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**Child Custody Evaluations: Ethical, Scientific, and Practice Considerations**

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**Abstract**

Child custody evaluations are among the most difficult of forensic evaluations. The current paper examines differences between custody evaluations and other types of psychological and forensic evaluations. We also discuss important ethical issues regarding these evaluations and review the typical components of a custody evaluation, with particular attention on psychological testing as a component of custody evaluations. We then discuss the role of research in informing the interpretation of the evaluation data and provide a complete sample custody evaluation report to illustrate several points from the manuscript.

**Author Notes**

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Child Custody Evaluations: Ethical, Scientific, and Practice Considerations

Some have argued that child custody evaluations are the most difficult of forensic psychological evaluations to complete (Otto, 2000; Otto, Edens, & Barcus, 2000), in part because of the multifaceted nature of what the evaluations entail and the high pressured nature surrounding contested custody disputes. Indeed, unlike most forensic psychological evaluations that involve the assessment of one individual for a particular circumscribed legal issue (e.g., competency to stand trial, criminal responsibility), child custody evaluations are very time consuming and involve interviews with numerous parties (e.g., parents, children, potential stepparents, grandparents) regarding a variety of issues above and beyond psychological functioning, such as parenting ability, geographical consideration of the parents’ homes and schools, and parental legal and health status. Moreover, the parties in these cases are often highly emotional and invested in obtaining their particular desired outcome, which can impact their interactions with the forensic evaluator and create potentially heated situations.

The practice of child custody evaluations is a complex, difficult, and challenging process that has been subject to substantial controversy and criticism, in part due to a perception that forensic evaluators base their opinions regarding custody issues on less than sound scientific assessment techniques (Emery, 2005; Emery, Otto, & Donohue, 2005; Erikson, Lilienfeld, Vitacco, 2007; Otto, Edens et al., 2000). The purpose of the current paper is to provide a broad context to understand custody evaluations in terms of how these evaluations differ from other types of psychological and forensic evaluations, important ethical issues regarding these evaluations, typical components of a custody evaluation, psychological testing as a component of custody evaluations, and finally, the role of research in informing the interpretation of the evaluation data. We also provide a complete sample custody evaluation report that is presented in the Appendix, completed by the second author, as an example to illustrate several points about custody evaluations.

Types of Evaluations

There are numerous types of psychological evaluations and the distinctions between these are often blurred and confusing. Greenberg and Shuman (1997) have noted the basic distinctions between evaluations conducted for clinical purposes and forensic evaluations. Clinical psychological evaluations typically include interviews and psychological testing performed for psychological diagnosis and treatment planning. The patient is the client and the intended user is typically the patient and/or their treatment provider (e.g., psychiatrist, psychologist, primary care physician, counselor). The goals of psychological evaluations are often to provide more accurate assessment of psychiatric diagnoses and psychological/cognitive functioning and to aid in treatment planning. Oftentimes, third-party information is only utilized in a limited manner and the release of the evaluation report is carefully restricted by laws and regulations (e.g., HIPAA). Moreover, the client’s participation is typically voluntary and results generally have no negative effects on the patient. The evaluation costs are typically covered, in part or in whole, by the patient’s health insurance or other third-party payer.

In contrast, forensic psychological evaluations, of which child custody evaluations are a subcategory, are typically requested by the court to provide information on
the psychological functioning of an examinee as it pertains to a standard or issue of law. The consumer or client in this instance is the court or an attorney, the examinee may or may not benefit from the results of the evaluation, and their participation may be involuntary. Consequently, the forensic examinee needs to understand that the results of the evaluation, typically in the form of a psychological report and occasionally in the form of courtroom testimony, is not covered under the typical therapist/patient privilege afforded in most clinical situations. Forensic psychological evaluations typically involve much more extensive record reviews than standard psychological evaluations as well as collateral interviews and consent procedures. In addition, the costs for a forensic evaluation are not typically covered by third party payer sources because they are not “medically necessary” and the purpose of the evaluation is not directly related to treatment of a mental illness.

Child custody evaluations often involve consideration of the parents’ capacity to serve as an effective and responsible caregiver for one or more children. These evaluations involve parental interviews, collateral interviews, extensive record reviews, observations of parent-child interactions, home visits, and psychological testing to provide assistance to the court in making decisions regarding custody and visitation under the criteria provided in state statute. In contrast to standard psychological evaluations, which typically focus on diagnostic issues, in child custody evaluations, psychiatric diagnoses are only important to the extent that they impact the parent’s ability to provide an environment that is in the best interests of the child. For example, a diagnosis of depression would not, in and of itself, preclude a parent from gaining or maintaining custody of his or her child. However, if the parent’s depression substantively impacted his or her ability to provide a stable and supportive environment or resulted in neglect, then it might substantially affect the evaluator’s opinion regarding custody arrangements.

Ethical Guidelines & Standards

There are several sets of codes or guidelines for a clinical psychologist conducting child custody evaluations. In 1991, a specific set of guidelines, referred to as the Specialty Guidelines for Forensic Psychologists, were developed by a task force composed of Division 41 of the American Psychological Association (APA), which is the American Psychology-Law Society, and the American Board of Forensic Psychology. These guidelines were developed in order to balance the self-interest of the individual professional in relation to those receiving services from a forensic clinician, such as those involved in a child custody evaluation. These standards were developed to ensure the appropriate use of skills, techniques, and judgment by individuals performing forensic evaluations. They are currently in the process of being revised.

The American Psychological Association released guidelines specifically pertaining to Child Custody Evaluations in 1994, which were most recently revised in 2009 (APA, 2009), as well as guidelines pertaining evaluation in child protection matters (APA, 1998). The revised versions of these guidelines are closely aligned with concepts discussed in APA’s Ethical Principles of Psychologists and Code of Conduct (“Ethics Code,” APA, 2002), which distinguishes them from earlier versions of the guidelines. Although compliance with these guidelines is not mandatory in most states, competent psychologists working in this area are advised to pay close attention to the guidelines in conducting their evaluations. Although practice
standards and legal standards are typically separate issues, several states have incorporated custody guidelines into their practice standards to form the basis of enforceable standards. Indeed, some licensure boards have included violations of various aspects of the standards as actionable offenses. These variations in the status of child custody guidelines from state to state underscore the importance of psychologists understanding child custody statutes within the state(s) in which they conduct evaluations. These custody evaluation guidelines are presented in summary form in Table 1. They provide objectives in approaching child custody evaluations (e.g., striving to maintain the child’s welfare as paramount, striving for impartiality) and discuss applications of the APA Ethics Code as they apply to these evaluations (e.g., avoiding conflicts of interest and multiple relationships). Moreover, the guidelines indicate that psychologists should employ multiple methods of data collection (e.g., clinical interviews, psychological testing, and observations). However, they do not provide guidance in regards to selecting specific evaluation methods, test instruments, or interview questions.

Practice parameters were also published by the American Academy of Child and Adolescent Psychiatry (AACAP, 1997) and provide additional guidance with regard to particular areas that need to be assessed in child custody evaluations (e.g., quality of attachment between child and parent, special needs of the child, parental finance).

The standards of practice often address problem areas, particularly for psychologists without forensic training who lack a familiarity with the basic “best interests of the child” standard. The “best interests of the child” standard was explicated in Michigan’s 1970 Child Custody Act (amended in 1993) and has been adopted by

Table 1


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<thead>
<tr>
<th>Orienting Guidelines: Purpose of the Child Custody Evaluation</th>
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<tr>
<td>1. The purpose of the evaluation is to assist in determining the psychological best interests of the child.</td>
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<td>2. The child’s welfare is paramount.</td>
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<td>3. The evaluation focuses upon parenting attributes, the child’s psychological needs, and the resulting fit.</td>
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<th>General Guidelines: Preparing for the Custody Evaluation</th>
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<tr>
<td>4. Psychologists strive to gain and maintain specialized competence.</td>
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<td>5. Psychologists strive to function as impartial evaluators.</td>
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<td>6. Psychologists strive to engage in culturally informed, nondiscriminatory evaluation practices.</td>
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<td>7. Psychologists strive to avoid conflicts of interest and multiple relationships in conducting evaluations.</td>
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<th>Procedural Guidelines: Conducting the Child Custody Evaluation</th>
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<td>8. Psychologists strive to establish the scope of the evaluations in a timely fashion, consistent with the nature of the referral question.</td>
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<td>9. Psychologists strive to obtain appropriately informed consent.</td>
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<td>10. Psychologists strive to employ multiple methods of data gathering.</td>
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<tr>
<td>11. Psychologists strive to interpret assessment data in a manner consistent with the context of the evaluation.</td>
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<td>12. Psychologists strive to complement the evaluation with the appropriate combination of examinations.</td>
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<tr>
<td>13. Psychologists strive to base their recommendations, if any, upon the psychological best interests of the child.</td>
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<tr>
<td>14. Psychologists create and maintain professional records in accordance with ethical and legal obligations.</td>
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most states and domestic relations courts as the guiding principle and legal standard utilized for determining custody arrangements (Otto, Buffington-Vollum, & Edens, 2003). Uninformed evaluators may mistakenly believe that child custody is about the best interests of the parents, or the presence or absence of psychiatric diagnoses per se. While these latter evaluators are clearly operating beyond the realm of expertise, it is unfortunately accurate to state that in our experience a substantial number of custody evaluations are undertaken by individuals without adequate training in this area of practice.

While the aspiration is that all custody evaluations will be objective and impartial, the most well intended psychologist will sooner or later encounter a case in which maintaining an objective and impartial stance is quite difficult. Some psychologists, however, misunderstand their role as that of advocating for one parent against another, or more typically serving as the child advocate. These biases often dramatically affect the outcome of their evaluations, and serve to provide inaccurate or misleading information to the courts (APA, 2009).

Psychologists and other mental health professionals are often tempted into serving in dual or conflicting roles in custody evaluations. Mental health professionals who have seen the parents in marital therapy or the children in treatment may be invited by the court or by an attorney to accept the role of an expert evaluator in a custody case. If the evaluator accepts this invitation, the resulting conflicting set of responsibilities eliminates the possibility of that psychologist serving as either an effective therapist or as a neutral and impartial custody expert, a point stressed in most standards of practice in child custody evaluations (e.g., AACAP, 1997; APA, 2009).

Psychologists lacking in specific training in the area of child custody evaluations unfortunately may also confuse forensic evaluation and clinical evaluation. Therefore, relevant medical and legal records are not reviewed, collateral interviews are not conducted, and family observations are omitted. In the worst cases, custody evaluations are sometimes conducted without evaluating both parents and the children. Custody evaluation reports are unfortunately encountered with recommendations that may be offered about custody/visitation without the evaluator’s contact with one of the parents, or with no contact with one or more of the children.

The issue of appropriate interpretation of test data and clinical findings is quite complex, particularly in forensic settings (see Archer, 2006), but at the core is the psychologist’s knowledge of the limitations of test instruments as well as the scientific limitations inherent in the combination of data to predict behavior. Almost all tests are valid for some purpose, but no psychological test is valid for all purposes. For example, some psychologists attempt to interpret the findings from the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher et al., 2001), a widely administered measure of psychopathology, or the Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, 1994, 1997), a test that was developed as a measure of psychopathology in clinical psychiatric settings, as providing meaningful evidence concerning parent’s adaptive functioning. The MCMI-III does not have a normative sample for parents (or any adults for that matter) expected to be free of major forms of psychopathology and its use with parents without histories of psychiatric treatment is subject to some controversy (e.g., Otto & Butcher, 1995). While the MMPI-2 is useful in detecting several forms of psychopathology that may in-
terfere with effective parenting, the test is not useful in identifying individuals more likely to be model parents because it generally does not measure positive adaptive functioning (Otto & Collins, 1995). Bow, Flens, Gould, and Greenhut (2006) have recently surveyed experienced psychologists concerning their uses and concerns regarding the MMPI-2 and MCMI-III in child custody evaluations. Findings revealed concerns included over-reliance on computer interpretive reports, failure to consider context specific data available for the MMPI-2 in custody populations and lack of knowledge about appropriate base rate cut-offs for the MCMI-III.

**Typical Components of a Child Custody Evaluation**

Child custody evaluations traditionally involve evaluations of all of the parties directly concerned with the care of the children under consideration (Ackerman & Ackerman, 1997; Otto et al., 2003). The evaluation process typically includes interviews, behavioral observations, and tests of intellectual and personality functioning. In addition, extensive collateral information is obtained through interviews with relevant or knowledgeable people (e.g., teachers, health care providers), medical records, court records, school records, and psychological treatment records.

Previous research has examined the most common components of custody evaluations. Ackerman and Ackerman (1997) surveyed 201 doctoral-level psychologists, the results of which are shown in Table 2. They found that clinical interviews with the parents, clinical interviews with each of the children, and observations of parent–child interactions are the most common components of these evaluations. The reason that collateral contacts and home visits are placed at the end of this list probably have to do with the expense and time required to complete these components, rather than the absolute value placed on these important activities by forensic psychologists. Ackerman and Ackerman results regarding evaluative components are generally consistent with the findings of Bow and Quinnell (2002) based on the latter’s review of 52 child custody evaluations.

Parent-child interactions in the office or home are typically a standard part of custody evaluations. These evaluations may range from informal (at one end of the spectrum) to very standardized and reliable observations such as those done by Robert Marvin and his colleagues at the Ainsworth Child-Parent Attachment Clinic at the University of Virginia, who have developed formal rating systems to evaluate the strength and attachment between child and parent (e.g., Marvin & Britner, 1999). Home

| #1 Clinical interview with parents |
| #2 Clinical interviews with children |
| #3 Parent-child observation sessions |
| #4 Psychological testing of parents |
| #5 History of child provided by parents |
| #6 Psychological testing of child |
| #7 Document evaluation/review |
| #8 Collateral contacts |
| #9 Home visits |
visits are a useful and important component of child custody evaluations and typically assess numerous variables, such as the degree to which the family home contains adequate accommodations for the children. Another variable includes the home’s availability of age-appropriate educational materials, books, and toys or recreational materials in the home. Moreover, it is important to assess the general cleanliness and safety of the residence. With regard to more specific issues, home visits can also provide evidence to the extent that each parent displays pictures of the other parent involved in the custody litigation in order to support attachment with that parent. Even when home visits occur on a scheduled basis, evaluators can sometimes encounter parents who have failed to adequately prepare for the visit and/or display attitudes and behaviors that clearly pose significant problems regarding parenting effectiveness.

Extensive record reviews are also a typical part of custody evaluations. These reviews typically involve acquiring academic records, particularly if the child is having performance or conduct issues in the educational setting. Police records and prior court records should also be reviewed, and psychiatric and medical treatment records for all of the major parties involved in the custody evaluation as permitted under state statutes related to custody evaluation. Among the materials that may be less useful are e-mails, often offered by one or both parents as demonstrations of the unreasonableness or communication difficulties manifested by the other parent. Since the e-mails may be altered prior to being presented to the evaluator, or the series of emails may be edited by one or both parents, unprotected electronic materials are not very reliable sources of data in most cases.

No matter how detailed or obsessive the evaluator, however, there will always be potentially relevant and important individuals who are not interviewed in the custody evaluation, or collateral records that are not reviewed. Pragmatic issues related to the expense of the evaluation, as well as avoidance of data redundancy, ensure that not all sources can be considered in any custody evaluation. However, the crucial question is the extent to which the evaluator did a reasonable and balanced job of collecting data for their evaluation. Evaluator bias might be demonstrated in several ways, such as spending substantially more time with one parent than the other, or interpreting data using a different standard for each parent.

Psychological testing is an area of unique contribution by psychologists in child custody evaluations. The major categories likely to be found are Self-Report or Objective Inventories of personality and psychopathology (e.g., MMPI-2, Personality Assessment Inventory [PAI, Morey 1991/2007], and MCMI-III), standardized intelligence tests on occasions when the child’s behavior or academic performance indicates a need to address this issue, and parent rating scales such as the Child Behavior Checklist (Achenbach, 1991) or Parenting Stress Index (Abidin, 1995). The psychological testing component of a custody evaluation may typically involve several hours for each participant (Ackerman & Ackerman, 1997).

Many clinicians will interview children as young as three years of age, but usually do not ask about parental preference with younger children (Ackerman, 2006). Each expert has a different method of conducting behavioral observations. Some favor observations of structured activities such as homework, whereas others prefer structured observation of play activities. Moreover, some clinicians favor surprise home visits, whereas others always utilize scheduled home visits.
Ackerman and Ackerman (1997) estimated that an average total of 26.4 hours are spent by psychologists in conducting custody evaluations. Outside of report writing, the largest components of time are spent conducting psychological testing and clinical interviews of the parents. Table 3 highlights Ackerman and Ackerman’s findings regarding the average breakdown of time spent on the various aspects of custody evaluations. Many professionals who perform custody evaluations have suggested that these time estimates appear to be substantial underestimates. It would not be unusual for testing to occupy a total of 10 to 12 hours for both parents and children. Many psychologists would probably concur with the experience of the authors that the total hours now required to do a comprehensive custody evaluation is somewhere in the upper twenties to as high as 40 hours per case.

**Psychological Testing as a Component of Custody Evaluations**

One of the most important aspects of psychological test results in custody evaluations is that these findings provide another perspective or viewpoint that can be compared with the perspectives derived about the examinee from other methodologies (e.g., clinical interviews) and is consistent with the 2009 APA guidelines for practicing in this area. In addition to assessing various psychiatric symptoms, behavioral proclivities, and personality characteristics, psychological testing can be used to formulate hypotheses about those involved in custody cases, which can be explored further and corroborated with clinical interview and records. In most cases, psychological tests incorporate normative samples and thus provide the clinician with a nomothetic orientation from which normative comparisons can be derived. For example, tests like the MMPI-2/MMPI-2-RF/MMPI-A or PAI can provide a quantitative appraisal of various psychological symptoms via the use of t-scores. Certainly, consistency among the various types of data collected in a child custody evaluation can raise the evaluator’s confidence in their overall opinion. However, the psychologist never knows in advance if one of these sources of information will be the more important at the onset of a case, and often the final conclusion is dependent upon the integration of data from all sources in roughly equal proportion.

Several national surveys have examined the extent...
to which psychologists utilize psychological testing in custody evaluations. Ackerman & Ackerman (1997) conducted a survey of doctoral level psychologists that rapidly became the standard in the field and covered many areas of custody evaluation practices. Bow & Quinnell (2001) also surveyed 198 psychologists nationally and evaluated test utilization issues. Table 4 shows the most frequently reported test instruments used in custody evaluations in these two surveys.

There have been several other surveys, including a recent one by the first author (RPA) and colleagues at Eastern Virginia Medical School, with very similar findings. Archer, Buffington-Vollum, Stredny, and Handel (2006) conducted an Internet survey with members of Division 41 of the American Psychological Association and/or diplomates of the American Board of Forensic Psychology. 152 individuals responded, with an average of 17 years of post-doctoral experience and 80% of them identified themselves as forensic psychologists. The respondents were asked to report their test use within broad categories including custody evaluations. The MMPI-2 was used nearly twice as frequently as the PAI, a relatively recent self-report personality measure developed by Morey (1991, 2007). The MCMI-III was used with a frequency that was roughly equivalent to the PAI, with a significant drop-off occurring for all remaining objective personality tests.

Some discussion is warranted concerning overwhelming popularity of the MMPI-2 in custody evaluations. The MMPI-2 is the most widely used measure of psychopathology in custody evaluations, followed by the Wechsler Intelligence Scales, with the MCMI and the Rorschach used in somewhat less than half of all custody evaluations.

The MMPI-2 has now been translated into over 40 languages and has an international database of empirical support. It has the most extensive data of any personality measure with American ethnic groups (Graham, 2006).

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<tr>
<td>MMPI-2</td>
<td>92%</td>
<td>94%</td>
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<tr>
<td>WAIS</td>
<td>43%</td>
<td>47%</td>
</tr>
<tr>
<td>MCMI</td>
<td>34%</td>
<td>52%</td>
</tr>
<tr>
<td>Rorschach</td>
<td>48%</td>
<td>44%</td>
</tr>
<tr>
<td>TAT</td>
<td>29%</td>
<td>24%</td>
</tr>
<tr>
<td>MMPI-A</td>
<td>43%</td>
<td>20%</td>
</tr>
<tr>
<td>CBCL</td>
<td>31%</td>
<td>4%</td>
</tr>
<tr>
<td>Family/Kinetic Drawing</td>
<td>45%</td>
<td>18%</td>
</tr>
<tr>
<td>PCRI</td>
<td>44%</td>
<td>11%</td>
</tr>
<tr>
<td>PSI</td>
<td>41%</td>
<td>9%</td>
</tr>
<tr>
<td>ASPECT</td>
<td>16%</td>
<td>11%</td>
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Note. * A & A = Ackerman & Ackerman (1997); B & Q = Bow & Quinnell (2001). MMPI = Minnesota Multiphasic Personality Inventory. WAIS = Wechsler Adult Intelligence Scale. MCMI = Millon Clinical Multiaxial Inventory. TAT = Thematic Apperception Test. MMPI-A = Minnesota Multiphasic Personality Inventory-Adolescent. CBCL = Child Behavior Checklist. PCRI = Parent Child Relationship Inventory. PSI = Parenting Stress Index. ASPECT = Ackerman-Schoendorf Scales for Parent Evaluation of Custody.
Graham (2006) estimates that over 2,800 MMPI-related journal articles have appeared since the MMPI-2 was published in 1989. This is in addition to the thousands of articles (some estimate over 12,000) and book chapters that have been written about the original MMPI. The test’s extensive use among psychologists and its strong empirical background certainly lend the instrument credibility in most forensic court settings.

The strength of psychological testing in forensic settings, including custody evaluations, often rests on the ability of the psychological test to detect various forms of response bias, such as random responding (by individuals who do not adequately understand test content and are functionally illiterate) and to detect individuals who are providing inaccurate information about their psychological adjustment because they are under-reporting or over-reporting their symptoms. There are many tests of validity that are currently available, some of which are built into the broader test instrument such as the MMPI-2 and PAI, and many “free-standing” tests of malingering or under-reporting. Adequate scientific data on these validity tests varies greatly. The best understood validity scales in the scientific literature are those of the MMPI-2.

According to Pope, Butcher and Seelen (2006), the MMPI-2 has a well established and known error rate (what psychologists would refer to as a standard error of measurement) and a very comprehensive literature concerning the accuracy of predictions and classifications derived from test findings. These characteristics are likely to result in findings based on the MMPI-2 to be admissible in state and federal setting (e.g., Bow, Gould, Flens, & Greenhut, 2006).

There is also survey data available on the most widely used test instruments with adolescents and children in child custody evaluations. Recent survey findings by Archer, Buffington-Vollum et al. (2006) found that the adolescent version of the MMPI (MMPI-A; Butcher et al., 1992) is the most frequently used adolescent self-report test, used twice as frequently as the Millon Adolescent Clinical Inventory (MACI; Millon, 1993).

Archer, Hagan, Mason, Handel, and Archer (2010) recently examined the 338-item Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF; Ben-Porath & Tellegen, 2008) in a sample of 344 child custody litigants. These authors reported that validity scales L-r and K-r produced comparable elevations for the MMPI-2-RF to the L and K scale results found for the MMPI-2 in custody samples. Further, the scale reliabilities and inter-correlations found for MMPI-2-RF in a custody population were similar to these reported in other populations.

The Parenting Stress Index (PSI; Abidin, 1995), the Child Behavior Checklist (CBCL; Achenbach, 1991), and the Personality Inventory for Children-2nd Edition (PIC-2; Lachar & Gruber, 2001) are among the three most widely used parental self-report measures (Archer et al., 2006). The PSI was developed to measure parent’s perception of their relationship with their child and to estimate their overall stress level. Higher stress levels lead to more difficult parenting experiences and greater difficulty in the parent’s ability to buffer stressors acting on their children. The CBCL and the PIC-2 are parental self-report measures that seek to quantify the parent’s perspective on the psychological functioning of their child, assessing such qualities as the extent to which they perceive their child as anxious or depressed, socially withdrawn, or hy-
perative. They also provide an estimate with regards to whether the mother and father evaluate their child’s psychological health and functioning in a similar or widely different manner, and may indicate which parent has a more accurate understanding of their child’s particular needs.

Relatively recent development of assessment instruments in child custody evaluations include systems of standardized methods of collecting custody evaluation data. These include the Uniform Child Custody Evaluation System (UCCES; Munsinger & Karlson, 1994), which was designed to assist the evaluator in conducting data collection, including interviews, in a systematic and balanced manner. Little empirical data is currently available on the reliability or validity of this standardized form (Lampl, 2009).

The Ackerman-Schoendorf Scale for Parent Evaluation of Custody Test (ASPECT; Ackerman & Schoendorf, 1994) is another example and combines scores from a series of test interviews and records to reach general conclusions in custody evaluations. While these two systems are the most popular in this category, they are used far less frequently than the standard clinical tests such as the MMPI-A or the Parenting Stress Index (Archer et al., 2006) and the supporting literature for the ASPECT has been limited and mixed. Otto, Edens, & Barcus (2000) and Otto & Edens (2003) have provided thoughtful criticisms of the ASPECT. The three primary concerns identified by Otto et al. include a basic concern regarding the psychometric properties of the ASPECT, a lack of a clear relationship between the ASPECT and custody outcomes, and a perceived failure of the ASPECT to incorporate relevant custody evaluation factors. Melton (1995) has been more aggressive in his criticism of the ASPECT, stating “in short, the ASPECT was ill-conceived: an instrument that results in a score showing the parent who should be preferred in a custody decision necessarily results in over-reaching by experts who use it.” (p. 23).

Research Informed Evaluation

The Daubert 1993 Supreme Court decision, and its subsequent refinements, generally created a legal environment that favors testimony based on scientific instruments and procedures with established reliability and validity. Scientific reliability and validity is established, in turn, by research findings that have been subjected to peer-reviews in professional journals, techniques that have quantifiable error rates, as well as having gained general acceptance in the field (see Sellbom, 2012, this issue, for a review of this standard in relation to the recently released Restructured Form of the MMPI-2). While the Daubert Standard has not been adopted in all state courts, it does set a bar or an expectation that is relevant to most forensic evaluations.

Bow, Gould, Flens, and Greenhut (2006) recently surveyed 89 psychologists concerning their opinion about which test instruments could meet the Daubert standard or challenge. The MMPI-2 and MMPI-A were identified as satisfying these standard criteria, as well as the various forms of the Wechsler intelligence scales and the Millon adult and adolescent instruments (MCMI-III; MACI).

Because custody evaluations represent a complex and challenging assessment area, there is typically a variety of valid perspectives and seldom a clear consensus among experts concerning the many evaluation issues. Yet, many psychologists provide testimony in custody cases without referencing their source or basis of scientific evidence. These witnesses are able to testify in very general terms because attorneys typically never ask expert
witnesses to justify or support their conclusions by quoting or citing the scientific literature. However, the court is entitled to know if the psychologist conducted a literature review surrounding the legal standard or issue involved in the case and what scientific research the expert cites in support of their opinions. Further, custody evaluators who claim expertise should be able to identify the most seminal or important references in a particular field (of child sexual abuse, detection of substance abuse, relationship of depression to parenting ability, etc.) and the leading national and international experts in that topic area. Further, the psychologist should be able to explain how they dealt with contradictory findings given that there are almost always some contradictory findings in the scientific literature. These issues lead to several potentially useful questions for attorneys when questioning expert witnesses in child custody testimony. Sample questions for cross-examination of expert witnesses may include:

- What research literature was cited by the evaluator?
- What studies were selected for emphasis?
- Which studies were excluded?
- How were contradictory research findings handled?

**Incremental validity**

Incremental validity is defined as the gain in predictive accuracy achieved by adding additional prediction variables to your assessment (see Hunsley & Meyer, 2003 for a review). If the addition of a new variable increases predictive accuracy, that variable has incremental validity. In most prediction tasks, incremental validity ceases to increase after two to four tests are combined that use the same assessment method. The greatest gains in incremental validity typically come from adding data from different sources such as clinical interview, behavioral observation, and test results. Combining results from five self-report questionnaires for instance might do little in terms of providing incrementally valid information, particularly if the measures are highly correlated. For this reason it is important to incorporate information from varying sources using different methods in any custody evaluation.

Related to this issue of incremental validity, David Faust (Faust & Nurcombe, 1989; Faust, 2003) noted that it is far more damaging to include an inappropriate instrument in a test battery then to omit a useful instrument. Stated differently, excessive and poorly focused batteries are more damaging than under-testing in terms of vulnerability during cross examination. This principle may be generally summarized as “less is often more”. This latter principle is largely counterintuitive, and many attorneys as well as psychologists believe that more tests included in a battery produces greater accuracy of prediction. Numerous research studies have shown, however, that only reliable and valid tests providing incremental validity add to predictive accuracy. Adding unreliable tests to a battery typically results in decreased accuracy of prediction. For example, there is no scientific data to support the use of figure drawing tests, such as the Draw-A-Person or House-Tree-Person projective test in any forensic setting including custody evaluations (Erikson et al., 2007). These tests simply do not meet reasonable standards for reliability of scoring or for predictive or concurrent validity and would almost certainly fail a Daubert challenge and should not be included in the psychologist’s test battery or used to form conclusions in custody evaluations.
Interpretative considerations within the context of child custody evaluations

In his famous discourse regarding actuarial versus clinical judgment, Paul Meehl (1954) emphasized the importance of adjusting actuarial or statistical predictions to account for the base rates unique to setting. Both psychologists and lay people often ignore base rate and their role as a very powerful predictor. For example, the base rate of clinical range elevations on the defensiveness validity scales of the MMPI are generally low in clinical settings, however, the frequency of mild to moderate elevations on defensiveness measures in custody cases is much higher in this latter context (Bagby, Nicholson, Buis, Radovanovic, & Fidler, 1999). Therefore, the elevation of these scales in custody scales has quite a different meaning than in typical clinical settings. Moreover, it becomes important to frame psychological test results in a manner that will not be misunderstood within the legal setting. For instance, Gould, Martindale, and Flens (2009) discuss how descriptive terms used to describe under-reporting of psychopathology, such as "faking good" and "defensive" may be attributed to dishonesty by the courts, whereas, psychologists typically do not ascribe such pejorative meanings to these findings, particularly in settings such as child custody, where individuals often put their best foot forward. Moreover, the importance of considering contextual influences in test results is accordance with the 2009 APA guidelines for child custody evaluations (specifically #11).

Many examples of the importance of adjustment of actuarial predictions based on base rate and evaluation context considerations are often found in the interpretation of psychometric data in custody evaluations. Three specific examples are taken from the actual cases recently encountered by the authors.

In a recent custody evaluation, the senior author was asked to review MCMI-III test findings produced by a mother. The Millon Clinical Multiaxial Inventory-III (MCMI-III) may or may not be appropriate for use in a custody evaluation depending on such factors as the psychiatric history of the respondent, the assessment issue, and the respondent’s gender. In general, the MCMI-III is more controversial when used with a parent without a prior psychiatric history or evidence of psychopathology. This is because the test instrument does not have a non-clinical normative sample through which to interpret an examinee’s test responses, and responses are compared against patient norms in a manner that may exaggerate estimates of psychopathology for normally functioning individuals. There is also substantial evidence of gender bias in the interpretation of MCMI-III scores, particularly for the Histrionic, Narcissistic, and Compulsive personality disorder scales and for the Desirability scale (see Hyman, 2004; Lampel, 1999; McCann et al., 2001). These scales are most typically elevated in custody evaluations and the identical raw scores result in a much higher base rate score for women than for men. In this case, an extensive history of previous psychotherapy and psychiatric diagnoses produced elevations which suggested to the original examiner that the parent “cloaked her defensiveness about acknowledging psychological problems beneath a façade of social adaptability. She had a strong fear of expressing negative emotions, maintained hidden feelings of insecurity and dependency, and was excessively self-centered and immature.” In fact, her MCMI-III scores were quite typical of women in custody evaluations. In view of these factors, Hyman (2004) cautions that practi-
tioners need to be particularly careful about using the MCMI-III personality disorder scales in custody evaluations, indicating a small likelihood that an individual completing the test will appear well adjusted. Groth-Marnat (2003) recently recommended that this test only be used for individuals in psychiatric populations for treatment planning purposes; Ackerman (2006) also cautions about its use in child custody evaluations.

An additional case also clearly illustrates a failure to make necessary adjustments in interpretation of test results. A mother in a contested custody case produced a MMPI-2 validity scale profile that displayed an elevation (T=61) on the Lie Scale. Elevations on the Lie Scale are commonly encountered among parents in parenting capacity evaluations because there is a common tendency for respondents to portray themselves in the most favorable light and to deny common human failings or moral weaknesses. Based on the L scale results, the psychologist in this case labeled the respondent a “pathological liar”, despite the absence of any scientific support that elevations on the Lie Scale indicate a conscious effort to deceive. In fact, this woman’s elevation on the L scale was quite typical of most male and female respondents in custody evaluation situations (Bagby et al., 1999). Similarly, many individuals produce some elevation on the Paranoia (Pa) scale because they feel that they are being talked about and treated unfairly by others, and that they lack understanding and support from one or more family members. In the case of a father who produced a T-score elevation of 66 on the Paranoia scale in a custody evaluation, the psychologist noted in his report that the respondent was, “angry, distrustful, suspicious and hostile” and “displayed evidence for serious and troubling psychopathology”. This type of interpretation is quite inappropriate in a custody evaluation context and fails to make the necessary interpretive adjustment in behavioral descriptors for this individual given the situational context. These three examples of inadequate interpretation practices underscore the importance of adhering to ethical guidelines, which stress that psychologists should have the background, training and experience necessary to interpret the psychological instruments they select for custody evaluations with an appropriate appreciation for, and knowledge of, the ways in which test scores are influenced by the many unique factors involved in the custody evaluation process.

Case Example

In order to illustrate various points discussed earlier in the manuscript, we have included a sample child custody report in the Appendix. This evaluation was completed by the second author (DBW) and has been altered to mask the identity of all individuals involved in the case. This sample report simply illustrates one viable method of presenting data in a custody report while recognizing that there are many useful approaches to the organization of custody report data and recommendations.

As evident in the report, this case involved parents with an adolescent son and pre-adolescent daughter. The parents had divorced several years prior to contesting custody and both had since remarried. However, as their children entered middle school, the parents disputed their previously satisfactory custody arrangement due to arguments about housing arrangements, schooling, and medical treatment, issues that are frequently disputed in contested custody arrangements.

The evaluation included clinical interviews of both parents and children, psychological testing of both parents and children, observations of parent-and-children interac-
tion in both homes, and collateral interviews with both stepparents. The client contact time for this evaluation included approximately nine hours of interviewing, ten hours of psychological testing, and an hour at each parent’s home, totaling approximately twenty hours, a figure that is consistent with previous research regarding child custody evaluations (Ackerman & Ackerman, 1997). This figure does not include time for reviewing records, contacting the guardian ad litem, test interpretation, and report writing, which would add approximately eight hours to the total time for completing this evaluation, resulting in a 28-hour total.

As evident in the report, it was the evaluator’s opinion that while both parents showed genuine concern for the two children, the father in this case exhibited several concerning characteristics regarding his parenting ability. Of primary concern was the father’s lack of recognition of his son’s adjustment difficulties in light of the contested custody. In this case, psychological testing was important in establishing a disparity between the fathers’ rating of his son’s emotional adjustment on the Child Behavior Checklist (CBCL) and the son’s MMPI-A results. Indeed, the father rated his son’s symptoms in the non-pathological range, whereas symptoms of anxiety and depression were markedly evident in the son’s MMPI-A results. In contrast, the mother in this case had a much more accurate appraisal of her son’s emotional adjustment. Additionally, the father displayed a cognitively rigid approach in interacting with the mother regarding mutual aspects of raising their children (e.g., medical treatment and schooling).

One of the most controversial aspects of forensic work is whether the forensic evaluator should address the ultimate issue, in this case regarding child custody decisions, when writing a forensic report or providing expert testimony (Sageman, 2003). As Sageman contends, "The legal profession is very jealous of its turf, especially in regard to its function as fact finder." (p. 328). Nevertheless, specific courts differ widely on this issue and some will request that the forensic examiner provide an opinion regarding the ultimate forensic issue at hand. As you will notice in this particular case example, the Court requested that the examiner provide an opinion regarding a custody arrangement. Bow and Quinnell (2004) surveyed 121 judges and lawyers and reported a general preference for the provision of custody and visitation recommendations within the context of court-appointed and objective evaluations submitted to the court in a timely manner. Further, Bow and Quinnell (2002) found that most (94.2%) of custody reports contained specific custody or visitation recommendations. It is recommended that forensic evaluators be very clear at the onset of a custody case how far their particular Court will want them to go in terms of forming an opinion regarding the ultimate issue.

Regarding the outcome of this case, the judge agreed with the evaluator’s opinion and granted residential custody to the mother, but granted both parents shared parenting with regard to decision making in order to keep the father involved in the children’s lives, which illustrates that courts can vary in how much they utilize recommendations made by forensic evaluators. Subsequent outcome data in this case indicated that within several months of this court decision, the father began taking the children out of school to visit private schools without informing their mother. He also stopped paying child support to the mother and was eventually found to be in contempt of court and only resumed payment when threatened with jail time. The judge eventually awarded the mother full
Custody evaluations involve serious decisions that profoundly impact the lives of parents and their children. These evaluations should be based on a process that emphasizes solid science with well-established concepts of reliability and validity, and should be grounded in ethical principles that serve to reduce the probability of significant biases entering into evaluation outcomes. Of course, the use of sound scientific principles and firm ethical standards will never guarantee evaluation findings that are consistently “in the best interests of the child”, but the use of such an approach certainly increases the likelihood of such outcomes.

It is quite possible to separate sound psychological evaluation opinion based on reliable and valid procedures from what has been labeled as “junk science” or less than credible testimony (see Emery et al., 2005; Erikson et al., 2007; Faust, 2003; Faust and Nurcombe, 1989). In the absence of standardized criteria for defining or credentialing forensic psychology, the courts will continue to be left with the burden of separating competent from incompetent practitioners.

Skillful attorneys can discredit or lead a witness to impeach their testimony under careful cross-examination. It is our hope that some of the information provided in this article may prove helpful in supporting the work of skillful and careful evaluations and in challenging experts presenting poorly formed opinions without scientific merit.

References


Daubert v. Merrell Dow Pharmaceuticals. 509 U.S. 579, 113 S Ct 2786 125 L Ed 2d 469 (Supreme Court 1993).


Appendix: Sample Custody Evaluation

**FORENSIC CUSTODY/PARENTING CAPACITY EVALUATION**

(Confidential Material)

**Biological Parents:**
Father: Steven Wright  Mother: Jennifer Smith
DOB: 01/15/61  DOB: 04/12/63
Age: 47  Age: 45

**Biological Children:**
John Wright  Julie Wright
DOB: 07/15/94  DOB: 10/19/96
Age: 14  Age: 12

**Examiner:**
Dustin B. Wygant, Ph.D.

**Date of Report:**
June 11, 2008

**Guardian Ad Litem:**
Stacy Atkins

Note that names, identifying information, and case details have been changed or altered to protect the confidentiality of those involved in this case.
Background and Referral Information:

Steven Wright is a 47 year old, married Caucasian male and Jennifer Smith is a 45 year old, married, Caucasian female who were referred by the Hamilton County Court of Domestic Relations for a psychological evaluation to aid in determining a custody arrangement for their two children, John Wright, aged 14 years, and Julie Wright, aged 12 years. Mr. Wright and Ms. Smith divorced in 2001 and agreed to a shared parenting plan, with no designated residential parent. Their original parenting plan designated a month to month living arrangement and Mr. Wright and Ms. Smith agreed that the children would alternate between their residences on a two day, three day, two day schedule, with each parent having the children every other weekend. Both parents agreed to a change in the visitation schedule in July 2007, when the children alternated between residences on a week by week basis, spending the majority of Thursday with the opposite parent.

The above schedule continued successfully until October 2007, when Ms. Smith filed a motion for a revised parenting plan. Her motion requested that she and Mr. Wright continue to share legal custody and visitation. She requested a change in the children’s living arrangements, with her residence becoming the primary residence for the children. Ms. Smith further requested that Mr. Wright maintain separate gender living arrangements for the children at his residence. Regarding visitation time, she requested that the children reside with Mr. Wright every other week, from Thursday until Monday mornings.

INTERVIEWS AND TESTS ADMINISTERED:

**Mr. Steven Wright**
- Individual Clinical Interview
- Minnesota Multiphasic Personality Inventory-2 (MMPI-2)
- Stress Index for Parents of Adolescents (SIPA)
- Child Behavior Checklist for Children ages 6 through 18 (CBCL)

**Ms. Jennifer Smith**
- Individual Clinical Interview
- Minnesota Multiphasic Personality Inventory-2 (MMPI-2)
- Stress Index for Parents of Adolescents (SIPA)
- Child Behavior Checklist for Children ages 6 through 18 (CBCL)

**John Wright**
- Clinical Interview
- Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A)

**Julie Wright**
- Clinical Interview
- Youth Self-Report (YSR)

**Ms. Theresa Wright**
- Individual Collateral Interview

**Mr. Richard Smith**
- Individual Collateral Interview

ADDITIONAL EVALUATION DATA:

- Observation of Mr. Steven Wright and Ms. Jennifer Smith conducted on May 26, 2008
- Interviews with John Wright and Julie Wright, conducted on May 11, 2008
- Copy of Revised Shared Parenting Plan, no date provided
- Copy of Decree of Dissolution of Marriage, Separation Agreement, and Shared Parenting Plan, filed October 4, 2001
- Copy of Consent Entry, filed April 11, 2003
Statement of Informed Consent:

All parties involved in the evaluation (Mr. and Ms. Wright, Mr. and Ms. Smith, and both children) were informed that the purpose of the evaluation was to examine the family based on the Best Interests of the Child statute and make a recommendation regarding a custody arrangement to the court. All parties were informed that the results of this evaluation would not be confidential and would be summarized in a report to the Hamilton County Court of Domestic Relations and that each parent's attorney would also receive a copy. It was explained that the judge would consider the evaluation report when making a custody determination. Everyone acknowledged that they understood this limit of confidentiality and agreed to participate under this condition by signing an informed consent form after review with the examiner.

INTERVIEW RESULTS:

Interview with Mr. Steven Wright:

Mr. Wright was born and raised in an intact family in Cincinnati, Ohio. He has one sister who resides near Indianapolis, Indiana. Mr. Wright did not report any mental health, drug and alcohol, and legal problems for his sister.

Mr. Wright did not report any history of drug, alcohol, mental health, and legal problems for his mother, who worked as a high school teacher before dying from a stroke in 2003. Mr. Wright’s father is a retired banker and reportedly has no history of drug, alcohol, mental health, and legal problems.

Mr. Wright described his childhood upbringing in positive terms and he did not report any history of abuse, neglect, and domestic violence.

Mr. Wright reportedly graduated from high school in 1979 with above average grades. He did not report any history of learning disability, participation in special education, and disciplinary problems, and he participated in tennis and the pep band. Mr. Wright graduated with a bachelor’s degree in management from the University of Cincinnati in 1983.
Mr. Wright reported that he worked at a restaurant as an adolescent and that he was fired for having a “personality conflict” with his employer. After graduating from college, he worked in a management position at a hospital in Indianapolis, Indiana from 1985 to 1986, when he quit and relocated back to Cincinnati, Ohio. Mr. Wright subsequently worked at a small marketing firm company in Cincinnati, Ohio from 1986 to 1987, when he quit and began working at a larger firm, Mass Media, Inc. He has worked at Mass Media since 1987 and he is currently in upper management for the company.

Mr. Wright reported that he met Ms. Smith in 1982, and they dated while they attended college. They married in 1985 and their marriage produced two children, John, aged 14 years, and Julie, aged 12 years. Mr. Wright reported that he and Ms. Smith divorced in 2001, stating, “Jen wasn’t happy anymore,” however; he subsequently stated, “I didn’t see any problems in the relationship at the time.”

Mr. Wright met his current wife, Theresa, in December 2006. They dated for six months and married in June 2007. Theresa has two daughters from a previous marriage, Katrina, aged fourteen years, and Andrea, aged twelve years. Both of the children reside with Mr. Wright and Theresa in Blue Ash, Ohio. He described the relationship with Theresa in positive terms, although he described her as “stubborn at times.”

Theresa reportedly completed her college degree in secondary art education, although she currently works in the art department at Mass Media, Inc. Mr. Wright reported that Theresa’s children get along well with John and Julie, although he acknowledged, “getting these two families together was not easy.” Theresa’s two daughters both have separate bedrooms. John and Julie share a bedroom on the first floor of the home, although Mr. Wright reportedly plans to initiate renovations to his home as soon as his construction financing is approved.

Mr. Wright indicated that Ms. Smith is the major source of stress in his current marriage. Indeed, he stated “right from the start Jen gave me hell about Theresa.” He believes that Ms Smith is very threatened by Theresa and that she does not want Theresa interacting with their children.

Mr. Wright reported that he has never been arrested or charged with any legal offense as a juvenile or adult.

Mr. Wright reported that he first consumed alcohol at sixteen years of age, and his heaviest use of alcohol occurred in the late 1980’s, when he consumed three to four drinks approximately three times per week. In the past year he has reportedly consumed two drinks twice per week. Mr. Wright reported that he has never experienced any problematic use of alcohol. Mr. Wright reported that he used marijuana on two occasions in college and he denied any use of marijuana since that time. He reported that he has never used any other illicit substances.

Mr. Wright did not report any history of significant medical problems, head injury, and known medical allergies. Mr. Wright did not receive any mental health treatment as a child and adolescent. As an adult, he and Ms. Smith attended seven marital counseling sessions with Dr. Robert Eaves. Records indicate that Ms. Smith initiated the couples counseling and the treatment was focused on improving their communication. Mr. Wright reported that he has never been hospitalized or prescribed medication for a psychiatric disorder.
Parenting Knowledge- Mr. Steven Wright

Mr. Wright was able to provide adequate information regarding his children’s sleep schedule, medical needs and educational status and he reportedly disciplines his children by “taking away privileges.” He stated that his children “must” attend private high schools in order to “get into a good college, like an Ivy League school” and persisted in describing Ms. Smith as unable to make decisions about the children’s schooling, stating “she’s okay with them just attending a state school, but I know how important it is in the business world to get the best education.” Moreover, Mr. Wright wanted his children to transfer their medical care to his primary care physician because he covers them on his medical insurance and its “closer to my house.”

Mr. Wright described his relationship with his children as “close,” particularly with John. Indeed, he stated, “there’s nothing that boy can’t tell me.”

Mr. Wright said that he did not see a problem in his children sharing a room at his residence until he and Theresa complete the revision to their house.

Behavioral Observations & Mental Status Examination- Mr. Steven Wright

Mr. Wright was interviewed in the examiner’s office on two separate occasions for approximately three hours in duration. His psychological testing was conducted on a separate appointment at the examiner’s office for a total of two and a half hours.

Mr. Wright is a forty-seven year old, Caucasian male who appeared his stated age. He was dressed neatly and his grooming and hygiene were good. Mr. Wright’s thought processes were clear and he was oriented to person, place, and time. He did not report any problems with memory, attention, and coordination. Moreover, Mr. Wright did not report any symptoms of depression, anxiety, and thought disorder. His insight was poor and his judgment was limited.

Mr. Wright was only marginally cooperative with the evaluation. He tended to lecture and control the conversation and was antagonistic, frequently interrupted the examiner, and he took notes throughout the evaluation. Mr. Wright was cognitively rigid and concrete in his thinking. Indeed, he stated, “I want to make the decisions because I’m better at it than her. I think decisions made on logic are better than decisions made on emotions.” Mr. Wright persisted in blaming Ms. Smith for their current custody dispute stating, “Jen has an inability to deal with change since our divorce and my remarriage. She feels threatened by Theresa.” Mr. Wright also expressed several strong opinions about the influence of Ms. Smith’s current husband, such as “I don’t want my kids growing up thinking that working in a factory is good enough. I guess somebody’s got to work in those places, but I don’t want it to be my kid.” He acknowledged that one of his “weak points” is his sarcasm in his dealings with his ex-wife. Mr. Wright reported that there “may be some validity to Jen’s points about me excluding her, but I still can’t work with her.”

When interviewed in the presence of Ms. Smith, Mr. Wright was antagonistic and uncompromising. He argued points even when she agreed with him and his positions on areas of disagreement kept changing. Furthermore, at the end of the observation session with Ms. Smith he continued to explain how he still wanted to be the pri-
mary decision maker regarding the children and that visitation should remain on a week-to-week schedule.

**Interview with Ms. Jennifer Smith:**

Ms. Smith is the youngest of three children, born and raised in an intact family in Cincinnati, Ohio. She has an older sister who resides in Cincinnati, Ohio and an older brother who resides in Chicago. She did not report any history of mental illness, drug or alcohol problems, and legal difficulties for her siblings and reported having close relationships with them.

Ms. Smith’s father worked as a supervisor for Procter & Gamble before dying of cancer in 2006. Her mother currently resides in Cincinnati, Ohio and worked as a teacher for approximately thirty years. She did not report any history of mental illness, drug or alcohol problems, and legal difficulties for her parents. Ms. Smith described her upbringing in positive terms, indicating that it was devoid of abuse, neglect, and domestic violence.

Ms. Smith reportedly achieved above average grades and graduated from high school in 1981. She did not report any history of learning disability, participation in special education, and disciplinary problems. She participated in the yearbook committee and arts society. Ms. Smith graduated from the University of Cincinnati with a bachelor’s degree in art design in 1985.

Ms. Smith reported that she worked as a graphic artist for a small marketing firm for one year, beginning in 1985, before she quit and relocated to Indianapolis with Mr. Wright, where she worked for an advertising company from 1986 to 1987. She quit that position when she and Mr. Wright relocated back to Cincinnati. Ms. Smith has worked fulltime in the marketing division of a bank since 1989.

Ms. Smith reported that she met Mr. Wright in the spring of 1982 and they dated for three years before marrying in 1985. She reported she was “homesick” while residing with Mr. Wright in Indianapolis. Ms. Smith stated, “I felt lost as a person.” She also indicated that Mr. Wright was controlling, stating, “we always had to do things his way.” Their marriage produced two children, John, aged 14 years, and Julie, aged 12 years. Ms. Smith stated “as I grew stronger as a person our marital problems increased.” She also reported that their marital tension increased because she received “attention from others” in their neighborhood. She was petitioned for divorce from Mr. Wright, which was granted in 2001.

Ms. Smith reported that she has known her current husband, Richard, her entire life, since he grew up in the same neighborhood. They began dating within a year of her divorce from Mr. Wright and they married in July 2003. Richard has no children and works in a factory as a shift supervisor. Ms. Smith described her current marriage in positive terms, however; she reported financial issues and stated that Richard sometimes experiences difficulty in his role as a stepparent. She further reported that her current custody situation with Mr. Wright has resulted in tension in her current marriage.

Ms. Smith reported that she has never been arrested or charged with any legal offense as a juvenile or adult.

Ms. Smith reported that she began consuming alcohol at nineteen years of age and her heaviest use of alcohol occurred in 2001, after her divorce from Mr. Wright. For approximately one to two months in 2001,
she consumed six beers three times per week. In the past year, Ms. Smith has consumed approximately three beers twice per week. She reported that she has never experienced any problematic use of alcohol, or ever used any illicit substances.

Ms. Smith did not report any history of significant medical problems, head injury, and known medical allergies. Ms. Smith did not receive any mental health treatment as a child and adolescent. As an adult, she reportedly participated in several sessions of marital counseling with Mr. Wright. Ms. Wright reported that she has never been hospitalized or prescribed medication for a psychiatric disorder.

**Parenting Knowledge- Ms. Jennifer Smith**

Ms. Smith was able to identify appropriate information regarding her children’s educational and medical needs, along with their sleep schedules. In regards to discipline, she reported that she removes privileges from the children such as the computer, telephones, and time with friends. Ms. Smith reported that she believes the children would be better suited to remain in the same school system because they have always been in these schools and have positive experiences in their schools.

Ms. Smith stated that her biggest challenge as a parent over the past few years has been Mr. Wright excluding her from the decision making process and not informing her of his plans for the children’s schooling and healthcare.

**Behavioral Observations & Mental Status Examination- Ms. Jennifer Smith**

Ms. Smith was interviewed in the examiner’s office on two separate occasions for approximately three hours in duration. Her psychological testing was conducted on a separate appointment at the examiner’s office for a total of two and a half hours.

Ms. Smith is a forty-five year old Caucasian female who appeared her stated age. She was dressed neatly for her appointments and her grooming and hygiene were good. Ms. Smith’s thought processes were clear and she was oriented to person, place, and time. She did not exhibit any problems with memory, attention, and coordination. Ms. Smith did not report any symptoms of depression, anxiety, or thought disorder. Her insight and judgment were adequate.

Ms. Smith was cooperative during the evaluation, although her anger and animosity toward Mr. Wright occasionally negatively impacted her ability to remain focused. Indeed, she initially focused on past events and arguments with Mr. Wright rather than identifying potential solutions for their conflict. As the evaluation progressed Ms. Smith became more solution focused and willing to compromise on issues for the benefit of the children. She became tearful at several times during evaluation, particularly when discussing her children and how Mr. Wright has “excluded” her from parenting decisions.

When observed in the presence of Mr. Wright, Ms. Smith indicated her desire to solve their difficulties amicably. She also proposed several compromises to their differences and indicated that she would maintain her com-
promised positions despite Mr. Wright’s reluctance to compromise his positions.

**Observations of Mr. Steven Wright and Ms. Jennifer Smith together:**

Mr. Wright and Ms. Smith were observed together for one hour to identify how they interact with each other and determine whether they can communicate and cooperate with each other regarding their children. The purpose of this session was to observe both parents together to assess their communication styles with one another. This was fully explained to each party at the onset of the interview. Moreover, both parties were informed that nothing discussed during the interview would be legally binding and would need to be addressed with their respective legal counsel.

They identified several areas for discussion, including the children’s residence, education, and medical care. Both of them suggested that they equally split visitation so that each would be able to maintain contact with the children, with a week to week visitation schedule. Ms. Smith strongly objected to John and Julie sharing a living space at Mr. Wright’s residence. Mr. Wright reported that plans for an addition to their residence were complete, but they were still waiting for financing. He refused to identify alternative living arrangements in the meantime.

When discussing the children’s education, Mr. Wright and Ms. Smith initially disagreed regarding the high schools their children would attend. Mr. Wright expressed his desire for the children to attend private schools and Ms. Smith wanted them to remain in their current public school system. Ms. Smith eventually expressed agreement that their son could attend a private Catholic school as long as he was interested in attending the school. She suggested that John remain in his current public school system should he not strongly want to attend the private school, noting that the private school would be expensive and he has been attending the public school system his entire life. Mr. Wright told Ms. Smith that he wanted the children to transfer to the school district near him because “we have better schools over here.” Ms. Smith maintained a similar stance with their daughter attending a private school. However, similar to their son, Mr. Wright would like his daughter to attend the school of his choice or transfer to the school district near his residence.

The parents also discussed their children’s medical care. Ms. Smith indicated that she wanted to maintain the children’s routine medical care with their current physicians in her geographical area. She noted that, contrary to Mr. Wright’s initial claims, his health insurance coverage provided reimbursement for provider services in her area. She noted that the children could receive any specialized care at a medical facility closer to Mr. Wright’s geographical location. She only requested that she be notified of any medical emergencies regarding the children as soon as possible. Mr. Wright reluctantly agreed to inform Ms. Smith of any medical emergencies. He stated he would prefer to transfer the children’s medical care to his physicians and dentist because he pays their medical and dental insurance and felt that this entitled him to select the providers.

**Child Interview and Behavioral Observations of John Wright:**

John remained quiet when interviewed and bit his
John indicated that he preferred the previous visitation schedule, which was week-to-week visitation. He did not report a preference for one parent over the other, although he expressed more interest in maintaining his mother’s residence because he has more friends there. He reported that he does not have any friends near his father’s house.

John reported that the conflict between his parents escalated when Mr. Wright married Theresa and relocated to Blue Ash. John stated, “Theresa changed the way he does stuff,” although he expressed positive feelings towards both stepparents, describing Theresa as “pretty cool,” and Richard as “supportive.”

John reported that he had difficulty relating to his father. For instance, his father insisted that he learn a musical instrument, stating that it would eventually be helpful for him getting into college. John stated that he “hated the piano,” a feeling he had maintained over the past year and a half. However, he was “too scared” to tell his father that he did not enjoy playing the piano, and consequently, he persisted in his weekly practice.

John reported that he would prefer to remain in his current school district for high school, stating “I’ve always gone there. That’s where my friends are going.” John did note, however; that several of his friends were also considering the Catholic high school that his father wants him to attend.

John indicated that his parents only communicate via email and their attorneys. He said that he feels “trapped in the middle sometimes” and wished that the custody argument were “finally over.” John acknowledged that his mood has been depressed since his parents revisited the issue of custody. Indeed, he reported that he has not slept as well as he used too, frequently waking throughout the night. Although he denied any thoughts of suicide and homicide, John indicated that he is “not happy anymore.”

Child Interview and Behavioral Observations of Julie Wright:

Julie was cooperative during the evaluation and comfortable in providing responses during the interview. She reported that she preferred the week-to-week visitation schedule and stated, “I want to be with both parents.” However, similar to John, Julie indicated that her friends reside near her mother’s residence and that she does not socialize with children in her father’s neighborhood.

Julie reported that the recent escalation in conflict between her parents has been especially rough on John. Indeed, she stated, “he’s not like he used to be. He’s so quiet now.” Julie described her brother as increasingly withdrawn from others and nervous around their father.

Julie did not report any significant emotional dysfunction, although she reported that she has been more prone to experiencing anger since her parents revisited the issue of custody.

Child Interview and Behavioral Observations of John Wright and Julie Wright together:

After interviewing both children separately, they were brought together for a brief interview session. Julie was more vocal than John in describing how the conflict between Mr. Wright and Ms. Smith has impacted them.
John slouched in the chair and nodded his approval of Julie’s statements.

Julie generally expressed positive feelings for Theresa, however; she also described her as “moody,” and stated, “she can get pretty mad at times.” Julie expressed some dissatisfaction that her father wants them to transfer their medical treatment to his physician and dentist, stating “we don’t want to have appointments across town.” She reported that she would prefer to maintain her medical care near her mother, stating “I would prefer to go where we’ve always gone.” John agreed with Julie’s position on medical appointments.

Regarding their stepfather, Richard, both children again expressed positive feelings. They both indicated that he was harsh approximately several years ago. Julie stated, “he was like that because he never had kids, but he’s used to us now.” John agreed and reported positive feelings about Richard.

Both children expressed positive feelings towards Theresa’s children. Indeed, Julie stated, “Even though they both have different personalities, we all get along.”

Julie reported that Mr. Wright believes that she is influenced by Ms. Smith to make negative statements regarding Theresa. Indeed, she stated, “He thinks my mom told me to say it, but I don’t say things she tells me.” John then stated, “I don’t tell my dad things because I don’t want to get into a big conversation.”

Regarding their living arrangements at Mr. Wright’s residence, both children reported that they share a room. They both indicated that the situation was temporary and Julie stated, “They’re supposed to start an addi-

tional this month,” to which John replied, “but it always keeps getting pushed back.”

**PSYCHOLOGICAL TEST FINDINGS:**

**Test Results for Mr. Steven Wright:**

The Minnesota Multiphasic Personality Inventory-2 (MMPI-2) is the most widely used test of psychopathology in the United States and is frequently used as a standard component of child custody and parenting capacity evaluations. The MMPI-2 contains a variety of validity scales that are sensitive to the examinee’s tendencies to over-report or under-report psychological problems. These validity scales are also useful in identifying when individuals respond to test items in a random or inconsistent manner.

Mr. Wright responded to the MMPI-2 in a cautious and defensive manner, by minimizing psychological problems and personal faults (L = 69, K = 64). Consequently, the resulting profile may underestimate his current psychological problems. This is a relatively common pattern of defensiveness found in parents in child custody evaluations.

Only one of Mr. Wright’s clinical scales were in the pathological range. He produced a moderate clinical range elevation on the MMPI-2 Clinical Scale 9(Ma = 67). Individuals who produce elevations on this scale are self-centered, have an exaggerated appraisal of their self worth, and have difficulty judging their limitations. Beyond this finding, individuals with similar profiles are narrow-minded and have a limited range of interests, preferring mechanical and practical activities (Mf = 35). They are not interested in the expression or discussion of feelings and they deny distressing emotions.
Interpersonally, individuals with profiles similar to Mr. Wright display an average interest in socializing with others and feel support from those around them (Si = 47). They can be interpersonally insensitive, intolerant, and domineering (AGGR = 64). While they often create a positive first impression and like to be around other people, they tend to have significant difficulties in long-term interpersonal relationships.

The Child Behavior Checklist (CBCL) is a widely used 113-item rating form used to obtain information regarding a parent or guardian’s perception of a child’s psychological and social competence.

Mr. Wright completed the CBCL for both of his children. He indicated that John is involved in a number of recreational activities including piano practice, baseball, and swimming. His chores at his residence include cleaning up the bathroom and assisting with yard work during the summer. Mr. Wright rated John’s school performance as average in language skills, social studies, math, and science. He identified “upset about sharing a room” and “upset with parent’s divorce” as his major concerns for John. John’s total competence score was in the normal range for parent’s ratings of boys ages 12 through 18. His rating scores on the Activities, Social, and School scales were also all within the normal range, although Activities approached the clinical level.

On the CBCL Problem scales, Mr. Wright’s rating of John’s Total Problems scale was in the normal range. Moreover, his ratings of John on the Internalizing, Anxious/Depressed, and Withdrawn/Depressed Syndromes were in the normal range. These CBCL results indicate that Mr. Wright reported no problems for John than are typically reported by parents of children in John’s age range.

On CBCL scales related to psychiatric diagnoses, John’s scores on the Somatic Problems, Attention Deficit/Hyperactivity Problems, Oppositional Defiant Problems, Affective Problems, Anxiety Problems, and Conduct Problems were all within normal ranges. These results suggest that Mr. Wright does not perceive John as having any symptoms of a psychiatric disorder.

Mr. Wright also rated Julie on the CBCL. He reported that dance is his daughter’s primary interest. Her chores at his residence include making her bed and cleaning up the kitchen. Mr. Wright rated Julie’s school performance as average in language skills, social studies, math, and science. He identified “not liking sharing a room with brother” as his major concern for Julie. Julie’s total competence score was in the normal range for parent’s ratings of girls ages 12 through 18. Her rating scores on the Activities, Social, and School scales were also all within the normal range. On the CBCL Problem scales, Julie’s Total Problems score was in the average range, as were the remainder of her problem scales. These CBCL results indicate that Mr. Wright reported no problems for Julie than are typically reported by parents of children in Julie’s age range.

On CBCL scales related to psychiatric diagnoses, Julie’s scores on the Somatic Problems, Attention Deficit/Hyperactivity Problems, Oppositional Defiant Problems, Affective Problems, Anxiety Problems, and Conduct Problems were all within normal ranges. These results suggest that Mr. Wright does not perceive Julie as having any symptoms of a psychiatric disorder.

The Stress Index for Parents of Adolescents (SIPA) is a 120-item questionnaire designed to assess two
major dimensions of stress related to the parenting of adolescents: an Adolescent domain and a Parent domain. Mr. Wright’s ratings for John on the SIPA revealed scores in both the adolescent and parent domains that were within the normal range. Mr. Wright rated John as emotionally stable, socially involved, and behaviorally controlled and appropriate. Mr. Wright also indicated that he felt he had sufficient resources to provide effective parenting for John, he had a sufficient social support group to provide help to him when needed, and he was secure in his ability to provide effective parenting for his son. Mr. Wright’s overall level of life stressors, as well as stressors related to parenting activities, was within normal or expected levels.

Test Results for Ms. Jennifer Smith:

Ms. Smith responded to the MMPI-2 in a candid and forthcoming manner, producing a profile that is valid for interpretation. All of Ms. Smith’s validity scales were within normal ranges.

Individuals with profiles similar to Ms. Smith report normal levels of personal distress (RCd = 53) and present themselves as in control of their emotions. None of her clinical scales were in the pathological range. Overall, Ms. Smith’s responses to the MMPI-2 indicate normal personality functioning without any evidence of psychological disorders or significant psychiatric symptoms.

Interpersonally, individuals with profiles similar to Ms. Smith are outgoing and have a strong need to be around others (Si = 38, INTR = 35). Moreover, they are comfortable in social situations.

Ms. Smith completed the CBCL for both of her children. She reported that John is involved in a number of recreational activities including piano practice, baseball, and swimming. His daily chores include making his bed, helping in the kitchen, and cleaning up his bathroom. Ms. Smith rated John’s school performance as average in language skills, social studies, math, and science. She identified “being cut off from others” and “anger towards father” as her major concerns for John. John’s total competence score was in the normal range for parent’s ratings of boys ages 12 through 18. His rating scores on the Activities, Social, and School scales were also all within the normal range, although Activities approached the clinical level. On the CBCL Problem scales, John’s Total Problems score was in the Borderline Clinical range (84th to 90th percentile) and his Internalizing score was in the Clinical range above the 90th percentile for his age group. In particular, his scores on the Anxious/Depressed and Withdrawn/Depressed Syndromes were in the Clinical range above the 97th percentile. These CBCL results indicate that Ms. Smith perceived John’s behaviors as possibly meeting the diagnostic criteria for an

On CBCL scales related to psychiatric diagnoses, John’s scores on the Somatic Problems, Attention Deficit/Hyperactivity Problems, Oppositional Defiant Problems, and Conduct Problems were all within normal ranges. In contrast, John’s scores on the Affective Problems scale was in the Clinical range, above the 97th percentile, and his score on the Anxiety Problems scale was in the Borderline Clinical range, between a 93rd and 97th percentile. These results suggest that Ms. Smith perceives John’s behaviors as possibly meeting the diagnostic criterion for an
affective disorder, particularly a Depression Disorder diagnosis.

Ms. Smith also rated Julie on the CBCL. She reported that dance and art are her daughter’s primary interests. Her daily chores include making her bed, helping in the kitchen, and cleaning up her bathroom. Ms. Smith rated Julie’s school performance as average in language skills, social studies, math, and science. She identified “being upset about going back and forth between Mom and Dad” as her major concern for Julie. Julie’s total competence score was in the normal range for parent’s ratings of girls ages 12 through 18. Her rating scores on the Activities, Social, and School scales were also all within the normal range. On the CBCL Problem scales, Julie’s Total Problems score was in the average range, as were the remainder of her problem scales. These CBCL results indicate that Ms. Smith reported no problems for Julie than are typically reported by parents of children in Julie’s age range.

On CBCL scales related to psychiatric diagnoses, Julie’s scores on the Somatic Problems, Attention Deficit/Hyperactivity Problems, Oppositional Defiant Problems, Affective Problems, Anxiety Problems, and Conduct Problems were all within normal ranges. These results suggest that Ms. Smith does not perceive Julie as having any symptoms of a psychiatric disorder.

Ms. Smith’s ratings for John on the SIPA indicated that while she is concerned about John’s adjustment, she is not particularly stressed in dealing with her son and her total life stress score was within the normal range. Ms. Smith’s scores in the Parent domain dimensions were generally within normal limits and her highest perceived source of stress was in her relationship with her ex-
husband. Within the Adolescent domain scales, Ms. Smith perceived John as having significant problems in terms of moodiness and emotional liability. In addition, she perceived John as emotionally isolated and withdrawn and displaying deficits in terms of social skills and responsiveness in social situations.

Test Results for John Wright:

The MMPI-A is the adolescent version of the MMPI. Similar to the adult version, the MMPI-A is a self-report measure of psychopathology and personality that contains validity scale indicators to determine whether the test-taker over-reported or under-reported symptoms and problems.

John responded to the MMPI-A in a candid and forthcoming manner and his results are subject to valid interpretation. All MMPI-A validity scales were within normal ranges. John produced moderate clinical range elevations on Clinical Scales related to depression (D = 67) and anxiety (Pt = 70). Adolescents with profiles similar to John feel overwhelmed and lack the emotional resources to deal with their problems (A = 73). They experience significant symptoms of depression, such as depressed mood, low self-esteem, fatigue, and irritability. Moreover, they feel hopeless, apathetic, and inadequate and tend to find many faults with themselves (INTR = 72). Prone to experiencing significant guilt and self-criticism, similar adolescents tend to ruminate a great deal and have difficulty making decisions and they are apt to give up easily (OBS= 70). They also experience numerous symptoms of anxiety, including excessive worry, stress and tension, and difficulty with concentration (ANX = 77, NEGE = 73).

Interpersonally, adolescents with profiles similar
to John are dependent and perceived by others as shy (SOD = 68, ALN = 70). They often have extensive histories of family discord (FAM = 72).

Test Results for Julie Wright:

Julie completed the Youth Self Report (YSR), an objective self-report inventory designed to elicit adolescent’s perceptions of their competencies and their psychological functioning. Julie’s Total Competence Score was in the normal range for girls ages 11 to 18 and her scores on the Activities and Social scales were also within normal ranges. On the YSR Problem scales, Julie’s Total Problems, Internalizing score, and Externalizing score were all within the normal range. Her scores on specific problems syndromes were similarly within the normal range and these results indicate that Julie reported no more problems than are typically reported by girls in her age group. Finally, on the YSR scales related to psychiatric diagnoses, Julie’s scores were also consistently subclinical on such measures as Affective Problems, Anxiety Problems, Somatic Problems, Attention Deficit/Hyperactivity Problems, Oppositional Defiant Problems, and Conduct Problems. These results indicate that Julie is unlikely to meet the diagnostic criterion for disorders characterized by these psychiatric dimensions.

COLLATERAL INTERVIEWS:

Interview with Theresa Wright:

Ms. Wright was interviewed alone in the examiner’s office for approximately thirty minutes. She was generally cooperative throughout the interview, however; at times she questioned the “usefulness” of the evaluation process. She also blamed Ms. Smith for all of the current turmoil throughout the custody dispute and was unwilling to acknowledge Mr. Wright’s role in the conflict.

Ms. Wright described her family life as good, noting that her two children get along with John and Julie very well. She also indicated that both she and Mr. Wright have very good relationships with all of the children. Ms. Wright acknowledged that it was “not ideal” for John and Julie to share a room, although she indicated that the family was “working on it.”

Interview with Richard Smith:

Mr. Smith was interviewed alone in the examiner’s office for thirty minutes. He was cooperative throughout the interview process, although he remained quiet and tended to only respond when directly questioned. Mr. Smith indicated that he had known Ms. Smith since their childhood and that they began dating shortly after her divorce from Mr. Wright. He reported that he works as a shift supervisor in a factory.

Mr. Smith reported that it was a difficult transition to being a stepparent, having no children of his own. Indeed, he stated “I didn’t know how to talk to kids” and frequently lost his temper when the children “acted up.” Mr. Smith reported that she never used corporal punishment with the children and stated “I prefer to let Jen handle discipline.” Although he described his current relationship with his stepchildren as “very good,” he noted that his marriage with Ms. Smith has been strained both emotionally and financially by the current custody dispute.

Interview with Dr. Eaves:

Dr. Eaves reported that he saw Mr. Wright and Ms. Smith or seven sessions of marital counseling. He
indicated that Ms. Smith initiated the counseling because of her increasing frustration with Mr. Wright. Dr. Eaves described Mr. Wright as "inflexible" and noted that he was reluctant to cooperate and engage in the sessions and frequently denied having any problems in the relationship. Moreover, he often blamed Ms. Smith for "nagging" too much and he became argumentative when the therapist attempted to constructively discuss communication styles. Dr. Eaves reported that Mr. Wright discontinued the counseling. Ms. Smith attended an additional individual session, during which she expressed frustration at her husband's discontinuation of therapy.

**RECORD REVIEW:**

**Letter from Deanne Miller:**

Deanne Miller, mediator for the Hamilton County Court of Domestic Relations indicated in a letter dated December 6, 2007 that several agreements were made between Mr. Wright and Ms. Smith in their mediation session. These agreements included week to week visitation, with a mid-week visit with the other parent. They also agreed to contact each other on Monday morning to facilitate communication between the parents regarding their children’s upcoming schedules. Both parents agreed on a visitation schedule for holidays and special events. Furthermore, they agreed to discuss their children’s educational needs and Mr. Wright would have separate living arrangements for the children at his residence by January 31, 2008.

**Blue Ash Police Department Incident Report:**

Theresa Wright filed a complaint against Ms. Smith at the Blue Ash Police Department on March 9, 2008, stating that she frequently arrived at the children’s school when Theresa picked them up. Theresa reported to the police that she “felt harassed.”

**RESULTS OF PARENT/CHILD OBSERVATION AND HOME VISIT:**

**Mr. Steven Wright:**

Mr. Wright was observed with his two children at his residence in the Blue Ash neighborhood of Cincinnati. The Wright residence is an approximately 3300 square foot two story house with a fully finished basement, which is attractive and well kept. The home also has a fenced in backyard with a deck and extensive landscaping. At the time that the home observation was conducted, John and Julie had just returned from school.

During the home observation, Mr. Wright provided this examiner with a tour of the residence. In general, Mr. Wright’s residence was clean, well stocked with food, and did not contain any safety hazards. There were photographs of the children displayed in the house and educational and recreational activities appropriate to the developmental level of the children. John and Julie have a room that they share in the basement, which is decorated, but does not provide adequate privacy given their ages and separate genders.

After concluding the tour of the residence, Mr. Wright and both children were observed together in the family room engaging in a board game activity selected by Mr. Wright. While the children were actively involved in the game activity, it was also apparent that Mr. Wright took a dominate role in the game activity, gratuitously telling each child when it was their turn to participate and frequently offering advice or counsel concerning their game strategy. While the children participated, they were
generally fairly quiet during the game and at times appeared irritated or annoyed by their father’s degree of control and dominance. In general, Mr. Wright was able to communicate clearly with his children and he appeared to be warm towards them. He was not particularly sensitive to signals from his children regarding their irritation with his dominance and his interactions with them did little to support their independence. Mr. Wright was consistent in his interactional style with the children and both parent and child appeared to be reasonably comfortable in interacting with each other.

Ms. Jennifer Smith:

Ms. Smith was observed with her children and Richard at her residence in Colerain Township. Ms. Smith and Richard own a four bedroom, two story house of approximately 2200 square feet with a fully finished basement. The residence includes a fenced in and fully landscaped backyard and the entire property is clean and well-kept. The home visit occurred in the late afternoon shortly after John and Julie had returned home from school.

During the home observation, Ms. Smith and Richard provided this examiner with a tour of the residence. In general, the Smith’s residence was clean, well-stocked with food, and did not contain any safety hazards. John and Julie each have a bedroom on the second floor of the residence and they share a bathroom.

Ms. Jennifer Smith was observed with her two children involved in washing and cleaning the family automobile. Both children appeared generally relaxed in the presence of their mother, and there was a free-flowing interaction that displayed a considerable amount of cooperation between all parties. Ms. Smith gave each of the children a particular area of responsibility for cleaning and waxing the vehicle and she used the opportunity to foster independence in the children and she appropriately avoided the use of negative or punitive controls. Ms. Smith appeared to accurately perceive the children’s responses and needs and she was consistent in terms of her interactional style with both Julie and John. Finally, both Ms. Smith and her children appeared to be comfortable in interacting with each other and Ms. Smith appeared warm and responsive towards her children.

SUMMARY AND RECOMMENDATIONS:

Steven Wright and Jennifer Smith were referred by the Hamilton County Court of Domestic Relations for a psychological evaluation to aid in determining a custody arrangement for their two children, John and Julie Wright.

Mr. Wright is a generally well functioning individual, however; he is very controlling and may, at times, confuse his own needs and desires with those of his children. He has a stable financial situation and he has appropriate knowledge regarding his children’s needs. Although he presents himself as a conscientious and open minded individual, Mr. Wright is concrete in his thinking and he is unwilling to compromise for the benefit of the children. He is self-centered and displays a demanding and insensitive reaction to Ms. Smith’s concerns regarding their children, stating that he has superior decision-making abilities. As such, he has excluded Ms. Smith from the discussion of several important parenting decisions, particularly the children’s education and medical care. Indeed, Mr. Wright attempted to transition the children’s medical and dental care from their previous and
established providers to professionals in his area of residence. Moreover, he has poor insight into his relationship with his son, overestimating the sense of security that John has with him. Despite Mr. Wright’s maladaptive personality traits, he is emotionally attached to his children and is genuinely concerned for their well-being.

Ms. Smith is also a generally well functioning individual, although she has on occasion allowed her anger towards Mr. Wright to result in significant parenting conflicts. She expressed concern that Mr. Wright has excluded her from several important parenting decisions regarding her children’s education and medical treatment. Since Mr. Wright’s marriage to Theresa, Ms. Smith has become increasingly antagonistic towards Mr. Wright. Nevertheless, Ms. Smith is emotionally attached to her children and is genuinely concerned for their well-being.

While both parents are genuinely concerned about the welfare of their children, it appears that their animosity toward each other has hindered their parenting ability and resulted in undue stress regarding a custody arrangement for their children. Further, Mr. Wright does not appear to appreciate the emotional distress that is being experienced by his children as reflected in both interview findings and results from the CBCL and SIPA.

John and Julie both expressed the desire to maintain contact with Mr. Wright and Ms. Smith and expressed positive feelings toward their parents and stepparents. The conflict and animosity between Mr. Wright and Ms. Smith has resulted in feelings of confusion and resentment for both children. Indeed, John has become significantly more withdrawn and quiet since the animosity has increased between his parents. He is ambivalent regarding his choice of high school, although he indicated a preference towards his mother’s residence because his friends all reside in Colerain Township. Julie is an outspoken girl, and she indicated a desire to remain attached to both parents, however, she would prefer to maintain her schooling and medical treatment in Colerain Township. Moreover, she strongly expressed her wish that her father would include Ms. Smith when making major decisions.

Based on the results of this evaluation, it is recommended that Ms. Smith be designated the residential and custodial parent for John and Julie. She resides in Colerain Township and has separate sleeping arrangements that are suitable for adolescent children of the opposite gender. Ms. Smith’s residence provides continuity in the children’s education and social life. She is also more willing to include Mr. Wright in parenting decisions than he is with her.

Despite the fact that it is in the best interest of the children for Ms. Smith to be designated as custodial parent, John and Julie remain strongly attached to their father. Therefore, it is recommended that Mr. Wright have liberal visitation with both children, however; it is imperative that Mr. Wright provides accommodations for gender separate living arrangements for the children before overnight visitation is reinstated. It is also recommended that both children, but particularly John, be encouraged to discuss their feelings about the family’s current custody conflict with a mental health professional. Although Julie appears to be doing well despite the family conflict, John appears to be a particularly sensitive adolescent who may be experiencing symptoms of depression and anxiety in reaction to family turmoil. Therefore, treatment services appear to be optional for Julie, but it would appear im-
Targeted Risk Assessment: Intimate Partner Violence

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Abstract

Intimate partner violence (IPV) reaches epidemic proportions worldwide. There is obvious great need for reliable and valid assessment tools designed to estimate its risk. This article serves as a comprehensive review of prominent risk assessment tools designed to measure IPV, specifically, the Spousal Assault Risk Assessment Guide (SARA), the Ontario Domestic Assault Risk Assessment (ODARA), and its closely related Domestic Violence Risk Assessment Guide (DVRAG). For years, SARA has served as a framework by which clinicians can gather information about sex offenders, serving as a guide to law enforcement and mental health professionals. A significant and recent development in targeted risk assessment and actuarial prediction emerged with the advent of ODARA and by extension, the DVRAG. ODARA is not spe-

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Abstract continued

cifically designed for use by clinicians, rather, law enforcement personnel and persons assisting the courts (e.g., victim advocates, court clinicians). ODARA generates not only percent risk of recidivism scores, but can be interpreted with the purpose of determining how soon someone may reoffend, and potential lethality of this offensive behavior. Strengths and weaknesses of these tools are considered, followed by relevant sources should the reader desire to learn more about these assessment tools.

Targeted Risk Assessment: Intimate Partner Violence

Years ago at the annual meeting of the American Academy of Forensic Sciences, a presentation was given by attorneys and law enforcement officials from Cook County (Chicago), Illinois. The topic was domestic violence and each of the agencies presented information relevant to their specific mission. For those fortunate to be in attendance, the presentation is memorable for two reasons. Firstly, the amount of resources and dedication these persons put into their jobs was most obvious and impressive. Secondly, the scope of the problem, domestic violence in Chicago, was startling. The audience was informed that tens of thousands domestic violence complaints were phoned into Chicago area police over a given year. Moreover, these presenters asserted that the reported complaints were only the “tip of the iceberg,” with estimates that the problem is much greater and more severe than reports indicated. The cost to public health, the danger posed to law enforcement personnel, the heavy toll on the judicial system, these were but some of the factors discussed when presenting the complexity of this problem. Moreover, Chicago is not unique as domestic violence has reached epidemic proportions nationally, and it cuts across all segments of society. Recent Department of Justice statistics paint a picture of domestic violence in the USA. It is reported that one-third to one-half of all married couples will experience at least one episode of intimate partner violence across the life of their union together, with 9 of 10 episodes perpetrated by males against their female partners. This translates to over 4 million reported incidents yearly, and there is evidence that this number is likely a gross under-estimation of the sum of incidents actually perpetrated, as many incidents are never reported. It should be considered that with extreme cases such as murder, 10% are spouse on spouse; nearly one-third of women killed are victims of their husbands, domestic partners, or boyfriends (http://bjs.ojp.usdoj.gov/).

Mental health professionals who work in hospitals, community settings, judicial systems, and correctional settings are often called upon to evaluate and treat both victims and perpetrators of intimate partner violence. Therefore, it is imperative to have the requisite skills to identify either who is at risk for perpetrating such violence, or who may be at risk for victimization. This article introduces the reader to specific risk factors strongly associated with domestic violence, also specifically termed “intimate partner violence.” A framework for assessing such risk will be discussed in detail with a description of the Spousal Assault Risk Assessment Guide (SARA; Kropp, Hart, Webster, & Eaves, 1999). In addi-
tion, an actuarial tool for the prediction of intimate partner violence risk called the Ontario Domestic Assault Risk Assessment (ODARA; Hilton, Harris, Rice, Lang, Cormier, & Lines, 2004) and its more in depth version, the Domestic Violence Risk Appraisal Guide (DVRAG; Hilton, Harris, Rice, Houghton, & Eke, 2008) are discussed.

The SARA was designed to assess risk of recidivism in persons who have been arrested for domestic partner violence. The normative sample (N = 2,309) was largely composed of two groups of adult male offenders in Western Canada, one larger sample containing probationers (N = 1,671) for crimes related to spousal abuse, and a smaller sample of male inmates (N = 638) serving custodial sentences for various crimes, but with known histories of spousal assault (Kropp, et. al., 1999). Correctional, mental health, and research staff made SARA ratings. Interrater reliability of the SARA was analyzed using the normative samples and was found to be high for overall predictive risk (Total score = .84, Part 1 = .68, and Part 2 = .87; Kropp & Hart, 2000). Grann and Wedin (2002) used receiver operating characteristics (ROC) analyses to examine the predictive validity of the SARA among spousal assault and spousal homicide offenders. The ROC-curve plots the sensitivity (hit rate) and specificity (false-alarm rate) of the measure as well as the area under the ROC-curve (AUC) to interpret the probability that a randomly selected recidivist will score higher than a randomly selected non-recidivist. The AUCs ranged from .49 to .65 and the SARA total scores identified recidivism with a sensitivity of .82 and specificity of .50. This indicates that the SARA demonstrates a marginal but statistically significant ability to predict recidivism over chance.

Additional studies that examined the psychometric properties of the SARA include Williams and Houghton (2004) and Wong and Hirashima (2008) (as cited in Otto & Douglas, 2010). Williams and Houghton primarily examined the predictive and concurrent validity of the Domestic violence screening Instrument (DVSI); however, referenced the SARA for comparison purposes. The SARA was completed on a subsample (N = 434) of the original 1465 male offenders arrested for violent acts against female intimate partners. Williams and Houghton utilized ROC analysis in examining the predictive validity of the measure. The authors’ findings suggested the SARA total scores (AUC = .65) predicted intimate partner violence recidivism significantly better than chance. Furthermore, the concurrent validity of the SARA was assessed by correlating the SARA with the DVSI. The authors found agreement between the two instruments to be moderate (r = .54; Otto & Douglas, 2010). Wong and Hirashima studied the predictive validity of the SARA using a sample of 196 violent offenders from the years 2003 to 2007. The authors categorized the offenders into two groups of risk, low-medium and high, based on the percentile distributions provided in the Spousal Assault Risk Assessment guide: User’s manual (Kroop, 1999). Analyses discovered that 32% of those offenders placed in the high-risk category and 17% of offenders placed in the low-medium-risk category were arrested for domestic violence offenses within the three months following the original assessment. Furthermore, 66% of the high-risk offenders and 45% of the low-medium-risk offenders were rearrested for general offenses (Otto & Douglas, 2010).

Based on a thorough review of both the clinical literature and empirical studies relevant to domestic violence, in particular, spousal assault, a list of risk factors
for violence was generated by the authors of the SARA in its development. “Spousal assault,” was defined as “any actual, attempted, or threatened physical harm perpetrated by a man or woman against someone with whom he or she has, or has had, an intimate sexual relationship” (Kropp et al., 1999, p.1). The assessment is based (ideally) on multiple sources of information. The more sources you have and greater their reliability (i.e., thru corroboration), the more accurate the risk assessment. The old adage, “Garbage in, garbage out!” holds particularly true here. Interviews with both victim and perpetrator are recommended. Any standardized measures that rate physical and emotional abuse, and the extent of substance abuse are useful. Collateral records of any kind including police reports, previous criminal records, and pre-sentence investigations are excellent sources of information. After collecting these, the risk evaluator can use the SARA Assessment Form to rate 20 different factors. Some of the risk factors are considered to be “static,” that is, historical in nature; they cannot be changed (e.g., a previous conviction for domestic violence). Others are seen as “dynamic” risk factors that tend to wax and wane over time (e.g., substance abuse). These 20 risk factors are rated on a 3-point ordinal scale (absent, subthreshold, and present; 0 thru 2 respectively). In this manner, a SARA Total Score can be generated at the end of the assessment process. However, the point of the evaluation is not to generate a number per se, but rather to carry out a comprehensive risk assessment that considers all known parameters of risk. In this sense, the SARA is better considered a memory aid for the evaluator entrusted with carrying out a comprehensive risk assessment for domestic violence (Kropp et al., 1999).

SARA factors are divided into two main categories: (A) Risk Factors for General Violence; (B) Risk Factors for Spousal Abuse. When assessing for violence risk in general, the SARA considers the evaluatee’s criminal history, all factors well known to be associated with criminal recidivism. These include rating the evaluatee’s history of past assault toward family members (1), past assault of others (2), and past violation(s) of conditional release or community supervision (3) such as pretrial probation or parole. The SARA then considers the evaluatee’s adjustment to living life in the community, the “psychosocial” functioning of the perpetrator. Factors rated include whether or not the evaluatee has a stable relationship history (4) and occupational history (5). It also includes the evaluatee’s exposure to domestic violence either as a victim (e.g., during his/her formative years), or as a witness to family violence (6). Further, consideration is given to dynamic factors such as whether the evaluatee has recently struggled with active mental illness (e.g., psychosis or mania; 7), substance abuse (8), or experienced suicidal and/or homicidal ideation (9). Lastly, constituting both a static and dynamic factor, the evaluatee is rated for the presence of personality disorder, that is, enduring character traits that influence a person’s proclivity to act out impulsively, perhaps with anger or rage (10) (Kropp et al., 1999).

The following SARA risk factors are specifically related to spousal assault history. The evaluatee is rated on history of physically assaultive behavior (or attempts thereof) toward past or present intimates (11), a history of previous sexual assaults and/or extreme sexual jealousy (12), and past use of weapons during assault incidents or otherwise credible threats to kill their intimate partners (13). Consideration is given to the cycle of intimate partner violence with attention paid to recent escalation in number of violent incidents, and/or increased severity of the violence (14). As with the factor described above rat-
ing failure of community supervision, SARA specifically considers past violations of no contact orders, sometimes labeled restraining orders, protection orders, or peace bonds, created to protect an intimate partner from her assault prone domestic partner (15). These next risk factors take into consideration how the assault perpetrator frames their experience. Do they deny culpability and/or minimize the effect of their violent acts? If so, this is rated by SARA (16). Do they espouse beliefs that demonstrate tacit support for violence against their spouse? For example, a subgroup of intimate partner violence perpetrators have been known to cite passages from the Bible which they believe condone their right to “keep their wife in line” when they determine such actions are “required.” In another context, persons known to participate in sadomasochistic sexual relationships with reported mutually agreed upon seemingly abusive acts, have been known to sometimes escalate their aggression to dangerous, illegal proportions. The first author recalls one felony assault and kidnapping case in which the perpetrator, when evaluated, strongly asserted that “she (the victim) loves it,” referring to his physical abuse of her, and that she specifically requested that he “punish” her when he deems she is getting “out of line.” She was addicted to heroin, much of which he supplied. These can be considered examples of justification for spousal assault and are rated as a risk factor (17). The last three risk factors assessed are specific to the most recent “index” offense (either alleged or perpetrated). The degree of offense severity is rated (18), use of weapons and/or threats of lethality are considered (19), and lastly, whether or not the most recent assaultive episode constituted a violation of a no contact order (20; Kropp et al., 1999).

According to Kropp et al. (1999), cumulative scores can be computed and these tallies can be compared with scores generated by the normative sample or other studies. Yet, the strength of the SARA is its comprehensive approach to risk assessment. It allows one to take a behavior analytic perspective and if deemed clinically appropriate, place more emphasis on specific risk factors that may be seen as “triggering” the assault. This approach to assessment stands in contrast to the ODARA and the DVRAG, our next assessment tools to be described, which are designed to be used as actuarial instruments in predicting risk of recidivism for domestic violence.

The ODARA is designed specifically to assess for risk of domestic assault in men toward their intimate partners. By “risk,” it is meant the probability of another act of domestic assault, recidivism of physical violence. The ODARA is an actuarial tool meaning that it is designed solely for prediction and as such, there is no room for unstructured clinical decision making as allowed (or even encouraged) by the SARA. There is also no emphasis placed on self-report, an approach seen as too open to misrepresentation of the facts (Hilton, et al., 2004). The development of the ODARA simply involved tracking a group of known intimate partner violence perpetrators over time and see who reoffends and who does not. Characteristics of the offender, the offense, and the victim were carefully analyzed to generate a best fit risk assessment equation to predict recidivism. Most importantly, the equation does not need to account for every factor that is associated with recidivism. Only those factors that contribute uniquely to the formula are taken into account; redundant factors are cast aside, not needed, as they add nothing to the betterment of the risk equation’s accuracy.
or predictive validity. Moreover, since the exact prevalence of domestic violence may not be known in a given population, the ODARA is created to minimize the number of false positive predictions (i.e., persons who will not reoffend though predicted to do so), as well as false negatives (i.e., persons predicted to not reoffend though in fact, they will; Hilton, Harris, & Rice, 2010).

The ODARA was normed on three separate samples of individuals known to be perpetrators of intimate partner violence totaling greater than 1,400 males. There were more than 30 independent variables all shown to significantly correlate with recidivism, and these were limited to the 13 that best predicted who would reoffend (described below). These variables are all taken directly from police reports and criminal records, and do not rely upon any self-report data. The percentage of recidivists in the total sample was 32%. The interrater reliability of the ODARA was found to be .90 (Hilton et al., 2010). In terms of predictive validity, the ODARA yielded an AUC of .77 indicating there is a 77% chance that a randomly selected recidivist would have a higher score than a randomly selected nonrecidivist (Hilton, et al., 2004, Hilton et al., 2010).

One starts the ODARA assessment by identifying the “index assault,” that is, the most recent assault known by law enforcement in which physical contact with a wife (present or previous) or domestic partner (present or previous) or a credible death threat is made with weapon in hand. The first rated ODARA risk factor (#1) is entitled Prior Domestic Incident defined as the index assault plus another prior domestic violent incident along with these incidents being reported or handled by law enforcement. If all three of these elements are present along with an identifiable victim (wife, intimate partner, or her child(ren)), then the risk factor is marked as present and as with all risk factors, it is assigned a score (1). If not, no score is assigned (0). The next risk factor (#2) is labeled Prior Nondomestic Incident defined as an violent incident perpetrated by the man prior to the index offense that was reported to or investigated by police and did not involve a wife, prior spouse or domestic partner, or her child(ren). Prior Custodial Sentence of 30 Days or More is the next identified risk factor (#3). This is defined as a “sentence” meted out before the index assault resulting in incarceration of 30 days or more in a jail, prison, or like facility where civil liberties are restricted by law enforcement. The key element here is that the sentence itself must be for 30 or more days and at some time must be served incarcerated (no suspended sentences). The next risk factor is Failure on Prior Conditional Release (#4) defined as a criminal incident in violation of conditional release (e.g., probation or parole) occurring at the time of the index offense (i.e., the index offense constitutes the actual “failure”), or on a separate occasion prior to the index assault), or a charge committed while on conditional release (Hilton et al., 2010).

Hilton et al. (2010) found the next two risk factors to be specific to the index assault itself. If there was a threat to harm any person physically regardless of whether it was carried out, this constitutes a Threat to Harm or Kill at the Index Assault (#5). If there was actual physical prevention of the victim from fleeing or leaving the place where the assault occurs, that qualifies as Confinement of the Partner at the Index Assault (#6).

The next identified risk factor, Victim Concern (#7), is most interesting. It is defined as the following: “a statement made by the female partner who is a victim of
the index assault and a statement made in the victim’s first reports to the police, or to victim services ... and a statement that indicates concern, fear, worry, or certainty pertaining to a possible future domestic assault” (Hilton, Harris, & Rice, 2010, p.160) toward her or the child(ren). The ODARA takes the female victim’s expressed concerns for her or her children’s safety very seriously as it was found to be a significant factor in the risk equation; if the risk factor was not found to be statistically significant as adding to the betterment of the prediction equation, it would not have been added to the ODARA. Though the inclusion of this factor on the surface seems like a victory of sorts for victims’ rights, the decision to include it is statistically driven and thus, defensible in the court as meeting evidentiary standards (Hilton et al., 2010).

Two risk factors are included in the ODARA that are relevant to children of the perpetrator and the victim. It simply considers “the number” of children sired or adopted by the perpetrator plus “the number” of children given birth or adopted by the victim. If the total for both is greater than one child, that factor is significant and assigned a value (1) and is labeled the More Than One Child (#8) factor. The other factor considers whether the assault victim has a biological child or children sired by another male other than the perpetrator of the index offense. If so, this factor labeled Victim’s Biological Child from a Previous Partner (#9) is included in the ODARA total score and the value (1) is added (Hilton et al., 2010).

The perpetration of violence by the male who was reported in the index assault is considered next. The incident of violence must have occurred on a separate occasion before the index assault, and the victim must be someone other than the female assaulted at the time of the index event, or any previous female domestic partner. Most importantly, what makes this risk factor different from Prior Nondomestic Incident (#2) is that no police involvement is a requirement for this factor. So, if the perpetrator met criteria for Prior Nondomestic Violence, he will automatically meet criteria for Violence Against Others (#10), the label assigned to this risk factor. However, the reverse does not hold necessarily true. Where do these reports of violence come from? It may be related by collateral informants cited in other investigations (e.g., presentence reports, records from civil commitment proceedings, etc.).

As with so many other assessment tools that consider risk of violence across differing populations, ODARA rates Substance Abuse as a significant factor (#11). To qualify, two or more of any number of conditions must be present including: the male assault perpetrator having drank alcohol and/or used drugs prior to or during the index assault; abuse of alcohol and/or drugs in the days or weeks prior to assault; the increased abuse of alcohol and/or drugs in the days or weeks prior to the index offense; substance abuse correlated with increased anger and violence; a history of abusing alcohol and/or drugs and acting out in a criminally offensive manner; alcohol and/or drug usage since age 18 causing significant interference in his day-to-day functioning (Hilton et al., 2010).

If the male perpetrator has any history of domestic violence (including the index assault) toward his spouse or domestic partner indicating that he assaulted at the time of the index offense or at any time period in which she is pregnant, this qualifies for the next ODARA risk factor called Assault on Victim When Pregnant (#12).
Lastly, the ODARA carefully considers the life circumstances of the victim of the index assault looking to
determine if there are “barriers” that may impede the woman from reporting domestic violence. For example, it
considers if the victim has minor dependent children living with her, whether she has a phone, access to transportation (e.g., a car, near a public transit station, can afford a taxi), lives near others (as opposed to an isolated rural existence), and finally, whether or not she abused alcohol and/or which can interfere with her ability to respond appropriately to domestic abuse. Any one of these conditions triggers this risk factor labeled Barriers to Victim Support (#13; Hilton et al., 2010).

The ODARA total score is simply summed and compared to the normative sample’s scores yielding a percent recidivism score to consider when classifying risk of the offender being assessed (Hilton et al., 2004). For a more refined risk assessment of offenders deemed more dangerous, the same risk factors from the ODARA can be scored on a continuous scale (as opposed to the ODARA’s dichotomous “1 or 0”) and then factored in to the risk equation is the “gold standard” of all risk instruments, the Psychopathy Checklist – Revised (PCL-R; R.D. Hare, 2003), which is added to many other violence risk assessment tools (e.g., HCR-20) to sharpen the process yielding more precise risk of violence predictions (Hilton et al., 2008). After nearly twenty plus years of research on psychopathy, it is now well understood that persons who score high on the construct of psychopathy as measured by the PCL-R are significantly more dangerous individuals, typically perpetrating more heinous violent crimes and in disproportionately higher numbers than criminals without strong psychopathic traits (see Christopher J. Patrick’s book entitled Handbook of Psychopathy published by Guilford Press (2007) for a good review of this literature). This more in depth measurement of the 13 ODARA risk factors along with the PCL-R makes up an instrument called The Domestic Violence Risk Appraisal Guide (DVRAG; Hilton et al., 2008). With addition of the PCL-R to the DVRAG, the qualifications for using this assessment tool are more stringent. Learning how to score the PCL-R requires specialized training and practice, and it tends to lend itself more to those with clinical training in the mental health assessment and treatment fields. In fact, psychopathy is now being called a personality disorder by many researchers and there are indications that the forthcoming (in 2013) Diagnostic and Statistical Manual (DSM-V) task force studying personality disorders may in fact label one of the personality disorders “Antisocial/Psychopathic.”

This brief article describes what are considered the best tools for the assessment of domestic violence risk or what many now call “intimate partner violence.” In addition to the sources listed at the end of the article, the Handbook of Violence Risk Assessment by Otto & Douglas (Eds.; 2010) is a beneficial guide on the usage of the SARA and ODARA. The sources introduce the reader to the relevant literature so that one can give proper consideration as to when to do formal risk assessment, how to interpret it, and most importantly, how to frame the parameters of risk in reports to legal authorities, as well as treatment providers. These are skills utilized by forensic evaluators who are called upon to prepare risk assessments for the courts (e.g., pre-sentence), or who may work collaboratively with victim advocacy groups. Law enforcement can use these tools to gauge risk of reoffending, and make informed decisions regarding implementation of scarce resources associated with pre-trial release,
probation, and parole. Treatment providers can utilize these measures to specifically identify risk factors related to relapse, thereby identifying targets for clinical intervention and informing the creation of comprehensive relapse prevention plans.

Lastly, the authors would be remiss not to give caution; this is not a field of expertise to “dabble in,” so to speak. One should always consider how others with different agendas or a distinctly different role than the evaluator could use the results of formal violence risk assessment. Just as there could be dire consequences for someone labeled “a malingerer” possibly precluding him or her from receiving needed mental health services, persons labeled as “psychopaths” could be deprived of civil liberties or kept from receiving innovative psychosocial treatment. With tools designed to measure intimate partner violence, scores on assessment instruments should not automatically trigger implementation of protection orders as such intervention may inculcate more danger for the victim whom it is designed to protect (Benitez, McNeil, & Binder, 2010). Those considering using these risk assessment tools are encouraged to become familiar with the ethical guidelines promulgated by professional organizations servicing forensic psychiatrists, forensic psychologists, and forensic social workers.

References


Best Practices in Adult Sex Offender Treatment

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Abstract
Societal concern regarding the placement and presence of adult sex offenders has reached new highs in recent years. A significant body of research has developed demonstrating the efficacy of various techniques (e.g. Hall, 1995; McGrath, Hoke, & Vojtisek, 1998) in the treatment of adult sex offenders. Treatment of adult sex offenders is beneficial in terms of reduced recidivism and lowered cost for incarcerating those who do reoffend as well as providing offenders with increased opportunities to integrate themselves back into society. This review will address the methodological issues and problems that have delayed the development of empirically supported treatment, summarize the recent developments in the treatment of sex offenders, and finally discuss the future directions of research in this area, including the development of the Good Lives Model (Ward & Gannon, 2006) as well as techniques used to address criminogenic needs (Ward & Stewart, 2003).

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ers), in the questions that they can ask (mandated reporting laws may prevent research from examining crimes for which offenders have not been prosecuted) and in methodology available (the standard techniques of using an untreated or not meaningfully treated comparison group may not be used). Given the great cost of potential recidivism, one would think research in this area would have progressed more quickly, when compared to research on anxiety or mood disorders, which have much lower societal costs. However, research in the area of sexual offending has lagged behind its potential, due in part to the fact that many of the standard techniques of the clinical researchers, such as wait-list controls and non-treatment comparison groups, are generally unfeasible with this population. Furthermore, because of the cognitive-behavioral nature of the interventions, placebo controls are also problematic.

Generally speaking, because of mandated reporting laws, the illegal nature of the behaviors in question, and the uncertainty inherent in any human legal situation, determining the presence of recidivism or even defining it is not only problematic, it is the subject of a great deal of debate. Treatment, too, has ethical and practical concerns; many clinicians have strong emotional reactions to sex offender clients that may compromise their ability to work with them, and mandated reporting issues can become very salient and may prevent the client’s disclosure of necessary or important information. All told, to the uninformed clinician, finding an ethical, efficacious and effective treatment for a sexually offending client can be quite the frustrating experience. In this review, we will first review the pertinent methodological issues affecting the research, focusing mainly on Randomized Controlled Trials (RCTs) and the interpretation thereof, and how these issues affect the treating clinician. We will also review alternative research designs. Second, we will review the currently accepted best practice techniques for the treatment of sexual offenders, along with the strengths and weaknesses of each treatment. Finally, we will review the future directions of research in this area, focusing particularly on the need for a change in attitude towards the treatment of sexual offenders.

**Methodological Issues**

Over the last two decades the emphasis on empirically supported treatment has grown within the psychotherapy community (see Chambless et al., 1998). In order to select empirically supported treatments appropriately, it is necessary to understand some of the methodological issues involved in developing them. In the area of sex offender treatment research the key issues include: What constitutes a methodologically sound study, and how do we define recidivism?

The “gold standard” for sound methodology in clinical research is the randomized controlled trial (RCT). In this type of study, clients are randomly assigned different groups. The groups then each receive interventions, with one typically getting a placebo or some other sort of control treatment (attentional, alternate treatment, etc.), and the other receiving the treatment under investigation. The groups are evaluated immediately before and after the intervention, and the results are compared. Groups are assigned randomly in order to distribute error variance randomly (this evens out any differences between the groups that may affect the final outcome by allowing randomization to spread those differences across the groups). Evaluation before and after the intervention allows a measurement of the groups “absolute improvement.” Evaluation of
multiple groups allows a measurement of their relative improvement, thereby allowing a determination of which interventions are better than a placebo control, and which are better than each other. Although the concept is simple, running an RCT is frequently logistically difficult. It is difficult to perform truly random assignment (e.g., individuals who can attend morning interventions may be systematically different from those who attend evening sessions), so situations may make this methodology unworkable. The strictures of the justice system cause many methodological problems. There are few authorities within the judicial system willing to sentence an offender to a placebo control, particularly if ANY type of therapy has been shown to be effective, given the consequences they may face if an offender who was not given treatment reoffends. This, of course, has the unintentional consequence of making RCTs using known sexual offenders functionally impossible in many jurisdictions.

The debate over the efficacy of sex offender interventions has been predicated on the necessity of RCTs. RCTs are widely considered to be the benchmark on which medical and psychological treatments are examined (APA Presidential Task Force, 2006). Treatments without RCTs to support their effectiveness are relegated to a lower level of scientific support. Many reviews have concluded that not only can the effectiveness of sex offender treatment not be established because of the lack of RCTs, but also that any evidence of treatment effectiveness is difficult to establish without them (Quinsey, Harris, Rice, & Lalumière, 1993). This issue is the heart of the debate surrounding the establishment of empirically supported treatments for sexual offenders. Early examinations of the treatment efficacy literature concluded that almost all the available evidence lack enough methodological rigor to conclude that treatment was effective (Marshall, Jones, Ward, Johnston, & Barbaree, 1991). Underlying these issues is an argument over the relative importance of internal and external validity. RCT proponents argue that without appropriate randomized control, efficacy research is fundamentally ineffective (APA Presidential Task Force, 2006), as any meaningful change in the dependent variables of non-RCT studies could not be isolated to the effect of the independent variable (in this case, the treatment in question). RCT detractors argue that the treatments used in research should reflect those used in the clinical world, where manualized, controlled treatments are relatively unused, due to their practical infeasibility. Practitioners of psychological treatments rarely possess the necessary resources to implement some manualized treatments, while others have only been shown effective with a relatively narrow band of disorders, thus limiting the generalizability of the manuals to general clinical practice. Recently the resistance against RCTs has coalesced, with Marshall and Marshall (2007) laying out the objections against them. They argue that, in the sample sizes used in these studies, groups are rarely large enough for randomization to be effective in controlling error variance. Matching designs (research designs that attempt to skirt randomization by controlling for all known variables affecting the dependent variable, thus creating the same effect as true randomization) are undermined by the fact that researchers currently lack the knowledge of which variables are salient, and thus should be the targets of matching. Furthermore, given that RCTs require participants to give consent in order to be involved, the offenders that do not give their consent are likely to be among the most dangerous and difficult to treat, further reducing external validity. Ultimately, the concern is that, with some of the contingencies involved in
forensic treatment, the ability of RCTs to measure treatment outcomes in a way that is representative of the way these treatments are used in the real world is necessarily compromised.

So if the RCTs, the technique of choice and the “industry standard” of establishing efficacy versus effectiveness had failed, what should clinicians focus on when attempting to provide effective and efficacious treatments to individuals with these disorders? Marshall and Marshall (2007) point to the importance of the responsivity principle (Andrews & Bonta, 1998), the need for the treatment supplied to match the learning style of the offender (Looman, Dickie, & Abracen, 2005). Within most treatment contexts, this is difficult to alter; within the confines of a strictly manualized RCT, this is even more difficult or impossible. They argue that research has shown that a significant proportion of the variability in outcomes in treatment is related to warmth, empathy, and directiveness; factors that are typically overlooked in favor of treatment specific component effects within an RCT based design. If these criticisms are valid, then RCTs will continue to fail to find an effect on recidivism for sex offender treatment (Marques, Nelson, Alarcon, & Day, 2000; Marshall, Jones, Ward, Johnston, & Barbaree, 1991). The bottom line, however, is that treatment designs that withhold treatment from potentially dangerous offenders are unacceptable to those in control of the judicial system. The contingencies for prison administrators, judges, and parole board members make allowing a group of sexual offenders to go untreated an impossible option. It is difficult to tear down established practice without providing alternatives, and some attempts at alternative strategies have been made.

The exploration of alternative design methodologies is still in its infancy and gives little in the way of comfort. Two principle techniques have been suggested, incidental designs (Hanson et al., 2002) and actuarial-based evaluations (e.g.; Beech & Ford, 2006; Friendship, Mann, & Beech, 2003). Incidental designs rely on the fact that within any system, some individuals will necessarily remain untreated despite the best efforts of the system to the contrary. This incidental comparison group may be formed of offenders who have gone untreated for a number of reasons, such as limited treatment resources or a lack of mandated treatment. Some incidental studies have drawn their comparison groups from archival information on offenders who were present before treatment was available. Although incidental designs bypass a number of the ethical and practical problems involved in RCTs, they have their own methodological problems. Most notably, studies employing this design must account for the often large differences between the comparison group and the group to receive treatment, in large part due to some of the factors (personality, lack of available resources, etc.) which resulted in a lack of treatment initially. Thus, due to the lack of randomization, there is no guarantee the comparison group matches the experimental groups on any number of variables that might affect their recidivism. Actuarial based evaluations rely on the growing body of research using actuarial indicators to measure the risk of reoffense. In these studies, the client’s recidivism is compared to predicted levels of recidivism, based on actuarial measures. Although this introduces an extra layer of experimental error, it overcomes the difficulty of having a direct comparison group, by having subjects essentially serve as their own control group. Although this method is not without limitations, and is inherently limited by the
ability of the actuarial formula to actually predict re-offense, Marshall and Marshall (2007) argue that, in the absence of a meaningful control group, this may be an effective route to take.

The final word in studying recidivism is that it is difficult, and that difficulty is inherent in the subject matter studied. Making sense of the research in this area will therefore require researchers to utilize multiple methods of study in order to develop converging lines of evidence, due to the inherent flaws in many of the designs outlined in the sections above. Evidence converging across multiple study designs lowers the probability that the outcomes observed were due to the systemic effects of any individual study design used. In addition, the difficulties inherent in conducting research in this population further requires those that make use of that research, either through policy or use of established techniques, to be critical consumers of research. Those who are dissatisfied with the current field of sex offender treatment research, who are also engaged in treatment, are encouraged to include their own measures of change and outcome with clients, if for no other reason than to establish that their own interventions are working. Indeed, whenever scientific evidence is scant or lacking, the treating clinician has an ethical obligation to the clients they serve to consistently and mindfully measure whatever variables their intervention is designed to alter, as well as monitoring the general outcomes of their clientele.

**Specific Intervention Techniques**

Common opinion amongst clinicians is that group therapy for sexual offenders is more effective than individual treatment, with the explanation that group members can learn from other offenders’ experiences and apply these lessons to their own situation. More cynical observation minimize the chance of relapse. Relapse prevention has been significantly modified from its original form, but the core concepts remain the same. The heart of relapse prevention is psychoeducational; offenders are taught to understand the imbalances of lifestyle, including events, choices, and states that contribute towards their offending. They are then taught compensatory strategies in order to avoid, escape, or cope with those contributory factors.

Offenders are required to generate a behavior chain (sometimes referred to as an offense chain or an offense cycle) and examine “seemingly unimportant decisions,” internal and external high risk situations, and triggers that took place during that period. “Seemingly unimportant decisions” are decisions that do not appear relevant at the time of the offense, but lead the offender to come into contact with high risk situations or triggers. High risk situations are divided into internal high risk situations and external high risk situations. Internal high risk situations are internal states that place the offender at higher risk to re-offend and may include sexual arousal, depression, anxiety, or boredom as well as altered states such as intoxication. External high risk situation are places or situations that cue inappropriate behavior. These may include bars, stress at work, or the presence of pornography. Finally, triggers are events or experiences that help initiate action towards a sexual offense, such as losing one’s job or an argument with one’s spouse. Marlatt and Gordon (1985) showed that negative emotional states were the most frequent cause of relapse in individuals trying to quit smoking, and it is generally accepted that negative emotional states are often the cause of relapses to other addictive behaviors as well.

Offenders are taught to recognize both lapses and relapses, and to differentiate between the two. A lapse consists of engaging in behavior that could lead to harmful
sexual behavior, such as fantasizing about promiscuous sexual behaviors. By contrast, a relapse is a return to actually engaging in harmful sexual behavior. A related concept is the abstinence violation effect (AVE). When an offender has made a commitment to not engage in harmful sexual behavior and subsequently lapses, the unpleasant feelings generated by the lapse often cause them to feel helpless and give up, thereby precipitating a full blown relapse into offending behaviors. Therefore, part of relapse prevention involves developing contingency plans for lapses and relapses. The offender is called upon to first define, and then generate appropriate courses of action to prevent, a return to harmful or inappropriate sexual behavior.

Relapse prevention has been shown to be effective in a wide variety of sexual offender treatment programs and with a variety of different populations (Hall, 1995) and is the basis of most sex offender treatment programs (McGrath, Cumming, & Burchard, 2003). Currently, a number of programs are beginning to utilize adapted versions of relapse prevention with developmentally delayed populations have shown some promise (Lindsay, Olley, Baillie, & Smith, 1999; Rose, Jenkins, O’Connor, Jones, & Felce, 2002) but the research base is still under development. The use of Relapse Prevention with developmentally delayed populations can be problematic, as many of the characteristics of offenders that Relapse Prevention based treatments seek to ameliorate, such as lack of sexual knowledge, poor impulse control, and poor social skills (Day, 1994) are present and may be seen to be intractable in sexual offenders with developmental disabilities (Lambrik, & Glaser, 2004). More tellingly, Relapse Prevention requires planning and cognitive skills that may be beyond the capacity of many offenders with developmental disabilities.

Researchers have suggested that it may be because offenders can challenge other group members more aggressively than many therapist feel comfortable doing. Whatever the reasons, group therapy for sexual offenders is the most common modality used in the United States (McGrath et al., 2003). However, little modern research literature exists comparing the efficacy of the group and individual treatment modalities. Certainly, group treatment requires fewer resources (both in terms of time and money) than individual treatment. Very little empirical research addresses the question of relative efficacy for group and individual treatment (Quinsey, 1977; Wakefield & Underwager, 1991). The general clinical literature indicates that group and individual treatment are approximately equal in effectiveness (Fuhriman & Burlingame 1994), but a number of studies have recently challenged the effectiveness of group therapy with juvenile sexual offenders (Chaffin, 2006; Hunter, 2006; Hunter, Gilbertson, Vedros, & Morton, 2004). Despite this, there appears to be little interest in determining if the same principles apply to adult treatment groups. One study (Di Fazio, Abracen, & Looman, 2001) compared a full treatment program including group and individual treatment with an individual program, including only individual treatment. Di Fazio and colleagues found the two treatment modalities to be similar, with no significant difference between the conditions both in terms of simple recidivism rates and in a survival analysis comparing time to recidivism. Generalizing from this study may be problematic, however, as Di Fazio and colleagues do not compare individual treatment directly to group treatment, instead they compare a compound of group and individual treatment to individual treatment. Thus, their results do not speak to whether group treatment alone is more effective than individual treatment alone. Additionally, the
amount of therapeutic contact is significantly higher than in many programs (individual clients received four hours of treatment per week and group clients received two hours of group and three hours of individual treatment per week) and was not even across experimental conditions. There remains little conclusive evidence suggesting the innate superiority of a group-delivered intervention to an individually delivered one, apart from the obvious economic advantages of the group model.

Relapse Prevention

If there is an industry standard in sex offender treatment, it is relapse prevention. Based on techniques developed by G. Alan Marlatt in the 1980s for the treatment of alcohol and substance abuse (Larimer, Palmer & Marlatt, 1999), relapse prevention is based on a harm reduction philosophy. In substance abuse treatment, it is a well known fact that some form of relapse is not only likely, but common (Marlatt & Gordon, 1985). Capitalizing on this knowledge, the relapse prevention treatment applied to sexual offending seeks to minimize the impact of these relapses, both on the client and those around them, by identifying when they are likely to occur and having specific interventions in place to prevent them. Relapse prevention also seeks to keep “relapses” small, and if they have occurred, prevent them from going further. In terms of sexual offenders, this means one of the main goals of relapse prevention strategies is to catch relapses, or slips, at the level of fantasy, and block them from progressing to a full-blown reoffense. Key in the use of relapse prevention is the understanding that offending is a multiply determined behavior. There are a multitude of factors that increase or decrease the likelihood of reoffense and manipulating many of them is necessary to

Covert Desensitization

Many of the first techniques for treating sexually problematic behavior were developed in the 1970s during the apex of the behaviorist revolution. Not surprisingly, these techniques were highly behavioral in nature, consistent with the prevailing theory of the time, and thus based on basic learning principles. The most common of these was covert sensitization (Cautela, 1967). Covert sensitization is a form of classical conditioning (US-CS-CR) which involves pairing an aversive experience (US) to a desirable one (CS) in order to reduce the desirability of the first experience. This technique has been applied in a number of ways. The first is a form of aversive conditioning which ties unpleasant imagery to deviant sexual fantasies. When successful, the sexual fantasies produce the same emotional reaction as the unpleasant imagery. The second ties normative sexual fantasy to ejaculation and deviant sexual fantasy to the inability to respond sexually.

In the first form, which is the most commonly researched, the client is asked to articulate their favored deviant sexual fantasy. The client is then asked to pick a point in that fantasy to diverge and at that point generate the most viscerally unpleasant alternative version of the fantasy. Examples of this unpleasant divergence might include having one’s penis violently removed or similar unpleasant imagery. The client is encourage to repeat the new version of the fantasy scenario over and over again, verbally and covertly, until the new “fantasy” replaces the old, presumably preventing the use of the old deviant, masturbatory fantasy. Unpleasant stimuli may also be introduced, such as noxious smells (Maletzky, 1980). Alternatively, the client is asked to masturbate to the verge of ejaculation while fantasizing about whatever they wish
(implicitly, this is taken to mean deviant sexual material) at the point just before ejaculation the client must switch to a new, appropriate fantasy. After intromission, the client is asked to switch back to the deviant sexual fantasy and to continue self-stimulation for up to half an hour; the belief being that conditioning will associate strong arousal with the appropriate fantasy and the inability to become aroused with the deviant sexual fantasy. Covert sensitization has a number of inherent problems: firstly, it involves generating an aversive experience for the client, something many find to be ethically problematic (Paul, Marx, & Orsillo, 1999). Furthermore, it is difficult to determine if the client is engaging in the required covert behaviors. Given that certain forms of covert sensitization involve masturbation and deviant sexual fantasy, poor adherence on the part of the client could lead to increases in deviant sexual fantasy.

This technique appears to have fallen out of favor in recent years. Covert sensitization was featured in one of the earlier collections of empirically supported treatments, “Treatments that Work” (Gorman & Nathan, 1998) but is not mentioned in the third edition (Gorman & Nathan, 2007). Research has suggested that the experimental effects maybe due to habituation to sexual responding rather than counter conditioning (Plaud & Gaither, 1997). Others have suggested that because of the low level of aversive stimuli involved (unpleasant mental imagery), covert sensitization itself may be subject to habituation and may lose its effects over time (Peeke & Petrinovich, 1984). Perhaps the greatest single threat to covert sensitization as a viable clinical treatment for sexual offenders is likely to be simple utility. As the standard for sex offender treatment has become group therapy, individual interventions (like Covert Sensitization) have become less desirable, particularly within “normative” cases in which there is a mild to moderate risk of reoffense. It is also worth mentioning, particularly in this, the age of managed care, that group interventions are inherently more cost efficient than those which require individual treatment, although it should be noted that this consideration holds considerably less weight with high-risk offenders. Moreover, even for an individual treatment, covert sensitization is not a particularly fast treatment, further impairing the real-world efficacy of this technique. Recent research has begun exploring the possibility of a related approach, covert association (Marshall, 2007). Covert association is intended to use similar principles of aversive counter conditioning, but against the grooming and preparation behaviors that lead up to the offense. This procedure has shown some promise, but requires further research in order to be established.

Penile Plethysmography

Psychophysiological measures have been used in treatment with limited success, due mainly to the limited ability of these measures to ensure proper utilization. Penile plethysmography (PPG), for instance, which is the measurement of penile tumescence, typically performed during the presentation of a standardized set of stimuli intended to provoke sexual arousal toward a particular deviant or non-deviant target. Although this method demonstrates high face validity, as expected, it may be vulnerable to conscious attempts at dissimulation (Simon & Schouten, 1991). Despite this, phallometric assessment is often discussed uncritically, due to both the high face validity of measuring penile tumescence and the assumption that sexual arousal is intrinsically linked to sexual behavior. Unfortunately, research into phallometric assessment suggests the technique is highly variable and the reliability of measurement is frequently lower than that of self-report
measures (Earls & Marshall, 1983; Wormith, 1986). Studies attempting to use PPG measurements to differentiate between groups have generated mixed and contradictory results (Kalmus & Beech, 2003). Looman and Marshall (2001) reported discriminative error rates as high as 65% while attempting to differentiate child molesters from rapists through plethysmography. Significant evidence suggests that erectile response can be consciously mediated in order to fake a normative or more normative pattern of responding (Golde, Strassberg, & Turner, 2000; Avery-Clark & Laws, 1984). These methods range from physical techniques, such as contracting penis muscles to cognitive strategies, such as focusing on appropriate stimuli and attempting to ignore inappropriate stimuli as they are presented. Partially due to the nature of the methodology itself, effective and well accepted PPG methods have not yet been developed (Kalmus & Beech, 2003).

**Pharmacological Interventions**

Research on pharmacological treatment of sexual behavior has focused on both the treatment of paraphilias, and sexual offenders. Much of the research is limited to case studies and single case designs and currently no randomized clinical trials exist (Briken & Kafka, 2007). Overall, anti-androgen treatment has proven to be effective, however, it has many potential side effects, including decreases in bone density, metabolic disturbances including weight gain, diabetes mellitus, and rarely depression (Giltay & Gooren, 2009), although others have argued that these risks should be placed in context next to the costs of recidivism (Berlin, 2009). The term “chemical castration” is often used to describe drug treatment for sexual offenders; this term is actually something of a misnomer, as no surgical castration takes place. Typically, testosterone reducing drugs (often hormonal birth control, such as depot-Provera) are used to reduce sexual desire and drive. Ethical questions aside, there as concerns about the efficacy of this as a long term strategy, as it makes normative sexual behavior difficult or impossible, this is problematic if treatment is based on a Good Lives Model approach. The recent Oregon study (Maletzky, Tolan & McFarland, 2006) found that men who were judged to need anti-androgen medication but did not receive it were more likely to commit both further sexual and non-sexual offenses, however, they noted inherent weakness in their methodology. Specifically, it should be noted that all offenders included in the study were those deemed to have some form of reduced intellectual capacity or had multiple offenses, further, assignment to treatment over non-treatment was not controlled and mostly due to lack of resources in the communities they were returned to. Many studies have shown that treatment with serotonin reuptake inhibitors can be effective; however, recent reviews of the literature have called into question the methodology of many studies (Adi, Ashcroft, Browne, et al., 2002).

**Polygraphy**

Polygraphic examination is a controversial topic. Often considered to be a very face valid technique, the actual evidence regarding its ability to be of clinical utility is mixed. Polygraphic examination has been used with post-conviction sex offenders since the 1970s (Abrams & Abrams, 1993) in order to gather information on sexual history and compliance with treatment and supervision goals. Estimates vary, but at least one study found that 70% of adult and 45% of juvenile treatment programs utilize polygraphs in some form (McGrath, Cumming, & Burchard, 2003). Despite its popularity, the evidence is still mixed as
to the efficacy of polygraphic examination. Among the chief concerns is that it may produce false confessions, since the penalty for being perceived as deceptive may be higher than admitting false information (Cross & Saxe, 1992, 2001). Kokish, Levenson, and Blasingame, (2005) found that in confidential and anonymous reporting five percent of participants admitted to admitting to things they had not done in response to accusations that they were lying. There is little consensus as to its efficacy as a treatment tool. For a detailed summary of the both sides of the argument see Ben-Shakhar (2008) and Grubin, (2008).

**Cognitive Restructuring**

Challenging maladaptive thoughts is one of the core components for nearly all varieties of cognitive behavioral therapy. Research has shown that sexual offenders show a wide variety of cognitive distortions that minimize their responsibility, justify their behavior, or blame the victim for their behavior (Abel, Gore, Holland, Camp, Becker, & Rathner, 1989; Murphy, 1990; Ward, Hudson, & Johnston, 1997). Cognitive restructuring and challenging, along with relapse prevention has become a core component of the majority of sex offender treatment programs (McGrath et al., 2003). Cognitive restructuring techniques teach offenders to monitor their thoughts and in conjunction with analyzing their behavior chain, noting thoughts that facilitate offending. Offenders are encouraged to note frequent or significant thoughts, as these often serve as triggers or priming thoughts for the rest of the chain. They are then encouraged to challenge or replace these thoughts with more adaptive, low risk thoughts, while simultaneously gathering information about the world that disconfirms these irrational thoughts. While broadly effective, some of the same questions regarding the effectiveness of covert sensitization are relevant when considering cognitive restructuring, more specifically that both techniques require the individual to thoughtfully and purposefully interrupt behavior chains that were previously highly reinforcing. This inherently requires the individual to be highly motivated to arrest the offending behavior pattern, a questionable assumption in most cases. Furthermore, many offending individuals may have difficulty consistently monitoring their thoughts, particularly if they have co-morbid cognitive difficulties.

**Acceptance**

Acceptance-based and “urge-surfing” techniques, drawn from traditions such as mindfulness meditation and Acceptance and Commitment Therapy (ACT) are growing in popularity as specific interventions in managing deviant sexual arousal are beginning to be integrated into a number of treatment programs. Clients are taught techniques that are intended to enable them to experience thoughts without the need to interact with them (Hayes, Strosahl & Wilson, 1999), thereby interrupting the behavior chain at the thought to action link. This is achieved by developing a willingness to experience the thought without judgment, thereby eliminating the perceived “need” to act on the thought. In contrast to cognitive restructuring, clients are not taught to challenge these thoughts, but to simply observe and accept them. One preliminary single case design study (Paul et al., 1999) showed effectiveness in treating an exhibitionist by using ACT in conjunction with Function Analytic Psychotherapy. This study only provides tentative evidence and has been criticized for using self report of urges, rather than polygraphy or recidivism as the principal criteria for success (Ball, 1999).
Mindfulness techniques have been shown to be effective when combined with relapse prevention in the treatment of substance abuse (Zgierska, Rabago, Zuelsdorff, Coe, Miller, & Fleming, 2008), primarily helping individuals deal with particularly strong cravings. Mindfulness meditation, when combined with cognitive behavioral techniques has been shown to be effective with a wide variety of psychological problems, including: relapse prevention in major depression (Ma & Teasdale, 2004; Segal, Williams, & Teasdale, 2002) and anxiety (Evans, Ferrando, Findler, Stowell, Smart, & Haglin, 2008). Mindfulness meditation has been shown to have a significant effect on negative affect. Although not all offending can (or should) be linked to coping with negative affect (McCoy, & Fremouw, 2010) it is a common theme throughout the treatment literature that negative affect is instrumental in generating deviant sexual fantasies (Pithers, Kashima, Cumming, Beal, Buell, 1989). Techniques that assist in managing negative affect and unwanted thoughts are likely to develop the requisite research base in the near future.

A Growing Groundswell: The Change in Attitude

Arguably more important than the incremental changes in techniques for the treatment of sexual offenders is the growing evidence for the importance of a change in the zeitgeist regarding attitudes towards this issue. In popular culture, we have a long-standing belief that sexual offenders are a vastly different species of offender (predators, if you will). They are considered more dangerous, preying on the innocent and less deserving of the “coddling” and sympathy involved in psychotherapy. Moreover, it is believed that they must be watched constantly and subjected to constant, invasive surveillance in the form of sex offender registration, polygraphy, and ple-thysmography in order to prevent their almost inevitable re-offending. Evidence suggests that this attitude, although it may be satisfying to some, may have a negative effect on treatment outcomes.

Research has come to show that not only is the rate of recidivism among treated sexual offenders low, approximately twenty percent; (Hanson, Gordon, Harris, Marques, Murphy, Quinsey, et al., 2002), they may be less likely to recidivate than other “less dangerous” offenders. Furthermore, these strict and punitive attitudes may increase the rate at which offenders recidivate. Many of the interventions that seem face valid fail under the scrutiny of investigation. A prototypical example of this is tagging offenders with global positioning system (GPS) units. The idea appears perfectly rational: tracking offender’s movements should provide a level of accountability that will prevent them from recidivating. However, studies investigating the use of GPS units show a marginal effect increasing the rates at which offenders engage in criminal behavior (Gendreau & Goggin, 1996). The reason for this effect has not yet been established, but a likely explanation is similar to the abstinence violation effect. The offender makes a small lapse that would otherwise go undetected, but knowing that the authorities know of it and they will be punished, the offender gives up and re-offends.

Leading researchers in the field of sexual offending suggest that attitudes may have a similar effect on sexual offending. For example, research into sex offender registration suggests that registration has little effect on preventing sexual offenses in general, as 95% of arrests for sexual offenses were of first time offenders (Sandler, Freeman, & Socia, 2008). Schram and Milloy (1995) working with a small matched sample found that recidivists were more quickly arrested, but that there was no difference in
the rate of recidivism between those who had to register and those that did not. Other studies (Adkins, Huff, Stageberg, Prell, & Musel, 2000; Zevitz, 2006, Sandler, et al. 2008) have found limited support for the effectiveness of registration laws.

So, if a more punitive approach is not effective in preventing recidivism, how should the treating clinician approach treatment with a sexual offender? It has been shown that therapist’s ability to develop a therapeutic alliance with their client is now a well established predictor of therapeutic outcome (Wampold, 2001). Marshall, Ward, Mann, Moulden, Fernandez, Serran, and Marshall (2005) argue that one of the reasons that some sex offender treatment programs fail to have an effect on recidivism is because this variable has been ignored. They argue that unsuccessful programs focus excessively on negative issues and language, fail to encourage hope that the offenders are able to change, fail to work collaboratively with the clients, ignore the influence of the therapeutic alliance, and fail to provide goals that appear to be of immediate benefit to the client. In particular, the failure of some treatment programs to provide goals that appeal to the immediate well-being of the client is likely to impede client motivation for attending or completing treatment; a complication that has frequently been explained (“they just want to offend again”) and solved (registration, GPS, etc) with punitive measures, with less than exemplary results, as noted above. Therefore, without treating offenders with a modicum of respect, and collaborating with them on developing treatment goals based on their individual needs, otherwise good programs will fail to have an effect on offenders. This attempt at positivity and acknowledgement of offenders as whole people has led to a more holistic approach of investigating the mechanisms underlying sexual offending, requiring the consideration of non-sexual characteristics into the treatment of the offending individual. Although recidivism has been strongly linked to deviant sexual arousal, as would be expected, it has also been linked to other characteristics, such as antisocial orientation, an unstable lifestyle or a history of rule violations, and general criminal history. Sex offenders are more likely to recidivate with a non-sexual, rather than a sexual crime (Hanson & Bussiere, 1998) further supporting the suggestion that they are meeting a variety of needs in inappropriate ways.

This idea that sexual offending and recidivism may be more a manifestation of the inappropriate meeting of needs rather than an innate characterological flaw (at least in many cases) has informed the Integrated Theory of Sexual Offending, (ITSO; Ward & Gannon, 2006) which addresses the concept of criminogenic needs (Ward & Stewart, 2003). Criminogenic needs address the “why” behind criminal behavior: advocates propose that offenders have needs (including sexual arousal), which they meet in maladaptive or criminal ways. Thus, sexual arousal and behavior become deviant only when they are attained in illegal or inappropriate ways, or are directed toward illegal or inappropriate people or activities. The ITSO is currently a work in progress with a variety of ongoing studies aimed at defining its components. It is intended to address biological functioning, psychological functioning, social learning and niche factors, and clinical symptoms. How the various factors and sex offending facilitate, maintain, and escalate each other are considered within the model. The applied version of the ITSO, the Good Lives Model – Comprehensive (GLM-C) uses the concepts outlined in the ITSO to generate specific and global interventions. These interventions are intended to provide a way for clients to identify and achieve their
healthy needs as well as manage desires for inappropriate needs, thereby avoiding the excessive focus on negativity seen in some techniques outlined earlier in this review. Although the ITSO and GLM-C are still under development, they provide an opportunity for understanding the mechanism behind sexual offending and developing treatments that are specifically attuned to the individual needs of the offending client. Thus, the GLM-C is an example of a more proactive treatment stance that is in contrast to the more punitive ones outlined earlier: if sexual offending is due to clients meeting their needs in inappropriate ways, rather than inherent human evil, the way to reduce recidivism is to collaborate with offenders and teach them appropriate, pro-social ways to meet those needs for themselves.

Conclusion: The Integrated Theory of Sexual Offending and the Keys to the Kingdom

So, in conclusion, what do we really know about the treatment of sexual offenders? Well, the typical answer in situations such as this is that we do not know much, and we require further research; however, in this situation we do know more than simply nothing. We have established that at least to some degree sex offender treatment is effective, although more research is required to define the exact degree and methods. We have established a series of techniques that appear to work and can continue to be tested. More importantly, we have set the stage for future directions, the development of a testable theoretical framework for the processes that underlie offending. Due to the incremental refinements that are a necessary part of the scientific process, the final form of the integrated theory of sexual offending will almost certainly bear little resemblance to its current form. The process involved in its development gives us something more useful, the capacity to access underlying mechanisms of sexual offending with which to refine old techniques and develop new, specific therapeutic techniques that can be applied within the context of a positive therapeutic alliance.

References


Best Practices in the Treatment of Juvenile Sex Offenders

Early on, many believed that juveniles were incapable of engaging in a number of crimes, including sexual crimes. As time passed, people became more and more aware of the fact that juveniles were committing many of the same crimes as adults. Further, research began to suggest that a substantial proportion of adult offenders (Hanson & Bussière, 1998) began committing crimes as juveniles. This led to an increased focus on identifying, treating, and in some cases, punishing juveniles who committed sexual offenses. Early research assumed that juvenile sexual offenders were the same as adult sex offenders, simply younger, and committed offenses for the same reasons as adult offenders. However, over time the evidence has come to suggest that many adolescent sexual offenders show a unique pattern of offenses; different and distinct from that of adult sexual offenders (see Zimring, 2004 for a review). These differences have important implications for the treatment and assessment of juvenile sex offenders. Unfortunately, in many cases, treatment and assessment practice have not kept pace with the changing research base regarding the nature of juvenile offenders, best treatment practices, and best assessment practices. This article will provide a brief overview of important differences between juvenile sexual offenders and adult sexual offenders and characteristics of juvenile sexual offenders, as well as summarize current research findings regarding juvenile sex offender treatment, and discuss the implications of these findings with regards to the best practices in this field.

Differences between juvenile and adult sexual offenders

Historically, it has been assumed that juvenile sexual offenders show the same general qualities as adult sexual offenders and are at high risk for continuing to commit sexual offenses into adulthood (see Letourneau and Minner, 2005 for a review). However, the empirical evidence has not supported this idea. For example, a recent review article summarizes data from 34 longitudinal studies, with time to follow-up ranging between approximately one year and fourteen years post-treatment. This review estimated the overall sexual re-offense rate for juvenile sexual offenders involved in treatment programs to be approximately 10% (Fortune and Lambie, 2006). Across studies included in this review, juvenile sexual offenders were at much higher risk for later committing non-sexual crimes instead of another sexual offense, with estimates of recidivism rates for nonsexual offenses ranging from 8% to 52%. It should be noted, that among the studies included in this review, definitions of recidivism varied. However, most of the included studies used the criteria of either re-arrest or conviction on new charges.

Comparatively, approximately 13 to 20% of treated adult sexual offenders have been found to commit further sexual offenses following treatment, with 36 to 46% committing non-sexual offenses (Hanson & Bussière, 1998). Hanson and Bussière compiled results from 61 studies, containing a total 23,393 offenders. Multiple methods were used to estimate recidivism in 44% of the included studies. The most frequently used measures of recidivism were reconviction (84%), offender’s report (25%), and parole violations (16%). Follow up intervals
varied from 6 months to 23 years. The mean follow up time was 66 months and the median was 48 months. All studies involved in the meta-analysis were matched, longitudinal follow-up designs. Studies were weighted based on the rigor of recidivism measures and studies relying on self-report alone were excluded from the analysis. Together, the findings from Fortune and Lambie (2006) and Hanson and Bussière, (1998) suggest that juvenile sexual offenders are at lower risk for both sexual and non-sexual recidivism than adult sexual offenders.

Differences in recidivism rates between adult and juvenile sexual offenders have been found even among those juvenile offenders rated at highest risk for reoffense. A study that followed 300 registered sexual offenders, who would presumably be the most serious juvenile sexual offenders, into adulthood found that only about 4% of these offenders were re-arrested for a sexual offense, although approximately half of these offenders were arrested for a nonsexual offense (Vandiver, 2006).

Together, this evidence suggests that juvenile sexual offenders are a population that is distinct from adult sexual offenders, with many juvenile sexual offenders ceasing to commit sexually-based offenses before becoming adults. However, for adult sexual offenders, young age at first offense and number of offenses is a strong predictor of future recidivism (Hanson & Bussière, 1998; Harris & Rice, 2007). This poses a significant puzzle. One key problem in resolving these discrepant findings may be that many studies comparing adult and juvenile sexual offenders are cross-sectional in design, relying on matching older and younger offenders (Harris & Rice, 2007). This design prevents evaluation of changes over time in offenders. Some studies of adult sexual recidivism show that the average age of first sexual conviction is in their 30s (Harris & Rice, 2007). As such, there is likely a small subset of juvenile sexual offenders whose behavior will continue into adulthood. These offenders are likely qualitatively different from those juvenile sexual offenders whose patterns of offending are time-limited. Much research has attempted to identify this small subset of juvenile sexual offenders. To date, however, no profile of persistent offenders has been identified.

There is some evidence to suggest that in general, juvenile sexual offenders may be more similar to other types of juvenile offenders than they are to adult sexual offenders. Several studies suggest that juveniles convicted of one sexual offense are at no greater risk for future sexual offending than juvenile delinquents convicted of non-sexual offences. In a longitudinal study tracking future sexual and non-sexual offending in a sample of incarcerated juveniles over a five-year follow-up period, 85% of new sexual offenses were committed by juveniles who had not previously been convicted of a sexual offense (Caldwell, 2007). Further, in this study, offenders initially convicted of non-sexual crimes committed significantly higher proportions of violent crimes during the follow-up period. Letourneau, Chapman, and Schoenwald, (2008) also found that when a population of sexually offending and non-sexually offending delinquent youth were followed for an average of 48.79 (SD = 8.7) months post-treatment, a higher proportion of the non-sexually offending sample committed sexual offenses during follow-up than those referred to treatment for sexually-based concerns. Combined, this data suggests that significantly fewer juvenile sexual offenders repeat sexually-based offenses compared to adult offenders. As such, it cannot be assumed that treatments that are effective with adult sexual offenders are effective with juvenile sex offenders.
nile sexual offenders or that research conducted on adult sexual offenders can be applied to juveniles. Instead, a fresh approach to conceptualizing and treating juvenile sexual offenders is warranted.

Who are juvenile sexual offenders?

Currently no single profile for children and adolescents who commit sexual offenses exists, although many researchers have attempted to identify a profile for typical offenders or for categories of juvenile offenders (see Andrade, Vincent, & Saleh, 2006 for a review). Juvenile sexual offenders are a heterogeneous population. Although there have been many attempts to provide typologies for juvenile sexual offenders, currently no typologies have held up under empirical investigation. The majority of juvenile sexual offenders are male, although there are also a number of female juvenile sexual offenders. Prevalence estimates for female sexual offending are unclear, as historically inappropriate sexual behaviors performed by young females have often been dismissed or minimized (Bumby & Bumby, 2003). Most research on juvenile sexual offending has focused on adolescents ages 12 and above. Recently, however, many have noted that not all sexual offenses are committed by juveniles over the age of 12. Although prevalence estimates are not available, there is a small but significant group of children below age 12 who engage in inappropriate sexual behaviors (ATSA, 2006).

Research has suggested that children and adolescents who engage in problematic sexual behaviors show higher prevalence rates of a variety of co-morbid concerns than do children who do not commit sexual offenses. For example, Letourneau, Schoenwald, and Sheidow (2004) found that children and adolescents who engaged in problematic sexual behaviors had experienced higher rates of

sexual abuse and physical abuse than children and adolescents not engaging in these behaviors. They also found that children and adolescents with sexual behavior problems were more likely to be diagnosed with internalizing problems, externalizing problems, and social problems in comparison to those who were not engaging in problematic sexual behaviors. These findings that youth with sexual behavior problems showed higher difficulties with internalizing and externalizing behaviors have been replicated. Letourneau, Chapman, and Schoenwald (2008) found that adolescents with sexual behavior problems had higher rates of both internalizing and externalizing symptoms at both intake and discharge from treatment, compared to non-sexually offending criminal youths. It should be noted, however, that both groups of adolescents showed significant decreases in internalizing and externalizing symptoms over the course of treatment.

Prediction of Re-Offense

There is still considerable debate over factors associated with increased risk for sexual re-offending. It has been suggested that adolescent sexual offenders who are considered to be at higher risk for future sexual offense than other adolescent sexual offenders experience more family conflict, engage in more general violent behavior, have lower self-esteem, and experience higher levels of discomfort in social situations, in addition to having increased frequency of deviant sexual fantasies and arousal than other at-risk adolescents (Smith, Wampler, Jones, & Reifman, 2005). Other researchers have linked higher rates of impulsivity with higher rates of both sexual and nonsexual re-offense (e.g. Waite et al., 2005). Additionally, Worling and Curwen (2000) identified deviant sexual attraction
to children as predictive of future sexual offenses. While some have suggested that deviant sexual arousal may be among the most significant predictor of sexual re-offense among adolescent sexual offenders, this conclusion is far from unanimous (see Veneziano and Veneziano, 2002 for a review).

To date, attempts to determine which juvenile offenders continue sexual offending into adulthood have met with little success. There have been several attempts to create empirically-supported risk assessment instruments for use with juvenile sexual offenders. While several of these measures have gained empirical support, particularly the ERASOR-2 (Worling & Curwen, 2001) and the J-SOAP-2 (Prentsky & Righthand, 2003), neither of these measures have yet been normed. As such, there is no set cut-off point to separate high-risk juvenile sexual offenders from low-risk sexual offenders and determinations of level of risk should be made with caution. However, adolescents who possess greater numbers of factors listed on these risk assessment instruments can be considered at higher risk for re-offense than those who possess lower numbers of risk factors.

In an attempt to determine methods to identify high-risk juvenile sexual offenders, Worling and Langstrom (2006) conducted a literature review of factors that have been hypothesized as being predictive of juvenile problematic sexual behaviors. They grouped risk factors that have been identified in the literature as those which have been empirically supported (which they defined as having at least two empirical studies linking the factor with offending behaviors and no contradictory findings), promising (at least one study supporting their predictive validity), and possible (those which are theoretically linked, but lack empirical support). The risk factors identified as having empirical support for being able to predict future sexual offending were: high levels of deviant sexual interest, repeated sexual offending, having multiple victims, having a victim who was a stranger, and increased social isolation. Failure to participate in a treatment program that includes specialized components to address sexual offending was also listed as an empirically-supported risk factor for future sexual offending. When attempting to determine risk for future sexual offending, clinicians should weigh these factors most heavily, such that the presence of more of these factors is suggestive of higher levels of risk.

A number of other possible risk factors were identified in Worling and Langstrom’s (2006) literature review. The presence of problematic parent-child relationships and attitudes supporting criminal offending were identified as promising risk factors for juvenile sexual offending. A number of the factors commonly included in juvenile sexual offender treatment were also identified as possible risk factors, with limited empirical evidence to support their utility in predicting future sexual offending. These factors included high levels of family stress, negative peer associations, sexual preoccupation, impulsivity and antisocial interpersonal beliefs. According to Worling and Langstrom (2006), High frequency of interpersonal aggression, offending against a child, the use of violence during a sexual offense, and offending against a male victim were possible risk factors identified as having mixed empirical support. Further research will be needed to determine if these factors can be used to predict sexual reoffense. Until this research is satisfactory, clinicians should use empirically-supported risk assessment instru-
ments and the empirically-supported risk factors identified by Worling and Langstrom’s (2006).

Prevalence of Different Interventions with Juvenile Sexual Offenders and Controversial Intervention Techniques

A number of different treatment approaches are currently being applied to working with juvenile sexual offenders. The literature base on the effectiveness of treatment techniques used with juvenile sex offenders is still in its infancy. As a result, little is known about the effectiveness of different types of treatment for juvenile sexual offenders or the mechanisms behind effective treatment. These are areas that should be addressed in future treatment. A recent study has attempted to identify and explore common practices used with juvenile sexual offenders.

A recent study of 112 practitioners working with juvenile sexual offenders found that most practitioners surveyed favored the use of cognitive-behavioral techniques in the treatment of juvenile sexual offenders. The majority of participants also indicated that they felt humanistic therapy techniques, psycho-educational treatment, group therapy, and systems-based treatments may be effective in treating juvenile sexual offenders (Brandes & Cheung, 2009).

In a review of previous research, Burton et al (2006) noted that most treatment programs for juvenile sexual offenders identify as using at least some cognitive-behavioral techniques, as well as a psycho-educational treatment component. Psycho-educational components of treatment programs covered a wide variety of areas, including communication, conflict resolution, dating skills, relationship skills, and values clarification. In this study, many programs also reported using addictive cycles, art therapies, autobiographical work, experiential therapies, work on sexual fantasies, and journal keeping as part of their treatment protocol. However, this study did not evaluate the effectiveness of each of these types of treatment nor examine mechanisms for change in treatment.

Although none of these studies addressed the rationale behind practitioners’ selection of different treatment modalities, theoretically each of these methods for treatment has gained significant support, particularly cognitive-behavioral treatment and systemic treatments. Many empirically supported treatments for children and adolescents involve systemic components, as children and adolescents are highly dependent on others and are heavily influenced by surrounding systemic factors (Bronfenbrenner, 1979). Cognitive-behavioral techniques have gained wide empirical support in the treatment of adolescent anti-social behaviors and form the foundation for many empirically-supported interventions for adult sexual offenders (Alexander, 1999; Hall, 1995).

Common components of cognitive-behavioral interventions for juvenile sex offenders include identifying situations that may trigger sexual offenses, relapse prevention, social skills development, problem-solving skills training, challenging cognitive distortions, and dealing with deviant sexual arousal (see Veneziano & Veneziano 2002 for a review).

Brandes and Cheung (2009) also asked participants in their study to identify factors that they viewed as important to successful treatment completion. Participants identified increased empathy, stable home environment, respect for authority, and increased self-control as most important in successful treatment completion, and improved academic achievement as least important. Many participants also identified family support and the
creation of positive peer associations as important for treatment success. The majority of professionals participating in this study supported referring juveniles to twelve-step sexual addiction programs if sexual addiction was found during assessment, supported the use of polygraphs during juvenile sexual offender treatment, and supported family re-unification if requested by caregivers. Practitioners support for re-unification of juvenile sexual offenders with their family of origin is likely related to the prevalent ideological belief that children and adolescents belong with their biological families when possible.

Although this study suggests that many practitioners favor the use of polygraphs other professionals have questioned the utility of this technique. Polygraph tests have consistently failed to meet with the Daubert Standard for evidence in court. Concerns have been expressed about the accuracy of polygraph results, leading some to suggest they should not be permitted as evidence in court (Hunter & Lexier, 1998). With results being unreliable, the clinical utility of polygraph results are questionable at best. Although Brandes and Cheung (2009) did not ask participants about the rationale for including polygraphs in the treatment of juvenile sexual offenders, it is likely based on the prevalent usage of these techniques with adult sexual offenders to assess deviant sexual arousal. To date, approximately one-third of treatment programs for adult sexual offenders include a measure of physiological arousal (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2009). It is also likely based on some researchers findings that deviant arousal can be used to predict sexual recidivism in juveniles (e.g. Smith et al., 2005). Some have questioned the applicability of these techniques with juvenile sexual offenders, however. First, many have questioned the ethics of using invasive assessment techniques with adolescents and expressed concerns that exposing adolescents to deviant pornographic images may have adverse effects (National Task Force on Juvenile Sexual Offending, 1993). Others have noted that the arousal patterns of adolescent sexual offenders are not dramatically different from those of non-sexually offending adolescents (Letourneau & Miner, 2005), possibly limiting the predictive utility of these instruments. Hunter and Lexier, (1998) recommended that for these reasons, plethysmography should only be used with adolescent male offenders who are at least 14 years of age, have a long history of offending, and who are suspected of deviant arousal patterns. Although these suggestions were published more than 10 years ago, research to date continues to support these conclusions. As such, practitioners should use caution when applying physiological measures of arousal with juvenile sexual offenders, particularly younger offenders.
Finally, Brandes and Cheung (2009) found that many practitioners support the use of addictions-based counseling for adolescent sexual offenders when there is evidence that they may have a sexual addiction. At this time, no published research articles could be found on the effectiveness of using twelve-step programs with juvenile sexual offenders. As such this is an area that will require significant attention in future research. However, in the area of substance abuse treatment, some researchers have questioned the applicability of twelve-step models to juveniles. These researchers have noted that many adolescents disengage from the programs due to their time commitment, emphasis on behavior as pathological, and emphasis on lifelong abstinence from substances (Miller, Turner, & Marlatt, 2001). These objections to twelve-step approaches to treatment are likely also applicable to twelve-step programs for sexual addiction. Therefore, it may be best for practitioners to rely on treatment approaches that have gained some empirical support first, saving addictions-based counseling approaches for clients who are not making progress in these types of treatment programs.

**Treatment Effectiveness**

As noted above, research as begun to establish common practices for the treatment of juvenile sexual offenders. Less is known about the effectiveness of different treatments in reducing the risk for sexual re-offense. A 2006 meta-analysis of nine research studies comparing treatment outcome of juvenile sexual offenders to a control group found that treatment for juvenile sexual offenders reduces the risk of recidivism for both sexual and nonsexual crimes, with an average treatment effect size of .43. Across studies, the average recidivism rate for sexual crimes overall was 12.53%, with recidivism rates for various nonsexual crimes ranging between 20 and 30% (Reitzel & Carbonell, 2006). These statistics are similar to those noted in the qualitative review conducted by Fortune and Lambie, (2006), who had estimated sexual recidivism to be approximately 10%, but noted wider variation in recidivism rates for non-sexual re-offense (8 – 52%). In this meta-analysis, recidivism rates were significantly lower for those adolescents who had received treatment (approximately 7% sexual recidivism) than for those in control groups who had not received treatment (about 19% sexual recidivism). Treatments that were identified as cognitive-behavioral had higher overall effect sizes than treatments of other modalities, although the difference in effect sizes were not statistically significant (Reitzel & Carbonell, 2006). This meta-analysis did not attempt to identify mechanisms of change in treatment or look at specific treatment components that may be most responsible for creating reductions in recidivism. As such, although it appears that cognitive-behavioral treatments lead to the greatest reductions in re-offense rates, it is unclear which components of these treatment protocols are most useful.

Previous research has found that the majority of juvenile sexual offenders have been receiving treatment on an outpatient basis. Nationally there are at least two times as many outpatient programs as inpatient programs for juvenile sexual offenders (Burton, Smith-Darden, & Frankel, 2006). A review of treatment studies for juvenile sexual offenders suggested that in general, adolescent offenders treated on an outpatient basis had lower recidivism rates than those treated in hospitals or prisons (Alexander, 1999). A study evaluating the effectiveness of an inpatient program for adolescents convicted of rape
estimated future sexual offense over a two-year follow-up to be approximately 20% (Hagan, King, and Patros, 1994). This rate of sexual re-offense is significantly higher than the average re-offense size identified in review studies, as well as re-offense rates from several studies evaluating the effectiveness of some outpatient treatment programs (discussed below). In a study comparing two treatment programs for incarcerated juvenile offenders, adolescents in the more intensive treatment program had approximately the same rate of sexual re-offense during a follow-up period as those in the less intensive treatment program, although they also committed lower rates of nonsexual offenses than those in the less intensive treatment program (Waite et al., 2005). This suggests that if the goal is to eliminate sexual offending, then less intensive programs may be sufficient to create change, however, if the goal is to eliminate juvenile delinquency, then more intensive programs may be required.

The differences in estimated re-offense rates between inpatient and outpatient treatment centers may be due to a number of factors. First, previous research has shown that adolescent sexual offenders placed in inpatient treatment centers have committed more serious or more violent offenses than those who receive community-based treatment (Burton, Miller, & Shill, 2002). It may then be that this population was at greater risk for re-offense than other treatment groups prior to beginning treatment, leading to unequal comparisons in outcome research. If this is true, higher rates of re-offense following treatment in inpatient may be more reflective of the nature of the sexual offenders receiving this program than of relative effectiveness of each treatment program.

Secondly, Hagan and colleagues (1994) evaluated the effectiveness of treatment with specific subset of juvenile sexual offenders (rapists). Meta-analyses provided estimates of treatment effectiveness for the overall population of juvenile sexual offenders, instead of specific sub-populations of juvenile sexual offenders. It is possible that juvenile rapists may be at higher risk for re-offense than other juvenile sexual offenders, leading to increased rates of re-offense for this population. Research has supported that idea that among adult sexual offenders, rapists are at a higher risk for re-offense than other adult sexual offenders. Meta-analysis with adult sexual offenders have shown that at a five year follow up 19% of rapists recidivate, 13% of those convicted of child molestation (of whom pedophiles are a small subset) recidivate (Hanson & Bussière, 1998). However, as noted above, juvenile sexual offenders are different from adult sexual offenders. As such, it cannot be assumed that juvenile sexual offenders convicted of rape are necessarily at a higher risk for recidivism than other juvenile sexual offenders just because of these findings in adults. Further research will be needed to evaluate this conclusion.

As a third possible explanation, some researchers have urged caution in placing adolescent offenders in confined, inpatient facilities, suggesting that this may be unnecessary and may even have iatrogenic effects (see Letourneau & Miner, 2005 for a review). Many have cautioned against treating large groups of youths engaging in antisocial or acting out behaviors together, as these juveniles may learn new negative behaviors from each other (deviancy training). This is particularly likely to occur when juveniles are confined together and have time to socialize during unstructured times (Dishion, McCord, & Poulin, 1999). Additionally, juvenile sexual offenders
likely reside in environments that are very different from the environment of inpatient treatment. This may lead to difficulties applying skills learned in inpatient settings to the outside world. During outpatient treatment, adolescents are acquiring and practicing new skills in their home environment, which may lead to increased generalization of new knowledge (Borduin, Schaeffer, & Heiblum, 2009). Additionally, due to the effectiveness of systemic approaches to juvenile sexual offending, keeping offenders in contact with positive social structures may contribute positive gains made during treatment. It may be possible that for these reasons, the inpatient model used for treating adolescent sexual offenders in these studies was less successful than empirically-tested outpatient treatment models. Further research is needed to determine the relative effectiveness of inpatient and outpatient treatment for juvenile sexual offenders.

Worling and Curwen (2000) tested the effectiveness of a community-based treatment program for juvenile sexual offenders by comparing post-treatment recidivism between adolescents completing at least one year of treatment and those who refused services or dropped out of treatment prior to one year. Sexual re-offense rates for the treatment group were significantly lower than those in the non-treatment group (5.7%), as well as lower than the mean recidivism rates noted by Reitzel and Carbonell, (2006) in their meta-analysis (12.53% for sexual recidivism, between 20 and 30% for nonsexual crimes). List rates so we can compare. Treatment completers also had significantly lower nonsexual re-offense rates compared to those adolescents who did not participate in treatment. This implies that there may be a dosage effect for treatment, such that adolescents benefit from a full year of treatment, but may also not require multiple years of intensive treatment in order to reduce both sexual and nonsexual recidivism. It further suggests that community-based treatments for juvenile sexual offenders may be among the most effective treatments for this population.

Several recent studies have also tested the effectiveness of Multisystemic Therapy (MST) in reducing problematic sexual behaviors in children and adolescents. The first study compared treatment efficacy with two groups of 24 juvenile sexual offenders who had been identified as being at high risk for future sexual offending. The first group of adolescents participated in MST, while the other half participated in a treatment as usual condition, which consisted of outpatient treatment on both a group and individual basis. Identified goals for the treatment as usual program included accepting personal responsibility for past sexual misconduct, increasing empathy for victims, improving social skills, reducing deviant cognitions, and relapse prevention. Participants were followed for 8.9 years post-treatment. At follow-up, adolescents who had completed MST had 83% fewer arrests for sexual offenses and 70% fewer arrests for nonsexual offenses compared to those who had not participated in MST. Further, adolescents completing MST self-reported significant decreases in delinquent behaviors at follow-up, whereas those who had not participated in the program reported increases in delinquent behaviors (Borduin, Schaeffer, & Heiblum, 2009).

Another recent, random controlled trial compared 67 adolescent sexual offenders participating in MST with 60 offenders participating in group therapy. Group therapy focused on increasing acceptance of responsibility for past criminal behavior, increasing awareness of triggers for committing sexual crimes, and developing a relapse.
prevention plan. At one year post-treatment, adolescents who had participated in MST showed significantly fewer sexual behavior problems, substance use, and mental health concerns, including externalizing behaviors than those participating in the group therapy condition (Letourneau et al., 2009). An exploratory study found that the effectiveness of MST is mediated by changes in caregiver discipline practices and changes in adolescent peer group (Henggeler, Letourneau, Chapman, Borduin, Schewe, & McCart, 2009), suggesting that parent involvement in treatment and parent change was critical in creating therapeutic change and lower recidivism rates.

**Treatment of younger children with sexual behavior problems**

In general, research with young children with sexual behavior problems suggests that most young children can be treated successfully through short-term, outpatient treatment (e.g. Silovsky, Niec, Bard, & Hecht, 2007). According to the Association for the Treatment of Sexual Abusers (2006), caregiver involvement in treatment is critical to achieving positive change in younger children with sexual behavior problems. Parenting-based treatment programs are among the most effective treatments for a wide variety of externalizing behavior problems in children and young adults. This is likely because problems experienced by young children are highly influenced by the child’s environment. Further, young children more quickly acquire new skills when they are taught daily at home by parents instead of once a week in individual therapy (Kazdin, 2005; see Zankman & Bonomo, 2004 for a review of including parents in treatment of juvenile sexual offenders).

Recently, St. Amand, Bard, and Silovsky (2008) conducted a meta-analysis on the effectiveness of different types of treatment for children, up to age 12, with sexual behavior problems. This study found that in general, treatment for these children was successful in reducing problematic sexual behaviors. St. Amand and colleagues (2008) attempted to identify the components of programs that had the most influence on the degree of therapeutic change. They concluded that acquisition of new parent management skills, teaching parents to establish house rules about sexual behaviors, sexual education, parents learning abuse prevention skills, and children learning self-control skills were responsible for behavior change in treatment, with changing parent management skills being responsible for creating the most change. Further, children who were younger and had higher levels of family involvement in therapeutic services showed the greatest decreases in problematic sexual behaviors over time. Interestingly, a number of therapeutic components commonly included in sexual behavior problems for older children showed no relationship with treatment success for children in this age group, including arousal reconditioning, educating children on the abuse cycle, and engaging in structured relapse prevention treatment.

This is likely related to children’s level of cognitive development. The frontal lobe, which is responsible for impulse control, decision-making, and other executive functions is not fully developed until the mid-20’s (Steinberg, & Morris, 2001). As such, children and adolescents who commit sexual offenses or engage in other problematic sexual behaviors do not show the same level of planning in these behaviors. Instead, many sexual offenses are committed impulsively, thus limiting the effectiveness of relapse prevention and providing education on abuse cycles in reducing re-offense rates. Further, many children and adolescents do not engage in problematic
sexual behaviors because of deviant sexual arousal (Silovsky & Bonner, 2003). Therefore, arousal reconditioning would have little impact of repeat offending. Research suggests that in general, children with sexual behavior problems respond well to structured, cognitive-behavioral interventions (ATSA, 2006). Due to these cognitive limitations, treatment with young children needs to be very concrete, such as establishing rules about sexuality, and avoid abstract concepts, such as cycles of abuse.

**Implications for best practices in treatment**

Research into effective treatments for juvenile sexual offenders is still in its infancy, with many assumptions and aspects of treatment remaining untested. This makes it difficult for clinicians to identify the most effective treatments to use with juvenile sexual offenders. The most important research finding to date is that treatment for juvenile sexual offender is effective in reducing recidivism for both sexual and non-sexual crimes. In particular, research supports the use of cognitive-behavioral, systemic, community-based approach for juvenile sexual offenders. Therefore, it is important to remain optimistic when treating this population, as most will not continue to offender sexually into adulthood. Despite the limited research base available, current findings do have some important implications for the implementation of effective treatment interventions for juvenile sexual offenders.

First, research suggests that developmental factors must be taken into account when treating and assessing juvenile sexual offenders. There are a number of important differences between juvenile sexual offenders and adult sexual offenders. Juvenile sexual offenders have comparatively low rates of recidivism. In fact, they may be less likely to re-offend for a sexual crime than juvenile offenders arrested for non-sexual crime. Adolescents convicted of only one sexual offense are no more likely to commit a sexual offense in the future than other juveniles who have not been convicted of a sex crime (Caldwell, 2007). They are less likely to progress to a violence offense than other adolescent offenders. Most importantly, they are likely to have significant social and psychological concerns, such as a history of victimization, internalizing symptoms and a history of other problematic acting out. As such, treatments that have been successfully applied to working with adult sexual offenders may not be effective with juvenile sexual offenders. Treatments applied to juvenile sexual offenders need to account for these important differences.

Further, there are important developmental differences between juvenile sexual offenders of different ages. Current research suggests important differences between young children who engage in problematic sexual behaviors and older adolescents engaging in these same behaviors, including increased impulsivity in offending. Research has also suggested that these children benefit more from parent-focused interventions than traditional, individually-based treatment. Unless these developmental factors are taken into account, children and adolescents with sexual behaviors problems are likely to receive ineffective or possibly harmful treatments.

Secondly, research suggests that most juvenile sexual offenders can be treated effectively on an outpatient basis, although some offenders may benefit from inpatient treatment. Research has shown that several outpatient treatment programs can be effective in reducing the risk of both sexual recidivism and engagement in non-sexual crimes. There is some evidence to suggest that re-
offense rates for adolescents treated in cognitive-behavioral, systemic outpatient treatment programs may have lower re-offense rates than those receiving more intensive, inpatient treatment. Further, overall rates of sexual re-offense for juveniles are low, particularly when juveniles receive treatment focusing on reducing risk for sexual offending. This suggests minimal risk to the community while juveniles receive outpatient treatment, achieving maximal treatment efficacy and cost effectiveness in the community. Currently, there is no empirically-validated way to identify those juveniles who will go on to commit sexually-based offenses as adults. When making treatment decisions, practitioners should look to the number of empirically-validated risk factors possessed by each offender. When offenders possess a high level of risk factors, more intensive treatment may be necessary. However, given the low base-rates of sexual re-offenses for juvenile sexual offenders, these decisions should be made cautiously and juveniles treated in the least restrictive environment whenever possible.

Third, research findings suggest that children and adolescents are likely to respond best to treatment when significant caregivers are involved in treatment. This appears to be especially true for younger children and adolescents. However, even in a population of older adolescents, Henggeler et al. (2009) found that parental change and engagement was critical to creating therapeutic change. Effective involvement of parents or other caregivers in treatment may include teaching behavioral management techniques, creating safety plans to prevent re-offense, and teaching parents about normative sexual development. If may also be important for therapists to work with parents and adolescents on resolving ongoing conflicts. These findings suggest that when working with juvenile sexual offenders, it is important to take a systemic focus in treatment, rather than focusing only on changes that the adolescent needs to make.

Fourth, research suggests that in general, cognitive behavioral treatments are most successful in reducing risk for future offenses. Common cognitive-behavioral treatments include using behavioral management systems, challenging faulty or deviant cognitions, and engaging in behaviors that are incompatible with future sexual offending. It is critical to improving the effectiveness of treatment that these and other cognitive-behavioral techniques routinely be included in the treatment of juvenile sexual offenders.

Fifth, several of the above studies note that high levels of social isolation and negative peer associations are associated with higher levels of risk for future offense. Therefore, treatment to reduce the risk of recidivism in juvenile sexual offenders may be made more effective if efforts are made to reduce social isolation and deviant peer associations. This may take the form of social skills training, increasing involvement in positive social activities, and helping parents to monitor or restrict their children’s social interactions.

Finally, research on treatment with juvenile sexual offenders has suggested that focusing on sexual behaviors in treatment is necessary to reduce recidivism, but not sufficient. Other components are necessary, most importantly enlisting the involvement of caregivers and other significant actors in the juvenile life. Most importantly, clinicians must remember that juvenile sex offenders are different from adult sexual offender. They are still undergoing daily dynamic changes in their personality and charac-
ter and as a result, many of them do not re-offend, even without treatment. The mechanisms behind their behavior are different, and for children and adolescents, sexual acting out is not simply due to “power and control” or “sexual deviance”. Therapeutic techniques must be carefully selected based on their proven efficacy with juveniles. This does not mean that the behavior that juvenile sex offenders have engaged in is non-sexual (it most certainly is sexual in nature), but it does mean that the behavior should be approached differently and examined within the context of the juvenile’s situation.

References


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**The MMPI-2-RF is Ready for the Daubert Challenge: Evidence, Implications, and Recommendations for Use in Court Testimony**

MARTIN SELLBOM, PH.D.

*The University of Alabama*

**Abstract**

This article describes how the Minnesota Multiphasic Personality Inventory – 2 – Restructured Form (MMPI-2-RF; Ben-Porath & Tellegen, 2008) meets the criteria for admissibility in court testimony as established in *Daubert v. Merrell Dow Pharmaceuticals, Inc* (1993) for its general purposes in forensic psychological evaluations. More specifically, the MMPI-2-RF has undergone substantial testing as documented in the *MMPI-2-RF Technical Manual* (Tellegen & Ben-Porath, 2008), many of its scales’ empirical validation studies have been subjected to peer-review, errors rates are known via reliability and standard error of measurement data, and a manual documents its standards for application. Although general acceptance of the scientific community cannot yet be determined, it appears promising. Implications and recommendations are discussed.

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The MMPI-2-RF is Ready for the Daubert Challenge: Evidence, Implications, and Recommendations for Use in Court Testimony

The Minnesota Multiphasic Personality Inventory – 2 – Restructured Form (MMPI-2-RF; Ben-Porath & Tellegen, 2008; Tellegen & Ben-Porath, 2008) is a recently published 338 item self-report inventory, which is conceptually and empirically linked to contemporary models of personality and psychopathology. It was designed to take advantage of the clinically useful variance in the Minnesota Multiphasic Personality Inventory – 2 (Butcher et al., 2001) in an efficient and psychometrically up-to-date manner. The MMPI-2-RF is organized into six sets of scales – nine validity scales, three higher-order (H-O) scales, nine restructured clinical (RC) scales, twenty-three specific problem (SP) scales, two interest scales, and five personality psychopathology five (PSY-5) scales. The names, scale labels, and number of items are listed in Table 1.

The nine validity scales consist of seven revised versions from the MMPI-2 and two new scales. The revised versions of Variable Response Inconsistency (VRIN-r) and True Response Inconsistency (TRIN-r) measure random and fixed responding, respectively. Infrequent Responses (F-r) is a revised version of the original F scale, and contains items that were infrequently endorsed (<10%) in both men and women in the MMPI-2 normative sample. Infrequent Psychopathology Responses (F_p-r) is a 23-item version of the MMPI-2 F_p scale, with a noteworthy revision being the deletion of four items that overlapped with the original L scale. (see e.g., Gass & Luis, 2001, for highlighting this need). Infrequent Somatic Responses (F_s) is a new scale developed to measure non-

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credible somatic responding. It consists of 16 items infrequently endorsed by both normative and medical samples. Symptom Validity (FBS-r) consists of 30-items of the original 43 FBS items that were retained for the MMPI-2. The Response Bias Scale (RBS) consists of 28-items associated with failure on cognitive malingering measures. Unlikely Virtues (L-r) and Adjustment Validity (K-r) are shorter version of their respective MMPI-2 counterparts designed to measure distinct and complementary aspects of under-reporting.

The three H-O scales represent measurement of the broad domains of internalizing, externalizing, and thought disturbance that have been consistently identified in the empirical literature, including large epidemiological stud-
ies (e.g., Krueger & Markon, 2006; Vollebergh et al., 2001). They also represent dimensional measurements of the three most common code types of the MMPI-2, 27/72, 68/86, and 49/94 (see e.g., Graham, 2006). The H-O scales were derived from factor analyses of the nine RC scales, which serve as the core set of scales for the MMPI-2-RF (Tellegen & Ben-Porath, 2008). The RC scales were initially developed for the MMPI-2 by removing (to the extent possible and conceptually indicated) a broad emotional distress factor common to all Clinical scales and identifying the remaining distinctive core constructs measured by each (Tellegen et al., 2003). This procedure resulted in nine non-overlapping scales, including one Demoralization scale (RCd) measuring the common distress factor, and eight scales measuring distinct core clinical scale components.

The SP scales were developed primarily to assist in clarifying H-O and RC scale interpretation, but also to measure clinical and personality domains not sufficiently covered by the RC scales. The SP scales include five Somatic/Cognitive, nine Internalizing, four Externalizing, and five Interpersonal scales. The Internalizing SP scales consist of four scales (SUI, HLP, SFD, NFC) specifically designed to measure different aspects of demoralization (i.e., RCd), whereas the other five scales (STW, AXY, ANP, BRF, MSF) measure various facets of dysfunctional negative emotions (i.e., RC7). Among the Externalizing scales, Juvenile Conduct Problems and Substance Abuse measure facets of Antisocial Behavior (RC4), whereas Aggression and Activation index Hypomanic Activation (RC9) facets. However, all SP scales are sufficiently reliable to be stand-alone measures for each specific construct. Furthermore, the two interest scales measure two distinct core components derived from the original MMPI-2 Clinical Scale 5 (Masculinity/Feminity) – Physical/Mechanical and Aesthetic/Literary interests.

Finally, the MMPI-2-RF includes a set of revised PSY-5 scales (Harkness & McNulty, 2007; Harkness, McNulty, Ben-Porath, & Graham, 2002), which emphasize an empirically supported dimensional model of personality disorders (e.g., Bagby et al., 2002; Bagby, Sellbom, Costa, & Widiger, 2008; Harkness, McNulty, & Ben-Porath, 1995) that is line with other contemporary empirical findings of optimal dimensional conceptualizations of personality pathology (e.g., Watson, Clark, & Chmielewski, 2008; Tackett, Silberschmidt, Krueger, Sponheim, 2008). The PSY-5 domains are identical to those on the MMPI-2: Aggressiveness, Psychoticism, Disconstraint, Neuroticism/Negative Emotionality, and Introversion/Low Positive Emotionality.

**Forensic Applications of MMPI-2-RF**

The MMPI instruments have a long-standing history in forensic assessment, starting soon after the instrument’s official publication in 1943 (e.g., Capwell, 1945a, 1945b; Hathaway & Monachesi, 1953, 1957). The present forensic applications of the MMPI-2 are extensive. Several surveys have indicated that the MMPI-2 is more frequently used in forensic settings than any other test (Archer, Buffington-Vollum, Stredny, & Handel, 2006; Lees-Haley, 1992) and is recommended or appropriate for most forensic questions (Lally, 2003). Moreover, the MMPI-2 is second only to the Wechsler Intelligence Scales in forensic neuropsychological evaluations (Lees-Haley, Smith, Williams, & Dunn, 1996). The test is also used quite frequently in other countries, such as Australia (Martin, Allan, & Allan, 2001), for forensic purposes. Sellbom and Ben-
Porath (2006) provide recommendations for uses (and limitations of use) of the MMPI-2 across various types of criminal and civil forensic evaluations.

Although still in its infancy, it is my expectation that the MMPI-2-RF will continue to rise to frequent use among forensic psychologists. It has several advantages relative to the MMPI-2, including substantially reduced length with minimal loss of psychometric information, as well as being better linked to contemporary models of personality and psychopathology. For instance, in terms of externalizing psychopathology, the MMPI-2-RF hierarchical structure maps conceptually on to that of Krueger et al. (2007) and promising empirical data has begun to show this as well (Sellbom, 2010).

In terms of using the MMPI-2-RF in forensic psychological evaluations, it is very important to keep in mind that this instrument (or its predecessors) was not designed to address psycho-legal questions, nor can it specifically address such questions. Nonetheless, the MMPI-2-RF can be very useful in forensic evaluations because it can yield very important information about a person that is highly relevant to the question at hand, such as self-presentation, symptoms of psychopathology, personality traits, and specific behavioral styles. More specifically, most forensic evaluations come with an external incentive to misrepresent oneself psychologically, and the MMPI-2-RF validity scales can be quite useful in detecting whether a person is responding in an inconsistent, exaggerated, or defensive manner on the test (Handel, Ben-Porath, Tellegen, & Archer, 2010; Sellbom & Bagby, 2008; Sellbom, Toomey, Wygant, Kucharski, & Duncan, 2010), which with corroborating information could assist in a judgment about whether the person is cooperating with the evaluation, possibly malingering, or under-reporting.

Substantive MMPI-2-RF scales can also aid in characterizing the level of psychopathology and/or personality functioning of the test-taker. For instance, in evaluations of competency to stand trial or criminal responsibility, a significant issue is frequently the mental state of the defendant, and in particular, whether or not this person is suffering from disordered thinking. The MMPI-2-RF has several scales that are useful in identifying thought disturbance, and can differentiate between paranoid and non-paranoid psychosis (e.g., RC6 and RC8; see Arbisi, Sellbom, & Ben-Porath, 2008; Handel & Archer, 2008; Tellegen et al., 2003). Another example is risk assessment evaluations. The MMPI-2-RF has several scales that measure externalizing proclivities, including RC4 and RC9, which have been associated with psychopathy (Sellbom, Ben-Porath, & Stafford, 2007; Sellbom, Ben-Porath, Lilienfeld, Patrick, & Graham, 2005), increased risk for violent re-offending (Sellbom, Ben-Porath, Baum, Erez, & Gregory, 2008), and substance abuse (e.g., Arbisi et al., 2008; Sellbom et al., 2007; Sellbom et al., 2008).

In sum, the MMPI-2-RF is likely to gain widespread use in forensic settings due to its utility in assisting the clinician in forensic psychological evaluations. However, a significant issue arises when MMPI-2-RF information is used as evidence to inform a psycho-legal opinion to be offered in court testimony and whether this evidence is admissible in court. It is my opinion that the MMPI-2-RF, for its general purposes in forensic examinations, will be up to the challenge as documented in the following.

The MMPI-2-RF and Daubert Criteria

When an expert relies on the MMPI-2-RF to form an opinion to be offered in testimony, the basis for this
opinion may be scrutinized and admissibility denied if it fails to meet certain standards. In federal court cases and in most state courts, these standards for admissibility are outlined in the U.S. Supreme Court decision in *Daubert v. Merrell Dow Pharmaceuticals, Inc* (1993). The Court unanimously ruled that the preceding *Frye v. U.S.* (1923) requirement that expert evidence should only be admissible in court if generally accepted by its scientific community was too stringent when applied to newly tested and validated techniques. Therefore, the Court highlighted the Federal Rules of Evidence -- Rule 702 to guide a more flexible determination of admissibility that included an emphasis on the scientific reliability and validity of the technique in question rather than general acceptance.

In its ruling on *Daubert*, the Supreme Court established that trial judges must determine the validity of inferences based on scientific techniques by considering whether (1) the technique can be and has been tested empirically, (2) the technique has been subjected to peer review, (3) the error rates of the technique are known, (4) there are standards for applying the technique, and (5) the technique is generally accepted in its scientific discipline. The last criterion refers back to the *Frye v. U.S.* (1923) ruling regarding expert testimony, which still applies in several states. The MMPI-2-RF is next considered in regards to each of these criteria.

**Has the MMPI-2-RF been tested?**

*Yes.* The MMPI-2-RF has very likely undergone more extensive testing to determine its psychometric properties than any other psychological test instrument has at the time of its release. In addition to standard information about the MMPI-2-RF normative sample (the MMPI-2 non-gendered normative sample; Ben-Porath & Forbey, 2003), the *MMPI-2-RF Technical Manual* (Tellegen & Ben-Porath, 2008) presents a considerable amount of information about internal consistency and test-retest reliability estimates in several normative and clinical samples. Furthermore, Tellegen and Ben-Porath (2008) also provide extensive validity data, with 136 tables reporting 53,886 correlations between various MMPI-2-RF scales and a total of 604 external criterion measures in a variety of samples, including criminal defendants, forensic disability claimants, community mental health center clients, psychiatric inpatients, substance abuse patients, medical outpatients, and college students. Overall, 4,336 men and 2,327 women were included across these samples. External criterion measurement modalities include therapist ratings, intake information, record review data, and other self-report instruments. This substantial amount of validity data offered the test authors ample opportunity to elaborate on individual scale interpretations.

In addition to inferential statistics, the *MMPI-2-RF Technical Manual* (Tellegen & Ben-Porath, 2008) also provides descriptive group data for numerous different settings, including (but not limited to) pre-trial criminal, civil forensic disability, correctional, outpatient mental health, inpatient mental health, outpatient medical, substance abuse treatment, personnel selection, and non-clinical settings. Overall, these samples include over 60,000 men and women. These group means and standard deviations can be highly informative to clinicians who wish to compare a test-taker’s scores to those of a particular setting. In terms of forensic psychological evaluations, the large pre-trial, civil disability, and correctional samples are particularly applicable.
Has the MMPI-2-RF been subjected to peer-review?

Yes. Although the MMPI-2-RF Technical Manual is very impressive in its own right, it was not subjected to the scrutiny of peer-review and editorial decision making prior to its publication. Nonetheless, a large amount of empirical data has already been generated on MMPI-2-RF scales and numerous projects are being conducted and/or published at the time of this writing. I will briefly summarize and highlight this literature below.

To my knowledge, there are approximately 130 peer-reviewed publications on the MMPI-2-RF to date. Most of these publications have focused on the RC scales, which were initially released for the MMPI-2 (Tellegen et al., 2003).¹ Overall, this research indicates that the RC scales are able to capture the core components of the original MMPI/MMPI-2 Clinical scales with little or no loss of convergent information, but with a substantial gain in discriminant validity (e.g., Forbey & Ben-Porath, 2007; Handel & Archer, 2008; Sellbom & Ben-Porath, 2005; Sellbom, Ben-Porath, & Graham, 2006; Sellbom, Ben-Porath, McNulty, Arbisi, & Graham, 2006; Sellbom, Graham, & Schenk, 2006; Simms, Casillas, Clark, Watson, & Doebbeling, 2005; Wygant et al., 2007; see also Tellegen, Ben-Porath & Sellbom, 2009, for a review of this literature).

Furthermore, research on the RC scales has yielded substantial information about construct validity (e.g., Tellegen et al., 2009). These scales map well onto contemporary models of normal personality such as Tellegen’s (1982) Multidimensional Personality Questionnaire (Sellbom & Ben-Porath, 2005), Clark’s (1993) Schedule for Nonadaptive and Adaptive Personality (Simms et al., 2005), and the Five Factor Model of personality (Sellbom, Ben-Porath, & Bagby, 2008b). The RC scales also measure constructs that are consistent with developments in the psychopathology literature. For instance, the RC scales have been linked to current developments in the conceptualization of mood and anxiety disorders (Sellbom, Ben-Porath, & Bagby, 2008a), post-traumatic stress disorder (Wolf et al., 2009), bipolar disorder (Quilty, Sellbom, Tackett, & Bagby, 2009), psychopathy (Sellbom et al., 2005; Sellbom et al., 2007), and autism spectrum disorders (Ozonoff et al., 2005).

In terms of peer-reviewed research directly relevant to forensic psychological evaluations, there have been several published studies on both the MMPI-2-RF validity scales and its substantive scales. Sellbom et al. (2010) used a known-groups design to examine the extent to which the MMPI-2-RF validity scales could detect malingering in a criminal forensic setting. The Structured Interview for Reported Symptoms (SIRS; Rogers et al., 1992) was used as the criterion to identify participants who were malingering (n=27) or not malingering (n=98). Malingers scored significantly higher than non-malingers on all four MMPI-2-RF over-reporting scales (F-r, F_p-r, F_s, FBS_r), but effect sizes were greatest for the F-r and F_p-r scales. Each of these two scales accounted for unique variance in differentiating between malingers and non-malingers. Classification accuracy data supported the cut-off scores recommended for the F-r and F_p-r scales in the MMPI-2-RF Manual for Administration, Scoring and Interpretation.

¹ The RC scales are identical across both MMPI-2 and MMPI-2-RF. Tellegen and Ben-Porath (2008) present data indicating the MMPI-2-
Interpretation (Ben-Porath & Tellegen, 2008). In a civil forensic setting, Wygant, Ben-Porath, Arbisi, Berry, Freeman, and Heilbronner (2009) examined these over-reporting scales in two simulation samples and one known-groups sample that utilized cognitive symptom validity tests as a criterion, and found that the scales were able to detect the various threats to protocol validity in civil forensic settings. However, unlike Sellbom et al. (2010), the FS and FBS-r scales worked much better relative to F-r and FP-r. This finding was entirely expected, as F-r and Fp-r were designed to measure malingering of psychopathology, whereas FS and FBS-r are more specifically focused on the detection of non-credible somatic and/or neurocognitive complaints. These general over-reporting findings have been replicated in numerous subsequent studies across settings (Gervais, Ben-Porath, Wygant, & Sellbom, 2010; Marion, Sellbom, & Bagby, 2011; Rogers, Gillard, Berry, & Granacher, 2011; Sellbom & Bagby, 2010; Wygant et al., 2011). Finally, in terms of validity scales, Sellbom and Bagby (2008) found that in two clinical and non-clinical samples L-r and K-r were able to differentiate between individuals asked to under-report problems on the test and honest test-takers. This study included both civil commitment (with schizophrenia patients as participants) and child custody contexts, which makes it particularly applicable to forensic psychological evaluations.

The literature also includes several studies conducted specifically in forensic and correctional settings. Sellbom et al. (2005) and Sellbom et al. (2007) have elaborated on the utility of the MMPI-2 RC scales in measuring psychopathy in both non-clinical and pre-trial forensic settings. Sellbom et al. (2005) found that high scores on RC4 and RC9 coupled with low scores on measures of negative emotionality (particularly fear) were effective in predicting psychopathy. Sellbom et al. (2007) found that RC4 captured psychopathy, as indexed via the Psychopathy Checklist: Screening Version (Hart, Cox, & Hare, 1995), better than the original Clinical Scale 4 and other MMPI-2 measures of antisociality. It is noteworthy that, in contrast to previous criticisms of the MMPI-2 (e.g., Hare, 1985), these studies indicated that the RC scales capture variance associated with the affective-interpersonal facet as well as the social deviance facet of the psychopathy construct. In addition to providing a greater understanding of a highly forensically relevant psychopathology construct, these findings have significant implications for risk assessment evaluations, as psychopathy is a very potent predictor of reoffending. Indeed, subsequent research has also shown that RC4 and RC9 are particularly strong predictors of treatment failure and recidivism at a 12-month follow-up in a male batterer’s intervention program (Sellbom, Ben-Porath, Baum et al., 2008). Furthermore, Forbey, Ben-Porath, and Gartland (2009) recently conducted a study on the RC scales in a large correctional sample, and found substantial evidence for convergent and discriminant validity in predicting not only forensically relevant personality traits, such as anger, alcohol abuse, and drug abuse, but also general mental health criteria, including depression, anxiety, somatization, and hypomania.

In terms of civil forensic settings, Gervais, Ben-Porath, and Wygant (2009) explored relationships between scores on the Cognitive Complaints (COG) scale, objective measures of cognitive deficits, and self-reported cognitive deficits in a large sample (n = 1,741) of disability claimants evaluated in a private-practice setting. COG scores were associated with subjective reports of cognitive and memory problems. This relationship was present even when insufficient cognitive effort and symptom ex-
aggeration were controlled. Gironda and Clark (2009) examined the MMPI-2-RF Somatic/Cognitive scales in two samples of patients in chronic pain programs. They found that these scales were associated with good convergent and discriminant validity when predicting scores on well-validated, external pain-specific measures.

Are the error rates of the MMPI-2-RF known?

Yes. This question can be directly answered with reliability data and, in particular for individuals’ scores, Standard Error of Measurement (SEM) data. The *MMPI-2-RF Technical Manual* (Tellegen & Ben-Porath, 2008) presents reliability and SEM data for the normative sample, as well as several clinical samples. Per this manual, internal consistencies and test-retest reliability estimates for almost all MMPI-2-RF scales are well within acceptable standards and comparable or better relative to other similar self-report inventories.

The most important statistic for an individual’s score on an MMPI-2-RF scale is SEM. According to the *MMPI-2-RF Technical Manual*, these values (in T-score units) range from 4 to 9 (normative sample) and 6 to 12 (clinical samples) for the Validity scales; from 3 to 5 (normative sample) and 4 to 6 (clinical samples) for the H-O scales; from 3 to 6 (normative sample) and 3 to 7 (clinical samples) for the RC scales; from 4 to 8 (normative sample) and 5 to 11 (clinical samples) for the SP and Interest scales; and from 3 to 6 (normative sample) and 5 to 6 (clinical samples) for the PSY-5 scales. These values are acceptable to excellent by psychometric standards, and at least comparable to those of other self-report inventories of personality and psychopathology. The somewhat lower reliabilities of the SP scales suggest that clinicians should have less confidence in inferences based on these scales than those based on the H-O, RC, and PSY-5 Scales, at least when interpreted in isolation. Tellegen and Ben-Porath (2008) recognize this issue, and state, SEMs are predominantly eight T-score points or lower, and a majority are six points or lower. Exceptions are SEMs of shorter and/or highly truncated measures like Suicidal/Death Ideation (SUI), Helplessness/Hopelessness (HLP), Anxiety (AXY), Behavior Restricting Fears (BRF), and Disaffiliativeness (DSF), which in the clinical samples range from 9 to 11 points. Larger SEM values imply that more extreme T-scores are needed to justify clinically significant inferences. (p. 26).

Furthermore, error rates can also be determined for scales used directly for dichotomous decision-making. This is particularly applicable to the MMPI-2-RF validity scales, which are used to make decisions about a person’s approach to the test and/or evaluation. The studies described earlier on the MMPI-2-RF over-reporting scales showed that error rates were generally very small (<10%) in terms of overall classification (e.g., Rogers et al., in press; Sellbom & Bagby, 2010; Sellbom et al., 2010; Wygant et al., 2009).

Are there are standards for applying the MMPI-2-RF?

Yes. The *MMPI-2-RF Manual for Administration, Scoring, and Interpretation* (Ben-Porath & Tellegen, 2008) describes these standards. Per this manual, the MMPI-2-RF should be administered in a professional manner and should always take place in supervised conditions. The test-taker’s ability to read and comprehend the items should be determined (a fifth grade reading level is required). The test can be administered via a printed booklet or computer software. For booklet administrations, responses are recorded on a separate answer sheet. A standardized audio version (both CD and via computer)
of the test is available for test-takers with borderline reading levels or with visual disabilities. The MMPI-2-RF manual (Ben-Porath & Tellegen, 2008) indicates that booklet and answer sheet administration typically takes 35-50 minutes, and computer administration typically takes 25-35 minutes.

Ben-Porath and Tellegen (2008) describe several options for scoring MMPI-2-RF protocols. Three methods are available if the test is administered via booklet and answer sheet. Answer sheets can be mailed to Pearson Assessments or hand scoring can be accomplished using scoring templates and profile sheets available from the test distributor. Responses can also be scored via computer software available from the test distributor. If the test was administered using a personal computer, scoring is accomplished easily by appropriate software. Pearson Assessments offers a Score Report that provides scores and profiles for all scales and has the option of providing mean data for various specific setting comparison groups (e.g., forensic pre-trial defendants, correctional inmates, civil disability litigants, mental health outpatients, psychiatric inpatients) previously discussed. Moreover, a computerized Interpretive Report is also available, which in addition to a narrative interpretation, includes everything from the Score Report.

Is the MMPI-2-RF generally accepted in its scientific discipline?

Unknown. To my knowledge, there have been no surveys systematically administered to determine the frequency of use of the MMPI-2-RF in psychological practice, or any other published data providing gross estimates of the general utilization of the instrument. Moreover, there is no case law established to inform the field on acceptability of forensic opinions where the MMPI-2-RF information has been used as evidence.²

Nonetheless, the main purpose of the Daubert standard was to go beyond the “general acceptance” criteria to allow for basing expert opinions on new and promising instruments that have not had sufficient time to gain general acceptance. Thus, the MMPI-2-RF is exactly the type of instrument that the Daubert standard was developed to accommodate -- a psychometrically sound, well-standardized, and well-validated instrument that simply requires several more years of exposure in the field before it gains the status of a technique that is “generally accepted in its scientific discipline.”

It is also important to consider that even in states where the Frye test (or a version thereof) was retained, most judges will likely rely on case law when making decisions about admissibility of psychological test evidence. Such case law has frequently considered other Daubert-like criteria, including psychometric properties of the test in question (Melton, Petrila, Poythress, & Slobogin, 2007).

Implications and Recommendations

It is my opinion that the MMPI-2-RF -- a psychological test instrument designed to measure response bias in psychological evaluations, symptoms of psychopathology, and personality and behavioral proclivities -- can withstand a Daubert challenge. The discussion of how the the MMPI-2-RF can meet Daubert criteria, however, is very general and implies that forensic psychologists can

² As an anecdote, I can note that I have conducted or consulted on over 50 forensic psychological evaluations in which MMPI-2-RF information was used as psychological evidence. Its use has never been questioned.
use the test on a routine basis, but it is not meant to suggest that all evidence derived from a test administration would be admissible in court. In any given case, the question is whether a specific MMPI-2-RF-based conclusion reached by an expert can meet the standards for admissibility. Thus, when faced with a Daubert challenge, the expert must be prepared to cite original peer reviewed research to support their conclusions as well as to answer any other Daubert-relevant questions. An informative example from the MMPI-2 literature has relevance to this issue. In *U.S. v. Huberty* (2000), Lt. Col. Huberty was facing criminal charges of indecent exposure. An expert witness testifying for the defense argued that Huberty could not be guilty of the crime, because his MMPI-2 profile was not indicative of exhibitionism. The testimony was not admitted, however, because no empirical research has demonstrated that exhibitionists produce specific MMPI-2 profiles.

It is also important to consider that the Validity and RC scales have undergone more empirical scrutiny than other MMPI-2-RF scales. There are, to my knowledge, no peer-reviewed empirical studies that have examined eternal correlates of the H-O, SP, Interest, or PSY-5 scales, except those previously mentioned regarding the Somatic/Cognitive scales (i.e., Gervais et al., 2009; Grionda and Clark, 2009) and two articles that examined such correlates in college samples (Burchett & Ben-Porath, 2010; Forbey, Lee, & Handel, 2010).³ Although the *MMPI-2-RF Technical Manual* contains substantial validity information about these scales, which is very helpful in generating interpretative information, it has not been peer-reviewed. In addition, the SEM values for several of the SP scales are quite large (up to 11 T-score points, indicating a 95% confidence interval with a 44 point range).

Therefore, forensic psychologists need to be careful in using evidence coming solely from the SP scales in their opinions until more peer-reviewed empirical data has been published. Fortunately, forensic examiners need not rely solely on these scales for now, as all of the Somatic/Cognitive, Internalizing, and Externalizing SP scales are facets of well-validated RC scales (i.e., RCd, RC1, RC4, RC7, and RC9), and can be interpreted within the context of clarifying these RC scale elevations. As the empirical research base on the SP scales accumulates over the next few years, this approach will become less necessary.

In conclusion, the MMPI-2-RF is a promising self-report instrument that has already accumulated an impressive amount of empirical support for forensic evaluations. The evidence of how this test can withstand a Daubert challenge, at least for its common purposes in forensic psychological examinations, implies that clinicians can be comfortable with its routine use. Nonetheless, as with any psychological test instrument, more empirical research (especially on H-O, SP, Interest, and PSY-5 scales) is recommended to further elaborate on the MMPI-2-RF’s validity and clinical utility in forensic psychological evaluations.

³ It should be noted that the MMPI-2-RF PSY-5 scales are very highly correlated with their MMPI-2 counterparts (> .90 for four of five scales; > .80 for DISC-r; see Tellegen & Ben-Porath, 2008); thus, the extensive empirical validation on the MMPI-2 versions are likely to apply to the MMPI-2-RF versions as well. The substantial external correlate data presented in the Technical Manual (Tellegen & Ben-Porath, 2008) for MMPI-2-RF PSY-5 scales supports this conclusion.
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Frye v. United States, 293 F.1012 (D.C.Cir. 1923).


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Empirically Guided Case Conceptualization of Posttraumatic Stress Disorder with the Minnesota Multiphasic Personality Inventory-2 Restructured Form (MMPI-2-RF) in a Forensic Disability Evaluation

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Abstract

The following article discusses how the Restructured Form of the Minnesota Multiphasic Personality Inventory (MMPI-2-RF; Ben-Porath & Tellegen, 2008) can be used in case conceptualizations for Posttraumatic Stress Disorder (PTSD), particularly in compensation seeking settings. We review contemporary conceptualizations of PTSD, particularly emphasizing the role that affect and personality in regards to etiology of the disorder, as well as different manifestations of the disorder. We then review the case of an individual seeking compensation for trauma related disability performed by the third author. Particular emphasis is placed on examining how interpretation of the MMPI-2-RF profile is guided by empirical findings.

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tings, where clinicians must often establish the validity of a patient's symptom reports. A benefit of this instrument is its ability to identify several threats to protocol validity in the context of a forensic evaluation, such as random responding, acquiescent responding, as well as over and under-reporting of symptoms and problems, which has been extensively researched (e.g., Arbisi, Ben-Porath, & McNulty, 2006; Rogers et al., 2003). Previous studies have supported the use of these validity scales, namely the Infrequency (F) scale, Infrequency Back (Fb) scale, Infrequency Psychopathology (Fp) scale, and the Symptom Validity Scale (FBS), in detecting the over-reporting of PTSD symptoms in compensation seeking individuals during forensic evaluations (DeViva & Bloem, 2003; Franklin, Repasky, Thompson, Shelton, & Uddo, 2002; Frueh, Gold, & de Arellano, 1997; Greiffenstein, Baker, Axelrod, Peck, & Gervais, 2004; Rogers, Sewell, Martin, & Vitacco, 2003; Smith & Freuh, 1996).

The MMPI-2 Restructured Form (MMPI-2-RF; Ben-Porath & Tellegen, 2008) represents the latest version of the MMPI test and was developed in an effort to modernize the test by addressing the psychometric limitations of the MMPI and MMPI-2, as well as assessing personality and psychopathology in line with more contemporary theories (Ben-Porath & Tellegen, 2008). The focus of this paper will be the use of the MMPI-2-RF in the conceptualization of PTSD.

The MMPI-2-RF utilizes a hierarchical structure that incorporates both broadband and narrowly focused scales that measure personality and temperament, psychological symptoms, individual differences, and specific behavioral proclivities (Tellegen & Ben-Porath, 2008). The three Higher Order (H-O) scales represent broadband measures of Emotional/Internalizing Dysfunction (EID), Thought Dysfunction (THD), and Behavioral/Externalizing Dysfunction (BXD), and provide clinicians with an overall evaluation of the general problem areas of the test-taker. These three broad dimensions of functioning represent consistent findings in larger meta-analytic and epidemiological investigations of psychopathology (e.g., Krueger & Markon, 2006). Moreover, they provide a dimensional representation of three commonly occurring code types in clinical settings (2-7/7-2; 4-9/9-4; 6-8/8-6; see Graham, 2006).

Following the H-O scales in the hierarchical structure of the MMPI-2-RF are the Restructured Clinical (RC) scales (Tellegen et al., 2003), which clarify the H-O scales with a more focused evaluation of symptom and trait patterns. In an effort to address the high inter-correlations between the Clinical Scales of the MMPI-2, which can complicate effective interpretation of multiple scale elevations, Tellegen et al. (2003) developed the RC scales prior to their inclusion in the MMPI-2-RF (Ben-Porath & Tellegen, 2008). These scales differ from the original Clinical Scales in that general emotional distress and dysfunction, which was identified as the main contributor to the high inter-correlations on the Clinical Scales on the MMPI-2 (Tellegen et al., 2003), is identified as a separate construct and found on the RC Demoralization scale (RCd). Demoralization is conceptually related to the general distress component found to be underlying many heterogeneous disorders (Brown, Chorpita, Barlow, 1998; Moses & Barlow, 2006). Indeed, measures of demoralization and negative affect have been found to correlate highly as indicators of psychological distress (Sellbom, Ben-Porath, & Bagby, 2008). Previous research has examined the use of the MMPI-2 RC scales in assessing constructs associated
with the symptom clusters of PTSD (Wolf et al., 2008). Specifically, Wolf and colleagues (2008) found that re-experiencing symptoms such as flashbacks were captured by Aberrant Experiences (RC8), emotional numbing was associated with Low Positive Emotions (RC2), and hyper-arousal was related to Dysfunctional Negative Emotions (RC7). Additionally, somatic complaints and the overall emotional distress associated with the chronic and pervasive effects of the disorder were associated with Somatic Complaints (RC1) and Demoralization (RCd), respectively.

The most narrowly focused scales on the MMPI-2-RF are the Specific Problem (SP) scales, which are grouped into indexes measuring somatic and cognitive complaints, internalizing and externalizing behaviors and cognitions, and interpersonal experiences. Several of the SP scales may also prove useful in case conceptualizations in assessing various symptoms of PTSD. Of the Interpersonal scales, the Family Problems scale (FML) should be considered, as the amount of post-trauma social support available to an individual can be a moderating factor on the development of pathology (Koenen, Stellman, Stellman, & Sommer, 2003; Ruscio, Ruscio, & Keane, 2002). Additionally, scores on Social Avoidance (SAV) and Disaffiliativeness (DSF) may provide insight into whether an individual is experiencing a feeling of detachment from others, consistent with the DSM-IV’s description of avoidance symptoms (APA, 2000). Lastly, Substance Abuse (SUB) of the Externalizing Scales might capture alcohol and drug misuse, which has long been associated with a diagnosis of PTSD in various trauma populations (Bremner et al., 1996; Epstein et al., 1996). Please refer to Table 1 for a more information regarding MMPI-2-RF scales and PTSD symptoms.

Lastly, the MMPI-2 Personality Psychopathology Five (PSY-5) scales, developed by Harkness & McNulty,

Table 1: MMPI-2-RF and PTSD Symptoms

<table>
<thead>
<tr>
<th>PTSD Cluster/Symptom</th>
<th>MMPI-2-RF Scales</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Re-Experiencing</strong></td>
<td></td>
</tr>
<tr>
<td>Recurrent distressing</td>
<td>AXY</td>
</tr>
<tr>
<td>dreams of the event</td>
<td>AXY</td>
</tr>
<tr>
<td>Intense psychological</td>
<td>AXY</td>
</tr>
<tr>
<td>distress at exposure</td>
<td>AXY</td>
</tr>
<tr>
<td>to cues reminiscent of the trauma</td>
<td>AXY</td>
</tr>
<tr>
<td>Physiological reactivity</td>
<td>AXY</td>
</tr>
<tr>
<td>at exposure to cues</td>
<td>AXY</td>
</tr>
<tr>
<td>reminiscent of the trauma</td>
<td></td>
</tr>
</tbody>
</table>

| **Avoidance/Numbing**      |                  |
| Avoidance of activities,   | BRF              |
| places, or people          |                  |
| associated with trauma     |                  |
| Inability to recall an     | COG              |
| important aspect of        |                  |
| the trauma                 |                  |
| Diminished interest/       | SAV              |
| participation in           |                  |
| significant activities     |                  |
| Feeling of detachment      | DSF              |
| or estrangement from others| INTR-r           |
| Restricted range of affect | RC2, RC7         |
| Sense of a fore-           | RC7              |
| shortened future           | HLP              |
(1994) to measure dispositional abnormal personality characteristics, were revised for inclusion in the MMPI-2-RF. The PSY-5-r scales include Aggressiveness (AGGR-r), Psychoticism (PSYC-r), Disconstraint (DISC-r), Neuroticism/Negative Emotionality (NEGE-r), and Introversion/Low Positive Emotionality (INTR-r). Certain personality traits measured by the PSY-5 scales have been linked to PTSD symptom expression in recent research. Miller (2003) found that low levels of constraint and inhibition appear to act as moderating factors on the PTSD symptoms expressed in traumatized individuals. Additionally, Miller and colleagues (2004) utilized a cluster analysis of the PSY-5 scales in a sample of veterans and found three distinct clusters of PTSD symptom expression: a low-level pathology group, an externalizing group characterized by high scores on AGGR, NEGE, PSYC, and DISC, and an internalizing cluster characterized by high scores NEGE and high scores on INTR. This study replicated and extended findings from an earlier examination of posttraumatic response subtypes (Miller, Greif, & Smith, 2003), and similar findings have been found in samples of female rape survivors (Miller & Resick, 2007) as well as workplace claimants (Sellbom & Bagby, 2009).

In addition to its various clinically substantive scale, the MMPI-2-RF contains a set of validity indicators that can be used to identify both non-content (e.g., random, acquiescent responding) and content-based response bias (e.g., over-reporting, under-reporting). The MMPI-2-RF over-reporting scales include revised versions of the Infrequency (F), Infrequency Psychopathology (Fp), and the Symptom Validity scale\(^1\) (FBS). The Infrequent Somatic Responses (Fs; Wygant, Ben-Porath, & Arbisi, 2004) was added to the MMPI-2-RF and contains items infrequently endorsed in medical and chronic pain samples. The MMPI-2-RF over-reporting validity scales have been found to be effective markers of response bias in both civil/disability settings (Wygant, Ben-Porath, Arbisi, Berry, Freeman, & Heilbronner, 2009; Wygant, Anderson, Sellbom, Rapier, Allgeir, & Granacher, 2011) and criminal forensic settings (Sellbom, Toomey, Wygant, Kucharski, & Duncan, 2010). Additionally, the Response Bias Scale (RBS; Gervais, Ben-Porath, Wygant, & Green, 2007) was recently added to the MMPI-2-RF. This scale contains 28 items that were found to effectively discriminate between individuals who passed or failed cognitive symptom validity tests commonly used in forensic disability settings. The strength of these scales is their ability to detect various features of malingering, such as severe psychopathology (Fp-r) or overreported (Fp-r) or overreported neurocognitive impairment (RBS), and somatic exaggeration (Fs & FBS-r). As such, these validity scales lend themselves well to the assessment of disorders with hetero-

\(^{1}\)Previously labeled the Fake Bad Scale, this measure was re-named Symptom Validity to provide a more descriptive and less inferential label (Ben-Porath, Tellegen, & Graham, 2008).
geneous symptom constellations, such as PTSD, in both clinical settings and in forensic situations where the veracity of the symptom presentation must be examined.

**Individual PTSD Case Conceptualizations Using the MMPI-2-RF**

An MMPI-2-RF profile, completed as part of a disability evaluation with the third author for claims of psychological damage in the form of PTSD, suggest that the test has good clinical utility for case conceptualizations in individuals with the disorder.

The conceptualized case is based on a 43 year old divorced male who was involved in a vehicular collision that resulted in the death of the other driver. Immediately following the accident, the individual experienced a dissociative episode that lasted for approximately 36 hours. At the time of the assessment, which occurred 10 years following the initial trauma, the man reported experiencing occasional, brief dissociative episodes, typically triggered by odors he associated with the accident. His assessment resulted in a diagnosis of PTSD.

In terms of his MMPI-2-RF results, a review of his validity scales suggests that he was generally cooperative with the evaluation (see Figure 1). His non-content based validity scale elevation (i.e., VRIN-r, TRIN-r) were in the normal range and none of the over-reporting validity scales were indicative of symptom exaggeration. Although he perhaps attempted to portray himself in an overly virtuous light (L-r =76), he still endorsed problematic symptoms on a number of the substantive scales of the MMPI-2-RF. In the absence of any elevations on the substantive measures of the MMPI-2-RF, his score on L-r might reflect defensiveness; however, given that the remainder of his profile shows marked elevations on scales reflecting the avoidance, re-experiencing, and hyperarousal symptom clusters of PTSD (APA, 2000), his score might actually reflect an orientation towards traditional values. Further supporting the veracity of his symptom report was his effort while testing and his non-elevated score on the Response Bias Scale. Indeed, his RBS t-score was 50 and he passed the three cognitive symptom validity tests administered during his evaluation, including 100% performance on the Word Memory Test and Medical Symptom Validity Test.

![Figure 1. MMPI-2-RF Validity Scales](image-url)
This client presented scale elevations suggestive of both emotional and behavioral avoidance, which support a diagnosis of PTSD. His overall level of emotional dysfunction is suggested by his elevated score on the Emotional/Internalizing Dysfunction Higher-Order Scale (EID=68), which measures the dysfunctional affect, emotional numbing, and rumination.

Examination of the client’s remaining profiles (Figures 2-4) provides more focused information about his symptom pattern, as well as his scores on the PSY-5-r scales (Figure 5), which suggests some potential underlying etiological factors to consider. His general sense of unhappiness, which may encompass the feelings of hopelessness that often occur as a result of PTSD, is exhibited by his elevation on Demoralization (RCd = 66). Hopelessness specifically appears to be a problem for this individual, as seen by his score on the Hopelessness/Helplessness scale (HLP=69). Additionally, this individual had an elevated score on Negative Emotionality (NEGE-r=73) of the PSY-5-r scales. This PSY-5-r scale elevation is consistent with findings that identify negative emotionality as a consistent feature of both internalizing and externalizing subtypes of PTSD MMPI-2 profiles (Miller et al., 2004). Previous research has supported broad-band personality factors such as those measured by the PSY-5-r scales as providing etiological continuity between Axis I and Axis II disorders (Krueger, 2005), suggesting these personological variables play a key role in the development of pathology such as PTSD. In terms of behavioral avoidance (PTSD Criterion C), the most striking evidence for behavior change as a possible result of this individual’s PTSD is found on the Behavior Restricting Fears scale (BRF=79). This score suggests a restriction of behavior and avoidance of normal activities as a result of intense fear or distress, which corresponds with the DSM-IV symptom criteria for the disorder (APA, 2000). This score may indicate that the individual is determined to avoid recollections of the trauma by drastically decreasing the breadth of his activities, which allows
him to attenuate his trauma-induced fears in a negatively reinforcing pattern. Additionally, his score on the Social Avoidance Scale (SAV=70) suggests that he is avoiding people and social gatherings as well. This interpersonal avoidance is also characteristic of individuals experiencing PTSD (APA, 2000), and in this case may result from cynical beliefs stemming from the trauma that others are not to be trusted (RC3=70). Active interpersonal avoidance may also account for this individual’s score on the Shyness scale (SHY=75). While this individual may have originally had some shyness as a natural component of his
temperament, his elevation on SHY may reflect emotional disengagement from those around him since the accident.

Evidence of symptoms inherent to the re-experiencing symptom cluster (PTSD Criterion B) can also be discerned from the client’s MMPI-2-RF profile. His score on the Psychoticism scale of the PSY-5-r Scales is mildly elevated (PYSC-r=63). This score is suggestive of a mild level of disconnect from reality. The intense psychological distress of reexperiencing a traumatic event in a vivid, recurrent manner may additionally elevate this scale, in addition to this individual’s particular style of dissociating in response to triggers associated with the original trauma. Moreover, Miller et al. (2004) suggested that Psychoticism might be measuring feelings of alienation and absorption, both of which are suggestive of PTSD.

Several scale elevations illustrate symptoms indicative of the Hyperarousal symptom cluster (PTSD Criterion D). In particular, the RC scale measuring Dysfunctional Negative Emotions is elevated on this profile (RC7=65). RC7 measures a wide range of dysfunctional negative emotions, such as maladaptive anxiety, anger, and irritability. Several SP scales provide further evidence of Criterion D symptoms. Indeed, his score on the Activation Scale (ACT=67) suggests a heightened excitation and energy level, which corresponds with the increased arousal that accompanies a diagnosis of PTSD. This maladaptive anxiety is also evidenced by elevations on Stress/Worry (STW=73) and Anxiety (AXY=91), as would be expected with an individual constantly reliving a traumatic event.

Discussion

PTSD is a complex disorder to assess in any setting, as a result of its heterogeneous symptom picture that is primarily discerned through self-report. The assessment of PTSD in a forensic setting further adds to the complexity of rendering a diagnosis, as the disorder is often a disability that is monetarily compensable. The MMPI-2-RF provides assistance in assessing empirically supported constructs associated with PTSD as a result of its hierar-
chical structure that differentiates internalizing and externalizing symptoms and its ability to isolate the impact of demoralization, or general emotional distress, which permeates many Axis I conditions. Additionally, the MMPI-2-RF contains validity scales that measure a variety of threats to protocol validity (e.g., exaggerated psychopathology, neurocognitive impairment, and physical health problems). These scales allow the clinician to form an opinion about the specific nature of potential symptom exaggeration, as PTSD can feigned in numerous ways (see Resnick et al., 2008 for a review).

The preceding case study and discussion should highlight the clinical utility of the MMPI-2-RF in interpreting individual presentations of PTSD. Further research, however, is needed to explore the association between the MMPI-2-RF and PTSD on a more empirical level.

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