

Poor Impulse Control and Mental Disorders in Criminal Proceedings

Posted on September 19, 2018

Introduction

Mental disorders and poor impulse control create difficult questions for criminal courts, correctional institutions, healthcare professionals, defendants, victims, and the wider community. A defendant may experience psychosis, severe depression, post-traumatic stress, an intellectual disability, a personality disorder, substance dependence, or impaired behavioral control. However, the presence of any diagnosis does not automatically establish that the person lacked legal responsibility, was unable to control an action, or is incompetent to participate in a trial.

Criminal law generally assumes that people should be held responsible when they voluntarily perform prohibited conduct with the mental state required by the offense. Mental health evidence may complicate that assumption, but its legal effect depends on a precise question. A court may need to determine whether a defendant currently understands the proceedings, whether a mental disorder affected the defendant at the time of the offense, whether the prosecution has proved the required intent, whether treatment is needed during detention, or whether mental impairment should influence sentencing. These are separate inquiries with different standards and consequences.

The language used to discuss this subject also matters. Expressions such as “normal offenders,” “mentally ill criminals,” or “genetic criminals” can reinforce stigma and suggest that mental illness naturally causes unlawful behavior. Most people with mental disorders do not commit serious violence, and psychiatric diagnosis alone is an inadequate measure of dangerousness. Research indicates that factors such as previous violence, substance misuse, antisocial attitudes, unstable housing, victimization, and inadequate treatment may be more informative than diagnosis by itself. One population study found that alcohol dependence, drug dependence, and antisocial personality disorder were more strongly connected with violence than psychosis alone; the researchers concluded that the risk associated with severe mental illness was comparatively low.

This paper argues that criminal proceedings should consider mental disorders and impaired impulse control carefully without adopting either of two extremes. Courts should not assume that a diagnosis excuses every offense, but they should also not ignore clinically significant impairments that affect fairness, culpability, treatment needs, or the risk of future harm. An effective response combines accurate forensic assessment, due process, proportionate accountability, evidence-based treatment, trauma-informed practice, and rehabilitation directed at both psychiatric symptoms and criminogenic needs.

Mental Disorders Within Correctional Populations

Mental health problems are substantially represented in prisons and jails. Data from the U.S. Bureau of Justice Statistics show that approximately 13% of state and federal prisoners surveyed in 2016 reported experiences meeting the threshold for serious psychological distress during the previous 30 days. Among prisoners with serious psychological distress, about 60% in state prisons and 42% in federal prisons reported receiving some form of mental health treatment after admission. These estimates demonstrate both the scale of mental health need and the existence of continuing treatment gaps.

These figures should be interpreted carefully. Serious psychological distress is a screening indicator rather than a complete clinical diagnosis. Similarly, having a history of depression, anxiety, bipolar disorder, schizophrenia, or another condition does not demonstrate that the disorder caused the offense. People may enter the justice system through multiple pathways involving poverty, homelessness, substance misuse, trauma, social exclusion, criminal associates, impaired judgment, or barriers to community treatment.

Mental disorders can nevertheless affect a person's contact with the justice system. Symptoms may contribute to disruptive behavior, difficulty following instructions, failure to comply with supervision, self-medication through alcohol or drugs, or an inability to obtain stable employment and housing. Once detained, individuals with mental health problems may struggle to understand institutional rules, communicate effectively with counsel, or tolerate restrictive conditions.

The justice system must therefore distinguish between diagnosis and function. The relevant question is not simply whether the person has a disorder. The question is how the condition affects comprehension, judgment, behavior, legal decision-making, safety, and the capacity to participate in treatment.

Understanding Poor Impulse Control

Impulse control refers to the capacity to delay action, consider consequences, regulate emotion, and resist urges that conflict with long-term goals or social rules. Poor impulse control may appear in several mental and behavioral conditions, but it is not itself proof of legal insanity.

A person can act impulsively while still understanding what they are doing and recognizing that the conduct is unlawful. For example, an individual may respond immediately to anger, temptation, or perceived disrespect without carefully considering the consequences. Such behavior may help explain an offense, but explanation and legal excuse are not the same.

Courts must also avoid assuming that every offense committed quickly or emotionally resulted from a psychiatric impairment. Impulsive behavior may be influenced by intoxication, learned behavior,

personality traits, peer pressure, environmental stress, or a deliberate willingness to accept risk. A proper assessment should examine the defendant's condition rather than applying a broad label.

Poor impulse control can be clinically relevant in at least four ways. It may contribute to the circumstances of an offense, affect the defendant's ability to comply with court orders, increase the likelihood of institutional misconduct, or identify a target for rehabilitation. Treatment may therefore include emotional-regulation training, cognitive behavioral interventions, substance use treatment, medication when clinically indicated, and structured planning for high-risk situations.

Mental Illness Does Not Automatically Establish Dangerousness

Public discussion frequently connects mental illness with unpredictable violence. This association can create fear and may affect bail, sentencing, housing, employment, and treatment decisions. However, psychiatric diagnosis alone provides an incomplete picture of risk.

People with severe mental illnesses may face an increased risk of some harmful outcomes under particular conditions, especially when substance misuse, treatment interruption, prior violence, unstable relationships, or recent victimization are present. They are also highly vulnerable to becoming victims of violence. Research therefore supports individualized risk assessment rather than categorical assumptions.

Risk assessment should examine both static and dynamic factors. Static factors, such as previous convictions or a history of violence, cannot be changed. Dynamic factors, including substance use, medication adherence, housing, relationships, antisocial thinking, anger, and access to treatment, can potentially be improved.

This approach protects public safety more effectively than stigma. A court that assumes every person with schizophrenia is dangerous may impose unnecessary restrictions while failing to identify a person without psychosis whose history, substance use, threats, and access to weapons indicate a more immediate risk.

Childhood Adversity and Later Criminal Behavior

The original paper correctly recognizes childhood adversity as a possible influence on later behavior. Childhood maltreatment, neglect, domestic violence, family instability, and exposure to substance misuse can affect emotional development, attachment, stress responses, and behavioral regulation.

Dargis et al. (2016) studied incarcerated adult men and found that the severity of childhood maltreatment was associated with psychopathic and antisocial characteristics. Physical abuse was particularly related to the antisocial dimension of psychopathy. Dargis and Koenigs (2017) also found

an association between witnessing domestic violence during childhood and psychopathic traits among adult male offenders.

These studies demonstrate association, not inevitability. A history of childhood abuse does not determine that a person will become violent, develop psychopathy, or commit a crime. Many survivors do not engage in criminal behavior, and protective factors such as supportive relationships, education, treatment, stable housing, and positive community involvement may reduce adverse outcomes.

Trauma should therefore be treated as clinically and socially relevant without being used to remove personal agency automatically. It may help explain how emotional dysregulation, distrust, aggression, or substance misuse developed. It may also guide treatment. Nevertheless, a criminal court must still evaluate the particular offense, the defendant's mental state, and the applicable law.

The Limits of Genetic Explanations

The expression "genetic mental disorder" should be used with caution. Mental disorders may involve biological vulnerability, but they usually emerge through complex interactions among genetic, developmental, psychological, and environmental influences.

No genetic result can establish that an individual was compelled to commit a particular offense. Even when a biological characteristic is associated statistically with impulsivity or aggression, it cannot determine what one defendant understood, intended, or could control at a specific moment.

Genetic information may occasionally contribute to a broader clinical evaluation, but it should not replace behavioral history, psychiatric examination, collateral evidence, offense reconstruction, and assessment of social circumstances. Treating genes as destiny risks weakening both scientific accuracy and individual justice.

The law generally evaluates the defendant's functional mental condition rather than the mere existence of a biological vulnerability. A person's family history or genetic profile does not automatically establish incompetence, insanity, diminished intent, or mitigation.

Competency to Stand Trial

Competency to stand trial concerns the defendant's mental condition during the criminal proceedings. It does not ask whether the defendant was mentally disordered when the alleged offense occurred.

In *Dusky v. United States* (1960), the U.S. Supreme Court held that competency requires more than orientation to time and place or the ability to remember events. The defendant must have sufficient present ability to consult with counsel with a reasonable degree of rational understanding and must

possess both a rational and factual understanding of the proceedings.

Federal law permits the defendant, the prosecution, or the court to raise competency when reasonable cause exists to believe that a mental disease or defect prevents the defendant from understanding the proceedings or assisting properly in the defense. A psychiatric or psychological examination may then be ordered.

A defendant may have a serious mental illness and remain legally competent. For example, a person with controlled bipolar disorder may understand the charges, recognize courtroom roles, communicate with counsel, and make reasoned decisions. Conversely, a person without a previously documented diagnosis may be incompetent because of acute psychosis, cognitive impairment, neurological injury, or another condition.

When a defendant is found incompetent, the usual result is not an acquittal. Proceedings are delayed while the court determines whether competency can be restored through treatment, education, stabilization, or other services. The purpose of restoration is to make a fair trial possible rather than to punish the person for being unwell.

Insanity and Criminal Responsibility

The insanity defense concerns the defendant's mental condition at the time of the offense. It is therefore fundamentally different from competency.

Under the federal insanity statute, a defendant must prove by clear and convincing evidence that a severe mental disease or defect made the person unable to appreciate the nature and quality or wrongfulness of the conduct. The statute also states that a mental disease or defect does not otherwise constitute a defense. State standards differ, and some jurisdictions use different tests or restrict the defense substantially.

A diagnosis alone is insufficient. A defendant may experience depression, personality disorder, post-traumatic stress, or impaired impulse control while still understanding the nature and wrongfulness of the act. The legal standard is deliberately narrower than the clinical definition of mental disorder.

The insanity defense is also not equivalent to release without supervision. A successful defense may lead to hospitalization, evaluation, and civil commitment procedures rather than immediate freedom. The justice system must balance the defendant's lack of legal culpability with treatment needs and public safety.

Mens Rea and Diminished Capacity

Mens rea refers to the mental state required for a criminal offense, such as intent, knowledge,

recklessness, or negligence. Mental health evidence may sometimes be introduced to challenge whether the prosecution has proved a specific mental element.

This argument differs from insanity. A defendant may not meet the jurisdiction's insanity standard but may claim that a mental impairment prevented the formation of the particular intent required by the charged offense. The availability and scope of such evidence vary considerably among jurisdictions.

For example, evidence of severe cognitive disturbance might be relevant when the offense requires purposeful planning. However, generalized claims of anger, poor self-control, or emotional distress normally do not erase intent automatically.

Courts should require a clear connection between the clinically documented impairment and the specific legal element being contested. Forensic experts should explain functional effects without deciding the ultimate legal question reserved for the judge or jury.

Sentencing and Mitigation

Mental illness may remain relevant even when a defendant is competent, legally responsible, and convicted. At sentencing, courts may consider the seriousness of the condition, its relationship to the offense, treatment history, trauma, intellectual functioning, risk, and prospects for rehabilitation.

Mitigation does not mean that harm to victims is ignored. It allows the sentence to reflect differences in culpability, need, and future risk. A person whose untreated psychosis played a substantial role in a nonviolent offense may require a different response from a person who carefully planned the same offense for profit.

Mental impairment should not always reduce a sentence. Some conditions may have little relationship to the offense, and public protection may require secure treatment. The most appropriate outcome may combine accountability with placement in a setting capable of providing psychiatric care.

The Legal Questions Must Remain Separate

Legal or clinical issue	Relevant time	Central question	Possible consequence
Competency to stand trial	During proceedings	Can the defendant understand the case and assist counsel rationally?	Suspension of proceedings and competency restoration

Legal or clinical issue	Relevant time	Central question	Possible consequence
Insanity	At the time of the offense	Did a severe disorder prevent appreciation of the act or its wrongfulness?	Insanity verdict and possible hospitalization
Mens rea	At the time of the offense	Has the prosecution proved the required intent or knowledge?	Conviction of a lesser offense or acquittal on the relevant charge
Sentencing mitigation	Before sentencing	Does impairment reduce culpability or change treatment and risk needs?	Modified sentence, treatment conditions, or specialized placement
Correctional treatment	During detention or imprisonment	What care is needed to stabilize the person and support safe functioning?	Medication, therapy, hospitalization, or specialized programming
Rehabilitation and reentry	Before and after release	Which psychiatric, behavioral, and social factors increase reoffending risk?	Coordinated treatment, supervision, housing, and community support

Confusing these questions can produce unfair outcomes. A person may be competent but legally insane at the time of an earlier offense, although this combination is uncommon. Another person may have been responsible at the time of the offense but later become incompetent. A third may have a disorder relevant to sentencing but not to guilt.

The Right to Mental Healthcare in Custody

Once the state imprisons a person, the individual cannot independently obtain ordinary medical care. Correctional authorities therefore acquire legal and ethical responsibilities.

In *Estelle v. Gamble* (1976), the U.S. Supreme Court held that deliberate indifference to a prisoner's serious medical needs can violate the Eighth Amendment's prohibition against cruel and unusual punishment. The principle applies to serious mental health needs as well as physical conditions, although negligence or disagreement about treatment does not automatically establish a constitutional violation.

Adequate correctional mental healthcare should include timely screening, suicide prevention, psychiatric evaluation, medication management, psychological treatment, crisis response, and continuity of care. Facilities should also avoid using disciplinary measures as substitutes for treatment.

Treatment is important for the individual's dignity and health, but it can also support institutional safety. Stabilized symptoms, improved coping, and better behavioral regulation may reduce self-harm, conflict, victimization, and disciplinary incidents.

Stigma and Unequal Treatment

Justice-involved people with mental disorders may face stigma from officials, other incarcerated individuals, employers, landlords, families, and communities. Stigma can lead to social rejection, reduced self-esteem, avoidance of treatment, and difficulty rebuilding a stable life after release.

Moore et al. (2016) found that stigma can negatively affect the functioning of people with criminal records. When mental illness and criminal justice involvement occur together, the person may experience multiple forms of exclusion.

The original claim that federal authorities generally treat offenders with mental illness “more badly” requires more specific evidence. Different institutions provide different levels of care, and unfair treatment cannot be assumed in every case. However, documented treatment gaps and disproportionate exposure to restrictive conditions justify serious concern. Bureau of Justice Statistics data have shown that incarcerated people reporting mental health problems were more likely than those without such histories to have experienced restrictive housing.

Reform should therefore focus on measurable practices, including access to assessment, time spent waiting for treatment, continuity of medication, suicide rates, use of isolation, disciplinary outcomes, and release planning.

Evidence-Based Rehabilitation

Research supports the conclusion that structured psychological treatment can improve outcomes among justice-involved people. A systematic review and meta-analysis found that psychological interventions delivered in prisons can reduce reoffending after release, although effectiveness varies according to program design and implementation quality.

Morgan et al. (2012) synthesized research on interventions for offenders with mental illness. The results suggested improvements in psychiatric distress, coping, institutional adjustment, and behavioral functioning. The authors also emphasized that the evidence base was limited and that programs should continue to be evaluated carefully.

Treatment should not focus exclusively on symptom reduction. Skeem et al. (2011) argue that psychiatric services alone may not be sufficient to reduce recidivism because justice-involved people with mental disorders often share the same criminogenic needs as other offenders. These may include antisocial attitudes, substance misuse, criminal peer relationships, impulsivity, unstable employment, and poor problem-solving.

An effective program must therefore address both mental health and criminal risk. Treating hallucinations may improve functioning, but it may not correct substance misuse, criminal thinking, or violent relationship patterns. Similarly, a standard correctional program may be ineffective if untreated psychosis or cognitive impairment prevents meaningful participation.

Components of an Effective Treatment Program

A comprehensive rehabilitation program should begin with individualized assessment. Clinicians should identify diagnoses, symptoms, substance use, trauma history, cognitive functioning, suicide risk, violence risk, treatment motivation, and social needs.

The treatment plan may then include several coordinated components:

Psychiatric Treatment

Medication and psychiatric monitoring may be necessary for psychotic disorders, bipolar disorder, major depression, attention-deficit/hyperactivity disorder, anxiety, and other conditions. Medication should be selected and monitored according to clinical need rather than used primarily as a behavioral control mechanism.

Cognitive Behavioral Therapy

Cognitive behavioral interventions can help participants examine distorted thinking, recognize triggers, consider consequences, improve decision-making, and practice alternative responses. Programs should be adjusted for literacy, cognitive impairment, culture, and psychiatric stability.

Emotional-Regulation and Impulse-Control Training

Participants may learn to identify early signs of anger, pause before acting, tolerate distress, use problem-solving strategies, and leave high-risk situations. Repeated practice is important because knowledge alone may not change behavior under stress.

Trauma-Informed Care

Trauma-informed treatment recognizes the possible effects of abuse and violence without assuming that every participant has the same history. It emphasizes safety, choice, collaboration, trust, and avoidance of unnecessary retraumatization.

Substance Use Treatment

Substance use is a major risk factor for offending and relapse. Treatment may involve motivational interviewing, cognitive behavioral therapy, peer support, relapse prevention, and medication for alcohol or opioid use disorders.

Social and Practical Support

Housing, employment, identification documents, family relationships, transportation, healthcare access, and income affect the ability to maintain treatment after release. A person discharged without medication, accommodation, or appointments may deteriorate rapidly despite making progress in custody.

Continuity of Care

Discharge planning should begin before release. Correctional and community providers should exchange necessary information lawfully, arrange appointments, continue medication, and address insurance or funding barriers.

Mental Health Courts and Diversion

Mental health courts and diversion programs attempt to move eligible defendants from ordinary criminal processing into supervised community treatment. These programs may combine judicial monitoring, treatment plans, case management, and regular review hearings.

Evidence regarding mental health courts is encouraging but not uniformly positive. A meta-analysis found a small overall reduction in recidivism among participants compared with traditional criminal processing. Federal program reviews have rated multisite mental health courts as promising for some criminal justice outcomes while finding weaker or inconsistent effects on clinical outcomes.

Diversion should therefore not be presented as a guaranteed solution. Programs require suitable eligibility criteria, voluntary and informed participation, qualified providers, stable community services, and procedures for responding proportionately to relapse or noncompliance.

A defendant should not be pressured into a demanding treatment program without understanding the consequences. Nor should people be excluded automatically because they have complex needs. Diversion decisions should consider legal eligibility, public safety, treatment availability, and the connection between the condition and justice involvement.

Protecting Victims and Public Safety

A treatment-centered approach does not require minimizing the harm caused by an offense. Victims have legitimate interests in safety, information, recognition, and justice. Rehabilitation should complement rather than erase accountability.

Public safety is best protected when decisions are based on evidence rather than fear. Secure hospitalization may be necessary for a person experiencing severe symptoms and presenting an immediate danger. Community treatment may be more appropriate for a low-risk defendant whose offense resulted partly from untreated illness and instability.

Risk should be reviewed over time because it can change. Successful treatment, sobriety, stable housing, and social support may reduce risk. Treatment refusal, substance misuse, threats, and increasing symptoms may raise concern.

The purpose of rehabilitation is not simply to make the defendant feel better. It is to improve functioning, reduce suffering, strengthen self-control, support lawful behavior, and lower the likelihood of further victimization.

Ethical Responsibilities of Forensic Professionals

Psychiatrists and psychologists involved in criminal proceedings must distinguish clinical care from forensic evaluation. A treating clinician generally works to benefit the patient, whereas a forensic evaluator provides an independent opinion to a court or legal party.

Defendants should understand the purpose of an evaluation and the limits of confidentiality. Statements made during a forensic assessment may appear in a report or testimony. Evaluators must avoid promising therapeutic privacy when the assessment is being conducted for legal purposes.

Experts should remain within their competence and explain uncertainty honestly. They may diagnose a disorder, evaluate functional impairment, and discuss clinical findings. They should not exaggerate the ability of psychology or psychiatry to reconstruct a defendant's mental state with perfect certainty.

Forensic reports should connect evidence to the relevant legal standard. A lengthy diagnostic history is not helpful if it does not explain whether the defendant can assist counsel, appreciate

wrongfulness, form intent, or participate safely in treatment.

Recommendations for Criminal Justice Reform

Criminal justice systems should adopt several measures to improve responses to defendants with mental disorders and impaired impulse control.

First, screening should occur early. Courts and detention facilities should identify acute psychosis, suicide risk, intellectual disability, withdrawal, and cognitive impairment before these conditions lead to crisis.

Second, competency evaluations should be ordered when genuine concerns arise, but unnecessary delays should be avoided. Defendants should not remain in jail for extended periods awaiting restoration services when community-based alternatives are safe and appropriate.

Third, correctional facilities should provide timely, evidence-based mental healthcare equivalent in seriousness to the treatment of physical conditions.

Fourth, rehabilitation should address both psychiatric symptoms and criminogenic factors. Mental health treatment alone will not reduce every form of reoffending.

Fifth, trauma history should inform treatment without being treated as proof of diminished responsibility.

Sixth, courts should expand carefully evaluated diversion and mental health court programs while protecting voluntary participation and procedural fairness.

Finally, reentry planning should connect individuals with housing, medication, therapy, substance use treatment, employment support, and community supervision before release.

Conclusion

Poor impulse control and mental disorders can influence criminal behavior, participation in legal proceedings, institutional adjustment, and rehabilitation. Nevertheless, diagnosis does not automatically establish criminal causation, dangerousness, incompetence, insanity, or lack of responsibility.

Criminal courts must identify the exact legal question being considered. Competency concerns the defendant's current capacity to understand proceedings and assist counsel. Insanity concerns criminal responsibility at the time of the offense. Mens rea concerns whether the required mental element has been proved. Sentencing considers culpability, treatment, risk, and proportionality.

Childhood abuse and exposure to domestic violence are associated with later psychological and behavioral difficulties, but they do not determine criminal conduct. Genetic and biological factors are similarly probabilistic rather than destiny. Individualized assessment is therefore essential.

Justice-involved people with mental health problems should receive appropriate care because treatment is a matter of dignity, legal responsibility, institutional safety, and public protection. However, psychiatric treatment should be combined with interventions addressing substance misuse, impulsivity, criminal thinking, relationships, housing, employment, and other risk factors.

A balanced criminal justice response neither excuses every offense nor treats mental disorder as irrelevant. It holds individuals accountable in a manner consistent with their actual capacities while providing treatment capable of reducing suffering and preventing future harm.

References

Beaudry, G., Yu, R., Perry, A. E., & Fazel, S. (2021). Effectiveness of psychological interventions in prison to reduce recidivism: A systematic review and meta-analysis of randomised controlled trials. *The Lancet Psychiatry*, 8(9), 759–773. [https://doi.org/10.1016/S2215-0366\(21\)00170-X](https://doi.org/10.1016/S2215-0366(21)00170-X)

Bronson, J., & Berzofsky, M. (2017). *Indicators of mental health problems reported by prisoners and jail inmates, 2011–12*. Bureau of Justice Statistics.

Bronson, J., & Maruschak, L. M. (2021). *Indicators of mental health problems reported by prisoners: Survey of Prison Inmates, 2016*. Bureau of Justice Statistics.

Coid, J., Yang, M., Roberts, A., Ullrich, S., Moran, P., Bebbington, P., Brugha, T., Jenkins, R., Farrell, M., Lewis, G., & Singleton, N. (2006). Violence and psychiatric morbidity in a national household population. *American Journal of Epidemiology*, 164(12), 1199–1208. <https://doi.org/10.1093/aje/kwj339>

Dargis, M., & Koenigs, M. (2017). Witnessing domestic violence during childhood is associated with psychopathic traits in adult male criminal offenders. *Law and Human Behavior*, 41(2), 173–179. <https://doi.org/10.1037/lhb000022> witnessing domestic violence during childhood is associated with psychopathic traits in adult male criminal offenders

Dargis, M., Newman, J., & Koenigs, M. (2016). Clarifying the link between childhood abuse history and psychopathic traits in adult criminal offenders. *Personality Disorders: Theory, Research, and Treatment*, 7(3), 221–228. <https://doi.org/10.1037/per0000147>

Dusky v. United States, 362 U.S. 402 (1960).

Estelle v. Gamble, 429 U.S. 97 (1976).

Lowder, E. M., Rade, C. B., & Desmarais, S. L. (2018). Effectiveness of mental health courts in reducing recidivism: A meta-analysis. *Psychiatric Services*, 69(1), 15-22.

<https://doi.org/10.1176/appi.ps.201700107>

Moore, K. E., Stuewig, J. B., & Tangney, J. P. (2016). The effect of stigma on criminal offenders' functioning: A longitudinal mediational model. *Deviant Behavior*, 37(2), 196-218.

<https://doi.org/10.1080/01639625.2014.1004035>

Morgan, R. D., Flora, D. B., Kroner, D. G., Mills, J. F., Varghese, F., & Steffan, J. S. (2012). Treating offenders with mental illness: A research synthesis. *Law and Human Behavior*, 36(1), 37-50.

<https://doi.org/10.1037/h0093964>

Skeem, J. L., Manchak, S., & Peterson, J. K. (2011). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. *Law and Human Behavior*, 35(2), 110-126.

<https://doi.org/10.1007/s10979-010-9223-7>