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Intimate Partner Violence Among Men With Disabilities: The Role of Health Care Providers

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Abstract

Men with disabilities experience higher rates of interpersonal violence (IPV) than either women or men without disabilities, yet research exploring this problem is limited. This retrospective descriptive study examines the clinical files of male survivors of IPV with disabilities who received services from the Secret Garden, a disability-specific nonresidential IPV program located in New York City. These data inform the role health care providers may fill in helping address IPV against men with disabilities. Abuse history, medical and mental health service utilization, and the channels through which men accessed IPV assistance were areas of focus for analysis. Data were analyzed descriptively and outcomes reported as frequencies and percentages. Results indicate that more than half of study participants were abused by an intimate partner (66.2%) and nearly two-thirds described an act of physical abuse as the most serious type of abuse perpetrated (71.7%). Nearly half (40.8%) had previous contact with medical providers due to abuse. The high prevalence of physical abuse in this sample has critical physical and mental health implications, and could further exacerbate already precarious health statuses. While nearly half reported previous contact with health care providers due to abuse, only 15.8% were referred for IPV assistance by a health care provider, indicating a missed opportunity to identify signs of abuse and direct survivors to additional resources.

Keywords

intimate partner violence, general health and wellness, health screening, disabilities

Introduction

Little is known about the experience of interpersonal violence (IPV) among men with disabilities. Recent studies have documented higher rates of abuse among men with disabilities than either women or men without disabilities (Mitra & Mouradian, 2014; Mitra, Mouradian, & Diamond, 2011; Olofsson, Lindqvist, & Danielsson, 2015). Despite these statistics, violence against men with disabilities is a largely invisible issue. The stigma of seeking help as a male, combined with a lack of awareness regarding disability-related abuse, may deter the identification of abuse in this population (Powers et al., 2008). If the perpetrator of abuse assists with self-care or other integral personal needs, the obstacles to reporting abuse are even greater (Saxton et al., 2006). The limited number of IPV services addressing men's needs further restricts the options available to those experiencing abuse (Hines, Brown, & Dunning, 2007; Lund et al., 2015).

Given these barriers, men are less likely to seek IPV assistance via traditional channels, such as criminal justice or IPV-focused social service agencies (Douglas & Hines, 2011). However, men do visit health care professionals with somewhat regular frequency. In 2012, 79% of adult men visited the doctor at least once and 31% saw a doctor four or more times (National Center for Health Statistics, 2013). Among adults with disabilities, nearly 90% visited the doctor at least once in 2012, with 29% reporting 10 or more visits (National Center for Health Statistics, 2013).

Health care providers may be a first point of contact for men with disabilities experiencing IPV due to the relationship between abuse and a number of comorbid adverse health conditions, and are thus in a prime

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position to observe potential signs of IPV. Poor health is a risk factor for IPV among men with activity limitations (Cohen, Forte, Du Mont, Hyman, & Romans, 2006), and men with disabilities who have experienced lifetime IPV are more likely than nondisabled men to report poor physical health status, symptoms of stress, and mental health issues (Coker et al., 2002; Mitra & Mouradian, 2014). Nondisabled men experiencing IPV identified medical and mental health providers among the most helpful sources of assistance as compared with others, including IPV programs (Douglas & Hines, 2011). It is thus crucial that health care providers are equipped with the tools to identify abuse among men with disabilities, as well as sources for referral when abuse is identified.

Trends in health care continue to be shaped by evidence-based practice for enhancing patient care and safety. The World Health Organization notes that health care providers are a first point of contact for many survivors, and are thus integral in providing support, referrals, and appropriate follow-up care (World Health Organization, 2013). Based on a systematic review of evidence related to screening women for IPV, the U.S. Preventive Services Task Force recommended that clinicians screen all women of childbearing age for IPV, and provide or refer women who screen positive to IPV services (Moyer, 2013). Recognizing the seriousness of IPV as a public health problem, the Affordable Care Act covers IPV screening and counseling for all female adolescents and adults (Sebelius, 2012). Despite these recommendations, a recent study of women with disabilities determined that while nearly 90% of the sample reported past abuse, only 15% had ever discussed abuse with a health provider (Curry et al., 2011). This finding raises concerns for men with disabilities, as well, given the high rates of abuse among this population and their lack of attention within current health care policies such as the Affordable Care Act.

Prior research established heightened rates of sexual victimization among men with disabilities (Mitra et al., 2011), and revealed significant health problems among men without disabilities seeking help for IPV (Hines & Douglas, 2015). This article builds on these findings and adds to the limited body of research regarding male survivors of IPV with disabilities. Given that research on IPV against men with disabilities is in its nascent stages, a descriptive analysis was deemed most appropriate for the purpose of building on the emerging understanding of this issue. The purpose of this study is to explore relevant demographic characteristics and help-seeking behaviors of this population with the intention of delineating the role health care providers, a crucial point of contact for men with disabilities, may fill in helping address IPV. The study examines the case records of male survivors of IPV with disabilities seeking help from a disability-specific IPV program for key information regarding abuse history, medical and mental health service utilization, and the channels through which men were referred to the program. Findings are discussed in terms of their relevance to the health of male survivors of IPV with disabilities, and help illuminate the role health care providers may play in assisting this overlooked population.

Method

Study Setting and Participants

This retrospective descriptive study examines the clinical files of male survivors of IPV with disabilities who received services from the Secret Garden, a disability-specific nonresidential IPV program of Barrier Free Living, Incorporated. Male clients were exclusively included in this study due to the dearth of research on male survivors with disabilities (see Ballan et al., 2014, for analysis of female clients). The Secret Garden, located in New York City, is one of few programs nationwide exclusively serving survivors of IPV with disabilities. Clients, who are either self-referred or referred by other community agencies, are eligible for the program if they: (a) are experiencing or have experienced IPV, (b) have a diagnosed or self-identified disability, and (c) are at least 16 years old.

The operational definitions of disability and IPV are agency-based and determined during the agency's intake process. Using standards set by the Americans with Disabilities Act (1991), disability is considered "a physical or mental impairment that substantially limits a major life activity" (sec. 12102, para. 1). The Secret Garden further categorizes disability as physical, psychiatric, developmental, or sensory.

Similarly, using standards established by the New York State Coalition Against Domestic Violence (n.d.), the agency considers IPV to entail physical, sexual, psychological, and economic abuse, perpetrated by an intimate partner, and/or a member of the same family or household. Because some individuals with disabilities use personal assistants or require aid from medical professionals with intimate bodily functions and needs, these providers were included as potential perpetrators. This is consistent with empirical studies and reflects a more comprehensive definition of IPV against individuals with disabilities (Curry et al., 2009; Nosek, Hughes, Taylor, & Taylor, 2006). The terms *domestic violence, abuse*, and *intimate partner violence* are often used interchangeably to describe behaviors intended to exert power and control over another known individual, including physical, sexual, verbal, emotional, or financial abuse. This article uses the term *interpersonal violence*, as employed by Lund et al. (2015), to capture the range of perpetrators of

abuse of men with disabilities, including intimate partners, friends, family members, and personal assistance providers.

Data collection commenced in January 2010 on receipt of Columbia University Institutional Review Board approval. In adherence with the Health Insurance Portability and Accountability Act (1996), the Secret Garden destroys client files after a case has been closed for 7 years. Client files opened during the service period spanning January 2002 to December 2009 (N = 1,056) were reviewed. This study focuses on the client files of male survivors of IPV with disabilities (N = 70). Analysis was conducted in 2014.

Relevant information covering nearly 100 variables were extracted from various records within client files (e.g., psychosocial intakes, mental status exams, hospital records, police reports). Variables included in the current analysis are as follows: age, race/ethnicity, primary language spoken, relationship status, occupation status, number of children, education level, type of disability, relationship with the perpetrator, types of abuse perpetrated, referral source, presenting problem on referral to agency, and utilization of police and medical services due to abuse.

Statistical Analysis

All analyses were conducted using SPSS, version 22.0. Frequencies and percentages are reported for all outcomes. Percentages represent the percentage of available responses for each reported item. Because the amount of missing data varied across items, the frequency representing each percentage for each response was reported.

Results

Sample demographics are presented in Table 1. The majority of the sample reported having a physical disability (75.4%, n = 49), as African American (50.0%, n = 30) or Hispanic (28.3%, n = 17), and over the age of 40 years (70.8%, n = 46). More than half of study participants were abused by an intimate partner (66.2%, n = 45) and nearly two-thirds described an act of physical abuse as the most serious type of abuse perpetrated (71.7%, n = 33); see Table 2 for further description of dynamics of abuse and perpetrator characteristics. Participants were most often referred for disability-focused IPV services by criminal justice entities such as police and the court system (43.7%, n = 28). See Table 3 for additional information on referral channels.

Nearly half (40.8%, n = 20) had previous contact with medical providers due to abuse (see Table 4). Among those who sought medical assistance, 88.9% (n = 16) reported physical abuse, 77.8% (n = 14) previously contacted the police due to abuse, and 15.8% (n = 3) were referred for IPV services by medical or mental health providers.

Table 1. Sample Demographic and Psychosocial Characteristics.

	N (%)[a]
Disability type[b]	
Physical	49 (75.4)
Psychiatric	34 (63.0)
Sensory	12 (22.3)
Developmental	6 (12.0)
Race/ethnicity	
African American	30 (50.0)
Hispanic	17 (28.3)
White	13 (21.6)
Country of origin	
Born within United States	35 (72.9)
Born outside United States	13 (27.1)
Age (years)	
20-29	5 (7.6)
30-39	14 (21.5)
40-49	25 (38.5)
50-59	9 (13.8)
60-69	10 (15.4)
70+	2 (3.1)
Primary language	
English	45 (71.4)
Spanish	5 (7.9)
American Sign Language	1 (1.5)
Bilingual or multilingual	9 (14.3)
Other	3 (4.7)
Occupation status	
Employed	5 (11.9)
Unemployed	37 (88.1)
Highest level of education	
College degree	4 (12.5)
Some college	11 (34.4)
High school diploma/GED	6 (18.7)
Less than high school	11 (34.4)
Marital status	
Married	22 (33.8)
Separated/divorced	8 (12.3)
Single	32 (49.2)
Other	3 (4.6)
Children	
Has children	32 (53.3)

[a]Percentages represent the percentage of valid responses. [b]Some clients reported more than one disability type; therefore, percentage for this category adds up to greater than 100%, and n is greater than 70.

Discussion

Previous studies established the heightened rates of IPV among men with disabilities (Cohen et al., 2006; Mitra et al., 2011; Mitra & Mouradian, 2014; Olofsson et al.,

Table 2. Abuse Dynamics/Perpetrator Characteristics.

	N (%)[a]
Relationship with abuser	
Current or former intimate partner	45 (66.2)
Family member, including children	11 (16.2)
Multiple abusers	7 (10.3)
Other	5 (7.3)
Of married men: Married to abuser	20 (90.9)
Type of abuse reported as most severe incident of abuse	
Physical abuse involving weapon	22 (47.8)
Physical abuse not involving weapon	11 (23.9)
Financial	6 (13.0)
Verbal/emotional	3 (6.5)
Multiple forms of abuse	4 (8.7)
Type of abuse reported as most severe incident of abuse among clients with physical disabilities	
Physical abuse	24 (75.0)[b]
Other type of abuse (i.e., sexual, verbal, financial)	8 (25.0)
Relationship with abuser among clients reporting physical abuse as most severe incident of abuse	
Current or former intimate partner (at time of incident)	25 (73.5)[c]
Family member, including children	7 (20.6)
Other	2 (5.9)

[a]Percentages represent the percentage of valid responses. [b]Percent given is percentage within table row reporting physical disability. [c]Percent given is percentage within table row reporting physical abuse.

Table 3. Referral Channels and Client Needs.

	N (%)[a]
Referral source (outside source referring client to Barrier Free Living for IPV services)	
Criminal justice entity/legal services	28 (43.7)
Disability-focused social service agency	4 (6.2)
IPV-focused social service agency	17 (26.5)
Social service agency, not IPV- or disability-focused	4 (6.2)
Medical or mental health provider	4 (6.2)
Self-referral	2 (3.1)
Other	5 (7.8)
Focus of "presenting problem" cited by client on referral to Barrier Free Living	
Abuse-related	26 (53.1)
Housing-related	11 (22.4)
Legal needs	2 (4.1)
Financial needs	2 (4.1)
Mental health needs	8 (16.3)
Referral source among clients reporting previous contact with the police for assistance with abuse	
Criminal justice entity/legal services	19 (47.5)[b]
Medical or mental health provider	1 (2.5)
Social service agency	20 (50.0)

Note. IPV = interpersonal violence.
[a]Percentages represent the percentage of valid responses. [b]Percent given is percent within table row reporting previous contact with police.

2015) and drew a connection between IPV and compromised health (Cohen et al., 2006; Hines & Douglas, 2015; Mitra et al., 2011; Mitra & Mouradian, 2014). This study expands on previous research by considering the extent to which men with disabilities have attempted to access assistance for IPV, from which sources, and considers the role health care providers may play in assisting this overlooked population. Findings indicate that men with disabilities seeking IPV assistance from a disability-specific IPV agency experience high rates of physical abuse,

Table 4. Service Utilization Among Clients Who Have Previously Accessed Medical Attention Due to Abuse.

	N (%)
Clients reporting previous contact with medical providers due to abuse[a]	20 (40.8)
Among clients reporting previous contact with medical providers due to abuse[b]	
Type of abuse reported as most severe incident	
Physical abuse	16 (88.9)
Other type of abuse (verbal, sexual, financial)	2 (11.1)
Referral source to Barrier Free Living	
Criminal justice entity/legal services	10 (52.6)
Medical or mental health provider	3 (15.8)
Social service agency	6 (31.6)
Previous contact with police for assistance with abuse	
Client did previously call police	14 (77.8)
Client did not previously call police	4 (22.2)

[a]Percentage represents the percentage of valid responses. [b]Percent given is percentage within table row reporting previous contact with medical providers.

primarily perpetrated by an intimate partner. Many reported previous contact with health care providers, yet health care providers seldom were noted as a point of referral for additional IPV assistance. Knowing that men with disabilities experience a disproportionate rate of IPV compared with the general population, and that IPV is associated with a host of physical and mental health conditions, health care providers could be a crucial point of contact for male survivors with disabilities. The current findings highlight opportunities for health care providers to implement disability-sensitive screening for IPV, as well as collaboration with community agencies for information and referral purposes.

The finding that physical abuse was the most common type of abuse reported has critical physical and mental health implications. These serious forms of abuse could further compromise existing disabilities. Furthermore, men who reported receiving medical attention due to abuse were more likely to report physical abuse than other types of abuse. The prevalence of physical abuse in this sample suggests men with disabilities who are experiencing IPV present with identifiable injuries during medical office visits.

The majority of men in this study made contact with a service provider prior to their intake at the Secret Garden. The most common referral sources were criminal justice entities and outside IPV social service providers. Given the presenting problem was described most often as abuse-related, it is likely referral sources determined these needs would be met more effectively by a disability-focused agency. The higher rates of referral from IPV service providers and criminal justice entities could be a result of more knowledge of signs and symptoms of IPV. Training efforts should focus on helping health care professionals identify IPV in men with disabilities and know the available community resources to address their abuse-related needs.

This study illuminates opportunities for identifying signs of abuse among men with disabilities in clinical health care settings. Health care providers were not frequently cited as referral sources, although nearly a third of study participants reported receiving medical attention due to abuse prior to referral to Barrier Free Living. Among clients who previously sought police assistance for IPV, only 2.5% ($n = 1$) were referred for IPV services by a medical provider, with the overwhelming majority referred from a criminal justice entity or social service agency. This indicates a missed opportunity for health care providers to identify signs of abuse and direct survivors to additional resources. Men with disabilities experiencing IPV may have multiple contacts with health care providers, while remaining isolated from other types of IPV assistance. Health care settings vary in makeup of provider teams and may include a physician and/or physician's assistant, resident, nurse, social worker, and other specialized staff. Each member of the care team independently evaluates patients with attention to biomedical and environmental events. Every encounter with a health care provider presents an opportunity for patients to report instances of abuse, and possibly prevent further adverse consequences.

In order for health care providers to detect IPV among patients, education and training is crucial. Health care providers may fail to routinely assess for IPV simply because they have never received adequate training on the topic (Nunez, Robertson, & Foster, 2009). Beginning in medical and nursing school, focused training is effective in increasing knowledge and skill in asking about and responding to IPV (Hamberger, 2007). Training physicians on recognizing and responding to abuse has been reported to benefit IPV survivors and increase referrals to support services (Zaher, Keogh, & Ratnapalan, 2014). Education and training efforts should make note of the

increased risk of abuse among men with disabilities, as well as the potential for disability-related abuse, in order to heighten attention to this patient population.

When assessing men with disabilities for IPV, several considerations must be taken into account. Medical professionals are not immune to cultural biases around disability, gender norms, or abuse. Effective assessment of abuse among men with disabilities must also address attitudinal barriers. Due to the cultural framework of IPV and the common misconception that men are rarely subject to this type of violence, survivors may not recognize the violence as abuse. This is reinforced by the focus on women in discussions of screening for IPV in health care settings. However, recognizing that men and women alike may experience IPV, the Family Violence Prevention Fund (2004) recommends that health care providers assess all patients, both male and female, for signs of abuse.

Assessment should always occur in private and be kept confidential, except when contraindicated by mandatory reporting laws. Given that the majority (86.9%) of the married sample stated that their spouse was a perpetrator of abuse, a consideration critical to effective assessment includes patient–health care provider contact separate from an intimate partner who may accompany patients to appointments.

Disability-related abuse may not be detected using traditional screening questions. For instance, a personal assistant's refusal to assist with an integral personal care need such as going to the bathroom or getting out of bed may not be identified using a standard abuse screening tool, but constitutes abuse. Practitioners also should be aware of the possibility of financial abuse (e.g., taking a client's Social Security Disability Insurance payments), and isolation tactics such as preventing a patient from obtaining physical and mental health care or denying access to needed mobility supports such as a wheelchair. Patients may offer information about these incidents in the course of a routine appointment, not realizing that such behaviors are abusive. Practitioners in frequent contact with individuals with disabilities are directed to the Abuse Assessment Screen–Disability for examples of questions considering types of abuse unique to this population (McFarlane et al., 2001).

If a patient answers affirmatively to screening questions inclusive of disability-related abuse, or otherwise reveals abuse, referral to an on-site social worker is advised. Social workers play a critical role in biopsychosocial assessment in health care settings and have specialized training to respond to identified trauma (National Association of Social Workers, 2005). If an on-site social worker is unavailable, health care providers may direct patients to local IPV hotlines or agencies. It is recommended that materials for these agencies be maintained and made available to patients. A systematic review of primary care interventions suggested that connection to IPV-related resources is a noted positive outcome of such encounters (Bair-Merritt et al., 2014). However, patients should be advised to conceal these materials, particularly if they are living with the perpetrator. The patient's safety could be compromised if a perpetrator was to discover evidence that the patient is seeking assistance for IPV.

Finally, collaboration with community agencies is an essential component of ensuring appropriate referral in the event that abuse is disclosed within a health care setting. IPV screening alone is not an effective intervention; referral to IPV services and related follow-up are necessary (Coonrod et al., 2000; Kendall et al., 2009). Determining which service providers have expertise to address the needs of men with disabilities in a culturally competent manner is a vital step in this process. Arranging meetings between health care providers serving the community and IPV- and disability-focused agencies may increase the likelihood of appropriate referrals being made, and aids in the sharing of information and building of rapport (Ferguson, 2010).

Limitations

Secondary analyses of data are inherently bound by the limitations of the original data. The data examined in this study were entered into client files by agency staff at intake and intended for internal monitoring of clients' service needs. Accordingly, variables were sometimes defined or categorized differently than the researchers would have chosen, thereby altering the questions the study sought to answer. Missing information varied across client files and limited options for data analysis.

The sample included only the client files of men with disabilities who had sought assistance for IPV from a single agency. This agency was selected for its unique focus on survivors of IPV with disabilities, a specialization limited to less than 20 IPV agencies nationwide. However, focusing on one agency limits the generalizability of the study's findings, as does the small sample size. The small number of men receiving services for IPV at the Secret Garden is likely reflective of the cultural and social bias surrounding IPV among men with disabilities. Information about men who are unable or choose not to access such services is a critical area for further exploration.

Finally, client files from the years 2002 to 2009 were analyzed. The issue of IPV against individuals with disabilities has received greater attention in recent years, and it is possible that data gathered beyond 2009 would reveal different findings in terms of service utilization, referral channels, client needs, and experiences of abuse. Conducting a similar analysis with client files drawn

within the past 5 years and comparing the data for significant differences are areas requiring further exploration.

Conclusion

Individuals with disabilities face unique risk factors for IPV, compounded by the intersection of race and gender. Social awareness of IPV among men with disabilities is limited and IPV programs able to address their needs are scarce. IPV is associated with a host of physical and mental health conditions, which may further compromise the health of men with disabilities. Until services for male survivors of IPV with disabilities are expanded, health care providers may be among the few community resources accessed by this population.

Accordingly, health care providers are a crucial point of contact for individuals with disabilities, with every office or clinic visit representing "the potential for secondary prevention, intervention, and provision of referrals to further reduce the adverse health impacts of IPV" (Black, 2011, p. 434). The study's findings highlight opportunities for health care providers to implement disability-sensitive screening for IPV. Collaboration with community agencies for referral and information purposes will yield greater awareness and understanding of the problem, and ultimately enhance safety and health among men with disabilities.

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