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***“It’s always good to ask”*: A mixed-methods study on the perceived role of sexual health practitioners asking gay and bisexual men about experiences of domestic violence and abuse**

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ABSTRACT

Development of joint displays is a valued approach to merging qualitative and quantitative findings in mixed methods research. This study aimed to illustrate a case series mixed methods display and the utility of using mixed methods for broadening our understanding of domestic violence and abuse (DVA). Using a convergent design, 532 gay and bisexual men participated in a Health and Relationship Survey in a UK sexual health service and 19 in an interview. Quantitative and qualitative data were analysed separately and integrated at the level of interpretation and reporting. There were inconsistencies in perceptions and reports of abuse. Men were supportive of selective enquiry for DVA by practitioners (62.6%; 95% CI, 58.1% to 66.7%) whilst being mindful of contextual factors.

Key words: domestic violence, gay and bisexual men, routine enquiry, mixed methods, sexual health services,

INTRODUCTION

Domestic violence and abuse (DVA) is highly prevalent amongst gay, bisexual and other men who have sex with men (MSM) (Finneran & Stephenson, 2013). A systematic review reports lifetime prevalence of any type of DVA among MSM to be between 29.7% and 78.0% (Finneran & Stephenson, 2013). DVA in MSM is significantly associated with an increased risk of HIV, depressive symptoms, substance abuse and unprotected anal sex (Buller et al. 2014a). Despite the high prevalence and impact on health, their views on the potential role of healthcare services in supporting those who experience or perpetrate abuse has not been explored.

In high income countries there is evidence that DVA interventions in health care settings can promote positive outcomes for women and that many women find routine enquiry for DVA by health care practitioners acceptable (Feder, Hutson & Ramsay, 2006; Feder et al. 2009). However, there continues to be international debate about a policy of routine enquiry for DVA in healthcare settings due to insufficient evidence of improved outcomes (Moyer et al. 2013; O'Doherty et al. 2014; World Health Organization, 2013). The World Health Organization recommends that providers should be trained in how to respond to disclosures of abuse and to be aware of the indicators. However, the UK National Institute for Clinical Excellence guidelines on DVA cite sexual health services as a setting where clinicians should ask service users about DVA as part of routine good clinical practice "*even where there are no indicators of such violence and abuse*" (NICE, 2014). Furthermore, the guidelines state that practitioners need to be aware of the needs of gay, bisexual and transsexual people who are at risk of abuse. Public Health England highlights DVA as a major social determinant of health in gay, bisexual and other MSM, necessitating further research to improve clinical practice and service provision (PHE, 2015).

Existing mixed methods studies on DVA tend to report quantitative and qualitative findings separately. There has been little consideration of how meaningful integration could build strong and useful conclusions that are greater than the sum of the individual qualitative and quantitative components. Whilst mixed methods research has received increasing attention as an important methodology for investigating complex health issues, a review of the quality of mixed methods studies in health service research concluded that integration is not well developed or practiced. Researchers often fail to provide justification for, and transparency of, the mixed methods design. The qualitative components are more likely to be inadequately described, with inferences based disproportionately on one method rather than the findings of all methods (O’Cathain et al. 2008).

The development of joint displays has emerged as a highly valued approach for integrating qualitative and quantitative findings in mixed methods research. They facilitate the process of analysis and interpretation and provide a visual representation of mixed method results to generate new inferences (Fetters, Curry & Creswell, 2013). There are various approaches to building joint displays which are usually linked to the type of mixed method study (Gutterman et al. 2015). In a convergent design, Dickson et al. (2011) developed a cross-case comparison of interview data with quantitative scores on measures of self-care, cognitive function and knowledge in patients with heart failure. This approach enabled them to validate quantitative findings and identify instances of inconsistency. It also provided a fuller understanding of the cognitive influences of self-care. In an exploratory sequential design Haggerty et al (2012) used themes from qualitative studies of patients’ views of continuity of care to refine existing instruments. An instrument development joint display mapped the qualitative dimensions of continuity of care to quantitative instrument items. Despite growing interest in joint displays, their use for case study research on DVA is lacking thereby

limiting our understanding of how individuals interpret and respond to abuse items on surveys. Quantitatively assessing the predominant view amongst men regarding routine enquiry for DVA by health practitioners is important for informing future healthcare policy. However, this needs to be combined with qualitative data that helps to clarify the conditions that facilitate their seeking help from health practitioners.

Men are less likely than women to seek help from health professionals for problems such as depression, substance abuse, physical disabilities and stressful life events (Galdas, Cheater & Marshall, 2005). Their reluctance has been linked to internalised gender notions about masculine identity which cause men to be silent about emotional events in their life (Gascoigne & Whitear, 1999; Möller-Leimkühler 2002; Moynihan, 1998). A UK study of heterosexual men attending general practice surgeries found that many expressed difficulty in seeking help from professionals for relationship abuse (Morgan et al. 2014). Lesbian, gay, bisexual and transgender (LGBT) people are often reluctant to seek help from formal services due to fear of homophobic or inappropriate responses from providers (Ball 2011; Donovan et al. 2006; Duke & Davidson, 2009). Kashak (2001) refers to the “*double closet*” that surrounds DVA in same-sex relationships in which victims suffer the dual burden of shame and silence surrounding two highly stigmatised issues, that of being gay (same sex-sexuality) and being abused by a same sex partner.

The reluctance of the LGBT community to seek help can also be understood within historical discourses on DVA. Ball (2011) refers to the binary and hetero-normative feminist frameworks which rely upon there being a female victim and a male perpetrator. He argues that as a consequence, the LGBT community have no language with which to articulate their experiences. This is echoed in the work of other researchers who have emphasised the

powerful role of the "*public story about domestic violence*" which marginalises those who are not female victims in a relationship with a male partner (Donovan & Hester, 2010).

Interventions in health care settings have also been developed within a hetero-normative framework and different interventions may be needed for gay and bisexual men. Health practitioners experience multiple challenges when trying to integrate abuse questions into clinical practice with women patients. These include lack of time and confidential space; inadequate training, fear of offending women; feeling frustration when women do not act on advice given; safety concerns and discomfort with asking questions about abuse (Feder et al. 2009). The presence of heterosexism and homophobia within health care settings, combined with health care practitioners' poor understanding of the experiences of LGBT victims of DVA is likely to make their identification and the provision of culturally appropriate services more difficult (Freedburg, 2006).

Case studies outside of the field of violence offer important theoretical insights that help to broaden our understanding of the factors that inhibit integration of DVA responses in to health care delivery. Spector & Pinto (2011) explored the manifestation of culture-based countertransference (i.e. unconscious and/or repressed feelings towards a client) amongst substance abuse counsellors and how this undermined their efforts to integrate HIV prevention with MSM. They found that substance abuse counsellors were uncomfortable initiating discussions about sexual practices and HIV, and that their heteronormative assumptions and beliefs resulted in missed opportunities for exploring their client's sexual preferences. In another study, the authors used social cognitive theory to explore the extent to which primary care workers in Brazil integrated public health interventions (i.e. referral to drug services) as part of the National Family Health Strategy. Those with higher levels of

personal and collective agency were more likely to offer drug use services. This was evidenced in worker's having greater knowledge of current research, evidenced based practice and the availability of peer support (Spector et al. 2015).

In view of the myriad health problems and psychosocial risk behaviours associated with DVA in gay, bisexual and other MSM (Buller et al. 2014a) it is imperative that health services acknowledge and address DVA as a potential underlying factor to ensure the delivery of appropriate care. The purpose of this research is to (i) use data from a survey and semi-structured interview on gay and bisexual men's experiences of DVA to illustrate a case series mixed methods display and (ii) explicate the utility of a mixed methods approach for broadening our understanding of a highly stigmatised and sensitive issue and informing future interventions in sexual health services.

The study is part of PROVIDE, Programme of Research on Violence in Diverse domestic Environments (<http://www.bristol.ac.uk/social-community-medicine/projects/provide/>) which investigated the epidemiology of domestic violence and interventions in a range of health care settings in collaboration with third sector organisations in the UK.

METHODS

The theoretical orientation underlying the mixed methods approach is pragmatism which rejects paradigm debates and focuses on "*what works as the truth regarding the research questions under investigation*" (Teddlie & Tashakkhori, 2009). Pragmatists believe that epistemological issues regarding objectivity and subjectivity exist on a continuum, rather than in opposition. Furthermore, they believe that qualitative and quantitative methods are useful

and decisions regarding their use should be driven by the research questions. We used a convergent design where qualitative (semi-structured interviews) and quantitative (survey) methods were used simultaneously in order to (i) develop a more comprehensive picture by linking complementary data sources (ii) avoid bias intrinsic to single-method approaches and (iii) as a means of compensating specific strengths and weaknesses associated with particular methods (Denscombe, 2008). Combining these methods enabled triangulation which increased the credibility and validity of the findings, as well as a method for confirming or disconfirming hypotheses (Flick 2014). Integration occurred through linking the methods of data collection and at the level of interpretation and reporting. At the methods level integration occurred through connecting, whereby the sub-sample of men who participated in the semi-structured interview were recruited from the population of participants who completed the survey. Integration at the level of interpretation and reporting was achieved by synthesising qualitative and quantitative data through a narrative approach in the results and discussion using weaving. The results were connected to each other thematically, with qualitative and quantitative data weaving back and forth around the key themes (Fetters, Curry & Creswell, 2013).

Health and Relationships Survey

Between September 2010 and May 2011, an anonymous Health and Relationships Survey was conducted in the waiting rooms of two generic sexual health clinics and one specialist sexual health clinic for (LGBT) patients in London. The survey took approximately fifteen minutes to complete. It elicited demographic information and sexual orientation as well as reported diagnoses of sexually transmitted infections in the last 12 months. Current anxiety and depression were measured with the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1984). Alcohol use was measured with the AUDIT-C test (Saunders et al. 1993) and

illicit drug use was assessed using single item yes/no questions on past year use of cannabis and class A drugs (Ecstasy, LSD, cocaine, crack, heroin and injected amphetamines). Men were asked dichotomous ‘yes’ or ‘no’ questions about whether they had experienced or carried out negative and potentially abusive behaviours in the context of an adult intimate relationship including: ever felt frightened of the behaviour of a partner; ever needed to ask a partner’s permission to work, go shopping, visit relatives or visit friends (beyond being considerate to and checking with a partner); ever been slapped, hit, kicked or otherwise physically hurt; and ever forced to have sex or made to engage in any sexual activity against one’s will. This was followed by questions on whether this had occurred in the last 12 months, relationship with the perpetrator, frequency, escalation and perceived impact of the abuse. Men were also asked whether they had ever carried out the behaviours towards a current or former partner, whether this occurred in the last 12 months and whether they perceived an effect on their partner. Finally, respondents were asked whether they felt they had been in “domestically violent or abusive relationship” currently and/or in the past. The abuse questions were based on the Comparing Heterosexual and Same Sex Abuse in Relationships (COHSAR) survey (Hester, Fahmy & Donovan, 2010).

The survey included a question asking respondents if they thought health professionals should ask their patients “whether they have been hurt or frightened by their partner” with response options of: ‘Yes, they should ask all their patients’; ‘Yes, but they should only ask some of their patients, depending on the symptoms they describe’; and ‘No, they should not ask any of their patients’. Further details of the survey content are published elsewhere (Hester et al. 2015; Williamson et al. 2014). In order to avoid temporal bias, the clinics were randomised across 28 weeks for survey administration. After registering for a clinic appointment, male patients were invited by a researcher to participate in the survey if they

were aged 18 or over, attending the clinic alone and could read and write English. Upon returning the survey, men were invited to provide contact details if they were willing to take part in an interview at a later date.

Semi-structured interviews

Men who provided contact details were telephoned by the researchers to explain the purpose of the interview. Semi-structured interviews were conducted between October 2010 and May 2011 in a confidential consulting room at the clinic and included questions about: completing the clinic survey; experiences and perpetration of potentially abusive behaviours in relationships; experiences of help seeking; and views on enquiry for DVA by sexual health practitioners. Research shows that individuals may report experiencing or carrying out behaviours, but not consider them harmful nor perceive them as abusive, or only define some types of behaviours as abuse (Hearn, 2013; Hester, Fahmy & Donovan, 2010). Therefore, men were asked about behaviours they experienced from a partner that caused them to feel frightened or unsafe as well as behaviours they had carried out towards a partner that may have caused their partner to feel frightened or unsafe. Probes about specific acts of abuse were used to determine the types of behaviours. Men were asked what they understood by the terms domestic violence and domestic abuse and what types of behaviours they would include in their definition. Following this, they were asked whether or not they would define any of the concerning behaviours they had experienced or carried out as domestic violence or domestic abuse. Further support for this approach to questioning is evidenced in the fact that nearly two thirds of men who reported experiencing at least one negative behaviour in the survey, said that they had never been in a domestically violent or abusive relationship in response to the single item question (Bacchus et al. 2016). Men were asked for their views on

enquiry for DVA by health professionals, including the reasons for their preference, how this might be approached in a sexual health clinic and the potential barriers.

Sampling was opportunistic and the survey results were not used to guide the choice of participants. Interviews were conducted by LJB and AMB, lasted up to 3 hours and were conducted in a private clinic room. To avoid interviewer bias, the researchers were blinded to the participant's survey responses to the items on potentially abusive behaviours and participants were informed of this before the interview commenced. All participants were offered information about support services for men affected by DVA.

Survey participants

Of 2,657 men who attended the sexual health clinics during the study period, 1,132 (42.4%) completed a survey. Of the 1,127 men who reported their sexual orientation, 471 (41.8%) were gay, 61 (5.4%) bisexual and 595 (52.8%) heterosexual. The analysis will focus on the views of 532 (47.2%) gay and bisexual men.

Semi-structured interview participants

Of 47 men who provided their contact details upon completion of the survey, 36 had usable telephone numbers and were contacted, of which 24 agreed to be interviewed, of which 17 reported their sexuality as gay, two bisexual and five heterosexual. Data are presented on 19 gay and bisexual men. Interviews were conducted by two female researchers (LB and AMB).

Analysis of the survey data

Quantitative data were analysed in Stata version 12.0 (StataCorp LP, 2011). Descriptive statistics were computed for variables on routine enquiry for DVA by health practitioners. A

logistic regression was undertaken to examine factors associated with men's views on routine versus selective enquiry for DVA. The question regarding views on enquiry for DVA by health professionals was transformed to a dichotomous variable indicating whether men favoured 'routine enquiry of all patients' or 'selective enquiry of some patients based on presenting symptoms' as these were the predominant views. Only 14 (2.7%) of men disagreed with any type of enquiry for DVA and they were removed from the analysis to ensure clarity in the dichotomous dependent variable. Furthermore, none of the men who participated in a semi-structured interview were opposed to the practice of health practitioners asking men about DVA. For the regression analysis, respondents are men who completed all four survey questions on experiencing negative behaviour from a partner and/or all four questions on carrying out negative behaviours. Independent variables included in the regression model were age, ethnicity, maximum level of education attained, employment status, partner status, experiencing a negative behaviour from a partner and carrying out a negative behaviour towards a partner. Adjusted odds ratios and 95% confidence intervals are presented.

Analysis of semi-structured interviews

Interviews were digitally recorded, transcribed verbatim and uploaded onto NVivo 10 for organisation of the analysis. The initial coding framework was developed in conjunction with colleagues from the wider PROVIDE programme following a deductive approach by which the coding tree parents and child nodes mirrored the interview schedule themes. When testing the initial coding framework we allowed for open coding in an inductive process which allowed new themes to emerge from the data and the subsequent modification of the initial coding framework. After agreeing the final coding framework two researchers, LJB and AMB, coded 5 transcripts separately. When discrepancies arose, these were discussed as a

check for coding consistency (Miles & Huberman, 1994). When choosing quotes for this paper, the authors chose quotes which represent the views from a wide range of interviewees.

Due to the lack of robust evidence and the small number of bisexual men in both the survey (n=61) and the semi-structured interviews (n=2) we chose not to conduct separate analyses for gay and bisexual men. The main nationally representative UK survey on DVA, the Crime Survey for England and Wales (CSEW), has tended to aggregate data on abuse experienced by those identifying as lesbian, gay or bisexual due to the small numbers. In 2010 they published data on 500 lesbian, gay and bisexual respondents from the 2007/8 and 2008/9 domestic violence surveys, and reported higher rates of DVA amongst this group compared to heterosexual people, although they did not dis-aggregate data for gay and bisexual men (Donovan & Hester, 2015). Therefore, it is not known whether the experiences of DVA in gay men are qualitatively different from those of bisexual men.

Connecting qualitative and quantitative analysis

Quantitative and qualitative data collection occurred in a parallel and separate manner, but were designed to answer related aspects of the same research questions. We used a parallel mixed data analysis which involved two separate processes: quantitative analysis of the survey data using descriptive and inferential statistics, and multivariate analysis; and thematic analysis of qualitative data. The two types of analyses were independent, but each contributed to developing a more comprehensive understanding of men's views about enquiry for DVA by health practitioners. Triangulation of the survey and interview data were used to compare how men reported experiences of negative and potentially abusive behaviour. We developed a variation of a joint display for case series research in which we present the qualitative accounts of abuse alongside the survey responses for each participant. This provided a visual

means to elicit new insights beyond those obtained through separate analysis of these data sources (Gutterman et al. 2015).

RESULTS

Socio-demographics

Table 1 presents the socio-demographic characteristics of men who participated in the Health and Relationships survey and men who participated in the semi-structured interviews. Men who participated in the interviews were slightly older, less educated and predominantly white compared to the survey sample.

TABLE 1 HERE

Disclosure of negative and potentially abusive behaviours: triangulation of survey and interview data

In the survey, 33.9% (95% CI, 29.4% to 37.9%) reported ever experiencing a negative behaviour from a partner; 16.3% (95% CI, 13.0% to 19.8%) reported ever carrying out a negative behaviour towards a partner; and 11.4% (95% CI, 8.7% to 14.2%) reported experiencing and carry out negative behaviour.

TABLE 2 HERE

Table 2 is joint display presenting a case comparison of negative and abusive behaviour reported by men in the interview and the survey. The display revealed a number of discrepant findings related to underreporting of behaviours experienced and carried out in the survey. For example, in his interview Samuel [56 yrs] admitted being frightened of his behaviour

towards his partner, which included throwing objects at him and verbal abuse. His minimisation and normalisation of these behaviours as “*par for the course*” and “*just aggression in the house*” may explain his decision not to report these behaviours on the survey. There was also evidence to support this hypothesis in the survey findings. Of 168 men who reported at least one negative behaviour from a partner, 107 (63.7%; 95% CI: 56.0–70.9%) said that they had never been in a domestically violent or abusive relationship. Similarly, 57 of 82 (69.5%; 95% CI: 58.8–79.7%) who reported carrying out at least one negative behaviour towards a partner stated that they had not been in a DVA relationship.

In the interviews some men reported objects being thrown directly at them or around them, verbal abuse and feeling belittled, which negatively affected their emotional wellbeing. However, these acts were not captured by the four survey items. Lewis [21 yrs] described feeling jealous and insecure, and constantly required his partner to tell him of his whereabouts, which is a subtle form of controlling behaviour. Consequently his partner would avoid contact with certain friends. However, he did not respond positively to the survey item about requesting a partner to seek permission. The perceived impact of the abuse may also have influenced whether or not men chose to define their experiences as “abusive” in the survey. For example, in the case of Martin [32 yrs] who did not feel unsafe or fearful of his partner’s behaviour.

Some forms of abuse, such as forced sex, may have been too sensitive for men to discuss in a face-to-face interview. Both Nathan [46 yrs] and Edwin (42 yrs) disclosed various forms of abuse that they had experienced, but maintained that sexual decision making and negotiation was never an issue in any of their relationships. Yet both of them responded positively to the

item on forced sex in the survey, suggesting that the survey method may have been more effective at eliciting disclosure of sexual violence and abuse because it offered anonymity.

Views and experiences of routine versus selective enquiry for DVA

In the Health and Relationships Survey, of 522 gay and bisexual men who responded to the question, 181 (34.7%; 95% CI, 30.6% to 39.1%) felt that health professionals should ask all patients whether they have been hurt or frightened by a partner, 327 (62.6%; 95% CI, 58.1% to 66.7%) only some patients based on symptoms, and 14 (2.7%; 95% CI, 1.4% to 4.2%) stated that health professionals should not ask any patients. Twenty-one out of 523 (4.0%; 95% CI, 2.4% to 5.9%) gay and bisexual men reported ever being asked by a health professional whether they had been hurt or frightened by a partner and 9 out of 523 (1.7%; 95% CI, 0.7% to 2.9%) had ever been asked about perpetrating these behaviours. In terms of whether health professionals should ask patients about having ever hurt or frightened a partner, 146 (28.0%; 95% CI, 24.0% to 32.2%) indicated that health professionals should ask all patients routinely, 340 (65.3%; 95% CI, 61.0% to 69.6%) only some patients based on presenting symptoms, and 35 (6.72%) stated that no patients should be asked.

The semi-structured interviews help to illuminate men's preferences. There was concern that routine enquiry may result in a health practitioner asking a patient about abuse in the context of a worrying or serious sexual health problem and that neglecting a patient's immediate concerns may deter them discussing abuse.

A lot of people who come here will be frightened, scared, very, very nervous and not wanting to talk about really the reasons why they are there. Especially if they think they maybe be infected with HIV...[discussion about domestic violence] is not

necessarily going to be reasoned and coherent. They're not necessarily going to be in the best place to be listening. [Chris, 43 yrs]

I think it should be done on a case by case basis. I suppose possibly by the information they've kind of deduced from the patient. I think they should only do it if it's related to the kind of symptoms that the person shows. [Lewis, 21 yrs]

One man who preferred selective enquiry for DVA suggested that a more conversational approach might elicit honest responses, and that highlighting the connection between abuse and sexual health problems would be a way to open up communication.

Yeah, I think that a bit of an explanation along with the question would probably be more benefit and [elicit] more accurate responses. Something along the lines that "we often find that people might be susceptible to infections if they are in an abusive relationship and you could list a few possibilities. If you wanna talk about these issues we do have trained people here to discuss it with, maybe offer advice and help".

[Dylan, 57 yrs]

Some men felt that the hectic environment of the sexual health clinic would make it challenging for sexual health practitioners to ask all patients about DVA and respond to disclosures sensitively. Creating a domestic violence aware culture within sexual health clinics was seen as more important, for example, by having posters and leaflets available in the waiting areas or notices informing men that they could talk to a practitioner about abuse.

I don't know if the practitioner has time to ask everybody that question...should they ask everybody? I don't think so. Some people might get upset by that question, may think "where is this coming from? Why are you asking me that?" Maybe what should be more obvious is having much more leaflets and posters in the waiting area. Maybe a poster saying if you want to discuss domestic abuse with a practitioner feel free to do so, give them that option rather than ask everybody. [Gabe, 33 yrs]

Choosing the right moment in the development of the patient-practitioner relationship, when trust has been established was regarded as a facilitator to disclosing abuse, and that selective enquiry for DVA would best support this process.

When I come here I just want to get the job done and go. I probably may not have met that person before, I don't want to start spluttering out all the things that have been going on. I now have a very good relationship with my HIV consultant and if he were to ask me that question, I would probably be much more open about discussing it with him. [Gabe, 33 yrs]

Some felt that routine enquiry for DVA should only take place if there were properly resourced services to which men could be referred. It was also suggested that immediate on-site support might be preferable to referring men to external services.

It's very dangerous to start to explore something that you then can't support...In an ideal world I think it would be wonderful and then I think that you would be able to refer them to a service which could see them immediately and then give them all the help they needed. The world that we live in is one of funding cuts and under resourced

services. I don't think they should ask everybody, only some if it's quite obvious.

[Shaun, 52 yrs]

It sounds a great idea, but where is the help available? Do the staff here offer help?

Or maybe there are counsellors here or maybe the health advisors would be

counsellors? [Dylan, 57 yrs]

TABLE 3 HERE

Table 3 presents the logistic regression which examines men's views about routine enquiry for DVA (i.e. ask all patients) versus selective enquiry (i.e. ask some patients based on presenting symptoms) by health professionals in relation to different socio-demographic characteristics and abuse status. The comparator group for each independent variable is the reference category. Men who reported their ethnic group to be white were significantly less likely to support routine enquiry for DVA compared to non-white men (32.8% vs 47.2%; OR=0.6, 95% CI, 0.40 – 0.88). In the semi-structured interviews there were only two non-white respondents, although both supported routine enquiry for DVA. None of the other independent variables in the regression model were significantly associated with views about routine enquiry for DVA (i.e. age, educational level, employment status, partner status, and experiences of negative behaviour).

If it's done in a more routine fashion, if they were asking everyone. If they were asking me, I would feel more comfortable if they were just like...in the normal questions they ask, not like "I spot an issue with you". [Francis, 30 yrs]

I think it's always good to ask, but whether people give you the right answer is probably another matter. [Graham, 27 yrs]

In the survey, men who reported experiencing negative and potentially abusive behaviour from a partner were more likely to support routine enquiry for DVA compared to those with no history of such behaviour (44.0% vs 31.6%) although the result did not reach statistical significance. In the semi-structured interviews, amongst those who favoured routine enquiry for DVA, were two men who experienced severe acts of abuse, one of whom was pushed through a window resulting in a broken arm, and another who was raped. There was a recognition that routine enquiry was important because abuse may cause or worsen a sexual health problem. Furthermore, that asking about different types of DVA would help men to label experiences as *abuse* and convey a message that health professionals were willing to listen and offer support.

You've got to ask yourself why are people coming here in the first place? They might be here because they've contracted something through some sort of abuse. Yes in this environment [asking about domestic abuse] could be an added thing. [Edwin, 42 yrs]

Just because I couldn't say it [disclose domestic violence] doesn't mean other people might not start to see that they have a problem with their relationship. Eventually even I realised what was going on. Maybe being asked could have triggered that question in my head. [Francis, 30 yrs]

The most appropriate sexual health practitioner to ask about DVA

The sexual health clinic is staffed by a multi-disciplinary team of doctors, nurses and health advisors and a patient may have contact with any or all of these practitioners. Therefore, it was important to elicit men's views about the most appropriate practitioner to ask about DVA. Health advisors were regarded as well placed to ask about DVA as they also provide counseling about sexual risk behaviours which also requires an empathic and non-judgemental approach. Therefore, discussion about relationships was seen as a natural extension of their role. In comparison, doctors and nurses were viewed as working within a more medical model that was not conducive to addressing relationship issues.

Definitely a health advisor and the reason is...I think that nurses and doctors are trained very much to a medical model and not to a health promotion model...Definitely health advisor cos they are much more likely to have an empathic approach. And the doctors would be like "I don't know which pill to give you for that". [Shaun, 52 yrs]

I'm not being disparaging with the consultants and the Special Registrars, but they're very much like "this is what you have wrong with you, we are going to do this, this and this" and if they ask [about domestic violence] in that type of tone as well, nobody is going to want to spill everything out when they have been asked everything in such a rushed way. It's not that they don't care, it comes across like that. I think that nurses are much better or even the health advisors are very good at that as well. They've got that more empathic feel to things and seem to have a bit more time to discuss these things. [Gabe, 33 yrs]

The most appropriate time to ask about DVA

Men were also probed for their views on the most appropriate time during their trajectory in the clinic to ask about abuse. The initial assessment was seen as an opportune time to raise the issue of DVA because questions about sexual history are asked, or alternatively during counselling sessions with health advisors. However, asking about abuse during procedures such as taking blood or providing urine samples was deemed to be inappropriate.

I'd say the initial assessment when you go in and are seen by the doctor at just the general round up. They could perhaps say "are there any potential abusive or violent episodes in your life that you might want to discuss with a professional?" ...I think that it's good at that time because they are discussing disease and being susceptible to receiving infection and that sort of thing. I suppose it comes in hand with it doesn't it? [Dylan, 57 yrs]

I spoke to somebody who wasn't a doctor [referring to a health advisor] who said "you're here today because you're worried that you may have picked up HIV infection so let's talk about what happened". I think that would be a good point to [ask about domestic violence] rather than the first stage where you're getting your blood taken and it's just dropped into the conversation. [Brian, 33 yrs]

Gender of the health practitioner

There were mixed views on whether gender of the health practitioner might influence men's decision to disclose abuse. Some felt more comfortable talking to female practitioners and feared that they might be judged by a male practitioner. Although the social stigma of being abused by another man was seen as a barrier to seeking help, it was ultimately the

interpersonal skills of the health practitioner that were considered important regardless of gender.

I do wonder, in a MSM relationship with the addition of testosterone, machismo is probably an even bigger social barrier to admitting as a man that you're in a relationship between men [and] that you are being abused. [Chris, 43 yrs]

I think it's difficult...I feel more able to talk to a woman than a man. I always feel that if I talk to a man they're judging me and I always feel when I talk to a woman, they're not. [Lewis, 21 yrs]

I think a lot of gay guys are quite effeminate and they have a real attachment to women. I know lots of gay guys who do really get on well with women. I'd be happy for you to ask me and I think it depends on their approach and I suppose some people might prefer male some might women. [Ian, 43 yrs]

Asking men about DVA in other health care settings

There were fairly strong views about general practitioners not having the time or skill to discuss relationship abuse. Men said that their GP was unaware of their sexual orientation which created a barrier to open communication. Sexual health clinics were seen as ideal places in which to ask about DVA because sensitive issues, including sexual orientation, are already discussed and they provide a greater sense of confidentiality.

I think [with] the GP you don't get a sense of anonymity and confidentiality. You almost think that when you see a GP that everything is written down and that's going

to be on your record for a very long time. So even if that GP leaves you're still never allowed to forget your past. But whereas coming here [sexual health clinic] and speaking to the health workers here, are almost non-judgemental. [Alex, 29 yrs]

R: Have you ever been open about your sexuality with your GP?

P: No funnily enough, it has never come up. I've known my doctor for as long as I've lived, so 30 years, and I don't think that I have ever discussed with her anything to do with my sexuality whatsoever. I don't think I would feel comfortable talking about my sexuality whatsoever. [Omar, 29 yrs]

DISCUSSION

The primary aim of this paper is to illustrate the use of a case series mixed methods display for integrating interviews and survey data on gay and bisexual men's experiences of negative and abusive behaviour in the context of intimate relationships. The joint display provided a visual means for displaying mutually informing qualitative and quantitative findings which helped to generate new meta inferences that would not have been identified through separate analysis of the data components (Bazeley, 2011; Fetters, Curry & Creswell, 2013). It revealed a tendency for men to under-report experiencing and/or carrying out negative and abusive behaviour in the survey. The semi-structured interviews elicited more detailed accounts of these behaviours, particularly when these were directed towards a partner, and the potential reasons for under-reporting in the survey. This included a lack of recognition of the effects of their abuse towards a partner, not feeling fearful of a partner's aggressive behaviour towards them, and minimising or normalising abusive behaviour. It is also possible that men in current abusive relationships are more likely to minimise abuse experiences due to fear,

shame or not recognising behaviours as abusive, which may also lead to under-reporting in surveys. This was corroborated by the survey data which found that the majority of men who had experienced or carried out negative and abusive behaviour, did not perceive themselves to have been in a domestically violent or abusive relationship (Bacchus et al. 2016). Use of the case series display also demonstrated that the validated abuse measure did not fully capture the subjective abuse experiences of men. Some of the abusive behaviours described by men in the interviews were not accurately reflected in the four survey items. Common behaviours identified in the interviews include the use of verbal abuse, belittling, pushing and throwing objects at or near a partner. Integration of the quantitative and qualitative findings regarding abuse highlighted the difficulty of reducing complex behaviours within an intimate relationship to a small number of checklist items (Testa et al. 2004). However, the anonymous survey may have been better for eliciting disclosures of forced sex than the interview. Men's subjective definitions about what constitutes abusive behaviour were sometimes very different to those captured by the survey items. Additional questions on the perceived impact of abusive acts and intent to cause fear or harm are needed to contextualise behaviours.

Evans et al. (2016) also highlighted the limitations of using single methods for exploring abuse experiences among women. Cognitive and qualitative interviewing was conducted with abused women who also completed the Composite Abuse Scale, a validated multidimensional measure of the frequency and severity of abuse. Their study also found underreporting of abuse on the scale, particularly with regards to coercive control, threatening behaviour, restrictions to freedom and sexual abuse. This related to interpretation of abuse items and response choices, fear of answering truthfully, and an unwillingness to identify with certain types of abuse. There is a need to augment quantitative approaches to the study of DVA with

qualitative enquiry, to better understand the complexity of the phenomenon and assist with interpretation.

In the survey 11% of men reported both experiencing and carrying out negative behaviour which suggests that knowledge of services of victims and perpetrators is necessary amongst health care practitioners. It is important for health practitioners to understand that a wide range of mild to severe acts of violence and situations of unilateral and bidirectional DVA can occur in gay men (Stanley et al. 2006). Orliffe et al. (2015) suggest that gay men normalise violence as being characteristic of a close and turbulent relationship, but also normalise and conceal physical and mental injuries as part of being a strong man that can withstand the abuse. Furthermore, that the discourse around masculine aggression used to rationalise mutual aggression, obscures the boundary between victim and perpetrator, which creates a barrier to men seeking help from victim support services. In our interviews, all men interpreted the open ended question on views of routine enquiry for DVA in the context of victimisation experiences and none offered views on enquiry for perpetration. Further research is needed to explore how enquiry for DVA might incorporate both victimisation and perpetration experiences.

With regards to our secondary aim, the use of a mixed methods approach enhanced our understanding of gay and bisexual men's preferences for support from health practitioners in relation to enquiry for DVA. This generated new knowledge, which has important implications for public health and clinical policy, contributing to the evidence base needed to develop an effective health care response to male patients who experience or perpetrate DVA. Integration of quantitative and qualitative data at the level of reporting and interpretation helped to contextualise men's preference for selective enquiry for DVA.

Although the survey found that very few men had ever been asked about DVA by a health practitioner, the majority supported the practice of health practitioners asking about relationship abuse. The interviews clarified the conditions that would best facilitate interventions in sexual health service and the reasons underpinning men's preferred method of enquiry. Important contextual factors were identified such as the most appropriate time to ask about abuse during consultations, the most appropriate practitioner to ask, as well as how to initiate a conversation about partner abuse and ask questions sensitively. A third of men in the survey supported routine enquiry for DVA, whilst two thirds preferred selective (i.e. asking in the context of symptoms or conditions that are consistent with experiences of DVA). Support for the practice of routine enquiry about DVA in our sample of gay and bisexual men is lower compared to studies eliciting women's views (Feder et al. 2009). However, the results are comparable to a general practice survey of heterosexual men's views of enquiry for DVA by health practitioners in which 65% of men supported selective enquiry (Morgan et al. 2014). Possible reasons include prior negative experiences with formal organisations which can play a significant role in gay and bisexual men's decision to remain silent about abuse, homophobic discrimination and fears that disclosure will result in them being "outed" (Donovan and Hester, 2006). Men's preference for selective enquiry for DVA can also be understood within the social construction of masculinities which discourage men from talking about emotional problems (Gascoigne & Whitear, 1999; Moynihan, 1998).

Sexual health clinics were regarded as favourable settings in which to discuss DVA with gay and bisexual men. Men regularly attend for check ups as well as for symptom-related visits and health practitioners are accustomed to discussing sensitive issues including sexual risk behaviours. However, men in long-term relationships may not access sexual health services frequently, thereby reducing opportunities for them to seek help for partner abuse. Health

advisors were identified as the best placed practitioner to ask about DVA because they provide counselling in relation to risk behaviours such as unsafe sex and alcohol and substance abuse and depression, all of which can co-occur with DVA (Buller et al. 2014a).

Furthermore, they have time to develop a trusting relationship with patients which can facilitate disclosure of abuse, a finding which has been reported in a Canadian study of a screening protocol for intimate partner violence in an HIV clinic (Raissi et al. 2015).

Men felt that enquiry for DVA should not take place without available resources which could potentially be provided by the clinic. For example, having a link to a local DVA organisation with an identified advocate for the clinic, a model that has been successfully employed in UK general practice settings with women affected by DVA (Feder et al. 2011) and in a US community health centre for LGBT people (Basham et al. 2015). Alternatively, health advisors can be skilled-up to be the initial point of referral and link to other services. Within the health setting this may require referral to mental health or drug and alcohol teams, HIV services or Sexual Assault Referral Centres. Outside of the health setting, staff with additional DVA training should have knowledge of local and national organisations that offer support to LGBT people who are experiencing and/or perpetrating DVA. Displaying posters and leaflets in clinic waiting rooms will promote the message that health practitioners view DVA as a health issue and are able to support.

Health services need to commission training for health practitioners to increase their awareness of DVA that occurs in the LGBT community and the specific challenges they encounter when seeking help. Training should also support health practitioners in developing communication skills and client trust that enable them to make sensitive enquiries when they suspect that a patient may be abused. The majority of tools that are currently used to assess

for DVA have been developed for use with heterosexual women. Stephenson and colleagues (2013) developed a 6-item tool for gay and bisexual men and recommend that its acceptability and feasibility be tested in health care settings. In our study, a pilot training intervention for sexual health practitioners was implemented in the LGBT clinic to promote identification, documentation and referral of male patients experiencing or perpetrating DVA. As a result of the training, practitioners reported increased awareness of the issue and confidence in asking men about abuse (Buller et al. 2014b).

Our study has a number of limitations and the findings should be interpreted within the context of this particular sexual health service. It was not possible to sample purposively for the semi-structured interviews, which may have generated a more diverse group of men in relation to severity of abuse, victimisation, perpetration, and socio-demographic characteristics. Additionally, the study may have excluded gay and bisexual men in long-term relationships who do not make frequent use of sexual health services, whose views may have differed to those presented. The semi-structured interviews were conducted by female researchers and male researchers may have elicited qualitatively different data. However, given men's views about feeling more comfortable discussing DVA with female health practitioners, it is possible that the use of female researchers enhanced the quality of the data. Lastly, integration of qualitative and quantitative findings regarding abuse experiences suggest that the survey results are most likely an under-estimate of the occurrence of DVA.

Integration in mixed methods research can be challenging and careful planning is necessary to determine how it can be used at various stages of the research process to achieve greater leverage (Fetters & Freshwater, 2013). We propose that further mixed methods research is needed to develop and test gender sensitive interventions for gay men that move beyond

heteronormative discourses of victim and perpetrator and reflect gay men's constructions of their relationships and of DVA.

Table 1: Socio-demographics

Socio-demographics	Health and Relationships Survey N=522			Semi-Structured Interview N=19	
	N	%	95% Confidence Interval	N	%
Mean Age Range	35 (range 18 – 75)			39 (range 21 – 57)	
Ethnicity					
White	416	80.8	77.1% - 84.3%	17	89.5
Mixed	30	5.8	4.0% - 8.2%	0	-
Asian/Asian British	17	3.3	1.8% - 5.0%	1	5.3
Black/Black British	27	5.2	3.5% - 7.2%	0	-
Other	25	4.9	2.9% - 6.8%	1	5.3
Highest qualification					
No education	12	2.3	1.2% - 3.7%	2	10.5
¹ GCSE/O Levels	32	6.2	4.1% - 8.5%	0	-
² NVQ	11	2.1	1.0% - 3.6%	1	5.3
³ A Levels	59	11.5	8.4% - 14.1%	3	15.8
Professional qualification	41	8.0	5.8% - 10.8%	1	-
Bachelor degree	189	36.7	32.5% - 41.0%	6	31.6
Postgraduate degree	17	33.3	29.1% - 37.8%	5	26.3
Paid employment					
Yes	464	92.4	90.1% - 94.5%	18	100.0
No	38	7.6	5.3% - 9.8%	0	-
⁴Has a current partner					
Yes	244	47.3	43.0 – 52.1	-	-
No	272	52.7	47.0 – 57.0		

¹ General Certificate of Secondary Education (GCSE) and Ordinary Level are academic qualifications of UK examination boards conferred on students

² National Vocational Qualification (NVQ) is a work based award in England, Wales and Northern Ireland achieved through assessment and training

³ Advanced Level (General Certificate of Secondary Education A Level) is an academic qualification of UK examination boards conferred on students

⁴ A specific question on current partner status was not asked in the semi-structured interviews. However, men's accounts of DVA included information about whether the abuse pertained to a past or current relationship.

Table 2: Joint display demonstrating cross case comparison of negative and abusive behaviour reported in the interview and survey

Case	Interview reports of behaviours experienced from a partner	Survey reports of behaviours experienced				Interview reports of behaviours carried out towards a partner	Survey reports of behaviours carried out				Meta inferences
		Frightened	Permission	Physical	Forced sex		Frightened	Permission	Physical	Forced sex	
A	None	N	N	N	N	None carried out	N	N	N	N	
B	None	N	N	N	N	None carried out	N	N	N	N	
C	None	N	N	N	N	None carried out	N	N	N	N	
D	None	N	N	N	N	None carried out	N	N	N	N	
E	None	N	N	N	N	None carried out	N	N	N	N	
F	None	N	N	N	N	Stated he had “a lot of hot air” could be “all arms, shouting and quite vocal”, which has frightened his partner, but he has never been physical to anybody.	N	N	N	N	Behaving in a manner that causes fear, may not be defined as abusive compared to acts of physical violence, which may explain negative reporting on the survey.
G	Ex-partner had “temper tantrums” and was jealous. Pots and pans were thrown around him which caused him to be frightened. Relationship could be “physically bolshie” after alcohol. Reported that he kept the peace by not reacting.	N	N	N	N	In a different relationship he described becoming angry with his partner who cheated on him. “It got bad, it got very bad, a lot of screaming, yelling and a fair amount of pushing”.	N	N	N	N	Survey items do not reflect the behaviour experienced (e.g. temper tantrums, objects thrown around) or less severe acts of physical aggression that were carried out (e.g. pushing/shoving). Implies a need to include specific items on throwing objects directly at or near to a partner and impact questions about intent to cause harm or fear.
H	Current partner threw objects at him. Described it as “mild”, “hardly any level on the abuse scale”. He said he changed his behaviour to keep the peace.	N	N	N	N	None carried out	N	N	N	N	Survey items do not reflect the behaviours experienced (e.g. having objects thrown). Men in current abusive relationships may be more prone to minimising abuse experienced due to fear, shame or a lack of recognition that behaviours might be abusive. This may also contribute to negative reporting in surveys.
I	None	N	N	N	N	Reported throwing things at ex-partner (e.g. chairs) who “knew what buttons to press” to make him angry. Was “frightened” of his own behaviour and how he might react (“I had to hold myself back”). Was verbally abusive and once felt like hitting his partner, but describes behaviours as “just aggression in the house” and “par for the course”.	N	N	N	N	Minimisation and normalisation of less severe forms of aggressive behaviour and verbal abuse towards a partner, may partially explain negative reporting on survey items. Survey items may not accurately reflect men’s experiences. Implies a need to include specific items on throwing objects directly at or near to a partner and impact questions about intent to cause harm or fear.
J	Reported feeling belittled by ex-partner (e.g. being told he was young and naïve), but did not consider it to be abuse.	N	N	N	N	Felt jealousy and insecurity with an older, more educated ex-partner. Demanded to know which friends his partner was seeing and what they were doing. His partner stopped seeing and talking about certain friends in order to keep the peace.	N	N	N	N	Under-reporting of controlling behaviour on the survey item (i.e. requiring a partner to seek permission to see friends) which does reflect behaviours described in the interview.
L	Described ex-partner as “abusive” (e.g. insults, being put down).	N	N	N	N	Described a different past relationship in which he was “extremely jealous”, “I beat him more than once, I hit him with my fists...I’d break something or just punch him”.	N	N	N	N	Survey items do not reflect behaviours experienced (e.g. verbal insults, belittling). Men may be reluctant to report perpetration of severe abuse in surveys as the behaviours described are captured by the survey item.

Case	Interview reports of behaviours experienced from a partner	Survey reports of behaviours experienced				Interview reports of behaviours carried out towards a partner	Survey reports of behaviours carried out				Meta inferences
		Frightened	Permission	Physical	Forced sex		Frightened	Permission	Physical	Forced sex	
M	Described ex-partner as angry and verbally abusive. The behaviour affected his self-esteem and he stopped seeing friends, but he did not feel unsafe or fearful.	N	N	N	N	Felt concerned about his own behaviour towards an ex-partner and described “ <i>pushing him quite hard into a wall</i> ”. Was also “ <i>verbally abusive</i> ”.	Y	N	N	N	Additional survey item needed to capture verbal abuse, and pushing and shoving, as well as impact questions about intent to cause harm or fear and feeling unsafe.
N	Stated his current partner “ <i>may</i> ” have kicked him and “ <i>probably</i> ” had punched or slapped him.	N	N	N	N	Reported throwing or kicking objects (e.g. the TV) on to the floor during arguments and kicking his partner. Said his partner was scared (“ <i>he would freeze</i> ”), but said his behaviour was “ <i>not menacing, not violent</i> ”.	Y	N	N	N	Men in current abusive relationships may be more prone to minimising abuse experienced out of fear, shame or a lack of recognition that behaviours might be abusive. This may contribute to under-reporting in surveys. The ability to recognise the impact of aggressive behaviour towards a partner may be an important aspect in disclosing perpetration.
O	Ex-partner pushed him through a window, resulting in him being hospitalised for two weeks with injuries. Described him as jealous (“ <i>going through my phone messages</i> ”). Ex-partner also pushed wood and matches through his letterbox when he ended the relationship. Stated there “ <i>was never an issue with sex</i> ”.	Y	Y	Y	Y	None	N	N	N	N	Men may experience more difficulties in disclosing experiences of sexual violence in a face-to-face interview compared to an anonymous survey.
P	Ex-partner with mental health problems was “ <i>verbally abusive</i> ”, drove both of them in a car at high speed threatening to end his life, which scared him.	Y	N	N	N	Said he could be “ <i>passively aggressive and controlling</i> ”, but examples provided were not abusive (e.g. decisions about fixing up the flat).	N	N	N	N	Additional survey item needed on verbal abuse and insults.
Q	Ex-partner was very jealous, would shout at him in public. He tried to keep the peace by acquiescing to his partner’s decisions.	Y	Y	N	N	During an argument he threw his trainers at his ex-partner. His partner told him he was “ <i>very scared</i> ”.	N	N	N	N	Survey items may not accurately reflect men’s experiences. Implies a need to include specific items on throwing objects directly at or near to a partner and impact questions about intent to cause harm or fear.
R	Ex-partner would force him to have sex and hit him.	Y	N	Y	Y	None	N	N	N	N	
S	Ex-partner would use violence when drunk.	Y	N	Y	N	Said that he has never hit a partner, but only pushed them away.	Y	N	N	N	Men may only report only the consequence of their behaviour towards a partner (i.e. causing fear) rather than the specific behaviour (i.e. pushing) in surveys. This may be a form of minimising.
T	Early in the relationship, ex-partner exhibited “ <i>mental anger</i> ”, was “ <i>quite verbal</i> ” and “ <i>just a slap</i> ”. The behaviours escalated and, ex-partner was verbally abusive, threw things, punched him and hit him around the head. Had to go to casualty and had two black eyes. However, he stated that negotiating sex “ <i>was not an issue</i> ”.	Y	N	Y	Y	Described “ <i>shutting down</i> ” on his partner and “ <i>not communicating</i> ” with him, stating it could have been a form of “ <i>mental abuse</i> ”. Whilst his partner perceived it to be mental abuse, he felt unsure.	N	N	Y	N	Men may experience more difficulties in disclosing experiences of sexual violence in a face-to-face interview compared to an anonymous survey. Conflicting ideas may exist in relationships about what constitutes psychological abuse which are not easily captured in surveys. In this case, under-reporting of perpetrating physical abuse occurred in the interview rather than the survey.

Table 3: Logistic regression to examine association between socio-demographics and abuse status on views about enquiry for DVA by a health professional

Socio-demographic characteristics and abuse status	Views on routine enquiry for DVA by health professionals			
	Ask some patients n (%)	Ask all patients n (%)	Adjusted Odds Ratio	95% Confidence Interval
Mean Age SD Range	35.1 9.2 19-75	33.7 9.5 18-66	1.0	0.96 - 1.01
White White Other ethnic group (reference)	273 (67.2) 47 (52.8)	133 (32.8) 42 (47.2)	0.6	0.40 – 0.88
Graduate and above Graduate/Postgraduate/Professional None, GCSE, A Level, NVQ (reference)	255 (65.6) 66 (61.7)	134 (34.5) 41 (38.3)	0.9	0.46 – 1.60
In paid employment Yes No (reference)	285 (65.2) 37 (58.7)	152 (34.8) 26 (41.3)	1.0	0.28 – 3.48
Currently has partner Yes No (reference)	151 (64.8) 167 (63.7)	82 (35.2) 95 (36.3)	1.0	0.59 – 1.83
Ever experienced negative behaviour from a partner Yes No (reference)	93 (56.0) 229 (68.4)	73 (44.0) 106 (31.6)	1.6	0.72 – 3.52
Ever carried out negative behaviour towards a partner Yes No (reference)	47 (59.5) 273 (65.6)	32 (40.5) 143 (34.4)	1.0	0.80 – 1.19

Based on 474 observations.

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