

# Male victims of domestic abuse

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Implications for health visiting practice

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## **Abstract**

Domestic abuse is a significant public health issue globally. Although it is recognised that both sexes may be victims of domestic abuse, the phenomenon is commonly understood from the perspective of male to female violence, supported by a substantial body of research and policy focusing on female victims of domestic abuse. However, evidence shows that significant numbers of men are victims of female-perpetrated violence, but as the issue is under-explored, the extent and effects of abuse are poorly understood. For health visitors, working within communities in the United Kingdom (UK), knowledge of all aspects of domestic abuse is vital in the delivery of evidence-based practice.

A systematically conducted critical literature review aimed at establishing the current body of knowledge on male victims of domestic abuse was undertaken, and implications for health visiting practice considered.

Nineteen primary research studies were included in the review. A thematic analysis identified four themes: 'violent relationship', 'harms and behaviours', 'risk', and 'seeking help'. Results show that men reported being victims of female-perpetrated physical, emotional, psychological and sexual abuse, with some experiencing severe aggression, control and fear.

Health visitors have an important role to play in influencing policy and in practice addressing the health and social care needs of male victims of domestic abuse and their families.

**Key Words:** domestic abuse, domestic violence, intimate partner violence, male victims, abused men, female perpetrators, health visiting

## **Introduction**

Domestic violence and abuse, also termed intimate partner violence (IPV) may be experienced by individuals from all socioeconomic backgrounds. It is a significant public health issue globally. In England and Wales 8.2% of women and 4.0% of men are estimated to have reported domestic abuse in the last year, equivalent to a likely 1.3 million female and 600,000 male victims (ONS, 2016).

Domestic violence and abuse is defined as:

“any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass but is not limited to: psychological, physical, sexual, financial, emotional abuse” (Home Office, 2013, p.1).

This UK definition was extended to include young people under 18 years, and to include coercion, recognising that domestic abuse and violence may involve patterns of behaviours such as threats, humiliation and intimidation, which are used to harm, punish and frighten victims (Home Office, 2013). Women are more likely to be affected by all types of abuse and are at significantly higher risk of serious harm, with 81 female homicides perpetrated through partners or ex-partners recorded from April 2014 to March 2015 in England and Wales, as compared to 19 male deaths during this period (ONS, 2016).

Health visitors, as specialist community public health nurses, offer information, support and intervention for families with young children, seeking to improve health outcomes and

reduce inequalities (NICE, 2014a). Four guiding principles – searching for health needs, stimulating an awareness of health needs, influencing policies affecting health and facilitating health enhancing activities – underpin health visiting, with child safeguarding a core component of practice (NHS England, 2014; Appleton, 2015). Domestic abuse and violence adversely affects health, increasing risk of harm for adults and children exposed to this abuse (DH, 2009), and as such is an important issue for health visitors to understand. Women are at greater risk of harm from domestic abuse, yet substantial numbers of men are also affected (ONS, 2016). Research has predominantly examined male to female violence, with little focus on men’s experiences as victims (Mulrone and Chan, 2005; Graham-Kevan, 2007; Dempsey 2013). Indeed a recent Special Issue on Domestic Abuse and Safeguarding (Humphries and Bradbury-Jones, 2015) focused mainly on mothers’ and children’s experiences. Health visitors are identified as requiring “*detailed understanding*” of domestic abuse enabling them to effectively assess and identify risk (NICE, 2015, p 13). Seeking to address knowledge limitations and determine research needs, a preliminary literature review was undertaken relating to male victimisation of abuse and implications for health visiting practice considered.

### **Preliminary literature review**

Obtaining reliable data regarding the impact of domestic abuse on individuals is challenging but research indicates that male and female victims experience similar effects (Dempsey, 2013). Although similarities between the sexes exist, differences are evident. Fear has been reported by both men and women experiencing domestic abuse, but appears heightened in female victims (Dempsey, 2013). Women are more likely than men to identify domestic abuse as a crime and report, whilst men tend to minimize or trivialise the abuse experienced, with a greater reluctance to inform others (Dempsey, 2013). Although studies show that both men and women perpetrate violence (Graham-Kevan, 2007), knowledge of assessing victimisation risk for men is limited (Robinson and

Rowlands, 2009) and understanding of female perpetration of abuse, poor (Kernsmith and Kernsmith, 2009). Domestic abuse within same-sex relationships also appears underexplored, however comparable experiences to heterosexual relationships are reported (Donovan et al, 2006; Richards et al, 2003). Donovan et al (2006) found 40.1% of female respondents and 35.2% male respondents reported experiencing domestic abuse in a same-sex relationship, with similar numbers of lesbian and gay men reporting physical abuse. Supporting this, women have been found to equal or slightly exceed men in their use of physical violence towards intimate partners (Graham-Kevan, 2007; Palmetto et al, 2013), but are however more at risk of injury (Palmetto et al, 2013; Dixon et al, 2007). Furthermore, female-perpetrated violence, particularly in younger age groups, is reported to have increased (Kernsmith and Kernsmith, 2009).

Considering lifestyle factors, strong associations between unhealthy alcohol use, drug use and domestic abuse exist, increasing IPV perpetration (WHO, 2013; Atkinson et al, 2009) and victimisation risks (Dutton, 2007; WHO, 2014; Atkinson et al, 2009).

Social support is beneficial to health, reducing the deleterious effects of stress and adversity (Bidmead, in Cowley, 2002). Since the 1990s national UK policy has facilitated the development of formal community support networks for female victims of domestic violence and their children (Hester, 2007) but services within the United Kingdom (UK) for men experiencing domestic abuse are few, and largely helpline based (Robinson and Rowlands, 2006; Panteloudakis, 2014). "*Lack of public recognition*" of the issue is argued to increase difficulties for male victims (Cook, 2009, p. 107). Compounding this, healthcare practitioners are guided to focus on protecting women and children, routinely asking women about domestic abuse (DOH,2009; DOH, 2013). Individuals in same-sex relationships may experience particular difficulties in securing support, fearing disclosure of sexuality or homophobia (Richards et al, 2003).

In considering attitudinal and cultural influences, domestic abuse is increased where violence and gender inequality are accepted (WHO, 2013). Many societies were shaped by a patriarchal belief system under which hegemonic masculinity embracing hierarchy, aggression and heterosexuality, is valued (Dutton, 2006; Hatty, 2000). Hatty (2000) asserts that in modern industrialised nations men are generally considered capable of causing more harm to others than are women. Such beliefs may result in communities failing to recognise or acknowledge acts of female-perpetrated violence (DeFrancisco and Palczewski, 2014).

Challenging patriarchal systems, success in tackling violence against women is often attributed to feminist activism. In 1993, global pressure by women's groups facilitated adoption of the Vienna Declaration by 171 states, condemning violence against women, with European Union initiatives occurring after the mid-1990s. Implementation of agreements has been found most effective in countries with strong feminist movements (Weldon and Htun, 2013), and this has shaped domestic abuse policy within the UK. Whilst acknowledging the importance of this in protecting women and their children, a counter-argument to delivery of gendered policy is offered. Dempsey (2013) asserts that the feminist model viewing men as violent and women as victims of their violence, reinforces gender stereotypes, minimising the seriousness of female-perpetrated abuse and increasing the invisibility of male victims of domestic abuse. Furthermore it may be argued that such a philosophy also disadvantages female victims within same-sex relationships, failing to acknowledge that women may abuse other women (Richards et al, 2003). Yet the Gender Equality Duty (2007) which applies in England, Wales and Scotland seeks that people are not discriminated against in terms of gender, age, race, religion, disability and sexual orientation, (Scottish Government, 2007), and the Equality

Act (Home Office, 2010) directs public sector employees to eliminate discrimination in service delivery.

Acknowledging the above arguments and knowledge limitations, this study undertaken in completion of a master's degree, sought to establish the current body of knowledge on male victims of domestic abuse, with a general aim of making recommendations to enhance health visiting practice

Five specific research objectives were identified:

- 1) To identify the types and range of domestic abuse experienced by men
- 2) To identify the effects of domestic abuse on the physical and psychological health, and lifestyle behaviours of male victims.
- 3) To determine risk factors for male victimisation of domestic abuse
- 4) To determine what formal and informal support systems are accessed by male victims of domestic abuse and the acceptability and efficacy of these networks.
- 5) To determine what facilitates male disclosure of victimisation of domestic abuse

## **Methodology**

A critical literature review was undertaken adopting a systematic approach, within a 'critical theory' model. Critical theorists argue that research is neither value-neutral nor detached from political, historical and ethical influences (BERA, 2013) This approach encouraged reflexivity, and examination of personal beliefs and attitudes influencing understanding of the research topic.

Fink's (2014) framework was applied to the research process, facilitating a systematic approach. A search of the following health and social care data bases was conducted in

April 2014: CINAHL, Medline, BNI, PsychINFO, Web of Science and the Cochrane Collaboration for primary research papers published in the English language from 2004 to 2014. The search was restricted to a 10 year period to examine contemporaneous research.

Search terms were formed using key words identified through the preliminary literature review, refined using MeSH. Boolean logic operators 'AND' and 'OR' were used in searches to maximise information retrieval. Research focusing on female victims of domestic abuse or on children exposed to domestic abuse was excluded, and acknowledging the scope of this study, research focusing solely on victimisation within homosexual relationships or sexual abuse of men was also excluded. Included studies were undertaken in developed countries relevant to UK practice, and papers peer-reviewed. The 1678 search 'hits' were screened for relevance and duplicates removed. Of those potentially eligible, abstracts were read and full-text articles retrieved if appropriate, resulting in 22 eligible research studies (see PRISMA diagram, appendix 2)

Final review eligibility was determined through the use of a methodological screen using Critical Appraisal Skills Programme (CASP, 2013) tools. The majority of papers retrieved were cross-sectional studies using surveys. As CASP (2013) offers no generic quantitative appraisal assessment tool, an additional appraisal tool was sought. The Center for Evidenced- Based Management (CEBMA, 2014), a resource for researchers, provides a critical appraisal tool for surveys. This and the CASP (2013) appraisal tools were adapted for uniformity into 8 questions. Each question was scored 2 points for 'YES', 1 point for 'UNSURE/PARTIAL', and 0 points for 'NO' resulting in a possible total score of 16 points. A cut-off score of 10 was determined, below which papers were excluded from the review. This scoring system was applied to all 22 eligible papers resulting in the final 19 research studies included in the literature review (see Appendix 1 for templates). Of the 22 eligible studies, 21 were retrieved through database searches and one (Hines, 2007) through snowball sampling.

### Data analysis

Although five specific research objectives were formed through the preliminary literature review, an inductive approach to analysis was adopted to enable the results to be data driven. Thematic analysis, following Braun and Clarke's (2006) template was used whereby the entire data set was organised into initial codes and then grouped into themes once patterned responses were identified. Themes were initially identified through



prevalence of a patterned response, but were reviewed in relation to the initial study objectives.

## **Results**

### **Characteristics of studies**

Of the 19 studies, 17 were quantitative although some included limited supplementary qualitative data, and two were qualitative. Fourteen studies were conducted in the United States (US), three in Europe, one in South Africa and one internationally across 60 sites. Seven studies (Douglas and Hines, 2011; Drijber et al, 2013; Hines and Douglas, 2010; Mele and Roberts, 2011; Mills et al, 2006; Nayback-Beebe and Yoder, 2012; Reid et al, 2008) included male participants only, investigating experiences of men reporting domestic abuse, characteristics, and health effects. Hogan et al (2012) sought to inform professional practice through exploring the experiences of counsellors working with male victims of female-perpetrated abuse. Two studies focused on IPV perpetration, Whitaker (2014) researched motivational attributions in men and women, and Storey and Strand (2012) examined characteristics of women arrested by police for IPV. Muller et al (2009) sampled court records exploring male requests for legal protection from domestic abuse and subsequent judicial responses. The remaining eight studies included male and female participants investigating mental health symptomology (Afifi et al, 2009; Prospero, 2007; Prospero and Kim, 2009) and gender differences relating to domestic abuse (Gass et al, 2011; Cho and Wilke, 2010; Houry et al, 2008). Although focusing on male victims, studies involving both men and women were included if findings related to research objectives. Studies involving comparison between genders were considered valuable in increasing knowledge and understanding of the research topic, particularly regarding female perpetration of abuse.

Most studies were cross-sectional, and surveys/questionnaires were the commonest method of data collection. Researchers used similar measures, and the Conflict Tactics Scale (CTS), (Strauss, 1979) or Revised CTS (CTS-2), (Straus et al, 1996), tools most commonly employed.

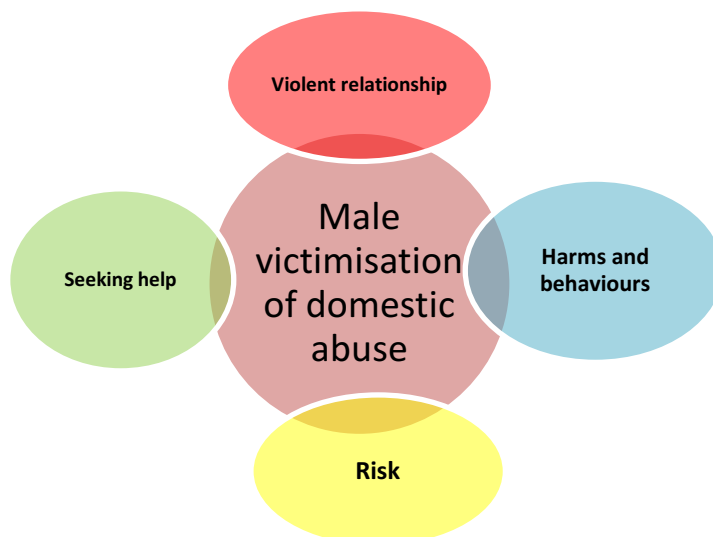
The CTS and CTS-2 are commonly used tools in medical and social research for measuring IPV, with the CTS considered the “*gold standard*” and the CTS-2 a refined version (Mills et al, 2005, p.448) thus explaining common usage of this instrument in the research studies. However, these tools have been criticised. The CTS-2, extended to include 78 individual items, may compromise results through respondent fatigue,

particularly when used in conjunction with other measures (Dietz & Jasinski, 2007). This applies to the review studies, where for example Douglas & Hines (2011) use seven measures including the CTS-2 to gather data. Furthermore, the CTS and CTS-2 are argued to inaccurately reflect violence within a relationship as intent or motive cannot be determined. Therefore pushing a partner away in self-defence, or pushing with intent to harm, would both score positively on the CTS (Chan, 2011). It may be argued that the CTS may produce findings supporting gender symmetry through emphasizing less severe forms of IPV such as “*stomping out of room*” (Whitaker, 2014, p 522). Dutton and Nicholls (2005) however dispute that the CTS and CTS-2 are gender-biased, arguing that the discovery of female violence through using these research measures can provoke criticism as findings may be contrary to societal beliefs and perceptions. Recognising that the CTS and CTS-2 are broad measures of IPV, they argue that the absence of contextual evidence applies equally to men and women, asserting that the tools are sensitive measures of IPV across both genders.

### **Data analysis and formation of themes**

This interpretive process led to the formation of four themes (figure one) – ‘violent relationship’, ‘harms and behaviours’, ‘risk’, and ‘seeking help’ – with each theme linking to study objectives.

*Figure One: Themes*



## **Violent Relationship**

The first theme 'violent relationship' relating to research objective one, reflects the specifics of abuse within the relationship, and the direction of relational conflict, both unilateral and bidirectional.

Coker et al (2008) report a lifetime prevalence of physical IPV alone of 5.8% for men. In contrast Reid et al (2008) report a lifetime prevalence of physical and non-physical IPV in men aged 18-54 years of 28.8%. Houry et al (2008) found 21% of men reported IPV in the past year, and in Afifi (2009), victimisation rates were higher in men in their current relationships. Young men appeared most at risk (Gass et al, 2011; Hines, 2007, Reid et al, 2008), although older men were also affected (Drijber, 2011, Reid et al, 2008) with Drijber et al (2013) finding victimisation to be most common in men aged 35 to 54 years.

Men reported experiencing physical assaults (Cho and Wilke, 2010; Coker et al, 2008; Drijber et al, 2013; Hines and Douglas; Mele and Roberts, 2011; Mills et al, 2006; Nayback-Beebe and Yoder, 2012; Reid et al, 2008). An object, such as a household item was commonly used (Drijber et al, 2013) and men were found more likely than women to be victim of aggravated assaults involving use of a weapon (Drijber et al, 2013; Cho and Wilke, 2010). Emotional, psychological, verbal (Coker et al, 2008; Drijber et al, 2013; Hines and Douglas, 2010; Mele and Roberts, 2011; Mills et al, 2006; Muller et al, 2009; Nayback-Beebe and Yoder, 2012; Reid et al, 2008), and sexual abuse (Hines and Douglas, 2010, Prospero, 2007; Prospero and Kim, 2008), were reported. Hines and Douglas (2010) found that female partners of male victims seeking help for domestic abuse were reportedly 5.28 more likely to insist on sex when their partner did not want to compared to the comparison sample.

Men were significantly more likely than women to report verbal abuse (Coker et al, 2008).

Men reported harassment (Mele and Roberts, 2011) and threats of harm (Mele and

Roberts, 2011; Mills et al, 2006; Nayback-Beebe and Yoder, 2012) with all respondents in Mele and Robert's (2011, p.68) sample of men seeking 'Protection From Abuse' (PFA) against their female partners, reporting that they felt "*in immediate danger*". A PFA is a court order granted in Pennsylvania state, US, to a person who is "*assaulted or threatened by a current or former intimate partner*" (Mele and Roberts (2011, p.64). Mills et al (2006) found an association between threatening harm and physical violence, which may partially explain male victims' perceptions of fear.

Duration of abuse varied. In Drijber et al's (2013) study, 79% (n=286) men reported IPV victimisation lasting over 1 year, with half of those reportedly abused for more than 5 years. Nayback and Yoder (2012) reveal victimisation experienced by one man lasting over an 18 year marriage, continuing for 1 year after divorce. Reid et al (2008) found the duration of non-physical abuse to be greater. Men cited multiple incidents of domestic abuse (Drijber et al, 2013; Mills et al, 2005; Reid et al, 2008) with nearly half of Drijber et al's (2013) respondents reporting more than 10 abuse episodes a year.

Comparing male and female attributions for perpetrating IPV, women reported a higher loss of temper and use of controlling behaviours than men (Whitaker, 2014). Similarly, female partners of men seeking help for IPV were reported to use significantly higher levels of severe psychological abuse, physical aggression, and controlling behaviours, in comparison to a community sample (Hines and Douglas, 2010)

However, indicating complexity, bidirectional violence within relationships was reported in 5 studies (Coker et al, 2008; Hines and Douglas, 2010; Houry et al, 2008; Mele and Roberts, 2011; Prospero and Miseong, 2009) with male and female respondents reporting both perpetration and victimisation of IPV. Significantly high levels of bidirectional aggression were found in Hines and Douglas's (2010, p.52) 'helpseeking' sample, with male victims of abuse also using violence against their partners. The authors suggest this

could be attributed to retaliation or “*violent resistance*”, as these findings are similar to those of studies focusing on ‘battered women’.

### **Harms and behaviours**

This theme, relating to research objective two identifies the health effects and associated lifestyle behaviours of men experiencing domestic abuse.

Men reported sustaining physical injuries (Hines and Douglas, 2010; Mills et al, 2006), although did not report compromised physical health (Reid et al, 2008; Coker et al, 2008). However, men who sustained physical and psychological IPV were more likely to report heavy alcohol use, and therapeutic and recreational drug use (Coker et al, 2008; Afifi et al, 2009) suggesting that indirectly the physical health of male victims is harmed.

Examining police records, Storey and Strand (2012) found 54% (n=28) of male victims had ‘personal problems’ including substance misuse, mental health and employment difficulties, and about a quarter were extremely fearful and considered by police to be living in an unsafe situation.

A consistent finding in this review is of stress and psychological harm. Psychiatric comorbidity was found for men reporting domestic abuse (Afifi et al, 2009; Coker et al, 2008; Douglas and Hines, 2011; Hines, 2007; Houry et al, 2008; Prospero, 2007; Prospero & Kim, 2009; Reid et al, 2008) with those experiencing loss of power and control reporting significantly increased symptomology (Coker et al, 2008; Houry et al, 2008) and chronic mental illness (Coker et al, 2008). Significantly severe depressive symptoms were reported in older physically abused men (Reid et al, 2008). A significant positive correlation between the level of abuse sustained and PTSD symptoms in men was found (Hines, 2007). Male and female IPV victims equally suffered psychological harm (Prospero, 2007), with mental health symptoms related to amount and severity of abuse experienced, irrespective of gender (Prospero, 2007; Houry et al, 2008). Sustaining

psychological abuse was as strongly related as physical abuse to negative mental health outcomes (Coker et al, 2008), but men were less likely than women to disclose this form of abuse (Drijber et al, 2013).

Of those disclosing bidirectional abuse, 29.2% men indicated that they felt controlled, unsafe and fearful of their partner, with these perceptions associated with depressive and post-traumatic stress disorder (PTSD) symptoms (Houry et al, 2008). Significant associations between male sexual IPV victimisation and mental health symptoms, was found (Prospero, 2007; Prospero and Kim, 2008) with increased anxiety, depression and somatization reported. Mental health effects on men sustaining IPV were found to differ between racial groups (Prospero and Kim, 2009; Houry et al, 2008), and Hines (2007) found that PTSD symptoms reported by male victims varied across international sites, indicating that ethnicity and culture may influence experiences.

## **Risk**

Relating to research objective three, this theme identifies risk factors for male victimisation of domestic abuse. Childhood experiences appear influential with consistent reports in the literature regarding associations between early traumatic events and later perpetration and victimisation of domestic abuse. Highly relevant to health visiting practice, the theme also includes current involvement of children in domestic abuse, with review findings indicating harm risks to children.

Men exposed to physical and sexual abuse in childhood were more likely to report victimisation of domestic abuse (Afifi et al, 2009; Coker et al, 2008; Gass et al, 2010).

Female IPV perpetration was significantly associated with childhood exposure to physical

abuse and with low educational attainment (Gass et al, 2010). Witnessing parental violence and lack of a close relationship with the primary female caregiver in childhood were significantly associated with male victimisation and with female perpetration of domestic abuse (Gass et al. 2010).

Abuse was more likely to be experienced by those living with their partners (Storey and Strand, 2012). Gass et al (2011) found men on low incomes more commonly sustaining IPV, although Coker et al (2008) found no significant association between employment, family income and IPV victimisation for men. An association between alcohol use and perpetration of domestic abuse was found (Coker et al, 2008; Gass et al, 2011), this association significant for females with increased likelihood of early onset alcohol abuse and/or dependence (Gass et al, 2011). Mental health difficulties were also associated with female perpetration of abuse (Gass et al, 2011; Storey and Strand, 2012), as were substance misuse, employment problems and previous criminality (Story and Strand, 2012).

A large number of research participants reported living with children (Reid et al, 2008, Storey and Strand, 2012, Nayback and Yoder, 2012). A high percentage of children are recorded in Hines and Douglas's (2011) 'helpseeking' sample, with this sample reporting high levels of severe bidirectional psychological and physical aggression. Male victims of domestic abuse reported fears that abuse escalation could result in injury to their children (Storey and Strand, 2012). Children were sometimes used 'as a means of power' forming part of the abuse, with men feeling helpless for fear of losing contact. Nayback-Beebe and Yoder (2012) describe the exposure of a male victim's children to severe verbal abuse perpetrated by their mother, and their alienation through the abuse from their father. Child involvement was a reason for contacting police (Drijber, 2013) and appeared influential over male requests for legal protection from abuse (Mele and Roberts, 2011).

## Seeking help

Relating to research objectives four and five, this theme reports on sources of support accessed by male victims and associated help-seeking experiences.

Men experiencing domestic abuse largely accessed informal sources of help such as friends, relatives and neighbours, and anonymous online support (Douglas and Hines, 2011; Drijber et al, 2013) with ninety per cent finding family and friends helpful (Douglas and Hines, 2011). Few (18.1%) accessed medical professionals, but when they did were mostly satisfied with the support received, reporting that they 'been taken seriously' and their injuries investigated (Douglas and Hines, 2011). Underreporting by men appears a common thread. Male IPV victims articulated feelings of embarrassment, denial, minimization and self-blame (Hogan et al, 2012; Storey & Strand, 2012). Deterring men from contacting the police were perceptions of shame, "*not being taken seriously*" and believing "*the police cannot do anything*" (Drijber, 2013, p.175). Less than 15% of male victims in Drijber et al's (2013) study reported abuse to the police, but were more likely to call police following a physical assault (Drijber, 2013). Douglas and Hines (2011), report that only 44% of men contacting the police found the resource helpful. Inconsistencies in judicial decision-making were also reported (Muller et al 2009; Mele and Roberts, 2011), with judges 16 times more likely to grant 'Temporary Restraining Orders' for women in cases of low level violence than they were for men (Muller et al, 2009).

Men also reported largely negative experiences when seeking help from domestic violence agencies with 95.3% men (n=81) feeling that the agency "*was biased against men*". Some reported being "*accused of being the batterer*", and were then were redirected to "*batterer's program information*" (Douglas and Hines, 2011, p.479).

Possibly contributing to help-seeking barriers is professional uncertainty regarding this issue. Counsellors working with male victims expressed disbelief – "*how can this possibly be happening to a man*", and surprise at the "*extent of violence, mental and emotional abuse inflicted by female partners*". (Hogan et al, 2012, p. 47-49). Difficulties accessing support for male victims due to limited availability of services was also reported (Hogan et al, 2012).



Furthermore, Douglas and Hines (2011) evidence significant health effects relating to male victims success in securing support, with cumulative positive experiences on seeking help reducing men's alcohol consumption, and cumulative negative support episodes increasing PTSD.

A further barrier to securing help appears the lack of a validated screening tool for IPV in men. Mills et al (2005) investigated the use of two brief screening tools, finding neither sufficiently sensitive in detecting male victimisation of physical and psychological aggression. No other study researched screening methods, so it remains unclear how to effectively identify male domestic abuse victims in professional settings.

Reference	Sample and purpose of study	Method	Results
Afifi et al (2009)  Country: US	1,116 males; 1,138 females 18 yrs. + Recruited from National Comorbidity Survey Replication (NCS-R) representative of US population  To understand epidemiology of IPV experienced by men/women	Cross-sectional Face-to-face interviews Conflict Tactic Scale Statistically weighted analysis. Adjusted logistical regression models	<u>Men</u> : exposure to child sex abuse associated IPV risk. IPV associated with disruptive behaviour and substance misuse. Externalising symptoms <u>Females</u> : exposure to child physical and sexual abuse associated with IPV. IPV increased odds of anxiety and suicidal ideation. Internalising symptoms
Cho & Wilke (2010)  US	298 men; Comparison: 2,462 women 18 yrs. + Recruited from National Crime Victimization Survey (NCVS)  To examine male victimisation of IPV exploring effect of perpetrator arrest on re-victimisation	Cohort study Longitudinal Face-to-face interviews 6 monthly for 3 years. Descriptive statistics Logistic regression models	More women reported IPV victimisation than men; more women injured Female perpetrators used more weapons and severe violence in comparison to male perpetratorstims Same number of men and women reported severe injuries Male victims revictimised less than women but female arrest did not reduce odds of revictimisation for men No significant differences in the likelihood of police arrest by gender
Coker et al (2008)  US	6,790 women 7,122 men  To understand epidemiology of IPV experienced by men/women	Cross-sectional, telephone survey Conflict Tactic Scale Power & Control scale Health questionnaire Statistical analysis using SAS 8.1	IPV lifetime prevalence of physical abuse alone: 13.3% women; 5.8% men Prevalence of psychological IPV alone: 17.3% men; 12.1% women. Current employment and family income <u>not</u> significantly associated with IPV for men Strongest risk factor for IPV, both men/women: childhood physical abuse Partner's alcohol use associated with IPV for men/women All forms of IPV significantly associated with depressive symptoms men/women; Heavy alcohol use and therapeutic drug use associated with both physical and psychological IPV Men all forms of IPV associated with recreational drug use. Increasing psychological IPV scores strongly associated with increased risk of current poor health and depressive symptoms men and women
Douglas & Hines (2011)  US	302 men seeking help for IPV victimisation  To explore experiences of men seeking help for IPV	Cross-sectional, telephone interview On-line questionnaire Revised Conflict Tactic Scale Logistic regression analysis	Informal support most commonly accessed <i>Most helpful support</i> : family/friends; medical professionals. <i>Least helpful support</i> : police; DV agencies Significant relationship between cumulative positive helpseeking experiences and alcohol abuse Significant positive relationship between cumulative negative help seeking experiences & Post Traumatic Stress Disorder (PTSD).
Drijber et al (2013)  Netherlands	380 male participants (8 excluded from analysis as questionnaires incomplete = 372 male participants (n=372)  To investigate characteristics of male victims in Netherlands	On-line survey questionnaire Descriptive statistical analysis, chi-square test, logistic regression analysis	Most common age group of victims: 35 – 54 years Duration of violence: 1–5 yrs. (40%); over 5 yrs. (39%) Female perpetrator 90% (n=335) 67% of victims reported emotional and physical abuse 46% reported more than 10 incidents of abuse per year Physical and psychological harms reported 23% (n=85) reported that alcohol/drugs used prior to violence (60% by offender)

			<p>Less than 15% of victims reported violence to police;  <i>Reasons for not contacting police:</i> fear of not being taken seriously; shame; belief that police can't do anything.  <i>Reason for contacting police:</i> wishing police could stop violence (42%); children involved (42%); need for help (40%)  Men more likely to contact police following physical assault  62% spoke to friend/family/doctor. 42% sought anonymous help on internet</p>
Reference	Sample and purpose of study	Method	Results
<p>Gass et al (2011)</p> <p>South Africa</p>	<p>4,351 men and women from national study.  Sample taken from survey of 4351 adults.  Study cohort = 1,715 adults  Men (n=641)  Women (n=1,074)</p> <p>To understand epidemiology of IPV experienced by men/women</p>	<p>Cross-sectional Questionnaires and interviews  Statistical analysis: Taylor series linearization method, chi-square tests, logistic regression.</p>	<p>IPV victimisation reported by 29.3% women and 20.9% men within their most recent intimate relationship  Prevalence of reported male victimisation of IPV highest in 1 -34 yrs. age group  Income of male victims lower than those not reporting victimisation  Male victims twice as likely to have experienced physical abuse in home; 3.5 times to have witnessed parental violence; 3 times as likely to report no close relationship with primary female caregiver in childhood.  Low income, parental violence and lack of close relationship with primary female caregiver remained significant risks for male victimisation of IPV after statistical analysis  <i>Significant factors associated with female perpetration of IPV:</i> low educational attainment; childhood physical abuse and exposure to parental violence; early and adult onset alcohol abuse.  Women perpetrators more likely to report lack of close relationship with primary female caregiver in childhood</p>
<p>Hines (2007)</p> <p>US researchers. Data from 60 international sites</p>	<p>3,461 male and 7,367 female university students - responses used for site-level scores</p> <p>To examine posttraumatic stress as a possible consequence of IPV in male victims</p>	<p>Cross-sectional survey. Measures: Revised Conflict Tactic Scale (CTS2), Post Traumatic Stress (PTS) symptoms scale, Gender Hostility to Men scale (site- level measure) and Violent socialization Scale (site-level measure)  Statistical analysis using software</p>	<p>25.9% men reported sustaining IPV in previous year (9.3% severe). Female responses eliminated from dataset so no comparison available  <i>Variations in IPV sustained:</i> 0% in Taiwan, to 77.3% in Iran (minor); 0% in Calcutta, to 28.6% in New York (severe IPV)  IPV victimisation significantly associated with Post Traumatic Stress (PTS) symptoms in all sites.  Significant positive correlation with level of IPV sustained and PTS symptoms  PTS symptoms increase in sites with higher 'Hostility' scores and in sites with <i>lower levels of violent socialisation.</i></p>
<p>Hines &amp; Douglas (2010)</p> <p>US</p>	<p><i>Sample 1:</i> 302 men seeking help for IPV  <i>Sample 2:</i> 520 men random community sample</p> <p>To examine the experiences of men seeking help for IPV</p>	<p>Cross-sectional telephone interview  On-line questionnaire  Revised Conflict tactics scale  Statistical analysis</p>	<p><u>Helpseeking sample:</u> women partners reported to use all types of IPV; statistically significantly higher rates of all forms of IPV, consistent with some men experiencing 'intimate terrorism'.  Community sample: rates and frequencies of IPV significantly lower than sample 1. IPV consistent with 'common couple violence'.  Men in helpseeking group: perpetrated more psychological and physical aggression. Used significantly more minor psychological aggression than community sample, but <i>fewer</i> controlling behaviours.  High level of aggressive behaviour in helpseeking group</p>
<p>Hogan et al (2012)</p> <p>UK</p>	<p>6 counsellors working with male victims</p> <p>To increase knowledge of the male victimisation of domestic abuse considering practice implications for those working therapeutically with male victims</p>	<p>2 semi-structure interviews  Data analysis: Interpretive Phenomenological analysis</p>	<p><i>Counsellor's experiences:</i> surprise at victims reports - "how can this happen to a man"; client's feelings of embarrassment, denial, difficulty in acknowledging victimisation. Lack of recognition  <i>Impact on counsellors:</i> surprise on learning of victim's experiences; negative impact on counsellor's views of women and society; personal views, assumptions challenged. Sense of reward and responsibility.  <i>Coping strategies used by counsellors:</i> challenging, concern over victims safety compounded by lack of resources for men; need for supervision; need to keep self safe ('time-out', recreation); value of experience</p>

Houry et al (2008) US	Convenience sample 2,737 patients accessing hospital Emergency Department (ED) department. Unable to identify gender breakdown of sample.  To compare differences between male and female victimisation and perpetration	Cross-sectional Survey Women's Experience With Battering Scale (WEB) Statistical analysis; chi-square and Fisher's analysis	772 participants reported perpetration, victimisation or both 22% women & 21% men positive for victimisation. 7% women, 5% men positive for perpetration. 12% women, 13 % men reported bidirectional IPV Female victims significantly higher WEB scores (reflecting high level of abuse): 27% female victims vs 6.3% male victims. Women disclosing victimisation and perpetration significantly higher WEB scores in comparison to men disclosing both victimisation and perpetration: 45.9% women; 29.2% men reporting bidirectional IPV had high WEB scores. Depressive symptoms and PTSD associated with higher WEB scores (men and women)
<b>Reference</b>	<b>Sample and purpose of study</b>	<b>Method</b>	<b>Results</b>
Mele & Roberts (2011) US	77 men who obtained Protection From Abuse (PFA) against female partner  To address knowledge limitations regarding men seeking PFA against female partner	Data from individual case files analysed	<u>Men who did not withdraw PFA:</u> all felt in 'immediate danger from defendant'. 82.1% men reported experiencing physical abuse; 39.3% threatened with firearm. 39.3% reported psychological/emotional abuse. 35.7% had reciprocal PFA files against them <u>Men who withdrew PFA:</u> 42.9% had PFA files against them. 61.9% filed for more than 1 incident of abuse. 81% reported physical abuse. Reasons given for withdrawal of PFA included 'getting back with defendant', 'attending counselling'. In both groups men were unsuccessful in obtaining relief requested from court (housing, release of defendants firearms)
Mills et al (2006) US	Convenience sample of 55 men attending Emergency Department (ED)  To determine accuracy of screening tools for male victims of IPV	Prospective verbal survey Revised Conflict Tactics Scale Hurt/Insult/Threaten/Scream (HITS) tool Partner Violence Screen (PVS)	HITS and PVS not sensitive tools for detecting psychological aggression and physical violence. 14-33% men identified as IPV victims on CTS-2 would have been missed with these tools
Muller et al (2009) US	Court records: 157 petitions involving intimate partners seeking temporary restraining order (TRO). 131 female plaintiffs; 26 male plaintiffs.  Investigating likelihood of male TRO requests being granted	Comparison of male and female applicants. Analysis of court records. Statistical analysis; Chi Square analysis; logistic regression models. SPSS Version 15.0	Female requests for protection significantly higher (83.4%) TRO requests involving low level violence more likely to be granted for female plaintiffs. When controlling for violence, judges 16 times more likely to grant female TRO request compared to male request No evidence of discrimination in cases reporting moderate to high violence.
Nayback-Beebe & Yoder (2012) US	One 44 yr. old male  To gain a holistic understanding of the lived-experience of a male IPV victim	3 in-depth semi-structured interviews. Phenomenological data analysis (Colaizzi's technique)	<i>Living in the relationship: "confrontation from within".</i> Questioning own beliefs, values and actions; "what have I done to cause this?" trying to make sense of situation. Setting boundaries and changing these when 'line crossed'. Belief that IPV was a private issue until violence escalated. Internal turmoil <i>Living in the relationship: "confrontation from without":</i> actions or experiences that precipitated abuse; victim verbally challenging abuser about behaviour resulting in excuses, ignoring, minimising, physical assault, threats to kill. Witnessed by children. Other people involved. External turmoil. <i>Leaving the relationship:</i> realised only 2 options: to accept situation and remain in relationship or to leave. Children motivator for leaving. Sense of loss, fear, sadness for children as relationship relinquished. <i>"Living with a knot in your stomach":</i> overarching theme.
Prospero (2007)	573 university students =	Cross-sectional Survey	Significant associations in both females and males between victimisation of high physical and

US	241 male 332 female  To explore gender differences in mental health outcomes among university students reporting IPV victimisation	Revised Conflict Tactics Scale Statistical analysis: Chi-square analysis; correlation analysis; multivariate analysis	psychological IPV and higher levels of anxiety, depression, hostility and somatization. No significance difference between gender in reporting of mental health symptoms: higher mental health problems related to amount of violence experienced not whether victim male or female.
Prospero & Kim(2009) US	676 university students 257 male 419 female  To investigate the effects of IPV on mental health among women and men in four different racial/ethnic groups	Cross-sectional Survey Revised Conflict Tactics Scale, Revised Controlling Behaviours Scale, Symptom Questionnaire. Statistical analysis: Pearson's correlations; binary logistic regressions; SPSS 15.0.	All racial/ethnic groups revealed high levels of mutual violence and coercion. Victimisation associated with mental health symptoms Asian American women and Latino American men reported highest effect of IPV and coercion on mental health symptoms
Reid et al (2008) US	450 males  To describe prevalence, severity, duration of IPV and associated health outcomes in adult men	Telephone interview Statistical analysis: multivariate logistic regression models.	<i>Demographics:</i> participants largely high income and education status; 81% white; 85.2% in intimate relationship, 95.5% with women. 28.8% men aged 18-54 yrs. and 26.5% men 55+yrs. reported physical and non-physical victimisation of IPV in their adult lifetime. No men reported sexual IPV. 68.1% men reported multiple occurrences of physical IPV; 92.4% reported more than one episode of non-physical IPV. Across all age groups 29% of those reporting physical IPV reported moderate or extremely violent abuse. Higher in 55+yrs group - 40.7% <i>Duration:</i> 52.5% 18-54yrs reported physical IPV lasting over 1 year (12.5% over 10 yrs.); 82% in this age group reported non-physical IPV lasting more than 1 yr. 42.3% of 55+yrs reported physical IPV lasting over 1 yr. (11.5% over 10 yrs.) 72.5% men 55+ yrs. reporting non-physical IPV lasting over 1 yr. <i>Health:</i> Mental health outcomes poorer in men reporting IPV experiences; greater in older men; physically abused older men 3.1 times more likely to report severe depressive symptoms. No compromised physical health reported in either age group.
<b>Reference</b>	<b>Sample and purpose of study</b>	<b>Method</b>	<b>Results</b>
Story & Strand (2012) Sweden	Women arrested by police for perpetration of IPV (n=106)  To examine characteristics of female perpetrators of IPV and characteristics of their male victims	Audit of police records comparing 2 samples where 2 different risk assessment tools were used: Spousal Assault Risk Assessment (SARA); Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER)	<i>Demographics:</i> Mean age of perpetrators = 36 years; 55% of cases perpetrator and victim had child; 43% co-habiting; 35% married <i>Perpetrators:</i> all female in sample; all arrested; actual/attempted/threatened violence 82% cases. Escalating violence (frequency/severity) 38% cases; 19% previous criminality; 83% intimate relationship difficulties (lack of ability to establish/sustain relationships); 26% evidence of substance misuse; 23% evidence of mental health problems; 21% employment problems. <i>Male victims:</i> 54% inconsistent attitudes/behaviour toward perpetrator (minimization; denial; normalizing; blaming self; justifying perpetrators actions); 54% men had personal problems (mental health/substance misuse/employment/legal difficulties); 27% considered to have inadequate access to resources; 23% considered to have unsafe living situation; 21% extremely fearful of perpetrator.

Whitaker (2014) US	5,035 university students 1,336 male 3,699 female  To explore whether males and females attribute different reasons to their IPV and to explore whether IPV tactics differ	Cross-sectional survey Revised Conflict Tactics Scale Statistical using software	<i>Male perpetration:</i> 15% male respondents reported perpetration of physical IPV; 39% psychological IPV within past yr. <i>Female perpetration:</i> 29% females reported perpetration of physical IPV; 41.1% psychological IPV within past yr. <i>Severity of IPV perpetration:</i> reported higher in males: 1.0% of males, 0.59% females reported choking/burning partner <i>IPV attributions:</i> higher use of controlling behaviours reported by women (to make partner do what I wanted/make listen) and higher loss of temper. 9.9% men vs 6.2% women using IPV in self-defence. 4.3% men compared with 2.7% women used IPV in retaliation to physical IPV
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*Table 1: Summary of Studies Included in Literature Review*

## Discussion

The first objective of this review sought to determine the types and range of domestic abuse experienced by men. Findings collated under the theme of 'violent relationship' indicate that abuse experienced by men encompasses the breadth of harms as defined in the UK definition of domestic violence and abuse (Home Office, 2013), including exposure to coercive and controlling behaviour. Johnson (1995; 2006) defined a pattern of controlling violence within intimate relationships as intimate terrorism whereby the perpetrator seeks to dominate using force and emotional abuse. He argued that intimate terrorism is largely perpetrated by men against women, stemming from patriarchal beliefs and structures, and that victims may use 'violent resistance' in self-defence or retaliation. Johnson (1995) classified less severe, non-controlling conflict within intimate relationships, where both partners use violence equally, as 'common couple violence'. Research shows that many perpetrators of domestic abuse are victims too (Dixon et al, 2012). Bidirectional violence is found in this review, but the absence of contextual information makes it difficult to assess relational dynamics. However, it appears that some men are victims of intimate terrorism, experiencing control and coercion, and feeling unsafe within their relationships (Hines and Douglas, 2010; Nayback-Beebe and Yoder, 2012). This is supported through police assessment (Storey & Strand, 2012), and through the reporting of 'fear' observed by counsellors working with male IPV victims (Hogan et al, 2012).

Reflecting on research objective two, psychological harm emerged as the most significant health effect, with alcohol and substance misuse also associated. Large numbers of men reported non-physical abuse with Coker et al (2008) finding that men were significantly more likely than women to be verbally abused by their partner. A comparison of studies indicates that men more commonly experience psychological IPV than women (Nowneski & Bowen, 2012). This appears particularly important given the significance of

psychological abuse on mental health (Coker et al 2008), and given that this form of abuse appears unlikely to be reported by men (Drijber et al, 2013).

Considering risk factors for domestic abuse, review findings answered research objective three, with childhood events and relationships emerging as significant influences predicting adult likelihood of domestic abuse. Results focused on male victims and female perpetrators, but studies showed that early experiences affected risk of domestic abuse for both sexes (Afifi et al, 2011; Coker et al, 2008; Gass et al, 2011). Social factors associated with risk were also identified. Findings therefore may support Dixon et al's (2012) argument against gender being the most significant factor in perpetration and victimisation risks for domestic abuse.

Although not identified as a research objective, review findings highlight risks for children. The deleterious enduring effects of childhood exposure to domestic abuse are well documented, increasing with severity of abuse and through early and prolonged exposure (Holt et al, 2008). A substantial body of knowledge has been gained through research with female participants living in shelters, and through mother's self-report (Holt et al, 2008; CAADA, 2014). Although the effects on children of female to male domestic violence appear underexplored, risks to children are evident, acknowledging the range, duration and severity of male abuse reported. Parental mental health difficulties and substance misuse adversely affect child health and social outcomes (WAVE, 2013) both of which are found to be associated with male IPV victimisation. Increasing risks further, women who abuse their partners are reportedly more likely to abuse their children (Dixon et al, 2007).



The final research objectives sought to understand men's experiences of seeking support, and to determine what may facilitate male disclosure of abuse. Child safety appears influential in determining male actions and decision-making, motivating men to seek help. However, low numbers of men in the studies in this review disclosed abuse to formal agencies such as police or healthcare agencies. In keeping with common understanding of the issue, men expressed shame, embarrassment, disbelief and fears that they would not be believed. Women too experience difficulty disclosing domestic abuse (Bradbury-Jones et al, 2016), but it is suggested that masculinity, influenced by social norms, may serve as a barrier to seeking help, with men reluctant to appear weak or ineffectual (Stanley et al, 2009). Supporting this, women are reported to be nearly twice as likely as men to tell someone in a professional position of their abuse (ONS, 2016).

When men sought formal help they commonly reported external barriers and inconsistencies in support. Feminist activism has achieved much in addressing population knowledge of male to female domestic violence (Weldon and Htun, 2013), but it is argued that this has led to a gender-specific approach within westernised nations focusing on male perpetration of violence, with public policies underpinned by patriarchal theories (Hamel, 2009). Shaping approach to IPV in the UK is the Duluth model stemming from 'power and control' theory focusing on behaviours displayed by male perpetrators of abuse (Dixon et al, 2012; Hester et al, 2007; Farmer and Callen, 2012). Resulting from this, a co-ordinated, multi-agency approach to tackling domestic abuse has developed centring on female and child safety (Hester et al, 2007). Findings from this review suggest however that some females perpetrate significant violence, and that individual experiences and psycho-social dimensions contribute to perpetration and victimisation in both sexes. Arguably adherence to the above model may narrow practices, discriminating against male victims (Dixon et al, 2012), and failing to address

the needs of female IPV perpetrators (Farmer and Callan, 2012). Strengthening the need for professional understanding of policy drivers, Donetto et al (2013, p. 94) caution that health visiting practice may “*potentially reinforce prevailing social stereotypes*”.

Reflecting on the above, implications for health visiting practice are identified. Health visitors are guided to ‘search for health needs, stimulate an awareness of health needs, influence policies affecting health and facilitate health-enhancing activities’ (Cowley and Frost, 2010, p.1), with holistic assessment of children and families a key practice component (NHS England, 2014). The findings of this review strengthen the significance of identification and assessment particularly relating to safeguarding. Shaping practice, and appropriate to this issue, *The Healthy Child Programme* (DH, 2009) underlines the importance of working with whole families, engaging with fathers. Furthermore, in protecting children, health visitors require ‘expert knowledge’ regarding domestic abuse (NHS England, 2014, p.16) highlighting the importance of a broad, evidenced-based understanding of the issue. Yet research has shown that some health visitors do lack confidence in this area and in particular around having the ‘difficult conversations’ and broaching the subject of domestic violence (Bradbury-Jones et al, 2014; Bradbury-Jones, 2015)

Relevant to male victimisation of domestic abuse, need may be present although unrecognised by individuals or groups (Luker et al, 2012), indicating a role for educative strategies around men’s health. NICE (2014b) identify a lack of evidence into effectiveness of specific primary prevention programmes for domestic abuse including media awareness campaigns. However, increased provision of public information, improved staff training, knowledge and work protocols are advocated (NICE, 2014b), with these measures applicable to both genders. Although no validated screening tool for domestic abuse identification has been determined for use with men, male research

participants expressed the importance of being believed and listened to, strengthening the importance of a facilitative environment and effective communication skills.

Significant psychological harm is associated with male victimisation of domestic abuse, although the UK practice focus remains on assessing maternal mental health (DH, 2009; NICE, 2014b), suggesting a need for greater exploration of paternal mental health during routine health visiting assessment. Collaborative working with mental health professionals may also increase male access to specialist services.

Review findings indicate male IPV victimisation to be a complex, multidimensional issue with societal and formal barriers inhibiting access to support. Policy shapes socio-economic conditions, cultural beliefs and practices, but as Wallace and Wray (2011) caution, policy-makers may be influenced by ideological values and assumptions resulting in policies uninformed by research evidence. As an emotive issue involving perceptions regarding gender and violence, this appears highly relevant when discussing domestic abuse, strengthening the need for researchers and practitioners to examine, question and appropriately challenge practice and policy.

### Limitations

This review included studies investigating varying aspects of male victimisation of domestic abuse and has enabled a comprehensive perspective on this issue to be gained. Limitations however exist. The appraisal criteria applied may have resulted in the exclusion of potentially valuable papers from the review.

Studies commonly used cross-sectional surveys resulting in a lack of contextual information, making it difficult to understand the nature of violence within the relationship

and the experiences of those involved. Interviews as a means of collecting survey data may influence participant response, resulting in under or over-reporting of IPV. The CTS and CTS-2, tools used to measure IPV, have been argued to inaccurately reflect violence within a relationship as intent or motive cannot be determined (Chan, 2011), and may result in findings supporting gender symmetry (Whitaker, 2014).

## **Conclusion**

This study sought to determine current research evidence on male victimisation of domestic abuse, considering the implications of this knowledge for health visiting practice. A systematically conducted critical literature review established that this issue is reported by significant numbers of men in heterosexual relationships, with men experiencing physical, emotional, psychological and sexual abuse, and some subject to severe violence. Thematic analysis resulted in the identification of four themes: the violent relationship, harms and behaviours, risk and seeking help. Findings enabled the first four research objectives to be achieved but did not adequately address the fifth objective regarding male disclosure of abuse.

To increase knowledge qualitative research is recommended, particularly regarding differing male experiences relating to race and ethnicity. Aiding identification and disclosure of domestic abuse, research into screening methods for men is warranted exploring efficacy and acceptability of such interventions.

In the delivery of equitable evidenced-based practice, health visitors may work with others increasing awareness of male victimisation of domestic abuse facilitating greater support for men and families affected by this issue.

**Key points:**

- Significant numbers of men report being victims of domestic abuse
- Men are reluctant to disclose or report domestic abuse victimisation
- Societal, attitudinal and formal barriers may reduce support options for male victims
- Research has largely focused on male to female violence with male victimisation of domestic abuse underexplored

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## REFERENCES

- Afifi, T. Macmillan, H. Cox, B. Asmundson, G. (2009) Mental health correlates of intimate partner violence in marital relationships in a nationally representative sample of males and females. Journal of Interpersonal Violence. 24: 1398-1418
- Aldgate, J. Jones, D. Rose, W. Jeffery, C. (2006) The developing world of the Child. London. Jessica Kingsley
- Atkinson, A. Anderson, Z. Hughes, K. Bellis, M. Sumnall, H. Syed, Q. (2009) Interpersonal violence and illicit drugs. Centre for Public Health, Liverpool John Moore University. [www.cph.org.uk](http://www.cph.org.uk) accessed 29/02/16
- Bradbury-Jones, C. Appleton, J. Watts, S. (2016) Recognising and responding to domestic violence and abuse: the role of the public health nurse. Community Practitioner. March 2016; vol 89; No 03 p.24-28
- Bradbury-Jones C., Taylor J., Kroll T. & Duncan F. (2014) Domestic Abuse Awareness and Recognition among Primary Healthcare Professionals and Abused Women: a qualitative investigation. Journal of Clinical Nursing, 23(21-22), 3057-68.
- Bradbury-Jones, C. (2015) Talking about domestic abuse: crucial conversations for health visitors. Community Practitioner, 88(12), 44-47.
- British Educational Research Association (BERA) (2013) [www.bera.ac.uk](http://www.bera.ac.uk) accessed 09/11/13
- Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. Qualitative Research in Psychology, 3 (2). pp. 77-101.
- Carmo, R. Grams, A. Magalhaes, T. Men as victims of intimate partner violence. Journal of Forensic and Legal Medicine Vol 18: 355-359
- Carney, M. Buttell, F. Dutton, D. (2007) Women who perpetrate intimate partner violence: A review of the literature with recommendations for treatment. Aggression and Violent Behavior. 12: 108-115
- Center for Evidenced-Based Management (CEBMA) (2014) [www.cebma.org](http://www.cebma.org) accessed 10/05/14
- Chan, K. (2011) Gender differences in self-reports of intimate partner violence: a review. Aggression and Violent Behavior. 16: 167-175
- Cho, H. Wilke, D. (2010) Gender differences in the nature of the intimate partner violence and effects of perpetrator arrest on revictimization. Journal of Family Violence 25: 393-400
- Coker, A. Davis, K. Arias, I. Desai, S. Sanderson, M. Brandt, H. Smith, P. (2008) Physical and mental health effects of intimate partner violence for men and women. American Journal of Preventative Medicine. 24(4): 260-268
- Cook, P. (2009) Abused men. The hidden side of domestic abuse. Second edition. Westport. Praeger.

Co-ordinated Action Against Domestic Abuse (CAADA) (2014) In plain sight: The evidence from children exposed to domestic abuse. [http://www.safelives.org.uk/sites/default/files/resources/In\\_plain\\_sight\\_the\\_evidence\\_from\\_children\\_exposed\\_to\\_domestic\\_abuse.pdf](http://www.safelives.org.uk/sites/default/files/resources/In_plain_sight_the_evidence_from_children_exposed_to_domestic_abuse.pdf) accessed 1/2/16

Cowley, S. Frost, M. (2010) The principles of health visiting: opening the door to public health practice in the 21<sup>st</sup> century. London. Community Practitioners and Health Visitors Association.

Critical Appraisal Skills Programme (CASP) (2013) [www.casp-uk.net](http://www.casp-uk.net) accessed 16/03/14

Dahlgren, G. Whitehead, M. (1991) Policies and strategies to promote social equity in health. Stockholm. Institute for Future Studies.

DeFrancisco, V. Palczewski, C. (2014) Gender in communication. A critical introduction. Second edition. London. Sage.

Dempsey, B. (2013) Men's experiences of domestic abuse in Scotland. What we know and how we can know more. Abused men in Scotland. (AMIS). [www.amis.org.uk](http://www.amis.org.uk) accessed 27/10/13

Department of Health (DH) (2009) Improving safety, reducing harm. Children, young people and domestic violence. A practical toolkit for front-line practitioners. London. The Stationery Office.

Department of Health (DH) (2009b) Healthy Child Programme: Pregnancy and the First Five Years of Life. [www.gov.uk](http://www.gov.uk) accessed on: 10/08/14

Department of Health (DH). (2011) Health visitor implementation plan 2011 – 15. A call to action. London. The Stationery Office.

Department of Health (DH) (2013) Health visiting and school nursing programmes: supporting implementation of the new service model. No. 5: domestic violence and abuse – professional guidance. [www.gov.uk](http://www.gov.uk) accessed 18/01/14

Dixon, L. Hamilton-Giachritsis, C. Browne, K. Ostapuik, E. (2007) The co-occurrence of child and intimate partner maltreatment in the family: characteristics of the violent perpetrators. Journal of Family Violence. 22: 675-689

Dixon, L. Archer, J. Graham-Kevan, N. (2011) Perpetrator programmes for partner violence: are they based on ideology or evidence? Legal and Criminological Psychology. 1: 196-215

Donovan C. Hester, M. Holmes, J. McCarry, M. (2006) Comparing domestic abuse in same sex and heterosexual relationships. University of Sunderland; University of Bristol

Donetto, S. Malone, M. Hughes, J. Morrow, E. Cowley, S. Maben, J. (2013) Health visiting: the voice of service users' experiences to inform the development of UK health visiting practice and services. Department of Health Policy Research Programme. National Nursing Research Unit. London. Kings College London.

- Douglas, E. Hines, D. (2011) Helpseeking experiences of men who sustain intimate partner violence: an overlooked population and implications for practice. Journal of Family Violence. 26: 473-485
- Drijber, B. Reijnders, U. Ceelen, M. (2013) Male victims of domestic violence. Journal of Family Violence. 28: 173-178
- Dutton, D. (2006) Rethinking domestic violence. Vancouver. UBC Press
- Dutton, D. (2007) Female intimate partner violence and developmental trajectories of abusive females. International Journal of Men's Health. 6.1 (Spring 2007): 54-70
- Dutton, D. Nicholls, T. (2005) The gender paradigm in domestic violence research and theory: Part 1 – The conflict of theory and data. Aggression and Violent Behavior. 10: 680-714
- Farmer, E. Callan, S. (2012) Beyond Violence. Breaking cycles of domestic abuse. London. The Centre for Social Justice
- Fink, A. (2014) Conducting research literature reviews. From internet to paper. London. Sage
- Gass, J. Stein, D. Williams, D. Seedat, S. (2011) Gender differences in risk for intimate partner violence among South African adults. Journal of Interpersonal Violence. 26(14): 2764-2789
- Graham-Kevan, N. (2007) The Re-Emergence of Male Victims. International Journal of Men's Health. Vol. 6; no 1: 3-6
- Hamel, J. (2009) Gender inclusive systemic treatment of intimate partner abuse (GIST). Journal of Aggression, Conflict and Peace Research. Vol. 1, No 3, 71-76
- Hatty, S. (2000) Masculinities, violence and culture. London. Sage
- Hester, M. Pearson, C. Harwin, N. Abrahams, H. (2007) Making an impact. Children and domestic violence. Second edition. London. Jessica Kingsley Publishers.
- Hines, D. (2007) Posttraumatic stress symptoms among men who sustain partner violence: an international multisite study of university students. Psychology of Men and Masculinity. Vol. 8, No. 4, 225 – 239
- Hines, D, Brown, J, Dunning, E. (2007) Characteristics of callers to the Domestic Abuse Helpline for Men. Journal of family Violence. Vol. 22, 63-72
- Hines, D. Douglas, E. (2010) Intimate terrorism by women towards men: does it exist? Journal of Aggression, Conflict and Peace Research. Vol 2, No 3: 36-56
- Hogan, K. Hegarty, J. Ward, T. Dodd, L. (2012) Counsellors' experience of working with male victims of female-perpetrated domestic abuse. Counselling and Psychotherapy Research. 12(1): 44-52



Holt S, Buckley, H. Whelan, S. (2008) The impact of exposure to domestic violence on children and young people: a review of the literature. Child Abuse and Neglect. 32: 797-810

Home Office (2010) The Equality Act, [www.gov.uk](http://www.gov.uk) accessed 23/01/14

Home Office, (2013). Information for Local Areas on the change to the definition of domestic violence and abuse. [www.gov.uk](http://www.gov.uk) accessed on 10/11/13

Houry, D. Rhodes, K. Kemball, R. Click, L. Cerulli, C. McNutt, L. Kaslow, N. (2008) Differences in female and male victims and perpetrators of partner violence with respect to WEB scores. Journal of Interpersonal Violence. 23: 1041 – 1055

Johnson, M. P. (1995) Patriarchal terrorism and common couple violence: two forms of violence against women. Journal of Marriage and the Family. 57: 408-418

Johnson, M. P. (2006) Conflict and control: gender symmetry and asymmetry in domestic violence. Violence against Women. 12 (11): 1003-1018

Kernsmith, P. Kernsmith, R. (2009) Treating female perpetrators: state standards for batterer intervention services. Social Work. Vol 54, 4: 341-349

Luker, K. Orr, J. McHugh, G. (Eds) (2012). Health visiting. A rediscovery. Third edition. Chichester, Wiley-Blackwell

Mele, M. Roberts, J. Wolfer, L. (2011) Men who seek protection orders against female intimate partners. Partner Abuse. Vol 2, No 1:61-75

Mills, T. Avegno, J. Haydel, M. (2006) Male victims of partner violence: prevalence and accuracy of screening tools. The Journal of Emergency Medicine. Vol 13, No 4: 447-452

Mulrone, J. Chan, C. (2005) Men as victims of domestic abuse. Australian Domestic and Family Violence Clearinghouse. Topic paper. 1-18

Nayback-Beebe, Yoder, L (2012) The lived experiences of a male survivor of intimate partner violence: a qualitative case study. MedSurg Nursing.21:2 (March/April 2012) p89-95

National Institute for Health and Care Excellence (NICE) (2014a) NICE local government briefings. Health Visiting [www.nice.org.uk](http://www.nice.org.uk) accessed 26/09/15

National Institute for Health and Care Excellence (NICE) (2014b) Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. February 2014. [Guidance.nice.org.uk/ph50](http://guidance.nice.org.uk/ph50) [www.nice.org.uk](http://www.nice.org.uk) accessed 27/08/14

National Institute for Health and Care Excellence (NICE) (2015) Nice pathways: domestic violence and abuse overview. [www.nice.org.uk](http://www.nice.org.uk) accessed 05/02/16

NHS England (2014) 2015 -16 National Health Visiting Core Service Specification [www.england.nhs.uk](http://www.england.nhs.uk) accessed 26/09/15

Nowinski, S. Bowen, E. (2012) Partner violence against heterosexual and gay men: prevalence and correlates. Aggression and Violent Behavior. 17: 36-52

Office for National Statistics (ONS) (2016) Crime Survey for England and Wales. Crime Statistics, focus on violent crime and sexual offences: intimate personal violence and partner abuse. Home Office. [www.ons.gov.uk](http://www.ons.gov.uk) accessed 19/02/16

Palmetto, N. Davidson, L. Breitbart, V. Rickert, V. (2013) Predictors of physical intimate partner violence in the lives of young women: victimization, perpetration and bidirectional violence. Violence and Victims. Vol 28; 1: 103-121

Panteloudakis, I. (2014) Domestic violence happens to men too – and they must talk about it. The Guardian. 12 March.

Prospero, M. (2007) Mental health symptoms among male victims of partner violence. American Journal of Men's Health. Vol 1, No 4: 269-277

Prospero, M, Kim, M. (2009) Mutual partner violence: mental health symptoms among female and male victims in four racial/ethnic groups. Journal of Interpersonal Violence. Vol 24, No 12: 2039-2056

Reid, R. Bonomi, A. Rivara, F. Anderson, M. Fishman, P. Carrell, D. Thompson, R. (2008) Intimate partner violence among men. Prevalence, chronicity, and health effects. American Journal of Preventative Medicine. Vol 34, No 6: 478-485

Richards, A. Noret, N. Rivers, I. (2003) Violence and abuse in same-sex relationships. A review of literature. York St John College of the University of Leeds

Robinson, A. Rowlands, J. (2006) The Dyn Project: supporting men experiencing domestic abuse. Final evaluation report. Cardiff University. The Dyn Project. [www.dynproject.org](http://www.dynproject.org)

Robinson, A. Rowlands, J. (2009) Assessing and managing risk among different victims of domestic abuse: limits of a generic model of risk assessment? Security Journal. Vol 22, 3: 190-204. Palgrave Macmillan

The Scottish Government (2007). Making the Equality Duty real for children, young people and their fathers. Children in Scotland. [www.scotland.gov.uk](http://www.scotland.gov.uk) accessed 23/01/14

Stanley, N. Fell, B. Miller, P. Thomson, G. Watson, J. (2009) Strength to Change. Men's Talk: Research to inform Hull's social marketing initiative on domestic violence. Preston. University of Central Lancashire

Storey, J. Strand, S. (2012) The characteristics and violence risk management of women arrested by the police for intimate partner violence. European Journal of Criminology. 9(6) 636-651

Wallace, M. Wray, A. (2011) Critical reading and writing for postgraduates. Second edition. London. Sage

WAVE Trust (2013) Conception to age 2: the age of opportunity. Framework for local area service commissioners. [www.wavetrust.org](http://www.wavetrust.org) accessed 26/08/14

Weldon, S. Htun, M. (2013) Feminist mobilisation and progressive policy change: why governments take action to combat violence against women. Gender and Development. Vol. 21, No. 2: 231 – 247

Whitaker, M (2014) Motivational attributions about intimate partner violence among male and female perpetrators. Journal of Interpersonal Violence. 29(3): 517-535

World Health Organization (WHO) (2013). Violence against women. Intimate partner and sexual violence against women. Factsheet No. 239. October 2013.

[www.who.int/mediacentre/factsheets/fs239/en/](http://www.who.int/mediacentre/factsheets/fs239/en/) accessed: 01/12/13

World Health Organization (WHO) (2014) Intimate partner violence and alcohol factsheet. [www.who.int/violence/world\\_reports/factsheet](http://www.who.int/violence/world_reports/factsheet) accessed 08/01/14

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**Appendix 1: Critical Appraisal Templates:**

Amended from; Critical Appraisal Skills Programme (CASP, 2013): Cohort Study

Eight questions below assessed when appraising each paper.

Scoring system: YES = 2 POINTS; UNSURE/PARTIAL = 1 POINT; NO = 0 POINTS

<b>Was the cohort recruited in an acceptable way?</b>	
<b>Was the exposure accurately measured to minimise bias</b>	
<b>Was the outcome accurately measured to minimise bias?</b>	
<b>Have the authors identified all important confounding factors?</b>	
<b>How precise are the results?</b>	
<b>Do you believe the results?</b>	
<b>Can the results be applied to the local population?</b>	
<b>Do the results of this study fit with other available evidence?</b>	

Amended from: Critical Appraisal (CASP, 2013; CEBMa, 2014): Survey

Eight questions below assessed when appraising each paper.

Scoring system: YES = 2 POINTS; UNSURE/PARTIAL = 1 POINT; NO = 0 POINTS

<b>Is sample recruited in an acceptable way? (ethics and minimisation of selection bias)</b>	
<b>Was the sample representative of population to which findings referred?</b>	
<b>Are the measurements valid and reliable?</b>	
<b>Have the authors identified all important confounding factors?</b>	
<b>Are results precise? (Statistical power; statistical significance assessed; adequate response rate; confidence intervals given?)</b>	
<b>Do you believe the results?</b>	
<b>Can the results be applied to the local population?</b>	
<b>Do the results of this study fit with other available evidence?</b>	

Amended from: Critical Appraisal Skills Programme (CASP, 2013): Qualitative Study

Eight questions below assessed when appraising each paper.

Scoring system: YES = 2 POINTS; UNSURE/PARTIAL = 1 POINT; NO = 0 POINTS

<b>Was the research design appropriate to address the aims of the research?</b>	
<b>Was the recruitment strategy appropriate to the aims of the research?</b>	
<b>Were the data collected in a way that addressed the research issue?</b>	
<b>Has the relationship between researcher and participants been adequately considered?</b>	
<b>Have ethical issues been taken into consideration?</b>	
<b>Was the data analysis sufficiently rigorous?</b>	
<b>Is there a clear statement of findings?</b>	
<b>How valuable is the research?</b>	

## Appendix 2: PRISMA flowchart

