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Dr. Campbell’s specific areas of research include risk factors and assessment for intimate partner homicide; abuse during pregnancy; marital rape; physical and mental health effects of domestic violence; dating violence; and testing interventions to prevent and address domestic violence. She has authored or co-authored more than 150 articles and chapters and six books. With continuous research funding since 1984, she has been principal investigator on nine major grants from the National Institutes of Health and Justice, the Centers for Disease Control and Prevention, and the Department of Defense. She was Co-Chair of the Steering Committee for the World Health Organization Multi-Country Study of Violence Against Women and Health.

A hallmark of Dr. Campbell’s career has been her collaborations with domestic violence advocacy organizations including board membership at four domestic violence shelters in Michigan, New York, and Maryland and now at the Family Violence Prevention Fund. Policy work includes the National Advisory Council on Violence Against Women, the congressionally appointed Department of Defense Task Force on Domestic Violence, former U.S. Surgeon General C. Everett Koop’s Workshop on Violence and Health (1986), research agendas for CDC, NIH, and ARRQ, and three major Institute of Medicine Committees.
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Daniel J. Webster, MPH, ScD, is an Associate Professor and Co-Director of the Johns Hopkins Center for Gun Policy and Research in the Johns Hopkins Bloomberg School of Public Health Department of Health Policy and Management. His MPH is from the University of Michigan and ScD from Johns Hopkins University. He has an active program of research in violence prevention, and has published many articles on youth violence, intimate partner violence, evaluation of violence prevention programs and intimate partner homicide risk.
All of the contributors to this volume have been in clinical situations in which we have been asked to assess or have tried to determine how violent an individual is likely to be and how much danger his or her potential victim is actually in. In courts, clinics, conference rooms, battered women’s shelters, hospital emergency rooms, child protective service offices, schools, research settings, home visits, batterer intervention programs, parenting programs, domestic violence advocacy programs, and child abuse and intimate partner violence prevention programs we have faced the difficult problem of predicting family violence just as you have and probably still do if you are interested enough in the issues to read this preface. We have been acutely aware of how this issue has profound implications, intersecting our clinical judgments, advocacy, agendas, and professional and ethical responsibilities.

The contributors are all clinicians to some extent, collaborate with practitioners from many disciplines, and share a profound respect for the work that practitioners are doing in the family violence field. But each of us has also added a research involvement to his or her clinical base. Thus we are trying to add what we know from our research to the difficult problem of clinical prediction of violence in situations of child and wife abuse and sexual violence.

We have learned a great deal over the past 20 years since the first edition of this volume, and we have tried to incorporate this information in user-friendly language and approach. We have tried to be helpful to all of us—clinicians and researchers in various combinations of history and roles—in this volume. We offer you our summary of the research in this area, as well as the instruments that may be helpful and the criteria by which to judge them. To this, you will add your own clinical expertise.

I want to first thank all the abused women who have helped me understand what it would be like to be in danger. I started this journey with a homicide study back in the late 1970s, and to all those who have been killed and their families whose lives I have marked in my research as well as all those who have died as the result of intimate partner violence and child abuse in this country and around the world, I stand in tribute and remembrance. I especially want to acknowledge Anne, whose death in 1979 inspired me to be the best clinician, advocate, and researcher I could possibly be. We must never
forget the strengths of abused women like Anne. We also must not forget abused children and the incredible attempts they take every single day to keep safe and healthy.

I also would like to thank all of the contributors to this volume for their responsiveness to reviews, their patience with the process, and their collective wisdom and commitment to these issues. Especially I would like to thank Jon Conte for his leadership in creating the original volume and in the field of interpersonal violence. The staff at Springer, especially Jennifer Perillo, has been extremely helpful and patient in this production, a rather difficult process at times because of my own distractions and competing demands.

I also want to thank all of the practitioners in this field that I have trained, collaborated with, advocated with, and corresponded with over these many years. I always think of those I have known the longest: David Adams, Nancy Durborow, Ed Gondolf, Ricardo Guzman, Barbara Hart, Ann Menard, Joyce Thomas, Oliver Williams, my colleagues on the Task Force on Domestic Violence in the Military, the shelters where I have volunteered in various capacities over the years—now at the House of Ruth Maryland where Carole Alexander, Tania Araya, Dorothy Lennig, and Terri Wurmser provide such talented leadership—and last but never least, the Family Violence Prevention Fund (FVPF). I admire and am proud to work with everyone on staff at the FVPF but especially the amazing director, Esta Soler, and her leadership team, Debbie Lee, Leni Marin, and Janet Carter.

Finally, I would like to acknowledge the unfailing help and support of my students, former students, research colleagues of the Nursing Research Consortium on Violence and Abuse (each and every one of you), national and international research colleagues from all over the globe, research staff at Johns Hopkins University School of Nursing, and particular collaborators and friends in the field of family violence at Hopkins: Andrea Gielen, Nancy Glass, Joan Kub, Pate Mahoney, Phyllis Sharps, Dan Sheridan, Daniel Webster, and she who supports all of us, Nadiyah Johnson.

I would also like to extend my thanks to two moms of incredible wisdom and love, Dorothy Bowman and Constance Morrow; a father and brother committed to nonviolence, Joseph Bowman Sr. and Jr.; an incredibly brilliant sister, Deborah; an always supportive brother and sister-in-law, Patrik and Shelley; my especially wonderful children, Christy and Brad; their amazing spouses and children, Nik, Nadia, Grace, Sophie, and Nathan; and most of all to Reg, the love of my life, my thanks and love.

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Clinicians who work in interpersonal violence are asked frequently to make predictions about their patients, or clients’ violent behavior. Most notably, clinicians are asked by law enforcement personnel, child and elder protective services workers, and civil and criminal court officials to predict the likelihood of future violence by alleged and/or convicted family violence and sexual assault perpetrators. These assessments of “dangerousness” serve the primary functions of developing safety strategies for victims and controlling future violent behaviors of the perpetrator by treatment or confinement (Campbell & Glass, in press; Campbell, Sharps, & Glass, 2001; Gondolf, Mulvey, & Lidz, 1990).

In this chapter, we review what is generally known about the prediction of violent behavior and then discuss implications for the prediction of interpersonal violence. Succeeding chapters address the specific variables involved in the prediction of child abuse and neglect, and intimate partner violence (both heterosexual and same-sex). This volume represents the most current research, trends, and professional viewpoints regarding the prediction of interpersonal violence.

Although the prediction of interpersonal violence is a relatively young science, it is an area of utmost importance. As aptly stated by Hilton and
Harris (2005), “Predicting violence is quite a different task from explaining it” (p. 3). Clinicians working in the field will always be concerned that a case with which they have worked will end in a serious injury, homicide, or homicide-suicide unless they take every possible action to avert such an outcome. Consider the following scenario.

**A CLINICAL REALITY: HOSPITAL-BASED INTERVENTION**

8:00 a.m.: You are paged to the intensive care unit to see a critically injured patient just admitted from the emergency department (ED). The woman has multiple fractures to her face, bruises to her chest and back, and a partially ruptured spleen. She tells you that 2 days ago her husband struck her with a board and kicked her multiple times. He would not let her seek medical care. She thinks that earlier today she must have passed out at home from internal bleeding. She was driven to the ED by her husband, who then left the hospital. She tells you that her husband has a permit to carry a concealed weapon and that he frequently has threatened to kill her and the children if she ever tried to leave the relationship. She asks, “Will my husband beat me again? Could he kill me or my kids?”

8:25 a.m.: The hospital administrator pages you and wants to know whether this patient’s husband poses a risk of harm to other patients, staff, or visitors.

8:50 a.m.: You are paged by a child protective services department investigator. She tells you she has been investigating this family because of a recent child abuse allegation filed by the school. The children did not arrive at school this morning, and they are not at home. She thinks they may be with their father. She asks you whether you think the children are at risk of abuse and whether the mother knows of their whereabouts.

9:00 a.m.: You are paged by the ED staff to see another patient, a woman who was just raped and then shot in the hip by her former husband. On the basis of the patient’s initial history, the ED staff has fears that he may come to the hospital to “finish what he started.” They ask whether you think this man is capable of coming to the ED to kill his former wife.

9:05 a.m.: You are paged by the prosecuting attorney’s office to confirm that you will testify in court later that day around 1:00 p.m. on a case from several months ago.

**PREDICTIVE SETTINGS**

The above scenario is a real-life example of a day in the life of a clinician who works with domestic and sexual violence survivors in crisis. As illustrated,
the clinician is called on repeatedly to make assessments and predictions of risk for repeat violence, often after obtaining only a cursory history of the violent behavior and without any direct contact with the alleged perpetrator. Clinicians in acute incident settings (e.g., hospital social workers, forensic nurses, physicians, field investigators, hot-line workers) are especially pressed for time. In these instances, predictions are likely to be best guesses, based on intuition, knowledge, experience, and often biases.

Typically this initial prediction, or assessment of risk, will be revisited several times and in a number of settings. In the criminal justice system, documentation and/or testimony regarding the defendant’s propensity for violence may influence a variety of judicial outcomes. For example, the court may ask the clinician to predict the likelihood of future violence when sentencing a convicted offender. The expert opinion of the clinician may significantly affect the type and length of sentence. Likewise such testimony may influence the eligibility of convicted offenders to participate in new, innovative, deferred sentencing programs or other forms of alternative dispensation, such as community-based treatment programs. In family court, clinicians’ predictions of future violence may influence the court’s ruling on a protection or stalking order or on issues of child custody and protection.

Clearly the clinician’s assessment of dangerousness can be an enormously valuable resource. This value highlights the need for the development of accurate and reliable models for the prediction of interpersonal violence. The accuracy of using clinical judgment to predict risk for violence has been questioned (Grove, Zald, Lebow, Snitz, & Nelson, 2000; Monohan et al., 2001). In fact, Hilton and Harris (2005), in their review of research literature predicting intimate partner violence against women, clearly state that actuarial risk assessment techniques and tools are far more accurate than unstructured clinical judgments or structured clinical risk assessment tools.

**Actuarial Risk Assessment**

Actuarial risk assessment is an evidence-based prediction process based on statistical analysis (Hilton & Harris, 2005). The Violence Risk Appraisal Guide (VRAG) is an actuarial risk assessment tool that was created in 1993 to address violence potential in men undergoing pretrial psychological forensic assessments (Harris, Rice, & Quinsey, 1993). It has been used to assess violence recidivism in sex offenders, prison inmates, nonforensic psychiatric patients, and domestic violence perpetrators (Hilton & Harris, 2005). While it was created to assess violence, “the VRAG may be the assessment tool of choice when measuring risk of wife assault recidivism” according to Hilton and Harris (2005), although it has not been used widely and has not been
extensively validated with that population. It is composed of 12 variables that require a thorough understanding of the background of the offender and the offender's psychological adjustment, including knowledge gained from using the Hare Psychopathy Checklist-Revised (PCL-R). Thus, it takes considerable training and time to learn how to administer and evaluate findings from the VRAG (Hilton & Harris, 2005). Nonetheless, the PCL-R, developed by Hare, Clark, Grann, and Thornton (2000), is a very strong predictor of violence recidivism, in general, and specifically among more serious male abusers of women (Harris, Skilling, & Rice, 2001).

The Ontario Domestic Assault Risk Assessment (ODARA) is another actuarial risk assessment tool that contains only 13 items and was created for use by police officers in the field who respond to domestic violence emergency calls (Hilton et al., 2004). The items on the ODARA are scored 0 or 1 and include threats and confinement during the most recent assault, domestic and nondomestic criminal history, offender substance abuse, victim barriers to support, and children in the relationship (Hilton & Harris, 2005). With minimal training, police officers had perfect interrater reliability of the items on the ODARA (Hilton et al., 2004).

**Does Treatment Work?**

For over 20 years, court systems in North America have been ordering men into counseling in hopes of stopping or reducing their abuse toward women. The success of these programs is a matter of debate. According to Hilton and Harris (2005), “there is no scientifically persuasive evidence that current treatments for wife assaulters reduce recidivism” (p. 15). However, success of a batterer intervention program is more complex than just measuring whether the violence stopped. Gondolf (2002) found that women reported significantly less violence and improved quality of life after their partners completed batterer intervention programs and that an extremely important contributor to treatment failure was abusers dropping out of the program. Clients/patients more likely to drop out of abuser treatment tend to be younger and to have less education, less money, and unstable social lifestyles (Scott, 2004).

Craig, Browne, and Stringer (2003) reviewed the literature on sexual assault recidivism after treatment and found treatment effectiveness to be questionable. They found most promising those cognitive-behavioral treatments that targeted deviant arousal, increasing appropriate sexual desires, improving interpersonal skills, and modifying distorted thinking (Craig, Browne, & Stringer, 2003).

Veneziano and Veneziano (2002) reviewed the research on adolescent sex offenders and found they shared many characteristics that were predictive of recidivism such as: being reared in a dysfunctional home, experiencing prior
physical and/or sexual abuse, separation from parents as when placed in foster care, isolation, and having academic and behavioral problems at school. Most treatment programs designed for adolescent offenders were modeled after adult offender programs, which do not have huge success rates. Not surprisingly, Veneziano and Veneziano (2002) found, in general, little research that supports any effectiveness in adolescent treatment programs. Obviously, more research is needed in treatment programs for perpetrators of many abuses in order to reduce recidivism.

**CLASSIC CLINICALLY BASED PREDICTION MODELS**

The prediction of interpersonal violence demands the use of psychometrically sound measurements and an understanding of such tools’ limitations. Classic research in clinical decision making (Benner, 1984; Harbison, 1991; Schon, 1983a) identifies three major models for prediction: (a) the linear, rationalist model, (b) the hypothetico-deductive model, and (c) the risk assessment model (Gottfredson & Gottfredson, 1988). Depending on the goal of the assessment, the clinician may use aspects of one or more of these models.

**Linear (Rationalist) Model**

Because prediction has such significant forensic implications, clinicians may use a linear model, including a decision tree or critical pathway, to guide them when making decisions that have legal ramifications. For example, Gross, Southard, Lamb, and Weinberger (1987) proposed seven steps to follow when a client makes suggestive threats.

Step 1 is to clarify the threat. Many clients/patients make vague comments that may or may not indicate a real danger. Thus the clinician must take the time to fully explore intent. For example, after an acute beating, a battered woman may state that she wishes someone would “blow his [the abuser’s] brains out.” In this case the clinician needs to ask the client/patient directly whether she intends to kill her abuser. This woman simply may be expressing her anger rather than verbalizing a true threat. Further inquiry might reveal that she does not own or have access to a firearm. The risk factor for retaliatory violence is therefore low, especially when compared with the client/patient who tells the clinician that she would like to kill her abuser and has borrowed her brother’s loaded handgun.

Thus, if there is a clear threat, Step 2 is to assess its lethality, as well as the likelihood of the person acting on the threat. As with suicidal thoughts, not all “threats” pose a true danger or can be enacted. The incarcerated client or
hospitalized patient may verbalize specific threats of violence against someone outside of prison or the hospital but have no means to carry through on the threats.

If there is evidence of danger, Step 3 is to identify a specific, intended victim. In family violence and family sexual assault cases, it is easy to identify intended victims. The violence is seldom random, even within homes in which multiple members reside. The clinician working with a client/patient who is verbalizing concerns about physically and/or sexually assaulting a stranger may find it more difficult to identify a specific victim (by name). However, the clinician can ask the client/patient to indicate the intended victim’s gender and any specific victim characteristics. If the person can name the intended victim or specifics about the type of victim who will be sought, the threat of harm is imminent (Step 4). At this point the clinician needs to consider his or her duty to warn the specified victim. Specifically, according to the California Supreme Court Tarasoff decision, “When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps. Thus, it may call for him to warn the intended victim, to notify the police, or to take whatever steps are reasonably necessary under the circumstances.” For more detail the reader is referred to the body of literature on the Tarasoff decisions (Tarasoff v. Regents of the University of California, 1974, 1976).

The clinician also must take into account the client/patient’s relationship to the intended victim (Step 5). If the intended victim is a family member, rather than a political figure, the clinician may employ different preventive and treatment strategies.

Step 6 requires the clinician to decide whether a family or couples therapy intervention would be suitable. For example, if the family violence is ongoing, family therapy may impose greater danger to the potential victim or victims.

Finally, Step 7 requires the clinician to consider whether civil commitment or involuntary hospitalization would provide the greatest good to the client/patient and potential victim or victims. At the completion of Step 7, the clinician needs to follow up on the results of the decisions made and may need to recycle through the decision tree at a later date.

The strength of the linear model is that it provides relatively clear direction for the clinician, as well as a “logical” argument for the decision. Using the linear model, the clinician approaches problem solving with some notion of probability. He or she weighs outcomes according to objective standards or theory. The weakness of this model is also its objectivity; contextually relevant information is given little consideration. In other words, factors such as treatment outcomes, social support, and stabilization of stress are not
considered in making the prediction. The decision is driven by formula, more than by the specifics of the actual situation.

**Hypothetico-Deductive Model**

By contrast, the hypothetico-deductive model tends to be relational and complex in assessing factors that influence clinical decisions. As with the linear model, the clinician weighs different factors, but the problem is considered more in context. In addition, past experiences with similar situations provide the clinician with patterns of cues to consider and ways to categorize the cues. In considering all of the information in the current situation, the expert is searching for a “pivotal cue” to frame all of the cues and to link with extensive theoretical and experiential knowledge (Regan-Kubinski, 1991; Schon, 1983b).

After the clinician has focused his or her questioning and assessment, he or she begins to search specifically for additional cues relevant to violence and protectiveness. In clustering the cues, the expert continually loops back to the context of the specific client and to the overall context of the community in which the situation is occurring. Finally, the clinician arranges the cues into some hypotheses and reviews the hypotheses for completeness. He or she may seek additional cues to complete the picture if necessary. The hypotheses then are tested for confirmation or refutation, and a final decision is made. The following case example illustrates this process:

> While tightly clenching his fists, a young man tells his high school counselor that his grades plummeted because his girlfriend, whom he refers to in sexually derogatory terms, broke off their relationship. The counselor knows that this student has a history of frequent alcohol abuse and fighting on school grounds. The young man's father is in the Army on an extended overseas assignment in the Middle East. The mother reports that her son refuses to accept her authority and that he has become difficult to manage in the absence of the father.

> Using the hypothetico-deductive model, the clinician first focuses on the cues of anger, age, rejection by the girlfriend, and alcohol abuse, reaching the pivotal cue of “potential for dangerousness.” The counselor also hypothesizes that the young man may be depressed, feeling out of control, and feeling abandoned, all of which would contribute to his potential for violence. In addition, the counselor considers such cues as the school’s location in New Orleans and the school’s climate after Hurricane Katrina, reports of several similar situations with the other young men in the school, and reports that the girls in the school have been complaining about violence by the boys. The
counselor reaches the judgment that not only is this young man potentially dangerous but also there may be a systemic problem in the school and community. Thus the immediate plan is to confront the young man’s anger and to recommend some structured physical activity. The counselor also determines that the girlfriend has different classes from the boyfriend and that the possibility of contact that day is slight. The young man contracts to stay away from the girlfriend and not harm her. To meet the community problem recognized by this model, the counselor consults with his female colleague and together they plan a special assembly on the topic of dating violence. They also set up gender-segregated peer groups to discuss violence in the community and within dating relationships.

**Risk Assessment Model**

A major reason for poor predictive accuracy of interpersonal violence is the assumption that violence is dichotomous and single dimensional (Gottfredson & Gottfredson, 1988). Instead of a binary notion of violence, Gottfredson and Gottfredson propose a risk-to-stakes matrix wherein the seriousness of the action is weighed with the likelihood of repetition. Seriousness permits the assessor to consider types of harm possible across a multitude of variables.

Alcohol and drug use, for example, might influence the likelihood of harm, as well might a history of violence. By means of the risk assessment model, clinicians can provide assessments of risk factors or risk markers that may contribute to violence. Such a model incorporates the social and political climate, as well as the individual’s internal climate. The risk assessment model permits clinicians to weigh both the environmental and personal factors present in any given situation. The following case demonstrates this model:

Convicted of felony assault on his former girlfriend, a 28-year-old male with a history of alcoholism is up for parole after serving half of a 12-month sentence. While in prison, he completed extensive alcohol treatment and anger management programs. On release from jail he intends to live with his mother. As the clinician, it would be imperative to know that his mother lives less than a block from the former girlfriend and that living in the mother’s home are several alcoholic siblings. Releasing this man into his mother’s home, into close contact with alcoholic siblings, places him at high risk for drinking. Because his mother lives so close to his former girlfriend, further abuse and stalking is also quite possible. Instead of recommending against parole, the clinician may advise that parole be contingent on housing arrangements that do not place the offender in such close contact with either alcohol or his prior victim.
The three clinical decision-making models discussed above are distinct, but not necessarily exclusive, means for deciding on interventions. In courtrooms, linear decision routes are much easier to substantiate. However, decisions are rarely so clear-cut in the clinical arena. Therefore, clinicians need to be adept in approaching (or at least justifying) these decisions from multiple perspectives.

**PREDICTIVE RELIABILITY AND VALIDITY**

The accuracy (validity) and consistency (reliability) of predicting dangerousness and violence depends on multiple, complex factors. In general, the more rare an event, the more difficult it is to predict (Campbell, Webster, & Glass, in press; Lambert, Cartor, & Walker, 1988; Webster et al., 2003). For example, predicting the risk of intimate partner violence (IPV) re-assault has become the primary aim of the majority of IPV risk assessment instruments. IPV re-assault is easier to accurately predict because it has a much higher occurrence (approximately 25% to 30% of IPV cases) than does intimate partner homicide (approximately .04% of IPV cases) (Campbell, 2004).

Factors that are known to influence the accuracy, or validity, of predicting dangerousness include: the type of violence (e.g., physical assault, sexual assault, homicide); the perpetrator’s relationship to the victim (e.g., stranger, intimate, acquaintance); the characteristics of the perpetrators (e.g., history of violence, mental health issues); and the time period of the prediction (e.g., acute danger or chronic danger).

The succeeding chapters discuss in greater depth challenges with assessment measures and factors used to predict future violence. It is clear, however, that assessments of risk for future violence are improved when appropriately administered, psychometrically sound risk assessment scales are used. Further, clinicians need to couple these objective measures with information collected on the characteristics of the perpetrators, the perpetrator’s relationship to victim, the victim’s assessment of risk, clinician experience and judgment, and context-specific factors (e.g., poverty, unemployment, discrimination, social support).

**Poor Record of Past Predictions**

Clinicians, in general, have a poor track record of predicting future violence among perpetrators of violence (Convit, Jaeger, Lin, Meisner, & Volavka, 1988; Gondolf et al., 1990; McNeil, Binder, & Greenfield, 1988; Miller & Morris, 1988). For example, although an assessment of danger to others and/or self is a
basic assessment element of involuntary confinement or psychiatric treatment, individual clinicians have not been very successful in accurately predicting this danger for violence victims (Beigel, Barren, & Harding, 1984; McNeil et al., 1988; Meloy, 1987; Steadman & Morrissey, 1982).

However, when clinicians consult with each other (e.g., multidisciplinary review boards) and with victims of violence, they are able to pool their diverse knowledge and expertise in reaching a consensus. The social worker, psychologist, advanced nurse clinician, psychiatrist, counselor, parole officer, and victim have very different perspectives; together they form a more complete assessment of risk for future violence.

We also are learning that predictions can be made more accurately when evaluators take into account such interactive factors as age, gender, unemployment, perpetrator-victim relationship status, perpetrator’s history of violence, use of alcohol and/or illegal substances, history of mental health issues, and availability of guns (Campbell et al., 2001; Meloy, 1987; Segal, Watson, Goldfinger, & Averbuck, 1988). Although risk factors such as age, gender, and prior history of violence cannot be changed by intervention, risk factors such as unemployment, perpetrator access to gun, and use of alcohol and illegal drugs can be the focus of intervention. Risk for future violence may thereby be reduced (Campbell et al., 2003).

**PREDICTIVE FACTORS**

**History of Violence**

Research into the prediction of interpersonal violence consistently shows that a history of violence is one of the best predictors of future violence (Convit et al., 1988; Janofsky, Spears, & Neubauer, 1988; Lewis, Lovely, Yeager, & Femina, 1989; McNeil et al., 1988). For example, the most important risk factor of homicide in an intimate relationship is violence against the female partner. Approximately 67%–75% of intimate partner homicides have a reported history of IPV against the female partner, no matter which partner is killed (Bailey et al., 1997; Campbell, 1992; Campbell et al., 2003; McFarlane, Parker, Soeken, Silva, & Reed, 1999; Mercy et al., 1989; Moracco, Runyan, & Butts, 1998; Pataki, 1997; Websdale, 1999).

Two studies in different U.S. jurisdictions (Dayton, Ohio, and the state of North Carolina) documented that intimate partner homicides against men were characterized by a documented history of violence against the female perpetrator by the male partner or ex-partner victim in as many as 75% of the cases (Campbell, 1992; Hall-Smith, Moracco, & Butts, 1998; Moracco et al., 1998).
When predicting reoccurrence of intimate partner violence, one important source of information about the likelihood of re-assault is the victim (Hilton et al., 2004; Weisz, Tolman, & Saunders, 2000). “Battered women’s rated likelihood of partner violence strongly correlated with violence in subsequent months and years, over and above history, and other predictors” (Hilton & Harris, 2005, p. 7). However, psychometrically validated instruments were somewhat more accurate than victim perception in an experimental test of IPV risk assessment (Campbell, O’Sullivan, Roehl, & Webster, 2005).

There is limited research on risk factors for lethal or near-lethal violence in marginalized populations such as sexual minorities. For example, data from the Supplemental Homicide Reports (SHR) estimate that from 1981 to 1998, 6.2% of the total murder rate for men in the United States was male same-sex couple intimate partner homicides in comparison to 0.5% female same-sex partners homicides. However, we have been unable to find any systematic study of risk factors for male same-sex partner homicides, and there has been only one study of female same-sex intimate partner homicides (Glass, Koziol-McLain, Campbell, & Block, 2004). In that subsample analysis of five intimate partner homicides and four attempted intimate partner homicides by female partners, a prior history of violence by the female intimate partner was a notable risk factor to the lethal or near-lethal violence event.

Although a history of violence is a risk factor consistent with lethal and near-lethal violence in heterosexual couples, because of the small sample, definitive conclusions cannot be drawn for risk factors in female same-sex relationships. Currently, Glass and colleagues are conducting a study to better understand and assess for risk factors for repeat violence in abusive female same-sex relationships.

**Mental Illness**

Further research is needed to explicate the link between mental illness and risk for violence and repeat violence. Studies have produced mixed information regarding the role of mental health issues and violence perpetration. Given information for one study, perpetrators of intimate partner homicide appear to be more likely to have a history of mental illness. Specifically, 13% of perpetrators (11% of males, 15% of females) of 540 intimate partner homicides had a reported history of mental illness, that is compared to 3% (not reported by gender) of nonfamily murderers (Zawitz, 1994).

In other data, approximately one-third of the 200 male perpetrators from a multicity study of lethal and near-lethal intimate partner violence were described as being in poor (versus fair, good, or excellent) mental health (Sharps, Campbell, Campbell, Gary, & Webster, 2001). Although perpetrator mental health was significantly associated to risk for intimate partner
homicide, it did not remain significant when examined with other factors in the multivariate analysis for the study (Sharps et al., 2001). In the Dobash et al. (2004) United Kingdom study, 27.5% of the men who perpetrated intimate partner homicide were labeled as having mental health problems, a proportion approximately the same as men who perpetrated other types of murder (non-intensive partner).

Perpetrators who are psychopaths have a high likelihood of re-offending. While psychopaths represent a relatively small percentage of men who abuse women (15% to 30%) their behavioral traits of superficial charm, need for stimulation, callousness, and manipulation are quite familiar to clinicians who provide service to their victims (Hilton & Harris, 2005). Psychopaths will have a history of early behavioral problems, impulsivity, antisocial behavior, and callousness.

Clinicians are often called upon to make predictions of dangerousness as a requirement of their roles in health care settings such as psychiatric hospitals and emergency departments, but as mentioned earlier, clinicians are often not provided with the training related to assessment of dangerousness and, therefore, have historically had a poor rate of predictive accuracy (Quinsey, Harris Rice & Cormier, 2006). Because of (or in spite of) these poor predictive accuracy rates, there is great internal and external pressure on clinicians to develop more effective means of identifying patients or clients who are likely to be violent.

One challenge to assessing risk of violence among patients or clients who have been diagnosed with a mental illness is the criteria used to identify “violent” acts and “violent” people. For example, psychiatric patients or clients have traditionally been assessed for danger to self and danger to others. As a result, suicide and self-mutilation may be included in the findings, potentially overestimating the patient’s or client’s dangerousness. Likewise, the patient or client may demonstrate very different patterns of behavior when hospitalized (Holcomb & Ahr, 1988; Myers & Dunner, 1984) simply because they are receiving treatment. Because the severe mental illnesses (e.g., schizophrenia, bipolar disorder) are relapsing ones, violence is a greater factor in times of decompensation and psychosis than during stabilization (Craig, 1982; Krakowski, Jaeger, & Volavka, 1988; Tardiff & Sweillman, 1982).

**Substance Abuse**

Although alcohol and/or drug abuse has classically been frequently reported as the cause of interpersonal violence, most research describes a relationship between the use of alcohol and other substances with incidents of violence (Dobash & Dobash, 1979; Frieze & Schafer, 1984; Goodman, Mercy, & Loya, 1986; Goodman, Mercy, & Rosenberg, 1986; Lenke, 1982; Norton & Morgan, 1989a, 1989b, 1989c).
Alcohol

The majority of research articles on substance use and its relationship to violence focus on alcohol usage, mainly of the perpetrator. To understand this potential causal relationship, it is important to understand the effects of alcohol on the body. Alcohol is a depressant, with its short-acting action associated with arousing, euphoric effects followed by dysphoric, depressing effects. Its effect on behavior can be roughly correlated with the level of alcohol present in the body as measured by blood alcohol content, although it does not follow a simple pharmacologic dose-effect relationship, and is different in each person (Miczek et al., 1994).

Theoretical explanations of alcohol’s role in child and partner violence consider both proximal and distal influences. The proximal effect model is that there should be a temporal relationship between substance use and violence, meaning that episodes of violent acts would closely follow ingestion of the substance. The psychopharmacologic effects of alcohol on cognitive processing facilitate violent behavior, in that persons having ingested significant amounts of alcohol are more likely to interpret others’ behavior as hostile and are less likely to be able to problem solve a nonviolent solution to conflict, especially if they have learned violent behaviors in their family of origin. Distal influences include individual difference factors such as personality characteristics and life experiences and contextual influences such as relationship type, all of which may create an environment that facilitates violent behavior, especially when added to alcohol (Chermack & Blow, 2002; Fals-Stewart, Golden, & Schumacher, 2003). Regardless of the theories, alcohol use is one of the accepted risk factors for child and partner violence.

Fals-Stewart (2003) discovered in his longitudinal diary study that the likelihood of male-to-female aggression was substantially higher on days of drinking by male partners compared with days of no drinking. In fact, physical aggression was 8–11 times higher on days of drinking. Also, it was determined that the violence occurred shortly after the drinking episodes ended, supporting the proximal effects model described above. The study concluded “use of alcohol by the male partner is a significant risk factor for the occurrence of physical aggression among couples with a history of interpartner violence” (Fals-Stewart, 2003, p. 50).

Additionally, Fals-Stewart et al. (2003) studied male-to-female physical aggression over a 15-month period to determine that interpersonal violence was significantly higher on days of alcohol use. Once again, there was a decelerating relationship between the amount of time between cessation of use and the occurrence of violence, supporting the proximal role of substance use in occurrences of IPV.
Alcohol use was significantly higher on days where physical violence and interpersonal conflict occurred, and alcohol consumption appeared to be the most potent predictor (Chermack & Blow, 2002; Thompson & Kingree, 2004). Although alcohol use is an accepted risk factor for IPV, there still remains controversy on whether there is enough evidence-based practice to support this assumption (Gil-Gonzalez, Vives-Cases, Alvarez-Dardet, & Latour-Perez, 2006). “The marked correlations between alcoholism and various types of violent acts do not permit, however, any clear insight into the pharmacologic conditions of alcohol exposure that are necessary or sufficient for these violence-promoting effects” (Miczek et al., 1994).

**Other Substances**

**Cocaine**

Cocaine is a central nervous system stimulant, the strongest stimulant derived from natural sources. Initially, use of this drug reduces appetite and makes the user feel more alert, energetic, and euphoric. With high doses, users can become delusional, paranoid, and even suffer acute toxic psychosis. As the drug’s effects wear off, depression sets in, leaving the user feeling fatigued and anxious. Cocaine has also been shown to increase the incidence of IPV (Chermack & Blow, 2002; Fals-Stewart et al., 2003). It is important to also recognize the correlation of alcohol and cocaine; the interaction between the two drugs could account for the resulting effects related to aggression.

**Methamphetamine**

Methamphetamine is an intense, man-made stimulant. Upon ingestion, it releases high levels of the neurotransmitter dopamine, which causes excitation, euphoria, intensification of emotions, increased alertness, and heightened sexuality. Unlike other stimulants, methamphetamine is metabolized at a slower rate. Because of this, a sustained euphoric state is produced that can last up to 8 hours (Cartier, Farabee, & Prendergast, 2006). A 2006 survey of United States counties found that more counties (48%) report methamphetamine as the primary drug problem than cocaine, marijuana, and heroin combined. Additionally, 62% of counties reported an increase in domestic violence and a 53% increase in simple assaults between 2004 and 2005 (National Association of Counties, 2005).

Despite the overwhelming prevalence of methamphetamine use, there is a paucity of research examining use of the drug related to IPV. Von Mayrhauser, Brecht, and Anglin (2002) found that about two-thirds of methamphetamine
users studied reported violent behavior as a result of their usage. In a multi-state study from 1999 to 2001, 1,016 methamphetamine users were examined. Eighty percent of women participating in the study reported abuse or violence by a partner (Cohen et al., 2003). It is difficult to assess from this data how much contribution methamphetamine makes to the pattern of violence reported. Researchers need to evaluate the use of methamphetamine and IPV more. Because of the heightened sexuality that the drug stimulates, researchers also need to examine possible correlation with sexual violence as well.

An important barrier exists in examining the relationship between substance abuse and violence: It is difficult to identify with certainty a perpetrator’s substance abuse at the time of a violent incident. If the perpetrator has committed suicide or has volunteered samples at the time of the incident, then blood alcohol and other toxin levels are available to evaluate substance abuse potential.

Recent research has examined the role of alcohol and substance use in interpersonal violence. For example, perpetrator problem drinking and illicit drug use were significantly related to lethal violence in intimate relationships in the multicity study examining risk factors for intimate partner homicide (Campbell et al., 2003). However, neither perpetrator problem drinking nor perpetrator illicit drug use prior to the violent event were significant predictors of lethal violence when controlling for other important factors, such as use of a gun, threats to kill, and a nonbiological child of the perpetrator in the home.

Illicit drug use was a stronger predictor of lethal violence in the study than problem drinking and it did remain as a significant predictor of lethal violence until perpetrator aggressive behavior toward the partner was added into the risk model. Although subsumed by more powerful predictors (especially gun use) at the incident level, a remarkable 70% of the male perpetrators were using drugs and/or alcohol at the time of the homicidal incident (Campbell et al., 2003; Sharps, Campbell, Campbell, Gary, & Webster, 2003). Dobash et al. (2004) found that although a substantial proportion of intimate partner perpetrators had alcohol and drug problems (37.9% and 14.7% respectively), alcohol and drug problems were reported in a significantly higher proportion of males who commit other types of murders (nonintimate murder).

**Gender**

The literature about interpersonal violence tends to be gender-specific, depending on discussions about perpetrators or about victims. For example, many of the studies seeking to identify factors related to delinquency
and violence have looked only at male behaviors (Josephson, 1987; Lewis et al., 1989; Mulvey & Reppucci, 1988). Therefore, the research provides a limited perspective on the precursors to interpersonal violence perpetrated by females. In the case of intimate partner violence, research indicates that women are more likely to report violence by an intimate partner that resulted in an injury (Tjaden & Thoennes, 2000).

Research on the effects of childhood exposure to violence, including witnessing violence, on later aggression is inconclusive. In their review of police records, Lewis et al. (1989) found that juvenile violence was not sufficient explanation for violent criminal behavior as an adult. Instead they found it to be an interaction between a history of abuse and/or family violence and the cognitive, psychiatric, and neurological impairments of the child.

**Race/Ethnicity**

There are clear racial/ethnic disparities in rates of intimate partner homicide, with Native American and African American women at increased risk (Mercy & Saltzman, 1989; Morton, Runyan, Moracco, & Butts, 1998). Although a significant proportion of this variation can be explained by increased rates of unemployment among Native American and African American men (Campbell et al., 2003), few investigations have tried to delineate what accounts for these discrepancies. In the 11-city study, although the majority of risk factors were similar for the African American, White, Hispanic, and mixed-race couples, we found different strengths of risk factors in certain groups and some risk factors not applying for some groups (Walton-Moss, Campbell, & Sharps, in press).

For instance, prior arrest was found to be strongly protective against intimate partner homicide for White and mixed-race couples but not protective at all for African American and Hispanic couples. When looking at the data more closely, this was related to the finding that males in ethnic minority groups who killed their partners were more frequently arrested than the White male killers, and those ethnic minority men were equally often arrested among both the lethal and abusive control groups.

**ETHICAL CONSIDERATIONS**

Although the empirical study of the prediction of interpersonal violence is important, a number of moral and ethical issues should be considered. The clinician who must render an assessment of the probability of future violence has a responsibility to weigh several ethical issues; he or she must
consider not only the social injustice of violence perpetrated against the victim but must also weigh the perpetrator’s individual rights to autonomy and freedom.

An ethical concern for clinicians is using mental health interventions as a form of social control of violent behavior versus using them to alleviate emotional and psychological distress potentially linked to violent behavior. In other words, when the clinician recommends commitment of an individual judged to be “dangerous,” is the purpose of the action to help or control the perpetrator? If social control is the purpose, what treatment is ethical and appropriate—psychotropic medications or psychotherapy? Is informed consent necessary for the provision of treatment and is such consent even possible within a coercive environment?

Another problematic issue regarding the prediction of interpersonal violence is the potential for racism and classism. Evidence indicates that people of color are more likely to be prosecuted and convicted of violent crimes than white people (Spohn, 2000). Race, ethnicity, and class influence clinical judgment, as every clinician can be influenced by his or her identification with the victim or the offender.

Whether or not we participate in formal research to test the predictive properties of a particular instrument or assessment method, all clinicians make predictions about dangerousness. It can be argued that it is not possible to truly refrain from making “predictions.” These predictions may be based on such factors as past behaviors, risk factors, similar behaviors that have been observed in others, clinical evaluation of the alleged offender, conversation with the victim, and/or risk assessment instruments.

Some clinicians will tend to under-predict (false negative—the person is predicted to be less dangerous than he or she actually is) the potential for danger, while others may over-predict (false positive—the person is predicted to be more dangerous than he or she actually is). If they under-predict the risk of further violence, the clinicians place the potential victim at risk of being killed or seriously hurt. When the clinician over-predicts the potential for danger, the potential victim may lose trust in the clinician’s ability to identify dangerous perpetrators and situations. The client may choose to ignore future assessments by the clinician, again being placed in a vulnerable position. To over-predict the potential dangerousness of an identified perpetrator also may be to participate in a process that unjustly incarcerates, labels, and/or blames a person for past behaviors. The difficult task for the clinician is to make a judgment between the two extremes. Obviously, this requires training, skill, and a willingness to weight multiple factors using validated measures as well as trusting the opinions of colleagues and the victim(s) (Campbell, Webster, & Glass, publication submitted for review).
SUMMARY

In general, there is a series of behaviors that should raise concerns that violence will re-occur in any number of settings. These behaviors include the following:

- Prior history of being violent
- Experiencing violence as a child
- Substance abuse
- History of mental illness, especially psychopathy and antisocial behaviors
- Failing to complete an offender treatment program
- Being young and poor
- Unemployment

In intimate partner relationships all of the above are risk factors for violence with the addition of the following as risk factors for women in heterosexual relationships:

- Leaving an abusive relationship for another man
- Having a child or children from a previous relationship
- Stalking
- His access to firearms

Assessing dangerousness for further violence by sexual offenders, batterers, and child abusers is a developing science. The following chapters explore the most current research, trends, and professional viewpoints regarding the prediction of interpersonal violence.

REFERENCES


