The perpetrators of domestic violence

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ABSTRACT

- There has been little useful research in recent years into those who perpetrate domestic violence.
- Domestic violence is always anchored in a social context in which the aspirations of men and women are dealt with unequally. The majority of perpetrators of domestic violence are men.
- Perpetrators are often young, troubled, unemployed, and of low self-esteem; they have often experienced abuse (of various types) themselves. However, these factors do not justify their abusive behaviour.
- General practitioners and other health workers have a responsibility to broach the subject of domestic violence with both perpetrators and victims. They are in a key position to break the silence that allows it to continue.
- Programs for stopping domestic violence can be effective for those who are motivated to change their behaviour and see the programs through to completion.

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"DOMESTIC VIOLENCE is an abuse of power. It is the domination, coercion, intimidation and victimisation of one person by another by physical, sexual or emotional means within intimate relationships."[1]

We have adopted this definition of domestic violence as we feel it highlights the distortion of human relationships where one partner exerts excessive control over the other, and properly stresses the emotional as well as physical damage done.

While this article focuses on partner abuse against women, who are most commonly the victims, we acknowledge that women may also be perpetrators of domestic violence.

Recent developments in our understanding of domestic violence

Most of the major advances in domestic violence research and management have dealt with victims. The past 30 years have seen proper recognition of the impossible situation of many victims and the development of "safe houses" and treatment facilities for women and their children. We also now have a clear analysis of the patriarchal societal attitudes that permit domestic violence (see Box 1).[8,9]

Much less has been done for perpetrators, who also need help, although their behaviour is much less likely to elicit compassion or understanding. The latest challenge for health and law professionals concerned with domestic violence is to deal effectively with perpetrators, without being pessimistic about the real difficulties in changing their violent behaviour. We disagree with those who argue that resources should not be channelled into developing batterers' programs because this diverts resources from effective services for battered women.[9] Medicine often has to be proactive and political if the health of the community is to be improved.

Why do perpetrators commit domestic violence?

To understand why domestic violence occurs, we need to examine the psychological makeup and background of perpetrators and the natural history of those who develop nonviolent ways of handling the conflict inherent in close interpersonal relationships. Violence towards women occurs in a specific cultural context of discrimination against women, in which control by many means, including physical aggression, has been tolerated and often legitimised.[8] However, discriminatory attitudes do not fully explain violence against women, as not all men raised in such cultures are violent.

Men may show violence when they feel threatened or attacked by some interaction with their partner that touches on an area of low self-esteem. The interrelated pressures, internal and external, which can create a perpetrator of domestic violence are shown in Box 2.

Who perpetrates domestic violence?

Most perpetrators of domestic violence are men. While surveys typically show that 20%–30% of men have committed at least one act of physical violence in the previous year,[8] the number who regularly use psychologically abusive, controlling violence (ie, who fit the pattern of "perpetrators") is much smaller — perhaps 5% of partnered men.[2]

Perpetrators may fall into one of three types:[10]

- "cyclically emotional volatile perpetrators", who are emotionally dependent on their partner's presence, and have developed a pattern of escalating tension that is defused by an act of aggression towards the partner and followed by a period of contrition. This cycle often progresses from psychological abuse to increasingly severe physical violence;
- "over-controlled perpetrators", who have developed a pattern of control relying more on psychological than physical violence;

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- "psychopathic perpetrators", who lack emotional engagement or feelings of remorse, and are likely to be also involved in male–male violence and other criminal behaviours.

Men who commit domestic violence are more likely to be young, unemployed, and in casual or de facto relationships rather than legal marriages; they are likely to have witnessed violence as children in their own families;[3] and they may have a range of psychiatric problems ranging from depression to substance misuse.[8] Many perpetrators are violent under the influence of alcohol but a substantial proportion are violent even when sober.[5]

It is important to remember that most men experiencing negative pressures will not be physically aggressive. The intergenerational and social transmission of violence, although influential, can be avoided. Impulses to violence are mediated by the perpetrator's attitudes, which are formed by the sum total of past experiences.

Problems with research on perpetrators

Published research on perpetrators has been variable in quality. Methodological deficiencies include biased samples (often using only those perpetrators who have been referred for treatment), retrospective designs, and inadequate or absent control groups. Gortner and colleagues have made a strong plea for including control-group subjects who have non-violent but unhappy relationships.[8]

Results generated by research instruments such as the Conflict Tactics Scale (CTS)[11] can distort our understanding of domestic violence. These studies, which rely on counts of aggressive acts (slaps, kicks and punches), find that women are as violent towards their partners as men.[5] However, such studies fail to consider the degree of force inflicted, disparity in size, and the psychological power wielded by those who have control of income and resources.

In two substudies on partner violence involving a cohort of nearly 1000 men and women, questions about partner violence were asked in two separate interviews. One, using the CTS, found equal male–female rates of aggressive behaviour during interpersonal disagreements.[12,13] The other, which asked about physical assault by partners, identified three times as many male partners as females as the aggressors.[5] While women do perpetrate domestic violence, especially emotional violence, in both heterosexual and same-sex relationships, the greatest need, on a numerical basis, is to identify and intervene with male offenders.

What can be done with perpetrators?

There are several steps in effective intervention, and health professionals should be involved in each. They need to recognise domestic violence and identify the perpetrator; to understand (but not excuse) the perpetrator's actions; and to provide effective management for both victim and perpetrator.

Health professionals can break the cycle of domestic violence by providing opportunities for patients to discuss violence and making appropriate referrals for both victims and

1: Perpetrators of domestic violence — common myths

- *Domestic violence is rare.* At least a quarter of partners admit to using some degree of physical violence during their relationships. A greater number are emotionally abusive. At least 5% of men use repeated serious physical and emotional violence to control their partners.[2]
- *Domestic violence is only about hitting.* Victims regularly report emotional and psychological abuse to be even more devastating than physical violence. Almost all physical violence is preceded and accompanied by emotional violence.[3,4]
- *Perpetrators of domestic violence are seriously mentally ill.* While many perpetrators are depressed or have substance-misuse problems, relatively few have severe conditions such as schizophrenia or obsessive jealousy.[3]
- *Perpetrators can not control their anger.* Most perpetrators are able to control their reactions in social situations, and are abusive only in the home.[5] Most people who are violent in the home can not be distinguished from other "normal" members of society.
- *Perpetrators are driven to violence by the behaviour of their partners.* Perpetrators are unaffected by partners' efforts to change their behaviour — the behaviour they choose to target at any time usually can not be predicted by the partner, and this unpredictability is a major means of maintaining control.[6]
- *Domestic violence is widespread only among lower classes and minority groups.* While disadvantaged groups have a higher concentration of family violence, it can and does exist at every level of society.[2,7]
- *Domestic violence is a private affair.* It is precisely this belief that allows it to continue and to flourish.

2: Multiple and interactional influences on the development of domestic violence perpetration

perpetrators. Doctors can raise the subject with patients in a number of ways:

- by asking patients directly if they have trouble with anger or whether they have done anything when angry that they later regretted. Such questions sometimes fit well with other general lifestyle questions (eg, relating to smoking,or alcohol/drug use);[14]
- by using opportunities presented when perpetrators do present — opportunities may arise at times of marital crisis, or when patients make non-specific comments about poor communication with their partners;
- by placing written material about domestic violence in both public and private locations, such as rest rooms, where it can be collected without others observing.

One general practitioner reported that wearing a button stating his personal opposition to domestic violence dramatically increased his patients' willingness to discuss the issue.[15]

GPs may be reluctant to deal with domestic violence issues (see Box 3), but ignoring domestic violence is essentially an act of collusion with the perpetrator and is not a neutral action. In order to be able to broach the subject with a perpetrator, a GP needs to have some empathy with the perpetrator's situation and confidence that some benefit can come from initiating discussion of the topic.

Few perpetrators presenting to doctors identify domestic violence as "the problem". They tend to minimise their violence or deny it altogether, and their behaviour is notoriously difficult to change.[9] Those who do present need support in their decision, encouragement to take responsibility for their actions and referral for help (see Box 4). The majority will present in a situation of crisis. They may have been directed by a court to attend a rehabilitation course, or their partner may be threatening to leave or have already left the relationship. Other clinical situations that may alert doctors to the possibility of partner abuse include drug- and alcohol-related problems, stress-related situations and depressive illness. A past history of childhood abuse is also a possible indicator, as is any new relationship where stepchildren are involved.

In managing these time-consuming and often stressful consultations, consideration of the safety of female victims and children is paramount, while responsibility for domestic violence should be placed on the perpetrators, not the victims.[16]

While there have been a number of protocols developed to help recognise and assist *victims* of domestic violence, there are only a few specifically designed to help doctors manage consultations involving *perpetrators*.[10,17] The Ministry of Health in New Zealand has supported research by an Auckland group on interventions for GPs to use with both victims and perpetrators (see Box 5).[17]

Many men are motivated to change their violent behaviour when they recognise its destructive impact on their children.[18] A useful approach to take with some perpetrators is to explain how persistent fear and threats of violence can adversely affect physical, emotional, behavioural, cognitive and social aspects of child development.[19,20]

Effective intervention reduces subsequent physical and emotional injury to the victim, enhances self-efficacy in both partners and reduces the transgenerational transmission of violence.

3: Some reasons for doctors' reluctance to deal with domestic violence issues[8,10,14,16,17]

- Lack of knowledge and training on how to address the issues in a way that is safe for all concerned.
- Lack of knowledge about referral services, or knowing that there are no easily accessible services.
- Personal experience of domestic violence by the doctor.
- Concern about opening a "Pandora's box" in a situation in which there may be limited time.
- A tendency to minimise the history and symptoms of the victim when the doctor knows the perpetrator personally.[10]
- Concern about alienating or even losing patients.
- Secondary trauma for doctors who have been inadequately trained to deal with traumatic incidents generally. This may be a particular problem for rural general practitioners.

Ethical and practical issues

There are difficult ethical issues for doctors who have both perpetrator and victim as patients, and also for patients living in rural areas or small towns in which there may be no alternative choice of GP. Doctors can be confident that dealing actively with domestic violence with both partners as patients does not present a conflict of interest.[21] Domestic violence issues can be discussed with each partner independently. However, GPs have a greater duty to warn victims in this situation, if they are considered to be in imminent danger, than to protect perpetrators' confidentiality. For reasons of safety, the issue should not be raised with a perpetrator without the consent of the victim. It is important to keep full clinical records in these complex situations, noting clinical reasons for actions taken.

Confidentiality issues are especially difficult when the victim continues to be at risk but does not want the doctor to raise the issue of domestic violence with the perpetrator and does not want police intervention. Forcing interventions on unwilling patients is a violation of the ethical principle of respect for patient autonomy.[22] Usually, victims prohibit intervention by doctors because they fear (often with justification) that it will make their situation worse. Doctors may be able to do no more than provide support and education for victims until the victims themselves judge that the time is right to make a move.

The community faces ethical dilemmas in deciding when and how to intervene in what is perceived as people's "personal business". The price of not intervening may be preventable death, serious injury, or persistent mental and physical health problems.

Another important practical issue is that of raising the problem with perpetrators when the doctor knows that there are few appropriate services to which they can be referred. This is particularly so in rural areas or small towns, where access to help may be difficult because of distance, cost or perceived lack of confidentiality. In this situation, doctors need to be as well informed as possible about the issues so they can manage the situation alone to the best of their abilities.[21] GPs and practice nurses need good counselling skills

to manage perpetrators effectively; currently, many are inadequately prepared for this task.

Treatment programs

Legislation and community attitudes are moving towards zero tolerance of domestic violence (eg, *Domestic Violence Act 1995* (NZ); *Domestic Violence Act 1976* (UK); mandatory reporting in some states in the United States). Courts frequently direct perpetrators to attend rehabilitation programs. Such programs operate after the violence has occurred and aim at secondary rather than primary violence prevention.

Cognitive behaviour therapy and "pro-feminist" educational programs are arguably the most useful models for treatment programs.[9] Cognitive therapy recognises the functional value of abuse to the perpetrator and places responsibility for the violence on the perpetrator alone. It has been criticised for being value neutral, for not incorporating issues of unequal power between men and women, and because teaching perpetrators conflict management skills can give them new weapons of abuse. The pro-feminist approach aims to change men's discriminatory and controlling attitudes towards women, and makes safety of the victim paramount, even over confidentiality. Both perpetrators and program facilitators are held accountable for changing attitudes and behaviours. Pro-feminist and cognitive approaches can be effectively combined. Such programs also work closely with the criminal justice system.

Cultural issues have not been widely researched, but, in New Zealand, it is considered that programs appropriate for Europeans may not be appropriate for Maori or Pacific Islander peoples.[9] Group programs are widely preferred over treatment for individuals or couples. Most program attendees are there because someone else (a court or their partner) has insisted they attend. Not surprisingly, attrition rates are high. Although the low success rate for court referrals is disheartening, it is important that courts are seen to be taking a firm stance against violence.

Many couples who voluntarily seek counselling for marital distress have an initially unrecognised element of violence in their relationship that will often respond to couple therapy.[3] Couple therapy is generally not recommended if violence is an important issue in the relationship.

How effective are treatment programs?

Despite almost 20 years of evaluating treatment programs, their effectiveness remains questionable.[8,9,23,24] Several methodological problems are common: evaluations tend to be based only on people who complete programs, ignoring the substantial proportion (up to 40%) who drop out;[25] most assessments adopt an input–output design rather than considering the program components that contribute to its success; and, most importantly, researchers are not all agreed on what determines an "effective program".

Program effectiveness is commonly measured in terms of whether participants remain non-violent for an extended period after attending the program.[9] Data collected from both partners are more valid than information collected only from perpetrators, for obvious reasons. It appears that most

4: Example of action taken in a case of domestic violence presenting in general practice

Mr L rang the practice doctor on duty at 1 am to say his wife had a cut lip. He was vague about what had happened. On arrival, Mrs L was quiet, anxious and verging on tears. She had a cut to her upper lip which required suturing, with associated bruising.

When asked how this had happened, she became very distressed. Mr L admitted he had punched her in the face after an argument. He said he had been drinking after a stressful day at work.

They discussed the situation next day with their regular GP and identified Mr L's pattern of intimidation and verbal abuse, which had been present through most of their eight-year relationship, but worse since they married five years ago. Physical violence had been rare and this was the first episode requiring medical attention. Mrs L expressed real fear of her husband in such situations.

Mr L agreed to accept help. The GP sought advice about available programs, and found one that seemed effective and was acceptable to Mr L. Mr L attended the program, keen to change his abusive behaviour, as the relationship meant a great deal to him. His wife attended separate counselling, to which Mr L was invited when it was clear he was determined to change.

When seen 12 weeks later, the couple felt that these interventions had helped them understand the issues and strengthened their relationship. Mr L had reduced his drinking and his workload, but, most importantly, the couple had re-examined the way they made decisions. She had learnt the importance of not accepting situations of interpersonal violence and intimidation.

5: Useful tips in consultations with perpetrators[17]

- Be direct, starting with broad questions before becoming more specific. Ask how disagreements or situations of conflict are resolved, before enquiring whether hitting or isolating actions are part of this. (For example, "Do you find you want to hit her to make her see sense?".)
- Focus on the abusive conduct, not on the explanations or rationalisations, and make the connection between the perpetrator's behaviour and the victim's injuries. (For example, "When you hit her on Saturday night you broke her nose. This is a criminal offence and there are consequences. You need to make some changes and we need to consider some things you could do.".)
- Help the perpetrator to see domestic violence as a healthcare issue and to understand that it negatively affects him as well as his partner and children. Ask what effect he thinks his violence has on his wife and children, and how it might change his relationship with them. Ask whether he wants his children to learn about violence in relationships from him.
- Discuss options for treatment and referral. These could include referral to accredited behavioural change programs, or to therapists who have expertise in domestic violence counselling *(see end of article for useful contacts).*

perpetrators who complete a program do stop their violence for a period, although some replace their physical violence with heightened verbal or psychological violence, which may be equally or more psychologically damaging for the victim.

The "Minnesota" study,[26] with a follow-up period of 18 months, found that two-thirds of those who completed a program remained free from subsequent violent behaviour, but less than half of the men who made contact with the program completed the full course.

In a review of 22 evaluations of programs involving men who batter, Tolman and Bennett[27] reported that most participants stopped their physical violence. Perpetrators who attended programs voluntarily did better than those referred by the courts (40% of men referred by courts had subsequent convictions for violence over the next five years[25]). A number of other processes (eg, arrest, separation from partner) sometimes happened while the program was under way, which may have accounted for some observed changes. In order to develop and evaluate these programs some writers have suggested the need to match specific types of perpetrators to specific programs.[10] The ultimate measure of success of treatment programs is whether there is a perceptible change in community attitudes away from condoning violence.

Robertson[9] has suggested that effective treatment programs are ones that

- make the safety and autonomy of victims a priority;
- educate perpetrators and victims, discussing the sociocultural context of the violence;
- emphasise the need for participants to take responsibility for their own behaviour;
- are clearly linked with the criminal justice system so that perpetrators know the consequences of using violence and victims are aware of their right to be protected.

Conclusions

Domestic violence is a problem that will not disappear without positive action. Failure to address issues of violence may be interpreted by perpetrators as tacit agreement with their actions. It also tells victims that doctors do not consider domestic violence an important problem.

Domestic violence has been present for millennia and we should not be disheartened by the difficulty of bringing about change. Behaviour is difficult to alter, and relapse into previous damaging patterns of interaction is common. The role of health professionals is to be fully informed, clear in understanding the destructive nature of domestic violence, and available over time to facilitate change for perpetrators and victims.

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Useful contacts in Australia and New Zealand

- Men's Responsibility Group, Monash Link Community Health Service, Hughesdale, VIC 3166. Tel: (03) 9568 2599; website: <www.infoxchange.net.au/mrg>.
- No to Violence, an Australian umbrella organisation for workers running groups for men who are violent. Tel: (03) 9428 3536; website: <www.ntv.net.au>.
- Stopping Violence, a New Zealand-based group. Tel: NZ (04) 499 6384; National Network of Stopping Violence Services, PO Box 10632, The Terrace, Wellington, New Zealand.