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Asking men about domestic violence and abuse in a family medicine context: Help seeking and views on the general practitioner role

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ABSTRACT

Reflecting the higher prevalence of domestic violence and abuse experienced by women, and the recognised health impacts of such abuse, studies have focused on the responses of health-care practitioners to women in heterosexual relationships. Comparatively few studies have looked at the health impacts or help-seeking of men who may be perpetrators and/or victims of abuse within intimate relationships. In this paper we report on help seeking and the health professional's role based on a survey of 1368 men attending 16 general practices in the southwest of England and 31 interviews with a sample of survey respondents. The survey had a number of questions on experience or perpetration of behaviours which could be considered abusive, on whether respondents had ever been asked about such behaviours by health-care professionals, and on whether they had ever sought formal or informal help for such behaviours. Men were most likely to seek informal support from friends or family. The next most likely source of support was the family doctor. This paper suggests that health-care practitioners in general, and family doctors in particular, have a role in asking male patients about the experience or perpetration of domestic abuse and need training to do so effectively and safely.

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1. Introduction

Amongst the wider literature, there is uncertainty about how notions of masculinity influence the help seeking behaviour of men and

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male patients. Möller-Leimkühler found that the 'masculine stereotype does not allow help-seeking, even if help is needed and could be available' (2002, p. 6). Galdas, Cheater, and Marshall (2005) point out that their review of gender-comparative help-seeking studies demonstrates that other factors including occupation and socio-economic status are more significant than gender although they also found that amongst the gender-specific literature, there was increasing evidence to suggest that 'masculinity beliefs' delayed men's help-seeking. However, they concluded that there is insufficient research into masculinity and male perceptions of help-seeking 'to inform policy or clinical practice' (Galdas et al., 2005, p. 621).

This dearth of research into men's experiences of help-seeking is even more pronounced in relation to domestic violence and abuse (DVA). In relation to the help-seeking practices of men who have experienced or perpetrated abusive behaviours, the Home Office Statistical Bulletin based on the Crime Survey of England and Wales (CSEW) reported that men who had experienced physical injuries or emotional abuse from partners were less likely than women to tell a medical professional (4% compared to 18%) (Smith, Coleman, Eder, & Hall, 2012, p. 68). The same report also noted that male and female victims of DVA were both most likely to tell family about the abuse (56% women and 43% men) with a friend or neighbour being the next most likely to be told (41% women and 39% men). Canadian research (Mihorean, 2005) reported that despite a reluctance of men to seek help compared to women 44% reported talking to family, 41% reported talking to a friend and neighbour, and 12% reported talking to a doctor or nurse about DVA.

Previous research about the response of health-care practitioners to patients experiencing DVA has predominately focused on women in heterosexual relationships, reflecting the higher prevalence, greater severity and more damaging health impact of DVA on women (Feder et al., 2009; Hegarty, Taft, & Feder, 2008; Kimberg, 2008; Soglin, Bauchat, Soglin, & Martin, 2009; Sprague et al., 2013; Taket et al., 2003). Studies of help-seeking by women experiencing DVA have consistently shown that women talk predominately to friends and family, but health care practitioners, doctors and nurses in particular, are consistently named as a professional source of help (Smith et al., 2012; Barrett & Pierre, 2011; Fanslow & Robinson, 2010; Feder et al., 2009; Feder, Hutson, Ramsay, & Taket, 2006; McGibbon, Cooper, & Kelly, 1989; Mooney, 1994). Qualitative studies of women survivors of DVA report that women want to be asked about abuse by their doctors (Feder et al., 2006) and the majority of women in surveys, find it acceptable to be asked about DVA in health care settings (Feder et al., 2009). Westmarland, Hester, and Reid (2004) found that 73% of female patients and 75% male patients surveyed thought that it would be useful for patients to be asked about DVA.

The primary aim of this paper is to expand the current body of knowledge on male help-seeking in relation to DVA by measuring and characterising help-seeking practices. Using the PROVIDE (Programme of Research On Violence in Diverse domestic Environments) survey (Williamson et al., 2014) of male general practice patients and interviews with a sub-sample of those patients, this paper looks at male patients' opinions of the role of health practitioners in asking about experience or perpetration of potentially abusive behaviours. It is important to remember however, that this research is relevant to general practice in the UK. Furthermore, the demographic profile of the participants in this study may undermine the generalizability of our findings to other contexts.

2. Methods

Our data are derived from a cross-sectional survey and follow-up interviews investigating the impact of men's relationships on their health (Buller, Devries, Howard, & Bacchus, 2014; Williamson, Jones, Hester, & Feder, 2014). The survey was conducted between September 2010 and June 2011. During this period, consecutive male patients attending 16 GP surgeries in the south west of England were approached and asked to complete a two-part survey and to indicate whether or not they would be willing to take part in an interview. The study received research ethics approval from the local NHS research ethics committee (South West REC 10/H0106/22).

2.1. Sample

Of the 2431 men who were asked to complete the survey, 1368 (56% of those approached) completed part one, answering questions about themselves, their health and well-being and their relationships, whilst 669 (28% of those approached) also completed the more detailed questions in part 2. The age of the survey respondents ranged from 18–90 (mean 57.5) and the standard deviation was 18.4.

Attached to the survey was a form asking respondents if they would agree to take part in an interview. Seventy eight men agreed and between March and August 2011, we were able to arrange and conduct interviews with 31 men (mean age of 49, standard deviation = 17.9). Twenty-nine of the men that we interviewed were heterosexual and only two of the 31 interviewees identified as having had sexual relationships with men.

2.2. Survey questions

The survey itself included sections on the experience or perpetration of potentially abusive behaviours; the potential impact of those behaviours; general health and mental health data; alcohol and drug use; as well as questions about the role of health practitioners in asking men about potentially abusive relationships, and help-seeking activities. Survey respondents who had experienced potentially abusive behaviours were asked to complete a follow-up question about whether they had told anyone else about how they were being treated. Respondents were also asked about whether at any time they had been asked by a family doctor, nurse or other health care professional if they had been hurt or frightened by a partner. The survey then asked a further question about whether respondents thought that health professionals *should* ask if their patients had been hurt or frightened by a partner. The same question was asked again in relation to whether patients had ever been asked if they had hurt or frightened a partner, and whether health practitioners *should* ask their patients if they had hurt or frightened a partner. Respondents were given three response options to these questions; 1) Yes, they should ask all their patients, 2) Yes, but they should only ask some of their patients, depending on the symptoms they describe, and finally, 3) No, they should not ask any of their patients. At the end of the survey was a separate form for respondents to complete if they were willing to be approached to take part in a semi-structured interview.

2.3. Interview questions

The 31 interviews were conducted using a semi-structured interview schedule, with the majority being conducted by telephone. The interview schedule included questions relating to, first of all, how the participants felt about being asked to complete a survey about relationships whilst they were in a general practice waiting room, about their experiences and perpetration of potentially abusive behaviours, their views about help-seeking, and on the role of health practitioners in asking about relationship issues. The questions were designed to give the participants an opportunity to explain and expand upon their survey responses. The interviewer was blind to those responses. Participants were informed of this at outset, and although most claimed not to recall their survey responses anyway, it did provide them with the opportunity to expand upon or contradict their survey responses without feeling constrained by what they had previously indicated.