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Asking the Right Questions: Screening Men for Partner Violence

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Abstract

With lifetime intimate partner violence (IPV) victimization rates for self-identified men between 14% and 20%, and an expanding understanding of gender as a nonbinary construct, practitioners in some clinical environments have expressed interest in screening all patients for IPV. Yet, few IPV screening instruments have been validated for use in nonfemale populations. This research tests the appropriateness and acceptability of a screening instrument developed for use with women. A literature review was completed to determine the current state of research into IPV screening practices tailored to men. Next, cognitive interviews were conducted to test a 9-question IPV screening instrument with men considered at average and elevated risk for experiencing partner violence. Participants were read the questions aloud and asked about item comprehension and question appropriateness and acceptability. The literature review uncovered no published reports describing routine clinic based IPV screening of men, and only two screening instruments had been validated with men. Twenty men

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participated in cognitive interviews from a variety of settings in a large urban center. All participants accurately described the intended meaning of each question and verified the appropriateness of asking the questions. This work addresses the gap in research on routine IPV screening with men, building on efforts to screen individuals and support improved health and response to violence to those across the gender spectrum.

Keywords
disclosure of domestic violence, domestic violence, GLBT, intervention/treatment, domestic violence

Introduction

Across North America, consensus surrounding the utility of routinely identifying and responding to partner violence among reproductive-age women in clinical settings remains weak, despite recommendations from numerous governmental and professional organizations (Bair-Merritt et al., 2014; Canadian Task Force on Preventive Health Care, 2013; Cherniak et al., 2005; Miller et al., 2015; Moyer & U.S. Preventive Services Task Force, 2013; Registered Nurses' Association of Ontario, 2005; Sweeney et al., 2013). Yet, while rates of universal screening of female patients for IPV are generally low (Kapur & Windish, 2011; Klap et al., 2007), practitioners in some clinical settings have expressed interest in screening *all* patients, not only women (Kimberg, 2008), for experiences of IPV.

Although male victimization rates are substantially lower than for women, they are not trivial. A U.S. surveillance study found 14% of men reported ever experiencing severe nonsexual physical violence from a partner (Black et al., 2011), while in Canada, roughly 1 in 5 incidents of partner violence reported to the police involves male victims (Canadian Centre for Justice Statistics, 2013). Further, a probability sample of California residents aged 18-70 found gay men had 2.5 odds of both lifetime and one-year IPV, compared to heterosexual men (Goldberg & Meyer, 2013). Rates of IPV among transgender individuals are also likely to be higher, with prevalence rates reported between 31% and 50% (Brown & Herman, 2015). Within health care settings, male victimization rates range widely, depending on setting, timeframe, and screening instrument used. In trauma and emergency department settings, rates may be as high as 16% for past year experience to 20% lifetime experience (Bazargan-Hejazi et al., 2014; Mechem et al., 1999; Mills et al., 2006).

Yet few partner violence screening instruments have been validated in noncisgender female populations generally, or with men in particular (Rabin et al., 2009). When considering the implementation of a universal partner violence screening and response program with all patients regardless of gender identification, a number of concerns arise. *What are the right questions to ask?* Screening questions may need to be tailored to the specific population being screened, particularly if the way that respondents understand or experience violence is different from the majority cisgender female populations generally used to validate instruments (e.g., Is a slap the same level of threat to men as to women?) (Mills et al., 2006; Rabin et al., 2009; Shakil et al., 2005). Moreover, questions need to be culturally safe, phrased in nonoffensive and nonjudgemental language (Churchill et al., 2017) that allows patients or clients to feel comfortable, respected, and able to be themselves.

Secondly, regardless of the screening questions, *will the population* (in this case, self-identified men) *acknowledge victimization*? Much has been written on masculine gender norms preventing many men from acknowledging victimization, particularly at the hands of a women (Machado et al., 2017; Migliaccio, 2001). Work in this field suggests that men may be averse to discussing partner violence for numerous reasons, including shame or guilt about the way men (including themselves) treat women, a general sense of fear over disclosing personal experiences, and concern about how they will be perceived by others (e.g., as perpetrators, even if they are not) (Machado et al., 2017; Migliaccio, 2001). Transgender individuals and gay men may face additional barriers of reporting violence in relationships that are already stigmatized in many larger societies (Giblon & Bauer, 2017; Harvey et al., 2014; Merrill et al., 2000; Oliffe et al., 2014). Are there contextual factors that need to be in place to increase the likelihood that men (or anyone) will disclose?

If patients do disclose, *what are the right responses by medical staff*? When responding to women's disclosure, clinicians are taught to acknowledge that the experience is common, to reinforce that they are not at fault, to express concern for the patient's safety, and to offer "warm referrals" to services that could be useful (Chamberlain et al., 2013). While these may be appropriate responses regardless of the patient's gender identity, some approaches may be more acceptable to male-identified patients than others (e.g., Will physician's safety concerns be interpreted positively?). Finally, *Are there effective and appropriate resources for noncisgender female victims of partner violence*? This answer will depend on the local community but should be investigated carefully before initiating a screening and referral program.

This research addresses the initial concern of identifying appropriate questions for screening individuals who present in health care settings as men. As part of a larger project to embed a universal partner violence screening

protocol in an orthopedic fracture clinic, we sought to test the appropriateness and acceptability of a screening instrument initially developed for use with women. From the outset, clinic staff were firm in their desire to screen all patients, not only patients who present as cisgender women. The physical environment of the clinic does not allow clinicians to engage in private conversations, and preliminary planning suggested that technology-based screening was an intervention that fit the setting (Velonis et al., 2019). Finally, while the brevity of most existing screening tools increases their ease of use in busy settings, few include questions addressing experiences with coercive or controlling behaviors. We carefully reviewed over 10 existing IPV screening instruments, selecting the Hurt, Insulted, Threatened with harm, and Screamed (HITS) instrument to serve as the base of our screening tool (Sherin et al., 1998). To ensure that we could capture multiple types of violence, including sexual violence and coercion and control, we identified 5 additional questions from the other scales to include. Using cognitive interviewing methods, we asked multiple groups of women about their understanding of the questions and the acceptability of the wording. This was followed by reliability testing, by asking the same 9 questions to female participants at two timepoints with 1 month in between (we found excellent test-retest reliability: intraclass correlations 96%, CI 90%-99%, publication forthcoming). Before using these same questions with men, however, we needed to know if they were acceptable, and if not, what adaptations needed to be made.

In preparation for this research, we conducted an extensive literature review to address the following questions: (a) Are there any screening programs described in the literature that are tailored to men in health or non-health care settings? (b) What screening questions or tools are used to screen men for intimate partner violence (IPV)? (c) Are there specific subpopulations of interest for men's partner violence screening? (d) Are there any post-screening response and referral systems?

We identified a number of studies that recognized the importance of measuring and screening for IPV among men as well as women. However, we found no published reports documenting experiences of routine clinic based IPV screening that included men or focused on men. We did find many studies that examined rates of partner violence among men recruited from clinic settings. The screening questions used in those studies varied from the Conflict Tactics Scale-2, HITS, Partner Violence Screen, STaT (Slapped, Threatened, and Throw things), shortened versions of tools such as the Abuse Assessment Screen, and then questions developed for the purposes of screening in clinics (Houry et al., 2008; Kalokhe et al., 2012; Pantalone et al., 2011; Rhodes et al., 2009). Only two tools had been validated for use with men, the HITS and an 8-question tool from the George Washington University

Universal Violence Prevention Screening Protocol (Rhodes et al., 2009; Shakil et al., 2005). Men who have sex with men and those living with HIV received the greatest attention for IPV screening followed by patients seen in an emergency department setting. One study engaged close to 1,000 men who self-reported as gay to identify key domains to include when measuring partner violence experienced by men, defining domains not typically included in screening or even research tools such as the perpetrator monitoring the victims' behaviors (Finneran & Stephenson, 2013). Another study reported on postscreening activities that resulted from a computerized intervention demonstrating that 35% of IPV survivors who were exposed to this module accessed community services within 3 months (Houry et al., 2008).

With these findings in mind, our team tested our existing screening instrument through a series of cognitive interviews on the 9 screening questions (Figure 1) with men of varying risk for partner violence recruited from multiple settings.

Methods

Cognitive interviewing is a method commonly used in survey development to ensure that participants understand the meaning of questions in the same way that researchers intend them to be interpreted (Jobe & Mingay, 1989; Willis, 2005). Cognitive interviewing can augment validity and reliability testing as it provides the survey developer with insight into how the participant interprets the question(s) being asked, whether the participant would use different language, and (in the case of our research) if the participant finds

1. Over the last 12 months how often did you feel uncomfortable doing or saying things around your current partner or someone you're currently dating?

Over the last 12 months, how often did your partner, an ex-partner, or someone you dated:

2. insult you or talk down to you? *
3. yell, shout, or curse at you? *
4. control who you see, where you go, what you do, or what you wear?
5. make you feel afraid or scared of them?
6. threaten to harm you or someone you care about? *
7. physically hurt you? *
8. beat, punch, kick, strangle or hurt you with a weapon?
9. force, threaten, or pressure you to participate in any sexual activity when you didn't want to?

Figure 1. Screening Questions

Note: * Represents HITS question.

any of the questions disagreeable or off-putting (Willis, 2005). Unlike *think aloud* interviewing processes that have participants describe their thoughts while reading and responding to a question, we specifically asked participants *not* to provide a response to the survey question, due in large part to the sensitive nature of the questions themselves. Rather, we used *concurrent probing* techniques, in which the interviewer reads the participant the question, followed immediately by probing questions such as "In your own words, what is this question asking?" (Willis, 2005). Probing techniques provide a straightforward approach to assessing question comprehension (Beatty & Willis, 2007), and allowed participants the privacy of not disclosing potentially difficult personal information.

Interview Preparation

Our cognitive interview guide was constructed to ascertain *question and response comprehension* (e.g., what participants understood each question to be asking, if they found the questions to be clear or had suggestions for alternative wording, if they understood the response options) and the *survey experience* (e.g., was the question order and length of the survey acceptable, did they think that any questions were missing, were any questions unnecessary). Additionally, we developed a distress protocol outlining how interviewers should respond if participants appeared upset by the nature of the questions. This included actions such as stopping the interview, acknowledging feelings and providing time for participants to express their emotions, and assisting the participant with seeking services or support from friends or family (Mccosker et al., 2001; Parker, 1990; World Health Organization, 2001). All interviewers were trained to conduct cognitive interviews and provided the opportunity to role play a variety of interview scenarios.

Recruitment

To increase the likelihood that we obtained responses from men with a range of experiences, including possible experiences with partner violence, we purposively identified and recruited participants from two different settings. Our first group, drawn from the general population, was considered to be at "average risk" for having lived experience with partner violence. This convenience sample of men was recruited from everyday settings, including cafes, a shopping mall, a health research center, and the waiting room of the fracture clinic that will be the setting for our screening program. Recruitment was conducted by pairs of researchers going to predetermined locations to conduct encounter interviews. The lead interviewer introduced himself to potential

participants and explained the project, asking if the individual had time to complete a brief, anonymous survey about a new "health safety app." Potential participants were told that they would receive a $5 gift card in exchange for their time. All participants provided informed consent prior to the interview starting. To encourage robust responses, the researchers established a safe environment with participants, instilling no pressure or stress on the participant to respond in any specific way. Adopting conversational-style interviewing strategies helped participants feel more comfortable providing honest feedback to the screening questions.

The second group of participants was identified from organizations who provide direct support services to individuals and families experiencing partner violence. Prior to embarking upon data collection, discussions with support services established that this group was comprised of men who may be at a high risk of having lived partner violence experience, based on the services they were receiving at the agency. Study information was provided to the identified organizations, and support service staff identified times when researchers could be on site to recruit and interview potential participants at the respective organizations. Potential participants approached the interviewer. The interviewer introduced himself to potential participants and explained the project including the voluntary nature of the activity. All participants provided informed consent prior to being interviewed by a research team member. At the request of participants and the organizations, a support services staff member was present during the interviews to provide support, assisting participants to feel as comfortable as possible when discussing a topic that is sensitive in nature.

Interviews

During interviews, the lead researcher explained to participants that they would be asked a series of 9 questions, but rather than answer the question itself, we wanted their perceptions and opinion about the content and wording of the questions. As the questions were asked, a second researcher was present to take notes and record the participant's responses on paper. Hard copies of the data were stored and locked in the research facility office and shared only with principal members of the research team. Participant names were not recorded on any documents that were collected.

Each question was read aloud to the participant, followed by a probe, such as "In your own words, what is this question asking?" Interviewers also queried about the meaning of specific terms that were used in the questions, such as "If someone said that a partner 'restricted their actions,' what behaviors, attitudes, or actions might they be thinking about? At the conclusion of the

interview, participants were asked for their overall feelings about the survey. This included opinions about the appropriateness of the questions, the difficulty of answering the questions using the scale provided (e.g., *never, rarely, sometimes, frequently*), and if there were other words they would use, if they thought all of the questions were necessary or if a question was missing, how long they thought it would take someone to respond, and if the order of the questions seemed appropriate. Finally, participants were asked to complete a demographic questionnaire, which included one question about whether they or "someone close to you" experienced partner violence in the past 5 years, and participants were offered information about partner violence resources for men. The demographic sheet was not linked to participant responses. On average, each interview took approximately 10 to 15 minutes.

The project received approval from the Unity Health Research Ethics Board.

Findings

Our sample of 20 men had variability with regard to being born in or outside of Canada, sexual orientation (e.g., participants reported being straight, bixesual or gay), gender (e.g., cis and transgender men participated). Half of our participants were recruited from agencies versus the general public. The detailed interview notes were thematically coded, with each analyzed to pinpoint recurring themes of significance (e.g., approval or disapproval of the wording of questions).

Appropriateness of the Screening Questions

All participants accurately described the intended meaning of each of the questions in their own words. All felt that the screening questions were appropriate for men, and that the questions were clear and easily understood. Several participants discussed similarities between questions, while acknowledging key differences. Specifically, a number of participants discussed similarities between questions 2 and 3 (*Over the last 12 months, how often did your partner, an ex-partner, or someone you dated INSULT you or talk down to you*? and *Over the last 12 months, how often did your partner, ex-partner, or someone you dated yell, shout, or curse at you*?), questions 5 and 6 (*Over the last 12 months, how often did your partner, an ex-partner, or someone you dated make you feel afraid or scared of them?* and *Over the last 12 months, how often did your partner, an ex-partner, or someone you dated THREATEN to harm you or someone you care about?*), and questions 7 and 8 (*Over the last 12 months, how often did your partner, an ex-partner, or someone you dated physically HURT you?* and *Over the last 12 months, how often did your*

partner, an ex-partner, or someone you dated beat, punch, kick, strangle or hurt you with a weapon?). However, participants recognized that there were key differences between questions and that each could elicit unique and important information.

Next, participants discussed the flow of questions, suitability, and their respective uniqueness, explaining that all 9 screening questions were appropriate, and captured important information about partner violence while building familiarity with the line and logic of the screening questions. In addition, two participants recommended asking about being forced to use substances, two other participants suggested seeking more explicit questions about emotional manipulation and/or emotional control, and two participants recommended asking about sex trafficking. Further, a participant suggested asking about partners who make self-harm threats, while another participant suggested seeking information about threats to children, taking children, or if children had been abused. Overall, participants suggested that having 9 questions was fitting, and the median response indicated that it would take approximately 10 minutes to complete the 9 questions, with participant responses ranging between 5 minutes and up to 30 minutes.

Acceptability of Screening

In completing the cognitive interview, all participants indicated they would be comfortable answering all the screening questions. However, one participant suggested that the screening tool should come with a trigger warning or disclaimer. Further, another participant indicated that they would not want to confirm how often their partner, ex-partner, or someone they dated beat, punched, kicked, strangled, or hurt them with a weapon because they would have to deal with their admission of being a victim. This participant suggested that they would not necessarily disclose a true or accurate response to this question (Question 8), which asked, *Over the last 12 months, how often did your partner, an ex-partner, or someone you dated beat, punch, kick, strangle or hurt you with a weapon*? However, all participants indicated the questions were relevant and they would respond to each of the questions. There were no differences in participant opinions based on their level of risk.

Discussion

This research begins to address a growing issue facing service providers who are committed to screening all their patients or clients for partner violence. While universal partner violence screening of all reproductive age women remains the recommended standard of care in medical settings (Moyer &

U.S. Preventive Services Task Force, 2013), high IPV prevalence rate among gay men and transgender individuals, regardless of gender identity, suggests a need to expand these efforts, particularly in key settings. As acceptance of gender fluidity becomes more common, limiting screening and response protocols to individuals who identify as women will no longer be sufficient for programs that wish to effectively address relationship violence and coercion in the lives of patients or clients.

In arguing that more research is needed to create effective screening programs for patients who do not identify as women, we are not suggesting that the prevalence of partner violence experienced by men is similar to women (it is not), or that screening programs should be completely "gender neutral" in their approach (they should not). The impetus for the research described here was the determination of practitioners in our partner clinic to routinely screen *all* patients for partner violence. As implementation scientists, we were not comfortable taking that step without looking closely into the evidence supporting that intervention (Fixsen et al., 2005). Our review of the literature found little to either support or discourage screening men in clinical settings, and fewer that provided guidance on how to screen men or how to respond to disclosures. Having based our questions on validated instruments and conducted extensive testing with both low- and high-risk women, we were not certain about its effect in (or on) other populations. Thus, before embarking on this aspect of the screening program, we wanted to learn what if any changes would need to be made to the tool to increase the acceptability and appropriateness for men.

Our participants made a number of interesting observations. Rather than saying that men do not need to be screened for partner violence or that men would not respond well to these questions these men were overwhelmingly receptive to the idea of being asked very specific questions about partner violence in health care settings. The suggestion that the screening be prefaced with a "trigger warning" is a comment that we heard from women while conducting cognitive interviews about these screening questions, as well, and speaks to the notion that men who experience abuse from a partner are also likely to be traumatized. While one participant acknowledged that they may not respond honestly to a question about some forms of physical assault because they would be uncomfortable acknowledging this type of victimization, it is difficult to conclude that this has to do with gender, per se, given the reluctance that many women also have around disclosing experience with violence (Montalvo-Liendo, 2009; Overstreet & Quinn, 2013; Spangaro et al., 2011).

Finally, the suggestions that some participants made about expanding the screening questions to include trafficking as well as examples of emotional and nonphysically abusive behaviors, including threats to children, threats of

self-harm, and forced substance use are thought-provoking. On one hand, these are behaviors that physically weaker partners can use to control stronger individuals (often assumed to be the case in female-to-male IPV) and may reflect a perception that abuse leveled at men is more likely to be nonphysical in nature. Yet our experience is that women also identified these behaviors as important forms of abuse that should be recognized, and thus having these examples brought up may represent a generally broader understanding of what constitutes "violence" in relationships.

In spite of this, we chose not to expand our screening instrument. Ideally, the goal of an IPV screening program is to provide patients in unsafe relationship with the option of disclosing, and to provide providers with the skills and tools they need to address IPV as a medical issue affecting many patients. Use of the HITS scale as part of our set of screening questions ensures that we were using questions that had been validated for both women and men. Although we added a number of questions to the existing HITS scale to capture sexual violence and coercive control, the purpose of a screening instrument is to identify general experiences likely to be indicative of IPV, not every possible manifestation. The suggestions and comment made by our participants provide insight into specific experiences of men in our sample yet were primarily one-off observations rather than consistent themes. After reflecting on our initial items, we believed that they would likely capture the dynamics in which the specific examples suggested by participants would occur, were they part of a pattern of coercive and controlling violence.

Both women (in our earlier research) and men mentioned the need for a warning at the start of the screener. There is a strong supportive culture of screening for partner violence in the clinic where screening is happening, including posters on the walls in each room and staff who are well aware of the issue of violence and the need for screening. All patients who screen positive are approached soon after a positive screen by a nurse to have a discussion about the screening and to inquire about accessing resources. As such we did not feel the need to preface the questions with a warning.

Strengths and Limitations

To our knowledge, this is one of the few studies examining the applicability of partner violence screening questions for men. While multiple studies have tested and validated various screening instruments used with women, the same level of attention has not been given to men, despite knowing that some providers ask men about experiences with partner violence (as our partner clinic did). While we cannot claim to have comprehensively validated the use of these questions in this population, we employed rigorous methods to

determine that a diverse sample of men consistently interpreted the questions as they were intended. The men indicated that they would not be offended or upset by being asked these questions, and that they believe that they are appropriate to use on other men to identify partner violence. While our final set of questions included a scale that has been validated with men, the HITS, by adding questions to the HITS we may have modified or reduced the original validity and reliability statistics.

We purposively recruited men from a variety of settings to ensure that the perspectives of a variety of men were captured, including men with lived experience of IPV. Because of the sensitivity of the topic, we did not recruit men based on their lived experiences with partner violence (we reached out to the few organizations who provided these services, who were understandably apprehensive about allowing two researchers on site to interview a single participant). To address this gap, we went to social service organizations that provide services to men that could be inclusive of partner violence support.

Finally, we did not specifically target gay or transgender men, or individuals who identity outside of the traditional binary gender labels. For the most part, the men who provided feedback on these questions presented as cisgender heterosexual men. We would strongly suggest future research be more intentional about identifying individuals across the gender and sexual orientation spectrum. Because gay men and transgender or nonbinary individuals are at substantially higher risk for partner violence compared to heterosexual men, and because of the increased stigma and discrimination members of these groups face regarding gender and surrounding their sexual and romantic partnerships, efforts should be made to identify whether the questions here are appropriate for these populations. While the screening questions themselves are gender neutral (in that they refer to "partner" and do not use masculine or feminine pronouns), the appropriateness of the questions themselves still needs to be tested, as well as barriers and facilitators for screening generally.

Conclusion

While it is likely that men's and women's experiences and perceptions of violence in relationships differ (Velonis, 2016), the findings from this research suggest that the same questions that are useful for identifying violence with women would be acceptable and appropriate for use when screening men. This may be welcome news for clinics or organizations with established screening protocols for women and a desire to expand this to all patients (but do not wish to use multiple screening tools). While this research does not speak specifically to the efficacy of screening men for IPV, we recognize that the values that guide many organizations and individual staff are grounded in equity and inclusion; choosing to only screen women may feel like a

violation of those principles. We urge clinicians and others who are considering implementing IPV screening programs or expanding existing ones to familiarize themselves with the services and resources that are available in their communities for survivors of partner violence to ensure that they are able to refer all survivors to appropriate services, regardless of gender.

More work remains to be done regarding the creation and implementation of universal IPV screening programs for all. Although we discovered that our screening questions were acceptable and appropriate to individuals who identify as men, the notion that screening and response protocols should be gender-neutral has not been shown. More research is needed into what needs to be in place before men (and individuals who are not cisgender women) would be willing to disclose violence to a health care provider, and what are the most appropriate responses to a disclosure. Without evidence of effective strategies to identify and respond to patient needs, we are hesitant to recommend universal screening for IPV for male-identified patients. In some health care settings, screening is taking a back seat to "Universal Education," or the process of explaining to patients that partner violence is an issue that a lot of individuals face, that serious health problems can arise as a result of violence, and that there are resources that can help. To our knowledge, there are no published evaluations of this approach, and even though actual disclosure of violence is not the primary intention of the intervention, we encourage research that explores whether and how approaches may need to be tweaked, depending on the personal attributes of patients, including gender identity.

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