a charge out of the shoes, so we bought him two more pairs (blue and red). He wore a different color each week and occasionally showed up with different colors on the left and right foot. Jim said that whenever he started to get upset, he would close his eyes and see Zender's shoes. Laughing, he said, "It reminds me I don't want to do anything that would make me go back to your group!", but went on to say that it helped him to calm down and remember to use some of the skills he had been taught. He said the shoes and the laughter the first night made him feel comfortable in the room -- that's what kept him coming back initially -- and then he started to enjoy the group and recognize we were talking about things that would help him. Again, not something that would work with everyone (likely not Max), but it helped to engage Jim.

A man like Max is likely to complete a program regardless of how he feels because he has been told he must do it. A man like Jim will be much less reliable about attendance unless he is quickly, and continuously, engaged in the progress. Like Max, Jim wanted to feel that he mattered in the world and wanted to be seen as unique and accepted. Jim didn't explore his

10 This meant attending 15 of the 16 sessions.

life in as sophisticated way as Max did and did not make such dramatic changes, but he internalized a risk management strategy that was working at that time.

Adam and the Signature

The final story does not have such a positive outcome for the client, but was positive in what it taught us about responsivity. Adam (not his real name) had been charged twice with assaulting his common-law wife of 10 years. He was given probation for his first offense and ordered to attend counseling as directed by the probation officer. The probation officer strongly recommended he attend the program, but Adam was unwilling. Adam had been unemployed for a couple of years and in the 6 months between the assault and ending up on probation, he had stopped drinking and managed to find a job that he feared losing if he attended the program. His wife reported that things were going well in the relationship and that she too was concerned about his losing his job. She was going to counseling and said she would not hesitate to ask for help if she felt concerned for her safety. As a result, Adam was excused from attending the program. About a year later, Adam was again charged with assault. As with the first assault, his wife did not require any medical attention, but this time the order was specific about attending the program. Adam tried to create the same argument with his probation officer about losing his job. When that didn't work, he said he would rather go to jail than attend a program and was adamant that he would not go. The probation officer pointed out that he was more likely to lose his job if he went to jail, but Adam insisted he wasn't going to a program. It was at this point we were asked to see him.

Adam was very hostile at the beginning of the interview. After much validation of his emotions and questions focused on getting him to think about how this response was helping him, he ultimately admitted he was worried about his ability to be a good father and husband and knew he needed help. He finally admitted that his fear in attending group centred on the fact that he was illiterate. He had managed to hide this from everyone in his life -- including at his workplace. He cried as he talked about it. He was terrified of being humiliated in the group. He had taken a risk to trust me with his story. Adam was told that many of our participants had literacy problems and out of respect for that, we did not do any written activities in the group. There were some pre- and post-questionnaires involved, but we opted for a modified oral version. With an increasing degree of comfort, he agreed to attend. We had created relevance and reduced his sense of anxiety in the interview.

Three weeks passed between the interview and the first night of group. Sufficient time goes by between interviews and groups beginning that it can be difficult to remember the names of everyone on the first night. We ask the men to print their names on a piece of paper so we will know who is there for the purpose of reporting back to probation the next day. We specifically ask them to print so the name will be legible. As is often the case, on this night someone signed their name with an illegible scrawl. I held the list up to the group and asked whose signature it was. No one responded. I counted men and signatures and the numbers corresponded so I asked again. At this time, Adam stood up, pushed the table in front of him, swore loudly at me, and stormed out of the room. I immediately realized what had happened. I followed him out the front door of the probation office and one of the probation officers followed me. We called him to stop and finally he did. He was very angry, and he said, "You did that on purpose to embarrass me." I apologized. I explained that I didn't realize the extent

of his challenge with writing and that it hadn't occurred to me it was his signature. He seemed to accept the explanation but was still very upset and said he wouldn't go back into the room.

We called his wife to let her know what happened and that he was on his way home. Although he appeared to have believed me, we were concerned for her safety. She called us back after he got home to say everything was okay, but, in the end, we could not convince him to come back to group. He believed all the men would know and would judge him. The probation officer arranged for some individual work with him, and he was responsive to this; however, had this not been available, it is difficult to know what would have happened to this Adam.

This story reflects the importance of never becoming complacent about responsivity issues. I was aware that the posturing of men who are refusing to attend is often rooted in anxiety and fear of being embarrassed. I was aware of how often illiteracy will lead men to say they don't need treatment. I was aware of the need to create relevance and safety. I thought we had attended to all of that prior to the group but, in one brief moment, did something that destroyed the fragile foundation of safety that had started in the interview and that we hoped to build on during the group.

When dealing with responsivity issues, no two people are the same, and, in a one- size-fits-all program, we need approaches that will meet the relevance and safety needs of as many people as possible. We learned from Adam, and we built into subsequent groups a different process for getting names on the first night. This truly reflects a qualitative action research approach for on-going program development most simply described by Stringer (1996) as "look, think, act."

It would be entertaining to continue to tell stories about the men who have taught us so much, but the message is that one can never be sure what will engage people, or, as in the case of Adam, disengage them. There is a philosophy that helps us to find interventions that will make it more likely we will engage participants. We typically refer to this as "Be Nice. Be Curious. Be Committed." It not only engages clients in group, but teaches the men the skills for engagement in their own relationships. It is what helps us to move beyond empathy to a truly compassionate approach that will bring out compassion in others.

PHILOSOPHY OF ENGAGEMENT

Engagement is the process of building an effective and committed working relationship with the participant, also referred to as *therapeutic alliance*. As stated earlier, this helps to keep the men in the room. External sanctions (partner or court) bring them to the door. Without engagement (with the therapist and the material), it is unlikely they will attend, complete the program, or benefit from it.

For some reason, our programs had a high completion rate for those who started (80% in the community; 98% in the prison.) The only factors that would lead us to screen a man out of the program were psychosis, serious substance abuse that resulted in an inability to be sober for group, or being an untreated sex offender. Participants would only be suspended if they did not show up; in the community groups, they were allowed to miss one session, and, in the prison, two. Frequently, they did not miss any. I believe this success derives from a combination of three things: a firm belief in the importance of maintaining dignity, a belief in

the positive purpose behind behavior, and a desire to overcome obstacles and do the best job possible when given a task (driven by fear of incompetence of course.) This is the "Be Nice. Be Curious. Be Committed" philosophy around which we framed the program. A fourth reason for this success is that I want to enjoy what I am doing -- to have fun -- and this is possible. Finally, there is a fifth: being blessed to work with two wonderful co-therapists.[11] Together, we try to model the relationship skills we are trying to teach.

Be Nice

From the earliest days of our program, my co-facilitator, Zender Katz, would say to the participants the first night of group, "We could send you all home tonight if you simply remember two words: *be nice*." Of course, he would then go on to explain how difficult this can be. It doesn't mean becoming a doormat or being phoney, but rather it means finding ways to always maintain dignity, our own and others', while attempting to get our needs met during difficult times. It means creating an environment, and insisting on an environment, that is emotionally and physically safe for self and others; being kind, being caring, being compassionate.

Being nice means that we always treat the men with dignity and respect, and we expect the same from them. In fact, our definition of *violence* is any attempt to impose our will in a way that denies dignity. We set the bar high. We acknowledge that there are times when we might need to impose our will on others (parenting, workplace supervision, stopping someone from doing harm to self or others), but that we can always do it in a way that maintains dignity. The men are in the program because the court has imposed its will on them; however, program providers must be committed to maintaining the dignity of participants and invite participants to call them on breaches of conduct. It needs to be expected that, at times, the participants will breach this conduct. This is the reason they are in the program. Client behavior is not a reason for therapists to respond in kind or suspend the participant from the program, but rather an opportunity to use skills to help participants work through what is happening for them in that moment and to keep them in the room.

Being nice means creating a program that takes into account the challenges some of the men face in attending the program. It means attending to emotional safety and practical difficulties like transportation and literacy. Groups need to be offered at times when the men are more likely able to attend and some choice of time and location needs to be provided.[12] Although it is important to provide handouts, it is important to run groups in a way that meets the needs of men who are illiterate and/or anxious about attending a program that might revive unpleasant memories of school failures. Concepts must be kept simple and questions

11 Male/female co-facilitation is a tremendous opportunity to demonstrate respectful interactions. It can also negatively impact the program if the relationship between the co-facilitators is not one of equality and respect. Recently Zender and I provided some training in Japan, and we were told by some participants that the most significant part of the training was the relationship that he and I modeled. We have also been told this by the men who have attended our programs.

12 In our program, groups were offered either in the evening or on the weekend. Men were given the choice which cycle they could attend. In addition, if they were prepared to travel, they could attend a group at a different time in another community. Much like children, adults are more receptive to things they don't really want to do if they perceive they have some control over how it is done. "Do you want to take your medicine with juice or with milk?"

encouraged. The environment needs to be safe for the men to speak and practice skills; it must take into account public speaking and public performance anxiety and anxiety about humiliation.[13] If processes that lead to humiliation and shame have no place in a relationship, they also have no place in a group about relationships. They do not help to engage people.

There is a commonly held belief that programs for offenders must encourage the men to disclose publicly to others in the group what they have done to their partners. This appears to be rooted in a belief about denial -- that until offenders admit what they have done, they will not change. Though it may seem logical that someone needs to admit there is a problem in order to decide to change it, there appears to be no research that supports the notion that making a man describe aloud what he did will lead to change. In fact, many men who were very reluctant to attend the program admitted they did not want to talk about what they had done to strangers, and they were worried about being judged and humiliated. The work needs to be done in their brains, but since we don't have access to what is going on in those brains, we ask people to say it out loud. This seems to be the only reason to have the men describe what they did aloud. The problem is that anxiety and fear of rejection can lead to defensive responses. In addition, they can also lead to someone saying what they think the therapist wants to hear.

It can be helpful to point out to participants that their dignity will be maintained in the group, and they will not be asked to share anything that would cause them to feel shame or humiliation in the group. At the same time, in order to be nice to themselves and care about themselves, it is important they at least admit to themselves what they have done and what needs to change. Asking the men to keep a record of and occasionally report on a scale of 1 to 10 how much they are minimizing, denying, or blaming in their comments and in their thoughts can break down the defenses raised by fear of rejection and humiliation and free the brain up to accept the new information and think about the impact of past behavior. The work needs to be done in their heads because ultimately that’s the only tool they will be taking with them. If they are being honest with themselves about their own behavior, it will become evident in group discussions. With no pressure to disclose, men often do it anyway as they start to feel more comfortable. There is another issue around the process of disclosure that many therapists don't consider, however, and that is whether it is maintaining the dignity of the victim. In talking about his behavior aloud to a group of men, he is also sharing his wife’s story, and she may not want it shared with others. Therapists frequently forget this part of the picture. Being nice is remembering the victim -- in spirit, always keeping her in the room and keeping her there safely and respectfully.

Being nice involves bringing laughter into the process and providing some entertainment. My co-facilitator in the prison groups, Larry, is a competent and humble juggler. He sometimes teaches the men to juggle in the first session in order to explore the challenge of learning something new. Some would be competitive, some would refuse to try, and some would get easily frustrated and stop. Some would ask questions and have fun. It provided an opportunity to talk about the importance of play and having fun. It was also a good metaphor for approaching new learning in the program and provided the opportunity to explore thinking that creates barriers to new learning. Finally, it was a good place to explore the importance of

13 Apparently people fear public speaking more than they fear death. As Jerry Seinfeld says, “That means we’d rather be the person in the coffin than the person doing the eulogy.” Talking about this to the men at intake eases their concerns.

appropriate laughter in relationships and how people can talk about difficult topics and still find a way to laugh together. Laughter is a tremendous tool for defusing anger and anxiety.

Being nice also means providing nourishment and a comfortable space in which to learn. Providing food and coffee can be incentive for some men to attend. Although it is not always possible to have control over the group space, it is important to make it as comfortable as possible. It is amazing how many groups are run in rooms where there is no ventilation, where participants are crammed in like sardines in order to meet number requirements, and where they are expected to be alert and engaged for 2 hours or more. At one time, we were starting groups with more men than the space comfortably allowed. An interesting thing happened when we moved to a larger room. We had fewer dropouts. Much like goldfish grow or shrink to the size of the pond, -- so it is with group size.

Finally, and most importantly, being nice means not stereotyping; not seeing them as bad or wrong, ill or weak. We are more likely to engage with a process when we feel accepted and also when we feel our uniqueness and potential are recognized. It is always possible to accept the person and his emotional experience, while not accepting the behavior. If we don't confront problematic thinking and behavior, we are not being nice to either the victim or the offender, and neither will be helped. If we don't confront it in a way that maintains dignity, however, we will build walls, not connections, and we will not be modeling how to continue to look after the relationship during stressful times.

Be Curious

Curiosity stems from a belief that behind all behavior is positive purpose, that is, a need for safety, self-worth, happiness, comfort, and competence. Every person wants to feel special and important in some way, -- to believe that they matter in the world. Ward (2002) has developed a Good Lives model which suggests that all of us live our lives in search of some primary goods -- in particular, happiness -- but some of the strategies we use to get them actually preclude the attainment of these goods. This concept is similar to that of Aristotelian *eudaimonia* (our innate desire to be happy and to flourish), which only those who were virtuous would acquire. It seems humans have been struggling with this for a long time. We may all have the same positive purpose but not follow a path that leads to the desired outcome. It can be very helpful when working with offenders to get curious about what motivates behavior that is not helpful. It is also an important skill to model for working out problems in relationships. Growth comes from continuing to be curious about what is going on within us and around us. Relationships grow when those in the relationship continue to be curious about what is going on in each other.

Curiosity is the ability to ask questions that help us to think, to think about our thinking, and to confront our thinking. This is a process that many people have not fully developed by adulthood. Finding a good question and giving people the time and space to think about their answer will encourage meta-cognitive processes. The question Max was asked challenged a fundamental belief and created some cognitive dissonance. The space provided after the question was asked allowed for time to think about his thinking. Had he been pushed to say what the therapist wanted to hear, the impact would have been lost. Intense emotion can lead people to stop being curious and to grab on to deeply held beliefs. It is helpful at those times to ask a curiosity question to move people out of the emotion and into a meta-cognitive

process. A favorite question in our program is How does your thinking (or behavior) help (you, your relationship, to keep you safe, to improve your life)?

Curiosity is also the ability to wonder about what is going on for someone else. Frequently the men in the program will tell stories that support their point of view. If this story involves another person, particularly their partner, the question the therapist will ask is "If your partner was here telling the story, how would she tell it differently?" "What does it mean that her story is different from yours?" In relationships, individuals frequently stop being curious about each other, particularly during stressful times. It can be helpful to participants to acknowledge that this can happen and then to strategize ways to remain curious during those times.

Curiosity keeps us engaged. Jim's experience with the coloured shoes, the cognitive dissonance between what he anticipated group sessions would be like and his experience the first night, created curiosity that brought him back to the first few sessions. A good mix of questions, stories, exercises, and information that were relevant to his experiences and helped him identify his positive purpose kept him coming, kept him thinking, and promoted change. Therapists need to continue to be curious to come up with effective strategies that will promote engagement. This needs to start with a basic belief that everything the participants are doing has a positive purpose, that is, they believe it will help them in some way, followed by the use of questions to help the client identify the purpose and whether certain thinking and/or behavior is more likely or less likely to actually be helpful. Curiosity is an extension of being nice and springs naturally from a commitment to finding effective treatment.

Be Committed

Relationship strength and stability requires commitment both to the other person and to principles that maintain the connection. Applying this to the work not only models what therapists want participants to learn about relationships, but also keeps them focused on finding strategies that will engage participants in the learning rather than on finding reasons to say they are resistant to treatment. It keeps therapists focused on what is happening in the room and builds commitment from participants.

What's in it for me? is a critically important question the men need addressed in order to build commitment. The goal of programs funded by the courts is to stop the violent behavior and, thus, success is often measured by recidivism. Men frequently feel that their place in the program is all about helping others and has nothing to do with their own needs. It is more likely that by helping the men reach beyond the goal of stopping violence to the goal of a better life, they will attain the goal of stopping violence and also more likely remain engaged and committed. Asking someone to stop a problem behavior is less likely to lead to engagement and change (particularly if that behavior is being reinforced in some way) than inviting him to engage in a process whereby he will gain something of value. Maintenance is more likely to occur when the problematic behavior simply has no place in the beliefs and values to which the person has committed. For this reason, it is important that programs target more than simply stopping violence. Men are unlikely to be motivated to stop violence and abuse toward their partners if they are resentful and blaming, but they are usually willing to work towards having a good life and better relationships. Because violence and abuse have no

place in good relationships, learning how to have better relationships means stopping the violence and abuse.

Commitment means using the intake interview and the early stages of the program to build the relationship, rather than to confront behavior. It is common for men to express hostility in an intake interview, minimize their behavior, and blame their partner. Some therapists believe they must start challenging the man at this point, rather than using the opportunity to hear as much as they can about how the man is thinking and then working to engage him in the group process. This is the time to build engagement and trust that the program will look after the rest. A man's statements at intake may reflect what he really believes or it may reflect his anxiety and sense of shame. Either way, the job is to engage him in the long-term process.

As mentioned earlier, many men fear they will be humiliated in group in some way. Many are ashamed of their behavior and don't want to be labeled as a "wife beater." Many men believe they are not criminal, but that the other men in the program are, and they don't want to associate with criminals. Some truly do believe they are not the abusive one in the relationship (and in reality this is sometimes true). Rather than being hostile, participants can also deal with the same feelings and beliefs by calmly trying to convince the therapist that there are no problems. This starts to unravel when the therapist does not respond by agreeing that they don't need to attend. It should not be a surprise that men who deal with difficult emotions and feelings of powerlessness, and have learned to use violence and aggression to overcome feelings of powerlessness, become aggressive in the interview when those feelings are elicited. There are a few important points to remember about building commitment:

- Every encounter is an opportunity for engagement to occur, but the first encounter is significant.
- Every encounter is an opportunity to model relationship skills.
- Engagement, like all healthy relationships, requires a foundation of safety and trust. Acknowledge emotions, be clear about expectations, and maintain dignity.
- Empathy, respect, and maintaining dignity is not agreeing or colluding and is essential for creating engagement.
- Clinical confrontation is more effective (and safer for the therapist) when a relationship has been built. Timing is everything. Trust that the program material and process will do a lot of the work.
- The safer the environment, the more the client will talk and the more the therapist will learn about the participant's risk, needs, and responsivity factors.
- Creating relevance is critical to responsivity and commitment.

STRATEGIES FOR ENGAGEMENT

Over the years, a number of probation officers have described how wonderful it felt when their clients thanked them for insisting they attend the program. It was certainly music to our ears too. We went to great lengths to cover information and skills that were beneficial and to find exercises that would promote relevance.

Useful Concepts

One of the concepts we brought into the programs in the late 1990s was emotional intelligence. As a framework for programs, it works very well: self-awareness, self-regulation, motivation, empathy, and social skills. This concept was discussed at the first session along with its relationship to life success, not just relationship success. This was of tremendous interest to the men in the programs and provided them with the sense that the program was not just about don't hit your wife but, rather, about concepts that could be of benefit in their entire life. This topic is also included in training, because engagement requires emotionally intelligent facilitation. This topic warrants a chapter in and of itself, and therapists are encouraged to explore the topic of emotional intelligence and discuss it with participants. It can be useful for goal setting and for a framework for progress, not just for domestic violence but for any program for offenders.

Another concept critical to the program is compassion and a normalization of conflict and differences. It is acknowledged that relationships are very difficult and that there is always potential for invitations to conflict. It is a mistake to assume that men who engage in hurtful behavior during an argument are blind to how it makes their partners feel. In fact, they very often know exactly how their partner feels. The problem is that in that moment, they don't care. Empathy is the ability to identify how someone is feeling. Compassion is the ability to care about how that person is feeling (Katz, 2001). It is the ability to focus on maintaining emotional and physical safety of self and other. Compassionate people can continue to care about someone throughout the conflict and act in ways to ensure the relationship (and everyone's dignity) remains intact at the end of the conflict. The only way to teach someone compassion is to be compassionate in our interactions. This is why maintaining dignity is so important, as well as curiosity and commitment, and respectfully challenging the man's belief that violence and attempts to control others will somehow help him stay emotionally and physically safe.

A third concept that is part of our program is that we are not there to take away participants' power, but, rather, to help them replace negative and fleeting ways of gaining a sense of power (that they matter in the world; that they are secure, that they are competent) with more effective and enduring strategies. We refer to violence as "plundered" power (along with a lot of "P" words for other types of power that are not helpful in relationships such as "power by proximity," "pity power," and "pretend power") and focus on the benefits of building personal power (Katz, 1998). The emotional intelligence competencies fit nicely into a personal power framework.

A fourth concept is that it is difficult to give to someone as an adult what we didn't get as a child. A foundation of safety, trust, skills, and self-worth necessary for personal development is also necessary for relationship development. The program promises to help the men identify both strengths and gaps that will help to not only build their relationship foundation, but also their personal foundation for a successful life. The modeling of this foundation is important in building the engagement in the group. As with Adam, the men can be very sensitive to environments that are unsafe because of their childhood experiences and their own fragile foundations. Therapists need to focus on safety first in order to build participants' trust in the therapist and the program, a willingness to learn new skills, and an appropriate sense of self-worth and self-confidence.

Useful Exercises

Years of experience have resulted in the development of a number of exercises that have proven helpful in teaching men difficult concepts or in moving them beyond reluctance. The development of these exercises usually starts with the spontaneous use of a metaphor which has been helpful in challenging thinking. This metaphor is then deconstructed into a series of questions which can be used in the group to help lead other men through a process of challenges and conclusions created by the metaphor.

Connecting – maintaining. It can be helpful to start a program by pointing out the positive skills the participants bring to a relationship, as well as the fact that they have all been loved by spouses. They all have skills that made it possible to get into a relationship. The men are asked to identify skills used to initiate a connection (there is usually a lot of laughter through this process) and then to identify skills for maintaining a relationship. The differences between these skills are quite obvious. We refer to this as the difference between sales skills and service skills.[14] Some men are very good at the sales skills but have a great deal of difficulty with maintenance.

We then ask for behaviors that get in the way of maintaining a relationship.[15] These are referred to as isolating behaviors. This information is then all placed into a cycle of violence concept, along with the emotional context at each stage. The honeymoon stage is simply a return to initiating the relationship, something they know how to do. The build-up stage of the cycle reflects their lack of maintaining skills and ultimately leads to the explosion stage of the cycle of violence.

This process of focusing on behaviors that isolate men from others as opposed to behaviors that connect men to others becomes a theme throughout the program. A man may not be ready to admit that calling his wife a bitch is abusive, but it is difficult for him to argue that it is connecting behavior. When a man is asked, "Is it more likely to harm or help?" or "Is it more likely to push her away or bring her closer?", the answer is clear. The terms *more likely* and *less likely* have tremendous power. Most men are looking for guaranteed outcomes to new behaviors and are quick to point out why something won't work for them. Focusing on more likely and less likely is more realistic and builds engagement. During this process, a myriad of abusive behaviors can be discussed. It is unlikely that there will be a man in the room who cannot relate, and admit, to some of the behaviors.

A topic that is almost always raised in the discussion of initiating, maintaining, and isolating behaviors is sex. It is then that a brief discussion about the impact of power imbalances and abuse on sexual desire is relevant and helpful. It is very common for men in

14 This approach arose while working with a man in prison who had been in eight different relationships and had children in half of them. His crime was fraud. He insisted he had great relationship skills because he was on good terms with all of the mothers and the children, and he denied any use of violence. The metaphor arose spontaneously as I grappled with a way to challenge him. The metaphor was his bike shop, and it was pointed out that he was great in the sales department but not so good in the maintenance department, followed by a discussion on the likely longevity of his store if he was the only employee. It worked so well in creating relevance for him, and the entire group, that it became part of the program.

15 We hear a lot at this time about what they blame on their partners. Even though one of the group rules is "no blaming others for our own behavior," we respond to statements like "my wife's drinking gets in the way of this" by saying "so that's very difficult isn't it? When someone in the relationship is drinking too much it can certainly get in the way of having a good relationship," rather than challenging him on his blaming. We are likely to then ask, "How do you respond when she drinks? Is that something that helps to maintain the relationship or is it something that increases the isolation?"

domestic violence programs to have partners who have lost interest in sex. This often helps to feed jealousy and the cycle of feelings of rejection, increased violence, and increased withdrawal and loss of desire on the part of the victim. Verbal abuse also often takes the form of criticizing the woman's physical appeal, and this is very hard to undo. Sexual intimacy is something that many therapists are reluctant to address in programs, yet it is a central element of the dynamics of violence in relationships and very important to the men. Talking about women's loss of sexual interest in the first session not only generates conversation and motivation from the men but also demonstrates the therapist's comfort with the discussion. They readily acknowledge that the behavior they use in the relationship now would not have helped with sexual intimacy when they were initiating the relationship.

A focus on identifying strengths and areas for development (i.e., maintaining skills) makes a great deal of sense to participants and identifies the challenges involved in keeping a relationship going.

Rustling in the bushes. Another exercise we developed that is extremely useful is called "Rustling in the Bushes." In this exercise, we are attempting to create an understanding of the impact of violence and why it takes their partners a long time to get past it. The men are asked to think of a time when they were violent towards their partner. This might be physical violence, threats of violence, or other intimidating behavior. They are then asked, "Imagine your wife was walking down the street one day, a street she walked down often, and suddenly a man jumped out from behind the bushes and did to her whatever it was that you did to her -- yelled, grabbed her, slapped her, threatened her, pushed her down. How do you imagine she would feel?" The men are quick to say "frightened." They are then asked, "Suppose she came home to you and told you what happened. What would you do?" The answers range from comforting her, to going to find the man, to calling the police. This is followed with the question, "Often with things that traumatize us, we have difficulty forgetting about it. Let's say she woke up in the night and was having a nightmare about what happened. What would you do?" Most men say they would try to reassure her she was safe and provide some comfort. Finally they are asked, "One day she decides she wants to walk down that street again. As she is going past the bushes, the wind blows and the bushes start to rustle. How might she react?" Most say she would be afraid, even though the bushes pose no threat.

It is easy to see where the exercise goes after this. The discussion returns to the initial behavior and a reminder that they were asked to imagine someone doing to their partner the same thing they have done. Their responses about what they would do to another person are compared to what they believe was an appropriate response to their own behavior. They are asked how they respond when their partners bring up what they did (most get angry and say something like, "I said I was sorry. When are you going to forget about this?"). They are then asked to identify behaviors they engage in that "rustle the bushes" (such as their response to her bringing up past abuse). Things that did not cause concern prior to the incident may now elicit much fear.[16] They are finally asked the question, "What is harder to get over -- an incident involving a stranger or a similar incident by a loved one?" Most men simply have to

16 One man in our group couldn't understand why his wife continued to be afraid of him. He was in the Phase 2 program and had done a lot of work and was committed to being non-violent. He was a body-builder, and, one night, he wore a muscle shirt to group. He was asked if he dressed this way at home and answered, "All the time." So, grasping at straws, it was suggested that maybe the man should try covering up his arms at home to see what would happen. He reported a couple of weeks later that his wife told him she was feeling more comfortable. Neither she, nor her husband, was aware that the arms were rustling the bushes for her.

look at their own childhood histories to know the answer to that. "Home is supposed to be the place we go to get away from the frightening people on the street. Where do we go when home is not safe?" This is a powerful exercise for building relevance, understanding, and commitment.

Good boss – bad boss. The last exercise that will be described is one that was developed in response to characteristics of the community in which the program was delivered. At the time the program began, there was a large military base in the community. This is also a community with a very strong fundamentalist Christian population as well as a large immigrant population from countries that support patriarchal beliefs about men's and women's roles. It was not uncommon to encounter situations where both the man and the woman believed the man was the head of the household. Discussions of equality did not tend to go very far. Program therapists don't have the right to change religious and cultural beliefs; neither are they likely to be effective if they try to do so. What is important is that therapists find a way to work within the confines of these cultural and religious beliefs. The following exercise is another one that arose spontaneously in the second year of the program during an attempt to challenge the thinking of a participant. It is named the "Good Boss/Bad Boss" exercise, and it became a main staple of the program.

The session begins with the therapist saying, "Tonight we're going to talk about stress in the workplace since many of you have suggested this is something that contributes to your relationship difficulties." The men are then asked how many are currently happy in their jobs and how many are not. Some general information about the reasons for their satisfaction or dissatisfaction is gathered. Then the discussion zeroes in on the boss. "Often how we feel about our work depends on our boss. How many of you have worked for someone who has been unpleasant to work for?" It is common that most men will acknowledge having worked for someone unpleasant. A brainstorming procedure is then used to generate a list of "bad boss" characteristics. Often the responses are spontaneously provided, but sometimes the therapists need to coach the men to elicit some responses. The men may be specifically asked questions about whether they have worked for someone who didn't care about their safety. The men are readily engaged in this discussion. They love to tell the stories and talk about work. These characteristics always look remarkably like the list of abusive behaviors in the home, but it is important that the therapist not make this connection just yet.

The men are then asked, for purposes of comparison, how many have worked for a really good boss. The previous procedure is used for eliciting characteristics. The topic then turns to stress, and the men are asked, "For those of you who have worked in this bad boss environment, what effect does working for this type of boss have on you?" The men talk about increased substance abuse, lack of loyalty, low productivity, depression, anxiety, accidents, health problems, and a desire to quit. This leads to a discussion about self-care for those working in an abusive environment and the option of leaving. The impact of feeling pressure to stay for financial reasons is explored, along with a discussion about feeling trapped and powerless. The men are then encouraged to compare this with how if effects people to work with a good boss. They are then asked, "How would an emotionally intelligent boss operate in order to be successful?" To the question that follows, "Does a boss have a right to treat you badly?", there is unanimous agreement that, in fact, a boss has a responsibility to treat the staff positively. Even when firing an employee, a boss has the responsibility to maintain dignity.

This discussion is followed by asking, “Why are we talking about this in a program about family violence?” It doesn’t take long for people to make the connection (some already have) that home is just another work environment. Another discussion is initiated with the question, “If a man is acting in all the ways that a bad boss acts, what impact does it have on his wife?” It makes sense that she would be waking up every day wishing she could quit. The therapist connects the impact to the way the men identified feeling in an abusive worksite -- particularly to the experience of feeling trapped, powerless, and anxious. It is then applied to children: "How does a child quit a family when one or both parents are being a bad boss?" In addition to making the same emotional connections, connections are made between their comments about hyper-vigilance and an inability to concentrate in the abusive work environment and attention deficit in their children.

The exercise is ended by saying, “Our job is not to tell you that you are wrong in your beliefs about the man being the head of the household if both you and your partner hold that belief. As head of the household, it is important to remember you don’t have a right to mistreat people, you have a responsibility to make sure they are treated well. Otherwise, don’t be surprised if they find a way to directly or indirectly quit the relationship.” This also allows for those in the group who don’t have this belief to identify that by engaging in the negative behaviors they are acting like a boss, and a bad one at that. It is unnecessary to point fingers or accuse anyone in particular. The exercise is wonderful for increasing engagement for all. Following this exercise, it is often useful to return to a discussion about self-care in abusive environments.

Dealing with Substance Use

The involvement of substance abuse, particularly alcohol, in domestic violence has been well documented. Estimates of concurrent use of violence and alcohol range from 25% to 60%, and "use" does not imply a drunken state. Abuse of alcohol and drugs contributes to risk and can be a significant barrier to treatment effectiveness; however, it is currently a generally supported view that alcohol does not cause violence. It is important that alcohol and drugs not be used as an excuse for violence. Pernanen (1991) found that the average amount of alcohol consumed prior to a violent episode was only a few drinks, which suggests that the alcohol is used as a socially endorsed excuse. Choices are made under the influence of alcohol and drugs about the nature and location of the violence.

Men in our program are reminded that liquor stores have bottles of gin, vodka, and rye; they do not have bottles of "Good Old Hit Your Wife" or "Good Old Rob A Bank" or "Good Old Sexually Assault Someone." If it was in the bottle, then everyone who drank it would do it, and every time they drank, they would do it. This is a reminder that beliefs the men have when sober influence the choices they make when they are drinking. Most men will acknowledge that if they didn't think about sexually assaulting someone or robbing a bank when they are sober, they would not do it drunk. The same is true with domestic violence. The issue remains one of responsibility and choice. There may be overlapping issues that lead men to engage in violence and to abuse substances. It is not uncommon for men to complete a program without ever talking about substance abuse and at the end report they have stopped drinking or using drugs. A focus on building a better life and better relationships seems to lead to healthier choices.

Program Content

Along with these exercises and concepts, the "thoughts/feelings/behavior" associations are explored and emotions management skills are taught as well as communication and conflict management and problem-solving skills. Simple and easy skills for having a safe argument are provided, for safely and respectfully responding to (and defusing) their partner's difficult emotions and behavior, as well as strategies for self-care. There are also discussions about the nature of abuse, jealousy, family of origin, sexual intimacy, financial management, and parenting. Men in these programs are particularly motivated by the impact their behavior is having on their children. The content and the exercises are important, but the strategies described are the ones that increase engagement, and they don't take a lot of time. Men are reminded at the beginning of the program that good relationships are not about whether we love someone, but how we treat that person in all of our encounters with them, particularly when they are in our face, doing and saying things that are not helpful or easy to take. It is important that when participants are in the therapists' faces, saying and doing things that are not helpful, that effective and appropriate skills are modeled.

Some Specific Responses to Reluctance

Initially it is quite common for men who are court-referred to try to get out of taking the program using a variety of strategies or to try to get permission to miss sessions. It is important for therapists to validate their experience and attempt to identify and deal with any reluctance or responsivity issues. If the man continues to be unwilling to attend, the therapist can use a variation of the following statement to be clear about the man's situation if he is court-referred:

> The judge has ordered you to attend and in order for us to say you have completed you need to be present in mind and body. I understand that might create some difficulties for you, but I am bound by this. It is always a choice for you to go back to the judge to have the order changed or to choose not to come and deal with the consequences with the court. Typically the courts are not happy when people don't comply with an order, but that might not happen in your case. In the meantime, it is important to see this as a court-imposed sanction, much like jail or a fine. The court doesn't usually ask if, how, where, and when you would like to go to jail. The same is true for the program. We try to do our best to make the program helpful to you and enjoyable because I also want to enjoy our time together. I trust you to make the decision that will be most helpful for you.

Sometimes men do not recognize how the program will be relevant to them, particularly if the physical violence was a relatively isolated incident, resulted in minor (or no) injury, and they were otherwise very pro-social in their behaviors. Finding common ground helps men to find relevance in the program. Some statements that help are the following:

> Some people have difficulty believing they belong here and are not sure how the group will help them. Everyone in the group is here because the police were called and/or their partner left. This suggests that for everyone, there are issues in the relationship that they were not able to solve with the skills they had. For some, this involved threats and verbal abuse. For some, it

> involved physical violence. Some people in the group are also the victims of abuse and violence from their partners. We don't believe everyone who comes to the program is in a relationship with a perfect angel. This is a program about solving problems in relationships so that people don't get hurt emotionally or physically, can stay connected in a healthy way, and so that police intervention doesn't happen.

There is no such thing as low-risk violence. There are men in prison who are there because they pushed their partner, she fell and hit her head and died. Granted, it's not a frequent occurrence, but when it does occur, it is immensely sad, and the man would give anything to have those few minutes back to make a different decision. The woman is dead, the man is in prison, and the children are being raised by someone else. It is not that difficult to kill someone. Once a person uses physical force death is a very real possibility.

It is amazing how often offenders, victims, and therapists do not recognize the potential for harm from minor violence. During the first cycle of our program, we were not funded to run a women's group. I stayed in contact with the women throughout the group, however. On one occasion, half way through the program, a woman told me that the program was having a wonderful effect on her husband. She said he had not been violent since he started the program. About 10 minutes later, in the same conversation, she told a story about a conflict the previous week and said he had grabbed her wrists. I stopped her and asked about her statement that there had been no violence, and she said, "That's not violence." Her life experience led her to believe this was not a violent act. This interaction, among others, helped convince our contract manager to support the funding for a women's program.

Over the years, I have worked with men who, prior to a homicide, would have shown up low on a risk assessment. Any violence has the potential to cause death, and violence in relationships almost always escalates over time to more extreme forms of violence. There are some theorists who hold that treatment should only be given to moderate and high-risk offenders. This is based on a belief that treatment with higher risk offenders further entrenches the low-risk offender in criminal behavior. I absolutely do not agree, nor have I seen evidence to prove, that this applies to domestic violence offenders. In fact, the group process suggests it may actually be the opposite. In any event, regardless of the identified risk factor, it is important to highlight the potential high risk of the behavior -- not only for the potential to unwittingly cause physical harm but to also destroy the relationship and impact the children negatively.

Finally, as mentioned earlier, it is important to find ways to keep men in the program. If a man is being disruptive, he can be taken aside and something like the following could be said:

> I am having difficulty knowing how to make this program work for you. It seems my skills are limited in helping me find a way to engage you in the program. I'm wondering if you could help me to find a way to make this work for us so that you and the others in the room can benefit. If not, I may have to admit defeat and hope that the next program will provide a better fit between you and the therapist.

Effective responses can be generated easily with the core skills most therapists have been trained to use. The critical factor is using them strategically.

THE CORE SKILLS AND CONFRONTATION

Some therapists working with men who use violence believe that confrontation is the most important skill and forget the importance of engagement first. These are the ones who will ask the man to describe what happened and then read him the police report and point out discrepancies, effectively accusing him of lying. They are also the ones who are then surprised that he is "resistant" to attending. A man is more likely to be engaged in an intake interview if, when asked for specific information about behavior, he is not confronted on discrepancies or denial. There is plenty of time to let this happen throughout the program. The first order of business is to get him in the door. It was our experience that the men were also more open to admitting their behavior on a written questionnaire, particularly after being in an interview where a compassionate approach had been used to deal with reluctance issues. Confrontation has a place, but must be used strategically.

The following describes ways to use basic skills in the program. Many people working with offenders either forget the power of these skills and/or have not been trained to use them strategically in these settings.

Empathy

While empathy for expressed emotion is necessary for engagement, greater engagement can result when a therapist uses a higher level of empathy and safely identifies an emotion that is not expressed. If the deeper emotion isn't an issue, nothing is lost. If it is an issue, much is gained. Participants are very comfortable expressing anger, but anxiety and sadness are emotions that are seldom expressed openly (e.g., "I am anxious about attending."). The strategic use of higher levels of expressions of empathy in the intake interview may lead to greater engagement:

> "Sounds like you are in a difficult relationship that is causing you a great deal of distress and sadness".
>
> "Many people are uncomfortable in a group setting, in fact most of us fear public speaking more than death. We believe people cannot learn and do their best if they are anxious, so we will do everything we can to make it a safe environment for you. Do you have any concerns about speaking up in group?"
>
> "Many people have difficulty with reading and writing, so we really limit that in the program. In addition, lots of people have had negative experiences in classrooms. Do you have any concerns about what we will be doing in the group?"

Responding with empathy first to any negative comment helps to engage the client.

Respect

Respect statements are simply a way to let the man know that his emotions make sense given what is going on in his world, to acknowledge his positive purpose, his efforts, and his self-efficacy:

"It makes sense you would rather not be here. No one likes to be told what to do."
"It took a lot of courage to show up, particularly given how you are feeling."
"Sounds like you have been trying hard to make the relationship work."
"You are picking this up very well. You have the ability to make this work."

Genuineness

This is an opportunity for the therapist to talk about why the work is important to him or her. The men frequently believe people have no genuine feelings of interest or concern. Genuineness also requires that the therapist acknowledge and take responsibility for his or her emotions. It involves appropriate self-disclosure:

"I appreciate you coming in. It is important to me that we get a chance to meet and that you feel comfortable about the program."

"You are told you need to be here, and I am told I need to take you into the program. It requires both of our time and effort so it's important to me that this is a positive experience for both of us."

"Yes, I do get very sad when I think about the effect violence has on people."

"Yes, you're right. I'm here because I get paid to be here, but there are a lot of jobs I could be doing. I'm doing this one because it is important to me that people have safe and happy relationships. It's been my experience that most people want this. I also like to enjoy my work so I try to make sure that we have a good experience in the program."

"I really enjoy the men who attend these programs. I don't like the behavior they engage in, but then I know they don't feel good about it either. For the most part, they are trying to get their needs met in a relationship with some skills that are not very effective. It feels good when they say they wish they had taken the program years ago. It's amazing how often that happens."

Concreteness (Used after an Empathy and Respect Statement)

This is simply an attempt to get specific information without the man feeling that he is undergoing an inquisition. Many programs, including ours, have a checklist of behaviors that the men are asked about during the interview. We found that men responded more openly to these questions when we either integrated them in a less structured way during the interview or asked them following a discussion that had dealt with reluctance and promoted their engagement with the program:

"Tell me what you think will happen in the program."
"Tell me what happened that got you here".
"Can you give me a specific example of what she did and what you did in response?"

Immediacy

Immediacy is recognizing and responding to what is going on in the moment. This includes recognizing that the line of conversation or the approach being taken is not helpful

and finding another strategy. It may or may not involve stating this observation aloud prior to making a shift. It can also include recognizing that the man is in an uncomfortable emotional place and asking thinking questions that would help him move out of the emotion. If he is in an uncomfortable thinking place, asking him a feeling question may be helpful. This also involves recognizing group process as it is happening.

"I noticed that as you're telling the story you are experiencing some strong emotions. Can you tell me what is happening to you right now?"

"What could you do right now that would be helpful?"

"Those are very powerful statements. Can you tell me what you are feeling?"

"Well, it sounds as if I didn't say that very clearly. Let's see if I can come at it from a different angle".

"There seems to be a lot of agitation in the room at the moment. What could we do right now that would be helpful?"

Confrontation

Clinical confrontation is simply pointing out discrepancies in the hope that it will create some cognitive dissonance, raise awareness, and enhance commitment to change. It is one of the most significant skills in treatment, and the one that is frequently a struggle for therapists working with offenders. Part of effective, sophisticated confrontation is timing, saying as little as possible and giving the participant time to safely reflect on the challenge (similar to the intervention with Max). Therapeutic confrontation is not cajoling or pressuring someone into responding. It is not challenging every statement a man makes at the intake interview or the beginning of the program in an effort to get him to change "now". It is not ridicule, accusation, or sarcasm. All of these styles can lead to increased anxiety in the room, resulting in a myriad of defensive behaviors from group participants, including a refusal to talk. That type of confrontation leads participants to "resist" the therapist.

Therapists need to trust that the material and the group process will provide lots of opportunities for cognitive dissonance to develop over the course of the program. Because the men often believe their behavior is self-protective, some of the most effective confrontations used throughout the program are the following:

"How does it help you to do these things?"

"How does it help you to respond to her that way?"

"How does it help you to think that way?"

"You say you want to have a good relationship with her. Is that more likely or less likely that behavior will get you what you want?"

"You are saying that everything is fine and you don't need this program, yet clearly you are telling me there are lots of problems in the relationship."

"If your partner was here telling the story, how might she tell it differently?"

Do it First

The strategic use of these skills throughout the program will deal with responsivity issues. It will also model for the participants the use of skills that will help in their own relationships. As mentioned, it is not uncommon for men to be hostile during intake. Using these skills and the following will usually help to gain commitment:

- Never disagree.
- Acknowledge the difficulties and the emotion.
- Demonstrate understanding of the man's unique situation.
- Avoid endorsing his perceptions or conclusions.
- Be clear about realities.
- Focus on "more likely" and "less likely" with respect to future difficulties.
- Look for positive purpose.
- Be patient (and breathe deeply).

Usually, at the end of the interaction, the man will apologize for his behavior. Not only does this help with compliance, but it also provides an opportunity for engagement with the material. Frequently men will express reluctance at learning communication skills. They will say that the skills will only work if both people are using them. It is then possible to respond by saying, "Well, yes, that would certainly be the most helpful situation, but even one person knowing them can prevent things from escalating. Remember during the intake interview how angry some of you were? Only one of us was using respectful communication and problem solving skills. What happened?" There is almost always a man who will acknowledge that he calmed down and ultimately apologized for his behavior. This can be followed by the following questions:

> "How did that impact your willingness to attend the program?"
> "How did you feel towards me at the end of it?"
> "If I had engaged in the same behavior you were using – being loud, aggressive and hostile – what is more likely to have happened?"
> "How did both of us benefit from my commitment to use those skills?"

It is not uncommon for the men to then say, "Well, yeah, if my wife had the skills you have things wouldn't escalate." This is when the therapist must address responsibility and reality: "Yes, there will always be people in our lives that don't have these skills. What is more helpful to us in getting through life with as few problems as possible, to expect others to have them, or to learn them and use them ourselves?" Many of the men have developed a belief that personal safety requires that we get others before they get us. They can be challenged to apply the "do it first" philosophy to behaviors that are helpful. Another helpful response is to suggest to the men that they "respond in a way that is more likely to lead people to think about what they did, not what you did." They recognize that had I responded in kind to their behavior, it was much less likely they would have apologized and much more likely they would have felt justified in their own negative behavior. In the same way that my response strengthened their commitment to the program and helped to build a relationship, they learn that these skills will strengthen their own relationships.

CONCLUSION

Regardless of how men arrive at our door, there are some very important things to keep in mind: They have demonstrated that they have the potential to hurt others; they typically don't want to be there; and they seldom bring with them the skills that will help facilitate the process of change. In simpler words, the man is reluctant to attend, he's reluctant to disclose, he's reluctant to change, and he has used violence to express his negative emotions in the past. He is a danger to someone. It is important for the therapist to always be cognizant of this; however, it is equally important to not let this define him. Group processes that do not restrict men's identities to offender status alone can facilitate therapeutic engagement (Augusta-Scott, 1999; Stefanakis, 2000). This requires the therapist to be able to see the men as we want them to be, as men who are able to desist from violence in relationships.

Maruna (2000) refers to *desistance* as "the long-term abstinence from crime among individuals who had previously engaged in persistent patterns of criminal offending" (p.26). It is a process of engaging in a life and an identity characterized by pro-social positive relationships in family, work, and society. Maruna, LeBel, Mitchell, and Naples (2004) suggest criminal desistance consists of two phases: primary and secondary desistance. *Primary desistance* is the giving up the criminal activities; *secondary desistance* is defined as "the movement from the behavior of non-offending to the assumption of the role or identity of a 'changed person'" (p. 274). Flavin (2005) believes this secondary desistance is a function of strengthening people's social capital, which includes "networks, shared norms, values and understandings that facilitate cooperation within or among groups" (p. 209). Attending to responsivity issues will lead to greater secondary desistance.

There are a myriad of issues that affect responsivity. This chapter has dealt with only one piece of the puzzle, albeit a significant piece. Without question, a timely, coordinated community response is critical (Gondolf, 2004).[17] A great deal of money has gone into program development and delivery and risk assessment. It is time to look more closely at all the significant factors that lead to effective treatment. While we have made significant progress, there remains much to be done. It is important to note that given the large number of incidents of domestic violence, even small or modest statistically significance results can have a large social impact in reducing violence in the community. When programs fail, however, the fall-back position is "once an abuser, always an abuser," and there is a cry for stiffer sentences or punishment. Anything less than 100% success can be seen as failure in the eyes of the public. At the present time, our programs fall short of that, and the on-going challenge is to prevent this being taken as an indication that treatment doesn't work. It requires a committed belief in rehabilitation, in much the same way that desistance from abuse in relationship requires a committed belief in the principles of non-violence. Challenges

17 A most significant issue in group programs for men is the nature of victim contact and parallel programs for victims, neither of which has been addressed in this chapter. It was our experience that men whose partners had taken part in a program and could hold the men accountable for all forms of abuse were more successful in maintaining their behavior.

must not cause us to question these beliefs but rather to lead us to look for more effective strategies.

In: Intimate Partner Violence Prevention and Intervention ISBN: 978-1-60456-039-8
Editors: A. C. Baldry and F. W.Winkel, pp. 177

ACKNOWLEDGMENT

Several people need to be acknowledged for the outcome of this book. First of all, our appreciation goes to the scholars who contributed to the book and demonstrated, from the beginning, their enthusiasm and dedication for this project. Without them, there could have been no book. They are the leading scholars in the field and their contributions have made the book a unique piece of scientific work.

Two other scholars deserve our acknowledgment: our friends and colleagues, Ronald Roesch and Raymond Corrado, both from the Simon Fraser University, British Columbia, Canada, who are leading scholars in the field of forensic psychology and criminology. They have our gratitude for supporting our work and providing useful insights.

We also owe a special thanks to Kathy Roesch for her invaluable editing work of the book.

We would also like to thank the European Commission for its support through the Daphne Programme which supports European projects for the prevention and reduction of violence against women and children. Three European Daphne projects have been financially supported through the Italian NGO "Differenza Donna," which, in Italy, is in charge of helping women victims of crime, and one through the Department of Psychology of the Seconda Università degli Studi di Napoli.

We would also like to thank other two bodies that supported the implementation of risk assessment approach in Italy and in the Netherlands: the Regione Autonoma della Sardegna, Commissione Regionale per la Realizzazione della Parità fra Uomini e Donne and the Achmea Foundation Victim and Society in the Netherlands (Stichting Achmea Slachtoffer en Samenleving). In addition, we are thankful to the Achmea Foundation also for their willingness to further support the INTERVICT research program on re-victimization risk assessment in cases of domestic violence at Tilburg University.

A special note of appreciation goes to the Italian Police Force (Polizia di Stato) for their collaboration and willingness to introduce the SARA method in their practice. In particular we would like to show sign of appreciation to the Servizio Centrale Operativo, Direzione Centrale Anticrimine, Dipartimento di Pubblica Sicurezza, Ministero dell'Interno for their support in the organization and set up of the numerous training courses for police officers on the risk assessment method, now spread in different parts of the country. We would also like to thank the Arma dei Carabinieri, Minister of Defense in Italy as well as the Netherlands Victim Support for the victims of crime (Slachtofferhulp Nederland).

In: Intimate Partner Violence Prevention and Intervention ISBN: 978-1-60456-039-8
Editors: A. C. Baldry and F. W.Winkel, pp. 179-180

AUTHORS' BIOGRAPHIES

Dr. Stephen D. Hart is Professor in the Department of Psychology at Simon Fraser University, Canada, and Visiting Professor in the Faculty of Psychology at the University of Bergen, Norway. His primary area of expertise is clinical-forensic psychology. Most of his work focuses on clinical-forensic assessment in criminal and civil settings, and especially on the assessment of violence risk. He frequently provides training to mental health, corrections, and law enforcement professionals on the assessment and management of risk for intimate partner violence.

Dr. Randal Kropp is a clinical and forensic psychologist specializing in the assessment and management of violent offenders. He works for the Forensic Psychiatric Services Commission of British Columbia, Canada, is a research consultant with the British Columbia Institute against Family Violence, and is Adjunct Professor of Psychology at Simon Fraser University. He has conducted numerous workshops for mental health professionals, police officers, corrections staff, and others in North America, Australia, Asia, Africa, and Europe. This training has focused on risk for violence, psycho-legal assessments and criminal harassment (stalking). He has frequently consulted with provincial, state, and federal government ministries on matters related to violence against women and children, and the assessment and treatment of violent offenders. He has published numerous journal articles, book chapters, and research reports, and he is co-author to several works on risk assessment, including the Manual for the Spousal Assault Risk Assessment Guide, the Manual for the Sexual Violence Risk – 20, and the Risk for Sexual Violence Protocol (RSVP).

Dr. Don Dutton is Professor of Psychology at the University of British Columbia. He is author of The Domestic Assault of Women, The Abusive Personality and Rethinking Domestic Violence, as well as over 100 papers on domestic violence.

Kelly Watt is a graduate student in the Clinical/Community Division of the Department of Psychology at the University of Illinois at Urbana-Champaign. Her primary research interests are intimate partner femicide, violence risk assessment, and coordinated community responses to domestic violence. She has assisted with the development of safety assessment and planning guidelines for victims of intimate partner violence. She has also provided training on the assessment and management of risk for intimate partner violence and the establishment of domestic violence fatality review teams.

Prof. Frans Willem Winkel is Professor of victimology at the International Victim Institute (INTERVICT), Tilburg University. He studied criminal law and procedure (MA) at Erasmus University Rotterdam, experimental psychology (MA, cum laude) at the University

of Amsterdam, and earned a PhD (psychology) from Vrij Universiteit Amsterdam (VUA). Thesis: Crime prevention through mass media persuasive communication. He was affiliated with the VUA departments of social and clinical psychology, respectively directing the psychology and law - , and the psycho-traumatology programs. He has served on the executive boards of the Netherlands Victim Support, the Focus on Victims Foundation, the Help Northern Ireland Foundation, and the European Association of Psychology and Law (EAPL President). He currently serves on the executive board of the World Society of Victimology (WSV), and is affiliated with the International Victimology Institute Tilburg (INTERVICT, Tilburg University).

Dr. Henrik Belfrage, Ph.D. is Professor of Applied Criminology at Mid Sweden University and Director of Research at Sundsvall Forensic Psychiatric Hospital. He has worked for years with research on risk assessment and risk management in various contexts of violence. He has published more than 100 scientific papers and book capters, and is co-author of the B-SAFER.

Dr. Jane Katz is a Registered Clinical Counsellor in British Columbia, Canada. She is a pioneer in the development and delivery of treatment programs for men who use violence in intimate relationships, providing programs in both community and custody settings. She has also worked extensively with victims of violence, been involved with community coordination efforts and developed safe relationship programs for youth and for women offenders. She has provided training and workshops in North America and Japan. In addition to private practice, Jane is a consultant and trainer for BC Corrections and the Justice Institute of BC, and associate faculty in the Faculty of Social and Applied Sciences at Royal Roads University in Victoria, B.C.

Dr. Anna Costanza Baldry is Associate Professor of social psychology at the Department of Psychology, Second University of Naples, and has an appointment as senior researcher at the International Victim Institute (INTERVICT), Tilburg University. She has coordinated five European Commission 'Daphne' projects on the assessment of risk of recidivism in domestic violence cases, and on Fatality review cases. She is director of the *Cesvis*, a research centre on victimological issues, based at the Department of Psychology in Italy, that promotes research and training course of forensic psychology and victim related issues and she directs ASTRA (Assessing STalking Risk Assessment) a service for victims of stalking implemented in collaboration with the Italian Police. She has extensively published articles in National and International scholarly Journals and has written several book chapters. Her field of work is applied social psychology to the forensic sector.

Dr Sevaste Chatzifotiou is an assistant professor of Social Work, at the Department of Social Administration, at the Democritus University of Thrace. Her areas of expertise are researching gender issues, domestic violence against women and children, feminist and comparative social work, action research in social sciences and social work and social research methods.

In: Intimate Partner Violence Prevention and Intervention ISBN: 978-1-60456-039-8
Editors: A. C. Baldry and F. W.Winkel, pp. 181-201

REFERENCES

Abrams, M. L., Belkap, J., and Melton, H. (2000). *When domestic violence kills: The formation and findings of the Denver metro domestic violence fatality review team.* Denver, CO: Project Safeguard.

Aldridge, M. L., and Browne, K. D. (2003). Perpetrators of spousal homicide: A review. *Trauma, Violence, and Abuse,* 4, 265-276.

Alfarnes, S. (2004). Grunnlag for politiets vurdering av risiko for framtidig partnervold (SARA:PV). Translation into Norwegian of P. R. Kropp, S. D. Hart, and H. Belfrage, 2004: Brief spousal assault form for the evaluation of risk (B-SAFER). Oslo: Kompetensesenter for sikkerhets-, fengseloch rettspsykiatri.

Altman, I., and Rogoff, B. (1987). World views in psychology: Trait, interactional, organismic, and transactional perspectives. In D. Stokols and I. Altman (Eds.), *Handbook of environmental psychology* (pp. 7- 40). New York: Wiley.

Andrews, D. A., and Bonta, J. (1994). The psychology of criminal conduct. Cincinnati, OH: Anderson Publishing.

Andrews, D. A., and Bonta, J. (2003). *The psychology of criminal conduct*, 3rd ed. Cincinnati, OH: Anderson Publishing.

Antonopoulou, C. (1999). Domestic violence in Greece. American Psychologist, 54, 63-64.

Archer, J. (2000). Sex differences in aggression between heterosexual partners: *A meta-analytic review. Psychological Bulletin*, 126, 651-680.

Archer, J. (2006). Cross-cultural differences in physical aggression between partners: A social-structural analysis. *Personality and Social Psychology Review, 10,* 133-153.

Arntz, A. (1994). Treatment of borderline personality disorder: A challenge for cognitive-behavioral therapy. *Behavior, Research and Therapy,* 32(4), 419-430.

Augusta-Scott, T. (1999). Reinventing the wheel. Finding new stories for men who batter. Thesis submitted in partial fulfilment of the Master of Social Work, Dalhousie University, Halifax, N.S.

Babcock, J.C., Jacobson, N.C., Gottman, J.M.,and Yerington, T.P. (2000). Attachment, emotional regulation, and the function of marital violence: Differences between secure, preoccupied, and dismissing violent and nonviolent husbands. *Journal of Family Violence*, 15, 391-409.

Babcock, J. C., Green, C. E., and Robie, C. (2004). Does batterers' treatment work?: A meta-analytic review of domestic violence treatment outcome research. *Clinical Psychology Review*, 23, 1023-1053.

Bailey, J. E., Kellerman, A. L., Sommes, G. W., Banton, J. G., Rivara, F. P., and Rushforth, N. P. (1997). Risk factors for violent death of women in the home. *Archives of Internal Medicine*, 157, 777-782.

Baldry, A.C. (2001). Italy. In R. Summers and A. Hoffman (Eds.), Domestic violence: Global perspective (pp. 55-68). Westport,CT: Greenwood Publishing.

Baldry, A.C. (2003). Sticks and stones may hurt my bones but his glance and words hurt more. The impact of emotional and physical violence by current and former partners in Italian battered women. *International Journal of Forensic Mental Health*, 2, 47-57.

Baldry, A.C.(2006). Dai maltrattamenti agli omicidi.La valutazione del rischio di recidiva e dell'uxoricidio. (From domestic violence to omicide. Risk assessment of recidivism and of femicide), Milano: FrancoAngeli.

Barratt, E. S. (1994). Impulsiveness and aggression. In J. A. Monahan and H. J. Steadman (Eds.), Violence and mental disorder: *Developments in risk assessment* (pp. 61-79). Chicago: University of Chicago.

Beck, A.T. (1976). Cognitive therapy and the emotional disorders.New York: International Universities Press.

Belfrage, H. (2004). Bedömning av risk för upprepat partnervåld (SARA:SV). Translation into Swedish of P. R. Kropp, S. D. Hart and H. Belfrage, 2004: Brief spousal assault form for the evaluation of risk (B-SAFER). Sundsvall: Rättspsykiatriska regionkliniken.

Belfrage, H., and Rying, M. (2004). Characteristics of spousal homicide perpetrators. A descriptive study of all cases of spousal homicide in Sweden 1990–1999. *Criminal Behaviour and Mental Health*, 14,121-133.

Bernstein, P. L. (1996). Against the gods: The remarkable story of risk. New York: Wiley.

Binney, V., Markell, J., and Nixon, J. (1981). Leaving violent men: A study of refuges and housing for battered women.London: WAFE.

Blalock, H. M. (1984). Contextual effects models: Theoretical and methodological issues. *Annual Review of Sociology*, 10, 353-372.

Block, C. R. (2003). How can practitioners help an abused woman reduce her risk of death? National Institute of Justice, 250, 4-7.

Bodnarchuk, M. (2002). Psychological and behavioural typologies of men who assault their female partners.Vancouver, B.C.: British Columbia Institute Against Family Violence.

Borkowski, M., Murch, M., and Walker, V. (1983). Marital violence: The community response. London: Tavistock.

Borum, R. (1996). Improving the clinical practice of violence risk assessment: Technology, guidelines, and training. *American Psychologist*, 51, 945-956.

Bourget, D., Gagne, P., and Moamai, J. (2000). Spousal homicide and suicide in Quebec. *The Journal of American Academy of Psychiatry and the Law*, 28, 179-183.

Bower, S. A., and Bower, G. H. (1976). Asserting yourself: A practical guide for positive change. Reading, MA: Addison-Westley.

Bowlby, J. (1969). Attachment and loss: Attachment. New York: Basic Books.

Bowlby, J. (1988). A secure base: Clinical applications of attachment theory. London: Routledge.

Bowman, M. (1997). Individual differences in posttraumatic response. Mahwah, NJ: Erlbaum.

Brewer, J. E., and Paulsen, D. J. (1999). A comparison of US and Canadian findings on uxoricide risk for women with children sired by previous partners. *Homicide Studies*, 3, 317-332.

Brewin, C. R., Andrews, B., and Valentine, J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology*, 68, 748–766.

Brewin, C.R., and Holmes, E.A. (2003). Psychological theories of posttraumatic stress disorder. *Clinical Psychology Review*, 23, 339–376.

Brewin, C. R., Rose, S., Andrews, B., Green, J., Tata, P., McEvedy, C., Turner, S., and Foa, E. B. (2002). Brief screening instrument for post-traumatic stress disorder. *British Journal of Psychiatry*, 181, 158–162.

Briere, J, and Runtz, M. (1989) The trauma symptom checklist (TSC-33): Early data on a new scale. *Journal of Interpersonal Violence*, 4(2), 151-162.

Bronfenbrenner, U. (1979). The ecology of human development. Cambridge, MA: Harvard University Press.

Browne, A. (1987). When battered women kill. New York: Free Press.

Browne, A., Williams, K., and Dutton, D. (1999). Homicide between intimate partners: A 20-year review. In M. D. Smith and M. A. Zahn (Eds.), Homicide: *A sourcebook of social research* (pp. 149-164). London: Sage.

Brunet, A., Weiss, D.S., Metzler, T.J., Best, S.R., Neylan, T.C., Rogers, C., Fagan, J., and Marmar, C.R. (2001). The peritraumatic distress inventory: A proposed measure of PTSD criterion A2. *American Journal of Psychiatry*, 158(9), 1480 – 1486.

Bruno, T. (2003). Percorsi di uscita dalla violenza. (Path to escape violence) In U. Nizzoli, M. Pissacroia (Eds.), Trattato generale degli abusi e delle dipendenze (*Handbook on abuse and dependency*) (pp. 497 – 523). Padova, Italy: Piccin.

Bureau of Justice Statistics (1998). Violence by intimates: Analysis of data on crimes by current or former spouses, boyfriends, and girlfriends. Washington, DC: U.S. Department of Justice.

Bureau of Justice Statistics (2004). Homicide trends in the United States. Washington, DC: U.S. Department of Justice.

Burgess, A. W., Baker, T., Greening, D., Hartman, C. R., Burgess, A. G., Douglas, J. E., and Halloran, R.(1997). Stalking behaviors within domestic violence. *Journal of Family Violence*, 12(4), 389-403.

Campbell, J. C. (1964). Honour, family and patronage. Oxford: Clarendon Press.

Campbell, J. C. (1986). Nursing assessment for risk of homicide with battered women. *Advances in Nursing Science*, 8, 36-51.

Campbell, J. C. (1992). "If I can't have you no one can": Power and control in homicide of female partners. In J. Radford and D. E. H. Russell (Eds.), Femicide: The politics of women killing (pp. 99–113). New York: Twayne Publishers.

Campbell, J.C. (1995). Assessing dangerousness. Newbury Park,CA: Sage.

Campbell, J. C. (1995). Prediction of homicide of and by battered women. In J. C. Campbell (Ed.), Assessing dangerousness: *Violence by sexual offenders, batterers, and child abusers* (pp. 96-113). Thousand Oaks, CA: Sage.

Campbell, J.C. (2004). Helping women understand their risk in situations of intimate partner violence. *Journal of Interpersonal Violence*, 19(12), 1464 -1477.

Campbell, J. C., Sharps, P., and Glass, N. (2001). Risk assessment for intimate partner homicide. In G. Pinard G. and L. Pagani (Eds.), Clinical assessment of dangerousness: Empirical contributions (pp.136-157). Cambridge, UK: Cambridge University Press.

Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., et al. (2003). Risk factors for femicide in abusive relationships: Results from a multi-site case control study. *American Journal of Public Health*, 93, 1089-1097.

Campbell, J. C., and Wolf, A. D. (2001, November). The danger assessment: Research validation from twelve city femicide study. Paper presented at the America Society of Criminology Conference, Atlanta, Georgia.

Carlson, B. E. (1984). Causes and maintenance of domestic violence: An ecological analysis. *Social Service Review*, 58, 569-587.

Carlson, B. E., and Dutton, M.A. (2003). Assessing experiences and responses of crime victims. *Journal of Traumatic Stress*, 16(2), 133-148.

Carmen, E.H., Reiker, P.P., and Mills, T. (1984) Victims of violence and psychiatric illness. American Journal of Psychiatry, 141, 378 - 379

Chatzifotiou, S. (2000). Seeking informal support: Marital violence against women in Greece, *Violence Against Women*, 9(7),1024-1054, Sage.

Chatzifotiou, S. (2001). The last violent event: The experiences of Greek battered women. *South European Society and Politics*, 6(3), 55-78.

Chatzifotiou, S. (2005). Domestic violence against women and children: The challenges for social work professionals. Thessaloniki: Tziolas.

Chermack, T. J., and Lynham, S. A. (2002). Definitions and outcome variables of resource planning. Human Resource Development Review, 1, 366-383.

Chermack, T. J., and van der Merwe, L. (2003). The role of constructivist learning in scenario planning. *Futures*, 35, 445-460.

Cleckley, H. (1976). The mask of sanity (5th ed.). St. Louis, MO: Mosby.

Cooke, D., and Michie, C. (2003, April). Content-related validity of the SARA: A psychometric evaluation. Presentation at the 3rd Annual Conference of the International Association of Forensic Mental Health Services, Miami.

Cook, R.F., Smith, B.E., and Harrell, A.V. (1987). Helping crime victims: Levels of trauma and effectiveness of services. U.S. Department of Justice. Executive Summary. National Institute of Justice: Washington, DC.

Cooper, M. (1993).Assessing the risk of repeated violence among men arrested for wife assault: A review of the literature.Vancouver, B.C.: British Columbia Institute on Family Violence

Currie, D.H. (1990). Battered women and the state: From the failure of theory to a theory of failure. *Journal of Human Justice*, 1, 77-96.

Dahlberg, L. L., and Krug, E. G. (2002). Violence – A global public health problem. In E. G. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, and R. Lozano (Eds.), World report on violence and health (pp. 1-21). Geneva: World Health Organization.

Daly, M., and Wilson, M. (1988). Homicide. New York: Adeline De Gruyter.

Daly, M., Wiseman, K. A., and Wilson, M. (1997). Women with children sired by previous partners incur excess risk of uxoricide. *Homicide Studies*, 1, 61-71.

Daraki, P.(1995). To orama tis isotimias tis ginekas [The vision of the equality of the sexes].Athens: Kastaviotis.

Davis, N.J. (1988). Implications for social control. Contemporary Crises, 12, 345-372.

Davis, R.C., and Taylor, B.G. (1999) Does batterer treatment reduce violence? A synthesis of the literature. *Women and Criminal Justice*, 10, 69-93.

Dawson, M., and Gartner, R. (1998). Differences in the characteristics of intimate femicides: The role of relationship state and relationship status. *Homicide Studies*, 2, 378-399.

Den Hertog, P.C. (1992). De IE-18 locus of control vragenlijst. Nederlands Tijdschrift voor de Psychologie, 47, 82 - 87.

Denkers, A.J.M.(1996). Psychological reactions of victims of crime: The influence of pre-crime, crime, and post-crime factors. Dissertation. Amsterdam: Vrije Universiteit.

Denkers, A., and Winkel, F.W. (1997). Criminal victimization and well-being: A prospective study on the direct and buffering effects of personality traits. In S. Redondo, V. Garrido, J. Perez, and R. Barabaret (Eds.), Advances in Psychology and Law: International Contributions (pp.77-88). New York: De Gruyter.

Denkers, A., and Winkel, F.W. (1998a). Crime victims' wellbeing and fear in a prospective longitudinal study. *International Review of Victimology,* 5, 141-163.

Denkers, A., and Winkel, F.W. (1998b). The social and personal influence of positive beliefs on coping with direct and indirect victimization. In J. Boros, I. Munnich, and M. Szegedi (Eds.), Psychology and Criminal Justice: International Review of Theory and Practice (pp. 354 - 366).Berlin, New York: De Gruyter.

Diener, E. (1984). Subjective wellbeing. *Psychological Bulletin,* 95, 542 - 575.

Diener, E., Emmons, R.A., Larsen, R.J., and Griffin, S. (1985). The Satisfaction with Life Scale. *Journal of Personality Assessment,* 49, 71 - 75.

Dobash, R.E, andDobash, R. (1979) Violence against wives: A case against patriarchy.Sussex: Open Books.

Dobash, R.E., and Dobash, R.P. (1992) Women, violence and social change. London: Routledge

Dobash, R.E., Dobash, R.P., Cavanagh, K., and Lewis, R. (2000), *Changing violent men*. Thousand Oaks, CA: Sage.

Dobash, R. E., Dobash, R. P., Cavanagh, K., and Lewis, R. (2001). Homicide in Britain: Risk factors, situational contexts and lethal intentions. Research Bulletin No. 1. University of Manchester.

Dobash, R. E., Dobash, R. P., Cavanagh, K., and Lewis, R. (2004). Not an ordinary killer – just an ordinary guy: When men murder an intimate women partner. *Violence Against Women,* 10, 577-605.

Dobash, R. P., Dobash, R. E., and Medina-Ariza, J. (2000). Lethal and non-lethal violence against an intimate partner: Risks, needs and programs. Manchester, England: Economic and Social Research Council.

Dominy, N., and Radford, L. (1996) Domestic violence in Surrey: Towards an effective inter-agency response. Surrey, England: Surrey Social Services, Roehampton Institute.

Du Boulay, J. (1974) Portrait of a Greek mountain village. Oxford: Clarendon Press.

Dugan, L., Nagin, D., and Rosenfeld, R. (2003a). Exposure reduction or retaliation? The effects of domestic violence resources on intimate partner homicide. *Law and Society Review,* 37, 169–198.

Dugan, L., Nagin, D., and Rosenfeld, R. (2003b). Do domestic violence services save lives? *National Institute of Justice,* 250, 2-25

Durfee, M., Tilton Durfee, D., and West, M. P. (2002). Child fatality review: An international movement. *Child Abuse and Neglect,* 26, 619-636.

Dutton, D. G. (1995a). The batterer: A psychological profile. *New York: Basic Books*.

Dutton, D. G. (1995b). The domestic assault of women. Vancouver: University of British Columbia Press.

Dutton, D.G. (1995c) Intimate abusiveness. *Clinical Psychology:Science and Practice*, 2(3), 207-224.

Dutton, D. G. (1995d). Male abusiveness in intimate relationships. *Clinical Psychology Review*, 15(6), 567-581.

Dutton, D.G. (1995e). A scale for measuring the propensity for abusiveness. *Journal of Family Violence*, 10(2), 203-221.

Dutton, D. G. (1995d). Trauma symptoms and PTSD-like profiles in perpetrators of intimate abuse. J*ournal of Traumatic Stress*, 8, 299-316.

Dutton, D. G. (1998). The abusive personality: Violence and control in intimate relationships. New York: Guilford Press.

Dutton, D.G. (2002a). Psychiatric explanation of intimate abusiveness. Journal of Psychiatric Practice, 8(4), 216-228.

Dutton, D. G. (2002b). The abusive personality: Violence and control in intimate relationships. (2nd edition) New York: Guilford Press.

Dutton, D. G. (2002c). The neurobiology of abandonment homicide. *Aggression and Violent Behavior*, 7, 407–421.

Dutton, D.G. (2003a). The abusive personality: Violence and control in intimate relationships. Revised Paperback Edition. New York: Guilford Press.

Dutton, D.G. (2003b) Treatment of assaultiveness. In D.G. Dutton and D. L Sonkin (Eds.), Intimate violence: Contemporary treatment approaches. New York: Haworth Press.

Dutton, D. G., Bodnarchuk, M., Kropp, R., Hart, S., and Ogloff, J. (1997a). Client personality disorders affecting wife assault post treatment recidivism. *Violence and Victims*, 12(1), 37–50.

Dutton, D. G., Bodnarchuk, M., Kropp, R., Hart, S., and Ogloff, J. (1997b). Wife assault treatment and criminal recidivism: An eleven year follow-up. *International Journal of Offender Therapy and Comparative Criminology*, 41(1), 9-23.

Dutton, D.G., and Hemphill, K.J. (1992). Patterns of socially desirable responding among perpetrators and victims of wife assault. *Violence and Victims*, 7(1), 29 -40.

Dutton, D. G., and Kerry, G. (1999). Modus operandi and personality disorder in incarcerated spousal killers, *International Journal of Law and Psychiatry*, 22, 287-300.

Dutton, D. G. and Kropp, P. R. (2000). A review of domestic violence risk instruments. *Trauma, Violence, and Abuse*, 1(2), 171-181.

Dutton, D. G., and Starzomski, A.J. (1993). Borderline personality in perpetrators of psychological and physical abuse. *Violence and Victims*, 8(4), 327-337.

Dutton, D.G., and Starzomski, A.J. (1994). Psychological differences in court-referred and self-referred wife assaulters. *Criminal Justice and Behavior*, 21(2), 203-222.

Dutton, D.G., Starzomski, A., Saunders, K., and Bartholomew, K. (1994). Intimacy-anger and insecure attachment as precursors of abuse in intimate relationships.*Journal of Applied Social Psychology*, 24(15), 1367-1386.

Dutton, D.G., Starzomski, A., and van Ginkel, C. (1995). The role of shame and guilt in the intergenerational transmission of abusiveness. *Violence and Victims*, 10(2), 121-131.

Dutton, D.G., Swihart, G., Winters, J., Clift, R., and Thomas, L. (2001) The Abusive Personality: A New "Third Variable" Linking Alcohol and Drug Use Amongst Wife

Assaulters. Unpublished manuscript, Department of Psychology, University of British Columbia.

Dutton, D. G., and Winters, J. (1999).Tracking cyclical abuse.Unpublished manuscript,Department of Psychology, University of British Columbia.

Easteal, P. W. (1993). Killing the beloved. Canberra: Australia Institute of Criminology.

Eckhardt, C. I., Barbour, K. A., and Stuart, G.L. (1997). Anger and hostility in martially violent men: Conceptual distinctions, measurement issues and literature review. *Clinical Psychology Review*, 17(4), 333-358.

Eckhardt, C.I., Barbour, K.A., and Davison, G.C. (1998). Articulated thoughts of martially violent and nonviolent men during anger arousal. J. *Consulting and Clinical Psychology*, 66(2), 259–269.

Edelson, J. (1995). Do batterer's programs work? Minnesota Centre Against Violence and Abuse: http://www.mincava.umn.edu/documents/battererprogram/battererprogram.html

Edelson, J., and Syers, M. (1991). The effects of group treatment for men who batter: An 18-month follow-up study. Research on Social Work Practice, 1(3), 227-243.

Edleson, J., and Tolman, R. M. (1992). Intervention for men who batter: An ecological approach. Newbury Park, CA: Sage.

Edwards, S. (1989) Policing domestic violence. London: Sage.

Ehrensaft, M.K., Moffitt, T.C., and Caspi, A. (2004). Clinically abusive relationships in an unselected birth cohort:Men's and women's participation and developmental antecedenta.*Journal of Abnormal Psychology,* 113(2), 258-270.

Ellingworth, D., Farrell, G., and Pease, K. (1995). A victim is a victim is a victim: Chronic victimisation in four sweeps of the British Crime Survey. *British Journal of Criminology*, 35(3), 360-365.

Ellis, A. (1992) Group rational-emotive and cognitive behavioral therapy. *International Journal of Group Psychotherapy*, 42, 63 -80.

English, K., Jones, L., and Patrick, D. (2003). Community containment of sex offender risk: A promising approach. In B. J. Winick and J. Q. La Fond (Eds.), Protecting society from sexually dangerous offenders: Law, justice, and therapy (pp. 265-279). Washington, DC: *American Psychological Association.*

Eu.r.e.s. (2004). Rapporto Eures sull'omicidio volontario in Italia, (Report from Eures on voluntary homicide cases in Italy), Eures: Rome.

Evason, E.(1982) Hidden violence: A study of battered women in Northern Ireland. Ireland, Farset: Cooperative Press.

Fattah, E. A. (1999). From a handful of dollars to tea and sympathy: The sad history of victim assistance. In J.J. M.Van Dijk, R.G.H. Van Kaam, and J. Wemmers, (Eds.), Caring for Crime Victims (pp. 187-207). Monsey, NY: Criminal Justice Press.

Feder, L., and Forde, D. (1999) A test of the efficacy of court-mandated counseling for convicted misdemeanor domestic violence offenders: Results from the Brouward experiment. Paper presented at the International Family Violence Conference, Durham, N.H.

Felner, R. D., Felner, T. Y., and Silverman, M. M. (2000). Prevention in mental health and social intervention: Conceptual and methodological issues in the evolution of the science and practice of prevention. In J. Rappaport and E. Seidman (Eds.), *Handbook of community psychology* (pp. 9-42). New York: Kluwer/Plenum.

Fitzgerald, L. F., Hulin, C. L., and Drasgow, F. (1994). The antecedents and consequences of sexual harassment in organizations: An integrated model. In G. P. Keita and J. J. Hurrell, Jr. (Eds.), Job stress in a changing workforce (pp. 55–71). Washington, D.C.: American Psychological Association.

Fitzgerald, L. F., Drasgow, F., Hulin, C. L., Gelfand, M. J., and Magley, V. J., (1997). The antecedents and consequences of sexual harassment in organizations: A test of integrated model. *Journal of Applied Psychology,* 82, 578-589.

Flavin, J. (2005). Employment, counseling, housing assistance…and Aunt Yoland?: How strengthening families' social capital can reduce recidivism. *Criminology and Public Policy,* 3(2), 209-216.

Florida Domestic Violence Fatality Review Team (1994). Florida fatality review project. Retrieved October 25, 2001, from http://www.fdle.state.fl.us/CitResCtr/Domestic_Violence/2001_DV_FRT.pdf

Foa, E.B., Riggs, D.S., Dancu, C.V., and Rothbaum, B.O. (1993). Reliability and validity of a brief instrument for assessing posttraumatic stress disorder. *Journal of Traumatic Stress,* 6, 459–473.

Fragoudaki, A. (1987). E askisi vias kata ton ginekon: Ekthesi tou evropaikou kinobouliou [Violence against women: The report of the European Council]. *Dine,* 2, 7-12.

Freeman, M.A.D. (1987) Dealing with domestic violence. UK: CCH Edition, Bicester.

Friedl, E.V. (1962) A village in modern Greece. New York: Holt and Winston.

Frye, V., and Wilt, S. (2001). Femicide and social disorganization. *Violence Against Women,* 7, 335-351.

Ganley, A. (1981).Participant's manual:Court-mandated therapy for men who batter - A three day workshop for professionals. Washington, DC:Center for Women Policy Studies.

Gelles, R. J., and Straus, M. A. (1988). Intimate violence: The causes and consequences of abuse in the American family.New York: Simon and Schuster.

Gendreau P., and Andrews D. A. (1990). What the meta-analyses of the offender treatment literature tells us about "what works." *Canadian Journal of Criminology,* 32, 173-184.

Gilligan, S.G., and Bower, G.H. (1984). Cognitive consequences of emotional arousal. In C. E. Izard, J. Kagan, and R.B. Zajonc (Eds.), *Emotions, Cognitions, and Behavior* (pp. 547-587). Cambridge: Cambridge University Press.

Glass, G. (1976). Primary, secondary, and meta-analysis of research. *Educational Researcher,* 5, 3-8

Gold, J.H. (1998). The intolerance of aloneness. *The American Journal of Psychiatry,* 153(6), 749-750.

Gondolf, E. W. (1988). Who are those guys? Toward a behavioral typology of batterers. *Violence and Victims,* 3, 187-203.

Gondolf, E. (1999). A comparison of four batterer intervention systems: Do court referral, program length, and services matter? Journal of Interpersonal *Violence,* 14(1), 41-61.

Gondolf, E. (2002). Batterer Intervention Systems. Thousand Oaks, CA: Sage Publications.

Gondolf, E. (2004). Evaluating batterer counselling programs: A difficult task showing some effects and implications. *Aggression and Violent Behaviour,* 9, 605-631.

Gondolf, E., and Jones, A. (2001). The program effect of batterer programs in three cities. *Violence and Victims,* 16(6), 693-704.

Griffin, D., and Bartholomew, K. (1994). The metaphysics of measurement: The case of adult attachment. In K. Bartholomew and D. Perlman (Eds.), Advances in Personal Relationships. Vol.5, Attachment processes in Adulthood.London: Jessica Kingsley.

Grove, W. M., and Meehl, P. E. (1996). Comparative efficiency of informal (subjective, impressionistic) and formal (mechanical, algorithmic) prediction procedures: The clinical-statistical controversy. *Psychology, Public Policy, and Law*, 2, 293-323.

Hadjiyanni, A., and Kamoutsi, F. (2005) Dimensions of public debate on sexual violence against women: Similarities and differences between Greece and EU policy framing. The Greek Review of Social Research, 117, 189-220.

Hague, J., and Malos, E. (1993) Domestic violence: action for change.U.K. Gretton, Cheltenham, New Clarion Press.

Hanmer, J., andMaynard, M.(1987)Women, violence and social control. London: Macmillan.

Hanmer, J., and Saunders, S. (1984) Well founded fear: A community study of violence to women. London: Hutchinson.

Hanson, R. K., and Wallace-Capretta, S. (2000). Predicting recidivism among male batterers. User Report 2000-06. Ottawa: Department of the Solicitor General of Canada.

Hare, R. D. (1993). Without conscience: The disturbing world of psychopaths among us. New York: Simon and Schuster.

Hare, R.D. (1995). Psychopathy: A clinical construct whose time has come. *Criminal Justice and Behavior*, 23, 25-54.

Hare, R., and Wong, S. (2003). Programme guidelines for the institutional treatment of violent offenders. Multi-health Systems, Toronto.

Harris, G. T., Rice, M. E., and Cormier, C. A. (1991). Psychopathy and violent recidivism. *Law and Human Behavior*, 15, 625-637.

Hart, L.K. (1992) Time, religion, and social experience in rural Greece. Oxford, UK: Rowman and Littlefield, Inc.

Hart, S. D. (1998). The role of psychopathy in assessing risk for violence: Conceptual and methodological issues. *Legal and Criminological Psychology*, 3, 123-140.

Hart, S. D. (2001). Assessing and managing violence risk. In K. S. Douglas, C. D. Webster, S. D. Hart, D. Eaves, and J. R. P. Ogloff (Eds.), HCR-20 violence risk management companion guide (pp. 13-25). Burnaby, British Columbia: Mental Health, Law, and Policy Institute, Simon Fraser University, and Department of Mental Health Law and Policy, Florida Mental Health Institute, University of South Florida.

Hart, S. D., Douglas, K. S., and Webster, C. D. (2001). Risk management using the HCR-20: A general overview focusing on historical factors. In K. S. Douglas, C. D. Webster, S. D. Hart, D. Eaves, and J. R. P. Ogloff (Eds.), HCR-20 violence risk management companion guide (pp. 13-25). Burnaby, British Columbia: Mental Health, Law, and Policy Institute, Simon Fraser University, and Department of Mental Health Law and Policy, Florida Mental Health Institute, University of South Florida.

Hart, S. D., Kropp, P. R., Laws, D. R., Klaver, J., Logan, C., and Watt, K. A. (2003). The Risk for Sexual Violence Protocol (RSVP): Structured professional guidelines for assessing risk of sexual violence. Burnaby, British Columbia: Mental Health, Law, and Policy Institute, Simon Fraser University; Pacific Psychological Assessment Corporation; and the British Columbia Institute Against Family Violence.

Healey, K., and Smith, C. (1998). Batterer intervention: Program approaches and criminal justice strategies (NCJ Publication No. 168638). Washington, DC: National Institute of Justice.

Heckert, D.A., and Gondolf, E.W. (2004). Battered women's perceptions of risk versus risk factors and instruments in predicting repeat reassault. *Journal of Interpersonal Violence*, 19(7), 778-800.

Heilbrun, K. (1997). Prediction versus management models relevant to risk assessment: The importance of legal decision-making context. Law and Human Behavior, 21, 347-359.

Heise, L. I. (1998). Violence against women: An integrated, ecological framework. Violence Against Women, 4, 262-290.

Henning, K., and Feder, L. (2004). A comparison of men and women arrested for domestic violence: Who presents the greater risk? Journal of Family Violence, 19(2), 69-80.

Henning, K., Jones, A., and Holford, R. (2003). Treatment needs of women arrested for domestic violence: A comparison with male offenders. *Journal of Interpersonal Violence*, 18(8), 839-856.

Herman, J.L., and van der Kolk, B. (1987). Traumatic antecedents of borderline personality disorder. In B. van der Kolk (Ed.), Psychological trauma (pp.111-126). Washington DC: American Psychiatric Press.

Herve, H. F.M. (2002). The masks of sanity and psychopathy: A cluster analytical investigation of subtypes of criminal psychopathy. Unpublished dissertation, Department of Psychology, University of British Columbia.

Hilton, N. Z., and Harris, G. T. (2004). Predicting wife assault: A critical review and implications for policy and practice. Trauma, Violence, and Abuse, 6(1), 3-23.

Hilton, N. Z., Harris, G. T., Rice, M. E., Lang, C., and Cormier, C. A. (2004). A brief actuarial assessment for the prediction of wife assault recidivism: The ODARA. *Psychological Assessment*, 16(3), 267-275.

Hodgins, S. (1992). Mental disorder, intellectual deficiency, and crime. *Archives of General Psychiatry*, 49, 476-483.

Home Office Statistical Findings, Research and Statistics Directorate (1996). Victims of violent crime recorded by the police, England and Wales, 1990-1994, July 1996, Issue 1, 1-15. London, UK, Home Office Publishing.

Homer, M. et al. (1984) Private violence public shame: A report on the circumstances of women leaving domestic violence. Middlesbourough, UK:Cleaveland Refuge and Aid for Women and Children.

Hotaling, G. T., and Sugarman, D. B. (1986). An analysis of risk markers in husband-to-wife violence: The current state of knowledge. *Violence and Victims,* 1, 101-124.

Hoyle, C. (1998). Negotiating domestic violence: Police, criminal justice and victims.Oxford: Clarendon Press.

Human Rights Watch/Africa, (1995). Violence against women in South Africa: The state response to domestic violence and rape. London: Human Rights Watch.

Janoff-Bulman, R. (1989).Assumptive worlds and the stress of traumatic events:*Applications of the schema construct.Social Cognition,* 7, 113-136.

Janus, E. S., and Meehl, P. E. (1997). Assessing the legal standard for the prediction of dangerousness in sex offender commitment proceedings. *Psychology, Public Policy, and Law,* 3, 33-64.

Johnson, H. (1998) Rethinking survey research on violence against women. In R. E. Dobash and R. Dobash (Eds.), Rethinking violence against women (pp. 23-50). London: Sage.

Johnson, H., and Hotton, T. (2003). Losing control: Homicide risk in estranged and intact relationships. *Homicide Studies*, 7, 58-84.

Johnson, H., Sacco, V. F. (1995). Researching violence against women: Statistics Canada's national survey. *Canadian Journal of Criminology*, 37, 281-304.

Jones, A., D'Agostino, R., Gondolf, E., and Heckert, A., (2004). Assessing the effect of batterer program completion on reassault using propensity scores. *Journal of Interpersonal Violence*, 19(9), 1002-1020.

K.ETH.I. (2003). Domestic violence against women.Research report. Athens: National Centre for Research on Equality Issues.

Kabat-Zinn, J. (1990). Full catastrophe living: Using the wisdom of your body and mind to face stress, pain and illness.New York: Delta.

Kantor, G., and Straus, M. (2002). The "drunken bum" theory of wife beating. In M.A. Struas and R. J. Gelles (Eds.), Physical violence in American families. New Brunswick, NJ: Transaction Publishers.

Kapp, M. B., and Mossman, D. (1996). Measuring decisional competency: Cautions on the construction of a "capacimeter." *Psychology, Public Policy, and Law*, 2, 73-95.

Kapur, N. (2000). Evaluating risks. *Advances in Psychiatric Treatment*, 6, 399-406.

Katz, J. (1998). Power replacement and maintaining dignity: Leading male offenders to non-violence. In A. Hamilton (Ed.), BCACAM 1998 Proceedings.Victoria, B.C.: BCACAM.

Katz, J. (2001). Be nice, be curious, be committed: Moving beyond empathy to compassion. In H. Stefanakis (Ed.), BCACAM 2001 Proceedings. Vancouver, B.C.: BCACAM.

Kellerman, A. L., Rivara, F. P., and Rushforth, N. B. (1993). Gun ownership as a risk factor for homicide in the home. The New England Journal of Medicine, 329, 1084-1091.

Kelly, L. (1988) Surviving sexual violence.Cambridge: England, Massachusetts, Polity Press.

Kilpatrick, D.G., and Acierno, R. (2003). Mental health needs of crime victims: Epidemiology and outcomes. *Journal of Traumatic Stress*, 16(2), 119 –132.

Kirkwood, C. (1993) Leaving abusive partners: From the scars of survival to the wisdom for change. London: Sage.

Kraemer, H., Kazdin, A., Offord, D., Kessler, R., Jensen, P., and Kupfer, D. (1997). Coming to terms with the terms of risk. Archives of General Psychiatry, 54, 337-343.

Kropp, P. R. (2004). Some questions about spousal violence risk assessment. *Violence Against Women*, 10(6), 676-697.

Kropp, P.R. and Bodnarchuk, M. (2001).Evaluation of three assaultive men's treatment programs: A summary report.Vancouver: British Columbia Institute Against Family Violence. Available: http://www.bcifv.org/pubs/Evaluation %20of%20 Three% 20 Programs.pdf

Kropp, P. R., and Hart, S. D. (2000). The Spousal Assault Risk Assessment (SARA) Guide: Reliability and validity in adult male offenders. *Law and Human Behavior*, 24, 101-118.

Kropp, P. R., Hart, S. D.,and Belfrage, H. (2004). Brief spousal assault form for the evaluation of risk (B-SAFER). User manual. Vancouver: British Columbia Institute on Family Violence.

Kropp, P. R., Hart, S. D., and Belfrage, H. (2005). Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER). Vancouver, British Columbia: ProActive ReSolutions Inc.

Kropp, P. R., Hart, S. D., Lyon, D., and LePard, D. (2002). Managing stalkers: Coordinating treatment and supervision. In L. Sheridan and J. Boon (Eds.), Stalking and psychosexual obsession: *Psychological perspectives for prevention, policing and treatment* (pp. 138-160). Chichester, UK: Wiley

Kropp, P. R., Hart, S.D., Webster, C. D., and Eaves, D. (1995) Manual for the spousal assault risk assessment guide (2nd ed.). Vancouver, BC: British Columbia Institute Against Family Violence.

Kropp, P. R., Hart, S. D., Webster, C.D., and Eaves, D. (1999). Spousal Assault Risk Assessment: User's Guide. Toronto: Multi-Health Systems, Inc.

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., and Lozano, R. (Eds.). (2002). World report on violence and health. Geneva: World Health Organization.

Kurz, D. (1993). Physical assaults by husbands: A major social problem.In R. J. Gelles and D. R. Loseke (Eds.), *Current controversies in family violence* (pp. 88-103).Newbury Park, CA: Sage.

Larimer, K., and Marlatt, G.A. (1994). Addictive behaviors. In L.W. Craighead (Ed.), Cognitive and behavioral interventions: An empirical approach to mental health problems. Boston: Allyn and Bacon.

Linehan, M. (1987). Dialectical behavior therapy for borderline personality disorder. *Bulletin of the Menninger Clinic*, 51(3), 261-276.

Linehan, M. (1993a).Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford.

Linehan, M. (1993b). Skills training manual for treating borderline personality disorder. New York: Guilford.

Linney J. (2000). Assessing ecological constructs and the community context. In J. Rappaport and E. Seidman (Eds.), *Handbook of community psychology* (pp. 647-668). New York: Kluwer Academic/Plenum Publishers.

Lipsey, M., and Wilson, D. B. (1993). The efficacy of psychological, educational and behavioral treatment. *American Psychologist*, 48(12), 1181-1209.

Litwack, T. A., and Schlesinger, L. B.(1999). Dangerousness risk assessments: Research, legal, and clinical considerations. In A. K. Hess and I. B. Weiner (Eds.), Handbook of forensic psychology, 2nd ed. (pp. 171-217). New York: Wiley.

Loizos, P., and Parataxiarchis, E. (1991) Contested identities: Gender and kinship in modern Greece.Princeton, NJ, Princeton, Princeton University Press.

Loseke, D.R. (1987) Lived realities and the construction of social problems: The case of wife abuse. *Symbolic Interaction*, 10(2),229-243.

Losel, F. (1996) The efficacy of correctional treatment: A review and synthesis of meta evaluations. *Criminal Justice and Behavior*, 22, 91-105.

Losel, F. (1998). Treatment and management of psychopaths. In D. C. Cooke, A. E. Forth, and R. D. Hare (Eds.), Psychopathy: Theory, research and implications for society (pp. 89- 113).Dordrecht: The Netherlands.

Magdol, L., Moffitt, T. E., Caspi, A., Newman, D. L., Fagan, J., and Silva, P. A. (1997). Gender differences in partner violence in a birth cohort of 21-year-olds: Bridging the gap between clinical and epidemiological approaches. *Journal of Consulting and Clinical Psychology*, 65(1), 68-78.

Mahoney, M.R. (1994) Victimization or oppression? Women's lives, violence, and agency. In M. A. Fineman and R. Mykitiuk (Eds.), *The public nature of private violence: The discovery of domestic abus*e (pp. 59-92). London: Routledge.

Main, M., and Goldwyn, R. (1994). An Adult Attachment Classification System. Unpublished scoring manual. Department of Psychology, University of California at Berkeley.

Maiuro, R.D., Cahn, T.S., Vitaliano, P.P., Wagner, B.C., Zegree, J.B. (1988). Anger, hostility and depression in domestically violent versus generally assaultive and nonviolent control subjects. *Journal of Consulting and Clinical Psychology*, 56, 17 -23.

Maiuro, R. D, and Avery, D. H. (1996). Psychopharmacological treatment of aggression. *Violence and Victims*, 11(3), 239-262.

Marcus, I. (1994). Reframing 'domestic violence': Terrorism in the home. In M. A. Fineman and R. Mykitiuk (Eds.), The public nature of private violence: The discovery of domestic abuse (pp. 11-36). London: Routledge.

Marlatt, G.A. (1985). Relapse prevention: Theoretical rationale and overview of the model. In G.A. Marlatt and J.R.Gordon (Eds.), *Relapse prevention* (pp. 250 – 280). New York: Guilford Press.

Marlatt, G.A. (2002). Buddist philosophy and the treatment of addictive behavior. *Cognitive and Behavioral Practice*, 9, 44 -50.

Maruna, S. (2000). Making good: How ex-convicts reform and rebuild their lives. Washington, D.C.: American Psychological Association.

Maruna, S., LeBel, P., Mitchell, N., and Naples, M. (2004). Pygmalion in the reintegration process: Desistance from crime through the looking glass. Psychology: *Crime and Law*, 10(3), 271-281.

McFarlane, J., Campbell, J., Wilt, S., Sachs, C., Ulrich, Y., and Zu, X. (1999). Stalking and intimate partner femicide. *Homicide Studies*, 3, 300-316.

McGuire, J. (1995). What works: Reducing reoffending.Chichester: John Wiley and Sons.

McWilliams, M., and McKiernan, M. (1993). Bringing it out in the open: Domestic violence in Northern Ireland. Belfast: HMSO.

Meehl, P. E. (1996). Clinical versus statistical prediction: A theoretical analysis and a review of the literature. Northvale, NJ: Jason Aronson. (Original work published in 1954.)

Melton, G. B., Petrila, J., Poythress, N., and Slobogin, C. (1997). Psychological evaluations for the courts: A handbook for attorneys and mental health professionals, 2nd ed. New York: Guilford.

Meltzer-Brody, S., Churchill, E., and Davidson, J.R.T. (1999). Derivation of the SPAN, a diagnostic screening test for post-traumatic stress disorder. *Psychiatry Research*, 88, 63–70.

Menzies, R., Webster, C. D., and Hart, S. D. (1995). Observations on the rise of risk in psychology and law. In Proceedings of the Fifth Symposium on Violence and Aggression (pp. 91-107). Saskatoon: University Extension Press, University of Saskatchewan.

Michigan Domestic Violence Homicide Prevention Task Force (2001). 2001 Report. Retrieved October 19, 2001 from http:www.michigan/gov/emi/0,1303,7-102-112_219_240-2351--CI,00.html.

Mikulincer, M. (1998). Adult attachment style and affect regulation: Strategic variations in self-appraisals. *Journal of Personality and Social Psychology*, 75, 420–435.

Mill, J.S. (1991). *The subjection of women.* Oxford: Oxford University Press. (Original work published in 1869)

Miller, M. (2003). Personality and the etiology and expression of PTSD: A three-factor model perspective. *Clinical Psychology: Science and Practice*, 10(4), 373–393.

Miller, P.A., and Eisenberg, N. (1988). The relation of empathy to aggressive and externalizing/antisocial behavior. *Psychological Bulletin*, 103(3), 324–344.

Millon, T. (1997). The Millon Inventories: Clinical and personality assessment. New York: Guilford.

Moffitt, T. E., Caspi, A., Rutter, M., and Silva, P. A. (2001). Sex differences in antisocial behavior. Cambridge: Cambridge University Press.

Moffitt, T. E., Robins, R. W., and Caspi, A. (2001). A couples analysis of partner abuse with implications for abuse-prevention policy. Criminology and Public Policy, 1(1), 5-36.

Monahan, J. (1995). The clinical prediction of violent behavior. Northvale, NJ: Jason Aronson. (Original work published in 1981)

Monahan, J., and Steadman, H. J. (1994). Violence and mental disorder: Developments in risk assessment. Chicago: University of Chicago Press.

Moracco, K., Runyan, C. W., and Butts, J. D. (1998). Femicide in North Carolina, 1991-1993: A statewide study of patterns and precursor. Homicide Studies, 2, 422-446.

Moracco, K. E., Runyan, C. W., and Butts, J. D. (2003). Female intimate partner homicide: A population-based study. *Journal of American Women's Medical Association, 58,* 20-5.

Morse, B. J. (1995). Beyond the Conflict Tactics Scale: Assessing gender differences in partner violence. *Violence and Victims*, 4, 251-271.

Morton, E., Runyan, C. W., Moracco, K. E., and Butts, J. (1998). Partner homicide-suicide involving female homicide victims: A population-based study in North Carolina, 1988-1992. *Violence and Victims*, 13, 91-106.

Mouzos, J. (2000). Homicide encounters: A study of homicides in Australia 1989-1999. Canberra: Australian Institute of Criminology.

Mullender, A. (1996). Rethinking domestic violence: The social work and probation response. London: Routledge.

Mulloy, R., Smiley, C., Hart, S., and Dawda, D. (2000). Psychopathy and cognitive-behavioral treatment success in personality disordered offenders. Paper presented at the American Psychological Association, Toronto, Canada.

National Report of Greece, The physical and sexual violence against women in Greece. (Ministry to the Presidency, December, 1990).

New, M., and Berliner, L. (2000). Mental health service utilization by victims of crime. J*ournal of Traumatic Stress*, 13, 693–707.

Ogloff, J. R. P., Wong, S., and Greenwood, A. (1990). Treating criminal psychopaths in a therapeutic community program. Behavioral Sciences and the Law, 8, 181-190.

Otto, R. K. (2000). Assessing and managing violence risk in outpatient settings. *Journal of Clinical Psychology*, 56, 1239-1262.

Ozer, E.J., Best, S.R., Lipsey, T.L., and Weiss, D.S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. Psychological Bulletin, 129(1), 52–73.

Pagelow, M.D. (1981). Woman battering: Victims and their experiences. Beverly Hills, CA: Sage.

Pahl, J. (1978). A refuge for battered women. London: HMSO.

Pahl, J. (1985). Private violence and public policy: The needs of battered women and the response by the public services.London: Routledge and Kegan.

Pampel, F. C., and Williams, K. R. (2000). Intimacy and homicide: Compensating for missing data in the SHR. *Criminology*, 38, 661-680.

Pence, E. (1989). Batterer programs: Shifting from community collusion to community confrontation.In P.L. Caesar and L.K.Hamberger (Eds.), Treating men who batter. Duluth, MN: Minnesota Program Development, Inc.

Pence, E., and Paymar, M. (1986).Education groups for men who batter: The Duluth Model.New York: Springer-Verlag.

Perloff, L. (1983). Perceptions of vulnerability to victimization. Journal of Social Issues, 39, 41–61.

Pernanen, K. (1991). *Alcohol in human violence.* NewYork: Guilford.Petrosino, A.J., Fellow, S., and Brensilber, D. (1997). Convenient victims: A research note. Criminal Justice Policy Review, 8(4), 405-420

Piipsa, M. (2002). Complexity of patterns of violence against women in heterosexual partnerships. *Violence Against Women*, 8, 873-900.

Pizzey, E. (1974). Scream quietly or the neighbours will hear.Harmondsworth:UK, Penguin.

Plotnikoff, J., and Woolfson, R.(1998). Policing domestic violence: Effective organisational structures.*London, UK,H*ome Office, Policing and Reducing Crime Unit, Police Research Series, Paper 100.

Polk, K. (1994). When men kill: Scenarios of masculine violence. New York: Cambridge University Press.

Pomerol, J. C. (2001). Scenario development and practical decision making under uncertainty. *Decision Support Systems*, 31, 197-204.

Prochaska, J. O., DiClemente, C. C., and Norcross, C. C. (1992).In search of how people change: Applications to addictive behaviors.*American Psychologist*, 47, 1102-1127.

Ptacek, J. (1999). Battered women in the courtroom. The power of judicial responses. Boston: Northeastern University Press.

Quinsey, V. L., Harris, G. T., Rice, G. T., and Cormier, C. A. (1998). Violent offenders: Appraising and managing risk. Washington, DC: American Psychological Association.

Reich, W. (1945/1972).Character analysis. New York: Touchstone /Simon and Schuster.

Richie, B. E., and Kanuha, V. (1997). Battered women of color in public health care systems. In M. Baca Zinn, P. Hondagneu-Sotelo, and M. Mesner (Eds.), Through the prism of difference (pp.121-129). Boston: Allyn and Bacon.

Riggs, D. S., Caulfield, M. B., and Street, A. E. (2000). Risk for domestic violence: Factors associated with perpetration and victimization. *Journal of Clinical Psychology*, 56, 1289-1316.

Rimsza, M. E., Schackner, R. A., Bowen, K. A., and Marshall, W. (2002). Can child deaths be prevented? The Arizona child fatality review program experience. Pediatrics, 110(1). 11.]

Ringland, G. (1998). Scenario planning: Managing for the future. Chichester, UK: Wiley.

Rondeau, G., Brodeur, N., Brochu, S., and Lemire, G. (2001). Dropout and completion of treatment among spouse abusers. *Violence and Victims*, 16(2), 127-142.

Rosenfeld, B. D. (1992). Court-ordered treatment of spouse abuse. Clinical Psychology Review, 12, 205-226.

Rosenthal, R. (1983). Assessing the statistical and social importance of the effects of psychotherapy. *Journal of Consulting and Clinical Psychology,* 51(1), 4-13.

Rothbaum, B.O., Meadows, E.A., Resick, P., and Foy, D.A. (2000).Cognitive behavioral therapy. In E.B. Foa, T.M. Keane, and M.J. Friedman (Eds.), Effective therapy for PTSD. New York: Guilford.

Rotter, J (1966). Generalized expectancies for internal versus external control of reinforcement. *Psychological Monographs,* 80(1), 1-28.

Roussos, S. T., and Fawcett, S. B. (2000). A review of collaborative partnerships as a strategy for improving community health. Annual Review of Public Health, 21, 369-402.

Ryan, G.H., Bensinger, P.B., Kane, C.M. (2000). The Chicago women's health risk study at a glance. Chicago, IL: Illinois Criminal Justice Information Authority.

Rying, M. (2001) Dödligt våld mot kvinnor i nära relationer. BRÅ-rapport 2001:11. Stockholm: Brottsförebyggande rådet. Fritzes. (Swedish).

Sales, E., Baum, M., and Shore, B. (1984). Victim readjustment following assault. *Journal of Social Issues,* 40, 117 – 136.

Santa Clara County Domestic Violence Council Death Review Committee (2000). Final report: 2000. Unpublished manuscript.

Saunders, D. G. (1992). A typology of men who batter women: Three types derived from cluster analysis. *American Journal of Orthopsychiatry,* 62, 264-275.

Saunders, D. G. (1993). Husbands who assault: Multiple profiles requiring multiple responses. In N. Z. Hilton (Ed.), Legal responses to wife assault: Current trends and evaluation (pp. 9-34).Newbury Park, CA: Sage.

Schechter, S. (1982). Women and male violence: The visions and struggles of the battered women's movement.Boston: South End Press.

Schillinger, E. (1988). Dependency, control and isolation: Battered women and the welfare system. *Journal of Contemporary Ethnography,* 16, 469-490.

Schneider, M.E. (1994). The violence of privacy.In M. A. Fineman and R. Mykitiuk (Eds.), The public nature of private violence: *The discovery of domestic abuse,* (pp. 36-58). London: Routledge.

Schumacher, J. A., Feldbau-Kohn, S., Slep, A. M. S., and Heyman, R. E. (2001). Risk factors for male-to-female partner physical abuse. *Aggression and Violent Behavior,* 6, 281-352.

Schwartz, P. (1990). The art of the long view. New York: Doubleday.

Serran, G., and Firestone, P. (2004). Intimate partner homicide: A review of the male proprietariness and the self-defense theories. *Aggression and Violent Behavior,* 9, 1-15.

Shackelford, T.K. (2001).Cohabitation, marriage, and murder: Woman killing by male romantic partners.*Aggressive Behavior,* 27, 284-291.

Sharps, P. W., Campbell, J. C., Campbell, D., Gary, F., and Webster, D. (2003). The role of alcohol use in intimate partner femicide. *The American Journal on Addictions,* 10, 122-135.

Sharps, P. W., Koziol-McLain, J., Campbell, J., McFarlane, J., Sachs, C., and Xu, X. (2001). Health care providers' missed opportunities for preventing femicide. *Preventive Medicine,* 33, 373–380.

Sharps, P., Campbell, J. C., Campbell, D., Gary, F., and Webster, D. (2003). Risky mix: Drinking, drug use, and homicide. National Institute of Justice, 250, 8-13.

Shepard, M. (1987) Interventions with men who batter: An evaluation of a domestic abuse program. Paper presented at the third National Conference on Domestic Violence: University of New Hampshire.

Shepard, M. (1992). Predicting batterer recidivism five years after community intervention. *Journal of Family Violence*, 7(3), 167-178.

Showalter, C. R., Bonnie, R. J., and Roddy, V. (1980). The spousal-homicide syndrome. *International Journal of Law and Psychiatry*, 3, 117–141.

Skogan, W. G. (1999). Victim surveys at century's end. In J.J. M.Van Dijk, R.G.H. Van Kaam, and J. Wemmers, (Eds.), Caring for Crime Victims (pp. 41-55). Monsey, NY: Criminal Justice Press.

Smith, P. H., Moracco, K. E., and Butts, J. D. (1998). Partner homicide in context: A population based perspective. *Homicide Studies*, 2, 400-421.

Solomon, Z. (1995). Coping with war-induced stress: The Gulf war and the Israeli response. New York: Plenum.

Sonkin, D.J., and Durphy, M. (1989). Learning to live without violence: A handbook for men. Volcano, CA.: Volcano Press.

Sparks, R., Genn, H., and Dodd, D. (1977). Surveying victims. London, UK: Wiley.

Spinellis, C.D. (1997) Crime in Greece in perspective. Athens: Sakkoulas.

Statistics Canada (2003). *Homicide in Canada*, 2003, 24(8), 1-23.

Stefanakis, H. (2000). Understanding and facilitating change for men who are violent. In H. Stefanakis (Ed.), The proceedings of the BC Association of Counsellors of Abusive Men Conference: 2000. Victoria, B.C.: BCACAM.

Steinman, M. (1990). Lowering recidivism among men who batter women. *Journal of Police Science and Administration, 7*, 124-132.

Stets, J., and Straus, M. (1992). The marriage license as a hitting license. Physical violence in American families. New Brunswick, N.J.: Transaction Publishers.

Stith, S.M., Smith, D.B., Penn, C.E., Ward, D.B., and Tritt, D. (2004). Intimate partner physical abuse perpetration and victimization risk factors: A meta-analytic review. *Aggression and Violent Behavior, 10*, 65 – 98.

Stosny, S. (1995). Treating attachment abuse. New York: Springer.

Stout, K. D. (1993). Intimate femicide: A study of men who have killed their mates. *Journal of Offender Rehabilitation*, 19, 81-94.

Straus, M. A. (1979). Measuring family conflict and violence: The conflict tactics scale. *Journal of Marriage and the Family*, 41, 75-88.

Straus, M.A., Hamby, S.L., Boney-McCoy, S., and Sugarman, D.B (1996). The revised Conflict Tactics Scale (CTS-2). *Journal of Family Issues*, 7, 283-316.

Stringer, E.T. (1999). Action research: Second edition. Thousand Oaks, CA: Sage Strube, M.J.,and Barbour, L.S. (1983) The decision to leave an abusive relationship: Economic dependence and psychological commitment. *Journal of Marriage and the Family*, 45, 785-793.

Syers, M., and Edleson, J. L. (1992). The combined effects of coordinated criminal justice intervention in woman abuse. *Journal of Interpersonal Violence, 7*, 490-502.

Taft, C.T., Murphy, C.M., Elliot, J.D., and Morrel, T.M. (in press). Attendance enhancing procedures in group counseling for domestic abusers. *Journal of Counseling Psychology*.

Tangney, J., Wagner, P., Fletcher, C., and Gramzow, R. (1992). Shamed into anger: The relation of shame and guilt to self reported anger and aggression. *Journal of Personality and Social Psychology*, 62, 669 -675.

Tolman, R. M., and Bennett, L. W. (1990).A review of research on men who batter.*Journal of Interpersonal Violence*, 5, 87-118.

Tolman, R.M. (1989). The development of a measure of psychological maltreatment of women by their male partners. *Violence and Victims*, 4(3), 159-177.

Tsikris, A. (1996). Viasmos [Women and Rape]. Athens: Sakkoulas.

van der Heijden, K. (1997). Scenarios: The art of strategic conversation. New York: Wiley.

van der Kolk, B. A. (1987). Psychological trauma. Washington, DC: American Psychiatric Press.

van der Kolk, B.A., McFarlane, A.C., and Weisaeth, L. (1996). Traumatic stress: The effects of overwhelming experience on mind, body and society. New York: Guilford Press.

van Dijk, J.J. M., Van Kaam, R. G. H., and Wemmers, J. (Eds.). (1999). Caring for crime victims.Monsey, New York: Criminal Justice Press.

van Kesteren, J., Mayhew, P., and Nieuwbeerta, P. (2000). Criminal victimization in seventeen industrialized countries. Leiden, Den Haag: NSCR/WODC.

Venis, S., and Horton, R. (2002). Violence against women: A global burden. *Lancet* , 359, 1172.

Walker, L. (1979). The battered woman. New York: Harper and Row.

Wallace, A. (1986). Homicide: The social reality. Sydney, Australia: New South Wales Bureau of Crime and Statistics.

Wallace, R., and Nosko, A. (1993).Working with shame in the group treatment of male batterers. *International Journal of Group Psychotherapy*, 43(1), 45-61.

Waltz, J. (2003). Dialectical behavior therapy in the treatment of abusive behavior. In D. Dutton, and D. J. Sonkin (Eds.), Intimate violence: Contemporary treatment innovations.New York: Haworth Press.

Ward, T. (2002). Good lives and the rehabilitation of offenders:Promises and problems. *Aggression and Violent Behaviour*, 7, 513-528.

Ward, T., Day, A., Howells, K., and Birgden, A. (2004). The multifactor offender readiness model.*Aggression and Violent Behaviour*, 9, 645-673.

Watt, K. A. (2003). Intimate partner femicide: An ecological-transactional approach. Unpublished Masters thesis, Department of Psychology, University of Illinois at Urbana-Champaign.

Watt, K. A., Hart, S. D., Kropp, P. R., and Bain, P. (2004). Intimate partner femicide in British Columbia: Issues, findings, and recommendations. Vancouver, BC: British Columbia Institute Against Family Violence.

Websdale, N. (1999). Understanding Domestic Homicide. Boston: Northeastern University Press.

Websdale, N. (2003). Reviewing domestic violence deaths. National Institute of Justice, 250, 26-31.

Websdale, N., Moss, H., and Johnson, B. (2001). Domestic violence fatality review: Implications for law enforcement. The Police Chief, July, 65-74.

Websdale, N., Sheeran, M., and Johnson, B. (2001). Reviewing domestic violence fatalities: Summarizing national developments. Minneapolis, MN: Center Against Violence and Abuse.

Websdale, N., Town, M., and Johnson, B. (1999). Domestic fatality reviews: From a culture of blame to a culture of safety. *Juvenile and Family Court Journal*, Spring, 61-74.

Webster, C. D, and Douglas, K. S. (1999). Predicting violence in mentally and personality disordered individuals. In R. Roesch, S. D. Hart, and J. R. P. Ogloff (Eds.), Psychology and law: The state of the discipline (pp. 175-239). Dordrecht, The Netherlands: Kluwer.

Webster, C. D., and Jackson, M. A. (Eds.) (1997), Impulsivity: Theory, assessment, and treatment. New York: Guilford.

Webster, C. D., Douglas, K. S., Eaves, D., and Hart, S. D. (1997). HCR-20: Assessing risk for violence, version 2. Burnaby, British Columbia: Mental Health, Law, and Policy Institute, Simon Fraser University.

Webster, R., Schnitzer, P., Jenny, C., Ewigman, B., and Alario, A. (2003). Child death review: The state of the nation. *American Journal of Preventive Medicine,* 25, 58-64.

Weisz, A., Tolman, R., and Saunders, D.G. (2000). Assessing the risk of severe domestic violence: The importance of survivor's predictions. *Journal of Interpersonal Violence,* 15, 75-90.

Wexler, D. (2000). Domestic Violence 2000: Group leaders' manual. New York: W.W. Norton.

Widom, C. S. (1989).*The cycle of violence. Science*, 244, 160-166.

Wietkiewitz, K., and Marlatt, G.A. (2004) Relapse prevention for alcohol and drug problems: That was Zen, this is Tao. *American Psychologist*, 59(4), 224–235.

Williams, K., and Houghton, A. B.(2004). Assessing the risk of domestic violence reoffending: A validation study. *Law and Human Behavior*, 24(4), 437-455.

Wilson, M., and Daly, M. (1992). Till death do us part. In J. Radford and D. E. H. Russell (Eds.), Femicide: The politics of women killing (pp. 83-98). New York: Twayne Publishers.

Wilson, M., and Daly, M. (1992). Who kills whom in spouse killings? On the exceptional sex ratio of spousal homicides in the United States. *Criminology*, 30, 189-215.

Wilson, M., and Daly, M. (1993). Spousal homicide risk and estrangement. Violence and Victims, 8, 3-16.

Wilson, M., Daly, M., and Wright, C. (1993). Uxoricide in Canada: Demographic risk patterns. *Canadian Journal of Criminology*, 35, 263-291.

Wilson, M., Johnson, M. H., and Daly, M. (1995). Lethal and non-lethal violence against wives. *Canadian Journal of Criminology,* 37, 331-362.

Winkel, F. W.(1995). Slachtofferschap van Misdrijven als Psychologische Calamiteit: een nuancering vanuit het strain-pain model. (Criminal victimization as a psychological calamity: An analysis based on the strain-pain model). *De Psycholoog*, 30, 155-161.

Winkel, F. W. (2000). Susceptibility profiling and traumatisation: A new look at 'trauma memories' and emerging guidelines for police and victim support workers. In A. Czerederecka, T. Jaskiewicz-Obydzinska, and J. Wojcikiewicz (Eds.), Forensic psychology and the law:Ttraditional questions and new ideas(pp. 265 – 272). Krakow: Institute of Forensic Research Publishers.

Winkel, F. W., Wohlfarth, T., and Blaauw, E. (2004). Police referral to victim support: The predictive and diagnostic value of the Risk (10) screening instrument. *Crisis,* 25(3), 118 – 127.

Winkel, F.W. (1987). Politie en voorkoming misdrijven: Effecten en neveneffecten van voorlichting. (Police and crime prevention: effects and side-effects of persuasive communication). Amsterdam: Mens and Recht Publishers.

Winkel, F.W. (1998). Fear of crime and criminal victimization: Testing a theory of psychological incapacitation of the 'stressor' based on downward comparison processes. *British Journal of Criminology*, 38(3), 473 - 485.

Winkel, F.W. (1999). Repeat victimization and trauma-susceptibility: Prospective and longitudinal analyses. In J.J.M.Van Dijk, R.G.H. Van Kaam, and J.Wemmers (Eds.), Caring for crime victims (pp. 207-221). Criminal Justice Press: Monsey, New York.

Winkel, F.W. (2003). Geboden toegang tot slachtofferhulp: Een studie naar de diagnostische waarde van de Scanner. (Facilitated access to victim support: an empirical examination of the diagnostic value of the Scanner). Tijdschrift voor Veiligheid en Veiligheidsstudies, 3, 4–24.

Winkel, F.W. (2004). Politiele verwijzing naar slachtofferhulp: Naar een verbeterde afstemming van slachtofferzorg en slachtofferhulp door middel van screening. (Police referral to victim support: creating a better fit between police victim care and victim support through screening). Rapport Ministerie van Justitie. Amsterdam: Vrije Universiteit.

Winkel, F.W., and Denkers, A. (1995). Crime victims and their social network: A field study on the cognitive effects of victimisation, attributional responses, and the victim-blaming model. *International Review of Victimology*, 4(2), 309-322.

Winkel, F.W., and Vrij, A. (1993). Facilitating problem- and emotion focused coping in victims of burglary: Evaluating a police crisis intervention programme. *Journal of Community Psychology*, 21(2), 97-113.

Winkel, F.W., and Vrij, A. (1998). Who is in need of victim support?: The issue of accountable and empirically validated selection and victim referral. *Expert Evidence*, 6, 23-41.

Winkel, F.W., Blaauw, E., and Wisman, F. (1999). Dissociation-focused victim support and coping with traumatic memory. *International Review of Victimology*, 6, 179-200.

Winkel, F.W., Blaauw, E., Sheridan, L., and Baldry, A. (2003). Repeat criminal victimization and vulnerability for coping failure: A prospective examination of a potential risk factor. Psychology, *Crime and Law*,9(1), 87–96.

Winkel, F.W., Denkers, A., and Vrij, A. (1994). The effects of attributions on crime victims' psychological re-adjustment. Genetic, Social, and General Psychology Monographs, 120(2), 147 -169.

Winkel, F.W., Wohlfarth, T., and Blaauw, E. (2003). Police based early detection of Type A trauma symptomatology in crime victims: The validity of rapid, objective risk assessment. *International Journal of Law and Psychiatry*, 26, 191–206.

Wohlfarth, T. D., Van den Brink, W., Winkel, F.W., and Ter Smitten, M. (2003). Screening for posttraumatic stress disorder: An evaluation of two self-report scales among crime victims. *Psychological Assessme*nt, 15(1), 101 - 109.

Wohlfarth, T., Winkel, F.W., and Van den Brink, W. (2000). Identifying crime victims who are at risk for post traumatic stress disorders: Developing a practical referral tool. Achmea Foundation Research in Progress Report. Amsterdam: Departments of Clinical and Social Psychology.

Wohlfarth, T., Winkel, F.W., and Van den Brink, W. (2002). Identifying crime victims who are at high risk for post traumatic stress disorder: Developing a practical referral instrument. *Acta Psychiatrica Scandinavica*, 105, 451 – 460.

Wohlfarth, T., Winkel, F.W., Ybema, J.F., and Van den Brink, W. (2001). The relationship between socio-economic inequality and criminal victimization: A prospective study. *Social Psychiatry and Psychiatric Epidemiology*, 36(7), 361-370.

Women's Aid Federation of England (1998). Families without fear: Women's aid agenda for action on domestic violence: Recommendations for a national strategy. London: WAFE.

Wong, S. (2001). Treatment of violent offenders: It works! *Paper presented at meeting of Swedish Correctional Services Orebreo, Sweden.*

Yalom, I. (1975). The theory and practice of group psychotherapy. New York: Basic Books.

Zawitz, M. W. (1994). Violence between intimates. Washington, DC: Bureau of Justice Statistics.

Zimmerman, M., and Mattia, J.I. (2001). A self-report scale to help make psychiatric diagnoses. *Archives of General Psychiatry*, 58, 787–795.

INDEX

A

B

C

D

E

F

G

H

I

J

K

L

M

N

O

P

Q

R

S

T

U

V

W

Y