

Ending the Cycle of Abuse in Battered Women Defenses

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Intimate partner violence (IPV) is a public health concern, and multiple types of IPV have been described. Women, like men, have various motives for committing intimate partner homicide. This issue of *The Journal* includes an article reviewing the use of a Battered Woman Syndrome (BWS) defense in American courts. The time was right for a BWS defense a generation ago when there was a lack of understanding of the reasonableness of a woman's action, but not at present. We review the inherent problems of having a gendered law, looking to infanticide acts, as examples. We discuss the validity of BWS considering the DSM and the ICD-10. We explore the role of a forensic psychiatrist in these evaluations, particularly given the lack of a diagnostic, scientific basis for BWS, and consider the similarities with sexually violent predator hearings. In conclusion, we outline considerations for forensic psychiatrists when conducting these examinations. This includes awareness of potential gender bias, recognizing clinical and scientific challenges in the legal diagnosis of BWS, and consideration of the role of posttraumatic stress disorder.

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Holliday and colleagues¹ valuably review the use of Battered Woman Syndrome (BWS) in American criminal courts in this issue of *The Journal*. Intimate partner violence (IPV) includes physical, sexual, and psychological violence between partners who are current or former spouses, romantic partners, or sexual partners. According to the Centers for Disease Control,² intimate partner violence includes physical violence and sexual violence, as well as stalking and psychological aggression, including coercion. Approximately one-fifth of women and one-seventh of men have experienced severe IPV during their lifetime.² Violence in relationships does not only occur in heterosexual or married relationships.

IPV is not monolithic. Kelly and Johnson³ describe four patterns of intimate partner violence. These include: coercive controlling violence, violent resistance, situational couple violence, and separation-instigated violence. Coercive controlling violence is defined as “a pattern of emotionally abusive intimidation, coercion, and control coupled with physical violence against partners” (Ref. 3, p 478). This subtype includes the well-known Power and Control Wheel⁴ of domestic violence developed in the 1980s; it is the model used in many women's shelters. Coercive controlling violence has also been known as intimate terrorism.⁵ Violent resistance, rather than focusing only on a female response to male violence, “posits the reality that both women and men may, in attempts to get the violence to stop or to stand up for themselves, react violently to their partners who have a pattern of Coercive Controlling Violence” (Ref. 3, p 479). Situational couple violence is another type of violence within a relationship, which is not based upon power and control themes, but rather has violence related to conflict without the control aspect. Finally, separation-instigated violence is violence that first occurs at the end or separation of a relationship.

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Depending on the sample type, rates of the patterns of partner violence are different. For example, court samples and shelter samples tend to include more cases of coercive controlling violence with men outnumbering women as perpetrators, while in more general surveys, situational couple violence is most common.^{3,5} A better understanding of the various types of IPV is critical for prevention. Straus⁶ made the following recommendations: replace the belief that partner violence is male with the understanding that it can also be bi-directional or female only; replace the perception of a patriarchal system as the single causal factor with a multi-causal model; do not consider male dominance as the major risk factor; and focus attention on prevention programs.

Rates of intimate partner violence perpetration are similar for women and men,^{7,8} varying depending on the type of violence. Friedman noted “there is a danger in conceptualizing women only as victims” (Ref. 9, p 274). Women can be violent aggressors as well as engaging in self-defense or bi-directional relationship violence.⁹ The recent media coverage¹⁰ of the Johnny Depp and Amber Heard civil lawsuit has challenged many to consider the societal bias and alleged female violence.

A systematic review¹¹ found that women with severe mental illness were at increased risk of victimization by partners, but a high proportion of these women may also assault their intimate partners. Their motive for violence may range from protecting themselves to irritability related to bipolar disorder to paranoid self-defense. Mutual violence may also occur.

Women are less likely than men to kill their partner.¹² When this does occur, similar to the multiple motivations for IPV, multiple motivations for homicide may exist, other than only killing in self-defense. Some women who kill their partners have been described as black widows (killing with malicious intent), others may experience pathological jealousy, and still others may be mentally ill at the time that they kill. A higher proportion of murders committed by women are motivated by jealousy compared with murders committed by men.¹³ Further research is needed into the different motivations of women who kill their partner, rather than the presumptions of a monolithic model such as BWS.

Despite limited research and its continued lack of inclusion in the DSM-5, battered woman syndrome (BWS), initially defined in 1979 by Lenore Walker,

Edd¹⁴, has been admitted in legal proceedings in the United States, the United Kingdom, Canada, Australia, and New Zealand.^{15,16} When experts were used in self-defense cases involving women who killed or harmed their male partner, Holliday and colleagues¹ noted that expert testimony had usually been introduced to demonstrate the subjective reasonableness of a woman’s fear of being imminently harmed. Decades ago, there was much less lay communal understanding of intimate partner violence. Today, questions can be raised about community understanding versus expert understanding, as well as syndrome validity.

Further, the use of BWS in this context can be taken to the extreme. For instance, in *Porter v. State*,^{17,18} a woman solicited a third party to kill her husband for \$400. She introduced evidence of BWS at trial. The jury was given modified instructions regarding imperfect self-defense and were not given the language of the BWS statute, despite their request. She was convicted of murder in the first degree, as well as other charges including conspiracy to commit murder.¹ This case made its way to Maryland’s highest court, the Maryland Court of Appeals. The court remanded for a new trial because Ms. Porter was entitled to an instruction on imperfect self-defense. The court noted that “battered spouse syndrome is a form of posttraumatic stress disorder” (Ref. 17, p 1044) and emphasized that the woman’s fear of imminent danger is crucial, and this imminence may occur even with nonconfrontational homicides. The court further stated: “[W]e decline to hold that a woman suffering from battered spouse syndrome must experience abuse within minutes or hours of her defensive action to be entitled to an instruction on imperfect self-defense. Doing so would ignore the reality of intimate partner violence” (Ref. 17, p 1061). The court discussed the importance of BWS testimony in helping a jury understand how a woman may be in imminent fear even in the scenario of a contract killing. Of note, the Maryland court’s holding differs from that of at least three other jurisdictions that have declined to admit BWS supporting a self-defense claim in the context of contract killings.^{19–21}

BWS is a Problematic Defense

The gendered nature of BWS laws and the BWS defense is problematic. Indeed, as Holliday and colleagues note, “the use of the phrase BWS also risks disregarding the experiences of men, nonbinary individuals,

and people who endure IPV in nonheterosexual or non-monogamous relationships” (Ref. 1, p 378). BWS is a defense for only one gender, and only for some of them. In this way, they are like infanticide laws, which only provide defenses for women, but not men, who kill infants. Friedman, Cavney, and Resnick²² noted the following weaknesses of the infanticide defense: the inherent gender bias when it is available to women only; the insanity defense already providing exculpation if caused by severe mental illness in men or women; the possibility of diminished capacity and mitigating factors at sentencing for either men or women; as well as problems with the difference between neonaticide and infanticide. Each of these weaknesses, save for the last, could also apply to the BWS laws.

Diagnostic Considerations

The terminology “battered woman syndrome” is not common parlance among clinicians. Rather, battered woman syndrome is primarily utilized in the legal arena, which should be the first clue to the diagnostic integrity of BWS. As Holliday *et al.*¹ note, BWS has never been included in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The ICD-10 includes a category, “adult physical abuse, confirmed,” which may establish the violence but which is not specific regarding one’s response. As referenced by Holliday and colleagues, some scholars have suggested that BWS be included as a subset of posttraumatic stress disorder (PTSD). But the research on the impact of battering demonstrates that psychological sequelae are diverse and not fully explained by the diagnosis of PTSD.²³ Furthermore the undefined diagnosis of BWS does not require any of the PTSD criteria outlined in the DSM.

Holliday *et al.*¹ note the limited research supporting the validity and reliability of the diagnosis of BWS, including its exclusion from the DSM. Since the introduction of BWS over four decades ago, there is limited research supporting a syndrome specifically derived from intimate partner violence. Key theories underlying BWS, the cycle theory of violence and learned helplessness, have been widely criticized. Subsequent studies examining both the cycle theory of violence and learned helplessness have found that neither characterizes all battering relationships nor are they an inevitable component of the abuse.^{24–26} Peterson and colleagues²⁷ specifically cited Walker’s misuse of the terminology “learned helplessness.” They argue that the passivity of an abused woman

does not necessarily indicate a learned helplessness as described by Walker. Furthermore, neither the presence of the cycle of abuse nor learned helplessness are sufficient to diagnose BWS. Dutton²⁶ suggests that literature best supports a focus on the effects of battering rather than conceptualizing behaviors into a syndrome after homicide, such as BWS.

BWS focuses on the victim’s pathology and suggests a uniform response to intimate partner violence. Individuals, regardless of gender, react differently to stressors, and this single option for BWS could be damaging to others who do not fit the mold. With BWS, certain women are excused from criminal acts while others are not. Thus, “the argument can also be advanced that the battered woman syndrome defense implies both that women who respond in other ways to male violence are more blameworthy for their acts, and that women lack free agency” (Ref. 9, p 274). The limitations outlined by Dutton include the following: there is no agreed upon definition of BWS; BWS is not supported by the empirical research and thereby not scientifically validated; and BWS conveys a stereotypical image which is pathologizing.²⁸

Given the absence of an agreed upon definition of BWS and the lack of scientific validity, it is important to consider the risks of classifying a criminal defendant as having BWS without such criteria in either the DSM or ICD. If one were to make such a diagnosis in a clinical setting rather than in the aftermath of a murder, the risks appear quite low and may be overshadowed by the benefits of a common language to define a syndrome relevant to some battered individuals. The risks of diagnosing BWS in a forensic setting are more substantial and threaten the integrity of our field. If forensic evaluators ignore the DSM and ICD and choose to offer diagnoses that are not generally accepted, the scientific integrity of the field is threatened and, equally importantly, the trier of fact is provided with information which may be inaccurate.

A similar challenge arose in the civil commitment setting for sexually dangerous or violent predators (SDP/SVP). As outlined in *The Journal* by Alan Frances, “the misuse of psychiatric diagnosis in legal settings should occasion grave concern” (Ref. 29, p 192). SDP/SVP hearings have been fraught with diagnostic misuse in an effort to meet legal criteria. As Frances comments, “nonspecified labels are necessary as placeholders and for reimbursement in uncertain clinical situations that do not yet allow for an official diagnosis, but they are inherently unreliable and

useless in forensic settings because they do not provide explicit defining criteria sets, as do all of the specific diagnoses included in the DSM” (Ref. 29, p 193). Historically, these diagnostic categories have remained outside the courtroom due to the absence of scientific certainty. BWS is not even akin to an “other specified or unspecified” diagnostic category in DSM-5 because the behaviors are not necessarily part of a formal diagnosis.

Role of Forensic Psychiatrists

Holliday and colleagues note: “Given the existence of standard PTSD criteria in the DSM-5, as well as frequent use of PTSD in clinical settings, forensic psychiatrists may feel more comfortable evaluating and testifying about PTSD than about BWS in forensic practice” (Ref. 1, p 379). We take a more directive stance: that forensic psychiatrists should, rather than may, consider PTSD rather than BWS as a potential diagnosis in a case involving IPV. As the authors note, at least one-third and perhaps three-quarters of those who have experienced IPV meet criteria for PTSD.^{1,30} In addition, PTSD is a well-researched and valid phenomenon which has specific timing and criteria requirements.

Some individuals who develop PTSD develop partial remission of their symptoms over time. Yet the DSM-5 does not allow a partial remission specifier. Thus, if an individual meets some but not all symptoms for PTSD, the evaluator may consider diagnosing Other Trauma or Stressor-Related Disorder, if applicable, to capture the link between the trauma and the individual’s symptoms. This, however, raises the earlier concerns addressed in using a nonspecified diagnosis. Other mental disorders may be present and be exacerbated by or connected to trauma. These should be diagnosed judiciously.

PTSD or other psychiatric symptoms can possibly explain an individual’s actions, cognitions, and emotions about their abuser or abusive situation, regardless of gender. PTSD and related disorders offer a scientific, physiologic, and psychologic explanation for some IPV victim behaviors, in contrast to BWS which is a “syndrome” not supported by rigorous research or incorporated into the DSM. Any syndrome defined by law and not the medical community is problematic, particularly if it based on gender alone.⁹ Thus, examiners should be particularly attuned to problems with gender stereotype and bias when BWS is raised in court.

If a forensic psychiatrist, because of statutory requirements, must evaluate and comment on the presence of BWS, the case should be approached in a systematic way, using multiple data points to arrive at an opinion. Glancy and colleagues³¹ recommend that evaluators follow an organized approach which allows for a comprehensive assessment of the IPV victim’s situation and actions,³¹ looking beyond the theory of learned helplessness, since an IPV victim may not fit this stereotype. As Holliday *et al.* note,¹ the use of BWS implies one single predictable response to battering, which is not borne out of research or clinical experience. For instance, a woman who reacts to the abuse with rage and anger may be perceived as contributing to the violence, versus a woman who cowers and retreats. Juries should hear that an individual’s trauma victimization can present in various ways. Glancy and colleagues³¹ recommend evaluation of the following: environmental factors; attempt to leave or alter the situation and the results; risk factors for violence of the abuser and victim; triggers for violence, including presence of threats toward children; and contrary evidence. This allows for a more complex formulation which takes the IPV victim’s personality and individual factors into account and may allow the evaluator to steer clear of gendered stereotypes of a helpless, passive, and female victim.

In addition, forensic evaluators should be particularly attuned to the presence of co-occurring disorders and how these may play a role in the alleged criminal act. For example, women who have experienced IPV also have higher rates of alcohol use and depression.^{30,32} Substance intoxication or withdrawal could lead to disinhibition, impulsivity, mood dysregulation, and other changes that could play a role in a woman’s decision to harm or kill an abusive partner. Holliday and colleagues¹ also note that women may kill their partners based on a variety of motives, not simply because they feared harm to themselves or their children. We would further expand on this statement and offer that, similar to any forensic evaluation, the examiner in a BWS case should specifically consider and rule out alternative motives to kill or harm. Violence can also be bidirectional and reciprocal; an IPV victim might also be a perpetrator or commit crimes in the heat of passion rather than in self-defense.⁹

Legal Considerations

Testimony on BWS has most commonly been admissible in claims of self-defense in the United States,

the United Kingdom, Canada, Australia, and New Zealand.¹⁶ In Ohio, for example, BWS is described in the revised code as being “commonly accepted scientific knowledge” and outside of the knowledge of the general population.³³ Furthermore, in *State v. Goff*,³⁴ the Ohio Supreme Court held that expert testimony should be limited to testimony about BWS and whether the defendant experienced BWS. In that case, Ms. Goff claimed battered woman syndrome after shooting her estranged husband 15 times, killing him. Dr. Philip Resnick, the state’s expert, did not diagnose battered woman syndrome but rather testified about the inconsistencies in Ms. Goff’s reporting. In this case, the Ohio Supreme Court noted that only a limited evaluation concerning the BWS and its effect on the defendant’s behavior was allowed. They noted that expert testimony should be limited to “testimony about the syndrome in general, testimony regarding whether the defendant experienced the syndrome, and testimony concerning whether the syndrome accounts for the requisite belief of imminent danger of death or great bodily harm to justify the use of the force in question” (Ref. 34, p1087). Kimmel and Friedman further noted concerns with this, including “if the expert has serious questions about the credibility of the defendant’s reports, the expert is not allowed to testify regarding the presence of BWS, even though it may be pivotal in reaching an opinion regarding a BWS defense. . . . [and] will not even be allowed to explain why a conclusion could not be reached” (Ref. 14, p 586). Concerns include that the defense’s expert testimony could go unrefuted and “dishonesty will be encouraged during the state’s expert examination, as a defendant’s deceitfulness has little consequence, unless the diagnosis of malingering is substantiated” (Ref. 14, p 587). This ruling prohibited expert testimony on the credibility of the defendant’s claim of BWS, as the expert in this case opined that he could not arrive at an opinion because of inconsistencies between the defendant’s statements, records, and other materials. This illustrates some of the inherent problems with the use of a clinical syndrome constructed for legal purposes.

Expert Witness Considerations

BWS has no established scientific certainty, and without scientific certainty, it is difficult for an expert to opine regarding BWS to the requisite degree of medical certainty. This again raises the question of the role of the expert witness in BWS cases. At a

minimum, given the controversy of BWS as a purported legal diagnosis, expert witness testimony should illuminate the limitations of BWS as well as the relevance to the case at hand. As discussed in *State v. Goff*,³⁴ the Ohio Supreme Court specifically limited the role of the expert, not allowing the expert to discuss the inconsistencies in the defendant’s report of BWS. A diagnosis which is only made when individuals kill their partners (or hire other persons to kill their partners) is clearly problematic. As previously noted, “a syndrome should not be defined by law, but by the medical community” (Ref. 9, p 274).

Though Holliday *et al.*¹ point out that the challenges in the use of BWS may be circumvented by considering BWS as a subcategory of PTSD, the problem with this approach is that many defendants do not meet criteria for PTSD. Perhaps trying to come up with a diagnosis that explains maladaptive or criminal behavior is the wrong approach. This is the approach that has been taken with rapists in SDP settings who are diagnosed as “other specified paraphilic disorder” in an effort to achieve a legal result of civil commitment.³⁵ One might consider the most important role of the expert in BWS cases as being education of the trier of fact. This can include a discussion about what is not known about BWS, and potential bias inherent in its use as a legal diagnosis. In addition, the expert should diagnose and explain other psychiatric conditions, which may or may not have a relationship to the woman’s criminal act. When experts must opine whether a woman meets legal criteria for BWS, then they should undertake a rigorous examination of the various factors, motivations, and contributors to the woman’s violence, recognizing that a woman’s decision to act violently in an abusive relationship may arise from reasons other than self-defense.

Consequences of Our Involvement

Though BWS, as Holliday and colleagues note,¹ has been admitted into evidence in all 50 states and the District of Columbia, concerns with relevance and reliability of expert testimony may still exist. For one, not all courts allow the expert to use the term “battered woman” or state that the woman is experiencing “battered woman syndrome.”³⁶ Second, experts should be wary of invading the province of the factfinder and offering opinions that are not based in scientific, technical, or other specialized knowledge. In some cases, the threat toward the abused is so obvious and

understandable by a lay person, that an expert may not be necessary at all and the woman's case may proceed under a traditional framework of self-defense.

As mentioned earlier in this commentary, we may also unwittingly perpetuate gender stereotypes when offering testimony about BWS. BWS implies that "a single effect or set of effects characterizes the responses of all battered women" and carries the "connotations of disease or pathology. . . [creating] a false perception that the battered woman 'suffers from' a mental defect" (Ref. 36, p vii). The forensic examiner should be particularly attuned to these gender stereotypes and explain the woman's actions not according to stereotype but with a nuanced, balanced, and objective opinion about the woman based in scientific and evidence-based research and reasoning.

Conclusions

In summary, BWS is not a clinical diagnosis, nor included in the DSM or ICD, but only a syndrome diagnosed within the legal system. Since the BWS was proposed by Lenore Walker in the 1970s, great strides have been made in understanding intimate partner violence. There is not merely one response to IPV. Intimate partner homicide has multiple motives which bear consideration. We have considered various problems with such a construct and a law for only one gender, and drawn comparisons to both the infanticide act and SVP legislation. Forensic psychiatrists should recognize clinical and scientific elements in these cases, and complete objective assessments. Whether a diagnosis of PTSD or another psychiatric disorder is merited is an important consideration. As forensic psychiatrists, we need to consider our own potential biases and remember that women can be aggressors, not only victims.

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