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Intimate Partner Violence (IPV): Clinical and Societal Perspectives

Marudan Sivagurunathan, *The University of Western Ontario*

Supervisor: Dr. Joy MacDermid, *The University of Western Ontario*

A thesis submitted in partial fulfillment of the requirements for the Doctor of Philosophy degree in Health and Rehabilitation Sciences

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Abstract

Intimate Partner Violence (IPV) can have a lasting impact on survivors' emotional, physical, and psychological wellbeing. IPV is multifaceted and can influence survivors' interactions across various institutions, including healthcare settings. This PhD project consists of both qualitative and quantitative studies aimed at exploring the clinical and societal perspectives around IPV.

Study #1 sought to explore the discourses around male IPV drawn from a social networking site (Reddit.com). While some areas related to IPV are well researched, studies on male intimate partner violence survivors are limited. The results from study #1 show that male IPV disclosure is a complex process. While some negative responses are present, overall, the responses to disclosure are positive. In addition, the study revealed multiple perceived systemic issues that negatively impact male IPV survivors.

Study #2 examined clinicians' experiences (attitudes and perceptions regarding IPV and IPV assessment). Findings from previous research indicate musculoskeletal (MSK) injuries are the second most common trauma. As such, it is an important topic for hand therapists (HTs). The study findings show that while HTs agree dealing with IPV is part of their job responsibilities (3.8/5) they reported a neutral level of self-efficacy (2.9/5), perceived system support (3/5), and victim provider safety (3/5). Furthermore, findings indicate that majority of HTs (66%) reported that they had not assessed for IPV in the past 3 months.

Fear of offending the patient was identified from study #2 as being one of the barriers to screening for IPV. As such, study #3 sought explore patient attitudes regarding IPV inquiry in an upper limb extremity clinic. The findings indicate a majority of patients felt that neither they nor other people would be offended by IPV inquiry. However, a substantial minority felt that other people would be offended by IPV inquiry.

The results of this PhD project have implications for both rehabilitation practice and further research. Public awareness programs aimed at society, clinicians, and policy makers is imperative for fostering an environment in which conversations around male IPV

victimization can take place without shame or stigma. Additionally, the results indicate the need to evaluate currently available services to males who have disclosed their sexual abuse histories to ensure their needs are effectively met. Further research on IPV assessment in the rehabilitation context is needed to ensure that needs of both male and female IPV survivors are adequately met.

Keywords:

Intimate Partner Violence, Gender, Disclosure, Screening, Hand Therapy, Social Networking Site.

Lay Summary

Summary of Study #1 (Chapters 2-3): Web-Based Discourses around IPV in Reddit: a qualitative analysis

We have learned a lot about what happens when women experience violence from their partners. But we still do not know very much about what it is like for men who are abused by their partners. This study used postings on social networking sites (SNSs) to understand how people talked about violence against men by their partners. Chapter 2 looked at postings on reddit.com where the content included 1) men telling other people about being abused by their partner, and/or 2) how people responded when men said they had experienced violence from a partner. The study in Chapter 3 examined all postings that talked about the abuse of men by their partners and looked for all examples of bias or mistreatment by services and agencies that were supposed to help people in these situations.

Summary of Study #2 (Chapter 4-5): Survey of Intimate Partner Violence Preparedness and Practices Amongst Hand Therapists

We know that musculoskeletal (MSK) injuries including upper extremity sprains and fractures are common amongst victims of intimate partner violence. While we know about the attitudes of nurses, physicians, surgeons and students and other clinicians in regard to IPV, we don't know very much about HTs, who specialize in rehabilitation of MSK related injuries. Study #2 was a survey designed to examine HTs' attitudes and perceptions regarding IPV and their ability to deal with clients who may have IPV experience in their clinical setting. Chapter 4 looked at HTs' perceptions of self-efficacy, available system support, victim blaming attitudes, whether HTs believed dealing with IPV was part of their job responsibility, and whether HTs perceived they could safely deal with IPV in their clinic. Meanwhile, Chapter 5 examined the assessment and response to IPV amongst HTs.

Summary of Study #3 (Chapter 6): An Anonymous Survey of Patients' Screening Attitudes

Previous studies, including those published in this thesis, have found one of the barriers to screening for IPV amongst clinicians is fear of offending the patients. Study #3 looked at whether patients would be offended if their clinicians assessed patients for IPV. The quantitative study used a survey to examine if patients might be embarrassed by inquiry regarding IPV amongst patients visiting an upper extremity specialty clinic.

Co-Authorship Statement

Study #1 (Manuscript #1¹ & Manuscript #2²): Marudan Sivagurunathan conceptualized the research questions, designed the study, collected and analyzed the data, and wrote the initial drafts of all manuscripts. Dr. Richard Booth reviewed the objectives and methods of the study and provided feedback on the manuscript. Dr. Joy MacDermid provided feedback with the data analysis and helped to refine the manuscript. Dr. Tara Packham and Dr. David Walton provided feedback with the analysis and helped with preparing the manuscript for publication.

Study #2 (Manuscript #3³ & Manuscript #4⁴): Data for the study was collected by students of Dr. Tara Packham. Marudan Sivagurunathan conceptualized the research questions, analyzed the data, and wrote the initial draft of the manuscript. Dr. Joy MacDermid provided feedback with the data analysis and helped to refine the manuscript. Dr. Tara Packham provided feedback with the analysis and helped with preparing the manuscript for publication.

Study #3 (Manuscript #5⁵): Marudan Sivagurunathan conceptualized the research questions, designed the study, collected and analyzed the data, and wrote the initial drafts of all manuscripts. Dr. Joy MacDermid provided feedback with the data analysis and helped to refine the manuscript. Dr. Tara Packham and Dr. David Walton provided feedback with the analysis and helped with preparing the manuscript for publication.

¹ Not submitted for publication

² Not submitted for publication

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⁴ Sivagurunathan, M., Packham, T., Dimopoulos, L., Murray, R., Madden, K., Bhandari, M., & MacDermid, J. C. (2018). Perceptions of preparedness and intimate partner violence screening practices amongst hand therapists. *Hand Therapy, 23*(4), 139–147. <https://doi.org/10.1177/1758998318798668>

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Chapter 1

1 Introduction

Intimate partner violence (IPV), is defined by World Health Organization (WHO) as “behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours”(WHO, 2013, p. vii). Findings from a study by Black et al. (2011) showed 29% of men and 36% of women had experienced physical violence, and/or stalking behaviour. Similarly, a study by Devries et al. (2013) found that globally in 2010, 30.0% of women aged 15 and over had experienced some form of IPV in their lifetime. In terms of Canadian population, a 2017 Statistics Canada report indicated that IPV represented close to one-third of all crime reported to police, with 8 in 10 victims being female (Burczycka et al., 2018).

1.1 IPV and Gender

IPV may impact any person regardless of race, sexual orientation, socioeconomic status, sex or gender. However, research shows significant gender differences in terms of IPV victimization and perpetration exist.

While both men and women may experience IPV, studies on IPV perpetration and victimization show women disproportionally experience IPV, in both prevalence and severity. For example, a multi country study by the WHO showed IPV to be a significant issue for women (Garcia-Moreno et al., 2006). A Statistics Canada report indicates that women accounted for 79% of all IPV cases reported to police in 2017 (Burczycka et al., 2018). Comparative study by Breiding et al. (2008a) showed that 26.4% of women

experienced some combination of physical violence and/or unwanted sex in their lifetime, compared to only 15.9% of men. Similarly, a study on men and women entering a substance use disorder treatment found 1 in 2 women had experienced IPV, while 1 in 10 men indicated IPV victimization (Schneider et al., 2009).

Studies on risk factors also show gender differences in terms of IPV perpetration and victimization (Gass et al., 2011; Lee et al., 2014). For example, both alcohol dependence/abuse and childhood physical abuse was seen as a predictive factor for IPV perpetration in both men and women (Gass et al., 2011; Lee et al., 2014; Schafer et al., 2004). However, while childhood witnessing of parent-to-parent IPV was significantly associated with adult IPV perpetration amongst males (Roberts et al., 2010) it is not a predictive factor in female perpetration of IPV (Hughes et al., 2007). Lee et al. (2014) found low education level to be associated with perpetration of verbal violence in men while it was associated with both perpetration and victimization of verbal violence in women. Similarly, Gass et al. (2011) found mood disorders to be associated with IPV perpetration in men but not in women.

In terms of severity, studies have consistently shown that women suffer more serious injuries due to the relative size and strength of men and the forms of IPV perpetrated. A systematic review by Chan (2011) found that men are more likely to initiate and perpetrate more severe forms of IPV resulting in more severe forms of injury or consequences. Similarly, Archer (2000) found that while women are more likely to engage in minor acts of physical violence, acts of physical violence by men are often more injurious. A national survey by Tjaden & Thoennes (2000) found women are more likely to be hospitalized for severe IPV related injuries than men. Studies on mental

health impacts of IPV on male and female victims have shown IPV victimization to be significantly related to negative psychological outcomes (L. J. Bacchus et al., 2018; Hines & Douglas, 2010; Meekers et al., 2013; Randle & Graham, 2011). However, while comparative studies on male and female victims of IPV are limited, existing studies suggest female IPV survivors are more likely to experience negative psychological outcomes than men. For example, a study by Anderson (2002) found that depression and substance abuse were higher amongst women than men in cases of mutual violence.

1.1.1 IPV in Men

While women experience IPV victimizations at a higher rate, men also experience IPV at the hands of their female or male partners. However, the majority of the research on IPV to date has focused on female victims of IPV to the exclusion of male IPV survivors. For example, a systematic review by Laskey et al. (2019) found only 7 studies on IPV victimization experiences which included only men as their sample population. A focus on female IPV survivors may be due to “higher burden of IPV on women compared with men and the higher impact of IPV that women experience”(M. C. Black, 2011). However, findings from epidemiological studies on the impact of IPV on male survivors must be examined with caution given that men may be less likely to report their IPV experiences (Chan, 2011).

Patterns of IPV perpetration and victimizations maybe shared by male and female perpetrators and victims, but the sociocultural and biological context may result in unique experiences as well (Ansara & Hindin, 2010b, 2010a; Archer, 2000). For example, an analysis of the General Social Survey by Ansara & Hindin (2010a), found that male and female IPV survivors have similar as well as unique patterns in terms of IPV experiences.

Social notions of hegemonic masculinity, which “embodied the currently most honored way of being a man, it required all other men to position themselves in relation to it, and it ideologically legitimated the global subordination of women to men” (Connell & Messerschmidt, 2005, p.832), may also result in unique facets in terms of experiences of IPV. Therefore, generalizing the findings from studies on female IPV survivors may not provide an accurate picture of male IPV experiences.

1.2 Health Impacts of IPV

IPV has serious health implications and far reaching consequences. Victims of IPV may experience a multitude of negative health outcomes. IPV may contribute to immediate and long-term physical, emotional, and psychological issues (M. C. Black, 2011; Bonomi et al., 2009; Breiding et al., 2008b; Hines & Douglas, 2010; Meekers et al., 2013; Randle & Graham, 2011). For example, research shows IPV is associated with post-traumatic stress disorder (PTSD), depression, and anxiety as well as suicidal attempts in females IPV survivors (L. J. Bacchus et al., 2018; Meekers et al., 2013). Similarly, A review by Randle & Graham (2011) found men with experiences of IPV are more likely to experience PTSD, psychological distress, depression, and suicidal ideation than men without experiences of IPV. Hines & Douglas (2010) found 23.5% of men in abusive relationships had been diagnosed with some form of mental illness, almost half of whom (40.8%) indicated the diagnosis had been made only since becoming involved in their abusive relationship.

Research on physical health outcomes of IPV on men are limited. However, research on female IPV survivors show IPV is associated with a host of negative health outcomes in women and impact multiple systems (e.g. gastrointestinal system, brain and

nervous system, cardiovascular system, and immune system) (M. C. Black, 2011; Campbell, 2002). Some physical health outcomes (stroke, joint disease, and asthma) have been found to be significantly associated with IPV victimization in both men and women (Breiding et al., 2008b).

While some of the health impacts of IPV may be shared between male and female IPV survivors, there are also unique gender differences. IPV in women has been associated with gynecological issues such as abnormal vaginal discharge, lower abdominal pain, dysuria (discomfort associated with urination), and dyspareunia (pain during penetrative sexual acts), and menstrual irregularities (L. J. Bacchus et al., 2018; Stockman et al., 2015). Similarly, (L. J. Bacchus et al., 2018; Islam et al., 2017) show IPV is associated with postpartum depression (PPD) in female IPV survivors. However, given findings that show PPD can also occur in men, further research on male IPV survivors and PPD is warranted.

Additionally, individual men and women with IPV experiences may engage in negative health behaviors, such as drinking, smoking, unsafe sexual practices (unprotected sex, multiple sexual partners, engaging in sex with HIV infected partners, inconsistent condom use), not using adequate antenatal care or skilled delivery care, and/or not having regular health checkups (Breiding et al., 2008b; Buller et al., 2014; Cerulli et al., 2014; El-Bassel et al., 2007; Houston & McKirnan, 2007; Musa et al., 2019; Teitelman et al., 2008). These negative health behaviors may have further consequences for IPV survivors' health. In addition to the adverse health outcomes IPV experiences can impact job stability and education attainment (Adams et al., 2012), as well as housing stability (Pavao et al., 2007).

Studies indicate that children with exposure to IPV also are at high risk. IPV and child maltreatment often co-occur in the same household (Karen M. Devries et al., 2017; Guedes & Mikton, 2013). Furthermore, IPV experienced during prenatal period have been found to be associated with low birth weight, preterm birth, and neonatal death (Alhusen et al., 2014). Children who witness IPV are also more likely to experience or perpetrate this and other forms of violence later in life (Guedes & Mikton, 2013).

Study by Peterson et al. (2018) found the financial cost of IPV in United States was USD \$103,767 per female victim and \$23,414 per male victim, which includes medical costs, loss of productivity, and criminal justice costs as well as property loss or damage. These findings highlight the economic impact as well as the gendered nature of IPV. Given the array of negative health, social, and financial consequences of IPV, it is imperative that further research on this phenomenon be conducted.

1.3 Disclosure of IPV Experience

Disclosure of IPV can help inform clinicians on effective support for IPV survivors (Sylaska & Edwards, 2014). However, studies on IPV reporting show that while rates of underreporting vary by gender (Ansara & Hindin, 2010b; Sylaska & Edwards, 2014), both men and women underreport their IPV victimization (Chan, 2011). As such current prevalence rates of IPV may be under-estimates. For example, Ansara & Hindin (2010b) found that only 80% of women and 57% of men with experiences of IPV disclosed to informal sources while only 64% of women and 32% of men reported to formal sources. Multiple factors (demographic, intrapersonal, and situational) may influence disclosure of IPV experience (Sylaska & Edwards, 2014). A literature review by Sylaska & Edwards (2014) showed multiple demographic factors (gender, age, race,

and SES) may influence disclosure, with victims who are female, younger, white and have higher SES more likely to disclose their IPV experiences. Intrapersonal factors such as victim's feelings may also prevent disclosure. For example, Chan (2011) found both men and women under-report their IPV due to feelings of shame and guilt as well as need for social desirability, defined as "desire to be viewed positively" (Chan, 2011, p.172). Similarly, stigma may serve as a barrier to help seeking for both genders (Barney et al., 2006).

1.3.1 Underreporting in Men

While both men and women underreport IPV, unique gender-related barriers to disclosure may also exist for both male and female IPV survivors. Research on male IPV disclosure is limited (Simon & Wallace, 2018). However, a few studies have shown that males are less likely to disclose experiences of IPV (Sylaska & Edwards, 2014). Many complex factors may result in men underreporting experiences of IPV and minimizing the impact of IPV on the various facets of their lives. Men's general tendency to not seek help may serve as a barrier to disclosing IPV. Studies in the area of gender and help-seeking behaviour show that men are less likely to seek help for diverse issues including, substance abuse, depression, and even milder issues such as concerns about school work or, issues with parents (Farrand et al., 2007; McKay et al., 1996). Research on help-seeking behaviour amongst men with suicidal behaviours show that coping mechanisms used by men coupled with trouble identifying distress may serve as a barrier to help seeking (Cleary, 2012).

Social and cultural attitudes regarding what it means to be a victim and what it is to 'be a man' may also play a role in the decision to disclose or how male IPV survivors

construe their experiences of IPV victimization. For example, a study by Entilli & Cipolletta (2017) noted men tended to justify women's act of violence against them, and had trouble recognizing themselves as victims. Subsequently, a study by Nybergh, Enander, & Krantz, (2016) found men's narratives regarding their abuse often consisted of framing physical violence perpetrated by women as less threatening. Social responses to disclosure of male experiences of IPV may also lead to reluctance in disclosing their IPV victimization. When men sought help for IPV, they reported that social and victim services, police and the justice system were unhelpful (Douglas & Hines, 2011; Machado et al., 2016). For example, Douglas & Hines (2011) found men who attempted to access domestic violence services, hotlines, and agencies experienced being turned away, being accused of perpetrating the IPV, and being inappropriately referred to the batterers intervention program (even though they had experienced the abuse).

1.4 High Rates of Service Utilization by IPV victims

Prior studies show persistently high rates of service utilization by women who have a history of IPV experience compared to women without an IPV history. Rivara and colleagues (2007) found that even women whose abuse had ceased 5 years prior had 20% higher health care utilization rates than women without such a history. Similarly, a more recent study by Ford-Gilboe et al. (2015) found higher service use by female IPV survivors across both general and mental health care services, with the general health provider being visited by 77% of women in the study at least once in the past month. A study by Bhandari and colleagues (2011) examined the prevalence of IPV in a sample of 282 women attending a Level-I trauma centre in Ontario. The results showed 32% of the women who attended the clinic had experienced IPV, which included emotional,

physical, or sexual abuse, in the past 12 months with 8.5% experiencing physical abuse (Bhandari et al., 2011). Additionally, the study indicated 2.5% of the women attributed the reason for the visit to the clinic to be directly related to physical injury caused by an intimate partner (Bhandari et al., 2011). Similar rates of IPV in fracture clinic settings have been found in other studies. An international study by Petrisor et al. (2013) examined IPV prevalence in a sample population of 2945 females from 12 fracture clinics in Canada, USA, Netherlands, Denmark, and India. The results showed one in six (16%) of the women had experienced IPV in the last year and one in three (35%) had experienced IPV in their lifetime (Petrisor et al., 2013). Furthermore 1.7% of the sample population indicated that the reason for the visit to the clinic was due to IPV. While there's growing body of evidence for increased service utilization and help-seeking behaviors amongst women who have been impacted by IPV, research on health care utilization by male victims of IPV is limited. The limited research on health service utilization by male IPV survivors show high rates of service utilization (Ballan et al., 2017; Mechem et al., 1999). However, studies show that female IPV survivors had higher rates of service utilization compared to male IPV survivors (Kothari et al., 2015).

1.5 IPV and Musculoskeletal Injuries

Studies on hand or upper limb injuries related to IPV are scarce but compelling. Findings from previous research suggest that injury to the upper extremities is one of the most common forms of injury related to IPV in women (Bhandari et al., 2006; Muelleman et al., 1996). For example, a study by Bhandari and colleagues (2006) examined the types of injury associated with IPV. The results showed that musculoskeletal (MSK) injuries to the limbs, such as fractures and dislocations (28%) are

the second most common injuries faced by women who experience intimate partner violence preceded by head and neck injuries (40%) (Bhandari et al., 2006). Research on male IPV survivors is limited, however, findings from a study by (Loder & Momper, 2020) show significant gender difference with 89% of female IPV survivors being diagnosed with fractures compared to 11% of men.

1.6 Screening

Despite the high prevalence rate of IPV among women who utilize services for their MSK injuries (Bhandari et al., 2011; Wu et al., 2010) a high number of clinicians continue to be unaware of the extent to which persons in their community experience IPV. A study by Shearer & Bhandari (2008) examined 505 Ontario chiropractors' knowledge, attitude and belief about IPV among their client population. The results showed that 88% of the chiropractors believed IPV was rare or very rare (0.1% to 1%) in their practice while 34% believed IPV was very rare in their community (Shearer & Bhandari, 2008). Similarly, a study by Bhandari and colleagues (2008) examined attitudes regarding IPV in a sample population of 186 orthopaedic surgeons. The findings indicate an overwhelming majority (n=170) believed less than 10 percent of the women in their community are victims of IPV while 148 participants believed that less than 1 percent of the population in their care have experienced IPV (Bhandari et al., 2008).

This underestimation of prevalence of IPV by clinicians maybe attributed low rates of awareness surrounding IPV amongst clinicians. Several studies have been conducted to examine barriers to asking about IPV across health professional groups (Conn et al., 2014; Della Rocca et al., 2013; Ramsay, 2002; Sormanti & Smith, 2010). For example, a study by Sormanti & Smith (2010) examining universal screening for IPV

in emergency departments found barriers to screening for IPV in female patients included: a) inadequate training, b) perception screening wasn't part of the scope of practice, c) lack of time, d) limited privacy to support screening, e) lack of policies around screening, and f) fear of offending the patient (Conn et al., 2014; Gutmanis et al., 2007; Sprague, Swinton, et al., 2013).

To date majority of research on the efficacy of universal screening, defined as “a procedure that involves directly questioning -- in writing and orally -- every adult client, regardless of the presenting issue(s), about current and previous IPV victimization” (Todahl & Walters, 2011, p.357) has been on female IPV survivors. Research on benefits and health outcomes of universal screening for male IPV victims are limited. However, existing research on female IPV survivors show insufficient evidence supporting universal screening. For example, a systematic review (Feltner et al., 2018) on universal screening and the efficacy of universal screening on female IPV survivors has found universal screening as having no significant benefit in terms of reduction in IPV following screening, quality of life improvement, or improved outcome in health effects. Guidelines on screening are equivocal. The US Preventive Services Task Force recommends screening for IPV in women of reproductive age and providing appropriate referrals and support (Curry et al., 2018). The Canadian Task Force on Preventive Health Care and the World Health Organization (WHO) find the evidence too limited to merit universal screening policies (WHO, 2013). However, WHO does recommend universal IPV inquiry by trained service providers for pregnant women in antenatal care setting.

Rather than universal screening for IPV, the WHO suggests that clinicians be prepared to ask about experiences of IPV “when assessing conditions that may be

caused or complicated by intimate partner violence” (WHO, 2011, p.3), an approach called case-finding. As such, it is important that clinicians be aware of symptoms/ injuries that patients experiencing IPV may present with in clinical settings. Furthermore, clinicians should be made aware of IPV disclosure patterns and be better educated on providing referrals to effective resources and services when appropriate. It is imperative that clinicians are prepared to manage presenting cases in an appropriate manner as to ensure better outcomes for male and female IPV survivors.

1.7 Rehabilitation practice and IPV

Despite the prevalence of MSK injuries amongst female victims of IPV (Bhandari et al., 2006), there is a lack of assessment for IPV by clinicians, including within rehabilitation practice. One of the prevalent barriers to IPV inquiry identified by clinicians is the lack of time, or brevity of patient-clinician interactions (Sormanti & Smith, 2010; Sprague, Swinton, et al., 2013). Compared to specialist physicians who may only see the patient once or twice, physical therapists (PTs) and occupational therapists (OTs) may be able to form a closer rapport with patients during the rehabilitation process. Given that PTs and OTs work with clients on an extended basis, they may be uniquely positioned to assess for and offer appropriate referrals and assistance to patients with experience of IPV. However, while studies have examined perceptions, knowledge and screening practices of various clinician groups including orthopedic surgeons (Bhandari et al., 2008; Della Rocca et al., 2013), medical students/ surgical residents (Sprague, Kaloty, et al., 2013), and chiropractors (Shearer & Bhandari, 2008), there is a paucity of research examining the knowledge and attitude of OTs and PTs.

Given that hand fractures are the second most common MSK injury from IPV, the therapist-client dyad in hand therapy is of particular interest. Due to the nature of rehabilitation programs where these providers spend considerable time with clients with traumatic injuries, physical and occupational therapists are in a unique position to identify IPV in their clients and/or support disclosure, as well as offer appropriate referrals and assistance. Therefore, it is imperative that we study this clinician population. Research on the knowledge and attitudes of occupational and physical therapists practicing in a hand therapy setting can inform development of educational programs that can help identify and provide assistance to clients with history of IPV victimization.

1.8 Social Networking Sites.

Individuals may be reluctant to seek help face-to-face when: 1) the issue that they are seeking help for is stigmatizing; 2) there is fear of the disclosure jeopardizing the relationship between the abuser and the confidant; or 3) there is fear of having to reciprocate the help they receive (Andalibi et al., 2016). However, the anonymous nature of the internet allows for more intimate disclosures (Tidwell & Walther, 2002) and removes some of the barriers associated with face-to-face help-seeking. Studies have found online health support communities to be helpful in a spectrum of health conditions (Finfgeld, 2000; Tanis, 2008).

However, using social media platforms as source of data has both strengths and limitations. Rob Kitchen (Sloan & Quan-Haase, 2016) notes that social media platforms provide data deluge – “a constantly flowing torrent of rich, highly informative information about people, their lives, and what is happening in different societies in places around the world” (p.29). Furthermore, data from social media platforms can be

real-time (Sloan & Quan-Haase, 2016). However, some limitations exist in regarding to collecting data from social media platforms. Collecting data from social media raises ethical concerns regarding their use in research (Sloan & Quan-Haase, 2016). One of the more relevant ethical concerns in terms of data mining for academic purposes being the collection and use of data without participant's knowledge or consent. Furthermore, due to the nature of data collection, there is little possibility for further clarifications on the collected data.

1.9 Conclusion

IPV is a global health issue, with MSK injury being one of the primary physical injuries associated with IPV. The responses of both clinical caregivers and the broader society to IPV may impact disclosure and help-seeking amongst male and female IPV survivors. This thesis explored both clinical and social perspectives regarding IPV in men and women. The thesis is comprised of 5 unique manuscripts presenting data from three studies. Study #1 (chapter 2 & chapter 3) used qualitative research methods to examine social perspectives around IPV among men with data scraped from a social networking site (Reddit.com). Study #2 was a cross-sectional survey used to explore the perspectives of a segment of rehabilitation clinicians regarding attitudes and behaviour around managing IPV in their clinic (chapters 4 & chapter 5). Finally, study 3 (chapter 6) used quantitative survey methods to understand clinical population perspectives about IPV inquiry in the context of hand rehabilitation.

The specific research questions addressed in this thesis were (by chapter):

Chapter 2 (Manuscript #1): What is the nature (supportive/negative) and content of responses to IPV disclosure from male IPV survivors on social networking sites (Reddit)?

Chapter 3 (Manuscript #2): What are the discourses around the systems being utilized by male IPV survivors?

Chapter 4 (Manuscript #3): What are the attitudes and beliefs of HTs regarding IPV (Sivagurunathan et al., 2019)?

Chapter 5 (Manuscript #4): What are the IPV assessment practices and perceived preparedness of HTs to manage IPV (Sivagurunathan et al., 2018)?

Chapter 6 (Manuscript #5): What are patients' attitudes regarding IPV inquiry by clinicians at an upper limb surgery clinic?

1.10 References

- Adams, A. E., Tolman, R. M., Bybee, D., Sullivan, C. M., & Kennedy, A. C. (2012). The Impact of Intimate Partner Violence on Low-Income Women's Economic Well-Being: The Mediating Role of Job Stability. *Violence Against Women, 18*(12), 1345–1367. <https://doi.org/10.1177/1077801212474294>
- Alhusen, J. L., Ray, E., Sharps, P., & Bullock, L. (2014). Intimate Partner Violence During Pregnancy: Maternal and Neonatal Outcomes. *Journal of Women's Health, 24*(1), 100–106. <https://doi.org/10.1089/jwh.2014.4872>
- Andalibi, N., Haimson, O. L., De Choudhury, M., & Forte, A. (2016). Understanding social media disclosures of sexual abuse through the lenses of support seeking and anonymity. *Conference on Human Factors in Computing Systems - Proceedings, 3906–3918*. <https://doi.org/10.1145/2858036.2858096>
- Anderson, K. L. (2002). Perpetrator or victim? Relationships between intimate partner violence and well-being. *Journal of Marriage and Family, 64*(4), 851–863. <https://doi.org/10.1111/j.1741-3737.2002.00851.x>
- Ansara, D. L., & Hindin, M. J. (2010a). Exploring gender differences in the patterns of intimate partner violence in Canada: A latent class approach. *Journal of Epidemiology and Community Health, 64*(10), 849–854. <https://doi.org/10.1136/jech.2009.095208>
- Ansara, D. L., & Hindin, M. J. (2010b). Formal and informal help-seeking associated with women's and men's experiences of intimate partner violence in Canada. *Social Science and Medicine, 70*(7), 1011–1018. <https://doi.org/10.1016/j.socscimed.2009.12.009>

- Archer, J. (2000). Sex differences in aggression between heterosexual partners: A meta-analytic review. *Psychological Bulletin*, *126*(5), 651–680.
<https://doi.org/10.1037/0033-2909.126.5.651>
- Bacchus, L. J., Ranganathan, M., Watts, C., & Devries, K. (2018). Recent intimate partner violence against women and health: a systematic review and meta-analysis of cohort studies. *BMJ Open*, *8*(7), e019995. <https://doi.org/10.1136/bmjopen-2017-019995>
- Ballan, M. S., Freyer, M. B., & Powledge, L. (2017). *Intimate Partner Violence Among Men With Disabilities : The Role of Health Care Providers*.
<https://doi.org/10.1177/1557988315606966>
- Barney, L. J., Griffiths, K. M., Jorm, A. F., & Christensen, H. (2006). Stigma about depression and its impact on help-seeking intentions. *Australian and New Zealand Journal of Psychiatry*, *40*(1), 51–54. <https://doi.org/10.1111/j.1440-1614.2006.01741.x>
- Bhandari, M., Dosanjh, S., Tornetta, P., & Matthews, D. (2006). Musculoskeletal Manifestations of Physical Abuse After Intimate Partner Violence. *The Journal of Trauma: Injury, Infection, and Critical Care*, *61*(6), 1473–1479.
<https://doi.org/10.1097/01.ta.0000196419.36019.5a>
- Bhandari, M., Sprague, S., Dosanjh, S., Petrisor, B., Resendes, S., Madden, K., & Schemitsch, E. H. (2011). The Prevalence of Intimate Partner Violence across Orthopaedic Fracture Clinics in Ontario. *The Journal of Bone and Joint Surgery-American Volume*, *93*(2), 132–141. <https://doi.org/10.2106/JBJS.I.01713>
- Bhandari, M., Sprague, S., Tornetta, P., D'Aurora, V., Schemitsch, E., Shearer, H., Brink, O., Mathews, D., & Dosanjh, S. (2008). (Mis)Perceptions About Intimate Partner Violence in Women Presenting for Orthopaedic Care: A Survey of Canadian Orthopaedic Surgeons. *The Journal of Bone and Joint Surgery-American Volume*, *90*(7), 1590–1597. <https://doi.org/10.2106/JBJS.G.01188>
- Black, M. C. (2011). Intimate Partner Violence and Adverse Health Consequences. *American Journal of Lifestyle Medicine*, *5*(5), 428–439.
<https://doi.org/10.1177/1559827611410265>
- Bonomi, A. E., Anderson, M. L., Reid, R. J., Rivara, F. P., Carrell, D., & Thompson, R. S. (2009). Medical and psychosocial diagnoses in women with a history of intimate partner violence. *Archives of Internal Medicine*, *169*(18), 1692–1697.
<https://doi.org/10.1001/archinternmed.2009.292>
- Breiding, M. J., Black, M. C., & Ryan, G. W. (2008a). Prevalence and Risk Factors of Intimate Partner Violence in Eighteen U.S. States/Territories, 2005. *American Journal of Preventive Medicine*, *34*(2), 112–118.
<https://doi.org/10.1016/j.amepre.2007.10.001>

- Breiding, M. J., Black, M. C., & Ryan, G. W. (2008b). Chronic Disease and Health Risk Behaviors Associated with Intimate Partner Violence—18 U.S. States/Territories, 2005. *Annals of Epidemiology*, *18*(7), 538–544. <https://doi.org/10.1016/j.annepidem.2008.02.005>
- Buller, A. M., Devries, K. M., Howard, L. M., & Bacchus, L. J. (2014). Associations between Intimate Partner Violence and Health among Men Who Have Sex with Men: A Systematic Review and Meta-Analysis. *PLoS Medicine*, *11*(3), e1001609. <https://doi.org/10.1371/journal.pmed.1001609>
- Burczycka, M., Conroy, S., & Savage, L. (2018). Family violence in Canada: A statistical profile, 2017. *Juristat: Canadian Centre for Justice Statistics*, *38*(1). <https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2018001/article/54978-eng.pdf?st=d0-rM50a>
- Campbell, J. C. (2002). Health consequences of intimate partner violence. *Lancet*, *359*(9314), 1331–1336. [https://doi.org/10.1016/S0140-6736\(02\)08336-8](https://doi.org/10.1016/S0140-6736(02)08336-8)
- Cerulli, C., Bossarte, R. M., & Dichter, M. E. (2014). Exploring Intimate Partner Violence Status Among Male Veterans and Associated Health Outcomes. *American Journal of Men's Health*, *8*(1), 66–73. <https://doi.org/10.1177/1557988313492558>
- Chan, K. L. (2011). Aggression and Violent Behavior Gender differences in self-reports of intimate partner violence : A review. *Aggression and Violent Behavior*, *16*(2), 167–175. <https://doi.org/10.1016/j.avb.2011.02.008>
- Cleary, A. (2012). Suicidal action, emotional expression, and the performance of masculinities. *Social Science and Medicine*, *74*(4), 498–505. <https://doi.org/10.1016/j.socscimed.2011.08.002>
- Conn, L. G., Young, A., Rotstein, O. D., & Schemitsch, E. (2014). I've never asked one question." Understanding the barriers among orthopedic surgery residents to screening female patients for intimate partner violence. *Canadian Journal of Surgery*, *57*(6), 371–378. <https://doi.org/10.1503/cjs.000714>
- Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic masculinity rethinking the concept. *Gender and Society*, *19*(6), 829–859. <https://doi.org/10.1177/0891243205278639>
- Curry, S. J., Krist, A. H., Owens, D. K., Barry, M. J., Caughey, A. B., Davidson, K. W., Doubeni, C. A., Epling, J. W., Grossman, D. C., Kemper, A. R., Kubik, M., Kurth, A., Landefeld, C. S., Mangione, C. M., Silverstein, M., Simon, M. A., Tseng, C. W., & Wong, J. B. (2018). Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: US Preventive Services Task Force Final Recommendation Statement. *JAMA - Journal of the American Medical Association*, *320*(16), 1678–1687. <https://doi.org/10.1001/jama.2018.14741>
- Della Rocca, G. J., Sprague, S., Dosanjh, S., Schemitsch, E. H., & Bhandari, M. (2013).

Orthopaedic surgeons' knowledge and misconceptions in the identification of intimate partner violence against women trauma. *Clinical Orthopaedics and Related Research*, 471(4), 1074–1080. <https://doi.org/10.1007/s11999-012-2749-x>

Devries, K. M., Mak, J. Y. T., García-Moreno, C., Petzold, M., Child, J. C., Falder, G., Lim, S., Bacchus, L. J., Engell, R. E., Rosenfeld, L., Pallitto, C., Vos, T., Abrahams, N., & Watts, C. H. (2013). The Global Prevalence of Intimate Partner Violence Against Women. *Science*, 340(6140), 1527–1528. <https://doi.org/10.1126/science.1240937>

Devries, Karen M., Knight, L., Child, J. C., Kyegombe, N., Hossain, M., Lees, S., Watts, C., & Naker, D. (2017). Witnessing intimate partner violence and child maltreatment in Ugandan children: A cross-sectional survey. *BMJ Open*, 7(2), 1–9. <https://doi.org/10.1136/bmjopen-2016-013583>

Douglas, E. M., & Hines, D. A. (2011). The Helpseeking Experiences of Men Who Sustain Intimate Partner Violence: An Overlooked Population and Implications for Practice. *Journal of Family Violence*, 26(6), 473–485. <https://doi.org/10.1007/s10896-011-9382-4>

El-Bassel, N., Gilbert, L., Wu, E., Chang, M., Gomes, C., Vinocur, D., & Spevack, T. (2007). Intimate partner violence prevalence and HIV risks among women receiving care in emergency departments: Implications for IPV and HIV screening. *Emergency Medicine Journal*, 24(4), 255–259. <https://doi.org/10.1136/emj.2006.041541>

Entilli, L., & Cipolletta, S. (2017). When the woman gets violent: the construction of domestic abuse experience from heterosexual men's perspective. *Journal of Clinical Nursing*, 26(15–16), 2328–2341. <https://doi.org/10.1111/jocn.13500>

Farrand, P., Parker, M., & Lee, C. (2007). Intention of adolescents to seek professional help for emotional and behavioural difficulties. *Health and Social Care in the Community*, 15(5), 464–473. <https://doi.org/10.1111/j.1365-2524.2007.00705.x>

Feltner, C., Wallace, I., Berkman, N., Kistler, C. E., Middleton, J. C., Barclay, C., Higginbotham, L., Green, J. T., & Jonas, D. E. (2018). Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Evidence Report and Systematic Review for the US Preventive Services Task Force. *JAMA - Journal of the American Medical Association*, 320(16), 1688–1701. <https://doi.org/10.1001/jama.2018.13212>

Finfgeld, D. L. (2000). Therapeutic groups online: the good, the bad, and the unknown. *Issues in Mental Health Nursing*, 21(3), 241–255.

Ford-Gilboe, M., Varcoe, C., Noh, M., Wuest, J., Hammerton, J., Alhalal, E., & Burnett, C. (2015). Patterns and Predictors of Service Use Among Women Who Have Separated from an Abusive Partner. *Journal of Family Violence*, 30(4), 419–431. <https://doi.org/10.1007/s10896-015-9688-8>

- Garcia-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. H. (2006). Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *The Lancet*, *368*(9543), 1260–1269. [https://doi.org/10.1016/S0140-6736\(06\)69523-8](https://doi.org/10.1016/S0140-6736(06)69523-8)
- Gass, J. D., Stein, D. J., Williams, D. R., & Seedat, S. (2011). Gender Differences in Risk for Intimate Partner Violence Among South African Adults. *Journal of Interpersonal Violence*, *26*(14), 2764–2789. <https://doi.org/10.1177/0886260510390960>
- Guedes, A., & Mikton, C. (2013). Examining the Intersections between Child Maltreatment and Intimate Partner Violence. *Western Journal of Emergency Medicine*, *14*(4), 377–379. <https://doi.org/10.5811/westjem.2013.2.16249>
- Gutmanis, I., Beynon, C., Tutty, L., Wathen, C. N., & MacMillan, H. L. (2007). Factors influencing identification of and response to intimate partner violence: a survey of physicians and nurses. *BMC Public Health*, *7*(1), 12. <https://doi.org/10.1186/1471-2458-7-12>
- Hines, D. A., & Douglas, E. M. (2010). A Closer Look at Men Who Sustain Intimate Terrorism by Women. *Partner Abuse*, *1*(3), 286–313. <https://doi.org/10.1891/1946-6560.1.3.286>
- Houston, E., & McKirnan, D. J. (2007). Intimate partner abuse among gay and bisexual men: Risk correlates and health outcomes. *Journal of Urban Health*, *84*(5), 681–690. <https://doi.org/10.1007/s11524-007-9188-0>
- Hughes, F. M., Stuart, G. L., Gordon, K. C., & Moore, T. M. (2007). Predicting the use of aggressive conflict tactics in a sample of women arrested for domestic violence. *Journal of Social and Personal Relationships*, *24*(2), 155–176. <https://doi.org/10.1177/0265407507075406>
- Islam, M. J., Broidy, L., Baird, K., & Mazerolle, P. (2017). Intimate partner violence around the time of pregnancy and postpartum depression: The experience of women of Bangladesh. *PLOS ONE*, *12*(5), e0176211. <https://doi.org/10.1371/journal.pone.0176211>
- Kothari, C. L., Rohs, T., Davidson, S., Kothari, R. U., Klein, C., Koestner, A., Deboer, M., Cox, R., & Kutzko, K. (2015). *Emergency Department Visits and Injury Hospitalizations for Female and Male Victims and Perpetrators of Intimate Partner Violence. 2015.*
- Laskey, P., Bates, E. A., & Taylor, J. C. (2019). A systematic literature review of intimate partner violence victimisation: An inclusive review across gender and sexuality. *Aggression and Violent Behavior*, *47*(April 2018), 1–11. <https://doi.org/10.1016/j.avb.2019.02.014>
- Lee, M., Stefani, K. M., & Park, E. C. (2014). Gender-specific differences in risk for

- intimate partner violence in South Korea. *BMC Public Health*, 14(1), 1–10.
<https://doi.org/10.1186/1471-2458-14-415>
- Loder, R. T., & Momper, L. (2020). Demographics and Fracture Patterns of Patients Presenting to US Emergency Departments for Intimate Partner Violence. *JAAOS: Global Research and Reviews*, 4(2), e2000009. <https://doi.org/10.5435/jaaosglobal-d-20-00009>
- Machado, A., Hines, D., & Matos, M. (2016). Help-seeking and needs of male victims of intimate partner violence in Portugal. *Psychology of Men & Masculinity*, 17(3), 255–264. <https://doi.org/10.1037/men0000013>
- McKay, J. R., Rutherford, M. J., Cacciola, J. S., Kabasakalian-McKay, R., & Alterman, A. I. (1996). Gender differences in the relapse experiences of cocaine patients. *The Journal of Nervous and Mental Disease*, 184(10), 616–622.
<https://doi.org/10.1097/00005053-199610000-00006>
- Mechem, C. C., Shofer, F. S., Reinhard, S. S., Hornig, S., & Datner, E. (1999). History of Domestic Violence among Male Patients Presenting to an Urban Emergency Department. *Academic Emergency Medicine*, 6(8), 786–791.
<https://doi.org/10.1111/j.1553-2712.1999.tb01207.x>
- Meekers, D., Pallin, S. C., & Hutchinson, P. (2013). Intimate partner violence and mental health in Bolivia. *BMC Women's Health*, 13(1), 1. <https://doi.org/10.1186/1472-6874-13-28>
- Muelleman, R. L., Lenaghan, P. A., & Pakieser, R. A. (1996). Battered women: Injury locations and types. *Annals of Emergency Medicine*, 28(5), 486–492.
[https://doi.org/10.1016/S0196-0644\(96\)70110-5](https://doi.org/10.1016/S0196-0644(96)70110-5)
- Musa, A., Chojenta, C., Geleto, A., & Loxton, D. (2019). The associations between intimate partner violence and maternal health care service utilization: a systematic review and meta-analysis. *BMC Women's Health*, 19(1), 36.
<https://doi.org/10.1186/s12905-019-0735-0>
- Nybergh, L., Enander, V., & Krantz, G. (2016). Theoretical Considerations on Men's Experiences of Intimate Partner Violence: An Interview-Based Study. *Journal of Family Violence*, 31(2), 191–202. <https://doi.org/10.1007/s10896-015-9785-8>
- Pavao, J., Alvarez, J., Baumrind, N., Induni, M., & Kimerling, R. (2007). Intimate Partner Violence and Housing Instability. *American Journal of Preventive Medicine*, 32(2), 143–146. <https://doi.org/10.1016/j.amepre.2006.10.008>
- Peterson, C., Kearns, M. C., McIntosh, W. L. K. W., Estefan, L. F., Nicolaidis, C., McCollister, K. E., Gordon, A., & Florence, C. (2018). Lifetime Economic Burden of Intimate Partner Violence Among U.S. Adults. *American Journal of Preventive Medicine*, 55(4), 433–444. <https://doi.org/10.1016/j.amepre.2018.04.049>

- Petrisor, B. A., Drew, B., Rajaratnam, K., Williams, D., Wong, I., Kwok, D., Denkers, M., Cameron, A., Resendes, S., Ramnath, I., Chien, T., Pham, N. K., Avram, V., Ayeni, O. R., De Beer, J., Winemaker, M., Ogilvie, R., Peterson, D., Swaleh, R., ... Sprague, S. (2013). Prevalence of abuse and intimate partner violence surgical evaluation (PRAISE) in orthopaedic fracture clinics: A multinational prevalence study. *The Lancet*, 382(9895), 866–876. [https://doi.org/10.1016/S0140-6736\(13\)61205-2](https://doi.org/10.1016/S0140-6736(13)61205-2)
- Ramsay, J. (2002). Should health professionals screen women for domestic violence? Systematic review. *BMJ*, 325(7359), 314–314. <https://doi.org/10.1136/bmj.325.7359.314>
- Randle, A. A., & Graham, C. A. (2011). A Review of the Evidence on the Effects of Intimate Partner Violence on Men. *Psychology of Men and Masculinity*, 12(2), 97–111. <https://doi.org/10.1037/a0021944>
- Rivara, F. P., Anderson, M. L., Fishman, P., Bonomi, A. E., Reid, R. J., Carrell, D., & Thompson, R. S. (2007). Healthcare Utilization and Costs for Women with a History of Intimate Partner Violence. *American Journal of Preventive Medicine*, 32(2), 89–96. <https://doi.org/10.1016/j.amepre.2006.10.001>
- Roberts, A. L., Gilman, S. E., Fitzmaurice, G., Decker, M. R., & Koenen, K. C. (2010). Witness of Intimate Partner Violence in Childhood and Perpetration of Intimate Partner Violence in Adulthood. *Epidemiology*, 21(6), 809–818. <https://doi.org/10.1097/EDE.0b013e3181f39f03>
- Schafer, J., Caetano, R., & Cunradi, C. B. (2004). A Path Model of Risk Factors for Intimate Partner Violence among Couples in the United States. *Journal of Interpersonal Violence*, 19(2), 127–142. <https://doi.org/10.1177/0886260503260244>
- Schneider, R., Burnette, M. L., Ilgen, M. A., & Timko, C. (2009). Prevalence and Correlates of Intimate Partner Violence Victimization Among Men and Women Entering Substance Use Disorder Treatment. *Violence and Victims*, 24(6), 744–756. <https://doi.org/10.1891/0886-6708.24.6.744>
- Shearer, H. M., & Bhandari, M. (2008). Ontario Chiropractors' Knowledge, Attitudes, and Beliefs About Intimate Partner Violence Among Their Patients: A Cross-Sectional Survey. *Journal of Manipulative and Physiological Therapeutics*, 31(6), 424–433. <https://doi.org/10.1016/j.jmpt.2008.06.011>
- Simon, C. T. M., & Wallace, T. W. H. (2018). Disclosure of victimization experiences of Chinese male survivors of intimate partner abuse. *Qualitative Social Work*, 17(6), 744–761. <https://doi.org/10.1177/1473325017694080>
- Sivagurunathan, M., Packham, T., Dimopoulos, L., Murray, R., Madden, K., Bhandari, M., & MacDermid, J. C. (2018). Perceptions of preparedness and intimate partner violence screening practices amongst hand therapists. *Hand Therapy*, 23(4), 139–147. <https://doi.org/10.1177/1758998318798668>

- Sivagurunathan, M., Packham, T., Dimopoulos, L., Murray, R., Madden, K., & MacDermid, J. C. (2019). Hand therapists' attitudes, environmental supports, and self-efficacy regarding intimate partner violence in their practice. *Journal of Hand Therapy, 32*(3), 353–360. <https://doi.org/10.1016/j.jht.2017.11.042>
- Sloan, L., & Quan-Haase, A. (2016). The SAGE Handbook of Social Media Research Methods. In L. Sloan & A. Quan-Haase (Eds.), *University of Aberdeen*. SAGE Publications Ltd. <https://doi.org/10.4135/9781473983847>
- Sormanti, M., & Smith, E. (2010). Intimate partner violence screening in the emergency department: U.S. medical residents' perspectives. *International Quarterly of Community Health Education, 30*(1), 21–40. <https://doi.org/10.2190/IQ.30.1.c>
- Sprague, S., Kaloty, R., Madden, K., Dosanjh, S., Mathews, D. J., & Bhandari, M. (2013). Perceptions of Intimate Partner Violence: a cross sectional survey of surgical residents and medical students. *Journal of Injury and Violence Research, 5*(1), 2–10. <https://doi.org/10.5249/jivr.v5i1.147>
- Sprague, S., Swinton, M., Madden, K., Swaleh, R., Goslings, J. C., Petrisor, B., & Bhandari, M. (2013). Barriers to and facilitators for screening women for intimate partner violence in surgical fracture clinics: A qualitative descriptive approach. *BMC Musculoskeletal Disorders, 14*, 1–10. <https://doi.org/10.1186/1471-2474-14-122>
- Stockman, J. K., Hayashi, H., & Campbell, J. C. (2015). Intimate partner violence and its health impact on disproportionately affected populations, including minorities and impoverished groups. *Journal of Women's Health, 24*(1), 62–79. <https://doi.org/10.1089/jwh.2014.4879>
- Sylaska, K. M., & Edwards, K. M. (2014). Disclosure of Intimate Partner Violence to Informal Social Support Network Members: A Review of the Literature. *Trauma, Violence, and Abuse, 15*(1), 3–21. <https://doi.org/10.1177/1524838013496335>
- Tanis, M. (2008). Health-related on-line forums: What's the big attraction? *Journal of Health Communication, 13*(7), 698–714. <https://doi.org/10.1080/10810730802415316>
- Teitelman, A. M., Ratcliffe, S. J., Morales-Aleman, M. M., & Sullivan, C. M. (2008). Sexual relationship power, intimate partner violence, and condom use among minority urban girls. *Journal of Interpersonal Violence, 23*(12), 1694–1712. <https://doi.org/10.1177/0886260508314331>
- Tidwell, L. C., & Walther, J. B. (2002). Computer-Mediated Communication Effects on Disclosure, Impressions, and Interpersonal Evaluations: Getting to Know One Another a Bit at a Time. *Human Communication Research, 28*(3), 317–348. <https://doi.org/10.1111/j.1468-2958.2002.tb00811.x>
- Tjaden, P., & Thoennes, N. (2000). Extent, Nature, and Consequences of Intimate

PartnerViolence. In *National Institute of Justice/Centers for Disease Control and Prevention*.

Todahl, J., & Walters, E. (2011). Universal screening for intimate partner violence: A systematic review. *Journal of Marital and Family Therapy*, 37(3), 355–369.
<https://doi.org/10.1111/j.1752-0606.2009.00179.x>

WHO. (2013). *Responding to intimate partner violence and sexual violence against women WHO clinical and policy guidelines*. www.who.int/reproductivehealth

Wu, V., Huff, H., & Bhandari, M. (2010). Pattern of physical injury associated with intimate partner violence in women presenting to the emergency department: A systematic review and meta-analysis. *Trauma, Violence, and Abuse*, 11(2), 71–82.
<https://doi.org/10.1177/1524838010367503>

Chapter 2

2 Exploring discourses around male intimate partner violence disclosures through Reddit submissions and replies.

2.1 Glossary:

Original Poster (OP): Reddit user who started the submission

Submission ID: Unique identifying code associated with each submission.

Submission: Consists of the submission title, and submission body.

Submission Title: The title of the submission.

Submission body: The main message of the submission. Consisting of either self-posts, link posts or combination of both.

Comments/Replies: Responses or questions left by Reddit users in response to the original submission and/or to other comments.

Repost – links that have already been shared on Reddit.

Upvote – To like a submission or comment

Downvote – To dislike a submission or comment

Upvotes ratio- Ratio of upvotes to downvotes

2.2 Introduction

Intimate partner violence (IPV) can have negative impact on an individual's personal security, identity, agency, interpersonal connectedness, economic situation, and health. IPV has been associated with significant economic costs resulting from medical costs, lost productivity of victims and perpetrators, as well as legal costs (McLean & Bocinski, 2017; Peterson et al., 2018). Similarly, IPV has been associated with both short

term and long-lasting negative health outcomes (Hines & Douglas, 2015; Reid et al., 2008; Rioli et al., 2017).

While some areas of IPV have been well studied, a focus on female IPV survivors predominates. A systematic review by Conceição, Bolsoni, Lindner, & Coelho (2018), found 81.1% of studies conducted in the Brazilian population sampled only women. The paucity of research on men who have experienced IPV maybe attributed to a gendered conceptualization of IPV "... as a problem perpetrated by men and experienced by women" (Corbally, 2015, p. 3113). The predominant narrative regarding male IPV is that the prevalence rates are negligible and "where men are abused by women, there is no fear, or any immediate or long-lasting negative effects, and only minor injury" (Barry, Kingerlee, Seager, & Sullivan, 2019, p. 134). However, assumptions regarding prevalence rates of male IPV and its impact on male victims are questionable. Studies show that male IPV victims are reluctant to disclose their IPV experiences (B. M. Black et al., 2008; Sylaska & Edwards, 2014). As such, the current prevalence rates may be conservative. A high prevalence of bilateral violence (violence perpetrated by both parties) during instances of IPV has also been reported in population-based studies (Langhinrichsen-Rohling et al., 2012; Madsen et al., 2012). Hines & Douglas (2016) noted that surveys on partner violence show men are the victims of 25%- 50% of all physical partner violence within any given year. Subsequently, health outcomes for male IPV victims can be substantial (Fergusson et al., 2005; Hines & Douglas, 2009, 2016; Reid et al., 2008).

The lower disclosure rates in men may be attributed to both a) internal barriers such as attempts to maintain their masculinity, feelings of shame, a belief in taking

responsibility for the children, internalized societal expectations regarding gender roles, fear of not being believed, and perceptions regarding the usefulness of available resources; and b) external barrier including limited services for men who have experienced IPV (TSANG, 2015). Studies on social reactions to disclosure of IPV victimization are limited. Within that limited area of research, findings suggest female victims of IPV more commonly received positive reactions to disclosures compared to male IPV survivors (Edwards & Dardis, 2020). Similarly, research on men's help-seeking experiences show that men report social and victim services, police and the justice system to be unhelpful (Douglas & Hines, 2011; Machado et al., 2016). Douglas & Hines (2011) found men who attempted to access domestic violence services, hotlines, and agencies reported being turned away, being accused of perpetrating the IPV, and being referred to a batterers intervention program.

Help-seeking in an online community may remove some of the barriers associated with face-to-face help-seeking. Contextual factors associated with online communication can serve to reduce inhibition and make it more likely for individuals to disclose sensitive information (Suler, 2004). Findings suggest that users who feel stigmatized find the anonymity presented by online support communities to be helpful and allow users to ask questions or express themselves without shame (Tanis, 2008). Furthermore, benefits of online support groups and supportive exchanges with strangers online have been well documented by previous studies (Barak et al., 2008; Tanis, 2008).

As internet availability and usage increases, there has been a greater global trend towards sharing one's personal life online. Social networking sites (SNSs) that offer some degree of perceived anonymity can provide individuals like male IPV survivors a

platform from which to disclose their IPV experiences and seek support without the risk that is associated with other disclosure approaches whereby a male IPV survivor may publicly identify themselves. Reddit is a suitable platform for exploring the topic of male IPV due to multiple factors. Reddit is one of the largest SNSs with over 430 million average active monthly users, and 21 billion average screen views per month⁶. Users from more than 200 different countries access Reddit (Sharma et al., 2017). Additionally, Reddit is not constrained by a small character or word limit, boasting a generous 40,000-character limit. Finally, unlike some of the other SNSs which encourage users to create accounts with real names, Reddit not only allows pseudonyms but also allows ‘throwaway’ accounts, which are used as proxies of anonymity” (Pandrekar et al., 2018, p. 867). Subsequently, the anonymous nature of the throwaway accounts may allow users to discuss sensitive topics and be more candid in their discussion (Pandrekar et al., 2018).

Given the benefits and harm associated respectively with positive and negative responses to disclosures of IPV, coupled with the increasing use and availability of SNSs and desire of male IPV survivors to disclose their status in anonymous fashion online, there is an opportunity to examine how male IPV survivors discuss their experiences via social media. Disclosure of and response to male IPV on SNSs such as Reddit may differ from face to face or other traditional disclosure interactions. The findings of the current study are part of a larger project which sought to explore men’s discourses of IPV in an online forum (Reddit.com). The purpose of the current study is to examine the

⁶ According to redditinc.com, accessed January 26, 2020,

disclosures and the related responses to self-disclosure of male IPV as it happens on an online SNSs.

2.3 Methods and Study Design

2.3.1 Data Collection

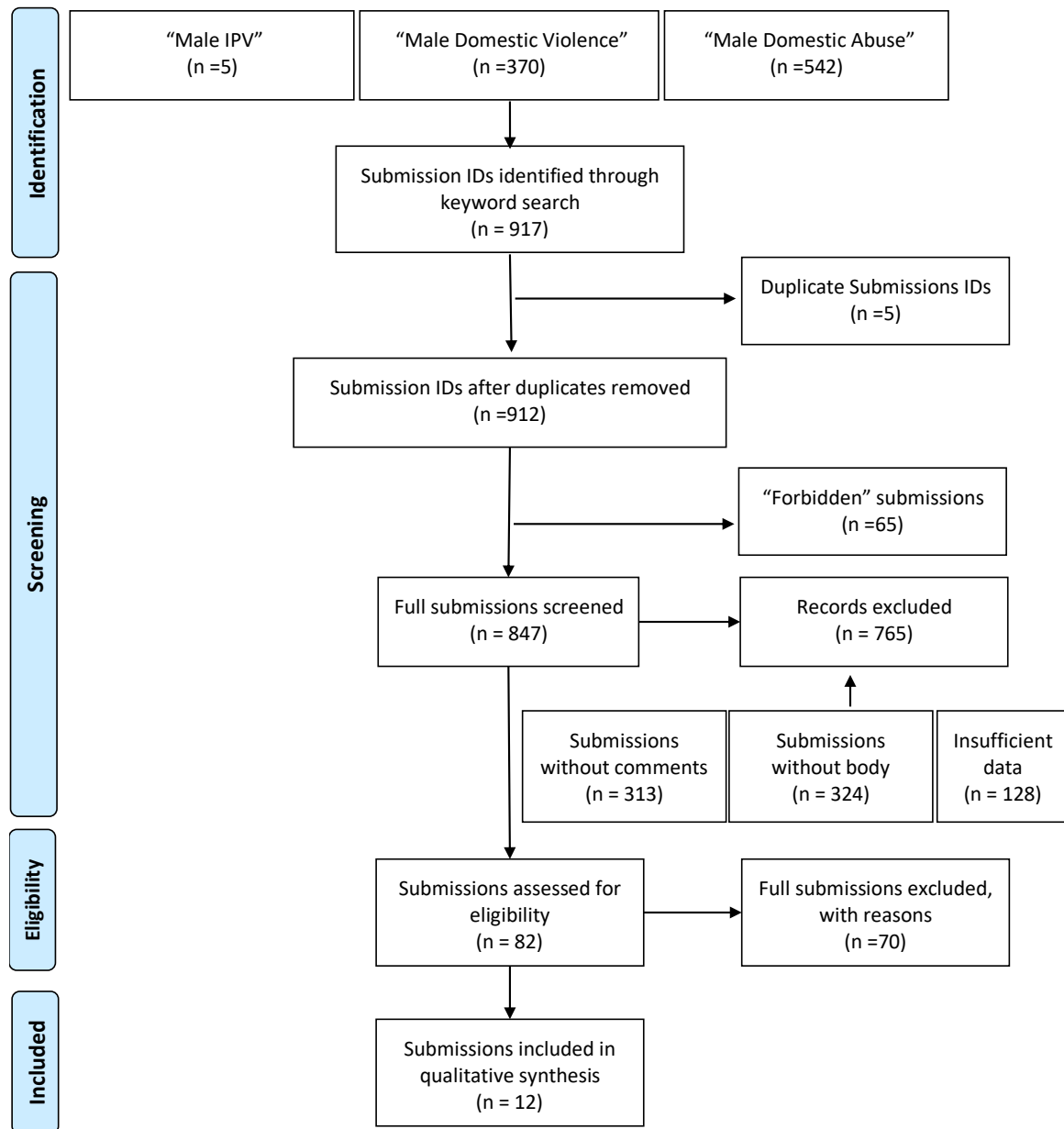
Data for the current study were collected from Reddit.com. In order to collect, or ‘scrape’, the data from Reddit, an automated system was developed by the first author (M.S) using Python (Python Software Foundation. Python Language Reference, version 3.8). In February 2019 the web scraper was used to carry out a search of all Reddit submission titles and submission bodies using 3 separate keywords (“male IPV”, “male domestic abuse”, and “male domestic violence”). This provided the authors with the unique identifying code (submission ID) associated with each submission that contained the keywords in either the submission title or submission body. The submission IDs were then used to collect the submission title, submission body, popularity metrics (upvote, upvote ratio, number of comments), and all associated comments.

2.3.2 Submission Data

The search terms resulted in 917 total submission IDs that included the search terms in either the submission title or body. Five submission IDs were removed for being duplicates while 65 submission IDs were excluded as access to full submission information was “forbidden” by Reddit because of site privacy restrictions. The submissions titles, submission body, and associated comments for all 847 submissions were collected and screened. Through screening some of the submissions were removed for being reposts with no associated comments. Some submissions were removed for not

having a submission body; this included cases where submission body was removed by the administrators of the subReddit, submission body was deleted by the author of the submission, or submission body consisted of external links to YouTube, newspaper articles, research articles, or other sources. Some submissions were also excluded for having insufficient data, which was operationalized as a submission having less than half a page of data pertaining to male IPV. This was done because posts that were too small lacked qualitative density to fully appreciate/interpret the nature of the discussion. This resulted in a final set of 82 submissions that were assessed for eligibility. To be eligible the submission had to contain a disclosure of male IPV (personal experience or experience of friend/family/ other). The final set of data contained 12 disclosures of male IPV and associated comments (See Figure 2-1).

Figure 2-1: PRSIMA Inclusion



2.3.3 Data Analysis

The final set of data was imported into NVivo (QSR International Pty Ltd. Version 12, 2018) for data analysis. The data analysis was carried out in two phases: (a) content analysis was used to analyze the initial disclosure of male IPV by original poster (OP);

and, (b) (b) thematic analysis using a template analysis drawn from J. Brooks, McCluskey, Turley, & King, (2015) to explore the comments responding to disclosure.

2.3.3.1 Quantitative content analysis of submission.

Descriptive data (number of comments, upvotes and upvote ratio) were obtained through scraping Reddit. We utilized content analysis to code the disclosures by OP. A codebook was developed a priori and was informed by previous research on male IPV survivors. Codes related to “Seeking Support” were informed by the works of Cutrona & Suhr (1992). The Social Support Behaviour Code (SSBC) developed by Cutrona & Suhr, (1992) “to assess social support behaviors in the context of help-intended dyadic interactions in which one member of the couple discloses a personal problem to the other”(Kerig & Baucom, 2004, p. 307).

2.3.3.2 Thematic analysis of replies to submission.

Phase two consisted of analyzing the comments associated with the disclosure submissions using thematic analysis. Analysis followed the template analysis as outlined by outlined by J. Brooks, McCluskey, Turley, & King, (2015). The initial coding process consisted of creating an a priori codebook of themes and codes informed by existing framework on social support, the SSBC (Cutrona & Suhr, 1992). Through the coding process new codes that did not fit into the themes present in the initial codebook emerged as being salient and the new, emergent codes were added to the codebook, where applicable.

2.4 Results

Twelve submissions were included in the analysis and included 8 personal experiences of IPV and 4 disclosures of IPV experiences of friends/family/ and others (see Table 2-1).

Table 2-1: Summary of Submissions Disclosing Male IPV

Submissions with disclosure of personal IPV experience				
IPV Disclosure	Number of Comments	Upvotes	Upvote Ratio	Brief summary of presenting submission
Submission #1	9	6	0.88	Gay man's disclosure of IPV and its impact on him and his perpetrator.
Submission #2	139	643	0.90	Account of IPV by wife, false allegation, worry about child, divorce.
Submission #3	6	4	0.75	Account of disclosing his IPV on a radio talk show and its consequence.
Submission #4	3	6	0.72	False allegation by female partner. Looking for financial help to settle legal case.
Submission #5	7	11	0.74	Account of how biased IPV campaign silenced him from disclosing his own IPV by female partner.
Submission #6	70	196	0.97	Looking for help (financial, moving) to leave abusive female partner.
Submission #7	272	105	0.80	Looking for other men with experience of IPV by female perpetrator.
Submission #8	31	61	0.85	Looking for other men with experience of IPV by wife.
Submissions with disclosure of IPV experience of family/friends/ other				
Submission #9	9	6	1.0	Gay man seeking advice on how to help ex-boyfriend deal with abuse by ex-boyfriend's current partner.
Submission #10	10	23	0.87	Medical student dealing with a patient who had been admitted to the hospital due to IPV injury.
Submission #11	4	33	0.88	Disclosing IPV experience of an acquaintance remaining in an abusive marriage due to children.

Submission #12	9	0	0.13	Seeking clarification and advice regarding IPV experience of a friend by friend's fiancée.
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2.4.1 Content Analysis of IPV Disclosures

Male IPV disclosure is a complex process. Multiple content categories emerged across each disclosure process. See Table 2-2 for complete list of content categories.

Table 2-2: Content Analysis of Disclosure Submissions

Content Category	Percentage in total submissions
1. Facets of IPV Experience	
Type of Disclosure	100%
Disclosure of Personal Abuse	66.7%
Disclosure of abuse experienced by others	33.3%
Gender of Perpetrator	100%
Female	83.3%
Male	16.7%
Emotions	50%
Fear	33.3%
Shame	25%
Sadness	8.3%
Loneliness	8.3%
Hope	16.3%
Types of Abuse	58.3%
Physical	58.3%
Emotional	33.3%
Isolation	25%
Control	25%
Legal/Administrative	25%
Verbal	16.7%
Financial	8.3%
Contextual Factors	25%
Alcohol	16.7%
Politics	8.3%
Impact of Abuse	25%
Suicide Attempt	16.6%
Stress	8.3%
Financial Issues	8.3%
2. Reason for Disclosure	
Seeking Support	66.7%

Informational Support	33.3%
Network Support	25%
Tangible Aid	16.7%
Raising Awareness	8.3%
3. Dimensions of IPV Disclosure	
Outcomes of Past Disclosure	33.3%
Negative Response	33.3%
Positive Response	16.7%
Abuse Narrative	25%
Self-Blame	25%
Naming the abuse	16.7%
False Allegation	25%
Systemic Bias	33.3%
*More than 1 content category can appear in each submission.	

1. Facets of IPV Experience.

The analyzed submissions consisted of both OP's personal experience of IPV as well as IPV experiences of other people. Most of the submissions on disclosure (n=8) consisted of disclosing personal experiences of IPV, while the rest of the disclosures (n=4) included IPV experience of friends (n=2), ex-boyfriend (n=1), and a patient (n=1). Females were identified as being the perpetrator in majority (n=10) of the submissions, while 2 submissions identified abuse by male partner.

Some of the submissions (n=6) explicitly referenced emotions associated with the IPV experience or disclosure. These emotions identified by the submissions included 4 negative emotions (sadness, loneliness, shame/embarrassment, and fear) and 1 positive emotion (hope). Men expressed fear of: the abuser, the abuser finding out about the disclosure, false allegations, not being believed by friends and family, and losing their children. Men also expressed they were hopeful the situation was temporary and that they would come out if it stronger (n=2).

Some of the disclosure submissions (n=7) contained the type of abuse they had experienced. Physical abuse was the most prevalent (n=7) type of abuse disclosed by the men followed by emotional abuse (n=4), isolation (n=3), controlling behavior (n=3), legal/administrative abuse (n=3), verbal abuse (n=2), and finally financial abuse (n=1). Controlling behavior included perpetrators not allowing the men to socialize with friends and family, checking their phone and social media accounts, taking away their phones and other means of communication and monitoring their time.

While most submissions (n=9) did not provide a context for abuse, alcohol (n=2) and politics (n=1) were identified as the trigger for the abuse by the men who did identify a reason. Finally, the impact of the IPV experience mentioned by participants included victims attempting suicide (n=2), facing financial burden (becoming homeless, losing their job) (n=1), and stress (n=1).

2. Reasons for IPV disclosure.

The majority of submissions were seeking some form of support (n=8), while 1 submission indicated that they were disclosing their abuse to raise awareness of the issue of male IPV. Three of the support seeking themes described by Cutrona & Suhr (1992) emerged through the coding process. The three support seeking themes were informational support (n=4), network support (n=3), and tangible assistance (n=2). Informational support seeking consisted of OP looking for advice on how to deal with his personal IPV situation or how OP can help someone else who is dealing with IPV. Information seeking could take the form of indirect question such as “I feel like there's something else I should be doing, but I have no idea what... It's infuriating”, as well as direct information seeking such as “if anyone who can help or wants to, want any proof

of my medical situation or anything else i will try my best to provide it, im just wanting some help or advice”. Network support seeking consisted of submissions where the OP sought out other men who had experienced IPV to relate with or share his experience with. For example, one poster indicated “My wife has been violent towards me and I'd love to talk to someone anonymous about it. Willing to humor me? PM me or just reply to this post. Thanks.” Finally, Tangible assistance consisted of OP seeking financial aid so they can leave the abusive relationship as well as help with moving out.

3. Dimensions of IPV Disclosure.

Submissions (n=4) that mentioned having previously disclosed their IPV experience indicated having received both positive and negative reactions to disclosure of IPV. Submissions identified they had disclosed to friends and family(n=4), IPV services (n=2), healthcare professionals (n=1) as well as police and court personnel (n=2). Negative responses (n=4) identified by OPs were lack of belief regarding the IPV by friends and family, blaming the victims, and anger directed at the victim for disclosing. Furthermore, submissions also mentioned that healthcare professionals as well as police and court system were unhelpful. However, participants also mentioned helpful responses from friends (n=1) as well as domestic violence services (n=2). For example, one participant mentioned “I cannot begin to explain how difficult and awkward it is to seek help as a male domestic violence victim. That being said, Refuge House was a major help -- they helped me file motions and the initial paperwork for a restraining order.”

Naming the abuse (n=2) and self-blame (n=3) were also identified across some submissions. In terms of naming the abuse, male IPV survivors had trouble identifying the violence as abuse or accepting the relationship as abusive. For example, one poster

indicated that they had been “Punched in the balls, still not sure if I’m in a abusive relationship.” Men also blamed themselves for being in the abusive relationship or the abusive incident. Men indicated that they had a personality that predisposed them to abuse “I might have personality traits that predispose me to being taken advantage of. I need to work on that. Maybe I’m eager to please, easily swayed, liking forward women etc.” Men also attributed the abuse to their own behavior such as “I was perhaps dismissive of my wifes emotions during her lows”.

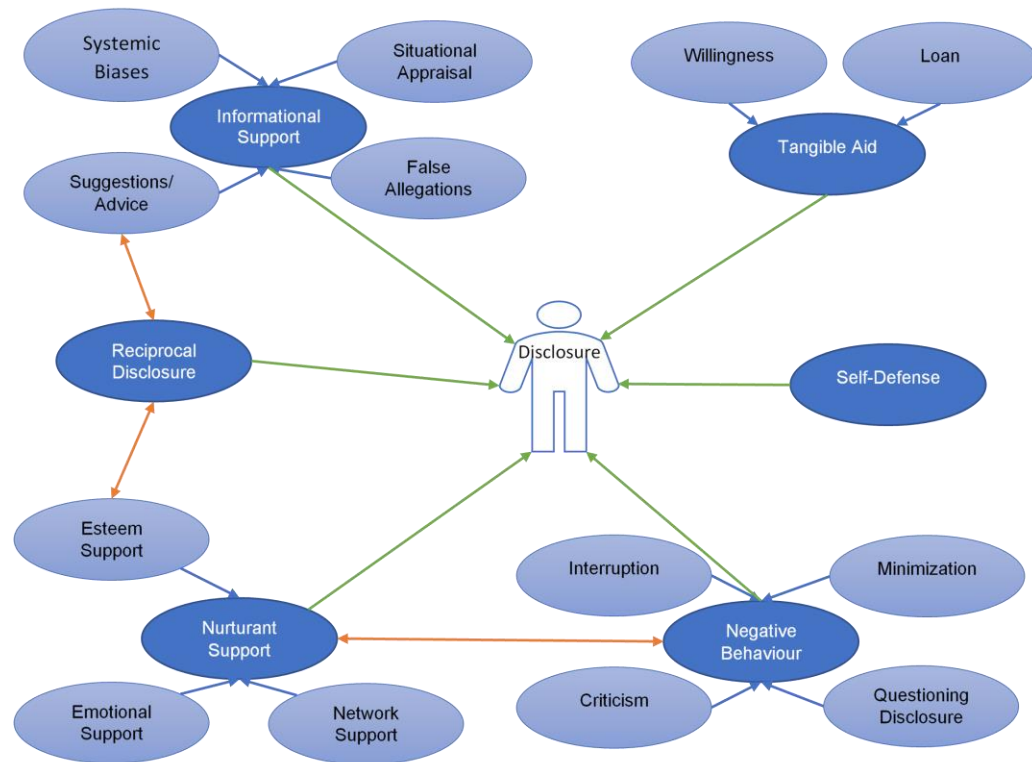
False allegations were also a dimension of disclosure that emerged across some submissions (n=3). Experiences included instances where female perpetrator made the false allegation to either the OP or to the police. One OP speaking about their experience of false allegation indicated “I am one of the many stories of domestic abuse by their female partners and one who was actually falsely accused and now in dire threat to serve 6 to 20 years in jail for something I did not do.”

Finally, some of the OPs (n=3) recounted experiences of systemic biases. Given the breadth and depth of this dimension of disclosure it has been explored in detail elsewhere (Chapter 3).

2.4.2 Thematic Analysis of Replies to Submission

Responses to the OP’s disclosure fell on a spectrum, with both positive and negative responses. The major themes that emerged as response to disclosure included: (1) Informational Support, (2) Nurturant Support, (3) Tangible Aid, (4) Negative Behavior (5) Self-Defense, and (6) Reciprocal Disclosure. See Figure 2-2 for themes and sub themes.

Figure 2-2: Thematic Map



1. Informational support.

Informational support composed of “Behavior that provides information to the person under stress about the stress itself, about how to deal with the stress, or about how to appraise the situation” (Jensen, 2001, Pg. 109). The theme consisted of 4 major subthemes: (a) Suggestion/Advice; (b) Situation Appraisal (c) false allegation, and (d) systemic biases.

a. Suggestion/Advice.

The Suggestion/ Advice subtheme consisted of commenters providing course of action to deal with the abuse. The suggestion/ advice took either a direct form or was indirect

through a story. Indirect suggestion/advice consisted of disclosure of personal IPV experience or IPV experience of friends/family and how the IPV survivor dealt with the abuse. For example, one commenter whose advice was to document the male survivor's interaction with the abuser commented:

I have seen this entire situation play out with my husband's best friend. He was arrested for domestic violence, even though he never touched her. Now he has a record and can't get the job he went to school for. Sad thing is, he is one of the nicest people I know. I would record every interaction you have with her. EVERY single interaction.

Advice provided by commenters fell in a broad spectrum and included legal advice, self-care, maintaining the relationship, and referrals.

(1) *legal advice.*

Commenters advised men to minimize and document their contact with the abuser. Most of the commenters noted that the men should minimize or avoid contact with the female abuser entirely, and if contact could not be avoided then the commenters advised documenting the abuse or any contact with the abuser as well as having a witness present when meeting with the abuser. This advice stemmed from personal experiences of being falsely accused or commenters fearing that the OP might be falsely accused. One commenter noted:

Buy a voice-activated recorder and carry it at all times. You may not be able to use it in court but I know a few men who have had their hides saved by the evidence. Even better, nannycams, webcams, and cell phones on record are also excellent ways to demonstrate that you're not the one who hit first.

In addition to fear of being falsely accused of IPV, commenters believed that documenting the interactions and having witnesses could help in family court. The men

reported that having the interactions with the abuser documented would prevent the perpetrator from making false claims in family court. One commenter advised:

Text her that you are leaving the house for 30 minutes. That way she cannot claim in the future that she tried coming to the house with your daughter for a visit and you weren't there. Save these messages as proof that you are trying to communicate and she isn't.

Another commenter suggested documenting the abuse given the biases they perceived as present in the justice system "Make sure you record her being abusive. The police still aren't that open minded about male domestic abuse". The commenters believed that documenting the abuse would make it easier when dealing with the justice system.

While commenters believed that females had an unfair advantage when dealing with the justice systems, the commenters still advised OP to seek help from the police and lawyers. Commenters indicated that police officers can "escort you to the residence, and watch over you while you pack up your own stuff without being hassled" and provide referrals to IPV services as "they know local agencies who can offer support to you" and help establish your IPV experience "even if it's just a case of getting some contact on record." Commenters also stressed the importance of male IPV victim having good legal counsel to protect themselves from false allegations. One commenter noted:

I'd be inclined to call a lawyer first and discuss your options before I called the cops, since there's been some nasty precedents set in situations like this, specifically where a man gets abused, calls the cops, and gets arrested himself even if he's the only one with injuries.

Commenters also urged the men to be as honest as possible and to not “hold back or gloss things over” and that men should “stop trying to be Mr. Nice Guy”. Commenters felt that given the possibility that the female aggressor would make false allegations, glossing things over to protect the abuser would work against the victim when interacting with the police and judicial system, and felt downplaying the abuse would also be problematic in custody hearings as well.

Finally, the commenters advised that there is a high possibility of the perpetrator may turn their abusive behavior on the child; as such, some urged that the OP try and get custody of the child to prevent the child from being abused. Commenters indicated that being raised by an abusive parent would have negative psychological consequences for the child and have negative impacts on the child’s development. Therefore, the commenters advised the male victims to seek full custody.

(II) Self-Care.

Commenters also provided OP with self-care advice including seeking support from one’s social circle, seeking help from healthcare professionals, and healthy lifestyle habits. Commenters stressed the importance of reaching out to friends and family for support during episodes of abuse or during separation. Commenters suggested that men should not “be afraid to lean on family and close non-mutual friends” or “Hang out with friends and family” to reduce stress. Commenters also suggested that victims of abuse “should see a therapist it isn't healthy to bottle stuff up even if you are dealing with it correctly”. The commenters suggested that mental health professionals would be helpful in not only dealing with the emotional trauma of the abuse but also provide support during separation. In addition to seeking help from mental health professionals,

commenters also suggested speaking to physicians to receive medications to help alleviate any physical or emotional issues.

Finally, commenters stressed the importance of maintaining healthy lifestyle habits and ensuring that the victims get proper diet and rest.

Keep eating, sleeping, and drinking **water** dude. Seriously, it's easy to forget while dealing with persistent anxiety, and you might not recognize the symptoms of malnutrition, dehydration and sleep deprivation once they've already manifested.

Other commenters expressed the benefits of exercise on mental health and reducing stress and anxiety and suggested that men “Get some exercise too, it helps burn off the anxiety.” Another commenter mentioned, “You've got a lot of pent up emotions that need to go somewhere. Go for a run”.

(III) Leaving the relationship.

Commenters felt that the OP should leave the relationship as soon as possible.

Commenters believed that it would be better to leave the abusive relationship rather than staying and trying to reform the abusive partner. Some commenters indicated that the OP should “man up and leave the abuser”. Others felt that OP deserved to find someone who truly loved them and staying in the abusive relationship will prevent OP from finding someone to have a healthy relationship with. When OP mentioned having a child, commenters urged them to leave the relationship for the sake of the child. Commenters indicated that staying in an abusive relationship may endanger the child’s development and wellbeing. Subsequently commenters suggested that the OP should take the children with them and leave to prevent the abuser from targeting the child.

(IV) Referral.

Commenters provided general advice to reach out to agencies/organizations to seek support for IPV as well as suggesting that the OP educate themselves about IPV. Furthermore, commenters also provided referrals to specific organizations/ services, as well as online communities/blogs/subReddits that are catered towards male IPV survivors. Despite commenters highlighting the systemic issues present in regard to male IPV services they stressed that males should seek out support from IPV services. Commenters noted that organizations can “help you escape, either by referring you to a refuge or hostel, or helping you to find a privately rented flat” or provide informational support as “you can get in touch with one of the agencies that specialise in this kinda thing, they'll be able to give you something more accurate of what will happen.” Commenters also provided specific referrals by providing links to organizations website or providing phone number:

There are a lot of associations that can help him get out if he's ready. I don't know what or where they are in Texas (a quick google search led me [to this site](<http://www.tcfv.org/resources/resources-for-survivors/>) and [this hotline](<http://www.loveisrespect.org>) and [this list] (http://www.ncdsv.org/ncd_linkstexas.html) and also [this one](<https://www.hhsc.state.tx.us/Help/family-violence/centers.shtml>).

They also provided OP with subReddits that cater to male IPV survivors, and websites that provide information and education as well as providing support for male IPV survivors.

b. situational appraisal.

The Situational Appraisal subtheme consisted of commenters providing their perspectives on the situation surrounding IPV. These perspectives included: (I) this is war, (II) abuser has psychological issues, (III) you deserve better, and (IV) do what's best for your child.

(I) This is war.

Commenters urged that OP think of the situation as a war. They stressed that the perpetrator would try to convince friends, family, society and the legal system that she was the victim and advised the men; “put on your battle armor and consider this war. She already does.” When OP disclosed having a child with the perpetrator, commenters likened child custody hearings to a battle: “it's pretty much a legal (uphill) battle, so you can drop the gloves and wage all-out war”. Commenters warned against being nice or underplaying the abuse and stressed that it is important “to get more cutthroat”.

(II) Abuser has psychological issues.

Commenters believed that the perpetrators' abusive behavior stemmed from some form of psychological issue. Commenters advised the men to “find out if she has a history of mental illness”. They also advised the men to “talk to a psychiatrist” about diagnosing and medicating the perpetrator. Commenters also provided possible diagnoses as causes of the abuse including Bipolar Personality Disorder, Histrionic Personality Disorder, and Narcissistic Personality Disorder. For example, one commenter indicated, “From her emotional outbursts, it sounds like she could have bipolar disorder or some other sort of mood disorder”. Another indicated, “your wife sounds like she has narcissistic personality disorder”. Commenters provided links to mental health resources and urged men to educate themselves on how to deal with such individuals.

(III) You deserve better.

The sentiment that the male victims of IPV don't deserve the abuse or to put up with an abusive partner were expressed by many of the commenters. Replies indicated that the male survivors deserve to find happiness and that they did not do anything wrong to deserve the violence perpetrated by the abuser. Commenters remarked that the male victims "are not worthless and do deserve help". Commenters also stressed that the men deserve to find true love and that staying with the perpetrator will prevent the men from finding someone who truly loves them and is supportive. One commenter remarked, "if you want to ever meet someone who will love you then you must move on from her." Commenters expressed that the men should not confuse the abusive behavior with love and that if the perpetrator truly loved them, they would not abuse them. One commenter observed:

Here's the thing. If your partner belittles/demeans you, strikes you, raises their voice at you in anger or frustration, you probably aren't with the right person. people who love each other shouldn't feel the need to do those things.

(IV) Do what's best for your child.

In cases where the men indicated that they had a child with the abusive partner, the commenters urged the men to do what's best for the child. Once commenter indicated that "It's obvious she doesn't have the best interest of the child as a priority". One comment on the effect of witnessing IPV expressed:

Keep your daughter in mind when you waver, too. She shouldn't grow up seeing this. She shouldn't grow up learning that this is what love is, that this is how a person treats another. Being exposed to abuse is damaging, even if she hasn't been hit (yet).

Others believed that the abuser may eventually turn on the child: “Your daughter will be the one that is being chased with a knife/choked/hit” and that it was important for the men to leave the relationship to protect the child from being a victim of violence.

c. False allegations

The notion of false allegations emerged across both suggestions/advice and situational appraisal subthemes. In terms of situation/ advice fear of false allegation by female perpetrators of IPV colored the advice given to male IPV survivors who disclosed their abuse on Reddit. Many of the men who disclosed their own experiences of IPV as a response to the disclosure by OP indicated that they had been victims of false allegations and advised that OP be wary and take measures to protect themselves from these false allegations. In terms of situational appraisal comments replying to IPV disclosure felt that given the systemic bias that exist within the society, law enforcement and court system (reported elsewhere) (Chapter 3) false allegations by women might lead to male IPV victims being disadvantaged in multiple ways. Commenters noted that women may play the victim and falsely accuse the male of perpetrating the IPV in order to gain sympathy from law enforcement, court system, and organizations. Commenters mentioned that women would falsely accuse men in order to have an advantage in custody cases, divorce cases or to avoid being arrested or sentenced for their IPV.

d. Systemic Biases.

Commenters indicated experiencing and being further victimized by various systemic biases. Commenters provided suggestions/advice to help navigate the social, healthcare, and legal spheres without being further marginalized due to the existing systemic biases. Furthermore, commenters also suggested that men should take the systemic biases into

account when considering their situation and actions. Some commenters identified systemic biases as a major barrier to disclosure of male IPV. These systemic biases have been reported elsewhere (Chapter 3).

2. Nurturant Support.

Nurturant support consisted of three subthemes that elicit warmth and consists of comments that have a positive emotional tone (Baucom & Kerig, 2004): (a) emotional support, (b) esteem support, and (c) network support.

a. emotional support.

“Emotional support is behavior that communicates caring, concern, sympathy, or understanding. Attempts to comfort or console the stressed person” (Jensen, 2001, Pg. 109). The emotional support subtheme consisted of: (I) sympathy, (II) understanding/empathy, (III) reassurance, and (IV) expressing concern.

(I) sympathy.

Replies expressed sympathy for the male victim through comments such as “Sorry for your situation” or “It really sucks you have to go through this”. The commenters expressed sympathy for the men’s experience of IPV, having to be separated from their children, and for the negative emotions such as loneliness or sadness that men may be experiencing due to the violence or separation from the abusive partner.

(II) understanding/empathy.

Commenters also expressed understanding/empathy regarding the IPV and the fallout that resulted from the IPV. Commenters expressed their empathy through replies such as “I

feel your pain” or “I know it's hard”. Commenters used reciprocal disclosure to situate their understanding.

(III) reassurance.

Reassurance as a subtheme consisted of comments that were aimed at reducing the fear of male IPV survivors and indicating that things would get better. Most of the comments stressed that it will get better, such as, “You are in for a long, hard fight but it won't last forever” or “Yes you are walking towards the light.”

(IV) expressing concern.

Commenters also expressed concern for the wellbeing of the male survivors of IPV and expressed this concern through replies urging the men to “be safe and don't hurt yourself or worse”. They expressed concern that the abuser would further hurt the men. Some commenters also expressed concern that the men may be further victimized by the criminal justice system.

b. esteem support.

The Esteem subtheme consisted of: (I) compliments and (II) validation, both of which were aimed at reassuring the male IPV survivors of their intrinsic worth and that their actions are correct or justifiable (Jensen, 2001, Pg. 110).

(I) compliments.

Compliment were given to male victims for seeking help for their IPV or taking steps to leave the abusive relationship. For example, one commenter expressed “You've done a good job by going to the authorities. I'm proud of you”. Similarly, another commenter replied “Good for you, mister ;] All of this is tough, but you're not only bettering yourself

by moving away, but you're bettering your wife. Way to hold yourself high and protect your life!” Other commenters complimented the male victims’ parenting skills or complimented their decision to ask for custody of the child: “Glad to hear your son is doing fine. You did well to get him out of that environment”.

(II) validation.

Validation composed of comments that expressed the validity of male survivors’ thoughts, emotions and actions. Commenters validated men’s IPV experience as “absolutely heinous, and unacceptable” and validated male IPV as just as harmful and abusive as female IPV. Another commenter validated the feeling that any type of violence is abuse. Commenters also validated men’s decision to seek help from organizations that offer services to IPV victims and police officers. Finally, commenters also validated men’s feeling of loneliness and sadness. Another commenter validated male survivor’s decision to leave the relationship and have a brand new start and expressed: “That's definitely understandable. After the load of crap you went through, I don't blame you at all for wanting to just put it behind you”.

c. network support.

Network support consisted of offering companionship for OP. Commenters expressed willingness to listen to OP’s problems or reminded OP that they have a support system available as one commenter remarked “All my love for you at this hard time and remember you aren’t alone”. Commenters urged OP to “stay connected” to the group and keep them updated about the situation. They also expressed that they are willing to connect on a more private one-on-one basis through private messages (PM), as one commenter indicated, “If you need to vent feel free to pm me. Here to listen.”

3. Tangible Aid.

Tangible Aid consisted of “offers to provide tangible resources, services, or assistance to eliminate, solve, or alleviate the problem” (Jensen, 2001, p. 111). Following subthemes emerged: (a) loans and (b) willingness.

a. loans.

In some replies to submissions, commenters expressed willingness to provide financial aid lend material objects to men who mentioned they could not leave the abusive relationship because they could not afford either transportation, living accommodations or costs associated with moving. Commenters were willing to provide either cash or pay for transportation, or pay the costs associated with moving. For example, one commenter indicated that if the male survivor needed a train ticket “I’ll gladly buy you a ticket anywhere in the UK.” Similarly, another commenter noted they were “more than willing to chip in” for a van to transport the survivor’s property.

b. Willingness.

Commenters also expressed willingness to loan material such as loaning a vehicle to help with moving. Willingness consisted of replies where commenters expressed willingness to help the male survivor without specifying the exact nature of the help such as the commenter who indicated “If you’re anywhere near central Bedfordshire, let me know if I can help.”

4. negative behavior.

Four subthemes emerged and highlighted the various facets of negative behavior: (a) Interrupting, (b) Criticism, (c) Minimizing the disclosure, (d) Questioning disclosure.

a. interruption.

Interruption consisted of comments that changed the subject of the topic and directing the conversation from the OPs disclosure. This was done primarily through dismissing male IPV as a serious issue or through expressing that women experience IPV at higher rates as one commenter replied, “Statistics show that women are the overwhelming majority of victims of domestic violence”. Similarly, commenters also mentioned that given females are much weaker than males male IPC cannot be considered seriously. Rather than focus on OPs disclosure or the reason for the disclosure the comments distracted from the topic to argue about who the real victim of IPV is.

b. criticism.

Some commenters were critical of the OP and included blaming the OP for the abuse and name-calling. One commenter replying to OPs disclosure about ex-boyfriend IPV mentioned that “he deserves the abuse” because he broke up with the OP and began the relationship with the current abusive boyfriend. Another commenter replied that “The queers follow the hate”. Other commenters mentioned that the men may have made questionable decisions or missed the warning signs that resulted in them entering into an abusive relationship. Commenters also blamed the victim’s personality for the abuse and indicated they stay in the abuse because they like playing the victim card, is a pushover, or has low self-esteem that predisposes them to stay in the abusive relationship suggesting, “you need help for your self-esteem problem”. Still others mentioned that OP may have codependency issues or mental health disorders such as “down syndrome”.

c. minimizing the disclosure.

Some commenters minimized the disclosure by either making jokes about the abuse or with sarcastic replies. One commenter speaking about the reason OP hasn't left the abusive relationship replied, "I'm going to guess OP's wife is smoking hot." Some commenters also made jokes about the abuse, for example when OP disclosed being physically abused by a broom in front of his friends by his abusive girlfriend one commenter replied "Get a broom, you two", this response resulted in reply chain of other commenters making fun of the abuse. Other commenters provided advises that were meant to be taken as a joke such as "maybe you should hurry up with the sandwich?" or "sometimes, the simplest solution [is the best solution](<http://snookipunch.com/>)".

d. questioning disclosure.

Commenters questioned OPs version of the abuse or implied there was more to the story than what the OP has posted. One commenter speaking about OPs disclosure of an IPV experience of his friend indicated that "I'm guessing your friend isn't telling the full story and there was more information that the police had access to that you don't". Another commenter replied "just cuz you get the shit beat out of you doesn't mean you're the victim, either way."

5. self-defence.

The theme of self-defence centered around the discussion regarding men's right to defend themselves and what constitutes as self-defence. The conversation centered around whether men have the right to retaliate as a form of self-defence. Some commenters, both male and female, believed that men have the right to hit back, one female commenter mentioned that "if I'm fighting with some guy (boyfriend, say) and I hit him... I wouldn't be at all surprised/offended that I got hit back. You're asking for it when you put your

hands on someone else.” Similarly, another commenter indicated:

“Most people believe that if a guy is hitting you, you should hit him back in self defence. The same applies to women, many are perfectly capable of causing damage and are old enough to figure out that attacking someone is likely to result in retaliation”

Other commenters however, believed that given that women are physically weaker men should not be retaliating with violence and should attempt to either leave the situation or restrain the female perpetrator as a preventive measure as one commenter expressed “the first thing he should try is to escape the situation if he can, and secondarily try to restrain her from continuing to hit her”. Still others believed that even restraining the female abuser would constitute as violence and the only course of action would be to leave the situation, as one commenter replied, “restraining a woman with whom you are in a romantic relationship is considered domestic violence in every jurisdiction in North America.” Therefore, some commenters expressed that they were afraid any form of self-defence would be construed as violence and lead to them being arrested. Other commenters mentioned how the socially ingrained notion of “never hit a woman” prevented them from defending themselves (Chapter 3). Some commenters mentioned this socially ingrained attitude resulted in men not knowing how to respond to the abuse by their female partners.

6. reciprocal disclosure.

Disclosure by OP elicited reciprocal disclosure by some commenters. Reciprocal disclosure included both self-disclosure as well as disclosure of IPV experience of friends and family. When commenters disclosed PV experience of friends and family, they

recounted both having directly witnessed the IPV abuse or injury as well as having heard about the abuse second-hand. The reciprocal disclosures seemed to serve two purposes. Reciprocal disclosure was used to either supplement a suggestions/advice, or as way to express that their understanding/empathy resulted from previous exposure to IPV. Some reciprocal disclosure only served one purpose or other, while in other cases they served both purposes. One commenter using disclosure to suggest/advice the victim to seek help from police and charities commented:

I'll say the same thing to you that I'd say to any woman in the same situation (my sister got out of an abusive relationship a few years ago and is now happy) - it's not your job to prove it. Talk to the police (and not for nothing but local council and relevant charities), they'll do anything they can to help.

Another commenter indicated that they understood the experience of the male survivors because they had faced similar situation replied “Hey man. This was my life to a TEE 6 years ago. Hang in there. I know it's hard but trust me. Your life is going to get so much better”.

2.5 Discussion

The current study is one of the few studies to examine the disclosure process of male IPV survivors, particularly in the realm of online disclosures. This study found a wide range of discourses on male IPV disclosures on Reddit reflecting a number of ways that respondents provide social support to victims. While the majority of responses were supportive, some dismissive or ridiculing responses were also evident.

Given that Reddit has an average active user count of 430 million users a month and is used predominantly by young men (Barthel et al., 2016), the number of

submissions related to male IPV disclosure is surprisingly limited. This may reflect both the lower prevalence of IPV with men as victims and the ongoing stigma around IPV disclosure. The content analysis of men's disclosure reinforce previous findings that men are reluctant to identify the abuse as IPV (C. Brooks et al., 2017; Machado et al., 2016). This may be due to men having trouble incorporating the concepts of being a "man" and "victim"(C. Brooks et al., 2017). Durfee (2011) noted how notions of hegemonic masculinity, which "embodied the currently most honored way of being a man, it required all other men to position themselves in relation to it, and it ideologically legitimated the global subordination of women to men" (Connell & Messerschmidt, 2005, p.832), can influence men's narratives around victimization. Even in cases where men are victims of violence perpetrated by men, ideas of hegemonic masculinity can influence the men's narrative of victimization (Burcar & Åkerström, 2009).

Subsequently, it is possible that men who disclosed on Reddit described their experiences of IPV using terminology that was not framed as male IPV and allowed men to "conform to ideals of hegemonic masculinity" (C. Brooks et al., 2017, p.12). Therefore, the limited amounts of submissions maybe due to the limitations of the search strategy which used a narrow set of keywords. Furthermore, the limited number of disclosures on reddit may also be attributed to men perceiving reddit.com as being less conducive to sensitive disclosures due to its negative culture. Unlike health forums which are often heavily moderated and aim to foster positivity, Reddit.com sustains many fringe communities whose leanings tend towards shock value through sexism, and racism (Kilgo et al., 2018; Klein et al., 2019). The toxic culture exhibited by some of the subReddits may have served as a barrier to men disclosing their IPV experiences on Reddit.com.

The findings from the current study reinforce the results of previous research in that all of the men mentioned having experienced some form of physical abuse (Hines & Douglas, 2010). Other types of abuse included emotional abuse, controlling behavior, and verbal abuse (Hines & Douglas, 2010, 2016). These types of IPV experiences are similar to those experienced by female IPV survivors (Ansara & Hindin, 2010a). However, rates and specific patterns of IPV maybe gendered (Ansara & Hindin, 2010a).

When speaking about outcome of past disclosures, men indicated that they had received both positive and negative response to their disclosure. However, similar to previous studies (Machado et al., 2016; Russell, 2018), many of the redditors mentioned having received unhelpful and negative response from police and justice system. These negative responses are similar to female IPV survivor's experience with the legal systems (Barrett et al., 2011; Meyer, 2011; Wolf et al., 2003). Despite these negative experiences or perceptions in regard to police and judicial systems, redditors often advised the men to seek help from police officers and the judicial system.

Commenters' replies to men's disclosures also contained some negative responses such as victim blaming, jokes about IPV and sarcastic responses, as well as questioning the disclosures version of the event. These negative responses maybe rooted in notions of hegemonic masculinity and ideas related to who can be "victims". These negative responses may also serve to further victimize men who are disclosing their experiences on Reddit and act as barrier to future disclosure attempts. However, majority of the responses by commenters were supportive and reflects previous results from other studies such as the one by Machado et al. (2016) which found that men were satisfied with the support they received from informal sources. Research on female IPV survivors

show that supportive response to disclosures of IPV had positive mental health impacts (Edwards et al., 2015). The limited research the effects of positive and negative responses on male IPV survivors have shown a similar pattern. For example Douglas & Hines (2011) found that positive help seeking experiences resulted in lower levels of alcohol abuse while negative experiences were associated with higher rates of PTSD. Therefore, the findings from the current study suggest that disclosing IPV online may have beneficial impacts for male IPV survivors.

It is important to consider some of the responses in broader context. Many of the commenters advised the male IPV survivors to leave the abusive relationships. Being told to leave the abusive relationship may be interpreted as positive or negative depending on the victim's desire to leave the relationship. For example, Edwards et al. (2015) found that being told to leave the abusive relationship was positively correlated with leaving intention but also Posttraumatic Stress Symptoms amongst women. Another study found that women were less likely to seek formal intervention for the abuse if they were told to leave the abusive relationship by informal helpers (Fugate et al., 2005). Therefore, advice to leave the abusive relationship may have conflicting effects on mental health well-being. However, no studies to date have examined the effects of advice to leave relationship on men's mental health and intention to leave and as such further studies are needed. Similarly, commenters also advised men to "man up" and leave the relationship. Commenters' suggestion to "man up" could be construed as negative comment meant to further emasculate the male survivors or as a positive call to arms, to channel the perceived inherent masculine traits such as strength and protectiveness to make positive changes in one's life. While a majority of studies to date have focused on male gender

role stress or toxic masculinity and the impact of masculine ideologies on problems in various facets on men's health and wellbeing, a growing number of researchers have called for the need to examine masculinity using the positive psychology positive masculinity paradigm (McDermott et al., 2019). It may be argued that replies to “man up” by commenters in the current study are meant to evoke the positive masculine role norms such “stay calm in the face of adversity, display courage, power through obstacles”(McDermott et al., 2019, p.14).

While some forms of stigma maybe common to both male and female IPV survivors, other forms of stigma maybe unique. One form of stigma that maybe unique to male IPV survivors seems to be related to discourses around self-defence. Some commenters mentioned fear of social stigma associated with hitting women and the belief “you don't hit girls”. Studies on self-defence motives for IPV perpetration show that both men and women indicate using physical violence as a form of self-defence (Leisring & Grigorian, 2016). There has been extensive research on female IPV survivors' self defense strategies (Ballan & Freyer, 2012; Downs et al., 2007; Hollander, 2004), however, research on effective self-defence strategies for male IPV survivors are limited. Further research on effective self-defence strategies and education for men are warranted.

One of the prevalent themes that emerged in both the disclosure and response was fear of false accusation. Both men who disclosed male IPV and commenters mentioned being falsely accused of IPV perpetration (as a form of legal and administrative violence) or being threatened of false allegation (possibly as a tactic to threaten and silence the male victim). These findings reinforce previous research on male IPV victims (Entilli & Cipolletta, 2017; Hines & Douglas, 2010). While all the participants in the study by

Entilli & Cipolletta (2017) had been acquitted of all accusations, the participants in the current study reported having to pay restitution and/or spend time in jail due to false allegations. While research on false IPV allegations is limited, the findings are equivocal with researchers finding both male and females may use false allegations to control their partners (Mazeh & Widrig, 2016). In the current study commenters advised using tape recorders and security cameras to record the abuse, as tactic to prevent false allegations and as a way to establish victimhood. These findings may point to men's fear of invalidation. a phenomenon whereby "disclosure of abuse was blatantly ignored or discounted" (Lutenbacher et al. 2003, p.60).

Strengths and Limitations

The study is not without its limitations. Submissions included in the study were gathered using search terms that specifically mentioned male IPV and, as such, may not have captured the entire spectrum of conversation on male IPV. Including general search terms may result in additional data. Furthermore, given the relative anonymity of the platform we could not make any assumptions about the demographics of the OPs or the commenters. Finally, due to the nature of data collection, we were unable to explore reasons for commenter's posts or ask for further clarifications, as such there is a potential to misinterpret some statements out of context. Despite the limitation, this study is one of the few to explore responses to male IPV disclosure. Furthermore, to our knowledge this is one of the first studies to explore the area of discourses around male IPV disclosure in an online forum.

2.6 Conclusions

This study shows that male IPV disclosure and response to such disclosure fall on a spectrum. Findings from the study show similarity between the experiences of male and female IPV survivors, as well as some unique facets. While the submissions contained a lot of sensitive information, overall, the complexion of the response to disclosure appeared to be positive in nature. References

2.7 References

- Ansara, D. L., & Hindin, M. J. (2010). Exploring gender differences in the patterns of intimate partner violence in Canada: A latent class approach. *Journal of Epidemiology and Community Health, 64*(10), 849–854. <https://doi.org/10.1136/jech.2009.095208>
- Ballan, M. S., & Freyer, M. B. (2012). Self-Defense Among Women With Disabilities: An Unexplored Domain in Domestic Violence Cases. *Violence Against Women, 18*(9), 1083–1107. <https://doi.org/10.1177/1077801212461430>
- Barak, A., Boniel-Nissim, M., & Suler, J. (2008). Fostering empowerment in online support groups. *Computers in Human Behavior, 24*(5), 1867–1883. <https://doi.org/10.1016/j.chb.2008.02.004>
- Barrett, B. J., St. Pierre, M., & Vaillancourt, N. (2011). Police response to intimate partner violence in Canada: Do victim characteristics matter? *Women and Criminal Justice, 21*(1), 38–62. <https://doi.org/10.1080/08974454.2011.536057>
- Barthel, M., Stocking, G., Holcomb, J., & Mitchell, A. (2016). “Nearly Eight-in-Ten Reddit Users Get News on the Site.”
- Baucom, D. H., & Kerig, P. K. (Eds.). (2004). *Couple Observational Coding Systems*. Lawrence Erlbaum Associates, Inc. <https://doi.org/10.4324/9781410610843>
- Black, B. M., Tolman, R. M., Callahan, M., Saunders, D. G., & Weisz, A. N. (2008). When will adolescents tell someone about dating violence victimization? *Violence Against Women, 14*(7), 741–758. <https://doi.org/10.1177/1077801208320248>
- Brooks, C., Martin, S., Broda, L., & Poudrier, J. (2017). “How Many Silences Are There?” Men’s Experience of Victimization in Intimate Partner Relationships. *Journal of Interpersonal Violence, 32*(17), 3111–3128. <https://doi.org/10.1177/0886260517719905>
- Brooks, J., McCluskey, S., Turley, E., & King, N. (2015). The Utility of Template

- Analysis in Qualitative Psychology Research. *Qualitative Research in Psychology*, 12(2), 202–222. <https://doi.org/10.1080/14780887.2014.955224>
- Burcar, V., & Åkerström, M. (2009). *Negotiating a Victim Identity: Young Men as Victims of Violence*. 3858(May). <https://doi.org/10.1080/14043850902815073>
- Conceição, T. B., Bolsoni, C. C., Lindner, S. R., & Coelho, E. B. S. (2018). Gender asymmetry and symmetry in Brazilian intimate partner violence research. *Ciencia e Saude Coletiva*, 23(11), 3597–3607. <https://doi.org/10.1590/1413-812320182311.23902016>
- Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic masculinity rethinking the concept. *Gender and Society*, 19(6), 829–859. <https://doi.org/10.1177/0891243205278639>
- Corbally, M. (2015). Accounting for Intimate Partner Violence: A Biographical Analysis of Narrative Strategies Used by Men Experiencing IPV From Their Female Partners. *Journal of Interpersonal Violence*, 30(17), 3112–3132. <https://doi.org/10.1177/0886260514554429>
- Cutrona, C. E., & Suhr, J. A. (1992). Controllability of Stressful Events and Satisfaction With Spouse Support Behaviors. *Communication Research*, 19(2), 154–174. <https://doi.org/10.1177/009365092019002002>
- Douglas, E. M., & Hines, D. A. (2011). The Helpseeking Experiences of Men Who Sustain Intimate Partner Violence: An Overlooked Population and Implications for Practice. *Journal of Family Violence*, 26(6), 473–485. <https://doi.org/10.1007/s10896-011-9382-4>
- Downs, W. R., Rindels, B., & Atkinson, C. (2007). Women’s Use of Physical and Nonphysical Self-Defense Strategies During Incidents of Partner Violence. *Violence Against Women*, 13(1), 28–45. <https://doi.org/10.1177/1077801206294807>
- Durfee, A. (2011). “I’m not a victim, she’s an abuser”: Masculinity, victimization, and protection orders. *Gender and Society*, 25(3), 316–334. <https://doi.org/10.1177/0891243211404889>
- Edwards, K. M., & Dardis, C. M. (2020). Disclosure Recipients’ Social Reactions to Victims’ Disclosures of Intimate Partner Violence. *Journal of Interpersonal Violence*, 35(1–2), 53–76. <https://doi.org/10.1177/0886260516681155>
- Edwards, K. M., Dardis, C. M., Sylaska, K. M., & Gidycz, C. A. (2015). Informal Social Reactions to College Women’s Disclosure of Intimate Partner Violence: Associations With Psychological and Relational Variables. *Journal of Interpersonal Violence*, 30(1), 25–44. <https://doi.org/10.1177/0886260514532524>
- Entilli, L., & Cipolletta, S. (2017). When the woman gets violent: the construction of

- domestic abuse experience from heterosexual men's perspective. *Journal of Clinical Nursing*, 26(15–16), 2328–2341. <https://doi.org/10.1111/jocn.13500>
- Fergusson, D. M., Horwood, L. J., & Ridder, E. M. (2005). Partner Violence and Mental Health Outcomes in a New Zealand Birth Cohort. *Journal of Marriage and Family*, 67(5), 1103–1119. <https://doi.org/10.1111/j.1741-3737.2005.00202.x>
- Fugate, M., Landis, L., Riordan, K., Naureckas, S., & Engel, B. (2005). Barriers to domestic violence help seeking: Implications for intervention. *Violence Against Women*, 11(3), 290–310. <https://doi.org/10.1177/1077801204271959>
- Hines, D. A., & Douglas, E. M. (2009). Women's use of intimate partner violence against men: Prevalence, implications, and consequences. *Journal of Aggression, Maltreatment and Trauma*, 18(6), 572–586. <https://doi.org/10.1080/10926770903103099>
- Hines, D. A., & Douglas, E. M. (2010). A Closer Look at Men Who Sustain Intimate Terrorism by Women. *Partner Abuse*, 1(3), 286–313. <https://doi.org/10.1891/1946-6560.1.3.286>
- Hines, D. A., & Douglas, E. M. (2015). Health problems of partner violence victims: Comparing help-seeking men to a population-based sample. *American Journal of Preventive Medicine*, 48(2), 136–144. <https://doi.org/10.1016/j.amepre.2014.08.022>
- Hines, D. A., & Douglas, E. M. (2016). Sexual Aggression Experiences Among Male Victims of Physical Partner Violence: Prevalence, Severity, and Health Correlates for Male Victims and Their Children. *Archives of Sexual Behavior*, 45(5), 1133–1151. <https://doi.org/10.1007/s10508-014-0393-0>
- Hollander, J. A. (2004). "I Can Take Care of Myself": The Impact of Self-Defense Training on Women's Lives. In *Violence Against Women* (Vol. 10, Issue 3). <https://doi.org/10.1177/1077801203256202>
- Jensen, S. L. (2001). Development of a scale to code the elicitation of social support [Iowa State University, Digital Repository]. In *Proquest Dissertations and Thesis*. <https://doi.org/10.31274/rtd-180813-8823>
- Kilgo, D. K., Ng, Y. M. M., Riedl, M. J., & Lacasa-Mas, I. (2018). Reddit's Veil of Anonymity: Predictors of engagement and participation in media environments with hostile reputations. *Social Media and Society*, 4(4). <https://doi.org/10.1177/2056305118810216>
- Klein, C., Clutton, P., & Dunn, A. G. (2019). Pathways to conspiracy: The social and linguistic precursors of involvement in Reddit's conspiracy theory forum. In *PLoS ONE* (Vol. 14, Issue 11, pp. 1–23). <https://doi.org/10.1371/journal.pone.0225098>
- Langhinrichsen-Rohling, J., Misra, T. A., Selwyn, C., & Rohling, M. L. (2012). #3 Rates of Bi-directional versus Uni-directional Intimate Partner Violence Across Samples,

- Sexual Orientations, and Race/Ethnicities: A Comprehensive Review. *Partner Abuse*, 3(2), 1–2. <https://doi.org/10.1891/1946-6560.3.2.e3>
- Leisring, P., & Grigorian, H. (2016). Self-Defense, Retaliation, and Gender: Clarifying Motivations for Physical Partner Violence. *Journal of Family Violence*, 31. <https://doi.org/10.1007/s10896-016-9874-3>
- Lutenbacher, M., Cohen, A., & Mitzel, J. (2003). Do We Really Help? Perspectives of Abused Women. *Public Health Nursing*, 20(1), 56–64. <https://doi.org/10.1046/j.1525-1446.2003.20108.x>
- Machado, A., Hines, D., & Matos, M. (2016). Help-seeking and needs of male victims of intimate partner violence in Portugal. *Psychology of Men & Masculinity*, 17(3), 255–264. <https://doi.org/10.1037/men0000013>
- Madsen, C. A., Stith, S. M., Thomsen, C. J., & McCollum, E. E. (2012). Violent Couples Seeking Therapy: Bilateral and Unilateral Violence. *Partner Abuse*, 3(1), 43–58. <https://doi.org/10.1891/1946-6560.3.1.43>
- Mazeh, Y., & Widrig, M. (2016). The Rate of False Allegations of Partner Violence. *Journal of Family Violence*, 31(8), 1035–1037. <https://doi.org/10.1007/s10896-016-9882-3>
- McDermott, R. C., Pietrantonio, K. R., Browning, B. R., McKelvey, D. K., Jones, Z. K., Booth, N. R., & Sevig, T. D. (2019). In search of positive masculine role norms: Testing the positive psychology positive masculinity paradigm. *Psychology of Men & Masculinities*, 20(1), 12–22. <https://doi.org/10.1037/men0000160>
- McLean, G., & Bocinski, S. G. (2017). Fact Sheet: The Economic Cost of Intimate Partner Violence, Sexual Assault, and Stalking. *Institute for Women's Policy Research, August*, 1–7. [file:///C:/Users/Erin Bergren/Documents/CAHC 700/Research/B367_Economic-Impacts-of-IPV-08.14.17.pdf](file:///C:/Users/Erin%20Bergren/Documents/CAHC%20700/Research/B367_Economic-Impacts-of-IPV-08.14.17.pdf)
- Meyer, S. (2011). Seeking help for intimate partner violence: Victims' experiences when approaching the criminal justice system for IPV-related support and protection in an Australian jurisdiction. *Feminist Criminology*, 6(4), 268–290. <https://doi.org/10.1177/1557085111414860>
- Pandrekar, S., Chen, X., Gopalkrishna, G., Srivastava, A., Saltz, M., Saltz, J., & Wang, F. (2018). Social Media Based Analysis of Opioid Epidemic Using Reddit. *AMIA ... Annual Symposium Proceedings. AMIA Symposium, 2018(3)*, 867–876. <http://www.ncbi.nlm.nih.gov/pubmed/30815129>
- Peterson, C., Kearns, M. C., McIntosh, W. L. K. W., Estefan, L. F., Nicolaidis, C., McCollister, K. E., Gordon, A., & Florence, C. (2018). Lifetime Economic Burden of Intimate Partner Violence Among U.S. Adults. *American Journal of Preventive Medicine*, 55(4), 433–444. <https://doi.org/10.1016/j.amepre.2018.04.049>

- Reid, R. J., Bonomi, A. E., Rivara, F. P., Anderson, M. L., Fishman, P. A., Carrell, D. S., & Thompson, R. S. (2008). Intimate Partner Violence Among Men. Prevalence, Chronicity, and Health Effects. *American Journal of Preventive Medicine*, *34*(6), 478–485. <https://doi.org/10.1016/j.amepre.2008.01.029>
- Rioli, G., Sgarbi, C., Moretti, V., Sinisi, A., De Fazio, L., Giambalvo, N., Ferrari, S., & Galeazzi, G. M. (2017). An update on intimate partner violence and mental health. *Minerva Psichiatrica*, *58*(4), 216–233. <https://doi.org/10.23736/S0391-1772.17.01943-4>
- Russell, B. (2018). Police perceptions in intimate partner violence cases: the influence of gender and sexual orientation. *Journal of Crime and Justice*, *41*(2), 193–205. <https://doi.org/10.1080/0735648X.2017.1282378>
- Sharma, R., Wigginton, B., Meurk, C., Ford, P., & Gartner, C. E. (2017). Motivations and limitations associated with vaping among people with mental illness: A qualitative analysis of reddit discussions. *International Journal of Environmental Research and Public Health*, *14*(1). <https://doi.org/10.3390/ijerph14010007>
- Suler, J. (2004). The Online Disinhibition Effect. *CyberPsychology & Behavior*, *7*(3), 321–326. <https://doi.org/10.1089/1094931041291295>
- Sylaska, K. M., & Edwards, K. M. (2014). Disclosure of Intimate Partner Violence to Informal Social Support Network Members: A Review of the Literature. *Trauma, Violence, and Abuse*, *15*(1), 3–21. <https://doi.org/10.1177/1524838013496335>
- Tanis, M. (2008). Health-related on-line forums: What's the big attraction? *Journal of Health Communication*, *13*(7), 698–714. <https://doi.org/10.1080/10810730802415316>
- The Palgrave Handbook of Male Psychology and Mental Health. (2019). In J. A. Barry, R. Kingerlee, M. Seager, & L. Sullivan (Eds.), *The Palgrave Handbook of Male Psychology and Mental Health*. Springer International Publishing. <https://doi.org/10.1007/978-3-030-04384-1>
- TSANG, W. W.-H. (2015). DO MALE VICTIMS OF INTIMATE PARTNER VIOLENCE (IPV) DESERVE HELP? SOME REFLECTIONS BASED ON A SYSTEMATIC REVIEW. *The Hong Kong Journal of Social Work*, *49*(No. 1/2), 51–63. <https://doi.org/10.1142/S0219246215000066>
- Wolf, M. E., Ly, U., Hobart, M. A., & Kernic, M. A. (2003). Barriers to Seeking Police Help for Intimate Partner Violence. *Journal of Family Violence*, *18*(2), 121–129. <https://doi.org/10.1023/A:1022893231951>

Chapter 3

3 Discourses Around Male IPV Related Systemic Biases on Reddit.Com

3.1 Introduction

According to the World Health Organization (WHO), intimate partner violence (IPV) refers to any “behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours” (WHO, 2013, p. vii). According to a Statistics Canada report (Burczycka et al., 2018), in 2017 close to one-third (30%, n=95,704) of all police reported victims were victims of IPV. IPV can negatively impact physical and psychological (Fergusson et al., 2005; Hines & Douglas, 2009, 2016; Reid et al., 2008), financial (McLean & Bocinski, 2017; Peterson et al., 2018), and social (Fowler & Chanmugam, 2007) outcomes.

Men may experience IPV from their same-sex and other-sex partners. A meta-analysis of 80 studies found that 35% of the participants injured by their partners were men, with 39% of those requiring medical treatment (Archer, 2000). Many factors may contribute to the incorrect perception of low prevalence rates of male IPV. Male IPV survivors often feel reluctance to report their experiences of IPV (Brown, 2004). Additionally, police officers are more likely to identify an incident as IPV when the victim is a female, even in cases of severe physical violence (Brown, 2004; Fagerlund et al., 2018). Therefore, current prevalence rates of male IPV may not reflect the true extent of IPV amongst men.

Studies on male survivors have found IPV to have devastating consequences on men's health and wellbeing. Therefore, it is imperative to not to trivialize the experiences of male IPV survivors. The limited research on health consequences of IPV in male victims indicates that men experience a range of adverse health outcomes (Coker et al., 2002; Fergusson et al., 2005; Hines & Douglas, 2009, 2016; Reid et al., 2008). In addition to negative health outcomes IPV has been associated with health risk behaviours (Buller et al., 2014; Cerulli et al., 2014; Coker et al., 2002; Houston & McKirnan, 2007).

Given the health, legal, and financial consequences of IPV, male IPV survivors may seek access to health care, legal, and social services. However, studies on men's experiences of help-seeking are limited. Subsequently, this may have resulted in a lack of services and policies directed at male IPV survivors. Viergever, Thorogood, Wolf, & Durand, (2018) noted that when lesser known victims of violence, abuse, neglect or exploitation are neglected in terms of polices and service delivery, it may result in individuals not being identified appropriately by healthcare professionals leading to individuals not receiving appropriate treatment. This may lead to further victimization of already marginalized populations.

Underreporting IPV by male survivors may be attributed to the shame and stigma associated with being a male victim of IPV. Subsequently, the vulnerability of males with lived experience of IPV may pose problems for researchers interested in exploring the area of male IPV. Given the sensitive nature of the topic at hand it may be difficult for researchers to recruit male IPV survivors who are willing to share their experience of IPV. Advances in technology have grown the number of social media users across the globe to 2.8 billion people (Taylor & Pagliari, 2018). subsequently, individuals

increasingly seek health related information from the internet (Macias et al., 2004). As such, social networking sites (SNSs) may be ideal way to explore sensitive topics (Yuan et al., 2014). Similarly, Taylor & Pagliari (2018) found multiple benefits of using social media in research including, accessing a larger number of participants than it would have been possible through other means of recruitment. Reddit.com boasts 430 million average monthly active users and 21 billion average screen views per month. Given the large userbase which employ Reddit to share content and discuss issues including topics of sensitive nature, Reddit is an ideal place to explore the topic of male IPV.

Systemic biases may result in marginalized service users receiving unsatisfactory healthcare (Hall et al., 2015). Furthermore, systemic biases (whether perceived or experienced) may impact survivors' decision to disclose and seek help. For example, a study by Barney et al.(2006) showed that even perceived stigma is significant predictor of help-seeking behaviour with greater perceived stigma reducing the likelihood of seeking help from all sources. Studies on systemic biases and their impact on male IPV are limited. The current study sought to examine the discourses on Reddit.com in regards to systemic biases for male IPV survivors. The findings presented below are part of a larger project which sought to explore the discourses around male IPV on Reddit.com. The purpose of the first examination, presented elsewhere (Chapter 2), was to examine male IPV survivors' disclosures and responses to the disclosures. Social and institutional biases emerged as a salient theme in the previous study (Chapter 2). The purpose of the current study is to report on these systemic biases (experienced or perceived) in greater depth.

3.2 Method

3.2.1 Content Extraction

The data for the study was collected from a popular social media site (Reddit.com) using Python Reddit Application Programming Interface (API) wrapper (PRAW). Each Reddit submission consists of the submission title, submission body, and the comments. Authors carried out a search of Reddit submission title and bodies in February 2019 using 3 separate keywords (“male IPV”, “male domestic abuse”, and “male domestic violence”). The search returned 917 submission IDs (unique identifying code associated with each submission) which contained the keywords in their submission title or submission body. 765 submissions were excluded through screening (See Figure 3-1). 82 submissions were deemed eligible for inclusion for data analysis. Submissions were included in the current study if the submission body was primarily related to male IPV.

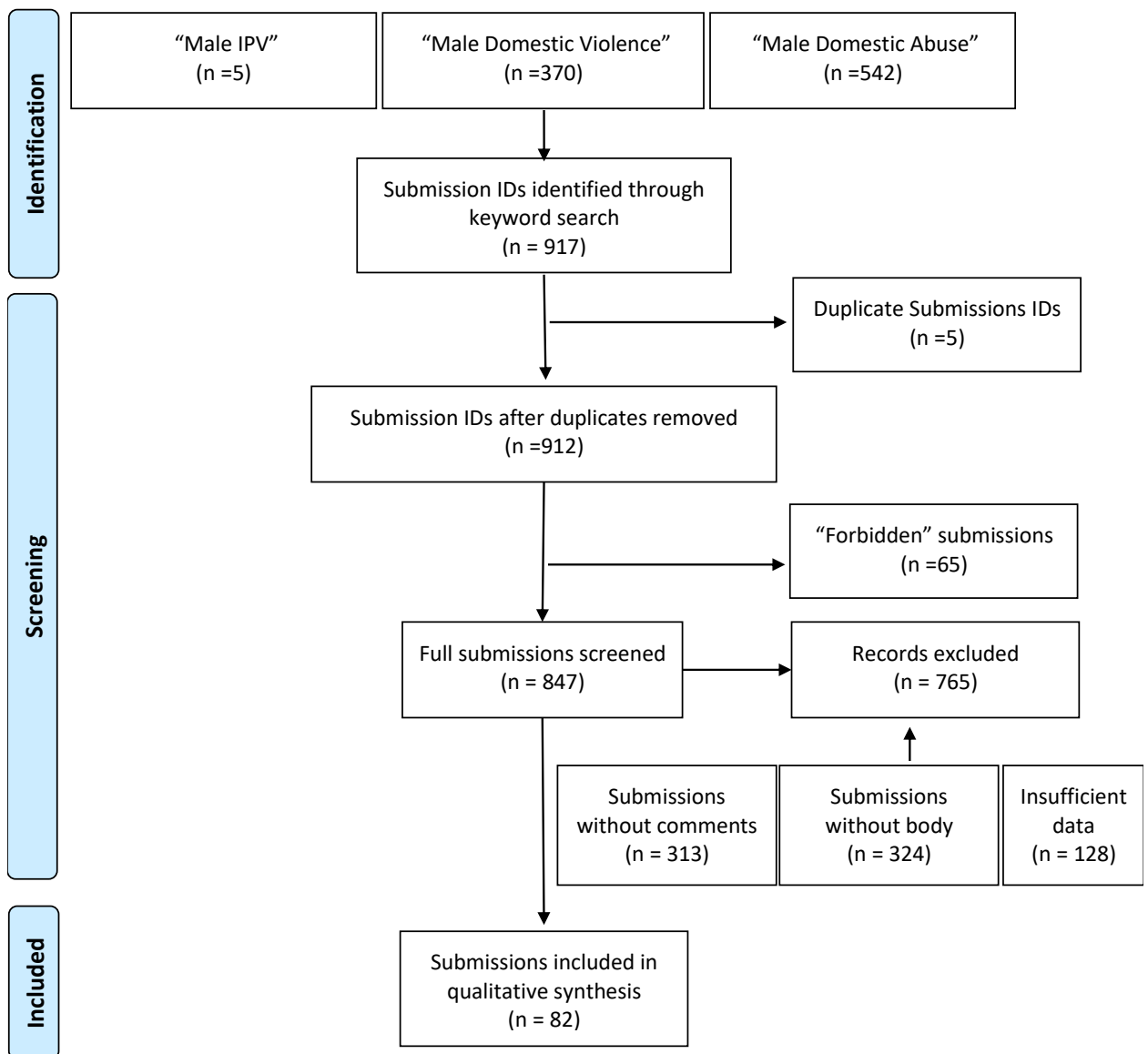


Figure 3-1: PRISMA Inclusion Criteria

3.2.2 Data Analysis

The current data analysis followed the reflexive thematic analysis procedures as outlined by Braun and Clarke (2006). The analysis process involved 1.) the first author familiarizing themselves with the data through repeated reading and rereading of the Reddit submissions, 2.) generating initial codes in an inductive manner, with the codes emerging from the data, 3.) collating the codes into larger themes, and 4.) reviewing the themes to ensure that the findings accurately represent the data, and collapsing some of the smaller themes to form larger themes, and creating a thematic map. Throughout the process all the authors met to discuss the codes and themes identified by first author and any assumptions or biases.

3.3 Results

The findings reported below depict the discourses around systemic biases for male IPV survivors. Both perceptual and experiential systemic biases are presented. While most reddit users identified these biases as problematic, a small number of redditors endorsed/internalized these systemic biases. Systematic issues were identified across 5 different levels: 1) Social Attitudes 2) Legal System, 3) Social Services, 4) Media, and 5) Government (See Figure 3-2)

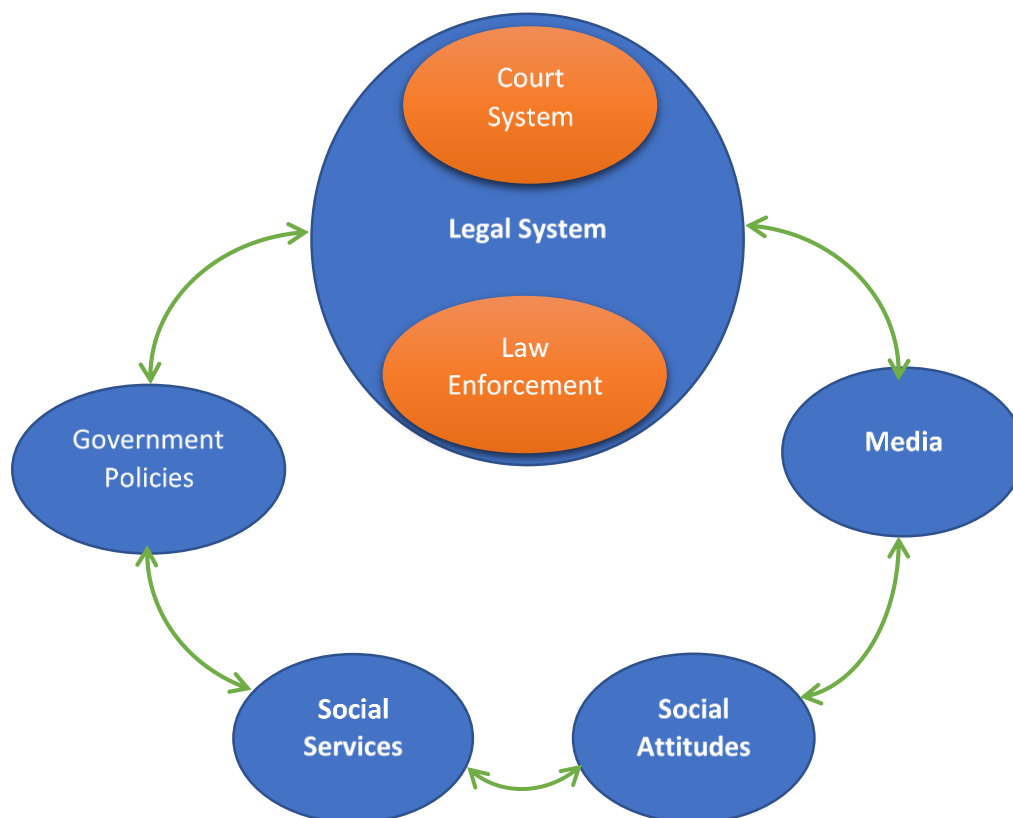


Figure 3-2: Thematic Map

1. Social Attitudes

Redditors identified multiple societal biases that may present as problematic for male IPV survivors. Redditors discussed that society has certain attitudes and perceptions regarding IPV and about male IPV. Redditors identified five societal attitudes and related behaviours that may negatively impact male IPV survivors: a) men as perpetrators, b) male IPV as a joke, c) shame, d) dismissive platitudes, and e) a lack of accountability.

a. Stereotype of men as perpetrators.

In the data analyzed, some redditors observed that society at large tends to see women as victims and men as perpetrators. One redditor expressed “I think there are stereotypes associated in the home where men are always seen as the 'abusers' and women as the victims.” Redditors noted that even in cases of bilateral IPV or when the perpetrator is the female, we as a society are more likely to assume victim of the IPV to be the female partner. As one redditor remarked “societally we tend to side with and assume it's always women as the abused and it's not true.” Another redditor speaking about this double standard regarding victimhood and perpetrators wrote:

Men being seen as abusers and not victims is dated thinking from a more sexist time that doesn't have a place within our equal society. Men and women are both abuser and abused, both need preventative education and support and only dealing with half the problem is not going to solve the problem.

b. male IPV as a joke.

Redditors commonly remarked that there is a double standard in how society reacts to male and female IPV. Redditors expressed that friends and family members of male IPV survivors may see the situation as humorous or a joke. Redditors noted that this may prevent them from providing help for male IPV survivors. One redditor expressed: “People will straight up laugh at you if you tell them you're having problems with a woman stalking/hitting you”. Another redditor recalling the reaction of his friends to witnessing an incidence of IPV perpetrated by his girlfriend remarked: “my gf had a tantrum started hitting me with a broom. all my friends were there and they just laughed. it wouldn't have been as funny if i was hitting her with the broom”

Redditors commented that this attitude may also be internalized by male IPV survivors themselves. Redditors noted that male IPV survivors may see the abuse perpetrated by their female partners as a joke or view the abuse as an inevitable part of the relationship, something to be joked about. One redditor speaking about his experience of a friend sharing an IPV incidence commented:

I was hanging out with my group of friends and one of them shows me a pic of another friend who's lip is gashed open and blood all over his face. he said his girlfriend hit him. then the one guy showing me laughed and said "damn, i've been hit but never that bad" [...] they knew it wasn't right but i got the impression that's just the way it was, women were going to hit them when they wanted to.

c. shame.

Social attitudes may result in male IPV survivors experiencing additional facets of shame that may be unique in comparison to female IPV survivors. Redditors noted that male IPV survivors may be shamed for being a victim or being victimized by female partners. One redditor commented that “men are socialised to be big and strong and not get beat by girls, so there's a tremendous amount of shame attached to it.” Redditors observed that the idea that IPV only happens to females may result in men feeling “powerless and ashamed of their manhood”. Furthermore, men may also be shamed for seeking help for their abuse. One redditor speaking in regard to societal reaction to male victimization and male IPV survivors seeking help for their IPV commented: “problem is the gender role of men to be ‘tough’ and ‘strong’ which results in men accepting the abuse and not speaking about it or being mocked when they look for help.”

Subsequently, redditors observed that male IPV survivors may also internalize this attitude and feel ashamed to seek out help or feel less masculine when they seek out help for the abuse. One redditor expressed, “sadly men often don't feel like ‘men’ if they seek out such help.”

In addition to being ashamed of being victims of IPV, males may also be shamed by society for defending themselves against the abuse. One redditor remarked “Men are ridiculed by the public or shamed if they fight back against a woman”. Redditors mentioned that in cases where the male IPV survivor tried to defend himself they are shamed by society as being the perpetrator of the abuse.

d. dismissive platitudes.

Redditors remarked there are multiple platitudes that are harmful for male IPV survivors. Two platitudes that were commonly noted by redditors as being used by society which results in further victimization of male IPV survivors are notions of “man up” and “never hit a woman”.

Redditors observed that societal gender norms minimize male IPV and not only discourages men from seeking help for the abuse but also encourages men “that they should ‘man up’ and take the abuse. One redditor on this attitude commented “We have the sort of attitude that can be described in one saying: ‘harden up mate’”. In terms of male IPV survivors seeking help, one redditor remarked that when “male is abused and tries to tell someone about it, the person they try to tell will most likely mock them and tell them to ‘man up’”. Redditors noted that the idea of male IPV survivors should “man up” shames and silences men. One redditor remarked that this attitude is also ingrained into men, noting “It's just ingrained in men that they are not worth anything if they speak

out”.

Redditors also noted that the attitude that men should “never hit a woman” is also damaging to male IPV survivors. This attitude prevents men from attempting to defend themselves against female perpetrators and emboldens female perpetrators. Redditors noted that this attitude prevents men from any source of recourse as male IPV survivors are not sure what they can do to defend themselves. One redditor recalled one of his coworkers who was in an abusive relationship and remarked: “Like most guys I know he had been brought up to never hit a woman so he had no idea what to do.” Another redditor commented: “There are many men who will die before they hit a woman, literally, just because they've always been taught never to hit a woman under any circumstance”. Subsequently, male IPV survivors may fear trying to defend themselves against physical abuse due to internalized attitude that hitting a woman is unacceptable in any situation and fear of social repercussion of fighting back even as a form of self defence. One redditor on this fear commented

For men who are willing to defend themselves from abuse or be the abuser, they have to consider what others will do. A woman who wants to defend herself or be the abuser doesn't have to worry too much about what those around her will do.

Some redditors expressed that this idea of never hitting a woman also emboldens female perpetrators of IPV. Redditor commented that this attitude allows women to be violent towards men without fear of repercussion or fear or the male IPV victim defending himself, as one redditor remarked: “because women often have a mindset that a man should never hit them, they become emboldened to abuse.”

e. lack of accountability.

Redditors commonly expressed that female perpetrators of IPV are not held accountable for their abuse. One redditor remarked “You think women experience accountability for their behaviors. They don't.” Some redditors expressed that abusive behaviour by female perpetrators are seen as a justified response to abusive behaviour by male partner. One redditor expressed how female IPV is often seen as being self-defence by society, commenting “If women beat men, it's normally in self-defence because he was violent to her.” Another redditor expressed that they perceived female perpetrators’ abusive behaviour is often legitimized, noting:

Most societies allow women to slap, shove, throw glasses' content, pinch, punch, and even groin attack men, without them ever being *allowed* to report this as DV, or this being discouraged. Regardless of provocation, cause or anything, it's always legitimate. "What did he do to cause her to do X" is extremely common worldwide.

Other redditors expressed that IPV by female perpetrators are not seen as abusive behaviour. As one redditor mentioned “For women (Jenna Jameson for example), throwing shit at their man isn't DV because they aren't touching him and ‘didn't mean to hitm him with it’.”

2. Legal System

a. law enforcement.

Two systemic issues that were identified by redditors as being problematic in terms of the law enforcement were: I) police attitudes II) police policies.

I. police attitudes.

Redditors commonly expressed that police attitudes regarding intimate partner violence were biased in favour of females. Redditors believed that police officers were less likely to take male IPV seriously. One redditor mentioned how “some police departments in rural areas won't accept that it happens, and the male subsequently becomes an outcast.” Another redditor commented: “if a man went to the police with visible wounds, and said his wife was abusing him, he would be ignored.” Additionally, redditors noted that police officers are more likely to assume that the male was the aggressor in most cases. One redditor mentioned that: “Many men are arrested or threatened by police when the woman was the one abusing the man, not him abusing the woman.” Some redditors observed that in cases where the police officers attend a domestic violence call, they are less likely to arrest females and more likely to believe the women’s version of the events. For example, one redditor remarked: “An abusive woman saying the right things can get an ex boyfriend hassled by the police or thrown in jail easily.” Redditors felt that in most cases the female perpetrators are more likely to get away with a slap on the wrist compared to male perpetrators who are more likely to be arrested, for example one redditor mentioned how he had gone to the police several times in the past six months and was only able to get his female intimate partner reprimanded twice by the police.

Another redditor recounting his experience with police officers responding to an IPV call:

police would then take my wife far away, talk to her for a few minutes, then come back to me without ever asking me a single question, and this is how the conversation would then take place:

Cops: "you know we could take you to jail now, but she isn't pressing charges??" (BTW the law has since been changed to where I MUST be taken to jail given their assumptions)

Me: "Uhhh... for WHAT exactly?"

Cops: "She has bruises on her arm which show that you have abused her!"

Me: "Uh huh... the bruises from her frenetic swinging at me. Perhaps you missed the 6" gash on my face? Would you like to see the bruises all over my body perhaps?"

Subsequently redditors commonly mentioned false allegations by female perpetrators as a cause for concern in their interaction with the police officers.

II. police policies.

In addition to the police attitudes, which redditors often mentioned as being biased in favour of females, redditors also felt that the training and policies for police officers as being in favour of females or not taking male IPV survivors into consideration. Redditors commonly mentioned police officers being trained to look for “for signs of DV in the woman, not the man.” Similarly, redditors also mentioned that police officers are trained to “Keep digging for facts when faced with an apparent female on male domestic violence incident”. One redditor recounted an incident in which a male IPV survivor was unable to obtain a safety plan because police officers were only trained on how to create safety plans for female IPV survivors. Redditors also observed that policies for police officers do not take male IPV into consideration. For example, one redditor speaking about the lack of consideration about male IPV when creating policies mentioned:

some jurisdictions have **primary aggressor** policies which say whoever is the primary aggressor should be the handcuffed and removed from the home. And just how is the **primary aggressor** determined? Among the criteria are "relative size", "apparent strength", how much "fear" the parties claim to have to one another, and "likelihood of future injury". These criteria, ... make primary aggressor policies heavily skewed against males.

Redditors felt these policies and training create unfair systems and function to create attitudes in police officers which may serve to prevent male IPV survivors from receiving adequate assistance from police officers.

b. court system.

Another systemic issue identified by the redditors were at the level of the court system. This theme incorporated perceptions related to: I) biased attitude regarding IPV, and II) biased judicial verdicts.

I. biased attitude regarding IPV.

Common opinion expressed by redditors was that legal professionals (judges, prosecutors, and lawyers) were more likely to be sympathetic to females in IPV cases. This sympathetic attitude may result in male IPV survivors being disadvantaged. redditors in the sample felt that when a female accuses their male partner of IPV they are more likely to be believed by the legal professionals than their male counterparts. Redditors felt that even in cases of false allegation by females the court system is more likely to believe the female perpetrator rather than the male victim of the IPV. Furthermore, even in cases where both parties are arrested for IPV, a belief was expressed that the court system was more likely to believe that the male was the aggressor. One redditor who had experienced IPV by his female partner recalled his experience dealing with the court system as follows:

I dealt with this recently and unfortunately will now be dealing with it the rest of my life. I will say this if a women goes in front of a judge and plays the victim they usually win... Even in my case where there was actually evidence of abuse. This girl made me sound and look crazy by being soft spoken and downplaying everything that happened the night of our domestic violence issue. In the judges ruling against me he even said she was guilty [of] simple assault but me saying she was a cunt was much worse...

II. biased judicial verdicts.

Biased Judiciary verdicts regarding IPV was also described by redditors. Two major issues mentioned by redditors were sentencing for IPV and child custody. In cases of IPV redditors felt that male perpetrators of IPV are more likely to be convicted and have harsher sentencing for the IPV. For example, one redditor mentioned that “women who do get accused of abuse by their spouses are convicted of domestic violence crimes at a much lower rate than when the genders are reversed, probably (but it's hard to make a 1:1 inference)”. Subsequently, redditors felt that when female perpetrators do receive a sentence for IPV the sentences are more lenient compared to the sentences for male IPV perpetrators. One redditor discussing the disparity in sentencing for IPV remarked “Male on female assault is compared to assault on a minor and thus you can be imprisoned up to 2 years opposed to the regular 1 year for standard assault.”

In addition to gender disparities in conviction rate and sentencing for IPV, decisions regarding child custody were also brought up as being in favour of females. Redditors commonly mentioned being discriminated against in custody cases. Redditors mentioned that even in case where the perpetrator of the IPV was a woman, most judges are likely to award the custody to the woman. One redditor commented that “if you leave and take the kids, she *will* show up in court crying and moaning and will very likely be awarded custody, and then the kids will be in some seriously dire straits.” Additionally, redditors observed that social biases such as mothers being more competent in child rearing may result in judges awarding custody to the mothers, as one redditor commented:

The court system assumes that because you are male, you are not only an inferior parent, you are likely also the abuser, regardless of the evidence at hand. It can take years to get a solid custody case in hand to prove otherwise.

3. Social Service

Redditors expressed multiple concerns with social service organizations and their policies. Major subthemes that were identified included a) gendered language, b) lack of services, and c) shelter

a. gendered language.

Redditors commented that gendered language may silence and serve to further marginalize male IPV survivors. Redditors mentioned that many of the services and resources being offered for IPV survivors use gendered language and reinforce stereotypes. Redditors noted that organizations use gendered language in their campaigns/ads, and resources (websites, pamphlets). One redditior commenting on campaigns/ads targeted at IPV survivors expressed:

The problem is, various campaigns and ads from feminist organisations seem to directly support and reinforce these patriarchal stereotypes. I'm thinking of, for example, anti-domestic violence campaigns which almost always portray men as perps as women as victims (reinforcing the stereotypical roles), "end violence against women" campaigns (which suggest that violence is a particular problem when it is against women, reinforcing the stereotype that women's role is to be protected)

Another redditior who had experienced IPV by his female partner recalled the effect of seeing gendered IPV campaigns/ads on his experience as a male IPV survivor:

I was a male domestic violence victim. Patriarchal stereotypes made it very hard for me to speak out about this. The only anti-DV campaigns or ads I saw, while this was happening to me, were from feminist charities and portrayed men solely

as aggressors (reinforcing the patriarchal stereotype), or as protectors (again, reinforcing).

Redditors remarked that the gendered language is not just limited to campaigns/ads and that many of the resources shared by IPV services use gendered language and perpetuate stereotypes that are harmful for male IPV survivors. Furthermore, redditors noted that this gendered language is present even in resources shared by government funded organizations or government resources. One redditor expressing their frustration about the gendered language in government resources articulated:

As I was looking at the Department for Children and Families page [...] However, when looking at tab I felt something was pretty peculiar to me. The first paragraph goes on to say that domestic violence is a pattern that stretches all walks of life and many Americans don't realize how widespread it is. But then lists facts and figures that only support the notion that women are abused, which is wrong, in my opinion.

Redditors also observed that organization that offer services may use gendered language when describing the services that they offer. One redditor commenting on services being offered by a national organization observed:

Under the Judges portion is says "Aiding judges to make constructive decisions in support of women and children facing violence," why doesn't it just say 'in support of victims facing violence'. There is a program "Coaching Boys into Men" but no "Coaching Kids into Adults", there's "Preventing Violence against Women on College Campuses" but no "Preventing Violence on College Campuses".

Redditors reported that the gendered language may prevent men from trying to take advantage of IPV services even in cases when the organization does cater to men.

Redditors indicated that when organizations that offer IPV services use gendered language men may assume that only services for women are being offered, as one redditor remarked, “It only refers to women when gender is mentioned at all, which I can only take to mean that this service is not offered to male victims. “

b. lack of services.

Lack of services emerged as a prevalent sub theme when discussing services of male IPV survivors. One redditor remarked “I’ve been aware of the lack of services for male victims of domestic violence in Canada for a while, it is something we desperately need”. Another redditor expressing his frustration with the lack of services for male IPV survivors remarked “The one-sided support needs to stop”. Multiple concerns were expressed by redditors when discussing the lack of services for male IPV survivors. Redditors noted that many of the organizations that provide services for IPV survivors barred male IPV survivors from accessing their services. Redditors observed that this practice of barring male IPV survivors was also prevalent in state run IPV services as well. One redditor mentioned that, “Until 2008, California specifically barred male domestic violence victims from state DV services. There no shelters, no programs, nothing.”

In addition to barring male IPV survivors from accessing existing IPV services, redditors also noted that many of the services treated them like the perpetrator. Redditors remarked that in comparison to female IPV services that cater to female victims and their children male IPV services are catered towards perpetrators of IPV. For example, one redditor on the disparity in services commented:

The Women's Helpline provides an umbrella of services, all of which are targeted at female victims. Contrast this with the Men's Helpline which on the same page, only mentions a counselling service for males who are concerned about becoming violent themselves.

Similarly, another redditor remarked that “The vast majority of DV organisations that provide services for men are in the form of perpetrator interventions or male behaviour change programs. There are very few services that actually cater to *male victims* of DV.” Subsequently, redditors also mentioned that services for female perpetrators are also limited.

c. shelter.

The discussion around IPV shelter for male survivors were complex. There is a small minority of redditors who believed that there was no need for male specific shelters. Opponents of male centered IPV shelters argued that IPV survivors do not need male only shelters due to the low prevalence rates for male IPV survivors and low demand for male IPV shelters. One redditor speaking about the low prevalence rates for men noted:

the 50% statistic is "fragile"—you have to ask certain narrow questions in certain ways to get a number like that, while other polling methods have women at much higher rates than men. But more importantly, even if it were true **there are DV shelters all over Canada that take men**—they problem is emphatically *not* a lack of services.

Other redditors noted that there is lack of demand for male IPV shelters as male IPV survivors are less likely to utilize such services. One redditor noted that “Battered men stay at buddies' houses, their parents, a motel, or the car. Another redditor commented:

Men's only shelters have opened up. (Last I checked, there were two in the U.S.) They later shut down because they were empty and no one was using them. Not because men don't get abused. Because men are more likely to have \$\$ for a hotel. Or feel safe in a general shelter

Another redditor commented that the lack of demand for male IPV shelters maybe attributed to the fact that “men do not come forward about abuse anywhere near as often as it occurs or as often as women do.”

However, majority of redditors noted the importance of more shelters for male IPV survivors, specifically male only IPV shelters. One redditor on lack of male IPV shelters expressed:

Let's say there is a shelter that has 200 women in it but only one man (exaggerated I know, but bear with me). Just because this shelter was open to admitting the man doesn't make it any less a women's shelter.

Redditors noted multiple concerns with mixed or women's shelters. Redditors noted that mixed gender or women's shelters do not adequately meet the needs of male IPV survivors. redditors noted that women's shelters are less likely to cater to male IPV survivors and will turn male IPV survivors away. one redditor on women's shelter turning men away expressed:

There are other ignorant/naive/misguided feminists who think men don't need a men's only shelter because there are "DV shelters" that would take everyone one (news flash: they don't. Their reasoning is often that taking in a man would make the women uncomfortable

Another redditor noted that many mixed gender shelters give priority to female PV survivors and noted:

There aren't really any DV shelter resources dedicated to male victims. The closest thing I can find is [one DV shelter in Strathmore](<http://strathmoreshelter.com/about-us/frequently-asked-questions/>) that has one room available for male victims when it isn't already being used by a woman

Redditors also commented that “Most of the shelters that admit male victims of domestic violence aren't dedicated DV shelters but rather *emergency housing* or part of a *safe home network* and offer between one and three nights of accommodation.” Redditors noted that the limited accommodations may not be adequate for some male IPV survivors.

Finally, redditors also expressed that when male IPV survivors try to access services from mixed gender of women's shelter the organizations tend to “treat the abuse victims there as perpetrators the same way they do at existing shelters.”

Proponents of male centered IPV shelter expressed that lack of such facilities may hinder IPV disclosure by male survivors. As one redditior expressed:

Looking at the numbers, if 40% of men are victims then there shouldn't be a shortage of demand. But there is, and the only reason to really explain that is because men don't seek help as much for one reason or another. Well how do we fix that? The main way is to establish shelters for men. Think about it: you are a male domestic abuse victim looking for help when you suddenly find that the only way for you to get that is by joining a women's domestic abuse shelter. [...] Admitting them into women's shelters isn't going to do much good and is actually probably the reason why many men refuse help in the first place

Furthermore, redditors noted that male IPV survivors may have unique or additional issues that need specialized services that may not be offered in current mixed or women's

shelter due to male IPV survivors not being a priority. For example, one redditor noted “as a victim of abuse by the hands of a woman you would most likely want counselling from a man who has been through what you have and can relate with you.” Other redditors noted that male IPV survivors may have safety concerns with sharing a shelter with females, as one redditor observed: “Because a man who has been abused by a woman should get time in an environment where he feels safe -- and for the most part, that would mean away from women.”

4. Media

Redditors also highlighted the depiction of male IPV in the media as being significantly problematic. Redditors observed that representation of male IPV survivors is limited in the media. Redditors remarked that when discussing the topic of IPV media is most likely to focus on female victims, as one redditor observed “Roughly 50% of DV victims are male but they have a program talking exclusively about female victims, bastards. Literally ignoring half the problem just to guilt trip all the non-violent men.” Another redditor commented that even when abusive behaviour against men are portrayed it is usually ignored:

this reminds me of the show Teen Mom (yeah, yeah. Shut up). There was this crazy chick on it who used to punch her guy in the head and stuff and for 90% of the season MTV didn't even acknowledge anything wrong was happening. I found it funny because if HE did it to HER the show would probably have been pulled off the air.

Conversely, redditors remarked that when male IPV is portrayed it is often used as comic relief. One redditor recalled a TV show in which a male character experiences IPV by his female partner:

in the episode one of the main characters (the fish dude) gets trapped a relationship with a extremely violent and temperamental female side character. Throughout the episode he is under threat of violence. At one part, the female character accuses him of being interested in other girls and goes ape shit. The characters make jokes about it throughout the episode and it was clear the whole thing was suppose to be humorous.

Another redditor expressed his frustration with a radio program where the hosts laughed about male IPV, commenting:

I found it really disgusting this morning to hear the two replacement radio hosts laughing and joking about a male domestic violence victim. How is it appropriate to laugh at the expense of someone who has gone through an atrocious ongoing abusive relationship? Would the same jokes and laughter have been aired if they were speaking about a female abuse victim?

5. Government

Redditors felt that in general the government focus was on female IPV to the exclusion of male IPV. Redditors felt this was reflected by government decisions in terms of funding and policies that are discriminatory against male IPV victims. The 2 major subthemes that emerged were: a.) Biased Funding and b.) Biased Policies.

a. biased funding.

Redditors noted that government funding for both services and resources, as well as research were biased in favour of female IPV survivors. Redditors remarked that the government is less likely to provide funding for organizations that offer services for male

IPV survivors. Redditors frequently pointed to the disparity in government funding for shelters as an example of biased government funding. Redditors pointed out governments are more likely to fund shelters that cater exclusively to female IPV survivors more so than shelters that serve male IPV survivors. One redditor commenting on the disparity mentioned:

Currently the provincial government spends almost \$200M annually on over 50 transition houses and programs for women fleeing domestic violence. We certainly applaud this spending and believe it is money well spent. However, compare that to spending on men's programs and/or male transition houses (none) and we see a huge disparity.

Others mentioned the government providing funding to “support a range of initiatives to reduce violence against women and their children” while initiatives that focus on gender neutral IPV initiatives or initiatives that focus on male IPV survivors is ignored. One redditor on the disparity of funding initiatives noted:

The Plan has committed \$86 million to support a range of initiatives to reduce violence against women and their children, according to the Department of Families, Housing, Community Services and Indigenous Affairs

The Plan has committed in comparison only committed \$0.75 million to expand counselling services for male victims of violence through Mensline;

Redditors also expressed that there is disparity in government funding for research programs and researchers. Redditors mentioned that the government is more likely to provide funding for research that focuses on female IPV research or take a feminist theoretical lens in their analysis. One redditor expressed “Like Australia,

government funded research into domestic violence will probably also be tainted by placing the money under sexist terms and handing it to sexist players:”

b. biased legislation.

Redditors frequently also expressed that government policies are discriminatory as they do not take male IPV survivors into consideration when creating legislations aimed addressing IPV. One of the commonly cited examples by redditors was the United States’ Violence against Women Act of 1994 (VAWA). Redditors noted that the VAWA not only provided discriminatory funding for female IPV but also has far reaching implications and has informed further policies and regulations across the criminal justice system, social organizations, and research. One redditor commenting on the implications of the VAWA expressed

More than a year after men and boys were given unquestionable equality under the 2013 reauthorization of VAWA, male survivors are routinely ignored and criminalized through programs funded under the program. These effects also impact their civil rights as parents under Title IV-D and Title IV-E as children are likely routinely endangered by being removed from the care, custody, and safety of their DV victim fathers, often handed over to their dangerous DV perpetrating mothers, while evidences of crimes and violence by the later parents are ignored.

Another legislation that redditors expressed as being discriminatory was the mandatory arrest law for domestic violence. Redditors noted that many of the “States had mandatory male arrest laws, meaning that even if a woman was abusing and assaulting the man, if he called the police, HE would be the one arrested”. This discriminatory legislation resulted in male IPV victims “who suffered years of abuse, and when they finally called the

police, the police showed up and arrested the man, even if he was waiting outside, covered in blood, and hurt.”

3.4 Discussion

Systemic biases emerged as a salient theme throughout examination of men’s disclosure process and responses to disclosure (Chapter 2). The current chapter aimed to explore the discourses on these systemic biases in greater depth. Due to the ease of presentation, the themes are presented as independent. However, it is important to recognise these systems as separate yet interrelated and they inform and influence each other.

The discourses around systemic biases- whether based on experience or perceptual- serve both negative and positive functions. Even perceptions (whether right or wrong) can influence help-seeking behaviour. For example, Barney et al. (2006) showed perceived stigma reduced help seeking for depression. Male IPV survivors may have fears of invalidation, a phenomenon whereby “disclosure of abuse was blatantly ignored or discounted” (Lutenbacher et al. 2003, p.60). Posts by redditors in which they share perceptions or experiences of invalidation may serve to substantiate male IPV survivors’ fears of invalidation and prevent male IPV survivors from seeking further formal and informal help.

Redditors also identified forms of hegemonic masculinity when discussing social attitudes of being a “man” and ideas around shame. Redditors discussed how notions such as “man up” can serve to silence male IPV victims. Redditors also discussed hegemonic masculinity can serve to shame male IPV survivors for being a “victim”, for seeking out help, and for fighting back as a form of self-defence. Previous research

(Machado et al., 2016; Tsui et al., 2010), has shown the deleterious effect of shame in terms of help-seeking.

Redditors expressed frustration with the media representation regarding male IPV. Machado et al. (2017) called for a gender-informed approach to IPV and advised for inclusive public campaigns. Similarly, participants in the study by Tsui et al. (2010) believed that gender inclusive public service announcements in the media may serve to increase public awareness. The current study supports the need for such an approach with many comments expressing frustration with perceived lack of representation of male IPV victims in IPV campaigns and ads. Furthermore, it is imperative that media portrayal of male IPV be measured. Findings shows that redditors perceived current media representation of male IPV to be biased with male IPV often being used for comic relief, normalized or entirely overlooked. These representations can be harmful for men experiencing IPV and serve to normalize such acts.

Similar to previous research (Machado et al., 2016) current results suggest that some male IPV survivors may be highly distrustful of the police, social services and the legal system. Findings from previous studies (Machado et al., 2016, 2017; Tsui et al., 2010) show that some male IPV survivors have reported unhelpful responses from legal, judicial and social services. Similarly, the current study indicated that redditors perceived police and the judiciary as having failed to respond to appropriately to male IPV survivors. However, it is important to note that findings are not limited to male IPV survivors, as studies on female IPV survivors and their experiences with help-seeking behaviour also show unhelpful responses from formal services (Barrett et al., 2011; Meyer, 2011; Wolf et al., 2003). Gender-stereotyped attitudes by police and judiciary

may serve to further victimize IPV survivors. Both threatened and actual legal and administrative violence has been shown to have negative consequences for both the men and their children (Berger et al., 2016). One of the primary ways that men in the current and previous studies (Chapter 2) identified legal and administrative violence was through false allegations of IPV by their female partners. However, while research on false allegations of IPV is limited and findings are equivocal. For example, a study by Trocmé & Bala (2005) on false allegations of child abuse in custody cases showed low rates of false allegations and that fathers are more likely to make false claims. However, these findings have been contested (Mazeh & Widrig, 2016). Furthermore, many redditors highlighted false allegations of IPV perpetration as potentially having a negative impact on custody hearings. Research on false allegation of IPV in custody hearings are limited, however, studies on abuse allegations in custody cases (Meier & Dickson, 2017) show that allegations are often discredited. Further empirical research on false allegations is needed and may serve to inform courts on custodial decisions.

Similar to previous research (TSANG, 2015; Tsui et al., 2010) results of the current study show redditors perceived multiple limitations in terms of accessing services for male IPV survivors. A systematic review by Huntley et al. (2019) showed that men were either not aware of services or viewed the services as not being appropriate for male survivors. As such, it may be possible that the perceptions regarding lack of services maybe result of lack of awareness rather than an actual lack of services. However, as Huntley et al. (2019) note, the perception of IPV services as being limited to female survivors may serve as a barrier to accessing existing services.

Finally, despite a majority of redditors expressing negative experiences and perceptions around the various systems (police, judicial, social service), findings from chapter 2 indicate that redditors recommended male IPV survivors seek help from these sources. Which indicate that despite perceived systemic biases and unhelpful experiences, redditors believe that these systems can provide some benefits.

The findings from the current study must be examined with caution. The systemic biases identified by the redditors may be due to limited personal experiences or incorrect perceptions rather than indicative of wide-spread systemic issues. Limited research on male IPV survivors' interactions with police and judiciary show unhelpful responses (Douglas & Hines, 2011). Due to the limited amount of quantitative research on men's experiences with these systems it is hard to determine if the negative perceptions identified by redditors are justified. However, the current findings do highlight that a majority of redditors hold troubling negative perceptions about how police and the judiciary interact with male IPV survivors. Given that even misperceptions can serve to prevent help-seeking, it is imperative that further research on these systems be conducted. Findings from future studies can inform ways to either correct existent systemic biases or improve public perceptions regarding these formal services through education.

3.4.1 Recommendations for Practice and Research

Services should strive to be more gender-inclusive in both the programs offered and, in their efforts to increase public awareness. Similar to Mulé et al. (2009) in which the authors noted the problem of promoting heterosexuality by 'not naming'(p.3) gender diverse populations, the men in the current sample felt excluded from services and resources that weren't gender-sensitive in the language used. A trauma (and violence)

informed care (TVIC) approach to dealing with IPV may serve both male and female IPV survivors better. Redditors identified both policy and attitudinal issues in the current study. The TVIC guidelines (EQUIP Healthcare, 2017) which provides recommendations at both macro (organizational policy) level and micro (individual service provider) level can serve to address some of the gaps identified by male IPV survivors. Campaigns and advertisements that address IPV should strive to use gender informed approach in their endeavours. Furthermore, using gender sensitive- approach when creating resources for IPV survivors is recommended. Resources should be inclusive, and IPV statistics used in resources (pamphlets, websites) should present statistics that are relevant to both sexes (i.e. IPV prevalence rates for both men and women, statistics on both male and female perpetrators).

Similarly, media depiction of IPV should be measured. Carlyle, Scarduzio, & Slater, (2014) noted the power of media to not only influence public opinion but also public policies. Given the reach and impact of media representations, gender inclusive representations could serve to educate the public on the issue of male IPV. In addition to being gender sensitive in the representation of both victims and perpetrators, media should also be sensitive in how IPV is framed. Studies show that media framing of the IPV can serve to reduce accountability amongst female perpetrators (Carlyle et al., 2014; Sellers et al., 2014). Carlyle et al. (2014) noted that media portrayals of women as perpetrating the violence due to their overly emotional nature, as responses to male perpetrated violence, or history of criminal behaviour can serve to excuse their violence behaviour. In addition to reducing accountability, characterizing male IPV as comical or normal behaviour in the media may cause further harm.

Similar to previous research (Brown, 2004), participants in the current study perceived the policies for police officers and legal professionals to be overwhelmingly gendered. However, findings from female IPV survivors interactions with police also show troubling patterns in police responses (Barrett et al., 2011). As such, it may be beneficial to re-examine current policies for dealing with IPV and update them with both male and female victims of IPV in mind. Policies on responding to and recording incidences of IPV, and referrals to services may benefit from gender- and trauma-informed approaches.

In addition to gender informed policy changes, sensitivity training which includes training on a gender-inclusive approach to IPV for police is imperative. Studies by Grant & Rowe (2011) showed that police officers may be influenced by time management and other factors resulting in foregoing existing policies. As such it is important to educate police officers on importance of best practice models for responding to IPV and result in better outcomes for both male and female IPV victims.

Similarly, Kernic, Monary-Ernsdorff, Koepsell, & Holt (2005) noted “Custody determinations have the potential to significantly affect the future health and safety of victims of IPV and their children”. Furthermore, studies show high rates of co-occurrence of IPV perpetration and Child Abuse (Holt et al., 2008). The findings from the current study suggest that some participants perceived the judicial process to be biased against them, particularly, in custody cases. However, these experiences are not unique to male IPV survivors. Gutowski & Goodman (2020) found that mothers with experiences of IPV also found the custodial and family court proceedings to be invalidating. Therefore, further education is necessary to ensure that judiciary biases do not place children in

further harm. Recently the Canadian Judicial council has called for sensitivity training for judges so they can be better equipped when handling sexual harassment cases. It would be beneficial to expand the scope of such training to include training on IPV to better serve victims of IPV.

Future research on aspects of IPV as it pertains to male IPV survivors is imperative. A one-size-fits-all approach to research may not be appropriate. Further research on male IPV survivors and their needs will serve to highlight the issues faced by this marginalized group. Furthermore, future research should focus on male IPV survivors' experience in family courts and family rights, male IPV survivors' interaction with police, the judiciary and social services are important, and may serve to better inform researchers and policy makers in regards to the validity of the perceived systemic biases from the current study. While the current research serves to highlight some systems that need critical analysis, given the limitations of the current study, further studies are needed. Additionally, research is also needed on how witnessing male IPV impacts children and their expectations around gender and gender norms. Research on how comedic portrayal of male IPV in media and its impact on social perception and the effect on male IPV survivors is also warranted.

3.4.2 Strengths and Limitations

The study has some limitations. The Reddit submissions included in the study were collected using 3 keywords (“male IPV”, “male domestic abuse”, and “male domestic violence”). Other forms of male IPV might exist that were missed due to using loaded key terms. Additionally, the anonymous nature of Reddit.com prevented us from making any assumptions about the population. The nature of the data collection process

also prevented us from seeking further clarifications regarding some comments, as such there is a potential to misinterpret some statements out of context.

Furthermore, the data collection method did not allow us to examine if these systemic biases are perceptual or experiential. And as such while the data allows us to examine the discourses around systemic biases in male IPV, further research is needed to qualify if these systemic biases are present within the systems.

However, the current study adds to the existing work around male IPV experiences and highlights some areas for future research. To our knowledge the current study is one of the few studies to explore the discourses around male IPV in an online forum.

3.5 Conclusion

Redditors perceived multiple systemic biases as being present. Further research on systemic biases experienced by male IPV survivors are needed. Policies and programs developed for IPV survivors should attempt to be sex and gender sensitive. Given that male IPV survivors continue to utilize these avenues for help-seeking it is imperative to re-examine these systems and ensure that the needs of this often-marginalized population are adequately met.

3.6 References

- Archer, J. (2000). Sex differences in aggression between heterosexual partners: A meta-analytic review. *Psychological Bulletin*, *126*(5), 651–680. <https://doi.org/10.1037/0033-2909.126.5.651>
- Barney, L. J., Griffiths, K. M., Jorm, A. F., & Christensen, H. (2006). Stigma about depression and its impact on help-seeking intentions. *Australian and New Zealand Journal of Psychiatry*, *40*(1), 51–54. <https://doi.org/10.1111/j.1440-1614.2006.01741.x>

- Barrett, B. J., St. Pierre, M., & Vaillancourt, N. (2011). Police response to intimate partner violence in Canada: Do victim characteristics matter? *Women and Criminal Justice, 21*(1), 38–62. <https://doi.org/10.1080/08974454.2011.536057>
- Berger, J. L., Douglas, E. M., & Hines, D. A. (2016). The mental health of male victims and their children affected by legal and administrative partner aggression. *Aggressive Behavior, 42*(4), 346–361. <https://doi.org/10.1002/ab.21630>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Brown, G. A. (2004). Gender as a factor in the response of the law-enforcement system to violence against partners. *Sexuality and Culture, 8*(3–4), 3–139. <https://doi.org/10.1007/s12119-004-1000-7>
- Buller, A. M., Devries, K. M., Howard, L. M., & Bacchus, L. J. (2014). Associations between Intimate Partner Violence and Health among Men Who Have Sex with Men: A Systematic Review and Meta-Analysis. *PLoS Medicine, 11*(3), e1001609. <https://doi.org/10.1371/journal.pmed.1001609>
- Burczycka, M., Conroy, S., & Savage, L. (2018). Family violence in Canada: A statistical profile, 2017. *Juristat: Canadian Centre for Justice Statistics, 38*(1). <https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2018001/article/54978-eng.pdf?st=d0-rM50a>
- Carlyle, K. E., Scarduzio, J. A., & Slater, M. D. (2014). Media Portrayals of Female Perpetrators of Intimate Partner Violence. *Journal of Interpersonal Violence, 29*(13), 2394–2417. <https://doi.org/10.1177/0886260513520231>
- Cerulli, C., Bossarte, R. M., & Dichter, M. E. (2014). Exploring Intimate Partner Violence Status Among Male Veterans and Associated Health Outcomes. *American Journal of Men's Health, 8*(1), 66–73. <https://doi.org/10.1177/1557988313492558>
- Coker, A. L., Davis, K. E., Arias, I., Desai, S., Sanderson, M., Brandt, H. M., & Smith, P. H. (2002). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine, 23*(4), 260–268. [https://doi.org/10.1016/S0749-3797\(02\)00514-7](https://doi.org/10.1016/S0749-3797(02)00514-7)
- Douglas, E. M., & Hines, D. A. (2011). The Helpseeking Experiences of Men Who Sustain Intimate Partner Violence: An Overlooked Population and Implications for Practice. *Journal of Family Violence, 26*(6), 473–485. <https://doi.org/10.1007/s10896-011-9382-4>
- EQUIP Healthcare. (2017). *Trauma-and-Violence-Informed Care (TVIC): A Tool for Health & Social Service Organizations and Providers*. <https://equiphealthcare.ca/toolkit>
- Fagerlund, M., Kääriäinen, J., & Ellonen, N. (2018). Recording of offences on police

- domestic violence call outs. *International Journal of Comparative and Applied Criminal Justice*, 42(2–3), 119–137.
<https://doi.org/10.1080/01924036.2017.1364277>
- Fergusson, D. M., Horwood, L. J., & Ridder, E. M. (2005). Partner Violence and Mental Health Outcomes in a New Zealand Birth Cohort. *Journal of Marriage and Family*, 67(5), 1103–1119. <https://doi.org/10.1111/j.1741-3737.2005.00202.x>
- Fowler, D. N., & Chanmugam, A. (2007). A critical review of quantitative analyses of children exposed to domestic violence: Lessons for practice and research. *Brief Treatment and Crisis Intervention*, 7(4), 322–344. <https://doi.org/10.1093/brief-treatment/mhm019>
- Grant, S., & Rowe, M. (2011). Running the risk: police officer discretion and family violence in New Zealand. *Policing and Society*, 21(1), 49–66.
<https://doi.org/10.1080/10439463.2010.540662>
- Gutowski, E., & Goodman, L. A. (2020). “Like I’m Invisible”: IPV Survivor-Mothers’ Perceptions of Seeking Child Custody through the Family Court System. *Journal of Family Violence*, 35(5), 441–457. <https://doi.org/10.1007/s10896-019-00063-1>
- Hall, W. J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., Eng, E., Day, S. H., & Coyne-Beasley, T. (2015). Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: A systematic review. *American Journal of Public Health*, 105(12), e60–e76.
<https://doi.org/10.2105/AJPH.2015.302903>
- Hines, D. A., & Douglas, E. M. (2009). Women’s use of intimate partner violence against men: Prevalence, implications, and consequences. *Journal of Aggression, Maltreatment and Trauma*, 18(6), 572–586.
<https://doi.org/10.1080/10926770903103099>
- Hines, D. A., & Douglas, E. M. (2016). Sexual Aggression Experiences Among Male Victims of Physical Partner Violence: Prevalence, Severity, and Health Correlates for Male Victims and Their Children. *Archives of Sexual Behavior*, 45(5), 1133–1151. <https://doi.org/10.1007/s10508-014-0393-0>
- 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 & Neglect*, 32(8), 797–810. <https://doi.org/10.1016/j.chiabu.2008.02.004>
- Houston, E., & McKirnan, D. J. (2007). Intimate partner abuse among gay and bisexual men: Risk correlates and health outcomes. *Journal of Urban Health*, 84(5), 681–690. <https://doi.org/10.1007/s11524-007-9188-0>
- Huntley, A. L., Potter, L., Williamson, E., Malpass, A., Szilassy, E., & Feder, G. (2019). Help-seeking by male victims of domestic violence and abuse (DVA): A systematic review and qualitative evidence synthesis. *BMJ Open*, 9(6), 1–13.

<https://doi.org/10.1136/bmjopen-2018-021960>

- Kernic, M. A., Monary-Ernsdorff, D. J., Koepsell, J. K., & Holt, V. L. (2005). Children in the crossfire: Child custody determinations among couples with a history of intimate partner violence. In *Violence Against Women* (Vol. 11, Issue 8). <https://doi.org/10.1177/1077801205278042>
- Lutenbacher, M., Cohen, A., & Mitzel, J. (2003). Do We Really Help? Perspectives of Abused Women. *Public Health Nursing, 20*(1), 56–64. <https://doi.org/10.1046/j.1525-1446.2003.20108.x>
- Machado, A., Hines, D., & Matos, M. (2016). Help-seeking and needs of male victims of intimate partner violence in Portugal. *Psychology of Men & Masculinity, 17*(3), 255–264. <https://doi.org/10.1037/men0000013>
- Machado, A., Santos, A., Graham-Kevan, N., & Matos, M. (2017). Exploring Help Seeking Experiences of Male Victims of Female Perpetrators of IPV. *Journal of Family Violence, 32*(5), 513–523. <https://doi.org/10.1007/s10896-016-9853-8>
- Macias, W., Lewis, L. S., & Shankar, V. (2004). Dr. Mom and Dr. Web. *Journal of Interactive Advertising, 4*(2), 9–19. <https://doi.org/10.1080/15252019.2004.10722083>
- Mazeh, Y., & Widrig, M. (2016). The Rate of False Allegations of Partner Violence. *Journal of Family Violence, 31*(8), 1035–1037. <https://doi.org/10.1007/s10896-016-9882-3>
- McLean, G., & Bocinski, S. G. (2017). Fact Sheet: The Economic Cost of Intimate Partner Violence, Sexual Assault, and Stalking. *Institute for Women's Policy Research, August*, 1–7. file:///C:/Users/Erin Bergren/Documents/CAHC 700/Research/B367_Economic-Impacts-of-IPV-08.14.17.pdf
- Meier, J. S., & Dickson, S. (2017). Mapping Gender: Shedding Empirical Light on Family Courtss Treatment of Cases Involving Abuse and Alienation. *SSRN Electronic Journal, 311*(201). <https://doi.org/10.2139/ssrn.2999906>
- Meyer, S. (2011). Seeking help for intimate partner violence: Victims' experiences when approaching the criminal justice system for IPV-related support and protection in an Australian jurisdiction. *Feminist Criminology, 6*(4), 268–290. <https://doi.org/10.1177/1557085111414860>
- Mulé, N. J., Ross, L. E., Deepröse, B., Jackson, B. E., Daley, A., Travers, A., & Moore, D. (2009). Promoting LGBT health and wellbeing through inclusive policy development. *International Journal for Equity in Health, 8*, 1–11. <https://doi.org/10.1186/1475-9276-8-18>
- Peterson, C., Kearns, M. C., McIntosh, W. L. K. W., Estefan, L. F., Nicolaidis, C., McCollister, K. E., Gordon, A., & Florence, C. (2018). Lifetime Economic Burden

- of Intimate Partner Violence Among U.S. Adults. *American Journal of Preventive Medicine*, 55(4), 433–444. <https://doi.org/10.1016/j.amepre.2018.04.049>
- Reid, R. J., Bonomi, A. E., Rivara, F. P., Anderson, M. L., Fishman, P. A., Carrell, D. S., & Thompson, R. S. (2008). Intimate Partner Violence Among Men. Prevalence, Chronicity, and Health Effects. *American Journal of Preventive Medicine*, 34(6), 478–485. <https://doi.org/10.1016/j.amepre.2008.01.029>
- Sellers, B. G., Desmarais, S. L., & Tirrotti, M. (2014). Content and Framing of Male- and Female-Perpetrated Intimate Partner Violence in Print News. *Partner Abuse*, 5(3), 259–278. <https://doi.org/10.1891/1946-6560.5.3.259>
- Taylor, J., & Pagliari, C. (2018). Mining social media data: How are research sponsors and researchers addressing the ethical challenges? *Research Ethics*, 14(2), 1–39. <https://doi.org/10.1177/1747016117738559>
- Troc me, N., & Bala, N. (2005). False allegations of abuse and neglect when parents separate. *Child Abuse & Neglect*, 29(12), 1333–1345. <https://doi.org/https://doi.org/10.1016/j.chiabu.2004.06.016>
- TSANG, W. W.-H. (2015). DO MALE VICTIMS OF INTIMATE PARTNER VIOLENCE (IPV) DESERVE HELP? SOME REFLECTIONS BASED ON A SYSTEMATIC REVIEW. *The Hong Kong Journal of Social Work*, 49(No. 1/2), 51–63. <https://doi.org/10.1142/S0219246215000066>
- Tsui, V., Cheung, M., & Leung, P. (2010). Help-seeking among male victims of partner abuse: men’s hard times. *Journal of Community Psychology*, 38(6), 769–780. <https://doi.org/10.1002/jcop.20394>
- Viergever, R. F., Thorogood, N., Wolf, J. R., & Durand, M. A. (2018). Supporting ALL victims of violence, abuse, neglect or exploitation: guidance for health providers. *BMC International Health and Human Rights*, 18(1), 39. <https://doi.org/10.1186/s12914-018-0178-y>
- WHO. (2013). *Responding to intimate partner violence and sexual violence against women WHO clinical and policy guidelines*. www.who.int/reproductivehealth
- Wolf, M. E., Ly, U., Hobart, M. A., & Kernic, M. A. (2003). Barriers to Seeking Police Help for Intimate Partner Violence. *Journal of Family Violence*, 18(2), 121–129. <https://doi.org/10.1023/A:1022893231951>
- Yuan, P., Bare, M. G., Johnson, M. O., & Saberi, P. (2014). Using online social media for recruitment of human immunodeficiency virus-positive participants: A cross-sectional survey. *Journal of Medical Internet Research*, 16(5), 1–9. <https://doi.org/10.2196/jmir.3229>

Chapter 4

4 Hand Therapists' Attitudes, Environmental Support, and Self-Efficacy Regarding Intimate Partner Violence in Their Practice⁷

4.1 Introduction

Intimate Partner Violence (IPV) is a global phenomenon with serious health implications and far reaching consequences (World Health Organization, 2012). IPV is a broad categorization of abuse, which "...may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation, and intimidation" (McCloskey et al., 2007). According to an international IPV survey of women aged 15-49 years, 15-71% experience either physical violence, sexual violence, or both by their intimate partner in their lifetimes (Garcia-Moreno et al., 2006). IPV is recognized as a primary public health issue in Canada and the United States, accounting for one in four violent crimes reported to the Canadian police in 2011 (Sinha, 2013). IPV is estimated to cost the Canadian health care system \$7.4 billion annually which includes health care utilization as a result of the associated mental and physical injuries, as well as the frequency with which persons directly impacted by IPV access health-related services (Zhang et al., 2012).

⁷ Sivagurunathan, M., Packham, T., Dimopoulos, L., Murray, R., Madden, K., & MacDermid, J. C. (2019). Hand therapists' attitudes, environmental supports, and self-efficacy regarding intimate partner violence in their practice. *Journal of Hand Therapy*, 32(3), 353–360. <https://doi.org/10.1016/j.jht.2017.11.042>

Studies show a high rate of service utilization by women who have been impacted by IPV (Bhandari et al., 2011; Petrisor et al., 2013; Sprague et al., 2014). A study by Bhandari and colleagues (2011) examined prevalence of IPV in a sample of 282 women attending a Level-I trauma center in Ontario. The results showed 32% of women attending the clinic had experienced IPV (including emotional, physical and sexual abuse) within the past 12 months, with 8.5% reporting physical abuse (Bhandari et al., 2011). Recent studies have shown musculoskeletal injury to be the second most common form of injury resulting from IPV (Bhandari et al., 2006; Sprague, Madden, et al., 2013).

Despite the high rates of service utilization by those affected by IPV, previous literature suggests health care professionals vastly underestimate the prevalence of IPV in their practice (Bhandari et al., 2008; Shearer & Bhandari, 2008; Sprague, Kaloty, et al., 2013). Although orthopaedic surgeons and chiropractors believed less than 1% of their female clients are victims of IPV (Shearer & Bhandari, 2008), the prevalence in primary care settings has been reported to be as high as 29%, and up to 41% in emergency departments (Bhandari et al., 2008; Shearer & Bhandari, 2008). Further, while many clinicians believe knowledge regarding IPV is relevant to their practice, very few health professionals routinely screen for IPV (Petrisor et al., 2013; Rasouljan et al., 2014). Common barriers to screening include a) fear that questioning regarding IPV would offend the patient, b) lack of time, c) lack of knowledge of how to respond to a positive screen, or lack of community resources, d) inadequate training or education regarding screening, e) uncertainty about roles and responsibilities, and f) personal discomfort in performing a screen (Conn et al., 2014; Sprague et al., 2012; Sprague, Kaloty, et al., 2013; Sprague, Swinton, et al., 2013). Considering the immediate and long-term psychological (Khadra

et al., 2015; Meekers et al., 2013; Peltzer et al., 2013), and physical (Stacey B. Plichta, 2004; Ruiz-Pérez et al., 2007) health consequences, health care providers can play an important role in IPV survivors receiving appropriate referrals and support.

While previous research has examined attitudes and beliefs in regards to IPV amongst orthopedic surgeons (Bhandari et al., 2008; Della Rocca et al., 2013), medical students/surgical residents (Conn et al., 2014; Connor et al., 2011; Sprague, Kaloty, et al., 2013), and chiropractors (Shearer & Bhandari, 2008), there is a paucity of research regarding the attitudes and beliefs of Hand Therapists (HT) regarding IPV, and their readiness to address this sensitive issue. As client rapport is built over regular contact during the hand rehabilitation process, physical and occupational therapists practicing in this area are perhaps uniquely positioned to assess for IPV and offer appropriate referrals and assistance. Musculoskeletal (MSK) injuries are the second most common trauma resulting from IPV, with 39.3% of persons presenting with a finger fracture or dislocation (Bhandari et al., 2006). This emphasizes the importance of this issue for hand therapy practice.

Since hand therapists are predominantly female and usually spend more time with their clients in comparison to surgeons, who are more commonly male (Della Rocca et al., 2013); there is the potential disclosure may happen in the context of a therapy interaction that would not take place during surgical consultations. Understanding therapists' current level of confidence in assessing and responding to IPV in their clinical setting is required to define the need for educational interventions and resources to support assessment and management of IPV within hand therapy clinical interactions.

The primary aim of this study is to describe the attitudes and beliefs of hand therapists regarding IPV: specifically, to assess perceptions of a) self-efficacy about managing IPV within the context of their practice, b) access to services for persons experiencing IPV, c) victim blaming attitudes/beliefs, d) professional role resistance, and e) client and provider safety. The secondary objective is to determine whether gender, country of practice (Canada or United States), hand therapy certification status, professional training (PT or OT), and experience with IPV (firsthand versus second hand/ no experience) predicts hand therapists' attitudes and beliefs about IPV.

4.2 Methods

4.2.1 Recruitment

Researchers contacted both the Canadian and American Societies of Hand Therapists (CSHT and ASHT) to inquire regarding interest in study participation. Specifically, the purpose of the study was outlined, and the societies were asked if mass e-mails advertising the survey could be sent to their member base. Both societies agreed to participate, and one mass email was sent to the members of each representative society explaining the project, which provided a link to the online questionnaire hosted on a LimeSurvey platform. Participants were informed that participation in the study was voluntary and all answers were confidential and anonymous. A subsequent reminder email was sent approximately two weeks following the initial invitation. The questionnaire was active between February and April 2015. Ethics approval for the study was obtained from the research ethics board at McMaster University in Hamilton, Ontario.

4.2.2 Measures

The researchers utilized a 27-item questionnaire that was modified from the two surveys previously published by Maiuro et al. (2000) and Connor et al. (2011). While minor modifications in wording were made to focus on the target population of hand therapists the essential constructs of all items were retained. The health care provider survey initially published by Maiuro et al. (2000) was a 39 item survey intended to measure primary care providers attitudes, beliefs, and self-reported behaviors related to the identification and management of IPV. Item domain Cronbach alpha for the survey was reported as between 0.73 and 0.91 with an overall alpha of 0.88 (Maiuro et al., 2000). The IPV tool developed by Connor et al. (2011) was intended to measure readiness of healthcare students to deal with IPV: it demonstrated Cronbach alpha scores greater than 0.7 (Connor et al., 2011). The final modified version of our survey included the following seven domains: (1) perceived self-efficacy about managing IPV within the context of their practice, (2) access to services for persons after IPV, (3) victim blaming attitudes/beliefs, (4) professional role resistance, (5) client and provider safety (6) frequency of IPV inquiry and (7) perceived preparedness. Self-efficacy, systemic support, victim blaming, professional role responsibility, and safety were rated on a 5-point Likert-type scale ranging from 1 = strongly disagree to 5 = strongly agree. In some cases, items were reverse coded so that higher numbers reflected a positive attitude and less negative behaviors (i.e. 5 = strongly disagree to 1 = strongly agree).

After the survey, a section was added where participants were encouraged to comment on their experiences with IPV in practice; however, formal qualitative analysis of this data is

beyond the scope of the current paper. Additional variables collected included demographic information (e.g., gender, age, and marital status), professional background (Occupational Therapist (OT) or Physical Therapist (PT)), years in professional practice, practice setting, location, and whether the participant was a certified Hand Therapists (CHT). Participants were also asked about their experience with IPV.

4.2.3 Statistical Analysis

Statistical analyses were conducted using SPSS statistical package version 24.0 (SPSS Inc, Chicago, Ill). At the first stage, data quality was checked by examining the data for out of range values and recoding the items that were reverse coded.

Normality was assessed using the Shapiro-Wilk test. Results showed the social support ($W(181) = 0.98, p = 0.003$), blame victim ($W(182) = 0.72, p = 0.00$), and professional role ($W(183) = 0.96, p = 0.00$) subscales were not normally distributed. Self-efficacy ($W(178) = 0.99, p = 0.51$), and Safety ($W(158) = 0.99, p = 0.45$) scale scores were normally distributed. For answering the primary research question, descriptive analysis was performed. Transformations were attempted for the three (of five) subscales that were not normally distributed. However, data remained skewed despite transformations. As such, Mann-Whitney U analysis was used to examine if there were differences in therapists' attitudes and beliefs regarding persons experiencing IPV, safety, self-efficacy, professional roles, and available support systems based on comparison groups defined by gender, country of practice, certified or non-certified Hand Therapists, occupation (PT or OT), and experience with IPV (first hand versus second hand/ no experience).

4.3 Results

4.3.1 Response Rate and Missing Data

The combined membership of CSHT and ASHT provided a potential sampling frame of 3,256 emails; although since some people are members of both organizations there would be fewer potential individual participants. Initially, a total of $n = 232$ participants responded to the survey (estimated response rate: 7.1% of emails resulted in respondents). After removal of those responses ($n=45$) with incomplete data (partial or full demographic responses with no other data: thought to represent persons abandoning the survey), this resulted in a final sample size of $n = 189$ (response rate: 5.8% of the emails sent). For the group comparisons using Mann-Whitney tests, data sets were removed for participants missing more than 1 item per scale; the resulting sample size is therefore reported with each analysis. The response rate of 189 participants should provide a 7% margin of error at the 95% confidence level.

4.3.2 Participants

Participants included 189 HTs from Canada and the United States (M age = 49 years, $range = 24$ —73 years). The sample consisted primarily of female, married OTs practicing in the United States. The mean number of years in practice and certified hand therapy were 23.7 years ($SD= 10.4$) and 17.6 years ($SD= 10$) respectively. Of the sample population, 119 participants had some familiarity with IPV (66.1%), which included previous experiences with clients (41.7%), family and/or friends (17.8%), or firsthand encounters (6.7%). For a complete list of demographic data see Table 4-1.

Table 4-1: Participant Demographics

Characteristics	Descriptive
Mean Age (Range)	49 (24-73)
Gender (%)	
Male	20 (10.8)
Female	165 (89.2)
Degree (%)	
PhD	21 (11.5)
MSc	72 (39.3)
BSc	90 (49.2)
Profession (%)	
PT	24 (13)
OT	160 (86.5)
Mean Years of Practice (SD)	23.7 (10.4)
Mean Years of HT (SD)	17.6 (10)
Relationship Status (%)	
Single	20 (10.8)
Common Law	5 (2.7)
Married	140 (75.3)
Separated	1 (0.5)
Divorced	18 (9.7)
Widowed	2 (1.1)
Practice Setting (%)	
Urban	82 (43.6)
Small Town	21 (11.2)
Suburban	71 (37.8)
Rural	12 (6.4)
Other	2 (1.1)
Previous experience with IPV (%)	
Client	75 (41.7)
Family member or friend	32 (17.8)
First-Hand	12 (6.7)
None	61 (33.9)
Country of Practice (%)	
Canada	28 (14.8)
United States	161 (85.2)
Hand Therapy Certification status (%)	
Certified Hand Therapist	152 (81.3)
Not Certified	35 (18.7)

4.3.3 Descriptive Analysis

On average, therapists demonstrated high levels of variability in their responses regarding their confidence (i.e., self-efficacy) in addressing the issues regarding IPV with their clients ($M=3$, $SD=0.8$), systemic support available in their workplaces ($M = 3$, $SD = 1$), as well as the safety of themselves or their clients when addressing these issues ($M = 3$, $SD = 0.7$) (see Table 4-2). The moderate mean scores reflected diversity in opinions. While 41% thought they had strategies to adequately deal with perpetrators of IPV, 33% disagreed (see Table 4-3). Similarly, 44% of the therapists were confident they make appropriate referrals for victims of IPV, whereas 35% were unsure of this (see Table 4-3). In terms of available systemic support, 38% of the therapists reported that they had access to mental health referrals, whereas 41% perceived inadequate mental health referral options that were present in their environment (See Table 4-4). While 38% of the therapists were reluctant to ask potential perpetrators of IPV about their abusive behavior out of concern for their personal safety, a similar number (41%) felt this was not a concern (see Table 4-5). Most participants either “somewhat disagreed” or “strongly disagreed” with statements blaming the victim of IPV ($M = 4.4$, $SD = 0.83$). Participants also “somewhat disagreed” with statements suggesting that addressing IPV was not part of their role as health professionals

Table 4-2: Perceived Self-Efficacy Scale

Sub Scale	Number (%) of Respondents
I don't have the time to ask about IPV in my practice.	
Strongly Agree/ Agree	19 (10.9)
Neutral	32 (18.3)
Disagree/ Strongly Disagree	124 (70.9)
There are strategies I can use to encourage batterers to seek help.	

Strongly Agree/ Agree	74 (40.9)
Neutral	48 (26.5)
Disagree/ Strongly Disagree	59 (32.6)
There are strategies I can use to help victims of IPV change their situation.	
Strongly Agree/ Agree	73 (40.1)
Neutral	53 (29.1)
Disagree/ Strongly Disagree	56 (30.8)
I feel confident that I can make appropriate referrals for batterers.	
Strongly Agree/ Agree	45 (24.6)
Neutral	40 (21.9)
Disagree/ Strongly Disagree	98 (53.6)
I feel confident that I can make the appropriate referrals for abused patients.	
Strongly Agree/ Agree	81 (44.3)
Neutral	38 (20.8)
Disagree/ Strongly Disagree	64 (35.0)
I have ready access to information detailing management of IPV.	
Strongly Agree/ Agree	44 (24.2)
Neutral	30 (16.5)
Disagree/ Strongly Disagree	108 (59.3)
There are ways I can ask batterers about their behavior that will minimize risk to the potential victim.	
Strongly Agree/ Agree	35 (19.7)
Neutral	31 (17.4)
Disagree/ Strongly Disagree	112 (62.9)

Table 4-3: System Support Scale

Sub Scale	Number (%) of Respondents
I have ready access to medical social workers or community advocates to assist in the management of IPV.	
Strongly Agree/ Agree	72 (39.3)
Neutral	30 (16.4)
Disagree/ Strongly Disagree	81 (44.3)
I feel that medical social work personnel can help manage IPV patients.	
Strongly Agree/ Agree	119 (65.7)
Neutral	34 (18.8)
Disagree/ Strongly Disagree	28 (15.5)
I have ready access to mental health services should our patients need referrals.	
Strongly Agree/ Agree	69 (37.5)
Neutral	40 (21.7)
Disagree/ Strongly Disagree	75 (40.8)
I feel that the mental health services at my clinic or agency can meet the needs to IPV victims in cases where they are needed.	

Strongly Agree/ Agree	47 (30.1)
Neutral	31 (19.9)
Disagree/ Strongly Disagree	78 (50.0)

Table 4-4 Victim Blaming Attitudes Scale

Sub Scale	Number (%) of Respondents
A victim must be getting something out of the abusive relationship, or else he/she would leave.	
Strongly Agree/ Agree	16 (8.7)
Neutral	22 (12.0)
Disagree/ Strongly Disagree	146 (79.3)
People are only victims if they choose to be.	
Strongly Agree/ Agree	10 (5.4)
Neutral	17 (9.2)
Disagree/ Strongly Disagree	158 (85.4)
When it comes to domestic violence victimization, it usually “takes two to tango.”	
Strongly Agree/ Agree	14 (7.6)
Neutral	12 (6.5)
Disagree/ Strongly Disagree	158 (85.9)
I have patients whose personalities cause them to be abused.	
Strongly Agree/ Agree	15 (8.5)
Neutral	17 (9.6)
Disagree/ Strongly Disagree	145 (81.9)
Women who choose to step out of traditional roles are a major cause of IPV.	
Strongly Agree/ Agree	9 (4.9)
Neutral	7 (3.8)
Disagree/ Strongly Disagree	169 (91.4)
The victim’s passive-dependent personality often leads to abuse.	
Strongly Agree/ Agree	23 (12.2)
Neutral	31 (16.9)
Disagree/ Strongly Disagree	129 (70.5)
The victim has often done something to bring about violence in the relationship.	
Strongly Agree/ Agree	11 (5.9)
Neutral	8 (4.3)
Disagree/ Strongly Disagree	166 (89.7)

Table 4-5: Professional Role Resistance Scale

Sub Scale	Number (%) of Respondents
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I am afraid of offending the patient if I ask about IPV.	
Strongly Agree/ Agree	42 (23.1)
Neutral	52 (28.6)
Disagree/ Strongly Disagree	88 (48.4)
Asking patients about IPV is an invasion of their privacy.	
Strongly Agree/ Agree	21 (11.5)
Neutral	44 (24.0)
Disagree/ Strongly Disagree	118 (64.5)
It is demeaning to patients to question them about abuse.	
Strongly Agree/ Agree	19 (10.3)
Neutral	33 (17.9)
Disagree/ Strongly Disagree	132 (71.7)
It is not my place to interfere with how a couple chooses to resolve conflicts.	
Strongly Agree/ Agree	21 (11.5)
Neutral	36 (19.7)
Disagree/ Strongly Disagree	126 (68.9)
I think that investigating the underlying cause of a patient's injury is not part of medical care.	
Strongly Agree/ Agree	17 (9.1)
Neutral	19 (10.2)
Disagree/ Strongly Disagree	151 (80.7)
If patients do not reveal abuse to me, then they feel it is none of my business.	
Strongly Agree/ Agree	41 (22.2)
Neutral	45 (24.3)
Disagree/ Strongly Disagree	99 (53.5)

Table 4-6: Victim/ Provider Safety Scale

Sub Scale	Number (%) of Respondents
I am reluctant to ask batterers about their abusive behavior out of concern for my personal safety.	
Strongly Agree/ Agree	64 (37.9)
Neutral	36 (21.3)
Disagree/ Strongly Disagree	69 (40.8)
There is not enough security at my workplace to safely permit discussion of IPV with batterers.	
Strongly Agree/ Agree	77 (44.3)
Neutral	40 (23.0)
Disagree/ Strongly Disagree	57 (32.8)
I am afraid of offending patients if I ask about their abusive behavior.	
Strongly Agree/ Agree	61 (34.9)
Neutral	43 (24.6)
Disagree/ Strongly Disagree	71 (40.6)

When challenged, batterers frequently direct their anger toward health care providers.	
Strongly Agree/ Agree	35 (22.3)
Neutral	73 (46.5)
Disagree/ Strongly Disagree	49 (31.2)
I feel there are ways of asking about battering behavior without placing myself at risk.	
Strongly Agree/ Agree	82 (48.0)
Neutral	51 (29.8)
Disagree/ Strongly Disagree	38 (22.2)
I feel I can effectively discuss issues of battering and abuse with a battering patient.	
Strongly Agree/ Agree	23 (13.1)
Neutral	46 (26.1)
Disagree/ Strongly Disagree	107 (60.8)
I feel I can discuss issues of battering and abuse with a battering patient without further endangering the victim.	
Strongly Agree/ Agree	28 (16.3)
Neutral	53 (30.8)
Disagree/ Strongly Disagree	91 (52.9)
I feel it is best to avoid dealing with the batterer out of fear and concern for the victim's safety.	
Strongly Agree/ Agree	36 (20.9)
Neutral	51 (29.7)
Disagree/ Strongly Disagree	85 (49.4)
There is no way to ask batterers about their behaviors without putting the victims in more danger.	
Strongly Agree/ Agree	34 (20.1)
Neutral	45 (26.6)
Disagree/ Strongly Disagree	90 (53.3)
I am afraid if I talk to the batterer, I will increase risk for the victim	
Strongly Agree/ Agree	83 (48.3)
Neutral	52 (30.2)
Disagree/ Strongly Disagree	37 (21.5)

Table 4-7: Scale Mean Scores

Scale	Response Rate (%)	Mean (SD)
Self-Efficacy	178 (94.2)	2.9 (0.8)
System Support	181 (95.8)	3.0 (1.1)
Blame Victim	182 (96.3)	4.4 (0.8)
Professional Role Resistance	183 (96.8)	3.8 (0.8)
Victim/ Provider Safety	158 (83.6)	3.0 (0.7)
Some items in the Self-Efficacy and Victim/ Provider Safety scale as well as the entire Scale of Blame Victim and Professional Role Resistance were reverse coded such that higher Mean scores represented a more positive attitude.		

4.3.4 Analysis of group differences

Mann-Whitney analysis was performed to examine differences in attitudes and beliefs regarding persons experiencing IPV, safety, self-efficacy, professional roles, and available support systems of HTs based on gender (male or female), country of practice (Canada or United States), certified or non-certified Hand Therapists, occupation (PT or OT), and experience with IPV (first hand versus second hand/no experience). Victim blaming was the only domain with significant differences. Results suggest men agreed significantly more ($mdn=4.3/5$) with items blaming the person experiencing IPV than women ($mdn = 4.7/5$), $U = 1067$, $p = 0.03$. Results also demonstrated that therapists with first-hand experience were significantly less likely ($mdn=4.9/5$) to blame victims of IPV than those without first-hand experience ($mdn = 4.6/5$), $U = 579$, $p = 0.02$. No significant between group findings were found for country of practice, certified Hand Therapists (versus not certified), or occupation.

Table 4-8: Mann-Whitney Analysis of Group Differences

	Count	Mean Rank	Mann-Whitney U	Asymp. Sig. (2 Tailed)
Self-Efficacy				
Gender	175		1266.5	0.7
Male	17	92.5		
Female	158	87.5		
Country of Practice	178		1860.5	0.3
United States	150	91.1		
Canada	28	81		
CHT	176		1815	0.06
Yes	144	92		
No	32	73.2		
Occupation	173		1552.5	0.4
PT	23	94.5		

OT	150	85.9		
IPV Experience	169		814	0.4
1st Hand	12	74.3		
Second-hand/ none	157	85.8		
System Support				
Gender	177		1303	0.5
Male	18	96.1		
Female	159	88.2		
Country of Practice	181		1677	0.1
United States	154	88.4		
Canada	27	105.9		
CHT	179		2251	0.7
Yes	147	89.3		
No	32	93.2		
Occupation	176		1614.5	0.5
PT	23	82.2		
OT	153	89.5		
IPV Experience	172		838	0.5
1st Hand	12	76.3		
Second-hand/ none	160	87.3		
Blame Victim				
Gender	178		1067	0.03
Male	19	66.2		
Female	159	92.3		
Country of Practice	182		1998.5	0.7
United States	155	90.9		
Canada	27	95		
CHT	180		2272	0.6
Yes	147	89.5		
No	33	95.2		
Occupation	178		1613.5	0.5
PT	23	82.2		
OT	155	90.6		
IPV Experience	173		579	0.02
1st Hand	12	119.3		
Second-hand/ none	161	84.6		
Professional Role Resistance				
Gender	179		1428	0.5
Male	20	98.1		
Female	159	89		
Country of Practice	183		1663	0.08
United States	156	94.8		
Canada	27	75.6		
CHT	181		2017.5	0.2
Yes	146	94		

No	35	80		
Occupation	178		1465	0.2
PT	23	75.7		
OT	155	91.6		
IPV Experience	174		820.5	0.4
1st Hand	12	100.1		
Second-hand/ none	162	86.6		
Victim/ Provider Safety				
Gender	154		886	0.1
Male	17	93.9		
Female	137	75.5		
Country of Practice	158		1350	0.7
United States	137	80.2		
Canada	21	75.3		
CHT	157		1760.5	0.7
Yes	128	78.3		
No	29	82.3		
Occupation	155		1039	0.4
PT	17	85.9		
OT	138	77		
IPV Experience	150		691	0.9
1st Hand	10	76.4		
Second-hand/ none	140	75.4		

4.4 Discussion

Our study found 66.1% of participants reported prior involvement with IPV as therapists (41.7%), with family and/or friends (17.8%), or firsthand (6.7%). First hand exposure to IPV is lower than the reported prevalence of IPV amongst the general public in both Canada (Statistics Canada, 2016) and the United States (Truman & Morgan, 2014). This may be due to the education level of the sample participants (see Table 4-1) as higher education appears to lower risk of experiencing IPV (Abramsky et al., 2011; Harwell & Spence, 2000; Nerøien & Schei, 2008). However, we cannot discount the possibility there was some reluctance to disclose personal experience with IPV because the survey came through their professional association, despite assurances of anonymity. Additionally,

41.7% of therapists had prior involvement with persons experiencing IPV in their clinic: this is similar to previous research by Della Rocca et al. (2013), which found 51% of orthopedic surgeons identified treating a victim of IPV.

The findings of this study demonstrate neutral mean ratings on therapists' perceptions and beliefs regarding how to address issues surrounding IPV in practice. This is evident as attitudinal scales yielded neutral mean perceptions of self-efficacy, safety, and systemic support available to address these issues. This may suggest HTs are generally unsure of their safety and ability to identify and handle clients presenting with history of IPV in a manner that ensures the safety of the client and their personal safety. However, it is important to note that the individual item responses were highly variable, which could be attributed to the variability in services and programs available amongst the different clinics in which these therapists work. In contrast to previous studies of male-dominated surgical samples, (Bhandari et al., 2008; Della Rocca et al., 2013) individual subscales in the current study show participants had higher rates of concern for their personal safety as well as the safety of their clients. For example, the study by Bhandari et al. (2008) found 30% of participants were reluctant to question perpetrators of IPV out of concern for personal safety and 42% felt there were ways to ask perpetrators about IPV without risk to victims, compared to our study results of 38% and 16% respectively. We attribute this difference in findings between the studies to the perceived superiority in physical status and power differentials between predominantly male surgeons and many of their clients, presumed to be less prevalent in therapist-client interactions where therapists are predominantly female. Another contrast with previous findings is that hand therapists did not report a lack of time as a barrier to assessing IPV victimization (71% of respondents:

see Table 4-2) compared to 8.8% surgical residents and medical students,(Sprague, Kaloty, et al., 2013) and 63% of orthopedic surgeons (Della Rocca et al., 2013). This supports our assertion the hand rehabilitation environment may be well suited to inquire and respond to IPV.

The results also indicate a low frequency of victim blaming attitude amongst hand therapists. When examining individual sub scales, participants from the current study showed higher disagreement with person/victim blaming statements than in previous studies (Bhandari et al., 2008; Della Rocca et al., 2013; Shearer & Bhandari, 2008). We posit this may reflect the high number of female respondents in our study (89.2%) compared to previous studies with predominantly male samples (Bhandari et al., 2008; Della Rocca et al., 2013; Shearer & Bhandari, 2008), rather than a difference in attitudes between the professional groups. When examining professional role resistance, participants in the current study rejected statements that dealing with IPV was not consistent with their professional role as hand therapists. However, the participants in the current study were less likely to disagree with role resistance statements than participants from previous studies (Bhandari et al., 2008; Della Rocca et al., 2013).

The secondary purpose of the current investigation was to examine differences in perceptions based on demographic factors. This study supports previous literature suggesting men were more likely to agree with statements suggesting victim blame than women (Shearer & Bhandari, 2008; Sprague et al., 2014). Our study indicates it would be important to target male therapists with educational strategies aimed at reducing victim blaming attitudes amongst therapists. Results also show that individuals with first-hand experience of IPV are less likely to engage in blaming attitudes and behaviors, therefore

it may be beneficial to involve therapists with first-hand experience with IPV to champion knowledge translation efforts.

4.4.1 Relevance to Hand Therapy Practice

Considering the frequency of finger fractures/dislocations after IPV (Bhandari et al., 2006), it is likely these persons will be referred for hand therapy: hand therapists may therefore be ideally positioned to assess for IPV victimization. It has been reported orthopedic surgeons may spend only a few minutes with each patient and often have residents accompanying them to appointments,(Della Rocca et al., 2013; Sprague, Swinton, et al., 2013) making conditions less than ideal to assess and provide support for such a sensitive issue. Conversely, HTs frequently allot more time per patient interaction and see their clients at regular intervals over a longer period after the initial acute management. This might allow therapists to build more rapport with clients, employing active listening techniques to facilitate an open and trusting relationship between the client and therapist (Hannah, 2011).

OTs and PTs are also increasingly becoming the first point of contact for persons requiring rehabilitation, which further stresses the importance of assessing their attitudes and beliefs. However, our results showed a significant barrier to assessing for IPV with this population of health professionals may be the perceptions regarding self-efficacy, lack of support systems, and safety concerns. Safety concerns must be addressed for HTs to feel safe probing into such a sensitive issue with victims and perpetrators of IPV, as this impacts the therapists' ability to fulfill the essential competencies of communication and advocacy for patient safety and care. Similarly, HTs in this study reported having

neutral confidence in their ability to address IPV in their clinics. This indicates a gap in preparedness that might be a knowledge exchange target for curricular, educational, peer-support or networking interventions. Potential solutions include online modules or in-person seminars to increase awareness of IPV and address appropriate and safe ways to discuss sensitive topics. Changes in entry-level curriculum for PT and OT trainees may also be important since this should be considered an entry-level competency, not specific to HT practice. However, hand therapists may be a professional group seeing higher rates of IPV due to the nature of the presenting injuries, so they may need to pay attention to preparing to deal with this issue in their practice. Since our findings indicate many HTs believe it is their role to assess and support patients with IPV victimization, educational resources on dealing with IPV may be accepted. However, further research is necessary as previous studies note that while more than 74% of orthopaedic surgeons believe that knowledge of IPV is relevant to their practice, only 49% of would welcome education and training regarding assessment and treatment of IPV (Della Rocca et al., 2013).

Lastly, with the multitude of physical and psychological symptoms that can result from IPV, it is clear that it is important to assess patients for IPV victimization, and be advocated for when possible, and with client consent. Our results indicate a large proportion of HTs feel there is inadequate systemic support and resources available to deal with IPV. Considering the high prevalence of IPV victims attending hand therapy clinics, therapists must make it their priority to familiarize themselves with the appropriate resources for clients to provide optimal, patient-centered care and promote patient safety. Further, the institutions in which HTs work share some responsibility in preparing their staff to deal with IPV, including facilitating access to appropriate internal

or external health or community agencies. From an implementation science perspective, a coordinated site-specific strategy is needed to address important contextual issues and foster linkages with local resources (MacDermid & Graham, 2009). Best practice guidelines such as LIVES guidelines by WHO (World Health Organization, 2014) or Trauma (and violence) Informed Care (TVIC) (EQUIP Healthcare, 2017) aimed at providing support for IPV survivors may result in better health outcomes for both male and female IPV survivors.

4.4.2 Strengths and Limitations

The current study has several strengths. Information about hand, physical or occupational therapists' attitudes and perceptions of about IPV is absent from the literature. Secondly, the study used a tailored version of a survey instrument with evidence supporting its' reliability and validity.

A significant limitation of this study was the low response rate. While we were unable to ascertain how many therapists actually received the survey, the final sample size is smaller than other studies that have sampled this same population (Grice, 2015; Lucado et al., 2018; Valdes et al., 2017). Given our response rate could be as low as 6%, our data suggests therapists who have previously answered surveys on clinical topics were more reluctant to answer this survey. This supports our position about the need for more awareness and practice support to address IPV. However, given our sampling, we cannot be confident that our estimates reflect the attitudes and beliefs of all hand therapists. The small cell size for some group analysis may have also resulted in estimation bias. Finally, the survey did not include questions regarding the therapists' estimates of the prevalence

of IPV in their practices; and did not allow for in-depth qualitative exploration of the experience of HTs in dealing with IPV, which would be important when planning future practice supports.

4.4.3 Future Directions

This study suggests hand therapists have uncertainty regarding safety when addressing IPV issues and in appropriate actions for assisting persons experiencing IPV. Results indicate that while there is disagreement about available systemic support; HTs did not display resistance to assuming this professional role and strongly disagreed with victim blaming statements. Our study supports the need for educational interventions to increase awareness of IPV and training in appropriate methods for approaching clients and facilitating access to needed services. Further, hand rehabilitation units may need to develop organizational procedures and referral connections to support front line therapists who are a point of first contact for clients. Research on effective and preferred methods for delivering education to hand therapists, such as online modules or in-person sessions would also be beneficial. Further, there is a multitude of literature outlining barriers to screening for IPV from the patients' perspectives and other personal factors (Paterno & Draughon, 2016; Stacey Beth Plichta, 2007). These must be considered when developing educational and point of care tools for therapists to ensure patient-centred approaches to care and efficacy of potential future interventions.

4.5 Conclusion

IPV is a prevalent problem that may be disclosed or elucidated following a hand injury.

This study indicates a gap in hand therapists' preparedness to deal with this disclosure.

4.6 References

- Abramsky, T., Watts, C. H., Garcia-Moreno, C., Devries, K., Kiss, L., Ellsberg, M., Jansen, H. A. F. M., & Heise, L. (2011). What factors are associated with recent intimate partner violence? findings from the WHO Multi-country Study on women's Health and Domestic Violence. *BMC Public Health, 11*.
<https://doi.org/10.1186/1471-2458-11-109>
- Bhandari, M., Dosanjh, S., Tornetta, P., & Matthews, D. (2006). Musculoskeletal Manifestations of Physical Abuse After Intimate Partner Violence. *The Journal of Trauma: Injury, Infection, and Critical Care, 61*(6), 1473–1479.
<https://doi.org/10.1097/01.ta.0000196419.36019.5a>
- Bhandari, M., Sprague, S., Dosanjh, S., Petrisor, B., Resendes, S., Madden, K., & Schemitsch, E. H. (2011). The Prevalence of Intimate Partner Violence across Orthopaedic Fracture Clinics in Ontario. *The Journal of Bone and Joint Surgery-American Volume, 93*(2), 132–141. <https://doi.org/10.2106/JBJS.I.01713>
- Bhandari, M., Sprague, S., Tornetta, P., D'Aurora, V., Schemitsch, E., Shearer, H., Brink, O., Mathews, D., & Dosanjh, S. (2008). (Mis)Perceptions About Intimate Partner Violence in Women Presenting for Orthopaedic Care: A Survey of Canadian Orthopaedic Surgeons. *The Journal of Bone and Joint Surgery-American Volume, 90*(7), 1590–1597. <https://doi.org/10.2106/JBJS.G.01188>
- Conn, L. G., Young, A., Rotstein, O. D., & Schemitsch, E. (2014). I've never asked one question." Understanding the barriers among orthopedic surgery residents to screening female patients for intimate partner violence. *Canadian Journal of Surgery, 57*(6), 371–378. <https://doi.org/10.1503/cjs.000714>
- Connor, P. D., Nouer, S. S., Mackey, S. T. N., Tipton, N. G., & Lloyd, A. K. (2011). Psychometric properties of an intimate partner violence tool for health care students. *Journal of Interpersonal Violence, 26*(5), 1012–1035.
<https://doi.org/10.1177/0886260510365872>
- Della Rocca, G. J., Sprague, S., Dosanjh, S., Schemitsch, E. H., & Bhandari, M. (2013). Orthopaedic surgeons' knowledge and misconceptions in the identification of intimate partner violence against women trauma. *Clinical Orthopaedics and Related Research, 471*(4), 1074–1080. <https://doi.org/10.1007/s11999-012-2749-x>

- EQUIP Healthcare. (2017). *Trauma-and-Violence-Informed Care (TVIC): A Tool for Health & Social Service Organizations and Providers*.
<https://equiphealthcare.ca/toolkit>
- Garcia-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. H. (2006). Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *The Lancet*, *368*(9543), 1260–1269.
[https://doi.org/10.1016/S0140-6736\(06\)69523-8](https://doi.org/10.1016/S0140-6736(06)69523-8)
- Grice, K. O. (2015). The use of occupation-based assessments and intervention in the hand therapy setting - A survey. *Journal of Hand Therapy*, *28*(3), 300–306.
<https://doi.org/10.1016/j.jht.2015.01.005>
- Hannah, S. D. (2011). Psychosocial issues after a traumatic hand injury: Facilitating adjustment. *Journal of Hand Therapy*, *24*(2), 95–103.
<https://doi.org/10.1016/j.jht.2010.11.001>
- Harwell, T. S., & Spence, M. R. (2000). Population surveillance for physical violence among adult men and women, Montana 1998. *American Journal of Preventive Medicine*, *19*(4), 321–324. [https://doi.org/10.1016/S0749-3797\(00\)00240-3](https://doi.org/10.1016/S0749-3797(00)00240-3)
- Khadra, C., Wehbe, N., Lachance Fiola, J., Skaff, W., & Nehmé, M. (2015). Symptoms of Post-Traumatic Stress Disorder Among Battered Women in Lebanon: An Exploratory Study. *Journal of Interpersonal Violence*, *30*(2), 295–313.
<https://doi.org/10.1177/0886260514534774>
- Lucado, A. M., Taylor, D. W., Wendland, D. M., & Connors, B. (2018). Health promotion, wellness, and prevention in hand therapy: A survey study. *Journal of Hand Therapy*, *31*(1), 59–67. <https://doi.org/10.1016/j.jht.2016.11.007>
- MacDermid, J. C., & Graham, I. D. (2009). Knowledge Translation: Putting the “Practice” in Evidence-Based Practice. In *Hand Clinics* (Vol. 25, Issue 1, pp. 125–143). <https://doi.org/10.1016/j.hcl.2008.10.003>
- Maiuro, R. D., Vitaliano, P. P., Sugg, N. K., Thompson, D. C., Rivara, F. P., & Thompson, R. S. (2000). Development of a health care provider survey for domestic violence: Psychometric properties. *American Journal of Preventive Medicine*, *19*(4), 245–252. [https://doi.org/10.1016/S0749-3797\(00\)00230-0](https://doi.org/10.1016/S0749-3797(00)00230-0)
- McCloskey, L. A., Williams, C. M., Lichter, E., Gerber, M., Ganz, M. L., & Sege, R. (2007). Abused women disclose partner interference with health care: An unrecognized form of battering. *Journal of General Internal Medicine*, *22*(8), 1067–1072. <https://doi.org/10.1007/s11606-007-0199-z>
- Meekers, D., Pallin, S. C., & Hutchinson, P. (2013). Intimate partner violence and mental health in Bolivia. *BMC Women's Health*, *13*(1), 1. <https://doi.org/10.1186/1472-6874-13-28>

- Nerøien, A. I., & Schei, B. (2008). Partner violence and health: Results from the first national study on violence against women in Norway. *Scandinavian Journal of Public Health, 36*(2), 161–168. <https://doi.org/10.1177/1403494807085188>
- Pascale Beaupré. (2015). Family violence in Canada: A statistical profile, 2013. *Juristat: Canadian Centre for Justice Statistics, 34*(1). <https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2014001/article/14114-eng.pdf?st=E5mjCfJy>
- Paterno, M. T., & Draughon, J. E. (2016). Screening for Intimate Partner Violence. *Journal of Midwifery & Women's Health, 61*(3), 370–375. <https://doi.org/10.1111/jmwh.12443>
- Peltzer, K., Pengpid, S., McFarlane, J., & Banyini, M. (2013). Mental health consequences of intimate partner violence in Vhembe district, South Africa. *General Hospital Psychiatry, 35*(5), 545–550. <https://doi.org/10.1016/j.genhosppsych.2013.04.001>
- Petrisor, B. A., Drew, B., Rajaratnam, K., Williams, D., Wong, I., Kwok, D., Denkers, M., Cameron, A., Resendes, S., Ramnath, I., Chien, T., Pham, N. K., Avram, V., Ayeni, O. R., De Beer, J., Winemaker, M., Ogilvie, R., Peterson, D., Swaleh, R., ... Sprague, S. (2013). Prevalence of abuse and intimate partner violence surgical evaluation (PRAISE) in orthopaedic fracture clinics: A multinational prevalence study. *The Lancet, 382*(9895), 866–876. [https://doi.org/10.1016/S0140-6736\(13\)61205-2](https://doi.org/10.1016/S0140-6736(13)61205-2)
- Plichta, Stacey B. (2004). Intimate partner violence and physical health consequences: Policy and practice implications. *Journal of Interpersonal Violence, 19*(11), 1296–1323. <https://doi.org/10.1177/0886260504269685>
- Plichta, Stacey Beth. (2007). Interactions between victims of intimate partner violence against women and the health care system: Policy and practice implications. *Trauma, Violence, and Abuse, 8*(2), 226–239. <https://doi.org/10.1177/1524838007301220>
- Rasoulilian, M., Shirazi, M., & Nojomi, M. (2014). Primary health care physicians' approach toward domestic violence in Tehran, Iran. *Medical Journal of the Islamic Republic of Iran, 28*(1), 148. <http://www.ncbi.nlm.nih.gov/pubmed/25695006>
- Ruiz-Pérez, I., Plazaola-Castaño, J., & Del Río-Lozano, M. (2007). Physical health consequences of intimate partner violence in Spanish women. *European Journal of Public Health, 17*(5), 437–443. <https://doi.org/10.1093/eurpub/ckl280>
- Shearer, H. M., & Bhandari, M. (2008). Ontario Chiropractors' Knowledge, Attitudes, and Beliefs About Intimate Partner Violence Among Their Patients: A Cross-Sectional Survey. *Journal of Manipulative and Physiological Therapeutics, 31*(6), 424–433. <https://doi.org/10.1016/j.jmpt.2008.06.011>

- Sinha, M. (2013). Family violence in Canada: A statistical profile, 2011. *Juristat: Canadian Centre for Justice Statistics*, 33(1).
https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2013001/article/11805-eng.pdf?st=FJZ_TjZg
- Sprague, S., Goslings, J. C., Hogentoren, C., de Milliano, S., Simunovic, N., Madden, K., & Bhandari, M. (2014). Prevalence of Intimate Partner Violence Across Medical and Surgical Health Care Settings: A Systematic Review. *Violence Against Women*, 20(1), 118–136. <https://doi.org/10.1177/1077801213520574>
- Sprague, S., Kaloty, R., Madden, K., Dosanjh, S., Mathews, D. J., & Bhandari, M. (2013). Perceptions of Intimate Partner Violence: a cross sectional survey of surgical residents and medical students. *Journal of Injury and Violence Research*, 5(1), 2–10. <https://doi.org/10.5249/jivr.v5i1.147>
- Sprague, S., Madden, K., Dosanjh, S., Godin, K., Goslings, J. C., Schemitsch, E. H., & Bhandari, M. (2013). Intimate partner violence and musculoskeletal injury: Bridging the knowledge gap in orthopaedic fracture clinics. *BMC Musculoskeletal Disorders*, 14(1), 1. <https://doi.org/10.1186/1471-2474-14-23>
- Sprague, S., Madden, K., Simunovic, N., Godin, K., Pham, N. K., Bhandari, M., & Goslings, J. C. (2012). Barriers to Screening for Intimate Partner Violence. *Women and Health*, 52(6), 587–605. <https://doi.org/10.1080/03630242.2012.690840>
- Sprague, S., Swinton, M., Madden, K., Swaleh, R., Goslings, J. C., Petrisor, B., & Bhandari, M. (2013). Barriers to and facilitators for screening women for intimate partner violence in surgical fracture clinics: A qualitative descriptive approach. *BMC Musculoskeletal Disorders*, 14, 1–10. <https://doi.org/10.1186/1471-2474-14-122>
- Truman, J. L., & Morgan, R. E. (2014). *Nonfatal Domestic Violence, 2003-2012*.
- Valdes, K., Szekeres, M., & MacDermid, J. C. (2017). Hand therapists report perceived differences in patient referrals from hand surgeons vs other referral sources: A survey study. *Journal of Hand Therapy*, 30(3), 314–319. <https://doi.org/10.1016/j.jht.2017.02.008>
- World Health Organization. (2012). Intimate partner violence. In *Understanding and addressing violence against women*. <https://doi.org/10.2307/1319341>
- World Health Organization. (2014). Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook. In *World Health Organization: Vol. WHO/RHR/14*. www.who.int/reproductivehealth
- Zhang, T., Hoddenbagh, J., McDonald, S., & Scrim, K. (2012). *An Estimation of the Economic Impact of Spousal Violence in Canada, 2009*. Department of Justice Canada.

Chapter 5

5 Perceptions of preparedness and Intimate Partner Violence screening practices amongst Hand Therapists.⁸

5.1 Introduction

Intimate partner violence (IPV) is a significant public health concern associated with adverse physical and psychological impacts and a wide range of health risk behaviors (M. C. Black, 2011; Breiding et al., 2008b; Hines & Douglas, 2015; Rioli et al., 2017).

Prevalence estimates by Devries et al. (2013) indicate that globally in 2010, 30.0% of women aged 15 and over had experienced some form of IPV in their lifetime. A study on the prevalence rate of IPV found 8.2%–32.1% of women and 10.1%–34% of men from the Asia and Pacific region experienced physical or sexual IPV in 2015 (Jewkes et al., 2017). Similarly, a quantitative study on the prevalence rate of IPV in 18 U.S. states or territories found 26.4% of the women and 15.9% of men reported some combination of physical violence and/or unwanted sex in their lifetime (Breiding et al., 2008a).

According to a 2015 Statistics Canada report (Burczycka & Conroy, 2017), instances of IPV accounted for 28% of the police-reported violent crime. Studies have found IPV to be associated with significant health risk behaviors including alcohol and drug abuse, smoking, unsafe sexual practices and physical inactivity (M. C. Black, 2011; Breiding et al., 2008b; Dude, 2007). While the incidence of hand or upper limb injuries related to IPV does not appear to have been a primary focus of any published literature, secondary

⁸ Sivagurunathan, M., Packham, T., Dimopoulos, L., Murray, R., Madden, K., Bhandari, M., & MacDermid, J. C. (2018). Perceptions of preparedness and intimate partner violence screening practices amongst hand therapists. *Hand Therapy*, 23(4), 139–147. <https://doi.org/10.1177/1758998318798668>

analysis of data presented by several authors is informative. Bhandari et al. (2006) detail sprains, dislocations and fractures affecting the upper extremity totalling 6.4% of the reported injuries in their sample of women attending a program for victims: however, it is worth noting an additional 22% of the sample had skin injuries (including bruises/contusions, bites, lacerations, burns, and gunshot wounds) that were not classified by anatomical location. Muelleman, Lenaghan & Pakieser (1996) conducted a cross-sectional survey of over 9,000 women seeking emergency care and reported on 280 persons with injuries confirmed to be the result of intimate partner violence. Of these, the primary injury was to the upper extremity in 27.5% of the cases.

Studies have found individuals with history of IPV will utilize health services frequently (Boyle et al., 2004; Riviello, 2009). For example, 45% of women who are killed by their intimate partner present to emergency departments within 2 years before their deaths (Riviello, 2009). This indicates the importance of disclosure when victims of IPV engage with the health care system. Given the high prevalence rate of IPV, it is likely a substantial number of individuals presenting for health care have a current or past history of IPV. Despite this, there are contradictory recommendations on screening for IPV in clinical settings: while mandatory reporting of potential abuse among children and vulnerable adults is a common requirement, duty to report in capable adults varies across geographic regions and health systems. However, a systematic review by Madden & Bhandari (2016) concluded while there is insufficient evidence to recommend screening all women for IPV in clinical settings, studies exploring the impact of identification coupled with referral and counselling services have found positive impacts.

WHO recommends a case-finding approach with clinicians inquiring about IPV when risk factors are present and providing appropriate referrals and support (WHO, 2013). However, studies show clinicians ask about IPV less often than other health risk factors (Rasoulilian et al., 2014). A study by Rasoulilian et al. (2014), conducted in Iran found only 10% of patients were routinely screened for IPV compared to 29% to 48% of patients screened for other risk factors. Studies on IPV inquiry in health care settings continue to show health care professionals are reluctant to ask about IPV (Bhandari et al., 2008; Conn et al., 2014; Della Rocca et al., 2013; Usta et al., 2014). Previous studies on IPV amongst health care professionals show the barriers to asking about IPV include perceived preparedness, lack of training on how to deal with IPV, and inadequate referral resources (Conn et al., 2014; Gutmanis et al., 2007; Sprague, Swinton, et al., 2013). The key theme emerging from a qualitative study by Conn et al. (2014) on barriers to for asking about IPV amongst orthopedic surgical residents suggested residents may not be prepared to deal with IPV disclosure in their practice. Similarly, a study on attitudes, environmental supports and self-efficacy regarding IPV amongst hand therapists (HTs) found they were not confident making referrals for abusers (53.6%) or victims of IPV (35%), and majority of HTs (59.3%) felt they did not have ready access to information on managing IPV (Sivagurunathan et al., 2019).

While previous studies have examined the relationship between IPV inquiry and perceived preparedness amongst physicians and nurses (Beccaria et al., 2013; Gutmanis et al., 2007; Usta et al., 2014), orthopedic surgeons and surgical trainees (Sprague, Swinton, et al., 2013), surgical residents (Conn et al., 2014), and paramedic students (Sawyer et al., 2017), studies on assessment and preparedness to deal with IPV amongst

rehabilitation professions such as HTs are limited. Other professions studied to date (i.e. orthopedic surgery) have brief encounters with patients and clinicians are predominantly men; whereas HTs may have more time with patients and are predominantly women. Both these factors could potentially affect the disclosure process relative to the concordance of the provider-patient gender, and associated roles and power dynamics. Since recent studies on IPV (Bhandari et al., 2006; Sprague, Madden, et al., 2013) have shown musculoskeletal injuries to be the second most common form of injury amongst IPV victims at 28% of total injuries (with at least 6% of total injuries localized to the upper extremity), assessment for IPV history in hand therapy practice may lead to identifying risk and providing appropriate intervention. Although we previously demonstrated the majority of HTs agree that dealing with IPV is part of hand therapy practice, we also found they are not confident in making the appropriate referrals for perpetrators or victims: further, their perceptions regarding system support are highly variable (Sivagurunathan et al., 2019). The primary aim of this study is to describe HT's IPV training, knowledge of referrals, perceived preparedness and IPV inquiry. The secondary aim is to determine if preparedness and IPV inquiry are affected by training, IPV experience, and knowledge of referral options.

5.2 Methods

5.2.1 Recruitment

This study represents a secondary analysis of data previously published describing attitudes and beliefs about IPV (Sivagurunathan et al., 2019), focusing on data collected but not previously published. Ethics approval was obtained from the research ethics board at the McMaster University in Hamilton, Ontario. Following ethics approval,

participants in the study were all recruited through the email list of the Canadian and American Societies of HTs (CSHT and ASHT). Researchers contacted both societies to inform them about the study and asked to send out mass- email to their members. Both societies consented and sent out a mass email which contained the email link to the online questionnaire, which was hosted on LimeSurvey, a secure survey data collection platform. Two weeks following the initial recruitment email, a subsequent reminder email was sent out. The questionnaire was active for 3 months from February to April 2015.

5.2.2 Measures/Questionnaire

The survey was an amalgamation and modification of two previously published surveys by Maiuro et al.(2000) and Connor et al.(2011). The survey by Maiuro et al.(2000) had an item domain Cronbach alpha between 0.73 and 0.91 and an overall alpha of 0.88 and was intended to measure attitudes, beliefs, and self-reported behaviors related to the identification and management of IPV amongst primary health care providers. The Connor et al.(2011) survey measured readiness of healthcare students to deal with IPV and reported a Cronbach alpha scores greater than 0.7 (Connor et al., 2011). The primary modifications were a) changing the language from a physician focus to a therapist/allied health care provider focus, and b) omitting questions addressing knowledge and behaviours outside of the role of a therapist such as pregnancy care. The final modified version of the survey contained questions from following seven domains: (1) perceived self-efficacy about managing IPV within the context of their practice, (2) access to services for persons after IPV, (3) victim blaming attitudes/beliefs, (4) professional role resistance, (5) client and provider safety (6) frequency of IPV inquiry and (7) perceived

preparedness. The self-reported frequency of IPV assessment was based on 3 questions, each rated on a 5-point Likert-scale ranging from 1= never to 5 = always. Perceived preparedness was evaluated based on 12 questions, each rated on a 7-point scale with 1= not prepared to 7 = quite well prepared. For the purposes of the current study, only questions on perceived preparedness and frequency of IPV inquiry are reported: questions from domain 1-5 are reported elsewhere(Sivagurunathan et al., 2019). Additionally, the survey collected demographic data on the participants and had a comments section encouraging participants to share any additional detail on their experiences with IPV in their practices.

5.2.3 Data Analysis

All statistical analyses were performed using SPSS version 24.0 (SPSS Inc, Chicago, IL). Data were checked for normality distribution and outliers.

Normality was assessed using the Shapiro-Wilk test. Results showed that perceived preparedness ($W(172) = 0.87, p < 0.001$), IPV assessment ($W(171) = 0.59, p < 0.001$), and IPV Training ($W(180) = 0.2, p < 0.001$) were not normally distributed.

Transformations were attempted, however, the data remained skewed despite transformations. Descriptive analysis was performed on number of hours of IPV training, perceived preparedness, knowledge of available referrals, and frequency of IPV assessment in the past three months by therapists. Due to fact that perceived preparedness and IPV assessment remained skewed, non-parametric Mann-Whitney analysis was used to examine if there were differences in therapists' perceived preparedness and frequency of IPV inquiry in the past three months based on experiences of IPV (first-hand, family

and/or friends, or client experience of IPV vs no experience) and IPV training (training vs no training), knowledge of referrals (no/unsure vs yes).

5.3 Results

5.3.1 Response Rate and Missing Data

The combined membership of CSHT and ASHT provided a potential list of 3,256 participants. However, as some participants may have been in both societies or not have registered their emails with the society, the number of persons who received the email may have been less. A total of 232 participants responded to the survey, resulting in an estimated minimum response rate of 7.1%. Of the 232 surveys, 45 (19.4%) had incomplete data with only full or partial demographics, and without any responses to the main questions. After removing these incomplete responses, the resulting final sample size was 189 (minimum response rate: 5.8%). For the purpose of data analysis, data sets missing more than 1 item per scale were removed from analysis for that scale. The response of 189 participants results in a 95% confidence level and 7% margin of error.

5.3.2 Participants

The final sample consisted of 189 participants, of which 165 (89%) were women. Participants were between ages of 24 and 73. The majority of the participants were OTs (N= 160) with 152 (81%) practicing as Certified HTs. On average, participants had been practicing for 24 years, with 161 (85.2%) working in the U.S. For a complete list of demographic data see Table 5-1.

Table 5-1: Participant Demographics

Characteristics	Description
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Median Age (Range)	49 (24-73)
Gender (%)	
Male	20 (10.8)
Female	165 (89.2)
Degree (%)	
PhD	21 (11.5)
MSc	72 (39.3)
BSc	90 (49.2)
Profession (%)	
PT	24 (13)
OT	160 (86.5)
Mean Years of Practice (SD)	23.7 (10.4)
Mean Years of HT (SD)	17.6 (10)
Relationship Status (%)	
Single	20 (10.8)
Common Law	5 (2.7)
Married	140 (75.3)
Separated	1 (0.5)
Divorced	18 (9.7)
Widowed	2 (1.1)
Practice Setting (%)	
Urban	82 (43.6)
Small Town	21 (11.2)
Suburban	71 (37.8)
Rural	12 (6.4)
Other	2 (1.1)
Previous experience with IPV (%)	
Client	75 (41.7)
Family member or friend	32 (17.8)
First-Hand	12 (6.7)
None	61 (33.9)
Country of Practice (%)	
Canada	28 (14.8)
United States	161 (85.2)
Hand Therapy Certification status (%)	
Certified Hand Therapist	152 (81.3)
Not Certified	35 (18.7)

5.3.3 Descriptive analysis

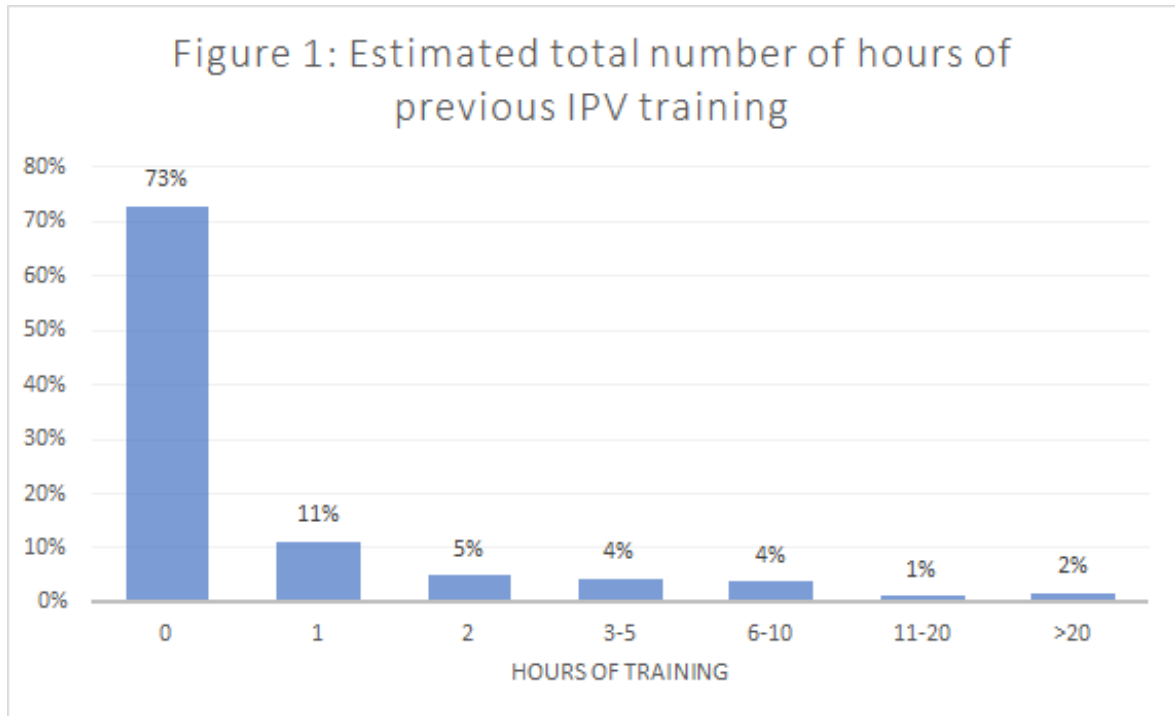
On average HTs reported 1.74 hours of IPV training. However, the majority of HTs 131 (73%) indicated they had 0 hours of IPV training; and of the 49 (27%) HTs with IPV training, 1 Hand Therapist had 100 hours of training (See Figure 5-1). Generally, HTs

indicated very low rates of IPV assessment in their clinic. Of the 171 participants responding to this question, 114 (66%) HTs indicated they had not assessed for IPV in their client population in the past 3 months, while 7 HTs (4.1%) indicated they always assessed for IPV. The majority of HTs (70%) indicated they had never assessed for IPV in patients presenting with injuries, while 73.5% had never assessed clients presenting with chronic pain, and 77% never assessed for IPV in clients presenting with comorbidities of headache, depression and/or anxiety in the past 3 months. On average, HTs indicated minimal preparedness (Median = 2.1/7) across all IPV related activities, with therapists' perceived preparedness being highest in appropriately responding to disclosure of IPV (Median = 3/7) (See Table 5-2 for complete descriptions). In terms of knowledge of referrals, the majority of HTs (59.3%) felt they did not have adequate knowledge of referral resources for patients in their community, while 21.5% felt they had adequate knowledge of referral, and 19.2% were unsure.

Table 5-2: Perceived Preparedness Scale

Items	Number (%) of Respondents						
	1	2	3	4	5	6	7
Ask appropriate questions about IPV (n=175)	53 (30.3)	50 (28.6)	30 (17.1)	16 (9.1)	18 (10.3)	6 (3.4)	2 (1.1)
Appropriately respond to disclosures of abuse (n=175)	26 (14.9)	41 (23.4)	40 (22.9)	29 (16.6)	19 (10.9)	15 (8.6)	5 (2.9)
Identify IPV indicators based on patient history and physical examination (n=175)	29 (16.6)	59 (33.7)	33 (18.9)	24 (13.7)	19 (10.9)	6 (3.4)	5 (2.9)
Assess an IPV victim's readiness to change (n=173)	93 (53.8)	35 (20.2)	22 (12.7)	11 (6.4)	5 (2.9)	6 (3.5)	1 (0.6)
Help an IPV victim assess his/her danger of lethality (n=174)	100 (57.5)	33 (19)	18 (10.3)	8 (4.6)	7 (4)	7 (7)	1 (0.6)

Conduct a safety assessment for the victim's children (n=173)	121 (69.9)	25 (14.5)	16 (9.2)	6 (3.5)	0 (0)	4 (2.3)	1 (0.6)
Help an IPV victim create a safety plan (n=172)	105 (61)	44 (25.6)	9 (5.2)	6 (3.5)	3 (1.7)	4 (2.3)	1 (0.6)
Document IPV history and physical examination findings in patient's chart (n=173)	58 (33.5)	44 (25.4)	20 (11.6)	20 (11.6)	9 (5.2)	14 (8.1)	8 (4.6)
Make appropriate referrals for IPV (n=174)	45 (25.9)	50 (28.7)	22 (12.6)	26 (14.9)	12 (6.9)	11 (6.3)	8 (4.6)
Fulfill state or provincial reporting requirements for IPV (n=171)	75 (43.9)	32 (18.7)	17 (9.9)	16 (9.4)	5 (2.9)	12 (7)	14 (8.2)
Fulfill state or provincial reporting requirements for child abuse (n=172)	59 (34.3)	38 (22.1)	18 (10.5)	14 (8.1)	9 (5.2)	16 (9.3)	18 (10.5)
Fulfill state or provincial reporting requirements for elder abuse (n=172)	61 (35.5)	38 (22.1)	17 (9.9)	11 (6.4)	11 (6.4)	17 (9.9)	17 (9.9)
1: Not prepared; 2: Minimally prepared; 3: Slightly prepared; 4: Moderately prepared; 5: Fairly well prepared; 6: Well prepared; 7: Quite well prepared							

Figure 5-1: IPV Violence Training Amongst HTs

5.3.4 Mann-Whitney Analysis

Hand therapists with IPV training (Median = 1; mean rank= 96.1) were more likely to ask patients about possibility of IPV in the past three months compared to HTs without IPV training (Median = 1; mean rank= 80.6). Results indicate that Mann-Whitney U value was statistically significant with $U = 2370$, $p = 0.03$ (See Table 5-3). Findings also indicate HTs with IPV training (Median= 3.1, mean rank = 114.3) have higher perceptions of preparedness when compared to HTs without training (Median= 1.8, mean rank = 76), $U = 1630$, $p < 0.001$.

Secondly, Mann-Whitney analysis was performed to examine the differences in IPV assessment and perceived preparedness based on IPV experience. Both IPV assessment

and perceived preparedness were found to be significantly different based on effects of IPV experience (See Table 5-3). HTs with experience of IPV (Median = 1; mean rank= 91.6) were more likely to ask patients about possibility of IPV in the past three months compared to HTs without experience of IPV (Median = 1; mean rank= 61.9), $U=1865$, $p < 0.001$. HTs with experience of IPV (Median=2.4; mean rank=93.5) scored higher on perceived preparedness than HTs without any experience of IPV (Median=1.7; mean rank=59.4) $U=1724.5$, $p < 0.001$.

Finally, differences in IPV assessment and perceived preparedness based on knowledge of referral sources available to HTs was examined using Mann-Whitney analysis (See Table 5-3). HTs with knowledge of where referrals could be sent (Median = 1.2; mean rank= 101.9) were more likely to assess for IPV in their client population in comparison to HTs without knowledge of referral (Median = 1; mean rank= 79.4), $U=1651$, $p = 0.004$. In HTs with knowledge of referral potential (Median = 3.6; mean rank= 123.2) had higher levels of perceived preparedness in comparison to HTs without knowledge of referral (Median = 1.9; mean rank= 76.4): this was statistically significant with $U= 1079.5$, $p<0.001$.

Table 5-3: Mann-Whitney Analysis of Group Differences

	Count	Mean Rank	Kruskal Wallis-H	Asymp. Sig. (2 Tailed)
IPV Assessment				
Training	169		2370	0.03
Yes	48	96.1		
No	121	80.6		
IPV Experience	162		1865	<0.001
Yes	107	91.6		
No	55	61.9		
Knowledge of referrals	167		1651	0.004

Yes	34	101.9		
No/Unsure	133	79.4		
Preparedness				
Training	172		1630	< 0.001
Yes	47	114.3		
No	125	76		
IPV Experience	163		1724.5	<0.001
Yes	108	93.5		
No	55	59.4		
Knowledge of referrals	171		1079.5	<0.001
Yes	35	123.2		
No/Unsure	136	76.4		

5.4 Discussion

This study suggests HTs have generally low levels of perceived preparedness, and most do not assess for IPV in patients with injuries, even with comorbidities of chronic pain, or the triad of headache, depression and anxiety. The low levels of preparedness and low frequency of IPV assessment amongst HTs are similar to previous studies on IPV inquiry by primary care providers (Beccaria et al., 2013; Maiuro et al., 2000; Rasoulilian et al., 2014), surgical residents and medical students (Conn et al., 2014; Sprague, Kaloty, et al., 2013), and paramedic students (Sawyer et al., 2017) also conveyed in the North American context. Given the low level of IPV inquiry and preparedness reported here, we are unable to predict if gender, or spending more time with their patients might facilitate disclosure of IPV.

In terms of IPV inquiry, the majority of participants indicated they had not assessed for IPV in their practice in the past three months, regardless of whether the patient presented with injury, chronic pain or comorbidities of headache, depression and anxiety. This is concerning since studies have found chronic pain, and comorbidities of headache, depression and anxiety are common amongst victims of IPV (Karakurt et al., 2014). We

posit this lack of IPV assessment may be due to the lack of training: HTs may not be aware about the symptoms associated with IPV. Previous studies on primary care providers show an increase in IPV inquiry following training (Maiuro et al., 2000). Additionally, results from the current study found therapists with IPV experience (personal or professional) showed significantly higher rates of assessment for IPV compared to therapists without IPV experience. This may reflect that previous experience with IPV increased therapists' awareness of risk factors, or positive perceptions of the value of IPV assessment. Finally, HTs with knowledge of referral options were more likely to assess for IPV in their client population. This is similar to previous studies which report one of the barriers to clinicians asking about IPV is the lack of referral resources (Colarossi et al., 2010; Sormanti & Smith, 2010). Clinicians may be more reluctant to assess for problems, should they have no solutions or resource where they can refer the patient for appropriate management.

The current study indicates a significant positive association between IPV training and preparedness. These findings are congruent with results from studies on physicians and nurses (Gutmanis et al., 2007; Papadakaki et al., 2013), dental students (McAndrew et al., 2014), and paramedic students (Sawyer et al., 2017). For example, the study by Gutmanis et al. (2007) found a significant increase in preparedness scores amongst physicians and nurses with training. Gutmanis et al. (2007) also reported higher preparedness scores in professionals with IPV experience regardless of training: we also saw significant differences in perceived preparedness amongst HTs with experience of IPV compared to HTs without any IPV related experience. We posit that previous experience with IPV, whether it be personal, family, friends or a client, instigated HTs to seek out resources

and ways to deal with the IPV experience. As such, this appeared to result in HTs with experiences of IPV feeling more prepared to deal with such disclosure in their clinical setting, compared to those without any experience of IPV.

5.4.1 Relevance to Hand Therapy Practice

Our previous study (Sivagurunathan et al., 2019) noted that HTs may be uniquely positioned to deal with IPV due to the nature of their occupation and the amount of time HTs spend with their patient population. However, these findings indicate the majority of HTs reported low rates of IPV inquiry in their clinical setting in the past three months. This low level of IPV assessment may be due to the low levels of training and preparedness reported by HTs in the study. While results from the current study indicate training is significantly related to preparedness and IPV assessment, 131 (73%) of HTs reported received zero hours of IPV training. Therefore, it is imperative that HTs receive adequate IPV training during their clinical and graduate education as well as be provided with opportunities for ongoing training on dealing with IPV in their client population. This echoes a previous call for more training in physiotherapy professional preparation programs (Walton et al., 2015). Previous findings suggest that preparedness is a key construct in IPV assessment amongst nurses (Gutmanis et al., 2007), surgeons (Bhandari et al., 2008), and surgical trainees (Sormanti & Smith, 2010). Finally, findings also highlight the importance of creating networks that connect clinicians with organizations providing non-healthcare based resources. Many HTs reported a lack of awareness and resources available for clients with IPV, and as such collaborations between HTs and organizations providing resources to individuals who experience IPV are important. We hope the awareness generated by this research will spur therapists to increase personal

knowledge about IPV in response to this identified gap. Finally, networks that bring together HTs and organizations providing IPV related services could result in clients with IPV receiving the needed referrals to appropriate providers offering services including shelters, counselling and support groups.

5.4.2 Strengths and Limitations

Studies on HT's assessment of IPV victimization, preparedness and training are absent from the current literature; therefore, this study addresses a significant knowledge gap. Additionally, the questions employed by the current survey are from two standardized surveys that have been previously validated. However, it is important to note these surveys represent a binary view of gender and may represent a bias towards representing the victims of IPV as female. Further, we did make minor alterations to the language of the surveys to tailor to a hand therapist population and did not generate new estimates for measurement properties through pilot testing.

One of the significant limitations was our inability to accurately calculate a response rate. We do not know the denominator to conduct a true calculation because we do not know how many email addresses were valid and were received. Many hospitals have aggressive firewalls that might filter out mass emails. Further, some people would have been members of both societies and double counted by simply adding the group memberships. Because of the privacy settings we chose to maintain absolute confidentiality, we were unable to ascertain if those that initially clicked on our email link and then failed to complete the survey were true non-responders, or if they returned later to complete the survey at a different time. Finally, while already low, this estimated response rate of 5.8% may be specifically be considered low. Previous surveys conducted with hand therapists

using similar recruitment methods report response rates ranging from 22% to 44% (Grice, 2015; Lucado et al., 2018; Valdes et al., 2017), with the average response rate for online surveys being 31% (Sheehan, 2006). Given that our response rate could be as low as 6% we cannot be confident that our results accurately represents the larger community of HTs. This likely represents a level of discomfort with the topic, which may result in a self-selection bias within the sample of participants. Further limiting generalizability, our sampling took place only in North America, although it is possible that international therapists also hold memberships in these societies and may have participated in the survey. Future research should seek to use different methodologies and sampling strategies to address these limitations.

Secondly, while this study examined IPV training amongst HTs, it did not include questions on HTs' attitudes regarding IPV training or specify the nature of the training previously received or desired. This detail would be crucial in planning additional support and ongoing training for this population.

5.4.3 Future Directions

Our results suggest hand therapists have not received adequate training to address IPV in their practices. Given that we also found training is significantly correlated with perceived preparedness and IPV assessment, further education about IPV aimed at HTs may be necessary. IPV training could be provided at the graduate level in professional preparation programs, as well as offered in continuing education opportunities. Training on how to assess for and address IPV when disclosure occurs is needed and may improve preparedness amongst HTs.

However, while previous work has found HTs believe dealing with IPV in their practice is part of their role (Sivagurunathan et al., 2019), further insights on HTs' attitudes towards IPV training is crucial to inform effective educational interventions. Therefore, HTs' attitudes towards training on dealing with IPV in their clinical setting should be examined before implementing training programs. Additionally, research aimed at exploring barriers to, and facilitators for accessing IPV training should be explored further to develop optimal training models for hand therapy practitioners. Both qualitative and quantitative explorations of these topics are justified to generate insights and inform the development of interventions. Finally, Cochrane review by Madden & Bhandari (2016) indicates that IPV assessment along with referrals is important for producing a positive impact in IPV victims: thus research on HTs and their referral practices is also warranted.

5.5 Conclusion

Training seems to play a significant role in hand therapists' perceived preparedness and IPV assessment practices. Further research on best methods for providing training to therapists is important to increase IPV assessment, leading to better referrals for hand therapy clients with IPV experience.

5.6 References

- Beccaria, G., Beccaria, L., Dawson, R., Gorman, D., Harris, J. A., & Hossain, D. (2013). Nursing student's perceptions and understanding of intimate partner violence. *Nurse Education Today*, *33*(8), 907–911. <https://doi.org/10.1016/j.nedt.2012.08.004>
- Bhandari, M., Dosanjh, S., Tornetta, P., & Matthews, D. (2006). Musculoskeletal Manifestations of Physical Abuse After Intimate Partner Violence. *The Journal of Trauma: Injury, Infection, and Critical Care*, *61*(6), 1473–1479. <https://doi.org/10.1097/01.ta.0000196419.36019.5a>

- Bhandari, M., Sprague, S., Tornetta, P., D'Aurora, V., Schemitsch, E., Shearer, H., Brink, O., Mathews, D., & Dosanjh, S. (2008). (Mis)Perceptions About Intimate Partner Violence in Women Presenting for Orthopaedic Care: A Survey of Canadian Orthopaedic Surgeons. *The Journal of Bone and Joint Surgery-American Volume*, *90*(7), 1590–1597. <https://doi.org/10.2106/JBJS.G.01188>
- Black, M. C. (2011). Intimate Partner Violence and Adverse Health Consequences. *American Journal of Lifestyle Medicine*, *5*(5), 428–439. <https://doi.org/10.1177/1559827611410265>
- Boyle, A., Robinson, S., & Atkinson, P. (2004). Domestic violence in emergency medicine patients. *Emergency Medicine Journal*, *21*(1), 9–13. <https://doi.org/10.1136/emj.2003.007591>
- Breiding, M. J., Black, M. C., & Ryan, G. W. (2008a). Prevalence and Risk Factors of Intimate Partner Violence in Eighteen U.S. States/Territories, 2005. *American Journal of Preventive Medicine*, *34*(2), 112–118. <https://doi.org/10.1016/j.amepre.2007.10.001>
- Breiding, M. J., Black, M. C., & Ryan, G. W. (2008b). Chronic Disease and Health Risk Behaviors Associated with Intimate Partner Violence—18 U.S. States/Territories, 2005. *Annals of Epidemiology*, *18*(7), 538–544. <https://doi.org/10.1016/j.annepidem.2008.02.005>
- Burczycka, M., & Conroy, S. (2017). Family violence in Canada: A statistical profile, 2015. *Juristat: Canadian Centre for Justice Statistics*, *37*(1), 108. <https://www.publicsafety.gc.ca/lbrr/archives/jrst11643-eng.pdf>
- Colarossi, L., Breitbart, V., & Betancourt, G. (2010). Barriers to Screening for Intimate Partner Violence: A Mixed-Methods Study of Providers In Family Planning Clinics. *Perspectives on Sexual and Reproductive Health*, *42*(4), 236–243. <https://doi.org/10.1363/4223610>
- Conn, L. G., Young, A., Rotstein, O. D., & Schemitsch, E. (2014). I've never asked one question." Understanding the barriers among orthopedic surgery residents to screening female patients for intimate partner violence. *Canadian Journal of Surgery*, *57*(6), 371–378. <https://doi.org/10.1503/cjs.000714>
- Connor, P. D., Nouer, S. S., Mackey, S. T. N., Tipton, N. G., & Lloyd, A. K. (2011). Psychometric properties of an intimate partner violence tool for health care students. *Journal of Interpersonal Violence*, *26*(5), 1012–1035. <https://doi.org/10.1177/0886260510365872>
- Della Rocca, G. J., Sprague, S., Dosanjh, S., Schemitsch, E. H., & Bhandari, M. (2013). Orthopaedic surgeons' knowledge and misconceptions in the identification of intimate partner violence against women trauma. *Clinical Orthopaedics and Related Research*, *471*(4), 1074–1080. <https://doi.org/10.1007/s11999-012-2749-x>

- Devries, K. M., Mak, J. Y. T., García-Moreno, C., Petzold, M., Child, J. C., Falder, G., Lim, S., Bacchus, L. J., Engell, R. E., Rosenfeld, L., Pallitto, C., Vos, T., Abrahams, N., & Watts, C. H. (2013). The Global Prevalence of Intimate Partner Violence Against Women. *Science*, *340*(6140), 1527–1528. <https://doi.org/10.1126/science.1240937>
- Dude, A. (2007). Intimate partner violence and increased lifetime risk of sexually transmitted infection among women in Ukraine. *Studies in Family Planning*, *38*(2), 89–100. <https://doi.org/10.1111/j.1728-4465.2007.00120.x>
- Grice, K. O. (2015). The use of occupation-based assessments and intervention in the hand therapy setting - A survey. *Journal of Hand Therapy*, *28*(3), 300–306. <https://doi.org/10.1016/j.jht.2015.01.005>
- Gutmanis, I., Beynon, C., Tutty, L., Wathen, C. N., & MacMillan, H. L. (2007). Factors influencing identification of and response to intimate partner violence: a survey of physicians and nurses. *BMC Public Health*, *7*(1), 12. <https://doi.org/10.1186/1471-2458-7-12>
- Hines, D. A., & Douglas, E. M. (2015). Health problems of partner violence victims: Comparing help-seeking men to a population-based sample. *American Journal of Preventive Medicine*, *48*(2), 136–144. <https://doi.org/10.1016/j.amepre.2014.08.022>
- Jewkes, R., Fulu, E., Tabassam Naved, R., Chirwa, E., Dunkle, K., Haardörfer, R., & Garcia-Moreno, C. (2017). Women’s and men’s reports of past-year prevalence of intimate partner violence and rape and women’s risk factors for intimate partner violence: A multicountry cross-sectional study in Asia and the Pacific. *PLoS Medicine*, *14*(9), 1–20. <https://doi.org/10.1371/journal.pmed.1002381>
- Karakurt, G., Smith, D., & Whiting, J. (2014). Impact of Intimate Partner Violence on Women’s Mental Health. *Journal of Family Violence*, *29*(7), 693–702. <https://doi.org/10.1007/s10896-014-9633-2>
- Lucado, A. M., Taylor, D. W., Wendland, D. M., & Connors, B. (2018). Health promotion, wellness, and prevention in hand therapy: A survey study. *Journal of Hand Therapy*, *31*(1), 59–67. <https://doi.org/10.1016/j.jht.2016.11.007>
- Madden, K., & Bhandari, M. (2016). Cochrane in CORR® : Screening Women for Intimate Partner Violence in Healthcare Settings (Review). *Clinical Orthopaedics and Related Research*, *474*(9), 1897–1903. <https://doi.org/10.1007/s11999-016-4957-2>
- Maiuro, R. D., Vitaliano, P. P., Sugg, N. K., Thompson, D. C., Rivara, F. P., & Thompson, R. S. (2000). Development of a health care provider survey for domestic violence: Psychometric properties. *American Journal of Preventive Medicine*, *19*(4), 245–252. [https://doi.org/10.1016/S0749-3797\(00\)00230-0](https://doi.org/10.1016/S0749-3797(00)00230-0)
- McAndrew, M., Pierre, G. C., & Kojanis, L. C. (2014). Effectiveness of an online tutorial

- on intimate partner violence for dental students: a pilot study. *Journal of Dental Education*, 78(8), 1176–1181. <https://doi.org/10.1002/j.0022-0337.2014.78.8.tb05789.x>
- Muelleman, R. L., Lenaghan, P. A., & Pakieser, R. A. (1996). Battered women: Injury locations and types. *Annals of Emergency Medicine*, 28(5), 486–492. [https://doi.org/10.1016/S0196-0644\(96\)70110-5](https://doi.org/10.1016/S0196-0644(96)70110-5)
- Papadakaki, M., Petridou, E., Kogevinas, M., & Lionis, C. (2013). Measuring the effectiveness of an intensive IPV training program offered to Greek general practitioners and residents of general practice. *BMC Medical Education*, 13(1), 1. <https://doi.org/10.1186/1472-6920-13-46>
- Rasoulilian, M., Shirazi, M., & Nojomi, M. (2014). Primary health care physicians' approach toward domestic violence in Tehran, Iran. *Medical Journal of the Islamic Republic of Iran*, 28(1), 148. <http://www.ncbi.nlm.nih.gov/pubmed/25695006>
- Rioli, G., Sgarbi, C., Moretti, V., Sinisi, A., De Fazio, L., Giambalvo, N., Ferrari, S., & Galeazzi, G. M. (2017). An update on intimate partner violence and mental health. *Minerva Psichiatrica*, 58(4), 216–233. <https://doi.org/10.23736/S0391-1772.17.01943-4>
- Riviello, R. J. (2009). *Manual of Forensic Emergency Medicine*. Jones and Bartlett Publishers.
- Sawyer, S., Coles, J., Williams, A., Lucas, P., & Williams, B. (2017). Paramedic Students' Knowledge, Attitudes, and Preparedness to Manage Intimate Partner Violence Patients. *Prehospital Emergency Care*, 21(6), 750–760. <https://doi.org/10.1080/10903127.2017.1332125>
- Sheehan, K. B. (2006). E-mail Survey Response Rates: A Review. *Journal of Computer-Mediated Communication*, 6(2), 0. <https://doi.org/10.1111/j.1083-6101.2001.tb00117.x>
- Sivagurunathan, M., Packham, T., Dimopoulos, L., Murray, R., Madden, K., & MacDermid, J. C. (2019). Hand therapists' attitudes, environmental supports, and self-efficacy regarding intimate partner violence in their practice. *Journal of Hand Therapy*, 32(3), 353–360. <https://doi.org/10.1016/j.jht.2017.11.042>
- Sormanti, M., & Smith, E. (2010). Intimate partner violence screening in the emergency department: U.S. medical residents' perspectives. *International Quarterly of Community Health Education*, 30(1), 21–40. <https://doi.org/10.2190/IQ.30.1.c>
- Sprague, S., Kaloty, R., Madden, K., Dosanjh, S., Mathews, D. J., & Bhandari, M. (2013). Perceptions of Intimate Partner Violence: a cross sectional survey of surgical residents and medical students. *Journal of Injury and Violence Research*, 5(1), 2–10. <https://doi.org/10.5249/jivr.v5i1.147>

- Sprague, S., Madden, K., Dosanjh, S., Godin, K., Goslings, J. C., Schemitsch, E. H., & Bhandari, M. (2013). Intimate partner violence and musculoskeletal injury: Bridging the knowledge gap in orthopaedic fracture clinics. *BMC Musculoskeletal Disorders*, *14*(1), 1. <https://doi.org/10.1186/1471-2474-14-23>
- Sprague, S., Swinton, M., Madden, K., Swaleh, R., Goslings, J. C., Petrisor, B., & Bhandari, M. (2013). Barriers to and facilitators for screening women for intimate partner violence in surgical fracture clinics: A qualitative descriptive approach. *BMC Musculoskeletal Disorders*, *14*, 1–10. <https://doi.org/10.1186/1471-2474-14-122>
- Usta, J., Feder, G., & Antoun, J. (2014). Attitudes towards domestic violence in Lebanon: A qualitative study of primary care practitioners. *British Journal of General Practice*, *64*(623), 313–320. <https://doi.org/10.3399/bjgp14X680077>
- Valdes, K., Szekeres, M., & MacDermid, J. C. (2017). Hand therapists report perceived differences in patient referrals from hand surgeons vs other referral sources: A survey study. *Journal of Hand Therapy*, *30*(3), 314–319. <https://doi.org/10.1016/j.jht.2017.02.008>
- Walton, L. M., Aerts, F., Burkhart, H., & Terry, T. (2015). Intimate Partner Violence Screening and Implications for Health Care Providers. *Online Journal of Health Ethics*, *11*(1). <https://doi.org/10.18785/ojhe.1101.05>
- WHO. (2013). *Responding to intimate partner violence and sexual violence against women WHO clinical and policy guidelines*. www.who.int/reproductivehealth

Chapter 6

6 Patient Attitudes Regarding Intimate Partner Violence Inquiry in Upper Extremity Specialty Clinic

6.1 Introduction

According to a Statistics Canada report, in 2017, 45% of women and 14% of men reported to police as having experienced intimate partner violence (IPV) (Burczycka et al., 2018). However, the true prevalence rate of IPV maybe higher, as studies show that disclosure rates for IPV is low in both men and women (Chan, 2011).

IPV is associated with extensive costs for both society and survivors of IPV. These costs include both immediate and long-term health consequences. IPV may result in negative physical and psychological health outcomes including physical health problems such as high cholesterol, asthma, sexually transmitted infections (STIs), diabetes, hypertension, and chronic pain, (L. J. Bacchus et al., 2018; Breiding et al., 2008b; Hawcroft et al., 2019) as well as mental health problems, including depressive symptoms, postpartum depression, sleep problems, suicidal thoughts and attempts, and anxiety. (L. J. Bacchus et al., 2018; Hawcroft et al., 2019) Furthermore, IPV experiences may result in survivors engaging in negative health behaviours such as drinking, smoking, illicit drug use, and unsafe sexual practices (L. J. Bacchus et al., 2018; Breiding et al., 2008b), which may further exacerbate the adverse health outcomes for IPV survivors. In addition to the health impacts of IPV it can also result in economic costs to survivors and society. IPV experiences may impact job stability and education attainment, (Adams et al., 2012) as well as housing instability (Pavao et al., 2007). A

study by Peterson et al. (2018) found that in the United States the lifetime costs associated with IPV were \$103,767 per female victim and \$23,414 per male victim .

The high rates of physical and mental health problems as well as negative health behaviours may result in higher health service utilizations in people with IPV experiences (Dichter et al., 2018; Logeais et al., 2019). These health service utilizations may continue even after the cessation of IPV (Fishman et al., 2010). However, while survivors of IPV are more likely to utilize health services, prior survey research indicates that many clinicians are not adequately aware of the prevalence rate of patients with IPV presenting in their clinic (Bhandari et al., 2008; Shearer & Bhandari, 2008). For example, 87% of orthopaedic surgeons in a study by Bhandari et al. believed that less than 1% of women in their practice were victims of IPV (Bhandari et al., 2008). Similarly, a more recent study found 57% of doctors and 15% of nurses thought IPV prevalence rate amongst orthopaedic trauma patients was less than 1% (Downie et al., 2019). This contrasts with actual rates reported by studies such as Petrisor et al. (2013) who found that amongst women attending orthopaedic clinics 16% experienced IPV in the past 12 months and 35% have experienced IPV in their lifetime.

One of the major reasons for this lack of awareness may be due to low rates of IPV identification amongst clinicians. For example Rasoulilian et al. (2014) found that screening for IPV occurs less often than screening for other health risk factors (10% vs 29-48%). Previous studies have extensively examined barriers to IPV inquiry amongst clinicians (Sprague et al., 2012). Fear of offending the patient was identified as a common barrier to IPV inquiry amongst orthopaedic surgeons (Bhandari et al., 2008; Della Rocca et al., 2013), chiropractors (Shearer & Bhandari, 2008), surgical residents

and medical students (Sprague, Kaloty, et al., 2013), nurses (Downie et al., 2019), as well as hand therapists (Sivagurunathan et al., 2019).

While research on men and their attitudes regarding clinicians assessing for IPV is limited, multiple studies have examined women's attitudes regarding clinicians screening for IPV in various clinical settings (L. Bacchus et al., 2002; Koziol-McLain et al., 2008; Spangaro et al., 2010; Usta et al., 2012; Webster et al., 2001). Findings indicate that women had positive opinions about health care providers asking about IPV in the clinic. For example Gielen et al. (2000) found 86% of the women in their sample thought it would be easier for women to get help addressing the IPV with routine screening. Similarly, a qualitative study by Usta et al. (2012) found that women trusted their primary care physicians and felt positively about routine IPV screening. However, results from these settings may not be generalizable to the perceptions of clients who utilize service of orthopaedic clinics. Since orthopaedic clinics are often fast paced, involve transient relationships, have a high percentage of older patients, and include persons with acute injuries as well as degenerative diseases, the level of comfort with IPV assessment may be influenced by these contextual factors.

Musculoskeletal injuries have been reported as the second most common injury resulting from IPV (Bhandari et al., 2006; Sprague, Madden, et al., 2013). Therefore, it seems reasonable that clinicians in orthopaedic trauma units should be ready and able to conduct IPV assessment, though prior research indicates that this does not appear to be consistently done (Bhandari et al., 2008; Della Rocca et al., 2013; Sivagurunathan et al., 2018).

Policies on universal or routine screening for IPV are varied, with the US Preventive Services Task Force recommending screening for IPV in women of reproductive age (Curry et al., 2018), while The Canadian Task Force on Preventive Health Care and the World Health Organization (WHO) do not currently recommend universal screening (WHO, 2013). WHO does, however, suggest that clinicians be prepared to ask about IPV history when “assessing conditions that may be caused or complicated by intimate partner violence” (WHO, 2011, p.3). Previous study showed that majority of hand therapists felt dealing with IPV in their clinic is part of their job responsibility (m= 3.8/5). HTs may be in a unique position to deal with IPV, due to high rates of musculoskeletal injury associated with IPV, and the amount of time HTs spend with their patients. As such the current study sought to (1) explore the attitudes of patients presenting at an upper extremity specialty clinic regarding clinicians assessing for abuse, and (2) identify gender differences in attitudes towards abuse inquiry amongst those presenting to an upper extremity specialty clinic staffed by hand therapists (OT and PT), orthopaedic surgeons, and plastic surgeons for either surgical or non-surgical interventions. .

6.2 Methods

6.2.1 Recruitment

Participants for the study were recruited from an upper extremity specialty clinic located in London, Ontario. The upper extremity specialty clinic is a regional centre that draws both urban and rural clients. Ethics approval for the study was obtained from the research ethics board at Western University. Research assistants approached patients who presented at the clinic and informed them that a study was being conducted and enquired

if they were interested in participating. If the person expressed interest in participating in the study, they were provided with the survey and letter of information and advised to drop off the completed anonymous survey in the drop box that was available at the clinic's reception area. In order to be included in the study the patient had to be (1) over the age of 18, (2) presenting at the clinic for their own appointment, and (3) able to read, understand, and write in English.

6.2.2 Measures

The survey was developed in collaboration with an occupational therapist, a hand therapist, and a health literacy specialist.

The first author developed the survey, in collaboration with experts in the field of sex and gender research (J.M.), and hand therapy (T.P.). Once the survey was developed, it was reviewed by a health literacy specialist. The survey was then modified based on the health literacy specialist's feedback to support a higher completion rate and ease of understanding. The final survey consisted of 21 close-ended questions and explored: (1) attitudes regarding IPV and personal violence (PV) assessment (2) perceptions regarding whether other patients would be offended by clinician inquiry of IPV, sexual abuse (SA), and child abuse (CA) victimization, and (3) patient reported pain scores. Additional variables collected included non-identifying demographic information (i.e., gender, age, and marital status, language, ethnicity, and education). The survey was expected to take 30 minutes to complete.

6.2.3 Statistical Analysis

All responses from surveys that were returned to the drop box were entered into SPSS and descriptive analyses were performed on all variables.

Chi-Square analysis was used to examine if there were differences in participants' perceptions regarding whether other people would be embarrassed by clinicians' assessment of IPV, sexual abuse, and child abuse victimization, as well as participants' perceptions regarding routine screening for IPV in patients with current injury and routine screening for past abuse history based on comparison groups defined by gender (male/female) and presenting to the clinic with an injury (yes/no). Statistical analyses were conducted using SPSS statistical package version 24.0 (SPSS Inc, Chicago, Ill). Two-tailed p-values were analyzed and findings with $p \leq 0.05$ were considered significant.

6.3 Results

6.3.1 Participants

Participants included 93 patients who were presenting at an upper extremity specialty clinic staffed by Hand Therapists (OTs and PTs), orthopaedic surgeons, and plastic surgeons. The majority (80%) of the participants were over the age of 45 (M age=58.2, Range= 18-90). The sample consisted of primarily married (59%), English speaking (83%), caucasian (80%) patients. For a complete list of demographic data, see Table 6-1.

Table 6-1: Demographics (n=93)	
Characteristics	n (%)
Gender	
Man	46 (49.5)
Woman	45 (48.4)
Prefer not to answer	2 (2.2)
Age	
18-24	6 (6.5)
25-44	13 (14.0)
45-64	33 (35.5)
Over 65	41 (44.1)
Marital Status	
Single	16 (17.2)
Married	55 (59.1)
Common Law	6 (6.5)

Separated	4 (4.3)
Divorced	4 (4.3)
Widowed	7 (7.5)
Language	
English	77 (82.8)
Arabic/Turkish/Persian	3 (3.2)
Hindi/Urdu/Punjabi/Bengali	1 (1.1)
Swahili	1 (1.1)
French/German/Dutch	6 (6.5)
Other	2 (2.2)
Ethnicity	
Caucasian	74 (79.6)
African-American	1 (1.1)
Hispanic-Latino	1 (1.1)
Middle-Eastern	4 (4.3)
Asian	2 (2.2)
Indigenous	2 (2.2)
Other	4 (4.3)
Educational Background	
Some Highschool	11 (11.8)
Highschool graduate or diploma	25 (26.9)
Trade/ Technical/ Vocational training	16 (17.2)
Some college or university	22 (23.7)
University Degree	13 (14.0)
* Responses do not total to n=93 or 100% due to missing participants	

6.3.2 Descriptive Analysis

Injury Characteristics

The majority of patients (55%) were presenting at the clinic because of an injury. Of those who were presenting to the clinic due to an injury, most of the injuries happened at the home (41%) followed by work (29%). Most injuries were attributed to something that they had been doing (73%). For a complete list of injury characteristics data, see Table 6-2.

Table 6-2: Information Regarding the Injury	
Characteristics	n (%)
Are you here because of an injury? (n= 93)	

Yes	51 (54.8)
No	40 (43.0)
Missing	2 (2.2)
Where did your injury happen? (n=51)	
Home	21 (41.2)
Work	15 (29.4)
Other	15 (29.4)
Did the injury happen because of something you were doing? (n=51)	
Yes	37 (72.5)
No	14 (27.5)
Did the injury happen because of the actions of someone else? (n=14)	
Yes-It was an accident	9 (64.3)
Yes – they caused the injury on purpose	0 (0)
No	4 (28.6)
Missing	1 (7.1)
If the injury happened because of someone else's actions who caused the injury? (n=9)	
Family member (parent, child, sibling)	0 (0)
Friend	1 (11.1)
Current or former partner/spouse	0 (0)
Caregiver	0 (0)
Others	7 (77.8)
Missing	1 (11.1)

Abuse Assessment

Participants who indicated they were presenting at the clinic due to an injury (n=51, See Table 6-2) were asked about whether they had been assessed for IPV and PV victimization by attending clinicians, and attitudes regarding IPV and PV assessments. Of the 51 participants who presented at the clinic due to an injury, the majority (83%) reported that neither their doctors nor hand therapists had asked if their injury was caused by their partner or spouse (See Table 6-3). In terms of patients being embarrassed by IPV assessment, the majority (83%) indicated that they would not be embarrassed if their doctor or hand therapists asked if their injury was caused by their partner or spouse (See

Table 6-3). Similarly, 85% reported that they would not be embarrassed if their doctor or hand therapists asked if their injury was caused by other types of personal violence (See Table 6-3).

Table 6-3: Assessment of Abuse (n=51)			
Characteristics	Man n (%)	Woman n (%)	Total n (%)
Did your doctor or hand therapist directly ask if your injury was caused by a partner or spouse?			
Yes – My doctor asked	1 (3.7)	1 (4.2)	2 (3.8)
Yes –My therapist asked	0	1 (4.2)	1 (1.9)
No	25 (92.6)	18 (75.0)	44 (83.0)
Would you be upset or embarrassed if a doctor or therapist asked you if your injury was caused by your partner or spouse?			
Yes	2 (7.4)	3 (12.5)	5 (9.4)
No	25 (92.6)	17 (70.8)	44 (83.0)
Would you be upset or embarrassed if your doctor or therapists asked you if your injury was caused by other types of personal violence?			
Yes	2 (7.4)	2 (8.3)	4 (7.5)
No	25 (92.6)	18 (75.0)	45 (84.9)
* Only participants who indicated they were presenting at the clinic due to an injury (answered “Yes” to question “Are you here because of an injury?”) were asked the questions above (n= 51)			
**Responses do not total to n=51 or 100% due to missing participants			

Perceptions Regarding Abuse Assessment

The majority of participants believed that other people would not be offended by clinicians asking them about IPV, sexual abuse, or child abuse (See Table 6-4).

Furthermore, the majority of participants also believed that clinicians should routinely ask if current injury was caused by IPV and routinely inquire about past abuse (See Table 6-4).

Table 6-4: Perceptions regarding assessment for abuse (n=93)			
Characteristics	Man n (%)	Woman n (%)	Total n (%)
Do you think that other people would be upset if their doctor or hand therapist asked them if			

they had ever been injured by their partner/spouse?			
Yes	17 (37.0)	15 (33.3)	33 (35.5)
No	27 (58.7)	22 (48.9)	49 (52.7)
Do you think that other people would be insulted if their doctor or hand therapist asked them if they had ever experienced sexual abuse?			
Yes	15 (32.6)	14 (31.1)	30 (32.3)
No	29 (63.0)	25 (55.5)	54 (58.1)
Do you think that other people would be insulted if their doctor or hand therapist asked them if they had ever experienced child abuse?			
Yes	15 (32.6)	16 (35.6)	32 (34.4)
No	28 (60.9)	23 (51.1)	51 (54.8)
Do you think doctors and therapists should routinely ask all people if their current injury was caused by someone else?			
Yes	35 (76.1)	35 (77.8)	72 (77.4)
No	11 (23.9)	8 (17.8)	19 (20.4)
Do you think doctors and therapists should routinely ask all clients if they have experienced abuse in their past? †			
Yes	21 (45.7)	30 (66.7)	53 (57.0)
No	23 (50.0)	13 (28.9)	36 (38.7)
* Responses do not total to n=93 or 100% due to missing participants			
†Significant gender differences p<0.05			

6.3.3 Chi-Square Analysis of Group Differences

Gender

The results of the Chi-Square test of association show that there is a significant association between gender and participant's belief that doctors, and HTs should routinely ask all clients if they had experienced abuse in their past ($X^2(1, N=93) = 4.36$, $p<0.05$). Women were more likely to report that clinicians should routinely screen for past abuse than men. Gender was not found to be significantly associated with any other perceptions regarding assessment.

Presenting to the clinic with an injury

Presenting at the clinic due to an injury was found to be significantly related to patient's perception of whether other people would be upset if their doctor or hand therapist asked them if they had been ever been injured by their partner/spouse ($X^2(1, N=81) = 5.76, p<0.05$). Patients who presented at the clinic due to an injury were more likely to believe that other people would be upset if their doctor or hand therapist asked them if they had ever been injured by their partner/spouse.

Additionally, the results of the Chi-Square test of association show that there is a significant association between presenting at the clinic due to an injury and a person's perception that doctors, and hand therapists should routinely ask all clients if they have experienced abuse in their past ($X^2(1, N=88) = 9.21, p<0.01$). Patients who did not present to the clinic with an injury were more likely to indicate that doctors and therapists should routinely screen all patients for past abuse.

Presenting at a clinic with an injury was not significantly associated with any other attitudes regarding abuse inquiry.

6.4 Discussion

A systematic review by Huntley et al. (2019) on male IPV survivors' help-seeking behaviour suggests that continuity of care is a facilitator for disclosure of IPV. As such, HTs who deal with patients on a longer basis maybe uniquely positioned to provider referral and support for male and female IPV survivors. However, the majority (n=44) of the participants who presented at the clinic due to an injury indicated that they had not been asked about IPV by either their doctor or HTs. This is in line with previous research

on hand therapists (Sivagurunathan et al., 2018), and orthopaedic surgeons (Della Rocca et al., 2013) which showed that hand therapists and orthopaedic surgeons are less likely to assess for IPV. However, more than 83% of patients presenting at the clinic with an injury felt they would not be embarrassed or upset if clinicians had assessed for IPV or other types of PV.

In terms of perceptions regarding abuse assessment, majority of participants felt that other people would not be embarrassed or upset by questions regarding IPV, child abuse and sexual abuse history. Similar to previous research on female IPV survivors, majority of the participants in the current study also found routine IPV screening to be acceptable (L. Bacchus et al., 2002; Usta et al., 2012; Webster et al., 2001). No gender differences were found in terms of perceptions regarding assessment for IPV, child abuse and sexual abuse. Both men and women believed that other people will not be offended by these questions. Furthermore, both men and women believed that clinicians should inquire if the current injury was caused by someone else. This indicates that both genders have a positive attitude towards assessment of abuse victimization. However, the study found significantly more woman felt that clinicians should ask if patients have experienced abuse in their past, than did men.

This study suggests that at upper extremity specialty clinics there is low prevalence of patients presenting with an injury as a result of IPV, since no cases of IPV were reported in a sample of 93 patients (0%). The current results conflict with previous studies in which 16-32% of women in orthopaedic patient populations had experienced IPV in the last 12 months (Bhandari et al., 2011; Petrisor et al., 2013). The lack of IPV reported in the current study may be attributed to multiple factors. Firstly, the sample

size of 93 is too small to detect low rates with precision. Furthermore, previous studies (Bhandari et al., 2011; Petrisor et al., 2013) in orthopaedic population examined the prevalence of IPV in the past 12 months or lifetime prevalence. In comparison, the current study sought to examine whether orthopaedic population was presenting at upper extremity specialty clinic as a direct result of IPV. Petrisor et al.(2013) found only 49 of the 2911 (2.7%) participants presenting at a fracture clinic had injuries directly related to IPV (Petrisor et al., 2013). Our lack of reporting may reflect the need for a much larger sample if rates are truly 1-2%. We think that if we had expanded the scope of the questions to capture 12 month and lifetime prevalence IPV rates that we would have found higher prevalence of IPV. Furthermore, studies have shown that men and women may take longer to disclose their IPV, as such it is possible that the lack of prevalence rates in the sample is due to lack of disclosure and the true prevalence rate of IPV in the current sample may be higher than findings indicate. Subsequently, we must interpret the findings of zero prevalence rate with caution.

The lack of patients presenting at clinic with injuries related to IPV in this sample may also be attributed to the demographic factors of this sample. A 2016 Census profile of the city of London, Ontario population showed that 20% reported being a visible minority, 20% had a mother tongue other than English, and 56% had post-secondary education. Our sample reflected these trends. Studies have shown being white (Yakubovich et al., 2018) or non-minority ethnic groups (Capaldi et al., 2012), having higher education level (Capaldi et al., 2012; Sanz-Barbero et al., 2019; Yakubovich et al., 2018), and being older (Sanz-Barbero et al., 2019; Yakubovich et al., 2018) all function as protective factors for IPV. Given that our current sample was a predominantly white,

highly educated, older age group, these combined protective factors may have resulted in lower IPV prevalence.

Despite majority of patients expressing positive attitudes regarding IPV assessment, it is important to note that a substantial minority indicated that they believed other patients would feel embarrassed about IPV, SA, or CA screening by clinicians. Similarly, while majority of patients in the current study felt clinicians should routinely ask if current injury was caused by someone else (77%), a large number (39%) indicated otherwise. These findings seem to support current clinical guidelines by WHO which suggests inquiring about IPV using a case-finding approach when risk factors are present. Furthermore, a recent systematic review (Feltner et al., 2018) shows universal screening to not be beneficial, with universal screening resulting in no significant reduction in IPV, improved quality of life, or better health outcomes. However, these findings are based on studies with only female participants. Future trials should aim to explore outcomes of screening and other forms of support for male IPV survivors. Future research should aim to explore how case-finding approach by clinicians may impact men and women's clinic attendance.

Given screening guidelines by WHO and The Canadian Task Force on Preventive Health Care as well as systematic reviews, a case-finding approach combined with appropriate therapeutic interventions may be more appropriate approach for IPV survivors presenting at HT clinics. Clinicians should be prepared to deal with patients presenting at the clinic with IPV related injuries and be able to provide appropriate referrals and services when disclosure occurs. Best practice guidelines for supporting

male IPV survivors is limited and, given some of the unique facets of male IPV experiences, a one-size-fits-all approach may not be appropriate. However, some approaches to supporting patients with IPV history such as LIVES (World Health Organization, 2014) and Trauma (and violence) Informed Care (TVIC) (EQUIP Healthcare, 2017) may result in better outcomes for both men and women.

Strengths and Limitations

This study contributes to further understanding of IPV and screening by collecting anonymous responses, which should have reduced social desirability bias. While multiple studies have examined women's perceptions regarding IPV inquiry in various clinical settings, (L. Bacchus et al., 2002; Koziol-McLain et al., 2008; Spangaro et al., 2010; Usta et al., 2012; Webster et al., 2001) male IPV victims' perceptions regarding IPV assessment is limited. This study is one of the few studies to examine men's attitudes regarding clinicians screening for abuse. Finally, while there seems to be an increasing awareness regarding IPV in hand therapy setting, research in the area is limited. These findings can serve to raise awareness amongst HTs and better prepare them for dealing with IPV in an appropriate manner.

However, this study also has limitations that should be considered when interpreting our findings. The major limitation was the sample size, which given the low rates of IPV as a source of presenting injury compromises the precision of this estimate for male or female victims. Additionally, we did not ask about IPV exposure in the past 12 months, so our estimates are not comparable to other work done in outpatient orthopaedic settings. Although we found a majority of patients supported screening and would feel comfortable if it was implemented, there was also a substantial minority who

felt other patients would feel embarrassed by screening, and our survey did not explore the reasons for these attitudes. Therefore, screening could be difficult to implement without further qualitative studies on what is needed to change attitudes or acceptance levels towards IPV screening. The highly homogenous sample (80% Caucasian 80% English) may also affect the generalizability of these findings.

6.5 Conclusion

While a majority of patients are comfortable with inquiring about abuse (IPV, CA, and SA), a substantial number of patients indicated that they believed others would feel embarrassed. Further qualitative studies are needed to better understand how IPV inquiry could best be implemented to meet the needs of men and women who either present with an IPV injury or have a history of abuse that might affect their recovery.

6.6 References

- Adams, A. E., Tolman, R. M., Bybee, D., Sullivan, C. M., & Kennedy, A. C. (2012). The Impact of Intimate Partner Violence on Low-Income Women's Economic Well-Being: The Mediating Role of Job Stability. *Violence Against Women, 18*(12), 1345–1367. <https://doi.org/10.1177/1077801212474294>
- Bacchus, L. J., Ranganathan, M., Watts, C., & Devries, K. (2018). Recent intimate partner violence against women and health: a systematic review and meta-analysis of cohort studies. *BMJ Open, 8*(7), e019995. <https://doi.org/10.1136/bmjopen-2017-019995>
- Bacchus, L., Mezey, G., & Bewley, S. (2002). Women's perceptions and experiences of routine enquiry for domestic violence in a maternity service. *BJOG: An International Journal of Obstetrics and Gynaecology, 109*(1), 9–16. <https://doi.org/10.1111/j.1471-0528.2002.00514.x>
- Bhandari, M., Dosanjh, S., Tornetta, P., & Matthews, D. (2006). Musculoskeletal Manifestations of Physical Abuse After Intimate Partner Violence. *The Journal of Trauma: Injury, Infection, and Critical Care, 61*(6), 1473–1479. <https://doi.org/10.1097/01.ta.0000196419.36019.5a>
- Bhandari, M., Sprague, S., Dosanjh, S., Petrisor, B., Resendes, S., Madden, K., &

- Schemitsch, E. H. (2011). The Prevalence of Intimate Partner Violence across Orthopaedic Fracture Clinics in Ontario. *The Journal of Bone and Joint Surgery-American Volume*, 93(2), 132–141. <https://doi.org/10.2106/JBJS.I.01713>
- Bhandari, M., Sprague, S., Tornetta, P., D'Aurora, V., Schemitsch, E., Shearer, H., Brink, O., Mathews, D., & Dosanjh, S. (2008). (Mis)Perceptions About Intimate Partner Violence in Women Presenting for Orthopaedic Care: A Survey of Canadian Orthopaedic Surgeons. *The Journal of Bone and Joint Surgery-American Volume*, 90(7), 1590–1597. <https://doi.org/10.2106/JBJS.G.01188>
- Breiding, M. J., Black, M. C., & Ryan, G. W. (2008). Chronic Disease and Health Risk Behaviors Associated with Intimate Partner Violence—18 U.S. States/Territories, 2005. *Annals of Epidemiology*, 18(7), 538–544. <https://doi.org/10.1016/j.annepidem.2008.02.005>
- Burczycka, M., Conroy, S., & Savage, L. (2018). Family violence in Canada: A statistical profile, 2017. *Juristat: Canadian Centre for Justice Statistics*, 38(1). <https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2018001/article/54978-eng.pdf?st=d0-rM50a>
- Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). # 4 A Systematic Review of Risk Factors for Intimate Partner Violence. *Partner Abuse*, 3(2), 1–27. <https://doi.org/10.1891/1946-6560.3.2.e4>
- Chan, K. L. (2011). Aggression and Violent Behavior Gender differences in self-reports of intimate partner violence : A review. *Aggression and Violent Behavior*, 16(2), 167–175. <https://doi.org/10.1016/j.avb.2011.02.008>
- Curry, S. J., Krist, A. H., Owens, D. K., Barry, M. J., Caughey, A. B., Davidson, K. W., Doubeni, C. A., Epling, J. W., Grossman, D. C., Kemper, A. R., Kubik, M., Kurth, A., Landefeld, C. S., Mangione, C. M., Silverstein, M., Simon, M. A., Tseng, C. W., & Wong, J. B. (2018). Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: US Preventive Services Task Force Final Recommendation Statement. *JAMA - Journal of the American Medical Association*, 320(16), 1678–1687. <https://doi.org/10.1001/jama.2018.14741>
- Della Rocca, G. J., Sprague, S., Dosanjh, S., Schemitsch, E. H., & Bhandari, M. (2013). Orthopaedic surgeons' knowledge and misconceptions in the identification of intimate partner violence against women trauma. *Clinical Orthopaedics and Related Research*, 471(4), 1074–1080. <https://doi.org/10.1007/s11999-012-2749-x>
- Dichter, M. E., Sorrentino, A. E., Haywood, T. N., Bellamy, S. L., Medvedeva, E., Roberts, C. B., & Iverson, K. M. (2018). Women's Healthcare Utilization Following Routine Screening for Past-Year Intimate Partner Violence in the Veterans Health Administration. *Journal of General Internal Medicine*, 33(6), 936–941. <https://doi.org/10.1007/s11606-018-4321-1>
- Downie, S., Madden, K., Bhandari, M., & Jariwala, A. (2019). A prospective

questionnaire-based study on staff awareness of intimate partner violence (IPV) in orthopaedic trauma patients. *Surgeon*, 17(4), 207–214.
<https://doi.org/10.1016/j.surge.2018.07.003>

EQUIP Healthcare. (2017). *Trauma-and-Violence-Informed Care (TVIC): A Tool for Health & Social Service Organizations and Providers*.
<https://equiphealthcare.ca/toolkit>

Feltner, C., Wallace, I., Berkman, N., Kistler, C. E., Middleton, J. C., Barclay, C., Higginbotham, L., Green, J. T., & Jonas, D. E. (2018). Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Evidence Report and Systematic Review for the US Preventive Services Task Force. *JAMA - Journal of the American Medical Association*, 320(16), 1688–1701.
<https://doi.org/10.1001/jama.2018.13212>

Fishman, P. A., Bonomi, A. E., Anderson, M. L., Reid, R. J., & Rivara, F. P. (2010). Changes in health care costs over time following the cessation of intimate partner violence. *Journal of General Internal Medicine*, 25(9), 920–925.
<https://doi.org/10.1007/s11606-010-1359-0>

Gielen, A. C., O'Campo, P. J., Campbell, J. C., Schollenberger, J., Woods, A. B., Jones, A. S., Dienemann, J. A., Kub, J., & Wynne, E. C. (2000). Women's opinions about domestic violence screening and mandatory reporting. *American Journal of Preventive Medicine*, 19(4), 279–285. [https://doi.org/10.1016/S0749-3797\(00\)00234-8](https://doi.org/10.1016/S0749-3797(00)00234-8)

Hawcroft, C., Hughes, R., Shaheen, A., Usta, J., Elkadi, H., Dalton, T., Ginwalla, K., & Feder, G. (2019). Prevalence and health outcomes of domestic violence amongst clinical populations in Arab countries: A systematic review and meta-analysis. *BMC Public Health*, 19(1), 1–12. <https://doi.org/10.1186/s12889-019-6619-2>

Huntley, A. L., Potter, L., Williamson, E., Malpass, A., Szilassy, E., & Feder, G. (2019). Help-seeking by male victims of domestic violence and abuse (DVA): A systematic review and qualitative evidence synthesis. *BMJ Open*, 9(6), 1–13.
<https://doi.org/10.1136/bmjopen-2018-021960>

Koziol-McLain, J., Giddings, L., Rameka, M., & Fyfe, E. (2008). Intimate Partner Violence Screening and Brief Intervention: Experiences of Women in Two New Zealand Health Care Settings. *Journal of Midwifery & Women's Health*, 53(6), 504–510. <https://doi.org/10.1016/j.jmwh.2008.06.002>

Logeais, M. E., Wang, Q., Renner, L. M., & Clark, C. J. (2019). Measuring Total Healthcare Utilization Among Intimate Partner Violence Survivors In Primary Care. *Scientific African*, 114(June), e00146. <https://doi.org/10.1101/19007377>

Pavao, J., Alvarez, J., Baumrind, N., Induni, M., & Kimerling, R. (2007). Intimate Partner Violence and Housing Instability. *American Journal of Preventive Medicine*, 32(2), 143–146. <https://doi.org/10.1016/j.amepre.2006.10.008>

- Peterson, C., Kearns, M. C., McIntosh, W. L. K. W., Estefan, L. F., Nicolaidis, C., McCollister, K. E., Gordon, A., & Florence, C. (2018). Lifetime Economic Burden of Intimate Partner Violence Among U.S. Adults. *American Journal of Preventive Medicine*, 55(4), 433–444. <https://doi.org/10.1016/j.amepre.2018.04.049>
- Petrisor, B. A., Drew, B., Rajaratnam, K., Williams, D., Wong, I., Kwok, D., Denkers, M., Cameron, A., Resendes, S., Ramnath, I., Chien, T., Pham, N. K., Avram, V., Ayeni, O. R., De Beer, J., Winemaker, M., Ogilvie, R., Peterson, D., Swaleh, R., ... Sprague, S. (2013). Prevalence of abuse and intimate partner violence surgical evaluation (PRAISE) in orthopaedic fracture clinics: A multinational prevalence study. *The Lancet*, 382(9895), 866–876. [https://doi.org/10.1016/S0140-6736\(13\)61205-2](https://doi.org/10.1016/S0140-6736(13)61205-2)
- Rasoulilian, M., Shirazi, M., & Nojomi, M. (2014). Primary health care physicians' approach toward domestic violence in Tehran, Iran. *Medical Journal of the Islamic Republic of Iran*, 28(1), 148. <http://www.ncbi.nlm.nih.gov/pubmed/25695006>
- Sanz-Barbero, B., Barón, N., & Vives-Cases, C. (2019). Prevalence, associated factors and health impact of intimate partner violence against women in different life stages. *PLoS ONE*, 14(10), 1–12. <https://doi.org/10.1371/journal.pone.0221049>
- Shearer, H. M., & Bhandari, M. (2008). Ontario Chiropractors' Knowledge, Attitudes, and Beliefs About Intimate Partner Violence Among Their Patients: A Cross-Sectional Survey. *Journal of Manipulative and Physiological Therapeutics*, 31(6), 424–433. <https://doi.org/10.1016/j.jmpt.2008.06.011>
- Sivagurunathan, M., Packham, T., Dimopoulos, L., Murray, R., Madden, K., Bhandari, M., & MacDermid, J. C. (2018). Perceptions of preparedness and intimate partner violence screening practices amongst hand therapists. *Hand Therapy*, 23(4), 139–147. <https://doi.org/10.1177/1758998318798668>
- Sivagurunathan, M., Packham, T., Dimopoulos, L., Murray, R., Madden, K., & MacDermid, J. C. (2019). Hand therapists' attitudes, environmental supports, and self-efficacy regarding intimate partner violence in their practice. *Journal of Hand Therapy*, 32(3), 353–360. <https://doi.org/10.1016/j.jht.2017.11.042>
- Spangaro, J. M., Zwi, A. B., Poulos, R. G., & Man, W. Y. N. (2010). Six months after routine screening for intimate partner violence: Attitude change, useful and adverse effects. *Women and Health*, 50(2), 125–143. <https://doi.org/10.1080/03630241003705060>
- Sprague, S., Kaloty, R., Madden, K., Dosanjh, S., Mathews, D. J., & Bhandari, M. (2013). Perceptions of Intimate Partner Violence: a cross sectional survey of surgical residents and medical students. *Journal of Injury and Violence Research*, 5(1), 2–10. <https://doi.org/10.5249/jivr.v5i1.147>
- Sprague, S., Madden, K., Dosanjh, S., Godin, K., Goslings, J. C., Schemitsch, E. H., & Bhandari, M. (2013). Intimate partner violence and musculoskeletal injury: Bridging

- the knowledge gap in orthopaedic fracture clinics. *BMC Musculoskeletal Disorders*, 14(1), 1. <https://doi.org/10.1186/1471-2474-14-23>
- Sprague, S., Madden, K., Simunovic, N., Godin, K., Pham, N. K., Bhandari, M., & Goslings, J. C. (2012). Barriers to Screening for Intimate Partner Violence. *Women and Health*, 52(6), 587–605. <https://doi.org/10.1080/03630242.2012.690840>
- Usta, J., Antoun, J., Ambuel, B., & Khawaja, M. (2012). Involving the health care system in domestic violence: What women want. *Annals of Family Medicine*, 10(3), 213–220. <https://doi.org/10.1370/afm.1336>
- Webster, J., Stratigos, S. M., & Grimes, K. M. (2001). Women's responses to screening for domestic violence in a health-care setting. *Midwifery*, 17(4), 289–294. <https://doi.org/10.1054/midw.2001.0279>
- WHO. (2013). *Responding to intimate partner violence and sexual violence against women WHO clinical and policy guidelines*. www.who.int/reproductivehealth
- World Health Organization. (2014). Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook. In *World Health Organization: Vol. WHO/RHR/14*. www.who.int/reproductivehealth
- Yakubovich, A. R., Stöckl, H., Murray, J., Melendez-Torres, G. J., Steinert, J. I., Glavin, C. E. Y., & Humphreys, D. K. (2018). Risk and protective factors for intimate partner violence against women: Systematic review and meta-analyses of prospective–longitudinal studies. *American Journal of Public Health*, 108(7), e1–e11. <https://doi.org/10.2105/AJPH.2018.304428>

Chapter 7

7 General Discussion

Intimate partner violence (IPV) is a global health concern. While the area of IPV is well studied some gaps in research exists. The current study aims to add to the existing knowledge around IPV. Understanding gaps in clinical practice and social attitudes around IPV is important to implement policy and practice changes that may better serve male and female IPV survivors, particularly in the arena of rehabilitation.

This thesis included 5 manuscripts, derived from 3 separate studies, which aimed to increase understanding of IPV considering both clinical and social perspectives, and that both men and women can perpetrate and be victims of IPV. A brief summary of the findings from each study, implication for practice and future research as well as strengths and limitations are discussed in this chapter.

7.1 Key Thesis Findings:

The findings from manuscript #1 indicate that male IPV survivors experience some of the same challenges as female IPV survivors (e.g. shame, fear, self-blame). However, male IPV survivors also experience some unique facets related to gender bias. Social norms and expectations regarding victimhood and masculinity are evident in high levels of gender-related shame in identifying as a victim or coming forward with their IPV experiences. The combination of general societal shame experienced by all victims of IPV and the additional gender related shame experienced by men can act as a barrier for disclosure. However, the current study found that on SNSs disclosure of male IPV was met with mostly supportive responses. While some negative behavior such as

questioning the disclosure and minimizing the abuse did exist, these negative responses were a minority. However, the existence of these negative responses does indicate the possibility that men disclosing IPV would receive some unhelpful responses in online forums.

Manuscript #2 examined discourses around perceived systemic biases for male IPV survivors. Redditors perceived that systemic biases extend across a matrix of institutional sectors (health, judicial, legal, media, and government), and may occur at multiple levels within each sector (e.g. individual health care clinicians, programs, facilities, funders, health systems). These discourses shows that high levels of negative perceptions regarding these systems exist.

The findings from manuscript #3 indicate that preparedness amongst HTs to deal with IPV in their clinical practice is low. While HTs believed that dealing with IPV is part of their job responsibilities (mean= 3.8/5) they had lower perceptions regarding self-efficacy (mean=2.9/5), available system support (mean=3/5), and victim/ provider safety (mean=3/5).

While HTs believed that dealing with IPV is part of their job responsibility findings from manuscript #4 indicate that IPV assessment is low amongst hand therapists, with only 4.1% of HTs indicating that they always assessed for IPV. HTs also reported low levels of preparedness to deal with IPV (2.1/7). Some problems with implementing IPV assessment in HTs clinics include low levels of training amongst HTs to deal with IPV, lack of resources in the community and lack of awareness amongst HTs about existing resources. Furthermore, HTs felt minimally prepared to fulfill state or

provincial reporting requirements for IPV. These issues must be addressed before implementing any IPV assessment guidelines.

Findings from manuscript #5 indicate that while the majority of patients are not embarrassed by clinicians' IPV inquiry, a significant minority reported that they believed others would be embarrassed. Further research is needed to inform the best ways to implement clinic wide IPV assessment to address the potential for negative emotional consequences.

7.2 Strengths and Limitations

7.2.1 Study Limitations

Study 1 had some limitations due to the functionality of Reddit. Due to the anonymous nature of the accounts the study was not able to obtain any demographic data.

Furthermore, statistics on internet users indicate that as of 2019 there are 4.13 billion internet users⁹ worldwide. While this increases the potential of generalizability because of the large sample frame, it is equally possible that the sample population for the study consisted of individuals from developed countries or individuals from middle and upper social classes with access to cellphones or computers and internet. Further, all of the submissions extracted were in the English language, which may amplify sampling bias. Finally, the nature of the data collection process prevented further clarification in cases where there was lack of clarity, as such some assumptions about meaning of the posts had to be made.

⁹ <https://www.statista.com/topics/1145/internet-usage-worldwide/>

Study 2 had some limitations in terms of sample size. The estimated response rate for the survey was 5.8%. We posit this may have been due to factors such as discomfort surrounding the topic, firewalls that may have prevented the recruitment emails from reaching the HTs, and lack of awareness about the importance of the topic. Given the low number of responses we cannot be sure how representative the findings are to the HT community at large. Furthermore, the sample was limited to HTs from North America.

The findings from Study 3 emphasized the difficulty in recruiting individuals with a history of IPV. None of the patients in the study indicated having experienced IPV. An adequate sample of individuals with IPV history would have allowed us to draw further conclusions about patient attitudes. Furthermore, to our knowledge no studies have examined male attitudes regarding IPV assessment in rehabilitation context. While manuscript #5 included both male and female patients, purposive sampling from a male IPV survivor population would have provided additional context to the findings.

7.2.2 Thesis limitations

Given the overarching goal of better understanding disclosure, and the preparedness of the clinical community to deal with IPV disclosure this thesis provides insights, and yet leaves many gaps. While the thesis addressed the experiences of disclosure and general attitudes towards IPV in men using social media scraping to access viewpoints that otherwise would have been difficult to obtain, we do not know how representative these viewpoints are of the larger experience of men. Without survey or qualitative studies to complement these findings, we cannot be confident of their trustworthiness or generalizability. While gender-related shame and the lower prevalence of IPV in men are

barriers in conducting these studies, this type of research is needed to fully inform what actions are needed.

While our studies suggest a lack of preparedness in the rehabilitation community for managing IPV that presents as either the cause or mediating factor in recovery following in musculoskeletal injury, the thesis sampled hand therapists who may not represent all therapists practising in the field of musculoskeletal rehabilitation. Further, while we obtained their perception that training and resources were not available, we cannot differentiate between real and perceived deficiencies. Further, we did not explore what solutions are required: to move beyond identifying this gap in clinical preparedness, it would be important to examine what types of services and resources are available, and how these could be best communicated and implemented across different types of practice settings and specialties.

While this thesis addressed literature gaps with respect to how men experience disclosure, we did not adequately consider gender diversity and sexual identity, or the nature of the intimate relationships, which may have overrepresented cis relationships. Since society often views IPV as a problem that primarily occurs with men as perpetrators and women as victims in traditional relationships, some important areas of diversity were not attended to in this thesis.

While we noted some discrepancies between previous literature about the prevalence of intimate partner violence rates and our own data, we are unable to determine why these differences might exist. We suspect that differences in reference

points and definitions might be contributing to differences in prevalence. Given that we anticipated higher rates, our sample size was inadequate for generating precise estimates.

The lack of consistency in how IPV exposures have been defined across the literature speaks to a larger issue with how trauma is defined. There is increasing recognition that both current and past trauma impact on physical, psychological and social health. However, the cumulative impact of trauma and how it is modulated over time and by other factors, as a determinant of health, is poorly understood. There has been a tendency to separate IPV from other types of trauma, and thus the extent to which different forms of trauma affect individuals is relatively unknown, and difficult to study. Our goal overall to improve the experience and support of victims of IPV could not be achieved through the early steps contained in this thesis, that primarily serve to increase awareness of errors and gaps, while doing little to resolve them. This is an important first step but requires further efforts to engage diverse opinions and methodologies that will support the next steps in achieving impact.

7.3 Implications:

The research, although preliminary, has implications for practice, policy and research. This thesis added new knowledge in an area that has previously been under-explored, by addressing a gap in knowledge about disclosure by male IPV survivors; and exploring the potential responses to disclosure in both men and women. The findings illustrate the importance of being both gender inclusive and gender sensitive when conducting research in the area of IPV. The studies examine IPV in both clinical and societal areas and have implications for clinical practice and policy as well future research.

7.3.1 Practice Implications

Professional Training needs to be provided to both health care professionals and legal professionals to ensure that IPV survivors receive appropriate services. Findings from our study on hand therapists identified the majority of therapists received less than 1 hour of training regarding IPV. Furthermore, HTs reported low levels of perceived preparedness to deal with IPV in their clinic. Findings indicate that training is significantly related to IPV assessment amongst HTs as such increased training can result in higher perceived preparedness amongst HTs and increased IPV inquiry which can result in identifying survivors of IPV and ensure patients receive appropriate services. In addition to training for HTs it is imperative that legal professionals (judges, lawyers, police officers) also receive training. The findings indicate male IPV survivors perceived multiple challenges when dealing with police officers, service providers, lawyers and judges. These perceptions may function as a barrier for male IPV survivors seeking help from these institutions, resulting in male IPV survivors not receiving appropriate services resulting in further victimization. Many of the systemic biases identified by men have also been identified by female IPV survivors as being problematic. Therefore, it is important to provide sensitivity training for healthcare professionals and legal professionals in order to ensure that IPV survivors receive adequate services. Previous research (Grant & Rowe, 2011) show that even when policies regarding responses to IPV exist police officers may not adequately follow these policies due to attitudes and logistical issues such as lack of time and other “priority” work demands. As such more sensitivity training in tandem with policy changes are needed to ensure policies are followed by police officers, resulting in better outcomes for IPV survivors who interact with police services.

Furthermore, training should aim to be gender inclusive and include examples illustrating women, men, and gender diverse people as potential victims. Training should aim to help health care and legal professionals recognize and respond appropriately to IPV survivors across various demographic spectrums, including sexual orientation, sex and gender, ethnicity, and SES.

Education around providing gender sensitive patient care should be implemented at university and college levels and should be part of the curriculum for clinical students. In addition, courses around identifying and dealing with abuse and IPV in the clinic would be helpful to ensure that service users receive appropriate care. Given that many HTs didn't feel confident they can make appropriate references for perpetrators (54%) and victims (35%) training for HTs on how to identify IPV victimization and to make referrals to appropriate service users in a safe and effective manner is imperative.

7.3.2 Policy Implications

The findings have implications for current policies in the legal system, services, and government. Our analysis suggests that male IPV survivors perceive police officers and legal system as being unhelpful to male IPV survivors. These findings are similar to research on female victims of IPV and their experiences with police (Barrett et al., 2011). Therefore, it maybe beneficial to re-examine current policies on responding to IPV and reevaluate them with a more gender-sensitive and nuanced lens, as to better serve both male and female IPV survivors.

Policies for health and social services should be gender inclusive or gender sensitive. Support services should aim to provide IPV services for both males and females. In cases where the services are only offered to one sex, policies should be in

place to mandate provision of appropriate referrals for all survivors. Policies should be in place to ensure that male IPV survivors are not referred to perpetrator services or turned away from services without appropriate referrals.

7.3.3 Future research

Future research on IPV needs to be gender sensitive. Our findings suggest redditors perceived multiple services gaps in the health and social sectors. Given the limitations of the studies, no claims can be made about whether these systemic biases are representative of actual gaps in services or merely perceptions. Future research should further examine these systems and male IPV survivors experiences with these systems through face-to-face interviews with both male IPV survivors and with individuals who are part of the systems (i.e. judges, lawyers, police officers and service providers). Furthermore, research should aim to qualitatively explore the attitudes of service providers, legal professionals and other point-of-contact workers regarding male IPV. Future research should also examine the impact of male IPV on children of male victims. Furthermore, studies (both quantitative and qualitative) on how the court system deals with custody in cases of female perpetrated IPV is imperative.

Research on the experiences of male IPV survivors when interacting with health care providers and service providers may also be of benefit and result in better outcomes for male IPV survivors who are seeking health services. Findings suggest that male IPV survivors have trouble naming the abusive behaviour. Therefore, future research on facilitators for disclosure would be beneficial.

Research with the LGBTQ population and service gaps present for bi-sexual and gay men are limited. Studies show that LGBTQ population have unique needs relative to heterosexual male and female IPV victims (Calton et al., 2016). Therefore, future research on LGBTQ population and their service needs are needed.

7.4 Conclusion

The current project aims to examine the area of IPV with a gender sensitive lens. The thesis examines both clinical and social perspective around IPV and has wide reaching implications. Findings can result in IPV survivors receiving appropriate services and lead to better health outcomes.

7.5 References

- Barrett, B. J., St. Pierre, M., & Vaillancourt, N. (2011). Police response to intimate partner violence in Canada: Do victim characteristics matter? *Women and Criminal Justice, 21*(1), 38–62. <https://doi.org/10.1080/08974454.2011.536057>
- Calton, J. M., Cattaneo, L. B., & Gebhard, K. T. (2016). Barriers to Help Seeking for Lesbian, Gay, Bisexual, Transgender, and Queer Survivors of Intimate Partner Violence. *Trauma, Violence, and Abuse, 17*(5), 585–600. <https://doi.org/10.1177/1524838015585318>
- Grant, S., & Rowe, M. (2011). Running the risk: police officer discretion and family violence in New Zealand. *Policing and Society, 21*(1), 49–66. <https://doi.org/10.1080/10439463.2010.540662>

Appendices

Appendix A: Study #2 – Ethics Approval

Ethics for Study 2 was provided by McMaster University Ethics Board and will be provided at a later date. It is currently unavailable due to Covid-19 lockdown.

Appendix B: Study #2 – Recruitment Email

Dear Hand Therapist;

As a member or adherent of the American Society of Hand Therapists (ASHT) or the Canadian Society of Hand Therapists (CSHT), you are being invited to participate in a survey about intimate partner violence conducted by a team at McMaster University. This study has been approved by our institutional ethics board (Hamilton Integrated Research Ethics Board), as well as the Research Division of ASHT and the executive committee of CSHT. The purpose of this research is to inform educational programming for our professional societies to support responsive and comprehensive care for the victims of intimate partner violence.

Attached you will find an information and consent form with an embedded link to the anonymous electronic survey. Please review this information and consider participating in this endeavor.

Kind regards,

Katherine Chan, Vincent Chow, Lindsay Dimopoulos and Robyn Murray

MScPT students, School of Rehabilitation Science
McMaster University, Hamilton, Ontario, Canada

In conjunction with:

Tara Packham, MSc, OTReg(Ont)
Dr. Joy MacDermid, PT, PhD
Dr. Mohit Bhandari, MD, FRCSC



Appendix C: Study #2 – Survey

There are 27 questions in this survey

Consent

Consent form

1 [Consent]**PARTICIPANT INFORMATION SHEET**

Title of Study: Intimate Partner Violence: Attitudes and Beliefs among Hand Therapists

Principal Investigator: Lindsay Dimopoulos, MScPT student, McMaster University;

Hamilton, Ontario, Canada

Local Investigator: Tara Packham, MSc, OTReg(Ont), McMaster University

Co-Investigators: Robyn Murray, MScPT student, McMaster University

Dr. Mohit Bhandari, MD, FRCPC

Dr. Joy MacDermid, PT, PhD

You are being invited to participate in a research study conducted by a team from McMaster University (under the direction of Tara Packham) to examine the attitudes and beliefs of hand therapists about intimate partner violence. Several of our team members are physiotherapy students, and their contributions to this research are in fulfillment of a research practicum for their studies in the School of Rehabilitation Sciences at McMaster University.

In order to decide whether or not you want to be a part of this research study, you should understand what is involved and the potential risks and benefits. This form gives detailed information about the research study.

WHY IS THIS RESEARCH BEING DONE?

Hand fractures are a common fracture seen as a result of intimate partner violence. Because persons with hand injuries often attend multiple appointments for rehabilitation, hand therapists may be the health team member best able to identify women whose musculoskeletal injuries are the result of intimate partner violence. We are conducting a survey of hand therapists from across the United States and Canada to understand their attitudes and beliefs about intimate partner violence. This information will help us to develop educational programs for therapists so they will do the best job possible to identify and assist persons who have experienced intimate partner violence.

WHAT IS THE PURPOSE OF THIS STUDY?

To understand the attitudes and beliefs of hand therapists about intimate partner violence.

WHAT WILL MY RESPONSIBILITIES BE IF I TAKE PART IN THE STUDY?

If you continue to the survey, you will be asked to answer questions about your knowledge, training and hand therapy practice. This survey will take approximately 15 minutes to complete.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

There are no foreseeable risks associated with this study. You may feel worried about your responses. There are no right or wrong answers, we do not ask your name or know what email the survey originated from, and all individual responses will be kept confidential.

HOW MANY PEOPLE WILL BE IN THIS STUDY?

We are inviting all members of the American Society of Hand Therapists (ASHT) and the Canadian Society of Hand Therapists (CSHT), and their associated local chapters to participate in this survey.

WHAT ARE THE POSSIBLE BENEFITS FOR ME AND/OR FOR SOCIETY?

We cannot promise any personal benefits to you from your participation in this study. The results of this study may benefit society and the scientific community by providing a foundation for the development of education programs for hand therapists to assist them in better screening, identification, and support of women who have experienced intimate partner violence. We will share the results of our study with ASHT and CSHT and work with these professional organizations to develop the appropriate educational resources.

WHAT INFORMATION WILL BE KEPT PRIVATE?

This survey is completely anonymous. The survey software is designed so that it is not possible to link it back to you or your computer. The anonymous information will be securely stored in a locked office at McMaster University.

For the purposes of ensuring the proper monitoring of the research study, it is possible that a member of the Hamilton Integrated Research Ethics Board may consult the research data. By pressing the "I accept" button at the end of this consent form, you are authorizing such access.

If the results of the study are published, the anonymous nature of our data collection means your name will not be used and no information that discloses your identity will be released or published.

CAN PARTICIPATION IN THE STUDY END EARLY?

If you volunteer to be in this study, you may withdraw at any time, simply by exiting the survey. You may also refuse to answer any questions you don't want to answer and still remain in the study.

WILL I BE PAID TO PARTICIPATE IN THIS STUDY?

You will not be paid to participate in this study.

WILL THERE BE ANY COSTS?

There are no costs associated with this study.

IF I HAVE ANY QUESTIONS OR PROBLEMS, WHO CAN I CALL?

If you have any questions about the research now or later, please contact:

Tara Packham at [REDACTED]

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HIREB). The HIREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair, Hamilton Integrated Research Ethics Board at [REDACTED]

I understand the terms of participation as outlined above and by clicking on the I Agree button below I am giving my consent to participate in the study.

*

Please choose **only one** of the following:

- I understand the terms of participation as outlined above and give my consent to participate in the study.
- Exit survey (please click on exit and clear survey button at bottom of the screen).

Part 1**2 [Gender]Gender**

Please choose **only one** of the following:

- Female
- Male

3 [Age]Age

Please write your answer here:

4 [Marital Status]Marital status

Please choose **only one** of the following:

- Single
- Married
- Common law
- Separated
- Divorced
- Widowed

5 [Language]First language spoken

Please choose **only one** of the following:

- English
- French
- Spanish
- Other

6 [Family]My family background (i.e. that of my parents or grandparents) would be best described as: (can choose from more than one answer but the intention is to represent your primary cultural association)

Please choose **all** that apply:

- Caucasian
- African-American/Canada
- Hispanic - Latino
- Middle-Eastern
- European
- Asian
- Aboriginal
- South-east Asian
- Other:

Part 2**7 [Education]Educational background (highest level of professional training)**

Please choose **only one** of the following:

- Bachelor's Degree
- Master's Degree
- Doctorate Degree

8 [Profession]Professional background

Please choose **only one** of the following:

- Occupational therapy
- Physiotherapy
- Other

9 [Practice]Years in professional practice

Please write your answer here:

10 [Practice]Practice setting

Please choose **only one** of the following:

- Urban
- Suburban
- Rural
- Small town
- Geographically isolated
- Other

Part 2 (cont.)**11 [Location]Practice location (please specify the province/territory or state in which you are currently practicing) ***

Please choose all that apply and provide a comment:

- Canada
- United States

12 [CHT]Please indicate if you are a CHT

Please choose **only one** of the following:

- Yes
- No

13 [Experience]Years of experience as a hand therapist

Please write your answer here:

14 [Experience]Personal experience with IPV

Please choose **only one** of the following:

- Yes (I have experienced IPV first-hand)
- Yes (I know a friend or relative who has experienced IPV)
- Yes (I have addressed it with clients)
- None

Part 7

Part 9**21 [Actions taken] In the past 6 months, which of the following actions have you taken when you identified IPV? ***Please choose **all** that apply:

- Have not identified IPV in past 6 months
- Provided information (phone numbers, pamphlets, or other information) to patient
- Counseled patient about options she/he may have
- Conducted a safety assessment for the victim
- Conducted a safety assessment for victim's children
- Helped patient develop a personal safety plan
- Referred patient to:
 - Individual therapy
 - Child Protective Services
 - Couples Therapy
 - Legal advocate/victim witness advocate
 - On-site social worker/advocate
 - Religious leader/organization
 - Battered women's program/shelter
 - Battered women's support group
 - Alcohol/substance abuse counseling
 - National DV/IPV hotline
 - Local DV/IPC hotline
 - Lesbian/Gay/Transgender/Bisexual support group
 - Police, sheriff, or other local law enforcement
 - Housing, educational job, or financial assistance
- Other:

Part 10**22 [IPV pt education] Do you provide abused patients with IPV patient education or resource materials? ***

Please choose **only one** of the following:

- Yes, almost always
- Yes, when it is safe for the patient
- Yes, but only upon patient request
- No, due to inadequate referral resources in the community
- No, because I do not feel these materials are useful in general
- No, other reason (specify in comment box)
- Not applicable to my patient population
- I am not currently in a clinical practice

Make a comment on your choice here:

23 [Knowledge of referral] Do you feel you have adequate knowledge of referral resources for patients in the community (including shelters or support groups) for adult IPV victims? *

Please choose **only one** of the following:

- Yes
- No
- Unsure
- I am not currently in a clinical practice.

24 [IPV training] Estimated total number of hours of previous IPV training: *

Please write your answer here:

Thank you for participating!

27 [Feedback] If you have any questions or concerns about this study, please feel free to provide us with feedback below!

Please write your answer here:

31.12.1969 – 19:00

Submit your survey.
Thank you for completing this survey.

Appendix D: Study #3 – Ethics Approval



Date: 29 January 2018

To: Dr. Joy MacDermid

Project ID: 110345

Study Title: Exploring attitude regarding screening for intimate partner violence (IPV) in Hand Therapy Patients

Application Type: HSREB Initial Application

Review Type: Delegated

Meeting Date / Full Board Reporting Date: 06/Feb/2018

Date Approval Issued: 29/Jan/2018

REB Approval Expiry Date: 29/Jan/2019

Dear Dr. Joy MacDermid

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above mentioned study, as of the HSREB Initial Approval Date noted above. This research study is to be conducted by the investigator noted above. All other required institutional approvals must also be obtained prior to the conduct of the study.

Documents Approved:

Document Name	Document Type	Document Date
Letter of Information(Study 2 Clean Copy) (3)	Paper Survey	09/Jan/2018
Poster Final	Paper Survey	
Survey (Final Version)(Clean Copy)	Paper Survey	18/Dec/2017

Documents Acknowledged:

Document Name	Document Type
Bhandari et al. - 2006 - Musculoskeletal Manifestations of Physical Abuse After Intimate Partner Violence	References
Bhandari et al. - 2011 - The Prevalence of Intimate Partner Violence across Orthopaedic Fracture Clinics in Ontario	References
Della Rocca et al. - 2013 - Orthopaedic surgeons' knowledge and misconceptions in the identification of intimate partner violence against	References
Gielen et al. - 2000 - Women's opinions about domestic violence screening and mandatory reporting	References
Ramsay - 2002 - Should health professionals screen women for domestic violence Systematic review	References
Rasouljan, Shirazi, Nojomi - 2014 - Primary health care physicians' approach toward domestic violence in Tehran, Iran	References
Sprague et al. - 2012 - Barriers to Screening for Intimate Partner Violence	References
Sprague et al. - 2013 - Intimate partner violence and Musculoskeletal injury bridging the knowledge gap in Orthopaedic fracture clinics	References
Usta et al. - 2012 - Involving the Health Care System in Domestic Violence What Women Want	References

No deviations from, or changes to, the protocol or WREM application should be initiated without prior written approval of an appropriate amendment from Western HSREB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

REB members involved in the research project do not participate in the review, discussion or decision.

The Western University HSREB operates in compliance with, and is constituted in accordance with, the requirements of the TriCouncil Policy Statement: Ethical

Appendix E: Study #3 – Letter of Information

Exploring attitude regarding screening for intimate partner violence (IPV) in Hand Therapy patients

Dr. Joy MacDermid (Principal Investigator), Professor, PhD, School of Physical Therapy,
 [REDACTED]
 Telephone: [REDACTED]
 Email: [REDACTED]

Marudan Sivagurunathan, PhD, Health and Rehabilitation, Western University,
 Telephone: [REDACTED]
 Email: [REDACTED]

Letter of Information

1. Invitation to Participate

You are being invited to take part in a research study that will help us understand the extent to which violence is a source of injury for people who use the services of hand therapists. This will help us to know how to ask people about violence, and if they need any other services.

2. Purpose of the Letter

The purpose of this letter is to provide you with the information required to make an informed decision regarding participation in this research. Please take the time to read and feel free to ask any questions. If you have any questions regarding the study please feel free to contact Dr. Joy Macdermid at [REDACTED] or Email: [REDACTED]

3. Purpose of this Study

This survey is part of a research project to help therapists understand the traumatic injuries that lead people to need treatment for their upper injury. The focus of the study will be on whether routine screening for violence would be acceptable to patients. We think that some people who have experienced violence may have unmet needs and some people may find these questions offensive. Understanding this will help clinicians provide better service in the future.

4. Inclusion Criteria

Individuals who are 18 years of age or older, utilizing hand therapy services who can read English.

5. Exclusion Criteria

Individuals who are less than 18 years of age, are unable to read English, who have previously completed the survey.

6. Study Procedures

If you agree to participate, you will be asked to complete a short survey. You will be asked to answer questions about your current injury and your level of comfort with

being asked if you were hurt by a stranger or partner. It is anticipated that the entire task will take 5 minutes.

7. Possible Risks and Harms

There are no foreseeable risks associated with the study. You may feel worried or uncomfortable with some questions. There are no right or wrong answers, we do not ask your name or other personal identifiers, and all individual responses will be kept confidential. You may choose not to answer.

8. Possible Benefits

You may not directly benefit from participating in this study, but the information gathered may help clinicians to know if they should ask patients about being injured by another person. It may encourage clinicians to be able to provide information about services for people who are injured by another person. The results may benefit society and the scientific community by providing a foundation for the development of education programs for hand therapists to assist them in better screening, identification, and support for individuals with experience of intimate partner violence.

9. Voluntary Participation

Participation in this study is voluntary. You may refuse to answer any questions you don't want to answer and still remain in the study. Your participation will not affect the care provided, or access to services. If you do not want to participate you can simply return the unanswered survey to the drop-box located at the center. If you do participate, you may complete the attached questionnaire and drop it off in the drop-box.

10. Confidentiality

We will respect your privacy. All data collected will remain confidential and accessible only to the investigators of this study. The survey is designed so that it is not possible to link it back to you. You do not need to put your name on the survey, so it is anonymous.

For the purposes of ensuring the proper monitoring of the research study, it is possible that a member of the Western Research Ethics Board or Lawson Quality Assurance and Education Program may consult the de-identified research data. By submitting the survey, you are authorizing such access.

11. Contacts for Further Information

If you require any further information regarding this research project or your participation in the study you may contact Marudan Sivagurunathan, [REDACTED]

If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Research Ethics, [REDACTED]
[REDACTED]

12. Publication

If the results of the study are published or presented, the anonymous nature of our data collection means your name will not be used and no information that discloses your identity will be released or published. Completing the survey does not constitute a waiving of your legal rights. If you would like to receive a copy of any potential study results, please contact Marudan Sivagurunathan, [REDACTED]
[REDACTED]

13. Consent

You indicate your voluntary agreement to participate by responding to the survey.

This letter is yours to keep for future reference.

Appendix F: Study #3 – Survey

HAND TRAUMA SURVEY

This survey is part of a research project to help therapists understand the traumatic injuries that lead people to need treatment for their upper injury. This survey has 3 parts: The following questions ask some information about your injury. It should only take you 10-15 minutes of your time to respond. Some of the questions are personal in nature. **If you prefer not to answer some of the questions, you can leave them blank. Even if you don't answer all of the questions, please return the survey in the envelope provided.** We will not be able to identify who filled out the survey, and it will not make a difference to your care if you do not do the survey. If you have any questions about this survey, you can contact Marudan Sivagurunathan at [REDACTED]

Part One: Information about you

1. I identify my gender as:

(please choose only **one** of the following)

Male

Female

Other: _____

Prefer not to answer

2. Age

Please write your answer here:

3. Marital status:

(Please choose only **one** of the following)

- Single
- Married
- Common law
- Separated
- Divorced
- Widowed

4. Language spoken most often at home:

(Please choose only **one** of the following)

- English
- Arabic/Turkish/Persian
- Mandarin/Korean/Cantonese/Japanese/Vietnamese
- Spanish/Portuguese/ Italian
- Hindi / Urdu / Punjabi/ Bengali
- Tagalog / Malay
- Swahili
- French/German/Dutch
- Other: _____

5. I would describe myself as (Please choose all that apply):

Caucasian

African-American

Hispanic – Latino

Middle-Eastern

Asian

Indigenous

Other: _____

6. Educational background

Please check the box for the highest level of education you have completed:

Some high school

High school graduate or diploma

Trade / technical / vocational training

Some college or university

University Degree

Part Two: Information about Your Injury:

7. Are you here because of an injury?

- Yes
 No (skip to question 15)

8. Where did your injury happen?

- Home
 Work
 School
 Other _____

9. Did the injury happen because of something you were doing?

- Yes (go to question 13)
 No

10. Did the injury happen because of the actions of someone else?

- Yes – it was an accident
 Yes – they caused the injury on purpose
 No (go to question 13)

11. If yes, who caused the injury?

- Family member (parent, child, sibling)
 Friend
 Current or former partner/spouse
 Caregiver
 Others: _____

12. If your partner or family member caused this injury, did you tell your doctor or hand therapist?

- Yes
 No

Part Three: Information about how injuries happen

Asking people whether a spouse or intimate partner caused their injury is a very delicate issue, But we know it is important. We want to ask some personal questions about this. If you do not feel comfortable with any question, you may leave it blank.

13. Did your doctor or hand therapist directly ask if your injury was caused by a partner or spouse?

- Yes – my doctor asked
- Yes –my therapist asked
- No

14. A) Would you be upset or embarrassed if a doctor or therapist asked you if your injury was caused by your partner or spouse?

- Yes
- No

B) Would you be upset or embarrassed if your doctor or therapists asked you if your injury was caused by other types of personal violence?

- Yes
- No

15. A) Do you think that other people would be upset if their doctor or hand therapist asked them if they had ever been injured by their partner/spouse?

- Yes
- No

B) Do you think that other people would be insulted if their doctor or hand therapist asked them if they had ever experienced sexual abuse?

- Yes
- No

C) Do you think that other people would be insulted if their doctor or hand therapist asked them if they had ever experienced child abuse?

- Yes
- No

16. Do you think doctors and therapists should routinely ask all people if their current injury was caused by someone else?

Yes

No

17. Do you think doctors and therapists should routinely ask all clients if they have experienced abuse in their past?

Yes

No

18. What do you think is the best way for doctors or hand therapists to ask about abuse?

Pain

19.A) Did you have pain in your hand or arm before this injury or surgery?

Yes

No

B) Do you have pain in other parts of your body (not part of this injury)?

Yes

No

20. Do you have pain now because of this injury?

a. Please indicate how bad the pain has been on average over the past week on a scale of 0 (no pain) to 10 (worst pain imaginable)


<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
0	1	2	3	4	5	6	7	8	9	10
none	mild			moderate			worst pain			

b. Please indicate on average how many days in the past week you had pain on a scale of 0 (none) to 7 (everyday)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
0	1	2	3	4	5	6	7

Feedback

21. If you have any questions or concerns about this survey, or if you would like to tell us more, please feel free to write comments in the space below.



If you want to talk to someone about this survey, please contact Marudan Sivagurunathan at [REDACTED] or contact Dr. Joy MacDermid at [REDACTED].

If your injury was caused by an act of violence and would like to know more about how you can protect yourself find support and services at: <https://crcvc.ca/links/>

Appendix G: Curriculum Vitae

MARUDAN SIVAGURUNATHAN**RESEARCH INTERESTS**

- Sex & Gender
- Gender-Based Violence
- Pain
- Child & Adolescent Health
- Marginalized Communities

EDUCATION

2016-2020	Doctor of Philosophy, Measurement & Methods, Western University, London, ON. Supervisor: Dr. Joy MacDermid, PT, PhD. Thesis: “Intimate Partner Violence: Clinical and Social Perspective”
2014-2016	Master of Science, Health Promotion, Western University, London, ON. Supervisor: Dr. Marilyn Evans, PhD. Thesis: “Self-disclosure among male survivors of child sexual abuse: Service providers’ perspective”
2012-2013	Bachelor of Arts (Honours), Religious Studies, McMaster University, Hamilton, ON. Supervisor: Dr. Anne Pearson, PhD. Thesis: “Feminist Interpretations of The Ramayana.”
2008-2012	Bachelor of Arts, Psychology McMaster University, Hamilton, ON.

RESEARCH

Peer Reviewed Publications:

1. **Sivagurunathan, M.**, MacDermid, J., Chuang, J. C. Y., Kaplan, A., Lupton, S., & McDermid, D. (2019). Exploring the role of gender and gendered pain expectation in physiotherapy students. *Canadian Journal of Pain*, 3(1), 128–136.
<https://doi.org/10.1080/24740527.2019.1625705>
2. **Sivagurunathan, M.**, Orchard, T., & Evans, M. (2019). Barriers to Utilization of

Mental Health Services amongst Male Child Sexual Abuse Survivors: Service Providers' Perspective. *Journal of Child Sexual Abuse*, 28(7), 819–839.
<https://doi.org/10.1080/10538712.2019.1610823>

3. **Sivagurunathan, M.**, Orchard, T., MacDermid, J. C., & Evans, M. (2019). Barriers and facilitators affecting self-disclosure among male survivors of child sexual abuse: The service providers' perspective. *Child Abuse & Neglect*, 88, 455–465.
<https://doi.org/10.1016/j.chiabu.2018.08.015>
4. **Sivagurunathan, M.**, Packham, T., Dimopoulos, L., Murray, R., Madden, K., Bhandari, M., & MacDermid, J. C. (2018). Perceptions of preparedness and intimate partner violence screening practices amongst hand therapists. *Hand Therapy*, 23(4), 139–147. <https://doi.org/10.1177/1758998318798668>
5. **Sivagurunathan, M.**, Packham, T., Dimopoulos, L., Murray, R., Madden, K., & MacDermid, J. C. (2019). Hand therapists' attitudes, environmental supports, and self-efficacy regarding intimate partner violence in their practice. *Journal of Hand Therapy*, 32(3), 353–360. <https://doi.org/10.1016/j.jht.2017.11.042>

Conference Presentations:

1. **Sivagurunathan, M.**, Ghodrati, M., MacDermid, J. C. Qualitative study on gender and post-operative pain management. Poster presented at the American Society of Hand 2020 Virtual Annual Meeting. 9/2020.
2. **Sivagurunathan, M.**, MacDermid, J. C., Walton D., Packham T. Patient attitudes regarding intimate partner violence in upper extremity specialty clinic. Poster presented at the American Society of Hand 2020 Virtual Annual Meeting. 9/2020.
3. **Sivagurunathan, M.**, MacDermid, J. C., Packham T., Walton D., Exploring discourses around male intimate partner violence disclosures through Reddit submissions and replies. Poster presented at Resilience 2020 Conference: Equity in Gender, Health & Water, Hamilton, ON. 3/2020.
4. **Sivagurunathan, M.**, MacDermid, J. C., Packham T., Walton D., Booth R. Exploring discourses around male intimate partner violence disclosures through Reddit submissions and replies. Poster presented at Resilience 2020 Conference: Equity in Gender, Health & Water, Hamilton, ON. 3/2020.
5. **Sivagurunathan, M.**, MacDermid, J. C., Chuang, J., Kaplan, A., Lupton, S., & McDermid, D., *Exploring the role of gender and gendered pain expectation amongst Physical Therapy Students*. Poster presented at The Chronic Pain Network Meeting, Toronto, ON. 4/2019
6. **Sivagurunathan, M.**, Packham, T., Dimopoulos, L., Murray, R., Madden, K., Bhandari, M., MacDermid, J., *Perceptions of preparedness and Intimate Partner Violence screening practices amongst Hand Therapists*. Poster presented at the MacHand Day, McMaster University, Hamilton, ON. 10/2018.
7. **Sivagurunathan, M.**, Packham, T., Dimopoulos, L., Murray, R., Madden, K., Bhandari, M., MacDermid, J., *Perceptions of preparedness and Intimate Partner*

- Violence screening practices amongst Hand Therapists*. Poster presented at the American Society of Hand Therapy 41st Annual Meeting, Dallas, TX. 9/2018.
8. **Sivagurunathan, M.**, Packham, T., Dimopoulos, L., Murray, R., Madden, K., Bhandari, M., MacDermid, J., *Perceptions of preparedness and Intimate Partner Violence screening practices amongst Hand Therapists*. Poster presented at the London Health Research Day, London, ON. 5/2018.
 9. **Sivagurunathan, M.**, Packham, T., Dimopoulos, L., Murray, R., Madden, K., MacDermid, J., *Hand Therapists' Attitudes, Environmental Supports and Self-efficacy regarding Intimate Partner Violence in their practice*. Poster presented at the Gender Summit 11, Montreal, QC. 11/2017.
 10. **Sivagurunathan, M.**, Orchard, T., Leschied, A., Evans, M. *Exploring issues related to disclosure and non-disclosure in males: Service provider perspective*. Poster presented at the Western Research Forum, Western University, London, ON. 3/2016.
 11. **Sivagurunathan, M.**, Orchard, T., Leschied, A., Evans, M. *Exploring issues related to disclosure and non-disclosure in males: Service provider perspective*. Poster presented at the Faculty of Health Sciences Research Day, Western University, London, ON. 3/2016.
 12. **Sivagurunathan, M.**, Orchard, T., Leschied, A., Evans, M. *Exploring issues related to disclosure and non-disclosure in males: Service provider perspective*. Lecture presented at the Health and Rehabilitation Sciences Graduate Research Conference, Western University, London, ON. 2/2016.
 13. **Sivagurunathan, M.**, Orchard, T., Leschied, A., Evans, M. *Factors of disclosure in boys aged 13-24 who were sexually abuse as children*. Lecture presented at the Health and Rehabilitation Sciences Graduate Research Conference, Western University, London, ON. 2/2015.