Mental health of perpetrators of intimate partner violence

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Abstract

Purpose – Intimate partner violence (IPV) represents a widespread social and public health problem. Researchers have shown a link between IPV and mental health problems. The purpose of this paper is to present a review of the literature on the relationship between wide ranges of mental health problems.

Design/methodology/approach – Research papers related to mental health problems among IPV perpetrators and published in leading academic journals in the UK and abroad from 1987 to 2017 were identified and reviewed.

Findings – Although there were some equivocal findings, the authors found that most of the available research suggests that there is a variety of psychological health problems among IPV perpetrators. Specifically, there was evidence of a significant relationship between anger problems, anxiety, depression, suicidal behavior, personality disorders, alcoholism, or problem gambling and perpetration of IPV. Results from analyzed studies identified high rates of co-morbid disorders in IPV perpetrators.

Practical implications – The findings highlight the need for treatment services to undertake screening and assessment of a wide range of psychological difficulties to be able to provide best treatment approaches.

Originality/value – To the best of our knowledge, this is the first systematic review that has included studies evaluating various psychological health problems among perpetrators of IPV.

Keywords Intimate partner violence, Mental health, Perpetrators

Paper type Literature review

Introduction

Intimate partner violence (IPV) represents a widespread social and public health problem that has economic consequences. It is defined as the physical, sexual, and psychological harm caused by a current or former partner or spouse (Saltzman et al., 2002). The traditional belief is that women are often the victims of IPV. However, recent studies have shown that women are perpetrators of IPV just as much as men (Desmarais et al., 2012; Dutton et al., 2005; Straus, 2011). Langhinrichsen-Rohling et al. (2012) found that nearly half of the couples in their study reported reciprocal partner violence. In a quarter of the couples, it was only the men that were violent towards their intimate partners. The remaining quarter reported only female violent behavior towards the intimate partner. These results are consistent for both mild and severe forms of violent behavior, as well as for different types of romantic relationships (dating relationship, cohabitation, or marriage) (Dutton et al., 2005). In recent decades, some of the studies regarding IPV have focused on the causes of violence in romantic relationships. Such research has also examined the role of mental health problems in IPV (Holtzworth-Munroe and Stuart, 1994; Kessler et al., 2001). These problems were recorded as both risk factors and consequences of violent behavior (Lipsky et al., 2011; Saltzman et al., 2002; Shorey et al., 2012). The most common mental health problems include mood disorders, various forms of anxiety disorders, personality disorders, psychotic spectrum symptoms and an increased risk of suicidal behavior. In view of the foregoing, this study aimed to examine recent or current literature about mental health problems among IPV perpetrators by using literature review method.

The relevant literature included in this literature review consists primarily of studies examining specific variables correlated with mental health problems and mental disorders of perpetrators of IPV.
IPV. Papers are organised in terms of specific groups of mental health problems and disorders associated with perpetration of IPV – psychological internalised negative emotions, suicidal ideation and suicidal behaviour, personality disorders, alcoholism and gambling.

Before we start with literature review we would like to define the distinction between mental health problems and mental disorders.

Mental health problems range from the worries we all experience as part of everyday life to serious long-term conditions. The majority of people who experience mental health problems can get over them or learn to live with them, especially if they get help early on. A psychological disorder, also known as a mental disorder, is a pattern of behavioural or psychological symptoms that impact multiple life areas and create distress for the person experiencing these symptoms. The latest edition of the American Psychiatric Association’s diagnostic manual, the DSM-5 (American Psychiatric Associations, 2013), defines a mental disorder as: “[…] a syndrome characterised by a clinically significant disturbance in an individual’s cognitive, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental process underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities”. The DSM-5 also notes that expected responses to a common stressor such as the death of a loved one are not considered mental disorders. The DSM also suggests that behaviours that are often considered at odds with social norms are not considered disorders unless these actions are the result of some dysfunction.

Methodology

We conducted a literature review of published studies on mental health of perpetrators of IPV. The review was performed according to the guidelines outlined in Grant and Booth (2009) review article. Inclusion criteria were: original scientific papers that covered cross-sectional and longitudinal population-based and clinical studies; literature reviews; or books; that analysed the mental health of perpetrators of IPV, with a clearly described methodology; papers with target population that included the young adults, adults and elderly; papers published in national and international journals. Letters, opinion papers, experience reports, case studies, and conference presentations were excluded. There were no restrictions regarding or language.

The search for papers was carried out in PubMed, Google Scholar, ResearchGate, and Academia.edu databases. The search terms were as follows: “Intimate Partner Violence” or “Spouse abuse” and “Mental Health” or “Perpetrators of Intimate Partner Violence” and “Mental Health” or “Psychopath” or “Suicidal Ideation” or “Depression” or “Anxiety disorders” or “Gambling” or “Alcoholism” or “Personality Disorders”. The search was conducted from January 1987 to April 2017. In total, 137 papers were identified in the searched databases and analysed.

Internalised negative emotions

Anger and hostility

Although most studies have described specific characteristics of IPV perpetrators (Holtzworth-Munroe et al., 1997; Tolman and Bennett, 1990), relatively few of them have examined the relationship between internalised negative emotional states and IPV (Dutton and Karakanta, 2013; Julian and McKenry, 1993; Maiuro et al., 1988; Pan et al., 1994). Internalised negative emotions include negative feelings and negative emotionality. Negative feelings represent the experience of negative emotions, while negative emotionality includes anxiety, sadness, anger, irritability and negative mood reactivity (Moffitt et al., 2001; Shiner and Caspi, 2003).

According to some studies findings (Eckhardt et al., 1997; Gilchrist et al., 2017; Quay et al., 2016; Norlander and Eckhardt, 2005; Schumacher et al., 2001) anger has been found to be a risk factor for IPV perpetration. Male perpetrators of IPV show elevated anger traits, an increased tendency to outwardly express anger and decreased anger control. Their problems with anger have been linearly related with more severe and more frequent violent behaviour in intimate partner relationships (Holtzworth-Munroe et al., 2000). However, other studies have not found significant
differences between the level of anger and hostility between violent and non-violent men (Tolman and Bennett, 1990). Methodological issues such as inconsistency in defining the construct and the different methods that were used for measuring anger and IPV may account for the inconsistent findings of the mentioned studies (Norlander and Eckhardt, 2005). Qualitative studies about the relationship between anger and IPV have shown that high levels of anger are associated with IPV (Holtzworth-Munroe et al., 1997; Tolman and Bennett, 1990). In such studies, the male perpetrators of IPV were more hostile and angry than participants in the control group (Tolman and Bennett, 1990). The same conclusions were also found in the research of Eckhardt et al. (1997). Schumacher et al. (2001) were one of the first groups of researches to conduct a meta-analytical study that explored anger as a discriminatory characteristic of IPV perpetrators. They analysed five available studies and found that anger and hostility were consistent predictors of IPV. According to the results of the analysed studies, the correlations between these two variables were in the range of low ($r = 0.18$) to moderate ($r = 0.52$), depending on the study and the measures that were used to estimate the examined variables. Although the meta-analysis has limitations (e.g. a small number of available studies), it still represents a significant contribution to the review of the first studies in this area.

Despite the significant correlation that has been shown to exist between anger, hostility, internalisation of negative emotions and IPV, difficulties in emotional regulation in perpetrators continues to be viewed with a high level of suspicion (Birkley and Eckhardt, 2015; Gondolf, 2012; Healey et al., 1998). According to Birkley and Eckhardt (2015), a possible reason for this is the fact that there is no theoretical explanation that explains the influence of negative emotions on IPV. Moreover, if we analyse the results of different studies, we can see that the terms “anger” and “hostility” have been used interchangeably, without taking into account the fundamental differences between the two constructs. Furthermore, in order to better understand this phenomenon, it is necessary to have conceptually clearer definitions of anger and hostility. This would give more precise information about how anger affects violent behaviour towards an intimate partner (Eckhardt et al., 1997, 2004).

These conclusions should also be taken into account when designing treatment programmes for perpetrators of IPV. Furthermore, some authors believe that stressing the importance of negative emotions in the context of IPV is a distraction from the “real” causes of intimate partner violence. Avoiding anger control treatment in standard batter intervention programmes (BIP) only serves to maintain existing ideology in its traditionally strong position. It also impedes progress in IPV prevention and intervention programmes (Maiuro and Eberle, 2008). Furthermore, IPV perpetrators treatment programmes should include cognitive behavioural therapy (CBT) focusing on emotion regulation skills, distress tolerance skills and identification as well as expression of emotions skills. Active listening and assertiveness skills should also be present (Babcock et al., 2000; Costa and Babcock, 2008; Holtzworth-Munroe and Stuart, 1994; Murphy and Eckhardt, 2005). CBT-based anger management therapy has proven to be a highly effective approach for individuals with anger problems (Del Vecchio and O’Leary, 2004; Kassinove and Tafrate, 2002).

**Anxiety disorders**

Anxiety disorders are factors associated with IPV in the elderly (Warmling et al., 2017). The results of previously conducted studies have shown that people with symptoms of posttraumatic stress disorder (PTSD) have an elevated risk for IPV (Bell and Orcutt, 2009; Crane et al., 2014; Jakupcak and Tull, 2005; Stuart Moore et al., 2006; Taft et al., 2005). Furthermore, Taft et al. (2007) reported that high levels of arousal and anger in men with PTSD were potential risk factors for frequent aggressive behaviour towards an intimate partner. The presence of PTSD symptoms has also been found in female IPV perpetrators. For instance, Stuart et al. (2006) found that 44 per cent of female court-referred perpetrators of IPV showed symptoms of PTSD. Additionally, they found that women who were involved in BIPs had higher levels of PTSD symptoms than women in the general population.

Perpetrators of IPV are also subjected to a high frequency of generalised anxiety disorder (GAD), panic disorder (PD) and social phobia (SP). Studies have shown that males who meet the criteria for these disorders are more aggressive than males without such histories (Shorey et al., 2012).
Stuart et al. (2006) examined Axis I (i.e. depression, PTSD, GAD, PD and substance use) and Axis II (i.e. antisocial and borderline) symptomatology among females who had been arrested for domestic violence and court-referred, and women in the general population \( (n = 103) \). The prevalence of GAD and PD was considerably higher among the females who had been arrested for domestic violence and court-referred than in the females in the general population.

Shorey et al. (2012) examined the associations between IPV perpetration, victimization and mental health among a sample of women who had been arrested for domestic violence and court-referred to BIPs \( (n = 88) \). The rates of PTSD (46.6 per cent), GAD (44.3 per cent), PD (35.2 per cent) and SP (36.4 per cent) were all considerably higher in this sample than the estimated prevalence rates of these disorders in the general population. For instance, in the general population of women, the lifetime prevalence rates for PTSD and SP are 10 and 15.1 per cent, respectively (American Psychiatric Association, 2013; Kessler et al., 1994). Thus, this study adds to the growing body of literature (Henning et al., 2003; Stuart et al., 2006) that show that participants in BIPs, whether male or female, may have elevated levels of mental health problems. Davoren et al. (2016) emphasise that association between anxiety disorders and IPV can be partly, but not fully, explained by coexisting psychiatric conditions and individual borderline traits.

**Depression**

Researchers have found depressive symptomatology among both male and female perpetrators of IPV (Caetano and Cunradi, 2003; Danielson et al., 1998; Feldbau-Kohn et al., 1998; Gilchrist et al., 2017; Pan et al., 1994; Warmling et al., 2017). Graham-Bermann et al. (2012) conducted a study to examine the relationship between physical IPV and depression. Their results showed that violent behaviour towards intimate partners represents a risk factor for depressive disorder in both men and women. For men, the most significant correlations were observed in the subjects that were categorised as IPV perpetrators (21.4 per cent), as well as in the subjects with confirmed mutual violent behaviour (17.2 per cent). In women, depression was significantly related with mutual IPV (35.7 per cent) and IPV victimization (33.5 per cent), while the lowest correlation was found for aggressive behaviour towards a partner (20.3 per cent). In contrast to this study, other studies have determined the asymmetry in depressive symptomatology regarding the gender of the IPV perpetrator. In such studies, IPV has been associated with an increased risk for depressive symptoms among women but not in men (Renner et al., 2014). This asymmetry was also found in research that examined the relationship between depression and physical aggression. Beach et al. (2004) indicated that physical IPV committed by a male as a response to female IPV may cause an increase in depressive symptoms in male perpetrators of IPV (Beach et al., 2004). Other studies that have only used a male sample have confirmed the relationship between IPV and depression (Boyle and Vivian, 1996; Coker et al., 2002; Feldbau-Kohn et al., 1998; Pan et al., 1994; Schumacher et al., 2001).

Research that was conducted on IPV perpetrators who were involved in different forms of BIPs showed significant correlations between aggressive behaviour towards their partner and depression. Boyle and Vivian (1996) found a highly significant relationship between self-reported anger and depressive symptomatology in a sample of men who were seeking marital therapy (many of whom had been violent towards their spouses). Feldbau-Kohn et al. (1998) conducted a study on physically violent males \( (n = 89) \) who had participated in BIPs together with their wives. The results showed a moderate depression rate in 27 per cent of the males and severe depression rate in 9 per cent of the males. The survey criteria for major depressive disorder met 11 per cent of the men. Further, Vivian Malone (1997) conducted a study on a sample of 327 couples that had voluntarily participated in therapy. This sample was divided into three groups, based on the form of IPV (verbal violence, physical violence and severe physical violence). The results showed an increase in the level of depression symptoms according to the severity of violent behaviour. Pan et al. (1994) found that for every 20 per cent increase in depressive symptomatology, the odds of engagement in moderate physical aggression increased by 30 per cent. Furthermore, the odds of engaging in severe physical aggression increased by 74 per cent. Although the mechanism behind this relationship is not clear, it is possible that violence may serve the function of increasing self-efficacy among male perpetrators who are depressed (Maiuro et al., 1988) or that irritability, which is associated with depression, may increase the risk for IPV.
Few studies have examined the level of depression among women who have been assaulted by an intimate partner (Caetano and Cunradi, 2003; Swan et al., 2005). Unsurprisingly, these studies also found a relationship between the perpetration of IPV and a high depression rate. Vaeth et al. (2010) examined the relationship between IPV (psychological, physical and sexual aggression) and depression. For women, the multivariate analysis showed that female-to-male aggression (physical and minor and severe psychological) was associated with a greater likelihood of depression. Interestingly, women in relationships with female-to-male sexual aggression did not have a significantly increased likelihood of being depressed. However, women that exhibited minor psychological female-to-male aggression were approximately twice as likely to be depressed, compared to their counterparts in non-aggressive relationships. The presence of female-to-male severe psychological and physical aggression was associated with an elevation in the risk of depression, which was nearly five times greater than that found among women in non-aggressive relationships. The cross-sectional design of this study prevented the determination of whether the depression is antecedent to or a consequence of female-to-male aggression. However, it is possible that the relationship of female-to-male aggression with depression may be caused by a conflict of role expectations, i.e. that the expected nurturing role of women is in conflict with an aggressive role (Caetano and Cunradi, 2003). The results of the above-mentioned studies have important implications for clinical practice. Professionals have to be aware that women experience a depression as a result of IPV, regardless of whether they are the perpetrator or the victim of IPV. Therefore, it is important that health providers can be prepared to screen, refer or treat depression among such women.

When it comes to male perpetrators of IPV who are diagnosed with depression, it is important to emphasise the differences in the clinical manifestation of depression, as well as the different forms of violent behaviour towards intimate partners. It has been shown that men manifest symptoms of depression in the form of irritability and anger (Boyle and Vivian, 1996). As anger can manifest itself in depression and is related to violence, the exploration of anger as a variable that relates to depression in male perpetrators should be further explored. It is also reasonable to include components of emotional regulation in treatment programmes for perpetrators of IPV. Furthermore, most of the current treatments for perpetrators of IPV are based on the assumption that violence has the function of expressing power and control. However, it is possible that the violent behaviour of depressed men with low cognitive resources is their reaction to a sense of personal threat, generalised anxiety or fear of powerlessness in their environment. It is possible that males impulsively engage in aggression in an attempt to regulate their emotions, as researchers have hypothesised that aggression might be used in an attempt to control negative emotions (Shorey et al., 2008). Thus, future research should examine this possibility. Accordingly, if the violent behaviour is a result of the difficulties in emotion regulation, but not a desire to control it, then the treatment should be adapted to the individual needs of the perpetrators. Therefore, similar to women perpetrators of IPV, an evaluation of the emotional state in men must play an integral part in the psychological assessment. The goal of the assessment is to provide optimal treatment, based on the individual needs of the perpetrators of violence but not the universal therapeutic forms.

Suicidal ideation and suicidal behaviour among perpetrators of intimate partner violence

The results of different studies indicate a relationship between IPV and suicidal ideation (Heru et al., 2006; Ilgen et al., 2009; Lopez-Ossorio et al., 2017; Nahapetyan et al., 2014; Rhodes et al., 2009). This relationship is especially strong in men that have been seen in domestic violence courts (Conner et al., 2002). Studies have shown that almost half of the male perpetrators who had been recruited from a domestic violence court reported threatening suicide in the past, with 70 per cent of the threats occurring in the past six months and 25 per cent occurring the week prior to court (Conner et al., 2002). These data highlight that interpersonal discord and related legal troubles may have a significant influence on the development of suicidal ideation and related behaviours. However, other studies have revealed a negative or non-significant relationship between IPV perpetration and suicidal ideation (Chan et al., 2007; Peek-Asa et al., 2005). Additional research conducted on suicide risk among court-involved men is critically needed to clarify this relationship.
While previous literature generally supports the relationship between IPV perpetration and suicidal ideation, little is known about the prevalence and correlates of suicidal ideation, specific to perpetrators who have been court-referred to BIPs. Wolford-Clevenger et al. (2015) conducted one of the first studies in this field. Research demonstrates that 22 per cent of perpetrators report suicidal ideation two weeks before the BIPs. This result is consistent with the work of Conner et al. (2002), which showed that 50 per cent of men had periods with suicidal ideation before beginning treatment. Wolford-Clevenger et al. (2016) also conducted cross-sectional, self-report survey, to identify the prevalence and correlates of suicidal ideation among 79 women attending batterer intervention programs. Of the sample, 33 per cent reported experiencing suicidal ideation during the two weeks prior to entering the programme. Identifying the prevalence and correlates of suicidal ideation among perpetrators in BIP will contribute to BIP service providers, exploring the potential need for individualised assessment and adjunct treatments that target suicide risk (Juodis et al., 2014; Stuart et al., 2007).

The results of previous studies have shown that men who are involved in domestic violence court or BIP are at risk of both suicidal ideation and suicidal threats. This is possibly due to their emotionally reactive and impulsive responses to crises (Conner et al., 2002). Furthermore, considering the context of domestic violence court and batterer interventions, it is possible that the interpersonal discord and legal involvement, which are inherent to these processes, might facilitate men’s risk for suicide (Conner et al., 2000; Yen et al., 2005). In addition, psychiatric symptoms that are prevalent among male perpetrators of IPV may facilitate impulsive and aggressive responses, such as suicidal ideation, to legal and interpersonal crises (Conner et al., 2003). Previous studies have identified symptoms of borderline personality disorder (BPD), antisocial personality disorder (ASPD) and depression as risk factors for suicidal ideas in IPV perpetrators, general population and participants involved in BIP, as well as convicted perpetrators of IPV (Black et al., 2010; Douglas et al., 2008; Holtzworth-Munroe et al., 2000; Ilgen et al., 2009; James and Taylor, 2008; Johnson, 2006; Kessler et al., 2005; Smith et al., 2014). However, male perpetrators differ in the level of symptoms of dysphoria, BPD and ASPD (Holtzworth-Munroe et al., 2000; Shorey et al., 2011; Waltz et al., 2000). This has a direct impact on the level of risk for suicidal ideations and suicidal threats.

There is inter-individual variability among patients with BPD and depression. This may be the reason why it is not possible to determine when specified symptoms of these disorders leads to an increased risk of suicidal behaviour (Conner et al., 2003). For example, a man who is involved in BIP may manifest symptoms of BPD (e.g. anger). Due to the separation of his partner, anger can be directed at himself through suicidal ideation. Equally, the symptoms of BPD and depressive symptoms may be the result of interpersonal difficulties, which is one of the possible causes of violent behaviour towards a partner. When these are combined (interpersonal difficulties, depression and violent behaviour), suicidal ideations are facilitated (Ilgen et al., 2009). Treatment planning should consider these complex relations between interpersonal difficulties, violent behaviour, depression, BPD, anger and suicidal behaviour.

Finally, it should be noted that it is difficult to prevent the development of suicidal ideation in male perpetrators of IPV. Clinicians need to have a more thorough understanding of who is at acute risk for suicide (Joiner et al., 1999; Kessler et al., 2005). In particular, it is important to pay attention to mental health problems, which are very common in male perpetrators. Such problems can facilitate impulsive and aggressive responses such as suicidal ideation and suicidal threats (Conner et al., 2008). Symptoms of BPD itself increase the risk of suicidal behaviour. This is because people with BPD have a history of self-harming and suicidal attempts (Linehan, 1993). Therefore, it is especially important to determine the presence of BPD symptoms in male offenders. This is because they have a greater availability to weapons, medicaments, alcohol and drugs, which can be used to commit suicide, than other males in the population (Campbell, Glass, Sharps, Laughon and Bloom, 2007; Campbell, Sareen, Paulus, Goldin, Stein and Reiss, 2007). Furthermore, according to some studies, BPD represents the mediating variable between ASPD and suicidal behaviour (Douglas et al., 2008; James and Taylor, 2008). However, due to the inconsistent results regarding the relationship between BDP symptoms and suicidal thoughts (Douglas et al., 2008; James and Taylor, 2008; Smith et al., 2014), practitioners should not eliminate ASPD as a potential risk factor for suicidal behaviour in IPV perpetrators. According to the Smith et al. (2014), symptoms of depression should also be considered as acute risk factors for suicidal behaviour and
should be involved in the evaluation process. Clinicians should consider the possibility of depression and BPD comorbidity. They should also administer a comprehensive suicide risk assessment (Soloff et al., 2000). Registered or convicted perpetrators, as well as men who have been seen in domestic violence courts, should be systematically risk-assessed for suicidal ideas and suicidal threats (Juodis et al., 2014).

Previous literature suggests that BIP are critical settings in which male perpetrators of IPV may become at risk for suicidal ideation, symptoms of depression, and BPD. Meanwhile, ASPD may be an indicator of such a risk (Conner et al., 2002; Ilgen et al., 2009; Johnson, 2006; Yen et al., 2005). Clinicians who deliver BIP should assess the presence of potential co-occurring suicide risk before, during and after the treatment (Belfrage and Rying, 2004; Koziol-McLain et al., 2006). Providers should consider both the acute and chronic risk for suicide (Joiner et al., 1999). Individuals with high levels of acute risk will have a suicidal ideation that occurs at a high frequency, duration and severity. According to Joiner and Rudd (2000), depressive and BPD symptoms should be considered as indicators of an acute risk for suicide and should warrant further assessment. Chronic risk is indicated by a history of two or more suicide attempts (i.e. multiple attempters). This is because multiple attempters have been found to have a lower threshold for internal and external crises. Thus, they are more prone to developing an acute risk for suicide. Given that some male perpetrators may have a history of frequent suicidal threats (Campbell, Glass, Sharps, Laughon and Bloom, 2007; Campbell, Sareen, Paulus, Goldin, Stein and Reiss, 2007) providers should distinguish suicidal threats and suicide attempts when assessing chronic risk.

**Personality disorders and intimate partner violence**

The findings from previous studies on the personality characteristics of IPV offenders show the presence of narcissistic personality traits or narcissistic personality disorder (NPD) in men and women (Beasley and Stoltenberg, 1992; Blinkhorn et al., 2018; Henning et al., 2003; Simmons et al., 2005). People with NPD (American Psychiatric Association, 2013) show an exaggerated sense of self-importance, excessive need for recognition by others and a lack of empathy for other people (Miller et al., 2007). This sense of grandeur is the most important and most commonly used diagnostic criteria for this disorder. Grandiosity is evident in the tendency to exaggerate their own abilities and merit, as well as reducing others, but in the expectation that other people are in the service to meet their needs.

Furthermore, a certain number of IPV offenders present characteristics of ASPD (Langhinrichsen-Rohling et al., 2000; Lopez-Ossorio et al., 2017; Stuart et al., 2008) and BPD symptoms (Armenti and Babcock, 2018; Dutton, 1998a; Peters et al., 2017; Stuart et al., 2008). Perpetrators with this kind of personality disorder commit moderate and severe forms of IPV. They also have a history of violent behaviour outside of their homes and possess criminal records. From the mentioned research, there is an apparent presence of “cluster B” personality disorder traits in those who perpetrate IPV. The “cluster B” disorders are characterised by traits such as poor behavioural control, and negative affectivity and impulsivity, amongst others. This cluster is made up of four disorders: borderline, which is described by instability in interpersonal relationships, self-image and affect; histrionic, which is marked by excessive emotionality and attention seeking; narcissistic, which is characterised by grandiosity, the need for attention and lack of empathy; and antisocial, which is characterised by an often blatant disregard for and violation of the rights of others (American Psychiatric Association, 2013). The results of previous studies (Gondolf, 1999; Hamberger et al., 1996) have shown that “cluster B” disorders are predictors of perpetrating repeated IPV in perpetrators who are involved in BIP. According to Ehrensaft et al. (2006), factors that are related to personality disorders have been found to predict IPV and have a mediating role in the intergenerational transmission of domestic violence. Moreover, personality disorders represent a more powerful predictor of IPV than gender. These findings are important for understanding the mental health of IPV perpetrators. Although they indicate that individuals with borderline and/or antisocial traits often perpetrate severe physical, sexual and psychological IPV (Holtzworth-Munroe and Stuart, 1994; Holtzworth-Munroe et al., 2000), it does not mean that all male perpetrators have personality disorders.

Personality disorders are also evident among female perpetrators of IPV (Goldenson et al., 2007; Orcutt et al., 2005; Simmons et al., 2005; Stuart et al., 2006). Initial research into the psychopathology
of female intimate partner perpetrators focused on women in conflict with the law. Simmons et al. (2005) compared court-referred females and male offenders. They found that 71 per cent of the female vs 26 per cent of the males showed clinically significant elevations on at least one of the subscales measuring personality psychopathology. The court-referred females scored higher on the histrionic, narcissistic, and compulsive subscales. Using the Millon Clinical Multiaxial Inventory-III (MCMI-III) Goldenson et al. (2007) compared female offenders who were court mandated to group treatment to women in a clinical control group (i.e. women in psychological treatment but who had not perpetrated IPV). They found that the female offenders of IPV had higher relative elevations on the antisocial, borderline and dependent subscales compared to the clinical control group. Stuart et al. (2006) examined the prevalence of psychopathology among women who had been arrested for domestic violence and court-referred to violence intervention programmes \( (n = 103) \). The women completed measures of IPV victimization, perpetration and psychopathology. The results revealed high rates of ASPD and BPD in the women who had been arrested for domestic violence in comparison to the women in the general population. Shorey et al. (2012) extended and replicated the findings of Stuart et al. (2006). Their study examined the relationship among a sample of women who had been arrested for domestic violence and court-referred to BIP \( (n = 88) \). Using self-report screening instruments for Axis I and Axis II mental health problems, the results showed that IPV perpetration was associated with increased mental health symptoms. The rates of BPD (29.5 per cent) and ASPD (39.8 per cent) were considerably higher in this sample than the estimated prevalence rates of these disorders in the general population. For BPD and ASPD, the lifetime prevalence rates for women in the general population were 3 and 1 per cent, respectively (Kessler et al., 1994). Henning et al. (2003) found a higher incidence of personality disorders in women compared to men. In their study, women who had been arrested for domestic violence had more symptoms of personality dysfunction than men who had been arrested for domestic violence. The majority of both the male (64.8 per cent) and female (67.9 per cent) offenders had no elevated clinical scales on Axis I of the MCMI-III. The women were significantly more likely to score in the clinical range for delusional disorder, major depression, bipolar disorder, somatoform disorder and thought disorder. The female offenders were more likely to score in the clinical range on the MCMI-III Axis II than the male offenders. One or more of the elevated personality disorder subscales were found in 95 per cent of the women compared to 69.8 per cent of the men. Goldenson et al. (2007) compared 33 women who were in court-mandated domestic violence group treatment with a clinical control group of 32 women who had not perpetrated domestic violence but were receiving psychological treatment. The female perpetrators of domestic violence were found to have clinically significant elevations on the subscales that tapped into borderline, antisocial and narcissistic traits. Most of the research on female offenders that has employed the MCMI-III has found women to have elevations on multiple subscales. Goldenson et al. (2009) suggested that it is possible that any combination of the above-mentioned and other personality features (e.g. dependent and histrionic) may be related to female-perpetrated IPV. Henning et al. (2003) concluded that many women who have been convicted of violent behaviour towards their intimate partners are likely to have stable personality disorders that complicate their intimate relationships.

Furthermore, it is important to mention the studies that have been conducted on samples of the general population. In a study conducted on female undergraduate students at the university in western Canada (Spidel et al., 2004), the authors found a high rate of personality disorders. In this research, according to self-reports on the Structured Clinical Interview for DSM disorders (SCID-II) of female students who abused their intimate male partners, 13.2 per cent of the female students met the criterion for one personality disorder. Furthermore, 16.9 per cent had two personality disorders and 33.1 per cent met the criteria for three or more personality disorders. The most prevalent disorders included OCD (34.6 per cent), ASPD (33.8 per cent), passive aggressive (28.7 per cent), narcissistic (22.8 per cent) and BPD (22.1 per cent). However, it is important to mention that the high prevalence rates may be partly due to the self-report measures for personality disorder and IPV. The results of this study are in line with other studies that have been conducted on males who commit intimate partner violence.

As evidenced by the presented studies, researchers who have examined the relationship between perpetration of IPV and personality disorders have mainly focused on recording the
rate of personality disorders in female perpetrators in clinical and non-clinical samples of women, without taking into account the forms of violent behaviour towards their intimate partners. Only a small number of researchers have focused their interest on the correlation between personality disorder and specific type of violent behaviour in female perpetrators of IPV. According to Spidel et al. (2004), BPD is associated with high levels of serious physical violence towards a male intimate partner. Furthermore, Moretti et al. (2007) concluded that women with narcissistic disorder are more frequently verbally aggressive. Women with ASPD symptoms manifest higher levels of aggressive behaviour and verbal aggression towards their intimate partners. Shorey et al. (2012) confirmed the relationship between BPD, ASPD, and psychological and physical violence in intimate partner relationships. Different forms of personality disorders are associated with different types of violent behaviour towards intimate partners (Dutton, 1998a; Huss and Langhinrichsen-Rohling, 2000). The differences are not just manifested in the type of violent behaviour but also, in the incidence of violent behaviour and stress reaction to a violent situation. Professionals must be aware of these differences regarding personality disorder and violent behaviour. They should pay attention to them during psychological assessment and when planning therapeutic treatments (Kropp et al., 1995). Finally, it can be concluded that focusing on specific personality disorders in perpetrators of IPV may be the only way to successfully change the process of evaluation and treatment. An example of effective treatment for perpetrators with BPD is dialectical behaviour therapy (Linehan, 1993). This is a cognitive behavioural intervention that aims to deal with people with BPD. By using this form of treatment, IPV perpetrators may learn to recognise their own negative affective responses in interpersonal situations. They also have the possibility to learn alternative, adaptive coping styles, which can result in a reduction of violent behaviour towards their intimate partners (Waltz et al., 2000).

Intimate partner violence and psychopathy

Numerous studies have highlighted the relationship between psychopathy and IPV (Cunha et al., 2018; Colins et al., 2015; Hart and Dempster, 1997; Hervé et al., 2001; Huss and Langhinrichsen-Rohling, 2000; Iyican and Babcock, 2017; Malamuth, 2003). Psychopathy is a personality disorder that is characterised by a constellation of traits including impulsivity, callousness, interpersonal manipulation and irresponsibility (American Psychiatric Association, 2013). Recent studies (Carton and Egan, 2017; Kiire, 2017; Pozueco-Romero et al., 2013) have found that psychopathy occurring in both men and women is strongly and consistently related to a wide range of problems in intimate partner relationships. It is not only connected to physical violence but also, to all other forms of violent behaviour towards an intimate partner. Psychopaths tend to use unacceptable methods to force their intimate partners into sexual activity such as the use of opiates, and physical and verbal methods of coercion. They often use intimidation and other forms of manipulation in order to dominate and control their partners (Malamuth, 2003). IPV perpetrators with diagnosed psychopathic personality disorder commit the most serious and frequent physical and emotional violence (Huss and Langhinrichsen-Rohling, 2000). Psychopathy is associated with negative attitudes towards intimate partners and intimate partner relationships. Negative attitudes have been identified as risk factors for sexual aggression. Perhaps the most disturbing fact is that psychopaths have positive attitudes towards rape. Therefore, these attitudes underline the violence towards their intimate partners (Malamuth, 2003). Furthermore, a high frequency of instrumental violence among psychopaths does not exclude the possibility of reactive IPV. A psychopath that feels that his narcissism has been damaged in some way, such as public embarrassment by his wife, responds with violent behaviour towards his partner (Hart and Dempster, 1997; Hervé et al., 2001). Furthermore, the results of recent studies (Williams et al., 2005) have confirmed the association between IPV and psychopathy, which can also be generalised to individuals with subclinical levels of psychopathy.

Given the rich empirical studies on psychopathy, the presence of a psychopathic subtype of perpetrators could have substantial implications for understanding IPV. Although there is evidence of the presence of psychopathic subtypes of IPV perpetrators, there is no clear path of psychopathy towards violence against a partner. Psychopaths are also violent towards their friends and other family members (Williamson et al., 1987). It is unlikely that the patterns of
violent behaviour in psychopaths are the same as in IPV perpetrators, in which violence is primarily driven by emotions such as extreme jealousy (Dutton, 1998a, b) or fear of abandonment. Although jealousy in psychopathic perpetrators may occur as a narcissistic injury, it is not known whether it is associated with a fear of abandonment. According to Dutton (1998a, b), it is less likely that emotional instability affects the behaviour of psychopathic perpetrators. Emotions are not the reason why psychopaths enter into a marriage or intimate relationship. To understand the dynamics of IPV between psychopaths and their partners, it is important to understand what leads an emotionally uninvolved person to enter into a marriage or committed relationship. One possible reason stems from the desire for grandiosity and status, which can be satisfied with the control and power over an intimate partner. Another possible explanation is that attacks on intimate partner are motivated by sadistic needs or their need to have someone on hand for maltreatment. Hypothetically speaking, it is possible that psychopaths enter a romantic relationship like a business relationship, which brings financial resources, power and control. All of these reasons could be the motives for their violent behaviour (Hart and Dempster, 1997; Hervé et al., 2001). Unfortunately, the limited quantity and quality of studies in this area, which are mostly based on criminal records and institutional documentations, disrupts interpretation and prevents a clear conclusion. In conclusion, for treatment of psychopathic perpetrators, it is crucial to determine whether the primary focus is psychopathy or IPV. According to previous literature, it should focus on the treatment of psychopathy before the treatment of IPV. Previous studies have also reported difficulties in implementing treatment. It has been found that it is rare for psychopaths to completely end their therapeutic treatments. They are also less active during treatment and very often relapse during the year after they were dismissed from treatment (Ogloff et al., 1990).

**Alcoholism**

Alcoholism is the most common mental disorder that is identified in perpetrators of IPV (Shorey et al., 2012; Warmling et al., 2017). This is confirmed by the results of different studies, which have been conducted in clinical (Caetano et al., 2007; Gilchrist et al., 2017; Murphy et al., 2001) and general population samples (Adejimi et al., 2014; Caetano et al., 2000; Christ et al., 2018; Cunradi et al., 1999; Guay et al., 2016; Lopez-Ossorio et al., 2017). Both types of studies found a strong association between alcohol and committing violence in intimate partner relationships (Stuart et al., 2006). Such studies also found that a reduction in alcohol consumption contributes to a reduction in IPV (Fals-Stewart et al., 2009; O’Farrell et al., 2004). According to the Roizen (1993), men were drinking in about 45 per cent of the events (the range across all studies was from 6 to 57 per cent) and women were drinking in about 20 per cent of events (the range across all studies was from 10 to 27 per cent) of IPV. Men who were drinking during IPV events occurred four times more often than women (Zaleski et al., 2010). This difference may be a reflection of the general rate of alcohol consumption, which is larger in men than in women. However, the connection between IPV and alcoholism is complex. It includes the frequency and form of alcoholism, as well as the presence or absence of problems that are associated with alcohol and/or alcohol addiction (Cunradi et al., 2002). Furthermore, it is necessary to take into account other variables, such as personality traits, which can be associated with addiction to alcohol and marital dissatisfaction (Murphy et al., 2001). Chronic alcoholism can cause brain damage, which may be associated with aggressive or violent forms of behaviour (Rosenbaum, 1989). As a result, the treatment of alcoholism should be an integral part of intervention programmes for IPV perpetrators (Stuart et al., 2007).

**Gambling**

Although so far, only a small number of studies have investigated the patterns of IPV in the problem gambling population, some evidence shows that IPV is among the most severe interpersonal correlates of problem gambling (Affi et al., 2010; Brasfield et al., 2012; Dowling et al., 2016; Goldstein et al., 2009; Korman et al., 2008; Liao, 2008; Muelleman et al., 2002; Roberts et al., 2018). However, the nature of the relationship between gambling and IPV is not entirely clear. Some authors believe that gambling may directly or indirectly lead to violent
behaviour (Afifi et al., 2010; Brasfield et al., 2012; Korman et al., 2008; Muelleman et al., 2002). Brasfield et al. (2012) found that gambling contributes to poor partner relationships and alcohol abuse, resulting in an increased risk of violent behaviour. Other researchers have found that IPV is more likely to occur as a reaction to gambling losses (Afifi et al., 2010; Korman et al., 2008; Muelleman et al., 2002). The evidence about the negative impacts of problem gambling on intimate partner relationship should be addressed in further research and clinical practice. Findings of previous research can be used to inform the treatment of problem gamblers and should be used to encourage routine screening for IPV in problem gambling services (Afifi et al., 2010; Korman et al., 2008). Furthermore, it is necessary to carry out preventive activities when detecting minor gambling problems and to direct them to all forms of IPV (Afifi et al., 2010).

Conclusions

There is a wide range of difficulties that are associated with the psychological health of IPV perpetrators (Huss and Langhinrichsen-Rohling, 2000). The variety of difficulties may also be why therapeutic treatments often do not give the expected results. Knowing the specifics of mental health problems of IPV perpetrators should be the basis for conducting a comprehensive psychological assessment, as well as for developing specific forms of treatment that are adapted to the difficulties of each perpetrator (Dutton et al., 1997). In males, particular attention should be paid to alcoholism, which has proven to be the most common mental disorder. It should be noted that there is still a limited number of studies that have investigated the mental health of female IPV perpetrators, compared with the number of studies in which participants were male perpetrators. This indicates that there is still not enough attention being paid to female perpetrators, despite numerous studies that indicate gender symmetry (Dixon and Bowen, 2012; Pornari et al., 2013). Finally, the results of the numerous studies about the mental health of the perpetrators of IPV that are presented in this review should be taken into account when designing intervention programmes. They should also be considered when trying to increase awareness of prevention and/or reduction of IPV.

Recommendations for further research

Further research should focus on testing the mechanism that is responsible for the connection between specific psychological difficulties and committing violence in intimate partner relationships. Taft et al. (2007) found that the hyperarousal PTSD symptoms cluster demonstrated a stronger relationship with general physical aggression in a large sample of male Vietnam veterans. These findings are consistent with larger literature, indicating a relationship between heightened arousal and reactivity with aggression (Lorber, 2004). Substance abuse may also be responsible for impulsive behaviour of men who batter and may increase the frequency or severity of their violent behaviour (Fals-Stewart and Kennedy, 2005). Difficulties in emotional regulation may be responsible for the association between mental health problems and the perpetration of IPV. Findings of previous studies suggest that the construct of emotional regulation is important for understanding the onset, maintenance and treatment of depression and anxiety disorders (Campbell-Sills and Barlow, 2007; Tull et al., 2007, 2009). At the same time, the dysregulation of emotion is associated with impulsive aggression (Davidson et al., 2000) and the dysregulation of negative emotion specifically has been linked to IPV (Gratz et al., 2009; Shorey et al., 2011). Therefore, it is possible that difficulties in emotional regulation can play a mediating role in the relationship between mental health problems and IPV. This explanation is also supported by other studies that have shown the dysfunction of the limbic system, which is responsible for emotional behaviour, in people with a personality disorder who show a high level of violence (Flannery, 2009). It is assumed that mental disorders are possible causes of violence. It is also a well-known fact that IPV can have a significant impact on the mental health of men and women who are exposed to traumatic experiences. Therefore, longitudinal studies are needed to clarify the relationship between mental illness and IPV. To understand the relationship of mental health problems and IPV, it is also necessary to carry out further research in accordance with the existing biological and psychological theoretical frameworks.
References


American Psychiatric Association (2013), Diagnostic and Statistical Manual of Mental Disorders, APA, Washington DC.


Dutton, D.G. (1998b), The Domestic Assault of Women: Psychological and Criminal Justice Perspectives, Allyn & Bacon, Boston, MA.

Dutton, D.G. (1998b), The Domestic Assault of Women: Psychological and Criminal Justice Perspectives, Allyn & Bacon, Boston, MA.


Flannery, R.B. (2009), The Violent Person: Professional Risk Management Strategies for Safety and Care, American Mental Health Foundation, New York, NY.


Further reading


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