ORIGINAL RESEARCH

Physicians' Experiences with Male Patients Who Perpetrate Intimate Partner Violence

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Introduction: **Despite the prevalence of intimate partner violence (IPV), there is a paucity of research exploring the role that physicians might play in intervening with IPV perpetrators.**

Methods: **A qualitative study explored interactions between family medicine physicians and male perpetrators of IPV. Fifteen physicians were purposefully sampled from 1 hospital system. The physicians were individually interviewed using a semistructured interview guide, and interview transcripts were analyzed using techniques from grounded theory.**

Results: **Three main themes relating to physicians' experiences were identified: (1) how physicians learned of or identified IPV perpetration by men (usually disclosure by the victim, but perpetrators also disclosed it); (2) how physicians assessed for comorbidities or responded to IPV perpetration by men; and (3) facilitators of and barriers to physician identification of and response to IPV perpetration by men. Facilitators identified include having a trusting relationship with the perpetrator and support services, whereas barriers consisted of strong negative emotions and a lack of training.**

Conclusions: **Family medicine physicians in this sample reported feeling underprepared to serve patients whom they know are perpetrators of IPV, particularly if they are also providing care to the victim. Additional research is needed to develop interventions and effective trainings. (J Am Board Fam Med 2017;30:239–247.)**

Keywords: **Disclosure, Emotions, Grounded Theory, Interpersonal Relations, Qualitative Research, Spouse Abuse**

Intimate partner violence (IPV) is defined as physical, sexual, or psychological harm committed by a current or former partner or spouse.[1] In the United States, according to the Centers for Disease Control and Prevention, more than one third of women have experienced rape, physical violence, and/or stalking by an intimate partner.[1] Given the negative impact of IPV on women's health[2,3] and the effectiveness of screening for IPV victimization and intervening,[4,5] the US Preventive Services Task Force endorses screening for IPV victimization among women in the health care setting.[6] Nonetheless, limited research has been conducted to explore whether there is a role for physicians to intervene with perpetrators of IPV.

Research suggests that 13% to 23% of male health care patients self-report having perpetrated IPV,[7–9] with 4.2% reporting at least 1 episode of severe violence (eg, kicking, beating, or threatening to use or using a knife or gun).[8] Research has also found that 42% to 63% of male perpetrators of IPV report having been treated in a health care setting in the previous 6 months,[10,11] and 2 of every 3 male perpetrators of IPV have a regular doctor they see for routine care.[12] Research suggests that male perpetrators are open to discussing family conflict with physicians,[13,14] and the American Academy of Family Physicians (AAFP), in its position paper on violence, states that family physicians

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have a role in recognizing and appropriately referring perpetrators of IPV.[15]

Studies have been conducted on the feasibility of screening patients for IPV perpetration in the health care setting.[7–9] Nonetheless, there is limited information about the circumstances in which physicians interact with perpetrators of IPV and the methods physicians use or should use when interacting with them. Numerous questions are unanswered. For example, do family medicine physicians regularly interact with these men while caring for the entire family? Do perpetrators present to physicians because they are seeking help for their violent behavior, and if so, what do physicians do in these cases? We conducted a qualitative research study to explore family medicine physicians' experiences when interacting with patients whom they know, or suspect, to have perpetrated IPV.

Methods

Participants

We recruited a purposeful sample of family medicine physicians who had experiences with male patients who they knew had perpetrated IPV within a large, urban safety-net teaching hospital and affiliated community health centers. Physicians were initially recruited for the study through a survey administered at a departmental meeting, asking whether they had experience with male perpetrators of IPV and, if so, would they be willing to be participate in a 15- to 30-minute interview. Additional E-mail invitations were sent on 2 different occasions through the departmental listserv, inviting physicians with experiences interacting with male patients known to have perpetrated IPV to participate in our study. Other recruiting announcements were made at departmental business meetings.

The research team consisted of 3 research fellowship-trained family medicine physicians (JW, HT, and BP, who was the principal investigator [PI]), a public health researcher with expertise in IPV (EFR), and the director of the hospital's domestic violence program (JT). The PI, who did the interviews, worked at the hospital outpatient clinic with some of interview subjects. The study was approved by an institutional review board (The Boston University Medical Campus).

Data Collection

The research team designed a semistructured interview guide through several iterations based on feedback from local researchers and pilot interviews in order to understand the physicians' experiences and opinions of working with male patients with a history of perpetrating IPV (see the Appendix). The interview guide covered the following topics: (1) how physicians learned that ≥1 of their patients had a history of perpetrating IPV and what they did in those circumstances; (2) what experiences physicians had of caring for the victim and other family members when also caring for the abuser; (3) what opinions physicians held about screening for the perpetration of IPV and providing care for those patients who perpetrate IPV; and (4) what resources physicians used or knew about to care for patients who perpetrate IPV and the obstacles encountered. Open-ended questions were used to explore these topics, followed by detailed prompts when indicated.

The interviews were conducted between October 2014 and September 2015, at which time additional information became redundant and no other physicians were recruited. The interviews were all conducted in person, except for 1 that was conducted by telephone because of the difficulty of scheduling an in-person meeting, and lasted, on average, 22 minutes. The first 5 interviews were transcribed from field notes, and the remaining interviews were audio-recorded to record the data more accurately.

Data Analysis

We conducted analyses using grounded theory, with the goal of developing theories about physician interactions with male perpetrators of IPV.[16] Audio-recorded interviews were transcribed verbatim, whereas interviews with written field notes were transcribed immediately afterward. When information from the field notes was unclear, the PI corresponded with the interviewee to clarify the transcription.

The interviews were initially coded separately by 2 members of the research team (BP and HT), line by line with 1- or 2-word summaries of the content. Initial coding decisions were then reviewed jointly by the coders, who grouped them into broader second-level codes. The second-level codes were reviewed by the research team and themes were identified during several different meetings. Inter-

Table 1. Summary of Themes Identified from Interviews with 15 Family Medicine Physicians About Their 32 Combined Experiences with Male Perpetrators of Intimate Partner Violence, October 2014–September 2015

Themes	Subthemes	Physician Respondents (n = 15)
How physicians learned of or identified IPV perpetration by men	• Victim disclosure (15 cases)	12
	• Perpetrator disclosure (6 cases)	6
	• Medical records (4 cases)	13
	• Observed behavior (2 cases)	2
	• Undetermined (5 cases)	2
How physicians assessed for comorbidities or responded to IPV perpetration by men	• No intervention per request of victim who disclosed	6
	• Assess readiness and motivation to change	5
	• Assess for substance abuse and mental health issues	6
	• Assess for safety of victim	7
	• Discuss coping strategies	3
	• Refer to specialists, with wide variation	11
	• Assess whether to support the couple staying together or separating	3
Perceived facilitators of and barriers to physician identification of and response to IPV perpetration by men	• Facilitators	
	• Trusting relationship	3
	• Integrated behavioral health system	4
	• Barriers	
	• Lack of training	13
	• Negative emotions toward perpetrator	8

IPV, intimate partner violence.

views continued during this process until the research team agreed that thematic saturation had been reached.

Results

Fifteen family medicine physicians were interviewed, of whom 10 were male and 5 were female. Eleven physicians reported having ≥10 years of experience in clinical practice. A total of 32 interactions involving male perpetrators of IPV were discussed among the 15 physicians (Table 1).

Researchers identified several themes relating to physicians' experiences with male patients with a history of perpetrating IPV (Table 1): (1) how physicians learned of or identified perpetration of IPV by the man; (2) how physicians assessed for comorbidities or responded to perpetration of IPV by the man; (3) facilitators of and barriers to physician identification and response to perpetration of IPV by a man.

Theme 1: How Physicians Learned of or Identified Male IPV Perpetrators

Twelve of 15 physicians interviewed reported that they learned that a male patient had perpetrated IPV because the female victim, who was also their patient, disclosed the information to them. In 6 cases, the female victims explicitly requested that the physician not intervene with the male abuser, although 2 women requested that the physician intervene with the abuser. A number of the disclosures occurred in the context of prenatal visits. One physician discussed this type of disclosure: "I would not have been aware of the abuse if I was not caring for the woman in the relationship, because in my care of men, I do not ask about this and do not know how to" (physician 13, male, >20 years of experience).

Six physicians reported situations where a male patient disclosed IPV perpetration. Half of the patient-initiated disclosures to the physician were done in order to receive assistance with stopping the abusive behavior. Other times, physicians inquired about IPV perpetration after observing clinical indicators suggesting a history of violent behavior, such as injuries on the hands or other signs of a physical altercation. Here is an example of a perpetrator disclosure: "I was the [primary care physician] for both the husband and his wife, and he had issues with anger management. He expressed concern that he might do something and regret it later. It came out of the blue" (physician 12, male, >20 years of experience).

Three physicians learned that their male patients perpetrated IPV through medical records, which include emergency department reports, patient charts, and inquiries from various government agencies. Two physicians reported directly observing threatening or abusive behavior in the clinic. None of the physicians in this study reported screening the general population for perpetration of IPV. Here are examples of observed behaviors and learning of abuse through medical records: "It was a prenatal clinic. I heard screaming and yelling. I saw the man angrily storm out and the woman was crying" (physician 2, female, <5 years of experience); "I was aware of multiple emergency department reports about domestic violence . . . which gives you the opening to say I have this information, and see what they say" (physician 10, female, >20 years of experience).

Theme 2: How Physicians Assessed for Comorbidities or Responded to IPV Perpetration by Men

Six physicians clearly reported that, per the victim's request after disclosing, they were not allowed to intervene with the abuser. Therefore the physicians were able to provide services and referrals to the victim but were unable to discuss the issue with the abuser, which left physicians feeling unsure of their role, as discussed by 1 physician: "The husband arrived for blood pressure checks after her disclosure, and I'd ask him how everything was at home. He'd say things are 'fine.' He did not give any openings to explore further. I felt stuck" (physician 7, female, >15 years of experience).

When physicians did intervene with a male patient seeking help for his abusive behavior—whether this was a physician's actual experience or was presented as a hypothetical situation—physicians reported a wide range of responses. While physicians repeatedly reported feeling unprepared to help men in these situations, many reported assessing perpetrators' motivations and readiness to change. One provider discussed assessing a male patient's readiness to change: "I need to understand the situation to better understand what might be the potential motivation to change behavior" (physician 4, female, <10 years of experience).

In addition to assessing readiness to change, physicians also reported assessing underlying diagnoses that they believed could be contributing to the behavior, such as substance abuse and mental illness. In addition, 4 physicians commented on assessing the abuser for exposure to violence during childhood. One physician discussed these points: "Is there untreated [posttraumatic stress disorder]? Is there psychosis? Is the abuse motivated by issues related to substance abuse? I would need to get a diagnosis to better understand willingness for change" (physician 3, male, >30 years of experience).

In situations where physicians attempted to provide services to a male IPV perpetrator, the intervention provided varied significantly. Three physicians discussed teaching coping strategies to help the man control his anger; for example, "We worked to help identify triggers, where they would self-monitor their feelings and emotions, and when they were aware they could get violent, they would go for a walk or a cigarette" (physician 3, male, >30 years of experience).

Most physicians referred the perpetrator for services, such as behavioral health specialists, psychiatrists, or marriage counselors, although 1 physician reported providing couples therapy directly to the perpetrator and his victim. Only 1 physician referred a perpetrator to a batterer intervention group, which he found after doing an online search. Multiple physicians reported conducting Internet searches to try to find resources. Overall, the physicians did not seem to have a clear understanding of where to refer IPV perpetrators, as discussed by one physician: "I recommended counseling, and offered a behavioral health referral. He had been to marriage counseling and to see a pastor . . . I also gave him some information about batterers groups that could be found online" (physician 6, male, >10 years of experience).

Physicians also reported assessing safety concerns when interacting with perpetrators of IPV, including the safety of the victim and of any children involved. Physicians reported contacting appropriate government agencies when indicated by state laws. Physicians also reported asking the perpetrators, in cases of self-disclosure, for permission to reach out to the victim to assess their safety: "He allowed me to communicate with the wife directly, to find out if she felt that she was in danger because of his violent outbursts" (physician 10, male, >20 years of experience); "One couple had 5 children, and 1 couple had 2. I made efforts to assess the safety of the kids" (physician 5, female, >10 years of experience).

Four physicians discussed how they, as the physician for both victim and abuser, had to make judgments about whether to be supportive of the couple in any attempt to try to stay together or whether it would be best to support the couple in separating. This was often difficult for the physician: "I wanted them to have a healthy relationship, but also did not want to perpetuate a relationship, with my presence, if it was not meant to be" (physician 14, male, >15 years of experience); "We need to make judgments about the goals of the family. Should they pursue incarceration of the abuser? Can they reconcile, or is time to separate the couple? It is not always clear what path the MD should take" (physician 3, male, >30 years of experience).

Theme 3: Facilitators of and Barriers to Physician Identification of and Response to IPV Perpetration by Men

Having a trusting relationship with the patient and having an integrated behavioral health system, which means primary care and behavioral health clinicians work together as a team to provide patient-centered care, were identified by physicians as facilitators for identifying and responding to IPV perpetration by men. The physicians reported that men who had disclosed abusive behavior and men who were responsive to getting help when the victim disclosed the abuse often had a long and trusting relationship with their physicians. Physicians reported they often cared for these patients for years before the disclosure was made. One physician commented, "I think the conversation went smoothly because I had been there for him in tough times. But I also knew he was accountable for his actions, and he knew I would treat him that way" (physician 14, male, >10 years of experience).

Another physician described how it took time after a man had disclosed his abusive behavior for him to engage in therapy, but being there for the male patient when he was ready to accept help allowed the physician to refer him to services: "I was surprised that he came back to see me because I had spoken to the wife about the abuse, with his permission. But he's come back again, and we have referred them to marriage counseling" (physician 12, male, >20 years of experience).

Four physicians reported that working within an integrated behavioral health system resulted in improved care for both the victim and the abuser. Behavioral health clinicians helped them find resources and develop appropriate care plans. One physician commented on the value of this teamwork when dealing with perpetrators of IPV: "Intervening usually does not involve individual heroics, but through thoughtful and effective teams, including substance abuse counselors, social workers, mental health counselors" (physician 3, male, >30 years of experience).

Common barriers to identifying and responding to perpetrators of IPV were strong negative emotions to the perpetrator and a lack of knowledge about how to intervene. Despite reporting that they would try to remain nonjudgmental of the male perpetrators of IPV, physicians repeatedly related having strong negative emotional reactions to these men. Both male and female physicians reported anger toward the perpetrators of IPV, whereas female physicians also mentioned concerns for their own personal safety: "It is difficult to put aside personal feelings when seeing the male abuser as a patient, especially when the man does not know you are aware. You are aware that this patient can become violent, and I am a small person" (physician 5, female, <10 years of experience); "A lot of doctors are going to have problems with abusers because of what they did. . . . I'd like to think I'd be mature enough to look past it, but it would be difficult" (physician 2, female, <10 years of experience).

Thirteen of the 15 physicians interviewed reported having had no training in identifying or intervening with male perpetrators of IPV, leaving physicians unprepared to provide guidance to men when they request help and unsure of their role when the victim requests the physician keep this information confidential. Only 2 physicians had been taught about batterer intervention programs during residency. A few physicians discussed these concerns: "I've had no training. I'd like to know more. I want to know what the available resources are" (physician 1, male, >10 years of experience); "I have a lot of male patients. I am sure a lot of them could be batterers, but I am not sure how to ask, and not sure what I'd do with the information. . . . I do not think it is the role of the [primary care physician] to treat the whole situation, but we should be able to diagnose, make appropriate referrals, and discuss the problem" (physician 6, male, >15 years of experience).

Discussion

Family physicians in this qualitative study usually learned of male patients perpetrating IPV through disclosures by the female partners also under their care. A number of physicians did however, report that their male patients self-disclosed the perpetration of abuse. Physicians reported feeling unprepared to deal with male patients who perpetrate IPV, with specific concerns about confidentiality issues, specifically when the victim discloses the abuse, and about a lack of knowledge about where to refer abusers. This lack of training is demonstrated by the wide variation in referral practices, the lack of knowledge about batterer intervention programs, and the provision of potentially inappropriate and possibly even unsafe responses. When interacting with perpetrators of IPV, physicians reported both anger toward perpetrators and fear for their own safety.

While the majority of physicians learned that their male patients had perpetrated IPV through disclosure by the victim, one third of the physicians learned about the IPV through disclosure by the perpetrator. This is consistent with research that has shown that, when seeking professional help for perpetration of IPV, men are most likely to seek help from their family doctor.[13] In addition, research has shown that men are more likely to disclose perpetration of IPV when they have a relationship of trust with their physician,[13] which is consistent with responses from the physicians interviewed here.

Research showing that male perpetrators of IPV see a regular physician[12] and regularly access health care[7–11] seems to conflict with the rarity with which physicians reported interacting with perpetrators of IPV. The 15 interviewees discussed a total of 32 interactions with male perpetrators of IPV (Table 1), and only 6 of the 18 physicians who completed the initial survey reported experiences with male perpetrators of IPV. This is consistent with the AAFP position paper on violence, which states family physicians consistently underestimate the number of their patients that are affected by violence.[15]

Our finding that physicians lack training to intervene with perpetrators of IPV is consistent with recent research that has shown that only 23% of family medicine residency training programs include any training regarding how to respond to IPV perpetrators.[17] Guidelines exist for interacting with perpetrators of IPV and could be used to develop a teaching curriculum for physicians,[18–20] but these guidelines are often based on expert opinion and lack evidence to support them. Nonetheless, given the prevalence of the problem and the AAFP recommendation to address IPV perpetration,[15] a curriculum needs to be developed.

Potential interventions that could be provided by physicians, if appropriately trained, include making referrals to certified intimate partner abuser education programs (ie, batterer intervention), diagnosing and treating underlying illnesses contributing to violent behaviors, assessing for safety, and, potentially, providing counseling and motivational interviewing.[21] When training is not provided, physicians may underuse existing resources such as batterer intervention programs and could potentially provide ineffective or even dangerous interventions, such as providing or referring to couples therapy without appropriate training in IPV.[22,23]

Proven interventions to address IPV perpetration are needed. Interventions to address IPV victims have been shown to be effective,[4,6] but research showing effectiveness of batterer intervention groups is limited.[24–26] Motivational interviewing, as discussed by physicians in our sample, has been explored as a possible intervention for IPV perpetrators.[21,27–29] To our knowledge, brief motivational interviewing interventions focused on IPV perpetration in primary care settings have yet to be explored. Additional research should explore the negative impact of IPV perpetration on the abuser,[30,31] as this may be beneficial for the development of effective interventions.

Physicians in our sample discussed the need to understand underlying diagnoses that may contribute to IPV perpetration. Research suggests that treating underlying comorbidities, such as alcohol dependence[32,33] and posttraumatic stress disorder,[34] can reduce IPV perpetration, but this may not address the underlying causes of IPV. Our study suggests that integrated behavioral health systems may be helpful in addressing these comorbidities, which is consistent with research that has shown that integrated behavioral health systems result in improved outcomes for patients with depression and anxiety.[35] Collaborative care models have been introduced to improve the care of victims of IPV,[36] yet the potential impact of this model to address IPV perpetration is unclear.

Given that family medicine physicians are often treating both partners in an abusive relationship, or the entire family, it is critical that family medicine physicians receive training on the complex dynamics of IPV as well as considerations relating to confidentiality, legal responsibility, and the safety of victims, perpetrators, and any other family members when providing care for perpetrators of IPV. Providing inappropriate care can result in harm to the victim[20,22,23]; hence the Royal Australian College of General Practitioners recommends that physicians, when seeing both partners in an abusive relationship, consider referring 1 member of the couple to a colleague for primary care.[19,20] Furthermore, given the negative effects of parental IPV on children,[37–39] it is important for physicians to assess the well-being of any children and be aware of state-mandated reporting laws.

Given physicians' concerns for their personal safety when interacting with patients with a known history of violence and the recent research on violence directed toward health care providers,[40] research should be done to explore whether there are actual safety issues when interacting with male perpetrators of IPV, and if so, what precautions physicians should take to protect their themselves.

Limitations of this study include the sampling of physicians from a single hospital system, which may have limited our saturation. In addition, the interviewees often worked with the PI and may have given answers to questions that present themselves as providing the best care possible (ie, social desirability bias). The findings may have also been affected by a self-selection bias, where a certain type of physician volunteered to be interviewed. The use of field notes may have resulted in a reporting bias.

Conclusions

In this sample, 12 of 15 family medicine physicians discovered that male patients perpetrated IPV because of disclosures made by the victims, although 6 of the 15 physicians reported male patients disclosing IPV perpetration. When intervening with a perpetrator of IPV, physicians often assessed the perpetrator's readiness to change and referred him to specialty services, but physicians are often limited in what they can offer because of a lack of training, which may result in underuse of batterer intervention programs and other interventions. Working within an integrated behavioral health system and having a trusting relationship with the male perpetrator may facilitate interventions with men who perpetrate IPV.

To see this article online, please go to: http://jabfm.org/content/30/2/239.full.

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Appendix

Structured Interview Guide Used During Interviews with Family Medicine Physicians About Their Experiences with Male Perpetrators of IPV

1. What are your thoughts about the role of a family medicine physician in screening for or discussing perpetration of IPV with male patients?
2. Suppose I was your patient and I disclosed to you that I had physically abused my partner on several occasions. What would happen next in our clinical visit?
3. How often have you treated a male patient who had been (or is currently) abusing his female partner? In the past year? In your lifetime?
   - 3a. What circumstances led you to become aware that your patient was abusing their partner?
   - 3b. What happens in these circumstances?
4. Have you had patients who you suspected were abusive to their partners but were sure? What did you do?
5. Have you also been the provider for the victim whom the male patient was abusing?
   - 5a. If YES, how did you handle this situation?
   - 5b. if NO, imagine you are placed in this situation. What would happen?
6. Have you been the provider for children of a male patient who abuses his partner?
   - 6a. If YES, how did you handle this situation?
   - 6b. If NO, imagine you are placed in this situation. What would happen?
7. Have you received training about what to do if you are treating a patient with a history of perpetrating IPV?
8. Are you aware of any community resources for men who abuse their partners?
9. How do you feel about having a male patient who has committed IPV? Or, how do you think you'd feel when working with a man who abuses his female partner?