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Barriers To Intervening Among Witnesses Of Intimate Partner Violence In Scotland

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Abstract

Background: Intimate partner violence (IPV) is a problem in many parts of the world, including Scotland. Bystander interventions can reduce the number and severity of episodes of IPV.

Objective: This study explored the potential barriers to intervening to stop intimate partner violence in Scotland.

Methods: This research is part of a larger study that used a mixed methods approach. Thirty-one people (14 males; an age range of 18-78 years) who participated in five focus groups (each comprising around six people) which were conducted in Alloa, Glasgow, and Kilmarnock, Scotland in July and August of 2013.

Results: Five key themes emerged as common to participants' experiences and important to their decisions whether to intervene if they witness or overhear violence: 1) the distinction between public and private violence, 2) concern about unintended consequences of intervening, 3) collective efficacy, 4) perceptions of victim vulnerability, and 5) self-efficacy. When these themes were analyzed together two significant barriers to intervention were revealed: 1) pervasive violence in some communities makes intervention unreasonably dangerous to bystanders, and 2) the private setting in which most IPV is perpetrated makes it difficult to identify and less conducive to intervention.

Conclusions: There is a need to raise awareness of IPV and the role the public can play in reducing the incidence and severity of IPV in Scotland. The findings provide insight into when and how members of the Scottish public might intervene in cases of IPV. This knowledge is important to inform the development of culturally-appropriate bystander interventions.

Keywords: intimate partner violence, focus groups, bystander intervention

Barriers to intervening among witnesses of intimate partner violence in Scotland

Every day women around the world are subjected to physical and psychological abuse at the hands of intimate partners and former intimate partners.[1] The World Health Organization (WHO) defines intimate partner violence (IPV) to include "acts of physical aggression, psychological abuse, forced inter-course and other forms of sexual coercion, and various controlling behaviours such as isolating a person from family and friends or restricting access to information and assistance" (Heise & Garcia-Moreno, 2002). The term "intimate partner violence" includes both episodic violence and coercive control, a term developed by Evan Stark to describe the process by which a victim's liberty and sense of self is taken away by the perpetrator (Stark, 2007). Sometimes called intimate terrorism, coercive control may or may not include actual violence (Stark, 2007). IPV, also referred to herein as domestic violence or domestic abuse, affects women without regard to age, sexuality, religion, income, geography, class or socioeconomic status (Heise & Garcia-Moreno, 2002). Awareness of the problem of IPV as a threat to the health and wellbeing of women around the world has led to the development of a variety of interventions. One type of intervention that seeks to reduce both the frequency and intensity of IPV is bystander interventions. Bystander interventions seek to teach witnesses who become aware of a situation but aren't sure what to do or whether action is warranted how to safely and positively intervene to stop violence.

This project explored the motivations and barriers to intervening among people who may witness or overhear intimate partner violence in Scotland. Scotland was chosen, in part, because Chief Constable of Police Scotland, Sir Stephen House, has identified domestic abuse as a priority. Consistent with this policy, the Violence Reduction Unit of Police Scotland (VRU) is eager to implement programs designed to address IPV. The VRU is especially interested in whether bystander interventions, which have been used successfully in other parts of the world, might be useful in Scotland. This study used qualitative methods to develop a deeper and more nuanced understanding of the thought processes that underlie decisions whether or not to intervene when one witnesses or overhears violence. Using focus groups we discovered that people in Scotland were concerned about violence and eager to learn about intervening in safe

[1] Men are also victims of IPV, and both men and women are victims of IPV in the context of same sex relationships. This paper will focus on the most common situation in which women are the victims of IPV perpetrated by male partners or former partners.

and effective ways. Specifically participants distinguished between public violence and private violence and this distinction had different significance for men and for women. Some of the male participants indicated that while they would generally ignore violence that took place "behind closed doors," they would view IPV perpetrated in public as a challenge to their masculinity. Thus, a failure to intervene to stop violence perpetrated by a man against a woman in public would make them not just complicit, but somewhat emasculated by this failure to act. Both male and female focus group participants were concerned about unintended consequences of intervening. In addition, focus group participants indicated that decisions whether to intervene would be influenced by their perceptions of victim vulnerability, lack of collective efficacy, and whether they thought they would be able to intervene successfully. When these themes were analyzed together, two significant barriers to intervention were revealed. First, pervasive violence and lack of collective efficacy in some communities makes intervention unreasonably dangerous to bystanders. Second, the private setting in which most IPV is perpetrated makes it more difficult to identify and less conducive to intervention.

Background

Due to concealment by both perpetrators and victims, intimate partner violence is almost certainly under-reported and under-estimated. The WHO estimates that one in three women will experience physical and/or sexual violence by an intimate partner during her lifetime (WHO, 2013). But women are not similarly situated with respect to the risk of IPV because its prevalence varies between and within countries. In fact, the WHO estimates that the percentage of women aged 15 to 49 years old who have experienced domestic abuse during their lifetime ranges from 15% to 71% (WHO, 2013). Similarly, in a recent review of 50 population-based surveys from around the world, researchers found that between 10% and 50% of women who had ever had partners had been hit or physically assaulted by an intimate male partner at some time (Watts & Zimmerman, 2002). This variation suggests that violence is not inevitable and that prevention is possible.

Like many countries, Scotland has a domestic abuse problem (Scottish Government Report, 2012). The Scottish government estimates that in 2012 only 17% of domestic abuse incidents were reported to police (Scottish Government Report, 2012). Moreover, the 2012 report indicates that the vast majority of IPV incidents in Scotland take place "behind closed doors." In fact, in 87% of the incidents in 2011-2012 in which the location was recorded, IPV

took place in a home (Scottish Government Report, 2012). Where the victim and perpetrator co-habited or were married, the percentage of IPV incidents that took place in a home increased to 93% (Scottish Government Report, 2012).

Intimate partner violence places women at risk for serious negative mental and physical health outcomes (García-Moreno, et al., 2005; Heise & Garcia-Moreno, 2002). Mental health risks associated with IPV include depression, anxiety, insomnia, social dysfunction, post-traumatic stress disorder (PTSD), and suicide (Campbell, 2002; García-Moreno, et al., 2005; Heise & Garcia-Moreno, 2002; WHO, 2013). In addition, battered women have higher rates of substance abuse than non-battered women (Campbell, 2002). IPV also poses a serious threat to victims' physical health including injuries, homicide, gynaecological problems and indirect stress-mediated health outcomes like cardiovascular disease and hypertension (Campbell, 2002; García-Moreno, et al., 2005; Heise & Garcia-Moreno, 2002; WHO, 2013). Finally, children who have witnessed IPV are at higher risk for poor physical and mental health than children who have not witnessed such violence (Heise & Garcia-Moreno, 2002).

Interventions to address IPV have taken many forms including support for victims such as emergency shelters, political and legislative reforms, and bystander interventions. Many of the existing interventions are necessary but insufficient to fully address this most serious public health problem. For example, even though many countries now have shelter systems for battered women, the uptake of those services is low and the availability of beds may be seriously limited due to resource constraints (García-Moreno, et al., 2005; Scottish Women's Aid, 2013). In 2006, the UN Secretary-General released a report which found that although 89 countries had some legislation regarding domestic violence, 102 countries did not (United Nations Secretary General, 2006). Moreover, even among countries that have laws that protect women from discrimination and violence, it is unclear to what extent those laws are enforced. Bystander interventions, rather than relying on structural or legal support for victims, are based on the assumption that all members of a community have a role in shifting social norms and behaviors around violence. These interventions seek to convert passive bystanders into active bystanders, and in so doing change the ways in which people talk about violence and react to violence that they witness.

In other parts of the world bystander interventions have been implemented in an effort to reduce the number and severity of interpersonal abuse episodes using methods that are safe for

both the interveners and the victims (Banyard, Moynihan, & Plante, 2007; Barone, Wolgemuth, & Linder, 2007; Casey & Ohler, 2012; Coker, et al., 2011; Foshee, et al., 1996; Fox, Corr, Gadd, & Butler, 2012; Katz, 1995; Potter & Stapleton, 2012). Bystander interventions in the context of IPV serve two purposes: to change social norms around violence and to prevent the escalation of dangerous episodes of interpersonal violence. The former seeks to affect long-term change by addressing the underlying causes of violence, and the latter has immediate consequences for the safety of the victim. By raising awareness of both the problem of IPV and the opportunity to intervene, bystander interventions seek to affect a paradigm shift with respect to attitudes and behaviors as they relate to violence.

First, bystander interventions seek to change social norms that equate manhood with violence against women (Hong, 2000). Specifically, these interventions seek to deconstruct these social norms and to alleviate the real or perceived peer pressure among men to act and speak in violence-promoting or violence-accepting ways (Hong, 2000). In addition, research suggests that men often misapprehend the prevailing norms with respect to whether their peers would intervene in violent situations. In this case the task of interventions is to expose the inconsistency between actual norms and perceived normative behavior and beliefs (Fabiano, Perkins, Berkowitz, Linkenbach, & Stark, 2010). Bystander interventions also seek to remind people that they are members of a community and as such they have a role in preventing violence (Potter, Stapleton, & Moynihan, 2008). For example, in many interventions men are encouraged to be "social justice allies" and to confront the misbehavior of other men as it relates to women (Casey & Ohler, 2011; Coker, et al., 2011; Fabiano, et al., 2010). Although women are also encouraged to intervene, these interventions primarily seek to confront the culture of masculinity that perpetuates the perpetrator-victim dichotomy that is often identified with male-female relationships.

Second, bystander interventions seek to educate people about when and how to intervene to stop violence by altering the bystander decision-making process and thus overcoming the inhibitory bystander effect. The *bystander effect* refers to the social psychological phenomenon whereby an individual's decision whether or not to provide help in a critical situation is influenced by the perceived presence of other bystanders (Darley & Latané, 1968; Latané, & Darley, 1969; Latané & Nida, 1981). The bystander effect was first identified following the 1964 murder of Kitty Genovese in New York (Manning, Levine, & Collins, 2007). Although there is

some question about what actually happened on that day, the common understanding was that over thirty witnesses watched while Ms. Genovese was murdered in public, and these witnesses did nothing either directly or indirectly to help her. Latané and Darley suggested that it was not that the bystanders deliberately decided not to help, but rather they were caught in a state of indecision (Darley & Latané, 1968).

Latané and Darley proposed a five step process model to explain bystander apathy and the decision-making process that underlies it (Latané & Darley, 1969). In 2001, Hoefnagels and Zwikker adapted Latané and Darley's model to domestic violence (Hoefnagels & Zwikker, 2001). Using this model, first the bystander must notice the event. Second, the bystander must interpret the event as an emergency and recognize that someone needs help. Where an event is ambiguous, people will likely interpret it in ways that will not require intervention (Solomon, Solomon, & Stone, 1978). Third, the bystander must determine that it is his or her responsibility to intervene. Several factors are thought to predict whether a bystander is likely to intervene: a) bystander characteristics, b) victim characteristics, c) the relationship between the victim and the perpetrator, and d) situational factors (Latané & Darley, 1970). Situational factors may include poverty, lack of social cohesion, lack of collective efficacy and community violence. Fourth, the bystander must decide to help and what form that help should take. Perceived self-efficacy is an important determinant in this regard (Banyard, 2008), but may be attenuated in situations in which individual bystanders view their own contribution as essential, such as where the victim appears to be in extreme danger (Fischer, Greitmeyer, Pollozek, & Frey, 2006; Fischer, et al., 2011; Greitemeyer & Mügge, 2013). Finally, after deciding what to do the bystander must take action. One of the main deterrents to action is fear that the bystander will get hurt (Piliavin & Piliavin, 1972). This process may be interrupted at any of the five stages and thus bystander interventions seek to address these pivot points to facilitate efficient and well-reasoned decision-making.

Bystander interventions typically include some combination of skills training and awareness-raising. Research suggests that educating individuals about violence-related issues and opportunities for intervention is necessary but insufficient because such training does not lend itself well to diffusion of information models (Potter, Moynihan, & Stapleton, 2011). In contrast, although mass media campaigns are inherently less flexible than individual training sessions, such campaigns are a cost-effective way to disseminate messages to a broad audience.

Thus, a combination of individual training and mass media awareness-raising may be the best way to promote safe and effective bystander intervention and to change social norms around violence. Typically bystander interventions seek to encourage bystanders to refer a victim to authorities, to a helpline, or to other resources for victims. In at least one campaign, *Bell Bajao* (described in greater detail below), bystanders are encouraged to intervene directly by distracting the parties involved in the altercation.

In recent years both the popular press and academic researchers have devoted considerable attention to whether bystander interventions might be effective in preventing violence against women in a variety of settings including college campuses, U.S. military installations, and within the LGBT community (Coker, et al., 2011; Exner & Cummings, 2011; Fabiano, et al., 2010; Hong, 2000; Moynihan, & Banyard, 2008; Potter, Fountain, & Stapleton, 2012; Potter & Moynihan, 2011; Potter, et al., 2008; Winerip, 2014). One of the most successful large scale interventions to address IPV was called Bell Bajao ("Ring the Bell"). The impetus for the original campaign, which was launched in 2008 in India, was the Protection of Women from Domestic Violence Act in India. The law was enacted in 2005 to protect and compensate women who were abused in their homes. "Ring the Bell" was meant to be both a metaphor to raise awareness of the law and a suggested practice targeted to men and boys. The intervention was designed to work as follows: when someone overhears a woman in distress they ring the doorbell at the home or apartment where it is taking place and use a pretext such as asking to borrow sugar to intervene. The idea is that this intervention would prevent the escalation of violence and also indicate to the perpetrator that people were aware of what is happening. By the end of the three year campaign, *Ring the Bell* had reached 130 million people and trained 75,000 rights advocates to become agents of change (Silliman, 2011). During that time, the number of women aware of the Protection of Women from Domestic Violence Act in India increased 49% and access to services for survivors increased 15% (Silliman, 2011).

In part due to the success of *Bell Bajao*, the international community has begun to embrace the bystander intervention approach. For example, a decade ago this approach was recommended by the Centers for Disease Control and Prevention (CDC) (CDC, 2004). In addition, in 2008 the UN Secretary-General launched the UNiTE to End Violence Against Women campaign to increase the political will and resources required to end violence against women and to engage men and boys in this endeavor (United Nations Secretary-General, 2008).

In 2010 the Clinton Global Initiative vowed to expand the Bell Bajao campaign globally, and U.N. Secretary-General Ban Ki-Moon publicly endorsed it as part of the UNiTE Campaign to End Violence Against Women (Silliman, 2011). In 2014 the United Nations launched the HeForShe campaign which seeks to turn men and boys into social justice allies in the effort to end violence against women.

Two bystander campaigns have been launched in Scotland to address violence against women. In 2010 Scottish Women's Aid launched the *Together We Can Stop It* campaign which sought to raise awareness about domestic abuse and to change social norms that condone it. This campaign does not encourage bystanders to intervene directly, but rather encourages them to be supportive of victims and to disseminate information about where victims can go for help. The campaign includes print advertisements, videos, leaflets, and a website. In addition, the *White Ribbon Campaign* provides training to men and boys in Scotland to "give them the skills to stand up to violence against women." The *White Ribbon Campaign* seeks to empower men and boys to change social norms that link masculinity to violence against women. Men are asked to take the following pledge: **"**I pledge never to commit, condone or remain silent about men's violence against women" (White Ribbon Campaign, 2014). In February 2014, almost 4,000 men and boys had taken the pledge (White Ribbon Campaign, 2014). To date, the effectiveness of these campaigns has not been evaluated and the willingness of people in Scotland to intervene has not been assessed.

Would a campaign like *Ring the Bell* be successful in changing norms around violence against women and prevent further violence? Both violence and barriers to intervention are culturally bound. This study sought to identify barriers to intervening to stop intimate partner violence in Scotland. Using qualitative methods, researchers conducted focus groups comprised of people from communities with diverse socio-demographic profiles to identify the individual and contextual factors underpinning decisions whether to intervene. Because the focus groups were comprised of individuals who were similarly situated in terms of age, gender (except for the mixed gender group), and socioeconomic factors, we believe that participants were quite forthcoming. These data provide insights into the thought processes of the bystanders whom such interventions would seek to influence.

Methods

This paper is based upon qualitative findings from focus groups which were part of a larger mixed methods study. The study consisted of a paper-based survey followed by a deeper exploration of some of the issues raised using focus group sessions. The survey was distributed at various community-based groups of single-and mixed-sex adults by the researchers with a short, general introduction. Participants were provided with information sheets before and debriefing sheets after completing the surveys. Informed consent was obtained from all respondents prior to their participation. After collecting the surveys the researcher asked participants if they would be willing to participate in a short focus group. Participants who agreed to participate in the focus groups were provided with information sheets before and debriefing sheets after participating. Informed consent was obtained from all respondents prior to their participation and the sessions were audiotaped. The focus groups were conducted by the primary author and in three of the five groups a second researcher was present. The focus groups were conducted immediately after participants completed the surveys so that the vignettes contained in the surveys could be referenced in the discussions. Audiotapes from the focus groups were transcribed by a professional transcription service and transcripts were then reviewed by the primary author. In addition, audiotaped interviews were conducted with experts in law enforcement, intimate partner violence, and trauma medicine. These interviews were conducted by the first author and were transcribed by a professional transcription service and reviewed by the first author with the exception of the interview with Detective Chief Inspector Ruth Gilfillan and Detective Superintendent Louise Raphael, which was transcribed by the first author.

Focus groups

Using a semi-structured approach, the focus groups addressed six main issues concerning bystander intervention in the case of domestic abuse:

1. What role do you think members of the public have in relation to witnessing or overhearing violence? And in particular domestic violence?
2. Do you think that if you witness or overhear domestic abuse you should intervene? Followed by a further exploration of if yes, why and if no, why?
3. Would anything concern you about intervening in such a situation? What would you identify as the major risks and benefits?

4. How would you feel about intervening if the people involved were family members/close friends/ acquaintances/ complete strangers? Discuss your response in each case.
5. How would a ring the bell type intervention be received?
6. Would a media campaign make you more or less likely to intervene?

In addition, the focus groups discussed issues raised by participants and explored patterns of results that emerged from the surveys.

Expert Interviews

Expert interviews were conducted with members of Police Scotland including Sergeant Keith Jack of the Violence Reduction Unit, Detective Superintendent Louise Raphael and Detective Chief Inspector Ruth Gilfillan, both of whom are members of the National Rape Task Force. Lily Greenan and Nel Whiting of Scottish Women's Aid were interviewed to learn about formal and informal responses to intimate partner violence. Dr. Ian Holland, a trauma surgeon specializing in violence-related injury, was interviewed concerning the types of injuries and treatment protocols that are common in cases of interpersonal and intimate partner violence. Information obtained through expert interviews was used to inform the questions asked in the focus groups and to provide context.

Analysis

The first author conducted a thematic analysis of all focus group transcripts. The thematic analysis used an integrated approach that included both inductive development of codes and a deductive organizing framework that was based upon a review of the relevant literature. Surveys and focus group transcripts were reviewed on an ongoing basis during data collection to identify emergent themes and tailor subsequent focus group discussions as necessary. Specifically, the content analysis included identification of themes relating to willingness of people who live in Scotland to intervene when they overhear or witness interpersonal violence.

Results

Demographics

Five focus groups were conducted in Alloa, Glasgow, and Kilmarnock, Scotland, with an average of 6.2 participants per group. The groups included males aged 44 to 78, females aged 48 to 81, females aged 21 to 45, a mixed group of males and females aged 24 to 47, and males aged

19 to 20. With the exception of the mixed gender group which was comprised of professionals, all focus group participants were from deprived areas.

Themes

Focus group participants shared a general concern about violence in Scotland and in some cases within their own communities. Participants were aware of the scope of the intimate partner violence problem in an abstract way, but few participants indicated that they had experienced it or knew anyone who had. Five key themes emerged as common to participants' experiences and important to their decisions whether to intervene if they were to witness or overhear violence: 1) the distinction between public and private violence, 2) concern about unintended consequences of intervening, 3) collective efficacy, 4) perceptions of victim vulnerability, and 5) self-efficacy. Below is a description of these key themes with exemplary quotations from focus group participants to illustrate each theme.

The distinction between public and private violence. In Scotland, as in many other places, there are social norms that preserve the privacy of intimate relationships. In the focus groups, although most participants agreed that domestic violence was a problem, they were hesitant to get involved when violence occurred "behind closed doors." As a general rule, violence that was merely overheard did not warrant invasion of private space.

In contrast, some participants identified a countervailing social norm that required men to intervene when they *see* a woman being victimized. That is, one should not enter someone else's home even if someone might be getting hurt, but if a violent incident is taking place in public then there may be an obligation to defend the victim. A male participant from Alloa explained:

> *"I don't mind someone hitting a woman as long as I don't see it. If I see it I'll intervene right away. The guy will be getting it."*

The decision by a male perpetrator to engage in IPV in public seemed to make intervention by other men not only acceptable but expected. In fact, some male participants from deprived parts of Scotland believed that when a man hits a woman in public, that man challenges the masculinity of male bystanders. In their opinion, men who fail to intervene in such circumstances are emasculated in the eyes of other men.

It is significant that IPV is more likely to take place in private and thus bystanders who are not close friends or family members are more likely to overhear it than see it. Research has demonstrated that people are less likely to trust auditory cues than visual cues when they are

assessing how dangerous a situation is for a victim, and this ambiguity can lead to bystander apathy (Solomon, et al., 1978). In a classic study in which subjects either overheard or both overheard and witnessed what they believed to be an emergency situation, subjects in the audio-only condition were less likely to intervene (Solomon, et al., 1978). Researchers surmised that this was because subjects in the audio-only condition were less certain of the need for help and so were able to rationalize their decision not to provide help (Solomon, et al., 1978). Focus group data in the current study suggest that in Scotland this problem of interpretation is exacerbated by cultural norms that discourage people from getting involved where disputes take place in private settings. As previously noted, in Scotland, like many other places, the vast majority of intimate partner violence takes place "behind closed doors" and thus interventions to prevent or stop this violence would require bystanders to overcome at least two hurdles. First, bystanders must interpret somewhat ambiguous auditory cues to indicate a violent situation requiring intervention. Second, bystanders must overcome the cultural taboo against intervening in private spaces.

Moreover, although the social taboo against intervening in private altercations was consistent across groups, the groups identified different motives for remaining silent and uninvolved. For example, one group of women from a deprived part of Glasgow indicated that their reluctance to get involved stemmed primarily from a fear of reprisals rather than social norms around privacy. One woman provided an example of why this is such a potent concern:

> *"I've been in situations where I've actually saw a neighbour hitting a neighbour, their wife, and we've went out to try and help and what's happened is they've turned on our family. That can happen a lot. So they're back together again and lovey-dovey and hunky-dory but there's a fight between families. So it puts people off getting involved in things. It was outside, and it does, it puts people off."*

The private/public dichotomy took a different form for members of the mixed gender focus group, all of whom were either medical professionals or students training to become medical professionals. Members of this group distinguished between situations in which they were confronted with IPV in their capacity as professionals and IPV that they became aware of in their private lives. In the former situation there is an ethical obligation under NHS rules to report IPV, and in the latter there is not. In addition, participants noted the difference between being approached by a patient seeking help and approaching someone who may need help but has not chosen to identify him or herself this way. That is, it makes a difference whether the

victim has presented to them in a professional setting, and thus chosen to expose their abuse, as compared to violence that they might overhear in their private lives which would require them to enter into the private sphere of the victim without the victim's consent:

> *". . . . That's a very clinical thing in terms of it's within our environment, they're coming to us. Which is a very different scenario to you witnessing it at home. So we have overriding principles and we have an ethical guidance and all that from our working situation, that's very different from what happens at home."*

This distinction between public and private roles may expose a general desire not to become involved in interpersonal violence which is tempered by professional obligations. In fact, this is likely the reason for mandated reporting requirements – to overcome people's reluctance to get involved.

Police Scotland has addressed the issue of public versus private violence as a matter of policy and of practice. The notion that intervening to address violence perpetrated in private is inappropriate was once standard among police in Scotland. Detective Superintendent Louise Raphael, who heads the National Rape Task Force in Scotland, noted that police policy and practice has recently changed in this regard, and that women in Scotland are safer because of it (L. Raphael, personal communication, August 22, 2013). She believes that community norms around violence perpetrated in private are slowly changing but admits that "it's been a real uphill struggle" (L. Raphael, personal communication, August 22, 2013). When Sir Stephen House became the first Chief Constable of Police Scotland in 2012, he made eradication of violence against women a priority. Detective Chief Inspector Ruth Gilfillan summarized the progress made to this point and the challenges that lie ahead:

> *"I think we've got, I think what we've now got is we've got the public on board if you like. We've now actually managed to win them over in terms of the spirit of what we're trying to achieve in that domestic abuse should not be tolerated. But we maybe still need to do that extra wee bit of work in the back of that now to say here's what you can actually do. We'll help you out here. We expect you to do something but we'll help you out along the way."*

(R. Gilfillan, personal communication, August 22, 2013). Police Scotland understands that people will be willing to intervene to stop IPV when they can identify the problem, are trained in how to react, and feel supported by the police.

Concern about unintended consequences of intervening. We know from the literature that one of the main deterrents to action is fear that the bystander will get hurt (Piliavin & Piliavin,

1972). Consistent with this research, participants indicated that they were less likely to intervene if they believed they might get hurt. Several focus group participants indicated that they were concerned that if they intervened they might be drawn into the violence.[2] For example, one young man said that in deciding whether to intervene in a particular situation he would think about "self-preservation" and would weigh the potential risk to his health versus the risk to the victim. Interestingly, a police officer who sat in on one of the focus groups expected that people might not intervene for fear of getting involved with the criminal justice system, but participants clarified that they would be concerned about getting injured. A male participant in the Alloa group explained:

> *"It's not the system, it's what they can do to you. They can stab you or something like that because you're getting involved."*

For young Scottish males in deprived areas who are not involved in gangs, such as the young men in one of our focus groups, there is no backup should they intervene in a violent situation. These young men do not have the support of their communities, are not affiliated with gangs, and lack confidence that the police will come to their aid if their initial attempts to intervene are unsuccessful. In short, when these young men appraise a violent situation to determine whether intervening might cause them serious bodily harm, the decision not to intervene is often both rational and prudent. Unfortunately, this failure to intervene has repercussions not only for the victim(s) but for the bystander who has, by cultural standards, abdicated some degree of masculinity in failing to do so.

When members of the professional group were asked about domestic violence situations in which they could hear but not see what was happening, participants indicated that if they heard what sounded like serious violence taking place they would call the police rather than becoming personally involved. A male participant in the professional group explained:

> *"I think the other aspect to domestic violence is if you do become involved yourself, then by the nature of some of these interactions and dynamics you can then become the focus of the violence and the cause of the whole problem. Which, either perceived or in reality, I think that's something that would weigh on how I would intervene directly."*

[2] This emphasis on the safety of the intervener may have been due to the nature of the discussions, which asked participants to consider circumstances under which they might intervene, rather than focusing on the experience of the victims.

This is consistent with a rational fear for one's own safety, and in fact consistent with what the police prefer in such circumstances (L. Raphael, personal communication, August 22, 2013).

Participants' concerns about getting hurt were mostly focused on strangers who might have weapons and whose behaviour people believed to be less predictable and therefore more dangerous. Several of the female participants indicated that they would get involved if it was a neighbor or family member (someone they knew), but not if it was among people they didn't know well because then they were more likely to get hurt.

In addition, participants were concerned about fights escalating and broadening in scope. For example, a female participant from a deprived part of Glasgow explained that where she lives fights between children often escalate into fights between their mothers. She said that she had intervened in a situation like that before, but that such situations can be dangerous for the intervener. In fact, she noted that if she thought that her safety or her family's safety would be jeopardized by intervening she would "take a back seat" and not get involved. The same woman explained that fights sometimes escalate into family vendettas:

> *". . . . A fight might not finish there. It might go on to later on that night, the next night, there might be a family vendetta. So our ones are afraid now to get caught up in violence to cut it out, and I think that's why violence is escalating. That doesn't help."*

Participants distinguished between domestic abuse and what they considered to be extremely dangerous violent episodes. Several participants indicated that they would behave differently depending upon their assessment of how high they believed the risk to the victim to be. In highly dangerous situations participants indicated that they might be more likely to intervene directly. For example, a male participant from Alloa said that if a woman was getting hurt he would get involved regardless of whether the perpetrator was armed:

> *"If I seen it happening, it'd make no difference what they had in their hand. If they had a gun in their hand it'd make no difference, I just don't like seeing women getting battered, hate it, hate women getting hit."*

For many participants, where extreme violence was involved, intervening meant phoning the police rather than becoming directly involved. This is important because there was a general sense among participants in all groups that the police would both over-react and escalate the violence, and respond too slowly to prevent further harm to the victim.

Collective Efficacy. Participants were hesitant to get involved in violent episodes in part due to a general lack of collective efficacy. Collective efficacy is generally defined as willingness of individuals to work together toward a common goal, such as reduction of crime, in their neighborhood. The lack of collective efficacy in deprived areas of Scotland was closely related to changes in perceptions of policing of deprived areas. Participants indicated that they did not believe that if they became involved as bystanders they would have timely and effective police support.

All of the focus groups brought up the role of police in preventing and addressing violence. Older participants remembered a time when police actively patrolled their communities and believed that there was less violence during that time. Many participants indicated that today they lack confidence in the police. An older woman from a deprived part of Glasgow used to call the police, but doesn't anymore because she doesn't believe it will stop the violence:

> *"No, I used to call the police. But you could see the violence that plain. And you would call the police and the police would never come. And they would come half an hour later when the ambulance has already taken away the bodies."*

Participants were reluctant to call police because they anticipated an inadequate and ineffective police response and the serious negative social repercussions of calling the police. Specifically they believed that police would arrive too late or otherwise fail to prevent further harm to the victim(s). A young male focus group participant explained:

> *"A lot can happen in fifteen, twenty minutes depending on how bad the situation is. I don't think they're quick enough to respond."*

That is, not only might the victim be gravely injured by the time police arrived, but the intervener might be badly hurt as well. Lack of confidence in the police affected people's decisions whether to intervene to stop violence. Members of the professional group noted that because they did not view the police as reliable, they would be more hesitant to intervene directly in a violent situation. That is, they had no expectation that if they got involved, the police would provide backup that might buffer the danger to the bystander. A male member of the mixed gender professional group explained:

> *"My perceptions are, and it's not based on any experience, that I'm not sure the police would be there overly quickly, just with the pressures the police work under. So again, that would make you wonder whether you would actually take direct action yourself, if you thought police backup was going to be essential."*

These findings are important because young males who do not feel safe intervening in IPV might underestimate the willingness of other males to intervene and thus misperceive the social norms around this issue (Fabiano, et al., 2010). This is significant because the willingness to intervene is influenced by perception of social norms. When men accurately assess the beliefs and behaviors of their peers, they may be more likely to intervene to prevent violence against women or by challenging language and behavior that is inconsistent with those norms. But men may fail to intervene not because they condone violence against women but because they are legitimately concerned about their own safety. As violence has become pervasive in some areas of Scotland, young people feel helpless to stop it and this helplessness evolves into bystander apathy. Although older members of even the most deprived communities can recall a time when there was less violence, young Scots in some areas are growing up in a culture in which violence is endemic.

With respect to IPV, participants indicated that the police were unwilling to kick down doors and pursue the parties. In rare instances an inadequate response by police gave rise to community efficacy. For example, in one Glasgow community, the women remembered that years earlier there had been a heroin problem and a child had been killed. When the police were unable to expel the dealers, the mothers held a candlelight vigil that pushed the dealers out. This was a notable exception which may have been glorified over time.

In deprived communities, people believed that the housing association was more effective in controlling the community. Thus, in at least one focus group, participants noted that when people witnessed or overheard violence they were more likely to contact the housing association, which has authority to evict tenants for domestic violence or vandalism, than the police.

Participants in deprived areas believed that community policing ended when the level and frequency of serious violence perpetrated against police increased as a result of illicit drug activity. In fact, women from Glasgow noted that community policing is just too dangerous in certain areas. In reality, within each ward there are dedicated police officers whose names and contact information are available on the Police Scotland website. Nevertheless, the lack of a visible police presence is problematic in some areas in Scotland. A female participant who lives in an area in which police rarely come explained that police have lost authority:

> *"I've seen the police being beaten, and they've had their hats taken off, the kids all throwing their hats around and making a mockery of them. I've seen that a few times and I think that's why the police don't come in unless there's four vehicles with vans and*

> *things. But you don't get the beat, like you know when we were young the police would walk around, you don't get that any more."*

In addition, some participants noted that this lack of visible community policing was accompanied by extreme over-reaction when police are called, which has a chilling effect. When the police come, they typically arrive in multiple vehicles including canine units. If the violence has not already abated, the entry of police into the neighborhood with sirens blaring typically escalates the situation and creates a whole new set of issues for the people who called the police. A female focus group member explained how serious it was to be labeled a whistleblower (a "grass"): *"you would be less than a paedophile if you're a grass."*

It therefore appears that the success of bystander campaigns in deprived areas will depend largely on whether the community, perhaps with the support of the police, can develop a sense of collective efficacy and shared values around violence. One approach that is gaining support in Scotland is an assets based approach to community development which seeks to identify and build on strengths as compared to deficit models that seek to address weaknesses. The Glasgow Centre for Population Health (GCPH) explains:

> *"Asset based approaches recognise and build on a combination of the human, social and physical capital that exists within local communities. They acknowledge and build on what people value most and can help ensure that public services are provided where and how they are needed."*

(GCPH, 2012).

An excellent example of the successful use of an assets based approach to community development is the Hawkhill area in Alloa, Scotland where two of the focus groups in this study were conducted. Hawkhill was selected due to its challenges around poverty, education, health, and anti-social behavior (Jack, 2013). In the year prior to the focus groups, Sergeant Keith Jack of Police Scotland's Violence Reduction Unit was assigned to use an assets based approach to improve the cohesion and wellbeing of the community (Jack, 2013). The Hawkhill Community Centre, which had become a place of employment rather than a resource for the community, was the focal point of the intervention. Using a partnership approach in which community members have an equal voice in developing and implementing programs such as health screenings and mutual support groups, participation in community center activities has increased 300 to 400% in the first year (Jack, 2013). In addition, the community has seen a decrease in anti-social behavior and improved community safety (Jack, 2013). Sergeant Jack also reports that the community's

"general sense of well-being, feelings of connectedness and sense of control over their lives" have improved (Jack, 2013). One measure of this improvement is the decrease in calls to police about anti-social behavior such as vandalism (Jack, 2013).

Notwithstanding the recent progress the community had made toward decreasing street crime and violence, the men in the Alloa focus group were reluctant to call police when they became aware of a violent episode. In particular, the male focus group participants believed they had an obligation to intervene directly if they witnessed intimate partner violence. This view was not shared by the women we talked to. In fact, female focus group participants from Alloa thought that recent police involvement had decreased the incidence of IPV in the community. An older female participant explained:

> *"More folk are inclined to talk about it, inclined to talk to their family about it now. Where a lot of people hid indoors and hid it. But it's coming out more and more. The police are coming out, and I think if they see the police coming more and more they're thinking 'we better slow down here.'"*

She believed that the police were coming to address domestic violence more often because people in the community were more frequently calling them to report it. Multiple women in the Alloa focus group indicated that they had regained trust in the police and would not hesitate to call them if they "*thought somebody was getting really battered*." The female participants from Alloa were among the very small number of study participants who indicated that they would and had called the police when they witnessed violence.

Through his work with the Hawkhill Community Centre, Sergeant Jack has successfully cultivated social cohesion and improved collective efficacy. It is undoubtedly the hope of the VRU that community centers like Hawkhill will provide a template for the successful use of an assets based approach in other high violence areas in Scotland and in so doing improve collective efficacy and decrease violence.

Perception of victim vulnerability. Participants were generally more inclined to intervene where they believed the victim either 1) could not do or say anything to an adult that would warrant a violent response or 2) the victim could not protect him or herself from the perpetrator. In particular several participants indicated that they would be more likely to intervene where they believed that the victim was vulnerable, such as a child or an animal. A female participant in the professional focus group explained:

> *"Maybe because with an animal there's nothing really that the animal could have done. Say, somebody's having an argument person to person, there could be a logical explanation for that but there's no real logical explanation for somebody abusing an animal because it's not as if the animal could have argued back."*

Similarly, one of the male participants in that same group said that he would intervene on behalf of an adult female victim because he did not believe that women will generally protect themselves. Members of the professional group indicated that people might be less likely to intervene on behalf of an adult than on behalf of a child because an adult is presumed to be capable of self-help.

> *"I think the problem is the child can't report that violence themselves and they don't know who to go to but with domestic violence you can always think that woman can help herself if she wants. She could contact the police but she hasn't. I'm the one contacting the police, she obviously hasn't taken it upon herself. Obviously there are other reasons. But the child really wouldn't know how to do it but you'd like to think the woman would know how to do it but she hasn't."*

But some of the men from deprived areas saw women as categorically vulnerable and in need of protection. One participant explained that it's wrong for a man to hit a woman because, unlike another man, she is less likely to defend herself.

Participants indicated that they would be more likely to intervene if they believed the victim to be in grave danger and that under such circumstances intervention might mean calling the police. A female member of the professional group believed that where serious violence occurred in public, the police would be more likely to respond quickly and effectively:

> *"I suppose it obviously depends on the circumstance, if the severity of the situation's there. If it's a more severe situation then you have the expectation the police will be there. Whereas if it's just there's a disturbance upstairs and two people are shouting at each other then I wouldn't expect that there would be a fast response."*

People might be more likely to call police to intervene in highly violent episodes where intervening places the safety of the intervener in greater jeopardy. Views of participants differed in this regard.

Self- efficacy. Many of the participants noted that even if they witnessed violence that warranted intervention, they would not know what to do and thought that training would be helpful. Participants in the professional group, in particular, were concerned that they would not know

how to properly intervene in an intimate partner dispute and that they might inadvertently destroy evidence or otherwise do the wrong thing:

> *"I think it's the concept of evidence as well, by intervening yourself, you may be messing up what was evidence that could be collected by the police. We're certainly talking when, as clinicians, we suspect child abuse, there's definite routes you go down, definite questions you do and don't ask and at what times these things happen. And if you take that to an adult setting I suspect it'd be just the same. So having the correct people in place at the right time I think is the way to go."*

Similarly, several participants indicated that they would be more likely to intervene on behalf of an animal victim than a human victim because they would know what to do to help the animal. For example, a member of the professional group said that she knew who to call (Scottish Society for the Prevention of Cruelty to Animals or SSPCA) if an animal was being hurt and was confident that they would act in the animal's best interest. In contrast, where the victim is a woman, there is a greater risk of unintended consequences, which might include greater risk of subsequent violence to the victim or to the intervener.

One professional group participant contrasted intimate partner violence with child abuse. Whereas professionals are trained regarding how to intervene in cases of suspected child abuse, there is little training regarding how to respond where the victim is an adult. Members of the professional group indicated that understanding the process that is initiated when they report suspected child abuse made them feel more comfortable doing so. In particular they trusted the authorities to properly process the cases and to develop the information necessary to make decisions to protect the child if necessary.

> *"We all sit round the table and the message with child abuse is our job is we're not going to be the ones accusing, we're not going to be the ones pointing the finger but we're to report it. You have this confidence that if I report it it's going to a place, they're going to tie up all the loose threads, they're going to put the picture together. I just don't think you have that in the case of violence or domestic abuse. You don't know where am I going to put this that someone's going to care? It's not going to be the police, they're one bit. You know, the children at school or the teachers see mum coming in with a black eye, they know their bit. You don't feel there is one place where all of this information could come together and tie up."*

Several groups talked about how the decision about whether to intervene was instinctual rather than the result of a conscious thought process. They further suggested that with proper training people could be primed to know what to do and how to do it. A young male participant

from Kilmarnock felt it would be important to introduce these issues beginning when children are young in order to prepare them to take the appropriate actions as adults:

> *"It would have to be implemented really young. . . . Like implemented in schools, the actual thought pattern. Because even now I think I'm ingrained in doing things the way I would do them and to react like that, you'd have to change the way your mind processes things from a really early age so it's built in, ingrained, and they don't think of it as a reaction."*

In general participants thought that guidance about what to do under particular circumstances ought to come from the government. The idea of using a media campaign to raise awareness of the issue of domestic violence and under what circumstances one ought to intervene was well received by the groups.

> ***"****I think anything that raises awareness about anything is never going to be a bad thing. I don't think it matters where it is. I think raising awareness of an issue is never going to be the wrong way to tackle it. It might not fix it but people should be aware of it. I think maybe most of us are guilty if we walk around and think it's not something that we'll ever, you see the numbers, you know most people will know someone but you still never think that will be, you always think it'll be someone else. I think if it was constantly you were being aware of it you might be more vigilant and might change your actions."*

Discussion

Intimate partner violence is a serious and widespread public health problem that primarily affects women and girls, including those who live in Scotland. Bystander interventions offer an opportunity to disrupt violence as it occurs and to address the underlying social norms that condone violence against women. Such interventions thus potentially address both episodic abuse and coercive control of women. If, however, people don't have the self-efficacy or support to intervene to prevent violence, then the struggle to change norms that condone violence becomes more difficult. Bystander interventions offer a means by which to accomplish both, but only if the proper foundation exists. This paper suggests that in the most deprived and violent areas in Scotland it does not.

Using qualitative methods, this study obtained rich data that revealed the factors that were most salient to focus group participants in their decisions whether or not to intervene: 1) the distinction between public and private violence, 2) concern about unintended consequences, 3) collective efficacy, 4) perceptions of victim vulnerability, and 5) self-efficacy. When these themes were analyzed together, it became clear that two significant barriers to intervention must

be addressed prior to, or as part of, any successful bystander intervention in Scotland. First, pervasive violence and concomitant lack of collective efficacy in some communities make intervention unreasonably dangerous to bystanders, Second, the private setting in which most IPV is perpetrated makes it more difficult to identify and less conducive to intervention.

The first barrier applies primarily to deprived areas in Scotland where violence is endemic and residents lack community or police support to intervene. Community policing seeks to develop a trusting relationship between community members and the police. Where it is successful, police are able to intervene to prevent violence and community members trust that if they call the police there will be a rapid and effective response. Police Scotland is devoted in principle to community policing, but there appears to be a threshold of violence over which community policing is too high risk to be tenable. In deprived areas in which drug trafficking and drug addiction are highly prevalent, police are less visible and less aware of what is happening within the community. In fact, according to focus group participants, in high violence communities police participation appears to be limited to responding to violence after the fact. The assets based approach that is being implemented in Hawkhill provides a promising means by which to develop community cohesion and collective efficacy. In addition to decreasing crime and violence, the assets based approach introduces police as community partners and potentially improves community-police relations.

The second barrier to intervention is related to the circumstances under which IPV is generally perpetrated. Both episodic violence and coercive control are perpetrated for the most part in private. As noted earlier, in order for a bystander to intervene in a violent episode, the bystander must interpret the event as an emergency and recognize that someone needs help. Thus, if one overhears what sounds like a violent interaction, he or she must then determine whether or not there is an emergency and whether someone needs help. Where an event is ambiguous, there is a greater likelihood of bystander apathy because people are inclined to interpret events in ways that do not require intervention (Solomon, et al., 1978). This is important for two reasons. First, with respect to coercive control, even the victims might not be able to articulate what is happening to them and so the value of bystander interventions is in changes to social norms that condone violence. Second, with respect to episodic violence, bystander interventions may educate people to identify what they hear as a potentially dangerous abusive episode rather than merely a heated argument.

This study has a number of strengths. The qualitative approach used in this study provided a rich source of data from which to understand the potential barriers to intervening to stop IPV. Our purposeful sample included both men and women from a variety of socio-economic and geographic locations within Scotland. But, in spite of these strengths, our findings should be interpreted in light of several limitations. First, the sample size was relatively small. Second, the sample did not reflect all potential populations of interveners such as people with high socioeconomic status or people who live in rural areas.

What are the implications of our findings for future interventions to prevent IPV in Scotland? First, there is reason for hope because both the police and the public are motivated to change attitudes and behaviors around intimate partner violence. Focus group participants recognized that violence was a problem in their communities and were eager to receive training in how and when to intervene safely. Future research should focus on how to reintegrate police into communities with high levels of crime and violence in a visible way using Sergeant Jack's work at the Hawkhill Community Centre in Alloa as an exemplar. In addition, research ought to focus on overcoming the cultural barrier against intervening when violence takes place in private. In addition, a government approved protocol for how IPV should be addressed through both formal and informal means ought to be created and disseminated to the public.

Intimate partner violence continues to threaten the health and wellbeing of women in Scotland in part due to bystander apathy, in part due to cultural norms that condone such violence, and in part because people simply do not know how to or do not have sufficient support to safely intervene. If practical and cultural barriers are effectively addressed, bystander interventions can be effective in the struggle to eradicate violence against women by providing bystanders with the means to stop violence as it happens and by addressing the social norms that condone intimate partner violence in any form.

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