REVIEWS

Addressing Intimate Partner Violence with Male Patients: A Review and Introduction of Pilot Guidelines

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Intimate partner violence (IPV) is a common and devastating problem affecting the health of women, men, and children. Most health-care research focuses on the effects of IPV on women and children and addressing IPV with women in the health-care setting. Less is known about addressing IPV with men in the health-care setting. This article reviews the challenges in interpreting research on IPV in men, its prevalence and health effects in men, and the arguments for addressing IPV with men in the health-care setting. It introduces pilot guidelines that are based on the existing literature and expert opinion.

KEY WORDS: intimate partner violence; domestic violence; victimization; perpetration; battering; men.
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INTRODUCTION

Intimate partner violence is a devastating epidemic with adverse effects on women, children, and men. The human cost of intimate partner violence (IPV) is staggering. Each year 1.5 million women and 834,732 men are raped and/or physically assaulted by an intimate partner in the US.[1] Millions of children are exposed to adult IPV, resulting in lasting psychological and physical damage.[2–7] The CDC estimates that IPV results in nearly 2 million injuries and 1,300 deaths nationwide every year.[8] Economic costs related to IPV are calculated to exceed 8.3 billion dollars annually.[9] Advocates, activists, community leaders, and public health officials have highlighted the preventable nature of this epidemic, set goals for the reduction of IPV, and called on the medical community and others to contribute to ending IPV.[10–19]

Much of the health-care literature on IPV focuses on women IPV victims, including expert advice and national guidelines on addressing IPV victimization in women in the health-care setting.[20–25] Health-care research on IPV and men, though, is quite limited. There are few studies that explore its prevalence in the health-care setting,[26–30] the accuracy and efficacy of medical screening,[29,31,32] the ability of interview procedures to distinguish victimization from perpetration,[32,33] and the efficacy of a health-care responses to men, including of batterer's treatment programs.[34,35] Although published expert experience exists,[33,36–39,40–42] there are no comprehensive health-care guidelines on addressing IPV specifically with men. This article will define IPV in men, review dilemmas regarding determining its prevalence and significance, describe its health effects, provide a rationale for addressing IPV with men, and discuss screening challenges. New "pilot" guidelines for addressing IPV victimization and perpetration with men in the health-care setting developed by the Family Violence Prevention Fund (FVPF) are introduced.

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DEFINITIONS

Tables 1 and 2

Dilemmas in Interpreting IPV Research

Making firm assertions about IPV in men is difficult given the limited, sometimes conflicting research results. Interpretation of research findings is complicated by inherent challenges in the study of a complex behavioral issue including: the inconsistent use of terminology, the "measurement" of behaviors and relationship dynamics, the effects of choice of study population, and the context given for survey questions. Despite suggested standard definitions [43], terminology in IPV research is inconsistent. Often "IPV" refers only to victimization rather than distinguishing between victimization and perpetration. "IPV" may be used to signify individual physical, sexual, or emotional acts of violence regardless of context and, alternatively, to refer to a "power and control" dynamic associated with one's primary role in a violent relationship. Comprehensive measurements of IPV prevalence necessarily involve self-report or partner report of experiences that are associated with shame, guilt, social stigma, painful emotions, and many adverse consequences that may affect self-report.[44,45] The significance of any behavior also depends upon its context. For example, a shove that initiates a sexual assault carries an entirely different meaning than a shove used to defend oneself from a sexual assault. Within the context of a violent and controlling relationship even a stern look may signify grave danger to the victimized partner. A behavior that is considered highly insulting in one culture may not hold the same significance in a different culture.[46–48] Thus, similar individual acts may have radically different significance, and how these acts are interpreted can lead to conflicting research results.

Table 1. Definitions

Intimate Partner Violence: Definitions
Intimate Partner Violence (IPV):
Intimate partner violence is 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. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at maintaining or establishing control by one partner over the other.[78]
Legal definitions of IPV reference state or federal laws and generally refer specifically to threats or acts of physical or sexual violence, including forced rape, stalking, harassment, certain types of psychological abuse, and other crimes where civil or criminal justice remedies apply. Laws vary from state to state.[78]
An IPV victim:
Is a person who is being physically, sexually, or psychologically harmed by another person repeatedly. The victim does not hold the bulk of the power or control in an intimate relationship. Power and control refers to physical, sexual, psychological, economic, and social power and control.
An IPV perpetrator:
Is a person who physically, sexually, or psychologically harms another person repeatedly. The perpetrator holds the bulk of the power or control in an intimate relationship. Power and control refers to physical, sexual, psychological, economic, and social power and control.

Conflicting research findings may also arise from comparing different populations of couples and posing survey questions in different contexts. "Family conflict" research has found a high degree of mutual or "bi-directional" violence perpetrated by women and men in heterosexual relationships.[49,50] Other literature has found much higher levels of violence and injurious violence of male perpetrators against female victims than that of female perpetrators against male victims.[1,27,51] Most studies find that in heterosexual relationships women are more likely to be seriously injured by a male partner when physical acts of violence exist in the relationship.[52–54] Researchers reconciling these findings theorize that survey tools that do not include context, measures of power and control, or injuries underestimate the prevalence and effects of male violence toward their female partners and that different populations of couples, from those with less harmful "situational" or "bidirectional" violence to those experiencing "intimate terrorism," have been studied.[55–58] The clinical interview provides an opportunity for gathering qualitative, contextual history and observing the health effects of relationship dynamics.

Prevalence Estimates of IPV Victimization in Men

In the "National Violence Against Women Study" (NVAWS), a national random-digit-dial telephone survey of 8,005 women and 8,001 men in the United States, 24.8% of women and 7.6% of men reported having been physically and/or sexually abused by an intimate partner at some point in their adult lives. This extrapolates to a yearly prevalence of 1.5 million women and 834,700 men raped or physically assaulted by an intimate partner.[1]

Men with a history of same-sex cohabitation were at higher risk of IPV victimization. Of same-sex cohabitants, 23.1% were raped and/or physically assaulted by a spouse or cohabiting partner (15.4% of these assaults were by a same-sex male partner and 10.8% of these assaults were by an opposite-sex

Table 2. Summary of Pilot Guidelines (on next pages)

Screening:
1. Establish privacy (screen patient alone)*
2. Use staff or professional translation for translation (not family or friends)
3. Ask direct questions:
   - •Has your partner ever hit you, hurt you, or threatened you?
   - •Have you ever hit, hurt, or threatened your partner?
   - •Have you and your partner ever had physical fights?
   - •Has your partner ever forced you to have sex when you didn't want to?
   - •Have you ever forced your partner to have sex when she/he didn't want to?
4. Ask indirect questions:
   - •How does your partner treat you?
   - •How do you treat your partner?
5. Also ask about past history of IPV:
   - •Have you ever had a partner who hit you, hurt you, or threatened you?
   - •Have you ever hit, hurt, or threatened your partner?
   - •Did you ever have a relationship in which you had physical fights?

Assessment of current IPV:

Assess for role in IPV: Ask questions to determine who holds the power and control in the relationship (or refer patient to a provider/advocate who can assess for patient's role in IPV)

Assess current safety immediately:
1. Assess for safety in clinic (are partner and children in clinic with the patient?)
2. Assess for current safety
   - •Threats of homicide by patient or partner
   - •Weapons involved in threats or fights
   - •History of strangulation or stalking
3. Assess for suicidality and homicidality in patient
4. Assess for safety of children

Assess current IPV over time:
5. Assess for pattern of abuse
6. Assess history of effects of abuse (Have there been injuries or hospitalization? Are there physical or psychological health effects, economic, social, or other effects?)
7. Assess for readiness for change
8. Assess for capacity to change (victim—level of support, autonomy, and coping strategies. Perpetrator—level of denial, motivating factors, societal sanctions against his violence)

Assessment of past IPV:
1. Assess for current safety ["Are you (and children involved) safe from this person now?"]
2. Assess history of effects of past IPV on health, economics, and social situation.

Intervention:
1. Give repeated important messages:
   Victim: Messages of support (violence is not his fault)
   Perpetrator: Messages of accountability (violence is his responsibility, is harmful, and he needs to stop it)
   Indeterminate role: Messages that IPV is harmful and dangerous to couple and children
2. Offer crisis phone numbers
3. Do safety planning (or connect patient with a person who can)
   Victim: Assist in making a safety plan for patient and children
   Perpetrator: Develop plan to stop violence. If imminent danger of homicide or severe injury to victim(s), commit patient to psychiatric hold and notify police and victim(s)
   Indeterminate: Develop plan to avoid violence and enhance safety of patient, partner, and children
4. Offer advocacy and counseling—batterer's treatment for perpetrator
5. Offer police and legal assistance
6. Arrange for follow-up visits and a safe way to contact patient

Documentation:
1. History:
   - •Write legibly
   - •Use patient's own words in quotes
   - •Document as much information as patient will provide regarding specific events (who, what, where, when)
2. Physical findings:
   - •Describe injuries in detail

(*continued on next page*)

Table 2. (continued)

- •Draw diagrams of injuries
- •If patient consents, take photographs of injuries
- •Take serial photographs of injuries over time

3. Clinical impression:
   - •Provide a clinical impression of the patient's role in the IPV (victim, perpetrator, or indeterminate) to guide the treatment plan
   - •Document the treatment plan
   - •Document any reports made to law enforcement in a manner consistent with state law
4. Physical evidence:
   - •If patient consents, preserve physical evidence in paper bag
   - •Describe physical evidence in detail

Reporting:

1. IPV reporting: Follow the laws of your state in reporting IPV or IPV injuries to the appropriate law enforcement and/or social service agencies
2. Duty to warn: Follow the laws of your state and the ethics guidelines of your profession in warning victim(s) of impending severe harm, committing perpetrator to psychiatric hold, and notifying law enforcement of impending severe harm to a victim
3. Child abuse reporting: If you suspect children are being neglected or harmed, file a CPS report. (Advocate on behalf of adult victim/survivor's safety with CPS)
4. Elder abuse reporting: If patient is ≥65 or a dependent adult, follow the laws in your state in reporting elder abuse

**If caring for a couple and the victimized partner tells you that screening her/his partner for IPV would increase danger of victim and/or children, do NOT proceed with screening. Family Violence Prevention Fund (http://endabuse.org) December 2007*

female partner), and 7.7% of the opposite-sex cohabitants were physically assaulted by a female intimate partner.[59]

In the health-care setting, there are a few estimates of IPV victimization in men. Recent studies in emergency departments have found a prevalence of IPV victimization of men from 6%-20% for current physical IPV[26–28,60] and 11%-32% for current non-physical IPV.[27,28] In a retrospective case-control ED study of men who were given ICD-9 assault code diagnoses and reported being assaulted by a female partner, 51% of the males who reported being assaulted by their partner had also been arrested for IPV in the past.[32]

Prevalence Estimates of IPV Perpetration in Men

There are few prevalence estimates of male IPV perpetration done in the health-care setting. In an anonymous written survey addressing IPV perpetration by male patients in a health-care clinic, 13.5% of the respondents reported perpetration of minor violence in past year, and 4.2% reported using severe violence against their partner in past year.[29] In an ED study asking about perpetration of violence against "someone close to you" using a computer touch screen tool, 14% of men reported having ever "physically hurt someone close to you" and 9% of men reported being "worried that you might physically hurt someone close to you."[27] A study examining IPV and sexual risk behaviors in young men found that 27.6% of the men reported physical IPV perpetration, 28.3% reported sexual IPV perpetration, and 13.8% reported IPV perpetration that resulted in injury or the need for medical services in the past year.[61] Descriptive studies of health-care use by male perpetrators have found that between 42% and 63% of the participants have seen a health-care provider in the past 6 months.[62]

Health Effects Associated with IPV Victimization of Men

There are scant studies on health problems associated with IPV victimization in men. A recent study on deaths from violence in North Carolina and the different epidemiologic patterns of death for males and females revealed that approximated 13% of all male homicides involved IPV in some way and that 4% of men killed were directly killed by an intimate partner.[63,64] Men also sustain injuries inflicted by their intimate partners, but these injury patterns have not been well studied.[65]

Coker et al. re-examined the NVAWS data to determine the physical and mental health effects of both physical and psychological IPV victimization on men and women. Both physical and the power and control forms of psychological abuse were associated with overall current self report of "poor" health in men. All IPV victimization was associated with depressive symptoms, heavy alcohol use, "therapeutic" drug use, recreational drug use, and a history of being injured in men. Physical IPV victimization was associated with developing an injury and a chronic disease in men. Psychological power and control abuse in men was associated with developing a chronic mental illness.[66] There has been little study of the health effects of IPV victimization in gay men. Studies report on HIV seroconversion resulting from IPV victimization,[67] review the scant data pertinent to HIV and IPV victimization in gay men,[68] and demonstrate an association between IPV victimization and increased physical and mental health problems in gay and bisexual men.[69]

Health Effects Associated with IPV Perpetration by Men

Descriptive studies of the health of male IPV perpetrators show high rates of: injuries related to IPV, psychiatric and substance use diagnoses, and sexually risky behavior. In a study of men in a batterer's treatment program in the VA, 23% of the perpetrators reported having injured themselves and having received health care for injuries related to their IPV perpetrator conduct. Fifty-five percent of these men had a psychiatric diagnosis and 45% had a substance abuse diagnosis.[70] IPV perpetrating men in a methadone clinic had an increased number of partners, rates of anal intercourse, and higher risk of having a partner with IV drug use history compared to non-perpetrators.[71] Male IPV perpetrators in an urban health center were less likely to use condoms during vaginal and anal sexual intercourse and more likely to have forced sexual intercourse without a condom and more female partners than non-perpetrators.[61]

Controversy over IPV "Screening" and Rationale for Addressing IPV with Men

Many of the arguments about screening and addressing IPV in women can be applied to men. Due to the high prevalence of IPV, the adverse health consequences and suffering of adult IPV victims and children exposed to IPV, as well as the intergenerational transmission of IPV,[72–74] advocates and health-care providers began experimenting with routinely inquiring about IPV with women in the 1980s.[75–77] Many health-care settings now

have well-established, successful programs to address IPV in their patient population. Multiple professional organizations recommend "screening" all women for IPV,[2,78–84] and more recent guidelines suggest providers should screen men for victimization as well.[78] JCAHO requires that hospitals assess patients "who may be victims of abuse, neglect, or exploitation."[85] In 2004, though, the USPSTF recommended that "there is insufficient evidence to recommend for or against routine screening of …women for intimate partner violence" due to a lack of study of "the harms of screening" and of randomized, controlled trial evidence that health-care interventions following screening have been proven effective.[86] The USPHTF guidelines have been criticized on multiple methodological, ethical, and practical grounds.[17,18,87]

Those advocating routine IPV screening of women cite qualitative studies demonstrating patient approval of routine inquiry, the harm of "not knowing" about IPV, and our ethical duty to address and possibly prevent the suffering of IPV victimization. Some suggest using the term "routine inquiry" rather than "screening" to accentuate that the goal "is not identification of disease but the provision of information, support, and a safe atmosphere for discussing abuse…."[16] Direct inquiry about IPV victimization to an entire population of patients (all women or all women and men) dramatically increases identification of patients exposed to IPV([88,89–95]) over the prevalence found with screening only those patients the health-care provider "suspects" are IPV exposed. Studies of different screening methods from the use of patient questionnaires to computer touch screens yield differing rates of IPV prevalence.[91,96–98]

Despite the dearth of published information on routine IPV victimization inquiry with male patients, the rationale for addressing this problem in men and women is similar. Although the prevalence of highly injurious IPV victimization of men by women is low, there are men who are victimized by their female partners and suffer ill effects of IPV victimization. Men in relationships with men are also at risk for IPV victimization and the adverse health consequences of victimization.

There are multiple reasons experts have begun to advocate for addressing IPV perpetration with men in the health-care setting. Childhood exposure to IPV is known to increase the risk of violence in later adult intimate relationships,[72,74] and in 30 to 60% of families affected by IPV, children are also directly abused.[99] To "break the cycle" of transmission of IPV, experts hypothesize that intervening with male IPV perpetrators in contact with children might reduce child exposure to IPV and direct child abuse. Even in the absence of direct physical or sexual abuse of the child, exposure to IPV can have lifelong physical, psychological, and behavioral effects.[2,100] Anecdotal evidence suggests that "responsible fatherhood" programs may influence men who are perpetrating IPV to change in order to be better role models.[101]

While creating behavior change in men who have long-established patterns of abusive behavior is extraordinarily challenging even in court-mandated programs, reaching men who are less controlling, have more insight and motivation to change, or are very early in the development of abusive behavior may be possible.[102,103] Identifying IPV perpetration as a health-care issue, modeling respectful behavior, and expressing concern for the health and well-being of a perpetrator allow providers to encourage men to change in a non-judgmental manner.

The health-care setting also presents an opportunity to participate in primary prevention by counseling boys (and girls) on "healthy relationships" in order to help change societal norms.[14] It presents a confidential setting to discuss healthy relationships, identify young men at risk for perpetration, and provide tools such as preventive counseling models to help them learn constructive ways of interacting and disagreeing in intimate relationships.[104–106] Health-care providers can also advocate for schools and school-based health clinics to adopt evidence-based, effective "Safe Date" programs.[107]

New Pilot Guidelines on Addressing IPV Victimization and Perpetration with Men

There are sources of expert opinion, but no comprehensive national guidelines on addressing male IPV victimization and perpetration in the health-care setting.[24,29,33,36,37,39,108,109] The attached pilot guidelines were written in response to requests by health-care providers for guidance in addressing IPV with male patients and the realization that, even in the absence of extensive research, providers are already addressing IPV with men. The FVPF convened a national committee to craft "Pilot Guidelines on Identifying and Responding to Male Intimate Partner Violence Victimization and Perpetration in the Health-Care Setting", based on existing data and expert experience. Due to the lack of data, these guidelines are not meant to represent standard of care, but, instead, to share expert opinion with those who are familiar with addressing IPV in women or working with men around violence and would like to expand their experience. The pilot guidelines can be found along with the electronic version of this article.

These guidelines present a multi-step process for health-care providers who have been trained in the dynamics of IPV, understand the potentially life-threatening risks of IPV, and how to promote safety and autonomy for IPV victims, and are competent in addressing the intersection of culture and abuse. First, the guidelines share recommended questions for inquiring about both IPV victimization and perpetration using a general question like, "Are you, or have you ever been, in a relationship where your arguments ever become/became physical?" More direct, behavioral, non-judgmental questions like, "Have you ever been hit, hurt, or threatened by your partner?" And "Have you ever hit, hurt, or threatened your partner?" are also recommended to determine whether any IPV exists in the relationship.

The guidelines, then, delineate an assessment process that may be used to distinguish IPV victimization from IPV perpetration. This determination requires a higher level of experience with addressing IPV than that required to determine whether any IPV exists in a relationship. In some health-care institutions, experienced providers may develop the expertise necessary to do a complete assessment. In other health-care settings, patients may be referred to a knowledgeable social worker or IPV advocate on-site or at a community-based collaborating agency to do a full assessment. The guidelines provide a practical series of questions to help one determine whether a particular patient is an IPV victim, perpetrator, or that the patient's primary role in the relationship is "indeterminate." Finally, the guidelines describe an intervention process based upon the suspected role the patient plays in the violent relationship.

Distinguishing IPV Victimization from IPV Perpetration in Male Patients: Challenges and Importance

When a provider inquires about both IPV victimization and perpetration with a male patient and identifies violence, it can be challenging to distinguish the patient's role in the violence. One may have a clinical suspicion that a male patient is being victimized based on witnessing that the patient consistently defers to his partner, seems frightened of his partner, or repeatedly asks for his partner's permission before making decisions. Or, one may suspect that a male patient is perpetrating violence against his partner if the patient is always present at appointments, highly controlling, manipulative, derogatory, or aggressive (or if this male patient's partner is also a patient and exhibits the above behaviors that could signify being victimized). Ironically, IPV victims often express shame and self-criticism, while IPV perpetrators may present themselves as victims even while they are highly violent and dangerous to their partner and family. Research and detailed observation of male perpetrators have demonstrated that they routinely deny their violent behavior, minimize the severity of their violent actions and the effects of their violence, and blame the violence on others.[103,110] Perpetrators of IPV may be so manipulative and present themselves so convincingly as victims that it is extremely challenging for health-care providers (or other such as judges, law enforcement officers, etc.) to suspect or understand the extent of their abusive behaviors.[110,111]

Making a determination as to whether a patient is primarily being victimized or primarily perpetrating IPV can be extremely helpful in establishing the appropriate treatment plan. Interventions for IPV victimization focus on the empowerment of the victim through the direct provision of a safer environment (shelter, restraining orders, police assistance, the arrest of the perpetrator), safety counseling, and empowering independent decision-making skills. In responding to IPV perpetration, accepted interventions include: holding a perpetrator legally and practically accountable for his actions, attempting to help the perpetrator understand how unacceptable his behavior is and truly empathize with his victims, and promoting new paradigms of non-coercive, equitable, respectful ways of relating through batterer's treatment programs, usually lasting a year or more.[110,112] Misidentifying an IPV victim as a perpetrator could have quite negative consequences in that a male patient who is already suffering from poor self-esteem and lack of safety due to the perpetrator's abusive treatment would be made to feel as if he were responsible for the abuse — the exact opposite message one would need to convey to improve his health and safety. Misidentifying an IPV perpetrator as a victim could exacerbate the perpetrator's sense of entitlement and create worsening danger for the victim.

Safety Concerns When Both Members of a Couple Are Patients in the Same Health-care Setting

Inquiry about IPV victimization and perpetration when both members of a couple are seen in the same medical practice is fraught with potential difficulty and danger. There is some evidence to support the safety of addressing IPV in this situation,[113] but experience suggests challenges. An IPV victim whose abusive partner is cared for in the same practice may feel unsafe revealing IPV victimization and may not trust that the confidentiality safeguards are sufficient to protect her/him. If the IPV perpetrator suspects that he has been asked about IPV due to a disclosure by the victim, he may retaliate with worsening abuse. The perpetrator may try to limit his partner's access to care, sabotage his partner's medical care, and manipulate the health-care provider in order to hurt the intended intimate partner victim.[114–116] Holding such a controlling and manipulative perpetrator accountable for his behavior can be challenging. There are published guidelines on working with couples experiencing IPV in both medical and mental health practices ([108,113,117]). The attached guidelines suggest ways to mitigate potential risks to patients when both members of a couple are cared for in the same practice.

Other Challenges in Addressing IPV Victimization in Male Patients

To address the USPHTF finding of insufficient study on the potential harms of screening for IPV victimization, researchers recently evaluated the safety of IPV victimization screening and found no significant adverse outcomes.[30] Theoretical risks of IPV victimization screening of men include a risk of shame and embarrassment, misidentification of a perpetrator as a victim, and patient and provider dismay over the lack of services available to male IPV victims.

Other Challenges in Addressing IPV Perpetration in Male Patients

Identifying IPV perpetration may challenge a provider's ability to sustain a compassionate focus on the perpetrator's health problems. As discussed above, the misidentification of a perpetrator as a victim may further endanger the victim. After identifying IPV perpetration, the provider may be unsure of the potential for serious harm or lethality.[33,118–120] Understanding one's ethical and/or legal obligation of a "duty to warn" intended victim(s) and the police of danger to intended victim (s) [121,122] may be difficult. Legal precedents vary from state to state, and there is no national legislation establishing a "duty to warn." The guidelines summarize helpful information on lethality risk and the provider's "duty to warn."

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