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Editorial

A focus on perpetrators of intimate partner violence in mental health settings is urgently needed

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A national study in the UK has shown that perpetration of intimate partner violence is common for men and women attending mental health settings. People who perpetrated intimate partner violence were more likely to have experienced intimate partner violence, particularly for women. Perpetrators who were men were more likely to also perpetrate non-partner violence against family, friends or strangers. Mental health clinicians require training in identification, risk assessment and response, including referrals to behavioural programmes. More research is required to inform such responses; however, the need to address this common hidden problem in mental health settings is urgent.

Keywords

Trauma and stressor-related disorders; patients and service users; mental health services; comorbidity; epidemiology.

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The links between intimate partner violence (IPV) experiences, mental ill health and mental health service use are well established.[1,2] However, there is much less research focusing on the prevalence of people perpetrating IPV who attend mental health settings.[3] The national study by Bhavsar et al[4] exploring IPV perpetration and mental health service use in England is a needed addition to the mental health field. Research has shown there are many structural barriers[5] for mental health practitioners to identify victims of IPV, which may also apply to perpetration.[6] Showing mental health practitioners that perpetrators of IPV are present in their clinical population is the first step to engaging them to ask about perpetration of IPV among their patients.

Bhavsar et al[4] summary of findings

The authors analysed data from the 2014 Adult Psychiatric Morbidity Survey in England to describe the association between people's perpetration of IPV and their use of mental health services (primary and secondary care) in the last year.[4] They found similar lifetime prevalence of perpetration for men (8%) and women (8.6%) as measured by physical abuse (e.g. pushed, kicked or thrown something that hurt), sexual abuse (e.g. forced to do something sexual) or fear for any partner (e.g. frightened by threatening to hurt a partner or ex-partner or someone close to them). There was a strong association between mental health service use and odds ratios of 2.8 for both men and women who had perpetrated IPV. This association was less once adjusted for IPV victimisation and other life adversities. However, the strong association remained when analysing for people without criminal justice involvement (men odds ratio 2.9 and women odds ratio 2.3).

Implications for research

Future research needs to take into account the context, severity and frequency of perpetration of IPV.[7,8] Studies reporting that women perpetrate as much IPV as or more IPV than men usually measure IPV by counting the number of IPV acts over a specific time period or lifetime.[7,8] Bhavsar et al,[4] using a broad definition of lifetime IPV perpetration, found gender symmetry of the findings. However, it would have been interesting to know if there were gender differences in the individual items, as sexual abuse is usually perpetrated more by men than women.[7,8] IPV victimisation in the study[4] included economic, emotional and technology-facilitated abuse; all these forms of abuse show greater gender symmetry between men and women.[7,8] As the authors[4] acknowledge, perpetration items did not capture severity or frequency which might be different for men and women.[7,8]

Context and motivations for perpetration of IPV may also be different for men and women, with some studies proposing that men are more likely to want to control their partner, while women may act more from anger, self-defence or retaliation.[9] Emotional regulation has also been proposed to be different across genders for perpetration of IPV.[10] Some authors propose that men are more likely than women to perpetrate coercive controlling IPV, rather than situational IPV in response to a conflict.[7,8] A cross-sectional study of men attending general practice in England showed that only a small proportion of men experienced coercive controlling IPV from their partner (4.4%), with half of these men also perpetrating against their partner.[11] Distinguishing between different types and patterns of IPV perpetration in research is important, as a coercive controlling pattern of behaviours is more likely to be associated with severe injury and death.

Future research needs to explore further the associations of IPV perpetration patterns (e.g. combined physical, emotional and sexual abuse), as victimisation has been shown to have a higher health burden for those women experiencing combined patterns of abuse.[12] Distinguishing the associations of perpetration of violence between non-partner family and friends, which can be a broader pattern of family violence that includes threats to people the victim cares about, and perpetration

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against strangers would be useful in identifying patterns.[11] In addition, following people longitudinally would allow exploration of IPV patterns over time to provide more evidence-based risk and prevention factors for health practitioners to work with in clinical practice.

Implications for clinical practice

There are many barriers to raising with patients the issue of perpetration of IPV, including a lack of training, referral processes and clear procedures for identification.[6] Mental health practitioners are skilled in assessing risk of suicide but have had much less training in risk assessment for homicide by partners or ex-partners. Screening tools have been validated to a limited extent by studies in the emergency department setting and in veteran clinics in the USA.[13] Further, there is a lack of evidence-based interventions in health settings for early identification and response to perpetrators.[14,15] In particular, there is a lack of rigorous evidence for what mental health practitioners should do as a response to perpetrators, particularly if a perpetrator also has substance use issues, as many perpetrator programmes exclude such people.[14,16] The need for more evidence-based interventions for perpetrators in mental health settings is urgent, to inform responses that can prevent further trauma and harm to families.

The findings by Bhavsar et al[4] suggest that identification of perpetration of IPV in mental health settings is urgent to ameliorate harm to women, men and their children.[3,14] As Bhavsar et al[4] point out, family members, including children, can also be at risk from those perpetrating IPV against their partners. All people attending mental health settings (including those people with alcohol and drug use, depression and suicide attempts) could be asked by health practitioners in a non-judgemental way about perpetration of IPV (see Box 1). Other warning signs or risk factors for perpetration of IPV that could trigger inquiry by a clinician include the individual level (low education, unemployment, history of child abuse and neglect, belief in strict gender roles) or the relationship level (divorce or separation, economic stress, controlling behaviours exhibited in interactions, cultural norms that support aggression).[17] The potential is evident for mental health practitioners to intervene by identifying and responding to this hidden epidemic underlying mental health service use.

Box 1 Clinical identification questions

What happens when you argue?
Are you worried about your behaviour in your relationship?
Do you sometimes regret things that you do to your partner or ex-partner?
Have you ever frightened a partner or ex-partner?

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Data availability

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