

# Screening Men for Partner Violence in a Primary Care Setting

## A New Strategy for Detecting Domestic Violence

Kathleen A. Oriel, MD, and Michael F. Fleming, MD, MPH  
Madison, Wisconsin

**BACKGROUND.** Health care domestic violence initiatives have given little attention to screening men for violent behavior toward their partners. We conducted this study to assess whether men would answer questions about partner violence in a health care setting, to estimate the prevalence of violent behavior in male primary care patients, and to identify characteristics associated with violent behavior.

**METHODS.** We used an anonymous written survey at three family medicine clinics. The survey instrument included the Conflict Tactics Scale to measure aggressive and violent behavior. Standard questions assessed demographic variables and health behaviors.

**RESULTS.** Three hundred seventy-five men were seen during the study. Of these, 317 (85%) participated and 237 met inclusion criteria. Thirty-two men (13.5%, 95% confidence interval (CI), 9.1-17.9) disclosed physical violence toward their partner in the previous 12 months. Ten men (4.2%, 95% CI, 3.7-4.8) reported severe violence. Men with increased alcohol consumption, depression, or history of abuse as children were more likely to report violent behavior. Presence of all three variables resulted in a probability of violence of 41%, compared with a baseline probability of 7% if no risk factors were present.

**CONCLUSIONS.** Primary care physicians should consider screening male patients for aggressive behavior toward their intimate partners. Physicians should be especially cognizant of this possibility in men who are depressed, heavy alcohol users, or were childhood victims of abuse.

**KEY WORDS.** Domestic violence; men; spouse abuse; primary care; depression. (*J Fam Pract* 1998; 46:493-498)

Domestic violence has been widely recognized as a major public health issue over the last decade.<sup>1</sup> Efforts at intervention have focused on identifying women in abusive relationships, offering empathy, assessing safety, referring to community resources, and assisting escapes from the violent situation.<sup>2</sup> Since 21% to 34% of women may be physically assaulted by a male partner during their lifetime,<sup>3</sup> removal from the home may not be practical or desired by many women. The frequency and severity of violence is believed to escalate over time,<sup>4</sup> yet prevention and intervention strategies for men are inadequately addressed in the medical literature.

A few authors<sup>5-7</sup> have recommended that physicians screen men for violence by asking what happens when they and their partners argue. They fur-

ther recommend that physicians be alert for derogatory references toward partners and terms such as "fighting," "not getting along," or "loss of temper." Adams<sup>8</sup> notes that many batterers are troubled by their violent behavior, and may feel relief when given an opportunity to discuss it. A recent review<sup>9</sup> concluded that it is not a conflict of interest for a physician to provide care for male and female partners in a domestic abuse situation if certain guidelines are followed.

The purpose of this study was to assess whether men would answer questions about partner violence in a health care setting; to estimate the prevalence of violent behavior in male primary care patients; and to identify characteristics associated with violent behavior in men.

## METHODS

### PARTICIPANTS AND SURVEY ADMINISTRATION

The study was conducted during a 6-week period from June to July 1996 in three family medicine clin-

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From the Department of Family Medicine, University of Wisconsin School of Medicine, Madison. Requests for reprints should be addressed to Kathleen A. Oriel, MD, Department of Family Medicine, 777 S Mills Street, Madison, WI 53705. E-mail: koriel@fammed.wisc.edu

ics in Wisconsin. Consecutive male patients aged 18 to 60 who were not too ill to participate and could read English were eligible. One research assistant was located at each of the clinics, two urban and one rural. After patients registered, research assistants approached them and brought those willing to participate to a private area of the waiting room.

Several measures ensured anonymity and prevented duplication of responses. Men filled out surveys in a private area, placed completed surveys in unmarked envelopes, deposited them in a box, then received a \$5 participation payment. Men who were missed by research assistants during office visits were sent surveys by mail. To receive the participation payment, they were asked to return the survey in an unmarked envelope and to return a separate postcard indicating they had completed the questionnaire. To prevent duplication, research assistants maintained a record of who completed the survey and who declined. These men were not approached a second time or sent a survey by mail. Researchers were faced with the difficult ethical issue of knowing that although some participants would disclose battering behavior, the anonymous nature of the study would not allow intervention. To encourage participants who recognized the seriousness of their behavior to seek help, all men were given information on domestic violence with resource telephone numbers. The project was approved by the University of Wisconsin Human Subjects Committee.

### SURVEY INSTRUMENT

The survey instrument included the Conflict Tactics Scale (CTS),<sup>10</sup> the most widely used instrument for detecting marital violence (Table 1).<sup>11</sup> The CTS is unique in that it can be used by either victim or perpetrator, or both partners for comparison. Six studies have assessed the internal consistency reliability of the CTS. Alpha coefficients for the physical aggression portion range from .83 to .96.<sup>12</sup> Validity of the CTS has been more difficult to document because there is no proven valid instrument to compare it against. However, the validity of the CTS is widely assumed, and it is the standard by which other instruments are measured. Most studies comparing reports of violence by husbands and wives using the CTS show underreporting by the perpetrator.<sup>12</sup>

The CTS enumerates 19 ways that couples may address their differences in order of increasing levels

TABLE 1

### The Conflict Tactics Scale Used to Detect Marital Violence

*No matter how well couples get along, there are times when they disagree, get annoyed with the other person, or just have spats or fights because they're in a bad mood or tired, or for some other reason. They also use many different ways of trying to settle their differences. Below are some things you might do when you have an argument. Please indicate how many times (once, twice, 3-5 times, 6-10 times, 11-20 times, more than 20 times) in the past 12 months you:*

- Discussed an issue calmly
- Got information to back up your side
- Brought or tried to bring in someone to help settle things
- Insulted or swore at her/him
- Sulked or refused to talk about an issue
- Stomped out of the room or house or yard
- Cried
- Did or said something to spite him or her
- Threatened to hit or throw something at her/him
- Threw or smashed or hit or kicked something
- Threw something at her/him
- Pushed, grabbed, or shoved her/him
- Slapped her/him
- Kicked, bit, or hit her/him with a fist
- Hit or tried to hit her/him with something
- Beat her/him up
- Choked her/him
- Threatened her/him with knife or gun
- Used a knife or fired a gun

Modified from Straus MA. Measuring intrafamily conflict and violence: the Conflict Tactics (CT) scales. *J Marriage Fam* 1979;41:75-78.

of emotional, verbal, and physical involvement. Response categories indicate how frequently each of the 19 approaches has been used. To mask the study's emphasis on domestic violence, the CTS was embedded within a larger survey instrument developed by the authors containing demographic, medical history, and health behavior inquiries familiar to patients in a health care setting. Alcohol consumption was measured by average number of days per week alcohol was consumed and average number of drinks consumed. Additional questions addressed illicit substance use; depression symptoms; personal history of physical, verbal, or sexual abuse; and family history of domestic violence. The instrument contained 50 items and could be completed in 5 to 10 minutes.

### DEFINITIONS

Men were defined as engaging in violent behavior if they responded positively to questions about throw-

ing, pushing, slapping, kicking, hitting, or threatening to use or using a gun or knife. Those responding positively were subdivided into a minor violence category (throwing, pushing, or slapping) and a severe violence category (kicking, beating, threatening to use or using a knife or gun). This classification follows the widely used definitions of minor and severe violence put forth by Straus.<sup>12</sup> The presence of major depression was defined as five or more positive responses on a symptom checklist. The symptom checklist was based on the diagnostic interview schedule and the *Diagnostic and Statistical Manual of Mental Disorders* criteria.<sup>13</sup> Binge drinking was defined as five or more alcoholic drinks consumed in one day within the previous month.<sup>13</sup>

### STATISTICAL ANALYSIS

In the descriptive analysis, frequency distributions of study variables were examined, and the prevalence of minor violence and severe violence was determined. A sample size of 228 was calculated using a power of .80, a *P* value of .05 with the intent of detecting a proportion in the affected group of 15% with an estimated prevalence in the unaffected group of 5%.<sup>14</sup>

Differences in men with violent behavior and men without violent behavior were tested using the Cochran-Mantel-Haenszel statistic for categorical variables.<sup>15</sup> Crude prevalence ratios were derived by using the prevalence of abuse in one category divided by the prevalence of abuse in the comparison category,<sup>16</sup> and confidence intervals were test-based using the Cochran-Mantel-Haenszel function.<sup>15</sup> Logistic regression modeling used statistically significant variables from the chi-square analysis to see which three best predicted violent behavior based on the log likelihood ratio. Logistic regression was also used to test all statistically significant variables for confounding and interaction. When possible, dichotomous variables were defined similarly to other studies, such as household income of less than \$20,000 per year.<sup>12</sup> If no previously defined cutoff existed, these were predetermined according to logical categories.

## RESULTS

Three hundred seventy-five men were eligible during the 6-week study period. Three hundred forty-three men were asked to participate and 297 (87%) agreed.

Of the thirty-two men who were missed in the clinics and sent questionnaires by mail, 20 (63%) returned their surveys. Men who had not been in an intimate relationship for at least 3 months during the previous year (*n*=80) filled out surveys and received payment, but were excluded, leaving 237 questionnaires for analysis.

Thirty-two men (13.5%, 95% confidence interval (CI), 9.1-17.9) disclosed minor violence over the previous 12 months. Ten men (4.2%, 95% CI, 3.7-4.8) indicated at least one episode of severe violence. All men who used severe violence also used minor violence against their partners.

Ninety men (38%) were younger than 35 years; 151 (64%) were married. Two hundred five men (86%) were white; 21 (9%) were African American. One hundred seventy-one men (72%) had more education than a high-school degree. Demographic characteristics significantly associated with presence of domestic violence were household income less than \$20,000 per year and nonwhite race. Age, education level, relationship length, marital status, and military experience were not significantly associated with increased prevalence of violent behavior.

Men who qualified as depressed according to the symptom checklist were more likely to be violent toward their partners than men who were not depressed (Table 2). Men who indicated they drank more than two drinks on average when consuming alcohol were more likely to be violent, but frequency of alcohol consumption and binge drinking were not associated with violent behavior. Use of any illicit drugs was associated with an increased risk of violence.

Forty-one men (17%) stated they had been verbally abused as children, 10 (4%) had been sexually abused, and 34 (14%) had been physically abused. Men who reported any abuse history during childhood were more likely to be violent than those not reporting an abuse history. Forty-nine men (21%) witnessed domestic violence as children, and these men were more likely to be violent than those who did not witness domestic violence between their parents. Men who lived with children from a partner's previous relationship were more likely to be violent than those living with their own children or men without children living at home.

### MULTIVARIABLE ANALYSIS

Although the number of participants was relatively

small, regression analysis was performed to look for confounding and interaction. Race became much less important but remained statistically significant once there was controlling for income and education. Drug use was no longer significant when alcohol use was included in the model. Statistically sig-

nificant psychosocial and medical variables were inserted into the regression model three at a time to determine which would best predict violent behavior. Depression, alcohol use, and any personal history of abuse (sexual, verbal, or physical) were the most important predictor variables. When none of the three risk factors were present, the baseline probability of violence was 7%. Probability increased to 41% if depression, drinking more than two drinks on average, or any history of abuse as a child was present. The predicted probability of violence, or positive predictive value, of these clinical characteristics is outlined in the Figure. There were no significant interactions among the three important predictive variables.

TABLE 2

**Psychosocial and Medical History Characteristics of Men who Completed the Domestic Violence Screening Instrument (N=237)**

Characteristic	n	Crude Prevalence Ratio (95% confidence interval)	P
Depression			
≥ 5 symptoms	52	2.4 (1.3-4.6)	.006
≤ 4 symptoms	185		
Average no. of drinks when drinking			
> 2 per day	129	2.7 (1.3-5.7)	.01
≤ 2 per day	101		
Drug use			
Yes	45	2.2 (1.2-4.3)	.02
No	192		
History of arrest			
Yes	40	1.6 (.78-3.4)	.20
No	195		
Family history of domestic violence			
Yes	49	2.3 (1.2-4.4)	.01
No	186		
Personal history of physical abuse			
Yes	34	2.0 (.96-4.1)	.065
No	203		
Personal history of sexual abuse			
Yes	10	2.3 (.80-6.9)	.12
No	227		
Personal history of verbal abuse			
Yes	41	2.1 (1.1-4.2)	.03
No	194		
Any personal history of verbal, sexual, or physical abuse			
Yes	70	2.4 (1.3-4.5)	.006
No	167		
Participant's own children living at home			
Yes	87	.68 (.33-1.4)	.28
No	150		
Children from partner's previous relationship			
Yes	18	2.3 (.95-5.4)	.07
No	219		

## DISCUSSION

We found that men in a primary care setting willingly answered questions about violent behavior toward their spouses. They disclosed violence at rates similar to large, representative studies with violence prevalence rates of 6% to 11% and prevalence of severe violence of 3% to 4%.<sup>13,17-19</sup> We also discovered that the clinical variables of depression, increased alcohol use, and victimization increased a man's probability of violence from 7% at baseline to 41% if all three risk factors are present. These risk factors point to another important reason for physicians to identify problem drinking and depression. History of childhood victimization is often not addressed in male patients, but our findings suggest such victimization is relatively common and is associated with violent behavior. Identification of abusive men and men at higher risk for being an abuser is an important step toward earlier intervention.

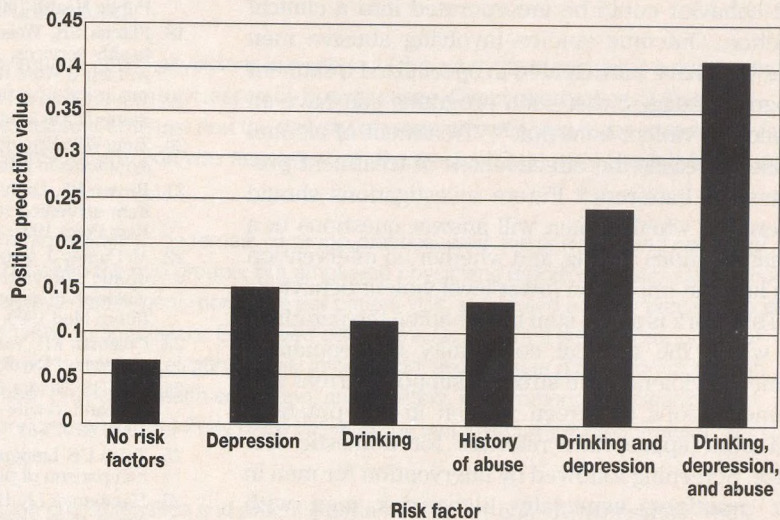
Many of our results are similar to those supported in the literature. The prevalence of depression,<sup>13,20</sup> alcohol use,<sup>13</sup> and illicit substance use<sup>21</sup> in our sample is similar to rates reported elsewhere in primary care settings. Many of the variables we found to be associated with increased rates of violence have been identified in other populations. Lower socioeconomic status,<sup>12,22-25</sup> depression,<sup>26-29</sup> alcohol use,<sup>12,23,24,30-32</sup> witnessing domestic violence as a child,<sup>31,33</sup> and a personal history of being abused<sup>33,34</sup> are reported risk factors for violence in an adult relationship. Our conclusion that presence of nonbiological children in the home is related to violence is also supported in the literature.<sup>35</sup>

Our finding of increased violence among nonwhite men, specifically African American men, is not, however, supported in the literature. In the largest study of domestic violence to date, when Straus<sup>12</sup> adjusted for income and occupation, black men had lower violence rates than whites. The National Crime Surveys have found rates of abuse for African American and white women<sup>19</sup> similar to those of other studies.<sup>21,23,36</sup> Lockhart<sup>37</sup> found that upper- or lower-class white women were slightly more likely to experience violence, and middle-class black women were slightly more at risk. Our results may be associated with social phenomena beyond income, education, or occupation in the relatively small African American community in Madison, Wisconsin.

The association between alcohol use and violence is complex and consistent.<sup>12,23,24,30-32</sup> Much of the data is difficult to interpret because of convenience sampling. Some investigators propose that alcohol use does not cause violent behavior but that the batterer uses alcohol with the intention of being violent.<sup>32</sup> We found men who drank more than two drinks when drinking alcohol were more likely to report violent behavior, but found no association between frequency of alcohol use or total weekly alcohol consumption and violent behavior toward partners. These

FIGURE

Predictors of violence in primary care patients



negative findings regarding several measures of alcohol use may be due to a smaller sample size, lack of power, or underreporting by heavier drinkers.

Our study has some limitations. It does not simulate usual circumstances in primary care settings, because it was anonymous and participants received a small payment. Sample size was adequate to estimate prevalence of violent behavior in male patients and several characteristics associated with violent behavior, but detailed analysis of large numbers of variables was not possible. Unrecognized selection bias was unlikely to have occurred, because sampling was consecutive and the participation rate was 85%. Asking men about their violent behavior most likely resulted in underreporting of violence frequency and severity if compared with reports of those men's partners.<sup>12</sup> This may not represent a methodologic weakness, because the only men available for intervention in a clinical setting are those who disclose violence in the first place.

There was concern that men in a health care setting might not be willing to answer questions about aggressive behavior toward intimate partners. The study anonymity and payment probably helped participation rates, but participants completed all CTS questions and disclosed violent behavior at rates consistent with other studies. The suggestion that the health care setting may not impede responses to such inquiries is encouraging, with important clinical

and public health implications. It is a first step toward understanding how screening men for violent behavior could be incorporated into a clinical practice. Outcome studies involving abusive men after they have participated in specialized treatment programs suggest that such programs can have an impact on violent behavior.<sup>38-41</sup> Treatment of alcohol abuse increases the effectiveness of treatment programs for batterers.<sup>42</sup> Future investigations should determine whether men will answer questions in a nonanonymous setting, and whether an intervention can have an impact on lower-level violent behavior.

This work is a first step in reshaping the paradigm by which the medical community conceptualizes domestic violence. We strongly support current recommendations to screen women in our practices and offer appropriate referrals for domestic violence. Screening followed by intervention for men in our practices, especially higher-risk men with depression, alcohol use, and history of victimization as children, could serve as important adjuncts to other efforts.

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