

FAM

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Female Additional Manual

Additional guidelines to the HCR-20^{V3} for
assessing risk for violence in women

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assessing risk for violence in women**

For more information or to order the FAM please go to:

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Preface from the authors

This is the *Female Additional Manual* (FAM), a tool with additional guidelines to the HCR-20^{V3} for assessing risk for violence in women who have demonstrated violent behavior before. Several risk factors for violent behavior in women differ substantially from those in men. Mental health professionals have recognized these differences and have expressed the need for more specific guidelines for risk assessment in women (see also Adams, 2002).

In 2007, the idea was proposed to develop a more gender-sensitive risk assessment tool and subsequently conduct research into the psychometric properties and clinical value of this tool for use with female (forensic) psychiatric patients. The internationally widely used HCR-20 was used as a basis because we believed that although the tool as a whole is not strongly predictive for violence in women (Schaap, Lammers, & De Vogel, 2009; De Vogel & De Ruiter, 2005), most of the items included in the HCR-20 / HCR-20^{V3} are important for women. The authors of the HCR-20 / HCR-20^{V3} are known with and supportive of the development of the FAM.

The FAM was originally developed as an additional manual to the HCR-20. The new version of the HCR-20, the HCR-20^{V3} (Douglas, Hart, Webster, & Belfrage, 2013) was published in 2013. Two of the FAM authors (Vivienne de Vogel and Michiel de Vries Robbé; see De Vogel, Van den Broek, & De Vries Robbé, 2014) have been involved in a pilot project into the HCR-20^{V3} and in the translation of the tool into Dutch. When developing the FAM, the authors were already familiar with the draft (items) of the HCR-20^{V3} and took the changes from the HCR-20 to the HCR-20^{V3} into account as much as possible. With adaptations, the original FAM can also be applied as an additional manual to the HCR-20^{V3}. The present manual is completely adapted to be used with only the HCR-20^{V3}. Furthermore, in the present manual we added recent research results from an ongoing Dutch multicentre study (see De Vogel, Stam, Bouman, Van der Horst, & Lancel, 2014) and some more information on violence towards children. No major changes were made to the items. We would like to refer to the website for updates and recent research results: www.violencebywomen.com.

The goal of the FAM is to provide mental health professionals with more concrete guidelines for gender-sensitive risk assessment and management for women in forensic psychiatry, but possibly also in general psychiatry or in the penitentiary system. We hope that the tool will be valuable for daily practice, in the way that it provides improvements for violence risk assessment in women and concrete guidelines for risk management. The FAM should be seen as work in progress; there is not yet sufficient evidence for the predictive validity of (the factors in) this tool for repeated violence in women and research into this topic is strongly needed. Although the FAM is still in development and should be interpreted with great caution, we believe that the combination of the HCR-20^{V3} and the FAM can be considered as best practice and that there is presently no suitable alternative available for the assessment of violence risk in adult women.

We would like to thank all mental health professionals from the Van der Hoeven Kliniek who contributed to the development of the FAM. Jeantine Stam has made an important contribution to the development of the FAM with her master research study on the FAM Research Version and more recently with her work for the multicentre study. We also kindly thank Duncan Greig for his valuable assistance with the English translation of the FAM.

Finally, we welcome all comments and suggestions regarding the FAM or the subject of (risk assessment for) violence in women, as this may help us to improve and refine gender-sensitive risk assessment with the FAM.

Vivienne de Vogel, Michiel de Vries Robbé, Willemijn van Kalmthout and
Caroline Place

September 2014

Preface

It is a considerable honour and a pleasure to be invited to write a preface for the Female Additional Manual (FAM). Although it has long been passionately discussed in the literature (Correctional Service of Canada, 1990; Corston, 2007), few concrete advances have been achieved to address concerns that the assessment, classification, management, and treatment of women offenders require gender-informed approaches. Increasingly, a light has been shone on the urgent need to include women in research samples and disaggregate data whenever possible (e.g., Canadian Institutes of Health Research, 2011). It is evident such efforts have had some success as the literature on female offending is burgeoning (Blanchette & Brown, 2006; Gendreau, Little, & Goggin, 1996; Zaplin, 2008) but those findings have been slow to be translated in advances in clinical practice. In particular, there has been considerable debate with regard to the extent to which clinicians working with women can comfortably rely on currently available risk assessment measures, ostensibly constructed with men in mind (Garcia-Mansilla, Rosenfeld, & Nicholls, 2009). Yet, with the exception of the Early Assessment Risk List for Girls (see Augimeri, Enebrink, Walsh, & Jiang, 2010), measures developed from the outset to inform evaluations with female populations at risk for violence are nonexistent.

The lack of empirically validated woman-centered practices in the violence risk assessment and risk management field largely reflects the fact that female violence is widely acknowledged to be a problem of a much smaller magnitude than that of male violence. As De Vogel and her co-authors remind us, on the whole, the data unequivocally support this conclusion. Gender is regarded as one of the best predictors of violent and criminal behaviour (Monahan et al., 2001). Worldwide, women represent a small proportion of individuals who perpetrate violence and as such they are found in much smaller numbers within offender and institutionalized populations of relevance to violence risk assessments (e.g., ~10% of inpatient forensic hospitals). The gender disparity in incarceration rates is particularly large for violent crimes. For instance, in the United Kingdom, the total prison population is comprised of 6.1% women, 17% of whom were incarcerated for violent offences (Home Office, 2003), these proportions are highly consistent with other Western nations (Nicholls, Greaves, & Moretti, 2008).

Acknowledging that men are by far the predominant perpetrators of violence and offending does not, however, overshadow the relevance and necessity of evidence-informed practice in the assessment of women's risk for violence.

The number of women who are the focus of violence risk assessments is not insubstantial, particularly if one considers the diverse populations and settings in which risk for violence is considered (jails, prisons, forensic and civil psychiatric inpatient and community settings) (e.g., women represent ~40% of civil psychiatric inpatients). It has been widely acknowledged that violence risk assessments are a well-entrenched aspect of mental health law and firmly rooted in the responsibilities of diverse mental health professionals and allied disciplines. There is little question that these assessments invariably have significant ramifications, regardless the gender of the individual being assessed (see Melton, Petrila, Poythress, & Slobogin, 2007).

In addition to the wide-ranging demand for violence risk evaluations, as the authors of the FAM demonstrate, research reveals ever-increasing numbers of girls and women being charged and incarcerated for criminal offences. Data across international borders suggests the growth rate in the number of individuals in prisons and jails is substantially higher among women than among men (Nicholls et al., 2008). For instance, the proportion of Canadian women charged with criminal offences has increased steadily over the past three decades, up from 15% in 1979 to 21% in 2009 (Hotton-Mahony, 2011). These increases in female offending tend to be relatively small once population growth is taken into account but it is noteworthy that they often are seen in parallel with decreasing rates of male offending (e.g., Federal Bureau of Investigation [FBI], 2005).

As the number of women in conflict with the law has continued to rise there has been an increasingly urgent call from decision makers (Auditor General of Canada, 2003), and academics alike (Hannah-Moffat, 2004; Webster & Doob, 2004) to avoid what some consider systematic bias against minority groups (women as well as ethnic minorities) in violence risk assessments. Many have been calling for a 'woman-wise' agenda for decades (Carlen, 1985; see Heilbrun et al., 2008). As De Vogel and her colleagues demonstrate so clearly in the FAM, there likely is considerable overlap in the variables of relevance to risk assessments with men and women; hence the value of the FAM as an 'add on' to the existing HCR-20 violence risk assessment scheme (Webster, Douglas, Eaves, & Hart, 1997). However, they remind us that not only does the rate of women's offending differ dramatically from that of men, in many ways the form and function of women's violence is unique (Nicholls et al., 2008). This suggests that the outcome criterion of interest may differ in meaningful ways when assessing violence risk in men versus women. Women tend to be arrested for different offences than men (embezzlement, prostitution; FBI, 2005, 2006). In fact, some

crimes are virtually unique to women (neonaticide) or men (uxoricide) or at least the rate of offending is drastically differentiated by the sex of the perpetrator. For instance, sexual offending (4-5% are women, Cortoni & Hanson, 2005), stalking (15-20% are women, Meloy & Boyd, 2003) and familicide (95% of perpetrators are male, Wilson, Daly, & Daniele, 1995) are predominantly perpetrated by one gender or the other. In contrast, other forms of violence are more evenly distributed across the sexes (e.g., child abuse, partner abuse, Archer, 2000; Hamel & Nicholls, 2007). In addition, women's violence most often is less chronic and on average their offences are predominantly of a minor nature when compared to their male counterparts (Nicholls et al., 2008).

When they are involved in violence, the victims of women's offences and the circumstances of their offending often also differ from that of men (Hotton-Mahony, 2011; Monahan et al., 2001; Morash, Bynum, & Koons, 1998). Although recent research suggests that perhaps women's changing societal roles and socialization may be decreasing these differences (Weizmann-Henelius, 2006). Unlike men, women do not generally commit crimes in pairs or in groups, they are less likely to use weapons, and these differences translate into lower out of pocket expenses and fewer injuries for their victims (e.g., Greenfield & Snell, 1999; Kruttschnitt, Gartner, & Ferraro, 2002). Commentators also contend that the motivations that drive the timing and nature of women's offending often are unique from that of men (Zaplin, 2008). In sum, the context (Triplett & Myers, 1995) or 'gestalt' of offences varies by the sex of the perpetrator and these discrepancies are asserted to increase as the severity of the offence increases (Daly, 1994; Zaplin, 2008).

As the FAM authors articulate, men and women do share many risk factors, but even then gender differences often are evident suggesting these variables may carry differential significance (Nicholls et al., 2008). Women tend to present with more severely dysfunctional backgrounds reflected in exceptional service needs even compared to male offenders who also present with high rates of disadvantage and victimization histories (e.g., disproportionately high rates of sexual and physical abuse, mental illness, drug abuse, adulthood victimization) (Abram, Teplin, & McClelland, 2003; Browne, Miller, & Maguin, 1999; Morash et al., 1998; Teplin, Abram, McClelland, 1996). There also is substantial evidence to support a consideration of feminine-specific risk factors that may have a causal relationship with girls' and women's entries into aggressive and antisocial behaviour. The research suggests that different pathways may bring men and women into contact with the justice system (Holtfreter & Cupp, 2007; Salisbury

& Van Voorhis, 2009) or that the threshold for the risk of antisocial behavior may be met earlier on in boys than in girls (Moffit & Caspi, 2001). For these reasons, additional variables or differing criteria may be required to inform violence assessments as well as prevention and intervention planning to ensure successful recovery in females. Finally, there is a measure to support such efforts.

Van Voorhis and Presser (2001) completed interviews with representatives of 50 US state correctional agencies and the Federal Bureau of Prisons (Feb to May, 2000) and found that a resounding 92% of respondents asserted that women have unique needs that should be addressed in correctional settings. Yet, Hardyman and Van Voorhis (2004) demonstrated that many agencies still rely on gender-neutral assessments for women. The absence of a validated gender-informed risk assessment model has had unknown but potentially dramatic implications for our efforts to successfully prevent and treat women's crime and violence. As I noted, many clinicians, academics, and decision-makers have decried the absence of 'woman-centered' services (Pollack, 2005) but experts caution that there is an absence of a strong empirical basis to support novel 'gendered' approaches (Heilbrun et al., 2008; Zaplin, 2008; though see Van Voorhis, Salisbury, Wright, & Bauman, 2008). The FAM authors' cautious recommendations in the FAM and its intended use in concert with the HCR-20 therefore represents a very welcome measured and responsible approach to introducing a gendered risk assessment measure to the field.

Despite forty years of progress, a critical limitation in the violence risk assessment field to date has been the failure to integrate our knowledge of the unique offending trajectories and profile of women offenders into risk assessment and risk management research and clinical practice in a systematic way. There also remains a pressing need to test the implications of efforts to optimize predictive accuracy (i.e., do female specific risk items add incremental validity over established risk items). The FAM is one in a long series of exceptional contributions from De Vogel and her colleagues at the Van der Hoeven Kliniek. This manual represents a pioneering effort to advance forensic mental health services. It simultaneously opens up new opportunities for research, potentially presents an innovation over existing assessment approaches, and provides possible avenues for improving clinical outcomes with at risk women.

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January 2012

Introduction

While women still represent a minority of the forensic psychiatric and prison population, worldwide the number of women committing violent crimes has increased steadily over the past two decades, especially among young girls. In addition, some types of violence, such as intimate partner violence and inpatient violence by psychiatric patients are as common in women as in men (see *Violence by women*). There are growing concerns, however, about whether the theoretical knowledge we have on violence in men and on violence risk assessment and management in men is sufficiently valid and useful for women. Research has demonstrated that different risk factors may be important for women compared to men and that the present risk assessment tools are not sufficient for predicting violence in women (see *Violence risk assessment in women*).

In 2007, the idea was proposed in the Van der Hoeven Kliniek to develop a gender-sensitive risk assessment tool. The Van der Hoeven Kliniek is a 262-bed forensic psychiatric hospital in the Netherlands admitting both male and female patients, mostly suffering from personality disorders (see for more information about this hospital Van Binsbergen, Keune, Gerrits, & Wiertsema, 2007; www.hoevenkliniek.nl). Most patients are admitted because of a tbs-order, which is a Dutch judicial measure implying compulsory inpatient psychiatric treatment (see for more information Van Marle, 2002). Females constitute approximately 20 percent of the patient population, and men and women live on mixed wards. Previous research within this setting into the value of the internationally widely used risk assessment tool for violence, the *Historical Clinical Risk management-20* (HCR-20; Webster, Douglas, Eaves, & Hart, 1997) and of the *Psychopathy Checklist-Revised* (PCL-R; Hare, 2003) in both female and male patients has demonstrated that both tools have good predictive validity for violence for men, but questionable predictive power in women (De Vogel & De Ruiters, 2005). These results are comparable with international findings (see Garcia-Mansilla, Rosenfeld, & Nicholls, 2009). More recently, however, greater effect sizes were found in samples containing higher proportions of women (O'Shea, Mitchell, Picchioni, & Dickens, 2013). Considering the equivocal results on the value of risk assessment tools for violence in women and the wish from mental health professionals for more specific knowledge on violence risk assessment in women, we decided to formulate a tool with gender-sensitive risk assessment guidelines and subsequently conduct studies into the psychometric properties and clinical value of this tool. Because of the considerable level of similarity in risk factors for men and women (see also Guy & Douglas, 2006), we chose not to create a completely new risk assessment tool for women but instead use the HCR-20 as

a basis. The result was an additional manual to the HCR-20 for the assessment of risk for violence in adult women who have shown violent behavior before: the *Female Additional Manual* (FAM). In 2013, the revision of the HCR-20 has been published; the *Historical, Clinical, Risk Management Version 3* (HCR-20^{V3}; Douglas, Hart, Webster, & Belfrage, 2013). Initially, the FAM was designed as an additional manual to the HCR-20, but the present manual is to be applied as an addition specifically to the HCR-20^{V3}.

In Part I *Background* the method of risk assessment according to the *Structured Professional Judgment* (SPJ) approach is briefly discussed. Next, the literature into violence by women, risk and protective factors for violence in women, the application of risk assessment tools in women and gender-responsive treatment will be summarized. The central focus in this literature review is to determine whether a specific risk assessment tool for women is needed or desirable. In Part II *The FAM*, the development and coding procedure of the FAM will be described as well as the actual coding instructions of specific risk factors for women and the additional guidelines for women to two HCR-20^{V3} items.

Part I Background

Risk assessment according to the SPJ approach

Like the HCR-20^{v3}, the FAM provides guidelines for violence risk assessment according to the *Structured Professional Judgment* (SPJ) approach. In the mid-1990's, researchers from Simon Fraser University in Vancouver, Canada developed the SPJ model. Their goal was to bridge the gap between clinical practice and empirical knowledge by developing a guideline for violence risk assessment that structures clinical judgment – and thus increases interrater reliability and validity – and can be used by trained mental health professionals in their day-to-day practice. In the SPJ model, risk factors are critically examined, combined, and integrated in order to reach a conclusion.

The best-known checklist based on this model is the HCR-20 (Webster et al., 1997) for the assessment of risk for violent behavior. Research in different settings and countries has demonstrated that the HCR-20 can be used reliably and validly (see for a comprehensive summary of research results: Douglas, Guy, & Weir, 2006; Douglas & Reeves, 2010; www.hcr-20.com). The Dutch HCR-20 has been implemented in several forensic psychiatric hospitals in The Netherlands. In one of these, the Van der Hoeven Kliniek, a research program into the value of the SPJ model for forensic clinical practice was conducted. The studies in the program provided strong support for the SPJ method of violence risk assessment in Dutch forensic clinical practice (De Vogel, 2005; see also De Vogel, Van den Broek, & De Vries Robbé, 2014). For men, the HCR-20 has demonstrated good interrater reliability and predictive validity for violent recidivism after discharge as well as for violent incidents during treatment, and predicts significantly better than does unstructured clinical judgment. For women, significant predictive validity was only found for the final risk judgment and not for the HCR-20 scores (De Vogel & De Ruiter, 2005). In 2013, the official HCR-20^{v3} was published (Douglas et al., 2013), as well as the Dutch version of the HCR-20^{v3} (De Vogel, De Vries Robbé, Bouman, Chakhssi, & De Ruiter, 2013), which was immediately implemented in the Van der Hoeven Kliniek.

Two recently developed SPJ tools are mentioned here because of their influence on the development of the FAM: the *Structured Assessment of PROtective Factors for violence risk* (SAPROF; De Vogel, De Ruiter, Bouman, & De Vries Robbé, 2009, 2012) and the *Short-Term Assessment of Risk and Treatability* (START; Webster, Martin, Brink, Nicholls, & Middleton, 2004; Webster, Martin, Brink, Nicholls, & Desmarais, 2009). The SAPROF is a recently developed tool for the assessment of protective factors intended to be used in conjunction with SPJ risk assessment

tools such as the HCR-20. This tool has been in use in the Van der Hoeven Kliniek since 2007 and the results thus far with respect to interrater reliability and predictive validity are good (De Vries Robbé, 2014). The START is a tool for short-term assessment of risks and treatability that is fully dynamic. In the START, not only is the risk for violence to others evaluated, but as are the specific risks such as risk for self-harm, suicide, unauthorized leave, substance abuse, self-neglect, and being victimized.

Violence by women

Prevalence of violence

Women commit fewer violent offenses than men, and 'being male' is one of the best predictors of violent and criminal behavior (Archer & McDaniel, 1995; Monahan et al., 2001). Although women constitute a minority within the prison system and in forensic psychiatry, it seems that violent behavior by girls and women is on the rise (Batchelor, 2005; Blackburn & Trulson, 2010; Heilbrun et al., 2008; Meichenbaum, 2006; Odgers, Moretti, & Reppucci, 2005; Pollock & Davis, 2005; Weizmann-Henelius, Viemerö, & Eronen, 2004). In a recently published Dutch study on juvenile delinquency between 1996 and 2007 it was found that although the proportion of male offenders is still clearly greater than the proportion of female offenders, offense rates for girls / women increased more (Van der Laan, Blom, Tollenaar, & Kea, 2010). Between 2002 and 2007, offense rates (convictions) increased 33% for 12-17 year old girls, and 48% for 18-24 year old women (for boys / men there was an increase of 19% and 20%, respectively). This refers to all forms of offenses, but violent offenses in particular increased sharply (see also Chesney-Lind & Pasko, 2004). A possible explanation for the increase in violent offenses by females is the emancipatory explanation; the catching up of girls with boys. It should be noted that changes in policies, police efforts, or changes in societal toleration for girls' and women's behavior may be skewing the data on increased female violence (Hawkins, Graham, Williams, & Zahn, 2009; Willison & Lutter, 2009). On the other hand, it is still true that in general there is a tendency to treat female offenders more leniently than male offenders, specifically with respect to arresting and sentencing (e.g., see Jeffries, Fletcher, & Newbold, 2003).

Nature of violence

Research has shown that in general, the nature, severity, frequency, and victim characteristics of violent offenses committed by women are significantly different from those committed by men. Overall, female violence less often

results in serious injuries and is less visible and more subtle, manifesting more often as relational violence, child abuse, or violence towards relatives (Monahan et al., 2001; Nicholls, 2001; Robbins, Monahan, & Silver, 2003). The most common victims of violence by adult women are partners or child(ren) and the most common victims by girls are brothers / sisters and peers (Batchelor, 2005). Violence by women is more reactive, indirect, less instrumental and occurs more commonly within the context of social relationships and less instrumental compared to men (Crick & Grotpeter, 1995; Monahan et al., 2001; Nicholls, 2001; Odgers et al., 2005; Robbins et al., 2003). Several explanations for this are discussed in the literature (see for a comprehensive review Bennett, Farrington, & Huesman, 2005). A commonly cited explanation is the different method of socialization, whereby boys are encouraged to act assertively while girls are encouraged to bond with others (see for example Brownie, 2007). In adulthood, women are more likely to describe themselves in terms of their relationship with others than in terms of their individual characteristics (Cross & Madson, 1997). Furthermore, women seem to have different motives for violent offenses; female violence is more often reactive and relational and less often characterized as instrumental (Crick & Grotpeter, 1995; Monahan et al., 2001; Nicholls, 2001; Odgers et al., 2005; Robbins et al., 2003). Claimed motives for violence by women are, for example, jealousy, self-defense and feeling disrespected by the other (Kruttschnitt & Carbone-Lopez, 2006). Women compared to men are more likely to use knives or so-called personal weapons, such as hands and teeth when they commit violence (Koons-Wit & Schram, 2003). Motives for offenses committed by girls were more often seen in the social sphere or within relations (revenge, jealousy and gossip) than in boys. In a recent U.S. study of the explanations for violent offenses by girls as seen by probation officers, the three most frequently cited explanations for girls were: 1) emotional outburst; 2) relational violence; and 3) history of abuse (Fusco, 2011). For boys, these three explanations were not once mentioned. The three most frequently cited explanations for violent offenses for boys were: 1) ego driven; 2) peer pressure; and 3) survival. Summarizing, violence by women is in general different in nature than violence by men. Research, however, also demonstrated that there is a subgroup of girls/young women who seem to show more 'masculine' forms of violence. In this subgroup of females, instrumental aggression, hostility, committing robberies and criminal gang membership is more prevalent (Babcock, Miller, & Siard, 2003; Batchelor, 2005; Bottos, 2007; MacKenzie & Johnson, 2003).

Five specific types of violence by women are discussed more in detail below.

1. Intimate partner violence

Intimate partner violence is the most studied form of violence committed by women. Research has demonstrated that the prevalence rate of intimate partner violence of women is comparable to or even higher than that of men (Adams, 2002; Magdol et al., 1997; Straus, 2008). However, violence by women in intimate relationships is less likely to lead to serious injury (Archer, 2000; Meichenbaum, 2006). Some researchers argue that violence by women towards the partner is almost always a response to previous violence by the male partner (Allen, Swan, & Raghavan, 2009; Swan & Snow, 2006). Others, however, found few differences between men and women regarding the prevalence of and motives for intimate partner violence (Archer, 2000; Carney, Buttell, & Dutton, 2007; McFarlane, Willson, Malecha, & Lemmey, 2000).

2. Violence towards own children

It has been suggested in the literature that overall prevalence rates of violence towards (step)children do not significantly differ between mothers and fathers. Moreover, certain types of violence towards children, like neonaticide (killing of a baby younger than 24 hours), infanticide (killing of a baby younger than one year), and Münchhausen by Proxy syndrome (deliberately inducing or feigning health problems in a child to gain attention) are almost exclusively committed by mothers. Differences have been found between women and men killing their own child. Mothers were more often diagnosed with depression and psychoses, were more often suicidal and more often had a history of severe abuse. Fathers more often had financial problems and alcohol abuse problems (Putkonen et al., 2010; Verheugt, 2007). Usually, the victims of fathers were older than victims of mothers and the offense more often concerned a familicide. Fathers were more often held criminally responsible by the court for their offense compared to mothers.

3. Sexual violence

The literature on sexual violence by women is rather limited. Research has demonstrated that women form only a small proportion of the total sex offender population (between 4-5%; Cortoni, Hanson, & Coache, 2010; Gannon & Cortoni, 2010; Logan, 2008). The question, however is whether official figures may underestimate the true prevalence rate. Sexual abuse by a woman is generally less visible, for example, occurring within the context of a nurturing role, or as a

teacher who has a sexual relationship with a student (see Wijkman, Bijleveld, & Hendriks, 2010). In a large international meta-analysis into recidivism of female sexual offenders (N = 2490), Cortoni and colleagues (2010) found that only 1 to 3% of the women were re-convicted of a sexual offense, 4 to 8% for a non-sexual violent crime, and 19 to 24% for an offense in general. The majority of female sexual offenders commit sexual assaults against young people (Logan, 2008; Wijkman et al., 2010). Female sexual offenders compared to male sexual offenders are more likely to be in a caretaking position and less likely to abuse strangers (Rudin, Zalewski, & Bodmer-Turner, 1995; Tsopelas, Spyridoula, & Athanasios, 2011). Furthermore, it is known that when women commit sexual offenses this occurs relatively often with a male accomplice (Beech, Parrett, Ward, & Fisher, 2009; Wijkman et al., 2010).

4. Arson

Women compared to men are more likely to be charged with or convicted of arson and to have previous histories of fire-setting behavior (Coid, Kahtan, Gault, & Jarman, 2000). In a literature review, Gannon (2010) concluded that research to date suggests that female arsonists differ in three ways from male arsonists: 1) pathology (often depression and absence of sexual fetishism associated with arson), 2) motivation (higher prevalence of attention seeking / 'cry for help') and 3) problems in childhood (higher prevalence of sexual abuse).

5. Inpatient violence

Regarding inpatient violence, it has repeatedly been demonstrated that female psychiatric patients cause as many violent incidents as male psychiatric patients (De Vogel & De Ruiter, 2005; Lam, McNiel, & Binder, 2000; Newhill, Mulvey, & Lidz, 1995; Nicholls et al., 2009; Tardiff et al., 1997). However, it has also been found that violent incidents by female psychiatric patients are less likely to result in serious injury compared to violent incidents by male psychiatric patients (Krakowski & Czobor, 2004).

Violence risk assessment of women

Research has demonstrated that unstructured clinical judgment relating to violence risk is sensitive to sex-based biases; mental health professionals of both genders tend to underestimate the risk for violence in female psychiatric patients (Skeem et al., 2005). Use of structured risk assessment tools is recommended to avoid these types of biases (Borum, 1996), however, widely used structured risk assessment tools such as the HCR-20 / HCR-20^{v3} are developed based on

violence risk research conducted primarily in male samples. Moreover, research into the psychometric properties of these tools has been carried out almost exclusively on men. Some scholars have taken the position that there is no reason to assume that male-based tools do not apply to women because most risk factors are considered valid for both sexes (Loucks & Zamble, 1999; Newhill et al., 1995), also referred to as the 'gender-blind' perspective (Garcia-Mansilla et al., 2009). However, there is little empirical evidence to support this perspective (Odgers et al., 2005). Recent research results and reviews on risk factors and risk assessment in female offenders suggest that although many violence risk factors seem to be valid for both men and women, the assessment and formulation of violence risk differs at least to a certain degree between men and women, and consequently, that there is a need for more gender-sensitive risk assessment (De Vogel & De Ruiter, 2005; Funk, 1999; Garcia-Mansilla et al., 2009; Logan, 2003; Logan & Blackburn, 2009; McKeown, 2010; Odgers et al., 2005; Penney & Lee, 2010; Rossegger et al., 2009; Salisbury, Van Voorhis, & Spiropoulos, 2009; Schaap et al., 2009; Van Voorhis, Wright, Salisbury, & Bauman, 2010; Vitale & Newman, 2001; Warren et al., 2005; Willison & Lutter, 2009).

It has been found that there are certain risk factors that have stronger effect for women compared to men, such as child abuse, adult victimization, disruptions in relationships and families, and economic disadvantages (Benda, 2005; Bottos, 2007; Funk, 1999; Odgers et al., 2005; Widom & Maxfield, 2001). A distinction can be made between factors to which women are exposed more often (e.g., sexual victimization) and factors for which the sensitivity of women is greater, i.e., those factors that have a stronger effect on later violent or criminal behavior for women than for men (e.g., disruptions in relationships). On the contrary, some risk factors have stronger effect on men than on women, for example, the presence of 'threat control-override symptoms' (Teasdale, Silver, & Monahan, 2006). Recently, Willison and Lutter (2009) reviewed the literature and concluded that although many of the risk factors for violent male offending also hold true for women, the route by which the two genders arrive at violence diverges sharply. It has been suggested that the interaction among risk factors, the causal mechanisms, and manifestation of violence do not fit the general models designed for male offenders (e.g., Heilbrun et al., 2008).

Use of risk assessment tools with women

HCR-20 / HCR-20^{V3}

Several studies have been conducted into HCR-20 scores in female samples. Guy and Douglas (2006) examined a large set of HCR-20 data from aggregated samples with *Item Response Theory* and found no big differences between men and women in how the items are relevant to the construct. Strand and Belfrage (2001) compared the HCR-20 scores of female and male forensic patients and found no significant differences in mean subscale scores and total scores. In a Dutch study in the Van der Hoeven Kliniek the HCR-20 was studied in a group of women and a matched group of men (De Vogel & De Ruiter, 2005). No significant differences were found between men and women with respect to mean subscale and total scores. However, there were significant differences in individual items: women obtained higher scores on *Relationship instability* and *Impulsivity* and lower scores on *Young age at first violent incident*, *Psychopathy*, and *Negative attitudes*.

Furthermore, several studies have been conducted in which the predictive validity of the HCR-20 was examined. Nicholls and colleagues (2004) examined the HCR-20 in female and male civil psychiatric patients and found good predictive validity for inpatient violence for men and women. Regarding violence in the community, they found modest levels of predictive accuracy for the occurrence of 'any violence' for both sexes. Predictive accuracy for 'physical violence' in the community was significant for men, but not for women, except for the *Historical* subscale. De Vogel and De Ruiter (2005) examined the HCR-20 in a group of female forensic patients and a matched group of male patients. For men, the HCR-20 total score demonstrated good to excellent predictive validity for violent outcomes. For women, only the HCR-20 final risk judgment, but not the HCR-20 total score, demonstrated significant predictive validity for violent outcomes. Thus, while a simple addition of individual HCR-20 risk factors was not adequate in predicting violence risk in female patients, the SPJ method based on the HCR-20 seemed to perform well. The same was recently found for the START (Petersen, Douglas, & Nicholls, 2011). Schaap and colleagues (2009) examined the predictive validity of the HCR-20 in female patients from two Dutch forensic psychiatric hospitals¹ and found no significant predictive accuracy for HCR-20 scores for violent outcomes. The same was found in a group of incarcerated women (Warren et al., 2005) and in a group of female short-term psychiatric inpatients (Strub, 2010). In a meta-analysis, however, greater effect sizes were found in samples containing higher proportions of women (O'Shea et al., 2013).

¹ The codings of 15 women from the study of De Vogel and De Ruiter (2005) were included in this study.

Concluding, the results are equivocal and the predictive accuracy of the HCR-20 items in female samples has not been convincingly proven. A similar conclusion was expressed in two recent reviews of risk assessment for violence among women. Garcia-Mansilla and colleagues (2009) reviewed the literature on different methods of violence risk assessment in a range of female populations. They concluded that structured methods of risk assessment are more accurate than unstructured methods, but that overall, the research supporting applicability of violence risk assessment tools in female populations remains equivocal. McKeown (2010) did a literature review into violence risk assessment with the HCR-20 in women and concluded that for now, the research supports the use of the HCR-20 with female populations, but that more research is needed and that a particular focus on additional risk factors that may further inform violence risk assessment in women would be valuable. No research has yet been published with respect to the predictive validity of the HCR-20^{v3} for women.

Other risk assessment tools

A number of studies have been conducted into the predictive validity of actuarial risk assessment tools such as the *Level of Service Inventory* (LSI; Andrews & Bonta, 2000) or youth versions of the LSI. The LSI is not specifically developed for assessing risk for violence, but rather of general recidivism, and most studies were conducted within populations with mainly property or drug related offenses. A group of American researchers has been working since 1999 to develop a more gender-sensitive method to predict general recidivism (see for example, Salisbury et al., 2009; Van Voorhis et al., 2010). They have adapted the LSI for use in women with the idea that it is more efficient to adjust an existing tool than to create a completely new instrument (Van Voorhis et al., 2010). The results for this adapted LSI for women show that both gender-sensitive factors and gender-neutral factors were predictive of misconduct in prison and general recidivism after release (Salisbury et al., 2009; Van Voorhis et al., 2010). Other studies found that the LSI performs equally well in male samples as in female samples in predicting general reoffending, though evidence was found for misclassification with respect to violence offenses (Reisig, Holtfreter, & Morash, 2006; Schwalbe, 2008).

There are several risk assessment tools developed for the assessment of intimate partner violence, such as the *Spousal Assault Risk Assessment guide* (SARA; Kropp, Hart, Webster, & Eaves, 1999) and the *Brief Spousal Assault Form for the Evaluation of Risk* (B-SAFER; Kropp, Hart, & Belfrage, 2005). Although according to their respective manuals these tools may be used for both men and women, the same

cautions warranted for other risk assessment tools are relevant for the SARA and the B-SAFER: the items are mainly based on studies in male populations, and there is little research on the value of these types of tools for female offenders. The item descriptions are generally expressed from the perspective of the male perpetrator and female victim. As far as we know, there is no specific tool available for assessing the risk for intimate partner violence by women.

Psychopathy and the use of the PCL-R with women

A number of reviews have been published on the use of the *Psychopathy Checklist-revised* (PCL-R; Hare, 2003) in female samples (Logan, 2009; Nicholls, Ogloff, Brink, & Spidel, 2005; Vitale & Newman, 2001). Although the PCL-R is not a risk assessment tool, psychopathy is an important risk factor and often incorporated in risk assessment tools like the HCR-20. It can be concluded from the reviews that there is considerable evidence that psychopathy is an important risk factor for violence in women, but that the effect is not as strong as it is for men. In general, a lower prevalence of psychopathy among women compared to men was found, as well as lower scores on the PCL-R. Good support was found for the reliability of the PCL-R in women, but only modest support for its predictive validity. Overall, the findings thus far are not sufficiently convincing so as to allow for conclusions about the applicability of the PCL-R structure across genders (Logan, 2009; Nicholls et al. 2005; Vitale & Newman, 2001). Some PCL-R items might not be adequately assessing the construct of psychopathy as it is expressed in women (Forouzan & Cooke, 2005; Weizmann-Henelius et al., 2010) and it might be useful to formulate the items differently for women. Also, it might be useful to lower the PCL-R cut-off score for women (e.g., Falkenbach, 2008; Kennealy, Hicks, & Patrick, 2007; Weizmann-Henelius et al., 2010). A measure that is more tailored to the assessment of psychopathy in women / girls could be valuable for forensic practice. Ideally, the PCL-R will be adjusted for use in women.

Recently, a Dutch multicentre study on psychopathy was conducted in 221 female forensic psychiatric patients (Klein Tunte, De Vogel, & Stam, 2014). In this study it was found that women with psychopathy as defined by the FAM cut-off score of 23 clearly differed from women without psychopathy regarding their criminal behavior. More specifically, psychopathic women were younger at their first conviction and had more criminal versatility in their offense histories. With respect to the index offense it was found that women with psychopathy less often committed a fatal index offense, were more likely to have stranger victims and more often committed offenses out of a *Bad* motivation (e.g., power, dominance, personal gain) compared to women without psychopathy.

In a second phase of this study, results were compared between 197 female forensic psychiatric patients from this sample and a matched group of 197 male forensic psychiatric patients. Men scored significantly higher on the total score, the Hare two factors / four facets and the Cooke and Michie three factors. Furthermore, men scored significantly higher on all individual PCL-R items, except for the item *Many short-term marital relationships* for which the mean score of women was significantly higher and for the items *Conning/ Manipulative*, *Poor behavioural controls* and *Impulsivity* for which no significant difference between men and women was found. Furthermore, clear differences were found in criminal and psychiatric characteristics between both women and men with psychopathy versus women and men without psychopathy. It was concluded that women with psychopathy are more 'like men' in their offending (e.g., younger age at first conviction, more criminal versatility), but still important differences were found between women with psychopathy and men with psychopathy. Women with psychopathy compared to men with psychopathy were more often diagnosed with Borderline Personality Disorder, committed more fraud, offended more often out of relational motives, and demonstrated more manipulative and self-destructive behaviour during treatment (De Vogel & Lancel, in preparation, see www.violencebywomen.com).

Protective factors in women

Gender-responsive assessment should not only consider risk factors but also evaluate strengths and signs of resilience (Meichenbaum, 2006). It has been suggested that each sex may respond differently to protective factors (Rumgay, 2004). For example, Hawkins and colleagues (2009) found that family connectedness and religiosity provided significant protection for girls, but not for boys. Positive social relationships were found to have a stronger protective effect for adolescent girls compared to boys (Hart, O'Toole, Price-Sharps, & Shaffer, 2007). Borowsky and colleagues (1997) found in a nonclinical population of students that academic achievement was a protective factor for sexually violent behavior specifically for female adolescents. In a Dutch study into gender differences in risk assessment using the *Structured Assessment of Violence Risk in Youth* (SAVRY; Borum, Bartel, & Forth, 2006) in adolescent girls and boys, it was found that scores on the protective factor *Positive attitude towards interventions and authority* were significantly higher for girls compared to boys (Lodewijks, De Ruiter, & Doreleijers, 2008). The total score on the six protective factors was a significant predictor of non-recidivism for both girls and boys.

For adult women, it has been found that marital satisfaction, employment and adequate financial management reduce recidivism (Holtfreter & Cupp, 2007). A protective factor for adult women that is often mentioned in the literature is dedication to their children²; this factor could be an important incentive for treatment (Benda, 2005; Kreager, Matsueda, & Erosheva, 2010; Simmons, Lehmann, & Dia, 2010; Willison & Lutter, 2009), although child care responsibility can also be an extra risk factor (see p. 72 FAM item R6 *Problematic child care responsibility*). In a study into gender-sensitive risk and protective factors for women in prison in the United States evidence was found for self-confidence, support from the family and partner, sound finances and education as protective factors for general recidivism (Van Voorhis et al., 2008; 2010). In a study into the intergenerational transfer of risk it was found that children of mothers with more education showed less antisocial behavior (Serbin et al., 1998). In a prospective study in the Van der Hoeven Kliniek it was found that the predictive validity of the SAPROF for abstention from violence during treatment was fairly good for women, but not as good as for men. There were differences in which factors were the most valuable. For men, the items *Self-control* and *Attitudes towards authority* were the best predictors for not committing violent incidents during treatment. For women, the items *Coping* and *Intelligence* were the strongest predicting factors (De Vries Robbé, 2014). Regarding the START it was found that female forensic psychiatric patients who made successful returns to the community had significantly higher START strength scores compared to women who were still in recovery (Viljoen, Nicholls, Greaves, De Ruiter, & Brink, 2011).

Gender-responsive treatment

In the past ten years, several authors have recognized a number of specific treatment needs of female offenders, often referred to as gender-responsive approaches (e.g., Blanchette & Brown, 2006; Bloom, Owen, & Convington, 2003; Bottos, 2007; Heilbrun et al., 2008; McClellan, Farabee, & Crouch, 1997; Morgan & Patton, 2002). In general, these treatment models stress the importance of using gender-sensitive risk assessment and addressing issues such as trauma, (sexual) abuse, and the role of social relations and disruptions in these relations in treatment. A central concept in North-American treatment programs for women is empowerment; i.e., increasing women's self-esteem and internal locus of control (Salisbury et al., 2009). It has been stated that the practice of violence risk management in women should respond to the observed high

² Obviously, this can also be a protective factor for men, but it is assumed that the impact is stronger for women.

levels of psychiatric comorbidity, especially Axis I/II comorbidity (Logan & Blackburn, 2009). Lewis (2006) recommends a treatment model for incarcerated women that recognizes gender differences but also gender challenges, i.e., the acknowledgement that working with female offenders is in some respects harder than working with male offenders. Foley (2008) reviewed twelve gender-specific programs for delinquent girls and concluded that most of these programs did not yet sufficiently incorporate relevant theories and gender-specific risk and protective factors into their curriculum. Dowden and Andrews (1999) conducted a meta-analysis of the value of the *Risk Need Responsivity model* (Andrews & Bonta, 1998, 2010) specifically for female offenders and concluded that there is sufficient empirical support for this model for both men and women. Hubbard and Matthews (2008) studied the "What works" literature (see for example Latessa, Cullen, & Gendreau, 2002) and "Gender-responsive treatment" literature (see for example Chesney-Lind & Pasko, 2004) and concluded that they are more complementary than competitive, and that together they provide a blueprint for how to effectively work with females.

The need for a gender-sensitive tool

In a recent meta-review into the predictive validity of risk assessment tools it was found that tools developed for a specific target group have better predictive value than general tools (Singh, Grann, & Fazel, 2011). The authors recommend, therefore, the development of tools for specific populations or specific types of offenses. Despite the many important advances in the field of violence risk assessment in the past thirty years and the fact that many risk assessment tools have become available for populations of different ages and for different types of violence, virtually no 'specific' tools have been developed for the assessment of risk for antisocial or violent behavior in female offenders. One exception is the *Early Assessment Risk List for Girls* (EARL-21G; Levene et al., 2001) for girls between 6 and 12 years old. Other than the risk factors valid for both boys and girls, this tool contains two items specific to girls; *Caregiver-daughter interaction* and *Sexual development*. Positive results have been found in terms of reliability, predictive validity and clinical applicability of the EARL-21G (Augimeri, Enebrink, Walsh, & Jiang, 2010). However, there is no such tool available for violence risk assessment in adolescent girls or adult women.

More knowledge on violence risk factors in female offenders as well as gender-sensitive risk assessment and management strategies is needed to prevent repeated violence in women. Many mental health professionals work with women on a daily basis recognize these differences and have called for more

gender-sensitive assessment of factors explanatory of violence risk in female offenders and relevant for its management (Adams, 2002; Odgers et al., 2005). Adams (2002) examined attitudes of professionals working in the field of domestic violence and concluded that many professionals indicate that there is a lack of appropriate guidelines to assist them in assessing violent women, and there is a need for more training in this area. Better risk assessment and management in women is also important from a public mental health perspective because research has demonstrated an intergenerational transfer of risk for violence between mothers and children; mothers with a history of violent offenses are more likely to raise disruptive, aggressive children (Kim et al., 2009; Meichenbaum, 2006; Motz, 2001; Serbin et al., 1998). Concluding, violent behavior by women is a problem that cannot be ignored and there is reasonable doubt as to whether the current theoretical understanding of male violence, violence risk, as well as prevention and treatment is sufficiently valid and applicable to women. In the next part, gender-sensitive guidelines for violence risk assessment are provided.

Part II The FAM

In the FAM, additional guidelines for women were formulated for two Historical HCR-20^{V3} items and eight new items were incorporated. Table 1 present the items of the HCR-20^{V3} and the FAM (see also Appendix 1 and 2). Additionally, two new coding aspects were incorporated in the FAM also based on clinical experiences with other tools like the HCR-20, the SAPROF and the START; 1) marking the final judgment on a five-point scale instead of a three-point scale; and 2) coding the extra risk ratings.

Table 1. Items of the HCR-20^{V3} and the FAM

| HCR-20 ^{V3} | | FAM | |
|-------------------------|-----------------------------------|---|--------------------------------|
| Historical items | | | |
| H1 | Violence | | |
| H2 | Other antisocial behavior | | |
| H3 | Relationships | | |
| H4 | Employment | | |
| H5 | Substance use | | |
| H6 | Major mental disorder | <i>Additional guidelines for women to the following HCR-20^{V3} items</i> | |
| H7 | Personality disorder | H7 | Personality disorder |
| H8 | Traumatic experiences | H8 | Traumatic experiences |
| H9 | Violent attitudes | | |
| H10 | Treatment or supervision response | | |
| | | <i>Specific risk factors for women</i> | |
| | | H11 | Prostitution |
| | | H12 | Parenting difficulties |
| | | H13 | Pregnancy at young age |
| | | H14 | Suicidality / self-harm |
| Clinical items | | | |
| C1 | Insight | | |
| C2 | Violent ideation or intent | | |
| C3 | Symptoms of major mental disorder | | |
| C4 | Instability | | |
| C5 | Treatment or supervision response | | |
| | | <i>Specific risk factors for women</i> | |
| | | C6 | Covert / manipulative behavior |
| | | C7 | Low self-esteem |

| HCR-20 ^{V3} | FAM |
|--------------------------------|---|
| Risk management items | |
| R1 | Professional services and plans |
| R2 | Living situation |
| R3 | Personal support |
| R4 | Treatment or supervision response |
| R5 | Stress or coping |
| | <i>Specific risk factors for women</i> |
| | R6 Problematic child care responsibility |
| | R7 Problematic intimate relationship |
| Conclusory opinions | |
| Risk for future violence | Risk for future violence |
| Risk for serious physical harm | Risk for serious physical harm |
| Risk for imminent violence | Risk for imminent violence |
| | Extra risk ratings for women |
| | Self-destructive behavior |
| | Victimization |
| | Non-violent criminal behavior |

Note. The HCR-20^{V3} items are reproduced with permission from the authors (see Douglas et al., 2013). See Tables 3, 4 and 5 for the subitems of the HCR-20^{V3} items (p. 49, 63, 71).

Development

The FAM was developed on the basis of:

1. A literature review.
2. Clinical expertise:
 - a. The most frequently coded Other considerations in the HCR-20 for female forensic psychiatric patients;
 - b. Semi-structured interviews with mental health professionals from different disciplines;
 - c. Experiences with the coding procedure of other assessment tools (SAPROF, START).
3. A pilot study into the interrater reliability and gender specificity of the *FAM: Research Version*.

Literature review

In 2007, the development of the FAM was initiated. First, a review of the literature on violence by women and violence risk factors in women was conducted (Van Kalmthout & Place, 2007). More specifically, a search was carried out for the applicability of the HCR-20 items with respect to female populations. Support was found for most Historical items of the HCR-20 although there were differences in interpretation and implication of some of the items for women. Almost no empirical studies on the dynamic HCR-20 items were retrieved in female samples, thus no direct empirical support was found for the validity of the dynamic HCR-20 items in women. Further, empirical studies on gender-specific risk factors that are not sufficiently covered by the items of the HCR-20 were searched. Overall, the literature review resulted in suggestions for additional guidelines to several Historical items and the inclusion of gender-specific risk factors such as a history of prostitution, pregnancy at young age and self-harm or suicidality (Blanchette & Brown, 2006; Messer et al., 2004; Morgan & Patton, 2002).

Clinical expertise

In a previous study, mental health professionals working in forensic psychiatry were specifically asked to consider case-specific risk factors that do not fit within the HCR-20 item descriptions (see De Vogel & De Ruiter, 2005). The three most frequently coded other considerations for women were 1) (pattern of)

problematic partner choice; 2) problems with child care responsibilities, and related stress; and 3) prostitution, particularly the often coinciding vulnerability and maladaptive lifestyle. Next, semi-structured interviews with mental health professionals from different disciplines were conducted, which revealed more new risk factors specific to women including covert behavior (i.e., hiding or concealing the truth, incitement), as well as a manipulative way of dealing with sexuality (i.e., sexual self-exploitation for personal gain) and low self-esteem (see Van Kalmthout & Place, 2007). Integration of the literature and clinical expertise led to a first draft of the FAM. This draft was implemented at the end of 2007 for all women in the Van der Hoeven Kliniek. In 2010, we revised the draft based on user feedback and experiences with coding procedures of other tools, specifically the SAPROF and the START. The revised tool was named the *Female Additional Manual: Research Version* (FAM:RV; De Vogel, De Vries Robbé, Van Kalmthout, & Place, 2010).

Pilot study FAM:RV

In 2010, a prospective pilot study was carried out on the psychometric properties of the FAM:RV in the Van der Hoeven Kliniek with the aim of establishing interrater reliability and gender specificity of the FAM items for women (Stam, 2010). The pilot study resulted in several revisions, such as the sharpening of some coding guidelines, for example of the item with the lowest interrater reliability *Problematic child care responsibility*; the revision and adaptation of the Historical item *Manipulative sexual behavior* into the Clinical item *Covert / manipulative behavior* and the deletion of a number of additional guidelines that on closer inspection proved irrelevant or insufficiently prevalent. The results of the pilot study led to the FAM.

The FAM as an additional manual to the HCR-20^{v3} instead of the HCR-20

In 2013, the FAM was slightly adapted for use as an additional manual to both the HCR-20 and the HCR-20^{v3}. The present manual is completely adapted for use with HCR-20^{v3}. The additional guidelines to the HCR-20 items H7 *Psychopathy* and H9 *Personality disorder* are now additional guidelines to HCR-20^{v3} item H7 *Personality disorder*. These additional guidelines are generally still applicable, but have slightly been changed with respect to use with the HCR-20^{v3} (see p. 50 and Appendix 1). The additional guidelines to HCR-20 items H6 *Major mental illness*, H8 *Early maladjustment* and H10 *Prior supervision failure* are no longer necessary when using the HCR-20^{v3}.

With respect to the FAM items specific for women: almost all FAM items are still considered useful in addition to the HCR-20^{V3}. Only FAM item H15 *Victimization after childhood* is no longer necessary as a new item as this is now included in the HCR-20^{V3} item H8a *Victimization / trauma*. HCR-20^{V3} item H8a considers traumatic experiences at any point during the lifespan (including victimization after childhood). The authors of HCR-20^{V3} recognize the importance of victimization and traumatic experiences during the different developmental stages (child, adolescence, adulthood) and have therefore included *indicators*³ that consider these different developmental stages for coding item H8a. However, we feel that for women the distinction between victimization during childhood and after childhood deserves to be made more explicit, given the empirical knowledge on the severe impact on women of victimization during multiple developmental stages in life. From a clinical and research perspective it is also valuable to be able to make a distinction between victimization during childhood versus victimization during adulthood. Concluding, since research has demonstrated that victimization after childhood is a strong risk factor for women in addition to victimization during childhood, it is recommended to divide the HCR-20^{V3} item H8a into H8a1 *Victimization and trauma during childhood* and H8a2 *Victimization and trauma after childhood*. The coding guidelines for item H15 in the previous version of the FAM can still be used for H8a2. Thus, instead of the former FAM item H15, new additional guidelines are offered for the HCR-20^{V3} item H8a.

Aims

The goal of the FAM is to provide a clinically relevant and useful additional tool for accurate, gender-sensitive assessment of violence risk, which offers concrete guidelines for risk management in women.

Definition of violence

The definition of violence in the FAM is basically the same as in the HCR-20^{V3}. Interpersonal violence is defined as *actual, attempted, or threatened infliction of bodily harm on another person* (Douglas et al., 2013, p. 36). This definition includes all violent offenses, homicides, sexual offenses and arson. There does not need to be a court conviction, but the violent behavior must be serious enough to potentially result in criminal or civil sanctions. In the FAM **influencing someone else to commit violence or being accessory to violence** is explicitly included in the definition of violence. It is not clear from the definition of violence in the HCR-

³ Coding indicators are representative examples of the kinds of information that evaluators should look for when making judgments regarding the presence of risk factors (see Douglas et al., 2013, chapter 3, p. 50).

20^{V3} if these types of behavior are included. The reason for the explicit inclusion of this in the FAM is because it is assumed that, relatively speaking, more women than men are convicted of aiding and abetting, although no official data could be retrieved. Mental health professionals believe that women are more likely than men to incite someone else to commit violent / antisocial behavior and their own share may not always be clearly seen. In addition, women may not actually commit violence themselves but may be accessory to violent behavior, for example, by failing to intervene when their partners commit violence.

Applications

The FAM is designed as an addition to the HCR-20^{V3} for violence risk assessment in adult women. Like the HCR-20^{V3}, the FAM can be used to evaluate risk for violence when there is a legal or clinical need to do so. The FAM is possibly also useful for women in prison or in general psychiatry who have demonstrated violence to others. For assessing violence by young girls (between 6 and 12 years), we refer to the EARL-21G. For adolescent girls there is - as far as we know - no gender-sensitive risk assessment tool available. The FAM may possibly be partly useful for violence risk assessment in adolescent girls, but caution is warranted because there are some risk factors specifically valid for adolescent girls that are not included in the FAM, such as interaction with deviant peers, being a member of a gang, and running away from home (see Funk, 1999; Hart et al., 2007; Park, Morash, & Stevens, 2010). Moreover, some of the FAM items are obviously not applicable for adolescent girls, for example, *Victimization after childhood*.

User qualifications

User qualifications are similar to those described in the HCR-20^{V3} (Douglas et al., 2013, p. 38-39). The evaluator should have expertise in conducting individual assessments and be familiar with the most recent empirical and theoretical knowledge of violence and the prediction of violence. Moreover, the evaluator should be familiar with the HCR-20^{V3}. Training in the use of the HCR-20^{V3} and FAM is highly recommended.

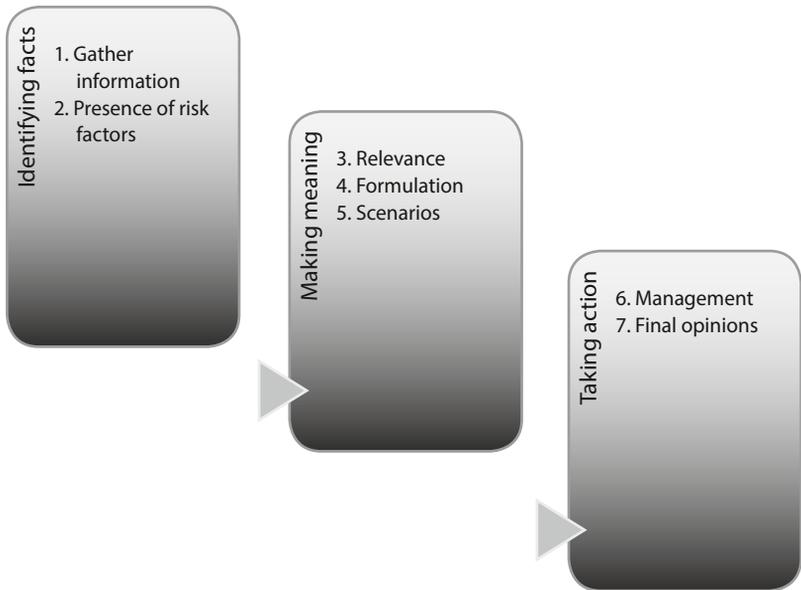
Coding procedure

The coding procedure of the FAM is basically the same as the coding procedure of the HCR-20^{V3}. In the HCR-20^{V3}, seven steps are distinguished (see Figure 1; Douglas et al., 2013, pp. 40-65). In the FAM, some adaptations were made in step 2 (Presence of risk factors) and step 7 (Final opinions). Based on clinical

experience (see also *General recommendations*, see p. 40) an additional suggestion is provided regarding step 3 (Relevance). It should be mentioned that this recommendation can also be valuable for men.

An example of the coding sheet that can be used for coding the FAM is provided on p. 78.⁴ For coding the FAM and HCR-20^{V3} it is necessary to apply both manuals simultaneously. For coding the HCR-20^{V3} items H7-H8 the evaluator is referred to the additional coding instructions for women in the FAM. These items should be coded on the FAM coding sheet and not on the HCR-20^{V3} coding sheet in order to prevent double rating of the same concepts.

Figure 1. HCR-20^{V3} steps adopted from Douglas et al., 2013



Step 1: Gather information (see Douglas et al., 2013)

Step 2: Presence of risk factors (see also Douglas et al., 2013)

The items are coded on a three-point scale based on the degree to which the risk factor is present; a 'No' indicates that the risk factor is absent or hardly present; a 'Partially' indicates that the risk factor is possibly or partially present, but there

⁴ The FAM Coding sheet can be downloaded from www.hoevenkliniek.nl or www.violencebywomen.com or be obtained digitally from the authors.

is no conclusive evidence for its presence; and a 'Yes' indicates that the risk factor is definitely or clearly present (see Table 2). If the information necessary to code the item is lacking or insufficient, the evaluator should first try to obtain the information, for example, by using multiple sources, deliberation with colleagues, or by asking the woman herself. If there is no information at all about a given item, or if the information is considered completely unreliable, the item has to be omitted. This option should be used sparingly and should not be used in case of doubt about the presence of the item (more indicative of a score of 'Partially'). When more than six items are omitted in total in the HCR-20^{V3} (not the subitems) and FAM the risk assessment is no longer usable. The item *Parenting difficulties* is not applicable if the woman has never had children (to take care of). In this case, there is the option to rate the item as n.a. (not applicable) and this is not seen as an omit. If the evaluator believes one or more risk factors are present in a given case that are not covered by any of the items in the HCR-20^{V3} and FAM these factors can be coded under Other considerations.

Table 2. Coding the presence of items

| | |
|------------------|---|
| No | The risk factor is definitely not present or does not apply. |
| Partially | The risk factor is possibly present, or is present to a limited extent. |
| Yes | The risk factor is obviously present. |
| Omit | There is insufficient valid information to decide upon the score. |

Step 3: Relevance (see Douglas et al., 2013)

Although the judging of relevance of the risk factors is seen as an important step in the coding procedure, in some settings coding the relevance of all risk factors may not be possible or realistic because it is too time-consuming. As an alternative to coding the relevance of all items, the evaluator could mark critical items, that is, risk factors that are considered essential for the case at hand. These items are intended to steer the development of treatment goals and to tailor clinical interventions. The option to code critical items is also available in the START and SAPROF and is highly appreciated by mental health professionals because it structures their thinking and helps them to focus and prioritize treatment goals (see De Vries Robbé, 2014).

Step 4: Formulation (see Douglas et al., 2013)

Step 5: Scenarios (see Douglas et al., 2013)

Step 6: Management (see Douglas et al., 2013)

Step 7: Final opinions

Similar to the HCR-20^{V3} and related tools, the final risk rating of future violence to others is not only determined by adding up the individual items, but depends on the interpretation, weighing, and integration of the items. In the FAM, the final risk ratings can be made on a five-point scale: 1) low; 2) low to moderate; 3) moderate; 4) moderate to high and; 5) high risk. The reason to apply five-point scales instead of three-point scales is because it is easier to pinpoint nuances; in a forensic population where the treatment progress is usually slow, it can be useful and motivating to be able to show small changes. In addition, research in the Van der Hoeven Kliniek showed higher predictive validities for five-point scales than for three-point scales (De Vries Robbé & De Vogel, 2012). Using a five-point scale instead of a three-point scale may also be valuable for men. The final risk rating should be made for the coming year and will not only include the likelihood of violent behavior, but also the context, frequency, duration and possible time frame in which violence could take place, as well as the identification of potential victims. In the HCR-20^{V3}, this process is referred to as *Risk scenario planning* (see for more details Step 5, Douglas et al., 2013).

Coding the extra risk ratings

In the FAM, the evaluator is invited to not only decide upon the three Final opinions *Risk for future violence* (including influencing others to commit violence or being accessory to violence), *Risk for serious physical harm*, *Risk for imminent violence*, but also to judge the *Risk for self-destructive behavior*, the *Risk for victimization* and the *Risk for non-violent criminal behavior*. This method of judging different types of risks is also applied in the START. Although there is presently no empirical evidence supporting the assumption that the risk factors in the FAM are indeed related to these specific risks, the distinction between the different types of risk may be useful for clinical practice. These three judgments should thus be seen as experimental and future research will have to demonstrate their value.

It is likely that the final judgments are related to each other (see also Strub, 2010). Hillbrand (2001) summarized the literature on co-occurring aggression

against self and others and concluded that there is a strong link between the two forms of aggression and that both types of risk assessment should occur jointly. Furthermore, research has shown that self-destructive behavior or a history of suicide attempts in women is a predictor of general recidivism (Blackburn & Trulson, 2010; Blanchette & Brown, 2006; Motz, 2001; see also the FAM item *Suicidality / self-harm*). Victimization may also lead to violent behavior, for example, in the form of reactive aggression or self-defense, but also indirectly, for example because the victim is experiencing stress or starts to abuse substances in response to traumatic experiences (see Hiday et al., 2001; additional guidelines to HCR-20^{V3} item H8 *Traumatic experiences*).

1. Risk for self-destructive behavior

Self-destructive behavior includes any behavior that results in injury or harm to the own body. This includes self-harm and suicidal behavior (see also p. 60), but also severe self-neglect by excessive use of alcohol, drugs or medication, or by not complying with medication requirements for physical symptoms with potentially serious consequences, or very poor personal hygiene. This should include serious self-destructive behavior, that is, it should lead to a clearly observable deterioration in the mental and physical condition of the woman. The items *Substance use problems*, *Major mental illness*, *Suicidality / self-harm* and *Low self-esteem* are especially important for assessing the risk for self-destructive behavior. It should be noted that the FAM is **not** a tool to assess the risk for suicide; there are predictors of suicidal behavior that are not included in the FAM (see for instance Bouch & Marshall, 2005).

2. Risk for victimization

Victimization is defined as being the victim of damaging behavior caused by another person. The most obvious cases are in victims of violence, such as violence within an intimate relationship, sexual abuse or being forced into prostitution. The items *Relationship instability*, *Traumatic experiences*, *Prostitution*, *Covert / manipulative behavior*, *Low self-esteem* and *Problematic intimate relationship* are especially important for assessing the risk for victimization.

3. Risk for non-violent criminal behavior

Non-violent criminal behavior includes all (non-violent) behaviors that are not in conformity with the law. This includes all offenses not involving (sexual) violent behavior, including fraud, arson without risk to persons, property offenses, and drug related offenses. Research into predictors of general recidivism (including violence) has found support for quite a few of the Historical items in the HCR-

20^{v3} / FAM, especially factors relating to mental illness, victimization, problems in relationships and problems with child care (see Van Voorhis et al., 2010). In addition to the above mentioned risk factors, the items *Other antisocial behavior*, *Prostitution* and *Covert / manipulative behavior* seem to be important for assessing the risk for non-violent criminal behavior, but this has yet to receive empirical support.

General recommendations

Based on experiences in clinical practice at the Van der Hoeven Kliniek, several recommendations are made here (see also De Vogel, Van den Broek, & De Vries Robbé, 2014). First, it may be useful to judge the Risk management items and the final risk ratings for different contexts, for example the situation 'inpatient setting' and the situation 'supervised living in the community'. By scoring for different contexts the evaluator can gain more insight into the possible need for continued treatment. In daily practice this way of coding is seen as useful, for instance, when writing a report to the court upon termination or extension of the tbs-order (compulsory treatment). Second, it is recommended to also examine protective factors in addition to risk factors, for example, using the SAPROF. By not only looking at risk factors but also at existing protective factors or protective factors that can be developed, it is possible to conduct a more balanced risk assessment and thus provide a more complete picture of the person. Furthermore, the positive, strengths-focused approach of the SAPROF may be motivating for both staff and patients, leading not only to a more balanced risk assessment, but also to more elaborate and patient-adjusted risk management strategies and improved risk communication (see for more information De Vogel, De Vries Robbé, De Ruiter, & Bouman, 2011; De Vries Robbé, 2014; www.saprof.com). Third, we highly recommend the consensus model for a valid risk assessment. It has become clear from research at the Van der Hoeven Kliniek that risk assessment using the consensus model (coding by both researchers and mental health professionals followed by extensive discussion in order to reach consensus) leads to a significantly more accurate prediction of the risk for recidivism (De Vogel, 2005; De Vogel & De Ruiter, 2006). During these case conferences, possible effects of rater bias can be ruled out; raters can sharpen their understanding of the items, and can correct each other, share information that is not available to everyone, discuss the meaning of the items, and discuss possible additional risk factors or protective factors and risk management strategies.

Risk communication

After the evaluator has scored the FAM, a report must be prepared in which the main risk factors (and protective factors) are described in relation to each other. The intention here is not to merely mention scores, but instead to report descriptively. In formulating the final risk rating, not only should the risk for violent behavior be reported, but also the possible context, time, frequency, duration of violent behavior, as well as the potential victims. It is desirable to communicate the main results of the risk assessment to the woman, preferably in the presence of treatment staff. Finally, a risk assessment should be followed by a risk management plan based on the main conclusions of the risk assessment.

Research

Research on the FAM is still limited. In 2011, a prospective study was started on the clinical value and psychometric properties of the FAM in the Van der Hoeven Kliniek. In this study, the FAM, HCR-20 and SAPROF are scored on standard risk assessment moments⁵ for all female patients admitted to the Van der Hoeven Kliniek. The first part of this research has been completed (Stam, 2010; De Vogel & De Vries Robbé, 2011). In this project, the FAM, the HCR-20, and SAPROF were scored for 42 female patients and 42 male patients. The women and men were matched with respect to their phase in treatment, type of psychopathology and type of offense. For 20 women, the tools were scored by two independent raters to determine interrater reliability. Good interrater reliability was found for all new FAM items and HCR-20 items with additional guidelines for women, the integrated total score of the HCR-20 and FAM, and the final risk judgment of Future violence (Intraclass Correlation Coefficient single measure (ICC) individual items ranging from .63 to .97, all $p < .05$; total score ICC = .95, $p < .001$; and final risk judgment Future violence ICC = .95, $p < .001$). For the extra final risk ratings moderate to high interrater reliabilities were found (ICC = .54-.85, all $p < .001$). Regarding the differences between women and men on FAM scores, it was found that women had significantly higher scores on seven of the nine new items; *Prostitution, Pregnancy at young age, Suicidality / self-harm, Victimization after childhood, Covert / manipulative behavior, Low self-esteem and Problematic intimate relationship* (see www.violencebywomen.com). No significantly higher scores were found for women on the HCR-20 items with additional guidelines for women and for two of these items the men scored significantly higher, i.e., on *Psychopathy* and *Problematic behavior in childhood*. The latter was anticipated.

⁵ The standard risk assessment moments in the Van der Hoeven Kliniek are: 1) upon admission; 2) prior to the first supervised leave; 3) prior to the first unsupervised leave; and 4) at the start of the transmurial phase. From step 2, the risk assessment is repeated yearly. Furthermore, the risk assessment may be repeated if deemed necessary (for example, in case of a changed context or a specific question from the treatment team).

In a preliminary analysis of a group of 46 women it was found that, overall, the FAM had good predictive validity for incidents of violence to others during treatment, but even more so for incidents of self-destructive behavior during treatment (De Vogel & De Vries Robbé, 2013). In an ongoing Dutch multicentre study it was found that the FAM / HCR-20 Historical subscale score was a significant, but modest predictor of different types of incidents during treatment (physical violence, verbal violence, verbal threats and arson). Furthermore, the FAM / HCR-20 Historical subscale score significantly predicted if a woman had to be transferred to another ward in the treatment setting, usually because of serious problems (De Vogel et al., 2014). Further research into the predictive validity of the FAM for incidents during treatment and recidivism after discharge will take place in the coming years.

In general, studies into female populations will encounter several difficulties, most importantly small sample sizes (see also Burman, Batchelor, & Brown, 2001). The group of female forensic psychiatric patients is relatively small and many of these women have such severe problems that they are admitted in forensic or general psychiatry for an extensive period of time, often even chronically. Most of these women do not return completely to society. Therefore, it will be relatively easy to study violent behavior within institutions, but it will be very difficult to examine violence in society. Also, a relatively large number of female forensic psychiatric patients die at a relatively young age. Eight of the 42 women who were examined in a previous study in the Van der Hoeven Kliniek (De Vogel & De Ruiter, 2005) had died within seven years after the study (of which two by suicide). In a British study, it was found that women from medium secure settings have an almost ten times higher mortality rate than the general population and two times higher than for men who were discharged from the same institutions (Davies, Clarke, Hollin, & Duggan, 2007). Furthermore, women who were treated in medium secure units in the UK were readmitted more often than men (Sahota et al., 2010). In short, research on violence by women and predicting such behavior is difficult and requires a longer period of time as well as good cooperation between institutions. In addition, the generally used outcome measures for violent recidivism are probably less useful in women, considering the different nature of violence by women compared to men and the fact that violence by women is still underrated. It is recommended for future research to use different outcome measures, such as self-destructive or suicidal behavior, victimization, or examine more subtle forms of violence such as verbal abuse, and other forms of antisocial behavior. It is possible that self-report and observational data in addition to data on official convictions may be more suitable to examine repeated violent behavior by women.

Limitations

The most important limitation of the FAM is that there is relatively little empirical evidence for the new risk factors and additional HCR-20^{V3} item guidelines for women employed in the FAM. For some of the factors there is clear empirical support with respect to the relation with general criminal offending, but not specifically for the relation to violence. In addition, for a number of items a correlation was found with violent behavior in the past, but this does not necessarily mean that the factor is also related to future violent behavior. Future research in various settings will have to examine whether the items in the FAM actually predict repeated violence to others. It is also still unknown whether the items actually have empirical value for the prediction of the extra risk ratings of self-destructive behavior, victimization and non-violent criminal behavior. Another limitation is that the FAM contains relatively many historical items. These items may point out important issues for mental health professionals to keep in mind, but unfortunately as a risk factor they are not or hardly changeable by clinical intervention. However, with the addition of the relevance ratings in the HCR-20^{V3}, the historical items become more useful clinically as their relevance is evaluated for the current level of risk.

Definition of the risk factors

The additional guidelines to the coding instructions of two HCR-20^{V3} items, as well as the new risk factors for women are described in the following section. For every new item, a definition is given for the inclusion of this item in the FAM based on the literature and the results of the interviews with mental health professionals, as well as a clinical case example. It should be noted that in the definitions in the FAM references to the literature are included, whilst for the HCR-20^{V3} items they are not included. A detailed description of the literature per item can be found on the website www.hcr-20.com. Furthermore, indicators and coding notes are provided in order to assist with the coding of the items. For coding the original HCR-20^{V3} items, the evaluator is referred to the HCR-20^{V3} manual (Douglas et al., 2013).



Historical items

The Historical items refer to the woman's past up **until the moment of the assessment**. Additional coding guidelines were formulated for two Historical HCR-20^{V3} items (H7-H8) and four new Historical risk factors for women were incorporated in the FAM (H11-H14). For coding the original HCR-20^{V3} Historical items, the evaluator is referred to the HCR-20^{V3} manual (Douglas et al., 2013).

Table 3. Historical items of the HCR-20^{V3} and the FAM

| Historical items | |
|---|---|
| H1 | Violence As a child (12 and under) As an adolescent (13-17) As an adult (18 and over) |
| H2 | Other antisocial behavior As a child (12 and under) As an adolescent (13-17) As an adult (18 and over) |
| H3 | Relationships a. Intimate b. Non-intimate |
| H4 | Employment |
| H5 | Substance use |
| H6 | Major mental disorder a. Psychotic disorders b. Major mood disorders c. Other major mental disorders |
| <i>Additional guidelines for women to the following HCR-20^{V3} items</i> | |
| H7 | Personality disorder a. Antisocial, psychopathic, and dissocial b. Other |
| H7 | Personality disorder a. Antisocial or psychopathic b. Other 1. Cluster B (other than antisocial) or traits of suspiciousness 2. Other personality disorders |
| H8 | Traumatic experiences a. Victimization / trauma b. Adverse childrearing experiences |
| H8 | Traumatic experiences a. Victimization / trauma 1. During childhood 2. After childhood |
| H9 | Violent attitudes |
| H10 | Treatment or supervision response |
| <i>Specific risk factors for women</i> | |
| H11 | Prostitution |
| H12 | Parenting difficulties |
| H13 | Pregnancy at young age |
| H14 | Suicidality / self-harm |

Note. The HCR-20V3 items are reproduced with permission from the authors (see Douglas et al., 2013).

H7 Personality disorder

additional guidelines to the HCR-20^{V3}

H7a Antisocial, Psychopathic, and Dissocial Personality Disorder

Psychopathy is no longer an item in the HCR-20^{V3}. Nevertheless, it is still advised to consider the level of psychopathy for the coding of subitem H7a *Antisocial or psychopathic personality disorder*. The differences between men and women with respect to psychopathy are relevant for the HCR-20^{V3} item H7a. Therefore we recommend to apply a different cut-off score for women when using the PCL-R to code HCR-20^{V3} subitem H7a.

Definition

In general, lower scores are found on the PCL-R for women as compared to men as well as a lower prevalence of the diagnosis of psychopathy (Logan, 2009; Nicholls et al., 2005; Vitale & Newman, 2001; see also p. 23). It has been suggested in the literature to lower the cut-off score of the PCL-R in women (e.g., Falkenbach, 2008; Kennealy, Hicks, & Patrick, 2007; Weizmann-Henelius et al., 2010). In the FAM, this advice is followed and the cut-off score of the PCL-R and the *Psychopathy Checklist: Screening Version* (PCL:SV; Hart, Cox, & Hare, 1995) are lowered. In a recent study into psychopathy in women, it was found that the diagnostic cut-off score of 23 as used in the FAM clearly differentiated women with psychopathy from women without psychopathy (Klein Tuente et al., 2014; De Vogel & Lancel, in preparation). Therefore, it may be argued that using a lower diagnostic cut-off score for the PCL-R is a meaningful aspect of the FAM. This cut-off score should still be seen as experimental and mainly to be used for research purposes and not to exclude women from treatment because of a high score.

Additional coding notes for women

- A score above 23 on the PCL-R, or above 15 on the PCL:SV should be interpreted as definite / serious psychopathy and should be coded as Yes.
- A score of 14-23 on the PCL-R, or 11-15 on the PCL:SV should be interpreted as possible / less serious psychopathy and should be coded as Partially.
- A score of under 14 on the PCL-R, or under 11 on the PCL:SV should be interpreted as non-psychopathic and should be coded as No.

H7b Other personality disorders

When using the HCR-20^{V3} for women it is advised to divide H7b *Other personality disorder* into: H7b1 *Cluster B disorders (other than antisocial) or traits of suspiciousness* and H7b2 *Other personality disorders*.

Definition

Research has demonstrated that not all personality disorders are related to violence. The relationship with violence is particularly clear for Cluster B personality disorders and the paranoid personality disorder (Berman, Fallon, & Coccaro, 1998; Coid, 2000; Coid, Kahtan, Gault, & Jarman, 1999). This applies to both men and women. In a study of the relationship between personality disorder and violence in women, a relationship was found between previous violence and Cluster B disorders, specifically antisocial and narcissistic personality disorders (Warren et al., 2002). Further, borderline personality disorder was shown to be linked to violence within the sample. This study also found a relationship between Cluster A symptoms (suspiciousness and bizarre thoughts) and previous violent behavior. No significant relationship was found for Cluster C symptoms and previous violent behavior. Weizmann-Henelius and colleagues (2004) found a higher frequency of antisocial personality disorder and a high degree of psychopathy in women who had repeatedly been convicted of violent behavior compared to women who were first-time violent offenders.

Additional coding notes for women

- For coding item H7b1 for women the evaluator should explicitly consider cluster B personality disorders or personality disorders involving suspiciousness, such as paranoid personality disorder.
- An official diagnosis of one or more cluster B personality disorders or personality disorders involving suspiciousness should be coded as Yes.
- Possible / less serious cluster B personality disorders (traits) or personality disorders with traits of suspiciousness should be coded as Partially.
- No diagnosis of a cluster B personality disorder or personality disorder with traits of suspiciousness should be coded as No on H7b1.
- Although there is little evidence of a relationship between cluster C personality disorders and violent behavior (Warren et al., 2002), these are coded under H7b2. The same goes for cluster A personality disorders, other than those involving suspiciousness.

H8 Traumatic experiences

additional guidelines to the HCR-20^{V3}

H8a Victimization/Trauma

In the HCR-20^{V3} subitem H8a *Victimization / trauma* victimization at any point during the entire lifespan is considered (see the indicators for coding the item concern childhood, adolescence and adulthood). As for women victimization during multiple developmental stages increases violence risk, it is advised to divide item H8a into: H8a1 *Victimization / trauma during childhood* and H8a2 *Victimization / trauma after childhood*.

Definition

Victimization / trauma during childhood

Research shows that women who were neglected as a child or who were victims of (sexual) abuse have a greater chance of problems in adulthood, such as substance abuse and committing violent crimes (Bishop, Mahmoodzadegan, & Warren, 2008; Blackburn & Trulson, 2010; Herrera & McCloskey, 2003; Penney & Lee, 2010; Siegel, 2000). This relationship also exists for men, but seems to be stronger for women (Belknap & Holsinger, 2006; Blackburn & Trulson, 2010; Bottos, 2007; Widom & Maxfield, 2001). There is a strong relationship between having been a victim of child abuse and being a perpetrator of child abuse in later life (De Ruiter & De Jong, 2005). Furthermore, a relationship was found between other types of problematic circumstances in childhood and later perpetration of violent behavior. Parental divorce and witnessing abuse within the family distinguished women who have committed repeated violent behavior from women who had shown violence only once (Weizmann-Henelius et al., 2004). Women who committed violent offenses are more likely to have parents with mental health or substance abuse problems than women who committed non-violent offenses (Pollock, Mullings, & Crouch, 2006). For female inmates, a relationship was found between problematic circumstances during childhood, particularly physical and mental abuse by the mother, and being diagnosed with Cluster B personality pathology in adulthood, especially borderline personality disorder (Loper et al., 2008), which in itself constitutes a risk factor for violent behavior.

Victimization / trauma after childhood

Research has shown that victimization after childhood is related to: 1) violent behavior; 2) sexual offending; and 3) general criminal behavior. First, with regard to violent behavior it has been demonstrated that female violent offenders are more likely than non-offenders to have been mentally and physically abused as children and as adults (Weizmann-Henelius et al., 2004). Swan and colleagues (2005) found that women who frequently have been victims of violence by their partner often exhibit violent behavior towards their partner, especially if the woman was also victimized in childhood. Women who are abused by their partners use more aggressive discipline with their children than women who are not abused (Margolin, Gordis, Medina, & Oliver, 2003). Furthermore, it was found that these women have a greater chance of developing post-traumatic stress disorder and depression, and hence the risk for violent behavior towards others is increased. Second, women who commit sexual offenses often have a history of sexual abuse, both in childhood and in adulthood (Gannon & Cortoni, 2010). Women who are sexually abused are more likely to suffer from depression, post-traumatic stress disorder and feelings of anger / irritability (Spataro, Mullen, Burgess, Wells, & Moss, 2004), which in turn can lead to violent behavior. Third, there is a significant association between victimization in adulthood and general recidivism (Benda, 2005; Van Voorhis et al., 2010). Victimization is a risk factor for violence to others for both men and women, but the correlation is stronger for women (Benda, 2005). Women are generally more often exposed to victimization than men. In a study of female inmates nearly all women had at least one traumatic experience in adulthood (Green et al., 2005). In general, traumatic experiences are predictive of other risky behaviors such as substance abuse and risky sexual behavior (Rheingold, Acierno, & Resnick, 2004) and thus indirectly also serve as a risk factor for violence (Briere & Elliott, 2003; Coker et al., 2002).

Additional coding notes for women

- Victimization / trauma that occurred during childhood should be coded under H8a1, victimization / trauma that occurred during adulthood under H8a2.
- The severity of victimization depends on the duration, degree of bodily injury, material damage, and physical and / or psychological consequences for the victim.
- According to some mental health professionals, female patients may easily take on the role of a victim. Therefore, the credibility and reliability of sources that indicate victimization or trauma should be carefully considered.

H11 Prostitution

Definition

Past research (Morgan & Patton, 2002) and interviews with mental health professionals have identified prostitution as a risk factor for violence in women. Prostitution is defined as the act of performing sexual activities in exchange for money. Different causes and motives may underlie prostitution. Prostitution can be a personal choice, but can also be forced. Both voluntary and forced prostitution are seen as a risk factor for violent behavior. Forced prostitution is an indication of the suggestibility and vulnerability of a woman and her inability to set limits. A woman who is forced into prostitution is probably more vulnerable to the influence of others such as an antisocial partner or antisocial friends. A woman may end up in the criminal circuit as a result of the influence of such people. Voluntary prostitution can also be a risk factor for violent behavior. Voluntary prostitution may indicate an antisocial attitude. Prostitution can arise from a desire for power or money or can be used to fund a drug addiction. Furthermore, a woman who works as a prostitute may find herself in dangerous situations, especially in case of street prostitution. This may lead to victimization of the woman, but may also lead to her perpetration of violence as necessitated in self-defense.

Indicators

- Has worked as a prostitute for a period of time
- Has worked as a street or window prostitute
- Has worked as prostitute in a club
- Voluntary prostitution
- Was forced to work as prostitute

Coding notes

- This item involves both voluntary and forced prostitution.
- Assigning a score of Partially or Yes depends on the frequency and duration of prostitution. If a woman has worked as a prostitute only once or for a short period of time and no clear pattern was observable it should be coded as Partially.

Case example

Lisa has presented with many problems from an early age. Since the age of 13 she engages in school truancy, drug use, and (violent) offending behavior. She completely ignores and disrespects her parents, who try to impose boundaries on her. Lisa is sexually active since age 13. Since age 18 she works as a prostitute soliciting on the street, in sex shop windows, in nightclubs, and through an escort agency. She also becomes involved in the business end of the escort agency. She is repeatedly being accused of robbing her clients. At the age of 22, Lisa catches her boyfriend in bed with another woman. She becomes furious, grabs a knife and threatens to kill the woman. Lisa physically assaults the woman and cuts off her hair. Subsequently, she forces her boyfriend's brother to rape the woman.

H12 Parenting difficulties

Definition

There is a relationship between parenting difficulties and: 1) violence towards a child or children⁶; 2) violence towards an intimate partner; and 3) general criminal behavior. First, research has demonstrated that parents who abuse their children more often have inadequate parenting skills (see De Ruiter & De Jong, 2005; De Ruiter et al., in preparation). Motz (2001) suggests that women's own experiences of abuse and neglect may evoke negative feelings, which can lead to strong emotions and ultimately to the abuse of their own children. Second, an exploratory study on the relationship between parenting and domestic violence showed that women see parenting stress as a justification for violence to their partner, especially if they have low feelings of effectiveness in their parenting role and if they feel that the needs and demands of their children dominate their lives (Simmons et al., 2010). Third, a longitudinal study by Messer and colleagues (2004) demonstrated a strong link between parenting difficulties and general criminal behavior. An important factor here is that bringing up children can be very stressful, especially for a mother who is alone and has no partner to support her (Van Voorhis et al., 2010).

Indicators

- Structural neglect of children
- Physical abuse of children
- Emotional abuse of children
- Sexual abuse of children
- Failed to intervene in child abuse by the partner
- Intervention by professionals was required, e.g., Youth Bureau, Council of Child Care and Protection Board and other aid agencies
- Outplacement or custodial control of children
- Transfer of parental authority

⁶ Henceforth referred to as children, for reasons of readability.

Coding notes

- This item deals with problems with raising / taking care of children. Raising non-biological children (e.g., children of a spouse or adopted children) is also included in this item.
- When coding this item it is important to examine whether intervention by professionals was required. Contacts with Youth Bureau, Council of Child Care and Protection Board and other aid agencies are an indication of parenting difficulties. The outplacement or custodial control of children and transfer of parental authority indicate serious parenting difficulties.
- Whether to assign a code of Partially or Yes depends on the nature, severity and duration of the parenting difficulties.
- If a woman never had (foster / step) children and thus has never adopted a parenting role, the item is not applicable and the box n.a. should be checked.⁷

Case example

Sasha is a 33-year-old woman who was sentenced to a tbs-order following the manslaughter of her 2-year-old son. As a child, Sasha is severely neglected and abused by her mother. Since becoming a mother herself, she shows the exact same behavior towards her children. The authorities remove her two children from the home as a result of the severe abuse and neglect they are suffering at the hands of their mother. A few years later, Sasha has two children with another man. She is not able to take care of the oldest boy and neglects and abuses him severely. The boy eventually dies as a result of physical abuse combined with malnutrition.

⁷ The reason that this item includes an n.a. option is that it distinguishes between a lack of parenting *opportunities* (scored n.a) and an absence of parenting *problems* (score of 0).

H13 Pregnancy at young age

Definition

Results of a longitudinal study by Messer and colleagues (2004) suggest a strong association between teenage pregnancy (before the age of 20) and criminal behavior. Becoming a mother at a young age may hinder a woman's own development and can lead to several negative consequences in the area of finances, education and social / intimate relationships (see also Serbin et al., 1998). Furthermore, if a mother loses her child after birth, for example, to adoption, this may have a strong emotional impact and possibly become a risk factor for violence (Motz, 2001).

Indicators

- Was pregnant before the age of 20
- Pregnancy before age 20 had a strong impact on life
- Pregnancy before age 20 had physical, psychological, social or financial consequences
- Was not able to finish her education because of pregnancy before the age of 20
- Pregnancy before age 20 resulted in serious problems in intimate relationship
- Pregnancy before age 20 caused severe stress
- Had an abortion before the age of 20 and this had strong negative impact
- Had a miscarriage before the age of 20 and this had strong negative impact

Coding notes

- This item deals with negative consequences of a pregnancy before the age of 20.
- When coding this item, the evaluator should also consider whether the woman has had an abortion or miscarriage, if she has had to give her child up for adoption, and whether it appears that such events have had a significant impact on her. Depending on the frequency and impact this will lead to a score of Partially or Yes.

Case example

At age 16, Lily unexpectedly becomes pregnant. Lily is seriously addicted to drugs and fails to stop using drugs during her pregnancy. Eventually, her daughter is born very preterm. The child is taken away almost immediately from Lily and placed within a foster family. Since then things have gone further downhill for Lily; she has many unstable relationships, often commits property and violent offenses and is regularly admitted to psychiatric institutions. At age 24, Lily is convicted to compulsory treatment because of robbery. In the hospital, Lily is diagnosed with schizophrenia in addition to personality disorder traits and substance use problems. Lily suffers from delusions and hallucinations that frighten her very much, for example, the delusion that she is pregnant and that she feels a child moving in her belly. This calls forth painful memories of her pregnancy and the surrendering of her daughter.

H14 Suicidality / self-harm

Definition

Both interviews with mental health professionals and past research have identified a relationship between self-harm or a history of suicidality and violent behavior towards others in women (Blanchette & Brown, 2006; Blanchette & Motiuk, 1995; Morgan & Patton, 2002; Völlm & Dolan, 2009; Weizmann-Henelius et al., 2004). A relationship was also found between suicidal thoughts and general criminal behavior in women (Benda, 2005; Wilkins & Coid, 1991). In forensic psychiatry and in prison, self-harm and suicide attempts are more common in women than in men (Belknap & Holsinger, 2006; Coid et al., 2000; Motz, 2001; Nicholls, 2001). A possible explanation is that self-harm is more common in disorders like depression and borderline personality disorder - disorders that generally occur more frequently in female forensic psychiatric patients than in male forensic psychiatric patients (Coid et al., 2000; Coid, Wilkins, Coid, & Everitt, 1992). Motz (2001) argues that aggression directed towards the self is a typical form of anger expression in females. Mental health professionals recognize this in daily practice; men tend to turn their aggression outward (externalizing), and women inward (internalizing). According to mental health professionals, suicidal behavior and self-harm evidence the presence of despair and frustration. When a woman exhibits destructive behavior to herself, this may turn into aggression directed against others or others' property. Mental health professionals further indicate that suicide may be the motive behind some offenses, like arson or infanticide (see also Wilson & Daly, 1988). The term suicidality is defined as encompassing a range of thoughts and behaviors involving deliberate attempts to injure or inflict death upon oneself (see Russell & Martson, 2010).

Indicators

- Serious self-harm (e.g., skin scratching or cutting, scraping, burning, banging head against walls, taking large amounts of toxic drugs or medication)
- Had a serious wish to end her own life
- Suicide attempts
- Suicidal thoughts or plans
- Had taken serious preparations for suicide

Coding notes

- In determining the severity, the evaluator should take into account the nature, severity and frequency of suicidal behavior / self-harm and the physical and / or psychological consequences.

Case example

Mary grows up in a strictly religious family. She is close with her father, but has a bad relationship with her mother who often hits her. When Mary is 9 years old, she is sexually abused by a family friend over the period of a couple of months. She tells her mother about the abuse but her mother blames Mary and tells her that she is dirty and evil. From that moment on, Mary begins to hurt herself, for example by cutting herself with sharp objects. She leaves home when she is 15 years old but is not capable of setting up a stable life or fostering interpersonal relationships. After she has been raped by an acquaintance, she carries out her first suicide attempt. Numerous suicide attempts follow, mostly using medication or drugs. Mary is often admitted to psychiatric hospitals, but treatment does not seem to work. Mary often behaves very aggressively towards nursing staff and she destroys things or commits arson to channel her anger. Eventually, she is sentenced to compulsory treatment after setting a fire in her room in a psychiatric hospital posing great danger to others.



Clinical items

For coding the Clinical items the evaluator should mainly focus on observable behavior during the **past 6 months and up until the moment of the assessment**. In the FAM, two new Clinical risk factors for women were incorporated (C6 and C7). For coding the original HCR-20^{V3} Clinical items, the evaluator is referred to the HCR-20^{V3} manual (Douglas et al., 2013).

In coding the HCR-20^{V3} Clinical items the evaluator should be cognizant of the fact that as a result of sex differences in socialization processes women are more sensitive and aware of their social environment than men, and thus are adept at determining what is socially desirable (Bennett, Farrington, & Huesmann, 2005). Therefore, it might be easier to overrate women’s self-insight and motivation for treatment compared than it is for men. Furthermore, it is often assumed that women have better verbal skills compared to men, although strong empirical evidence for this assumption is lacking (Wallentin, 2009).

Table 4. Clinical items of the HCR-20^{V3} and the FAM

| Clinical items | |
|----------------|--|
| C1 | Insight <ul style="list-style-type: none"> a. Mental disorder b. Violence risk c. Need for treatment |
| C2 | Violent ideation or intent |
| C3 | Symptoms of major mental disorder <ul style="list-style-type: none"> a. Psychotic disorder b. Major mood disorder c. Other major mental disorders |
| C4 | Instability <ul style="list-style-type: none"> a. Affective b. Behavioral c. Cognitive |
| C5 | Treatment or supervision response <ul style="list-style-type: none"> a. Compliance b. Responsiveness |
| | <i>Specific risk factors for women</i> |
| | C6 Covert / manipulative behavior |
| | C7 Low self-esteem |

Note. The HCR-20^{V3} items are reproduced with permission from the authors (see Douglas et al., 2013).

C6 Covert / manipulative behavior

Definition

Though direct empirical evidence for this item's predictive validity with respect to violent behavior has yet to be established, one indication for its value comes from studies that found that women show more indirect aggression than men (see for example Archer & Cote, 2005; Crick & Grotpeter, 1995; Hess & Hagen, 2006). Indirect aggression (also called relational or social aggression or covert social manipulation) is defined as a deliberate attempt to hurt another person through social relationships or by affecting others' social status, such as by gossiping or excluding others. Several studies found significantly more indirect aggression in girls than in boys (Brownie, 2007; Österman et al., 1998). There is less research into indirect aggression in adult women and the research results so far are less consistent than for girls. In a Dutch study into sex differences in forensic patients, it was found that women report significantly more indirect aggression on the *Buss-Durkee Hostility Index-Dutch* (BDHI-D) than men (Graat et al., 2011). Further, there may be a link between indirect aggression in women and a high Factor 1 score on the PCL-R (Isoma & Guyton, 2011). Importantly, however, the fact that, in general, women exhibit more indirect aggression than men does not necessarily imply that it is a predictor for future / direct violence. Mental health professionals have frequently mentioned covert behavior as a potential risk factor for violence (in particular the incitement of violence or other kinds of antisocial behavior) and as an important target for treatment. Female patients are seen as more adept at manipulating their environment than men, and often seem to play a less conspicuous role in violent incidents or disruptive behavior by others. Such practices do not necessarily lead to violence, but may lead to conflicts and problems. A specific form of manipulative behavior that is seen by mental health professionals as a strong risk factor for (inciting) violence is manipulative sexual behavior. Sexuality may have different functions for women and they may use their sexuality as leverage to have others do things for them. This is found relatively often in women with a high degree of psychopathy (Forouzan & Cooke, 2005). The deployment of sexuality to manipulate others (usually men) may also increase the chance of inciting others to engage in violent behavior. Finally, manipulative sexual behavior increases the risk for victimization, for example, when the other person realizes that he or she is being used.

Indicators

- Covert / manipulative behavior
- Gossiping
- Lying about having an intimate relationship
- Deceiving behavior
- Letting others do the dirty work for her
- Playing people against each other
- Unclear or subtle involvement in violent or disruptive incidents that take place in her social environment
- Using somatic complaints to avoid treatment programs
- The intentional use of sexuality for personal gain

Coding notes

- Covert behavior within an institution can be identified by observing how a woman moves within her social environment, for example the living-group in which she resides, by evaluating the extent of her influence over the group and by noting her involvement in violent or disruptive incidents that take place in her social environment.
- Covert and manipulative behavior may be symptoms of certain disorders such as psychopathy or borderline personality disorder, which are already scored with the Historical item *Personality disorder*. The current item, however, is dynamic; it pertains to behavior in the past six months and should be scored if present, even if it was already included in the Historical factors.
- To determine what score should be assigned, the evaluator should focus on concrete behavior during the past six months and also take into account the nature and severity of this behavior.

Case example:

Grace is a 46-year-old woman who has repeatedly been convicted of fraud, embezzlement and forgery. A few times she has engaged in (verbal) threatening behavior. She will readily deceive friends, acquaintances, and strangers alike. Grace commonly will engage in a behavioral pattern whereby she starts a relationship with a man, steals large sums of money from him and then disappears. Eventually, she is sentenced to compulsory treatment with a maximum duration of two years. In the forensic psychiatric hospital, Grace shows a pattern of covert and manipulative behavior: she frequently gossips and causes all kinds of misunderstandings and problems. She is involved in sale of mobile phones and facilitates secret relationships in the hospital by putting her room up for rent. Furthermore, she plays supervisors against each other. She asks other patients with leave privileges to bring her things and she borrows money from other patients or from the group budget, which she does not repay. Grace follows her treatment program irregularly and frequently claims to be ill. The treatment staff has the strong suspicion that she expresses her somatic complaints to avoid treatment and obligations.

C7 Low self-esteem

Definition

In a meta-analysis, an association was found between women's low self-esteem and antisocial and violent behavior towards others, especially to vulnerable others such as children (Larivière, 1999). In a study of criminal careers of girls in the Netherlands, it was demonstrated that almost all girls who had committed crimes had low self-esteem. Further, all girls with extremely low self-esteem had problems relating to regulation of aggression (Wong, Slotboom, & Bijleveld, 2010). Having low self-esteem was also associated with other risk factors. It has also been shown that women who have been abused in the past tend to have low self-esteem (Salisbury et al., 2009) and that low self-esteem is associated with an increased tendency to abuse substances (Hubbard & Matthews, 2008). Mental health professionals indicate that women's negative beliefs about themselves resulting from low self-esteem may be acted out through violent behavior both directed towards others and towards themselves.

Indicators

- Serious signs of low self-esteem
- Has negative attitudes about herself
- Has negative cognitions about herself
- Has negative feelings about herself
- Is devaluing herself
- Is making disparaging statements about herself
- Beliefs she is worthless
- Has feelings of hopelessness
- Feels she has nothing to lose

Coding notes

- In coding this item the evaluator must consider how this low self-esteem may, in a given case, increase the risk of the woman acting out violently; for example, feelings of hopelessness or having nothing to lose may facilitate violence towards others and / or themselves.
- To determine what score should be assigned, the evaluator should look at concrete behaviors in the past six months.

Case example

Chloe is a 30-year-old woman. As a child, she is belittled by her father and she grows up as an extremely insecure and timid girl. From an early age Chloe lies about many things, including telling others that she has serious diseases that she in fact does not have. Her motivation for doing so is to garner positive attention from parents and peers. The lying is pathological in nature and Chloe becomes increasingly entrenched in her own lies. To control her feelings of stress, Chloe begins to set fires that pose danger to both person and property. She is sentenced to compulsory treatment with a maximum duration of 2 years. In the hospital, Chloe is seen as a very insecure woman who has difficulties establishing her boundaries. This makes her vulnerable to abuse by others, but at the same time, she is manipulative and she constantly lies to both staff and fellow patients. Consequently, others do not take her seriously, do not respect her and ultimately reject her. In addition, she pushes others away with her lack of self-care and bad personal hygiene. This all leads to an accumulation of frustration and she shows destructive behavior, both to herself (self-harm) and to others in the hospital (arson, sabotage, indirect aggression).



Risk management items

For coding the Risk management items, the evaluator should make a prediction about the woman's risk for engaging in certain behaviors in the near future: **within the 12 months after the risk assessment**. It may be useful to code the Risk management items for different contexts in order to compare and decide upon the needed future intervention or aftercare, for example, continued sheltered living versus (conditional) discharge from a forensic psychiatric hospital. In forensic cases that appear in court, the double codings may be helpful for the evaluator to explain and justify their risk assessment to the court. In the FAM, two new Risk management risk factors for women were incorporated (R6 and R7). For coding the original HCR-20^{V3} Risk management items, the evaluator is referred to the HCR-20^{V3} manual (Douglas et al., 2013).

Table 5. Risk management items of the HCR-20^{V3} and the FAM

| Risk management items | |
|--|---|
| R1 | Professional services and plans |
| R2 | Living situation |
| R3 | Personal support |
| R4 | Treatment or supervision response a. Compliance b. Responsiveness |
| R5 | Stress or coping |
| <i>Specific risk factors for women</i> | |
| R6 | Problematic child care responsibility |
| R7 | Problematic intimate relationship |

Note. The HCR-20^{V3} items are reproduced with permission from the authors (see Douglas et al., 2013).

R6 Problematic child care responsibility

Definition

This item is concerned with two issues: 1) the heavy burden and responsibility of taking care of an underage child or children⁸; 2) the anger, frustration and sorrow that can result from the loss of contact or limited contact with children. First, raising children requires skills and entails many responsibilities that may be too difficult for women with severe problems or psychopathology.⁹ Research has demonstrated that women who have responsibility to children recidivate more often, especially in combination with poverty, limited social support and substance use problems (Greene, Haney, & Hurtado, 2000; Van Voorhis et al., 2008). Furthermore, the literature shows that when a woman has previously neglected or abused her children, having child care responsibility increases the risk for future violence towards both her own and other children who are under her care. (Motz, 2001; De Ruiter & De Jong, 2005; De Ruiter et al., in preparation). Second, it was found that women who have limited contact with their children because of detention or admission to an institution have elevated levels of stress and more psychological problems (Van Voorhis et al., 2010). If there is a threat that the woman will lose her children, for example, by transfer of parental authority this can often lead to intense feelings of anger and sorrow (Batchelor, 2005; Van Voorhis et al., 2008).

Mental health professionals recognize that problems may arise if women experience feelings of failure and disappointment stemming from an inability to help their children when their absence is as a result of the woman's detention or psychiatric admission. Further, unrealistic expectations about the frequency and intensity of contact with or care of her children may lead to feelings of anger and frustration directed towards the foster family or those who question her parenting skills, which may ultimately increase her risk of behaving violently.

Indicators

- There is a probability of problematic child care responsibility
- Feels frustrated, guilty or angry by not being able to take care of her children
- Is not willing to accept guidance in how to raise her children
- Will probably not regain custody of her underage children and feels frustrated by that
- Is not equipped to raise children

⁸ Henceforth referred to as children, for reasons of readability.

⁹ Having children may also have a protective effect (see p. 24. See also the SAPROF item *Life goals*).

Coding notes

- Child care responsibility does not only concern a woman's own children, but also, for instance, the children of a partner.
- Score assignment is based on the expected severity of problems the woman will face in caring for children.
- This item may seem to overlap with the Historical item *Parenting difficulties*. However, the present item is dynamic and has a broader scope. This item not only concerns parenting skills, but also problems in relation to desired child care responsibility, such as the consequences of not being able to raise or help children due to detention or hospital admission.
- This item refers predominantly to the (desired) care for underage children, but may also concern (young) adult children, for example, when there are specific circumstances in their life, such as serious psychological problems, illness or disability. These circumstances or problems may affect the woman, for example, cause a lot of worries and feelings of stress.
- If it is not likely that there will be a (desired) child care responsibility the item should be scored No.

Case example

Fatima grows up in affective neglectful conditions. She is almost totally incapable of bonding with others and has a lot of problems in intimate relationships and with social contacts. At age 30, she begins a relationship with a man with whom she has three children. However, her partner ends the relationship a year after the birth of their youngest child. Fatima is devastated, abandons her children and starts to live on the street. She begins to accrue debt and fails to honor visitation arrangements with her children who are living with her ex-husband's family. Fatima threatens to abduct the children and to hurt her ex-partner and his family. After a restraining order has been imposed on Fatima, she continues to make threats to her ex-husband, his family, and her children. Finally, she is sentenced to compulsory treatment in a forensic psychiatric hospital because of stalking. At the beginning of treatment the children visit Fatima. However, as it becomes clear that this is too heavy a burden for both Fatima and the children, the hospital together with the guardian decides to stop the visits. Fatima is very upset and initiates a lawsuit seeking the custody of her children. Though this certainly increases her stress, treatment staff believes that the lawsuit also serves as an excuse for Fatima to avoid treatment.

R7 Problematic intimate relationship

Definition

Women who exhibit violent behavior are more likely to have antisocial, violent and / or addicted partners than women who have not committed violent offenses (Leverentz, 2006; Weizmann-Henelius et al. 2004). Living together with an antisocial partner, having a marriage of poor quality, and lacking the support of the partner are strongly related to criminal behavior (Benda, 2005; Farrington, Barnes, & Lambert, 1996; Messer et al., 2004; Van Voorhis et al., 2010). The relationship between having a problematic intimate relationship and criminal behavior applies to both women and men, but the correlation is stronger for women (Benda, 2005). Women who have been sexually abused often seem to repeatedly become involved with the same type of partner (McCartan & Gunnison, 2010). They are more likely to continue the relationship with a problematic partner or to start a relationship with similar types of abusive partners.

Mental health professionals indicate that a problematic intimate relationship may lead to risk for future violence in several ways. First, in a problematic relationship characterized by violence and conflicts, the partner is a potential victim (see also p. 18). Second, many women commit offenses together with their partner as an antisocial partner may involve the woman in the commission of his crimes.

Indicators

- High probability of problematic (future) intimate relationship
- Likely (financially) dependent on partner
- Cannot bear to not be in a relationship
- Is inclined to flee in unstable relationships
- Unstable relationships characterized by many conflicts are anticipated
- Relationships are anticipated in which there is oppression or abuse
- Relationships with antisocial partners are anticipated

Coding notes

- This item applies to an existing or anticipated intimate relationship in which major problems are seen or expected.
- This item may be seen to overlap with the Historical item *Relationships* as both items involve (a pattern) of instability and problems in intimate relationships. The distinction is that the current item focuses on the future. This includes the expectation that a woman will maintain a problematic relationship or

will begin a new problematic relationship. A high score on the Historical item *Relationships* does not necessarily mean that a woman will also score highly on the current item, but the chances of this are considerably larger.

- Relationships in which there is a strong fusion or dependency are susceptible to the risk of joint offending. This includes not only actually committing offenses, but also being accessory to or inciting someone else to commit an offense.

Case example

Kimberly is a 27-year-old woman who, together with her boyfriend killed her uncle when she was 16. Kimberly suffers from a severe borderline personality disorder and she has been treated for a long time in a forensic psychiatric hospital. Despite her motivation and commitment to the treatment she does not manage to direct her own life. She is very vulnerable, is easily influenced by others, and is unable to establish boundaries. Kimberly has had many relationships within the hospital, with both men and women. These relationships seem to destabilize her every time. Her present relationship is with a man with severe addiction problems who frequently relapses into alcohol consumption. As alcohol is a risk factor for Kimberly herself, she finds it difficult to cope with his problems; she is angry with her boyfriend, but at the same time she craves alcohol. Also, she has a strong fear of losing her boyfriend, which causes her to be overly responsive to his dubious requests. For example, together they are involved in drug dealing within the hospital. Kimberly acknowledges the problems the relationship poses for her, but she also admits that she cannot live without her partner.



Coding scheme FAM

Additional guidelines to the HCR-20^{v3} for women

Identifying facts

- ① Gather information
- ② Presence of risk factors

Use both manuals for coding the items of the HCR-20^{v3} (HCR-20^{v3} items H7-H8 with the additional guidelines in the FAM) and the items of the FAM.



Making meaning

- ③ Relevance
- ④ Formulation
- ⑤ Scenarios



Taking action

- ⑥ Management
- ⑦ Final opinions

Make the three additional risk ratings:

- *Self-destructive behavior (e.g., self-harm, suicide attempt)*
- *Victimization (e.g., victim of domestic violence)*
- *Non-violent criminal behavior (e.g., property offenses, fraud)*

Note. For more detailed instructions see Coding procedure (p. 35). Further, it is advised to also examine protective factors, for example, with the SAPROF.

Coding sheet Female Additional Manual (FAM)

Additional guidelines to the HCR-20^{v3} for women

| | |
|--------------|------------------------------------|
| Name: | Date: |
| Age: | Context of risk assessment: |

| Historical items | Code | Relevance |
|------------------|---|-----------|
| H7 | Personality disorder: <i>additional guidelines to the HCR-20^{v3}</i> | |
| | a) Antisocial, psychopathic, and dissocial (lower PCL-R cut off scores for women) | |
| | b) Other personality disorder: | |
| | 1. Cluster B (except antisocial/psychopathic) or traits of suspiciousness | |
| | 2. Other personality disorder | |
| H8 | Traumatic experiences: <i>additional guidelines to the HCR-20^{v3}</i> | |
| | a) Victimization / trauma | |
| | 1. During childhood | |
| | 2. After childhood | |
| | b) Adverse childrearing experiences (original HCR-20 ^{v3} coding guidelines) | |
| H11 | Prostitution | |
| H12 | Parenting difficulties <input type="checkbox"/> n.a. | |
| H13 | Pregnancy at young age | |
| H14 | Suicidal behavior / self-harm | |

| Clinical items | Code | Relevance |
|----------------|--------------------------------|-----------|
| C6 | Covert / manipulative behavior | |
| C7 | Low self-esteem | |

| Risk management items | Code | Relevance |
|-----------------------|---------------------------------------|-----------|
| R6 | Problematic child care responsibility | |
| R7 | Problematic intimate relationship | |

| Other considerations |
|----------------------|
| |

| Final risk ratings near future (12 months) | | |
|---|---|---|
| Final risk ratings violence to others | | |
| Future violence | Serious physical harm | Imminent violence |
| <input type="checkbox"/> Low <input type="checkbox"/> Low - Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate - High <input type="checkbox"/> High | <input type="checkbox"/> Low <input type="checkbox"/> Low - Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate - High <input type="checkbox"/> High | <input type="checkbox"/> Low <input type="checkbox"/> Low - Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate - High <input type="checkbox"/> High |
| Extra risk ratings | | |
| Self-destructive behavior | Victimization | Non-violent criminal behavior |
| <input type="checkbox"/> Low <input type="checkbox"/> Low - Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate - High <input type="checkbox"/> High | <input type="checkbox"/> Low <input type="checkbox"/> Low - Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate - High <input type="checkbox"/> High | <input type="checkbox"/> Low <input type="checkbox"/> Low - Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate - High <input type="checkbox"/> High |
| Optional: Final judgment protective factors (assessed with the SAPROF) | | <input type="checkbox"/> Low <input type="checkbox"/> Low - Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate - High <input type="checkbox"/> High |

| | |
|----------------------|-------------------------------|
| Evaluator(s): | Position evaluator(s): |
|----------------------|-------------------------------|

Relevance: Yes/Partially/No; relevance of each item for the current risk for violent behavior.
 The original HCR-20^{V3} items need to be coded with the HCR-20^{V3} manual (Douglas et al., 2013).



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Appendix 2: Specific risk factors for women in the FAM in addition to the HCR-20^{V3}

| FAM items | Brief description | Literature |
|-----------------------------------|--|---|
| Historical items | | |
| H11 Prostitution | Has worked as a prostitute for a substantial period of time. Often maladaptive living circumstances / life style of a prostitute are seen as risk factor. Moreover, the vulnerability of a woman forced into prostitution makes her also vulnerable to be dragged into offenses. | Morgan & Patton, 2002 |
| H12 Parenting difficulties | Serious parenting difficulties, for instance, abuse or emotional neglect of children. Information is needed from official institutions like the Child Welfare Council. | Messer et al., 2004; Motz, 2001; Salisbury, 2007; Simmons et al., 2010; Van Voorhis et al., 2010 |
| H13 Pregnancy at young age | Serious impact of pregnancy at young age (before the age of 20). Abortions or miscarriages can also be included. | Messer et al., 2004; Serbin et al., 1998 |
| H14 Suicidality / self-harm | Serious and / or repeated suicide attempt(s) and / or self-harm. As level of suicidality increases, so does the frequency of externalizing violence. Suicide is also seen as motive for some violent offenses like filicide and arson. | Benda, 2005; Blanchette & Brown, 2006; Blanchette & Motiuk, 1995; Coid et al., 2000; Motz, 2001; Morgan & Patton, 2002; Völlm & Dolan, 2009; Weizmann-Henelius et al., 2004 |
| Clinical items | | |
| C6 Covert / manipulative behavior | Serious indications of covert or manipulative behavior. Examples of covert behavior are concealing or hiding the truth, stirring things up, gossiping, lying about relations, or blackmailing others. Examples of manipulative behavior are utilizing her sexuality in order to obtain power or other gains or utilizing somatic complaints in order to avoid treatment program. | No direct empirical evidence |

| FAM items | Brief description | Literature |
|--|--|---|
| C7 Low self-esteem | Negative beliefs and emotions about her own worth that may result in feelings of despair, hopelessness, having nothing to lose and consequently acting violently towards others and / or herself. | Larivière, 1999; Van Voorhis et al., 2008; Wong et al., 2010 |
| Risk management items | | |
| R6 Problematic child care responsibility | Serious problems because of the (desired) care for children. Raising children might be too stressful considering the woman's own problems / pathology. Also, grief over the loss of child(ren) through termination of parental rights, anger towards others for questioning her skills and / or taking away her parental rights. | Greene et al., 2000; Van Voorhis et al., 2010 |
| R7 Problematic intimate relationship | Problematic (anticipated) intimate relationship, e.g., living with a criminal partner, intimate partner violence. | Benda, 2005; Leverentz, 2006; Messer et al., 2004; Van Voorhis et al., 2010; Weizmann-Henelius et al., 2004 |



While women still represent a minority of the forensic psychiatric and prison population, worldwide the number of women committing violent crimes has increased steadily over the past two decades. Several risk factors for violent behavior in women differ substantially from those in men. Mental health professionals have recognized these differences and have expressed the need for more specific guidelines for risk assessment in women. Assessment of gender-sensitive risk factors in addition to general risk factors is vital for accurate assessment and management of women's violence risk. Despite the great advances in risk assessment over the past decades, very few tools have been developed specifically for the assessment of violence risk in females.

The first *Female Additional Manual (FAM)* was published in 2012 as an additional manual to the HCR-20. The present FAM is entirely adapted to be used with the new HCR-20^{V3} and contains additional guidelines to two historical items of the HCR-20^{V3} and eight new items with specific relevance to women. The aim of the FAM is to provide mental health professionals with a comprehensive violence risk assessment that offers additional guidelines for risk management in women.

