

Intimate Partner Violence and Men's Health

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The effects of violence on health range from subtle clinical morbidities to overt injury and death. Globally, violence results in 1.6 million deaths annually; violence-related deaths result from suicides, homicides, and armed conflicts. Men are much more likely to be victims and perpetrators of lethal violence than are women. Men are disproportionately victims of violence-related deaths: homicide rates of men are more than three times higher than for women, and rates of suicide for men are nearly twice as high as for women [1]. Men commit the overwhelming majority of homicides in the United States. Violence-related death rates vary with age and method: the burden of homicide deaths cluster in young-adult age groups and suicide rates increase with age.

Ongoing patterns of violence that result in negative health-related outcomes include interpersonal violence and, as a subset, domestic violence. The Family Violence Prevention Fund defines domestic violence as a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation, and threats [2]. Domestic violence encompasses elder abuse, child-maltreatment, and intimate partner violence (IPV). IPV behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent. IPV behaviors are aimed at establishing control by one partner over the other. This article will focus on the health effects and a primary care response to men affected by IPV.

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Why men are thought of as the perpetrators

Annually, approximately 1.5 million women and 834,700 men are raped or physically assaulted in other ways by an intimate partner in the United States [3]. The National Crime Victimization Survey estimates that 3% of IPV incidents result in serious physical injury [4]. In a landmark survey of family violence, Straus and Gelles [5,6] estimated that 16% of couples reported episodes of IPV in the past 12 months and 40% of these episodes involved actions such as punching, kicking, or use of a weapon.

National surveys, such as the National Family Violence Survey and surveys by the Centers for Disease Control and Prevention suggest that men and women report similar rates of IPV or emotional abuse [7,8]. However, national data support the position that most violence that results in injury, involves male violence against women, and that male-to-female violence tends to be chronic [9,10]. The National Violence Against Women Survey and the National Crime Victimization Survey found that women were more likely than men to report being IPV victims and were twice as likely to be injured in domestic violence incidents [11,12]. In 95% of IPV episodes that led to criminal investigation, and 59% of spouse murders, women were the victims [13,14].

It is clinically challenging to separate IPV victimization from perpetration. The medical model of IPV has historically been limited to male perpetration of IPV against female victims in heterosexual relationships. The current model is rooted in the pro-feminist movement that arose in the 1970s and served as the foundation of much of the work that addressed IPV in the United States. Overwhelmed health care providers who are faced with increased demands and an institutional reluctance to address issues shaped by social determinants, have the perception that addressing IPV is akin to opening Pandora's Box. Ultimately, a one-dimensional approach is a disservice to the complexity of the manifestation of IPV. Men can be victims or perpetrators of IPV in heterosexual, homosexual, or bisexual relationships. A dramatic association with childhood victimization and increased rates for both perpetration and victimization of IPV has been shown repeatedly in the literature [15–17]. Controversial typologies of IPV include descriptions of “mutually aggressive” relationships in which both intimate partners perpetrate and are victimized by their behaviors and the behaviors of their partners. The complexity of describing the manifestations of IPV necessitates that providers conceptualize IPV as an interdigitation of victimization and perpetration, the distinction between which is often unclear.

Characteristics of victims and perpetrators

It remains unclear how men who perpetrate may typically present to clinical providers. IPV is said to cross all ethnic and socioeconomic classes. However, rates of IPV tend to be higher in younger age groups, minority ethnic groups, and lower socioeconomic classes [15,16,18]. Some men may

have no apparent signs of IPV-related health consequences; others may be more obvious. Perpetrators may be more difficult to identify in clinical settings because they may appear normal and healthy in contrast to their partners who have been devastated by their victimization. Some common themes in proposed profiles emerge when perpetrators in treatment are described as inexpressive, impulse-driven, traditional, and rigid with low self-esteem and frequent drug and alcohol problems [19]. Other experts have suggested some of the following characteristics may be red-flags for perpetration: public fronts, controlling behaviors, excuses, bargaining, manipulation, and external locus of control [20]. Because no single typology has successfully predicted who may be perpetrators, identification of IPV perpetration will require a better understanding of how perpetration behaviors affect men's health and how best to reach men regarding IPV issues.

Why perpetrators perpetrate

There are many theories that have tried to explain perpetration of IPV [21–26]. No one theory can explain why every perpetrator becomes abusive. From a health care perspective, two concepts are important when trying to understand perpetration of IPV. The first is the concept of a cycle of violence. Children who grow up in families where IPV was present are more likely to become involved in relationships that are affected by IPV. Coker and colleagues [27] found that men were 2.5 times more likely to report exposure to IPV as adults if they had reported being physically assaulted as a child. Childhood exposure to violence is associated with increased risk for future IPV victimization and perpetration [6]. Providers need to be sensitive to the likelihood that men who are identified in clinical practice as IPV victims or perpetrators will have been exposed to IPV in the past.

A second important perspective explaining IPV victimization and perpetration comes from feminist theory. Feminist theory explains that transmission of IPV is maintained by a normative patriarchal social structure, based on gender-related power differentials [21,25,26]. It is important for providers to understand the social constructs of behaviors when they identify controlling behaviors that may be rationalized by patients in terms of strong gender roles. Addressing normative perspectives plays a key role in the treatment of IPV perpetration. Curricular content on men's beliefs about power and control over women is a critical component of perpetrator treatment programs. Programs that include this content are usually contrasted with anger management programs, which focus primarily on behaviors and do not address underlying causes.

Use of health care services

Although few health care providers screen for the IPV, 15% of women who visited an emergency department, and 12%–23% of women in family

medicine settings reported having been physically abused or threatened by their partner within the last year [28–30]. Oriel and Fleming [15] reported that 13.5% of male primary care patients in family medicine settings reported perpetrating minor violence (throwing, pushing, or slapping) over the past 12 months; 4.2% reported at least one episode of perpetrating severe violence (kicking, beating, threatening to use or using a knife or gun). Two studies reported 42%–63% of perpetrators had sought care in a health care setting within the previous 6 months of the study [9,31]. Coben and Friedman [31] determined that a large proportion of male perpetrators had been seen by health care professionals close to the time they were arrested; 42% of men in treatment for IPV perpetration had sought medical care within the past 6 months. Reasons for seeking health care included issues related to injury (36%), medical illness (30%), and “check-ups” (21%).

Health effects

IPV impacts the health of victims and perpetrators, although less is known about the effects on perpetrators. Most research has focused on the health effects of IPV victimization on women, but it is reasonable to consider that a parallel process occurs in men who are IPV victims. IPV victimization impacts the physical, mental, emotional, social, and financial dimensions of health. The burden of physical injuries includes contusions, lacerations, broken bones, and death. The psychological consequences of abuse can be as important as physical injuries: victims suffer from posttraumatic stress disorder, and abuse victims are more likely than non-abused persons to be depressed, attempt suicide, abuse alcohol or drugs, and transfer their aggression to their children [32].

In a population-based study, Coker and colleagues [27] determined that men who reported being victims of physical abuse, reported increased risk of current poor health, depressive symptoms, substance use, a chronic disease, chronic mental illness, and injury. Men were 1.8 to 2.6 more likely to report current poor health if they identified low to high levels of exposure to psychological abuse. Moderate physical or sexual IPV was associated with a twofold increase in the development of a chronic disease, and high levels of physical, sexual, or psychological IPV was associated with a twofold increase in rates of current depressive symptoms.

A complete model of IPV effects on the health of a man should include the effects of IPV on his family unit. Those most likely affected are his intimate partner and his children, who may also be our patients in primary care settings. Children exposed to IPV demonstrate higher levels of distress than non-exposed children [33–35]. Children who witness IPV are more likely to exhibit behavioral problems such as violence toward peers and abuse of drugs and alcohol. Running away from home, engaging in teenage prostitution, and committing sexual assault crimes, in addition to physical and mental health problems including depression and anxiety, are also more likely in children

who witness IPV [36,37]. Internalization of distress has been shown to result in increased rates of childhood depression and anxiety where externalization manifests as delinquency and aggression [38–41]. Rates of child abuse are extremely high in families affected by IPV, where in 30% to 60% of families affected by IPV, children are also directly abused [6,42,43].

Few studies have examined the health effects of men who perpetrate IPV, and the clarity of cause and effect remain ill defined. An association with increased rates of head injuries is one of the few medical conditions that has repeatedly been related to IPV perpetration [16,18]. More controversy surrounds the role of drug and alcohol use in risk for IPV perpetration. Higher rates of drug use and alcohol consumption have been well described in perpetration literature [9,15,18,31,44]. However, experts disagree about whether drug use or alcohol consumption directly increases the risk of perpetration behaviors or whether alcohol use is a means of self-medication in response to undesired feelings of shame, guilt, and anxiety by IPV perpetrators [45].

Men who are IPV perpetrators can present in health care settings with IPV-specific injuries or associated co-morbidities. Gerlock [9] reported that men in treatment for IPV perpetration used health care systems for the following symptoms: musculoskeletal (50%), cardiovascular (14%), gastrointestinal (13%), nervous system (10%), dermatological (10%), and pulmonary (8%) issues. Perpetrators attributed their medical problems, in part, to their perpetration behaviors and nearly a quarter of their injuries (lacerations, bruises, and broken bones) were reported to have resulted from IPV. In addition, perpetrators have higher rates of psychiatric problems, including: depression, anxiety, post-traumatic stress disorder, and personality disorders. Close to one-third of perpetrators analyzed believed that their symptoms of depression and anxiety resulted from their perpetration behaviors.

Outreach behaviors

Help-seeking behaviors of perpetrators include self-identification and self-referral to health care or other professional service providers. In addition, perpetrators may seek advice and support from family and friends. A study of IPV help-seeking strategies in a Milwaukee community sample of self-identified IPV victims and their partners [28] determined that informal help-sources for victims included family members, in-laws, neighbors, and friends; formal help-sources for victims included the police, social service agencies, lawyers and district attorneys, the clergy, and women's groups. A striking finding of this study was that the more contact the perpetrator had with their friends, the less likely they were to make an effort to end the violence in the relationship. This finding suggested the existence of a "peer subculture" that normatively supports IPV. Bowker [28] reports that 69% of female IPV victims reported that their husbands made at least

one contact with a formal or informal help-source in an attempt to end the abuse.

Professional service outreach behaviors include identification by screening men for perpetration of IPV in asymptomatic populations as well as secondary responses to signs concerning perpetration of IPV. Outreach behaviors may also include support, counseling, referral to community agencies or mental health providers, and treatment of co-morbidities. Little is known about outreach behaviors of primary care providers concerning perpetration of IPV and even less about how they might relate to the help-seeking behaviors of perpetrators.

How to identify victimization and perpetration in men

Sugg and coworkers [46] conducted one of the few studies that included issues related to identifying perpetration in the primary care setting. She found that 10% of primary care providers reported that they never identified an IPV victim and 55% reported that they never identified an IPV perpetrator. She was also able to demonstrate discordance between reported IPV prevalence rates and provider's perceptions of IPV prevalence in their practices. Most primary care providers reported that IPV was rare or very rare (1% and 0.1%) at their site. Reported rates of IPV prevalence increased when providers were asked about their health care system in general. This finding supports providers' often cited misperception that IPV is not an issue in their practice.

Identifying IPV in male patients is a burgeoning area of clinical research. As suggested earlier, a significant proportion of patients presenting in primary care settings report IPV victimization and perpetration within the past 12 months. Clinical protocols originally used for identification of female victimization have been adapted for clinical identification of male victimization and perpetration. In clinical settings, multiple short screening instruments have been shown to be valid identifiers of domestic violence, but most simply ask patients if they feel safe in their relationships and if anyone is abusing them physically, sexually, or emotionally. RADAR stands for Routine inquiry, Ask direct questions, Document findings, Assess patient safety and lethality, and Respond, Review options and Refer, and was created by the Massachusetts Medical Society and further developed into a training program by the Institute for Safe Families of Philadelphia. RADAR has been used effectively to provide clinicians with a useful approach for the identification and treatment of male victims and perpetrators of IPV [47].

Guidelines developed to address IPV when both partners are patients in the same primary care setting concluded that it was not a conflict of interest to address IPV with both partners, but that this should be done independently with the safety of the victim at the forefront [48]. When concerned about perpetration, it may be best to approach the victimized partner first

to get permission to approach this subject with the perpetrating partner in addition to discussing safety issues with the victimized partner. Each provider has their own personal style when asking about sensitive issues and the exact wording is not as important as the fact that pertinent questions are asked. Providers may also want to notify the patient of exceptions to confidentiality. Specifically, if children are being harmed, the appropriate authority will need to be notified, and if there is an imminent risk to the patient or someone else, the police may need to be involved.

An effective practice is to combine funneling techniques with direct questions, without being judgmental. Funneling techniques involve starting with more general and less sensitive questions or statements that guide the discussion toward more sensitive issues. For example, “All people argue. How do you and your partner handle disagreements or fights?” “Do your disagreements or fights ever become physical?” “Are you in a relationship in which you are being hurt or threatened?” “Have you ever used any kind of physical force against your partner?” “Has your partner ever pushed, grabbed, slapped, choked, or hit you?” “Have you ever done that to her/him?” “Has your partner ever forced you to have sex or perform sexual acts which you did not want to do?” “Have you done that to her/him?”

When men say yes to intimate partner violence

When a provider has identified behaviors suggestive of IPV, it is important to document what was asked and the patient’s response. Quotation marks should be used to document exact words and notes about observed injuries, if any, should be made. The provider should make an assessment of the potential for future violence including threats made. Describe safety and follow-up plans including the next scheduled appointment. A safety and lethality assessment involves determining the risk to the patient and their contacts after leaving the clinical encounter. Increases in the frequency or severity of violence, stalking behaviors, weapon use and accessibility, prior contact with the police or a Protection From Abuse Order, substance abuse, depression, or mental illness exacerbating behavior have all been associated with higher risk for homicide in relationships affected by IPV [49,50]. Finally, it is important to document that the provider asked about the safety of children in the home.

When a provider encounters an IPV victim, he should be encouraged to talk about it. The provider should validate his experience, emphasize the risk of violence to him and his families’ health and well-being, acknowledge that change is a process, and follow the situation over time. If the patient does not need immediate assistance, he should be offered information about resources in the community.

A health care provider who encounters IPV perpetration should positively reinforce the patient’s willingness to communicate the situation, and reframe the issue as a health issue. It is important to not condone the behavior and

to educate the patient about the consequences of his abusive behavior. A provider can offer hope that the patient can change his behavior and offer appropriate referrals, recognize that change is a process, and follow the pattern of behavior over time. Finally, the provider should make referrals and schedule a follow-up appointment.

Treatment of perpetration

Most IPV experts who have worked with men who are abusive would strongly support referral to a community-based batterer intervention program (BIP). BIP standards vary from state to state, but a few themes are common. Programs should: last for 6–12 months; monitor and confront abusive behaviors; screen for substance and mental health issues and offer referrals; identify the range of behaviors common to most batterers; teach avoidance techniques and responsibility plans; use content on men's belief about power and control over women; employ staff trained to work with women battering issues; develop linkages with domestic violence agencies and strong coordination with the criminal justice system [51].

Whether BIPs are effective is frequently debated. Recent studies have reviewed the literature on screening for IPV [31,44]. There has been a dearth of sound evidence to support any medical intervention to reduce IPV. IPV has not been addressed adequately by researchers using rigorous methodological approaches. Recent meta-analyses, and a study using propensity scores to address some of the methodological challenges, have suggested that BIPs can be effective in reducing IPV recidivism [52,53].

Ferris and colleagues [54] studied scenarios where both the man and the woman were the provider's patients, and demonstrated that the provider's relationship with a male partner was a stronger predictor of provider action than clinical signs of abuse in the female partner. If the provider identified the provider-perpetrator relationship as "good," providers were more likely to make a risky recommendation, such as discussing the issue with the couple or referring patients for couples counseling; both of which may put the victim at increased risk for abuse.

Although a minority of providers sampled believed they had strategies for helping IPV victims, 64% thought they had strategies that could help perpetrators. Just over one-third of providers were confident about how to refer domestic violence victims and even less (22%) were confident about how to refer perpetrators [15]. For effective referral, it is important for providers to be aware of community resources that address IPV with men. Physicians who view perpetration as a disease may be more likely to refer to psychotherapy or counseling rather than a batterer intervention program [55]. Mental health disorders and substance abuse are more common in samples of perpetrators when compared with non-perpetrators; however, most are without a diagnosis. Couples counseling is generally contraindicated in relationships affected by IPV [10,19,51]. A major concern is that couples

counseling is often an attempt to work out the couple's problems within the context of the relationship and does not address the issues of power and control that led to the abuse. It is important not to endorse processes that blame the victim. Most experts would strongly recommend avoidance of couples counseling until there has been a sustained violence-free period of 6–9 months.

Summary

There is little evidence to guide providers in what to do regarding men and IPV. It is important to appreciate that there may never be a time when the evidence supporting routine identification of IPV will reach the level of evidence for guidelines addressing colon cancer screening or use of aspirin in the prevention of cardiovascular morbidity and mortality. IPV is a highly complex issue that historically has been a moving target with high social domains. However, a plausible argument can be made for endorsing the role of primary care providers in the identification and referral of men for IPV-related issues. When a provider identifies and refers men for IPV-related issues, there is the potential to increase the safety of men's intimate partners and children, to interrupt the cycle of violence that perpetuates the transgenerational diffusion of abusive behaviors, and to reduce the associated negative social and health effects that IPV has on men's lives. Given the high prevalence of IPV among patients in primary care offices and the development of effective treatments for men who are perpetrators of IPV, it is reasonable for primary care providers to begin to ask questions of their male patients regarding IPV that can lead to the prevention of and early intervention for perpetration of IPV.

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