VI DIAGNOSIS AND RISK ASSESSMENT

0. Introduction

Risk Assessment is part of a complex **diagnosis** which usually should be done before deciding about taking in a perpetrator. Generally semi-standardised interviews and questionnaires are used to make a diagnosis. Both should cover at least

- personality,
- forms of violence,
- history of violence,
- state of being of taking over responsibility,
- alcohol and substance abuse,
- circumstances of present living situation (e.g. unemployment, same-sex partnership),
- motivation to join training,
- experience of violence/abuse in life of perpetrator

An assessment of the *personality* of perpetrator needs to make sure that for example in case of social/cognitive training classes the participant does not show any clinical psychological disorder. Those classes are designed for "healthy" people with social misbehaviour. Clinical cases should be in good hands of psychotherapists or even medical clinics. Further, *forms of violence* noticed to find out more about severity and *history of violence* takes a closer look at probable escalation of violence. For taking part at a social/cognitive training it is indispensable to show at least a minimum of willingness to take over *responsibility* for exerted violence. *Alcohol and/or substance abuse* are not only increasing risk of reassault but it also needs to be decided if the participant should first control addiction and take part at class later on since participants should be drug-free at class. *Present living situation* may be a risk factor as well if perpetrator is unemployed, step-children are living in the same house etc. It needs to be found out about stabilizing and de-stabilizing factors which might increase or decrease chance of change. Further, participant should be supported in strengthening stabilizing factors, for example increasing his chances at the labour market etc. Finally, the *motivation of perpetrator*

joining e.g. a training class should be illuminated. Research shows that court mandated participants show a higher rate in finishing trainings than volunteers or 'partner-mandated' members (Gondolf 2002). Finally, we recommend semi-structured interview about *history of violence in life of perpetrator*, since experience of violence/abuse in childhood may have an impact on bonding in partnership as well as expectations toward the partner.

Generally, risk assessment contains two aspects, first methods of **assessing risk** and second, **managing risk**. Since a vast majority of perpetrators and offenders of crime and violence is male, research on risk assessment focuses on male perpetrators. Again, vast majority of perpetrators of domestic violence also is male; risk assessment focuses here on male perpetrators as well. Understanding risk assessment means to know WHO is assessing WHICH risk. Thus, several considerations should be taken into account:

The **context of use** of risk assessment: the context depends on which organisation is assessing risk: a judge deciding about mandating offender to training, a social service deciding about intake of perpetrator into a program, police deciding about escalation and future violence or a counselling service providing case management (risk of reassault and escalation of violence) and/or groups for perpetrators, etc.

The **purpose** of risk assessment: Is it used to evaluate a client for intake, to predict further violence (reassault and recidivism), assess risk of lethality or to exclude the person from service, etc.

1. Dimensions of risk assessment

Subject of evaluation: several tools try to evaluate the

- probability of lethal violence,
- severity and frequency,
- escalation of violent dynamic,
- future violent behaviour.

In the field of domestic violence **checklists** to assist practitioner's judgement are widely used. Several instruments have been developed to assist domestic violence service providers in determining the cases most likely to escalate to severe or lethal violence. The first checklists had been developed by Daniel Sonkin 1985 and Barbara Hart 1988. But for the most part they had been psychological "clinical" risk factor lists, usually based on DSMR personality profiles. In

contrast to mental health practitioners conducting clinical assessment, social service providers like family centres or counselling services who come into contact with perpetrators and victims of domestic violence are not primarily and specifically trained in clinical assessment. Therefore, new methods needed to be developed to support them in their work. Nowadays a tendency can be observed from using complex psychological based clinical assessment instruments to easier to handle and sociological based methods of risk assessment.

This instrumentation is based on empirical item selection with fixed, explicit and validated formulas for assignment of risk categories (risk markers) and decision making (for example, "Cohens Kappa", a formula to measure the extent of concordance of assessment results of two "raters" – interrater reliability). Those formal risk assessment methods are different from the usual psychological tests in that combining common methods of instrument item selection with psychometric evaluation are less relevant.

None of the methods guarantees a 100% efficacy. There always is a risk of failure. Thus, various empirical methods can be combined in order to reduce risk or a further, very important indicator, the **victims risk assessment**, could be added. Research shows that their perception of danger is a very strong indicator to assess risk of re-assaults (Saunders/Tolman/Weisz 2000).

The following key indicators refer to **male perpetrators** of domestic violence and need to be discussed and supplemented with key indicators referring to female/lesbian perpetrators.

Key indicators for re-assault of male perpetrators

- strong indicators
    - substance abuse
    - unemployment
    - violence in family of origin
    - age ('younger, jobless men')
- less significant indicators
    - stress
    - depression
    - low self-esteem

    - status inconsistency
    - personality disorders
    - traditional sex role attitudes

Key indicators for high risk of lethality (male perpetrators)

- Strong indicators
    - prior domestic violence
    - access to weapons
    - estrangement
    - stepchild in home
    - unemployment
    - suicidality is particular risk factor for homicide
    - prior mental health problems
    - separation

- Less strong indicators
    - violence outside home
    - alcohol abuse
    - cultural issues and sensitivity

Key indicators for severe abuse of male perpetrators

- lack of remorse
- violence outside home

General key indicators for risk of opposite-sex domestic violence

- child abuse victimization
- witnessing domestic violence in childhood
- alcohol abuse
- stalking
- sexual assault

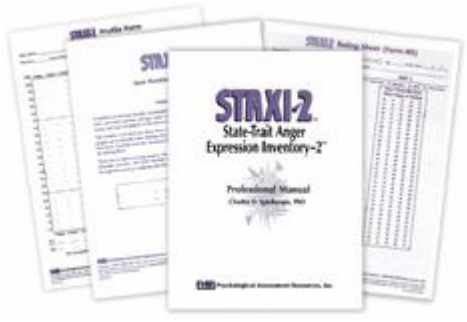
Substance abuse is more of a risk factor in domestic assault and re-assault than in domestic homicide while perpetrator suicidality is more of a risk factor in murder of intimate partner; Female Perpetrators are far less likely to have had a history of perpetrating any kind of vio-

lence.

Risk assessment is linked to anger management. The goal of anger management is to reduce emotional feelings and the physiological arousal that anger causes. The tools of **risk assessment** and **anger diagnostic** are usually applied to **male batterers** but use different ways of getting relevant information. Nowadays there are various tools for assessing risk. Because there is only little research on the efficacy of those tools (Dutton 2000, Campbell/Webster/Mahoney et.al. 2005), naming some of them does not mean we presume they are more effective than others. The "Spousal Assault Risk Appraisal Guide" (SARA) for example is designed to screen risk factors in male suspects and is used with male adults. Another Risk Assessment tool is called "Danger Assessment" (DA) and uses information from the victim.

Anger is a secondary emotion. It can arise as a reaction to other emotions. There are several anger assessment tools like the "Novaco Anger Inventory", developed by Raymond W. Novaco (1975). The long form contains 90 items intending to measure the degree of provocation or anger people would feel if placed in certain situations. The short version contains 25 items covering situations of daily life; an adaptation to couple interaction is missing. Another tool is named STAXI and an expanded version STAXI 2 – State Trait Anger Expression Inventory. Both versions have been developed by Charles D. Spielberger in the 90th of last century. The instrument consists of six scales, Trait Anger, Anger Expression-Out, Anger Expression-In, Anger Control-Out, Anger Control-In, and State Anger. The STAXI-2 also includes five subscales and an Anger Expression Index. It will be explained further in chapter 2, "Tools for professionals". A tool for volunteers and/or less trained people may be the "DVI" – Domestic Violence Inventory. It contains 6 scales measuring thruthfulness, violence, control, alcohol, drugs and stress coping abilities. It will be described in chapter 3.

2. Tools for professionals



The State-Trait Anger Expression Inventory-2 – STAXI-2 by Charles D. Spielberger 1999 is a revised version of the STAXI, developed by Spielberger in 1994. The 'Spielberger test' measures anger as a personality trait and as a psychological condition. STAXI-2 is a 57-item inventory containing of six scales, Trait Anger, Anger Expression-Out, Anger Expression-In, Anger Control-Out, Anger Control-In, and State Anger. Even though it targets at adults and adolescents, a major target group are psychiatric patients. Since it covers 'normal personalities' as well as 'psychopathologies', the tool can be characterized as a clinical one. A STAXI-2 test takes about 20 minutes. The STAXI-2 is an instrument which should be used by professionals who have completed an advanced level university course in psychological testing, as well as training under the supervision of a qualified psychologist. It has to be noted that the STAXI-2 manual provides no information on temporal stability (test-retest reliability).

Individuals *rate themselves* on 4-point scales that assess both the intensity of their anger at a particular time and the frequency that anger is experienced, expressed, and controlled: **Anger Expression Out**: expression of anger toward other people or objects in the environment; **Anger Expression-In**: holding in or suppressing angry feelings; **Anger Control-Out**: controlling angry feelings by preventing the expression of anger toward other people or objects in the environment; **Anger Control-In**: controlling suppressed angry feelings by calming down or cooling off. Final scale for anger trait is Anger Expression Index. The scales for **state anger** are: Feeling angry, feeling like expressing anger verbally, feeling like expressing anger physically.

Even though STAXI and STAXI-2 have been developed in the US of America, European versions in national languages are available. Due to copyright we will not publish a version, bus sometimes free test versions will be found on the internet.

3. Tools for volunteers and less trained people

A) The *'Domestic Violence Inventory'* (DVI) is designed to assess treatment needs and thus might be helpful to support volunteers' expertise and taking decision about **intake** of perpetrator. It is an automated and normed domestic violence offender assessment instrument containing 155 items. It takes about 30-35 minutes to complete.

The DVI contains six scales covering 'truthfulness', 'lethality', 'control', 'alcohol abuse', 'drugs' and 'stress coping strategies'. The problem is identified at a score of 70% and higher. Severe problems are identified by scale scores at or above the 90%.

The scale interpreting truthfulness measures how truthful the perpetrator/participant was while completing the test. The higher the score the more the scale is invalid since participant was overly guarded, minimising problems, faking answers etc. High scores also indicate uncooperative behaviour like trying to appear 'in a good light'. The violence scale aims at identifying participants that are dangerous to themselves and others. Physical force is the main focus. Elevated scores hint at insightless about how to express anger/hostility. The higher the elevation of scores the worse the prognosis. Within the context of domestic violence, control refers to the process of regulating, restraining or controlling others. These controlling behaviours vary from mild to severe. Severe control-related behaviour focuses on exaggerated, distorted or extreme behaviours like swearing, pushing, and intimidation, hitting and even battering. High scores of 70% to 89% indicate the presence of regulating, restraining and controlling behaviours. Severe problems appear at a score of 90% to 100%. The scale measuring alcohol use and severity of alcohol abuse has similar ratings, i.e. the higher the score the more severe the problem. The drug scale measures substance abuse of illicit drugs like cocaine, crack, barbiturates and heroin. An elevated Drugs Scale score of 70% to 89% indicates an emerging drug problem. A Drugs Scale score between 90% and 100% identifies serious illicit drug abusers. Finally, the stress coping abilities scale measures how well the respondent copes with stress. It is now known that stress exacerbates symptoms of mental and emotional problems. Here again, the higher the score the more severe the problem.

A scale on its own already may indicate risks but of more interest seems to be the conjunction with other scales. For example, when a person doesn't handle stress well, other existing problems are exacerbated. This problem intensification applies to substance (alcohol and other drugs) abuse, violence (lethality), control issues and stress-related problems. An elevated Al-

cohol Scale score in conjunction with other elevated scores increases the severity of the other elevated scores. For example, if there is a respondent with an elevated violence scale who also has an elevated alcohol scale score, that person is even more dangerous when drinking.

B) *Other tools*

Most of women help lines, women shelter houses and other social services additionally use questionnaires, i.e. including victim's expertise into their decision taking. Some of them aim at assessing risk of lethality and are structured similar to above outlined example:

Answering YES to 5 and more indicates a high risk:

Does your partner…

- Attacks you physically?
- Throwing things at you?
- Breaking your things?
- Derogates you in front of others?
- Humiliates you?
- Belittles you?
- Threatens to seriously harm you?
- Threatens to harm one of your children?
- Threatens to harm your pet?
- Told you, s/he cannot live without you?
- Being jealous or possessive?
- Accuses you of having affairs?
- Insists on accounting for every minute of your time without her/him?
- Stalks you?
- Checks up at your workplace?
- Keep you away from chosen family and family of origin?
- Threatens to 'out' you?
- Act like hurting you is your fault?
- Forced you to have sex with him/her?

Answering any of following items YES indicates high risk

- Has s/he ever used a weapon (e.g. knife) to threaten you?
- Did s/he ever ask you to kill him/her with a weapon s/he was getting?
- Did s/he ever tell in detail how s/he will kill you?
- Has s/he ever attempted to kill you?

Other questionnaires aim at identifying risk factors and may contain questions as follows. Again, they are victim oriented questionnaires.

- Escalation
    - Has the frequency of violence increased?
    - Has the severity of violence increased?
    - Did you experience dissolution of restraining factors?
    - Has a weapon, including household utilities, been used?
    - Did your partner threaten to use a weapon against you?
    - Does your partner say that no one else can have you if s/he cannot have you?
- Risk factors
    - Is your partner daily drinking alcohol?
    - Is your partner consuming illicit drugs?
    - Is your partner violent outside home?
    - Is your partner angry/hostile toward you?
- Dynamic
    - Does your partner killed or injured your pets?
    - Does s/he accuse you of promiscuous behaviour?
    - Is s/he constantly jealous of you?
    - Does s/he use degrading names?
    - Does s/he blame you for the violence?
    - Does your partner control your daily activities?
    - Does frequency of violence increases during pregnancy?

Finally, often only a fine line separates those counselling and/or teaching training classes from those perpetrating violence and attending classes, supervision is an indispensable working condition for volunteers and professionals as well. In some social services former perpetrators teach present perpetrators. Trainers and counsellors need to reflect one's own aggres-

sive/violent potential as well as they need to question own role models and attitudes toward homosexuals.

There are various forms of supervision from team supervision to single supervision, from attending external expert to collegial supervision. Even though social service providers may be short in budget it cannot be emphasised enough that working with perpetrators always needs to guarantee supervision for trainers and counsellors.

4. Mindset of facility

Working with female and/or lesbian perpetrators of domestic violence means to accept the idea that women can be aggressive, angry, hostile and violent. Since a lot of women's organisations/facilities support women who have been victims, several considerations have to be taken into account:

- Objectives of the social service/counselling centre need to include women as perpetrators. This decision needs to be carried by all stuff members.
- The facility should subscribe to violent free behaviour and support a climate of non-violence.
- Female perpetrators should be treated respectfully and supported to change.
- There is a high probability that violent women have been victims of violence in their lives; but present, they are perpetrating violent acts toward their partners, children, family, friends or strangers.
- Providing safety of victim is imperative.
- Treatment should be based on immediate stop of violence.
- At a women's centre, victims and perpetrators accidentally can meet. Measures should be taken to reduce risk at minimum.

Women's space is not free of violence. Dealing with violent women simply means to make women's violence visible. Violent women have a right to get all support they need to end their abuse. It is women's duty to meet them with respect but demanding violent-free behaviour at the same time.

5. Risk assessment of lesbian perpetrators

There is almost no research about identifying shared and unique risk and protective factors for domestic violence in lesbian partnerships. Above described measures of assessing risk are (1) originated in risk assessment for male perpetrators and (2) partially modulated for application of heterosexual women. It is unknown if they can be transferred to lesbian women.

Lesbian women do neither fulfil traditional gender role stereotyping as being non-violent, caretaking and nurturing nor do they fulfil the norm of heterosexuality. Their incongruent behaviour has significant implications on those women exerting violence and sharing same-sex lifestyle. Ignorance and stigmatisation puts those women at risk who experience violence in their partnerships. Usually they cannot count on traditional sources of help, such as friends, family of origin and domestic violence services. Further, lesbian women abusing their partners are as well in a kind of 'social vacuum', since they are not taken responsible for their acts and have no support in changing their violent behaviour.

Focussing on lesbian women exerting violence, risk factors on different levels need to be taken into account when assessing risk of reassault and escalation:

- individual
- sub-cultural
- and societal level.

According to Hassouneh 2008 risk factors include

- prior physical violence by an intimate partner (male or female)
- controlling behaviour,
- dependency,
- alcohol and drug abuse,
- depression
- and ending the relationship.

Nevertheless, European research indicates that especially women in their first lesbian partnership are at high risk of being victimized by their partners (Ohms 2008, Kers 2005).

Those factors address only the individual level, whereas sub-cultural and societal risk factors may play an important part as well. Those may be sub-cultural tabooization as well as hetero-normativity which implies repulsion of same-sex lifestyles.

But most outlined risk factors are shared by both, perpetrators and victims. This means, it is unknown why a woman abuses her partner, another woman is abused by her partner and another one does not get into violent dynamics even if she shares those risk factors. For example, a history of sexual abuse may be an indicator for the experience of violence in adulthood as well. Analysis of domestic violence in lesbian partnerships shows that lesbian perpetrators experience sexual abuse in their childhood as well. Thus, it is a risk factor for either being a perpetrator or being a victim.

Finally, the relation between possible risk factors and the exertion of violence is not clear at all: For example, studies about alcohol and drug abuse as relevant risk factors are not consistent here. First, not in all cases drug and/or alcohol abuse plays a role in the violent dynamic. Present, proportions are unknown. Second, the abuse may be related to oppression and not to violence. Depression may be related to oppression and not to abuse. It needs to be assumed that there is an interrelation between oppression, coping strategies and the exertion of violence.

Risk assessment will be subject of future research of this project.

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