

# What Can be Done About High-Risk Perpetrators of Domestic Violence?

Marcus Juodis · Andrew Starzomski · Stephen Porter ·  
Michael Woodworth

© Springer Science+Business Media New York 2014

**Abstract** This article addresses practical implications for preventing lethal and nonlethal domestic violence (DV) that stem from recent research on male domestic homicide perpetrators. The role of risk assessment and batterer intervention programs is emphasized, including specific programming for treatment-resistant perpetrators. Adjunct interventions for related problems (e.g., anger, suicidal behaviour, substance abuse) are offered, and risk management tactics are summarized. The article highlights the significance of safety planning for victims and teaching youth skills for forming and maintaining healthy relationships. Possible solutions to the problem of DV perpetrators who avoid arrest also are highlighted (e.g., public awareness campaigns). Additionally, this article discusses approaches for dealing with psychopathic DV perpetrators, including the possible benefits of community education on psychopathy and early intervention for youth at risk for developing these traits. Some policy implications concerning DV and psychopathy also are covered. The article underscores the importance of coordinated community responses to DV.

**Keywords** Domestic homicide · Domestic violence · Male perpetrators · Risk assessment and management · Treatment · Psychopathy · Coordinated community responses

---

M. Juodis (✉)  
Psychology Department, Dalhousie University, Life Sciences Centre,  
1355 Oxford Street, Halifax, Nova Scotia, Canada B3H 4R2  
e-mail: Marcus.Juodis@Dal.Ca

A. Starzomski  
East Coast Forensic Hospital, Dartmouth, Nova Scotia, Canada

S. Porter · M. Woodworth  
University of British Columbia – Okanagan, Kelowna, British  
Columbia, Canada

This article discusses some of the practical implications for preventing lethal and nonlethal domestic violence (DV) that stem from our research on perpetrators of domestic homicide (DH) (see Juodis et al. 2014). To summarize briefly, our research involved an examination of the correctional files of 37 male DH perpetrators. The victim, perpetrator, and offense characteristics of DHs were compared against those from 78 non-domestic homicide (NDH) perpetrator files to illuminate distinct dynamics. Risk factors that preceded DHs also were identified retrospectively using the revised Danger Assessment (DA; Campbell et al. 2009). Study results indicated that DHs exhibited distinct dynamics, particularly in terms of perpetrators' predominant drives to inflict harm out of proprietary revenge. Importantly, it was revealed that most DHs did not occur "out of the blue", as 82.9 % of cases showed elements of planning, and 86.5 % of cases were identified as a homicide risk according to the revised DA. Although we highlight these and some of the other noteworthy findings from our research throughout this paper as we discuss the practical implications, the reader is encouraged to consult our initial article cited above for a more detailed description of the study methodology and results.

The practical implications of our research are discussed in relation to preventing both DH and DV because the underlying issues involved in DHs also may apply to many cases of nonlethal DV (Wilson et al. 1995). Space limitations preclude an exhaustive review of all possible prevention strategies, so only some of those that are more closely related to our research findings are discussed here. More specifically, we emphasize the usefulness of risk assessment for identifying high-risk DV perpetrators and the importance of batterer intervention programs for targeting many DV and DH risk factors and dynamics, including programming specifically for treatment-resistant men. Possible adjunct interventions for related problems are offered (e.g., for anger, hatred, revenge,

suicidal behaviour, and substance abuse), and specific risk management tactics are summarized.

In this paper we address the problem of high-risk DV perpetrators who manage to avoid arrest (e.g., through public awareness campaigns). Safety planning for victims also is covered, as is teaching at-risk youth skills for developing and maintaining healthy relationships. Some attention is devoted to approaches for dealing with psychopathic perpetrators of DV. Early intervention with families of youth who are maltreated or exposed to DV is emphasized in this regard. Additionally, we highlight the potential benefits of community education on psychopathy and DV. Finally, some of the policy implications concerning DV and psychopathy will be discussed. By the end of this article, it will hopefully be apparent that multiple practitioners with various strengths and expertise are needed for ensuring the safety of women and children, and for preventing and managing the danger posed by high-risk DV perpetrators. Hopefully, the importance of coordinated community responses to DV also will be more apparent.

It should be noted that space limitations preclude specific step-by-step instructions on implementing many of the strategies discussed (e.g., those involving manualized treatments), so the reader is encouraged to consult the cited references for more of these details when they are available. It also should be noted that some of the highlighted strategies involve relatively recent developments, and research demonstrating their effectiveness is limited or nonexistent. Future research will ultimately shed light on their effectiveness. Until this research is conducted; however, practitioners must rely on the best of what is currently available (Quinsey et al. 2006). Thus, possible prevention strategies that have not yet been subjected to rigorous empirical scrutiny but that are hypothesized to be helpful or show some promise are still included in our discussion.

### Risk Assessment

Our research highlighted the usefulness of empirically-validated risk assessment tools, such as the revised DA, for identifying high-risk DV perpetrators. Summarized briefly, 86.5 % of our 37 DH cases would have been identified as a homicide risk using the benefit of hindsight and the most liberal cutoff for the revised DA (i.e., increased danger; Campbell et al. 2009). Consistent with previous research, the most common lethality risk factor for DH in our study was prior DV against the woman (Campbell et al. 2007). Specifically, 83.8 % of our DH cases were preceded by DV against the woman that was increasing in frequency and/or severity.

Moreover, 70.3 % of our DHs occurred in the context of relationship separation, 62.2 % involved constant and violent jealousy, 54.1 % involved perpetrators who controlled most or all of the victims' daily activities, 45.9 % involved new

partners in the women's lives, and 21.6 % occurred in the context of formal or informal child custody/access disputes. Other notable risk factors that preceded the DHs included: threats to kill (51.4 % of cases), stalking (45.9 % of cases), threats or assaults with a weapon (32.4 % of cases), forced sex (32.4 % of cases), the perpetrator threatened or attempted suicide (29.7 % of cases), and choking (18.9 % of cases). The revised DA is available for free online (see [www.dangerassessment.com](http://www.dangerassessment.com)). Because training also is available online at a minimal cost, it is argued that this tool be embedded within an array of criminal justice, social service, and healthcare agencies in a more high-profile manner.

### Batterer Intervention Programs

Given the findings summarized above, batterer intervention programming appears to be a vital component of intervention for high-risk DV perpetrators (see, for example, Pence and Paymar 1993). When delivered properly and by appropriately trained practitioners who are strong role models, such programming is often intended to target many of the DH dynamics and risk factors observed in our research and the research of others. Specifically, these programs seek to address: the use of violence, threats and abuse; controlling attitudes and behaviours; jealousy; forced sex; stalking; and the impact of suicidal behaviour on partners. Anger, using children to manipulate partners, and inappropriate emotional dependence on women also are addressed in many programs. Moreover, batterer intervention programs strive to help DV perpetrators take responsibility for their actions, and aim to teach them alternative behaviours to violence and abuse by facilitating practice of more adaptive communication and conflict-resolution skills. Many programs also aim to help DV perpetrators learn to accept women's decisions and boundaries, even when it means the end of a relationship.

Importantly, concurrent safety planning for women and children is an integral part of many batterer intervention programs (see Hardesty and Campbell 2004). When appropriate, intervention that directly targets child abuse, neglect, or exposing children to DV may be warranted (see Scott et al. 2006). This component appears particularly important for some high-risk DV perpetrators as children and adolescents were killed in 14.7 % of our DH cases, and DH perpetrators specifically threatened to harm children in 13.5 % of cases. See Jaffe and Juodis (2006), and Jaffe et al. (2012) for a more detailed review of issues surrounding children as victims and witnesses of DH.

### Treatment-Resistant DV Perpetrators

Because some high-risk DV perpetrators are extremely resistant to batterer intervention programming, Scott et al. (2011)

developed a short self-report screening measure to be used during intake, as well as a relatively brief pre-treatment program (six sessions) for these men to be used prior to their admission into standard batterer intervention programming. The pre-treatment program followed the Transtheoretical Stages of Change Model (Prochaska and DiClemente 1982) and used motivational interviewing techniques (Miller and Rollnick 2002) to prepare men for standard programming. Results from a quasi-experimental trial showed that highly-resistant DV perpetrators who received the pre-treatment program were significantly less likely to drop out of standard programming (84.2 % completed all programming) compared to highly-resistant DV perpetrators who did not receive the pre-treatment program (46.5 % completed all programming). Although the recidivism rates of these perpetrators are not known, the increased ability to keep highly resistant men from dropping out of treatment before it was even completed represents a very promising advancement for the field. The program materials are available from its developers upon request.

### Adjunct Interventions for DV Perpetrators

#### Emotional Reactivity, Anger, Hatred, and Revenge

Adjunct interventions may also be used to target some of the DH dynamics and risk factors addressed in our research, provided they are delivered by practitioners with a strong understanding of DV who will not excuse the actions of perpetrators. In our research, reactive violence was found to be more characteristic of DHs than NDHs; however, both groups were comprised of relatively few homicides involving reactive violence at a level that would be considered impulsive. Although powerful emotional arousal may have been observed more often in DHs than NDHs, the majority of DHs (82.8 % of cases) evidenced some degree of instrumental violence, suggesting some level of planning on the part of the perpetrators (even when powerful emotional arousal in response to conflict or provocation was involved). The results also indicated that powerful emotional arousal may not even be a necessary condition for DHs, as 40 % of DHs occurred in “cold blood” and were not immediately preceded by conflict or provocation, and did not immediately follow powerful emotional arousal on the part of the perpetrator. With regard to motives, DHs appeared to be chiefly about inflicting pain and suffering on the victims out of proprietary revenge. That is, it appeared to be male control/proprietaryness, jealousy, the woman leaving, the woman having a new relationship, and formal or informal child custody/access disputes that were underlying DH perpetrators’ desires for revenge and causing harm to victims (Campbell et al. 2003; Ontario DVDR 2005; Wilson and Daly 1993). More importantly, our results suggested that the revised DA may be a robust DH risk assessment

instrument in the sense that the total number of risk factors did not vary as a function of reactive versus instrumental violence. This latter finding was noteworthy because it suggested that even DHs characterized by relatively low levels of planning on the part of the perpetrators were still potentially preventable given their histories as captured by the DA.

As far as targeting emotional reactivity goes, practitioners can look to the work of Novaco and colleagues when addressing anger (Novaco 1997; Renwick et al. 1997). Beck (1999) also provided an account of how cognitive-behavioural therapy (CBT) can be adapted for cases of intimate abuse that implied abuse is related to heightened levels of anger in combination with cognitive distortions that excuse the abuse (e.g., sex role stereotypes and patriarchal attitudes) (Scott 2004). These interventions may be particularly useful when targeting anger, hatred, and revenge among DV perpetrators.

#### Suicidal, Obsessed, and Emotionally Dependent DV Perpetrators

Approximately 30 % of DH perpetrators in our study had threatened or attempted suicide prior to the commission of the homicide. For perpetrators who are suicidal, CBT (see, for example, Persons et al. 2007) in combination with antidepressant medication could be used to target distorted thinking, negative affect, and obsessive rumination. For DV perpetrators who are chronically suicidal, practitioners might consider using appropriately adapted components of Dialectical Behaviour Therapy (DBT; Linehan 1993a, b). DBT is an empirically-supported treatment (Chambless and Ollendick 2001), originally developed for chronically suicidal women, that has been adapted for some male perpetrators in correctional settings (Berzins and Trestman 2004). Fruzzetti and Levensky (2000) have demonstrated how DBT might be used for some DV perpetrators, and Rosenfeld et al. (2007) have reported some encouraging results on the use of DBT for male stalking perpetrators. With regard to DV perpetrators who are excessively emotionally dependent on their current or former intimate partners, schema-focused therapy (SFT; Young et al. 2003) may be of some benefit. Although there are currently no adaptations of SFT specifically for DV perpetrators, Bernstein et al. (2007) provided a theoretical model for forensic populations as well as recommendations for best clinical practice that may provide some guidance.

#### Substance Abusing DV Perpetrators

Obviously substance abuse/dependence intervention is necessary for perpetrators who are problem drinkers or drug users (see Daley and Marlatt 2006; Epstein and McCrady 2009). In our study, 75.7 % of DH perpetrators were problem drinkers, and 64.9 % were problem drug users. Moreover, perpetrator substance use appeared to be involved in the commission of

64.9 % of our DH cases. Abstinence is an appropriate goal for DV perpetrators, especially when substances are linked to their use of violence/abuse (Quinsey et al. 2006).

### Risk Management Tactics for DV Perpetrators

Hart (2008) provided a useful overview of risk management tactics that could be employed in addition to treatment for perpetrators. Of these tactics, monitoring and supervision appear to be of particular importance for high-risk DV perpetrators. More specifically, frequent contacts with perpetrators, victims, and their families by social service, health care, or criminal justice professionals were said to be an excellent form of monitoring when high-risk perpetrators have access to the community. Hart (2008) highlighted that, when appropriate, monitoring may involve field visits to work or home, electronic surveillance, drug testing, or inspection of communications, including mail, telephone or email.

Supervision in the form of restrictions on activity, movement, association and communication also may be necessary for many high-risk DV perpetrators when they have access to the community. Hart (2008) elaborated that these restrictions may include: attendance at programs, including vocational programs (51.4 % of DH perpetrators in our study were unemployed); house arrest; travel bans; curfews; travel only with chaperones; refraining from drug or alcohol use; weapon prohibitions (40.5 % of DH perpetrators in our study had access to firearms); not to operate a motor vehicle if involved in an offense; and not to communicate with specific people. It was further asserted that involuntary institutionalization in correctional or health care facilities, such as through civil committal, may be required when concordant with the risks posed by perpetrators. On this point, indeterminate detention may be warranted for some perpetrators with serious offenses and a high-risk of future violence (Quinsey et al. 2006). In Canada, it is possible for a DV perpetrator to be designated as a “dangerous offender” and receive a sentence of detention in a prison for an indeterminate period (see, for example, *R. v. Gaudry (R. E.)*).

### DV Perpetrators who Avoid Arrest

#### Reaching Out to Victims of DV

Over 60 % of the DH perpetrators in our study managed to avoid arrest for previous incidents of DV. Clearly, reaching out to women who are abused is an essential part of preventing DHs because women often experience the violence/abuse long before it comes to the attention of police (Hilton 2004). In our study, even though information from or about victims was limited, it was apparent that women in at least 40.5 % of DH cases believed the perpetrator was capable of killing them.

Practitioners in criminal justice, social service and health care settings must be aware of the protocols (or lack thereof) in their agencies for identifying and assisting battered women and their children, as there is evidence that opportunities to help them are missed by such agencies (Ontario DVDRC 2004, 2005, 2006). The same goes for men who perpetrate DV, as there is evidence of their own health-seeking behaviour for physical, mental health or substance abuse problems prior to some homicides (Sharps et al. 2001). Coordination and communication among agencies is ideal when possible because, in many DH cases, separate agencies each possessed unique and significant information with respect to lethality risk that, taken together, would have painted an alarming picture with respect to the need for formal risk assessment, risk management, and safety planning (Ontario DVDRC 2004, 2005, 2006).

### DV Public Awareness Campaigns

Public awareness campaigns also may help inform women who are abused about strategies for getting help, and may help change community norms about DV (Campbell and Manganello 2006). The latter point is particularly important because, in many cases of DH, family members and friends were aware of lethality risk factors but either did not fully understand their significance or did not know how to respond (Ontario DVDRC, 2004, 2005, 2006). The Neighbours, Friends and Families Campaign in Ontario, Canada, is a good example and resource for addressing these issues (see <http://neighboursfriendsandfamilies.ca/>). Some of the topics addressed by the Campaign include: warning signs for woman abuse, lethality risk factors, how to help women who are abused, safety planning, and how to talk to abusive men. Many practical materials (e.g., brochures, safety cards, community action kits, videos, public service announcements) can be downloaded from the Campaign’s website free-of-charge.

### Safety Planning for Victims of DV

It is important to note that those individuals who encounter women in danger of DH must be extremely assertive with respect to the risk of homicide and need for shelter (Campbell et al. 2003). If a woman is planning on leaving a high-risk DV perpetrator, then she must be warned NOT to confront him personally with the decision, and instead should leave a note or call him later if necessary. According to Campbell and colleagues (2003), some women like the idea of a health care professional notifying the police for them, so professionals should offer this option to them. For more information on safety planning for women who are abused, see M. A. Dutton (1992).

## Reaching Out to Perpetrators of DV

Another unique approach to prevention involves the development of marketing campaigns (e.g., using radio advertisements on sport programs) to recruit non-adjudicated and untreated abusive men for brief telephone pre-treatment interventions (see Mbilinyi et al. 2008; Roffman et al. 2008). The Men's Domestic Abuse Check-Up was designed to improve self-referral and motivate abusive men to enter treatment voluntarily. There is evidence suggesting that some abusive men make use of it.

## Teaching Youth Skills for Healthy Relationships

Perhaps one of the most promising and sustainable strategies involves implementing school-based programs aimed at preventing dating violence, as there is evidence suggesting that teaching youth about healthy relationships as part of their curriculum may reduce dating violence longitudinally at a low per-student cost (Wolfe et al. 2009). Boys need to be taught the skills that are necessary for forming and sustaining healthy intimate relationships characterized by equality. They also must be taught how to cope appropriately with the various conflicts that may arise in intimate relationships, especially with the potential dissolution of intimate relationships.

## Psychopathic Perpetrators of DV

DV perpetrators are a heterogeneous group (Holtzworth-Munroe and Stuart 1994), and some of them may be psychopathic. Psychopaths lack empathy, guilt and remorse, display shallow and labile emotions, and are short-tempered and unable to form strong emotional bonds (Hare 2006). These individuals also are superficially charming, grandiose, arrogant, callous, deceptive, manipulative, and dominant (Hare and Neumann 2009). Such features are associated with a socially deviant (but not necessarily criminal) lifestyle characterized by irresponsible behaviour, and a tendency to violate or ignore social norms (Hare 2006). Psychopathy has been found to be a strong predictor of persistent and severe violent recidivism against female intimate partners, earning its place on risk assessment tools such as the Domestic Violence Risk Appraisal Guide (Hilton et al. 2008) and the Spousal Assault Risk Assessment Guide (Kropp et al. 1999).

Nearly 20 % of the DV perpetrators in our study were psychopaths, and many other DV perpetrators were well-above average with regard to psychopathic traits when considering available norms for men in the general population (Neumann and Hare 2008). Thus, traits related to selfishness, callousness, remorselessness and antisociality may be relevant to the perpetration of many DVs. While the results of our research indicated that DVs committed by psychopathic and non-psychopathic men were similar in many ways,

psychopathic DV perpetrators were more likely to kill their victims in a dispassionate, premeditated and gratuitously violent manner. More importantly, the revised DV captured risk of DV by both psychopathic and non-psychopathic men, lending further evidence of its utility. Given these findings, the paucity of research on psychopathic DV perpetrators, and the questions often posed to us by practitioners and researchers at conferences or workshops, we devoted some attention to discussing strategies for dealing with psychopathic DV perpetrators.

## Identifying Psychopathic Perpetrators of DV

Of course, identifying psychopathic DV perpetrators is a crucial part of being able to manage them. The Psychopathy Checklist-Revised (PCL-R; Hare 1991, 2003) is considered the "gold-standard" for assessing psychopathy (Acheson 2005); however, many practitioners working in the DV field may not have the time, access to collateral information, financial resources, or training/qualifications necessary for carrying out these comprehensive assessments. The Psychopathy Checklist: Screening Version (PCL:SV; Hart et al. 1995) was developed to provide a more cost-effective way of determining whether full administration of the PCL-R is warranted, and the PCL:SV has been used with DV perpetrators in a non-correctional setting (Huss and Langhinrichsen-Rohling 2006). Again though, many practitioners may lack the required training/qualifications or financial resources for administering the PCL:SV. Although self-report measures of psychopathy do exist (e.g., Levenson et al. 1995; Lilienfeld and Andrews 1996), they are susceptible to impression management by perpetrators.

The P-SCAN (Hare and Hervé 1999) is an innovative tool that may be useful when formal PCL-R assessments are not possible, but when some understanding of a perpetrator's possible psychopathy status is required. Potential users include: law enforcement officers, judges, prosecutors, probation and parole officers, nurses, social workers, and therapists to name a few. The tool is not considered a psychological test, and does not provide a clinical diagnosis; but is considered a "rough screening device" (Hare and Hervé 1999, p. 1). Based on the available information, the user rates the person under consideration on 90 items requiring low levels of inference. Kirkman (2005) has already used the P-SCAN in her research documenting the experiences of women who survived abusive intimate relationships with men who had many psychopathic traits. Again though, use of the P-SCAN comes at a financial cost that some agencies may not be able to afford.

Depending on the purpose, practitioners working under difficult circumstances (i.e., settings where time, access to collateral information, financial resources or training opportunities are very limited) may consider using the DSM-IV-TR (American Psychiatric Association 2000) criteria for

antisocial personality disorder (APD) to assist them in identifying persistently antisocial perpetrators, among whom some might be psychopaths. It should be noted, however, that the way in which dichotomous APD diagnoses are arrived at tends to waste information (Quinsey et al. 2006). Alternatively, when DSM-IV APD items are each scored individually and then summed in a manner similar to the PCL-R, correlations between APD scores (not diagnoses) and PCL-R scores are in the 0.90 range (Skilling et al. 2002). On this point, Harris et al. (1994) also indicated that eight variables reflecting childhood antisocial behaviour, known as the Childhood and Adolescent Taxon Scale (CATS; see Quinsey et al. 2006), discriminated adult psychopaths and nonpsychopaths for some purposes. Although these latter two options may be the most accessible or affordable for many practitioners, they are not without their controversies and limitations (see Hare 2003; Hare and Neumann 2009; Quinsey et al. 2006). Thus, governments should consider increasing the funds made available to criminal justice, social service and healthcare agencies that wish to bring professional assessors on board to help them obtain the comprehensive information their practitioners require for managing risk.

#### Treatment Guidelines for Psychopathic Perpetrators of DV

Practitioners who encounter psychopathic DV perpetrators should refrain from providing treatment that is emotion-based; involves talk-therapy; is insight-oriented or psychodynamic in nature; or is geared toward building self-esteem, empathy, conscience or interpersonal skills, as these forms of treatment seem to be of little benefit to psychopaths (Hare and Neumann 2009). Moreover, perpetrators should not be allowed to “run” treatment programs (Wong and Hare 2005, p. 43). There is evidence suggesting that such interventions may actually *increase* the criminal behaviour of psychopaths (e.g., Rice et al. 1992), probably by enhancing their skills at manipulation and deception of others (including therapists).

A properly designed and empirically-supported treatment program for institutionalized psychopaths is not currently available (Wong and Hare 2005), let alone modules specifically designed for psychopathic DV perpetrators. As stated earlier, until such work is attempted and has survived empirical scrutiny, practitioners must rely on the best of what is currently available (Quinsey et al. 2006). Wong and Hare (2005) described one of the most carefully formulated treatment approaches for institutionalized psychopaths that may provide some guidance. These experts asserted that treatment should follow risk-need-responsivity principles (Andrews et al. 1990), and rely on combining the best available cognitive-behavioral correctional programs with relapse-prevention techniques. Because it is not realistic to expect that psychopaths will voluntarily work with practitioners after

legal sanctions are removed, the learning of self-monitoring and self-management skills was emphasized.

Self-centeredness, lack of motivation, and affective/information processing anomalies were conceptualized as key responsivity factors for psychopaths. Wong and Hare (2005) argued that treatment should be less concerned with attempting to alter the core personality traits of psychopaths, and more concerned with helping psychopaths acknowledge that only they are responsible for their actions, and that it is in their own best interest to use more prosocial ways to satisfy their wants and needs. Instead of using lack of motivation as a criterion to exclude psychopaths from treatment, the authors encouraged the adjustment of intervention strategies to match the level of treatment readiness.

With respect to affective/information processing anomalies, the experts recommended that practitioners: (a) teach psychopaths how to construct their own offense cycles and relapse prevention plans to bring high-risk situations to their attention; (b) help psychopaths acknowledge the limitedness of their emotions and coach them to use various perception checks to facilitate accurate appraisal of high-risk situations; (c) consistently encourage and reinforce consequential thinking to increase the saliency of negative consequences for antisocial behaviour; (d) assist psychopaths with identifying, documenting and over-practicing as many prosocial response options as possible for high-risk situations; and (e) facilitate the development of skills necessary to replace antisocial behaviours with prosocial behaviours.

To put these guidelines into perspective, it was recommended that such a program occupy at least 50–75 % of the perpetrator’s time for a period of 12 to 18 months (with an additional 12 months of observation in a less intensive/restrictive setting) to enable an impact on deeply ingrained patterns of antisocial behaviour. According to Wong and Hare (2005), highly trained therapists and program supervisors are needed to deal with treatment-interfering behaviours and to prevent staff burnout and boundary violations. These experts also advised “extreme caution” when evaluating apparent treatment progress, especially with respect to DV programming because incarcerated batterers may not be exposed to the kinds of situations (e.g., relationships with intimate partners) that escalated to violence (Wong and Hare 2005, p. 16). Thus, appropriately supervised releases were deemed necessary for public safety, and the authors stated that family members should be clearly informed of the potential risk of victimization and that relapse-prevention plans should be shared with them. On this point, practitioners can expect to be busy with providing such assertive safety planning, as psychopaths tend to have many intimate partners (Hare 1991, 2003).

There is some emerging evidence suggesting that approaches consistent with the aforementioned guidelines may help reduce the seriousness of recidivism of psychopaths (Wong et al. 2007). There also is emerging evidence

suggesting that sex offenders with significant psychopathic traits can be retained in such a treatment program and those displaying therapeutic gains can reduce their risk of both sexual and violent recidivism to some degree (Olver and Wong 2009). Thus, there appears to be reason for some cautious optimism that the guidelines provided by Wong and Hare (2005) may be helpful in the treatment of psychopathic DV perpetrators specifically, and high-risk DV perpetrators generally. The authors argued their guidelines are likely to be effective for other high-risk, high-need offenders with extensive histories of violence. Of course, such an approach must be appropriately adapted to target factors that are direct or indirect causes of DV and undergo rigorous evaluations to ensure its effectiveness.

#### Early Intervention for Youth at Risk for Developing Psychopathic Traits

Because evidence indicates that psychopaths have extensive histories of antisocial behaviour that begin early in childhood (Hare 1991, 2003), intervening early with youth who display childhood-onset conduct problems and callous-unemotional traits is a critical objective for preventing antisocial behaviour in adulthood (Frick 2009). As it relates to DV, early intervention is especially important for these youth who also have experienced child abuse, neglect, or exposure to DV (Widom 1989). Space limitations preclude a comprehensive discussion of these issues; however, Frick (2006, 2009) has provided some thoughtful reviews including assessment and treatment recommendations. Interested readers are also referred to the published works of Caldwell and colleagues (2006, 2007), who have reported some promising results regarding the treatment of adolescent offenders with significant psychopathic traits. It should be noted that the guidelines provided by Wong and Hare (2005) also are likely to be helpful for adolescents with significant psychopathic traits.

#### Risk Management Tactics for Psychopathic Perpetrators of DV

When treatment is unsuccessful, then intensive supervision must be emphasized (Quinsey et al. 2006). As has been the case in Canada, indeterminate detention may be warranted for some psychopathic DV perpetrators (see, for example, *R. v. Redwood* 2006). However, Hilton (2005) has correctly pointed out that most psychopathic perpetrators will inevitably be released to the community. It was argued then that effective intervention involves the challenge of applying similar behavioural principles consistent with those of a sophisticated institutional token economy to psychopaths under conditional release. Hilton (2005) highlighted the key features of such a token economy: (a) it is clear and focuses on reinforcing conduct incompatible with psychopathic behaviour, while issuing penalties for psychopathic behaviour; (b) it will not end; and (c) consequences for actions

are reliably monitored by staff that always base decisions on observed behaviour and not on self-report.

#### Community Education on Psychopathy and DV

What can be done about the risks posed by psychopathic DV perpetrators who are no longer under the arm of the law or those who manage to completely avoid detection by legal authorities? Again, reaching out to victims is essential. Harris (1998) also suggested “doing something, not for psychopaths, but for the rest of us.” Because some people appear to be interested in learning about psychopathy, Harris (1998) proposed that those who are taught how to recognize psychopaths and how they operate, may be in better positions to protect themselves. It was further argued that young women would benefit most from this kind of education.

We find these suggestions compelling, as the first author has been invited in the past by a branch of the Girl Guides of Canada to speak about such issues. More specifically, the branch requested a developmentally-appropriate talk on pursuing a career in forensic psychology because the Guides’, ages 15–18, were interested in learning more about the actual science behind various psychology-related topics (e.g., criminal profiling, deception detection, psychopathy) that arose in crime-related television dramas they watched. The request included integration of engaging activities (e.g., participation in a deception detection task, planning a mock suspect interview); and a discussion of identifying, responding to, and protecting oneself from dating violence and abuse because many of the Guides were either interested in or already forming dating relationships.

In line with a recommendation by Harris (1998), parts of the discussion on dating violence and abuse involved Socratic questioning to help the Guides understand the benefits of using “reputations earned over time” when evaluating the character of potential dating partners as well as the limitations of trusting only their first impressions and intuitions. Anecdotally, their appeared to be a high level of engagement from the Guides during the visit and feedback from them, their parents, and their Guider was positive. In fact, a second request was met to have these same discussions with an even larger group of Guides from several other surrounding branches. Thus, practitioners are encouraged to provide community education aimed at the prevention of DV (by both psychopathic and nonpsychopathic perpetrators) and to consider creative strategies when engaging members of their communities. Much more work needs to be done to engage men and boys in this regard (for some promising initiatives, see Crooks et al. 2007).

#### Policy Implications concerning Psychopathy and DV

Can anything be done at the policy level to prevent or reduce the harm caused by psychopathic DV perpetrators? Some of

the most interesting conjectures in this domain also come from Harris (1998) who argued that psychopaths are likely to prosper in environments characterized by social instability and scarce resources. Under these conditions it was said that people often have to deal with those who are unfamiliar to them. Thus, it was proposed that policies aimed at decreasing social isolation, increasing economic and social equity, and strengthening nonviolent community and family cohesiveness may make it more difficult for psychopaths to thrive. It is noteworthy that these policy recommendations also are among the many recommendations made by practitioners, researchers and policymakers focused on preventing DV (e.g., Campbell 2005). This overlap is thought-provoking because Harris (1998) further postulated that, over generations, policies addressing these issues also might lead to reductions in the incidence of psychopathy.

## Conclusion

This article discussed some of the practical implications for preventing lethal and nonlethal DV that stem from our research on DH perpetrators (Juodis et al. 2014). The usefulness of empirically-validated risk assessment tools for identifying high-risk DV perpetrators was emphasized; and the role of batterer intervention programs for targeting DV and DH risk factors and dynamics was highlighted, including specific programming for engaging treatment-resistant men. Adjunct interventions for addressing the emotional reactivity (e.g., anger, hatred, desires for proprietary revenge) of some DV perpetrators were offered; as were adjunct interventions for dealing with those who are suicidal, abusing substances, obsessed with, or are excessively emotionally dependent on their current or former intimate partners. Specific risk management tactics also were summarized. With regard to the problem of high-risk DV perpetrators who manage to avoid arrest, we discussed the importance of reaching out to victims and perpetrators through community/professional education and public awareness campaigns. The significance of safety planning for victims also was covered. It was argued that teaching at-risk youth skills for developing and maintaining healthy relationships was very promising.

Some special attention was devoted to approaches for dealing with psychopathic DV perpetrators that also may be useful for other high-risk DV perpetrators with extensive histories of violence. The relevance of early intervention with families of youth who are maltreated or exposed to DV also was emphasized, especially for youth at risk for developing psychopathic traits or engaging in dating violence. Additionally, we highlighted the potential benefits of community education on psychopathy to address the problem of those who avoid arrest or who are no longer monitored under the law.

Finally, we closed our discussion by addressing policy implications concerning DV and psychopathy.

As was the case for our initial article, this paper addressed only some of the complexities involved in understanding and preventing DV and DH. It is hopefully even clearer now that multiple practitioners with various strengths and expertise are needed for preventing and managing the danger posed by high-risk DV perpetrators, and for ensuring the safety of women and children. As we stated before, given that the most complete explanations for DH and DV will likely involve biological, psychological, and social factors, prevention also will likely involve strategies from each of these domains. Again, these strategies will address the factors that predispose some men to using DV, factors that precipitate most cases of DV, factors that perpetuate DV, and factors that are protective against DV. Thus, it is emphasized again here that a promising approach may involve multi-agency, high-risk case management teams (for examples of such teams, see Ontario DVDRC, 2004, 2005, 2006).

We conclude this discussion paper in a manner similar to our initial article. Ultimately, the effectiveness of DV prevention strategies will be determined through rigorous research from diverse perspectives. However, DV prevention strategies are likely to be most effective when offered in communities that emphasize: (1) quick and judicious adjudication of cases; (2) careful monitoring of correctional outcomes via regular court reviews or specialized probation/parole programs; (3) continued safety planning for victims and risk management for perpetrators; and (4) vigilant supervision involving consequences for those who fail to complete mandated batterer intervention programs (Gondolf 2002; Campbell et al. 2003). That is, prevention strategies are likely to be most effective when operating in the context of coordinated community responses where entire communities are responsible for responding to DV, not individual practitioners, stakeholders or agencies (Allen and Lehrner 2008).

**Acknowledgments** Preparation of this manuscript was supported by the Social Sciences and Humanities Research Council of Canada and the Nova Scotia Health Research Foundation through research awards to the first author. The authors would like to thank research assistants Tara Carpenter, Kevin Wilson, Jason Fawcett, and Samantha Difrancescantonio. The authors also wish to thank Katreena Scott, Amanda Saunders, Tim Kelly, Joseph Camilleri, and Leanne ten Brinke for their valuable feedback during the writing of this paper as well as Katreena Scott and Jeff McKillop for their helpful comments on an earlier draft of this manuscript.

## References

- Acheson, S. K. (2005). Review of the Psychopathy Checklist – Revised. 2nd edition. In R. A. Spies & B. S. Plake (Eds.), *The sixteenth mental measurements yearbook*. Lincoln: Buros Institute of Mental Measurements.

- Allen, N. E., & Lehrner, A. (2008). Coordinated community response. In C. M. Renzetti & J. L. Edleson (Eds.), *Encyclopedia of interpersonal violence* (Vol. 1, pp. 149–150). Thousand Oaks: Sage.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.
- Andrews, D. A., Zinger, L., Hoge, R. D., Bonta, J., Gendreau, P., & Cullen, F. T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology*, 28, 369–404.
- Beck, A. T. (1999). *Prisoners of hate: The cognitive basis of anger, hostility, and violence*. New York: HarperCollins.
- Bernstein, D. P., Arntz, A., & de Vos, M. (2007). Schema focused therapy in forensic settings: theoretical model and recommendations for best clinical practice. *International Journal of Forensic Mental Health*, 6, 169–183. doi:10.1080/14999013.2007.10471261.
- Berzins, L. G., & Trestman, R. L. (2004). The development and implementation of dialectical behavior therapy in forensic settings. *International Journal of Forensic Mental Health*, 3, 93–103. doi:10.1080/14999013.2004.10471199.
- Caldwell, M., Skeem, J., Salekin, R., & Van Rybroek, G. (2006). Treatment response of adolescent offenders with psychopathy features: a two-year follow-up. *Criminal Justice and Behaviour*, 33, 571–596. doi:10.1177/0093854806288176.
- Caldwell, M. F., McCormick, D. J., Umstead, D., & Van Rybroek, G. J. (2007). Evidence of treatment progress and therapeutic outcomes among adolescents with psychopathic features. *Criminal Justice and Behavior*, 34, 573–587. doi:10.1177/0093854806297511.
- Campbell, J. C. (2005). Assessing dangerousness in domestic violence cases: history, challenges, and opportunities. *Criminology and Public Policy*, 4, 653–672. doi:10.1111/j.1745-9133.2005.00350.x.
- Campbell, J. C., & Manganello, J. (2006). Changing public attitudes as a prevention strategy to reduce intimate partner violence. *Journal of Aggression, Maltreatment, and Trauma*, 13, 13–39. doi:10.1300/J146v13n03\_02.
- Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C. R., Campbell, D. W., & Curry, M. A. (2003). Risk factors for femicide in abusive relationships: results from a multisite case control study. *American Journal of Public Health*, 93, 1089–1097. doi:10.2105/AJPH.93.7.1089.
- Campbell, J. C., Glass, N., Sharps, P. W., Laughon, K., & Bloom, T. (2007). Intimate partner homicide: review and implications of research and policy. *Trauma, Violence & Abuse*, 8, 246–269. doi:10.1177/1524838007303505.
- Campbell, J. C., Webster, D. W., & Glass, N. (2009). The danger assessment: validation of a lethality risk assessment instrument for intimate partner femicide. *Journal of Interpersonal Violence*, 24, 653–674. doi:10.1177/0886260508317180.
- Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: controversies and evidence. *Annual Review of Psychology*, 52, 685–716. doi:10.1146/annurev.psych.52.1.685.
- Crooks, C. V., Goodall, G. R., Hughes, R., Jaffe, P. G., & Baker, L. (2007). Engaging men and boys in preventing violence against women. *Violence Against Women*, 13, 217–239. doi:10.1177/1077801206297336.
- Daley, D. C., & Marlatt, G. A. (2006). *Overcoming your alcohol or drug problem: effective recovery strategies* (2nd ed.): *Therapist guide*. New York: Oxford University Press.
- Dutton, M. A. (1992). *Empowering and healing the battered woman*. New York: Springer.
- Epstein, E. E., & McCrady, B. S. (2009). *A cognitive-behavioral treatment program for overcoming alcohol problems: Therapist guide*. New York: Oxford University Press.
- Frick, P. J. (2006). Developmental pathways to conduct disorder. *Child Psychiatric Clinics of North America*, 15, 311–322. doi:10.1016/j.chc.2005.11.003.
- Frick, P. J. (2009). Extending the construct of psychopathy to youth: implications for understanding, diagnosing, and treating antisocial children and adolescents. *Canadian Journal of Psychiatry*, 54, 803–812.
- Fruzzetti, A. E., & Levensky, E. R. (2000). Dialectical behavior therapy for domestic violence: rationale and procedures. *Cognitive and Behavioral Practice*, 7, 435–447. doi:10.1016/S1077-7229(00)80055-3.
- Gondolf, E. W. (2002). *Batterer intervention systems: Issues, outcomes, and recommendations*. Thousand Oaks: Sage Publications.
- Hardesty, J. L., & Campbell, J. C. (2004). Safety planning for abused women and their children. In P. G. Jaffe, L. L. Baker, & A. Cunningham (Eds.), *Protecting children from domestic violence: Strategies for community intervention* (pp. 89–100). New York: Guilford Press.
- Hare, R. D. (1991). *The Hare Psychopathy Checklist – Revised*. Toronto: Multi-Health Systems.
- Hare, R. D. (2003). *The Hare Psychopathy Checklist – Revised* (2nd ed.). Toronto: Multi-Health Systems.
- Hare, R. D. (2006). Psychopathy: a clinical and forensic overview. *Psychiatric Clinics of North America*, 29, 709–724. doi:10.1016/j.psc.2006.04.007.
- Hare, R. D., & Hervé, H. F. (1999). *Hare P-SCAN*. Toronto: Multi-health systems.
- Hare, R. D., & Neumann, C. S. (2009). Psychopathy: assessment and forensic implications. *Canadian Journal of Psychiatry*, 54, 791–802.
- Harris, G. (1998). Clear lessons from the past on treating psychopaths. *Entre Nous (the MHCP Newsletter)*. Ontario, Canada: Mental Health Centre Penetanguishene.
- Harris, G. T., Rice, M. E., & Quinsey, V. L. (1994). Psychopathy as a taxon: evidence that psychopaths are a discrete class. *Journal of Consulting and Clinical Psychology*, 62, 387–397. doi:10.1037/0022-006X.62.2.387.
- Hart, S. D. (2008). Preventing violence: The role of risk assessment and management. In A. C. Baldry & F. W. Winkel (Eds.), *Intimate partner violence prevention and intervention* (pp. 7–18). New York: Nova Science Publishers, Inc.
- Hart, S. D., Cox, D. N., & Hare, R. D. (1995). *The have psychopathy checklist: Screening version*. Toronto: Multi-Health Systems.
- Hilton, Z. (2004). What can we do about domestic murders? *Entre Nous (the MHCP Newsletter)*. Ontario, Canada: Mental Health Centre Penetanguishene.
- Hilton, Z. (2005). What treatment works for psychopathy? *Entre Nous (the MHCP Newsletter)*. Ontario, Canada: Mental Health Centre Penetanguishene.
- Hilton, N. Z., Harris, G. T., Rice, M. E., Houghton, R. E., & Eke, A. W. (2008). An indepth actuarial assessment for wife assault recidivism: the domestic violence risk appraisal guide. *Law and Human Behavior*, 32, 150–163. doi:10.1007/s10979-007-9088-6.
- Holtzworth-Munroe, A., & Stuart, G. L. (1994). Typologies of male batterers: three subtypes and the differences among them. *Psychological Bulletin*, 116, 476–497. doi:10.1037/0033-2909.116.3.476.
- Huss, M. T., & Langhinrichsen-Rohling, J. (2006). Assessing the generalization of psychopathy in a clinical sample of domestic violence perpetrators. *Law and Human Behavior*, 30, 571–586. doi:10.1007/s10979-006-9052-x.
- Jaffe, P. G., & Juodis, M. (2006). Children as victims and witnesses of domestic homicide: lessons learned from domestic violence death review committees. *Juvenile and Family Court Journal*, 57, 13–28. doi:10.1111/j.1755-6988.2006.tb00125.x.
- Jaffe, P. G., Campbell, M., Hamilton, L. H. A., & Juodis, M. (2012). Children in danger of domestic homicide. *Child Abuse & Neglect*, 36, 71–74. doi:10.1016/j.chiabu.2011.06.008.
- Juodis, M., Starzomski, A., Porter, S., & Woodworth, M. (2014). A comparison of domestic and non-domestic homicides: Further

- evidence for distinct dynamics and heterogeneity of domestic homicide perpetrators. *Journal of Family Violence*. doi:10.1007/s10896-014-9583-8.
- Kirkman, C. A. (2005). From soap opera to science: towards gaining access to the psychopaths who live amongst us. *Psychology and Psychotherapy: Theory, Research, and Practice*, 78, 379–396. doi:10.1348/147608305X26666.
- Kropp, P. R., Hart, S. D., Webster, C. D., & Eaves, D. (1999). *Spousal assault risk assessment guide*. NY: Multi-Health Systems Inc.
- Levenson, M. R., Kiehl, K. A., & Fitzpatrick, C. M. (1995). Assessing psychopathic attributes in a non institutionalized population. *Journal of Personality and Social Psychology*, 68, 151–158. doi:10.1037/0022-3514.68.1.151.
- Lilienfeld, S. O., & Andrews, B. P. (1996). Development and preliminary validation of a self-report measure of psychopathic personality traits in non-criminal populations. *Journal of Personality Assessment*, 66, 488–524. doi:10.1207/s15327752jpa6603\_3.
- Linehan, M. M. (1993a). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
- Linehan, M. M. (1993b). *Skills training manual for treating borderline personality disorder*. New York: Guilford Press.
- Mbilinyi, L. F., Zegree, J., Roffman, R. A., Walker, D., Neighbors, C., & Edleson, J. (2008). Development of a marketing campaign to recruit non-adjudicated and untreated abusive men for a brief telephone intervention. *Journal of Family Violence*, 23, 343–351. doi:10.1007/s10896-008-9157-8.
- Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford.
- Neumann, C. S., & Hare, R. D. (2008). Psychopathic traits in a large community sample: links to violence, alcohol use, and intelligence. *Journal of Consulting and Clinical Psychology*, 76, 893–899. doi:10.1037/0022-006X.76.5.893.
- Novaco, R. W. (1997). Remediating anger and aggression with violent offenders. *Legal and Criminological Psychology*, 2, 77–88. doi:10.1111/j.2044-8333.1997.tb00334.x.
- Olver, M. E., & Wong, S. C. P. (2009). Therapeutic responses of psychopathic sexual offenders: treatment attrition, therapeutic change, and long-term recidivism. *Journal of Consulting and Clinical Psychology*, 77, 328–336. doi:10.1037/a0015001.
- Ontario Domestic Violence Death Review Committee. (2004). *Annual report to the Chief Coroner*. Toronto: Office of the Chief Coroner.
- Ontario Domestic Violence Death Review Committee. (2005). *Annual report to the Chief Coroner*. Toronto: Office of the Chief Coroner.
- Ontario Domestic Violence Death Review Committee. (2006). *Annual report to the Chief Coroner*. Toronto: Office of the Chief Coroner.
- Pence, E., & Paymar, M. (1993). *Education groups for men who batter: The Duluth model*. New York: Springer.
- Persons, J. B., Davidson, J., & Tompkins, M. A. (2007). *Essential components of cognitive-behavior therapy for depression* (5th printing). Washington, DC: American Psychological Association.
- Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*, 19, 276–288. doi:10.1037/h0088437.
- Quinsey, V. L., Harris, G. T., Rice, M. E., & Cormier, C. A. (2006). *Violent offenders: Appraising and managing risk* (2nd ed.). Washington: American Psychological Association.
- R. v. Gaudry (R. E.), 186 A. R. 91
- R. v. Redwood. (2006). S. J. No. 664.
- Renwick, S., Black, L., Ramm, M., & Novaco, R. W. (1997). Anger treatment with forensic hospital patients. *Legal and Criminological Psychology*, 2, 103–116. doi:10.1111/j.2044-8333.1997.tb00336.x.
- Rice, M. E., Harris, G. T., & Cormier, C. A. (1992). Evaluation of a maximum security therapeutic community for psychopaths and other mentally disordered offenders. *Law and Human Behavior*, 16, 399–412. doi:10.1007/BF02352266.
- Roffman, R. A., Edleson, J. L., Neighbors, C., Mbilinyi, L., & Walker, D. (2008). The Men's Domestic Abuse Check-Up: a protocol for reaching the non adjudicated and untreated man who batters and who abuses substances. *Violence Against Women*, 14, 589–605. doi:10.1177/1077801208315526.
- Rosenfeld, B., Galietta, M., Ivanoff, A., Garcia-Mansilla, A., Martinez, R., Fava, J., et al. (2007). Dialectical behavior therapy for the treatment of stalking offenders. *International Journal of Forensic Mental Health*, 6, 95–103. doi:10.1080/14999013.2007.10471254.
- Scott, K. L. (2004). Predictors of change among male batterers: application of theories and review of empirical findings. *Trauma, Violence, & Abuse*, 5, 260–284. doi:10.1177/1524838003264339.
- Scott, K., Francis, K., Crooks, C., & Kelly, T. (2006). *Caring dads: Helping fathers value their children*. Victoria: Trafford.
- Scott, K., King, C., McGinn, H., & Hosseini, N. (2011). Effects of motivational enhancement on immediate outcomes of batterer intervention. *Journal of Family Violence*, 26, 139–149. doi:10.1007/s10896-010-9353-1.
- Sharps, P. W., Koziol-McLain, J., Campbell, J., McFarlane, J., Sachs, C., & Xu, X. (2001). Health care providers missed opportunities for preventing femicide. *Preventive Medicine*, 33, 373–380. doi:10.1006/pmed.2001.0902.
- Skilling, T. A., Harris, G. T., Rice, M. E., & Quinsey, V. L. (2002). Identifying persistently antisocial offenders using the Hare Psychopathy Checklist and DSM antisocial personality disorder criteria. *Psychological Assessment*, 14, 27–38. doi:10.1037/1040-3590.14.1.27.
- Widom, C. S. (1989). The cycle of violence. *Science*, 244, 160–166. doi:10.1126/science.2704995.
- Wilson, M., & Daly, M. (1993). Spousal homicide risk and estrangement. *Violence and Victims*, 8, 3–16.
- Wilson, M., Johnson, H., & Daly, M. (1995). Lethal and nonlethal violence against wives. *Canadian Journal of Criminology*, 37, 331–361.
- Wolfe, D. A., Crooks, C., Jaffe, P., Chiodo, D., Hughes, R., Ellis, W., et al. (2009). A school-based program to prevent adolescent dating violence: a cluster randomized trial. *Archives of Pediatrics & Adolescent Medicine*, 163, 692–699. doi:10.1001/archpediatrics.2009.69.
- Wong, S., & Hare, R. D. (2005). *Guidelines for a psychopathy treatment program*. Toronto: Multi-Health Systems.
- Wong, S. C. P., Gordon, A., & Gu, D. (2007). Assessment and treatment of violence-prone forensic clients: an integrated approach. *British Journal of Psychiatry*, 190(suppl. 49), s66–s74. doi:10.1192/bjp.190.5.s66.
- Young, J. E., Klosko, J., & Weishaar, M. (2003). *Schema therapy: A practitioner's guide*. New York: Guilford.