Intimate partner violence against men

How can GPs respond?

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Although women are most at risk of intimate partner violence, men can also be victims, and therefore exposed to its physical and psychological harmful effects. We reflect on the available evidence base in this field to offer some insight into the identification of male victims of intimate partner violence, and how GPs can best respond.

There is a strong association between exposure to interpersonal violence and adverse health problems, including increased risk of early mortality.[1] Over their lifetime, men are more likely than women to experience traumatic injury associated with interpersonal violence, primarily due to assault perpetrated by other men in the community.[1-3]

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Intimate partner violence (IPV), on the other hand, primarily affects women, and can take a number of forms including physical, emotional, verbal, economic and sexual abuse that takes place within an intimate partner or ex-partner relationship. Among women, IPV is considered one of the most pervasive health problems worldwide, including in Australia.[4,5] Although the overwhelming evidence is that women are most at risk of IPV, GPs should be cognisant that men can also be victims of IPV and therefore exposed to its physical and psychological harmful effects.[2,5-10]

Men as victims

Men's strength may contribute to the more serious risk for physical harm reported in female victims of IPV, and most men at risk of harm from IPV are in same-sex relationships.[11,12] However, men can also be exposed to adverse physical and psychological health effects of female-perpetrated IPV.[9,13] Men's exposure to IPV most commonly occurs in the context of bilateral violence (also referred to as common-couple violence).[4] Although bilateral violence in heterosexual relationships does not occur in a vacuum – unaffected by men's socially privileged status and physical strength – it tends to include escalatory patterns of interpersonal interaction where both partners engage in emotional or physical violence.[14,15] Women's violence towards men (in intimate relationships) is often retaliatory or protective in response to a threat to them or their children.[16] Violence within this context can lead to physical injury in men, but it is more often associated with psychological distress and psychosocial impairment.

Despite the seriousness of this form of IPV, it is differentiated from behaviours identified as 'intimate terrorism'.[17] Intimate terrorism is characterised by threats, intimidation, multiple forms of abuse, and coercive and controlling behaviour.[5,18] It is most commonly experienced by women and perpetrated by men. It is strongly related to gender inequality, attitudes that condone

1. REFERRAL AND SUPPORT SERVICES

MensLine Australia: 1300 789 978
https://mensline.org.au

1800RESPECT: 1800 737 732
www.1800respect.org.au

Lifeline: 13 11 14
www.lifeline.org.au

Men's Referral Service: 1300 766 491
(for perpetrators) www.ntv.org.au

Aboriginal Family Domestic Violence Hotline: 1800 019 123

violence against women, male entitlement and lack of redress for women.[18-21] Gendered forms of coercive and controlling violence are also identified in the high rates of homicide of women perpetrated by men.[22,23]

Health effects of IPV in men

IPV is associated with physical morbidity, as well as mental disorders including depression, post-traumatic stress disorder (PTSD) and suicidal ideation.[24,25] In a US study of both genders, IPV victimisation in men (either physical or emotional) was associated with depressive symptoms, heavy alcohol and drug use, and a history of being injured.[13] Psychological power and control affecting men, and perpetrated by women, was associated with developing a chronic mental illness.[5,13]

Anecdotally, GPs describe emotional abuse affecting men as the most common presentation of IPV in male patients, including scenarios where women can gain power in the relationship if they are more verbally proficient. GPs have also commented that men who are affected by emotional abuse tend to also be highly dependent on the woman, despite the abuse. With evidence of the risk for depression associated with emotional abuse, and a correlation between depression and functioning, these men may be rendered less able to take action to prevent or address the problem.[13] It is important to note that studies of homosexual men (when compared with heterosexual men) and IPV suggest an increased risk of physical and mental health problems, and an increased risk of HIV.[5,12,26]

Men as perpetrators

Men can be both victims and perpetrators of IPV, particularly in the context of bilateral IPV.[5,9] Male perpetrators of IPV also report greater use of psychiatric services, higher levels of substance use and sexually risky behaviours.[5] Men are also more likely to be harmed while perpetrating violence.[5]

Statistically, GPs are more likely to be consulted by male perpetrators than male victims of IPV. Studies suggest that 42 to 63% of male perpetrators of IPV reported treatment in a healthcare setting in the previous six months. GPs can therefore have an important role in identifying and referring perpetrators of IPV.[27,28] Interventions with male perpetrators of coercive and controlling forms of IPV are complex, and potentially dangerous for the victim. Although male perpetrator interventions are not the focus of this article, the evidence clearly suggests that the GP's first response should be to act to protect the victim and children.[29,30]

GPs describe emotional abuse affecting men as the most common presentation of IPV in male patients

Identifying male victims of IPV

Australia does not have a protocol for male IPV screening in general practice. Internationally, the evidence base for male victims of IPV is limited and insufficient to develop evidence-based guidelines.[5] Theoretical risks associated with screening for male IPV victimisation include shame and embarrassment, mistaking a perpetrator for a victim and not being aware of appropriate services to refer male victims.[5]

GPs should consider the possibility of IPV in cases where men present with symptoms of mental illness – particularly depression, PTSD symptoms and anxiety – and where there are repeated unexplained injuries, chronic pain or gastrointestinal problems.[31] Similar to identifying female victims, the GP's suspicion may be alerted if the male patient's partner often attends the practice with him, if he constantly defers to or seems afraid of his partner, or if he frequently asks for his partner's approval when making decisions.[5] IPV victims commonly express self-blame when asked about suspicious injuries. Self-blame can be a way of rationalising dependency and, in men, may reflect shame and avoidance related to socially constructed notions of masculinity and embarrassment at being a victim of female-perpetrated violence. These emotional reactions can also be identified in male victims of abuse from male partners. An explicit commitment to confidentiality is important to encourage disclosure. Fear of a breach of privacy can be heightened if both partners attend the same practice.[32] If a perceived victim is actually a perpetrator, the intervention to discuss IPV may lead to him blaming his partner, restricting her or his access to the GP, or abusive retaliation.[5,30]

2. MEN'S COUNSELLING SERVICE MODEL[34]

- Understanding the cycle of violence and how to prevent escalation of events
- Understanding the impact of stress on relationships
- Men's role in decision-making without conflict
- Self-esteem and understanding emotions
- Protecting children from the serious effects of intimate partner violence

The role of the GP

There is some evidence that brief interventions implemented for women affected by IPV may be useful. Intervention studies

with male patients are required. The general view supports an immediate affirming response from the GP followed by referral to a specialist centre and GP follow-up care as required.[28] Formal organisational support, specific training and allocated time is required for the GP to feel confident and equipped to take responsibility for the intervention.[31] The main responsibilities of the GP are to:

- be informed about IPV
- believe the patient and to validate his experience as unacceptable
- share information with the patient about the mental and physical health effects of IPV
- develop a trusting relationship with the patient and monitor his mental and physical status after a referral for specialised intervention.

It is important to be aware of the services available for men. GPs may refer patients to a psychologist or psychiatrist (in cases of severe mental health issues) or to a men's counselling and support service such as MensLine Australia. Attempts should be made to provide referral to culturally appropriate services, such as those available to Aboriginal and Torres Strait Islander men. Referral and support services are listed in Box 1. Men's counselling services for IPV may employ an empowerment based counselling or psychoeducation model as described in Box 2.[34] Practical skills for men may also include the provision of safer accommodation, a restraining order against the perpetrator and making a safety plan for the future.

Conclusion

Although women are most at risk of male-perpetrated IPV, men can also be victims. The harmful effects of IPV, which include physical morbidity and psychological disorders such as depression, anxiety, PTSD and suicidal ideation, can be addressed by being aware of the potential for this type of problem, and offering an immediate affirming response to the patient followed by referral to a specialist centre or men's counselling and support service. MT

References

A list of references is included in the online version of this article (www.medicinetoday.com.au).

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