Working with Abusive Men Day 3: Intake, Assessment, Evaluation, and Placement

Presented by Dr. Chris Huffine, Psy.D.
Allies in Change
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Evidence Based Practice

Thanks to Chris Wilson for significant contributions to this presentation

Evidence Based Practice

- Evidence Based Practice (EBP) is usually described one of two ways:
- 1. Using empirically supported techniques based on published research of others
- 2. Doing outcome studies of your own work to show that it is effective
- EBP has become increasingly popular in many fields as a way to support and justify whatever work is being done
- The term EBP is sometimes tossed around by people who don't know what they're talking about

Senate Bill 267

- Requires "the Department of Corrections, the Oregon Youth Authority, the State Commission on Children and Families, [and] that part of the Department of Human Services that deals with mental health and addiction issues to spend at least 75% of state moneys on evidence-based programs."
- This *only* applies to any batterer intervention provider who *receives funding or payment from Child Welfare or Corrections*
- A popular tool used to determine if a program is evidence-based is the Criminal Program Checklist (CPC).

Criminal Program Checklist (CPC)

- Created by Ed LaTessa
- Based on an extensive review of research primarily on working with felons/parolees
- Three key principles:
- Risk
- Need
- Treatment

Examples of CPC questions

- Program leadership
  - Is program director directly involved?
  - Is program stable in funding and community supported?
- Staff characteristics
  - Formal staff meetings?
  - On-going supervision?
- Offender assessment
  - Risk assessment?
  - Responsivity?
- Treatment characteristics
  - Is there a manual?
  - Separating by risk level?

Criminal Program Checklist (CPC)
Risk principle

- One study found:
- Low risk 9% recidivism
- Medium risk 34% recidivism
- High risk 59% recidivism
- Programs need to target the highest risk offenders for the bulk of services

Criminal Program Checklist (CPC)
Risk principle

- We see large decreases in recidivism when dosage levels go from 100 to 200 hours for high risk offenders---81% to 57%
- It is vital that high and low risk offenders not be mixed
- Low risk offenders may be negatively influenced by high risk offenders
- Intensive treatment for low risk offenders may actually increase recidivism
- The level of treatment may interfere with the pro-social networks and activities they already have in place

Criminal Program Checklist (CPC)
Need principle

- Programs should focus on addressing criminogenic needs
- This is especially important for more criminally oriented men
- This is less important for less criminally oriented men

Criminogenic Needs

- Anti social attitudes
- Anti social friends
- Substance abuse
- Lack of empathy
- Impulsive behavior
- Family relationships
- School/work satisfaction
- Limited leisure activities

Criminal Program Checklist (CPC)

Treatment principle

- Treatment should be more behavioral/cognitive behavioral in focus
- Behavioral: skill building, role plays practicing those specific skills
- Cognitive: Challenging anti-social beliefs/thinking errors and replacing with pro-social beliefs
- Treatment should focus primarily on current risk factors
- This is, again, most important for criminally oriented/higher risk abusive men

Problems with Applying EBP criteria in general and the CPC in particular to BIPs

- There is relatively limited research proving what works with domestically violent men
- The most clear evidence is that we do not yet KNOW what works with abusive men
- Much of the research the CPC is based on defines risk as committing a felony. Most of the men we see have never committed a felony and never will
- Most of the men we see are already considered low risk, which means much of what the CPC has found may not apply

Problems with Applying EBP criteria in general and the CPC in particular to BIPs

- Domestically violent men are qualitatively different than the generally criminal population that has typically been studied because most of them do not have a criminal history.
- Latessa himself has admitted that there has been no research specifically on DV offenders and that he is not an expert on that population.
- The CPC is, in part, focusing on program structure for high risk populations, which may not even be appropriate for DV offenders and/or low risk offenders.

Examples of CPC questions that aren't applicable for BI

- Discussion of punishers/rewards
- Focus on criminogenic factors
- Staff receive 40 hours training/year

CPC—Not All Bad

- However, as a measure to help programs improve, the CPC does have some value.
- A number of aspects are likely to be applicable even with our population:
  - Active supervision
  - Having a manual
  - Fidelity
  - Addressing underlying criminogenic needs
  - Etc
- The CPC is best when used as a means of helping a program improve rather than grading or excluding a program.

Concerns about EBP . . .

- "Criminological [experimental] randomists have overreached in their claims and generated their own folklores, or what I think are more appropriately referred to as myths. Experimental myths are more than just stories or part of a tradition—they have become actively institutionalized in the routine workings of criminology . . . Experiments are not the gold standard simply because there is no free-standing gold standard."
  - -Robert Sampson, Past president, American Society of Criminology (2010)

Concerns about EBP . . .

- "Even the field of medicine, which gave randomized clinical trials their heyday, has outgrown their constraints. The Roundtable on Evidence-Based Medicine of the Institute of Medicine called for a re-examination of what constitutes evidence and suggested that randomized clinical trials should not be considered the gold standard" (Lisbeth Shorr, 2009)
- **The alternative: complex interventions which blend research, theory, client population/cultural factors and experience (rather than research alone) are more effective and appropriate**

Domestic Violence Evaluations

Based on material originally presented by
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Definition of terms

- The words "evaluation", "intake", and "assessment" are often used synonymously when they are distinct things.
- An intake, intake assessment, and assessment all refer to the same thing—a process of accepting a person into a program with the presumption that they need to be in the program. In other words, it is assumed that treatment is needed.
- The goal of an intake assessment is to gather background information about the person, orient the person to the program and determine if there is anything that might prevent them from engaging in the program.
- More on the intake process in a few minutes.
- A domestic violence evaluation, within this context, is typically to determine whether a person needs any sort of treatment in the first place

Domestic violence evaluations

- A domestic violence evaluation is separate and distinct from a psychological evaluation
- Most domestic violence evaluations only take a few minutes. The client discloses enough to indicate a pattern/history of abusive behavior. (where there's smoke . . .)

Domestic violence evaluations

- A domestic violence evaluation is separate and distinct from a psychological evaluation
- Most domestic violence evaluations only take a few minutes. The client discloses enough to indicate a pattern/history of abusive behavior. (where there's smoke . . .)
- The true DV evaluations are needed when there is *not* a clear history, but there is some suspicion

Domestic violence evaluations

- There are no objective tests to determine if someone is a DV perpetrator
- There is no "typical" profile for a DV perpetrator on standard psychological tests
- Many DV perpetrators would display a "normal" psychological profile
- We are looking for a pattern of behavior

Domestic violence evaluations

- Components of a DV eval:
- Extensive evaluatee interview
- Review of any collateral material (police reports, psych evals, etc)
- Interviews with other individuals (victim, romantic partner, family members)
- The problem with all DV assessment tools (e.g., Conflict Tactics Scale, Domestic Violence Inventory) is that they have high face validity so it is easy to falsely deny past abusive behavior

How to figure out who needs full DV intervention

- The arrest or the abusive incident is a "snapshot". The question is what is the larger movie it is from?
- Just as getting a DUI may or may not be from the "movie" of an alcoholic, a DV arrest may or may not be from the "movie" of an abuser
- What possible "movies" could the "snapshot" be from?

A proposed classification system for people arrested for DV

- Virtually anyone who gets arrested for DV will fall into one of the following six categories, ordered from least to most severe:
  - Category 1. One time event
  - Category 2. A limited occurrence due to other psychological factors
  - Category 3. Secondary aggression/violent resistance
  - Category 4. One time severe event on top of a continuing pattern of more subtle abuse and control
  - Category 5. Continuing obvious aggression
  - Category 6. A larger criminal pattern of behavior

Source of this classification system

- While I originally came up with this system based on my own experience, I later discovered that a very similar classification system (minus category 4) based on empirical research was developed by Ellen Pence and Shamita Das Dasgupta of Praxis International in 2006
- The article outlining their findings is "Re-examining 'Battering': Are All Acts of Violence Against Intimate Partners the Same?"
- Available for download at: http://praxisinternational.org/files/praxis/files/ReexaminingBattering.pdf

Category 1: One time event

- A mistaken choice
- This is truly an isolated incident
- There is no pattern of abuse and control, obvious or subtle
- There is no pro-abuse belief system
- The family is not intimidated or concerned

Category 1: One time event

- Highly unlikely to get arrested or to come to the awareness of others. There is a single point of possible intervention. Akin to the only time you get drunk you drive drunk and you get arrested.
- The family itself will not be concerned since this is not normal, typical or indicative of a larger pattern
- No intervention is needed since, by definition, it won't happen again
- For the above reasons, very few people will fall into this category. However, others tend to misattribute people to this category, most notably Category 4 individuals

Category 2: A limited occurrence

- Scattered acts of abuse and control due to some other psychological condition
- There are multiple acts of abuse and control that do not form a pattern
- Typically this is a result of some other psychological condition (e.g., Bi-polar Disorder, PTSD) which, on a rare occasion, leads the person to make an abusive choice
- The person generally has pro-social behavior (i.e. no larger subtle pattern of abuse and control) and pro-social beliefs (i.e., does not want to be abusive)

Category 2: A limited occurrence

- No abuse intervention is needed for this group, although other psychological services may be needed/helpful
- Because the behavior is rare and does not form a pattern the family is unlikely to be intimidated by the behavior while they may be concerned about the underlying psychological issues
- For this reason this group is also highly unlikely to get arrested because the behavior is so infrequent and because the family is not concerned. In other words, this category will also have a very small number of people in it

Category 2: A limited occurrence

- Again, individuals from other categories may be misattributed to this group (including by the victim), ignoring/minimizing larger patterns of abuse and pro-abuse beliefs and misattributing them to "psychological issues". This is often what we have historically done with alcoholics/addicts.
- There will also be some people who have patterns of abuse and control (and related pro-abuse beliefs) that *also* have psychological issues. Those issues don't cause the abuse, but may aggravate it (like the alcoholic who also has PTSD or Bipolar Disorder). This would be another example of dual diagnosis—the presence of abusive behavior and a co-existing mental health condition

Category 3: Secondary aggression

- A victim of on-going abuse responding abusively
- Many people who are being abused will have isolated acts of responding abusively, akin to the kid hitting back at the bully who is beating him up
- Often times the "victim", who is routinely the one being abusive, takes advantage of this moment of abuse by calling the police
- No pro-abuse belief system and no abusive behavior of any kind outside of the abusive relationship
- The "victim" is not truly intimidated or generally concerned, although there may be heavily blaming of the person who gets arrested

Category 3: Secondary aggression

- Ideally this group should not be mandated to any services
- Alternatively, a specialized program for secondary aggression is offered where there is more heavy emphasis on victimization issues, which is the structure of many programs for female aggressors because of how pervasive secondary aggression is among women who are arrested for DV
- Alternatively, these individuals can be placed into a regular group where they are typically initially viewed as cooperative but with some denial. Many still do well in these programs and learn a lot about their perpetrator, although they may take on too much responsibility for the other person's abuse. Most of the (rare) male secondary aggressors end up in this group.

Category 3: Secondary aggression

- If there is no contextual analysis this person is more likely to get arrested, akin to both the bully and his victim getting suspended
- A disproportionate number of heterosexual women are arrested for this, due to the significant majority of DV being perpetrated by heterosexual men
- A substantial number of the women arrested for DV perpetration fall into this category while only a very small number of men fall into this category
- This family does need DV intervention, but the primary perpetrator is not being seen/being misidentified as the "victim"

Category 4: Continuing subtle pattern

- A more extreme/most extreme incident of someone with pro-abuse beliefs and more subtle patterns of abuse and control
- These individuals generally limit their abusive behavior to certain categories to avoid arrest or sanction (e.g., no physical abuse, no obvious abuse) but have a moment of "going too far" which leads to their arrest, alcohol use further increases the likelihood of this happening
- They and family members may be able to honestly say that the arresting incident was a one time event
- However there is a significant on-going pattern of more subtle non-physically abusive and controlling behavior

Category 4: Continuing subtle pattern

- There is a pro-abuse belief system in place
- The family is negatively affected by and concerned about the abuse and control, although they may or may not be intimidated by/in fear for their physical safety
- This may be the "last straw" which leads the family (or others) to call the police
- Because of the subtlety of the abuse and control, the family may not identify it as DV until their consciousness is raised
- There may not be any other criminal history or arrest history and perpetrators often score as low risk
- Most of these individuals fall into the Family Only category of abusers

Category 4: Continuing subtle pattern

- These individuals absolutely need a full length abuse intervention program although on the surface they may not look that bad (like the functioning alcoholic)
- This category is the least likely to receive the abuse intervention services they need because they are never arrested (except, possibly, for the single incident) and generally can't be arrested (because their abusive behavior is not illegal)
- This is also the group that is most likely to be mischaracterized as not needing services (inappropriately placed in Categories 1 or 2) when they actually do
- They may also be given shorter length of service when they actually need the full course

Category 4: Continuing subtle pattern

- This category likely has the largest number of people in it (based on my own 20+ years of experience in the Portland metro area)—even more true as we continue to speak out against physical abuse and to toughen up or arrest laws and sanctions against physical abusers
- In my opinion, this is the most important category of abusers for us to address because of how large it is and how tougher laws will push an increasing number of abusive partners into this category

Category 5: Continuing obvious aggression

- The classic/obvious abuser
- There is a clear, documented pattern of abusive behavior, either through arrests, police contacts, and/or self-disclosure/eye witness reports
- There is often an on-going pattern of physical abuse
- There is a pro-abuse belief system
- Most likely to be accurately identified
- While most likely to be arrested for DV, many times they are still not arrested
- They often score at medium or high risk
- They clearly need a full length abuse intervention program

Category 6: Larger criminal pattern

- The latest bad behavior from someone doing a variety of bad behaviors
- There are multiple acts of abusive and controlling behavior
- There is a pro-abuse belief system
- These behaviors and beliefs are just part of a broader array of criminal behaviors and beliefs
- Because other criminal behaviors (e.g., drug dealing, gang involvement, pimping) may be seen as more serious and/or easier to prosecute the DV crimes may not be charged/prosecuted and this person may not be viewed as an abuser

Category 6: Larger criminal pattern

- Because the other "more serious" criminal behaviors overshadow the domestic violence, abuse intervention programs are less likely to see these individuals who may not be tagged as abusers (but instead as pimps, drug dealers, gang members, etc.)
- Victim services/DV shelters, on the other hand, are more likely to see the victims of these individuals because of the extremity and physical danger these individuals pose
- This group typically will score highest on risk assessment measures
- This is the group most likely to *criminally* recidivate
- This is the group that needs the highest level of supervision

Category 6: Larger criminal pattern

- Just as with substance abuse, abuse intervention should be a distinct intervention, separate from any other programing. Other forensic interventions will not adequately address the pro-abuse belief systems and abusive behaviors.
- A (small) subset of these individuals, often those at highest risk, will be psychopathic
- Psychopathic individuals should NOT be placed in a regular group and need more specialized services
- The psychopathic abusers need to be treated separately, either in a specialized group or individually with someone knowledgeable about psychpathy

Difficulty assessing placement: Unreliable self-report

- Inaccurate self-report is common among abusive individuals
- Some willfully lie (e.g., fear of consequences, mistrust, shame)
- Some are in denial (e.g., not being honest with themselves, not being open to the experience of their partner, lacking awareness or insight)
- Some are ignorant (e.g., a limited or narrow understanding of abusive behavior)
- As a result, utilizing self-report only to determine placement is unwise and can lead to significant misplacement, particularly into the first three categories

What if it isn't clear what category they fit?

- If it isn't clear what category they are in then place them in a regular group and monitor/gather additional information
- If it is determined they are part of Category 1 or 2 then release from the group
- If it is determined they are Category 3 (Secondary aggressor) refer to a specialized group or release from the group
- If it is determined they are psychopathic then place in a specialized group (or solely monitor at a higher level)
- Otherwise Categories 4-6 would remain in the group to completion

Cultural Competence, Cultural Sensitivity, and Cultural Humility

Thanks to Dara Snyder from the YWCA for some material related to oppression in this presentation

What cultures are we referring to?

- Gender
- Ethnicity
- Class
- Sexual orientation
- Age
- Country of birth
- Able-bodied
- Deaf
- Urban/suburban/rural
- Religion

Culture

- Each person is of many different cultures and sub-cultures
- People of the same cultural group can be very different in other ways due to ways they are culturally different
- Each person identifies to different extents with various aspects of their cultural background
- What is the person's cultural identification?
- Typically we can identify common cultural ground as well as cultural differences with anyone with whom we interact

What is prejudice and bigotry?

- Your thoughts?
- I think as soon as we see a label rather than a person we have fallen into prejudice

Privilege

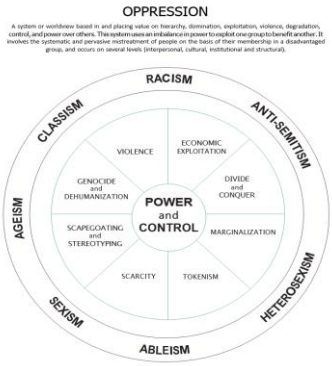
- Privilege refers to special unearned benefits one gets from simply being a member of a dominant group
- Some examples of privileged groups in the U.S.:
  - Males
  - Wealthy
  - Whites
  - Christian
  - Able bodied
  - Etc.
- You can't choose to have privilege or give it up, you have it whether you want to or not
- Another benefit of privilege is that it is typically taken for granted with the un-privileged group(s) being more aware of what they DON'T get

Oppression

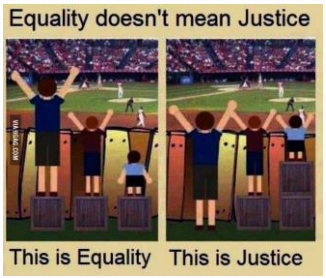
- Another aspect that is vital to consider with any cultural group is to what extent they have experienced oppression
- Oppression is the systematic and pervasive mistreatment of individuals on the basis of their membership in a disadvantaged group. It involves an imbalance in power, and one group benefiting from the systemic exploitation of other groups
- Oppression includes both institutionalized or "normalized" mistreatment as well as instances of violence
- It includes the invalidation, denial, or the non-recognition of the complete humanness (the goodness, uniqueness, smartness, powerfulness, etc.) of those who are members of the mistreated group
- ~ **Liberation Theory: A Working Framework**— By Ricky Sherover-Marcuse

Oppression

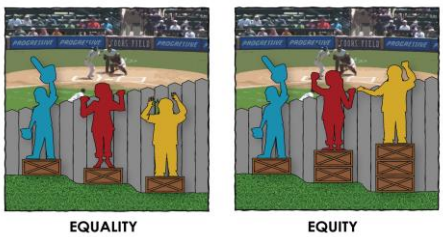
- The typical level of focus is usually on a national level, although it can also be on a smaller scale (their own neighborhood) or larger (around the world or over time)
- Oppression includes:
  - Interpersonal--specific behaviors against specific individuals
  - Generational and historical behaviors against family members and ancestors and peers that also affect individuals
  - Institutional--the network of institutions, structures, policies, and practices that create advantages and benefits for one group over another
- Not all oppression is the same or has the same impact
- Part of understanding a person's culture is understanding that person's cultural history of oppression including how that may still be playing a role in that person's life



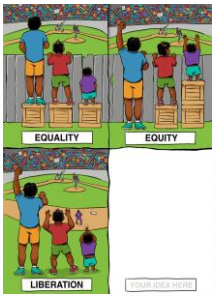
Equality is not enough . . .



But the problem is external, not internal and the barriers aren't the same . . .



How about just getting rid of the fence and the ruts in the 1st place?



Cultural challenges

- Every culture has a story/history which may affect the person's experience of the present. What is that particular culture's story?
- Abusive men can use cultural differences as a justification for their abuse and as a defense tactic
- There are also culturally specific forms of abuse
- How do we address this?
- One way NOT to address it is to see everyone as the same, that "we're all human". In doing so, a cultural arrogance can occur where you may assume everyone is like you.

Cultural Competence

- Requires you to be an expert on the specific culture, if not actually of that culture
- Culturally specific interventions and content are present that differ from dominant culture
- Typically focused on a single cultural aspect (e.g., ethnicity, gender)

Cultural Sensitivity

- Acknowledges that while the program may not be particularly knowledgeable in that specific culture, it is aware that there exist cultural differences.
- Attempts are made to be vigilant for, observant of, and open to those cultural differences as they manifest

Problems With the Concepts of Cultural Competence and Sensitivity

- You can't know every culture and sub-culture
- Each person is a unique intersection of a variety of different cultures (aka "intersectionality")
- You can't know what aspects they identify with the most strongly
- In focusing on one particular cultural aspect there's a danger of missing out on others
- Offering clients something closer to their culture can be better than a dominant cultural group, but it doesn't go far enough

Cultural Humility

- Developed within the medical field
- Not a particularly widely known phrase, although the underlying concepts are becoming increasingly widespread (from other perspectives)
- Acknowledges that there are too many cultures to know well
- Instead of trying to learn everyone else's culture, instead become introspective and insightful about your own
- Then be careful not to make cultural assumptions or impositions about anyone else (i.e., humility)

Cultural Humility

- Becoming open and "unlearning" things
- Focuses on intercultural exchange
- Deemphasizes differences/separation, instead focusing on our common humanity while acknowledging we are all unique and different
- Deemphasizes cognitively "knowing" someone else's culture
- Stepping into/being a part of—being with people rather than simply understanding them
- It is an on-going and evolving process

- "Cultural humility incorporates a lifelong commitment to self-evaluation and critique, redressing the power imbalances . . . And to developing mutually beneficial and non-paternalistic partnerships."

-Tervalon & Murray-Garcia, 1998

Cultural Competence	Cultural Humility
• Set knowledge base	• Evolving knowledge base
• Focus on endpoint	• Focus is on process
• Focus on generalities	• Focus on specifics/individuals
• Learning the "Truth" of a culture	• Learning the truths of an individual
• External focus (knowing the other)	• Internal focus (knowing yourself)
• Detached observer	• Interactive participant
• Intentional (assumptions can get in the way)	• Informational (have no idea what to expect)
• Becoming an expert	• Becoming a student
• Monologue-unidirectional	• Dialogue—discussion
• Potentially must submit to the culture being oppressed	• While oppression can be acknowledged, neither is inferior/superior

Cultural Humility Qualities

- Here is a list of qualities associated with cultural humility and included in a client measure to determine level of cultural humility:
- Respectful
- Open to exploring
- Does not presume to know a lot
- Considerate
- Genuinely interested in learning more
- Does not act superior

Cultural Humility Qualities

- Open to seeing things from the other's perspective
- Does not make assumptions about the other
- Open-minded
- Does not act like a know-it-all
- Does not think he/she knows more than she/he actually does
- Asks questions when uncertain
- Taken from: Hook, J.N., Davis, D.E., Worthington, E.L., & Utsey, S.O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology,* 60 (3), 353-366.

Here's the link to a 30 minute YouTube video on Cultural Humility including interviews with the two women who originally came up with the concept:
https://www.youtube.com/watch?v=SaSHLbS1V4w

Or look for: Cultural Humility: People, Principles and Practices on YouTube

Intake Process and Exclusions

Where Do Referrals Come From?

- From most common to least common:
- Legal system
- DHS – Child Welfare
- Family Court (i.e., custody evals, child visitation condition)—recent local development in past few years
- These are the primary referral sources for most programs.

Where Do Referrals Come From?

- At Allies, and other programs working with voluntary clients (e.g., ARMS) other referral sources:
- Romantic Partners
- Therapist/Doctor
- Work
- Attorney
- Family/Friend
- Clergy
- Self

Intake Process

- Paperwork to be completed prior to the intake interview:
- Client Information Form
- Client Informed Consent
- HIPPA Form
- Abuse Intervention Group Information Form
- Verbally review confidentiality and exceptions
- Complete a Psychosocial History
- Gather an Abuse History

Violence History

Ask about past abuse in each of the following categories done to anyone since he turned 18, giving examples of each type:

- Physical
- Verbal
- Psychological
- Economic
- Property
- Sexual

Violence History II

Ask for the approximate frequency of each category of abuse.

Ask for the worst threat to his current partner and/or victim.

Ask him to what extent he views himself as being a controlling person with his partner.

Ask him to what extent his partner thinks he is a controlling person if *she* was asked.

Why not do a thorough violence history?

- Some providers do a much more extensive history of abuse, which may seem, on the surface, to make sense but actually is not necessary
- The group intervention is the same regardless of history
- Self-report is likely to be inaccurate for a number of reasons so it's an incomplete history anyway
- Determining the level of accountability and denial can be done without a thorough history
- While it can help with risk assessment, most risk factors are not related to previous violence

Appropriateness for the Program

- Factors to consider to determine appropriateness for the group:
- Cognitive functioning
- Language/cultural issues
- Psychological issues
  - Psychosis
  - Severe mood disorder
  - Personality disorder

Personality Disorders

- Can only briefly touch on this today due to time limitations
- Characterized by rigid, inflexible interpersonal styles that lead to alienation from others *across the board*
- These issues are NOT just limited to the primary relationship, but are typically present in friendships, familial relationships, co-workers, etc.
- Most abusive men do not have personality disorders, as indicated by their ability to get along fairly well with most people except for their romantic partner
- Personality disorders are occasionally immediately obvious, but more typically only become apparent over time

Personality Disorders

- Abusive men with personality disorders often, but not always, ultimately struggle with their interactions with other group members as well as staff
- This group tends to cause the most reactivity in facilitators and in other group members
- These individuals can undermine the group culture and group progress
- This is the group most likely to drive you crazy

Personality Disorders

- The more time you spend thinking/talking about an individual, the more staff that "know" this individual, the more likely there is to be a personality disorder
- A disproportionate number of the individuals who can't seem to progress in spite of regular attendance and participation have personality disorders
- Firm, clear, non-reactive limits and guidelines can help manage some of these individuals
- Other individuals should be discharged as "time served" or to one of Allies' specialized groups (e.g., Criminally oriented, Emotionally intense)

Personality Disorders

- The personality disorders of greatest concern/relevance:
- Anti-social Personality Disorder
- Psychopathy
- Borderline Personality Disorder
- Narcissistic Personality Disorder
- Paranoid Personality Disorder

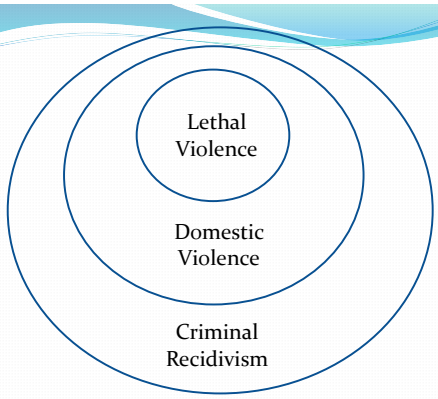
Appropriateness for the Program

- Factors to consider to determine appropriateness for the group:
- Cognitive functioning
- Language/cultural issues
- Psychological issues
- Psychosis
- Severe mood disorder
- Personality disorder
- Psychopathy
- Lifestyle instability
- Active drug and alcohol abuse
- Generally disruptive behavior

Risk Assessment

Risk Assessment for?

- When you are doing a risk assessment, be clear on what you are screening risk of
- Lethal violence?
- Domestic violence?
- General recidivism?
- People often use these terms interchangeably or without clarity even though they are quite different



Lethality Assessment

- Jacqueline Campbell is the expert of domestic violence lethality assessment
- Developer of the Danger Assessment (DA)
- Collected data comparing differences in demographics between abused women who had not had a lethal attempt made on their lives and those who had either been killed or could have died from the violence
- While intended to identify lethal risk, the DA has been shown to be a pretty good predictor of risk of general violence
- Unlike many other risk assessments, which are focused on criminal recidivism, it does not have a class or race bias

Danger Assessment Scores

	Mean	SD
Abused Controls	2.9*	2.8
Attempted Femicide	7.9	3.2
All Femicides	7.1	3.4
Femicide w/o suicide	7.0	3.6
Femicide / suicide	7.4	3.2

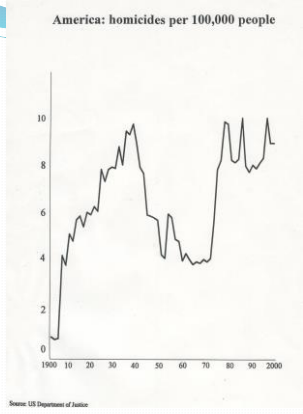
- Most Controls score: 0-6
- Most Femicides: 4/5-11

Attempted and Femicide scores significantly higher than abused controls (*p<.05)

99.99% Accurate Lethality Assessment Measure

- He's <u>not</u> going to kill her
- Copyright by Chris Huffine

- The issue relates to base rates
- Only 1 out of 10,000 people are murdered in the general population
- That's an extremely low base rate
- A lethality assessment tool needs to be incredibly sensitive to do better than that
- Better than 99.99%

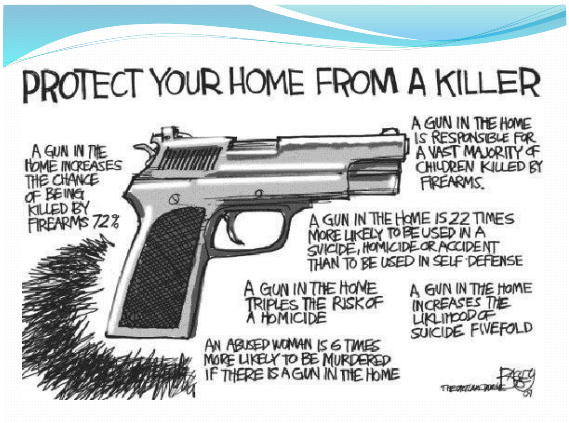


Firearms and lethality

- Prior threats with weapons increase risk of homicide by 3.8 times (Campbell, Portland presentation, 2014)
- When abusive partners have access to firearms, the risk of homicide increases by nearly 1300% compared to other IPV cases (Campbell)
- About 2/3 of DV homicides in Oregon are committed with firearms (Oregon Health Authority, 2011; 2013, 2014 stats)
- Restrictions on the purchase of firearms including in restraining orders and entered into a federal database led to a 12-13% decline in the rate of DV homicides in those states (Vigdor & Mercy, 2006)

Number of Americans killed annually by:	
Islamic jihadist immigrants[1]:	2
Far right-wing terrorists[1]:	5
All Islamic jihadist terrorists (including US citizens)[1]:	9
Armed toddlers[2]:	21
Lightning[3]:	31
Lawnmowers[4]:	69
Being hit by a bus[4]:	264
Falling out of bed[4]:	737
Being shot by another American[5]:	11,737

[1]10-year average of terrorist attacks "Deadly Attacks Since 9/11," New America, http://securitydata.newamerica.net/extremists/deadly-attacks.html
[2]www.snopes.com/toddlers-killed-americans-terrorists/
[3]10-year average of deaths by lightning, NOAA, www.nws.noaa.gov/om/hazstats/resources/weather_fatalities.pdf
[4]10-year average, Underlying Cause of Death 2014, CDC, http://wonder.cdc.gov/
[5]10-year average 2005-2014, CDC, Injury Prevention & Control: Data & Statistics (WISQARS™) www.cdc.gov/injury/wisqars/fatal_injury_reports.html



Lethal risk vs. other types of risk

- Here are some other points to consider . . .
- While there is some overlap between risk of lethality and more general risk, I think that they may be pretty distinct
- A sub-group of individuals who commit domestic violence homicides would otherwise score as quite low risk (e.g., no prior criminal history, no negative peer influences, personality disorder)
- For example, only a third had previously been arrested for DV or were on probation

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Lethal risk vs. other types of risk

- Some key themes that appear relevant for heightened risk of lethal risk:
  - Recent change in status of relationship
  - Recent loss of job
  - Other major negative life changes (e.g., serious financial or medical problems)
  - Deep sense of enmeshment

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Lethal risk vs. other types of risk

- Some key themes that appear relevant for heightened risk of lethal risk:
  - Stalking behaviors
    - Present in 87-95% of the homicides
    - Even with no physical abuse present, stalking present 58-72% of the time!
  - Fatalistic thinking including suicidality
  - Willingness to consider murder and/or suicide as an option
  - Presence of firearms (88% used a gun)

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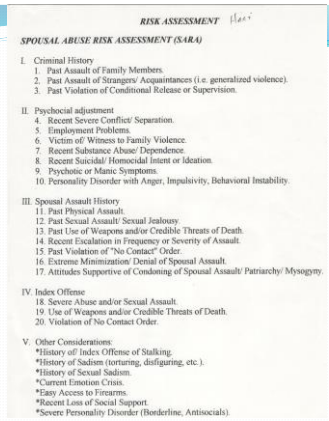
Types of Risk Assessment

- **Unstructured clinical risk assessment**
- Your "gut sense", drawing on past experience and knowledge. Not particularly accurate
- **Structured clinical risk assessment/structured professional judgment**
- Measures that offer guidelines on what to ask and focus on. Empirically based
- Spousal Assault Risk Assessment (SARA)
- Danger Assessment (DA)
- Psychopathy Checklist-Revised (PCL-R)

Spousal Assault Risk Assessment

- Developed by Kropp and Hart in Canada
- 20 item measure consisting of two parts: 10 item general violence risk and 10 item domestic violence risk
- Allows for clinical judgment
- Poor inter-rater reliability
- Only some items on the SARA are useful predictors (e.g., witness to violence, minimization of violence are not predictive)
- Adequate predictive ability
- Not as good as the ODARA

SARA



RISK ASSESSMENT

SPOUSAL ABUSE RISK ASSESSMENT (SARA)

I. Criminal History
1. Past Assault of Family Members.
2. Past Assault of Strangers/ Acquaintances (i.e. generalized violence).
3. Past Violation of Conditional Release or Supervision.

II. Psychocial adjustment
4. Recent Severe Conflict/ Separation.
5. Employment Problems.
6. Victim of/ Witness to Family Violence.
7. Recent Substance Abuse/ Dependence.
8. Recent Suicidal/ Homocidal Intent or Ideation.
9. Psychotic or Manic Symptoms.
10. Personality Disorder with Anger, Impulsivity, Behavioral Instability.

III. Spousal Assault History
11. Past Physical Assault.
12. Past Sexual Assault/ Sexual Jealousy.
13. Past Use of Weapons and/or Credible Threats of Death.
14. Recent Escalation in Frequency or Severity of Assault.
15. Past Violation of "No Contact" Order.
16. Extreme Minimization/ Denial of Spousal Assault.
17. Attitudes Supportive of Condoning of Spousal Assault/ Patriarchy/ Mysogyny.

IV. Index Offense
18. Severe Abuse and/or Sexual Assault.
19. Use of Weapons and/or Credible Threats of Death.
20. Violation of No Contact Order.

V. Other Considerations:
*History of/ Index Offense of Stalking.
*History of Sadism (torturing, disfiguring, etc.).
*History of Sexual Sadism.
*Current Emotion Crisis.
*Easy Access to Firearms.
*Recent Loss of Social Support.
*Severe Personality Disorder (Borderline, Antisocials).

Actuarial Risk Assessment

- Empirically based measures statistically developed based on multiple regression analysis
- Only items that are statistically distinct are included
- In other words, if two different items are closely correlated and predict about the same, then only one is included
- Examples of actuarial risk assessments:
- Violence Risk Appraisal Guide (VRAG)
- Ontario Domestic Assault Risk Assessment (ODARA)

ODARA

- The Ontario Domestic Assault Risk Assessment (ODARA) is one of the first (and only) actuarial based DV risk screening tools
- Originally developed in Canada to be used by law enforcement at crime scenes to determine victim risk level
- 13 item yes/no questions based on victim and perpetrator interview and law enforcement data
- Minimal training needed, quick and easy to complete

ODARA Questions

1. Has a prior domestic assault (against a partner or child)
2. Has a prior non-domestic assault (against anyone other than a partner or child)
3. Has a prior sentence to a term of 30 days or more
4. Has a prior failure on conditional release including bail, parole, probation, no-contact order during index offense
5. Threatened to harm or kill anyone
6. Unlawful confinement of victim during index offense
7. Victim fears repetition of violence
8. Victim and/or offender have more than one child together
9. Offender is in step-father role in this relationship
10. Offender is violent outside the home (to people other than a partner or child)
11. Offender has more than on indicator of substance abuse problem
12. Offender has ever assaulted victim when she was pregnant
13. Victim faces at least one barrier to support

ODARA

- Designed to answer 2 questions:
- 1. How likely is he to assault his partner again? (a score of X indicates a XX% chance of committing a future domestic assault within an average of 5 years)
- 2. How does his risk compare to other wife assaulters? (a score of X indicates that the accused represents a higher risk than X out of 10 known wife assaulters)
- Because it is actuarial, the higher the score, the quicker, more frequent, and more severe the assault is likely to be

Scoring and Interpretation of the ODARA

Score	Category	Overall Recidivism Rate	Cumulative Proportion
0	1	.05	11
1	2	.10	27
2	3	.20	48
3	4	.27	67
4	5	.41	80
5-6	6	.59	93
7-13	7	.70	99

ODARA

- The ODARA appears to be the single best risk assessment tool available to predict risk of re-assault
- It is free to use once the training manual has been read/training completed
- It has become quite popular in Oregon among probation

ODARA criticisms

- The questions selected were ones designed to be answerable by police officers, as a result some proven risk factors (e.g., lifestyle instability, negative peer associates) were not included
- There is no room for clinical judgment
- Little room to address dynamic factors that vary over time
- ODARA is best used as one risk assessment tool, not as THE risk assessment tool
- Actuarial risk assessment tools are best for people with more limited training whereas guided risk assessments are better for the more experienced professionals

"No matter how well actuarial tables and computer analogues predict the weather, it is still a good idea to look outside before deciding what to wear"

-- P. Randall Kropp
(co-creator of the SARA)

Level of Service/Case Management Inventory (LS/CMI)

- A probation classification tool to guide level of supervision that, while not DV specific, does identify a number of risk factors that are related to recidivism
- Increasingly popular/common in probation
- Far superior to earlier simpler classification tools
- The content is as relevant as the actual scores

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Level of Service/Case Management Inventory (LS/CMI)

- Areas addressed in the LS/CMI:
- Criminal history
- Procriminal attitudes
- Companions
- Antisocial patterns
- Family/Marital
- Education/Employment
- Alcohol/Drug problems
- Leisure/Recreation

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Domestic Violence Risk and Needs Assessment (DVRNA)

- Developed in Colorado by a panel of experts, based on extensive literature review
- It has received national attention and considered by some as a model of how to determine DV risk and intervention
- Identified 14 domains of risk, 8 of which are dynamic
- Places people into three levels of intervention based on how many domains of risk are present

Domestic Violence Risk and Needs Assessment (DVRNA)

- Domains:
  - Prior DV related incidents
  - Drug and alcohol abuse
  - Mental health issue
  - Suicidal/homicidal
  - Use and/or threatened use of weapons
  - Non-DV criminal history
  - Obsession with victim
  - Safety concerns

Domestic Violence Risk and Needs Assessment (DVRNA)

- Domains:
  - Violence and/or threat of violence toward family members
  - Pro-abuse attitudes
  - Prior involvement with DV treatment
  - Victim separated from offender within previous 6 months
  - Unemployed
  - Involvement with criminal peers

Domestic Violence Risk and Needs Assessment (DVRNA)

- Levels of treatment:
- Level A (low intensity)
  - 0-1 domains endorsed
  - Weekly contact, mainly psycho-educational
  - No patterns of abuse
  - Only for the small number of individuals where the arrest was truly an unusual incident

Domestic Violence Risk and Needs Assessment (DVRNA)

- Levels of treatment:
- Level B (moderate treatment)
  - 2-4 risk factors endorsed
  - Pattern of abuse
  - Psycho-ed plus CBT
  - The majority of individuals will fall into this category

Domestic Violence Risk and Needs Assessment (DVRNA)

- Levels of treatment:
- Level C (high intensity)
  - More than 4 domains endorsed
  - Twice a week contact
  - CBT plus crisis management/victim safety
  - DV offenders who also are anti-social/psychopathic
  - A small number of offenders will also land in this level

DVRNA Positives

- Distribution of arrested offenders consistent with the direct experience/report of many providers (including myself)
  - Very few don't turn out to have a pattern of abuse
  - While some are highly criminal, most are not
- Distinguishes between criminal and non-criminal abusive partners
- Does a good job of accurately reflecting the empirical knowledge of risk

DVRNA Negatives

- Does not adequately operationalize how to determine if there is a pattern of abuse
- Muddies up DV risk with criminal risk rather than clearly distinguishing between the two as a result some abusive partners may STILL end up in the lowest level if they have no criminogenic factors present
- Because it is drawing heavily on the forensic risk research (i.e., who's most likely to get arrested again) will disproportionately target working class/men of color

Demographic Variables Related to Increased Risk of Re-Assault

- Younger age
- Lower SES
- More extensive adult history of abuse
- Severe personality disorders/psychological problems
- Other criminal behaviors
- Violence in family of origin
- Level of hostility
- Active substance abuse

Required risk screening in Oregon

- Oregon state BIP standards require screening for a list of risk factors related to DV perpetration
- This list was developed by Curt St. Denis, in consultation with Kris Henning, Ph.D., based on empirical evidence of a connection between the factor and a risk of recidivism
- It is not intended to generate a score or determine a risk level, rather it is simply a list of risk factors to note/flag/be mindful of in the work

Oregon BIP standards risk factors

1. Safety concerns expressed by the victim
2. Prior assaults against intimate partner(s)
3. Violence criminal history, including prior assaults against strangers
4. Prior criminal history including prior non-violent offenses
5. Prior violation of conditional release, no contact, or restraining order(s)
6. On-going relationship conflicts, problems, or marital dissatisfaction, especially as identified by a victim's report at time of intake

Oregon BIP standards risk factors

7. Lifestyle instability (e.g., unemployment, lack of housing)
8. Drug (and alcohol) use, abuse, addiction
9. Personality disorder
10. Extreme dependency on/obsession with partner/ stalking history
11. Access to a firearm
12. Credible threats of injury, death, or suicide (i.e., an explicit, detailed plan and the means to carry it out)
13. Negative peer association (i.e., peers condoning domestic or other violence)

Oregon BIP standards risk factors

14. Negative response to prior services, including dropping out, lack of motivation, and resistance to change
15. Impulsivity/poor emotional self-control
16. Presence of young children
17. Younger age (< 40)

Based on information provided by Curt St. Denis, M.A. and Kris Henning, Ph.D.

Victim Assessment of Risk

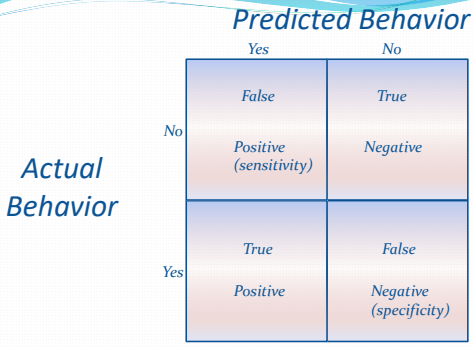
- Victims' assessment of their own level of risk of being re-assaulted by a partner has shown to be quite good—as good or better than most risk assessments
- One study found women's perceptions of their level of risk as good as the SARA but not as good as the Danger Assessment (or, presumably, the ODARA)
- While good, victims' assessments are not always accurate
- They appear to be better at predicting danger than safety

Victim Assessment of Risk

- Their concerns should be taken seriously, but their lack of concern is less accurate
- Likewise, victims who were uncertain about their level of risk (or said they were "somewhat safe") were more likely to be assaulted than victims very concerned or very unconcerned
- Very concerned: takes more safety measures
- Very unconcerned: less likely to be re-assaulted
- Ambivalent/"somewhat safe": more vulnerable without taking safety measures

False positives & negatives

- A false positive is when something is wrongly predicted to happen (e.g., he is predicated to re-assault, but doesn't)
- A false negative is when something is wrongly predicted not to happen (e.g., he is predicated not to re-assault, but he does)
- The more **sensitive** an instrument is, the more false positives, but the fewer false negatives
- The more **specific** an instrument is, the more false negatives, but the fewer false positives



False positives & negatives

- When it comes to re-assault, while we want measures to be as accurate as possible, false positives (he doesn't assault) are more tolerable than false negatives (he does assault)
- Also, if we are doing good work, we would expect there to be an increase in false positives due to the intervention.
- So, we should err on the side of over-predicting danger than under-predicting danger (more sensitive, even if not as specific)

Categories of risk factors

- **Static**
- Historical factors that do not change over time (e.g., criminal history)
- **Dynamic**
- Vary over time (e.g., access to a firearm, unemployed)
- **Stable**
- A subset of dynamic factors that are more enduring attributes that can change over time, but only tend to do so slowly (e.g., belief systems)
- **Acute**
- Present in the moment (e.g., intoxication, high distress)
- **Idiographic**
- Rare risk factors that are too infrequent to show up on risk assessment tools, but when present are alarming (e.g., sadistic arousal, command hallucinations, unusual qualities of the instant offense)

Risk/Needs/Responsivity (RNR) model

- The Risk/Needs/Responsivity (RNR) model is "state of the art" and becoming a standard of care in other forensic fields
- It is not a treatment model per se, but rather a series of organizing principles that can be applied not just to intervention, but to other parts of the criminal justice system as well (e.g., probation, law enforcement)
- It is strongly empirically rooted, albeit with a focus on traditional criminal behavior so limitations/criticisms mentioned earlier still apply
- The revised Washington state standards align much more closely with this model

Risk/Needs/Responsivity (RNR) model

- **Risk**… What is the individual's overall likelihood to criminally recidivate?
- The risk level should be a significant factor in determining what level/kind of treatment to offer
- The highest risk individuals should receive the most intensive treatment
- This is based on the same information covered earlier in the CPC explanation
- This is complicated when working with DV offenders

Some relapse risk factors

- In addition to thinking about general risk, some qualities increase the likelihood of relapse, including:
- Poor management of stress/poor coping skills
- Unrealistic expectations
- Anti-social attitudes
- Failure to utilize resources available
- Some things that are NOT risk factors:
  - Housing
  - Obtaining a job (alone)
  - Mental illness

Risk/Needs/Responsivity (RNR) model

- **Needs**... The focus of treatment should be on addressing/changing the dynamic criminogenic needs present which lowers risk
- A form of this is risk informed treatment planning
- This is especially important for more criminal groups/participants
- Research has found that the larger the number of criminogenic needs addressed, the more effective the program

Major criminal risk/need factors

- There are 8 widely supported criminal risk areas, also referred to as the "Big 8", with the first four particularly important:
- 1. Antisocial/pro-criminal attitudes, values, beliefs and cognitive-emotional states
- 2. Pro-criminal associates and isolation from pro-social others
- 3. Temperamental & anti-social personality pattern conducive to criminal activity
- 4. A history of antisocial behavior

Major criminal risk/need factors

- 5. Family factors that include criminality and a variety of psychological problems in the family of origin
- 6. Low levels of personal educational, vocational or financial achievement
  - It isn't just being unemployed, but not having a stable job that they enjoy and value
- 7. Low levels of involvement in pro-social leisure activities
- 8. Abuse of alcohol and/or drugs

Risk/Needs/Responsivity (RNR) model

- **Responsivity**… How do we provide services in a manner that the client is most likely to maximally benefit from? (e.g., motivation level, cognitive level, learning style, cultural issues)

Responsivity domains

- What are domains that we might consider how we respond to?
- Some domains to consider with regards to responsivity:
  - Cognitive functioning
  - Learning style
  - Level of motivation
  - Co-occurring psychological issues
  - Cultural differences
  - Current life issues (e.g., financial, job demands)
  - Trauma history

Risk Informed Treatment Planning

- Risk assessment needs to be an on-going process as opposed to a one time event
- The risk score alone means little. Of greater interest and concern are the particular risk factors present
- The process should help inform the treatment planning and case management of the client
- As risk shifts so should the nature of the interventions
- Another phrase for this is risk reduction

Risk informed treatment planning

- This means continually monitoring the men for increased risk and addressing the specific issues that have led to the increased risk
- What risk factors are currently present?
- What new risk factors have developed?
- How can we seek to reduce or eliminate those risk factors?
- Are there protective factors present (e.g., pro-social peers, satisfying employment)?
- How can we seek to put into place or increase protective factors?

Risk informed treatment planning

- One easy way of doing this is via the check-in board, particularly the "life changes" column
- This can help reduce risk in the present
- This also teaches the men how to practice risk reduction
- It is hoped that it becomes an on-going practice for the men even after they leave the group

Risk assessment summary

- There are 4 primary risk areas we are typically targeting with abusive partners:
  - Risk of committing lethal domestic violence
  - Risk of committing illegal domestic violence
  - Risk of committing another crime
  - Risk of committing legal domestic violence
- While there is some overlap, each of these risk areas is distinct and needs to be assessed separately and one area needs to not be confused with another

Risk assessment summary

- Risk of committing lethal domestic violence
  - Best and only tool is the Danger Assessment
  - Due to low frequency, likely to get primarily false positives
  - We don't really fully understand yet how to assess for this well, including acute factors that may play a significant role
- Risk of committing illegal domestic violence
  - ODARA is probably the best tool, although there are a number of other DV specific tools (e.g., SARA) that also address this
  - Biggest concern is that just because the illegal DV stops doesn't mean the legal DV does

Risk assessment summary

- Risk of committing another crime
  - This includes any kind of criminal behavior, including non-compliance with probation/court directives
  - Extensive research in this area with many factors well known

Risk assessment summary

- Risk of committing legal domestic violence
  - There is no tool available to determine this
  - Most common factors, in my opinion:
    - Previous pattern of abuse
    - Pro-abuse belief system
  - The tool that *should* be developed: a list of barriers to effectively receiving intervention (e.g., high denial, co-occurring mental health/substance abuse issues, other treatment interfering behaviors) as well as factors supporting intervention (e.g., sobriety, accountability)

Limitations of risk assessment

- Risk assessment does not tell us what, when, where, or to whom the assault will re-occur
- A more refined prediction, involving multiple possible outcomes tends to be more accurate than a simple, dichotomous yes/no prediction
- Because of its frequent focus on criminal recidivism, risk assessment tools can be culturally biased, overly focusing on working class men and men of color who are more likely to be targeted by and caught up in the criminal justice system

Limitations of risk assessment with DV offenders

- Criminal risk assessment typically focuses on risk of committing another *felony*
- Many DV crimes are classified as misdemeanors
- Most DV is not even illegal (e.g., verbal and psychological abuse)
- Domestic violence risk assessment typically focuses on committing another physical assault
- Most DV involves non-physical abuse
- In other words, there is limited research on assessing the risk of the majority of DV that is perpetrated

Limitations of risk assessment with DV offenders

- Given that the majority of domestic violence involves non-physical and non-illegal abuse, **many domestically violent men may score as a low risk even while they continue to be quite abusive**
- For that reason, risk assessment should NOT be used to determine length of treatment
- While lower risk may require less *supervision*, it does not mean there should be less intervention
- Many abusive individuals may stop or reduce their illegal/physical abuse while continuing or even escalating their legal non-physical abuse

Specialized Groups for Abusive Men

Allies in Change specialized abuse intervention groups

- Allies in Change has developed a number of specialized abuse intervention groups over the years for sub-populations of abusive partners
- We have more specialized groups for abusive partners than any other agency in the world!
- The primary differences are with the select people in the group (reach creates a different group culture), slight shifts in facilitation style, and some additions to the curriculum
- Note that members of these groups tend to be either high risk or low risk populations while those in the regular groups tend to be more varied but cluster around medium risk

Allies in Change specialized abuse intervention groups

- With the exception of the group for psychopathic abusive partners and short term anger management, all the groups use the same basic group structure and curriculum as the regular groups
- Due to time constraints I can't review the particulars of these groups today, but you are welcome to contact me for more information about any of them
- While each of these groups offers a better match/higher quality experience for the particular targeted sub-population, a regular group works adequately. The exception is **psychopathic abusive men who should not be placed in a regular abuse intervention group**

Allies in Change specialized abuse intervention groups

- Criminally Oriented group
  - For psychopathic and highly criminal abusive men
  - Specialized curriculum and facilitation style
  - Originally created by Curt St. Denis
  - Discontinued due to low referrals
- Criminal Lifestyle group
  - For abusive men with extensive criminal involvement who are capable of empathy
  - Discontinued due to low referrals
- Parenting groups
  - For abusive men who are fathers with a heavier focus on parenting issues
  - Includes a 12 session DV specific parenting class based on the Caring Dads curriculum

Allies in Change specialized abuse intervention groups

- Emotionally Intense/Externalizer group
  - For abusive men who have significant emotion dysregulation
  - Originally developed by Chris Wilson
- Voluntary abuse intervention group
  - For abusive men who are not court-involved
- Advanced/Relapse Prevention group
  - For voluntary abusive men wishing to do long term work on these issues and have previously been in an abuse intervention group
  - Originally developed by Chris Huffine

Allies in Change specialized abuse intervention groups

- Anger management group
  - 12 session group for mandated men who do not have a history/patterns of abuse and control and have a non-DV charge against them (e.g., road rage, bar fight)
  - Developed by Chris Huffine, based on Allies in Change curriculum

Allies in Change specialized abuse intervention groups

- Female primary aggressor group
  - For female identified individuals who have patterns of abuse and control and pro-abuse belief systems
- Female secondary aggressor group
  - For female identified individuals who are court involved with DV and do not have patterns of abuse and control and no pro-abuse belief systems

Specialized groups at Allies in Change

- Domestic Violence Sexually Abusive group
  - For abusive men with more extensive histories of sexually abusive/sexually inappropriate behavior
  - Originally created by Diana Groener and Curt St. Denis
  - Discontinued due to low referrals
- Low functioning abuse intervention group
  - For abusive men who are significantly cognitively compromised and unable to adequately track/understand material in a regular group
  - Discontinued due to low referrals

Psychopathy

Psychopathy

- Psychopathy has also been described as sociopathy. While there is some debate, I consider them to be more/less synonymous. Sociopathy is an older term.
- Psychopathy is not having a conscience—an inability to have empathy towards others
- Psychopathic individuals also tend to be significantly understimulated by their outside environment, so they are less fearful, less anxious, and generally care less
- They very much embrace criminality and the exploitation of others to take care of themselves

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Psychopathy

- You can't always "tell" that someone has psychopathy (e.g., hair on the back of the neck going up). Some can be quite charming and smooth and difficult to identify.
- They can be skillful and convincing liars where you can be completely fooled by them
- Some psychopaths, "white collar" ones in particular, may have little to no documented criminal history
- Psychopathic inmates rated as having good treatment program outcomes had the highest recidivism rates

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Psychopathy

- Psychopathy runs on a continuum—individuals can be "more" psychopathic or "less" psychopathic. Typically the higher the level of psychopathy, the poorer the prognosis
- Typically as psychopathy increases, their attachment to the world decreases

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Psychopathy

- Psychopathy is also quite rare. It has been estimated that approximately 1% of the population is psychopathic.
- While relatively rare, psychopaths do a disproportionate amount of the crime and recidivating
- 50% of serious crimes are done by psychopathic offenders, averaging 50/year, up to 200-300
- Most people with Anti-Social Personality Disorder (ASPD) are not psychopathic

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Psychopathy vs. ASPD

- It is not listed in the DSM, but is a sub-group (more/less) of Anti-Social Personality Disorder (ASPD)
- Only about 20-30% of those with ASPD are psychopathic
- Most criminals are not psychopaths. Even in maximum security prisons, most of the residents are not psychopathic.
- Hare has estimated that approximately 20-25% of prison inmates are psychopathic

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Psychopathy vs. ASPD

- People with psychopathy are significantly more likely to recidivate and to be treatment failures than people "just" with ASPD. 33-80% of chronic offenders are psychopathic
- ASPD is about breaking laws and rules, but many of those who do so are still capable of empathy and compassion (e.g., many are addicts or driven by cultural factors such as gang involvement). There is a much larger social/cultural factor with these individuals, including larger issues of oppression and historical trauma.

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Psychopathy

- There appears to be a significant biological basis to psychopathy
- It appears to be genetic, running in families
- It typically manifests in childhood, mean age of first symptoms is 8-9 years old, although most can be identified by 5 years old
- However, less than 50% of children with conduct issues are diagnosed with ASPD or psychopathy as adults (they "age out"/settle down as they mature)
- Biology/genetics determine if it will be present, environment determines how it will be acted out
- There is empirical evidence that it may be driven, at least in part, by the understimulation of the amygdala

Amygdala dysfunction

- Common psychopathic qualities consistent with amygdala dysfunction:
  - Reduced response to threatening stimuli
  - Reduced adversive conditioning
  - Reduced emotional responses in anticipation of punishment
  - Reduced startle response
- It isn't the amygdala alone that plays a role, but it does appear to play a central role
- The anterior temporal lobe may also play a role
- In general, they tend to show much less reactivity to conflict and provocative situations

Formal assessment tools

- There are four formal assessment tools developed by Robert Hare and his colleagues to assess for psychopathy:
- Psychopathy Checklist-Revised (PCL-R)
- Psychopathy Checklist-Screening Version (PCL-SV)
- P-SCAN
- Self-Report Psychopathy Scale 4th Edition (SRP_4)
- Another tool to screen for psychopathy that I am not familiar with and was not developed by Hare is the Psychopathic Personality Inventory-Revised (PPI-R)

PCL-R

- Psychopathy Checklist-Revised (PCL-R)
- Developed by Robert Hare as THE screening tool for psychopathy
- The PCL-R requires specialized training to use
- It takes quite some time to complete and requires an interview and a review of collateral information
- 20 items scored 0-2 (0: not present, 1:sub-threshold, 2:present)
- Scores can range from 0-40
- A score of 30 or higher is typically considered to be indicative of psychopathy
- Average score in prison populations: 22-24

PCL-R Factors

- **Factor 1: Interpersonal/Affective**
- **Interpersonal facet:**
- Glibness/superficial charm
- Grandiose sense of self-worth
- Pathological lying
- Conning/manipulative

- **Affective facet:**
- Lack of remorse or guilt
- Shallow affect
- Callous/lack of empathy
- Failure to accept responsibility

PCL-R Factors

- **Factor 2: Social Deviance**
- **Lifestyle facet:**
- Stimulation seeking
- Impulsivity
- Irresponsibility
- Parasitic lifestyle
- Lack of realistic, long term goals

PCL-R Factors

- **Antisocial facet:**
- Poor behavioral controls
- Early behavioral problems
- Juvenile delinquency
- Revocation of conditional release
- Criminal versatility

Working with psychopathic abusive partners

- The group we offered for them was significantly different in content, structure, and facilitation style from any of our other groups
- In lieu of offering a specialized group, these people should be seen individually by a clinician highly knowledgeable about psychopathy
- If the option is a regular group or no group, the choice should be NO GROUP!
- This is the subpopulation that most needs high level, intensive supervision and monitoring, more than anything

Thanks for listening!

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