

Factors involved in male perpetration of Domestic Violence (both psychological and physical), including Sexual Abuse, Intimate Partner Violence and Coercive Control (DIPV).

We acknowledge that this submission has been prepared on the traditional lands of the Kurna People. We pay our respects to Kurna Elders both past, present, and emerging and extend that respect to other Aboriginal and Torres Strait Islander peoples who are reading this submission. We recognize the deep spiritual connection and the relationship that Aboriginal and Torres Strait Islander people have to Country. We stand in respect of their custodianship, which continues to nurture and sustain these lands.

1. Submission overview

We recognise the WHO consensus that the underlying cause of violence against women is the social context of gender inequality (WHO 2010, UN Women 2015). This submission points out that structural factors such as power differentials, and those related to masculinity should not in all cases, be recognised as primary drivers in isolation.

This submission is driven by three critical observations:

1.1 Although the role of alcohol and other substance abuse was reported in 2020 by the Australian Institute of Criminology

<https://www.aic.gov.au/sites/default/files/2020-05/bulletin-7.pdf> there remains a confusing omission of mental health, alcohol consumption, and other substance abuse as significant factors in the perpetration DV in the Australian Institute of Health and Welfare (<https://www.aihw.gov.au/family-domestic-and-sexual-violence/types-of-violence/intimate-partner-violence>) review. The current frameworks for intervention and prevention should have a far greater intersectional focus across the criminal justice system, health and mental health, housing and social care.

1.2 Recent discourse by the South Australian Mental Health Commissioner, as published on LinkedIn on April 16, 2024, which reasonably raises pertinent questions regarding the extent to which mental health disorders contribute to the perpetration of violence. This is appropriately in the interests of not stigmatising people with mental illness since most people with mental illness do not engage in violent, controlling or coercive behaviour. However, it would be possible for the public to infer that there may be no link even as a contributor between any mental health disorder and domestic and intimate partner violence. This omission hinders a proper examination of the problem.

1.3 Aggressive, externalizing, and violent behaviors in men are often not recognised as indicators of underlying common mental health disorders,

and in particular the anxiety and depressive disorders all of which have prolonged irritable and/or depressed mood as part of their diagnostic criteria. This oversight can lead to inadequate responses both in prevention and in intervention strategies for DIPV but also for prevention of suicide and the optimal health of men in general.

While not suggesting a direct cause and effect relationship, a recognition and appropriate weighting of mental health (and related substance abuse) will allow for a more comprehensive and integrative strategy in preventing DIPV, supporting victims, and providing management programs for perpetrators.

This approach aligns with a more nuanced understanding of human behaviour and enhances the effectiveness of interventions aimed at reducing the incidence and impact of domestic violence.

2. Mental Health Disorders

There is a strong relationship between certain mental health disorders and the perpetration of DV. These mental health disorders include personality disorders, mood and anxiety disorders and substance use disorders.

Personality disorders, include borderline and antisocial personality disorders contribute to impulsivity, aggression, and a lack of empathy.

In a meta-analysis drawing on studies from multiple countries (recognised by the scientific community as the most reliable form of research evidence) examining mental and physical health correlates with emotional intimate partner violence perpetration, borderline personality disorder, narcissism, emotional dysregulation, post-traumatic stress, antisocial personality disorder, psychopathy, depressive symptoms, anxiety symptoms, and trauma were significantly associated with emotional IPV perpetration [1].

Using a longitudinal design, the association between mental disorders and IPV perpetrated by men towards women was assessed in a Swedish population-based sample. The strength of this study is that sibling comparisons were used to control for factors shared by siblings, such as genetic and early family environmental factors. The results showed that men with depressive disorder, anxiety disorder, alcohol use disorder, drug use disorder, attention deficit hyperactivity disorder and personality disorder at a higher risk of perpetrating IPV against woman than unaffected siblings. The highest risk of IPV against woman was in men where there was comorbid substance use disorder and personality disorder with the other common mental health disorders [3].

2.1 Common mental health disorders and male aggression and perpetration of violence

Common mental health disorders such as depression, anxiety, and bipolar disorder can manifest distinctly in men compared to women. Symptoms in men often include externalising symptoms including risk taking behaviours, substance abuse, heightened irritability, anger, and sometimes aggression. These factors are early warning signs that current practices either do not recognise or to which they cannot adequately respond.

2.1.1 Depression:

A recent systematic review and individual participant data (IPD) meta-mediation analysis of general population surveys (recognised by the scientific community as one of the highest levels of research evidence) of participants aged 16 years or older, conducted in a high-income country setting assessed the relationship between mental disorder and intimate partner violence (IPV) perpetration in the previous 12 months. Four datasets contributed a combined sample of 12,679 participants.

Depression was associated with a 7.4% and 4.8% proportion increase of past-year physical IPV perpetration among women and men, respectively with no evidence of mediation by alcohol misuse [2].

However, it is unclear whether the full extent of male depression was captured in the studies used. Men are half as likely to be diagnosed with depressive disorders than women [3-5]. This is not because men with

depressive disorders do not seek help [6]. Rather, the way many men experience and express symptoms of depression, such as irritability, aggression substance misuse, risk taking, and poor impulse control is not captured by diagnostic criteria and commonly used clinical depression screening tools [7-9]. Irritability, aggression, substance misuse, risk taking, and poor impulse control are factors that could be considered precursors to violence and should form part of risk assessment when observed.

The gender gap in depressive disorders (i.e., men being half as likely to be diagnosed with depressive disorders than women) disappears when symptoms such as irritability, anger, aggression, substance misuse, risk taking, impulsivity and over involvement in work are considered for depression diagnoses [10] [7].

2.1.2 Generalised anxiety disorder:

Although anxiety disorders are typically characterized by social withdrawal, inhibition and shyness, and discomfort in social expression, individuals with anxiety disorders often express intense and out of proportion anger and aggression [11] <https://www.ncbi.nlm.nih.gov/books/NBK396463/>.

Anxiety disorders and coercive control are linked. People experiencing forms of anxiety are predisposed to misattribute their anxiety to specific situations and contexts. They then attempt to control those situations to

alleviate their anxiety. Recognising forms of anxiety as precursors to coercive control and violence could be a significant prevention factor. Fear is a more common driver of aggressive behaviour than coercion.

2.1.2 Bipolar disorder:

Based on data provided by 190 (34% female) adult offenders during court-mandated substance use evaluation, Bipolar and PTSD diagnosed participants were more likely to perpetrate IPV than matched comparison and ADHD participants [12]. Bipolar disorder is associated with childhood trauma which may explain the increased occurrence of aggressive and potentially violent behaviour, particularly in undiagnosed or poorly managed circumstances

<https://www.psychiatrictimes.com/view/violence-bipolar-disorder>.

2.2 Brain injuries and DIPV.

Traumatic brain injury has been linked to increased aggression and violent behaviors. There is evidence to suggest that rates of brain injury among perpetrators of family violence are disproportionately high.

<https://www.braininjuryaustralia.org.au/download-bias-report-on-australias-first-research-into-family-violence-and-brain-injury/>

3. Substance Abuse

Substance abuse, particularly alcohol and drugs, significantly exacerbates violent behaviors in intimate settings. The influence extends to androgenic anabolic steroids, which are known to heighten aggression and impulsivity, thereby contributing to IPV incidents [13-15]

<https://www.who.int/docs/default-source/documents/child-maltreatment/interpersonal-violence-and-illicit-drug-use.pdf>

While alcohol use is unlikely to be a primary cause of DIPV, there are clear associations, and in some cases, strong correlations between alcohol use and DIPV including the severity of the violence.

https://anrows-2019.s3.ap-southeast-2.amazonaws.com/wp-content/uploads/2019/02/19024408/Alcohol_Consumption_Report_Compass-FINAL.pdf

Alcohol consumption intensifies the probability of DIPV, particularly when combined with other risk factors [16-20]. For example, data from a meta-analysis encompassing surveys from 7,914 men across seven countries in the Asia Pacific region (Bangladesh, Cambodia, China, Indonesia, Papua New Guinea, Sri Lanka, and Timor-Leste) revealed that regular heavy episodic drinking significantly increases IPV likelihood among men who hold less equitable gender attitudes [21].

Evidence for the efficacy of interventions to reduce alcohol consumption comes from measures implemented in the Northern Territory during 2017-2018 which led to a notable reduction in domestic and family violence [22]. Moreover, a complete ban on alcohol in Bihar, India, in 2016 not only curtailed alcohol consumption among males but also prevented an estimated 2.1 million cases of intimate partner violence against females [23].

4. **Intersectionality with masculinity, gender inequity and power relations and social determinants.**

The conventional understanding of DIPV often emphasizes structural factors such as masculinity, gender inequity, and power structures in isolation as primary drivers. While these elements are undeniably significant, a more nuanced, intersectional approach reveals a complex interplay of mental health, substance use, childhood trauma and social determinants that contribute to DIPV. Perpetrators are influenced by a confluence of factors that extend beyond traditional gender norms and power dynamics and can arise from various relational dynamics and individual psychological issues. For example, among patients in an urban emergency department (ED), the likelihood and severity of IPV increase with the number of risk factors identified. These included adverse

childhood experience, drug use in the past 12 months, at risk alcohol consumption impulsivity, presence of PTSD, partners problem drinking and depression (Hospital Anxiety and Depression Scale). The data showed that risk factors for DIPV co-occur in the same individual. Those who report the presence of 2 or more risk factors have increased odds of reporting DIPV. The authors recommend that in the ED there should be a focus on screening, brief intervention and referral to treatment programs [24].

A structured questionnaire administered to 2838 men aged 18 years and above in Zimbabwe assessed the prevalence and factors associated with IPV perpetration (multivariate regression) by men in heterosexual relationships, and modelled pathways to IPV perpetration using Structural Equation Modelling [25]. They concluded that while sexual relationship power and personal gender attitudes were important, IPV perpetration was also associated with childhood abuse history, mental ill health and alcohol consumption. We recommend that similar detailed studies be undertaken in an Australian context using gender sensitised mental health questionnaires.

5. Implications for prevention and intervention

5.1. Therapeutic Jurisprudence

Therapeutic jurisprudence (TJ) is an interdisciplinary approach to legal scholarship with the goal of reforming the law, so it has a positive impact on the well-being of defendants appearing in court. TJ researchers and practitioners typically make use of social science methods to explore ways in which negative consequences can be reduced, and therapeutic consequences enhanced, without breaching due process requirements. By taking a non-adversarial approach to the administration of justice, judges and lawyers work together to create strategies that help offenders make positive changes in their own lives. Therapeutic jurisprudence has been used successfully in mental health courts and other problem-solving courts, such as drug courts for defendants with addictions

https://en.wikipedia.org/wiki/Therapeutic_jurisprudence.

In South Australia the Courts Administration Authority receives government funding to establish intervention programs for men issued with an intervention order to protect their female partner or former partner, from abuse. Relationships Australia deliver the intervention programs which are called Domestic Violence Prevention Programs (DVPPs). The DVPPs focus on understanding the nature of abuse, developing respectful relationships, and learning non-violent conflict resolution skills. It is unclear whether the intended objectives are achieved. These programs should be (i) designed

with intersectional input and including all stakeholders, victims and perpetrators who have completed existing programs and (ii) be reviewed and outcomes reported . Key design considerations:

5.1.1 Recognise and address risk factors at multiple levels of the Socio-Ecological Model [26].

5.1.2 Be integrated and multidimensional and trauma informed. Mental health and substance abuse disorders need to be recognised and treated. Integrated strategies that address substance abuse are pivotal to the prevention and mitigation of DIPV [22 – 24].

5.1.3 Be culturally tailored.

5.1.4 Be subject to ongoing evaluation with outcomes of relevance to society, victims and perpetrators made publicly available.

5.2. Primary prevention and intervention

5.2.1 ensure widespread provision of education for health care professionals across all disciplines during both undergraduate and post graduate training to:

5.2.1.1 understand the health care needs of men and engage and effectively communicate with men in health care settings

<https://www.health.gov.au/resources/publications/final-report-of-the-mens-health-education-project-phase-1>

5.2.1.2 recognise and manage depression and other mental health

disorders in men [2]. Programs such as “Men in Mind”

<https://meninmind.movember.com/> while targeted at therapists could be adapted for a broader range of health care professionals.

5.2.1.2 recognise and respond to the warning signs of DIPV perpetration

5.2.2 Intervention programs that are integrated and multidimensional and

trauma informed must be accessible for health care providers to refer

people. These programs should ensure confidentiality and be culturally

tailored and sensitive. The “Mens Referral Service” can be accessed

confidentially, offers behaviour change programs and assists with access

to other services e.g. substance abuse or mental health

<https://ntv.org.au/mrs/getting-support/>. Integrated programs that do not require external referral would be preferable.

5.2.3 Provide training and referral resources for community-based

organisations interfacing with men

5.3.4 Outcome data from all programs should be available publicly and

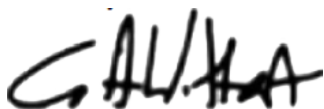
regularly reviewed.

5.3 Wherever legally possible, combine criminalisation with early detection and prevention

Unless personal and public safety requirements warrant restrictions on liberty, active monitoring or incarceration, men should be directed to DIPV programs without criminalisation which has devastating effects on, for example, future employability and perpetuates the problem. Relevant officers of the criminal justice system should be routinely provided information and training about such programs.

5.4 Avoidance of stereotyping in public discourse.

Men who are violent and abusive must of course be held accountable for their actions and women and children need to be protected. But at the same time there must be an understanding of the often-complex causes of men's behaviours and simplistic and inaccurate assumptions, and portrayals avoided. Without defending bad behaviours, a greater focus on men's mental health and substance abuse, prevention, early intervention and therapeutic jurisprudence could make a significant difference.



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Research.

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