



Examining men as victims of intimate partner violence in a French forensic department



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ABSTRACT

Objective: Intimate partner violence (IPV) is a particular type of interpersonal violence, in which violence is performed between individuals involved in an intimate relationship. Johnson developed a typology in which he differentiates common couple violence (CCV) from intimate terrorism (IT). We led a descriptive review of the cases of men treated at the victimology unit of the forensic department of Nancy for IPV-related abuse.

Method: We retrospectively investigated our database to extract every file of male patient treated at the victimology unit of the forensic department of Nancy (France) from 2014 to 2019 for IPV-related abuse. We studied several parameters relating to the protagonists and their relationship, the violence endured, and the statements made during the forensic consultation. An attempt to perform Johnson's typology was made.

Results: We had a total of 226 consultations. The age of the patients ranged from 18 to 88 years old. Almost all patients experienced physical violence. Psychological violence was noted in 138 files. Concerning Johnson's typology, we identified 92 cases consistent with the definition of CCV and 46 cases compatible with IT.

Conclusion: Male victims of IPV are now backed by an ever-growing corpus of studies that sheds an opportune light upon this challenging topic. Sadly, too many remain discredited and unaccounted for. We believe that escaping a gender-opposing conception in favor of a global understanding of this phenomenon would be of benefit to both men and women.

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1. Introduction

Intimate partner violence (IPV) is a particular type of interpersonal violence in which violence is performed between individuals involved in an intimate relationship. It is considered a major health problem in many countries, including France, where the estimated number of individual victims of IPV per year is 302,000, 83,000 (28%) of which are men [1]. In 2019, a three-month French national symposium ("Grenelle des violences conjugales") was held, during which numerous stakeholders expressed the

government's will to work to eliminate IPV. Various types of violence should be considered with physical, psychological, and sexual being the most significant areas, but others, such as economic, should not be disregarded [2,3].

The involvement of each gender in IPV is a controversial subject. On the one hand, some authors affirm that women are as likely as men to be violent towards their partner and postulate that this violence should be viewed as a chief component of a more global pattern labelled "family violence" [4,5]. On the other hand, many authors assure us that IPV is overwhelmingly committed by men towards women and is a result of the ruling patriarchy that characterizes most societies; this view is supported by the "violence against women" theorists [6,7]. Johnson suggested that considering the population in which the study is conducted is essential to correctly interpreting IPV. He developed a typology through which he differentiates *common couple violence* (CCV) from *intimate terrorism* (IT) [8]. The first is defined as an outburst of violence during an

Abbreviations: IPV, Intimate partner violence; CCV, common couple violence; IT, intimate terrorism; VR, violent resistance; MCV, mutual control violence

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argument caused by a malfunction in the management of conflicts that may be equally initiated by men or women. The second is a situation wherein one of the partners tries to control the other by means of diverse coercive behaviors (e.g., stalking, establishing financial dependency, restraining access to friends and relatives, and, of course, physical violence) and, according to Johnson, is performed in the vast majority of cases by men. He then noted that CCV is a phenomenon observed in the general population and described by the “family violence” theorists, while IT is another phenomenon usually studied by the “violence against women” supporters. Later on, Johnson extended his typology by adding two derivatives of IT: violent resistance (VR) occurs when an individual suffering IT retaliates without the intent to gain control and, as a consequence, would be predominantly endured by men—whereas mutual control violence (MCV) can be portrayed as two intimate terrorists fighting for control over the relationship [9].

Nonetheless, the IPV literature mainly focuses on women as victims [6,7,10], so knowledge about male victims remains scarce. In particular, few studies about men resorting to a forensic medicine department have been conducted [11–14]. In France, forensic departments deal with victims of assault, mistreatment, or accidents upon the request of the police or gendarmerie, which are both law enforcement agencies; basically, the police take action within a town area (more than 20,000 inhabitants), while the gendarmerie operates in rural areas (fewer than 20,000 inhabitants). Forensic doctors assess the physical and psychological impact of an attack, its consistency with the victim’s statement (regarding dating for instance), and its quantification via the “total incapacity to work” (*incapacité totale de travail* = ITT, a typical French concept reflecting the time during which the victim’s ability to execute most daily life activities is heavily hindered due to the sustained violence). This ultimately helps the magistrate better estimate the harm produced and deliver a proper condemnation to the perpetrator. As such, the forensic department is a central operator of the judiciary process and a mandatory step in the care of an IPV victim.

In these circumstances, we led a retrospective, descriptive review focusing on the cases of men examined at the victimology unit of the forensic department of Nancy (France) for IPV-related abuse, with the aim of describing their characteristics and then discussing them in light of those recorded in other European forensic departments.

2. Material and methods

We retrospectively investigated the database storing the file of every patient treated at the victimology unit of the forensic department of Nancy (France) from 2014 to 2019; this period corresponds to the period from the commissioning of the software managing its activity (MIGALE) to the present day. Such files hold information provided by secretaries, nurses, and forensic doctors—in particular, the medical certificate written at the end of the consultation.

As we focused on male patients who consulted for IPV-related abuse, we recovered the files encoded in MIGALE with the items “male” and “intimate partner violence.” Expecting the possibility of the same patient being treated multiple times, we distinguished between “constitutional” data that represent the characteristics of the protagonists and their relationship and “case-related” data that describe the context of the case. “Constitutional” data included the age of the patient, his birth country, his professional status, the sex of the abuser, his marital status with the abuser, the duration of the relationship, the existence of children born within the relationship, a history of previous physical violence, the time of onset of the violence, and a history of alcohol and/or drugs abuse by the assaulter. “Case-related” data included the place and time of the assault (morning: 06:00–12:00, afternoon: 12:00–18:00, evening: 18:00–00:00, night: 00:00–06:00); if the protagonists were living

together at the moment of the latest assaults; any physical, psychological, sexual or economic violence mentioned in the file that would have been perpetrated by the abuser; the existence of secondary assaulters and/or witnesses; resorting to a caregiver and the subsequent necessity of treatment, such as surgical acts (including stitches), dressings, plastering, advanced medication, and psychological support but not radiologic investigations and grade-I analgesics; the time interval between the latest aggression and the forensic consultation; the law enforcement agency (police or gendarmerie) in charge of the affair; the injury outcome and its topographic distribution at the moment of the forensic consultation and/or mentioned in the certificate of earlier caregivers; the psychological impact on the victim assessed by the forensic practitioner; a context of custody during the consultation; and, ultimately, the “total incapacity to work” prescribed.

We also attempted to determine which of Johnson’s IPV types the case could be regarded as based on the existence and severity of coercive behaviors, the chronicity of the abuse (not reported here due to a rather vague appraisal), and the overall impression produced after the examination of the consultation file.

2.1. Statistical analysis

According to their nature and distribution, data were expressed as frequencies (%) or as medians [IQR]. Normality was analyzed with the Kolmogorov-Smirnov test. Characteristics of the patients and characteristics of the aggressor were presented individually (215 subjects), whilst the circumstances and proceedings of the aggression and information regarding the forensic consultation were presented by the consultations (226 consultations). The Chi-squared test was used to analyze the possible association between the variables.

3. Results

We recovered a list containing 315 consultations. We dismissed 38 of them as wrongly encoded and another 51 as non-exploitable. In the end, we had a total of 226 consultations accounting for 215 individuals (11 individuals consulted twice). These files represent 11.39% of the IPV files, 2.68% of the male files, and 1.27% of the total files registered.

The period covered by our study ranges from the beginning of 2014 to mid-February 2019. The yearly distribution of the number of consultations shows an overall increase from 46 in 2015–59 in 2018. The mean monthly distribution varies from 15 in May, July, and August to 27 in June, without demonstrating any obvious trend.

The characteristics of the studied population are displayed in Table 1. The age of the patients ranged from 18 to 88 years old, the average being 39.85 years and the median 38. The most sizable age group comprised individuals from 30 to 39 years old. Most patients were born in France ($n = 182$; 84.7%). Of the 138 files provided, 103 patients (47.9%) were employed.

Four patients (1.9%) were assaulted by a partner of the same sex. The most reported type of relationship was marriage ($n = 86$; 40%). For 133 couples, most of the relationships lasted for at least one year. Of 148 couples, 103 had children (47.9%). Only 17 consulted after being physically assaulted for the first time (7.9%). A story of excessive alcohol and/or drugs consumption by the aggressor was identified in 23 certificates (10.7%).

Data on the aggressions and their subsequent medical repercussions are displayed in Table 2. The aggressions mostly occurred at home ($n = 94$; 41.6%)—in particular the common residence ($n = 66$; 29.2%)—and in the evening ($n = 51$; 22.6%). Almost all patients experienced physical violence ($n = 216$; 95.6%); more than half of them ($n = 116$; 51.3%) reported “blows” using natural weapons, especially punches ($n = 70$; 31%), whilst scratches ($n = 51$; 22.6%) and

Table 1
Characteristics of our patients and their aggressor (N = 215).

AGE OF THE PATIENT	(n = 215; 100%)
Mean (years)	39.85
Median (years) [IQR]	38.0 [30.0;48.0]
[18–29 y/o]	50 (23.3%)
[30–39 y/o]	63 (29.3%)
[40–49 y/o]	56 (26%)
[50–59 y/o]	32 (14.9%)
> 60 y/o	14 (6.5%)
BIRTH COUNTRY OF THE PATIENT	(n = 214; 99.5%)
France	182 (84.7%)
• Including Overseas Department	4 (1.9%)
Other countries	32 (14.9%)
PROFESSIONAL STATUS OF THE PATIENT	(n = 138; 64.2%)
Employed	103 (47.9%)
Unemployed	24 (11.2%)
Student	2 (0.9%)
Retired	9 (4.2%)
SEX OF THE AGGRESSOR	(n = 215; 100%)
Woman	211 (98.1%)
Man	4 (1.9%)
PARTNER'S STATUS	(n = 210; 97.7%)
Married	86 (40%)
Divorced	12 (5.6%)
Common-law partner	55 (25.6%)
Ex-common-law partner	51 (23.7%)
“Civil union pact” ^a partnership	1 (0.5%)
Ex “civil union pact” ^a partnership	4 (1.9%)
Adulterous partner	1 (0.5%)
RELATIONSHIP LENGTH	(n = 133; 61.9%)
< 1 year	15 (7%)
[1–10 years]	71 (33%)
> 10 years	47 (21.9%)
CHILDREN BORN OF THE RELATIONSHIP	(n = 148; 68.8%)
Yes	103 (47.9%)
No	45 (20.9%)
FIRST PHYSICAL VIOLENCE EPISODE	(n = 123; 57.2%)
ONSET OF THE VIOLENCE	
Since the beginning	22 (10.2%)
In the course of the relationship	66 (30.7%)
After breaking up	35 (16.3%)
SUBSTANCE USE BY THE AGGRESSOR	(n = 23; 10.7%)
Alcohol	21 (9.8%)
Drugs	6 (2.8%)

^a The “union civil pact” is a legal provision of civil partnership with more flexible clauses compared to marriage. Total might not amount to 100% due to some data leaking.

slaps (n = 48; 21.2%) were also often reported. Other mechanisms included biting, pushing, strangling, grabbing, blunt and sharp trauma with an object, throwing an object, tearing off clothes, a necklace, etc., liquid spraying, and spitting. Psychological violence was noted in 138 files (61.1%) and mainly exerted through verbal assault (n = 113; 50%), such as insults and humiliations, shouts, and threats. Coercive behaviors such as harassment, involving children in the conflict, deteriorating goods, economic violence, and confinement were also reported. Only two patients reported sexual coercion. The presence of at least one additional aggressor was mentioned in 19 certificates (8.4%). Exposure of children to the abuse was specified in 43 certificates (19%). Prior to the forensic consultation, 81 patients (35.8%) saw a doctor, usually from an emergency service (n = 46; 20.4%). Medical or psychological care was requested in 33 cases (14.6%).

Data on the forensic examination are displayed in Table 3. In 177 cases (78.3%), the forensic consultation occurred within 10 days of the last aggression. The police intervened slightly more often (n = 132; 58.4%) than the gendarmery (n = 93; 41.2%). Consecutively to the attack, pain was declared in 112 certificates (49.6%). Injuries consisted predominantly of abrasions (n = 108; 47.8%), ecchymosis or hematoma (n = 65; 28.8%), and open wounds (n = 36; 15.9%); edema, functional deficit, fractures, and burns were noted, while 48

Table 2
Circumstances and proceedings of the aggression (N = 226).

PLACE OF THE ASSAULT	(n = 133; 58.8%)
Common residence	66 (29.2%)
Victim's residence	20 (8.8%)
Aggressor's residence	8 (3.5%)
Public road	31 (13.7%)
Other private places	8 (3.5%)
TIME OF THE ASSAULT	(n = 102; 45.1%)
Morning	17 (7.5%)
Afternoon	25 (11.1%)
Evening	51 (22.6%)
Night	9 (4%)
LIVING TOGETHER	97 (42.9%)
PHYSICAL VIOLENCE ALLEGED	(n = 216; 95.6%)
Blows by natural weapons	116 (51.3%)
• Including punches	70 (31%)
• Including kicks	37 (16.4%)
• Including headbutts	7 (3.1%)
Scratching	51 (22.6%)
Slapping	48 (21.2%)
Blunt-object trauma	34 (15%)
Sharp-object trauma	25 (11.1%)
Shoving	22 (9.7%)
Biting	22 (9.7%)
Strangling	19 (8.4%)
Grabbing	17 (7.5%)
Throwing objects	13 (5.8%)
Falls	12 (5.3%)
Liquid spraying	7 (3.1%)
Spitting	7 (3.1%)
Tearing off clothes, necklaces, etc.	5 (2.2%)
None	10 (4.4%)
PSYCHOLOGICAL ABUSE ALLEGED	(n = 138; 61.1%)
Verbal abuse	113 (50%)
Insults and humiliations	62 (27.4%)
Threats	42 (18.6%)
• Including threats involving the use of an object	23 (10.2%)
• Including death threats	9 (4%)
Harassment	34 (15%)
• Including harassment by messaging	8 (3.5%)
Children involvement	24 (10.6%)
Breaking or deteriorating goods	22 (9.7%)
Shouts	11 (4.9%)
Economic violence	10 (4.4%)
Confinement	5 (2.2%)
SEXUAL VIOLENCE ALLEGED	2 (0.9%)
ADDITIONAL AGGRESSORS	(n = 19; 8.4%)
Family of the aggressor	12 (5.3%)
Other individual	6 (2.7%)
Child of the couple	1 (0.4%)
WITNESSES	43 (19%)
Children	19 (8.4%)
Adults	
MEDICAL COUNSELLING	(n = 81; 35.8%)
Emergency doctor	46 (20.4%)
General practitioner	35 (15.5%)
NECESSITY OF MEDICAL CARE	(n = 33; 14.6%)
Medical care	23 (11.5%)
• Including surgical acts	17 (7.5%)
Psychologic or psychiatric care	7 (3.1%)
Hospitalization	7 (3.1%)

certificates (21.2%) stated the absence of lesion or pain. Injuries were predominantly located around the head and neck extremity (n = 162; 71.7%) and the upper limbs (n = 80; 35.4%). The psychological impact of the violence and abuse was assessed during 203 consultations (89.8%); it was present in 151 certificates (66.8%). The most reported symptoms were anxiety and sleep disorders (n = 73; 32.3% each). In 27 cases (11.9%), the consultation occurred while the patient was held in custody. Almost all certificates (n = 220; 97.3%) attributed a “total incapacity to work” lasting fewer than 8 days.

Concerning Johnson's typology, we identified 92 cases (40.7%) consistent with the definition of CCV and 46 cases (20.4%) compatible with IT. We could not categorize any case as VR or MCV.

Table 3
Information regarding the forensic consultation (N = 226).

TIME INTERVAL UNTIL THE FORENSIC CONSULTATION	
Median (days)	5
[0–3 days]	85 (39%)
[4–10 days]	92 (42.2%)
> 10 days	41 (18.8%)
LAW ENFORCEMENT AGENCY	132 (58.4%)
Police	93 (41.2%)
Gendarmerie	
GLOBAL INJURY OUTCOME	112 (49.6%)
Pain	108 (47.8%)
Abrasions	65 (28.8%)
Ecchymoses or hematomas	36 (15.9%)
Open wounds	14 (6.2%)
Functional deficits	12 (5.3%)
Edemas	7 (3.1%)
Fractures	3 (1.3%)
Burns	48 (21.2%)
None	
LESIONAL TOPOGRAPHY	162 (71.7%)
Head and neck extremity	80 (35.4%)
Superior limbs	41 (18.1%)
Anterior trunk	23 (10.2%)
Posterior trunk	37 (16.4%)
Inferior limbs	4 (1.8%)
Genitalia	
PSYCHOLOGICAL IMPACT	(n = 203; 89.8%)
Present	151 (66.8%)
None	52 (23%)
Anxiety	73 (32.3%)
Sleep disorders	73 (32.3%)
Uneasiness	23 (10.2%)
Crying	20 (8.8%)
Depressive syndrome	20 (8.8%)
Revivification episodes ^a	19 (8.4%)
Appetite disorders	16 (7.1%)
Sadness	15 (6.6%)
Ruminations	14 (6.2%)
Asthenia	13 (5.8%)
Restriction in everyday life activities	9 (4%)
Auto-destructive behaviors	4 (1.8%)
CUSTODY	27 (11.9%)
TOTAL INCAPACITY TO WORK PRESCRIPTION	1.70
Mean (days)	67 (29.6%)
0 days	153 (67.7%)
≤ 8 days	5 (2.2%)
> 8 days	
JOHNSON'S TYPOLOGY	(n = 138; 61.1%)
Common couple violence (CCV)	92 (40.7%)
Intimate terrorism (IT)	46 (20.4%)

^a clinical symptom characterized by the repetition of the traumatic experience, reactivated suddenly by a stimulus/external factor.

Through our statistical analysis, we observed that the search for medical counselling was more associated with the police than gendarmerie procedures ($p = 0.033$) and not with the presence of a significant psychological impact ($p = 0.32$). As per Johnson's typology, IT was associated with the absence of injury outcome recorded ($p = 0.04$) and the presence of a psychological impact ($p = 0.001$) but not with any law enforcement agencies ($p = 0.468$ and $p = 0.488$ for police and gendarmerie respectively) and a situation where the protagonists were living together ($p = 0.559$). CCV and non-classified consultations were not associated with any of these variables. The results of our analysis are summarized in Table 4.

4. Discussion

We encountered four studies akin to ours: two from France by Savall [11] and Thureau [12], one from Portugal by Carmo [13], and one from Germany by Wörmann [14]. We estimated that the number of files identified in this study relating to male victims of IPV might

Table 4
Statistical analysis.

	Search for medical counselling	IT cases
Police	$p = 0.033$	$p = 0.468$
Gendarmerie	–	$p = 0.488$
Presence of a psychological impact	$p = 0.32$	$p = 0.001$
No injury outcome recorded	–	$p = 0.04$
Living together	–	$p = 0.559$

be slightly undervalued due to encoding errors. The total number of IPV files (11.39%) are similar to those recorded by Savall (12.8%), Thureau (13%), and Carmo (11.5%) and, furthermore, to the percentage of victims engaging in procedures with the French forces of order for IPV matters (12%) according to the 34th note of the National Observatory of Delinquency and Penal Responses published in March 2019 [15]. Wörmann had a lower rate (6.2%) while specifying that it was lower than German official crime statistics (18%).

Our patients' mean age was just below 40 years old, which is in line with the results from Savall, Carmo, Wörmann, Ebouat [16], and others [17], who all obtained a mean age of 41 years old, whereas Thureau found a slightly lower value of 36 years old. Unsurprisingly, most males in this study were born in France ($n = 182$; 84.7%), but individuals born in a foreign country still represented a sizable proportion ($n = 32$; 14.9%).

Using the police-gendarmerie ratio as an indicator of population density, the predominance of police procedures over gendarmerie ones might indicate that our patients were predominantly of urban origin. This is consistent with Machado [18]; however, Machado found a much larger difference, possibly due to a different sizing of “urbanity.” We suggest that this could be the result of facilitated access to the services in urban areas and a more conservative mentality in rural ones—particularly regarding the traditional role assigned to each gender—that would prevent men from seeking help or simply a higher population concentration in urban areas.

Most were employed, with highly diversified profiles; we could not determine reliable data to estimate the sociocultural level. Cases of IPV by a partner of the same sex were not widely represented in our work (1.9%), which is similar to the findings of Savall, who found seven incidences of same-sex IPV among 641 males, but noticeably lower than Wörmann (8.4%).

Just as in Thureau, 40% of our patients were married to the abusive partner (although nearly half were in the process of getting a divorce), and roughly 25% were partners or ex-partners respectively. Carmo's patients were also engaged in lasting relationships (mainly between one and 15 years). Less than half of our couples were cohabiting at the time of the assaults, which is not as much as Thureau (69%) and Carmo (66%); nevertheless, this parameter has not been systematically specified and might therefore be undervalued.

A story of substance abuse by the partner was reported in slightly more than 10% of our cases, mostly in a chronic fashion. Specifically, the alcohol abuse rate in our dataset is close to Carmo's (9.8% vs. 9.3%), while our drug abuse rate is a bit higher (2.8% vs. 0.8%).

Aggressions typically occurred at home in the evening; this pattern aligns with those of Thureau, Ebouat, Wörmann, and others [19]. As such, additional attention should be taken when special circumstances like quarantine induce higher risks of seclusion with the abuser [20].

The predominant injurious mechanism was blunt trauma by means of natural weapons, as recorded by Savall, Thureau, Carmo, and Wörmann. Other mechanisms, such as biting, grabbing—especially at the level of the neck (i.e., strangling)—and shoving, were also regularly mentioned in these works. Trauma by blunt (5.2% in

Savall and 16.6% in Carmo) and sharp (12.6% in Savall and 2.3% in Carmo) objects was also likely to be encountered ($n = 34$; 15% and $n = 25$; 11.1% respectively in our study); Thureau observed the use of objects or weapons by women against men in 33% of cases and concluded there is a significant difference between the rate of use of objects or weapons by men towards women (19%). We can argue that women tend to use more often objects than men to compensate for a generally lower physical strength. Almost all weapons were unintended objects (e.g., bottles, chairs, walking sticks, or even cars regarding blunt trauma; knives, forks, or broken glass regarding sharp trauma). Only Wörmann reported one case of use of a firearm against a man. Contrary to what one might think, women might perform physical violence on a similar level and frequency to men [21].

The cervico-cephalic extremity and the upper limbs ($n = 162$; 71.7% and $n = 80$; 35.4% respectively)—i.e., the most easily accessible areas by the attacker's upper limbs—were also recognized as favored targets in Savall (61% and 57.4% respectively), Carmo (43.9% and 35.8% respectively), and Wörmann (40% concerning the upper limbs). In all five works, superficial skin lesions (i.e., abrasions, ecchymosis/hematoma, and edema) constituted the common injury outcome. Other injuries, such as fractures and burns, were also reported in Savall (2.4% and 1%, respectively). The subsequent disabilities essentially affected the musculoskeletal system, but sensory impairment (auditive and ophthalmological) was observed in the case of head trauma. Contrary to Savall, no visceral or significant vascular damage has been noted in our work. When secondary aggressors were involved, they were usually blood related to the assaulter.

In margin or intricated to physical offences, many patients described various forms of psychological violence; some of them even said they never suffered any physical harm. Some declared that they endured coercive behaviors, and 15% considered themselves to be mentally harassed. Because the forensic consultation is not suited to extensively document these abuses (due to a shortage of time or a lack of familiarity of the practitioner in this field), these rates might be underestimated. Carmo also identified a high rate of insults, humiliations, and false accusations (60.3%) and noticed several coercive behaviors, such as "threatening to use a sharp instrument" (9.8%), interpersonal control (7.4%), "stalking or spying" (6.3%), and "destruction of victim's affective objects" (5.7%); Thureau and al. pointed out insults in 20% of their cases.

Although easily overlooked, investigating psychological abuse is of primal importance since 66.8% of our certificates found a significant psychological impact (60% in Thureau and al.). Furthermore, it has been suggested to be predictive of later physical violence [22] and bears its own harmful consequences. While Hines [23] stated that IPV may cause genuine post-traumatic stress disorder (PTSD), men interviewed by Dobash [24] reported extremely varied feelings about the aggression but frequently felt unconcerned and unaffected. This is congruent with the fact that almost a quarter of our patients declared that there was no psychological impact, while some developed chronic anxious and/or depressive syndromes significantly impacting their quality of life. It has been hinted that men and women's psychological impact regarding IPV may differ [25,26] and is heavily influenced by the cultural standards in which it takes place [27].

Both cases mentioning sexual violence (one from a man, the other from a woman) were categorized as IT. Two other French studies mention a low rate of sexual aggression by an intimate partner: the National Observatory of Delinquency and Penal Responses reported that 2% of the victims of rapes by intimate partners were men [15]; Hiquet, who studied male patients who consulted exclusively for sexual aggressions, found that 2.7% were assaulted by cohabitants [28], whilst Wörmann stated that 1.2% of their patients reported sexual violence, and Thureau found none.

Generally, sexual violence seems to be more frequently endured by women than by men [12,21,29]. Being a particularly taboo topic, rapes are certain to be underreported if not specifically asked for. Plus, victims of IPV might have difficulties recognizing sexual violence since sexuality is a specific feature of intimate relationships.

Although contradictory with the idea that men are reluctant to seek help [30,31], the high proportions of medical care prior to the forensic consultation—Savall (49.9%), Carmo (39.6%), and Thureau (66%) found an even higher rate than we did (35.8%), and their patients consulted an ER service—are consistent with the context of men prone to judiciary assistance. These patients were also significantly associated with the police area (i.e., urban areas that, as we already discussed, offer easier access to health facilities). Hospitalization was needed in 3.1% of our cases vs. 2.1% in Savall and 7% in Thureau.

Consistent with Savall and Thureau, patients usually consulted the forensic department a few days after the last assault. ITT is also an indicator of the most suited jurisdiction to take over the case: in cases of voluntary violence, an infraction causing an ITT value inferior or equal to eight days would be qualified as a lower-grade offence, while superior infractions would be called an intermediate-grade offence. However, IPV being considered an aggravating circumstance, any violence committed on an intimate partner would qualify as an intermediate-grade offence. In this respect, the vast majority of our cases ($n = 220$; 97.3%) had an ITT lower than eight days, of which barely 30% were equal to zero, meaning low damage, but these should nonetheless qualify as intermediate-grade offences. Of note, the highest ITT value prescribed was six weeks. Almost 98% of Thureau's ITT cases were shorter than eight days, and 14% were equal to zero. In fact, ITT is an ambiguous and controversial concept whose assessment methods can be quite different from one center to another and is regularly challenged among forensic practitioners.

When it comes to IPV, a crucial element to be reckoned with is the exposure of children to violence. Through our study, we regularly encountered custody of the children or their management as a motive to the onset of IPV. Since an exposed child is a potential victim of mistreatment and is more likely to perpetrate and/or suffer IPV as an adult [10,32], the exposure of children to violence should readily be investigated, and, if found, psychological and social advice should systematically be contemplated.

According to Johnson's typology, men usually endure CCV or VR, but very few would face IT. Hines stated that men being victims of IT is not such an extraordinary situation [33]. Based on the data in our possession, we classified 20.4% of our cases as IT, which is obviously considerable. Despite this, this assessment should be cautiously comprehended considering the limited material on which this judgement has been built (nearly 40% of the cases could not be classified due to the dearth of data), as well as its subjectivity. Interestingly enough, one patient who attended two consultations received different classifications for each: the first was classified as CCV, the second as ITT. Aside from illustrating the difficulty of the assessment, this led us to wonder about the potential scalability of the behavior of an abuser, i.e., the conversion from one type to another (most likely in the CCV to IT direction). Exploring the dynamic aspects of Johnson's typology thus deserves further consideration.

A strong association between IT patients and the presence of a psychological impact was expected, but we were at first astonished to also observe a significant association with the absence of injury outcome observed. We argue that physical violence is merely an aspect of the IT phenomenon, and, unlike CCV, IT victims undergo several coercive behaviors that might actually be the major motive for suiting. Moreover, fear of reprisal, personal beliefs, or tight control might delay the victims from seeking external help and therefore increase the chance of missing injuries after healing.

No single case could be classified as VR—certainly not because of their non-existence but rather because a one-sided testimony does

not allow for a wholly objective grasp of the situation that would unveil IT-evocative behaviors (no patient would spontaneously admit they perpetrated it). Herein lies one huge bias within this study. On the contrary, some files mentioning mutual violence and abuse have been determined as CCV given the absence of complex controlling patterns. In fact, violence between intimate partners seems to often be bidirectional [21,27]. Forensic doctors having some rudimentary knowledge about the different types of IPV might prove useful in detecting and unveiling sensitive features relevant to the assessment of one's health state, especially mental.

Another tricky question raised regards men consulting while being held in custody: are they the actual author of the infraction, or is it part of a victimization strategy orchestrated by an abusive partner? Filing a complaint can be used as a defensive option to balance another person's complaint or accusation. Again, having a single point of view and limited investigative elements at our disposal did not always allow us to fully grasp the motives of our patients. Still, since forensic doctors are required to display neutral expertise on objective bodily injuries, so this should fortunately not be a major hindering factor to their mission—much more delicate, however, is the psychological aspect of this same mission.

Finally, we would like to underline that we worked with a particular population—that is, French men examined at the request of law enforcement officers. This limits our spectrum of victims to those who ended up filing a complaint, notably excluding those that could choose to come on their own initiative, as can be seen in other European countries such as Switzerland. Men who succumbed to fatal IPV were also not covered in this study. Therefore, this sample cannot be considered representative of the overall population.

5. Conclusion

While our study provides further material to try and discuss IPV, much remains to be said about it. Despite many discrepant results amongst studies, it appears that IPV is not as unidirectional as it is commonly depicted. Male victims are now backed by an ever-growing corpus of studies that sheds an opportune light upon this challenging topic. Sadly, too many remain discredited and unaccounted for. We believe that escaping a gender-opposing conception in favor of a global understanding of this phenomenon would benefit both men and women.

We observed some striking points of agreement with other studies conducted in European forensic centers about male victims of IPV, while other parameters remain unclear. In the end, further research should definitely focus on the psychological facets of these patients. Forensic doctors used to focus on the somatic consequences of the assaults but are now urged to conjointly proceed to a careful psychological assessment, which is particularly relevant in situations propitious to the commitment of psychological abuse, such as intimate relationships.

CRediT authorship contribution statement

N. Dumont: Investigation, Writing – original draft. **L. Martrille:** Supervision, Writing – review & editing. **E. Albuissou:** Methodology, Formal analysis. **K. Baland-peltre:** Writing – review. **E. Marchand:** Writing – review & editing.

Declarations of interest

None.

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