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A Social Psychological Perspective on Impulsivity/Intimate Violence

DONALD G. DUTTON

As recently as the 1970s, academic texts divided aggression into two categories: "normal" aggression, which was believed to be directed toward either a stranger or an enemy, and "intimate violence," which was seen as abnormal, the act of madmen. Like the cursed monster created by Dr. Frankenstein and given the brain of a criminal by his assistant, men who abuse their wives or were believed by medical science to commit violence because of an aberrant neural structure that generates disordered impulses. In 1977 I went to an international conference of psychiatrists and criminal lawyers, and noticed that some research papers were to be presented on wife assault. These papers, much to my disappointment, focused exclusively on neurological "causes" of wife assault. This complex action—filled with symbolism and rich meanings of the woman as lover/savior/mother/betrayer, and awash with obsessions, revulsions, tensions, jealousy, anger, and rage—was being reduced to a perturbation in the limbic system, the part of the brain believed to control emotions. In effect, these psychiatrists were claiming that disturbances in a neural structure such as the temporal lobe could cause wife assault.

An example of this line of thought was an article first published in the medical journal *The Practitioner* in 1976 (Elliott, 1976/1977). Its author, Frank Elliott, was a psychiatrist at the Pennsylvania Hospital. The article describes something called the "episodic dyscontrol syndrome"—a term

coined first by the famous Karl Menninger, founder of the clinic named after him. Menninger had originally described episodic dyscontrol as an unconscious bodily reaction to chronic stress (Menninger, Mayman, & Pruyser, 1962). It referred to episodes in which a person suddenly and inexplicably goes out of control, literally runs amok. It was thought to be beyond rational "ego" control and to be explosive in nature. In this sense it was believed to stand out as a different level of reaction to stress, compared to the other types of stress adaptation, such as anxiety, neurotic symptoms, and psychosis. Episodic dyscontrol is currently listed in the *Diagnostic and Statistical Manual of Mental Disorders,* fourth edition (DSM-IV; American Psychiatric Association, 1994) as one of the impulse-control disorders; there, it is called "intermittent explosive disorder" (IED) and given the official code number of 312.34. The diagnostic criteria include several separate instances of loss of control of aggressive impulses, resulting in serious acts of assault or property destruction; the degree of aggression expressed is hugely disproportionate to any psychological or social factor that might have precipitated it. The episodes also do not occur during the course of a psychotic disorder or other disorders (e.g., antisocial personality disorder). In other words, the person is not psychotic or otherwise mentally disordered, but can burst out in a rage that is entirely out of proportion to whatever preceded it.

TWO CASE EXAMPLES

The following two case histories of wife assaulters highlight some of the features of IED, as well as related treatment and criminal justice issues. As one examines real-life cases, the difficulties and complexities of dealing with such individuals became quite apparent.

> A man I will call Robert was referred to our treatment group while his wife, Carol, was still hospitalized for injuries sustained through his beating (Dutton, 1995). He was, as they say, "average-looking"—medium height, medium build, brown hair. He wore blue jeans, a denim shirt, and heavy work boots. He was in his early 20s and a deep sea diver by profession. He looked tense, rocking back and forth in his chair, clenching and unclenching his fists repeatedly, and staring at the floor as if he was trying to burn a hole in it with his eyes. He avoided all eye contact and seemed, whenever asked a question, to be on the verge of tears. He made the other 10 men in the group nervous, even though they all had problems with anger and violence too. (In fact, 8 of the 10 had been sent for treatment by court order after having been found guilty of wife assault.) I asked Robert how he was feeling at that moment; he shrugged and said, "I don't know, not really anything. . . . Nothing, I guess." I asked the other men in the group how they experienced him, and they told him

he looked scared, depressed, and upset. They also told him that he made them nervous and edgy. He was surprised to hear this.

It took about 3 weeks before Robert could talk about the violence that had led to his being in the group. The trouble started at his wife's office party. About 30 people were drinking and chatting when, according to Robert, Carol disappeared (i.e., he could not find her in a large, unfamiliar house). After 10–15 minutes he did see her and insisted that they leave the party. I asked him what he was feeling at this point. "Nothing," he said after a pause. They drove home; she went to bed, and he began to watch television.

Robert's next memory was of seeing Carol lying in a pool of blood on the floor of their bedroom. He called her relatives and the police. The police report said that when asked what happened, he replied, "I must have hit her." He pleaded guilty in court, saying only that "I must have done it." When I asked him about the time period between watching television and seeing Carol covered in blood, he drew a blank. He said he believed he must have hit her, but he couldn't remember doing it.

At that time, I believed that shame had clouded Robert's memory. Now I know that something else was going on—a type of dissociative rage state with enormous physical arousal. Once he was back in his "normal" state, he really could not remember what had happened; the memory never got stored.

Carol remembered, though. "I was asleep when he grabbed me. He pulled off the covers and then yanked me out of bed by my hair. The light was on in the bedroom and I could see his face. . . . It was terrifying." His expression was grossly distorted: His mouth was pulled down at both corners "like a fish mouth," his teeth were clenched, his jaw protruded, his nostrils flared, and his eyes "were sort of blank." He started to punch her with a closed fist, first on her stomach and side, then in her face. She could hear him yelling, "You bitch, you cunt, you slut, you fucking whore!" Then she lost consciousness. She had a broken nose, a broken jaw, two chipped teeth, and bruised ribs. It was 2 months before she could go back to work.

Carol's mother told her office that she had been in a car accident. Only her mother and father, her sister, and two female friends knew what had really happened. Robert did not want to tell anybody.

In treatment, Robert eventually revealed his belief that his wife was having an affair, and that when she "disappeared" at the party she was having sex somewhere with a male coworker. (She was talking to two female coworkers on an outside balcony.) When we asked him where he imagined this to be happening in a crowded party, he said, "I don't know—in a car or something."

He also claimed that he would have what he called "red-outs," when he got angry and could not remember what happened after that. It was like "drowning in a red tide."

Two months into treatment, Robert phoned me in a panic: "I'm about to kill my wife!" He had returned from an out-of-town business trip to find "a key with a man's name on it." He "knew" his wife

was having an affair and became enraged. Fortunately, he had learned enough by this time to recognize imminent high-risk situations for his rage.

When he came to see me, Robert was shaking and distracted. I asked to see the evidence; he showed me the key. I recognized the name on it immediately—it was the largest key manufacturer in town. I told him this, but he did not believe me. I got the telephone book, opened it to the Yellow Pages, and showed him. He appeared to calm down. I asked him whether he could see how he jumped to conclusions about Carol's imagined infidelity. He said, "Yes," but he seemed distant, distracted, as if some inner voice was competing successfully for his attention. I spent another hour soothing him. I got him to do some deep relaxation exercises, and made him promise he would not go home until he was completely in control. I suggested that he spend the night with a male friend. He thought that was a good idea.

Robert left, but he drove directly to his house and his wife. A shouting match ensued but no violence, except that he smashed into a wall while screeching out of the driveway. Only then did he go to the friend's house. It took him 3 days to calm down completely.

Was this a case of IED? Although Robert may have felt some vague discomfort during his wife's office party, he did not act aggressively while at the party or even express his discomfort to his wife. Also, although his beliefs about her having an affair were delusional, he was not in any way psychotic. He did not have hallucinations, and he was in touch with reality as experienced by other people. He was entirely capable of carrying out his job as a deep sea diver—surely a dangerous occupation for a psychotic person. In addition, he did not appear to be psychopathic. He did not get into fights with people other than his wife, and he was not irresponsible. He had not had numerous jobs, relationships with women, or run-ins with the law. He was not emotionally shallow. In fact, he showed much remorse for what he had done, even calling the police on himself. In other words, Robert may have qualified for a diagnosis of IED. But does that diagnosis "explain" his behavior? Does it explain, for example, why his violence was always directed toward his wife and always occurred in private? I think not.

Recently I was phoned by a man in great distress, whom I will call Sam. He was a construction foreman, and although he was known on the job as demanding and irritable, he had had no major problems with the men he worked with. The previous week he had been at his golf club with his wife, casually drinking with some friends. He and his wife returned home and began making dinner. That was the last thing he remembered before waking in the middle of the night with the house trashed and his wife gone. He had a vague sense that he had caused the problem, but could not remember anything. His wife

phoned him at work the next day and agreed to meet him, but only in a public place.

Then and there, she told him she was afraid of him and was leaving. She told him how he had "gone off out of the blue" about the dinner's being cooked a certain way. He had screamed at her, pushed her, and (as she fled) threw the frying pan with steaks in it at her, hitting the wall. I talked to her alone first. She described Sam as moody and irritable but not abusive; however, there had been about three occasions when "he became someone else" and exploded. This one was the last straw for her.

Sam met the diagnostic criteria for IED. The only constant he could recall was that these bouts only occurred when he had been drinking. He now insisted that he would swear off alcohol. He fully believed his wife's account of his violence, but maintained that he could not remember it. His childhood had not been particularly happy; he had a great hatred for his mother who had taken a lover while his father was bedridden with illness. It was notable that all his bouts of IED were directed at his wife.

A CRITIQUE OF PSYCHIATRIC/NEUROLOGICAL EXPLANATIONS FOR INTIMATE VIOLENCE

Elliott (1976/1877) believed that episodes such as those Robert and Sam experienced are caused by a neurological disorder—literally, some electric microstorm in the brain. He speculated that the site of this disorder might be the limbic system, an "ancient" part of the brain situated in the brainstem, down underneath the cerebral hemispheres. The limbic system is called "ancient" because it is believed to have developed far back in humanity's evolution. It contains structures with fascinating names, such as the amygdala, the hippocampus, and the temporal lobe. Together, these areas are believed to constitute the "seat of emotion," and microelectrode stimulation of the amygdala in animals produces rage or pleasure, depending on the exact location of the implant. Some locations will cause monkeys to press a bar repeatedly to keep the stimulation turned on. They press until they literally drop from exhaustion. Other locations cause monkeys to bare their teeth and attack.

Almost every psychology student has sat through the riveting film of the Spanish neuropsychologist Jose Delgado, dressed like a matador and being charged by a bull. The bull, however, had received a microimplant that Delgado could activate by remote control. When Delgado flipped the switch in a small control box, the bull stopped in its tracks. Obviously, electrical activity in this area can have extensive effects on behavior associated with aggression. One kind of internally generated electrical activity in the brain is an epileptic seizure. Hence, authors such as Elliott (1976/1977) speculated that this kind of epilepsy might be the cause of uncontrollable aggression.

Elliott believed temporal lobe epilepsy to be the most common "organic" condition associated with explosive rage. Temporal lobe epilepsy, in turn, can be caused by any early trauma such as "an anoxic incident in early infancy" (i.e., the infant's air supply is cut off) or "traumatic scars" (Elliott, 1976/1977, p. 102). Elliott did not speculate as to how these traumatic scars might be inflicted. He did not explicitly connect temporal lobe epilepsy to being a victim of physical abuse, although in the years to come this type of experience would become a strong risk factor for adult abusiveness in men. The excellent cross generational studies by Egeland (1993) and his colleagues found a "transmission rate" of maltreatment from one generation to the next of 40% (meaning that 40% of adults who maltreated their children were themselves maltreated as children), and psychologists Rosenbaum and Hoge (1989) would found 61% of men assessed for outpatient treatment for wife assault had themselves received prior head injuries. The suggested causal pathway was as follows: Early trauma (e.g., blows to the head) causes temporal lobe epilepsy, which in turn causes IED. Is head trauma leading to temporal lobe epilepsy the source of these outbursts?

I must add that my own clinical experience has been that many men come into our treatment group who do have the obvious "soft signs" of neurological disorder. These sometimes include pronounced nystagmus (jerky or saccadic eye movement) and attention deficits.

> One man, whom I will call Mark, had all these signs plus an IQ level in the dull-normal range. He was a huge beefy man with the reflective ability of an 8-year-old. He had had a horribly conflicted relationship with his mother and was now living with a woman 20 years his senior, who was also his boss. We did not like his chances, but decided we had to try something. He reoffended within a few weeks of starting treatment. We asked him whether he knew he was getting angry. He said, "Yes." We asked him why he did not take a "time out" to calm down. It was clear that he was only taking in very limited amounts of information, and that his deficits were probably more than we could handle in the treatment group. He became the worst failure in the history of the group, with six repeat offenses in the decade after treatment. I have seen other men who also seemed to me to have neurological damage. But they also had, in every case, a rageful and conflicted relationship with their mothers. The neurology, by itself, was only part of the story.

Metabolic disorders can also cause explosive rage. Elliott (1976/1977) described a case of matricide triggered by hypoglycemia in a man who had suffered brain damage at birth or infancy. Elliott went on to describe the features of dyscontrol as being episodes of intense rage "triggered by trivial irritations and accompanied by verbal or physical violence" (p. 104). The individual usually has a "warm, pleasant personality" but may have "a history of traffic accidents resulting from aggressive driving" (p. 105). More

recent psychiatric explanations have maintained this focus. A study by Felthous, Bryant, Wingerter, and Barratt (1991) is typical. The authors found a group of 15 men (out of 443 studied) whom they diagnosed as having IED. The typical victim of their outbursts was "a spouse, lover, or boyfriend/girlfriend." In study after study, these neurological explanations seem to avoid the obvious—namely, that something about intimate relationships generates the violence, which only occurs in the context of intimacy and typically in private. How, then, is it uncontrollable?

The literary example provided by Elliott (1977) unintentionally underscores this problem with the concept of IED. He described the character of Jacques in Emile Zola's novel *La Bête Humaine* as "a man with the symptoms of temporal lobe epilepsy who could not always control an urge to kill women who attracted him" (Elliott, 1976/1977, p. 105). How does a neurological disorder lead one to attack only attractive women? Or, to restate the earlier question, why would Robert and Sam only attack their wives and only in private? Clearly, some higher-order process of mental association between the meaning of the target person to the perpetrator and the context of the violence must direct and influence the act of violence. In a case of intimate violence, what does the man's wife or partner mean to him? What symbolic baggage does this man carry from his earlier days that gives shape to this meaning? Is there something special about intimacy that alters the meaning of the other person?

Tics can be differentially expressed in different contexts. The best example is Tourette's syndrome, a tic disorder or impulse-related disorder that manifests itself in uncontrollable cursing (coprolalia) and/or involuntary mimicry of others (echolalia). Oliver Sacks (1995) has written a marvelous description of a surgeon in British Columbia who suffers from Tourette's syndrome and manifests its expressions every day, but never while he is operating. Is this not then an example of an impulse-related disorder expressed only in specific circumstances? Yes, but a tic is a relatively unintegrated response sequence, compared to the complexity of abusiveness. The tic utterance is not specifically aimed at whoever is present. Many abusive men, on the other hand, express abuse only toward intimate others. The behavioral sequence is person-specific and complex, including a chained sequence of verbal and physical actions. The contents are designed to hurt an intimate other and are based on knowledge of that individual's weaknesses. Whether the situational specificity of a tic disorder (which does have a neurological basis) could also apply to neurologically induced complex action patterns seems to be dubious.

The insufficiency of the activation of neural mechanisms as an explanation for more molar behavior was demonstrated in another classic study by Jose Delgado, reported by Bandura (1973). In this study, stimulation of an area of the temporal lobe in a dominant male monkey produced a rage response: teeth baring and attack. Stimulation of the same area in a subordinate monkey produced withdrawal, cowering, and

huddling in the corner of the cage. To Bandura (1973), as a social psychologist, this finding of Delgado's suggested that direct stimulation of brain systems is never a direct cause of aggression and that aggression always has learned aspects to it. The "prepotent" or most used response at the time of the brain stimulation is the response evoked by the stimulation. That habitual response should change with the circumstances. For example, the dominant monkey had learned to attack; attack was at the top of its hierarchy of responses, the one most likely to be used when neural mechanisms were kicked into action by any triggering event. The subordinate monkey had learned that any attempt to attack would be met by severe punishment. Its response hierarchy was different; it had learned to supplicate. The dominant and subordinate monkeys made opposite responses to stimulation of the same brain area. The neural mechanism did not have functions that were permanently fixed, and the decision to attack or to curl into a ball or show the jugular vein (in an act of submission) seemed to be based in part on what expectations were generated at that time by being in a particular social status.

Years later, in a study on humans, I found that human emotional responses were likewise very much determined by differences in hierarchical status (Dutton, Webb, & Ryan, 1994; Strachan & Dutton, 1992). I measured the emotional reactions of people while they were listening to recordings of family arguments. Some of these people were assigned to low positions in a hierarchical group created for the experiment, whereas others were assigned to high-status positions. I created on-the-spot "bosses" and "underlings." People in these two positions experienced the same family arguments differently. In these human experiments, however, greater rage was associated with low status—the opposite of what the monkey studies found. In either case, however, status mattered. There was no direct line from a neural event to broader actions like rage. The context in which rage could be acted out influenced not only the choice of action but the very experience of emotion. The potentially angry persons not only had their choice of action shaped by the context, but also their actual emotion, whether they felt anger or anxiety more strongly.

The question left unanswered by early psychiatric/neurological explanations was this: How do we explain the direction of rage outward only in specific circumstances and to specific targets (e.g., Zola's character's murderous impulses toward attractive women) when the problem is attributed either to a neurological disorder or to an incompletely defined one such as IED? Why, for example, would the rage not be generalized to whatever targets are available—to, in effect, whoever is around at the time? Why would Felthous et al.'s (1991) perpetrators only direct their rage to someone with whom they were in an intimate relationship?

The assault of intimate others typically occurs under specific circumstances (at home, in private) and at specific times (upon one partner's return home or late at night). Episodic dyscontrol would lead us to expect

random times for attacks that would be just as likely to occur in public as in private. The research data on intimate violence suggest that this is not at all a random act. Something more is going on. Something guides the direction or the focus of rage—something learned about male–female relationships.

SUBTYPES OF ABUSERS

I have predicated my critique of psychiatric/neurological explanations of intimate violence on the assumption that such abusiveness is relationship-specific. For many abusive men this is the case, whereas for other subtypes the violence seems to be expressed toward people in general. I have not so far addressed this issue of subtypes of abusers. Several reviews of subtypes have been written (Dutton, 1988; Holtzworth-Monroe & Stuart, 1994). Although the terminology may change from author to author, three categories of abusers are generally recognized: "psychopathic," "avoidant," and "borderline."

Of these three, the psychopathic batterers can be differentiated from the other categories as being generally violent and abusive. They are the only batterers whose violence and abuse are not relationship-specific. From descriptions by their wives or partners, these men appear to use violence instrumentally. Also, rather than being flooded by intense arousal states, psychopathic batterers appear to experience a paradoxical inner tranquility while acting out abusively (Jacobson, 1993). This autonomic suppression and the instrumental aspect of their violence appear to contradict notions that violence is impulsive. It appears, rather, to be a coolly sadistic form of control.

Avoidant batterers express relationship-specific violence and typically do so after extended periods of suppressed anger. Locating avoidant men on a continuum of impulsivity–instrumentality is difficult. These men do not exhibit the cool cunning of the psychopathic batterers. Their violence is typically a response to long-stored negative affect, which is itself generated by their deficits in assertiveness.

Borderline batterers fall more, I believe, toward the impulsive end of the continuum. They respond to strong inner cues, usually of building tension, accompanied by negative ruminations about the intimate other as the source of their misery. As I have argued elsewhere, these aspects appear to have early origins (Dutton, 1994; Dutton, Starzomski, Saunders, & Bartholomew, 1994; Dutton, Starzomski, & van Ginkel, 1995). The tension may be a lifelong reaction to intermittently rewarding–punishing attachment, and it may be relieved by cathartic abusive outbursts. These men are impulsive in their abusiveness, sexuality, and substance use, but all three forms of acting out are intimacy-related. The promiscuity and substance abuse are typically related to perceived loss of the intimate

other. The impulsivity occurs within parameters set by intimacy and attachment, and may in the future be described as a manifestation of an attachment disorder.

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