SPECIAL COMMUNICATION

How We Talk About "Perpetration of Intimate Partner Violence" Matters

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Many partners and children who are affected by intimate partner violence (IPV) are unable to leave abusive situations that put their health and safety at risk. Family physicians provide care for people who perpetrate IPV and are in a role that may allow them to recognize and counsel patients who are using violence. Appropriate referrals can potentially help these patients access effective interventions such as certified battering intervention programs in a manner that prevents violence for their families. The language used by physicians can facilitate or impede disclosures among patients perpetrating IPV who may be open or willing to discuss their use of violence. Talking about their behavior in ways that patients perceive as derogatory or confrontational may alienate people who use violence from initiating or engaging in meaningful discussions about their abusive behaviors in clinical settings and getting the help they need to stop their violence. To enable patients to safely talk about their own perpetration of violence, physicians need to develop appropriate language and a nuanced, evidence-based approach to broaching and discussing this issue with patients. As with other patient populations, being labelled may not accurately describe their identity, behavior, nor experiences, and result in them avoiding care. In keeping with trauma-informed approaches, we provide possible examples of respectful nonjudgmental language and nonthreatening clinically appropriate questions for people who use violence. Additional research is needed to identify how best to discuss perpetration of IPV with patients to help initiate change in their behavior while maintaining victim safety. (J Am Board Fam Med 2020;33:809–814.)

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To decrease the rates of intimate partner violence (IPV), physicians need to not just address IPV victimization with their female patients, but also with the men—and in some circumstances the women—who perpetrate violence. Every year, there are approximately 5 million episodes of IPV involving female victims in the United States,[1] with approximately 1000 femicides annually[2]. In addition, in the United States, 1 in 4 children witness parental IPV in their lifetime and 1 in 15 children witness parental IPV annually.[3] Failure to address perpetration of IPV with men leaves many women and their children, who are unable to leave the abusive relationship due to various reasons such as fear of injury or death, financial dependence, fear of job loss, and immigration concerns,[4] at risk for repeated trauma. Furthermore, to prevent the intergenerational cycle of violence, as young children who are exposed to violence in the household are more likely to perpetrate or experience violence as adults,[5] we must find ways to engage men who perpetrate IPV. Family physicians often see these men, as more than 60% of men who perpetrate IPV have a regular primary care physician,[6] even if we do not recognize them as abusive. As such, the American Academy of Family Physicians' Violence Position Article states that family physicians have a role in both recognizing perpetration of IPV and providing appropriate referrals.[7]

While people who perpetrate IPV need to be held accountable and take responsibility for their actions in order for change to occur, using

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potentially derogatory labels to describe them, such as *perpetrator*, *abuser*, *batterer*, *rapist*, *or monster*, may alienate those who could be open to initiating a discussion of the issue. This commentary is meant to discuss how labels used to describe abusive partners could potentially be hindering our ability to reach men who are open to receiving help. This special communication is not intended to provide comprehensive guidance on how to address IPV perpetration in clinical settings, which can involve complicated issues such as mandated reporting and referring to appropriate resources. It is imperative that any physicians who discuss IPV perpetration with their patients be aware of their legal and ethical responsibilities, such as to warn victims of violence (duty to warn) when there is a clear and present lethal danger and when their individual States require reporting to state authorities. We refer readers to the article published 2018 in this *Journal*, titled, "The Role of the Physician When a Patient Discloses Perpetration of Intimate Partner Violence, a Review of the Literature,"[8] for a comprehensive discussion about how to assess and intervene when a patient discloses perpetration of IPV in the primary care setting, which includes a section on addressing victim safety and mandated reporting. Furthermore, this commentary does not address screening for IPV perpetration, as there has been some research on this topic,[9,10] there is not yet enough research to assess the effectiveness, patient outcomes, and potential harms of such screening in the primary care setting.

Ideally, meaningful discussions in the health care setting could lead to abusive partners getting the help they need to stop using violence through proven effective interventions in a manner that prioritizes the health and safety of their families, such as through certified batterer intervention programs (BIP).[11] For those not familiar, BIPs are programs that address abusive behavior using a group approach, provide education rather than psychotherapy, and have consistent procedures for assessing dangerousness and protecting family members.[12] BIPs themselves sometimes do not include "batterer" in their titles for various reasons, including the realization that abusive behavior is not limited to physical battering but can include psychological abuse and controlling behavior, and labeling abusive partners solely as "batterers" is no more accurate than labeling people who have been abused solely as "victims." Hence, BIPs may go by entirely different names in different regions such as Domestic Abuse Intervention Programs in Minnesota and Intimate Partner Abuse Education Programs in Massachusetts. We encourage readers to become familiar with their local resources, including BIPs, and the referral process to such programs.

The transtheoretical model of behavioral change has been used to analyze the progression of people who perpetrate IPV through stages of change. The precontemplative stage (not recognizing a problem exists) and the contemplative stage (being aware of the problem, but having no intention to change) are associated with low motivation to change and resistance to interventions relative to the preparation, action, and maintenance stages.[13] If a precontemplative or contemplative person who uses violence against their partner does not engage in a discussion with their physician because of feeling alienated by a potentially derogatory term used by a clinician, then an opportunity to help a victim is lost. Per David Adams, EdD (Cofounder and Co-Director of Emerge, the first counseling program in the nation for men who abuse women), "nobody wants to identify as being a 'batterer'."[14] This is supported by an earlier study that showed that men were less likely to report IPV perpetration when asked directly by a physician compared with an anonymous survey.[10] In addition, previous research has shown that those who perpetrate violence often use a strategy of deny, attack, and reverse victim and offender (DARVO) when confronted about their violent behavior;[15] hence, physicians need to develop a nuanced and evidence-based manner to discuss perpetration of violence. To help readers with appropriate responses to use when addressing a patient who perpetrates IPV, we have included talking points developed by David Adams in Appendix 1.

Concerns for inappropriate labeling of people prevail in other areas, for example, addressing LGBTQ communities, and groups with disability or illness. With respect to the LGBTQ population, how a person is labeled may not be how they identify, and a person who identifies as *x*, does not necessarily have sex with a certain gender, any gender, or only one gender. Perceived discrimination and dissatisfaction with health care services may result in avoidance of routine health care services by the LGBTQ population[16]. Furthermore, we do not label people with mental illness, disabilities, diabetes, obesity, or other diseases, as labels are often experienced as derogatory, and to wholly define a

person by one aspect of them does not accurately describe identity, behavior, or experiences.

In the discourse on IPV, we need language that accurately describes the experience or use of violence by a person without other implicit connotations associated with labels. People who have had violence perpetrated against them often do not identify as a *victim* or *survivor*, and benefit from recognizing the limitations and harms of labeling. The briefing article, "Guidance for General Practitioners Responding to Domestic Abuse" encourages professionals "to adopt whichever language each patient uses to identify themselves."[17] If an individual frames their experience or use of violence with labels like *victim* or *abuser*, we recommend continuing to use clinically appropriate, respectful, accurate, and nonconfrontational language. Trauma-informed approaches include asking open-ended questions in a nonthreatening way such as, "What are you currently concerned about?" or "How are you dealing with this now?"

One of the most important principles in addressing violence is that a person is responsible for their own use of violence. Unfortunately, a person who abuses others may not recognize this until months or years of help, ideally through a BIP. Historically, labeling has sought to punish and criminalize, but is now increasingly understood as potentially alienating people from seeking help, perpetuating "us versus them" dichotomies, and causing harm instead of doing what is known to motivate people who use violence to change their ways. More specific ways of describing violence which also hold people accountable are to describe 1) their behavior, or 2) what happened. They "pointed a gun at him" or they "strangled her" are more definitive statements than to call someone a *perpetrator*, to which they may respond by deploying the DARVO response.

The exact phrase to describe the person who abuses others is context dependent, but in this article we have used the formula, "people who *x*," such that *x* refers to a specific behavior (eg, *people who use violence*, *perpetrate violence*, *engage in abusive or controlling behavior*, etc.). A phrase such as *people who abuse others* could be used rather than simply *people who abuse* which may be mistaken for a reference to substance use. The phrase, *abusive partner*, may be acceptable in certain contexts; however, partner-centric terminology may not always be appropriate when a person also uses violence against other family members. As terminology improves, we will need to reassess medical documentation and diagnoses, as ICD 10 codes for abusive partners, at present, tend to be various wordings of "perpetrator of spousal or partner abuse."

Improving the language of naming people who harm others will allow us to better address the problem of violence and create safety for people to talk about their own violence. Physicians previously interviewed stated that men would be unlikely to disclose perpetration of domestic violence if asked directly, but perhaps would be willing to discuss if asked how they handle conflict or if they witnessed domestic violence in the home when growing up.[18] Signage and other print materials in clinical settings may serve to facilitate such discussions. According to Promundo, "contrary to prevailing stereotypes, young men are eager to gain knowledge on safer and consensual sex, and are able to talk about manhood, emotions, and violence." [19] Hence, we should work to provide a safe environment to talk about any problem they are living with, including problems related to perpetrating violence.

In conclusion, to protect partners harmed by IPV and children who are exposed to violence at home, additional research is needed to explore how best to define persons who perpetrate IPV so as to not alienate them, and how to initiate safe and nonjudgmental discussions about perpetration of IPV in clinical settings. Addressing the behavior rather than applying potentially disparaging labels may facilitate such discussions and the provision of meaningful services, such as education about the harmful impact of IPV on families and referrals to BIPs. Physicians would need training and evidence-based guidelines, which ensure victim safety, on how to do such, which are currently lacking.[8,18] Developing the appropriate language to address IPV perpetration could lay the groundwork for developing screening protocols and possible clinic-based interventions for IPV perpetration.

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To see this article online, please go to: http://jabfm.org/content/33/5/809.full.

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Appendix
Tough (but Caring) Talk for Men Who Have Abused Their Partners

If you are a friend, co-worker, neighbor, teacher, coach or clergy of a man who has abused his partner, you are in a good position to help prevent future abuse, but only if you give the right feedback. Sometimes, we end up responding in a way that actually supports excuses for abuse; even if we are not intending to do that. Here are some talking points that will help you to hold your friend to a higher standard:

General Responses

1) Express concern and point out consequences:
   Say that you are concerned about him, citing 1 or more of the following possible consequences (based on your knowledge of what is most meaningful to him):

   - If this goes on, you could get arrested, or
   - ruin your relationship, or
   - push her (partner) away, or
   - harm your kids by being exposed to it, or seeing the aftermath, or
   - alienate your kids, or
   - cost a lot of money from legal consequences/paying for another residence, or
   - emotional and financial stress, or
   - harm your own, and partners, health, or
   - create bad publicity for you and your family, or
   - lose friends

2) Tell him that he needs to get help to make sure that this doesn't happen again (in his current or any future relationships). Point out the limitations of quick fix strategies, like:

   - Promises that it will never happen again (Your response: That's a good start but they backfire when immediate trust is expected)
   - Apologies (Your response: Great but apologies won't work if you expect immediate acceptance of your apology)
   - Gifts (Your response: Gifts don't mean anything if you keep repeating your behavior)
   - Getting help (Your response: Good but studies have shown that outcomes are poor for people who don't stick with it; also you have to get the right kind of help)
   - Bargaining (e.g. I'll get help if you get help; I'll get help if I can move back in) Your response: point out that he has to be committed to changing his behavior, and that she is not responsible for helping him to change, or rewarding him

Responses Specific to Particular Excuses He Might Be Making

"She provoked me"

- Nobody can cause you to do anything you don't believe in doing.
- You can't control her actions; you can only control your own.
- You are 100% responsible for how you choose to react.
- I'm not justifying what she did, but your violence can only made it worse.

"I lost control"

Point out things he did not do (punch partner with closed fist; stab her) as examples of how he did have control (as much as he wanted to)

That is a cop out; you are still responsible for your own behavior

"It is only because I love her so much that I have such strong feelings" (good intentions)

- That's not the way to show it.
- Your intentions are good but your behavior creates the opposite effects by pushing her away.

"I was just trying to point out how wrong she was" (good intentions)

- That may be but now all she remembers is your violence
- Would you want to listen to someone who hits you?

"I feel she's giving up on the relationship"

- If she doesn't want to reconcile, you must accept her decision.
- If you really love her, you must let her go. If she has concerns about your abusive behavior, you can work on that on your own. Even if it's too late for this relationship, it will help you to avoid repeating it in your future ones.
- (If he is young). This isn't going to be your only relationship. It's important for you to move on and to learn from your mistakes.

"I am just under so much stress"

- There's stress that you can't control and stress that you create for yourself
- Yes, all the more reason not to create more stress by getting yourself arrested, (point out other consequences)

"It only happened because I had too much to drink"

- You are still responsible for what you do when you drink. Not all drinkers hit their partners.

- Knowing that you might become violent or say ugly things when you are drinking, you should monitor your drinking.
- The consequences don't disappear just because you were drinking.

"It is the only time this has happened"

Great, but let us make sure it does not happen again.

"It was self-defense"

There's a difference between self-defense and paying someone back, with interest.

Self-defense means taking the minimum necessary actions to protect yourself from harm, for example by leaving the situation, blocking her blows, etc.

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