

# 'No one teaches us how to deal with this'

## *General practitioners' experiences of working with men who use violence in relationships*

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### Background and objectives

General practitioners (GPs) are, in theory, well placed in the healthcare system to identify and respond to male patients who perpetrate intimate partner violence (IPV). Men who use violence in relationships routinely present to healthcare settings, yet there is limited evidence to guide GPs in this area of their work. The aim of this study was to explore GPs' experiences of intervening early with male patients who use violence in their relationships.

### Methods

Semi-structured interviews were undertaken with 21 Victorian GPs and analysed thematically.

### Results

GPs were inexperienced and felt unprepared to identify and respond to male patients who perpetrate IPV, expressing concern that raising the issue may harm their therapeutic relationships with their patients.

### Discussion

Practical advice on how to identify and respond effectively to male patients who perpetrate IPV may help alleviate GPs' concerns. Our findings suggest that current guidelines and training provided to GPs are insufficient to help them navigate this challenging area.

**INTIMATE PARTNER VIOLENCE (IPV)** is a critical social and healthcare issue in Australia.<sup>1</sup> IPV refers to a pattern of behaviours, perpetrated by an intimate partner or ex-partner, that cause physical, sexual or psychological harm, and attempt to assert and maintain control over a partner.<sup>2</sup> Although both men and women can experience IPV,<sup>3</sup> it is mainly perpetrated by men against women.<sup>4</sup> One in four Australian women have experienced violence by an intimate partner,<sup>5</sup> although these figures are likely to be under-reported.

IPV is associated with a range of negative health outcomes, both for victims and perpetrators.<sup>6,7</sup> Male perpetrators can experience higher rates of alcohol and substance abuse and lower self-esteem, and are more likely to experience depression and anxiety than men who do not use violence.<sup>8,9</sup> Men who perpetrate IPV often attend healthcare settings and have a general practitioner (GP) whom they see regularly.<sup>8,10</sup>

In Australia, GPs are seemingly well placed in the healthcare system to have a key role in early intervention work with men who perpetrate IPV.<sup>5,11</sup> GPs see men regularly as part of their everyday practice, either alone or as part of a family, and consequently have an opportunity to discuss relationship issues including violence.<sup>24</sup> While GPs agree they have a

role in responding to IPV perpetrators,<sup>2,12,13</sup> it is unclear how GPs perceive this role or what factors might facilitate or hinder this work. Studies suggest that men who perpetrate IPV are willing to approach their GPs when seeking professional help for their violent behaviours and are open to discussing IPV with doctors.<sup>14</sup> Despite this, there is limited evidence or guidance for GPs on how to respond effectively to male patients who use violence in relationships.<sup>15,16,24</sup>

A recent review article<sup>17</sup> summarised the limited existing guidelines globally on what GPs should do when working with male patients who perpetrate IPV. Hegarty et al have suggested ways that GPs could identify and respond to men who use violence, and the partners of these men, in the Australian setting.<sup>24</sup> Few studies, however, have explored how GPs respond in practice. In the USA, a single study by Penti et al found that GPs responded in a variety of ways, including referral to psychiatrists or marriage counsellors, assessment for substance abuse issues, motivational interviewing and attempts at couples counselling.<sup>18</sup> To our knowledge, this is the only such study to date, and it is unknown how relevant the findings might be to the Australian context, which differs to the US healthcare setting (for instance, couples counselling is not recommended as a response to IPV [Box 1]).<sup>16</sup> Further

research that provides insight into GPs' experiences of working with men who perpetrate IPV is needed to inform training and support for GPs to ensure that their responses are effective. The aim of this study was to explore Australian GPs' experiences of intervening early with men who use violence in their relationships, and how GPs perceive they can be best supported in this work.

## Methods

We used semi-structured interviews to gain in-depth understanding of GP experiences.<sup>19</sup> Participants from metropolitan and rural Victoria were recruited via purposive sampling from a database of clinics involved in previous research projects. A research assistant contacted potential clinics to ascertain interest from the practice manager. The Plain Language Statement and consent form for the study was provided to all GPs at interested clinics. Consenting GPs returned their completed consent forms via fax or email.

Interviews were conducted by SM and KF, and covered topics such as GPs' encounters with male patients who perpetrate IPV, their views on asking men about IPV perpetration, the GPs' role in responding and their perceptions on how GPs can be supported. Individual

### Box 1. Why couples counselling is not recommended in cases of intimate partner violence<sup>16</sup>

- It is not appropriate to provide couples counselling when there is a power imbalance, such as in intimate partner violence.
- The general practitioner (GP) may inadvertently reveal information provided by the victim to the perpetrator, which puts the victim at increased risk of harm.
- Perpetrators can be persuasive in minimising or denying their use of violence, or blaming the violence on issues in the relationship.
- Perpetrators can also use violence-supporting narratives to minimise their responsibility, inviting the GP to collude with these narratives.

interviews took place via telephone (n = 18) or face-to-face (n = 1); one group interview was conducted face-to-face (n = 3). Interviews ranged from 19 to 35 minutes in length. The interviews were audio-recorded (with the exception of one participant who declined to be recorded but agreed to written notes being taken), transcribed, and analysed thematically using an inductive approach.<sup>20</sup> The data were coded by SM into descriptive codes, which were then grouped into broader interpretive codes and synthesised into overarching themes. The coding framework was reviewed by co-authors, who undertook a process of cross-coding.<sup>22</sup> QSR Nvivo 12 software<sup>21</sup> was used to aid the coding process. Ethics approval was obtained from the the University of Melbourne's Human Research Ethics Committee (ID 1543639).

## Results

Twenty-one GPs (11 female and 10 male) participated in this study; most of the participants (n = 16) worked in a metropolitan area. Five participants worked rurally.

The following four themes were developed through analysis of the participant interviews:

- an 'uncommon presentation'
- facing a role without confidence
- engaging perpetrators without losing them
- ongoing support.

### An 'uncommon presentation'

Overwhelmingly, GPs in this study claimed limited experience intervening with male perpetrators of IPV. Nine GPs stated that they had not worked with a perpetrator. For most of the remaining GPs who had knowingly dealt with perpetrators, it was something they did rarely.

*I don't know that I can recall a person or suspicion of a male patient being violent. (GP17)*

*The number of confessions I've had, that was a bloke, in, you know, 15 years, I could easily put on one hand, even half a*

*hand. So, it's [working with men who use violence] not something that I've done very often. (GP1)*

Male perpetrators were perceived by GPs to be hidden patients within the general practice population. This was often related to the idea that these types of men did not attend their practice or would not disclose the use of violence during a consultation if they did attend.

*It's very rare that a man is going to come in and sit down and say, 'I've got problems with the way I treat my partner'. That's pretty uncommon in my opinion. (GP10)*

*I think at a GP level it's more that somebody doesn't come in and say, 'I'm beating up my wife'. (GP13)*

Some GPs recognised the 'lack' of perpetrator presentations among their patient population as potentially due to their own failure to enquire during consultations.

*Of course, it doesn't mean that I haven't had patients who have [used violence], it just hasn't been, I guess, revealed, or I haven't asked [about] it as I've been seeing people. (GP7)*

For others still, IPV perpetration by male patients was situated within a context of a mutually unhealthy relationship. Rather than seeing a perpetrator of violence, some GPs saw a victim.

*I do feel that this guy is getting a bit stitched up by his wife actually ... I guess it's hard to know what's a chicken and what's an egg. (GP10)*

### Facing a role without confidence

GPs in this study acknowledged that they were well placed to have a role in responding to men who perpetrate IPV.

*Yeah, I think the GP's got an important role, because we probably see them [men] more than any other healthcare practitioner. (GP8)*

*I think we're in a perfect position for it [intervening early with men who perpetrate IPV]. (GP14)*

*General practice is the place to be really looking at this. We're a service that are ... you can go to a GP for anything ... so it's an obvious place to engage anybody. (GP11)*

Many perceived their role to be first-line responders (GP9) or a coordinator of care (GP10). However, many felt that they did not possess the necessary skills, or that they had not received adequate training, to be able to undertake this work effectively, leaving them feeling underprepared and lacking confidence.

*No one teaches us how to deal with this kind of situation [working with perpetrators]. It's not something we're taught how to do ... I don't know that I feel like I have the skills to deal with this ... very well. (GP4)*

*I second-guess sometimes whether I'm doing the right thing or not. (GP14)*

*I felt out of my depth. I felt probably anxious, probably upset, upset for the wife. I felt sort of, not very confident in my own ability to manage the situation ... I feel uncomfortable, I feel stressed, I feel that, you know, I'm not at ease when these sorts of issues are raised. (GP5)*

A key issue faced by GPs was how to raise the topic of IPV perpetration with male patients. Most were unsure of the appropriate language to use in these consultations.

*What are the right phrases? (GP20)*

*I actually think one of the barriers, possibly, for GPs is probably not knowing how to have the conversation about it with a male patient. (GP10)*

The uncertainty related to appropriate responses was reflected by some GPs engaging in couples counselling, a practice that is not recommended.

*What I would often do is I would try to actually invite the man to come with his*

*partner so that we can see what we could do to help the relationship. (GP15)*

When making referrals, GPs were more at ease with mental health specialists and medication or alcohol services, rather than specialist services for men's use of violence. GPs were relatively unfamiliar with men's behaviour change programs, despite these being the current recommended referral pathway in Australia.

*I didn't send him to any particular services or anything like that or, in fact I don't think I could name one of them ... I think I pretty much just managed his mood disorder. (GP2)*

*I don't know of any [referral services] that we have around that are working specifically with men who use violence in relationships. (GP9)*

### Engaging perpetrators without losing them

Striking a balance between naming the violence and supporting perpetrators to get help was a perceived challenge faced by GPs. Participants expressed that they had to find ways to keep their male patients engaged, while still acknowledging that their behaviour is unacceptable.

*It's often hard, sort of balancing between throwing them a life line and putting a way forward, but in the same time really acknowledging and saying that violence is unacceptable ... you have to find a way of engaging them in the process of saying, 'Well look, this is wrong, we need to do something', without losing them. (GP1)*

*I think the GP needs to ... still treat the patient as confidently and as humanely as possible, but nevertheless to indicate to the patient that this is not acceptable, and that for their partner's sake, and for their own sake, I need to do what I can to encourage them to get help. (GP5)*

GPs agreed on the need to address IPV perpetration in a supportive, non-judgmental way, yet some were

concerned about how to achieve this without colluding with their patients. For one GP, this balancing act was viewed as an 'ethical dilemma' (GP2).

*Your role is to be neutral and put aside your own biases and prejudices, step back and assess how you can help without being judgemental. (GP6)*

*It's trying to engage them without ... it has to be said, it's a difficult thing, so you don't want to ostracise them, you don't want to collude with them, you don't want to minimise it. (GP19)*

Building rapport with the perpetrator and expressing concern for their health were identified by GPs as enabling factors in engaging men in discussing IPV perpetration. Rapport was also seen as an important element for men to feel comfortable enough to disclose violence in the first place.

*If I know the patient well, and I've already built the rapport, then I kind of ... I usually just ask about things at home, things with your partner, anything happened that kind of worried them, or worried the partner, all that kind of stuff. More in and around home life and then kind of hone in on it. (GP8)*

*If the patient has come to me and I have a rapport with the patient then I don't have any fears. I'll just talk. Talk and talk in terms of, 'We are interested in your welfare. I'm concerned about you.' (GP20)*

Most GPs initially asked questions about relationships, mental health or alcohol and substance abuse as a strategy to engage in the topic without being too confronting.

*Yeah, I might make it a very open question, 'You seem a bit unhappy, how are things at home?' From that one, 'How are things between you and your partner?' Then just wait, see what the response is. (GP17)*

*I try to take a drug and alcohol history and within that I explore important relationships and whether there's been violence or not. (GP11)*

Questioning too hard about the topic raised concerns that it may adversely affect the doctor–patient relationship.

*If I start pushing, pressuring him, then he becomes closed up or defensive, then that's obviously going to potentially harm my therapeutic relationship with him. (GP2)*

*Sometimes [what happens] when you raise the topic, it puts them off. They won't come back to you even for a physical problem next time. (GP20)*

### Ongoing support

To effectively intervene with male perpetrators, GPs identified a need for further education and training in this area.

*I do need some specific skills on tackling or managing a man who uses violence in the home in a way that I know will actually work. (GP1)*

*In training GPs [to manage] domestic violence in general, we should be training them on how to deal with the perpetrator. (GP4)*

It was clear that GPs wanted specific, practical advice to guide their discussions with perpetrators, and well as easily accessible contacts to local men's behaviour change programs for referrals.

*Teach people the right phrases ... make it more standardised. (GP20)*

*Would make sense to have training regarding services for men, so people know where they are and how to access them. (GP4)*

The provision of emotional support and ability to discuss difficult consultations with colleagues was also seen as helpful.

*I think that support for the actual doctor in terms of their own emotional health might be needed. (GP7)*

*I mean debriefing afterwards is always helpful, so, you know, chat with your colleagues in the tea room at lunch. (GP2)*

### Discussion

This is the first study in Australia that specifically explores GPs' experiences of early intervention work with men who perpetrate IPV. Our findings suggest gaps in GPs' preparedness, knowledge and confidence to address perpetrators, highlighting areas for attention at the research and policy level.

Studies suggest that GPs consistently underestimate the number of patients that are affected by violence.<sup>11</sup> In this study, participants perceived that male perpetrators were uncommon in their patient population. Yet, statistically, this is unlikely to be accurate.<sup>5</sup> Misguided beliefs about the prevalence may stop GPs actively being alert to male patients who may be using violence. This may be compounded by GPs' uncertainty about how to ask their male patients about relationship behaviours. In a recent Australian study, male perpetrators from a men's behaviour change program called for the 'right person' to be asking the 'right questions' to enable self-awareness of behaviour and enact change.<sup>23</sup> GPs could potentially fulfil this role, and are therefore encouraged to move away from the image of a male patient disclosing, 'I'm bashing my wife', and to instead use appropriate language to promote an opportunity for discussion to occur.<sup>16</sup>

Engaging perpetrators and getting them to recognise and discuss their use of violence was a particular concern of the participants. GPs in this study were fearful that questioning male patients about IPV may have ramifications on the doctor–patient relationship. However, our study also found that establishing rapport and concern for welfare facilitated discussion about IPV perpetration. Studies from the UK<sup>17</sup> and the USA<sup>18</sup> have reported similar findings, suggesting that a trusting doctor–patient relationship made disclosure of IPV perpetration by male patients more likely. GPs who are able to foster a strong and supportive therapeutic alliance with their male patients may consequently find that help-seeking perpetrators feel more comfortable to disclose.<sup>14</sup>

GPs in our study reported limited responses to male patients perpetrating IPV. Men's behaviour change programs

were underused, and non-recommended approaches such as couple's counselling<sup>16</sup> were suggested by some participants. Australian<sup>24</sup> and international<sup>17</sup> guidelines consistently state that men's behaviour change programs are the referral option of choice for men who perpetrate IPV. However, in our study, any referrals made were more often to mental health or medication and alcohol services. Furthermore, as GPs often see the whole family, including both partners in an abusive relationship, it is critical that they receive adequate training on how to manage issues relating to confidentiality and victim safety.<sup>16,24</sup> Interestingly, challenges around undertaking safety assessments, mandatory reporting of child abuse and duty of care obligations were not mentioned by the participants in this study. This highlights that the aspects of addressing IPV perpetration with which GPs struggle most are in fact more basic and concentrated on communication skills and rapport-building.

Participants called for further training to help them navigate discussions about IPV with their male patients and to increase their awareness of men's referral services. Guidelines addressing these issues, particularly in the area of broaching the subject of violence with perpetrators, exist in the Royal Australian College of General Practitioners' (RACGP's) guideline *Abuse and violence: Working with our patients in general practice*.<sup>16,24</sup> Our findings imply that GPs are either unaware of these existing guidelines, or that guidelines alone are insufficient in regard to building confidence to respond to perpetrators. Peer support was also identified as being critical, yet there is little collaboration between GPs and specialists who may have more experience working with perpetrators (eg GPs working in prisons or in services with a focus on alcohol and substance abuse).

A major strength of this study is its novel contribution to an area that has previously been under-researched. The sample size (n = 21) and gender balance of participants for this qualitative study is also a strength. This study also had some limitations. GPs who agreed to participate may have had a particular interest in

IPV and were thus more engaged or knowledgeable about the topic. However, the lack of knowledge and readiness to respond to perpetrators among our study sample suggests that other GPs may be even less equipped to do this challenging work. Last, participants were limited to those practising in Victoria, primarily in metropolitan settings, and thus themes identified may not be reflective of GPs from a broader population.

### Implications for general practice

Our results highlight key gaps in the participating GPs' knowledge and confidence about identifying and responding to men's use of violence in relationships. Based on these findings, future training programs, undergraduate and graduate medical degrees and IPV curriculum for GPs could be strengthened to incorporate more information and practical skills specific to working with perpetrators. The RACGP's guidelines on working with perpetrators may need to be augmented with practical training that specifically targets the areas of concern identified in this study. Additionally, increasing cross-sectoral communication and collaboration (eg with women's shelters, Aboriginal health services, medication and alcohol services, and legal services) may assist in increasing GPs' practical skills in this area. It is also evident that assistance for GPs must include emotional support. We encourage GPs to engage in discussions with colleagues, peer support groups or formal counselling services in relation to the challenges of working with men who use violence in relationships.

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### References

- Department of Social Services. National plan to reduce violence against women and their children: Including the first three-year action plan. Canberra: DoSS, 2010.
- World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: WHO, 2013.
- Taft A, Hegarty K, Flood M. Are men and women equally violent to intimate partners? *Aust N Z J Public Health* 2001;25(6):498-500. doi: 10.1111/j.1467-842x.2001.tb00311.x.
- World Health Organization. Multi-country study on women's health and domestic violence against women. Summary report - Initial results on prevalence, health outcomes and women's responses. Geneva: WHO, 2005.
- Australian Bureau of Statistics. Personal safety survey 2016. Canberra: ABS, 2016.
- Campbell JC. Health consequences of intimate partner violence. *Lancet* 2002;359(9314):1331-36. doi: 10.1016/s0140-6736(02)08336-8.
- Rees S, Silove D, Chey T, et al. Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function. *JAMA* 2011;306(5):513-21. doi: 10.1001/jama.2011.1098.
- Coben JH, Friedman DI. Health care use by perpetrators of domestic violence. *J Emerg Med* 2002;22(3):313-17. doi: 10.1016/S0736-4679(01)00498-X.
- Gerlock A. Health impact of domestic violence. *Issues Ment Health Nurs* 1999;20(4):373-85. doi: 10.1080/016128499248547.
- Singh V, Tolman R, Walton M, Chermack S, Cunningham R. Characteristics of men who perpetrate intimate partner violence. *J Am Board Fam Med* 2014;27(5):661-68. doi: 10.3122/jabfm.2014.05.130247.
- American Academy of Family Physicians. Violence position paper. Leawood, KS: AAFP, 2014. Available at [www.aafp.org/about/policies/all/violence.html](http://www.aafp.org/about/policies/all/violence.html) [Accessed 10 May 2019].
- Miller D, Jaye C. GPs' perception of their role in the identification and management of family violence. *Fam Pract* 2007;24(2):95-101. doi: 10.1093/fampra/cmm001.
- Usta J, Feder G, Antoun J. Attitudes towards domestic violence in Lebanon: A qualitative study of primary care practitioners. *Br J Gen Pract* 2014;64(623):e313-e20. doi: 10.3399/bjgp14X680077.
- Morgan K, Williamson E, Hester M, Jones S, Feder G. Asking men about domestic violence and abuse in a family medicine context: Help seeking and views on the general practitioner role. *Aggress Violent Behav* 2014;19(6):637-42. doi: 10.1016/j.avb.2014.09.008.
- Tarzia L, Forsdike K, Feder G, Hegarty K. Interventions in health settings for male perpetrators or victims of intimate partner violence. *Trauma, Violence Abuse* 2017;1524838017744772. doi: 10.1177/1524838017744772.
- The Royal Australian College of General Practitioners. Abuse and violence: Working with our patients in general practice. 4th edn. East Melbourne, Vic: RACGP, 2014.
- Penti B, Timmons J, Adams D. The role of the physician when a patient discloses intimate partner violence perpetration: A literature review. *J Am Board Fam Med* 2018;31(4):635-44. doi: 10.3122/jabfm.2018.04.170440.
- Penti B, Tran H, Timmons J, Rothman EF, Wilkinson J. Physicians' experiences with male patients who perpetrate intimate partner violence. *J Am Board Fam Med* 2017;30(2):239-47.
- Hansen EC. Successful qualitative health research: A practical introduction. Crows Nest, NSW: Allen and Unwin, 2006.
- Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psych* 2006;3(2):77-101. doi: 10.1191/1478088706qp0630a.
- QSR International Pty Ltd. Nvivo qualitative data analysis, version 12 [computer software]. Melbourne: QSR International Pty Ltd, 2018.
- Barbour RS. Checklists for improving rigour in qualitative research: A case of the tail wagging the dog? *BMJ* 2001;322(7294):1115-17. doi: 10.1136/bmj.322.7294.1115.
- Forsdike K, Tarzia L, Flood M, Vlasis R, Hegarty K. 'A lightbulb moment': Using the theory of planned behaviour to explore the challenges and opportunities for early engagement of Australian men who use violence in their relationships. *J Interpers Violence* 2018;088626051878077. doi: 10.1177/0886260518780778.
- Hegarty K, Forsdike-Young K, Tarzia L, Schweitzer R, Vlasis R. Identifying and responding to men who use violence in their intimate relationships. *Aust Fam Physician* 2016;45(4):176-81.

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