

# Batterers: A Review of Violence and Risk Assessment Tools

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Batterers are often identified in the criminal justice system after they have inflicted significant abuse on their victims. The increasing public health initiatives surrounding intimate partner violence focus on identification of victims and their protection. Little emphasis is placed, however, on the batterers themselves. Forensic specialists become involved in risk assessment for violence only after a perpetrator has inflicted significant damage on his victim and entered the criminal justice system. This article serves to bring awareness of the many factors, including neurobiology and neuropsychology, that contribute to the development of a batterer. Two instruments useful in identifying violence risk will be highlighted, along with a proposal for future research that could broaden risk assessment applications to other noncriminal settings, allowing for early detection and prevention of violent acts.

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A batterer is someone who inflicts physical violence or severe psychological abuse during an intimate relationship. Such actions can occur during a dating relationship, marriage, partnership, separation, or divorce.<sup>1</sup> Batterers are not uncommon. At least 50 percent of married couples, for example, will experience one or more episodes of abuse during their unions.<sup>2</sup> Although women have been documented to perpetrate acts of domestic abuse, men are more commonly the batterers and will be referred to as such for the purpose of this article. Batterers often deny, minimize, or blame others for their use of violence. The man perceives his behavior as a natural and understandable response to frustration.<sup>2</sup>

## Neurobiology of Violence

Anatomical, chemical, and hormonal factors have all been implicated in the risk of violence. Aggression centers in the brain are the hypothalamus, amygdala, and prefrontal cortex. For example, within the hypothalamus, when the anterior, lateral, ventromedial, and dorsomedial nuclei are stimulated, the result is aggression. Similarly, when the amygdala is triggered, deregulation of fear and anxiety can cause aggression. The prefrontal cortex plays a role in execu-

tive functions such as judgment. Insults to or defects in the prefrontal cortex can thus lead to disinhibition, poor judgment, and violence.<sup>3</sup>

Neurochemical transmitters implicated in violence include serotonin (5-HT), acetylcholine (Ach),  $\gamma$ -aminobutyric acid (GABA), noradrenaline (NA), and dopamine (DA). Low 5-HT and GABA have been correlated with impulsive aggression. Violent patients have been found to have a low turnover of 5-HT as measured by its major metabolite 5-HIAA (5-hydroxyindoleacetic acid) in the cerebrospinal fluid (CSF). Neurochemicals that may increase aggression at higher concentrations are NA, Ach, and DA.<sup>4</sup>

The relationship between the XYY genotype and impulsivity remains inconclusive, although strong evidence indicates that hormones influence aggression. High levels of androgens, cortisol, and dehydroepiandrosterone sulfate are cited as a major factors in aggressive behavior.<sup>4</sup>

## Neuropsychology of Violence

The many cultural risk factors for developing into a batterer are listed in Table 1.<sup>5</sup> A strong predictor of whether a man will abuse his spouse or significant other appears to be whether he has experienced or witnessed violence in his own family while growing up. Although violence is a learned behavior passed down through generations, not every man exposed to violence becomes an abuser himself. Those who are

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**Table 1** Neuropsychological Characteristics of Abusers<sup>5</sup>

|  |
|--|
| Witness to violence in the childhood household   |
| Personality type: needy, dependent, nonassertive, low self-esteem, inadequate feelings |
| Pathological jealousy  |
| Abuse of alcohol or drugs  |
| Excessive concern with outward appearance  |
| Degrading attitude toward women  |
| Unable to resolve conflict using mature mechanisms                                     |

batterers are less capable of attachments, are impulsive, lack social skills, and have degrading attitudes toward women. Men who abuse alcohol and drugs are also at greater risk of displaying aggressive behavior. Some research has indicated that serious mental disorders in addition to impulsivity can contribute to violence.<sup>5</sup>

Three types of male batterers have been proposed, the psychological characteristics of which are detailed in Table 2.<sup>6</sup> The family-only batterers comprise about 50 percent of abusers who engage in periodic violence limited to times of frustration. They do not demonstrate discernable indications of severe mental disorders or psychopathology. In addition, they are less likely to have arrest records and alcohol problems.

The dysphoric and violent batterers on the other hand, do exhibit signs of psychological disturbance and are emotionally volatile. In addition, most abuse both drugs and alcohol. They often engage in moderate to severe spousal abuse, including psychological and sexual abuse. Violent batterers in particular correlate highly with diagnoses of antisocial personality disorder and psychopathy.

**Table 2** Batterer Typology<sup>6</sup>

| Type of Batterer | Description   |
|------------------|---|
| Family-only      | Fifty percent of all batterers<br>Violence precipitated by misinterpretation of social cues<br>Violence limited to extreme frustration<br>No history of psychopathy, criminal records, severe mental disorder, or drug or alcohol abuse |
| Dysphoric        | Twenty-five percent of all batterers<br>Is emotionally volatile<br>Abuses drugs and alcohol   |
| Violent          | Twenty-five percent of all batterers<br>Has antisocial personality disorder and psychopathy<br>Has a criminal record<br>Has a severe mental disorder<br>Abuses drugs and alcohol  |

**Table 3** SARA Items<sup>7</sup>

|  |
|--|
| Past assault of family members                                 |
| Past assault of strangers or acquaintances                     |
| Past violation of conditional release or community supervision |
| Recent relationship problems                                   |
| Recent employment problems                                     |
| Victim of or witness to child abuse                            |
| Recent substance abuse or dependence                           |
| Recent suicidal or homicidal ideation                          |
| Recent psychotic or manic symptoms                             |
| Personality disorder   |
| Past physical assault  |
| Past sexual assault or sexual jealousy                         |
| Past use of weapons or credible threats of death               |
| Recent escalation in frequency or severity of assault          |
| Past violation of no-contact orders                            |
| Extreme minimization or denial of spousal assault history      |
| Attitudes that support or condone spousal assault              |
| Severe or sexual assault                                       |
| Use of weapons or credible threats                             |
| Violation of no-contact order                                  |

## Risk Assessment

For the victim, battering leads to multiple physical and mental health consequences that can be grave in some circumstances. Attention to risk of violence, nevertheless, does not often occur before the criminal justice system becomes involved in a particular instance of abuse. Once a batterer has been identified, practitioners agree that ongoing safety for the victim is a priority consideration. Forensic specialists are then called on to opine about the risk of future battering. Two instruments that are useful in predicting risk are the Spousal Assault Risk Assessment (SARA)<sup>7</sup> and the Ontario Domestic Assault Risk Assessment (ODARA).<sup>8</sup>

The SARA provides a framework for assessing the risk of future violence in people arrested for spousal assault. It was developed in British Columbia as part of the Project for the Protection of Victims of Spousal Assault. This screening tool is a checklist of 20 factors (Table 3) used when a clinician wishes to determine the degree to which an individual poses a threat to his or her spouse, children, or other family members.<sup>7</sup>

The ODARA is the most recent actuarial tool developed in Canada. It evaluates and estimates the likelihood of recidivism in previously violent offenders who have been adjudicated guilty of battery. Applications of the ODARA are similar to those for the SARA. Notably, this is the only instrument in domestic violence that considers a woman's perceived

**Table 4** ODARA Items<sup>8</sup>


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|   |
|---|
| Prior violence against wife or children           |
| Prior nondomestic incident                        |
| Prior custodial sentence                          |
| Failure on prior conditional release              |
| Threat to harm or kill at index assault           |
| Confinement of the partner at the index offense   |
| Victim concern                                    |
| More than one child (from perpetrator or victim)  |
| Victim has biological child from previous partner |
| Violence against others                           |
| Substance abuse history                           |
| Assault on victim when pregnant                   |
| Barriers to victim support                        |

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fear of risk. The ODARA predicts not only risk of assault, but severity and timing. Thirteen items have been found to add incrementally to the predictive accuracy of this tool and are listed in Table 4.<sup>8</sup> The ODARA accuracy is maximized by its combination with the Hare Psychopathy Checklist Revised (PCL-R).<sup>9</sup>

Application of the SARA and ODARA are limited to presentence evaluations and correctional discharge risk stratification. The tools can also be applied to pretrial evaluations in charged individuals. They are not used, however, in general psychiatric hospitals to screen for risk among men with multiple predisposing factors for battering.<sup>7,8</sup>

## Discussion

Batterers develop through a series of complex biological and psychological vulnerabilities. The outcome of battering is intimate-partner violence, which the World Health Organization has identified as a major concern. The U.S. Department of Justice has published data showing that one-third of all homicide victims are slain by a husband or boyfriend.<sup>10</sup> Batterers leads to multiple health consequences for and sometimes even the death of the victim. Violence directly affects the health care system by producing a cost burden in the billion dollar range.<sup>11</sup>

The American Medical Association (AMA) has recommended that women be routinely screened for domestic abuse. There is no equivalent directive, however, to screen for risk of violence in men who present for health care attention. Forensic evaluations of batterers, to date, focus on identification of

risk in a criminal population. Broadening the applications of assessment tools like the SARA and ODARA to general inpatient psychiatric populations is controversial, but worth investigating.

Ethics-related dilemmas surround the implications and stigmatization of labeling an innocent person at high risk for becoming a batterer. Expanding the scope of risk assessment tools might result in criminalizing or further marginalizing an already vulnerable population of patients. On the other hand, advantages of early identification of batterers could lead to enhanced education, family interventions, closer mental health follow-up, and decreased cost burdens to the health care and legal systems.

Forensic specialists have been astute in identifying batterers and considering their risk of recidivism in criminal populations. As public health initiatives continue to focus on intimate-partner violence, forensic psychiatrists have the opportunity to investigate and debate the value and potential consequences of implementing risk assessment screening tools in a larger population.

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